Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Commonwealth of Massachusetts, Executive Office of
Health and Human Services
Docket No. A-12-86
Decision No. 2538
September 30, 2013

DECISION

The Commonwealth of Massachusetts, Executive Office of Health and Human Services, (Commonwealth or State) has appealed an April 13, 2012 determination by the Centers for Medicare & Medicaid Services (CMS) to disallow $17,397,376 in federal financial participation (FFP) claimed for the Commonwealth's Medicaid program for fiscal years (FYs) 2000 to 2002. CMS disallowed that claim as untimely under section 1132(a) of the Social Security Act (Act),[1] which requires that any claim for FFP with respect to a state's Medicaid expenditures be filed within two years after the calendar quarter in which the expenditures were made. *See also* 45 C.F.R. § 95.7. During the course of these proceedings, CMS discovered a computational error and increased the amount of the disallowance to $21,470,669, and the Commonwealth did not dispute the accuracy of the recalculated amount. CMS Br. at 14.

Based on an audit report issued by the Office of Inspector General (OIG) for the U.S. Department of Health & Human Services (HHS), CMS also determined that even if the Commonwealth's FFP claim had been timely made, $4.25 million of the total FFP the Commonwealth claimed for expenditures made for FYs 2000 and 2001 was not allowable because the expenditures were not authorized by the State plan.

For the reasons discussed below, we conclude that the claim for FFP in the Commonwealth's supplemental payments for FYs 2000 to 2002 was timely under section 1132(a) of the Act and, therefore, reverse the disallowance in part but sustain CMS's disallowance of $4,244,586 in FFP in expenditures as not authorized by the State plan.[2]

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

[2] The Commonwealth informed the Board that the OIG audit report listed the exact amount of these expenditures as $8,489,172, which would result in a disallowance of $4,244,586 in FFP. Commonwealth Br. at 34 n.4. CMS not dispute the accuracy of the more specific figures.

Applicable Law and State Plan

Under title XIX of the Act governing the Medicaid program, the federal government provides FFP to states that choose to provide medical care to persons with low income and resources. *See* Act §§ 1901-1903; 42 C.F.R. § 430.0. A state with a "plan for medical assistance" (State plan) approved by HHS is eligible to receive FFP for a percentage of its Medicaid program expenditures made in accordance with the State plan. Act §§ 1902 and 1903(a); 42 C.F.R. §§ 433.10(a), 433.15(a). A state's Medicaid expenditures consist largely of payments for health care services provided to program beneficiaries. 42 C.F.R. § 430.0. FFP in those expenditures is at a rate called the Federal Medical Assistance Percentage (FMAP). *Id.* § 430.10(a).

Medicaid FFP is disbursed to states in quarterly awards. Act § 1903(d); 42 C.F.R. § 430.30(a). A quarterly award is 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(d)(2)-(3). The amount of a quarterly award is based on the state's estimate (on form CMS-37, submitted 45 days before the start of the quarter) of its Medicaid funding needs for the quarter. 42 C.F.R. § 430.30(b).

Within 30 days after the end of a quarter, the state must submit to CMS a Quarterly Statement of Expenditures (QSE). 42 C.F.R. § 430.30(c)(1). The QSE (also known as form CMS-64, previously referred to as HCFA-64) is an "accounting of actual recorded expenditures" which the state believes are entitled to FFP. *Id.* § 430.30(c)(2); *see also* State Medicaid Manual (SMM) § 2500(A)(1).[3] The QSE "reconciles the monetary advance [of FFP] made on the basis of [the estimate] filed previously for the same quarter." SMM § 2500. The submission of a QSE is the required "manner and format" for claiming FFP for a state's Medicaid expenditures. 45 C.F.R. § 95.4 (defining "claim" as a request for FFP in the "manner and format required" by program regulations and "instructions or directives issued thereunder"); *id.* § 430.30(c) (requiring the submission of a QSE not later than 30 days after the end of each quarter); SMM § 2500(B) (stating that the QSE constitutes a state's "claim for Federal reimbursement").

Section 1132(a) of the Act, which applies to Medicaid and various other programs administered by HHS, establishes a two-year period within which FFP must be claimed. In particular, section 1132(a) states that "payment [by the federal government] shall not

[3] The State Medicaid Manual is a vehicle for communicating federal Medicaid policies and procedures to state Medicaid agencies and provides further guidance by interpreting regulatory definitions that implement the two-year rule "in light of specific situations encountered in managing the Medicaid program." SMM § 2560.3 (CAF, Vol. 1, at 30). Among other things, the manual contains detailed instructions concerning the reporting of Medicaid expenditures on a QSE. *Id.* § 2500.1-.2. The entire manual is available online at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html (last visited Sept. 26, 2013).

be made . . . on account of any expenditure [by the state]" unless a "claim . . . for payment with respect to [the] expenditure" is filed (in the "form and manner" prescribed by the Secretary) within two years after the quarter in which the expenditure was made.

The regulations implement the statute by providing that FFP for a state expenditure will be available "only if the State files a claim with us for that expenditure within two years after the calendar quarter in which the State agency made the expenditure." 45 C.F.R. § 95.7. The regulations further provide that an expenditure for Medicaid services will be considered "to have been made in the quarter in which any State agency made a payment to the service provider." *Id.* § 95.13(b). The SMM generally provides that an "expenditure occurs when cash or its equivalent is actually paid in the current quarter by an agency of the State." SMM § 2560.4.G.1 (CAF, Vol. 1, at 32). However, the SMM distinguishes between the treatment of expenditures to public and non-public providers. It states that an expenditure is made to a public provider "when it is paid or recorded, whichever is earlier, by any State agency." *Id.* § 2560.4.G.1.a.1 (CAF, Vol. 1, at 32). With respect to a payment to a "non-public" (that is, a private) provider, the SMM provides that "the expenditure is incurred when paid by any State agency." *Id.* § 2560.4.G.1.a.2 (CAF, Vol. 1, at 32).

The State can also report an "increasing adjustment" or "decreasing adjustment" with respect to the expenditures claimed on the form CMS-64 for a prior quarter. *See New Jersey Dept. of Human Resources*, DAB No. 2039, at 3 (2006). The SMM provides that, while "[i]ncreasing adjustments related to private providers are considered current expenditures" for the purposes of applying the applicable FMAP, "[i]ncreasing adjustments related to public providers are considered adjustments to prior-period claims and are matched using the FMAP rate in effect at the earlier of the time the expenditure was paid or recorded by any State agency." SMM § 2500.2.E.4.

Relevant State Plan Provisions

Under its approved State Plan, the Commonwealth reimburses acute care hospitals for an array of inpatient and outpatient services. During the periods at issue in this case (FYs 2000 to 2002), the Commonwealth's Medicaid program made base payments to hospitals called a "Hospital-Specific Standard Payment Amount Per Discharge" (SPAD) for inpatient services (CAF, Vol. 3, at 3, at 17-20), and an "Ambulatory Patient Group" (APG) rate for outpatient services (*id.* at 50-54). In addition to these standard payments, the State plan provided for disproportionate share hospital ("DSH") and non-DSH supplemental payments to be made to certain hospitals. For periods prior to January 20, 2001, the State plan included a special payment provision for "Non-Profit Teaching Hospitals Affiliated with a Commonwealth-Owned Medical School." *Id.* at 32, 87. This provision provided that the inpatient payment amount for non-psychiatric admissions at such a hospital would be equal to the hospital's unreimbursed Medicaid costs, which would be determined by cost data from specific lines of the hospital's most recent cost

report. *Id.* However, the plan provided that the availability of payment under the provision was "subject to specific legislative appropriation" and an intergovernmental transfer (IGT). *Id.* The plan included a comparable cost-based supplemental payment provision for outpatient services incurred by such a hospital. *Id.* at 61, 118-19, 263-64.

Effective January 20, 2001, the Commonwealth amended its State plan to allow supplemental payments to be made to "Essential MassHealth Hospitals" ("EMHs"). *Id.* at 122. The plan defined such a hospital as one that met at least four of five criteria and further provided:

> Subject to specific legislative authorization and appropriation and compliance with federal upper payment limit and other applicable regulations at 42 C.F.R. Part 447, the [State agency] will make a supplemental payment in addition to the standard reimbursement made under the [State agency's] Acute Hospital Contract, to [EMHs]. Such lump sum payments are made annually at the end of the fiscal year, or at such other times as the [State agency] may determine. The payment amount will be (i) determined by the [State agency] using data filed by each qualifying hospital in its financial and cost reports, and (ii) a percentage of the difference between the qualifying hospital's total Medicaid charges and total Medicaid payments from any source, which percentage shall in no event exceed 100 percent.

Id. The plan included a similar payment provision for outpatient services provided by EMHs. *Id.* at 126, 263.

Case Background

The following facts are undisputed between the parties and are based upon information in the record.

UMass Memorial is a non-profit corporation that was created through a series of mergers of several private and State entities. CAF, Vol. 3, at 260; CMS Ex. 3, at 33. The corporation is the controlling company for a large teaching hospital (UMass Memorial Medical Center) and four community hospitals (Health Alliance, Wing, Clinton, and

Marlborough hospitals), collectively referred to as "the Hospitals." CAF, Vol. 3, at 260. The teaching hospital is affiliated with the State-owned University of Massachusetts Medical School – Worcester (Medical School). *Id.*[4]

The Commonwealth initially made Medicaid standard rate payments (i.e., the SPAD and APG payments) to each of the five Hospitals for each of the fiscal years at issue in this appeal and received FFP for those payments. CMS Ex. 4, at 13 ("Appendix A") (Total FFS Payments – Actual).

The Commonwealth subsequently made supplemental payments to each of the Hospitals for patient care services provided in FYs 2000 to 2003. *Id*.; *see also* Spellman Decl. ¶ 15 (CAF, Vol. 3, at 515). The supplemental payments were in connection with each of the five categories of Medicaid payments for which the Hospitals were eligible: DSH payments; inpatient payments for non-profit teaching hospitals affiliated with a Commonwealth-owned medical school; outpatient payments for non-profit acute teaching hospitals affiliated with a Commonwealth-owned medical school; inpatient payments to EMHs (such as the Hospitals at issue here); and outpatient payments to EMHs. Spellman Decl. ¶ 25 (CAF, Vol. 3, at 517). The Commonwealth determined the amount of the supplemental payments based on a number of factors, including: (i) a determination of a reasonable payment level; (ii) the timing of appropriations, availability of funds, and State Plan approvals; and (iii) the individual hospital's cost and charge reports and reasonableness of its claims. Spellman Decl. ¶ 15 (*Id*. at 515). The supplemental payments were calculated using a methodology separate from the ones used to calculate the standard SPAD and APG rates. Spellman Decl. ¶¶ 25, 27 (*Id.* at 517); Oral Argument Transcript (Tr.) at 36.

The Commonwealth made the supplemental payments at issue to each of the Hospitals on or about April 15, 2005. *See* Sesay Decl. ¶ 5 (CAF, Vol. 3, at 521-23); Spellman Decl. ¶ 26 (*Id*. at 517). The Commonwealth made each of the supplemental payments pursuant to an "[IGT]-Supported Payments Agreement" between the State, the Hospitals, and the Medical School. CAF, Vol. 2, at 8, 28, 68, 93, 150. Each supplemental payment agreement provided that within three days of the individual Hospital's receipt of the supplemental payment, the Medical School would make an IGT of 50% of the payment to the Commonwealth. *See, e.g., id.* at 9.

[4] Prior to 1998, the teaching hospital was a part of the University of Massachusetts. In that year, the Commonwealth transferred the teaching hospital to a new non-profit entity – UMass Memorial. *See* 1997 Mass. Legis. Serv. 163 (West) (CMS Ex. 2). After the transfer, UMass Memorial still maintained a connection with the Medical School. For example, UMass Memorial has "the right to occupy portions of the … Medical School campus for a period of 99 years[,]" and it "share[s] responsibility for various capital and operating expenses relating to the occupied premises." CMS Ex. 3, at 33. Among other financial commitments, UMass Memorial reimburses the Medical School for "shared services, leased employees, and other agreed upon activities[.]" *Id.* at 34.

In 2005, in the course of reviewing certain proposed State plan amendments submitted by the Commonwealth, CMS determined that the Commonwealth had been effectively funding the non-federal share of the supplemental payments made to the Hospitals with funds obtained from the Medical School. CMS Exs. 5-7. At CMS's request, the Commonwealth agreed to discontinue this funding mechanism effective July 1, 2005. *Id*.

In September 2005, the Commonwealth submitted a form CMS-64 for the quarter ending June 30, 2005. In the form CMS-64, the State claimed $54,053,476 in expenditures ($27,026,738 in FFP) for the supplemental payments made to the Hospitals for services provided in FYs 2000 to 2003. Spellman Decl. ¶ 26 (CAF, Vol. 3, at 517). In response to an OIG audit report ("Review of Medicaid Supplemental Rate Payments to [UMass Memorial] for Fiscal Years 2004 and 2005" (A-01-07-00013)), which found that the State had overstated its supplemental payment claims by $11.5 million ($5.75 million in FFP), the Commonwealth reduced the claimed expenditures by $2,965,547 ($1,482,775 in FFP). *Id.* at 135, 266.

On March 17, 2006, CMS deferred payment of the FFP claimed by the Commonwealth for the supplemental payments made to the Hospitals for FYs 2000 to 2003. *Id.* at 145-156. The Commonwealth responded to the deferrals by letters dated May 24 and July 10, 2006. *Id.* at 171-245.

On February 3, 2011, CMS issued a letter disallowing $25,543,963 in FFP for the supplemental payments made to the Hospitals for FYs 2000 to 2003. *Id.* at 135-37. CMS based this disallowance on the ground that the Commonwealth had failed to claim FFP for the payments within the two-year claiming period specified in section 1132(a) of the Act. *Id.* at 136. CMS also determined, based on the OIG audit report, that the State had claimed $8.5 million (approximately $4.25 million in FFP) in excessive supplemental payments for FYs 2000 and 2001. *Id.*

The Commonwealth requested CMS to reconsider the disallowance. *Id.* at 132-34. In a reconsideration decision dated April 13, 2012, CMS affirmed the disallowance determination, except CMS determined that the State had timely claimed FFP for certain supplemental payments made for FY 2003. *Id*. at 247.

In a letter dated June 12, 2012, the Commonwealth appealed to the Board, challenging CMS's disallowance determination. On November 9, 2012, the Commonwealth filed a motion to compel discovery and to modify the briefing schedule. The Board denied the Commonwealth's motion in a ruling dated January 29, 2013. On May 20, 2013, UMass Memorial moved pursuant to 42 C.F.R. § 16.16(a) to intervene and appear in this proceeding on behalf of the Hospitals. The Board granted the motion to intervene in a ruling dated May 29, 2013. The Board heard oral argument from both parties and the intervenor on June 18, 2013.

Analysis

A. *The Commonwealth did not have notice that CMS would treat the September 2005 supplemental payments as a prior-period adjustment to payments previously made relating to hospital services provided in FYs 2000 to 2002.*

The issue in this case is whether for purposes of the two-year rule, the April 2005 supplemental payments triggered a new two-year time limit under section 1132(a) (as the Commonwealth argues), in which case CMS agrees that the Commonwealth's FFP claim for the payments was timely because the Commonwealth filed the claim in September 2005, or whether the payments must be regarded as prior-period adjustments to the standard (SPAD and APG) payments for hospital services provided in FYs 2000 to 2002 and subject to the same time limits as those initial payments. Tr. at 33.

CMS argues that the Commonwealth's standard payments to the Hospitals – i.e., the SPAD and APG payments – for patient care services that the Hospitals provided during FYs 2000 to 2002 were the expenditures that triggered the relevant two-year claiming period. CMS Br. at 21; Tr. at 80-81. CMS further argues that the supplemental payments made to the Hospitals in April 2005 constituted adjustments to prior year claims or "add-ons" to those standard rates – i.e., they were intended to enhance the amounts previously paid to those Hospitals for services rendered during those years. CMS Br. at 21-22; Tr. at 32-33. Thus, CMS concludes that to be timely, the FFP claim had to have been made within two years of the last quarter of the fiscal year when the initial payment at the standard rate was made to the providers for the underlying medical services. Tr. at 58, 80-81. Accordingly, CMS says that the claim for the supplemental payments at issue in this appeal was untimely because it was made beyond that time frame. CMS Br. at 22.

The Commonwealth counters that the supplemental payments were made in April 2005 and that its claim for FFP was submitted in September 2005, much less than two years after the payments were made. Commonwealth Br. at 3-4. The Commonwealth denies that the supplemental payments were revisions of or adjustments to prior payments, instead viewing them as new expenditures calculated pursuant to a separate methodology under the relevant State plan authority. *Id*. at 18, 21. In support of its position, the Commonwealth relies upon the criteria set forth in the regulations and CMS's interpretation of those authorities set forth in the SMM that, for purposes of the two-year rule, an expenditure occurs when payment is made by a state agency to a non-public provider. *Id.* at 6-7, 20-21. The Commonwealth argues that it had no notice (constructive or otherwise) of a contrary interpretation by CMS under which the April 2005 payments would be viewed as anything but new expenditures or would be imputed to a date years before April 2005. *Id.* at 31-32; Tr. at 29.

For the reasons discussed below, we find that the Commonwealth did not have timely and adequate notice that CMS would treat the April 2005 supplemental payments as prior-period adjustments that did not trigger a new two-year period. We also find that the Commonwealth reasonably relied upon an alternative interpretation of the regulatory language and the SMM provisions indicating that, based on the legal status of the Hospitals as private providers, the supplemental payments would be treated as current expenditures that could be claimed as timely in 2005. We conclude that the supplemental payments in this case involved a unique, public-private hybrid funding mechanism partaking of both private and public components and that neither CMS nor prior Board decisions previously provided any guidance, as to how to apply the two-year rule to such transactions. For these reasons, we find notice lacking in these specific circumstances. Accordingly, our decision is limited to the facts of this case.

1. <u>The public-private hybrid funding mechanism underlying the supplemental payments.</u>

Except for the amounts discussed in the next section, CMS does not dispute that the supplemental payments at issue were authorized by the State plan. The State plan provided that no supplemental payments could be made in the absence of specific legislative appropriation. *See* CAF, Vol. 2, at 32, 61; Tr. at 31. In addition, the State plan provided that the payments were subject to the availability of an IGT. *Id*. The Commonwealth made the supplemental payments pursuant to an "[IGT]-Supported Payments Agreement" between the State, each of the individual Hospitals, and the Medical School. CAF, Vol. 2, at 8, 28, 68, 93, 150. Pursuant to those Agreements, after the legislature appropriated the funds, the Commonwealth's Medicaid agency made the supplemental payments at issue to each of the Hospitals for unreimbursed costs for services provided in FYs 2001 and 2002. The Supplemental Payment and IGT Agreements further provided that within three days of a Hospital's receipt of the supplemental payment, the Medical School would make an IGT to the Commonwealth of 50% of the amount of the supplement payment received by the Hospital from the Commonwealth. CAF, Vol. 2, at 8, 28, 68, 93, 150.

As previously discussed, UMass Memorial maintains a close connection with the Medical School. CMS Ex. 3, at 33-34; Tr. at 74. For example, UMass Memorial "*does* make payments to the [Medical] School . . . to satisfy its obligations under several service and occupancy agreements." CMS Ex. 5, at 2 (emphasis in original); *see also id*. at 9-11 (listing nine different types of contractual arrangements between the Hospitals and the Medical School, which include teaching and educational services provided by the Medical School). In addition, the IGT agreement states that UMass Memorial "has entered into an agreement with [the Medical School] to purchase medical education,

clinical support, and clinical activities from the state-owned . . . medical school."[5] CAF, Vol. 2, at 150. As previously discussed, UMass Memorial has a right to occupy a portion of the Medical School's campus for a period of 99 years, and "UMass Memorial has agreed to share responsibility for various capital improvements to shared facilities." CMS Ex. 3, at 33. UMass Memorial also pays a $12 million annual fee (adjusted for inflation) to the Medical School for 99 years as long as the Medical School continues to operate and pays the Medical School a percentage of net operating income. *Id*.

In summary, the supplemental payments were made through a series of steps that involved a unique hybrid funding mechanism involving the Commonwealth, the Hospitals, and the state-owned Medical School. First, after the legislature appropriated the funds, the Commonwealth made each of the supplemental payments to the Hospitals. Second, the Medical School paid back to the Commonwealth 50% of the amount of those payments within three days after the Hospitals received them. Finally, UMass Memorial made annual payments to the Medical School for a variety of purposes, including for educational and health services that the Medical School provided to the Hospitals.

2. Prior to the deferrals in this case, the Commonwealth did not have timely and adequate notice that CMS would assert that the April 2005 payments were anything but new expenditures for purposes of the two-year rule in section 1132(a) of the Act.

In *Alaska Dept. of Health and Social Servs.*, DAB No. 1919 (2004), the Board stated:

> Our analytical approach . . . arises in part from the Administrative Procedure Act, which provides that, "[e]xcept to the extent that a person has actual and timely notice of the terms thereof, a person may not in any manner be required to resort to, or be adversely affected by, a matter required to be published in the Federal Register and not so published." 5 U.S.C. § 552(a)(1). Accordingly, the Board has previously applied any reasonable and permissible interpretation by CMS of ambiguous statutory language if CMS's interpretation was timely published in the Federal Register or, failing that, if the state had actual and timely notice of the interpretation. In addition, where the content of CMS's interpretation(s) has not been clearly articulated, we must consider what is the applicable CMS interpretation. Applicability must be weighed in terms of both a specific factual context and a specific timeframe.

[5] The IGT agreement further provides that pursuant to Massachusetts state law, the Hospitals have "a legislatively mandated common mission with the state-owned UMass medical school for the benefit of medical education, community based clinical care, and access to health care for indigent persons[.]" *See, e.g.*, CAF, Vol. 2, at 8, 150.

> Where CMS has not informed a state of an interpretation and the state asserts that it relied on its understanding of a prior CMS interpretation or on its own alternative interpretation, we must consider whether the state reasonably relied on the other interpretation.

Id. at 15 (citations omitted).

Section 1132(a) of the Act provides that "any claim by a State for payment with respect to an expenditure made during any calendar quarter by the State . . . in carrying out a State [Medicaid] plan … shall be filed (in such form and manner as the Secretary shall by regulations prescribe)" within two years after the quarter in which the expenditure was made. The regulations implementing the statute state that FFP for a State expenditure will be available "only if the State files a claim with us for that expenditure within two years after the calendar quarter in which the State agency made the expenditure." 45 C.F.R. § 95.7. Section 95.13(b) provides that an expenditure for services provided under title XIX is considered to be "made in the quarter in which any State agency made a payment to a service provider."

In describing when an expenditure is made, section 95.13(b) makes no distinction between payments to public or private providers. The SMM does, however, make a distinction between public and private providers. For example, section 2500.2.E.4 of the SMM states that "[i]ncreasing adjustments related to private providers are considered current expenditures for the quarter in which the expenditure was made[,]" while "[i]ncreasing adjustments related to public providers are considered adjustments to prior period claims[.]" CMS argued in its brief that the distinction made in the SMM between public and private providers was only for the purpose of determining the applicable FMAP rate and did not apply to the two-year rule. CMS Br. at 28; *see also* Tr. at 41-42. However, CMS conceded during oral argument that section 2500.2.E.4 also cross-references section 2560 of the SMM. Tr. at 68. Section 2560.4.G.1.a.2, which sets forth CMS's interpretation of section 95.13(b), states that for non-public providers, an "expenditure is incurred when paid by any State agency." *See* CAF, Vol. 1, at 32; *see also New Jersey Dept. of Human Resources* at 14 (Section 2560.4.G.1 of the SMM distinguishes between public and private providers "by stating that payments to private providers for rate adjustments are treated as 'current expenditures.'").

Similarly, in instructing states how to prepare a QSE, section 2500.2A of the SMM states: "Note that increasing adjustments made in the current quarter to private providers are reported on the Form HCFA-64.9 (now CMS-64), as they are considered current expenditures." CMS Ex. 1. In addition, as part of the instructions in completing line 7 of CMS-64 (Adjustments Increasing Claims for Prior Quarters), section 2500.1B of the SMM instructs states to report "increasing adjustments to private providers made in the current quarter *for an earlier period* on line 6 as a current expenditure" (emphasis added). This section of the SMM also cross-references section 2560 of the SMM. Thus, CMS's

long-standing interpretation of the regulation recognizes that an expenditure is incurred when payment is made by any State agency to a private provider, even if a state has previously made a payment to that provider for the same services.

The Board articulated the rationale for the distinction made in the SMM between public and private providers in *New Jersey Department of Human Resources*. There the Board explained:

> When a private provider performs a Medicaid-covered service, the provider is not entitled to payment until it submits a reimbursement claim for the service. If the claim is approved, the state usually disburses cash to the provider in compensation for that service. In contrast, there is ordinarily no post-service transfer or disbursement of cash to compensate a public provider for Medicaid services rendered. That is because the state or other public entity finances the public provider's operations on a prospective or ongoing basis. "A state does not ordinarily pay itself" for Medicaid services that its own facilities provide.

Id. at 8 (citation omitted). The Board further explained that one reason for the distinction is that the state has greater control over the timing of the payment process when it pays a public provider than it does with a private actor. *Id*. at 10. In other words, because a state has such control of the payment process, the SMM does not treat a supplemental payment to a public provider as a current expenditure for purposes of the two-year rule. Rather, when an additional payment is made to a public provider for services that a state has previously made or recorded, the additional payment is treated as a prior-period expenditure and a request for FFP in that expenditure is timely only if falls within one of the statutory exceptions to the two-year rule. In contrast, payments to private providers are considered to be more in the nature of an "arms-length" transaction that is less susceptible to manipulation, and, therefore, CMS treats those types of payments as current period expenditures.

The Commonwealth contends that because the Hospitals are private entities incorporated under Massachusetts state law, the supplemental payments should be treated as current-period expenditures and, therefore, as having been timely claimed. CMS argues that the Board should not focus on whether the Hospitals are technically "private" providers, which CMS concedes is the case, but instead focus on the reason for the distinction between public and private providers. CMS Br. at 29; Tr. at 42.

In support of its position, CMS relies on the rationale for the public-private provider distinction articulated in *New Jersey*, which "is that a State has greater control over the cost settlement and claim submission process involving public providers" than it has over "private actors" and, therefore, treating rate adjustments paid to public providers as current expenditures for FMAP purposes "would leave the Medicaid program vulnerable

to abuse by States who could simply time their claims submissions to coincide with those quarters when an enhanced rate is in effect." CMS Br. at 28, citing *New Jersey Dept. of Human Resources* at 10. CMS asserts that the Commonwealth had "the unbridled discretion to determine the timing and amount of the expenditures." *Id*. at 29. The Commonwealth, CMS asserts, was entirely in control of the process for making the supplemental payments because the payments were subject to both "specific legislative authorization and appropriation." Tr. at 43; *see, e.g.*, CAF, Vol. 3, at 122. CMS further asserts that the Commonwealth controlled the timing of the payments because they were conditioned on the availability of an IGT from the State-owned Medical School. *See, e.g.* CAF, Vol. 2, at 69; 2003 Mass. Legis. Serv. Ch. 26 (CMS Ex. 8) ("[n]o such funds shall be expended unless . . . the . . . Medical School makes an [IGT]"). CMS also points out that there was no reason for the delay in making the payments other than the lack of an appropriation. Tr. at 37. Thus, CMS contends that "regardless of whether the Hospitals are public or private entities, the payments at issue in this case should be characterized as prior period adjustments that did not trigger a new claiming period." CMS Br. at 29.

The situation in this case is novel due to the unique, public-private hybrid nature of the funding mechanism surrounding the supplemental payments. In this light, it is important to look at the entire transaction as a whole. CMS acknowledges that the Hospitals to which the Commonwealth made the supplemental payments are legally private entities. Tr. at 40-41, 72-73. However, the transactions here do not end with the simple making of those payments to a private provider. Instead, the public components of the transaction indicate that the payments were not simply the result of an "arms-length" process (as when a private provider bills a state after providing a service) because both the Supplemental Payment Agreements and the IGT Agreements require the State-owned Medical School to pay back to the Commonwealth 50% of the amount of those payments within three days of *receipt of the supplemental payment by the Hospital*. Indeed, those payments were also conditioned on the requirement that there be such an IGT by both contract and the State plan, as well as Massachusetts state law. Moreover, as discussed above, there is a close financial and working relationship between the corporation that controls the Hospitals – UMass Memorial – and the Medical School. This relationship, which involves substantial annual payments by UMass Memorial to the Medical School, further clouds the view that the Hospitals should be treated as private providers simply because of their legal status as a private entity. Similarly, some of the individual hospitals used to be public providers until their merger. In effect, CMS asks us to look behind the formalistic label of "private provider" and consider the entire transaction as a whole in determining whether to treat the supplemental payments as current expenditures.

However, the SMM does not address how payments under a public-private hybrid funding mechanism such as that used by Massachusetts should be treated for purposes of the two-year rule, i.e., when those payments are made to a hospital that is a private entity under state law but is part of a complete transaction involving public entities and intergovernmental funds transfers. Nor has CMS published or provided the

Commonwealth with any other guidance directly applicable to these unique circumstances prior to the deferrals in this case. Thus, we conclude the Commonwealth did not have timely and adequate notice that the Hospitals would be treated in the same manner as public providers for purposes of the two-year claims rule such that the supplemental payments would not be treated as current expenditures.

The record also indicates that at the time the Commonwealth made the supplemental payments at issue, it reasonably relied upon its understanding of the language of section 95.13(b) and the SMM in believing that the supplemental payments to the Hospitals were new and separate expenditures to *private providers* made under the authority of its State plan and that CMS would treat the payments as current expenditures made in April 2005, rather than as revisions of or adjustments to prior payments. Commonwealth Br. at 32, citing Spellman Decl. ¶ 28 (CAF, Vol. 3, at 517); *see also* Spellman Decl. ¶¶ 14, 15, 16, 25, 27 (CAF, Vol. 3, at 515, 517); Sesay Decl. ¶ 9 (CAF, Vol. 3, at 524). The Commonwealth argues that each of these payments is separate and distinct transaction and that its payments were made to the Hospitals, which were private entities, and that it did not have any notice CMS would look at the entire transaction as a whole in concluding that the supplemental payments should not be treated as current-period expenditures. Based on the statement of policy in the SMM regarding how CMS would treat private providers, we conclude that the Commonwealth reasonably relied on its interpretation of the regulation and SMM that because the Hospitals legally were private entities, it could make supplemental payments at any time and view them as new expenditures.

3. CMS's additional arguments are not persuasive.

Finally, CMS raises two additional arguments that we do not find persuasive. First, in its brief, CMS challenged the Commonwealth's position that the Hospitals are private providers, claiming such an assertion is contradicted by their own records. CMS Br. at 27-31; Tr. at 40-41. In support of this argument, CMS said that each time the Commonwealth made a supplemental payment to one of the Hospitals, various State officials completed a specially-designed form (the "MassHealth IGT Funded Payment Signoff" form) that designated the payee hospital (e.g., Wing Memorial Hospital) as the "Hospital/Public Entity," and that certified the appropriateness of an IGT-funded payment to "this public entity." CMS Br. at 30; CAF, Vol. 2, at 3, 17, 37, 48, 57, 77, 103, 108, 111, 118, 121, 124, 135. CMS asserted that on each form, the MassHealth Hospital Unit Director certified that "[a]n IGT-funded payment to this public entity for this amount is appropriate." *Id.* CMS argued that "[t]hese certifications reflect that the Commonwealth considered the Hospitals as public providers for the purpose of the State's scheme for financing the non-Federal share of the payments." CMS Br. at 30. CMS thus contends the Commonwealth cannot reasonably claim that the Hospitals are public providers for that purpose but are private providers for the purposes of the two-year claiming rule. *Id*.

During oral argument, CMS stated that it was not challenging the Commonwealth's representation that the Hospitals are legally private, non-public providers. Tr. at 40-41, 72-73. Instead, CMS argues that the above-mentioned forms show that the Commonwealth "understood" the Hospitals to be public entities at least for purposes of the funding mechanism at issue, and thus cannot now reasonably claim that it had no notice that CMS could subsequently treat the supplemental payments as though they were made to a public rather than a private entity. Tr. at 73.

Even though the forms indicate that the Commonwealth could have been aware that the transactions at issue were not solely with private providers, such awareness does not alter the fact, for the reasons previously discussed, that the Commonwealth did not have timely and adequate notice CMS would treat the supplemental payments as if they had been made to a public provider for purposes of the two-year rule.

Second, CMS argues that even if the regulations and SMM provisions did not provide the Commonwealth with notice that the payments at issue in this case would be considered prior-period adjustments for the purposes of the two-year rule, prior Board decisions provided the Commonwealth with constructive notice of CMS's position.[6] CMS Br. at 31-33. We disagree.

In support of this argument, CMS relies primarily on two Board decisions. First, CMS relies upon *South Carolina State Health & Human Servs. Finance*, DAB No. 943, at 3 (1988) to support the proposition that "[a]dditional payments made later on for the same period, no matter how computed, were not new expenditures which started a new claiming period running." CMS Br. at 32-33. Second, CMS relies upon *New York State Dept. of Health*, DAB No. 1867, at 8 (2003), where the Board stated that the regulatory and SMM provisions that pertain to the two-year claiming period mean that the period begins to run "[w]hen [a state] records or pays (whichever is earlier) an amount that includes an amount for a particular item of service provided by a public facility," and that "[a]n increase in the amount paid or recorded for that particular item of service is not a new expenditure" for the purposes of the two-year limit.[7]

[6] A decision of the DAB constitutes the final agency decision in the matter and, of course, such decisions are publicly available. Act § 1116 (e) (2). Consequently, CMS argues that the Commonwealth had constructive notice of the Board's decisions on the two-year limit issue.

[7] CMS also cited a number of other Board decisions in support of its position, none of which is apposite. CMS Br. at 19-20, 32-33, citing *Texas Health & Human Servs. Comm.*, DAB No. 2404 (2011); *Kansas Dept. of Social & Rehabilitation Servs.*, DAB No. 2014 (2006); and *Maryland Dept. of Health & Mental Hygiene*, DAB No. 607 (1984); Tr. at 39.

We conclude that these and other Board decisions cited by CMS did not provide the Commonwealth with constructive notice of CMS's position because they all pertain to public providers, whereas the Hospitals in this matter are private providers. In addition, none of the prior decisions dealt with the type of payment mechanism at issue in this case. Indeed, during oral argument, both parties agreed that the Board has not previously addressed whether supplemental payments that flow from an IGT transaction are expenditures triggering a two-year claiming period. Tr. at 42, 77. CMS specifically acknowledged that "none of those cases involve the situation here." *Id*. at 42.

In summary, we conclude that under the circumstances here, the Commonwealth did not have timely and adequate notice (constructive or otherwise) that CMS would assert that the April 2005 payments were anything but new expenditures permitted under the Commonwealth's State plan. We further conclude that the Commonwealth reasonably relied upon its understanding of the language of the regulation and the SMM in believing that CMS would treat the supplemental payments as current-period expenditures. For these reasons, we find that the Commonwealth claimed FFP for the supplemental payments made in April 2005 within the two-year period specified in section 1132(a) of the Act.

B. *CMS properly disallowed approximately $4.25 million in FFP based on the OIG's audit report.*

As indicated, based on an OIG audit report (CAF, Vol. 3, at 253-71), CMS disallowed approximately $4.25 million of the $21 million in FFP requested for supplemental payments on the additional ground that the payments were not authorized by the State plan. CMS Br. at 39, citing CAF, Vol. 3, at 136. The supplemental payments were for hospital services provided in FYs 2000 and 2001. CAF, Vol. 3, at 265.

For the period from October 1, 1999 through January 19, 2001, the State plan provided that supplemental payments to "Non-Profit Teaching Hospitals Affiliated with a Commonwealth-Owned Medical School" for inpatient services would be calculated based on a specific formula using cost data from specific line items of the hospitals' cost reports. *Id.* at 32. That provision was located in section IV.C.4 of the State plan. *Id*. Section IV.C.4.a provided that "[s]ubject to Section IV.C.4.b[,]" the inpatient hospital payment amount would be equal to the hospital's Medicaid costs per discharge, as determined by the methodology described above. *Id.* Section IV.C.4.b stated in turn that "[a]ny payment amount in excess of amounts which would otherwise be due any state-owned teaching hospital pursuant to Section IV.B is subject to specific legislative appropriation and intergovernmental transfer." *Id*. Section IV.B provided for the standard rate payments made to the Hospitals. Commonwealth Br. at 8-9; CAF, Vol. 3, at 17.

The OIG audit found that in calculating the amount of the supplemental payments, the Commonwealth had included costs that were not part of the formula contained in the State plan. CAF, Vol. 3, at 265. Specifically, the Commonwealth included costs for such items as free care assessments, provisions for bad debts, and payments from the Hospitals to the Medical School that did not correspond to the specified line items on the Hospitals' cost reports. *Id*. The OIG audit concluded that the inclusion of these additional cost items resulted in approximately $8.5 million in excessive expenditures and in the Commonwealth receiving about $4.25 million in unallowable FFP. *Id*.

On appeal, the Commonwealth does not dispute the factual basis for the OIG audit finding. Instead, the Commonwealth claims that it reasonably interpreted its State plan to provide for "two alternative caps": one based on the payment formula specified in section IV.C.4.a of the State plan (which called for use of specific cost report data), and the other "based on the availability of legislative appropriations and intergovernmental funds transfer" as set forth in section IV.C.4b. Commonwealth Br. at 34. Thus, the Commonwealth argues that it was not bound by the cap established by the formula using the cost report data if the legislature subsequently appropriated additional funds to pay the hospitals and an IGT occurred under the mechanism previously described.

We agree with CMS that the Commonwealth's position is unreasonable and inconsistent with the language of its plan. *See* 42 C.F.R. § 477.252(b) (State plan must specify comprehensively the methods and standards used by state agency to set payment rates for hospital and other services). The relevant State plan language does not describe an either/or situation in which the costs calculated by the formula may simply be disregarded if the legislature subsequently appropriates additional money for supplements. Indeed, the very concept of "two caps" in itself is unreasonable under these circumstances because the first "cap" would be superfluous, being eliminated altogether if additional funds were appropriated by the legislature. In addition, neither section IVC.4b nor section IV.B of the State plan provided any alternative methodology for calculating the supplemental payments at issue in the event that a legislative appropriation was enacted. The Commonwealth also does not explain how its interpretation is consistent with the language of its State plan.

Moreover, the Commonwealth has not shown that it historically interpreted its State plan to have two alternative caps. For example, the Commonwealth offers no contemporaneous evidence of its interpretation of its plan nor any showing that it had consistently or historically treated the language of section IV.C.4.b as creating such an alternative cap. The only evidence the Commonwealth offers on this point is an affidavit from the former Chief Financial Officer of the Massachusetts Medicaid program. CAF, Vol. 3, at 518. However, the affidavit does not state that the Commonwealth historically interpreted its State plan to have two alternative caps for purposes of calculating a supplemental payment. Rather, the affidavit merely states that the Commonwealth has

interpreted the supplemental payment methodology to authorize payments "based upon the specified formula and additional conditions tied to appropriations and intergovernmental transfers." *Id*. (emphasis added). During the oral argument, the Commonwealth stated: "We don't have specific manual guidance interpreting that provision [of the State plan], but we have taken that provision – that position consistently when asked in the context of the OIG audit and the CMS deferral." Tr. at 67. It appears from this comment that the Commonwealth's position on this issue is one that is taken after the fact when challenged and is not one that the Commonwealth actually relied upon at the time it made the supplemental payments in April 2005. *See Alaska Dept. of Health & Social Servs.* at 23 (the Board considers "whether the alternative interpretation is simply a position taken after the fact of litigation or one responsibly developed and relied upon by that party in its actions").

Under these circumstances, we conclude that the section IV.C.4.b in the State plan did not establish an "alternate cap" on supplemental hospital payments or any kind of alternate supplemental payment methodology. Instead, section IV.C.4.b merely established a limitation or condition on the availability of payments under section IV.C.4.a. CMS Br. at 41; Tr. at 47.

For these reasons, we sustain the disallowance of the approximately $4.25 million in FFP as set forth in the OIG audit report. *See Massachusetts Exec. Office of Health & Human Servs.*, DAB No. 2218 (2008) and cases cited therein ("When a disallowance is supported by audit findings, the grantee has the burden of showing that those findings are legally or factually unjustified.").

Conclusion

For the reasons set out above, we reverse CMS's disallowance of $21,470,669 in FFP that CMS based solely on section 1132(a) of the Act and sustain CMS's disallowance of the Commonwealth's claim for $4,244,586 in FFP based on the OIG audit findings.

/s/
Judith A. Ballard

/s/
Leslie A. Sussan

/s/
Stephen M. Godek
Presiding Board Member