Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

SUBJECT: Oregon Department of Human Services
Docket No. A-06-82
Decision No. 2208

DATE: November 7, 2008

DECISION[1]

The Oregon Department of Human Services (Oregon) appeals a determination by the Centers for Medicare & Medicaid Services (CMS) to disallow federal matching funds for quarterly Medicaid payments, known as "Proportionate Share" or "Pro-share" payments, that Oregon made to the Oregon Health & Science University (OHSU), an acute care hospital. These Pro-share payments supplemented the basic or standard Medicaid payments that Oregon made to OHSU for its inpatient services to Medicaid recipients. Pursuant to a provision in its state Medicaid plan, Oregon computed the Pro-share payment for each quarter using a formula that required it to calculate what the federal *Medicare* program would have paid OHSU for its inpatient services to Medicaid recipients during the quarter. An audit by the Department of Health and Human Services Office of Inspector General (OIG) later found that Oregon had used an outdated Medicare payment rate when it applied the Pro-share payment calculation formula to determine the amount of OHSU's Pro-share payments for the second, third, and fourth quarters of SFY 2003 (October 1, 2002 through June 30, 2003). The OIG also found that use of the outdated Medicare rate had caused Oregon's Medicaid payments to exceed the Medicaid upper payment limit (UPL) for non-State government-owned or operated hospitals (of which OHSU was one). CMS concurred with the OIG's finding that Oregon had exceeded the Medicaid UPL for the second, third, and fourth quarters of SFY 2003. On that basis, CMS disallowed $505,009 in federal reimbursement for the alleged excess payments.[2]

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[1] This decision is by a majority of the three-member panel that heard the above-captioned appeal. A dissenting opinion follows the majority opinion.

[2] CMS notified Oregon of the disallowance in a letter dated

(continued...)

Although it now concedes that Oregon did not exceed the Medicaid UPL in SFY 2003, CMS has articulated another legally sufficient ground for the disallowance – noncompliance with the state plan. We agree with CMS that Oregon's state Medicaid plan obligated Oregon to use the most current, applicable Medicare hospital payment rate in determining the amount of its quarterly Pro-share payments to OHSU. Because Oregon used an outdated Medicare rate to determine the amount of Pro-share payments made to OHSU for the second, third, and fourth quarters of SFY 2003, and because the outdated rate was higher than the rate Oregon should have used, Oregon's Pro-share payments to OHSU for those quarters exceeded what the state plan allowed. While we conclude that CMS had a proper basis for disallowing those excess payments, for the reasons discussed on page 27 of our decision, we remand this case to CMS to re-calculate the amount of the disallowance to ensure that it accurately reflects CMS's current basis for the disallowance, as upheld by the Board.

Legal Background

1. *Medicaid program law*

Medicaid, established under title XIX of the Social Security Act (Act),[3] is a program in which the federal government and states share the cost of providing necessary medical care to financially

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[2](...continued)
April 12, 2006. CMS Ex. 5. This notice of disallowance indicates that CMS initially disallowed $973,148 in federal reimbursement. Id. CMS later reduced the disallowance from $973,148 to $680,853. See CMS Ex. 16, ¶ 4. The reduced disallowance was based on two grounds: (1) that Oregon's Medicaid payments had exceeded the Medicaid UPL during the *first quarter* of SFY 2003; and (2) that Oregon had exceeded the UPL during the second, third, and fourth quarters of SFY 2003 as a result of using an outdated Medicare payment rate to compute OHSU's Pro-share payments for those quarters. Id. ¶ 6; CMS Br. at 7-8 & n.4. During this appeal, CMS abandoned the first ground for the disallowance. CMS Br. at 8 n.4. CMS also clarified that the amount of federal reimbursement disallowed on the second ground was $505,009. Id.

[3] The Social Security Act can be found at www.ssa.gov/OP_Home/ssact/comp-ssa.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section.

needy and disabled persons. Act §§ 1901, 1903. Each state establishes and administers its own Medicaid program subject to various federal requirements and the terms of its "plan for medical assistance" (state plan), which must be approved by the Secretary of Health and Human Services. Id. § 1902. Once the state plan is approved, a state becomes entitled to receive federal matching funds, also known as "federal financial participation" (FFP), for a percentage of its program-related expenditures. Id. § 1903(a); 42 C.F.R. §§ 430.1, 430.30.

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. 42 C.F.R. §§ 447.201(b), 447.252(b). Payment rates must be "consistent with efficiency, economy, and quality of care[.]" Act § 1902(a)(30) (A). That requirement is the basis for regulations in 42 C.F.R. Part 447 that impose upper payment limits (UPLs) on a state's Medicaid payments to hospitals and other medical providers. See 66 Fed. Reg. 3148 (Jan. 12, 2001).

Title 42 C.F.R. § 447.272 imposes UPLs for inpatient services furnished by hospitals. Under this regulation, a separate UPL applies to each of the following groups of hospitals: (1) state government-owned or operated hospitals; (2) non-State government-owned or operated facilities (that is, all government facilities that are neither owned nor operated by the state); and (3) privately-owned and operated hospitals. 42 C.F.R. § 447.272(a). For each group, the UPL is a "reasonable estimate of the amount that would be paid for the services furnished by the group . . . under Medicare payment principles[.]" Id. § 447.272(b)(1). Medicaid payments in excess of an applicable UPL are ineligible for FFP. Id. § 447.257.

2. *Medicare payment for hospital services*

As we indicated above and explain more fully below, this case involves Medicare payment principles applicable to inpatient hospital stays. With certain non-relevant exceptions, Medicare payment for inpatient hospital services is based on predetermined or prospectively fixed rates that are applied to a patient case or "discharge." See Act § 1886; 42 C.F.R. §§ 412.1, 412.23. The Medicare prospective payment for an inpatient hospital discharge is derived as follows. First, the hospital is assigned an "average standardized" — or "base" — payment rate. 67 Fed. Reg. 49,982 (Aug. 1, 2002). The base rate has two components: a labor-related component, and a non-labor-related component that is adjusted using a wage index in order to reflect regional differences in hospital labor costs. Id. The hospital's base

rate – that is, the sum of the non-labor component and the wage-adjusted labor component – is then multiplied by a payment weight that corresponds to the diagnosis-related group (DRG) to which the patient is assigned in order to arrive at a DRG-weighted Medicare payment for that case.[4] Id. at 49,982, 49,985. The DRG-weighted payment may be further adjusted or supplemented to account for other special factors, including: (1) the hospital's status as a "disproportionate share hospital" (DSH) – that is, a hospital that serves a disproportionate share of low-income patients; (2) the hospital's status as an approved teaching hospital; and (3) the existence of "outliers" – that is, hospital stays for which the cost of care is unusually expensive. Id. at 49,982; see also 42 C.F.R. § 412.1(a)(1).

By statute and regulation, CMS must publish the final "*methods, amounts, and factors* for determining prospective payment rates for inpatient hospital services not later than the August 1 before the Federal fiscal year in which the rates would apply." 42 C.F.R. § 412.8(b)(2) (italics added); see also Act § 1886(d)(6). Those methods, amounts, and factors include a wage index as well as dollar values for the labor and non-labor components of a hospital's base rate. See, e.g., 67 Fed. Reg. at 50,125-26, 50,134.

Case Background[5]

In 2001, Oregon obtained CMS approval of state plan amendment (SPA) 01-05, which had an effective date of January 1, 2001. Or. Ex. 5. SPA 01–05 authorizes Oregon to make Pro-share payments to certain academic teaching hospitals. Id. These Pro-share payments supplement Oregon's basic or standard Medicaid payments for inpatient hospital services. Id. (June 7, 2001 letter from CMS to Oregon stating that SPA 01-05 "provides for an additional payment of unreimbursed inpatient Medicaid charges").

SPA 01-05 provides in its entirety:

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[4] A DRG is a grouping of clinically similar cases that are expected to require similar amounts of hospital resources. See 48 Fed. Reg. 39,752, 39,760 (Sept. 1, 1983). To each DRG, CMS assigns "an appropriate weighting factor that reflects the estimated relative cost of hospital resources used with respect to discharges classified within that group compared to discharges classified within other groups." 42 C.F.R. § 412.60(b).

[5] The facts set out in this section are drawn from the documentary evidence submitted by the parties and are undisputed.

> Proportionate Share [payments] will be made to public academic teaching hospitals with 200 or more interns or residents. *Proportionate Share payments are subject to the federal Medicare upper payment limit for Inpatient hospital payments*. The Medicare upper payment limit analysis will be performed prior to making the payments.
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> Eligible academic hospitals will be classified as either a (i) State owned or operated hospital, or (ii) non-State government owned or operated hospital. The Proportionate Share payment will be specific to each classification and determined as follows:
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> > The federal upper payment limit is determined in accordance with the specific requirements for each hospital classification for all eligible hospitals during the State Fiscal Year 2001. *The Proportionate Share payment is calculated by the determination of the Medicare upper payment limit of the Medicaid Fee-For-Service Inpatient charges converted to what Medicare would pay, less Medicaid payments and third party liability payments*. The State of Oregon Medicaid Management Information System (MMIS) is the source of the charge and payment data.
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> *Proportionate Share payments will be made quarterly during each federal fiscal year.* Payments made during [the] federal fiscal year will not exceed the Medicare upper limit calculated from January 1, 2001 through September 30, 2001, and quarterly for each federal fiscal year thereafter.

Id. (italics added). For present purposes, three aspects of SPA 01-05 are noteworthy. First, it provides that Pro-share payments are to be made quarterly. Second, SPA 01-05 sets out a formula for calculating the amount of each quarterly Pro-share payment: "The Proportionate Share payment is calculated by the determination of the Medicare upper payment limit of the Medicaid Fee-For-Service Inpatient charges converted to what Medicare would pay, less Medicaid payments and third party liability payments." Third, SPA 01-05 states that Pro-share payments are subject to the "Medicare upper payment limit for Inpatient hospital payments." The latter statement is an apparent reference to the UPLs in 42 C.F.R. § 447.272 for inpatient

services furnished by state government and non-state government-owned or operated hospitals.

During SFY 2003, Oregon had 12 non-state government-owned or operated hospitals. Or. Ex. 40, ¶ 7 & Att. 40A. One of those was the Oregon Health & Science University (OHSU). Id. Att. 40A. From 2001 through 2003, OHSU was the only hospital in Oregon eligible to receive Pro-share payments under SPA 01-05 (that is, it was the only academic teaching hospital with 200 or more interns or residents). Or. Ex. 39, ¶ 12. Pursuant to SPA 01-05, Oregon started to make Pro-share payments to OHSU in 2001, with the first payment being for the quarter that began on January 1, 2001. See CMS Ex. 15.

In late 2003, the OIG initiated an audit to determine, among other things, whether Oregon had made UPL calculations that were reasonable and in accordance with its state plan. Or. Ex. 7 (Bates # CMS EX 00221-222). During the audit, the OIG examined how Oregon had calculated the Pro-share payments made to OHSU for SFY 2003 (July 1, 2002 to June 30, 2003). Or. Exs. 7-8. On this subject, the OIG interviewed Eric Larson, a Medicaid reimbursement specialist employed by Oregon's Medicaid agency. Or. Exs. 8, 11, and 39 (¶ 1). Larson was then (as now) "responsible for the analysis and calculation of Medicaid reimbursement to hospitals," including the calculation of a hospital's quarterly Pro-share payment. Or. Ex. 39, ¶¶ 3, 10. Summaries of the OIG's interviews of Larson are contained in the OIG's audit workpapers, copies of which Oregon submitted for the record. See, e.g., Or. Exs. 8, 11.

In interviews with the OIG, and in a declaration submitted by Oregon, Larson described how he determined whether a Pro-share payment could, in accordance with SPA 01-05, be made to OHSU in a given quarter and the amount (if any) of the allowable payment.[6] Two basic steps were involved.

In step one, Larson calculated what Medicare would have paid for the inpatient services that OHSU had provided to Medicaid recipients during the quarter for which a Pro-share payment (if any) would be made. Larson performed that calculation by first ascertaining OHSU's Medicare base payment rate for inpatient

[6] The description of the Pro-share payment calculation methodology is drawn from the following portions of the record: Or. Ex. 39, ¶ 11 & Atts. 39B, 39C, 39D, and 39H; Or. Exs. 8, 11; Or. Ex. 38 (Bates #s CMS EX 00538, 00542, 00543-44, 00548-552, 00716).

hospital services. As indicated, a hospital's Medicare base rate is computed by multiplying a standard labor value by a wage index and then adding the product to a standard non-labor value – that is, *base rate = (labor component x wage index value) + non-labor component*. Larson then multiplied the base rate by a Medicaid "case mix index" (CMI) – an average DRG weight for OHSU's Medicaid population – in order to account for the severity of Medicaid cases relative to non-Medicaid cases in the OHSU patient population. Larson made further adjustments to the base rate to account for OHSU's capital and medical education expenditures. The product of these computations was a "composite" DRG-weighted Medicare payment rate for a Medicaid recipient's inpatient hospital stay at OHSU. Finally, Larson multiplied the composite rate by the number of OHSU's Medicaid "claims" (each claim representing a period of Medicaid-covered hospitalization) from the quarter for which the Pro-share payment was being calculated. The product was Oregon's determination of what Medicare would have paid OHSU for Medicaid-covered services furnished by the hospital during that quarter.

In step two of the Pro-share payment calculation, Larson subtracted from the figure derived in step one the total Medicaid payments (e.g., fee-for-service and third-party liability payments) received by OHSU for the quarter. If the amount determined in step one exceeded total Medicaid payments received by OHSU for the quarter, then Oregon made a Pro-share payment to OHSU for the difference. Oregon determined whether a Pro-share payment could be made for a given quarter after the quarter ended, based on Medicaid claims from that quarter.

During its audit, the OIG learned that Oregon had used an outdated Medicare payment rate in calculating, in step one of the Pro-share payment formula, what Medicare would have paid OHSU for inpatient hospital services furnished to Medicaid recipients during the second, third, and fourth quarters of SFY 2003 (October 1, 2002 to June 30, 2003). More specifically, the OIG found that Oregon had used OHSU's Medicare base rate for federal fiscal year (FFY) 2002, *which ended on September 30, 2002*, in making the step-one calculations *for the three quarters beginning October 1, 2002*. Or. Ex. 18 (Bates # CMS EX 00341); see also Or. Ex. 39, ¶ 14. The OIG also determined that OHSU's Medicare base payment rate for FFY 2002, which ended September 30, 2002, was slightly higher than OHSU's Medicare base rate for FFY 2003. See CMS Ex. 3, at 28, 32.

When asked by the auditors in a July 2003 interview where or how he obtained or determined OHSU's Medicare base payment rate, Larson reportedly responded that he had obtained the rate from

OHSU's billing department. Or. Ex. 38 (Bates # CMS EX 00548). In an October 2003 interview, however, Larson indicated that he used "whatever CMS ha[d] published" to determine the applicable Medicare rate and obtained necessary information from the Medicare fiscal intermediary (contractor) once a year, usually at the beginning of the calendar year. Or. Ex. 11 (Bates # CMS EX 00771-772). When asked in a January 2004 interview to explain why he had used OHSU's FFY 2002 Medicare base rate to make Pro-share payment calculations for the second, third, and fourth quarters of SFY 2003, Larson responded that he was unaware that a more current Medicare rate was available and that his unawareness was an oversight. Or. Ex. 38 (Bates # CMS EX 00799-800).[7]

OIG workpapers refer to Eric Larson's step-one calculation of what Medicare would have paid OHSU for inpatient services to Medicaid recipients in a given quarter as a "UPL." See, e.g. Or. Ex. 8, 11. In his declaration, Larson explained that his Pro-share payment calculations did not involve the calculation of the UPL mandated by 42 C.F.R. § 447.272 for non-State government-owned or operated facilities (of which OHSU was one of 12), only the determination (at step one of the Pro-share payment formula) of what Medicare would have paid for Medicaid-covered inpatient hospital services furnished by OHSU in a particular quarter. Or. Ex. 39, ¶¶ 9, 11.

In February 2005, the OIG issued a report of its audit findings. CMS Ex. 12.[8] Referring to the amount calculated by Oregon in step one of the Pro-share payment formula as a "UPL," the OIG found:

> The State plan amendment [01-05] stipulated that Oregon make quarterly [Pro-share] payments to public (State or non-State government) academic teaching hospitals with 200 or more interns or residents and calculate a quarterly UPL for each category of eligible hospitals. From the [Pro-share] program's inception on January 1, 2001, through June 30, 2003 [the end of SFY 2003], only one hospital qualified for [Pro-share] payments:

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[7] In his declaration, Larson did not dispute the accuracy of any of the interview statements attributed to him in the OIG's workpapers.

[8] Department of Health and Human Services, Office of Inspector General, *Audit of Oregon's Medicaid Upper Payment Limits for Non-State Government Inpatient Hospitals for State Fiscal Year 2003*, Report No. A-09-04-00023 (February 2005).

> Oregon Health & Science University. Oregon calculated a UPL for this hospital as required by its State plan amendment.
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> * * *
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> Oregon used outdated Medicare payment rates in its UPL calculations for SFY 2003. For the second, third, and fourth quarters of SFY 2003 [October 1, 2002 to June 30, 2003], Oregon used Medicare rates for [federal fiscal year] 2002 even though [federal fiscal year] 2003 rates were available. *As a result, Oregon overstated its UPLs by $818,879*.

CMS Ex. 12, at 10, 14 (italics added; footnote omitted).[9]

The OIG illustrated this conclusion in a table entitled "Excess Medicaid payments Due to Use of Outdated Rates." CMS Ex. 12, at 14. For each of the three quarters in question, the table, which we reproduce below, shows:

- Column (1): "Total Medicaid payments" made to OHSU in the second, third, and fourth quarters of SFY 2003. These totals include basic Medicaid payments, Pro-share payments, and other supplemental Medicaid payments.
- Column (2): The "UPL Per Federal Regulations" for each quarter based on OHSU's FFY 2003 Medicare base rate (instead of the FFY 2002 rate used by Oregon); and
- Column (3): The amount by which Medicaid payments exceeded the figure in column 2.

[9] In response to the OIG's findings, Oregon agreed to use the most current Medicare payment rate information in calculating future (post-SFY 2003) Pro-share payments. CMS Ex. 12, at 15.

	(1) Total Medicaid Payments	(2) Less UPL Per Federal Regulations	(3) Medicaid Payments That Exceeded UPL
SFY 2003 2nd Q	$8,253,047	$7,960,476	$292,571
SFY 2003 3rd Q	7,600,354	7,330,914	269,440
SFY 2003 4th Q	7,104,761	6,852,893	251,868
		Column 3 Total	**$813,879**

On April 12, 2006, CMS issued a notice of disallowance. CMS Ex. 5, at 2. According to the notice –

> the OIG found that the State had used outdated rates to calculate the applicable UPL for non-State government inpatient hospitals and, as a result, overstated the UPL and made payments that exceeded the correctly calculated UPL (the State used 2002 Medicare rates even though 2003 rates were available).

Id. at 2. CMS concurred that Oregon had overstated the UPL and on that basis disallowed $505,009 in FFP. Id. This amount is the federal share of the $813,879 in Medicaid payments that exceeded what CMS called the "correctly calculated" UPL for SFY 2003. Id.; see also CMS Ex. 16, ¶ 6.

The Parties' Contentions on Appeal

In its opening brief, Oregon contended that the disallowance reflected a "misunderstanding" of the applicable Medicaid UPL in 42 C.F.R. § 447.272. Oregon Br. at 14. According to Oregon, the amounts shown in column two of the OIG's table (entitled "Excess Medicaid Payments") did not represent a UPL for the category of non-State government-owned or operated hospitals. Instead, says Oregon, those amounts were the OIG's calculation of what Medicare would have paid a single hospital – OHSU – for Medicaid-covered inpatient services furnished during the second, third, and fourth quarters of SFY 2003. Id. at 14, 16. Stressing that the Medicaid UPL is a limit on "*aggregate* Medicaid payments to a *group* of facilities," 42 C.F.R. § 447.272(b)(2) (italics added), Oregon asserted that the figures in column two did not constitute a UPL because they did not reflect what Medicare would have paid for Medicaid-covered inpatient services furnished by Oregon's 11

other non-State government owned or operated hospitals. Id. at 15-16. Oregon further contended that its SFY 2003 Medicaid payments did not, in any event, exceed the UPL for that group of hospitals. Id. at 16-24.

In its response, CMS argued that "[t]his case is *not* about the aggregate UPL — that is, at least not the aggregated UPL for non-state government hospitals that CMS has described in regulations at 42 C.F.R. § 447.272(a)(2)." CMS Br. at 10 (italics in original); see also id. at 6 (asserting that "[t]he Pro Share UPL is not designed and does not function as an aggregate UPL ceiling in conformity with the regulatory requirement for non-state government hospitals"). Rather, says CMS, this case concerns the formula that Oregon used to determine whether a Pro-share payment could be made to OHSU for a given quarter. CMS Br. at 12-21. As noted, in step one of that formula, Oregon calculated what Medicare would have paid OHSU for services furnished to Medicaid recipients during the quarter. CMS asserts that Oregon failed to make that step-one calculation in a consistent manner. Id. at 12.

According to CMS, for quarters beginning on January 1, 2002, Oregon used OHSU's FFY 2002 Medicare base payment rate (which took effect on October 1, 2001) instead of the FFY 2001 rate it had been using in the immediately preceding quarters. In other words, said CMS, for the quarter beginning January 1, 2002, Oregon made an adjustment which ensured that its Pro-share payment was based on the most current, applicable Medicare rate for OHSU. CMS asserts that Oregon failed to make a comparable adjustment when OHSU's FFY 2003 base rate took effect on October 1, 2002. That is, for the second, third, and fourth quarters of SFY 2003 — October 1, 2002 to June 30, 2003 — Oregon continued to make its step-one calculations using OHSU's base rate for FFY 2002 instead of the FFY 2003 rate that became effective on October 1, 2002. Id. at 12-13. CMS contends that Oregon's failure to use the most current or up-to-date Medicare payment rate in its step-one calculations for the second, third, and fourth quarters of SFY 2003 constituted a "significant" change to Oregon's "methodology for calculating and making Pro-share payments" and, as such, represented a change in its interpretation of SPA 01-05, as exemplified by its pre-October 1, 2002 practice of updating OHSU's Medicare base rate. Id. at 11, 14, 18-21. CMS asserts that this interpretive change was invalid because Oregon had made it unilaterally, outside the state plan amendment process. Id. at 11, 14, 20-21 (asserting that "Oregon cold not deviate from its chosen methodology unless it amended SPA 01-05"). To support that proposition, CMS cites 42 C.F.R. § 430.12(c), which states that a state Medicaid plan must provide

that it will be amended 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." CMS also relies on the Board's decisions in New Hampshire Dept. of Health and Human Services, DAB No. 1862 (2003) and Colorado Dept. of Health Care Policy and Financing, DAB No. 2057 (2006). Finally, CMS contends that Oregon's failure to use OHSU's FFY 2003 Medicare base rate in its Pro-share payment calculations for the second, third, and fourth quarters of SFY 2003 violated CMS "policy" that requires states to use the "best available data." CMS Br. at 17-18.

In its reply brief, Oregon contends that there is no basis to find that it had changed its Pro-share payment formula because its state plan did not dictate the necessity or timing of Medicare payment rate adjustments. Reply Br. at 10-13.

The parties supplemented their arguments in written responses to questions issued by the Board on December 28, 2007. Those responses were filed on February 8, 2008.

Oral argument was held in this appeal on April 1, 2008.

Analysis

1. *CMS was permitted to revise the rationale for the disallowance in this proceeding.*

As a preliminary matter, it is clear from the foregoing description of the parties' contentions that CMS has revised the basis for the challenged disallowance. According to its April 12, 2006 notice, CMS issued the disallowance on the ground that Oregon's Medicaid payments in SFY 2003 had exceeded the applicable Medicaid UPL in 42 C.F.R. § 447.272. CMS has abandoned that ground for the disallowance on appeal. It no longer contends that Oregon exceeded the UPL for non-State government-owned or operated hospitals. Instead, CMS asks us to uphold the disallowance because, in its view, Oregon unilaterally changed the state plan method of calculating Pro-share payments when it used an outdated Medicare payment rate to calculate OHSU's Pro-share payments for the second, third, and fourth quarters of SFY 2003. CMS Br. at 21. Oregon vaguely asks us to disregard CMS's new ground for the disallowance because it was not (according to Oregon) actually considered or articulated by CMS officials and is merely the "'post-hoc rationalization[ ] of appellate counsel.'" Reply Br. at 4 (relying on and quoting from Oglala Sioux Tribe of Indians v. Andrus, 603 F.2d 707, 715 n.7 (8th Cir. 1979)).

The Board has held that the federal government party may revise the basis for a disallowance on appeal as long as the opposing party is given an adequate opportunity to respond to the change in position. Wisconsin Dept. of Health and Social Services, DAB No. 696 (1985); New Hampshire, DAB No. 1862, at 10 n.5. Oregon had – and does not contend that it lacked – an adequate opportunity to respond to CMS's change in position. In addition, CMS presented evidence that the new ground for the disallowance was considered and articulated by its employees and was not the post-hoc rationalization of counsel. See CMS Ex. 16 (declaration of Thomas M. Eaton, Financial Analyst, CMS Region X), ¶ 7.l. (stating disagreement with Oregon's arguments "because the State did not provide any documented CMS authorization or evidence that the regulations allowed the use of outdated Medicare rates"); CMS Ex. 17 (declaration of James C. Frizzera, director of the CMS Financial Management Group), ¶ 6 (stating that "[o]nce Oregon chose a method by which to calculate the supplemental payments under the state plan, it had to stick with that method or change the state plan"). Consequently, CMS may rely on the new ground for the disallowance articulated in its response brief.

2. *Oregon's Pro-share payments to OHSU in the second, third, and fourth quarters of SFY 2003 exceeded what SPA 01-05 allowed because they were calculated using a Medicare base rate for OHSU that was not in effect during those quarters.*

Before discussing Oregon's response to CMS's new ground for the disallowance, we briefly summarize the context for the OIG's finding that Oregon used an outdated Medicare payment rate to calculate OHSU's Pro-share payments for the second, third, and fourth quarters of SFY 2003. On or about August 1 of each year, the Medicare program publishes in the *Federal Register* final "methods, amounts, and factors" for determining prospective payment rates for inpatient hospital services for the upcoming federal fiscal year, which begins October 1. See, e.g., 67 Fed. Reg. 49,982 (Aug. 1, 2002). Between FFY 2001 and 2003, these methods, amounts, and factors yielded the following Medicare base rates for OHSU:

FFY 2001 (Oct. 1, 2000 to Sept. 30, 2001) – **$4,289.04**
FFY 2002 (Oct. 1, 2001 to Sept. 30, 2002) – **$4,496.62**
FFY 2003 (Oct. 1, 2002 to Sept. 30, 2003) – **$4,457.95**

This information shows that OHSU's Medicare base rate *decreased* slightly from FFY 2002 to FFY 2003.[10]

As discussed in the previous section, Oregon determined the amount of OHSU's Pro-share payment for each quarter in two steps. In step one, Oregon made its calculation of what Medicare would have paid for the inpatient services furnished by OHSU to Medicaid recipients during the quarter. For the quarters between January 2001 and December 2001, Oregon made this step-one calculation using OHSU's FFY 2001 Medicare base rate of $4,289.04. CMS Ex. 15, at 1 (see the line for "DRG PMT" in the box entitled "Medicare Payment Rates"). On January 1, 2002, Oregon began to use OHSU's FFY 2002 Medicare base rate of $4,496.62. Id. On August 1, 2002, CMS published final Medicare payment methods, amounts, and factors for FFY 2003. 67 Fed. Reg. 49,982. Although OHSU's FFY 2003 base rate of $4,457.95 took effect (for Medicare program purposes) on October 1, 2002 and continued in effect through September 30, 2003, Oregon did not use the FFY 2003 rate to calculate what Medicare would have paid OHSU during the quarters between October 1, 2002 and June 30, 2003. Instead, Oregon continued to use the higher FFY 2002 rate ($4,496.62). CMS Ex. 15, at 1. In short, for the second, third,

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[10] These base rates were derived as follows:

FFY	Labor (A)	Non-labor (B)	Wage Index (C)	Wage-adjusted base Medicare rate for OSHU (A x C) + B	Federal Register Source
2001	$2,864.19	$1,164.21	1.0910	$4,289.04	65 Fed. Reg. 47,054, 47,126, 47,154 (Aug. 1, 2000)
2002	$2,955.44	$1,201.30	1.1150	$4,496.62	66 Fed. Reg. 39,828, 39,954, 40,003 (Aug. 1, 2001)
2003	$3,022.60	$1,228.60	1.0684	$4,457.95	67 Fed. Reg. 49,982, 50,134, 50,219 (Aug. 1, 2002)

The standardized payment amounts applicable to OHSU (the values in columns A, B, and C) were those for "large urban areas." See, e.g., 67 Fed. Reg. 50,134. OHSU is in the urban area designated as area number 6440.

and fourth quarters of SFY 2003, Oregon determined what Medicare would have paid OHSU for the Medicaid-covered services provided in those quarters using an out-of-date Medicare base rate for OHSU.

As Oregon concedes,[11] the key issue raised by CMS's arguments is whether Oregon's Pro-share payment calculations — in particular, its use of an outdated Medicare base rate — were consistent with the state plan. A state may claim FFP for expenditures on inpatient hospital services — expenditures such as Oregon's Pro-share payments to OHSU — only if the expenditures were made in accordance with the "methods and standards" prescribed in the state plan. 42 C.F.R. § 447.253(i). Thus, if Oregon's use of an outdated Medicare rate to calculate OHSU's SFY 2003 Pro-share payments was not in accordance with payment methods and standards in SPA 01-05, then Oregon is properly subject to disallowance of FFP that it received for Pro-share payments resulting from that noncompliance. See Act § 1903(d); New Hampshire at 3 ("The federal share of payments made at a rate higher than authorized in the approved state plan is considered an overpayment subject to recovery by CMS" (citing cases)).

To determine whether Oregon's Pro-share payment calculations were consistent with the state plan, we look first to SPA 01-05's text. Among other things, SPA 01-05 requires that Pro-share payments be made "*quarterly* during each federal fiscal year." Or. Ex. 5 (italics added). In addition, SPA 01-05 provides a formula for calculating an eligible hospital's quarterly Pro-share payment:

> *The Proportionate Share payment is calculated by* the determination of the Medicare upper payment limit of the Medicaid Fee-For-Service Inpatient charges converted to what Medicare would pay, less Medicaid payments and third party liability payments.

Id. (italics added). On its face, this formula required Oregon to compute a quarterly Pro-share payment by subtracting "Medicaid payments and third party liability payments" from the "Medicare upper payment limit of the Medicaid Fee-For-Service Inpatient charges converted to what Medicare would pay." There is, of course, no issue about how "Medicaid payments and third party liability payments" were calculated. The issue here is how Oregon calculated the "*Medicare upper payment limit* of the Medicaid Fee-For-Service Inpatient charges converted to *what*

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[11] See Reply Br. at 2-3; Oral Argument Tr. at 9.

Medicare would pay" (italics added). In practice, the "Medicare upper payment limit of the Medicaid Fee-For-Service Inpatient charges" was Oregon's step-one calculation of what Medicare would have paid OHSU for services that it furnished to Medicaid recipients in a particular quarter. See Or. Ex. 39, ¶ 11 (indicating that Eric Larson made a "reasonable estimate of the amount that would be paid for the services furnished under Medicare payment principles," from which he subtracted Medicaid and third party liability payments in order to determine the amount of the Pro-share payment that could and would be made).

Oregon contends that its use of an outdated Medicare rate to calculate OHSU's Medicare upper payment limit for the second, third, and fourth quarters of SFY 2003 does not violate SPA 01-05. Reply Br. at 3. We disagree. By using language such as "Medicare upper payment limit" and "what Medicare would pay" in the Pro-share payment calculation formula, SPA 01-05 expressly required Oregon to apply relevant Medicare payment principles, a point that Oregon concedes.[12] Under those principles, which are codified in section 1886 of the Act and 42 C.F.R. Part 412 (among other places), Medicare payment for the operating costs of an inpatient hospital stay is based (typically) on a prospective DRG-weighted rate for each patient "discharge" – with each discharge reflecting a discrete period of Medicare-covered hospitalization that ends with the patient's release from, or death in, the hospital. 42 C.F.R. §§ 412.2(a), (b)(2) (providing that hospitals are paid a pre-determined or prospective amount "per discharge," with such payment being made "for each stay during which there is at least one Medicare payable day of care"), 412.4(a) (specifying the conditions for when a patient is considered "discharged"). The DRG-weighted rate is determined using the "methods, amounts, and factors" in effect when the discharge occurs. 42 C.F.R. § 412.8(b) (requiring that annual updates to the methods, amounts, and factors used to determine hospital inpatient prospective payment system rates be published in the Federal Register "not later than the August 1 before the Federal fiscal year in which the rates would apply").

[12] In its response to the Board's written questions, Oregon stated that the Pro-share payment formula in SPA 01-05 "clearly contemplates that Oregon will first calculate the amount Medicare would pay under Medicare payment principles for the Medicaid fee-for-services discharges during the relevant quarter, then subtract payments already made." Or. Resp. to Board Questions at 4.

For each quarter of SFY 2003, Oregon used OHSU's FFY 2002 Medicare base rate to determine OHSU's composite (DRG-weighted) Medicare rate for the Medicaid patient population. Oregon then multiplied the composite rate by the number of OHSU's Medicaid "claims" (hospital stays) from the quarter to arrive at OHSU's Medicare upper payment limit for the quarter. In short, for the second, third, and fourth quarters of SFY 2003 — October 1, 2002 through September 30, 2003 — Oregon calculated OHSU's Medicare upper payment limit for Medicaid-covered services provided in that quarter based on Medicare payment "methods, amounts, and factors" that were no longer in effect during those quarters, even though the components of the base rate applicable to those quarters had been published in the *Federal Register* in August 2002. In our view, this was inconsistent with the Medicare principle that payment for a Medicare "discharge" be based on the methods, amounts, and factors in effect when the discharge occurs. Just as a Medicare discharge reflects a discrete period of Medicare-covered hospitalization, each Medicaid claim used by Oregon to compute OHSU's Medicare upper payment limit for a given quarter reflected a period of Medicaid-covered hospitalization *during that quarter*. Because OHSU's Medicare upper payment limit for a quarter purported to represent what Medicare would have paid for Medicaid-covered hospital stays (or discharges) during the quarter, that amount should have reflected the Medicare payment methods, amounts, and factors then in effect. Put another way, and using SPA 01-05's own words, OHSU's "Medicare upper payment limit" represented "what Medicare would pay" for the hospital's inpatient services during the quarter. SPA 01-05 required Oregon to calculate what Medicare would pay for OHSU's services in a quarter using the Medicare base rate in effect during that quarter because Medicare would *not* have paid for the services based on an outdated rate.

Oregon's contention that it did not violate SPA 01-05 appears to rest on the absence of a state plan provision expressly dictating whether or when it needed to update the Medicare rate used to calculate OHSU's Pro-share payment.[13] However, no such provision

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[13] Oregon states, "Given that the Oregon State Plan makes no reference to the timing with which Pro-Share payments will be updated or altered, there is no basis for asserting that the effect of the State's decision with respect to updating those payments was to change its methodology or violate the written terms of the State Plan." Or. Br. at 11. In connection with this contention, Oregon cites the holding in Concourse Rehabilitation & Nursing Center, Inc. v. DuBuono, 179 F.3d 38, 46 (continued...)

was required because SPA 01-05 expressly incorporated Medicare payment principles into the basic Pro-share payment formula, and because those principles required Oregon in these circumstances to determine what Medicare would pay for services furnished by OHSU during a quarter using the Medicare rate in effect during the quarter.[14] The Oregon employee responsible for implementing SPA 01-05, Eric Larson, understood that he was obligated to apply those principles. He stated in his declaration that he made OHSU's Pro-share payment calculations "using a reasonable estimate of the amount that would be paid for the services furnished under *Medicare payment principles*." Or. Ex. 39, ¶ 11 (italics added). Furthermore, the record shows that Oregon was

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[13](...continued)
(2nd Cir. 1999) that "a State's interpretation of its own Medicaid plan cannot constitute a 'change' as that term is used in §§ 430.12(c) and 447.253(b) unless, at a minimum, the clear and unequivocal effect of the interpretation is actually to alter the written terms of the plan." The Second Circuit made the holding in the course of deciding "whether a federal court may entertain a section 1983 claim alleging that a State's interpretation of its own plan departs so far from that plan's terms as to constitute a *de facto* amendment to it, thereby triggering federal approval requirements under the Act." Id. Assuming Concourse has precedential value here, our determination that Oregon's use of an outdated Medicare payment rate had effectively changed the state plan is consistent with that holding because the "clear and unequivocal effect" of Oregon's failure to use the appropriate Medicare rate was to alter – or render irrelevant – SPA 01-05's express requirement that Pro-share payment calculations be based on Medicare payment principles (and, in particular, on the Medicare principle that payment for a discharge be in accordance with the methods, amounts, and factors in effect when the discharge occurs).

[14] Even if SPA 01-05 did not expressly incorporate Medicare payment principles or specify a formula for calculating the Pro-share payment, Oregon was not free to use an outdated Medicare rate to calculate the Pro-share payment because using such a rate was not reasonable under the circumstances. Louisiana Dept. of Health and Hospitals, DAB No. 1542 (1995) (when a federally approved state plan "does not specify any particular method for calculating" payment rate amounts or adjustments, "any reasonable method should be acceptable"). Because the Pro-share payment calculation for a given quarter was retrospective, Oregon had ample opportunity to ascertain the rate applicable to that quarter before performing the calculation.

aware that Medicare principles required it to use the rate in effect when the services were provided. Larson told auditors that he calculated Pro-share payments based on what CMS had published, and that Oregon's failure to update OHSU's base rate for the second, third, and fourth quarters of SFY 2003 was an oversight. Or. Ex. 11 (Bates # CMS EX 00771-772); Or. Ex. 38 (Bates # CMS EX 00799-800). And, during oral argument, Oregon admitted that Larson was "very, very familiar with all kinds of Medicare information [and] hospital cost reporting," that it is a "commonly known fact" that Medicare hospital rates are updated every October, and that Larson "knows" when Medicare rates are updated.[15] Oral Arg. Tr. at 11, 19.

Even assuming that SPA 01-05 was ambiguous about what Medicare rate Oregon could apply in its Pro-share payment calculations for the second, third, and fourth quarters of SFY 2003, our overall conclusion would not change because the use of an outdated Medicare rate was contrary to Oregon's own interpretation of SPA 01-05, as exemplified by its prior or historic (pre-October 1, 2002) practice in calculating Pro-share payments.[16] From the outset of the Pro-share payment program in 2001, Oregon

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[15] Oregon asserts that there was nothing wrong about Oregon using an outdated Medicare payment rate to calculate OHSU's quarterly Medicare upper payments limits because CMS permits states to use "historical" payment data to set prospective payment rates and determine the UPLs mandated by section 447.272. Reply Br. at 6 & n. 11. The situation here does not involve prospective rate-setting, and, as we have indicated, the UPLs in section 447.272 are not at issue in this case. What CMS may permit in these other contexts is irrelevant to our decision. We note that a state which pays hospitals based on prospective rates may use historical provider cost data (from a base period) to calculate payment rates for an upcoming fiscal period and to determine the UPLs associated with those rates because actual costs of the rate period are not known (having not occurred). The situation here is simply not analogous. The calculation of the Pro-share payment is entirely retrospective; the relevant data from the periods for which the Pro-share payments were made were known to Oregon when it performed its payment calculations.

[16] We have said that "consistent administrative practice" may be evidence that the state "was applying an official interpretation of a plan provision or has advanced an interpretation only as an after-the-fact attempt to justify acting inconsistently with or simply ignoring its plan." South Dakota Dept. of Social Services, DAB No. 934, at 4 (1988).

calculated what Medicare would pay OHSU for its services using the base rate in effect when the services were provided. During the third and fourth quarters of SFY 2001 (January 1 through June 30, 2001) and the first quarter of SFY 2002 (July 1, 2001 through September 30, 2001), Oregon used a Medicare base rate of $4,289.04. See CMS Ex. 15, at 1. This rate was, in fact, the Medicare rate in effect from October 1, 2000 to September 30, 2001 (FFY 2001). See infra fn. 10. When a new rate (the FFY 2002 rate) of $4,496.62 went into effect on October 1, 2001, Oregon continued to use the previous year's (FFY 2001) base rate of $4,289.04, but only for a single quarter.[17] CMS Ex. 15, at 1. Oregon began to use the FFY 2002 rate starting in January 2002. Id. Eric Larson admitted in his declaration that it was his "practice to make the Pro-share payment, if applicable, quarterly *based on the data available to me at the time*." Or. Ex. 39, ¶ 14 (italics added). The "data available" to him as of October 1, 2002 included the Medicare ratesetting "methods, amounts, and factors" published in the *Federal Register* in August 2002. Larson's admission to the OIG auditors that Oregon's use of an outdated rate in SFY 2003 was an oversight suggests that Oregon's policy or normal practice was to use the Medicare base rate in effect during the quarter for which the Pro-share payment was being calculated.

Oregon maintains that it had no "consistent administrative practice" because it updated OHSU's Medicare rate only once prior to the second quarter of SFY 2003. Reply Br. at 7. However, for six of the seven quarters prior to the second quarter of SFY 2003, Oregon used the Medicare base rate that was in effect (for Medicare program purposes) during the quarter. This is sufficient evidence Oregon had a consistent policy or practice of using the Medicare base rate that was in effect during the quarter for which the Pro-share payment was being calculated. We agree with CMS that this policy or practice constituted an interpretation of SPA 01-05's basic Pro-share

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[17] It is unclear why Oregon did not use the OHSU's FFY 2002 Medicare base rate (effective October 1, 2001) in order to calculate the Pro-share payment for the quarter beginning on October 1, 2001. At oral argument, Oregon suggested that the delay was due to the fact it did not receive necessary data from the Medicare fiscal intermediary in time to effectuate the rate changes on October 1. Oral Arg. Tr. at 18-19. In any event, we find this lapse insignificant because Oregon corrected the problem quickly by using the FFY 2002 rate to calculate Pro-share payments for the next three quarters of FFY 2002 (January 1, 2002 through September 30, 2002). CMS Ex. 15, at 1.

payment formula – specifically, the component of that formula requiring Oregon to determine OHSU's Medicare upper payment limit (or "what Medicare would pay") – and that Oregon could not alter or deviate from that interpretation without amending its state plan.

Our conclusion that Oregon needed to amend its state plan before altering its policy or practice of updating OHSU's Medicare rate is based on 42 C.F.R. § 430.12(c)(ii), which requires that a state plan be amended "whenever necessary to reflect . . . [m]aterial changes in state law, organization, or policy, *or in the State's operation of the Medicaid program*." Our conclusion is also based on our holding in Colorado. In that case, an approved state plan amendment authorized Medicaid payments for school-based services based on "average statewide rates" derived from a "Department formula" but did not specify what the formula was. In September 1999, the state of Colorado submitted to CMS a formula or methodology for computing average statewide rates. Though this rate methodology was never approved by CMS or formally incorporated into the state plan, Colorado used it to claim FFP through 2004. Then, in 2005, Colorado unilaterally revised the average statewide rate methodology and applied the revised methodology to recalculate the FFP previously claimed for school-based services for 2003 and 2004. Based on that recalculation, Colorado submitted revised FFP claims for 2003 and 2004, seeking additional FFP for those two years. After CMS disallowed the additional FFP, the Board found that Colorado's revised FFP claims were based on a rate determination methodology that was "not described in the state plan" and was materially inconsistent with Colorado's prior interpretation of the plan – that is, inconsistent with the methodology that Colorado had historically used (prior to 2005) to calculate average statewide rates for school-based services. Accordingly, the Board upheld CMS's conclusion that the revised FFP claims were "'not consistent with the provisions of the approved State plan, as the State itself has interpreted those provisions.'" DAB No. 2057, at 5 (quoting CMS's notice of disallowance). The Board also upheld CMS's conclusion that use of the revised methodology constituted a "material change" in "policy" that required Colorado, under 42 C.F.R. § 430.12(c)(ii), to submit a state plan amendment containing the change.

Oregon contends that Colorado is distinguishable because Oregon did not change any aspect of its payment methodology in SFY 2003. Reply Br. at 12. However, as we have just explained, Oregon's use of an outdated Medicare rate was a material change to the state plan's payment methodology as Oregon understood and applied it prior to SFY 2003. Oregon asserts that it used the same

Medicare "rate components" in SFY 2003 that it did in previous years. Id. While this is true, it is also true that using historic or outdated values for a rate component (here, these values were the ones that were used to calculate OHSU's Medicare base rate), instead of the values in effect in the quarter for which a Pro-share payment was calculated, is also an aspect of a payment rate methodology, especially when it has a material effect on the amount of payment ultimately made, as it did here.

Oregon's remaining contentions lack merit. Oregon contends that it had "significant discretion" and "flexibility" to interpret SPA 01-05's requirement to calculate "what Medicare would pay." Or. Resp. to Questions at 8. Claiming that this requirement incorporated the regulatory definition of a UPL, Oregon asserts that its discretion and flexibility permitted it to perform the required calculation with less than absolute precision (using an outdated Medicare payment rate) as long as the resulting amount was "*within a reasonable estimate* of what Medicare would have paid." Id. We find this argument unpersuasive because the state elected to calculate "what Medicare would pay" based on the rate-setting "methods, amounts, and factors" that were published annually by CMS.[18] Having decided to calculate what Medicare would pay based on these published methods, amounts, and factors, the state was obligated to use or apply them in a manner consistent with Medicare payment principles. Given that OHSU's Medicare upper payment limit for services provided in a given quarter was determined after the end of the quarter, it was neither reasonable nor necessary — and thus inconsistent with Medicare payment principles — to rely on some "estimate" of what Medicare would have paid that did not reflect the published Medicare base rate in effect during the quarter. Although we agree Oregon had discretion or flexibility under SPA 01-05 to craft a method to determine "what Medicare would pay," SPA 01-05

[18] We also find the argument unpersuasive because Oregon failed to prove that it deliberately exercised its alleged discretion not to abide by the Medicare principle that payment be determined in accordance with the published rates in effect when the services were provided. As we have discussed, the evidence of record indicates that Oregon's failure to use OHSU's FFY 2003 base rate to calculate Pro-share payments made for the second, third, and fourth quarters of SFY 2003 was a mistake or oversight, not an act of policy discretion. Furthermore, the record shows that Oregon had a policy and practice of updating OHSU's base rate to reflect published changes in the Medicare program's prospective rate-setting "methods, amounts, and factors."

did not permit Oregon to apply its chosen method in a manner that was materially *inconsistent* with Medicare payment principles. Cf. State Medicaid Manual (CMS Pub. 45) § 6005 (instructing states that they do not need to "follow exactly every detailed [Medicare program] procedure" in determining an upper limit of what Medicare would pay "so long as the [Medicare] principles are satisfied").

Oregon contends that it merely followed CMS guidance when it used OHSU's FFY 2002 Medicare base rate – the rate in effect at the start of SFY 2003 (July 1, 2002) – in order to compute Pro-share payments for the second, third, and fourth quarters of SFY 2003. Reply Br. at 7-8. This contention is based on the uncorroborated recollection of Eric Larson. Larson stated in his declaration that he sought "oral guidance from [a CMS employee] in the CMS Seattle Region X office, and I recall being told that using the same Medicare data throughout the state fiscal year was acceptable." Or. Ex. 39, ¶ 14. However, Larson admitted that he had no "written confirmation" – and the record contains no contemporaneous documentary evidence – of the CMS employee's alleged guidance. Id. Even assuming that a CMS employee had endorsed or authorized Oregon's use of an outdated payment rate, it would not estop CMS here absent a showing of affirmative misconduct. Pacific Islander Council of Leaders, DAB No. 2091 (2007) (applying the prevailing view in the federal courts that equitable estoppel "does not lie against the federal government, if indeed it is available at all, absent at least a showing of affirmative misconduct"). Oregon has made no such showing.

Oregon suggests that its use of an outdated Medicare base rate was part of a deliberately-conceived strategy on its part to ensure that it did not exceed the applicable Medicaid UPL in section 447.272. Reply Br. at 8. Oregon asserts that updating a hospital's Medicare payment rate will generally increase a UPL from a prior period because Medicare rates typically rise from year-to-year. Id. The corollary to that proposition, says Oregon, is that a UPL will tend to be more "conservative" if payment rate updates are not done and the UPL is based on "historic data." Id. Oregon asserts that, with these factors in mind, it "chose" a "conservative approach" in making its Pro-share payment calculations by "making less frequent updates" of the Medicare payment rates used in those calculations. Id. This argument is unpersuasive. Although Eric Larson stated in his declaration that he "intentionally used a conservative approach when calculating the Pro-share payment in order to assure that Medicaid payments would not exceed the aggregate UPL under 42 CFR § 447.272," Or. Ex. 39, ¶ 11, he did not indicate that use of outdated Medicare rates was an element of that conservative

approach. In addition, Larson told OIG auditors that he obtained OHSU's base rates from OHSU and, after 2001, did not verify the accuracy or currency of those rates. Or. Ex. 38 (Bates # CMS EX 00548). And, as indicated, Larson told auditors at one point that Oregon's failure to update OHSU's Medicare base rate in SFY 2003 was an oversight. Or. Ex. 38 (Bates # CMS EX 00799-800). If anything, these omissions and statements indicate that Oregon's use of an outdated Medicare rate was a mistake, not an act of policy discretion.

Oregon contends that the validity of the disallowance ultimately should be judged according to whether its SFY 2003 Medicaid payments exceeded the applicable UPL in section 447.272. Reply Br. at 13-15. It suggests that CMS must reimburse a state for hospital payments whose amounts exceed what the state plan's payment methodology allows as long as the payments do not, in the aggregate, cause noncompliance with the applicable UPL. We find no merit to that suggestion, for which Oregon has offered no legal authority. A state must provide assurance that its Medicaid hospital payments will not exceed applicable UPLs. 42 C.F.R. § 447.253(a), (b)(2). But merely providing such assurance does not necessarily mean that the state intends or is authorized by its state plan to make hospital payments up to the UPL. Nor does it mean that CMS must reimburse a state for the federal share of expenditures up to the UPL regardless of whether the state complies with other Medicaid requirements. Cf. Minnesota v. Centers for Medicare and Medicaid Services, 495 F.3d 991, 998 (8th Cir. 2007) (holding that mere compliance with UPL regulations is not conclusive proof of compliance with the broader requirement that Medicaid payments be consistent with efficiency, economy, and quality of care). The amount or level of hospital payments is determined in accordance with rate-setting "methods and standards" in the state plan, see 42 C.F.R. § 447.252(b), and those methods or standards may in fact be designed to ensure that hospital payments fall substantially below the applicable UPL. Whatever the case, a state must adhere to the rate-setting methods and standards set out in its state plan, and may obtain FFP for hospital payments only if they were made in accordance with those methods and standards. 42 C.F.R. § 447.253(i); New Hampshire at 2, 12-15.

The dissent asserts that SPA 01-05's Pro-share payment formula expressly incorporates the regulatory definition of a Medicaid "upper payment limit," which is a "reasonable estimate of the amount that would be paid for services . . . under Medicare payment principles[.]" 42 C.F.R. § 447.272(b)(1). Thus, says the dissent, SPA 01-05 permitted Oregon to use a "reasonable estimate" of what Medicare would have paid OHSU for Medicaid-

covered services in step one of the Pro-share payment calculation, and that an estimate could have incorporated any applicable Medicare payment adjustment. Oregon presented evidence that OHSU's Medicare upper payment limits for the second, third, and fourth quarters of SFY 2003 would have been considerably *higher* than Oregon originally calculated had Oregon adjusted OHSU's Medicare base rate to account for its DSH status and outlier cases. See Or. Ex. 39G. The dissent asserts that "had Oregon included [the DSH and outlier] adjustments in making its estimates" of OHSU's quarterly upper payment limits, Oregon "could have made [Pro-share] payments considerably higher than the payments it did in fact make, even if it had also used current, 'updated' Medicare data for the base payment amount." In other words, had Oregon included other applicable Medicare rate adjustments in its step-one calculations for the second, third, and fourth quarters of SFY 2003, the Medicare upper limits for those quarters would have been higher and more than sufficient to offset the downward adjustments made by the OIG to account for Oregon's improper use of an outdated Medicare rate.

In effect, the dissent would permit Oregon to modify its Pro-share payment calculations retroactively in order to offset the consequences of an unrelated state plan violation. We are unaware of any case in which the Board has permitted such a retroactive adjustment, however. In fact, in at least one instance, the Board rejected a proposed retroactive payment rate adjustment to account for previously omitted cost elements. In Louisania Dept. of Health and Hospitals, DAB No. 1542 (1995), the Board held that the state of Louisiana could not incorporate certain fringe benefit costs in its calculation of nursing home payment rates in order to offset the consequences of unrelated mathematical errors in the rate-setting process:

> Louisiana chose not to include these [fringe benefit] costs in its State plan methodology and cannot now change that methodology retroactively. While the State has considerable flexibility under the Boren Amendment in shaping its payment methods and interpreting its State plan, it is not reasonable for the State to submit to [CMS] as part of its State plan amendment materials information about the breakdown of costs and *then alter those costs retrospectively after a review finds errors which the State would like to offset*.

DAB No. 1542, at 23 (italics added).[19] The Board also noted that CMS had "correctly argued that Louisiana needed to submit a plan amendment if it wished to change its rates" to recognize the additional costs. Id. at 22.

Retroactively increasing OHSU's Medicare upper payment limit for the second, third, and fourth quarters of SFY 2003 would, of course, require Oregon to make a commensurate and substantial increase in its Pro-share payments to OHSU for those quarters. See Or. Exs. 39F and 39G (indicating that, if DSH and outlier adjustments had been made, OHSU's quarterly Medicare upper payment limits for the second, third, and fourth quarters of SFY would have been approximately $2.5 million, $2.3 million, and $2.15 million higher respectively). Oregon did not argue that its state plan authorizes such a retroactive adjustment and, in response to a Board question, stated that it "has not requested that the Pro-Share payments made under SPA 01-05 be adjusted to account for Medicare DSH and outlier payments." Or. Response to Board Questions at 12. Oregon has also not argued that it could alter its Pro-share payment calculations for SFY 2003 in order to incorporate DSH and outlier rate adjustments without a state plan amendment.[20]

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[19] The Board in Louisiana discussed evidence indicating that the omission of fringe benefits as a "cost element" from the rate-setting methodology was deliberate. A state employee testified that although those costs could have been included, the State decided not to include them in order to be "very conservative" and ensure that providers were not overpaid. Louisiana, DAB No. 1542, at 22. Here, Oregon asserts that "Eric Larson's omission of DSH and outlier adjustments from Pro-Share payment calculations reflects Oregon's prudent practice of using an intentionally conservative approach to ensure that Pro-Share payments would not exceed the limit of what Medicare would pay." Or. Resp. to Board Questions at 7.

[20] In responding to CMS's argument that failure to use the most current applicable Medicare rate constituted a change in the Pro-Share payment methodology, Oregon states that in Colorado the state unilaterally altered its state plan by making "material changes" to its payment methodology, changes that included the addition of "a new cost component." Reply Br. at 11-12. Oregon asserts that it made no such changes to its method of calculating Pro-share payments in SFY 2003 because it continued to use the *"same Medicare rate components* and apply them in the same manner." Id. at 12 (italics added). Oregon does not claim that

(continued...)

In summary, we conclude that by using an outdated Medicare rate to calculate OHSU's Pro-share payments for the second, third, and fourth quarters of SFY 2003, Oregon failed to comply with the methods and standards prescribed in its state plan. As a result of this noncompliance, Oregon made Pro-share payments to OHSU in excess of what the state plan allowed. Thus, CMS has a basis for disallowing the federal share of those excessive Pro-share payments.

3. *Remand is appropriate to recalculate the amount of the disallowance.*

During oral argument, Oregon clearly acknowledged, in response to a direct question from a panel member, that it had not challenged the amount of the disallowance since CMS made certain downward adjustments at the outset of this proceeding (adjustments reflected in the current disallowance amount); Oregon also did not challenge the current disallowance amount at oral argument. Tr. at 69. Furthermore, neither party briefed, or sought to brief, the issue of how the disallowance was or should be calculated, an issue raised by a panel member during oral argument. Under these circumstances, the Board would be justified in affirming not only CMS's legal justification for the disallowance, as we have done, but CMS's calculation of the amount of the disallowance as well.

Nevertheless, we are concerned that the amount of the disallowance accurately reflect CMS's current justification for the disallowance, as upheld by the Board in this decision. As indicated, the Board concludes that Oregon failed to follow its state plan in calculating Pro-share payments for the second, third, and fourth quarters of SFY 2003, and that this failure resulted in Oregon making excessive Pro-share payments for those quarters. On its face, the amount of the disallowance does not appear to be consistent with our conclusion because, for the second and third quarters of SFY 2003, non-Pro-share payments as well as Pro-share payments were disallowed.[21] Thus, we think

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[20](...continued)
DSH and outlier adjustments are not new or different "rate components," or that their inclusion now would constitute a non-material change to the Pro-share payment methodology.

[21] The amount of the disallowance should reflect the difference between the amount of the Pro-share payments made by Oregon for the second, third, and fourth quarters of SFY 2003
(continued...)

justice is best served by remanding this case to recalculate the amount of the disallowance to ensure that it is consistent with our decision. If Oregon disagrees with the results of the recalculation, it may file an appeal with the Board pursuant to 45 C.F.R. Part 16 on that issue only.

Conclusion

We conclude that CMS had a proper basis to disallow FFP for Pro-share payments made by Oregon for the second, third, and fourth quarters of SFY 2003. We remand this case to CMS to recalculate the amount of the disallowance to ensure that it is consistent with our decision.

/s/
Sheila Ann Hegy

/s/
Constance B. Tobias

[21](...continued)
using an outdated Medicare base rate for OHSU, and the amount of Pro-share payments that OHSU could have received (if any) had those payments been calculated using the Medicare base rate in effect during those quarters.

DISSENT TO DECISION NO. 2208

I respectfully disagree with the majority. I would reverse the disallowance, for the following reasons, explained more fully below. Both parties now agree that, by using the terms "upper payment limit" and "what Medicare would pay" in the relevant provision of SPA 01-05, Oregon meant a "reasonable estimate of what Medicare would pay." Indeed, when asked, CMS declined to read the provision as adopting Medicare payment principles in their entirety. Moreover, since the term "upper payment limit" is a federal term of art adopted in the State plan, any ambiguity should be resolved by looking at federal guidance and practice. CMS acknowledges that it permits states to make reasonable estimates using only some of the Medicare payment adjustments and using historical data. Notably, CMS does not here deny that the amounts Oregon used in calculating Pro-Share payments in SFY 2003 were reasonable estimates of what Medicare would pay. Instead, CMS officials thought they were applying Board precedent by saying that Oregon should have followed its "usual practice" of using updated data as of January 1. That precedent, however, uses an analytical framework that applies only in interpreting an ambiguous state plan provision setting out a state-specific payment method, where there is a reason to defer to a state's interpretation. CMS officials focused on only one part of that framework – administrative practice, while ignoring other parts of that framework for determining intent. In fact, what Oregon did - sometimes using updated data and sometimes using historical data and omitting DSH and outlier adjustments - can be reconciled with reading the plan (as both parties do) to mean Oregon would make a reasonable estimate of what Medicare would pay. Oregon's practice cannot be reconciled with interpreting the plan to incorporate all of the Medicare requirements because then Oregon should have made adjustments for DSH and outliers, as Medicare does. In any event, the record shows that, if Oregon was required to follow all of the Medicare requirements, it should have made Pro-Share payments considerably higher than what it made, even using updated data. Thus, I see no reasonable basis for determining that Oregon claimed FFP in amounts higher than what the plan allowed.

The parties' responses to Board questions establish that they agree that the phrase the "Medicare upper payment limit of Inpatient Fee-for-Service charges converted to what Medicare would pay" in SPA 01-05 refers to "a reasonable estimate of what Medicare would pay." In other words, the parties agree that this phrase was meant to incorporate the concept, from the federal UPL regulations, of reasonably estimating what Medicare would pay for the Medicaid services at issue. This makes sense since 42 C.F.R.

§ 447.272 provides that the term "upper payment limit" refers to "a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles in subchapter B of this chapter."

The concept of "a reasonable estimate" of what Medicare would pay is a federal concept. In similar situations in the past where a state has adopted a federal concept, the Board has looked to federal guidance, not to state implementation, to discern intent if a plan provision was unclear. See, e.g., Alaska Dept. of Health and Social Services, DAB No. 573 (1984); California Dept. of Health Services, DAB No. 1474 (1994). That is, in fact, what both parties did here in response to Board questions. Specifically, in response to Board questions, CMS states:

> CMS has made clear that states retain significant flexibility in determining "what Medicare would pay" for Medicaid fee-for-service inpatient charges. In this regard, CMS has stated that the State is "relieve[d] . . . of the burden of having to use the detailed cost finding principles required by Medicare or of complying with a prescriptive formula approach," and that the states have "flexibility to develop procedures for applying the upper limit test." State Medicaid Manual § 6005. Accordingly, at the outset of a state's application of the Medicaid upper payment limit, states do indeed have some control over whether to include, for example, DSH and outlier payments in determining "what Medicare would pay." See also 66 Fed. Reg. 3153 (Jan. 12, 2001) (UPL is a "reasonable estimate based on Medicare payment principles," and States "may consider many factors and elements" in support of estimates).
>
> States have this option because "Medicare principles may be revised by statute or by regulation from time to time," so states may not want to include every detailed Medicare payment mechanism. See State Medicaid Manual § 6005.

CMS Response at 2. CMS also states:

> Upper payment limits need only be "reasonably expected" to pay no more than what a State agency "reasonably estimates would be paid for the services" under Medicare. State Medicaid Manual § 6005; see also 66 Fed. Reg. 3153 (Jan. 12, 2001) (UPL is a "reasonable estimate based on Medicare payment principles," and states "may consider many factors and elements" in support of estimates).

CMS Response at 4; see also Tr. at 40 ("upper payment limit has

to mean and does mean a reasonable estimate of what Medicare would pay"); Tr. at 50 ("the upper payment limit does allow the state flexibility in terms of determining what Medicare would pay"); Tr. at 62.

Oregon says:

> "Medicare payment principles" is short-hand for the regulatory UPL requirement that payments not exceed "a reasonable estimate of the amount that would be paid for the services furnished . . . under Medicare payment principles." 42 C.F.R. § 447.272(b)(1). The full regulatory context is important because the term "reasonable estimate" does not convey absolute precision. The State is not accountable for determining the exact amount that Medicare would have paid, but only to make payments within a reasonable estimate of what Medicare would have paid.
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> . . . As recently as September 28, 2007, CMS acknowledged (in the context of revising regulations regarding the outpatient UPLs to provide greater specificity and uniformity) that "the 'reasonable estimate' of what Medicare would pay for equivalent Medicaid services has varied interpretations," and that some cost reporting information used by the states "may not represent finalized data or accurately reflect Medicare payment and/or charge rates." 72 Fed. Reg. at 55160.

Or. Response at 8-9. This reading is also consistent with Oregon's response to the audit report. In that response, Oregon stated that "the UPL regulations provide the states with flexibility in estimating the amount that Medicare would have paid, 66 Fed. Reg. 3153 (2001), and the State's Medicaid Plan does not specify how the UPL should be calculated." Or. Ex. 17, at 2.

Since "upper payment limit" means "a reasonable estimate" and CMS did not require Oregon to specify the particular method it would use to calculate a reasonable estimate (either for purposes of the aggregate, federal UPL or for purposes of determining Pro-Share payments), the language of the plan read in light of the CMS guidance indicates that any calculation that is within the flexibility given states for calculating a reasonable estimate is permissible under the plan.

Notably, CMS does not deny that, in calculating Pro-Share payments for each quarter at issue here, Oregon used as the "upper payment limit of the Fee-for-Service charges converted to

what Medicare would pay" amounts that were in fact reasonable estimates of what Medicare would pay for those services. Further, CMS admits that the plan language gave Oregon the option of including DSH and outlier adjustments. CMS Br. at 16, n.13. The record shows that, had Oregon included those adjustments in making its estimates, it could have made payments considerably higher than the payments it did in fact make, even if it had also used current, "updated" Medicare data for the base payment amount. Specifically, the evidence shows that for the second quarter of SFY 2003 Oregon could have made $2,209,598 in additional Pro-Share payments to OHSU; for the third quarter Oregon could have made $2,034,852 in additional Pro-Share payments; and for the fourth quarter Oregon could have made $1,902,051 in additional Pro-Share payments if it had made its reasonable estimates using "updated" data, but including DSH and outlier adjustments. Or. Ex. 39E and 39G.[22] This affirms that the approach Oregon took to estimating what Medicare would pay was, as Oregon asserts, a conservative approach – one that could be reasonably expected to result in payments that were no more than what Medicare would pay.

More important, CMS concedes that it has permitted states to use historical data in calculating a reasonable estimate of what Medicare would pay. Tr. at 42; see also Or. Ex. 18, at Bates # 00342 (statement by member of CMS National Institutional Reimbursement Team that CMS allows states to use historical data in calculating UPLs so long as that is consistent with the State plan). The reason CMS allows this is that costs tend to go up, so use of historical data usually results in an estimate that is lower than if current, "updated" data were used. Or. Ex. 18, at Bates # 00342. In other words, CMS has not interpreted the reference to "Medicare payment principles" in its statements of what is meant by the "upper payment limit" to mean that, in making its reasonable estimate, a state must use the same data for a period that Medicare would use in that period. The fact that the Medicare regulations apply that data for purposes of

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[22] The Board specifically asked CMS whether it challenged this evidence, and, if so, to provide a reason. CMS provided no evidence to the contrary or any reason to think Oregon's calculations are inaccurate. CMS Response at 1-4. CMS says, instead, that once having made Pro-Share payments, Oregon cannot now add in DSH and outlier adjustments and claim more than the amounts paid. But that is not the point. The evidence shows that no disallowance is warranted because the payments Oregon made did not exceed the amount Medicare would pay, even if that amount is calculated using updated data.

Medicare to discharges occurring after the "effective date" of the rate change is therefore irrelevant.

This should end the Board's inquiry since what Oregon did - sometimes using historical data and sometimes using current, "updated" data – is consistent with the wording and agreed meaning of SPA 01-05 - that Oregon would calculate its Pro-Share payments using "a reasonable estimate of what Medicare would pay" and therefore had the flexibility to use either historical or current data. Oregon did not make any Pro-Share payment in excess of the amount allowable under the State plan (and CMS now concedes that the payments did not exceed the federal, aggregate UPL). Thus, neither section 447.257 nor section 447.253(i) of 42 C.F.R. provides a basis for disallowing the federal share of Pro-Share payments Oregon made.[23]

I do not agree with either the primary or alternative analysis on which the majority relies. First, the majority concludes that SPA 01-05 "expressly required Oregon to apply relevant Medicare payment principles." Majority at 16. This conclusion does not give effect to the agreed meaning of the term "upper payment limit." More important, it relies on an interpretation of SPA 01-05 that was never advanced by CMS and which CMS declined to adopt in response to Board questions. In my opinion, if the plan language expressly and unambiguously required Oregon to follow Medicare payment principles, then Oregon was required to include DSH and outlier adjustments in its calculations and to pay OHSU more than it did pay, not less. It is illogical to say that Oregon's plan expressly required it to apply Medicare payment principles and then to say that Oregon could exclude payment adjustments required under those principles.

On the other hand, no such conflict arises if the use of the terms "Medicare upper payment limit" and "what Medicare would

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[23] Section 447.257 provides that "FFP is not available for a State's expenditures for inpatient hospital . . . services that are in excess of the amount allowable under this subpart." Section 447.253(i) provides that a state "must pay for inpatient hospital services . . . using rates determined in accordance with methods and standards specified in an approved State plan." CMS also relies on section 430.12(c), which requires CMS approval for "material changes in State . . . policy, or in the State's operation of the Medicaid program." Any "change" here in the age of the data used is not material in my view since use of either historical or updated data resulted in "a reasonable estimate," consistent with the wording of the State plan.

pay" in SPA 01-05 is simply seen as confirming Oregon's intent to adopt the federal meaning of the phrase "upper payment limit" – a reasonable estimate of what Medicare would pay for the services. As discussed above, in explaining that federal concept of a reasonable estimate, CMS has said that a state has flexibility not to include all of the payment elements from the Medicare payment principles, and CMS has allowed states to apply the principles using historical data.

Moreover, the first step of Eric Larson's calculations was not, in fact, to calculate "what Medicare would pay" using Medicare payment principles. Medicare would have paid for DSH and outlier adjustments, but he did not include them in his calculations. Also, he applied a "case-mix index" to an adjusted base rate, rather than determining what Medicare would have paid for each Medicaid discharge during the quarter. Use of a "case mix index" is an estimation technique that CMS has approved (and accepted here in determining the aggregate UPL). As the majority notes, moreover, Mr. Larson's own description of what he was doing in the first step is that he was making a "reasonable estimate" of what Medicare would pay. Majority at 16, quoting Or. Ex. 39, ¶ 11.

Second, the majority's alternative analysis is that "[e]ven assuming that SPA 01-05 was ambiguous" their "conclusion would not change because the use of an outdated rate was contrary to Oregon's own interpretation of SPA 01-05, as exemplified by its prior or historic (pre-October 2002) practice in calculating OHSU's Pro-Share payments." Majority at 19. I disagree. It is unclear what ambiguous language was allegedly being "interpreted" by Oregon or why we would resort to examining administrative practice where the parties agree that the plan provision at issue here means that Oregon will first calculate "a reasonable estimate of what Medicare would pay" before subtracting Medicaid and third party payments. In other words, the parties agree Oregon intended to adopt a federal concept, not its own state-specific method for calculating Pro-Share payments. Any ambiguity should thus be resolved by resort to CMS guidance and practice, not by looking at state practice.

Third, when interpreting a provision of a state-specific rate-setting methodology, this Board has said that it will first examine the wording, history, and purpose of the provision, but that it may consider consistent administrative practice as evidence of intent, in part, to determine whether a state in fact was applying an "official" interpretation of the provision. This framework was first set out in South Dakota Dept. of Social Services, DAB No. 934 (1988), and recognized that there was a

reason to defer to a state's official interpretation of a methodology it had developed. CMS misinterprets this precedent by relying solely on what it refers to as Oregon's "usual" practice of updating the rates as of January 1 (which the record shows Oregon did only once) and viewing this practice as controlling. Taking a different approach, the majority here finds a "prior or historic practice" by looking at whether Oregon used updated or outdated (historical) data during the quarters prior to October 1, 2002 and finding that this meant Oregon interpreted its plan to mean it must always use updated data.[24] The majority acknowledges Oregon deviated from this alleged practice "but only for a single quarter," and finds this "lapse to be insignificant." Majority at 19, n.16. The significance of any lapse, however, is that it means there was no "consistent administrative practice," so reliance on Board precedent referring to such a practice as evidence of an official state interpretation is misplaced. In the past, the Board has rejected arguments by states that an interpretation was "official," even if it was not in writing and the administrative practice in implementing the plan varied. See, e.g., Louisiana Dept. of Health and Human Resources, DAB No. 731 (1986).

Moreover, undisputed evidence in the record shows that Oregon had calculated Pro-Share payments for ten quarters prior to the audit, using updated data for six of those quarters and historical data for four quarters. Finding a "lapse" of only one quarter depends on narrowing the inquiry to what Oregon did for quarters prior to October 1, 2002, but I see no justification for that limit. The record does not, in my view, support a finding that Oregon had either a consistent administrative practice to use "updated" data or any "usual practice" of updating the data for the quarter beginning January 1 of each year, contrary to what CMS officials apparently thought. (And, in any event, as explained above, using either historical or updated data was a permissible way to calculate a reasonable estimate of what Medicare would pay.)

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[24] I note that CMS's allegations about "usual practice" would at most support a disallowance only for the third and fourth quarters of SFY 2003. CMS's alternative basis (which it clarified in the conference it was relying on for disallowing claims for three quarters of SFY 2003) was that Oregon was required to use the "best available data." Oregon had pointed out, however, that the only regulation cited for this alleged requirement did not apply, and neither CMS nor the majority cites any legal basis for applying such a policy here.

Fourth, although Eric Larson said that it was an "oversight" that he did not use "updated" data in calculating the Pro-Share payments and that his practice was to use the data "available" to him, the Board has traditionally given little, if any, weight to the statements of a state employee like Mr. Larson, who was not involved in drafting or gaining approval for the state plan provision, had no authority to interpret the provision, and said he received no guidance on how to implement the provision. Under the particular circumstances here, I view Mr. Larson's statements as wholly irrelevant. Even if using outdated data was an oversight from Mr. Larson's perspective, that does not matter since the plan language permitted use of either historical or updated data, so long as the result was a reasonable estimate of what Medicare would pay.

CMS now argues that it is merely "correcting" for Mr. Larson's oversight by recalculating the payments using "updated" data. But Mr. Larson also told the auditors he was not aware that DSH could be included in the calculations. OR Ex. 11, at Bates #00771-00772. If "correcting" his alleged oversight were a legally sufficient basis for CMS to recalculate the hospital-specific upper payment limit for OHSU for the quarters in question (which it is not), then his oversight in failing to include DSH adjustments should also be corrected. CMS does not explain why it would correct for one of his "oversights" and not for the other. Correcting both "oversights" would, however, result in higher Pro-Share payment amounts than what Oregon calculated, and CMS would have no basis for any disallowance.

As indicated above, I think the Board precedent that applies are cases where the Board has looked to federal guidance in interpreting plan language that incorporates a federal concept. To the extent that decisions interpreting state-specific rate-setting methodologies are relevant, I would follow cases like Louisiana Dept. of Health and Hospitals, DAB No. 1542 (1995). In Louisiana, the Board found that any reasonable method was acceptable for calculating a payment adjustment amount because the approved state plan did not specify any particular method. Here, CMS approved SPA 01-05 even though it does not specify any particular method for calculating a reasonable estimate of what Medicare would pay. Oregon could, in my view, reasonably use historical data since CMS admits it allows states to use historical data in making reasonable estimates and this usually results in lower estimates than using updated data. Moreover, Oregon points out that, from its perspective, it made sense to use the same data throughout a State fiscal year, and SFY 2003 was the first full State fiscal year for which Oregon calculated Pro-Share payments.

On the other hand, I would conclude that Colorado Dept. of Health Care Policy and Financing, DAB No. 2057 (2006), on which CMS relies, is clearly distinguishable. The State plan provision at issue in that case referred to a "Department formula," and Colorado had provided a specific, written formula to CMS in response to its inquiry about what formula Colorado intended to use. Colorado had used that formula for many years before seeking to make material changes to it, resulting in much higher claims. Here, in contrast, CMS knew that it had permitted states flexibility in calculating reasonable estimates of what Medicare would pay, but had not asked Oregon to choose among the permissible methods, nor had Oregon officially done so. Indeed, although CMS first asked Oregon to specify a "base period" in the Pro-Share provision, CMS later approved SPA 01-05 without any such specification after Oregon amended the language to ensure its payments would not exceed the federal UPL.

Finally, the record shows that the $505,009 disallowed is the federal share of the amount the auditors erroneously calculated as the amount in excess of the federal UPL and includes the federal share of some of Oregon's "non-Pro-Share payments" made to OHSU in the second and third quarters of SFY 2003.[25] CMS may not properly disallow non-Pro-Share payments based on the theory that the Pro-Share payments exceeded the amount permitted under SPA 01-05.

I note that Oregon did argue in its reply brief that, contrary to what CMS said in its brief, CMS's disallowance was not based on the state plan, but treated the OHSU hospital-specific UPL as if

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[25] CMS concedes, and the record shows, the $505,009 is the sum of the amounts identified on the OIG workpaper at Oregon Exhibit 38, Bates # 00843 to 00844, as the "Federal Share of Payments that Exceeded UPL" for the second, third, and fourth quarters of SFY 2003. Tr. at 65; see also CMS Ex. 3, at 3-4. The amount included for the second quarter is $176,011.19, which is 60.16% of $292,571.80. The latter amount is the sum of both the Pro-Share payment for that quarter of $113,011.16 and the $179,560.64 that the auditors got by comparing the UPL that they had calculated for the quarter ($7,960,475.60) to the total non-Pro-Share Medicaid payments Oregon made to OHSU for the quarter ($8,140,036.24). Similarly, for the third quarter of SFY 2003, the disallowed amount included the federal share (63.11%) of both the Pro-Share payment amount of $258,757.20 and $10,682 in non-Pro-Share payments that the auditors had determined were in excess of the UPL they had calculated.

it were a federal, aggregate UPL. Or. Reply Br. at 2, 14-15. This is exactly what the documentation in the record shows that the OIG auditors did in the calculations that CMS used to determine the disallowance amount - they calculated a UPL specific to OHSU for each quarter, and then identified as unallowable any payments in excess of that amount, including both Pro-Share and non-Pro-Share payments.

Under the procedures that apply here, the Board is to base its decision on the record before it, has the authority to direct the parties to produce relevant information, and may hold an informal conference "to give the parties an opportunity to make an oral presentation and the Board an opportunity to clarify issues and question both parties about matters which the Board may not yet fully understand from the record." 45 C.F.R. §§ 16.9, 16.10, 16.13, and 16.21. As Presiding Board Member in this case, I determined that, in light of CMS's change in the grounds for the disallowance and the inconsistencies in its positions, the record needed further development and clarification. For example, in response to Board questions, CMS said the disallowance was only for two quarters of SFY 2003, but the record showed it covered three quarters. CMS Response at 6. The need to clarify both what quarters were at issue and what amounts were included arose because CMS had raised new grounds for part (but not all) of the original disallowance, without explaining how it computed the revised disallowance amount. See 42 C.F.R. § 430.42(a)(4).

In sum, I would reverse the disallowance, or, at the very least, reduce the disallowance amount.

/s/
Judith A. Ballard
Presiding Board Member