Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Texas Health and Human Services Commission
Docket No. A-11-12
Decision No. 2404
August 12, 2011

DECISION

The Texas Health and Human Services Commission (HHSC) appealed a September 30, 2010 determination by the Centers for Medicare & Medicaid Services (CMS) to disallow $47,923,792 in federal financial participation (FFP) for graduate medical education (GME) payments made by the State of Texas's Medicaid program to five county hospital districts (Hospital Districts).[1] Those GME payments reimbursed the Hospital Districts for costs incurred by their teaching hospitals to train medical residents during state fiscal years (SFYs) 1998 through 2001 and supplemented earlier payments made to the Hospital Districts for those years.

Texas made the supplemental GME payments for SFYs 1998 through 2001 to effectuate an August 2009 settlement agreement between HHSC and the Hospital Districts. The settlement resolved the Hospital Districts' demand that HHSC allocate to them additional Medicaid GME reimbursement for those years using a statutory formula enacted by Texas in 1997 (and repealed in 2003). The Hospital Districts demanded the supplemental payments after a sixth hospital district (Parkland Health and Hospital System) successfully sued HHSC in state court for failing to implement the statutory formula. HHSC reached settlement agreements in August 2009 to apply the statutory formula to calculate the amount of the Hospital Districts' supplemental GME payments for SFYs 1998 through 2001.

We conclude that CMS properly disallowed FFP for those supplemental payments because HHSC's claim for FFP in those payments was not filed within the two-year period specified in section 1132(a) of the Social Security Act and does not fall under any of the legally recognized exceptions to the two-year filing rule. In addition, we conclude that Texas was not entitled to FFP for the supplemental GME payments because they were not made in accordance with Texas's Medicaid plan or with an established interpretation of that plan. We also reject HHSC's contention that CMS was obligated to

[1] The five Hospital Districts are Bexar County Hospital District, El Paso County Hospital District, Harris County Hospital District, Lubbock County Hospital District, and Tarrant County Hospital District. Hospital districts are governmental units (with powers to levy taxes and issue bonds) created under title 4, subtitle D of the Texas Health and Safety Code. *Martinez v. Val Verde County Hosp. Dist.*, 140 S.W.3d 370, 371 & n.3 (Tex. 2004).

provide FFP under 42 C.F.R. § 431.250, which provides that FFP is available for certain Medicaid payments "made under a court order" or made to extend the benefit of a court order. Finally, we reject the argument was CMS was obligated to provide FFP for the Hospital Districts' GME payments because it had earlier approved FFP for supplemental GME payments to the Parkland Health and Hospital System. For these and other reasons discussed below, we sustain CMS's September 30, 2010 disallowance determination.

Legal Background

The federal Medicaid statute, found in title XIX of the Social Security Act (Act),[2] authorizes a program that furnishes medical assistance to low-income individuals and families. Act § 1901. The program is jointly financed by the federal and state governments and administered by the states. Act § 1903; 42 C.F.R. § 430.0. Each state administers its Medicaid program in accordance with broad federal requirements and the terms of its "plan for medical assistance" (State Plan), which must be approved by CMS on behalf of the Secretary of Health and Human Services (Secretary). Act § 1902; 42 C.F.R. §§ 430.10-430.16. A state with an approved State Plan is eligible to receive FFP for a percentage of the Medicaid program expenditures it makes in accordance with the State Plan. Act § 1903; 42 C.F.R. §§ 433.10(a), 433.15(a).

States submit claims for FFP on a quarterly basis using a form called the Quarterly Medicaid Statement of Expenditures (QSE). *New Jersey Dept. of Human Resources*, DAB No. 2039, at 3 (2006); State Medicaid Manual (CMS Pub. 45) (SMM) § 2500.[3] On that form the state reports actual Medicaid program expenditures made during the most recently completed calendar quarter (also known as "current quarter"). DAB No. 2039, at 3. On the same form, a state may also report "adjustments" with respect to expenditures reported on a previous QSE for some "prior quarter" (that is, a quarter prior to the "current quarter"). *Id.* Such "prior period" adjustments retroactively increase or decrease the amount of expenditures claimed by the state for the prior quarter. *Id.* With a few exceptions, a claim for FFP in a Medicaid program expenditure must be filed within two years after the quarter in which the expenditure was made. Act § 1132(a); 45 C.F.R. § 95.7.

As most other state Medicaid programs do, Texas's program helps to finance the costs of "graduate medical education" (GME), a term that refers to the medical training of new physicians by teaching hospitals and other institutions. *See* 72 Fed. Reg. 28,930, 28,932 (May 23, 2007). Although the federal Medicaid statute and regulations do not expressly authorize FFP for Medicaid GME expenditures, CMS has historically provided FFP for

[2] The current version of the Social Security Act can be found at http://www.socialsecurity.gov/OP_Home/ssact/ssact.htm.

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

those expenditures in recognition of the flexibility afforded to states in designing Medicaid service and payment systems.[4] *See Utah Dept. of Health*, DAB No. 2131, at 3-4 (2007) (and authorities cited therein).

GME programs also receive funding from the Medicare program, and, for reasons that will become apparent below, Medicare GME payment rules are relevant to this Medicaid dispute.[5] In general, Medicare "direct GME" payments are determined using a methodology mandated in section 1886(h) of the Act, which Congress enacted in 1985. Pub. L. No. 99-272, 100 Stat. 82, 171-745. Section 1886(h) is implemented in regulations initially published by CMS (then known as the Health Care Financing Administration) on September 29, 1989. 54 Fed. Reg. 40,286 (Sept. 29, 1989). During the relevant fiscal years, those regulations were codified in 42 C.F.R. Part 413.86 (Oct. 1, 1997 through Oct. 1, 2001).

Under Medicare rules, the starting point for calculating a hospital's direct GME payment is an "updated per resident amount" (PRA). 42 C.F.R. § 413.86(d)(1) (Oct. 1, 1997). The PRA is determined by dividing the hospital's Medicare-allowable GME costs during a prescribed base period by the average number of full-time-equivalent (FTE) residents working in the hospital during that period, with the quotient adjusted for inflation and other factors. *Id.* § 413.86(e). For most hospitals, the Medicare-prescribed base period is the cost reporting period beginning in federal fiscal year 1984 (October 1, 1983 through September 30, 1984). Act § 1886(h)(2)(A); 42 C.F.R. § 413.86(e)(1) (Oct. 1, 1997). The PRA is then multiplied by the hospital's "weighted" number of FTE residents during the cost reporting period for which the GME payment is to be made. 42 C.F.R. § 413.86(d)(1), (f)-(g) (Oct. 1, 1997). The product of that calculation (PRA x weighted number of FTE residents) is then multiplied by the hospital's "Medicare patient load" (the percentage of the hospital's inpatient days attributable to Medicare patients). *Id.* § 413.86(d)(2).

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[4] In 2007, CMS issued a proposed rule to eliminate federal payments for direct GME payments by state Medicaid programs. 72 Fed. Reg. 28,930 (May 23, 2007). Congress subsequently imposed moratoria on further action on the proposed rule. Pub. L. 110-28 § 7002(a)(1)(C), 121 Stat. 187; Pub. L. No. 110-252, § 7001(a)(1), 122 Stat. 2387. Although these moratoria have expired, CMS has taken no action to finalize the proposed rule.

[5] Unlike the Medicaid statute, the Medicare statute (title XVIII of the Act) expressly requires payments to support GME. Act § 1886(h)(1). Medicare and state Medicaid programs recognize both "direct" and "indirect" GME costs. *See* 72 Fed. Reg. at 28,931-28,933. Only direct GME costs are at issue in this case.

Case Background[6]

HHSC administers Texas's Medicaid program. *See* Tex. Ex. 4, at 3 n.4. During some of the years implicated by the disallowance, the program was administered by the Texas Department of Health under an agreement with HHSC. *Id.*

Prior to September 1997, Texas's Medicaid program reimbursed the costs of a hospital's "direct medical education" through "Diagnosis Related Group" (DRG) payments made to the hospital for "inpatient hospital services" furnished to Medicaid-eligible patients.[7] *See* HD Br., Att. 2, at 1; Tex. Ex. 9, at 2 (stating that prior to 1997, GME reimbursement was included as part of a hospital's prospective DRG payment). In addition, the record shows that both prior to September 1997 – and during the state fiscal years implicated by the disallowance (1998 through 2001) – Texas determined the amount of a hospital's Medicaid GME reimbursement using a methodology modeled on Medicare's GME payment methodology.[8]

In August 1997, the Texas Department of Health (TDH) issued a rule which amended section 29.606 of title 25 of the Texas Administrative Code, to "clarify" in various ways the state's Medicaid reimbursement methodology for inpatient hospital services. 22 Tex. Reg. 8389 (Aug. 22, 1997) (amending § 29.606 as proposed in 22 Tex. Reg. 4545 (May 20, 1997)). Among other things, TDH's August 1997 rule added a new paragraph (s) to section 29.606 that dealt expressly with reimbursement of direct GME costs. *See* 22 Tex. Reg. 4347; 22 Tex. Reg. 8391.[9] As issued, section 29.606(s) stated that "Medicaid

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[6] Citations to the record of this appeal include the following: HHSC's Initial Brief dated December 16, 2010 ("Tex. Br."); Hospital District's Initial Brief dated January 21, 2011 ("HD Br."); CMS Response Brief dated March 11, 2011 ("CMS Response"); HHSC's Reply Brief dated April 13, 2011 ("Tex. Reply"); Hospital District's Reply Brief dated April 13, 2011 ("HD Reply"); and HHSC's Exhibits ("Tex. Ex.").

[7] During the period relevant to this decision, Texas's Medicaid program paid for most inpatient hospital services using a prospective payment system. *See* 22 Tex. Reg. 8389-8390; 1 Tex. Admin. Code § 355.8063 (2002). Under this system, a hospital received a predetermined payment for each inpatient admission that was calculated by multiplying a "standard dollar amount" (an estimate of the average cost of an inpatient stay at the hospital) by the value associated with the patient's Diagnosis Related Group. *Id.*

[8] *See* CMS Response, Att. 2, at 1-2 (Jan. 26, 2006 letter from HHSC to CMS stating that HHSC "historically reimbursed hospitals for inpatient direct graduate medical education costs using Medicare GME methods and procedures"); Tex. Ex. 9, at 2 (June 25, 2010 letter from HHSC to CMS indicating that from 1997 through 2001, "HHSC paid teaching hospitals using a formula based on the 'per resident amount' methodology used to calculate GME payments in the Medicare program"); Tex. Ex. 4, at 6 n.6 (Texas court of appeals decision discussing evidence that HHSC continued to use 1984 base-year cost data after September 1997); HD Reply, Att. 2, Ex. A to Conway Affidavit, at 55 ¶ 7 (stating that "[a]s of early 1997, the [Texas Department of Health], under Department rules then in effect, was using Medicare-based methodology for reimbursing Medicaid GME costs of teaching hospitals under which cost and reimbursement calculations were made using average hospital payment-per-case figures from an historical 'base year,' which was the cost reporting period of October 1, 1983 – October 1, 1984.").

[9] In 1998, section 29.606 was recodified in section 355.8063 of title 1 of the Texas Administrative Code. 23 Tex. Reg. 12,660 (Dec. 11, 1998).

allowable" GME costs – "as specified under similar methods and procedures used in the Social Security Act, Title XVIII, as amended, effective October 1, 1982, by Public Law 97-248" – would be "calculated for each hospital having inpatient direct graduate medical education costs on its tentative or final audited cost report." 22 Tex. Reg. 8391. Section 29.606(s) further provided that, effective September 1, 1999, "[p]roviders with Medicaid allowable inpatient direct graduate medical education costs" would receive "an interim monthly payment based upon one-twelfth of their inpatient direct graduate medical education cost from their most recent tentative or final audited cost report." *Id.* In addition, section 29.606(s) specified that the interim monthly GME payments would be "subject to settlement at both tentative and final audit for provider cost reporting periods covering the state fiscal year." *Id.* In promulgating the changes to section 29.606, TDH stated that it was acting pursuant to provisions of the Texas Human Resources and Government Codes which granted HHSC the authority to administer the Texas Medicaid program. *Id.* at 8390 (citing section 32.021 of the Human Resources Code and section 531.021 of the Government Code).

In May 1997, two months prior to the promulgation of section 29.606(s), the Texas legislature enacted legislation – codified in section 32.0315 of the Texas Human Resources Code – to "establish procedures and formulas for the allocation of federal medical assistance funds that are directed to be used to support graduate medical education[.]" 2 Tex. Hum. Res. Code § 32.0315(a) (1998). Of key importance here is paragraph (d) of section 32.0315. That provision directed the Texas Medicaid program to calculate a hospital's GME reimbursement using a formula – which we henceforth call the "Statutory Formula" – that is similar to the Medicare GME formula. Section 32.0315(d), and the related provisions of paragraphs (d-1), (e), and (f), stated:

> (d) The department shall reimburse each teaching hospital under this section using the following formula:
>
> $$R = GME/P \times WNP \times MD/TD$$
>
> where:
>
> "R" is the annual amount to be reimbursed;
>
> "GME" is the hospital's annual cost of training resident physicians for the fiscal year;
>
> "P" is the number of resident physicians for the fiscal year;
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> "WNP" is the weighted number of full-time equivalent resident physicians trained by the hospital during the fiscal year and reported on its Medicaid cost report, adjusted to count each full-time equivalent resident in primary care as 1.2 residents and each other full-time equivalent resident as 1.0 residents;

> "MD" means the number of patient days for the hospital for the fiscal year that are attributable to Medicaid patients; and
>
> "TD" means the total number of patient days for the hospital fiscal year.
>
> (d-1) For purposes of the calculation under Subsection (d) made to determine the amount of reimbursement for a teaching hospital for the state fiscal year ending August 31, 1998, . . . a teaching hospital's average annual cost for training residents [GME/P] shall be determined using current cost reports for the hospital. This subsection expires January 1, 1999.
>
> (e) To determine a teaching hospital's average annual cost of training residents [GME/P] for purposes of this section, the department may use the most recent Medicaid cost report submitted to the department by the hospital, or may establish alternative procedures to determine that cost.
>
> (f) The department shall make payments under this section in equal monthly installments, except that the department may make adjustments in any payment or make additional payments as necessary to ensure that each teaching hospital or other entity receives the appropriate annual amount under this section.

2 Tex. Hum. Res. Code § 32.0315(d)-(f).

Like the Medicare GME formula, the Statutory Formula called for multiplying the hospital's average per-resident-amount (i.e., the PRA) of GME training costs for the relevant cost reporting period by a weighted number of full-time residents and then by the relevant program patient load.[10] Unlike the Medicare GME rules, however, the Statutory Formula did not mandate the use of 1984 base-year cost data to determine the PRA. Instead, the Statutory Formula required or authorized Texas (depending on the relevant cost reporting period) to determine the PRA using the hospital's "current" or "most recent" cost report (or by using other, "alternative" procedures). 2 Tex. Hum. Res. Code § 32.0315(d), (d-1), (e) (1998); *see also* Tex. Ex. 4, at 7; Tex. Ex. 10, at 3.

Section 32.0135 became effective on September 1, 1997. Tex. Ex. 1, at 6. On September 23, 1997, HHSC notified CMS that it proposed to amend its State Plan. Tex. Ex. 11. The proposed amendment, identified as State Plan Amendment (SPA) 97-10, contained

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[10] The PRA in the Statutory Formula is calculated by dividing "GME" (defined as the hospital's annual cost of training resident physicians for the fiscal year) by "P" (defined as the number of resident physicians for the fiscal year).

language similar to section 29.606(s) of the Texas Administrative Code and stated in relevant part as follows:

> Reimbursement of inpatient direct graduate medical education (GME) costs. The Medicaid-allowable inpatient direct graduate medical education cost, as specified under similar methods and procedures used in the Social Security Act, Title XVIII, as amended, effective October 1, 1982, by Public Law 97-248, is calculated for each hospital having inpatient direct graduate medical education costs on its tentative or final audited cost report. . . .
>
> Those allowable inpatient direct graduate medical education costs for services delivered to Medicaid-eligible patients with inpatient admission dates on or after September 1, 1997, will be subject to the cost determination and settlement provisions as described in this subsection.
>
> No Medicaid inpatient direct graduate medical education cost settlement provisions are applied to inpatient hospital admissions prior to September 1, 1997. Providers with Medicaid-allowable inpatient direct graduate medical education costs as described in this subsection will receive an interim monthly payment based upon one-twelfth of their inpatient direct graduate medical education cost from their most recent tentative or final audited cost report. The interim payment amount as described in this subsection will not be updated during the fiscal year to reflect new tentative or final cost report settlements. These payments are subject to settlement at both tentative and final audit for provider cost reporting periods covering the state fiscal year.

Tex. Ex. 11, at 2. In its notice of the proposed amendment, HHSC stated:

> Although the department is changing the method by which GME costs are paid, there is no fiscal impact. The department is moving from a prospective diagnosis related group (DRG) system to a retrospective cost-based system; the dollars remain the same in both systems. The department is using Medicare principles, meaning per resident amount methodology, to pay for GME costs.

Tex. Ex. 11, at 1 (emphasis added).

Before CMS approved SPA 97-10, HHSC revised the amendment in response to CMS's comments. *See* Tex. Exs. 12-13. Among other changes, the final version, which had an effective date of September 1, 1997, removed a reference to GME "cost, as specified under similar methods and procedures used in" Medicare law. This reference was replaced by the phrase "payment as specified under current Medicare methods and procedures." *Compare* Tex. Ex. 11, at 2 with Tex. Ex. 2, at 1 (emphasis added). In a letter notifying Texas of its approval of SPA 97-10, CMS stated that "you [HHSC] have

adequately responded to our request indicating the State's desire to follow the current per resident amount policy imposed under Medicare's rules, and have clarified your plan language accordingly." Tex. Ex. 13, at 1.

In 2002, the Parkland Health and Hospital System (Parkland) sued HHSC (and other state actors) in Texas District Court, claiming that despite the enactment of section 32.0315, HHSC continued to calculate a hospital's GME reimbursement using "Medicare-derived formulas, procedures, and methodologies" that were "indisputably different from and in conflict with the reimbursement formula prescribed by Code Section 32.0315[.]" HD Reply, Att. 2, Ex. A, at 10 (¶19). Parkland's suit sought a declaratory judgment and injunctive relief. HD Reply, Att. 3. In a motion for summary judgment, HHSC contended that "HHSC still uses 1983-84 as the 'base year' in its GME reimbursement calculations, not the fiscal year at issue for reimbursement purposes." *Id.*, Att. 2, Ex. A, at 36. Parkland also alleged that, for fiscal years 1998 through 2001, it received approximately $72 million less from the Texas Medicaid program than it would have received had the program used the Statutory Formula to calculate its GME payments. *Id.* at 47, 56.

On April 25, 2003, the Texas District Court issued a Final Judgment in favor of Parkland. App. Ex. 3. The Final Judgment incorporated by reference an order which declared that the "procedures, formulas, and methodologies used by [HHSC] for determining reimbursement amounts, allocating, and paying Medicaid GME funds under the Texas Medicaid Program, are inconsistent with and in violation of [section] 32.0315 and are therefore invalid and of no force and effect." *Id.* at 4. The Final Judgment (which we will henceforth refer to as the "Court Order") also permanently enjoined and prohibited [HHSC] from calculating, allocating or paying Medicaid GME funds for the support of graduate medical education in connection with the Texas Medicaid program to a teaching hospital . . . other than as required by Code Section 32.0315(d) and other applicable law[.]" *Id.* In addition, the Court Order directed HHSC to "calculate all reimbursement amounts, allocations and payments of such funds based upon the formula set forth in Code Section 32.0315(d)." *Id.* at 5.

Five months after the Texas District Court issued its judgment, the Texas legislature repealed paragraphs (d) and (e) of section 32.0315. Tex. Ex. 4, at 5 n.5 (citing state legislative material). In April 2004, a Texas appellate court affirmed the District Court's judgment, holding that "former section 32.01315(d) created a mandatory formula for [HHSC] to determine the amounts of medical-education costs for the purposes of reimbursement." *Hawkins v. Dallas County Hospital District,* 150 S.W.3d 535 (Tex. App. 2004) (App. Ex. 4). In discussing what it found to be the key difference between the Statutory Formula and Medicare's GME formula – namely, the Statutory Formula's reliance on a hospital's recent or current-year GME costs instead of 1984 base-year cost data – the appellate court noted that HHSC "did not amend its rules or methodologies" after section 32.0315 took effect on September 1, 1997. 150 S.W.3d at 539.

In April 2006, HHSC and Parkland entered into a settlement under which HHSC agreed to allocate additional Medicaid GME reimbursement to Parkland for SFYs 1998 through 2001 based on the Statutory Formula. HD Br., Att. 1. Texas subsequently claimed $72.6 million in FFP for that additional reimbursement. *See* Tex. Ex. 5.

In October 2006, CMS deferred a portion of the FFP claim for Parkland's additional GME allocation, requesting "detailed documentation and explanation supporting that the cost settlements for FY 1998 to 2001 are within the scope of the Medicaid program, and that Texas's State plan, in effect during the periods at issue, authorized such payment." Tex. Ex. 5, at 2.

In April 2007, while the deferral on the Parkland FFP claim was pending, the Hospital Districts demanded that HHSC reopen their Medicaid cost reports for SFYs 1998 through 2001 and "adjust them according to the mandatory GME formula set forth in former Section 32.0315(d)." Tex. Ex. 6. The Hospital Districts asserted that their cost reports were "properly subject to reopening" and that HHSC was "compelled to apply the [Texas] District and Appeals courts' determination through the cost report process by reopening [the Hospital Districts'] cost reports for its fiscal years 1998-2001 and promptly reimbursing [them] based upon former 32.0315(d)." *Id.*

HHSC avers (and CMS does not deny) that in January 2009, CMS lifted the deferral of the FFP claim relating to Parkland's additional GME reimbursement and "fully funded the $72.6 million in FFP." Tex. Br. at 5.

In August 2009, HHSC and the Hospital Districts executed a settlement agreement, similar to the agreement with Parkland, in which HHSC agreed to allocate additional Medicaid GME reimbursement to the Hospital Districts for SFYs 1998 through 2001 based on the Statutory Formula. Tex. Ex. 7. Pursuant to the August 2009 settlement, HHSC claimed $47,923,792 in FFP for that additional reimbursement. *See* Tex. Ex. 8. The FFP claim for the supplemental GME payments to the Hospital Districts was reported as a "prior period expenditure" on Texas's QSE for the quarter ending December 31, 2009. *Id.*

After deferring that claim in April 2010 (*see* Tex. Ex. 8), the CMS Regional Office in Dallas, Texas issued a notice of disallowance on September 30, 2010, stating that Texas's claim for FFP in the Hospital Districts' supplemental GME payments did "not comport with the criteria in the approved State plan[.]" CMS Response, Att. 3.

HHSC then filed this appeal, contending that the supplemental GME payments were reasonable and consistent with the State Plan and Medicaid program requirements. Tex. Br. at 20. Shortly after HHSC filed its notice of appeal, the Board granted a request by the Hospital Districts to participate in the appeal as intervenors. The Hospital Districts subsequently filed briefs supporting HHSC's appeal. The Board held oral argument on June 17, 2010.

Discussion

1. *HHSC and the Hospital Districts received adequate notice of CMS's grounds for the disallowance.*

The Hospital Districts argued in their initial brief that the September 30, 2010 notice of disallowance failed to inform them adequately of CMS's grounds for contending that the disputed GME payments were inconsistent with the State Plan. HD Br. at 2, 6-8. The Board has held, however, that a federal agency's legal justification for the disallowance may be clarified, revised, or supplemented during a Board proceeding if the non-federal party is given an adequate opportunity to respond. *See Massachusetts Executive Office of Health and Human Services,* DAB No. 2218, at 10 n.9 (2008), *aff'd, Massachusetts ex rel. Executive Office of Health and Human Services v. Sebelius*, 701 F. Supp.2d 182 (D. Mass. 2010).

In its March 11, 2011 response brief, CMS argued that the disallowance should be sustained on the following two grounds: (1) Texas failed to file its FFP claim for the supplemental GME payments within the two-year period described in section 1132(a) of the Act (*see* CMS Response at 10-11); and (2) the supplemental GME payments to the Hospital Districts were not made in accordance with the State Plan (*id.* at 16-20). After CMS submitted its brief, HHSC and the Hospital Districts had an opportunity to respond to CMS's legal arguments in their reply briefs and at oral argument. Neither contended that it was unable to discern CMS's position in this proceeding, or that it lacked an adequate opportunity to respond. Accordingly, we find no due process violation and proceed to address the issues joined by the parties.

2. *Texas's claim for FFP in the supplemental GME payments to the Hospital Districts was filed outside the two-year filing period established by section 1132(a) of the Act, and the claim did not qualify for any of the statutory exceptions to the two-year filing rule.*

Section 1132(a) of the Act, which applies to Medicaid and other programs administered by the Secretary, provides that the federal government will reimburse a state for a program "expenditure" only if the state files a FFP claim within two years after the calendar quarter in which the expenditure was made, unless the claim meets one of the exceptions recognized in the statute. Section 1132(a), and the Secretary's regulations which implement that section (45 C.F.R. § 95.1 through 95.34), provide that the two-year filing rule does not apply to any claim for (or resulting from): (1) "adjustments to prior year costs"; (2) "audit exceptions"; or (3) "court-ordered retroactive payments." Act § 1132(a); 45 C.F.R. § 95.19(a-c). In addition, section 1132(b) provides that the Secretary "shall waive" the two-year filing rule "with respect to the filing of any claim if he determines (in accordance with regulations) that there was good cause for the failure by the State to file such claim within the period prescribed under subsection (a)." Act § 1132(b); *see also* 45 C.F.R. § 95.19(d).

Ordinarily, a state agency's expenditure for Medicaid services such as inpatient hospital services is considered made in the quarter in which any state agency made a payment to the service provider. *See* 42 C.F.R. § 95.13(b). As the Board has noted in prior decisions, CMS has long interpreted section 1132 and the Part 95 regulations to mean that *with respect to public providers* (such as the Hospital Districts), an expenditure which triggers the two-year filing period occurs when a state agency first makes or records a payment to the provider for an item of service. *New York State Dept. of Health*, DAB No. 1867, at 2, 7-8 (2003) (citing SMM § 2560.4G.1). Furthermore, under this interpretation, no new expenditure occurs when the state in the "current quarter" (for which FFP is claimed) adjusts an expenditure amount previously claimed for a service furnished by the public provider in a "prior period" (i.e., a quarter predating the "current quarter"). *New Jersey Dept. of Human Resources*, DAB No. 2039, at 9. In other words, a transaction involving a public provider that occurs in the "current quarter" does not constitute a program expenditure of that quarter when the transaction's effect is to increase the amount of a previously claimed expenditure from a prior period. *See id.* at 9-16. The Board has found this interpretation to be reasonable because it recognizes the processes by which states ordinarily compensate public providers, because it serves to "tie the federal government's share as closely as possible to the quarters a state agency actually made cash outlays to finance the provision of Medicaid services," and because a contrary interpretation would "obviate the statutory exception allowing a state to claim FFP for an adjustment to prior year costs beyond the applicable two-year filing period." *Id.* at 9-10.

The evidence shows that in October 2009, HHSC transferred funds to the Hospital Districts in satisfaction of its obligation under the August 2009 settlement agreement to allocate to them additional Medicaid GME funds. Tex. Ex. 14. If those transactions constituted "expenditures" within the meaning of section 1132 and the Secretary's regulations, as HHSC argues (Tex. Reply at 11-14), then its FFP claim for the supplemental GME payments to the Hospital Districts would be timely because that claim was filed (during the first quarter of 2010) within two years after the quarter in which the transactions occurred. CMS contends, however, that HHSC's supplemental payments to the Hospital Districts were not "new expenditures" for purposes of the timely claims requirement.

During the fiscal years implicated by the disallowance (1998 through 2001), Texas made GME payments to the Hospital Districts as part of its reimbursement for the inpatient hospital services provided to Medicaid recipients in those years.[11] Those interim GME payments were later subject to retrospective adjustment pursuant to a "final audit" or "settlement." *See* Tex. Ex. 2, ¶ (s) of State Plan provision regarding GME reimbursement (stating that eligible hospitals were to receive "interim" monthly GME payments that

[11] The monthly payments were equal to one-twelfth of the GME costs reported on the hospital's most recent tentative or final audited (annual) cost report. Tex. Ex. 2, at 2.

were later "subject to settlement . . . at both tentative and final audit"). Because the Hospital Districts sought in April 2007 to "reopen" their hospitals' cost reports for SFY 1998 through 2001 in order to seek additional GME payments in accordance with the Statutory Formula (Tex. Ex. 6), it is reasonable to infer that those cost reports had, in accordance with the State Plan, become "final" or settled prior to the requests for reopening.

We conclude that Texas's supplemental GME payments to the Hospital Districts were not new expenditures for the purpose of determining whether the FFP claim for those payments was filed within the applicable two-year period. Because the supplemental GME payments represent an adjustment to amounts for inpatient hospital services provided during the relevant cost reporting periods and claimed in "prior periods," those payments are not new expenditures that trigger a two-year filing period under section 1132(a).[12] Texas filed its FFP claim for the supplemental GME payments more than two years after the quarters in which the prior-period expenditures were made. In these circumstances, as the Board as held, the dispositive issue is whether the supplemental GME payments qualify for the two-year filing limit for an adjustment to prior year costs. *New York*, DAB No. 1867, at 20 ("[I]f the increase is not claimed within the two-year period from when an amount for that item of service was first paid or recorded, the relevant issue is whether the exception for an adjustment to a prior year cost applies.").

We further hold that Texas's FFP claim for the supplemental GME payments to the Hospital Districts was not an adjustment to prior year costs. To qualify for that exception, the adjustment must be "an adjustment in the amount of a particular cost item that was previously claimed under an interim rate concept and for which it is later determined that the cost is greater or less than that originally claimed." 45 C.F.R. § 95.4; *see also New York*, DAB No. 1867, at 8. In addition, "[t]he adjustment must be consistent with the state plan reimbursement methodology; otherwise, the rationale underlying the timely claims requirements would be undercut because any state with a retrospective system could make whatever adjustments it wanted at whatever time." *Id.* at 21. Regarding the latter criterion, the Board recently reiterated that the adjustment-to-prior-year-costs exception does not apply unless the state shows that "a subsequent adjustment to an interim rate is consistent with and contemplated by its state plan and methodology." *West Virginia Dept. of Health and Human Services*, DAB No. 2365, at 8 (2011); *see also South Carolina State Health and Human Services Finance Commission*, DAB No. 943, at 7 (1988) (holding that "[t]he exception for adjustments to prior year costs is intended to give a state a reasonable opportunity to adjust its interim rate, consistent with the methods and procedures of its established rate-setting methodology"),

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[12] HHSC relies on *Missouri Dept. of Social Services*, DAB No. 1515 (1995), in which the Board held that a supplemental payment by the state to a provider for the same service pursuant to a settlement agreement constituted an expenditure for purpose of the two-year filing rule. However, the provider in *Missouri* was a *private* entity, a fact that the Board has held distinguishes *Missouri* from cases, like the present one, involving public Medicaid providers. *See Kansas Dept. of Social and Rehabilitation Services*, DAB No. 2014, at 21-22 (2006).

aff'd, S.C. Health & Human Servs. Fin. Com'n v. Sullivan, No. 88-1313-16 (D.S.C. July 17, 1989), *aff'd*, 915 F.2d 129 (4th Cir. 1990).

While the GME payments to the Hospital Districts during 1998 through 2001 were arguably made under an "interim rate concept," the disputed "adjustments" to those payments – namely, the supplemental GME payments – were not consistent with the State Plan's cost settlement procedures in the revised SPA 97-10. The only adjustment to the interim GME payments contemplated by those procedures was one resulting from a determination of the "actual" (versus an "estimated") number of a hospital's full-time-equivalent (FTE) medical residents. Tex. Ex. 2, at 2. The State Plan did not permit an adjustment resulting from any change to the established reimbursement methodology or from any failure by Texas's Medicaid agency to implement existing statutory requirements (in section 32.0315(d)). In addition, the parties did not identify any provision of the State Plan that provides a reopening process applicable to the GME payments.

As indicated, the Hospital Districts asserted in their April 2007 demand letters that their cost reports were "properly subject to reopening," implying that the cost reports had undergone final audits or cost settlements, which the Hospital Districts now wished Texas to revisit. The letters cite no legal authority authorizing the requested reopenings.

At oral argument, the Board asked HHSC to identify its authority to reopen a hospital's final cost report. Tr. at 60. HHSC replied that it followed 42 C.F.R. § 405.1885, a Medicare regulation governing reopening of a payment or reimbursement determination by the Secretary, a Medicare program contractor, or a "reviewing entity." Tr. at 65. However, HHSC did not point to any published state regulation, administrative notice, or program policy to corroborate that representation. In addition, HHSC did not produce evidence of a decision by a responsible state official to reopen the Hospital Districts' cost reports pursuant to section 405.1885 or any state or federal law.[13] For these reasons, we conclude that Texas's claim for FFP in the supplemental GME payments to the Hospital Districts was not an eligible adjustment to prior year costs.

None of the other exceptions to the two-year period are applicable here. The history of this case plainly shows that the disallowed claim did not result from an "audit exception," which is defined as "a proposed adjustment by the responsible Federal agency to any expenditure claimed by a State by virtue of an audit." 42 C.F.R. § 95.4. The disallowed claim also did not result from a "court-ordered retroactive payment." That term is

[13] Medicare regulations permit the reopening of a prior "determination" or "decision" that is not based fraud or similar fault if the request to reopen is made no later than three years after the date of the determination or decision. 42 C.F.R. § 405.1885(b) (Oct. 1, 2008); *id.* § 1885(a), (d) (Oct. 1, 2007). To the extent that section 405.1885 could be applied (by analogy) in this context, we are unable to determine whether reopening in response to the April 2007 demand letters would have been timely. Neither the Hospital Districts nor HHSC even identified the dates of the relevant final cost settlements that the Hospital Districts sought to reopen.

defined, in relevant part, to mean a retroactive payment the State makes to an assistance recipient or an individual, under a Federal or State court order." 45 C.F.R. § 95.4 (emphasis added). That definition does not cover these circumstances because the Hospital Districts' August 2009 settlement – and the payments made pursuant to that settlement – were not court-ordered (a circumstance that we discuss more fully below in section four).

The "good cause" exception is inapplicable as well. Section 1132(b) states that the "Secretary [of HHS] shall waive the [two-year filing] requirement imposed under subsection (a) . . . if he determines (in accordance with regulations) that there was good cause for the failure by the State to file such claim within the period prescribed under subsection (a)." (Emphasis added.) The regulations at 45 C.F.R. §§ 95.22-95.34 establish the process for securing a section 1132(b) waiver from the Secretary. Section 95.25 provides that the state "should request a waiver in writing as soon as the State recognizes that it will be unable to submit a claim within the appropriate time limit." Section 95.31(a) states that a waiver request affecting only one HHS agency "should be sent to the appropriate HHS agency." And section 95.34 states that the "Secretary will make a decision after reviewing the State's request for waiver." "In view of these regulations and the underlying statute, the Board has consistently held that it lacks authority to grant a section 1132(b) waiver request in the first instance." *Connecticut Dept. of Social Services*, DAB No. 1982, at 23 (2005) (citing cases). HHSC asserts that "CMS erred in failing to grant a good cause exception in this case," and alleges that a waiver request was "incorporated in the deferral response to CMS." Tex. Reply at 18 (citing Tex. Ex. 9, at 9).

The June 25, 2010 deferral response acknowledges that "neglect or administrative inadequacy on the state's part will not bring a claim" within the good cause exception. Tex. Ex. 9, at 9. Indeed, good cause is defined in the Secretary's regulations as "lateness due to circumstances beyond the State's control." 45 C.F.R. § 95.22(a). HHSC further acknowledges that it did not request a good cause waiver prior to submitting to CMS the claims for the supplemental payments to the Hospital Districts. Tex. Reply at 18. HHSC asserted in the deferral response that its failure to make a prompt waiver request arose from its reasonable belief that CMS's January 2009 decision to lift the deferral of FFP for Parkland's supplemental GME payments implied that the two-year filing rule would not be a bar to claims related to the Hospital Districts. Tex. Ex. 9, at 10. This argument overlooks the fact that any FFP claim for supplemental GME payments to the Hospital Districts was already untimely long before CMS lifted the Parkland deferral. HHSC should have been aware, in any case, that once it reached settlements with the Hospital Districts, a timely claims waiver was required. HHSC offers no explanation of how the delay in filing the claims, much less the delay in seeking a good cause waiver to excuse late claiming, resulted from circumstances beyond its control. Certainly, HHSC points to no basis on which declining to grant a good cause exception under these circumstances is arbitrary or capricious.

We note, finally, that the purpose of the timely claims requirement is to "ensure that states submit final reimbursement requests in a timely fashion so that HHS can plan its budget." *Connecticut v. Schweiker*, 684 F.2d 979, 982 (D.C. Cir. 1982), *cert. denied*, 459 U.S. 1207 (1983). In light of that purpose, the Board has said that –

> the exceptions to the timely claims requirement are intended to cover only extreme situations and do not apply to the routine situation where a state simply did not get around to getting its data together in time to file a claim within the statutory requirements. Instead, the exceptions are intended to take care of those cases where it would be patently unfair to a state to outlaw its claim merely because of the passage of time.

West Virginia Dept. of Health and Human Services at 2 (citations and quotations omitted). In this case, Texas has not shown that the timing of the supplemental GME payments was outside of its control or that it would otherwise be patently unfair to reject its FFP claim for those payments merely because of the passage of time.

HHSC's failure to satisfy the timely claims requirement in section 1132 is a sufficient reason to sustain the disallowance. However, even if we concluded that the FFP claim for the supplemental GME payments was timely, we would sustain the disallowance for the reasons explained in the following two sections.

3. *The supplemental GME payments to the Hospital Districts were not made in accordance with the State Plan.*

Federal law provides that a state's Medicaid expenditures are eligible for FFP only if they are made in accordance with the State Plan. *See* Act § 1903(a) (authorizing FFP in the "total amount expended under the State plan as medical assistance"); 42 C.F.R. § 430.10 (indicating that an approved State Plan serves as the basis for claiming FFP in the state's Medicaid program); 42 C.F.R. § 447.253(i) (requiring a state Medicaid agency to "pay for inpatient hospital . . . services using rates determined in accordance with methods and standards specified in an approved State plan"); 42 C.F.R. § 447.257 (providing that "FFP is not available for a State's expenditures for hospital inpatient or long-term care facility services that are in excess of the amounts allowable under this subpart"); *Maine Dept. of Health and Human Services*, DAB No. 2292, at 10 (2009) (citing authorities), *aff'd,* 766 F. Supp.2d 288 (D. Me. 2011).

Effective September 1, 1997 (by adoption of SPA 97-10), and during the four fiscal years at issue (1998 through 2001), the section of the State Plan governing Medicaid reimbursement for inpatient hospital services stated in relevant part:

> The Medicaid-allowable inpatient direct graduate medical education payment, as specified under current Medicare methods and procedures, is calculated for each hospital having inpatient direct graduate medical education costs on its tentative or final audited cost report. . . .

> Those allowable inpatient direct graduate medical education costs for services delivered to Medicaid-eligible patients with inpatient admission dates on or after September 1, 1997, will be subject to the reimbursement and settlement provisions as described in this subsection.
>
> Providers with Medicaid-allowable inpatient direct graduate medical education costs as described in this subsection will receive an interim monthly payment based upon one-twelfth of their inpatient direct graduate medical education cost from their most recent tentative or final audited cost report. The interim payment amount as described in this subsection will not be updated during the state fiscal year to reflect new tentative or final cost report settlements. These payments are subject to settlement (actual vs. Estimated number of FTEs) at both tentative and final audit for provider cost reporting periods covering the state fiscal year.

Tex. Ex. 2 (emphasis added). CMS contends that Texas's supplemental GME payments to the Hospital Districts were "beyond the scope of" this provision. CMS Response at 16-20. CMS asserts that the State Plan expressly required Texas to apply Medicare GME methodology – as set forth in section 1886(h) of the Act and the regulations that implement that section – to calculate its Medicaid GME payments. *Id.* Despite that explicit requirement, says CMS, Texas determined the amount of the Hospital Districts' supplemental GME payments by applying the Statutory Formula, which, according to CMS, deviated in significant ways from Medicare GME methodology. *Id.* at 19-20. Most notably, CMS argues, Texas used SFY 1998 costs instead of 1984 base-year costs to calculate each hospital's PRA. *Id.* at 19. CMS also contends that Texas departed from Medicare principles by weighting the number of primary care physicians more heavily than other types of physicians in calculating the total number of FTE residents and by including nursery and managed care days in calculating the Medicaid patient load. *Id.* at 20.

HHSC concedes that, in making the supplemental GME payments to the Hospital Districts under its settlement agreements, it used SFY 1998 costs to calculate the PRA, it weighted primary care physicians more heavily than others in calculating the number of FTE residents, and it included nursery and managed care days in determining Medicaid patient loads. Tex. Br. at 14-15. Nevertheless, HHSC contends that these "adjustments" were consistent with "current Medicare methods and procedures," that its calculation of the Hospital Districts' supplemental GME payments reflected a reasonable interpretation of the State Plan, and that the Board owes that interpretation deference. *Id.* at 12, 15; Tex. Reply at 6-11. HHSC argues that the payments were calculated in a manner consistent with "current Medicare methods and procedures" despite using the Statutory Formula because both methods "take a calculated average amount per resident, and multiply that amount by the weighted number of full-time equivalent residents and the program patient load." *Id.* at 13. HHSC also points out that the State Plan's text did not prescribe a particular method for *quantifying* the basic Medicare formula's three variables – the hospital's average GME cost-per-resident (or PRA), the number of full-time-

equivalent residents, and program patient load – or "require application of the Medicare GME methodology without deviation." *Id.* at 12 n.25, 15; Tex. Reply at 7. Furthermore, says HHSC, circumstances surrounding the adoption and approval by CMS of SPA 97-10 demonstrate that Texas retained discretion under the State Plan to select a base year (different than 1984) and otherwise define how a hospital's PRA would be determined. Tex. Br. at 12; Tex. Reply at 7-8.

As this summary of the parties' arguments makes clear, Texas clearly concedes that the calculation of the amount of the supplemental GME payments made to the Hospital Districts used a formula that departed *in some material ways* from the Medicare GME methodology specified in the Medicare statute and regulations. We find that Texas' "adjustments" to the Medicare formula either conflicted with Medicare GME rules or were, at minimum, not authorized or contemplated by those rules. *See* Act § 1886(h); 42 C.F.R. §§ 413.86(b), (e)-(h) (Oct. 1, 1997) (defining "Medicare patient load" and setting out procedures and methods for calculating PRA and number of FTE residents). The essence of HHSC's argument is that the language and purpose of the State Plan provision regarding GME reimbursement were nevertheless broad or flexible enough to permit the adjustments, and that, in adopting SPA 97-10, Texas and CMS contemplated reasonable variations on the Medicare payment methodology in recognition of essential differences between the Medicare and Medicaid populations and in order to accommodate the unique priorities of Texas's Medicaid program.

We conclude that the supplemental GME payments were not made in accordance with the State Plan because the method used to calculate those payments – namely, the Statutory Formula – conflicted in at least one critical respect (pertaining to the calculation of a hospital's PRA) with the State Plan's requirement that GME payments be determined in accordance with Medicare methods and procedures, and because the payment calculations were inconsistent with Texas's established interpretation of the State Plan.

As is clear from the regulations cited earlier about approved State Plans, the clear purpose of the State Plan is to specify the methods and procedures for determining provider program payments. Therefore, when the State Plan provision concerning GME reimbursement referred to a direct GME payment "as specified under current Medicare methods and procedures," we find that the language on its face assured CMS that Texas' GME payments were to be determined using Medicare methods and procedures, at least to the extent that those methods and procedures were not plainly inappropriate in the Medicaid context.

Even if we accepted that the State Plan was arguably ambiguous, however, we would find HHSC's position here untenable. As HHSC correctly asserts, the Board ordinarily defers to a state's *reasonable* interpretation of ambiguous State Plan language. *Texas Health and Human Services Commission*, DAB No. 2176, at 3 (2008). In deciding whether a state's interpretation is reasonable, the Board has articulated the following guidelines:

> If the provision is ambiguous, the Board will consider whether the state's proposed interpretation gives reasonable effect to the language of the plan as a whole. The Board will also consider the intent of the provision. A state's interpretation cannot prevail unless it is reasonable in light of the purpose of the provision and program requirements. Lacking any documentary, contemporaneous evidence of intent, the Board may consider consistent administrative practice as evidence of intent. The importance of administrative practice is in part determining whether the state in fact was applying an official interpretation of a plan provision or has advanced an interpretation only as an after-the-fact attempt to justify acting inconsistently with or simply ignoring its plan.

South Dakota Dept. of Social Services, DAB No. 934, at 4 (1988) (emphasis added).

Applying these guidelines, we find two obstacles to giving deference to HHSC's present "interpretation" of the State Plan as permitting use of the Statutory Formula in section 32.0315(d). First, that interpretation conflicts with "contemporaneous evidence of intent." When HHSC proposed GME payment rules in SPA 97-10, HHSC did not purport to act under authority granted by section 32.0135 (containing the Statutory Formula). Instead, it appears that HHSC acted under Texas statutory provisions that conferred general authority on HHSC to administer the state's medical assistance program. *See* HD Reply, Att. 3, at 9-10 ¶ 18 (citing legal authorities). Furthermore, correspondence from 1997 and 1998 that memorializes CMS's approval of SPA 97-10 does not mention section 32.0315(d) or even hint that either party contemplated that HHSC's method for calculating GME payments would vary significantly from Medicare's method. On the contrary, the correspondence in the record indicates that Texas led CMS to understand that Texas intended to use the Medicare methodology.

In a December 3, 1997 letter that commented on SPA 97-10 (as proposed), CMS asked HHSC to clarify whether it intended to use "current per resident amount methodology" (as promulgated by CMS's September 29, 1989 final rule to implement Medicare GME methodology in section 1886(h)) or the older Medicare reasonable-cost methodology. Tex. Ex. 12, at 3-4. CMS's December 3 letter further instructed:

> If [Texas] intend[s] to use Medicare principles as a starting point, but with exceptions for Medicaid, you should state that and describe the exceptions in the plan.

Id. at 3. HHSC evidently responded to CMS's request for clarification (although it has not provided its response for the record) because, in a September 14, 1998 letter, CMS acknowledged that HHSC had clarified its intent to "follow the current per resident amount policy imposed under Medicare rules." Tex. Ex. 13, at 1. HHSC does not allege that CMS's September 14, 1998 letter mischaracterized its response. Moreover, nothing in SPA 97-10, as approved by CMS, suggests that Texas acted on CMS's suggestion to

describe in the State Plan any Medicaid "exceptions" to the Medicare GME methodology, such as those contained in the Statutory Formula.

Second, the interpretation advanced by HHSC in this proceeding is contradicted by Texas's longstanding "consistent administrative practice." It is undisputed that during the four fiscal years implicated in the disallowance, Texas calculated the Hospital Districts' GME payments by applying Medicare methods and procedures that included the use of 1984 base-year cost data and did not overweight primary care physicians in determining the number of FTE residents or count nursery or managed care days in calculating Medicaid patient load. Having consistently interpreted its State Plan during that period to provide for use of methodology and data consistent with Medicare GME provisions (and not according to the Statutory Formula), Texas may not change that established interpretation unilaterally (as it is seeking to do retroactively in this proceeding) without first seeking CMS's approval through the state plan amendment process.[14] *Louisiana Dept. of Health and Hospitals*, DAB No. 2350, at 8-9 (2010) (noting that the Board "has long held that states must follow the methods and standards set out in their approved state plans, and may not change their plan methodologies unilaterally"); *Colorado Dept. of Health Care Policy and Financing*, DAB No. 2057, at 9-10 (2006) (upholding a disallowance of payments that were "not consistent with Colorado's interpretation of the [state] plan, as evidenced by [the state's] historic practice of administering it"); *Oregon Dept. of Human Services,* DAB No. 2208, at 19 (2008) (holding that the use of an outdated Medicare payment rate to calculate certain Medicaid hospital payments was "contrary to Oregon's own interpretation" of its State Plan, "as exemplified by its prior or historic practice" in calculating the hospital payments).

4. *CMS was not obligated under 42 C.F.R. § 431.250 to provide FFP for Texas's supplemental GME payments to the Hospital Districts.*

Title 42 C.F.R. § 431.250(b)(2) provides that "FFP is available in expenditures . . . [f]or services provided within the scope of the Federal Medicaid program and made under a court order." In its initial and reply briefs, HHSC contended that supplemental GME payments to the Hospital Districts were made "pursuant to a court order," and therefore CMS was obligated to provide FFP in those payments pursuant to section 431.250(b)(2). Tex. Br. at 9-11; Tex. Reply at 4-6. Alternatively, HHSC contended that FFP is available for the supplemental GME payments under section 431.250(d), which authorizes FFP for

[14] Ultimately, Texas's position in this appeal is compromised by its failure to modify its State Plan to reflect the adoption of section 32.0315(d). Federal Medicaid regulations require amendment of a state plan "whenever necessary to reflect, among other things, "[m]aterial changes in State law, organization, or policy, or in the State's operation of the Medicaid program." 42 C.F.R. § 430.12(c). The enactment of section 32.0315 may be viewed as a "material" change in state law given the differences between the Medicare GME methodology and the Statutory Formula and the magnitude of the additional GME payments made to the Hospital Districts under the Statutory Formula.

"[p]ayments made to extend the benefit of a hearing decision or court order to individuals in the same situation as those directly affected by the decision or order." Tex. Br. at 11.

We find no merit in these contentions. Preliminarily, it appears that section 431.250 was not intended by its drafters to cover "expenditures" or "payments" of the kind at issue here, irrespective of whether they were "made under a court order" or "to extend the benefit of" a court order. Section 431.250 is part of a regulatory subpart (42 C.F.R. Part 431, subpart E) implementing section 1902(a)(3) of the Act, which requires a state Medicaid program to grant "an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness." *See* 42 C.F.R. § 431.200(a) (stating, as relevant here, that subpart E implements section 1902(a)(3)). Consistent with that purpose, the preamble to the 1980 final rule which added paragraph (b) to section 431.250 states that that section "concerns Federal financial participation (FFP) for expenditures in services for individuals who are successful in their appeal." 45 Fed. Reg. 24,878 (April 11, 1980) (emphasis added); *see also Georgia v. Heckler*, 768 F.2d 1293, 1298 (11th Cir. 1985) (quoting the April 11, 1980 final rule and stating that section 431.250(b) "provides for federal funds to be furnished where a court has ordered a state to provide Medicaid benefits . . . ."). In other words, the expenditures covered by section 431.250(b)(2) are those that relate to a state's denial of (or failure to act promptly on) an individual Medicaid recipient's request for program assistance. The dispute in this case is about how payment rates for GME were calculated and does not implicate any particular individual's claim for program assistance.

Even assuming, for argument's sake, that the supplemental GME payments fall within the general scope of section 431.250, the payments do not satisfy the specific criteria in paragraph (b) of that section. Section 431.250(b)(2) requires the payment to have been "made under a court order." *Texas Dept. of Human Services*, DAB No. 1344, at 14 (1992). The supplemental GME payments here were not "made under a court order." The Court Order issued in the Parkland matter granted the plaintiff's request for a declaratory judgment and a permanent injunction. Although the Court Order declared that the method used by HHSC to calculate Medicaid GME reimbursement violated section 32.0315(d) and enjoined HHSC from calculating a teaching hospital's GME reimbursement in a manner "other than as required by Code Section 32.0315(d)," the Court Order did not direct HHSC to reopen cost reports or to recalculate Parkland's or any other Hospital Districts' GME reimbursement based on the Statutory Formula. At oral argument, HHSC conceded that its settlement agreement with the Hospital Districts was not "court-ordered." Tr. at 14 (Parkland settlement was not "court ordered") and 48 (Court Order "did not include an affirmative requirement to pay, and the resulting settlement was not ordered by the Court"). Having conceded that the payments to Parkland were not court-ordered, HHSC cannot reasonably contend that payments to the Hospital Districts were court-ordered.

In any event, the record does not reflect that Parkland had a final cost settlement at the time it filed suit or obtained the court order. The Hospital Districts never sought a court

order and have not demonstrated that, at the time Parkland obtained the court order, their cost reports were still open. *Compare* HD Reply, Att. 2, Ex. A, at 56 (¶ 9) (summary judgment affidavit stating that Texas' "allocation to Parkland Hospital of Medicaid funds for GME cost reimbursement" for SFYs 1998 through 2001 "has not yet been final[ly] determined") *with* CMS Response, Att. 2, at 2 (stating that the supplemental GME payments were determined by applying the Statutory Formula to Parkland's "final, audited" cost reports for SFYs 1998 through 2001). Therefore, it is not clear that Parkland and the Hospital Districts were similarly situated as to the court order.

For these reasons, we hold that FFP is not available under section 431.250(b) for the supplemental GME payments made to the Hospital Districts. Because the relevant court order did not direct HHSC to make supplemental GME payments to *any* entity, we further hold that FFP is unavailable under section 431.250(d), which merely extends the reach of section 431.250(b) to those "in the same situation as those directly affected" by the court order.[15]

5. *CMS is not required in these circumstances to accord consistent treatment to the Hospital Districts' and Parkland's supplemental GME payments.*

HHSC contends that the disallowance should be overturned because CMS acted inconsistently by authorizing FFP for Parkland's supplemental GME payments while disallowing FFP for the supplemental payments to the Hospital Districts. Tex. Br. at 7-9; HD Br. at 9-10; Tex. Reply at 6. Specifically, HHSC argues that payments to Parkland were calculated using the Statutory Formula "[p]ursuant to the Court Order and the terms of" the settlement agreement with Parkland and that therefore CMS must permit payments to the other Hospital Districts "using the same methodology and under the same circumstances." Tex. Br. at 8.

In support of this contention, HHSC submitted a March 16, 2011 letter from Cindy Mann, Director of the Center for Medicaid and State Operations at CMS, to the President and Chief Executive Officer of Harris County Hospital District (Harris County). HD Reply, Att. 1. The March 16 letter states that, as a result of the 2004 Texas Court of Appeals decision in the Parkland litigation, "CMS provided FFP for claims for GME payments to Parkland that were specifically addressed in the court decision, pursuant to Federal regulations at 42 C.F.R. 431.250." *Id.* (emphasis added). The March 16 letter

[15] In *Missouri Department of Social Services*, DAB No. 1035 (1989), a case that grew out of a dispute between nursing facilities and the state of Missouri over Medicaid payment rates, the Board observed that "[a]bsent any regulation or policy specifically applying [section 431.250(b)(2)] to rate appeals[,] there is no basis for FFP in court-ordered payments in excess of the amount authorized by the rate-setting methods in the State plan." DAB No. 1035, at 7. HHSC cites *Missouri* "for the proposition that CMS could choose to adopt a policy of allowing FFP in court-ordered payments under Section 431.250 outside the fair hearing context," Tex. Reply at 6 n.18, but as we discuss in the following section, there is insufficient evidence of any CMS policy extending section 431.250 to payments (like the ones at issue here) that at best have only an attenuated connection to individual claims for medical assistance.

further states that section 431.250 did not apply to the supplemental GME payments to the Hospital Districts because the Hospital Districts "were not part of that lawsuit." *Id.*

HHSC argued in its briefing, however, that the payments to the Hospital Districts were also made "pursuant to a court order." Tex. Br. at 9-10. According to HHSC, the Court Order enjoined GME payment using any methodology other than the Statutory Formula as to "a teaching hospital," not merely as to Parkland. *Id.* at 10 (citing Tex. Ex. 3, at 4-5). Therefore, Parkland and the Hospital Districts should be considered to be similarly situated and, under Board precedent, a federal agency must not apply its policies and procedures inconsistently. *Id.* at 9.

None of the cases cited by Texas suggest that the federal government can be required to make payments that are not authorized by applicable law merely because another party received payment. CMS would be under no obligation to repeat or perpetuate a legal interpretation that it determined was in error or inapplicable. *Cf. Cleveland National Air Show, Inc. v. U.S. Dep't of Transportation*, 430 F.3d 757, 765 (6th Cir. 2005) ("A government agency, like a judge, may correct a mistake, and no principle of administrative law consigns the agency to repeating the mistake into perpetuity."). It is, of course, well-settled that an agency may not depart from established policy or precedent without a reasoned explanation for doing so. *See, e.g., Northeast Hosp. Corp. v. Sebelius,* 699 F. Supp.2d 81, 93-85 (D.D.C. 2010), *appeal dismissed*, 2010 WL 4340372 (D.C. Cir. Oct. 10, 2010). In this case, however, the release of a single deferral does not demonstrate any established agency policy or practice regarding the application of section 431.250 to Medicaid payment disputes of this kind.[16]

HHSC argues that, although CMS questioned whether the supplemental GME payments to Parkland were consistent with the State Plan, CMS ultimately released that deferral and must therefore have determined that the payments were authorized. Tex. Br. at 11; *see also* Tr. at 16 (asserting that CMS had "conceded" that the supplemental payments to Parkland were "within the scope of the Medicaid program" because 42 C.F.R. § 431.250(b)(2) makes FFP contingent on compliance with program limitations not addressed by the relevant court order). The payment to Parkland is not before us, and we

[16] Neither of the two Board decisions cited by HHSC – *Pennsylvania Dept. of Public Welfare*, DAB No. 331 (1982) and *West Virginia Dept. of Health and Human Resources,* DAB No. 2278 (2009) – is on point. In *Pennsylvania*, the Board partly reversed a disallowance of FFP for certain payments to facilities whose Medicaid certifications had expired. DAB No. 331, at 3-4. While observing that the portion of the disallowance affected by its reversal was "inconsistent with" the federal agency's action in a prior case, the Board did not predicate its reversal on that circumstance. Instead, the Board found that the provider payments in question were allowable because they fell (or appeared to fall) within the bounds of an established, written agency policy. DAB No. 331, at 4 (stating that the Board found no basis in the relevant policy "to condition the availability of FFP pending appeal on the State having to give[ ] notice within five, six, or even eight months after expiration, at least where, as here, such an appeal is still timely under State statute or regulation"). And in *West Virginia*, while the Board noted that CMS's approach in calculating a disallowance amount was "inconsistent with the approach it took in another recent and factually analogous case involving the State," the Board did not hold that this inconsistency was, in itself, dispositive. DAB No. 2278, at 15-16 (citing three other factors for disapproving CMS's disallowance calculation).

therefore do not resolve whether the payment of FFP was proper or authorized under the circumstances applicable to Parkland. We decline to infer, however, from the CMS letter quoted above that a general policy was created that Hospital Districts not party to the lawsuit or court order were entitled to or authorized to receive FFP under the State Plan if the State chose to recalculate their payments as part of a settlement agreement.

Furthermore, we do not find that the record supports HHSC's claim that Parkland and the Hospital Districts were, in fact, similarly situated in material respects, as discussed above. Moreover, HHSC's position on the basis for making these supplemental payments to Parkland and the Hospital Districts has been inconsistent. At oral argument, HHSC counsel contradicted HHSC's prior assertion that both were paid "pursuant to court order," contending instead that the Court Order "did not include an affirmative requirement to pay, and that the resulting settlement was not ordered by the Court." Tr. at 48; *see also* Tr. at 14 (Parkland "wasn't a Court ordered settlement"). HHSC's counsel suggested that the absence of an affirmative court order to pay either Parkland or the Hospital Districts meant that CMS's distinction between them based on the fact that only Parkland was a party to the Court Order was "an artificial one." *Id.* The effect of HHSC's position at oral argument, however, is to undermine the factual premise on which CMS relied in applying section 431.250 to Parkland. It is not clear whether CMS was aware of this information before releasing the deferral. Certainly, this record cannot establish that the Hospital Districts could be entitled to payment under section 431.250(d) as being "individuals in the same situation as those directly affected" by the court order, if the settlement to Parkland itself was not "made under a court order" as required by section 431.250(b)(2).

Conclusion

For the reasons discussed, we sustain CMS's September 30, 2010 determination to disallow $47,923,792 in FFP that the state of Texas claimed for supplemental GME payments to the Hospital Districts.

/s/
Judith A. Ballard

/s/
Constance B. Tobias

/s/
Leslie A. Sussan
Presiding Board Member