Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

New Jersey Department of Human Services
Docket No. A-16-114
Decision No. 2780
March 31, 2017

DECISION

The New Jersey Department of Human Services (New Jersey) appeals the May 17, 2016 determination by the Centers for Medicare & Medicaid Services (CMS) disallowing $15,631,929 in Medicaid federal financial participation (FFP) claimed by New Jersey for the quarters ending March 31, 2014 through March 31, 2015. In essence, this case involves an attempt by New Jersey to obtain federal reimbursement at twice its regular rate for services provided to certain low-income childless adults under New Jersey Medicaid demonstration projects under several waivers (demonstrations). We conclude that the services are only reimburseable at New Jersey's regular rate for medical expenditures.

The Affordable Care Act permitted states to expand Medicaid coverage beginning January 1, 2014 to a specific category of newly eligible adults known as the "VIII Group." The VIII Group encompasses most adults under 65 who are not otherwise eligible for Medicaid and whose income does not exceed 133 percent of the federal poverty line (FPL). States are entitled to an increased reimbursement rate of 100 percent for services provided from January 1, 2014 through December 31, 2014 to VIII Group adults under the Medicaid expansion.

The services for which New Jersey made the claims at issue here were provided prior to January 1, 2014 and hence were provided at a time before the VIII Group was to come into existence. The recipients were eligible for Medicaid instead only under the terms of New Jersey's various demonstration projects (under which they met the criteria that their income did not exceed 133 percent of FPL which would become the standard for the expansion after January 1, 2014). The demonstration projects did not qualify for the increased rate. New Jersey argues that its claims should nevertheless qualify for the 100 percent rate because the state did not make payment for the services until after January 1, 2014 so the state's expenditures occurred after the Medicaid expansion went into effect. New Jersey contends that the increased rate should apply on the basis of when the state paid for the services, not on the basis of the dates the services were furnished.

CMS determined that New Jersey's regular rate applied and therefore disallowed the difference between the amount claimed by New Jersey at the increased rate for the quarters ending March 31, 2014 through March 31, 2015 for services furnished prior to 2014, and the amount payable under New Jersey's regular rate for those services.

As discussed below, we sustain the disallowance. We conclude that CMS reasonably interprets the Act and regulations as first establishing the VIII Group effective January 1, 2014, and, therefore, only expenditures for services provided on or after January 1, 2014 to newly eligible VIII Group individuals qualified for the increased rate. In addition, CMS's interpretation is consistent with written guidance that it circulated to state Medicaid directors in April 2010. We explain that the increased rate was not applicable to the services provided to low-income adults prior to January 1, 2014 under New Jersey's Medicaid demonstrations. Lastly, we reject New Jersey's argument that we should reverse the disallowance based on purportedly inconsistent statements made by CMS staff in August 2013 and April 2014 about whether the increased rate applied to the disputed costs.

I. Background

A. *Medicaid overview*

Congress established the Medicaid program under title XIX of the Social Security Act (Act). Each state that elects to participate operates its own Medicaid program in accordance with broad federal requirements and the terms of its Medicaid state plan, as approved by the Secretary of the Department of Health and Human Services.

The federal government pays each state specified percentages of allowable expenditures made under its Medicaid state plan. Act § 1903(a); 42 C.F.R. §§ 433.10, 433.15. The rate at which the federal government provides funding for most of a state's expenditures for health care services under Medicaid is called the federal medical assistance percentage (FMAP). For the period at issue, New Jersey's regular FMAP rate was 50 percent. The bulk of a state's Medicaid expenditures are for "medical assistance," defined in section 1905(a) of the Act to mean particular categories of care and services that must or may be included in a state plan (as "covered services"), when provided to certain groups of individuals who meet specific requirements ("eligible individuals"). For most medical assistance expenditures, a state receives FFP at a rate known as the FMAP, which is determined annually on the basis of a formula that takes into account the state's per capita income. Act §§ 1903(a)(1), 1905(b). Congress has provided exceptions to the regular FMAPs, however, for special situations, providers of services and types of

service. *See, e.g.*, Deficit Reduction Act of 2005 Pub. L. No. 109-171, § 6053, 120 Stat. 4, 95 (2006) (adjustment of FMAP rates for states with significant number of Hurricane Katrina evacuees); Act § 1902(a)(13)(C) (providing 100 percent FMAP for services furnished by primary care physicians in 2013 and 2014); Act § 1903(a)(5) (providing FMAP of 90 percent for family planning services and supplies).

Within 30 days after the end of each annual quarter, the state must submit to CMS a Quarterly Statement of Expenditures (QSE). 42 C.F.R. § 430.30(c)(1). The QSE is an "accounting of actual recorded expenditures" for which the state believes it is entitled to FFP. *Id.* § 430.30(c)(2).

Section 1115(a) of the Act gives the Secretary authority to approve "any experimental, pilot, or demonstration project which … is likely to assist in promoting the objectives of" the Medicaid program and to waive compliance with certain requirements "to the extent and for the period he finds necessary to enable such State or States to carry out such project…." A demonstration project may, for example, expand coverage to individuals not eligible for Medicaid, provide services not typically covered by Medicaid, or use innovative service delivery systems to improve care, increase efficiency, or reduce costs. CMS approves each section 1115(a) demonstration project subject to specific terms and conditions.

B. *Medicaid expansion under the Patient Protection and Affordable Care Act*

Section 2001 of the Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, 124 Stat. 119, 271 (2010), "Medicaid Coverage for the Lowest Income Populations," provided for states to expand their Medicaid programs to cover nearly all impoverished adults under age 65. Under section 2001(a) of the PPACA, Congress added section 1902(a)(10)(A)(i)(VIII) to the Act, which established Medicaid eligibility "beginning January 1, 2014," for most non-elderly, non-pregnant adults "whose income does not exceed 133 percent of the poverty line …."[1]

In addition, section 2001(a)(3) of the PPACA added section 1905(y) to the Act to provide "Increased FMAP for Medical Assistance for Newly Eligible Mandatory Individuals" for specific periods. As enacted under the PPACA, section 1905(y)(1)(A) provides that the FMAP for a state for the January 1, 2014 through December 31, 2016 "period with

[1] As originally enacted, the PPACA required each state to expand Medicaid eligibility to this "mandatory" group beginning in January 2014. The Supreme Court in *National Federation of Independent Business v. Sebelius*, 132 S.Ct. 2566 (2012) determined that the statutory provision authorizing the Secretary to withhold all Medicaid FFP of states that refused to participate in the Medicaid expansion was unconstitutional. The decision effectively gave states the option not to expand Medicaid coverage to this new group.

respect to amounts expended for medical assistance for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i) shall be equal to 100 percent." Section 1905(y)(2)(A) defines "newly eligible" to mean, "with respect to an individual described in subclause (VIII) of section 1902(a)(10)(A)(i), an individual who" as of December 1, 2009, could not qualify for Medicaid benefits under a state plan or under a waiver of the plan.

The PPACA also gave states an option to expand Medicaid coverage prior to January 1, 2014 to adults whose income did not exceed 133 percent of the FPL. Added by section 2001(a)(4)(A) of the PPACA, section 1902(k)(2) of the Act permitted states to "elect through a State plan amendment to provide medical assistance to individuals who would be described in subclause (VIII) of subsection (a)(10)(A)(i) if that subclause were effective before January 1, 2014."

C. *New Jersey's Medicaid demonstration coverage and claims*

New Jersey extended Medicaid coverage to some low-income adults categorized as "Childless Adults" under a section 1115 demonstration, which CMS approved effective April 15, 2011. Declaration of Robert Durborow, ¶ 6; NJ DHS 5-30.[2] New Jersey subsequently obtained CMS approval for a comprehensive waiver, which consolidated authority for several existing waivers, including the Childless Adults program, and initiated other reforms. Durborow Decl. ¶ 6; NJ DHS 31-35. The comprehensive waiver extended coverage to "Adults Without Dependent Children" (income up to 24% of the FPL) effective October 1, 2012, and to "FamilyCare Parents" (income up to 133% of the FPL) effective October 1, 2013. *Id.*

New Jersey thereafter obtained CMS approval for its VIII Group eligibility and FMAP methodologies under state plan amendments (SPAs) 13-0011, 13-0028, and 13-027. The SPAs were effective January 1, 2014. DHS 1-2.

New Jersey submitted QSEs through the quarter ending December 31, 2013 seeking FFP at its regular FMAP for medical assistance for the low-income adults covered under the demonstrations. "Beginning the first quarter of 2014," New Jersey acknowledges, it "claimed 100% FFP for services that may have been provided before January 1, 2014 but for which expenditures were not made by the Department until after January 1, 2014."[3] NJ Br. at 2.

[2] New Jersey did not assign a number to each of its exhibits. Instead, New Jersey numbered the pages of its exhibits collectively in consecutive order, DHS 1 through DHS 53.

[3] CMS's May 17, 2016 Notice of Disallowance states that the amounts disallowed for each quarter "were determined based on the Group VIII sampling methodology that [New Jersey] provided to [CMS] for each of the … quarters." New Jersey has not specifically disputed the calculations. Notice of Disallowance at 2.

II. The Disallowance

CMS determined on review of New Jersey's QSEs for the quarters ending March 31, 2014 through March 31, 2015 that "New Jersey inappropriately claimed 100% FFP for VIII Group services furnished before January 1, 2014." Notice of Disallowance at 1. CMS stated that section 1905(y) of the Act provided "for an increased FMAP (100% for calendar quarters in 2014 through 2016) for expenditures for medical assistance for individuals 'described in the subclause VIII of section 1902(a)(10)(A)(i)' who are 'newly eligible.'" *Id.* at 2. According to CMS, section 1902(a)(10)(A)(i)(VIII) "describes the VIII Group as beginning on January l, 2014." *Id.* "Because coverage for the VIII Group did not exist prior to January 1, 2014," CMS reasoned, "personal eligibility could not actually be established under this coverage group before that date." *Id.* Therefore, CMS concluded that "the state's regular FMAP rate, established pursuant to section 1905(b) [of the Act], applies to the state's provision of medical assistance for services furnished prior to January 1, 2014." *Id.*

CMS also explained that while states were permitted to provide early Medicaid coverage to individuals who would be considered VIII Group individuals if section 1902(a)(10)(A)(i)(VIII) were effective earlier than January 2014, Congress "did not provide an increased FMAP for such early coverage." *Id.* Rather, CMS explained, states would receive their regular FMAP for the services provided under the early expansion period, as CMS "clearly stated" in the April 9, 2010 "State Medicaid Director's Letter (SMDL) #10-005 (PPACA #1)… which discussed the new option for coverage of individuals under Medicaid in some detail." *Id.*

III. Analysis

A. *CMS reasonably interprets the Act and regulations as providing the increased FMAP of 100 percent for calendar quarters in 2014, 2015, and 2016 only for the costs of services furnished on or after January 1, 2014 to newly eligible VIII Group individuals.*

On review of an HHS agency's determination to disallow a claim for federal funds, the Board is bound by all applicable laws and regulations. 45 C.F.R. § 16.14. When the language of a statute or regulation is clear, the Board will apply it by its terms. When a statute or regulation does not directly address the precise question at issue, the Board will defer to the agency's interpretation so long as it is reasonable and the nonfederal party had actual and timely notice of that interpretation or did not rely to its detriment on another reasonable interpretation. *See, e.g., New Jersey Dep't of Human Servs.*, DAB No. 1773, at 5-6 (2001); *Louisiana Dep't of Health and Hospitals*, DAB No. 1772, at 4-5 (2001)(citations omitted). In determining whether the nonfederal party had actual and

timely notice, the Board will take into account, among other things, whether the agency's interpretation predates a disallowance or represents a position first articulated in litigation that the agency seeks to enforce retroactively. *Alaska Dep't of Health and Social Servs.*, DAB No. 1919, at 14 (2004).

In this case, the parties dispute the meaning of the legislation and implementing regulations that authorized state Medicaid programs to expand coverage to nearly all adults whose income does not exceed 133 percent of the FPL and established periods for enhanced FFP for medical assistance for those individuals. Relevant in this case, the enhanced FFP provision added at section 1905(y) of the Act, "Increased FMAP for Medical Assistance for Newly Eligible Mandatory Individuals," reads (with italics added):

> (1) Amount of increase.—Notwithstanding subsection (b), the Federal medical assistance percentage for a State that is one of the 50 States or the District of Columbia, with respect to amounts expended by such State for medical assistance *for newly eligible individuals described in subclause (VIII)* of section 1902(a)(10)(A)(i), shall be equal to—
>
> (A) 100 percent for calendar quarters in 2014, 2015, and 2016; . . . .

The implementing regulation at 42 C.F.R. § 433.10(c)(6)(i) uses similar wording (italics added):

> Beginning January 1, 2014, under section 1905(y) of the Act, the FMAP for a State . . . for amounts expended by such State for medical assistance *for newly eligible individuals*, as defined in §433.204(a)(1), will be an increased FMAP equal to: (A) 100 percent, for calendar quarters in calendar years (CYs) 2014 through 2016 . . . ."

New Jersey emphasizes the term "amounts expended by such State for medical assistance," used in both section 1905(y)(1) and section 433.10(c)(6)(i), to support its argument that the language of the Act and regulation does not "condition payment of the enhanced FMAP on when the services for the eligible Group VIII members were rendered …, but rather solely on when the expenditures for these services were made by [New Jersey]." NJ Br. at 12-14. "If Congress meant to condition payment of the enhanced FMAP on when the services were rendered," New Jersey argues, "it would have said so." *Id.* at 13. According to New Jersey, it is allowed to claim 100 percent FFP for the expenditures that it made on and after January 1, 2014 for medical assistance provided to adults whose income did not exceed 133 percent of the FPL, even if the expenditures were for services were provided before 2014.

We disagree with New Jersey that the language of section 1905(y)(1) of the Act and section 433.10(c)(6)(i) of the regulations provides for FFP at the enhanced FMAP solely on the basis of when the state paid for a covered medical service. While the statute and regulation associate the increased FMAP with "amounts expended by such State for medical assistance," the titles and wording of sections 1905(y) and 433.10(c)(6)(i) also link the increased FMAP *to the Medicaid coverage status of the individuals to whom the services were provided*. That is, the enhanced FMAP applies "with respect to" expenditures for medical assistance "for" a particular, defined group of Medicaid recipients, the "newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i)" of the Act; the same group as the "newly eligible individuals, as defined in § 433.204(a)(1)" of the regulations.

Section 1905(y)(2), in turn, defines "newly eligible" to mean, "with respect to an individual described in subclause (VIII) of section 1902(a)(10)(A)(i), an individual who is not under 19 years of age" and who, as of December 1, 2009, was not eligible under the State plan, not covered under a waiver of the plan, or eligible under a waiver but not enrolled because of limits or caps on waiver enrollment. Section 433.204(a)(1) of the regulations similarly defines "newly eligible individual" to mean "an individual determined eligible for Medicaid in accordance with the requirements of the adult group described in § 435.119," and who, as of December 1, 2009, was not covered under the Medicaid state plan, waiver or demonstration programs or was eligible under a waiver but not enrolled because of limits or caps on waiver enrollment.

The applicability of the increased FMAPs established under section 1905(y)(1) of the Act and section 433.10(c)(6) of the regulations therefore cannot be determined absent consideration of the language of the cross-referenced eligibility provisions, section 1902(a)(10)(A)(i)(VIII) of the Act and section 435.119 of the regulations. Section 1902(a)(10)(A)(i)(VIII) describes members of the VIII Group as individuals --

> *beginning January 1, 2014*, who are under 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of title XVIII, and are not described in a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) does not exceed 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved, subject to subsection (k)….

(Italics added.) Correspondingly, section 435.119 of the regulations, "Coverage for individuals age 19 or older and under age 65 at or below 133 percent FPL," provides:

> (b) *Eligibility. Effective January 1, 2014*, the agency must provide Medicaid to individuals who:
> (1) Are age 19 or older and under age 65;
> (2) Are not pregnant;
> (3) Are not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act;
> (4) Are not otherwise eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part; and
> (5) Have household income that is at or below 133 percent FPL for the applicable family size.

(Emphasis added.)

As CMS points out, the prefatory "beginning January 1, 2014" wording of section 1902(a)(10)(A)(i)(VIII), reiterated in the "Effective January 1, 2014" language of section 435.119, establishes that the new Medicaid adult eligibility group, the VIII Group, came into existence at the outset of 2014; therefore, an individual could not qualify for VIII Group coverage earlier than January 1, 2014. Notice of Disallowance at 2. Thus, CMS states, the coverage and matching provisions of sections 1902(a)(10)(A)(i)(VIII) and 1905(y) align as of the January 1, 2014 beginning date. CMS Br. at 2. CMS logically infers that, because the VIII Group did not exist prior to January 1, 2014, "[o]nly expenditures for services rendered on or after January 1, 2014 to newly eligible individuals who are described in the VIII Group are eligible for the increased FMAP." Notice of Disallowance at 2. In sum, a state expenditure for a service furnished prior to January 1, 2014 to an adult whose income was at or below 133 percent of the FPL could not qualify for enhanced FFP because at the time the service was provided, the recipient was not a "newly eligible" VIII Group individual.

Furthermore, while the PPACA also gave states the option to extend Medicaid coverage prior to January 1, 2014 to adults whose income did not exceed 133 percent of the FPL, Congress established that option under a separate Medicaid eligibility provision, codified at section 1902(k)(2) of the Act, which provides:

> Beginning with the first day of any fiscal year quarter that begins on or after April 1, 2010, and before January 1, 2014, a State may elect through a State plan amendment to provide medical assistance to individuals who would be described in subclause (VIII) of subsection (a)(10)(A)(i) if that subclause were effective before January 1, 2014….

Based on the wording of section 1902(k)(2), we conclude that CMS reasonably determined that the increased FMAP for newly eligible individuals was not applicable to the payments that New Jersey made after January 1, 2014 for services provided prior to that date. The use of the subjunctive mood in section 1902(k)(2), describing individuals with coverage prior to 2014 as "individuals who *would* be described in subclause (VIII) … *if that subclause were effective* before January 1, 2014," makes clear that during the early-option period, an adult whose income did not exceed 133 percent of the FPL who had Medicaid coverage was *not* covered as a VIII Group individual. Because the increased FMAP provided under section 1905(y)(1)(A) was available only for amounts expended for medical assistance for newly eligible individuals in the VIII Group, it therefore follows that payments for medical assistance provided to individuals covered before January 1, 2014 pursuant to section 1902(k)(2) did not qualify for the enhanced FFP rate.

B. *CMS's interpretation of the statute and regulations is consistent with its prior written guidance.*

New Jersey argues that "[n]one of the guidance issued by CMS relating to the early expansion population addressed" the issue presented in this appeal. NJ Brief at 16. Indeed, New Jersey contends, even though the April 2010 SMDL referenced in the notice of disallowance "devotes a paragraph to the increased federal match of state expenditures for the 'new option,' that discussion is devoid of any reference to either dates of service being the determining factor in whether an expenditure was appropriate for claiming or to any change to the existing rules … as to how claiming is done." *Id.*

We conclude, on the contrary, that CMS's interpretation of the Act and regulations is supported by the written guidance that CMS provided states well before the disallowance at issue here. In the April 2010 SMDL, CMS advised states that for "calendar year 2014, when the new eligibility group described at section 1902(a)(10)(a)(i)(VIII) is mandatory for all States participating in Medicaid, States will receive an increased matching rate for certain individuals in this new eligibility group." NJ DHS 51. In contrast, CMS

explained with respect to "Federal Matching of State Expenditures for New State Option," that "[u]ntil January 2014, States that adopt the new section 1902(k)(2) coverage option will receive Federal matching payments at their regular [FMAP]."[4] Similarly, CMS stated in the April 2013 preamble to the final rule implementing the PPACA's provisions related to the availability of increased FMAP rates with respect to the new adult eligibility group that "the newly eligible FMAP is available only for individuals *enrolled in the new adult group (as codified at §435.119*)." 78 Fed. Reg. 19,918, 19,921, 19,923 (April 2, 2013)(italics added).

Consistent with CMS's interpretation of the Act supporting the disallowance in this case, the SMDL and final rule specified that the enhanced FFP rates available under section 1905(y) of the Act were intended to finance medical assistance provided to newly eligible individuals described in the VIII Group, which did not exist until 2014. In contrast, the SMDL clarified that the medical assistance provided prior to 2014 to individuals in an optional expansion group did not qualify for the increased FFP rates. We agree with CMS that it logically flows from the guidance in the SMDL that the increased FMAP was not applicable to the payments at issue because the payments represented expenditures for medical assistance furnished to individuals in pre-2014 optional coverage groups, not expenditures for medical assistance provided to VIII Group individuals.

C. *New Jersey's reliance on section 1903(a)(1) of the Act and prior Board decisions to support its interpretation is misplaced.*

New Jersey also argues that its claim for FFP at the 100 percent FMAP for the payments it made on or after January 1, 2014 for services furnished before 2014 is "buttressed by reference to federal law concerning the methodology for how states are to seek payment from CMS and how payments are to be made to the states by CMS." NJ Br. at 14. Specifically, New Jersey contends that section 1903(a)(1) of the Act "clearly directs CMS to make payments to states based on the amount expended by the state during the relevant quarter; payment is not contingent on when services were rendered." *Id.*

[4] The SMDL also included the sentence, "The increased FMAP determined under the American Recovery and Reinvestment Act of 2009 [ARRA] is not available for this new optional group." As New Jersey points out in its Reply brief, the increased FMAP provided under the 2009 stimulus bill and subsequent legislation was not available after June 30, 2011. (FMAP rates were increased from the first quarter of FY2009 through the third quarter of FY2011, providing states with more than $100 billion in additional funds. All states received a hold harmless to prevent any decline in regular FMAP rates and an across-the-board increase of 6.2 percentage points until the last two quarters of the period, at which point the percentage point increase phased down. Pub. L. No. 111-5 § 5001, 123 Stat. 115, 496 , as amended by P.L. 111-226 § 201, 124 Stat. 2389, 2393 (2010).) Therefore, it appears that the SMDL's reference to the ARRA enhanced FMAP was in error. This error, however, is not material to our conclusion that the guidance provided in the SMDL discussed above and CMS's statement in the April 2013 Federal Register preamble support CMS's interpretation of the statute and regulations supporting the disallowance.

Furthermore, New Jersey argues that prior Board decisions require federal payment based on the FMAP in effect when the expenditure was made.[5] NJ Br. at 14-15, *citing New Jersey Dep't of Human Servs*., DAB No. 1016 (1989)(reversing determination that state did not timely file claims for services provided by public residential treatment centers during the January 1, 1985 through March 31, 1985 period); *New Jersey Dep't of Human Resources*, DAB No. 2039 (2006)(sustaining disallowance for FFP claimed at increased FMAP available for expenditures for the April 1, 2003 through June 30, 2004 period on the ground that cost settlements made during the quarter ending June 30, 2004 that increased interim payment rates previously used to claim FFP for earlier quarters did not constitute new expenditures).

New Jersey's reliance on section 1903(a)(1) and the cited Board decisions is misplaced. Section 1903(a)(1) provides that the Secretary "shall pay to each State which has a plan approved under this title, for each quarter … an amount equal to the [FMAP] (as defined in section 1905(b) ….) of the total amount expended during such quarter as medical assistance under the State plan…." Under section 1905(b), the regular FMAP for each state is based on a formula that takes into account the state's per capita income. As reflected in the wording of section 1903(a)(1) and the earlier Board decisions cited by New Jersey, historically, a single FMAP was applicable to the amount expended for medical assistance by each state for each fiscal period. As a result, to establish the FMAP applicable to a state's medical assistance expenditure, it was necessary only to determine when the state made the expenditures.

As noted above, however, Congress has established FMAP rate exceptions for certain time periods, certain providers, certain types of services, and certain populations. Consequently, a state's health care expenditures for a particular calendar quarter may not be subject to the same FMAP rate. Rather, for some quarters, a state may properly claim FFP at different FMAP rates based on different services, different providers, or different populations of Medicaid recipients. Relevant here, the PPACA's amendments provided for increased FMAPs to apply during different periods for medical assistance furnished to "newly eligible" individuals in the VIII Group. Consequently, the applicable FMAP for

[5] New Jersey also cited 45 C.F.R. § 95.13(b) to support its argument. The regulations at 45 C.F.R. Part 95, subpart A establish time limits for a state to claim FFP in expenditures under state plans approved under several different titles of the Act. Section 95.13 provides that for the purpose of determining whether a state has timely filed a claim in FFP for expenditures for services under title XIX, expenditures are considered "to have been made in the quarter in which" the state agency "made a payment to the service provider." The Board has addressed the applicability of the regulations in Part 95 in many cases reviewing federal agency disallowances based on the conclusion that a state's claims for FFP were untimely. The timeliness of New Jersey's claims in this case is not at issue. Rather, the question presented is what FMAP rate applies to certain expenditures.

medical assistance for adults with incomes not exceeding 133 percent of the FPL cannot be determined solely on the basis of when the state made a payment for a health care service provided to such an individual. Instead, as explained above, it is necessary to determine whether at the time of the service the individual was a "newly eligible" individual in the XIII Group.

Furthermore, New Jersey's contention that the FMAP rate applicable to the expenditures at issue should be determined solely on the basis of when it made the expenditures would permit states that chose to provide coverage to certain low-income adults prior to 2014 to manipulate the statutory payment scheme established under the PPACA. Specifically, by delaying payment for medical assistance provided prior to January 1, 2014 until after that date, a state could circumvent the intent of Congress to provide 100 percent FFP only for medical assistance provided in calendar years 2014 through 2016 to adults whose income did not exceed 133 percent of the FPL at the time they became newly eligible VIII Group individuals, i.e., after January 1, 2014. Accordingly, we reject New Jersey's argument that the rate of FFP for a state's medical assistance expenditures must be determined on the basis of when the state made the expenditures regardless of when the services were furnished.

D. *The disallowance is supported by the effective date of New Jersey's VIII Group eligibility and FMAP methodology SPAs.*

Each state that expanded its Medicaid program to cover individuals under section 1902(a)(10)(A)(i)(VIII) was required to file SPAs describing its adult group eligibility and FMAP methodology in order to claim the increased FMAPs.[6] 42 C.F.R. § 433.206(h). CMS stated in the May 2016 disallowance determination that New Jersey had claimed the disallowed costs at issue under the FMAP "rate of 100% on the [QSEs] for the listed quarter(s) under New Jersey's Eligibility & FMAP Methodology State Plan Amendments," which "have an effective date of January 1, 2014." Notice of Disallowance at 1-2. In its brief, CMS argues "that because the effective date of the [SPAs] related to New Jersey's eligibility & [FMAP] methodology was January 1, 2014, the increased 100 percent rate for FMAP claims for services provided prior to January 1, 2014, should not be paid." CMS Br. at 2. New Jersey did not directly respond to this contention in its appeal.

[6] *See also* Medicaid and CHIP FAQs: Funding for the New Adult Group, Coverage of Former Foster Care Children and CHIP Financing, December 2013; and Instructions for FMAP Claiming State Plan Amendment, Supplement 18 to Attachment 2.6A available at https://www.medicaid.gov/medicaid/financing-and-reimbursement/index.html.

We conclude that the January 1, 2014 effective date of New Jersey's SPAs supports the disallowance. Because the methodologies for New Jersey to determine whether an individual met the VIII Group eligibility criteria and to claim federal reimbursement for VIII Group services at the enhanced FFP rate were not operative until January 1, 2014, it logically follows that the increased FMAP of 100 percent was inapplicable to expenditures relating to any services provided to individuals prior to that date. That is, because no adult (even one whose income did not exceed 133 of the FPL) could qualify for VIII Group coverage under New Jersey's state plan before 2014, New Jersey could not claim the enhanced FMAP for any service provided to any individual before 2014. Consequently, we agree with CMS that, based on the effective date of the SPAs, only expenditures for services furnished on or after January 1, 2014 to newly eligible individuals with income at or below 133 percent of the FPL could qualify for the enhanced rate of FFP.

Moreover, while New Jersey did provide Medicaid coverage prior to January 1, 2014 for some groups of adults whose income did not exceed 133 percent of the FPL, as we discuss below, it elected to do so not through state plan amendments but under approved Medicaid demonstrations. Claims for FFP for the services furnished to the low-income adults under the demonstrations were subject to the special terms and conditions of the demonstrations.

E. *The increased FMAP was not applicable to the services provided to low-income adults prior to January 1, 2014 who were covered under New Jersey's Medicaid demonstrations.*

As summarized above, New Jersey elected to extend Medicaid coverage prior to January 1, 2014 to certain categories of adults whose income did not exceed 133 percent of the FPL through Medicaid demonstrations. Specifically, New Jersey extended Medicaid coverage to low-income adults categorized as "Childless Adults" under a section 1115 demonstration that was effective April 15, 2011. Durborow Decl. ¶ 6; NJ DHS 5-30. New Jersey subsequently obtained CMS approval for a comprehensive waiver, which consolidated authority for several existing waivers, including the Childless Adults program, and initiated other reforms. Durborow Decl. ¶ 6; NJ DHS 31-35. The comprehensive waiver extended coverage to "Adults Without Dependent Children" (income up to 24% of the FPL) effective October 1, 2012, and to "FamilyCare Parents" (income up to 133% of the FPL) effective October 1, 2013. *Id*

New Jersey's demonstrations were subject to Special Terms and Conditions (STCs), which "set forth conditions and limitations on those waivers and expenditure authorities, and describe[d] in detail the nature, character, and extent of Federal involvement in the Demonstration[s] and the State's obligations to CMS during the life of the Demonstration[s]." NJ DHS 8. The STCs of the Childless Adults Demonstration

included a "Program Description and Historical Context" explaining that the statewide project would "expand health care coverage to individuals who could have been included in the optional eligibility category under section 1902(k)(2)" of the Act, "permit[ting] early partial implementation of the expansion required [under the PPACA] in 2014." NJ DHS 9.

The program description further explained that the demonstration was "to further serve the objectives of title XIX by requiring New Jersey to seamlessly transition enrolled Demonstration enrollees to a coverage option available under" the PPACA. *Id.* Indeed, the STCs provided that the demonstration would not be extended beyond December 31, 2013 and that New Jersey was required to establish a transition plan detailing how it would obtain and review any additional information needed from each enrolled individual "to determine eligibility under all eligibility groups, and coordinate the transition of individuals enrolled" in the demonstration "to a coverage option available under" the PPACA. NJ DHS 17. Specifically, the STCs stated, New Jersey must:

> Determine eligibility under all January 1, 2014 eligibility groups for which the State is required or has opted to provide medical assistance, including the group described in § 1902(a)(10)(A)(i)(VIII) for individuals under age 65 and regardless of disability status with income at or below 133 percent of the FPL.

Id. Thus, the project description and STCs made clear that the low-income individuals enrolled in the demonstration were *not* coextensive with the individuals who would later qualify as part of the Act's VIII Group.

The STCs of the Childless Adults Demonstration further explained that to claim federal funding for medical assistance provided under the project, New Jersey was required to report demonstration expenditures based on the services provided during the demonstration period. Specifically, paragraph 37 of the STCs, "Reporting Expenditures under the Demonstration," stated:

> The State will provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the Demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the Demonstration period.

NJ DHS 20. In addition, the STCs explained, CMS would "provide FFP for allowable Demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs." *Id.* Those limits would include that the expenditures relate only to services rendered during the period, which ended by December 31, 2013. In fact,

New Jersey's arguments that only the date on which the services are paid for, not the date on which the services are rendered, may be considered in determining whether the expenditures are reimbursable would preclude reimbursement under the Demonstration.

Under the terms and conditions relating to financial requirements under title XIX, Paragraph 40 of the STCs provided that in order to properly account for demonstration expenditures, the state was required to "identify separately net expenditures related to dates of service during the operation of the section 1115 Demonstration on the Form CMS-64." NJ DHS 21. With respect to the applicable rate of FFP for demonstration expenditures, paragraph 43, "Extent of FFP for the Demonstration," explained: "CMS will provide FFP at the applicable Federal matching rate for … Medical Assistance expenditures made under section 1115 Demonstration authority, including those made in conjunction with the Demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability." NJ DHS 22.

The terms and conditions of New Jersey's Childless Adults demonstration project, viewed together, effectively undercut New Jersey's suggestion that, for the purpose of determining the applicable rate of FFP for the expenditures at issue, we should not distinguish the coverage status of the low-income individuals who had Medicaid coverage prior to January 1, 2014 under New Jersey's Medicaid demonstrations from the population of individuals who became newly eligible for Medicaid under section 1902(a)(10)(A)(i)(VIII) on January 1, 2014. To the contrary, as reflected in the program goal to "seamlessly transition enrolled Demonstration enrollees to a coverage option available under the [PPACA]" and the transition plan requirements, the adults with low incomes who were enrolled in the demonstration were not actually VIII Group individuals or yet covered under any other eligibility group available under the PPACA. NJ DHS 17. Moreover, the STCs made clear that federal funding for medical assistance for individuals enrolled in the demonstration project was based on the services provided during the project period and that CMS would provide FFP at the "applicable Federal matching rate for … Medical Assistance expenditures made under section 1115 Demonstration authority." NJ DHS 22. None of the STCs provided for the enhanced rate of FFP provided under section 1905(y)(1)(A) of the Act to apply to the demonstration expenditures.

Accordingly, we conclude that the terms and conditions of New Jersey's demonstration project support CMS's determination that the increased FMAP of 100 percent for calendar quarters in 2014 through 2016 for expenditures for medical assistance for newly eligible VIII Group individuals was not applicable to the services furnished prior to January 1, 2014 to the low-income adults enrolled in New Jersey's demonstrations.

F. *We reject New Jersey's contention that purportedly inconsistent oral guidance given by CMS representatives to New Jersey's representatives prior to October 2014 provides a basis for reversing the disallowance.*

New Jersey also argues that it attempted to obtain written guidance from CMS on the issue of whether a "state would receive a 100% match on the expansion population for claims with a date of service before January 1, 2014 and with a payment date after January 1, 2014," but its efforts "were fruitless." NJ Br. at 2, 5. New Jersey's Manager of the Office of Budget, Finance and Federal Reporting, alleges, however, that in August 2013, a CMS Senior Financial Advisor represented in an all-state technical assistance call, and reiterated in a subsequent telephone call with the New Jersey official, that a "state could get a 100% match on the expansion population for claims with a date of service before January 1, 2014 and a date of payment after January 1, 2014 for its early expansion population." Durborow Decl. ¶¶ 7, 8, 10. The same New Jersey official acknowledges that, in a CMS Regional Office conference call on or about August 23, 2013, another CMS representative "expressed his understanding that claims adjudicated after January 1, 2014 for the expansion population with a date of service prior to January 1, 2014 would *not* be eligible for a 100% match." *Id.* ¶ 11 (emphasis added). "Additional attempts to follow up with CMS to obtain written guidance," however, "produced no results." NJ Br. at 7. Furthermore, New Jersey asserts that during a CMS training session on or about April 14, 2014, CMS representatives gave "[v]aried responses" on the issue. *Id.* While New Jersey continued to seek definitive written guidance from CMS, New Jersey contends, it "was not until [New Jersey] received the first letter deferring payment in October 2014 that [it] learned of CMS's definitive position on the issue…." *Id.* at 8. New Jersey argues that it "should not be penalized for violating a standard that was contrary to law and that had not clearly been articulated by CMS." *Id.* at 2.

As we previously stated, when the language of a federal statute or regulation does not squarely address an issue, the Board generally will defer to the federal agency's interpretation of the statute or regulation so long as it is reasonable and the nonfederal party had actual and timely notice of that interpretation or did not rely to its detriment on another reasonable interpretation. For the reasons discussed above, we conclude that CMS's interpretation of the statutes and regulations applicable to New Jersey's appeal is reasonable and supported by the written guidance provided to states in the 2010 SMDL. Furthermore, in light of the effective date of New Jersey's VIII Group eligibility and FMAP methodology SPAs and the STCs of its early expansion demonstration project, we conclude that New Jersey had actual notice that its payments for services furnished during the demonstration periods to individuals enrolled in the demonstrations were not eligible for the 100 percent FMAP. Under the circumstances, a construction of the statutes and regulations contrary to CMS's interpretation would be unreasonable. At most, New Jersey may have had some uncertainty based on its construction of oral

comments allegedly made by the CMS representatives sufficient to cause the State officials to seek further written clarification, but those purported statements, conflicting with each other and with the existing written guidance, certainly would not justify New Jersey in forming a contrary interpretation. Moreover, New Jersey has not established that it actually relied on a contrary interpretation when it established coverage for some groups of low-income adults prior to 2014 under its approved demonstration projects, given the terms and conditions it placed on those demonstrations as discussed above.

IV. Conclusion

For the reasons discussed above, we sustain the disallowance.

/s/
Constance B. Tobias

/s/
Susan S. Yim

/s/
Leslie A. Sussan
Presiding Board Member