Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Virginia Department of Medical Assistance Services
Docket No. A-16-9
Decision No. 2727
August 8, 2016

DECISION

The Virginia Department of Medical Assistance Services (Virginia) appeals the Centers for Medicare & Medicaid Services' (CMS's) August 20, 2015 determination disallowing $40,830,020 in Medicaid federal financial participation (FFP) for disproportionate share hospital (DSH) payments made to two state-owned hospitals in 2010 and 2011. CMS determined that Virginia routinely shifted the allocation of indigent care costs incurred in one federal fiscal year (FFY) in which the state's DSH allotment was exhausted or nearly exhausted to a different fiscal year in which the state's DSH allotment had not been fully used. CMS concluded that this practice represented an unauthorized departure from Virginia's prior DSH payment distribution and allocation practices, which the Board found permissible under Virginia's state Medicaid plan and applicable federal requirements in a 2002 appeal. CMS also determined that the new methodology was inconsistent with the federal limitations on DSH spending.

Virginia contends that it applied the DSH payments to FFY state allotments through the use of a prospective methodology that was authorized by its Medicaid state plan and consistent with the Act and implementing regulations. Virginia argues that it did not, nor was it required to, associate the DSH payments with costs incurred in specific periods for the purpose of determining compliance with its annual statewide DSH allotments. Virginia also argues that CMS's position would require Virginia to institute a retrospective, cost-based DSH payment methodology that would conflict with its Medicaid state plan and federal law.

For the reasons discussed below, we conclude that Virginia's current interpretation of its Medicaid state plan is not reasonable. The methodology that Virginia used to allocate DSH payments is not supported by the language of the state plan and is materially inconsistent with what Virginia previously represented to be its administrative practices in distributing and allocating DSH payments. Moreover, the disallowance is consistent with the DSH statutes and regulations. We therefore sustain the disallowance.

I. Background

A. *Applicable statutes and regulations*

The Medicaid program, established under title XIX of the Social Security Act (Act), provides for joint federal and state financing of medical assistance for certain needy persons.[1] States that participate in Medicaid must observe broad federal requirements and the terms of their Medicaid state plans, as approved by CMS. Act § 1902; 42 C.F.R. §§ 430.0 - 430.16. A state with an approved Medicaid state plan receives federal matching funds, or FFP, for medical assistance provided under the state plan. Act § 1903(a)(1).

A state plan must describe the policies and methods used by the state to set payment rates for hospital services and other types of services covered by its Medicaid program. Act § 1902(a); 42 C.F.R. §§ 447.201(b), 447.252(b). The state plan must contain "all information necessary for CMS to determine whether the plan can be approved . . . ." 42 C.F.R. § 430.10. A state plan must be amended when necessary to reflect "[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)(1)(ii). States must promptly submit amendments so that "CMS can determine whether the plan continues to meet the requirements for approval" and to "ensure the availability of FFP . . . ." 42 C.F.R. § 430.12(c)(2)(i).

Each state plan must provide for inpatient hospital services for Medicaid patients. Act §§ 1902(a)(13)(A), 1905(a)(1). In 1981, Congress amended the Act to require that in establishing hospital payment rates, states "take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs ...." Pub. L. No. 97-35 § 2173(a)(1), 95 Stat. 357, 808 (1981). Section 1923 of the Act ("Adjustment in Payment for Inpatient Hospital Services Furnished by Disproportionate Share Hospitals") requires each Medicaid state plan to provide for "an appropriate increase in the rate or amount of payment" for "inpatient hospital services" to compensate DSHs that incur atypical costs in furnishing services to a disproportionate number of indigent patients. Act § 1923(a)(1)(B). These increases in payments are referred to as DSH "payment adjustments."

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[1] The current version of the Social Security Act can be found at http://www.socialsecurity.gov/OP_Home/ssact/ssact.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. 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.

A Medicaid state plan must specify the criteria for a provider to qualify as a DSH and the methodology that the state uses to calculate DSH payment adjustments. A state may choose from several different types of methodologies to calculate DSH payment adjustments, including a methodology that "results in an adjustment for each type of hospital that is reasonably related to the costs, volume, or proportion of services provided to patients eligible for medical assistance under a State plan ...." Act § 1923(c).

After claims for FFP for DSH payments increased dramatically in the late 1980s, Congress amended the Act in 1991 to provide for an annual "DSH allotment" for each state, limiting the aggregate amount of payments that any state may make to DSHs for which FFP is available. Pub. L. No. 102-234 § 3, 105 Stat. 1793 (1991). Section 1923(f) of the Act provides that FFP shall not be paid to a state for "any payment adjustment made under this section for hospitals in a State for quarters in a fiscal year in excess of the [DSH] allotment for the State for the fiscal year. . . ." The implementing regulation at 42 C.F.R. § 447.297(d)(2) provides that if CMS "determines that at any time a State has exceeded its final DSH allotment for a Federal fiscal year, FFP attributable to the excess DSH expenditures will be disallowed." Section 447.297(d)(3) further provides that if a state's actual DSH expenditures are less than its final DSH allotment for that FFY, the state is permitted, to the extent allowed by its approved state Medicaid plan, to make additional DSH expenditures applicable to that FFY up to the amount of its final DSH allotment for that FFY. CMS publishes the annual state DSH allotment amounts in preliminary and final form in the *Federal Register* each year. 42 C.F.R. § 447.297(c), (d).

In 1993, Congress further amended the Act to establish hospital-specific limitations on DSH funding. Pub. L. No. 103-66 § 13621, 107 Stat. 312 (1993). Under the hospital-specific limitations established at section 1923(g) of the Act, "a payment adjustment during a fiscal year" may not exceed the uncompensated "costs incurred during the year of furnishing hospital services . . . to individuals who either are eligible for medical assistance under the state plan or have no health insurance (or other source of third party coverage) for services provided during the year." These costs are referred to as uncompensated care costs.

B. *Virginia's Medicaid state plan*

Virginia's Medicaid state plan categorized DSHs as either Type One or Type Two hospitals: Type One hospitals are the state-owned DSHs, University of Virginia Health System (UVA) and Virginia Commonwealth University – Medical College of Virginia Health System (MCV); Type Two hospitals are all other DSHs. VA Ex. 2 (State Plan Att. 4.19-A, State Plan Transmittal No. 09-17, at 4-5, effective July 1, 2009); Declaration of William J. Lessard, Jr., Director of Provider Reimbursement, Department of Medical Assistance Services (Lessard Decl.) ¶ 4. *Id.* At issue here are payments to the Type One DSHs, UVA and MCV.

Virginia's Medicaid state plan provided for DSH payment adjustments to be "prospectively determined in advance of the state fiscal year to which they apply," subject to "settlement . . . when necessary" to ensure payments did not "exceed any applicable limitations . . . established by federal law or regulations and Sec. 1923(g) of the Social Security Act." ¶ VA Ex. 2 (State Plan Att. 4-19.A, State Plan Transmittal No. 03-08, at 10, 10.1, effective August 13, 2003; State Plan Transmittal No. 04-13, at 11, 12.1, effective April 1, 2005).

The state plan also set forth a formula, based on Medicaid utilization rates and operating reimbursement, to calculate each DSH's annual payment adjustment. VA Ex. 2 (State Plan Att. 4-19.A, State Plan Transmittal No. 03-08, at 10, 10.1; State Plan Att. 4.19-A, State Plan Transmittal No. 09-17, at 5); Lessard Decl. ¶¶ 7-9. The methodology used the same base formula to calculate the payment adjustment amounts for both types of hospitals. *Id.* For Type One DSHs, however, the product of the formula was multiplied by seventeen. *Id.*

C. *Virginia's practices in disbursing and allocating DSH payments*

According to the declaration of Virginia's current Director of Provider Reimbursement filed in this appeal, "prior to each fiscal year between 2004 and 2011," Virginia "prospectively calculated, for each disproportionate share hospital, the DSH payment adjustment for that hospital that was applicable to the following fiscal year." Lessard Decl. ¶ 10. Virginia made "regular" DSH payments to all DSHs. The amount of each "regular payment" was comprised of the state plan formula without the multiplier and was "paid during the fiscal year to which the DSH payment applied." Lessard Decl. ¶ 12.

Virginia also made "enhanced" DSH payments to the Type One hospitals. The "enhanced" payments, Virginia's current Director stated, "could be paid during the fiscal year to which they applied or in subsequent fiscal years." Lessard Decl. ¶ 12. In 2004, Virginia began a "multi-settlement" process for each fiscal year, the results of which it used in part to determine when and in what amounts to make enhanced DSH payments. *Id*. ¶¶ 15, 16. The process took into account "both the Medicaid cost report and cost reports for Medicaid managed care organization … services and indigent care as a whole in regard to the state indigent care policy." *Id. ¶* 15. "Prior to the institution of this 'multi-settlement' process," the Director stated, Virginia "had made disbursements of enhanced DSH payments to UVA and MCV that took into account the estimated costs associated with indigent care," but there "had been no settlement." *Id.*

When Virginia used the "multi-settlement" information "from prior years" to determine the amount or timing of an enhanced payment, it "made a notation" of the multi-settlement year "on a spreadsheet . . . "for [its] internal record-keeping." *Id.* ¶¶ 15, 16. However, the Director stated, Virginia "never contemplated the DSH payment

adjustments as reimbursement for specific services or specific costs." *Id.* ¶ 18. Instead, Virginia "made ongoing disbursements of enhanced DSH, . . . appl[ying] the payments to a fiscal year in which (1) the full DSH payment adjustment, as determined under the State Plan, had not been exhausted, and (2) the contemplated payment would comply with federal limits, including the statewide DSH allotment." *Id.*

For example, in June 2010 Virginia "decided, based on the multi-settlement process for fiscal year 2004, to disburse an enhanced DSH payment" of $1,286,904 to MCV. *Id.* ¶ 26. Because Virginia "took into account" the 2004 multi-settlement cost information, it "made a notation on an internal spreadsheet that described the DSH disbursement as 'MCVHospital DSH ENH FY 2004.'" *Id.* ¶ 27. Virginia, however, "applied the payment to fiscal year 2006" because, as of June 2010, it "had not yet paid the entire amount of the DSH payment adjustment that the State Plan authorized to be applied to fiscal year 2006." *Id.* ¶ 28. "Further," the Director stated, "the statewide allotment for fiscal year 2006 had not yet been exhausted." *Id.* Virginia therefore "reported the payment as a fiscal year 2006 DSH payment and claimed FFP in the amount of $643,542" on its Medicaid claim form for the quarter ending June 30, 2010. *Id.* ¶ 29.

D. *The disallowance*

In deferral notices dated September 30, 2010 and December 28, 2010, CMS notified Virginia that it was deferring funds for the quarters ending June 30, 2010 and September 30, 2010 on the grounds that Virginia was not allocating DSH payments to the proper DSH fiscal year allotment. VA Ex. 1, at 1-2.

In a January 2011 response to the deferrals, Virginia explained that it made enhanced DSH payments "to cover state-defined indigent care costs" in specified fiscal years that Virginia "accrued to [different years] because there was available allotment and total DSH payments did not exceed the amounts authorized in the State Plan." CMS Ex. 2, at 3. Virginia also explained that its "Standard Accrual Policy" for enhanced DSH payments was "to accrue the payments to the oldest year that there is [available funding under] both [the] hospital-specific DSH limit and statewide DSH allotment." *Id.* at 10.

On August 20, 2015, CMS issued a decision to disallow FFP in the amount of $40,830,020 for enhanced DSH payments that Virginia made to MCV and UVA in 2010 and 2011.[2] The disallowance included the previously deferred funds as well as funds Virginia claimed in subsequent quarters. CMS determined that Virginia had allocated the payments to prior years' DSH allotments, not "to the actual year in which DSH costs were incurred." VA Ex. 1, at 1. CMS specified –

- For DSH payments made in the quarter ending June 30, 2010,
  - payments for FY 2004 costs were applied against the FY 2006 and FY 2009 DSH allotments;
  - payments for FY 2005 costs were applied against the FY 2006 DSH allotment; and
  - payments for FY 2008 costs were applied against the FY 2006, FY 2007, and FY 2009 DSH allotments;

- For DSH payments made in the quarter ending September 30, 2010, payments for FY 2008 costs were applied against the FY 2010 DSH allotment;

- For DSH payments made in the quarter ending September 30, 2011, payments for FY 2009 costs were applied against the FY 2008 and FY 2011 DSH allotments.

- For DSH payments made in the quarter ending December 31, 2011, payments for FY 2009 costs were applied against the FY 2012 DSH allotment.

Id. at 1-2; *see also* CMS App. A (Chart of Disallowed Claims for FFP). CMS concluded "there is no provision in Virginia's State plan that allows for allocating costs from one year to the DSH allotment of another year with a remaining balance." *Id.* at 3. Furthermore, CMS stated, Virginia's interpretation of its Medicaid state plan as permitting these DSH distributions was inconsistent with Virginia's interpretation of the same state plan provisions presented in a 2002 appeal to the Departmental Appeals

[2] Virginia asserts that subsequent to the disallowance, it repaid to CMS $10,802,480 of the $40,830,020 FFP disallowed, leaving $30,027,540 in dispute. VA Br. at 16. Virginia states that the amount repaid "related to payments to the University of Virginia that were reported on the CMS-64.9D forms for the quarter ending September 30, 2011 and the quarter ending December 31, 2011." VA Reply at 2 n.1. CMS responds, "the substantive issues in this case must be decided before CMS can concur that the $10 million in question was truly recouped." May 24, 2016 CMS Status Report. CMS states that because Virginia "uses DSH funds from one fiscal year to cover costs incurred in a different fiscal year, CMS cannot be assured that the $10 million dollars allocated to 2011 and 2012 were not simply reallocated to a different fiscal year in order to cover the same costs." *Id.* If that were the case, CMS contends, "the $10 million dollars has not truly been recouped," and "if the funds were allocated against any year other than 2009, which is the year the costs were incurred, then CMS would still disallow those funds." *Id.* Because this decision resolves the legal issues presented, CMS should now make a determination, consistent with this decision, whether Virginia has repaid to CMS $10,802,480 of the disallowance.

Board. In that case, CMS stated, Virginia represented that, "using an accrual method, payments [were] matched to the state DSH allotment applicable to the year in which the services were performed and not the year in which the payment was made." *Id.* at 3 (quoting *Virginia Dept. of Medical Assistance Servs.*, DAB No. 1838, at 5 (2002)). Moreover, CMS explained, the DSH payments claimed here would have exceeded Virginia's annual DSH allotments if Virginia had properly accounted for the costs in the years in which they were incurred. "This is also inconsistent with the State plan," CMS determined, "insofar as the State plan recognizes and incorporates the requirement that payments may not exceed the annual DSH allotment." *Id.*

II. Analysis[3]

To determine "whether a state has reasonably interpreted and followed its approved state plan, the Board first examines the language of the plan itself." *Utah Dept. of Health*, DAB No. 2131, at 10 (2007)(citations omitted); *see also* DAB No. 1838, at 12. If the wording is clear, then the plain language of the plan will control. *Id.* If the provision is ambiguous, however, the Board will consider whether the state's interpretation gives reasonable effect to the language of the plan as a whole and whether it is reasonable in light of the purpose of the provision and program requirements. *Id.* "The Board also will consider the intent of the provision, as alleged by the state." DAB No. 2131, at 12. In evaluating the intent of the provision, the Board will consider contemporaneous documentation evidencing intent as well as whether the state has consistently administered its plan over time. *Id.* While a state has considerable flexibility in choosing standards, methods and payment rates under its state plan, the state is not free to implement ad hoc changes or unilaterally change the methodology set out in its state plan, once adopted and approved. *Colorado Dept. of Health Care and Policy Financing*, DAB No. 2057, at 1-2, 9 (citations omitted).

Applying this analytic framework, below we first explain why Virginia's current interpretation of its state plan is unreasonable under the language of the plan as a whole and is inconsistent with Virginia's prior representations about its administrative practices for allocating DSH payments. We then describe how the disallowance is consistent with the DSH statutes and regulations. Finally, we explain how Virginia's approach could effectively evade the federal limitations on FFP for DSH payments.

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[3] Virginia's notice of appeal and April 29, 2016 submission requested an oral proceeding to assist the Board in resolving the complex issues presented in this case. In a May 2016 ruling, the Presiding Board Member determined that the Board would notify the parties if after reviewing the record it determined that additional written briefing or an oral proceeding would assist its decisionmaking. The Board has determined that additional written briefing or an oral proceeding is unnecessary.

A. *Virginia's interpretation of its Medicaid state plan is unreasonable under the language of the plan as a whole and is inconsistent with its prior representations.*

The provisions of Virginia's Medicaid plan at issue here provide:

> 12 VAC 30-70-301. Payment to disproportionate share hospitals
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> A. Payments to disproportionate share hospitals (DSH) shall be prospectively determined in advance of the state fiscal year to which they apply. The payments shall be made on a quarterly basis, shall be final, and shall not be subject to settlement except when necessary due to the limit in subsection D of this section.
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> D. No DSH payments shall exceed any applicable limitations upon such payments established by federal law or regulations and Sec. 1923(g) of the Social Security Act.

VA Ex. 2 (State Plan Att. 4-19.A, State Plan Transmittal No. 03-08, at 10; State Plan Transmittal No. 04-13, at 11).

Notably, these provisions are unchanged in any material respect from the state plan provisions addressed in Virginia's 2002 appeal before the Board, which involved the timing of Virginia's enhanced DSH payments and claims.[4] In that appeal, CMS read the language of the plan to mean that Virginia could make only quarterly DSH payments,

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[4] Section VAC 30-70-301.A of the version of the State plan at issue in the 2002 appeal was identical to the version applicable in this case. Section VAC 30-70-301.D. of the version at issue in the 2002 appeal included a formula to calculate eligible uncompensated care costs for purposes of applying the hospital-specific limit established under section 1923(g), which was enacted under section 13621 of OBRA 1993:

> No DSH payments shall exceed any applicable limitations upon such payments established by federal law or regulations and OBRA 1993 § 13621. A DSH payment during a fiscal year shall not exceed the sum of:
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> 1. Medicaid allowable costs incurred during the year less Medicaid payments, net of disproportionate share payment adjustments, for services provided during the year. Costs and payments for Medicaid recipients enrolled in capitated managed care programs shall be considered Medicaid costs and payments for the purposes of this section.
> 2. Costs incurred in serving persons who have no insurance less payments received from those patients or from a third party on behalf of those patients….

CMS Ex. 3, at 11-12.

which had to be considered final payments under the plan. DAB No. 1838, at 1. CMS then determined that any subsequent enhanced payments must be imputed as having been made when Virginia made the regular quarterly payments, even though Virginia in fact made the enhanced payments at a later time. Comparing the imputed dates of the payments to the dates when Virginia filed claims for FFP for the payments, CMS concluded that Virginia had exceeded the two-year deadline for submitting claims under section 1132 of the Act. *Id.* at 1-2, 11-12. Virginia argued that the language of the state plan was ambiguous and could reasonably be interpreted to require Virginia "to administer the DSH process so that no violations occur regarding either the hospital-specific cap or the state DSH allotment." *Id.* at 12. According to Virginia, the state plan provided for it to delay making enhanced payments until it could be absolutely sure of what each hospital's full DSH entitlement would be for the periods at issue, applying hospital-specific caps on DSH payments and the state DSH allotment pursuant to statute. Moreover, Virginia argued, it had consistently interpreted and applied the state plan provisions at issue since 1993. *Id.* at 7. 12. The Board's decision in that appeal reversed CMS's disallowance, concluding that the language of the plan was ambiguous and that Virginia's interpretation was "a reasonable one which it ha[d] consistently applied in practice, and therefore entitled to deference." *Id.* at 12.

Virginia now argues that what it does not dispute is essentially the same language "unequivocally required" Virginia "to apply DSH payments … prospectively" and that it permitted Virginia to "apply" DSH payments "over time" to any fiscal year allotment up to the federal limits for that year. VA Reply at 8; VA Br. at 18-19; *see also id.* at 12-13. Virginia contends that it did not, and was not required to, allocate DSH payment adjustments to specific years to cover costs incurred by the hospitals in those years "even though… decisions as to the amount and timing of discrete DSH disbursements were on some occasions informed by data from prior years . . . ." Virginia Br. at 18. According to Virginia, the wording of VAC 30-70-301 meant that once "DSH payments … in the aggregate equaled the statewide allotment for [a] year, no more DSH disbursements were applied to the fiscal year" even though "UVA and MCV did not end up receiving the full DSH payment adjustment that had been calculated for that fiscal year under the State plan." *Id*. at 13, 18-19. Virginia also argues that this methodology was "consistent with longstanding … administrative practice," reflected in "annual rate letters" it sent to DSHs stating "that the payment adjustments [were] 'fully prospective amounts *determined in advance of the state fiscal year to which they apply* and shall not be subject to revision . . . .'" *Id.* at 20 (emphasis in brief, citing VA Exs. 3, 4). Virginia contends that the basis of CMS's disallowance here, requiring DSH payments to be "allocated to the time periods in which DSH-eligible costs were incurred by the hospitals in providing certain services," constitutes a "new and unreasonable interpretation of the Act and Regulations," of which Virginia had no advance notice. *Id*. at 15, 20, 23-25. Virginia further argues that CMS's current position "would amount to a requirement that Virginia institute a retrospective, cost-based DSH payment methodology." *Id.* at 2.

We conclude that the interpretation of the state plan that Virginia now advances is not supported by the language of the plan as a whole, contradicts Virginia's prior representations about the meaning of the same provisions, and is inconsistent with its past administrative practices in distributing and allocating DSH payments. As an initial matter, Virginia's state plan DSH provisions must be read in the context of the plan as a whole. Notably, the DSH payment provisions were established under the state plan's methodologies for compensating hospitals for the costs of providing inpatient services. VA Ex. 2 ("Methods and Standards for Establishing Payment Rates-Inpatient Services"). Indeed, in approving Virginia's proposed amendments to the state plan, CMS noted that the amendments "revise[d] the payment methodology for inpatient hospital services." *Id.* (May 11, 2004 letter approving Attachment 4.19-A submitted under transmittal number 03-08). As reflected in the structure of the State plan, the DSH payment adjustments were plainly designed to augment the compensation Virginia's hospitals received for providing inpatient services during periods in which they served a disproportionate number of Medicaid recipients and uninsured patients. Thus, the organization of the state plan contradicts Virginia's argument that enhanced DSH payments were not intended to relate to the periods in which the hospitals incurred costs for services entitling them to the payment adjustments.

Furthermore, Virginia's revised interpretation of the wording of the state plan DSH provisions is unreasonable. While it is true the language of the first sentence of subsection 30-70-301.A. required Virginia to "prospectively determine," or calculate in advance, the amount of each DSH's payment adjustment applicable to the upcoming fiscal year, no language in the plan directed Virginia to "apply" DSH payments to one or more future annual allotments without regard to when the hospitals incurred the costs that the payments were intended to support. VA Ex. 2 (State Plan Att. 4-19.A, State Plan Transmittal No. 03-08, at 10). To the contrary, as Virginia recognized in 2002, the second sentence of subsection 30-70-301.A., together with subsection D., provided for DSH payments to be "subject to" a "settlement" to ensure the payments for each fiscal year would not "exceed any applicable limitations established by federal law or regulations," including the annual DSH allotment and hospital-specific DSH payment limits for the year. *Id.* (State Plan Transmittal No. 03-08, at 10; State Plan Transmittal No. 04-13, at 11).

Specifically, Virginia explained in its prior appeal, the plan provided for "a verification process" to ensure that a DSH payment would not exceed either the statutory hospital-specific cap for that year (imposed under section 1923(g) of the Act and based on actual, uncompensated care costs) or any other federal limitation, including the state DSH allotment for the year to which the payments related (imposed under section 1923(f) of the Act). CMS Ex. 4, at 2 (VA Supp. Br. at 2, Dkt. No. A-02-17). Accordingly, Virginia previously explained, the "formula that the Commonwealth uses … project[s] the maximum amount of DSH funds that may be potentially available to VCU and UVA."

CMS Ex. 3, at 4 (VA Br. at 4, Dkt. No. A-02-17). Indeed, Virginia denied that the calculation established a prospective obligation (as it now alleges): "Not only is the projected maximum amount not treated as expenditure, it does not represent a State obligation, at least not until entitlement has been established vis-à-vis the hospital-specific limit and the State DSH allotment." *Id.* at 9.

Accordingly, the former Director of Cost Settlement and Reimbursement explained in the 2002 appeal, Virginia waited to make enhanced DSH payments until after the Type One hospitals had "performed the services that entitle[d] them to reimbursement and the hospitals ha[d] submitted their annual cost reports," typically "within 150 days after the provider's fiscal year end." CMS Ex. 1, ¶ 10 (Declaration of Stanley Fields, Dkt. No. A-02-17). Further, the Director stated, after a hospital filed its cost report, it could submit new uncompensated expenditure data. "This [led] to retrospective changing of DSH funds payable for that accounting period, and hence, the reasonable use of an accrual method … to account for and subsequently pay DSH." *Id.* "On account of the verification process," the Director added, hospitals were permitted "to submit new expenditure data to add to the cost report to recognize uninsured losses not included in the original cost report." *Id.* ¶ 12. In such a case, "the hospital-specific DSH cap [was] raised, which entitle[d] the hospital to reimbursement based on the services performed, the amount of funds remaining in the State DSH Allotment, and the availability of state matching funds." *Id.*

In sum, Virginia represented in the 2002 appeal, enhanced DSH payments were not made until the Type One hospitals had "submitted **the relevant cost data**" for the fiscal year to which the payments related, and Virginia had "verified that [a] payment would be (i) in accordance with the hospital-specific cap, (ii) within the funding available under the **applicable State DSH Allotment**, and (iii) in accordance with the" state plan. CMS Ex. 4, at 1 (emphasis added). Through this accrual method, the Director stated, "**Payments [were] matched to the State DSH Allotment applicable to the year in which the services were performed"** to ensure that funding was available under the applicable allotment. CMS Ex. 1 ¶ 17 (emphasis added).

Thus, while the DSH payment methodology in Virginia's state plan included a formula to calculate prospectively the maximum amount of DSH payments that a hospital could receive for the subsequent year, the plan language also obligated Virginia to follow a reconciliation process to prevent enhanced DSH payments from exceeding the uncompensated costs of services furnished that year or the state allotment for that same "applicable" year. Accordingly, contrary to Virginia's current argument that CMS is attempting to use the August 2015 disallowance to impose a new rule requiring Virginia

to retroactively allocate DSH payments based on when costs were incurred, it was Virginia itself that used, and in 2002 advocated for, that very process under the same provisions of its state plan. Indeed, Virginia previously argued that the process of matching DSH payments to the state DSH allotment applicable to the year in which services were performed was not only permissible, but required under its state plan.

Virginia now attempts to diminish the significance of the sworn statement by its former Director of Cost Settlement and Reimbursement and the representations it made about its DSH payment practices in the 2002 appeal. VA Reply at 13-15. Virginia asserts that the declaration "was not central to the State plan interpretation advanced by [Virginia] and upheld by the Board in DAB No. 1838, and it certainly had no bearing on [Virginia's] authority to disburse DSH payments … during the time period at issue in this disallowance." VA Reply at 15. According to Virginia, the "Declaration is irrelevant to this disallowance…." *Id.* at 13.

We disagree. The 2002 appeal involved whether Virginia reasonably interpreted its state plan to permit it to make the separate, enhanced DSH payments after it made regular DSH payments and whether the claims for FFP for the enhanced payments violated the two-year limit for filing claims established in section 1132 of the Act. While the central issue in this case differs from that presented in the 2002 appeal, Virginia's prior representations about the meaning of its Medicaid state plan and the administrative procedures used during the earlier period have a significant bearing on whether its current interpretation of essentially the same state plan language is entitled to deference. As noted above, the Board has repeatedly stated that in evaluating whether a state's proposed interpretation of its Medicaid state plan is entitled to deference, the Board will consider whether the interpretation reflects the state's established and consistent administrative practices. Moreover, as discussed below, the former Director's representations about how Virginia implemented its state plan directly relate to the question whether Virginia has materially changed its Medicaid program policies or operations without notice to or approval from CMS, as required under section 430.12(c) of the Medicaid regulations.

Not only are the arguments in Virginia's briefs in this appeal inconsistent with its 2002 representations, they are also at odds with Virginia's prior descriptions of the very same DSH payments at issue in this appeal. Virginia's January 6, 2011 response to CMS's deferrals of claims at issue here patently contradicts Virginia's current allegation that it never considered the enhanced DSH payments as reimbursement to the hospitals for costs incurred in specific periods. According to the January 6, 2011 letter, Virginia "determined the enhanced DSH payment amounts it wanted to pay" to "cover state-defined indigent care costs" for a specific fiscal year. CMS Ex. 2, at 1-3. For example, Virginia described one of the claims it made for the quarter ending June 30, 2010 as follows:

> MCV Hospital Enhanced DSH Payment FY2004 $1,288,904 – This is an enhanced DSH payment [Virginia] wants to make **to cover state-defined indigent care costs for SFY04**. [Virginia] previously disallowed these indigent care costs, but eventually agreed that these costs were covered under the state indigent care policy. These costs were accrued to FFY06, because there was available allotment and total DSH payments did not exceed the amounts authorized in the State Plan.

Id. at 3 (emphasis added). Thus, contrary to the arguments in Virginia's briefs, the January 2011 letter demonstrates that Virginia was using DSH payments allotted to one fiscal year to support indigent care costs incurred in a different fiscal year but that exceeded that fiscal year's available allotment for DSH payments.

In light of the language of the plan as a whole and Virginia's prior representations, we reject Virginia's argument that the interpretation of the plan that Virginia advances in this appeal is entitled to deference. Moreover, Virginia's own prior representations plainly belie its claim that the disallowance here rests on a new CMS interpretation of the DSH statutes of which Virginia had no advance notice. Rather, Virginia materially changed its DSH payment practice without notifying CMS, submitting a state plan amendment to reflect the change, or obtaining CMS approval before implementing the revised practices, contravening section 430.12(c) of the Medicaid regulations.

B. *The disallowance is consistent with DSH statutes and regulations.*

The Board has previously observed that "DSH payment adjustments are intended as supplemental payments to reflect the excess burden on some hospitals of the costs of providing uncompensated care, [and they] are structured as part of the reimbursement for Medicaid inpatient hospital services provided by those hospitals." *New Jersey Department of Human Services*, DAB No. 1652 (1998); *District of Columbia Dept. of Human Services*, DAB No. 1617, at 25 (1997). Indeed, the legislative history supports this understanding of the DSH provisions:

> . . . States, in developing their payment rates, [must] take into account . . . the atypical costs incurred by hospitals which serve a disproportionate number of low income patients. The conferees recognize that public hospitals and teaching hospitals which serve a large Medicaid and low income population are particularly dependent on Medicaid reimbursement, and are concerned that a State take into account the special situation that exists in these institutions in developing their rates.

H.R. Rep. No. 97-208, 97th Cong., 1st Sess. 962 (1981). The Board also has noted that the word "adjustment" implies something additional to what was previously provided. DAB No. 1435, at 5. Consequently, the Board has stated, a state's effort to treat its DSH payments as unconnected to specific periods in which uncompensated care costs are

incurred would be inconsistent with the intent of the Act. DAB No. 1652, at 8 (citing DAB No. 1435). We therefore agree with CMS that for "purposes of determining whether DSH payments are within limitations specified in Federal requirements, DSH payments are necessarily allocated to the time periods in which DSH-eligible costs were incurred by the hospitals in providing certain services." VA Ex. 1, at 4.

Furthermore, the disallowance is supported by the language of 42 C.F.R. § 447.297, which implements the limit on the aggregate amount of payments a state may make to DSHs for which FFP is available and discusses the process by which a state's DSH expenditures are reconciled with the state's allotment for each fiscal year. Under section 447.297(c), CMS prospectively calculates and publishes preliminary DSH allotments for each state prior to October 1 of the upcoming fiscal year. CMS then revises the preliminary allotments by April 1 of the fiscal year. 42 C.F.R. 447.297(d)(1). Section 447.297(d) (2) provides that if "CMS determines that at any time a State has exceeded its final DSH allotment for a Federal fiscal year," CMS will disallow the FFP attributable to the excess DSH expenditures. The regulation further provides that if "a State's actual DSH expenditures applicable to a Federal fiscal year are less than its final State DSH allotment for that Federal fiscal year," the state may, if allowed by its approved State plan, "make additional DSH expenditures applicable to that Federal fiscal year up to the amount of its final DSH allotment for that Federal fiscal year." The regulation, however, does not provide that a state may make excess uncompensated care costs from one year applicable under the DSH allotment for a different year. VA Ex. 1, at 4.

Virginia argues that by "stating that DSH payment adjustments must be 'applied' to years based on when specific service costs were incurred, CMS relies on the very interpretation that it rejected" in the August 1993 preamble to the final rule implementing the 1991 DSH allotment legislation, 58 Fed. Reg. 43,156 (Aug. 13, 1993). VA Br. at 25. We reject this argument.

The preamble explained that after CMS published an interim final rule, a commenter noted that the wording relating to the calculations of the yearly allotments in some instances referred to "payments in" a fiscal year, while in other places referred to "actual expenditures," "payments made by a State" or information "attributable" to the fiscal year. 58 Fed. Reg. at 43,177. The commenter asserted that the "use of the term 'actual expenditures' is inconsistent with the recognition of payments 'attributable to' the FFY. . . ." *Id.* The commenter "suggested revised language … to clarify the regulatory language regarding the calculation of the State base allotment." *Id.* The commenter also "suggested that each reference to the 'payments' or 'expenditures' that will be considered in the determination or application of the State allotment be clarified by adding, 'for services rendered during the FFY 1992 in the State base allotment, regardless of when payment is made.'" *Id.*

In response to the commenter's observations about the inconsistent language in the interim final rule, CMS explained in the preamble to the final rule that it had revised the regulations "to state that the amounts used in determining the DSH payments made by the States will be based on payments 'applicable to' rather than payments 'in' a FFY." *Id.* at 43,178. CMS stated that it had not made the second recommended change, however. "Since DSH payments are not necessarily directly tied to services," CMS stated, "we believe that including the word 'services' would cause considerable confusion." *Id.* Virginia relies on this sentence as evidence that CMS is now "seeking through a disallowance proceeding to enforce a position diametrically opposed to the one it advocated in the preamble to the implementing regulations." VA Br. at 26 (citing *Hawaii Dept. of Human Servs.*, DAB No. 1981 (2005)). According to Virginia, by stating that DSH payments are "not necessarily directly tied to services," CMS meant that "there was no expectation that DSH payment adjustments be applied, for purposes of the allotment, to fiscal periods when specific services were rendered." *Id.* at 27. Further, Virginia argues that the Board's decision in *Hawaii* shows that "the Board rightly views preamble language as an inherent part of a regulation where the role of the preamble statement is to add specificity to regulatory requirements." *Id.* at 27. Virginia contends that the "Board should hold CMS to the terms of the regulation, as explained in the preamble, just as it did in the *Hawaii* decision." *Id.*

Virginia misreads the Board's decision in *Hawaii* and CMS's 1993 preamble statement. The Board in *Hawaii* did not describe a preamble statement as an inherent or intrinsic part of the regulation itself. Rather, in *Hawaii*, as in other decisions, the Board determined that preamble statements should not be considered in isolation, but must be read in context and consistent with the language of the applicable statutes and regulations. In *Hawaii,* the Board concluded, an "example in the preamble to the interim final rule, when read in light of the regulations and other statements in the preambles, [did] not have the effect CMS says it [had]." *Id.* at 25. The Board also determined that CMS's position was inconsistent with a statement in the preamble to the final rule that was an attempt to be more precise and to eliminate vagueness. *Id.* at 20. Furthermore the Board concluded, CMS's position failed to give effect to a key statutory term and the regulation interpreting that term. *Id.* at 23-24.

In contrast, we conclude here that the CMS response in the 1993 preamble to the final DSH rule that Virginia cites, when read in context, is consistent with the language of the regulation, as well as CMS's position in support of the disallowance at issue. By revising the inconsistent wording in the interim regulation to clarify that expenditures or payments would be treated uniformly as "applicable to" a fiscal year, CMS acknowledged that a state may make a payment in one year to cover expenses incurred in a prior year. In such a case, the payment would be "applicable to" the earlier year, not the year in which the payment was made. CMS's next statement, that "DSH payments are not necessarily directly tied to services," alludes to a CMS statement in an earlier section of the preamble. In that section, CMS explained that a few commenters were concerned with

CMS's interim final rule regulatory impact statement that the regulations would not have "a direct or indirect effect on recipients since the rule will not preclude providers from receiving Medicaid payments for services that are furnished." *Id.* at 43,176. CMS explained in the final rule preamble that its earlier statement "was intended to mean" that it believed the rule would not adversely affect individual Medicaid recipients. "Since DSH payments are supplemental additional payments to hospitals not specifically tied to a specific Medicaid service provided to a specific Medicaid recipient," CMS explained, "we concluded that the interim final DSH regulations would not directly or indirectly affect Medicaid services provided to individual Medicaid recipients." *Id.*

Thus, Virginia takes out of context CMS's response in the latter part of the preamble, that "DSH payments are not necessarily directly tied to services." The fact that a DSH payment adjustment is not calculated based on, or directly incorporated in, the standard rates billed and paid for day-to-day services does not mean that the DSH payments bear no relationship to the costs incurred by the hospitals in a fiscal year. To the contrary, as explained in the preamble and in detail above, DSH payments are "supplemental additional payments to hospitals," intended to cover the atypical costs public and teaching hospitals incur during years in which they provide services to a disproportionate number of indigent patients. Accordingly, we conclude that CMS's statements in the 1993 preamble to the final rule are consistent with CMS's position here.

C. *We agree with CMS that Virginia's novel interpretation of its State plan to allow DSH allotments for one fiscal year to cover costs incurred in another fiscal year could allow it to impermissibly circumvent the federal DSH limits.*

Virginia's argument that its state Medicaid plan permitted it to allocate DSH payments to any fiscal year allotment so long as the DSH payments did not exceed the federal limits for any year is unreasonable because it could permit Virginia to effectively circumvent the annual statewide and hospital-specific DSH payment limits. For example, Virginia's Director of Provider Reimbursement represented in January 2011, that among the "DSH Payments for the Quarter Ending June 30, 2010" was "MCV Hospital Enhanced DSH Payment FY2004 $1,288,904." CMS Ex. 2 at 3. According to the Director, this was "an enhanced DSH payment [Virginia] want[ed] to make to cover state-defined indigent care costs for SFY04." *Id.* The Director further explained, "These costs were accrued to FFY06, because there was available allotment and total DSH payments did not exceed the amounts authorized in the State Plan." *Id.* If, as the Director's statement implies, Virginia's allotment for FY2004 had been exhausted, Virginia's decision to "accrue" the FY2004 costs to the FFY06 allotment permitted Virginia to obtain FFP that would have been disallowed had Virginia attempted to allocate the costs to the FY2004 allotment. Moreover, if MCV's hospital-specific limit for FY2004 had been reached, the hospital would have received more funding for 2004 than allowable under its annual hospital-

specific limit – a limit designed to ensure that the hospital did not receive DSH funding in excess of what the hospital itself reported in uncompensated care costs for that year. In sum, we agree with CMS that Virginia's approach was not reasonable because it allowed "for a constructive end-run around the state and hospital-specific limits imposed by Congress." CMS Br. at 17.

III. Conclusion

For the reasons discussed above, we sustain the disallowance.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Sheila Ann Hegy
Presiding Board Member