

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

Missouri Department of Social Services  
Docket No. A-17-79  
Decision No. 2892  
September 10, 2018

**DECISION**

This appeal, filed by the Missouri Department of Social Services (State), challenges a November 21, 2016 determination by the Centers for Medicare & Medicaid Services (CMS) to disallow \$10,011,389 in federal financial participation (FFP) for disproportionate share hospital (DSH) payments by the state of Missouri's Medicaid program to institutions for mental diseases (IMD) and other mental health facilities during federal fiscal years (FYs) 1995, 2014, and 2015. CMS issued the disallowance after the State reported those DSH payments as prior-period adjustments in Missouri's Quarterly Medicaid Statement of Expenditures (QSE) for the quarter ending December 31, 2015 (the first quarter of FY 2016).

CMS asserted two principal grounds for the disallowance. First, CMS found that the prior-period adjustments for FY 1995 and the first quarter of FY 2014 constituted untimely requests for FFP under section 1132(a) of the Social Security Act (Act),<sup>1</sup> which obligates a state to request FFP for a public assistance expenditure (such as a DSH payment) within two years after the calendar quarter in which the expenditure was made. Second, CMS found that the prior-period adjustments for FYs 2014 and 2015 would, if approved, cause Missouri to exceed annual caps, established under section 1923(h) of the Act, on the amount of FFP available for its DSH payments to IMDs and other mental health facilities. Both grounds are valid and sufficient bases to disallow federal reimbursement for the DSH payments reflected in the prior-period adjustments. We therefore affirm the November 21, 2016 disallowance determination.

---

<sup>1</sup> The current version of the Social Security Act can be found at [http://www.socialsecurity.gov/OP\\_Home/ssact/ssact.htm](http://www.socialsecurity.gov/OP_Home/ssact/ssact.htm). Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. Also, a cross-reference table for the Act and the United States Code can be found at [https://www.ssa.gov/OP\\_Home/comp2/G-APP-H.html](https://www.ssa.gov/OP_Home/comp2/G-APP-H.html).

## I. LEGAL BACKGROUND

The federal Medicaid statute, sections 1901-1946 of the Act, authorizes the federal government to provide grants to states that provide “medical assistance” (that is, health insurance benefits) to low-income persons and families. Act §§ 1901, 1903; 42 C.F.R. § 430.0. A state that operates a Medicaid program in accordance with federal requirements and the terms of its approved “State plan for medical assistance” is entitled to FFP for a percentage of its Medicaid program expenditures. Act §§ 1902(a), 1903(a); 42 C.F.R. § 430.30. The bulk of a state’s Medicaid program expenditures consists of payments to health care providers, such as hospitals and physicians, for services rendered to program beneficiaries. 42 C.F.R. § 430.0. The federal government’s share of such expenditures is known as the “federal medical assistance percentage” (FMAP). Act §§ 1903(a)(1), 1905(b).

### A. *The FFP claiming process*

FFP for a state’s Medicaid program is disbursed to the state in quarterly grants. 42 C.F.R. § 430.30(a). A Medicaid grant for a calendar quarter is provided prior to the quarter, and the amount advanced is based on the state’s estimate of its program funding needs. *Id.* § 430.30(b), (d).

Within 30 days after the end of a quarter, a state must file a QSE (form CMS-64). *Id.* § 430.30(c)(1). The QSE is an accounting of the just-completed quarter’s “actual recorded expenditures” which a state believes are entitled to FFP. *Id.* § 430.30(c); *see also* State Medicaid Manual (SMM) § 2500(A)(1).<sup>2</sup> CMS’s State Medicaid Manual contains instructions and procedures for completing and submitting the QSE. SMM § 2500.

In addition to being the vehicle for reporting expenditures made in the most recent (or just-completed) calendar quarter, a QSE allows a state to make “adjustments” to amounts reported on QSEs submitted for prior quarters. SMM §§ 2500(A)(1), 2500(C), 2500.1(B); *Ga. Dep’t of Cmty. Health*, DAB No. 2521, at 3 (2013). Such prior-period adjustments retroactively increase or decrease expenditure amounts reported on an earlier quarter’s QSE or the federal share claimed with respect to those expenditures. *Id.* Prior-period adjustments are often necessary because a state “is not always able to present a complete, accurate, or otherwise final accounting of the current quarter’s Medicaid expenditures on the QSE submitted for that quarter.” *Ga. Dep’t of Cmty. Health* at 3.

---

<sup>2</sup> The State Medicaid Manual is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>.

Expenditure amounts reported on the QSE, including prior-period adjustments, are charged against the Medicaid grant that was made in advance of the most recent quarter. *See* 42 C.F.R. § 430.30(c)-(d); SMM § 2500(A)(1) (stating that the QSE “reconciles” the quarterly award that was made for the quarter on the basis of funding estimate provided by the state for that quarter); *Ga. Dept. of Cmty. Health* at 10.

*B. The two-year filing rule for FFP claims*

Section 1132(a) of the Act states that “any claim by a State for payment with respect to an expenditure . . . made by the State . . . in carrying out a State plan approved under title . . . XIX . . . of this Act” shall be denied (disallowed) unless it was “filed (in such form and manner as the Secretary shall by regulations prescribe)” within two years after the quarter in which the expenditure is made. In enacting this two-year filing limit, “Congress wanted to discourage states from filing FFP claims long after they had made the relevant program expenditures, a practice that hampered federal budget planning and administration for Medicaid and other Social Security Act programs.” *Ga. Dep’t of Cmty. Health* at 3.

Regulations in 45 C.F.R. Part 95 implement the statutory filing limit. Section 95.7 of those regulations states that CMS “will pay a State for a State agency expenditure . . . only if the State files a *claim* with us for that expenditure within 2 years after the calendar quarter in which the State agency made the expenditure.”<sup>3</sup> 45 C.F.R. § 95.7 (italics added). Section 95.4 defines the term “claim” as a “request for Federal financial participation in the manner and format required by our program regulations, and instructions or directives issued thereunder.” *Id.* § 95.4. A QSE is the “manner and format” in which a state requests FFP in its Medicaid program expenditures. SMM §§ 2500, 2500(B) (stating that the QSE “constitutes [the state’s] claim for Federal reimbursement”); *Ga. Dep’t of Cmty. Health* at 10.

---

<sup>3</sup> Section 1132(a) of the Act and 45 C.F.R. § 95.19 specify FFP requests to which the two-year rule does not apply. Act § 1132(a) (stating that the rule “shall not be applied so as to deny payment with respect to” certain types of expenditures, including “court-ordered retroactive payments” and expenditures associated with “audit exceptions” and “adjustments to prior year costs”); 45 C.F.R. § 95.19 (listing the “claims” to which the two-year limit “do not apply”). The State does not claim that any of those exceptions applies here, Reply at 8 n.3, and none does.

*C. The statutory limit on FFP for DSH payments to IMDs or other mental health facilities*

The federal Medicaid statute requires states to make DSH payments to hospitals that serve disproportionately high numbers of low-income patients. Act §§ 1902(a)(13)(A)(iv), 1923(a)(1)(B). FFP for such payments may not exceed an annual, state-specific cap known as the “DSH allotment.” *Id.* § 1923(f). Within the DSH allotment, a state is subject to a separate annual limit, mandated by section 1923(h)(1), on the amount of FFP that may be provided for a state’s DSH payments to “institutions for mental diseases [IMDs] or other mental health facilities.”<sup>4</sup> We refer to that limit as the “IMD DSH limit.”

Under section 1923(h)(1), a state’s IMD DSH limit for a given year is the lesser of: (1) the state’s FY 1995 mental health DSH payments as reported on its QSEs for that year (§ 1923(h)(1)(A)); or (2) an “applicable percentage” of the state’s current-year DSH allotment (§ 1923(h)(1)(B)). For purposes of this case, the “applicable percentage” is a fraction whose numerator is equal to the state’s FY 1995 mental health DSH payments as reported on QSEs filed not later than January 1, 1997.<sup>5</sup> *See* Act § 1923(h)(2)(B).

CMS publishes its “preliminary” and “final” calculations of states’ annual IMD DSH limits in Federal Register notices. *See, e.g.*, 63 Fed. Reg. 54,142 (Oct. 8, 1998) (announcing FY 1998 and 1999 IMD DSH limits); 79 Fed. Reg. 11,436 (Feb. 28, 2014) (preliminary FY 2014 IMD DSH limits); 81 Fed. Reg. 74,432 (Oct. 26, 2016) (final FY 2014 and preliminary FY 2016 IMD DSH limits).

## II. CASE BACKGROUND

This appeal grows out of a prior disallowance appeal (docket number A-15-93) filed by the State and decided by the Board on February 11, 2016. *See Mo. Dept. of Social Servs.*, DAB No. 2677 (2016). This background narrative begins by recounting the circumstances and outcome of that prior appeal.

---

<sup>4</sup> CMS regulations define the term “institution for mental diseases” to mean “a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services.” 42 C.F.R. § 435.1010.

<sup>5</sup> The denominator of the fraction is equal to the state’s total DSH payments (mental health facility plus inpatient hospital) for FY 1995. Act § 1923(h)(2)(B); 63 Fed. Reg. 54,142, 54,143 (Oct. 8, 1998).

A. *The State's prior disallowance appeal*

In late 2014 – upon reviewing the State's QSE for the fourth quarter of FY 2014 – CMS determined that the State's total FY 2014 FFP claims for DSH payments to IMDs and other mental health facilities had exceeded Missouri's IMD DSH limit for that fiscal year (as determined by CMS). DAB No. 2677, at 7. The State Medicaid Manual instructs a state to claim FFP for mental health DSH payments on line 2B of the QSE's schedule for reporting medical assistance expenditures.<sup>6</sup> DAB No. 2677, at 4-6; SMM § 2500.2(E)(2). For FY 2014, the State claimed an amount equal to Missouri's FY 2014 IMD DSH limit on line 2B. *See* DAB No. 2677, at 7; Appeal File for Board Dkt. No. A-17-79 (AF) at 15. CMS discovered, however, that FY 2014 mental health DSH payments to *privately-owned* IMDs were included in the expenditure amounts entered on *line 1B*, the line designated for "inpatient hospital" DSH payments. *Id.* at 15, 16, 108. (From 1997 through at least 2015, the State's apparent practice was to report DSH payments to publicly-owned IMDs on line 2B, and DSH payments to privately-owned IMDs on line 1B.) The federal share of the incorrectly reported FY 2014 mental health DSH payments – that is, the federal share of the amounts incorrectly reported on line 1B – was (apparently) \$2,438,638. *Id.* at 15. Because the claim for that amount exceeded Missouri's FY 2014 IMD DSH limit (as calculated by CMS), CMS deferred its approval of the State's FFP claim for that amount. *Id.* at 16; DAB No. 2677, at 7.

In response to the deferral, the State asked CMS to revise its IMD DSH limit for FY 2014 in order to account for base-year (FY 1995) mental health DSH payments that had been (apparently) reported in error as inpatient hospital DSH payments on the State's QSEs for that year. DAB No. 2677, at 7. For FY 1995, Missouri reported \$207,234,618 in mental health DSH payments on line 2B. *Id.* at 6-7; AF at 20-21 (Attestation of Gina M. Jacobs). CMS's Federal Register notices identify that amount as Missouri's total computable FY 1995 mental health DSH payments for purposes of calculating its IMD DSH limits under section 1923(h)). DAB No. 2677, at 6-7, 11. However, the State indicated (in response to the deferral) that this figure included only DSH payments to publicly-owned IMDs. *Id.* at 7. The State further advised CMS that \$9,902,046 in FY 1995 DSH payments to privately-owned IMDs were reflected in expenditure amounts reported on line 1B as inpatient hospital DSH payments. *Id.* at 7-8. The State asserted that if those incorrectly reported DSH payments were added to the amounts reported on line 2B, Missouri's total base-year (FY 1995) mental health DSH payments would equal

---

<sup>6</sup> CMS instructs states to use schedule 64.9 to report "current quarter" medical assistance expenditures – that is, expenditures made during the most recently completed quarter – and to use schedule 64.9P to report medical assistance expenditures "made in a prior period [that is, a period prior to the most recent quarter] but not included on the expenditure report for that [prior] period" and expenditures "made as adjustments to amounts claimed in prior periods[.]" SMM §§ 2500.2(A), 2500.1(B).

\$217,136,664, and its FY 2014 IMD DSH limit would, by operation of section 1923(h)(1), be \$134,689,873 (equal to \$217,136,664 multiplied by Missouri's FMAP). *Id.* at 8. Because the revised limit would be greater than the amount of FFP claimed by the State for its FY 2014 mental health DSH payments, the State contended that there was no basis to disallow any portion of that claimed amount under section 1923(h)(1). *Id.*

In June 2015, CMS disallowed the deferred FFP (totaling \$2,438,638) for FY 2014 on the ground that it had been claimed in violation of Missouri's IMD DSH limit for that year. *Id.* CMS indicated that it had no authority to revise that limit to reflect the \$9.9 million in base-year mental health DSH payments incorrectly reported as inpatient hospital DSH payments on line 1B because section 1923(h) requires that a state's IMD DSH limit be determined on the basis of FY 1995 payments reported on the QSE as "mental health DSH" not later than January 1, 1997. *Id.* at 8-9.

The State appealed the June 2015 disallowance to the Board, requesting that Missouri's FY 2014 IMD DSH limit be revised to reflect the \$9.9 million in incorrectly reported FY 1995 mental health DSH payments, and asserting that the revised limit would remove the legal basis for the disallowance. *Id.* at 9. The Board sustained the disallowance. *Id.* at 1. In doing so the Board rejected the proposition that CMS should have revised Missouri's FY 2014 IMD DSH limit in order to account for the base-year mental health DSH payments that had been reported on line 1B as inpatient hospital DSH payments. *Id.* at 2, 12-13. The Board concluded that paragraph (1)(A) of section 1923(h), the provision which supplied Missouri's FY 2014 IMD DSH limit, "is properly read to require (or at least permit) CMS to calculate the IMD DSH limit using only the amount of 'mental health DSH' payments actually reported on line 2B of the QSE, the line expressly designated for those payments." *Id.* at 11. The Board also observed that the State had not attempted to adjust its base-year expenditure reporting in accordance with federal regulations and program instructions that require states to "report Medicaid program expenditures and retroactive adjustments *on the QSE* (as opposed to merely documenting them in a Board proceeding) and to certify that report as reflecting actual (rather than estimated) and allowable costs." *Id.* at 12 (italics in original, footnote omitted). In addition, the Board stated that it was "unaware of any circumstance in which the Board has approved, or directed CMS to approve, an adjustment to a state's QSE without the state's first having attempted to secure CMS's approval for the adjustment through the normal expenditure reporting process." *Id.* "[I]n the absence of an attempted prior-period adjustment to Missouri's FY 1995 expenditure report," the Board further stated, "any payment-limit recalculation that we might approve, or direct CMS to make, would circumvent the statutory requirement that an IMD DSH limit founded on section 1923(h)(1)(A) be based on amounts reported on the QSE 'as mental health DSH.'" *Id.* Finally, the Board cautioned that it was expressing "no view about the allowability of any increasing (prior-period) adjustment to line 2B of the QSE in order to account for base-year DSH payments that may have been incorrectly reported on another line of the QSE." *Id.* at 14.

*B. The pending disallowance appeal*

On February 29, 2016, a few weeks after the Board issued its decision (DAB No. 2677) upholding the June 2015 disallowance, the State filed a QSE for the quarter ending December 31, 2015, reporting “prior period adjustments” to its mental health and other DSH payments for FY 1995. AF at 58; *see also* June 28, 2017 Brief of Appellant (Mo. Br.) at 9. An “increasing adjustment,” entered on line 2B of form 64.9P, reported \$9,902,046 in total computable mental health DSH payments for FY 1995 and \$5,926,375 as the federal share of that total computable amount. Mo. Br. at 9; AF at 20, 59. A “decreasing” adjustment for FY 1995, entered on line 1B of form 64.9P, reduced the total computable amount and federal share of inpatient hospital DSH payments by \$9,902,046 and \$5,926,375, respectively. Mo. Br. at 9; AF at 20, 60. According to the State, these increasing and decreasing adjustments effectively shifted \$9.9 million in “misreported” base-year mental health DSH payments – payments earlier reported on line 1B as inpatient hospital DSH payments – from line 1B to line 2B. Mo. Br. at 9; AF at 21 (Attestation of Gina M. Jacobs) (stating that “[w]hen DSS discovers that it has misreported an expenditure, it makes a prior period adjustment to report the expenditure correctly, by making a decreasing adjustment on the line where the expenditure was reported and a corresponding increasing adjustment on the line where it should have been reported”).

The QSE for the quarter ending December 31, 2015 reported similar adjustments for FYs 2014 and 2015. AF at 20. These increased the federal share amounts reported on line 2B by \$2,409,185 for FY 2014 and by \$1,675,829 for FY 2015, and reduced the federal share amounts reported on line 1B by the same amounts. Mo. Br. at 9; AF at 20, 61-76. The State asserts that the adjustments for FYs 2014 and 2015, like the ones for FY 1995, “effectively moved . . . DSH payments to private IMDs . . . from Line 1B to Line 2B.” Mo. Br. at 9.

To summarize: on line 2B of schedule 64.9P of its QSE for the quarter ending December 31, 2015, the State made prior-period adjustments to its expenditure reports for FY 1995, FY 2014, and FY 2015 that increased the federal-share amounts for mental health DSH payments. The amounts of those increasing adjustments were \$5,926,375 for FY 1995, \$2,409,185 for FY 2014, and \$1,675,829 for FY 2015 – a total of \$10,011,389.

On November 21, 2016, CMS notified the State that it was disallowing \$10,011,389 in FFP “claimed” for the quarter ending December 31, 2015 based on the State’s “increasing prior period adjustments” (on line 2B) for FYs 1995, 2014, and 2015. AF at 36. CMS determined that the increasing adjustments for FY 1995 and the first quarter of FY 2014 were untimely under, and thus barred by, section 1132(a) of the Act. AF at 37, 38. In addition, CMS determined that the increasing adjustments for FY 2014 and 2015

were unallowable because they would, if approved, result in the State obtaining FFP in excess of Missouri’s IMD DSH limits for those years. *Id.* CMS further found that the increasing adjustment for FY 1995 is unallowable because the State “made no assurance that the [reported mental health DSH] payments [totaling \$9,902,046] did not exceed the unreimbursed costs of treating Medicaid and uninsured patients in accordance with Section 1923(g)(1)” and failed to “provide documentation to support the amount or the allowability of the increasing claim as required by the [CMS Regional Office] and as required by Section 2500(A)(1) of the [State Medicaid Manual].” *Id.* at 37.

The State filed a request for reconsideration with CMS on January 20, 2017, providing what it said was documentation of the \$9.9 million in mental health DSH payments reflected in its increasing adjustment for FY 1995. AF at 78-80. CMS denied the request for reconsideration on March 21, 2017, AF at 41-42, and the State then filed this appeal.

### III. ANALYSIS

In this appeal the State understandably focuses on CMS’s rejection of the prior-period increasing adjustment for FY 1995. The evident purpose of that adjustment was to provide a foundation upon which to argue that Missouri’s IMD DSH limits for FYs 2014 and 2015 should be revised.<sup>7</sup> Revising those limits would, according to the State, remove the legal ground for disallowing its prior-period adjustments for FYs 2014 and 2015 and ensure that Missouri’s Medicaid program would not be “unfairly” (the State’s word) deprived of federal reimbursement for future years’ mental health DSH payments. Mo. Br. at 4-5, 16-17. However, the State recognizes that, in order to achieve that result, it must first show that CMS erroneously disallowed the increasing adjustment for FY 1995 under section 1132(a) of the Act and 45 C.F.R. § 95.7. As previously stated, these provisions require a state to file any “claim” – that is, any request for FFP in a program expenditure – within two years after the quarter in which the expenditure was made. That time frame applies to both initial and adjusted claims. *Ga. Dept. of Cmty. Services* at 12. The State tries to avoid the time-bar by arguing that its increasing adjustment for FY 1995 was not a claim within the meaning of sections 1132(a) and 95.7. We reject that argument for the reasons explained in the following section.

---

<sup>7</sup> The State contends that if the “prior period adjustment [for FY 1995] is accepted, as it should be, [then] application of the statutory formula [in section 1923(h)] to the State’s IMD DSH limits for FFY [Federal Fiscal Year] 2014 and FFY 2015 will increase such that the FFY 2014 and 2015 [prior-period] adjustments do not result in payments exceeding the IMD DSH limit.” Mo. Br. at 5.

A. *The State's increasing adjustment for FY 1995 is a "claim" within the meaning of section 1132(a) and 45 C.F.R. § 95.7.*

Section 1132(a) of the Act states that the two-year filing rule applies to any "*claim . . . for payment [for FFP] with respect to an expenditure*" (italics added) made by a state in carrying out an approved State plan under title XIX (and other titles) of the Act. The regulations that implement section 1132(a) similarly state that FFP is available for a "State agency expenditure" only if the state files a timely "claim" for that expenditure, and that the term "claim" means a "request for Federal financial participation in the manner and format required by [the relevant] program regulations, and instructions or directives issued thereunder." 45 C.F.R. §§ 95.7, 95.4.

The State contends that its increasing adjustment for FY 1995 (entered on line 2B of the schedule 64.9P of the QSE for the quarter ending December 31, 2015) is neither a "claim for . . . payment" nor a "request for Federal financial participation." Mo. Br. at 11 (quoting sections 1132(a) of the Act and 45 C.F.R. § 95.7) (internal quotation marks omitted). The adjustment is neither of those things, says the State, because it "has absolutely no impact on the amount of FFP claimed or received for FFY 1995" and "simply corrects a reporting error by moving the amount claimed for DSH payments to private IMDs from Line 1B to Line 2B." *Id.* at 11 (further stating that "Line 1B decreases by the exact amount that line 2B increases"). Because its increasing adjustment for FY 1995 is not a claim, says the State, the two-year filing rule does not apply, and the disallowance of that adjustment should be reversed.

This argument overlooks the significance of a state's entries on the QSE. The Board has said that "how costs are claimed on departmental forms [such as the QSE] . . . is integral to determining whether, under applicable legal standards, a claim has been made." *N. J. Dep't of Human Servs.*, DAB No. 1655, at 6 (1998). The QSE calls on a state to report "actual" Medicaid program expenditures (made during the just-completed quarter or during prior quarters) by service or payment category and to certify that the reported expenditures are "allowable" (that is, eligible for FFP). AF at 58; SMM §§ 2500.2(A) (instructing a state to "report current period medical assistance expenditures by type of service") and 2500.5 (instructing that administrative costs be reported by cost categories listed on the applicable schedule (form 64.10) of the QSE). For any specific expenditure category, two key entries are made on the line of the QSE designated for that category: "total computable" expenditures (made during the current quarter or prior period); and, in a separate column, the amount that the state believes is the federal government's share of the total computable amount. *See, e.g.*, AF at 59. Coupled with the required certification, these two entries, when made on the appropriate schedule, constitute a claim – a request for FFP with respect to the type of expenditures reported on that line. *Ga. Dep't of Cmty. Health* at 15 (holding that a claim is made when a state "classif[ies] and quantif[ies]" its program expenditures on the QSE and certifies "the truth or accuracy of the information" on that form).

To make its increasing adjustment for FY 1995, the State entered \$9,902,046 as a total computable amount and \$5,926,375 as the “total federal share” on line 2B of the appropriate schedule – the line designated for reporting mental health DSH payments. AF at 59. Those entries presented a “claim” – a request that the federal share of the \$9.9 million in reported DSH payments be charged against the State’s most recent quarterly Medicaid grant (for the quarter ending December 31, 2015).<sup>8</sup> That the increasing adjustment was intended to correct an earlier reporting error does not mean that the adjustment was not a claim. A prior-period adjustment that corrects an expenditure reporting error constitutes a claim when it increases the amount of FFP sought with respect to a specific expenditure or category of expenditures. *See, e.g., N.Y. State Dep’t of Social Servs.*, DAB No. 818 (1986) (rejecting an argument that a prior-period increasing adjustment was merely an attempt to reverse an erroneous credit, rather than a request for FFP in previously unreported costs); *N.J. Dep’t of Human Servs.*, DAB No. 1655 (1998) (holding that a prior-period adjustment that “corrected” the FFP rate applicable to previously claimed expenditures was itself a “claim” subject to the two-year filing rule). That is precisely what the increasing adjustment did here: it increased, by \$5,926,375, the amount of FFP sought with respect to a specific category of Medicaid program expenditures (mental health DSH payments).

The State emphasizes that its increasing adjustment for FY 1995 is offset by a simultaneous adjustment that reduced the amount reported on line 1B, resulting in no *overall net* increase in FFP sought for that year. Mo. Br. at 9; Reply at 1. That fact also is immaterial, for reasons that the Board stated in rejecting a similar contention in *Georgia Department of Community Health*:

. . . CMS’s suggestion that expenditure amounts reported on a QSE are not “claimed” (for purposes of the two-year rule) to the extent they are offset by decreasing adjustments and other amounts in calculating net expenditures on line 11 [of the QSE’s Summary Sheet] is inconsistent with the regulatory definition of a claim and the content and function of a QSE. . . . By classifying and quantifying its Medicaid program expenditures on the various schedules supporting the Summary Sheet, specifying the FFP rate applicable to each type of expenditure, and certifying the truth or accuracy of the information on the schedules, Georgia is clearly making a “claim” – or a “statement of expenditures for which [it] is entitled to Federal reimbursement under title XIX” – with respect to the expenditures on those schedules. Contrary to CMS’s assertions here, the QSE’s Summary Sheet . . . does not operate to present a single, unified “claim” for

---

<sup>8</sup> The State does not allege that expenditures reflected in the base-year’s increasing adjustment were omitted from the “net expenditure” amount that was certified as eligible for FFP for the quarter ending December 31, 2015 (*see* AF at 58).

the quarter; the Summary Sheet merely aggregates expenditure amounts shown on the underlying schedules, then reduces (or offsets) the expenditure total to account for decreasing adjustments in order to calculate total “net” expenditures and the federal share of that net total – amounts that are, in turn, used to adjust the state’s estimate of quarterly Medicaid funding needs on form CMS-37 in order to determine the award amount.

DAB No. 2521, at 15 (record and legal citations omitted). To this we add that the increasing adjustment is a claim in the sense that it asks CMS to accept the State’s assurance, communicated via the certification on the QSE’s cover page (AF at 58), that the identified expenditures meet all applicable conditions for federal reimbursement (apart from compliance with the two-year rule).

The State contends that its stance regarding the two-year rule’s applicability is consistent with the rule’s legislative purpose, which is to prevent delayed FFP claiming that hinders federal budget planning. Mo. Br. at 11-13. But that contention rests on the State’s zero-net-effect argument we have just rejected. *Id.* at 12 (stating that the “correction” on lines 1B and 2B of the QSE “d[id] not hinder HHS’s ability to determine its obligations for each fiscal year within a reasonable time” because the correction “d[id] not result in changes to the FFP in those expenditures”). Furthermore, the Board has never held that the two-year rule’s applicability depends on the *magnitude* of a claim’s effect on federal budget planning. With certain specified (but inapplicable) exceptions, the rule expressly applies to “any” request for federal funding “with respect to” a state’s expenditures. Act § 1132(a); *see also Ga. Dept. of Cmty. Health* at 10, 12.

The State asserts that the November 21, 2016 notice of disallowance “confirms that the FFY 1995 prior period adjustment” is not a claim because the notice states that the disallowance “‘is for reporting purposes only,’ even though the State long ago received full FFP for its \$729,181,142 (total computable) in FFY 1995 DSH payments.” Mo. Br. at 11 (quoting AF at 38). According to the State, the disallowance “does not purport to seek to recoup” FFP paid with respect to any DSH payment made during FY 1995. *Id.*

CMS’s disallowance notice does not, in our view, imply that the increasing adjustment for FY 1995 was not a claim. In fact the notice refers to the adjustment as an “increasing claim” and “claims for FFP” with respect to its FY 1995 mental health DSH payments. AF at 37; *see also* AF at 41 (CMS letter affirming the disallowance on reconsideration stating that the increasing adjustments “represent new claims”). Moreover, CMS did not use the phrase “for reporting purposes only” to describe the disallowance. CMS instead used the phrase to characterize the *decreasing adjustments* of \$10,011,389 that it asked the State to make on its next QSE. According to the disallowance notice, the decreasing adjustments were for “reporting purposes only” because CMS had earlier “deferred” the

State's increasing adjustments for FYs 1995, 2014, and 2015 and "not paid" FFP based on those adjustments. AF at 38. It is true that CMS did not "recoup" FFP by issuing the disallowance, but that is because CMS deferred its payment of FFP with respect to the DSH payments reflected in the increasing adjustment. AF at 37-38; 42 C.F.R. § 430.40. In short, we see nothing in the November 2016 disallowance notice indicating that CMS regarded the increasing adjustment for FY 1995 as anything other than a claim against the State's most recent quarterly Medicaid grant (for the quarter ending December 31, 2015).

The State also contends that its position is "fully consistent with the line of Board cases that have rejected States' efforts to re-categorize costs, more than two years after the underlying expenditures were made, to access an increased federal match." Mo. Br. at 12. However, the State cited only one Board decision to illustrate its point – *New Jersey Department of Human Services*, DAB No. 1655 – and that decision tends to support CMS's position. In that case, an appeal of a title IV-D (child support enforcement) disallowance, the state of New Jersey timely sought and received FFP for certain program expenditures, but later requested additional FFP for the same expenditures based on an "enhanced" FFP rate. DAB No. 1655, at 3-4. The Administration for Children and Families denied the request for additional FFP as an untimely claim under section 1132(a). *Id.* at 1, 5. The State responded that its request for enhanced FFP was not a "separate claim" barred by the two-year filing rule but merely "*corrected* the FFP rate in its previous, timely filed claims[.]" *Id.* at 4, 5 (italics added). The Board rejected that argument, noting that the request for reimbursement at the enhanced rate "represented the first filing in which New Jersey sought enhanced FFP for the [underlying expenditures] in the manner prescribed by the Secretary's instructions, resulting in a new claim for . . . FFP . . ." *Id.* at 6. Similarly, in the case before us, the increasing adjustment for FY 1995 was the first filing in which the State identified and requested FFP for \$9.9 million in mental health DSH payments in the manner required by Medicaid program regulations and instructions (that is, by reporting them on line 2B of the appropriate QSE schedule), resulting in a claim with respect to those expenditures.

We find significant the State's acknowledgment that its increasing adjustments on line 2B for FYs 2014 and 2015 (discussed later) – which were paired with decreasing adjustments of equal magnitude on line 1B – "can arguably be characterized as 'claims' because they move items from a category ineligible for FFP (IMD DSH claims on an acute care line) to an eligible line (mental health DSH)." Mo. Br. at 13. The State does not explain why that reasoning is inapplicable to its base-year (FY 1995) increasing adjustment, which likewise moved mental health DSH payments from the acute care line (1B) to the mental health DSH line (2B).

Finally, to accept the State’s position that the base-year increasing adjustment is not a “claim” would arguably deprive the Board of authority to resolve any issue concerning it. The Board’s jurisdiction over disputes arising in mandatory grant programs such as Medicaid is limited to “disallowances.” *See* 45 C.F.R. Part 16, Appendix A, ¶ B(a)(1). If, as the State contends, the increasing adjustment for FY 1995 is not a “claim” and CMS’s determination regarding the adjustment was issued only for “reporting purposes,” then it follows that no disallowance (no denial of a request for FFP) has occurred, in which case any dispute regarding the adjustment’s validity is not properly before the Board.

For the reasons stated above, we conclude that the increasing adjustment for FY 1995 is a “claim” within the meaning of section 1132(a) of the Act and 45 C.F.R. § 95.7.

*B. Missouri did not file its claim for the FY 1995 increasing adjustment within two years after the quarter(s) in which the mental health DSH payments were made; thus, CMS properly disallowed the adjustment under section 1132(a) of the Act and 45 C.F.R. § 95.7.*

As stated earlier, the two-year filing requirement in section 1132(a) applies to both initial claims with respect to a quarter’s expenditures and to prior-period adjustments, such as those at issue here, that increase an FFP amount previously sought for an expenditure or category of expenditures. *Ga. Dep’t of Cmty. Health* at 12. “In other words, section 1132(a)” and section 95.7 “not only bar[] payment on account of any expenditure ‘if claim therefore is not made within’ the two-year period following the quarter in which the expenditure was made, but requires a state to make *any* FFP request *with respect to* the expenditure within two years after the end of that quarter unless the request falls within an exception recognized in the applicable statute and regulations.” *Id.* at 12-13 (quoting section 1132(a)) (italics in original). “In practical terms, this means that, unless a statutory exception applies,” and none is alleged to apply here, “a state must complete the claims adjustment process with respect to a quarter’s expenditures within two years after that quarter ends or risk losing federal funding for otherwise eligible expenditures.” *Id.* at 13.

The State did not timely complete the claim-adjustment process with respect to its FY 1995 mental health DSH payments. Its prior-period adjustment with respect to those expenditures – which increased the total computable amount on line 2B by \$9,902,046 and the corresponding federal-share amount by \$5,926,375 – was filed on February 29, 2016 (AF at 58-59), many years after the calendar quarters in which the expenditures were made. That claim was therefore properly disallowed under section 1132(a) of the Act and 45 C.F.R. § 95.7.

C. *The State did not claim the increasing adjustment for the first quarter of FY 2014 within two years after the end of that quarter; thus, CMS properly disallowed that adjustment under section 1132(a) of the Act and 45 C.F.R. § 95.7.*

The disallowed increasing adjustment for the first quarter of FY 2014 is identical in form and character to the increasing adjustment for FY 1995: it reflects mental health DSH payments (to private IMDs) reported for the first time in the “manner and form” required by federal Medicaid regulations and instructions, and it constitutes a “claim” subject to the two-year filing rule in section 1132(a) of the Act and 45 C.F.R. § 95.7 (for the reasons discussed in part A of our analysis).

The increasing adjustment for the first quarter of FY 2014 (which ended December 31, 2013) reported \$1,042,662 in total computable mental health DSH payments allegedly made during that quarter and \$646,763 as the federal share of the total computable amount. *See* Mo. Br. at 13-14; AF at 65. Because that adjustment is a request for FFP in the reported DSH payments, the State should have made the adjustment, on the QSE, within two years after the end of the first quarter of FY 2014 – or by December 31, 2015. *Ga. Dep’t of Cmty. Health* at 12-13. The State did not do so, as it concedes. Mo. Br. at 14. CMS therefore properly disallowed the adjustment for that reason.

D. *The increasing adjustments for FY 2015 and the second, third, and fourth quarters of FY 2014 were properly disallowed in accordance with section 1923(h) of the Act.*

The increasing adjustments for FY 2015 and the second, third, and fourth quarters of FY 2014 were, as CMS agrees (Response Br. at 9), timely filed in accordance with section 1132(a) of the Act and 45 C.F.R. § 95.7. However, there is no dispute that these adjustments caused Missouri to exceed its IMD DSH limits for FYs 2014 and 2015 (as published by CMS in the Federal Register).

The State asserts that if those limits are revised to account for the base-year increasing adjustment – which increased by approximately \$9.9 million the amount previously reported on the State’s FY 1995 QSEs as “mental health DSH” – then sufficient room will exist under the revised limits to allow the increasing adjustments for FYs 2014 and 2015. Mo. Br. at 16-17. But, as we have just concluded, the claimed base-year increasing adjustment is unallowable because it was not timely filed in accordance with

section 1132(a) and 45 C.F.R. § 95.7. Section 1923(h) does not require CMS to revise, or permit the Board to disregard, a published IMD DSH limit based on an unallowable prior-period adjustment to a state's reporting of base-year mental health DSH payments.<sup>9</sup> On its face, section 1923(h) calls on CMS to determine the IMD DSH limit to reflect “*reporting data* specified by the State on [CMS] Form 64 as mental health DSH, and as *approved by the Secretary* [of Health & Human Services].” Act § 1923(h)(1)(A), (B) (italics added). The increasing adjustment claimed for FY 1995, while it constitutes “reporting data specified by the State” on a QSE, was *not approved* by CMS (the agency to which the Secretary has delegated authority to implement section 1923(h)), and its disapproval was legally valid for the reasons discussed above.

The State asserts that it “repeatedly sought to correct” CMS’s “preliminary” and “artificially low” IMD DSH limits for FYs 2014 and 2015 before those limits were finalized in the Federal Register. Mo. Br. at 17. The State implies that CMS acted in bad faith by not revising those limits to reflect the \$9.9 million in misreported base-year mental health DSH payments, and by instead disallowing the prior-period adjustments intended to correct the misreporting. *Id.* at 17-18. However, we see no evidence of bad faith or of arbitrary or irrational decision-making by CMS. We agree with CMS that the State’s predicament is largely the result of its unexplained failure to properly classify certain mental health DSH payments on the QSE. Furthermore, even if CMS had discretion to revise Missouri’s FY 2014 and 2015 IMD DSH limits based on the State’s belated expenditure reporting, it is not the Board’s role to decide whether CMS should have exercised that discretion. Our review in this case is limited to deciding whether the *disallowance* is supported by the facts and applicable law. We conclude that it is.

---

<sup>9</sup> Even if the base-year (FY 1995) adjustment had been timely made under section 1132(a) and was an otherwise allowable claim, that fact would not settle the separate issue of whether section 1923(h) required CMS, or permitted the Board, to revise Missouri’s IMD DSH limit calculations in order to account for the adjustment.

Conclusion

For the reasons outlined above, we affirm CMS's November 21, 2016 determination to disallow \$10,011,389 in FPP for the State's Medicaid program.

\_\_\_\_\_/s/  
Constance B. Tobias

\_\_\_\_\_/s/  
Susan S. Yim

\_\_\_\_\_/s/  
Sheila Ann Hegy  
Presiding Board Member