**Department of Health and Human Services**
**DEPARTMENTAL APPEALS BOARD**
**Appellate Division**

Maine Department of Health and Human Services
Docket Nos. A-18-39, A-18-40, A-18-65, A-18-70,
A-18-109, A-19-48 and A-19-49
Decision No. 2931
March 12, 2019

# DECISION

The Maine Department of Health and Human Services (Maine) appealed determinations by the Centers for Medicare & Medicaid Services (CMS) disallowing in total over $72 million in Medicaid federal financial participation (FFP) for the quarters ending December 31, 2013, through September 30, 2018. CMS found that Maine's **Medicaid** payments to Riverview Psychiatric Center (Riverview), a state-owned psychiatric hospital, were not eligible for FFP after CMS terminated Riverview's **Medicare** provider agreement effective September 2, 2013.

CMS argues that both federal law and Maine's own Medicaid state plan required Maine to terminate its Medicaid agreement with Riverview once CMS terminated Riverview's Medicare provider agreement. Federal law provides that FFP is available only for Medicaid payments states make to providers with Medicaid agreements in place and that states must terminate the Medicaid agreements of, and make no Medicaid payments to, any psychiatric hospital that fails to meet applicable requirements, including complying with Medicare conditions of participation (COPs) and maintaining Medicare agreements. Maine's state plan assures CMS that it will comply with these requirements.

Maine argues, however, that these provisions merely authorize states to terminate agreements with Medicaid hospitals terminated from Medicare, but do not compel states to take such action or authorize the federal government to terminate a Medicaid agreement. Since Maine did not choose to terminate its Medicaid agreement with Riverview, Maine contends, it was entitled to continue claiming FFP in Medicaid payments to Riverview notwithstanding the termination of Riverview's Medicare provider agreement for noncompliance with Medicare COPs. Maine argues further that Riverview is not now a "psychiatric hospital," and so laws regulating psychiatric hospitals should not apply. After careful review of the applicable provisions, we do not find these arguments persuasive.

For the reasons discussed below, we conclude that federal law required Maine to terminate its Medicaid agreement with Riverview after its Medicare termination. We also conclude that Maine failed to adhere to the terms of the state plan, which likewise required Maine to terminate its Medicaid agreement with Riverview under these circumstances. We further reject Maine's attempts to revisit the Medicare termination decision or recast Riverview as something other than a psychiatric hospital that nevertheless was eligible to receive FFP in Medicaid payments. Therefore, we sustain the disallowances.

## Legal Background

### *The Medicaid Program*

The Medicaid program, established under title XIX of the Social Security Act (Act),[1] is jointly funded by the federal government and states to provide medical assistance to financially needy and disabled persons. Act §§ 1902(a)(10)(A), 1902(e), 1902(f); 42 C.F.R. Parts 430, 435, 436. Each state that chooses to participate administers its own Medicaid program under broad federal requirements and the terms of its "plan for medical assistance" (state plan), which must be approved by CMS on behalf of the Secretary of the Department of Health and Human Services (Secretary). Act § 1902; 42 C.F.R. Part 430, subpart B. Once the state plan is approved, a state becomes entitled to receive FFP for a percentage of its program-related expenditures.

The state plan is required to be a "comprehensive written statement" that describes "the nature and scope" of the state's Medicaid program and gives "assurance that it will be administered in conformity with the specific requirements of title XIX" of the Act, the implementing regulations, and other "applicable official issuances" of the Secretary. 42 C.F.R. § 430.10. The state plan sets out, among other things, the state's methodologies for calculating payments to hospitals.

A state plan must impose a duty on the state to exclude from Medicaid or terminate Medicaid participation of any provider who is terminated from Medicare. Act § 1902(a)(39). CMS is authorized to withhold payment to a state that fails to adhere to its state plan. 42 C.F.R. § 430.35. Moreover, CMS has a statutory obligation to disallow any federal Medicaid funds that have been overpaid. Act § 1903(d)(2)(A). An issue of noncompliance "may arise from the State's failure to actually comply with a Federal requirement, regardless of whether the plan itself complies with that requirement." 42 C.F.R. § 430.35(c).

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

The Act provides that states may only receive FFP in Medicaid payments to providers with Medicaid agreements in place. Act § 1902(a)(27); *see also* 42 C.F.R. § 431.107. Furthermore, states must terminate Medicaid agreements with, and make no Medicaid payments to, any psychiatric hospital that fails to meet applicable requirements, including meeting the Medicare COPs, or that has its Medicare agreement terminated. Act §§ 1902(y)(2)(B), 1902(a)(39); 42 C.F.R. § 455.416.[2] A state Medicaid agency "[m]ust deny enrollment or terminate the enrollment of any provider that is terminated" from the Medicare program. 42 C.F.R. § 455.416(c).

*Disproportionate Share Hospital (DSH) Funding*

In addition to reimbursing states for medical assistance provided to eligible Medicaid recipients for inpatient hospital services, the federal Medicaid statute provides for state Medicaid programs to make supplemental payments to hospitals that serve disproportionately high numbers of low-income patients. Act §§ 1902(a)(13)(A)(iv), 1923(a)(1)(B). Such DSH payments supplement Medicaid's rates and serve to offset a hospital's uncompensated costs of caring for the low-income population and ensure that Medicaid recipients will continue to have access to care. *See id.* § 1923(a)-(c). The federal government reimburses – that is, provides FFP to – a state for a share of its allowable DSH payments. *Id*. § 1903(a); 45 C.F.R. § 95.4 (defining "federal financial participation"). Federal reimbursement of DSH payments is subject to an annual, state-specific cap known as the "DSH allotment," as well as various other restrictions. Act § 1923(f).

*Special Requirements for Psychiatric Hospitals*

While Medicaid provides funding for "medical assistance," the definition of that term generally **excludes** inpatient hospital services provided in any institution for mental diseases (IMD) **except for** "inpatient hospital services . . . for individuals 65 years of age or over in an [IMD]" or "inpatient psychiatric hospital services for individuals under age 21" in an institution (or distinct part thereof) that is a "psychiatric hospital" or "another inpatient setting that the Secretary has specified in regulations." Act § 1905(a)(1), (14), and (16), 1905(h). For a psychiatric hospital to participate in Medicaid, it must meet the requirements established under section 1861(f) of the Act (i.e. under Medicare). Act § 1905(h)(1); 42 C.F.R. § 482.1(a)(5). Only services provided in a hospital that meets the definition of a "psychiatric hospital" (or in another non-hospital inpatient setting approved by the Secretary) qualify as Medicaid "inpatient psychiatric services for individuals under the age of 21." Act § 1905(h)(1)(A) *cross-referencing* Act § 1861(f)

[2] As discussed later in this decision, it is undisputed that Maine's state plan does provide assurances that it will comply with these requirements. CMS Exs. 6, 7.

(Medicare requirements). To be a "psychiatric hospital," a hospital must be "an institution which . . . is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons"; satisfies specified elements of the general definition of hospital; maintains appropriate clinical records; and meets staffing requirements as mandated by the Secretary. Act § 1861(f). In certain cases, if an institution meets only the first two parts of the definition but contains a "distinct part" that also satisfies the last two parts of the definition, the distinct part will be considered a "psychiatric hospital." *Id*.

States are authorized to terminate the Medicaid participation of any psychiatric hospital determined not to meet the requirements for a psychiatric hospital but may instead impose intermediate or alternative sanctions, which allow a state to continue participation by, and payments to, a noncompliant hospital if no immediate threat is found to "the health and safety of its patients." Act §§ 1902(y)(1)(A); 1902(y)(1)(B). If the state has elected to impose intermediate sanctions, however, the state must refuse payment for new admissions if compliance is not achieved in three months and must terminate and cease Medicaid payments for any services six months after a finding of noncompliance until the hospital achieves compliance. Act § 1902(y)(2). The Secretary is only permitted to provide FFP for Medicaid payments to a noncompliant psychiatric hospital for up to six months **if** the state has determined an intermediate sanction is more appropriate than immediate termination, the state has submitted a plan and timetable for corrective action to CMS which has been approved, and the state has agreed to repay the federal government for any such payments "if the corrective action is not taken in accordance with the approved plan and timetable." Act § 1902(y)(3).

**Standard of Review**

The Board is authorized to review specified "final written decisions," including Medicaid "disallowances." 45 C.F.R. Part 16, App. A, ¶¶ A, B(a)(1). The Board must sustain a disallowance "if it is supported by the evidence submitted and is consistent with the applicable statutes and regulations." *W. Va. Dep't of Health & Human Res.*, DAB No. 2185, at 20 (2008) (citing 45 C.F.R. §§ 16.14, 16.21), *upheld in W. Va. Dep't of Health & Human Res.*, 172 F. Supp. 3d 904 (S.D. W.Va. 2016). In decisions reviewing disputed disallowances, the Board "has consistently held that a state has the burden to document the allowability and allocability of its claims for FFP," once CMS has set out a lawful basis for its action. *N.J. Dep't of Human Servs*., DAB No. 2328, at 4-5 (2010) (citations omitted).

**Case Background**

Riverview is located in Augusta, Maine, and treats patients with mental health problems. The parties dispute how it should be characterized. CMS states that Riverview is a "state operated psychiatric hospital." CMS Opening Brief (CMS Br.) at 1. Maine, however, now describes it as an "acute care mental-health facility." Appellant Maine's Opening Brief (Maine Br.) at 5. We resolve this dispute in the analysis below.

*Termination of Riverview's Medicare Provider Agreement*

The Board has previously addressed issues relating to Riverview's loss of its Medicare provider agreement. In September of 2013, CMS terminated Riverview's provider agreement pursuant to 42 C.F.R. § 489.53. CMS acted after Maine state agency surveys found that Riverview was not in substantial compliance with Medicare participation requirements. *Riverview Psychiatric Ctr.*, DAB No. 2586, at 3 (2014) (citing Administrative Law Judge (ALJ) Ruling No. 2014-18, CRD Docket No. C-14-84, at 2 (January 3, 2014)). CMS determined that Riverview had not complied with several COPs, including 42 C.F.R. §§ 482.12, 482.13, and 482.23. CMS Br. at 15. CMS notified Riverview that its participation would be terminated unless it submitted an acceptable plan of correction (POC) and was found in a follow-up survey to have achieved substantial compliance. DAB No. 2586, at 3. That initial notice of proposed termination did not include any notice of a right to appeal or administrative review. Maine Br. at 6. Riverview submitted two POCs which CMS found unacceptable. DAB No. 2586, at 3, and record citations therein. The Board explained the subsequent events as follows:

> In a letter dated August 14, 2013, CMS notified Riverview that it would proceed with the termination effective September 2, 2013. The letter notified Riverview of its right to appeal the termination. The letter also gave Riverview a chance to "immediately" submit a final POC and stated that if CMS found the POC acceptable, "the [State agency] and the CMS psychiatric hospital contract surveyors may conduct a revisit survey to determine whether compliance has been achieved." The letter warned Riverview that this opportunity to submit a final POC and the possibility of another survey "should not be interpreted as an extension to the termination date of September 2, 2013."

*Id*. (record citations and footnote omitted). Riverview did not appeal the termination but did submit a third POC, and a supplement to that, which CMS accepted, and CMS conducted a re-survey on September 17, 2013 (after its Medicare agreement had been terminated). DAB No. 2586, at 4. A key element of Riverside's various POCs was creating a "distinct-part solution," by establishing a psychiatric ward that would be

separated in various ways from the other sections of the hospital. Maine Br. at 7-8. After the survey, CMS concluded that Riverview had not successfully returned to substantial compliance; the termination remained in effect and CMS declined to reopen its initial determination. *Id*. at 10.

Riverview sought a hearing before an ALJ who dismissed the appeal. ALJ Ruling No. 2014-18. The ALJ ruled that Riverview "did not file a hearing request timely in which it denied CMS's initial findings of noncompliance that are the basis for the termination of Petitioner's provider status. Rather, it challenged CMS's refusal to rescind those findings as a consequence of CMS's declination to accept certain corrective actions that Petitioner allegedly took subsequently." *Id*. at 3-4. As the ALJ pointed out, the regulation provides ALJ hearing rights only for specified initial determinations, which include termination of a Medicare provider agreement but not a denial of reopening or a dispute about a proposed POC. *Id*. at 3 (citing 42 C.F.R. § 498.3(b)), 4.

Riverview appealed the ALJ dismissal to this Board, DAB No. 2586. The Board agreed that Riverview's appeal to the ALJ was untimely and also noted that Riverview, even at the time it did file an appeal, "never argued that the substantive findings of noncompliance made by the Maine State agency surveyors at the March and May 2013 surveys were incorrect," but instead sought to challenge CMS's decision not to reopen the termination despite Riverview's various attempts at correction. *Id*. at 6-8 (quoting ALJ Ruling No. 2014-18, at 4). The Board therefore affirmed the ALJ's ruling.

On August 13, 2015, the U.S. District Court in Maine affirmed the Board decision and also concluded that it lacked jurisdiction to review a refusal to reopen the termination – a decision that was "entirely discretionary." *Maine Dep't of Health & Human Servs. v. U.S. Dep't of Health & Human Servs*., No. 1:14-cv-00391-JDL, 2015 WL 4872376, at *4 (D. Me. Aug. 13, 2015). Riverview did not appeal that decision, and the period for filing an appeal lapsed, rendering the district court's decision final.

*Disallowances*

In April 2014, CMS notified Maine that it was deferring $3,516,488 in FFP for services and DSH payments related to Riverview; CMS asked Maine to provide documentation that the claims were for services provided prior to Riverview's termination and, thus, comported with federal requirements. Maine Br. at 11; Maine Exs. Y, Z. After further correspondence between Maine and CMS, CMS agreed by e-mail dated July 29, 2014 to release the funds to Maine. Maine Ex. CC. CMS put Maine on notice in that communication, however, that "all future actions on the part of CMS related to [Riverview] will be based on later determinations of allowability." *Id.*

In June 2017, CMS notified Maine of its final determination to disallow FFP for services and Medicaid DSH payments claimed for Riverview following Riverview's termination from Medicare. Maine Ex. A (CMS Disallowance Letter, dated June 7, 2017). The letter stated that DSH payments are made as an adjustment to amounts paid for inpatient hospital services and that FFP is available "for inpatient hospital services provided by a terminated hospital only for 30 days after the effective date of termination," and even then, "only in limited circumstances." *Id*. at 2. CMS also reasoned that "CMS regulations define inpatient hospital services as services furnished in an institution that meets the Medicare COPs for hospitals," which Riverview did not. *Id*. CMS deemed Riverview ineligible for DSH payments because it was not in compliance with the following COPs (based on the results of the surveys before and after its termination):

- 42 C.F.R. § 440.160 -- Inpatient psychiatric services for individuals under age 21;
- 42 C.F.R. § 440.10(a)(3)(iii) -- Inpatient hospital services, other than services in an institution for mental diseases;
- 42 C.F.R. § 440.140(a) -- Inpatient hospital services, nursing facility services, and intermediate care facility services for individuals age 65 or older in institutions for mental diseases; and
- 42 C.F.R. § 441.151(a)(2)(i) -- General requirements for inpatient psychiatric services for individuals under age 21.

*Id.* Maine had reported approximately $3.5 million in expenditures originating from Riverview for FFP reimbursement each quarter over the period between October 2013 and 2017. Maine Br. at 11-12; Maine Ex. A. The total amount disallowed was $51,076,630, of which only $68,570 was for Medicaid services – the rest was DSH funding. Maine Br. at 12; Maine Ex. A, at 2. In August 2017, Maine asked the CMS Administrator to reconsider the disallowances then at issue; she denied the request in December 2017. CMS Ex. 8, at 4, ¶ 12; Maine Exs. 2, 3. Since November 2017, CMS has sent Maine disallowance notices for each subsequent quarter.

In February 2018, Maine filed a timely appeal with the Board. Thereafter, Maine filed timely appeals of each of the subsequent disallowance notices. The following table summarizes the outstanding disallowances.

| CMS NOTICE DATE | DISALLOWANCE NUMBER | AMOUNT | PERIOD | REFERENCE |
|---|---|---|---|---|
| | | | | |
| June 7, 2017 | ME/2017/002/MAP | $51,076,630 | quarters ending Dec. 31, 2013 through Mar. 31, 2017 | A-18-39, Ex. A |
| Nov. 17, 2017 | ME/2017/004/MAP | $3,507,424 | quarter ending June 30, 2017 | A-18-39, Ex. B; A-18-40 |
| April 4, 2018 | ME/2017/005/MAP | $3,515,246 | quarter ending Sept. 30, 2017 | A-18-39, Ex. C; A-18-65 |
| May 11, 2018 | ME/2018/001/MAP | $3,508,100 | quarter ending Dec. 31, 2017 | A-18-70 |
| July 12, 2018 | ME/2018/002/MAP | $3,505,818 | quarter ending Mar. 31, 2018 | A-18-109 |
| December 18, 2018 | ME/2018/003/MAP | $3,507,899 | quarter ending Jun. 30, 2018 | A-19-48 |
| December 18, 2018 | ME/2018/004/MAP | $3,506,392 | quarter ending Sept. 30, 2018 | A-19-49 |
| **TOTAL** | | **$72,127,509** | | |

Without objection, we have consolidated all the pending disallowance appeals and dispose of them all in this decision.[3]

**Issue**

The central issue is whether Maine is entitled to receive FFP in claims for payments, particularly DSH payments, under the Medicaid program for payments to a state psychiatric hospital after CMS terminated that state hospital's Medicare provider agreement.

**Analysis**

As explained below, we conclude that CMS is authorized to disallow Medicaid FFP in DSH payments and payments for services rendered after CMS terminated Riverview's Medicare participation agreement because both federal law and Maine's Medicaid state plan limit Medicaid FFP for hospital services to claims for hospitals participating in the

[3] While this appeal was pending, Maine requested that we rule on an expedited basis that CMS should permit Maine to have possession of the disallowed funds pending final resolution. After permitting additional briefing on this request, the Board denied Maine's motion in a ruling dated October 10, 2018, that we attach to this decision.

Medicare program. States participating in Medicaid are responsible for complying with federal law and with their state plans and bear primary responsibility for Medicaid enforcement. A state must ensure that it does not claim Medicaid funds for a Medicare-terminated psychiatric hospital and may not avoid that obligation by the expedient of failing to meet its obligations to implement Medicaid requirements.

1. *Maine's claims for Medicaid payments to Riverview after the termination of Riverview's Medicare participation are ineligible for FFP both under federal law and under Maine's own state plan.*

a. Federal law requirements

Federal law imposes a duty on the state to terminate the participation in Medicaid of any entity terminated from Medicare. Pursuant to statute and regulation, FFP is only available for Medicaid payments to providers with Medicaid agreements in place. Act § 1902(a)(27) (requiring state plans to "provide for agreements with every person or institution providing services" thereunder); *see also* 42 C.F.R. § 431.107 (setting out the purpose and required provisions of Medicaid provider agreements). A condition for any psychiatric hospital to have a Medicaid provider agreement is a showing that it complies with applicable Medicare COPs. Act §§ 1902(y)(2)(B), 1902(a)(39); 42 C.F.R. § 455.416.

Section 1902(a)(39) of the Act specifically provides:

> A State plan for medical assistance must — provide that the State agency shall exclude any specified individual or entity from participation in the program under the State plan for the period specified by the Secretary, when . . . participation of such individual or entity is terminated under title XVIII [Medicare] . . . , and provide that no payment may be made under the plan with respect to any item or service furnished by such individual or entity during such period . . . .

The language used is plainly mandatory – the plan **must** provide for what the state **shall** do to remove the terminated Medicare provider and stop Medicaid payments. Therefore, a Medicaid provider that has lost its Medicare agreement must be excluded from all participation in and payment under Medicaid. CMS thus rightly concluded that Maine was not entitled to FFP in any Medicaid payments to Riverview once CMS terminated its Medicare provider agreement because that termination triggered Maine's obligation to timely terminate Riverview's Medicaid agreement and stop Medicaid payments to it. CMS Br. at 23.

Moreover, once a state determines that a psychiatric hospital is out of compliance with the requirements for its provider type (which, as is clear above, include complying with Medicare COPs as well as not being terminated from Medicare participation), the state must terminate that hospital's Medicaid participation unless the state imposes temporary intermediate sanctions instead. Act §§ 1902(y)(1)(A); 1902(y)(1)(B); 1902(y)(2). The receipt of FFP in any payments made to such a hospital during a period of intermediate sanctions is conditioned on the state obtaining CMS's approval for a corrective action plan for the hospital and the state promising to repay all FFP in those payments if corrective action is not successfully completed.[4] Act § 1902(y)(3).

Maine nevertheless relies on statutory language providing for intermediate sanctions to support its position. Specifically, Maine argues that, "[w]hen *the State* determines" that a hospital no longer "meets the requirements," then "*the State* shall terminate the hospital's participation under the State plan" means that "Maine gets to make termination decisions regarding state mental health institutions." Maine Reply Br. at 5 (quoting Act § 1902(y)(1)-(1)(A)) (Maine's emphasis). Thus, Maine argues, since **it** did not determine Riverview was out of compliance and did not decide to terminate, Maine remained free to continue to make DSH payments to Riverview "notwithstanding its de-certification as a Medicare provider." *Id*. The fundamental error here is to construe Maine's responsibility to take action upon making the determination to terminate the Medicaid participation of a noncompliant psychiatric hospital as a license to refuse to make that determination despite a final determination that Riverview failed to correct noncompliance with Medicare COPs and its Medicare termination.

The statute will not bear this construction. The Act does give discretion to the states in many regards in operating the Medicaid program. For example, a state may or may not elect to include intermediate sanctions for psychiatric hospitals as an option in its Medicaid program. If it makes that election, as Maine has, the state also has discretion to determine whether the use of intermediate sanctions rather than immediate termination is preferable in a particular situation. The Act, however, places some limits on the discretion of states that choose to participate in Medicaid. Among those limits, section 1902(a)(39) mandates that every state commit to terminating the Medicaid participation of any psychiatric hospital that has failed to meet the Medicare participation requirements and has been terminated from Medicare. Maine agreed to do so (as discussed further below) and therefore simply refusing to make the required determination was not a permissible exercise of discretion but a violation of its obligations under federal law. *See also* 42 C.F.R. § 455.416(c) (state Medicaid agency "must deny enrollment or terminate the enrollment of any provider that is terminated" from the Medicare program).

[4] Maine did submit corrective action plans and ultimately received CMS approval for one, but it has been established by the prior case history discussed above that the approved plan was not successfully completed.

We conclude that the federal law requirements discussed here precluded Maine from claiming FFP for Medicaid payments to any psychiatric hospital terminated from Medicare.

b. State plan requirements

Maine asserts that its state plan nevertheless entitles it to receive FFP in the payments at issue. Maine argues that it interprets its state plan to merely **allow** Maine, in its own discretion, to terminate a hospital when Maine itself determines that the hospital does not meet requirements, but not to oblige Maine to do so. Maine Reply Br. at 5. First of all, this argument, even were the premise true, could not entitle Maine to receive FFP in payments made in violation of federal law. *Ark. Dep't of Health & Human Res.*, DAB No. 2201, at 16 (2008) ("Although states must follow their plans, longstanding regulations provide that plans must comply -- and if necessary be amended to comply -- with federal law."), *aff'd, Ark. Dep't of Human Servs. v. Sebelius*, 818 F. Supp. 2d 107 (D.D.C. 2011); *see also* 42 C.F.R. § 430.10 (describing a state plan as "a comprehensive written statement . . . giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department"). Since we have already concluded that federal law precludes continuing to claim FFP in Medicaid payments to psychiatric hospitals terminated from Medicare, we could not accept an interpretation of Maine's state plan that allowed it to violate these federal requirements.

In any case, the state plan does not, in fact, provide for Maine to refuse to determine that a psychiatric hospital terminated from Medicare is not eligible for further Medicaid participation or payments or to permit such a hospital to continue to receive Medicaid payments indefinitely. Since 2013, Maine's state plan has provided that "Maine [a]ssures that the State Medicaid agency will comply with section 1902(a)(39) of the Act and with the requirements outlined in 42 C.F.R. 455.416 for all terminations or denials of provider enrollment." CMS Ex. 6, at 1 (effective Oct. 1, 2013). Maine cannot justify simply ignoring its own commitment in its state plan.[5]

[5] Maine suggests that CMS is misreading the state plan as providing that a hospital terminated from Medicare is "*automatically* terminated from Medicaid." Maine Reply Br. at 5 (italics in original). This misframes the actual effect of the state plan provisions. The state plan indeed does not make the Medicaid termination happen automatically, in the sense of without further intervention or action. What the state plan does, as explained in the text, is commit Maine to taking the appropriate actions to terminate such a hospital and stop making Medicaid payments to it. Here, Maine seeks to profit (directly, as this is a state-owned hospital) from its own failure to take the actions to which it committed itself.

Maine focuses instead on the provisions in its plan permitting intermediate sanctions for non-compliant psychiatric hospitals. Thus, Maine asserts that it "retains absolute authority to terminate" non-compliant hospitals (Maine Reply Br. at 7), highlighting statements in its plan that "*[t]he State* terminates the hospital's participation under the State Plan when *the State* determines that the hospital does not meet the requirements" and that "[w]hen *the State* determines that the hospital does not meet the requirements . . . *the State* may . . . terminate the hospital's participation." *Id.* at 5 (quoting CMS Ex. 7) (emphasis added by Maine). Maine's interpretation of these statements improperly relies on selectively quoting state plan language while ignoring context and federal requirements.[6] *See, e.g., Va. Dep't of Med. Assistance Servs.*, DAB No. 2084, at 17 (2007) (rejecting state interpretation of state plan which "ignores applicable federal law and the context of the State plan provision at issue"), *aff'd, Va. Dep't of Med. Assistance Servs. v. Johnson*, 609 F. Supp. 2d 1 (D.D.C. 2009).

The State is indeed the actor in these statements, as it is in the corresponding statutory provisions for intermediate sanctions discussed above which are cited beside each of the state plan provisions. But the scope of the State's discretion in declining to act is also similarly constrained. Ultimately, the state plan provision upon which Maine relies also requires that, "[w]hen the psychiatric hospital described [in the prior subsection] **has not complied** with the requirements for a psychiatric hospital within 3 months . . . , **the State shall** provide that no payment will be made under the State plan" for any new admissions, citing section 1902(y)(2)(A) of the Act.[7] CMS Ex. 7 (emphasis added). In other words, the State is bound to stop payments, not merely empowered to do so.

Maine also suggests, as a procedural matter, that CMS cannot rely on Maine's failure to comply with the state plan because the disallowance letters did not specify this reason, which did not appear until CMS's response brief. Maine Reply Br. at 3-5. However, it is well-established that an agency may amend the basis for its action during the administrative adjudication process, so long as the appellant has an opportunity to

[6] The Board has long held that it will defer to a state's permissible interpretation of ambiguous language in its Medicaid state plan "if it is reasonable in light of the purpose of the provision and program requirements, gives effect to the language of the plan as a whole, and is supported by consistent administrative practice." *Ill. Dep't of Healthcare & Family Servs.*, DAB No. 2863, at 9 (2018) (and cases cited therein). To the extent Maine's state plan might be ambiguous about the State's leeway to decline to take action against a psychiatric hospital terminated from Medicare for noncompliance – which we do not think it is – Maine's reading would be unreasonable, especially in light of the overall purpose of the cited provisions, which spell out sanctions for noncompliant psychiatric hospitals and assure CMS of Maine's intended compliance with the applicable federal requirements for taking action against such hospitals. Maine's purported interpretation also appears to have been developed only in anticipation of this litigation as Maine failed to show any prior practice consistent with it apart from this dispute. Moreover, the Board cannot and will not defer to a proposed interpretation that would be impermissible under governing federal law, as Maine's theory here would be.

[7] The excerpt from the state plan in the record ends here and neither party submitted the next page, but we presume (and nothing Maine has argued suggests otherwise) that it goes on to track the requirement for stopping all payments after six months from subsection 1902(y)(2)(B) as it did in the prior subsections.

respond. "[T]he Board has long held that the respondent federal agency 'may raise new grounds for a disallowance after a disallowance letter is issued as long as the appellant is afforded an opportunity to respond.'" *Cnty. of Fresno*, DAB No. 2841, at 12 (2017) (quoting *Tex. Health & Human Servs. Comm.*, DAB No. 2187, at 5 n.3 (2008), and *N.Y. State Dep't of Soc. Servs.*, DAB No. 1666, at 20 (1998)); *see also, e.g., Pa. Dep't of Pub. Welfare*, DAB No. 1278, at 27 (1991) ("The Board has previously held that a party may raise new arguments before the Board as long as the other party has an adequate opportunity to respond to those arguments."), *aff'd, Pennsylvania v. U.S. Dep't of Health & Human Servs.*, No. 92-337 (W.D. Pa. July 15, 1993). The various court cases Maine cites (Maine Reply Br. at 4) for the proposition that an agency is held to the rationale on which its action is based are inapplicable. They apply to courts reviewing final agency actions; in this case, the final agency decision will be the Board decision not the disallowance letters which Maine appeals to us.

We conclude that CMS adequately identified in its response brief (at least) that the payments which have been disallowed were inconsistent with the requirements of Maine's state plan. Maine had ample opportunity to respond in its reply brief and has done so. The issue was thus properly before us and we have concluded, as explained above, that the payments were indeed in violation of state plan requirements.

*2. Maine cannot justify claiming FFP in its continued payments to Riverview by re-characterizing Riverview as something other than a state psychiatric hospital.*

Maine argues that, since CMS has determined that Riverview does not meet the requirements to participate as a psychiatric hospital under Medicare's definition, it must follow that Riverview is not a psychiatric hospital. Maine seeks to recast Riverview as a "psychiatric facility that is not a hospital and is accredited by the Joint Commission . . . ." Maine Reply Br. at 9-10 (quoting 42 C.F.R. § 441.151(a)(2)(ii)). Such a facility, Maine notes, can qualify to provide Medicaid inpatient psychiatric services for individuals under the age of 21. *Id*. at 9 (citing 42 C.F.R. § 440.160).

Section 440.160(b) allows such Medicaid services to be provided in: (1) a "psychiatric hospital" or "hospital with an inpatient psychiatric program" that has been determined by a state survey to meet the applicable Medicare COPs[8] or (2) a non-hospital psychiatric facility with recognized accreditation as such. Each setting has its own definitions and requirements. Maine's theory goes that, since Riverview is no longer qualified as a psychiatric hospital, it should be considered a psychiatric facility, and it still has

[8] The psychiatric hospital or distinct part may also qualify by equivalent approved accreditation but Maine expressly acknowledges that Riverview's current accreditation does not establish compliance. Maine Reply Br. at 9 n.7.

accreditation – and therefore its services should be reimbursed by Medicaid. Maine Reply Br. at 11-12. Maine cites no authority supporting this apparently novel position that failing to comply with the Medicare COPs as a psychiatric hospital somehow automatically converts Riverview into a psychiatric facility, and we find none.

Moreover, such an approach presents at least two serious problems. The first problem with Maine's contention is that, as a matter of fact based on the record before us, Riverview is a psychiatric hospital, albeit a non-compliant one, and not a psychiatric facility. The second problem is that, as a matter of law, if Riverview were indeed a facility and not a hospital, it could not receive DSH payments which are, under Maine's state plan, provided only to **hospitals**.

The record clearly reflects that Riverview is a psychiatric hospital. Maine consistently treated Riverview as a psychiatric hospital, continues seeking to have it participate in Medicare as such,[9] and sought to make payments to it as such under Medicaid. It is undisputed that Riverview participated in Medicare as a psychiatric hospital from 1993 through 2013. Section 1902(y)(2) therefore precluded Maine from receiving FFP for **any** Medicaid payments to Riverview once it was out of compliance with the statutory requirements for a psychiatric hospital for six months.

Riverview's own documentation establishes that it has been a psychiatric hospital for many years. Riverview's Medicaid Agreement, issued by Maine in 2010, identifies its provider type as "Psychiatric Hospital." CMS Ex. 15, at 1. In Riverview's state license issued in 2015, Maine identified Riverview as a "specialty hospital" with "psychiatric beds." CMS Ex. 8, at 297. Maine has made no showing that Riverview has in some way restructured since 2013 to cease providing hospital services and become a psychiatric facility. Maine offers no evidence that Riverview ever requested a reclassification of the hospital to become a non-hospital psychiatric facility. As late as 2017, Riverview was, according to Maine, still seeking a resurvey in an attempt to regain its certification as a psychiatric hospital. Maine Br. at 11-12. We conclude that Riverview remains a psychiatric hospital and must meet the requirements to participate in Medicare and Medicaid as such, which it has not.

Moreover, even if CMS were to treat Riverview as eligible for Medicaid reimbursement as a non-hospital psychiatric facility, the vast majority of the disallowed funding was tied to Riverview's status as a DSH. We discuss the DSH provisions further in the next section, but a basic principle is that disproportionate share hospital payments may

[9] Maine reports submitting the most recent application seeking to re-certify Riverview on October 8, 2017 and states that CMS review was still pending at the time Maine filed its brief in this appeal. Maine Br. at 3 n.2.

generally be made only to qualifying **hospitals**.[10] For example, section 1923(b)(4) of the Act provides authority to states "to designate **hospitals** as disproportionate share hospitals under this section." (Emphasis added.); *see also* Act §§ 1902(a)(13)(A)(iv); 1923(b) ("Hospitals deemed disproportionate share"); 42 C.F.R. § 412.106 ("Special treatment: Hospitals that serve a disproportionate share of low-income patients"). Hence, we would still uphold the overwhelming share of the disallowances even if Riverview could somehow qualify as a non-hospital psychiatric facility that could receive Medicaid payments for inpatient services unless Maine could show that Riverview was ever designated as eligible for DSH payments as a non-hospital.

In short, a psychiatric facility is a non-hospital psychiatric facility, not a noncompliant hospital psychiatric facility. We cannot accept Maine's novel assertion that a hospital that has breached the Medicare COPs established to ensure the health and safety of its patients somehow can automatically cast itself as a non-hospital psychiatric facility – much less that it ceases to be a hospital and yet remains eligible for DSH payments.

*3. Section 1923 provides states considerable discretion in directing DSH payments among qualifying hospitals, but does not authorize FFP in DSH payments to hospitals that were not qualified to participate in Medicaid at all.*

Maine argues that the disallowances violate section 1923 of the Act which Maine reads as not only providing states with virtually unlimited discretion to designate DSH hospitals but also precluding CMS from disallowing DSH payments to any institution regardless of whether it is in violations of the conditions for its participation because there are no specific COPs to be a DSH recipient. Maine Br. at 13-16. In support of this argument, Maine relies on several court cases recognizing that the Act does provide more flexibility to states in electing which hospitals to designate as DSH recipients under Medicaid than is available to states under Medicare. *Id*. at 13-14 (citing, with parentheticals and quotes from Maine's brief, *Northeast Hosp. Corp. v. Sebelius*, 699 F. Supp. 2d 81, 87 (D.D.C. 2010) ("[S]tates generally have flexibility in administering these Medicaid DSH payments."); *Banner Health v. Sebelius*, 715 F. Supp. 2d 142, 148 (D.D.C. 2010) (noting that this flexibility is unique to Medicaid DSH payments and that states do not maintain the same broad discretion with *Medicare* DSH adjustments); *Cooper Univ. Hosp. v. Sebelius*, 686 F. Supp. 2d 483, 487 (D. N.J. 2009) ("Under this framework, states have more flexibility to designate a Medicaid DSH . . . than is true for designating a Medicare DSH.")).

[10] While the Act allows a subset of DSH payments to go to "institutions for mental diseases and other mental health facilities" (section 1923 of the Act), Maine's own state plan limits the categories of facilities eligible for its DSH program to only two categories: "institutions for mental disease" (specifically "psychiatric hospitals") and "acute care hospitals." CMS Ex. 3, at 3 (State plan excerpt on DSH). In other words, under Maine's state plan, the only IMDs that may receive DSH payments are psychiatric hospitals. This language is consistent with the statutory purpose of including DSH payments in state plans, which is that the rates set by states must take into account "the situation of **hospitals** which serve a disproportionate number of low income patients with special needs." Act § 1902(a)(13)(A) (emphasis added).

We do not disagree, nor does CMS in its briefing (CMS Br. at 24), that states have more flexibility in designating hospitals as recipients of DSH payments under the Medicaid program, which is a federal-state partnership, than under Medicare, a fully-federally operated and funded program. Indeed, CMS did not prevent Maine from initially designating Riverview as a DSH under its state plan and has not challenged that initial designation, so the question is not before us. The question before us is whether CMS is compelled to continue FFP in Medicaid payments to Riverview after its final termination as a Medicare provider, in violation of the requirements for participation in Medicaid, simply because Maine wishes to continue providing supplemental Medicaid DSH payments to Riverview.

Maine also contends that, because federal law limits CMS's authority to impose restrictions on which hospitals a state may designate for Medicaid DSH status, CMS could not preclude DSH payments to Riverview even after it was found noncompliant with Medicare conditions of participation. Maine Br. at 3. Section 1923(b)(4) of the Act provides that "[t]he Secretary may not restrict a State's authority to designate hospitals as disproportionate share hospitals under this section." This provision of the statute applies to DSH designations, but does not on its face preclude disallowance of all Medicaid FFP to a hospital ineligible for Medicaid payments.[11] Congress plainly intended for DSH payments to alleviate the burden on hospitals that "are particularly dependent on Medicaid reimbursement." H.R. Conf. Rep. 97-208, 962, 1981 U.S.C.C.A.N. 1010, 1324. Given the purpose and context of the DSH program, therefore, it would make no sense to allow a state to be reimbursed for DSH payments to an entity unqualified to receive any Medicaid payments. Once Riverview was terminated from Medicare, Maine was obliged to timely remove it from Medicaid (as discussed in the first part of this analysis). If no Medicaid payments could properly be made to Riverview for services to recipients, no supplemental payments could properly be added to such payments. Maine's improper continuation of small amounts of direct Medicaid service payments cannot create a bootstrap justification for making DSH supplemental payments.

Moreover, Maine mistakenly treats the need for every provider to comply with applicable COPs to provide "medical assistance" under Medicaid as an unwarranted restriction on its freedom to designate a hospital as a DSH recipient. Maine Br. at 15. Maine suggests that the Act would have included in the definition of DSH express authority for CMS to impose CoPs on DSH recipients, as it does elsewhere for "other types of institutions,"

[11] Maine describes this provision as curtailing "the Secretary's ability to further regulate who may receive DSH payments," and then asserts that there exist "only one or two statutory requirements that a medical institution must meet in order to qualify for DSH designation," specifically relating to inpatient utilization rates and obstetric services. Maine Br. at 14 (and statutory citations therein). As we explain, however, the provisions to which Maine cites do not purport to restrict CMS's ability to regulate hospitals or to require state compliance with federal law and state plan requirements for Medicaid participation, as opposed to limiting specific restrictions CMS may impose on which hospitals the state may elect to designate as DSH-eligible.

had such authority been intended. *Id*. (and statutory citations therein). Conditions of participation are not imposed on types of payments (e.g., DSH supplemental payments) but on types of providers. DSH recipients are not a separate provider type but a subset of the provider type to which they belong, such as general hospitals or psychiatric hospitals. To receive any Medicaid payments, including supplemental payments (such as DSH) above the base Medicaid rates, all providers must comply with the COPs applicable to their provider type. For hospitals, Medicaid regulations expressly "specify that hospitals receiving payment under Medicaid must meet the requirements for participation in Medicare . . . ." 42 C.F.R. § 482.1(a)(5)[12]; *see also id.* §§ 440.10(a)(3)(iii) (hospitals providing inpatient hospital services must meet Medicare requirements) and 440.160(b)(1) (psychiatric hospitals providing inpatient services for those under 21 must meet Medicare requirements). The fundamental requirement that providers receiving Medicaid funding qualify to participate in Medicaid is not a restriction on state flexibility to designate particular providers as DSH recipients.

Pursuant to both statute and regulation, furthermore, the federal government may only issue Medicaid payments to providers with Medicaid agreements in place. 42 U.S.C. § 1902(a)(27); 42 C.F.R. § 431.107. Maine contends, however, that requiring DSH payments only be made to entities qualified as Medicaid providers that meet requirements for their provider type (which for Medicaid hospitals, expressly includes meeting Medicare COPs) is a novel interpretation of section 1923 of the Act which Maine says is "[a]t the very least, ambiguous." Maine Br. at 16. Therefore, Maine argues, CMS should not apply its interpretation "retroactively." *Id*. (citing *Haw. Dep't of Soc. Servs. & Hous.*, DAB No. 779 (1986) and *Cal. Dep't of Health Servs*., DAB No. 786 (1986)).

Maine acknowledges that CMS correctly points out "that DSH payments [in the Act] are framed in terms of 'an appropriate increase in the rate or amount of payment for [Medicaid] services.'" Maine Reply Br. at 8 (quoting 42 U.S.C. § 1923(a)(1)(B), also citing CMS Brief at 24, both of which actually refer to "inpatient hospital services" specifically). This alone would seem to support the conclusion that DSH payments may be made only to providers that receive Medicaid payments for inpatient hospital services and that must therefore qualify as Medicaid providers. Maine argues, however, that this provision applies only to DSH payments made prior to July 1, 1988 (which is, in turn, the date by which states were required to amend their state plans to provide for DSH

[12] We note that the COPs in part 482 are the basis for surveying hospitals to determine whether they qualify for provider agreements under both Medicare and Medicaid (42 C.F.R. § 482.1(b)), so Maine's claim that "[r]equiring Riverview to comply with a large body of Medicare regulations" places an onerous burden on the State (Maine Br. at 16) is unfounded since Riverview could not qualify for a Medicaid provider agreement if it could not comply with Medicare COPs.

payments).[13] *Id.* at 8-9. This argument is based on the following provision:

> **Adjustment in payment for inpatient hospital services furnished by disproportionate share hospitals**
>
> (a) Implementation of requirement
> (1) A State plan under this title shall not be considered to meet the requirement of section 1902(a)(13)(A)(iv) [of the Act] [[14]] (insofar as it requires payments to hospitals to take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs), as of July 1, 1988, unless the State has submitted to the Secretary, by not later than such date, an amendment to such plan that—
> (A) specifically defines the hospitals so described (and includes in such definition any disproportionate share hospital described in subsection (b)(1) which meets the requirements of subsection (d))[[15]], and
> (B) provides, effective for inpatient hospital services provided not later than July 1, 1988, for an appropriate increase in the rate or amount of payment for such services provided by such hospitals, consistent with subsection (c).

Act § 1923(a)(1). Maine argues that CMS incorrectly reads these provisions as defining "the entire universe of DSH FFP," rather than as limited only to hospitals providing Medicaid services no later than July 1, 1988, which interpretation would be absurd, Maine says, because then "no DSH FFP would be available for institutions that postdate 1988." Maine Reply Br. at 8. Instead, according to Maine, "these DSH provisions

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[13] The Omnibus Budget Reconciliation Act (OBRA) of 1987 required states to submit Medicaid state plan amendments authorizing DSH payments and explaining whether hospitals would be deemed eligible for DSH adjustments based on Medicaid or low-income utilization rate thresholds. Pub. L. No. 100-203 § 4112, 101 Stat. 1330-148 (1987).

[14] The referenced section states, in relevant part, that a state plan must provide "for a public process for determination of rates of payment under the plan for hospital services, nursing facility services, and services of intermediate care facilities for the mentally retarded" and that, "in the case of hospitals, such rates take into account (in a manner consistent with section 1923) the situation of hospitals which serve a disproportionate number of low-income patients with special needs[.]" Act § 1902(a)(13)(A)(iv).

[15] Subsection (b)(1) provides that a hospital will be "deemed" a DSH hospital if it exceeds specified levels for its "[M]edicaid inpatient utilization rate" or its "low-income utilization rate" and meets the requirements to be a DSH hospital laid out in subsection (d). Subsection (d) provides that no hospital can qualify for designation as a DSH unless it "has at least 2 obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services under such State plan" unless its inpatients "are predominantly individuals under 18 years of age" or it does not offer nonemergency obstetric care to the general public. Subsection (d) also provides that no **"**hospital may be defined or deemed as a disproportionate share hospital under a State plan . . . unless the hospital has a [M]edicaid inpatient utilization rate . . . of not less than 1 percent."

merely require State Plans to consider DSHs when formulating their rates of payment for Medicaid services" but "do not . . . mandate that states limit DSH designation to *only* Medicaid-services providers." *Id*. at 8-9 (emphasis by Maine).

It is Maine's proposed interpretation that would render the statutory language absurd and untenable by providing that the requirements for the state plan provisions for DSH payments to Medicaid hospitals both go into effect and end on July 1, 1988, and nothing in the statute remotely implies this conclusion.[16] In context, we find that the provisions above, read together, required the states to amend their state plans by July 1, 1988, to identify which hospitals would receive DSH supplemental payments and to make such payment increases **effective not later than July 1, 1988**. The supplemental payments are thus to be made available under the amended state plans beginning no later than July 1, 1988, but are thereafter available to hospitals defined or deemed by the State consistent with the requirements of the rest of the section (which nowhere limit hospitals to those existing in 1988). In sum, the only reading that makes sense of the words used is one which takes "not later than July 1, 1988" as establishing the effective date for the increase in payments for inpatient hospital services of DSH hospitals.

In any case, the possibly less-than-felicitous placement or use of "not later than July 1, 1988" occurs only in subsection (a)(1)(B), but the rest of the section clearly states that state plans going forward from July 1, 1988, must define DSH hospitals in a manner that complies with subsection (d) that prohibits **any** hospital from being defined as a DSH "unless the hospital has a [M]edicaid inpatient utilization rate . . . of not less than 1 percent." To have a Medicaid inpatient utilization rate at all means the hospital must be a Medicaid participant.

Maine also argues that Riverview can still meet the Medicaid inpatient utilization rate requirement, even if it is required to do so, because it continues to maintain a rate "well above 1%." Maine Br. at 15 (citing Maine Ex. K at ¶¶ 8-9). Further, says Maine, "CMS has never suggested otherwise." *Id*. Maine is simply engaging in a circular argument here. CMS has clearly argued, correctly as we have found above, that Riverview has not and could not provide Medicaid-covered services as a psychiatric hospital after having been terminated from Medicare for failure to comply with the applicable COPs. Maine's failure to live up to its assurances in its state plan to end the Medicaid participation of its state-owned psychiatric hospital once CMS terminated its Medicare agreement does not

[16] Although Maine frames its arguments regarding section 1923 as if it relied on a good faith belief that "Medicare certification was not required in order for Riverview to be eligible for DSH FFP" (Maine Br. at 17), that contention lacks credibility given that Maine did not only continue to direct DSH funds to Riverview but, as we have found, simply ignored its obligation to impose a derivative termination on Riverview and continued to make non-DSH payments for services as well. This conduct cannot be explained by any purported interpretation of state discretion in designating DSH hospitals under section 1923.

mean that Maine can treat the inpatient services provided by Riverview as Medicaid services. While Maine is and has been free to provide services through its own programs to its residents at Riverview, none of those services are eligible for reimbursement under Medicaid (for which reason, all Medicaid expenditures, not only DSH expenditures, for inpatient services at Riverview have been disallowed in the determinations at issue).

Maine also suggests that CMS has not consistently communicated a requirement that hospitals receiving Medicaid DSH supplemental payments must be Medicaid participants, based on a CMS response to a comment in a preamble to a rulemaking relating to DSH program audit and reporting requirements. Maine Br. at 22 n.7 (citing 73 Fed. Reg. 77,904, 77,929 (Dec. 19, 2008)); Maine Reply Br. at 8-9. A commenter noted that the proposed rule had not included a link to the definition of IMDs in section 441.40, even though the Act allows IMDs to participate in Medicaid DSH programs. 73 Fed. Reg. 77,929. CMS agreed that states should be required to identify "whether the DSH facility is an IMD," noting that an "additional limit applies to the percentage of the total Federally determined DSH allotment for each State that can be used for payments to IMDs that otherwise qualify for DSH payments under the Medicaid State plan" so the information "will assist CMS in assessing the appropriateness of the DSH payment." *Id*. CMS stated that this additional IMD percentage cap does not supersede the "hospital-specific limit" on all DSH hospitals "that is the primary focus of the reporting and auditing requirements under this regulation." *Id*. CMS went on to explain how to determine both IMD Medicaid inpatient services (for the limited Medicaid coverage of individuals in an IMD who are under 21 or over 65) and other uncompensated care costs (which may include uncompensated care of otherwise Medicaid-eligible inpatients between 21 and 65). *Id*. Finally, CMS reiterated that "DSH payments made to IMDs are subject to the same audit and report requirements as all other DSH hospitals to which the State has made payments." *Id*.

Maine claims that this "most recent guidance" implies that "providing inpatient services to patients between the ages of 22 and 64 could qualify for DSH FFP, even though such services do not qualify as Medicaid services." Maine Reply Br. at 9. The preamble explanation (which dates to 2008 and which made no change in the DSH eligibility of IMDs from before that) contains no such implication. The amount of uncompensated care provided to both Medicaid-eligibles and the uninsured is relevant to whether any hospital qualifies for DSH payments, that is, whether it is indeed bearing a disproportionate share of costs for serving the Medicaid and uninsured population. Nothing in the preamble remotely suggests that an IMD (which, as explained, under Maine's state plan means a psychiatric hospital) could receive DSH payments while ineligible to provide any Medicaid services. Furthermore, as the quoted language illustrates, Maine's late claim that CMS cannot deny DSH payments to Riverview even

though it admittedly "no longer meets" the definition of a "psychiatric hospital" because IMDs are not excluded from receiving DSH is unfounded. Maine Surreply Br. at 6. That some IMDs may qualify to receive Medicaid DSH payments does not mean that every IMD must be considered qualified. Riverview is not qualified as a DSH recipient under either federal law or Maine's state plan because only IMDs that are psychiatric hospitals providing Medicaid-eligible services are eligible to receive Medicaid DSH payments.

We find no novel interpretation here of law by CMS, as Maine contends, but instead conclude that Medicaid law has consistently permitted states to designate as DSH recipients **only** hospitals that participate in Medicaid and are eligible to receive Medicaid payments. To be Medicaid participants, longstanding regulations require hospitals to comply with Medicare COPs. Hence, we see nothing impermissibly retroactive about the disallowance here.

Nor does the fact that CMS released its initial deferral of some of the funds rather than immediately taking a final disallowance imply that CMS ever tacitly approved Maine's theory that it could ignore Riverview's noncompliance with Medicare COPs and continue to make Medicaid payments to the hospital. Maine Br. at 17-18. As we noted in the background discussion, CMS notified Maine at the time that the released funds and future CMS actions concerning Riverview would be subject to "later determinations of allowability." Maine Ex. CC. Maine has not shown any obligation for CMS to have completed those determinations or issue the disallowances sooner than it did and Maine had no basis to presume that the later determinations would be favorable.

*4. The termination of Riverview from Medicare is not subject to challenge in this case.*

Maine sought at great length in its briefing before us to revisit its arguments about the perceived unfairness of the original termination of Riverview and CMS's unwillingness to reopen and overturn that termination based on Maine's efforts to separate Riverview's forensic activities from its Medicaid patient care. Maine Br. at 13-24; Maine Reply Br. at 14-20. According to Maine, if we find that the Medicare termination indeed precludes Medicaid DSH payments to Riverview, as we have, we "*must* consider the merits" of the 2013 termination decision, which have "never been actually litigated." Maine Surreply Br. at 9 (emphasis in original).

We disagree. The merits of the original noncompliance findings which triggered the termination have, in point of fact, never been challenged and the time for challenging them is long past. Indeed, Maine **still** does not dispute that the hospital was noncompliant with the cited Medicare COPs. Maine chose to focus instead on trying to negotiate some way to reorganize care delivery that would allow Riverview to continue shared services to the criminally insane and other patients. Maine complains that CMS

somehow lured it into waiting until after the termination went into effect and Riverview failed the survey in 2015 which found its corrective efforts had not succeeded in bringing the facility into compliance.[17] *Id*. at 9-10. As the Board and the District Court concluded, CMS's resulting refusal to reopen the already-effective termination was not subject to review because it was not an appealable initial determination. DAB No. 2586, at 5; *Riverview*, 2015 WL 4872376, at *4, *5. That issue has been fully litigated.

We will, therefore, not revisit issues raised by Maine about Riverview's Medicare termination or reopening, as the Board has already rendered its final decision on that matter; the District Court upheld that decision; and the period for appeal has passed. Maine's contentions about both the merits and the proceedings relating to them are foreclosed and not subject to further review. Likewise, it is not within our discretion to review whether Maine's various attempts to separate forensic inmates and medical patients in response to the noncompliance findings should have been acceptable to CMS in the absence of an appealable initial determination.

If CMS determines at some point that Riverview has successfully addressed the Medicare deficiencies and complied with applicable Medicare COPs,[18] Riverview could again qualify to receive a Medicare provider agreement as well and so would be able to receive FFP in Medicaid payments as a psychiatric hospital. That is not the situation presented in this case because it is undisputed that Riverview remains terminated from Medicare at this point.

*5. The Board cannot overturn a disallowance based on equitable arguments.*

Finally, we recognize that Maine expresses serious concern about the loss of significant federal funding for Riverview which Maine states "is one of the only facilities in Maine equipped to handle its population of mentally ill patients" and which has been confronted with an "influx" of "criminally accused patients it was ordered to care for by the state court system." Maine Br. at 2, 4. While the criminally accused inmates' needs may well be pressing and acute, the longstanding federal policy is that inmates in state custody remain a state responsibility and the costs of their care for which the state is the

[17] We do note that Maine is mistaken (Maine Reply Br. at 14-15) that simply accepting a plan of correction from a noncompliant facility implies that CMS has determined that the facility has achieved compliance. An acceptable POC is prerequisite to a revisit or review to determine if completion of the plan has occurred and, if so, whether the facility has in fact successfully returned to compliance. 42 C.F.R. §§ 488.28, 488.30. As Maine admits, the revisit after Riverview's POC resulted in a determination that Riverview had not returned to compliance.

[18] To be reinstated after a termination, a provider must show not only that it is currently in compliance but that it has removed the reason for the termination of its previous agreement and provide reasonable assurance that the noncompliance will not recur. 42 C.F.R. § 489.57; *see also* CMS Ex. 1, at 29-31 (State Operations Manual, Ch. 2, § 2016D).

responsible third party are not part of the uncompensated care costs for which DSH funding is intended to compensate. *See, e.g.*, *N.Y. State Dep't of Health*, DAB No. 2037 (2008). In any event, we do not have the authority to take into account such equitable factors as the collateral impact of a disallowance on Maine's budget. In reviewing CMS disallowances, the Board is bound by all applicable statutes and regulations and must base its decision on the evidence in the record. 45 C.F.R. §§ 16.14, 16.21.

Similarly, Maine's complaint that CMS "took no action for almost four years" after releasing the initial deferrals (Maine Br. at 11) cannot entitle Maine to obtain federal funds to which it has not shown a lawful claim. The Board has recently restated, in a case involving a much longer delay, that "[t]he Act and regulations 'contain no statute of limitations or other time limit on the issuance of Medicaid disallowances.'" *Ill. Dep't of Healthcare and Family Servs.*, DAB No. 2863, at 17 (2018) (quoting *Ca. Dep't of Health Care Servs.*, DAB No. 2204, at 9 (2008)).

**Conclusion**

For the reasons stated above, we sustain the disallowances in full.

/s/
Susan S. Yim

/s/
Constance B. Tobias

/s/
Leslie A. Sussan
Presiding Board Member

DEPARTMENT OF HEALTH & HUMAN SERVICES

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**BY DAB E-FILE**

October 10, 2018

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RE: Maine Department of Health and Human Services
Docket No. A-18-70

**RULING ON APPELLANT'S MOTION TO EXPEDITE CONSIDERATION OF APPEAL IN PART**

On May 23, 2018, the Maine Department of Health and Human Services (Maine) appealed the May 11, 2018 decision by the Centers for Medicare & Medicaid Services (CMS) to disallow $3,508,100 in federal financial participation (FFP) claimed for Medicaid payments to Riverview Psychiatric Center (Riverview) for the quarter ending December 31, 2017 (Disallowance ME/2018/001/MAP). CMS's decision relied on the same underlying facts and reasoning as related disallowances for earlier periods, which Maine previously appealed to the Departmental Appeals Board (Board). The Board assigned docket number A-18-70 to Maine's appeal of Disallowance ME/2018/001/MAP and, at Maine's request, consolidated that appeal with the prior related appeals under lead docket number A-18-39.[1]

[1] The earlier appeals were docketed as A-18-39, A-18-40, and A-18-65. The Board has filed a copy of this document in the administrative record of lead docket number A-18-39.

On June 14, 2018, the parties submitted a joint request for leave for Maine to file an amended notice of appeal in docket number A-18-70 to address a May 17, 2018 CMS notice of a negative grant adjustment for the quarter ending December 31, 2017. Joint Request at 2 and Ex. A. Maine asserts that CMS "sought to withhold FFP that was the subject of this appeal" by issuing the "negative grant" and violated Maine's right under section 1903(d)(5) of the Social Security Act (Act)[2] "to retain disallowed funds pending a final determination" on the disallowance. Maine Reply at 20-21. The parties also requested an extension of time for Maine to submit its reply brief in the consolidated appeals to address this new issue, to permit an increase in the page limit for the reply brief, and for the parties to file sur-replies. The Board granted the parties' requests for additional briefing.

On July 5, 2018, Maine submitted a motion asking the Board to expedite consideration of the issue raised in docket number A-18-70 by "CMS's recent decision to withhold funds" and, in effect, order CMS to release the funds to Maine "to use … during the pendency of the appeal." Motion to Expedite Consideration of Appeal in Part, Docket. No. A-18-70, at 2-3. "If CMS is permitted to retain the funds in question until the Board issues a decision on the merits," Maine says, it "will lose the benefit of the statutory right" provided under section 1903(d)(5). *Id.* at 2. Maine argues that "[s]uch an order is clearly within the Board's delineated powers . . . ." *Id.* at 2-3 (citing 42 C.F.R. § 430.42(h)(1); 45 C.F.R. § 16.13).

Maine's request is best understood in the context of the administrative procedures for states to claim Medicaid FFP and to appeal Medicaid disallowances. Therefore, we first describe below the procedures for claiming Medicaid FFP and provisions for a state to appeal a Medicaid disallowance to the Board. We next summarize the background of the parties' dispute and arguments related to the federal funding claimed by Maine for the fourth quarter of 2017. Lastly, we explain why we deny Maine's motion.

## Legal Background

### *Process for Claiming Medicaid FFP*

Title XIX of the Act authorizes federal grants to states to aid in financing state Medicaid programs. Recognizing that states might have difficulty financing Medicaid programs, even if subsequently reimbursed by the federal government, Congress provided for quarterly awards to be made in advance and drawn down by the state during the quarter as needed to operate its Medicaid program. Act § 1903(d)(1); 42 C.F.R. § 430.30.

The amount of a quarterly federal Medicaid award is initially determined on the basis of a state's estimated Medicaid expenditures for the upcoming quarter, which a state reports on Form CMS-37 and submits to CMS before the start of the quarter. 42 C.F.R. § 430.30(a)(2), (b). CMS reviews the Form CMS-37, makes adjustments as it finds necessary, and

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

determines the amount to be advanced. 42 C.F.R. § 430.30(d); CMS Ex. 8 (McGreal Declaration) ¶¶ 13-15. The CMS "grant award computation form shows the estimate of expenditures for the ensuing quarter," and any "amounts by which that estimate is increased or decreased because of an underestimate or overestimate for prior quarters," or for any of several specified reasons including accounting adjustments, deferrals or disallowances, and interest assessments. 42 C.F.R. § 430.30(d)(2).

After the end of a quarter, the state submits a quarterly statement of expenditures (QSE) on Form CMS-64. 42 C.F.R. § 430.30(c). The QSE is the "accounting of actual recorded expenditures" that the state believes are entitled to FFP. *Id.* § 430.30(c)(2). CMS reviews the document and undertakes a reconciliation process to adjust the funds advanced based on the Form CMS-37. 42 C.F.R. § 430.30(c)-(e); CMS Ex. 8 ¶ 16.

If CMS determines on review of a QSE that an amount is not supported, it may issue a deferral or disallowance for that amount. 42 C.F.R. §§ 430.40, 430.42; CMS Ex. 8 ¶ 16. CMS issues a deferral if it questions the allowability and needs additional clarification or documentation to resolve the question. 42 C.F.R. § 430.40(a). CMS issues a disallowance if it concludes that a claim or portion of a claim is not allowable. *Id.* § 430.42(a). As explained in CMS Exhibit 8 ¶ 16, "[d]uring the deferral process the money is withheld." After a specified period, "a State may request that CMS release the money even if the State will ultimately have to repay it if a disallowance is upheld." CMS Ex. 8 ¶ 16.

*Provisions for Appealing a Medicaid Disallowance*

Section 1116(e)(1) of the Act provides that whenever CMS determines that an item or class of items for which a state claims Medicaid FFP should be disallowed for such participation, the state may request CMS to reconsider the disallowance by filing a request within 60 days of its receipt of the disallowance notice. *Accord* 42 C.F.R. § 430.42(b). Section 1116(e)(2)(A) provides that a state may directly appeal a disallowance to the Board, or appeal an unfavorable CMS reconsideration of the disallowance to the Board, during the 60-day period that begins on the date the state receives notice of the disallowance or of the unfavorable reconsideration. *Accord* 42 C.F.R. § 430.42(e)(3), (f).

The Board's decision is the final decision of the Secretary of the Department of Health and Human Services unless, within 60 days of the date of the decision, a party files a motion for reconsideration by the Board. If no motion for reconsideration is filed within that 60-day period, the State may obtain judicial review by filing, within that 60-day period, an action in federal district court. Act § 1116(e)(2)(B), (C).

*Section 1903(d)(5) of the Act*

As noted, Maine contends that CMS's withholding of federal funds relating to the fourth quarter of 2017 violates section 1903(d)(5) of the Act. Section 1903(d)(5) provides that –

> In any case in which the Secretary estimates that there has been an overpayment under this section to a State on the basis of a claim by such State that has been disallowed by the Secretary under section 1116(d), and such State disputes such disallowance, the amount of the Federal payment in controversy shall, at the option of the State, be retained by such State or recovered by the Secretary pending a final determination with respect to such payment amount.[3]

If the final determination is that any amount was properly disallowed and the state "chose to retain payment of the amount in controversy," the statute provides, CMS will offset from subsequent payments to the state an amount equal to the disallowance plus interest for the period beginning on the date the amount was disallowed and ending on the date of the final determination. *Id.*

The regulation at 42 C.F.R. § 433.38, based on section 1903(d)(5) of the Act, sets out the principles for CMS to charge a state interest on disallowed claims for FFP and the procedures for the state to follow to retain disallowed funds during the appeals process. The regulation states that the provision "does not apply to . . . [c]laims for expenditures that have never been paid on a grant award . . . ." 42 C.F.R. § 433.38(a)(2). CMS explained when it proposed the rule:

> If we determine that the State erroneously requested FFP on any of its claims, a notice of disallowance for those claims is issued. At the point of disallowance a claim may be "paid" or "unpaid" . . . . If the State does appeal, it retains the funds for claims that have been paid until the appeal is resolved. However, if we issue the notice of disallowance before we issue the final grant award for the quarterly expenditures, we do not pay the unapproved claim and we hold the funds during any subsequent appeal.

47 Fed. Reg. 29,275 (July 6, 1982). Later responding to a comment questioning its position that section 1903(d)(5) of the Act "does not apply to funds that are not physically in the hands of the State," CMS stated in the preamble to the final rule:

> The statute gives the State the option to "retain" the amount in dispute. . . . [I]f a State appeals a claim that could not be paid because the State had been formally notified that the claim was disallowed before the issuance of a grant award approving payment of that claim, the statute does not give the State the option to have the funds paid to it.

48 Fed. Reg. 29,480, 29,482 (June 27, 1983).

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[3] Prior to the enactment of the Omnibus Reconciliation Act (OBRA) of 1980 (Pub. L. 96–499), states were permitted to retain, interest-free, the FFP for state Medicaid expenditures that CMS had disallowed, until there was a final federal determination under the administrative appeals process. 47 Fed. Reg. 29,275 (July 6, 1982). If the determination upheld part or all of the disallowance, the state was obligated to return only that amount and did not pay the federal government any interest. *Id.*

A-18-70 Case Background

In a September 7, 2017 letter from the Boston Regional Office, CMS notified Maine that on review of Maine's request for Medicaid FFP for the upcoming quarter (ending December 31, 2017), CMS had identified $3,518,000 in costs associated with Riverview. CMS Ex. 16, at 1-2. The letter stated that Riverview "was not in compliance with the Medicare conditions of participation and failed to timely submit an acceptable plan of correction" for deficiencies identified in 2013. *Id.* at 2. In addition, the letter stated, Maine "did not make reasonable efforts to transfer to other facilities or provide alternate care for the Medicaid recipients who were admitted before the effective date of termination . . . ." *Id.* "As a result," the letter explained, "CMS will reduce the state's budget submission request in the amount of $3,518,000," from $441,681,000 to $438,163,000 in "Net Regular Title XIX Grant" FFP. *Id.* at 1, 2.

Consistent with the September 7, 2017 letter, CMS notified Maine on October 1, 2017 that CMS had approved an initial grant award of $438,163,000 FFP for allowable medical assistance payments for the quarter ending December 31, 2017. Maine Supp. Appeal File Ex. 5.

Maine subsequently filed its QSE for the quarter. By letter dated March 22, 2018, the Boston Regional Office notified Maine of the results of its review of the QSE. CMS Ex. 16, at 3-4. The letter showed that Maine had reported $457,389,800 on Line 6 of the QSE (expenditures in this quarter), that the Regional Office "Recommended" that $453,881,700 of the Line 6 claimed amount be included in the grant award, and that CMS "has requested a disallowance of $3,508,100 for the [Riverview] related expenditures." *Id.*

On May 11, 2018, CMS issued the determination to disallow $3,508,100 in FFP claimed by Maine for payments to Riverview for the quarter ending December 31, 2017. Maine Supp. Appeal File Ex. 1.

On May 17, 2018 CMS issued the negative grant award in the amount of $3,508,100 for the quarter ending December 31, 2017, reflecting the disallowance for payments to Riverview and "indicating that CMS would not pay the amount on the final grant award for the quarter." CMS Ex. 17; CMS Sur-Reply at 20.

Approximately one week later, Maine filed its notice of appeal of the May 11, 2018 disallowance determination for the quarter ending December 31, 2017. Maine stated in the notice that it was "exercising its right to retain the funds disallowed . . . pursuant to Section 1903(d) of the Act." Notice of Appeal of Disallowance Number ME/2018/001/MAP at 1.

On July 17, 2018, CMS issued a "Finalization Quarter" grant award for the quarter ending December 31, 2017, showing that the disallowance of $3,508,100 had already been "taken against the quarter ending 12/31/2017." CMS Ex. 18, at 1, 5; CMS Sur-Reply at 20.

Maine's Arguments and Motion to Expedite Consideration of Appeal in Part

Maine argues that the May 17, 2018 negative grant award, which CMS issued to "withhold funds that are the subject of the disallowance" for the quarter ending December 31, 2017, violates section 1903(d)(5) of the Act. Motion to Expedite at 2; Reply at 20. Maine contends that the wording of section 1903(d)(5) is clear and provides that "when a disallowance occurs and a state disputes that disallowance, 'the amount of the Federal payment in controversy *shall, at the option of the State, be retained by such State,*' pending resolution of the appeal." Reply at 21 (quoting Act § 1903(d)(5) (emphasis by Maine)). Maine says that CMS has "attempted to end-run this statutory provision . . . so that CMS does not have to disburse funds to Maine during the pendency of appeal." *Id.* at 20-21.

Maine recognizes that the Board previously stated that section 1903(d)(5) gives a state the right to retain funds during the pendency of appeal of a disallowance determination only if "a payment has been advanced to the state." Reply at 21 n.14 (quoting *California Dep't of Health Servs., Ruling on Request for Reconsideration of DAB No. 1285*, at 6 (1992) (attached)). According to Maine, that condition is satisfied here because "CMS advanced a $465 million payment to Maine in October 2017 for the upcoming fourth quarter." Reply at 21 n.14 (citing Maine Supp. Appeal File Ex. 5); *see also* Maine Sur-Reply at 13 ("CMS does not dispute that Maine received more than $438 million in Medicaid funding for the fourth quarter of 2017" or that "$3.5 million of the funds that CMS advanced to Maine were used during that quarter by Maine for Riverview.").

Maine also contends that CMS's decision to issue the negative grant award for the fourth quarter of 2017 is arbitrary and capricious. "CMS did not purport to issue 'negative grant awards' and offset funds used for [disproportionate share hospital] expenditures at Riverview during the second or third quarters of 2017," Maine says, "even though the factual predicates are identical to the circumstances" related to the fourth quarter of 2017. Maine Sur-Reply at 18. Yet, Maine contends, CMS suddenly changed its position without explanation or justification. *Id.*

In support of its motion for the Board to "issue an order on this aspect of the appeal as quickly as possible," Maine asserts that "[s]uch an order is clearly within the Board's delineated powers to 'modify the disallowance,' 42 C.F.R. § 430.42(h)(1), and to 'issue orders …,' 'take all steps necessary for the conduct of an orderly hearing,' 'to rule on requests and motions,' and 'to take any other action necessary to resolve disputes in accordance with the objectives of these procedures.' 45 C.F.R. § 16.13." Motion to Expedite Consideration of Appeal in Part at 2-3; *see also* Maine Sur-Reply at 11-12. Maine says that CMS's action is "part and parcel of the disallowance decision itself." Maine Sur-Reply at 12.

CMS's Arguments

CMS argues that the Board lacks jurisdiction to review Maine's argument that it is entitled to "retain" the federal funds claimed for the fourth quarter of 2017 pending the outcome of these proceedings. CMS Sur-Reply at 13-15. The Board's review is confined to the disallowance itself, CMS says, and the Board previously has declined to address ancillary matters raised in disallowance appeals. In this case, CMS argues, the "retention issue is a secondary matter," and its "resolution will have no impact on the disallowance challenge before the Board." *Id.* at 15.

In the event the Board determines that it has authority to address Maine's argument, CMS contends, the Board should deny Maine's request. CMS points to the above-quoted statements in the Federal Register that section 1903(d)(5) is inapplicable where the disputed federal funds have not been paid to the state. *Id.* at 16-18. CMS asserts that it "did not pay the negatively adjusted claims to the state" for the fourth quarter of 2017 and, consequently, "there is nothing for the state to retain." *Id*. at 15. Here, CMS says, the initial quarterly Medicaid grant for the fourth quarter of 2017 reflected a reduction of FFP for the amount sought for Riverview, and Maine did not receive a "settlement (*final)* grant award for [the quarter] approving payment for amounts claimed for Riverview." *Id.* at 19-20. Thus, CMS says, it properly withheld the funds. *Id.* at 20-21.

Denial of Motion

The Board does not have the authority to grant the relief Maine seeks in its motion. Maine's contention that CMS has violated section 1903(d)(5) of the Act and that we should therefore order CMS to release federal funds to Maine pending our final decision in this appeal is outside the scope of our review. The Board's jurisdiction in this case is based on section 1116(e) of the Act and Appendix A to 45 C.F.R. Part 16. As noted, section 1116(e) provides that whenever CMS determines that an item or class of items for which a state claims Medicaid FFP should be disallowed for such participation, the state may appeal *the disallowance* to the Board. Consistent with the Act, Appendix A, paragraph B(a)(1) of the Part 16 regulations provides that the Board reviews, among other things, "*Disallowances* under Titles . . . XIX . . . of the Social Security Act." (Emphasis added.) Accordingly, the Board has long recognized that, "[i]n disputes involving mandatory grant programs such as Medicaid, the Board is confined, by regulation, to a review of CMS's 'disallowance' determination. 42 C.F.R. § 430.42(b); 45 C.F.R. Part 16, Appendix A ¶ B(a)(1)." *Connecticut Dep't of Soc. Servs.,* DAB No. 1982, at 22-23 (2005) (explaining that the "Board lacks authority to consider" state's "request for a 'good cause' waiver of the two-year filing requirement").

The scope of review of a Medicaid disallowance determination encompasses whether a state's claimed expenditures for any item or class of items meet program requirements and whether CMS's grounds for imposing the disallowance are supported. *See, e.g., California Dep't of Health Servs.,* DAB No. 1490, at 6 (1994); *Michigan Dep't of Community Health*, DAB No. 2225, at 14 (2009). The Board has consistently ruled that matters ancillary to the

validity of disallowances, such as federal agency deliberations or actions preceding a disallowance and the payment of debts arising from disallowances, are beyond the scope of the Board's review under 45 C.F.R. Part 16. *See, e.g.*, *California Dep't of Health Servs. Ruling on Request for Reconsideration of DAB No. 1285*, at 6 ("[T]he matter before the Board is [CMS's] disallowance of these costs, not its prior deferral.")[4]; *Teaching & Mentoring Communities, Inc.*, DAB No. 2790, at 8 (2017) ("[M]atters relating to repayment of a valid debt arising from a disallowance" are outside the scope of Board review under 45 C.F.R. Part 16.); *Joint Consideration: Reimbursement of Foster Care Servs.*, DAB No. 337, at 22 (1982) (The Board's jurisdiction stems from the disallowance and the Board lacks authority to provide a remedy for any alleged failure to follow deferral procedures.).

Here, contrary to Maine's characterization, the subject of Maine's request for expedited consideration is not "part and parcel of the disallowance decision itself." Maine Sur-Reply at 12. Maine's motion asks the Board to determine whether Maine has a statutory right to access federal funds pending the Board's final determination on review of the disallowance. That issue, however, is separate from the validity of the disallowance itself. Whether Maine is entitled to access FFP claimed for the fourth quarter of 2017 at this juncture (and, depending on the outcome of its appeal, either retain the funds or return the funds with interest to the federal government) has no bearing on our decision as to whether the Medicaid payments to Riverside were eligible for FFP and whether CMS had a legal basis for imposing the disallowance.

Moreover, we reject the notion that the Board has the authority to "issue an order on this aspect of the appeal" based on "the Board's delineated powers to 'modify the disallowance,' 42 C.F.R. 430.42(h)(1), and to 'issue orders,' . . . 'take all steps necessary for the conduct of an orderly hearing,' 'to rule on requests and motions,' and 'to take any other action necessary to resolve disputes in accordance with the objectives of these procedures.' 45 C.F.R. § 16.13." Motion to Expedite at 2-3. Section 430.42(h)(1), addressing implementation of decisions, provides that the Board's decision may affirm, reverse or modify the disallowance, or remand the disallowance to CMS for further consideration. While the regulation thus authorizes the Board ultimately to adjust or revise the disallowance amount, section 430.42(h)(1) does not authorize the Board to address the control of disputed federal funds during the administrative proceedings.

[4] In DAB No. 1285, the Board remanded disallowances to CMS for further review under the decision's terms. The disallowances were preceded by deferrals, and CMS never advanced the claimed federal funds to California. California alleged in its request for reconsideration that the Board erred by "allowing" CMS to retain the claimed funds pending the review on remand. Ruling at 3-4. California asked the Board to "release the deferrals of California's claims and require [CMS] to pay California the federal funds at issue pending [CMS's] review of California's practices." *Id.* at 1-2. The Board cited numerous reasons for rejecting California's request, including that the matter before the Board was the disallowance, not the prior deferral, and that "section 1903(d)(5) sets forth a state's options where a payment has been advanced to the state," not "where no funds have been paid and there are therefore no funds to 'retain.'" *Id.* at 5.

Maine's reliance on the Board's general powers and responsibilities under 45 C.F.R. Part 16 also is misplaced. The Board's general powers and responsibilities are coextensive with the scope of its jurisdiction. In this case, therefore, the Board has the authority to issue orders, rule on requests and motions, and take any other action necessary to reach a resolution as to the validity of CMS's disallowance of claimed Medicaid payments to Riverside. The Board's general powers and responsibilities do not permit the Board to resolve issues beyond the scope of that review.

Accordingly, we deny Maine's motion.

/s/
Constance B. Tobias

/s/
Susan S. Yim

/s/
Leslie A. Sussan
Presiding Board Member

## Attachment

*California Dep't of Health Servs., Ruling on Request for Reconsideration of DAB No. 1285* (1992) is available here:
https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/1992/RULDAB1992-1.pdf