Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Georgia Department of Community Health
Docket No. A-11-112
Decision No. 2521
June 28, 2013

DECISION

The Georgia Department of Community Health (Georgia) has appealed a June 30, 2011 determination by the Centers for Medicare & Medicaid Services (CMS) to disallow $90,050,230 in federal financial participation (FFP) for Georgia's Medicaid program. Georgia requested that amount on a Quarterly Medicaid Statement of Expenditures (QSE) for the quarter ending June 30, 2009. CMS disallowed that request, finding it to be an untimely claim under section 1132(a) of the Social Security Act (Act),[1] 42 U.S.C. § 1320b-2(a), which provides that any claim for FFP with respect to a state's Medicaid expenditure be filed within two years after the quarter in which the state makes the expenditure. The parties disagree about whether Georgia's request for $90,050,230 is, in fact, a claim for FFP subject to the two-year limit in section 1132(a).

We conclude that Georgia's request for $90,050,230 is a claim for FFP, that it was untimely under section 1132(a), and that it is not exempt from the two-year rule under CMS's provider overpayment regulations. For these and other reasons, we affirm the disallowance in its entirety.

Legal Background

1. *FFP claims for Medicaid expenditures and the two-year rule*

Under 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 the Department of Health and Human Services (HHS) is eligible to receive FFP (*i.e.*, federal matching funds) for a percentage of its Medicaid program expenditures

[1] The current version of the Social Security 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.

that are 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.

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 QSE. 42 C.F.R. § 430.30(c)(1). The QSE (form CMS-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).[2] The QSE "reconciles the monetary advance [of FFP] made on the basis of [the estimate] filed previously for the same quarter."[3] 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"); 42 C.F.R. § 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 the U.S. Department of Health & Human Services (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 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

[2] The State Medicaid Manual is a vehicle for communicating federal Medicaid policies and procedures to state Medicaid agencies. *See* SMM, *Forward*. Among other things, the manual contains detailed instructions concerning the reporting of Medicaid expenditures on a QSE. *Id.* § 2500.1-.2; CMS Ex. 6 ¶ 3. Relevant portions of the manual are found in CMS Exhibit 5. The entire manual is available online at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html (last visited June 28, 2013).

[3] The QSE also serves as the "vehicle for making adjustments for any identified overpayment and underpayment" of FFP to a state. SMM § 2500(A). The statute and regulations require that a state's estimate (on form CMS-37) of federal funding needs for a quarter be "reduced or increased to the extent of any overpayment or underpayment" that CMS determines was paid to the state in the prior quarter. Act § 1903(d)(2)(A); 42 C.F.R. § 430.30(b)-(d).

years after the quarter in which the expenditure was made. In establishing the 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. *Minnesota Dept. of Human Services*, DAB No. 1791 (2001); *Connecticut v. Schweiker*, 684 F.2d 979, 982, 994-95 (D.C. Cir. 1982), *cert. denied*, 459 U.S. 1207 (1983); 46 Fed. Reg. 3527, 3527 (Jan. 15, 1981) (stating that the purpose for the two-year filing deadline "is to enable HHS to know the total amounts of its obligations for each fiscal year within a reasonable time after the end of the year").

2. *Mechanics of FFP claiming*

Some additional explanation of the mechanics of claiming FFP on a QSE is helpful in understanding the history of, and legal arguments in, this case. The QSE consists of several schedules on which the state reports expenditures made by its Medicaid program on various categories of "medical assistance" (*e.g.*, inpatient hospital services, physician services, nursing home care) and program administration. *See* SMM §§ 2500.1(A), 2500.2; *Connecticut Dept. of Social Servs.*, DAB No. 1982, at 4 n.2 (2005); Ga. Exs. 8, 10, 13. For each expenditure category, the schedules also show what the state believes to be the federal government's share of those expenditures. SMM § 2500.2.

On the QSE "base" schedules (CMS-64.9 and 64.10), a state identifies, by expenditure category, the amount of expenditures made during the most recently completed quarter, known as the "current quarter," and the amount of FFP requested for each category (as computed using the applicable federal matching rate). SMM §§ 2500.2. Different schedules (CMS-64.9p and 64.10p) show expenditure amounts that constitute "increasing" or "decreasing" adjustments related to a "prior period" (a prior period is a period that predates the current quarter). *Id.* § 2500.2(A). Such prior-period adjustments must be made because, for any number of reasons, 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. In such circumstances, a state uses a later quarter's QSE to adjust retroactively, either up or down, expenditure amounts reported on the earlier quarter's QSE or the federal share claimed with respect to those expenditures. SMM §§ 2500(C) ("If you later determine that an expenditure report submitted for a given quarter did not contain all expenditures for that quarter, include the additional expenditures on the next Form [CMS]-64 report as a prior period adjustment"), 2500(D)(2) ("Make adjustments to reflect the correct FMAP [federal medical assistance percentage] rate in subsequent HCFA-64 forms as adjustments to prior period claims"), 2500.1(B) (instructions for lines 7 and 10.B), and 2500.2(A) and (F) (instructing where to enter adjustments to amounts claimed in prior periods). Another schedule (CMS-64.9o), to which we refer later (*see footnote* 8), reports the amount of FFP refunded to CMS during the quarter on account of a state's "overpayments" to Medicaid providers. *Id.* § 2500.4.

Data on the various expenditure schedules are summarized on lines 6 through 11 of the QSE's "Summary Sheet" (henceforth, any mention of a "line" in the QSE refers to a line on the Summary Sheet). SMM § 2500.1; *see also* CMS Ex. 6 ¶ 3. Expenditure amounts, including the total of increasing adjustments, are aggregated on lines 6, 7, and 8.[4] SMM ¶ 2500.1(B). Line 9 is designated for "recoveries" and "collections" by the state. *Id.* On lines 10.A through 10.D, the state enters the total of any "adjustments *decreasing* claims for prior quarters" – that is, the total of decreasing adjustments for prior periods. *Id.* (italics added). A state is instructed to report all decreasing adjustments on line 10.B. except for those relating to "audit adjustments" (which are reported on line 10.A) and *overpayments* (which are reported on line 10.C). *Id.* Finally, line 11 shows the quarter's "net expenditures" and the claimed federal share of those expenditures. *Id.* Net expenditures are equal to the sum of lines 6, 7, and 8 minus the sum of lines 9 and 10. *Id.*; CMS Ex. 6 ¶ 3.

3. *Accounting on the QSE for provider "overpayments"*

In the context of this case (and referring specifically to line 10.C of the QSE), an "overpayment" means "the amount paid by a [state] Medicaid agency to a provider [a provider being "any individual or entity furnishing Medicaid services under a provider agreement with the Medicaid agency"] which is in excess of the amount that is allowable for services furnished under section 1902 of the Act and which is required to be refunded under section 1903 of the Act." 42 C.F.R. § 433.304 (cross-referencing 42 C.F.R. § 400.203). In other words, an overpayment is a payment to a provider that is, for any one of various reasons, unallowable under the state's Medicaid plan and therefore ineligible for FFP.[5] When a state has claimed FFP for a provider payment that is later determined to constitute an overpayment, the state must (with a few inapplicable exceptions[6]) report a decreasing adjustment that reduces the FFP claimed for the current quarter. *See* Act § 1903(d)(2)(A), (D); 42 C.F.R. § 433.312.

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[4] On line 6, which aggregates expenditure and federal share amounts on the QSE's "base" schedules, a state enters the total of Medicaid program expenditures – for all medical assistance and administrative cost categories – reported for the current quarter as well as the total "federal share" associated with those expenditures. SMM § 2500.1(B). Line 7 shows the total of all "adjustments *increasing* claims for expenditures in prior periods" – that is, entries on schedules 64.9p and 64.10p of the QSE that increase the amount of FFP requested for quarters predating the current quarter. *Id.* (italics added). Line 8 is for "other expenditures," a catchall category for expenditure amounts not reported on lines 6 and 7. *Id.*

[5] The State Medicaid Manual states that "[o]verpayments are not considered payments made in accordance with [a state's] approved State plan and, therefore, are not allowable for FFP," and that "examples" of overpayments include "duplicate payments," "payments for noncovered services," "payments to the wrong provider," and "payments made at incorrect rates." SMM § 2500.6(A).

[6] A state is not obligated to refund the federal share of an overpayment when the overpaid provider has been determined to be bankrupt or out of business. 42 C.F.R. § 433.312(b).

The Medicaid statute and CMS's provider overpayment regulations specify when and how the FFP refund must be made. *See* Act § 1903(d)(2); 42 C.F.R. § 433.312. When the events at issue in this case occurred, a state had "60 days from the date of discovery of any overpayment to a provider to recover or seek to recover the overpayment" before it was required to "refund" the "Federal share." 42 C.F.R. § 433.312(a)(1) (Oct. 1, 2010).[7] At the end of that 60-day period, and regardless of whether the Medicaid payment was recovered, a state was obligated to credit CMS with the federal share of that payment on the QSE "for the quarter in which the 60-day period following discovery . . . end[ed]."[8] *Id.* §§ 433.312(a)(2), 433.320(a)(2)-(3).

Case Background

There is no disagreement about the circumstances that led CMS to issue the challenged disallowance. During the period relevant to the parties' dispute, Georgia tracked, in a "provider receivables" account, the cumulative total of Medicaid payments that had been made to healthcare providers (such as hospitals) but which were later determined to be owed back to Georgia. *See* Ga. Ex. 19 ¶¶ 3, 6. Georgia also kept track of which receivables were more than 60 days old in order to determine what amount to credit CMS as the federal share of receivables that constituted provider overpayments. *Id.* ¶ 3. (As previously indicated, Georgia was obligated to credit CMS with the federal share of any Medicaid overpayment that was 60 days old, measured from the date of the overpayment's discovery.)

Between 2003 and 2005, Georgia accumulated a substantial amount of provider receivables due to problems with its Medicaid Management Information System (MMIS), which processes payment claims submitted by health care providers for the items and services they furnish to Medicaid beneficiaries. Ga. Ex. 19 ¶¶ 3-6. In 2003, Georgia launched a new MMIS system called MultiHealthNetwork (MHN). *Id.* ¶ 4. Soon after MHN's launch, Georgia discovered that it had serious flaws that caused significant delays in processing and paying Medicaid providers' claims. *Id.* ¶ 5.

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[7] For overpayments discovered after March 23, 2010, the Patient Protection and Affordable Care Act increased the period for reporting the overpayment following discovery from 60 days to one year. Pub. L. No. 111-148, § 6506(a)(1)(A)(i), 124 Stat. 119 (2010) (*codified in* Act § 1903(d)(2)(C)).

[8] The State Medicaid Manual instructs a state to enter the federal share of overpayments as a decreasing adjustment on line 10.C and to use schedule CMS-64.9o – a schedule supporting line 10.C of the Summary Sheet – to determine the amount of that adjustment. SMM §§ 2500.1(A), 2500.1(B) (instructions for line 10.C), and 2500.4(A)(5); *see also* CMS Ex. 6 ¶ 3. For purposes of this decision, we distinguish a "decreasing adjustment" on line 10 from a "downward adjustment" to an overpayment (a term used in CMS's provider overpayment regulations). We will use the term "decreasing adjustment" to mean an entry on the QSE that reduces a prior-period FFP claim. *See* SMM § 2500.1(A)-(B). On the other hand, and as we elaborate later, the term "downward adjustment" means a determination by the state to reduce the amount of a previously identified provider overpayment. *See* 42 C.F.R. § 433.320(c).

Providers complained that they could not remain operational without prompt and accurate payment of their Medicaid claims. *Id.* ¶ 6; *see also* CMS Ex. 8, at 2.

Responding to this concern, Georgia proposed, and CMS agreed, that until MHN's flaws were corrected, Georgia could make "advance" payments to providers – that is, make payments to providers prior to the submission and processing of appropriate payment claims for the services – with the understanding that the advance payments would later be matched and reconciled with actual payment claims once the MHN was able to process them. Ga. Ex. 19 ¶ 6; Ga. Ex. 4 (Sept. 30, 2003 e-mail from H. Webster (CMS) to M. Trail, Medicaid Dir., Ga. Dept. Cmty. Health). Under this arrangement, Georgia made approximately $2 billion in advance Medicaid payments to providers between April 1, 2003 and June 30, 2005.[9] Ga. Ex. 19 ¶ 6.

For internal accounting purposes, Georgia classified these advance payments as provider receivables. Ga. Ex. 19 ¶ 6. For purposes of FFP claiming, Georgia reported advance payments as current-quarter expenditures on the QSE for the quarter in which it made those payments. *Id.* Advance payments that were not reconciled with provider-submitted payment claims within 60 days were treated by Georgia as overpayments, and the federal share of those purported overpayments (together with the federal share of overpayments unrelated to Georgia's MMIS problems) was credited to CMS via decreasing adjustments on line 10.C of the QSE. *Id.* ¶ 7; Ga. Ex. 8; CMS Ex. 6 ¶ 12.[10] When a previous quarter's advance payment was reconciled with an approved provider claim, Georgia included the payment in its calculation of expenditures shown on line 8 of the QSE. Ga. Ex. 19 ¶ 8.

As of June 30, 2005, the end of state fiscal year (SFY) 2005, the total (or cumulative) balance of "60-day receivables" in Georgia's provider receivables account was approximately $60.7 million. Ga. Ex. 19 ¶ 10. The federal share of the 60-day receivables balance – that is, the federal funds used by Georgia to make the provider payments classified as receivables – was approximately $37.4 million. *Id.* Georgia submitted undisputed evidence that it had credited that federal share to CMS via decreasing adjustments on QSEs submitted between 1989 and June 2005. *Id.* Most of that crediting related to the advance Medicaid payments made between 2003 and 2005 in response to Georgia's MMIS problems. *Id.* ¶¶ 6, 10.

[9] The amount of an advance payment was based on the provider's prior Medicaid claims and payment history. Ga. Ex. 19 ¶ 6; CMS Ex. 8, at 2.

[10] These 60-day receivables had not, strictly speaking, actually been determined to be overpayments owed to Georgia by the providers since the actual allowable claims had not been reconciled to the advance payments made to the providers but Georgia included these amounts in its provider receivables without tracking the distinction.

In addition to 60-day receivables for which Georgia had refunded the federal contribution of $37.4 million, Georgia's provider receivables account as of June 30, 2005 reflected receivables that were less than 60 days old (that is, provider payments owed back to Georgia that were identified less than 60 days prior to June 30, 2005) and other receivables related to Georgia's pharmacy program. Ga. Ex. 19 ¶ 10. The federal share of these other provider receivables totaled approximately $7.6 million. *Id.* (Georgia does not allege that it refunded the federal share of these other receivables prior to June 30, 2005.)

In short, as of June 30, 2005, the federal share of Medicaid payments reflected in Georgia's provider receivables account consisted of:

- $37,402,375.33 for 60-day receivables, an amount that Georgia had credited to CMS on QSEs submitted between 1989 and June 30, 2005; and

- $7,622,739.76 for the less-than-60-day and pharmacy program receivables, none of which had been refunded to CMS as of June 30, 2005.

The total federal share of the June 30, 2005 provider receivables balance was $45,025,115.09 (the sum of $37,402,375.33 and $7,622.739.76).

For reasons which Georgia failed to make clear (despite numerous opportunities to do so), Georgia decided to report $45,025,115.09 as a "liability" on its financial statements for SFY 2005. Ga. Ex. 19 ¶ 9. In the process of preparing those statements, Georgia "inadvertently" included $45,025,115.09 in its calculation of a decreasing adjustment for inpatient hospital services on the QSE for the quarter ended September 30, 2005 ("September 2005 QSE").[11] *Id.* ¶ 11. (As indicated, a decreasing adjustment is an entry on the QSE that reduces FFP claims for periods predating the current quarter to which the QSE relates.)

At the end of SFY 2006, Georgia again sought to have the outstanding provider receivables balance reflected on its annual financial statements. Ga. Ex. 19 ¶ 12. In the process, however, Georgia inadvertently included another $45,025,115 in its calculation of a decreasing adjustment for inpatient hospital services, this time on the QSE for the

[11] The record shows that the amount of the decreasing adjustment for inpatient hospital services on the September 2005 QSE was $29,735,653. Ga. Ex. 8 (form CMS-64.9p, line 1A). Georgia calculated that amount by subtracting $15,289,462 (the amount of a prior-period increasing adjustment) from $45,025,115; the difference – or $29,735,653 – was entered on line 1A of the schedule supporting line 10.B of the QSE's Summary Sheet. *Id.*; Ga. Br. at 10 n.9.

quarter ended June 30, 2006 ("June 2006 QSE").[12] *Id.* Hence, Georgia twice included $45,025,115 on QSEs in calculating decreasing adjustments for prior periods, effectively crediting CMS with a total of $90,050,230 in FFP. (From this point forward, we round off these numbers to $45 million and $90 million, respectively.)

An audit of Georgia's 2008 financial statements found significant shortcomings in Georgia's ability to track and report accurately "account receivables due from the federal government" and to detect errors on its financial statements. CMS Ex. 9. That finding triggered an in-depth internal review by Georgia of its financial records and prior quarters' QSEs. Ga. Ex. 19 ¶ 14. During that review, Georgia discovered that it had twice erroneously credited $45 million in FFP to CMS. *Id.*

Georgia then attempted to undo its errors by including $90 million on line 8 of the Summary Sheet of its QSE for the quarter ended June 30, 2009 ("June 2009 QSE").[13] CMS Ex. 6 ¶ 6; Ga. Ex. 19 ¶ 16. (Line 8 is designated for "other expenditures.") In a "footnote" to the June 2009 QSE, Georgia stated that the basis for the "$90M claimed in [that] quarter" was "as an adjustment to 60 day receivables." Ga. Ex. 13. The schedule supporting line 8 identified that "adjustment" as relating to expenditures made during 2005 for inpatient hospital services. CMS Ex. 4, at 5 (form CMS 64.9p, line 1A); *see also* SMM § 2500.2 (A) (explaining that prior period expenditures shown on line 8 should be reflected on schedule CMS-64.9p with expenditures identified by year); *id* § 2500.1(A) (indicating that schedule CMS-64.9p is used to support the entry on line 8).

On June 30, 2011, CMS notified Georgia that it was disallowing $90 million in FFP for the quarter ended June 30, 2009. Ga. Ex. 17. In issuing the disallowance, CMS acknowledged that Georgia was attempting to reverse two "erroneous credit adjustments to inpatient hospital service expenditures" but concluded that the request for $90 million on the June 2009 QSE should be disallowed because it was submitted more than two years after the quarter in which "the original State payment was made." *Id.*; *see also* CMS Ex. 6 ¶ 7.

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[12] In calculating the decreasing adjustment for inpatient hospital services on the June 30, 2006 QSE, Georgia subtracted an increasing adjustment of $382,414 from $45,025,115 and entered the difference – or $44,642,700 – on line 1A of the schedule supporting line 10.B of the Summary Sheet. CMS Ex. 10 (form CMS-64.9p); Ga. Br. at 11n.11.

[13] Georgia initially attempted to reverse the two $45 million credits by entering $90 million on line 6 of its QSE for the quarter ended March 31, 2009 but, after meeting with CMS, removed that entry. Ga. Ex. 19 ¶ 15; CMS Ex. 6 ¶ 6; CMS Ex. 7 ¶ 3.

After the parties submitted their briefs, the Board held oral argument in this case on October 25, 2012. On February 8, 2013, the Board issued a "Preliminary Analysis" in which we rejected the arguments of both parties and set forth our view of the case. Both parties subsequently submitted written comments to that analysis.

Discussion

As indicated, section 1132(a) of the Act establishes a two-year limit for filing FFP claims. The Secretary of HHS has implemented that statute in regulations. *See* 45 C.F.R. §§ 95.1-.34. Those regulations state that "[HHS] will pay a State for a State agency expenditure . . . only if the State files a *claim* with [HHS] for that expenditure within 2 years after the calendar quarter in which the State agency made the expenditure." *Id.* § 95.7. The regulations define a "claim" to mean a "*request for Federal financial participation* in the manner and format required by [the federal agency's] program regulations, and instructions or directives issued thereunder." *Id.* § 95.4 (italics added). "Federal financial participation" is defined to mean "the Federal government's share of *an expenditure* made by a State agency . . . ." *Id.* (italics added). Hence, under these definitions, a "claim" is a request for the federal government's share of an expenditure and must be filed within two years after the quarter in which the expenditure was made.

Section 1132(a) specifies three exceptions to the two-year limit (for audit exceptions, court-ordered retroactive payments, and adjustments to prior year costs). *See also* 45 C.F.R. § 95.19. In addition, section 1132(b) authorizes the Secretary to waive application of the two-year limit to a claim that is filed outside the two-year period prescribed in section 1132(a) if a state shows "good cause" for failing to file the claim within that period. Georgia does not contend that any statutory exception applies and has informed us that it is not appealing the denial of a good cause waiver. Ga. Br. at 28; Transcript of Oct. 25, 2012 Oral Arg. (Tr.) at 6. Instead, Georgia contends that the two-year limit is, by its own terms, inapplicable and that the disallowance should be reversed for that reason. Feb. 27, 2013 Comments of Ga. Dept. of Cty. Health on Prelim. Analysis (PA Comments) at 2-5. We reject that contention, however, for the reasons discussed below.

1. *Georgia's request for $90 million on the June 2009 QSE is a "claim" subject to the two-year limit in section 1132(a) of the Act and the corresponding regulations.*

According to Georgia, the $90 million QSE entry is not a "claim" subject to the timely claims limits. Georgia argues that the two-year limit in section 1132(a) applies only to a request for federal matching funds for expenditures that a state delays in reporting for more than two years. Ga. Br. at 15-16 (stating "[t]he two year claiming limit . . . on its face applies only to claims for FFP for 'expenditures'"); Reply Br. at 1 (stating that the two-year rule "precludes federal reimbursement only of expenditures that States delay in

reporting"). Georgia contends that the two-year limit is inapplicable to its request for $90 million on the June 2009 QSE because that request does not seek federal funds to reimburse it for expenditures that it delayed reporting for more than two years (or for any other expenditures) but merely sought the recovery of "state funds . . . erroneously credited to CMS" on September 2005 and June 2006 QSEs. PA Comments at 1-2; *see also* Ga. Br. at 1, 15-17; Tr. at 5 (asserting that the two-year filing rule does not apply "because the $90 million is not a claim for federal reimbursement of expenditures"). Georgia asserts that "[t]here is no time limit on correcting an erroneous credit," and that there is no provision of the Medicaid statute and regulations which authorizes CMS to retain funds erroneously credited it to it. Ga. Br. at 1, 18, 26. To support the assertion that its request for $90 million did not involve delayed reporting of expenditures, Georgia points out that the federal share of the June 30, 2005 provider receivables balance that was inadvertently credited to CMS on the September 2005 and June 2006 QSEs reflected provider payments for which it had timely reported and claimed FFP on QSEs submitted prior to June 30, 2005. Reply Br. at 4.

Georgia's contention that its request for $90 million is not subject to the two-year limit cannot be squared with the Medicaid statute or regulations or with program instructions and directives concerning the submission of Medicaid FFP requests. Section 1132(a) expressly covers "any" request for federal funding "with respect to" a state's expenditures, and the QSE is the required "manner and format" for requesting FFP. *See* 45 C.F.R. § 95.4; 42 C.F.R. § 430.30(c)(1). Amounts reported as expenditures on the QSE are those which a state asks to be charged against the FFP award that is made in advance of the quarter to which the QSE relates. *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). Here, Georgia included $90 million in its calculation of "other expenditures" (line 8 of the Summary Sheet) that it sought to charge against its FFP award for the quarter ending June 30, 2009. That request was, of necessity, "with respect to" Georgia's Medicaid program expenditures because FFP is, in this context, available *only for expenditures* on medical assistance or Medicaid program administration. Act §1903(a) (1)-(2); 42 C.F.R. § 435.1000 *et seq*.; 45 C.F.R. § 95.13(d) (providing that a Medicaid expenditure occurs when a state agency makes a payment to a provider).

We see nothing on the face of the June 2009 QSE which required CMS to construe the inclusion of $90 million on line 8 of the QSE as anything other than a "claim" (request for FFP) subject to the two-year limit. Georgia supported its request for $90 million with a schedule showing, as a prior-period adjustment, $90 million of expenditures for inpatient hospital services. CMS Ex. 4, at 5. By including $90 million on line 8 of the QSE, Georgia represented that the expenditures were, in fact, eligible for FFP. *Cf. New Jersey Dept. of Human Servs.*, DAB No. 1655, at 6 (1998) (stating an evaluation of "how costs are claimed on departmental forms . . . is integral to determining whether, under applicable legal standards, a claim has been made"). Georgia points to nothing in the

applicable statutes, regulations, or program manuals suggesting that FFP may be claimed "with respect to" something other than an expenditure, such as an erroneous credit. We therefore conclude that Georgia's request for $90 million is a request for FFP – *i.e.*, a "claim" – subject to the two-year limit.

2. *Georgia's request for $90 million in FFP was not filed within the two-year limit established in section 1132(a) of the Act.*

Having determined that Georgia's inclusion of $90 million on the June 2009 QSE was a request for FFP "with respect to" Medicaid expenditures, and therefore subject to the two-year limit in section 1132(a), we must identify what those expenditures were in order to determine whether Georgia filed its claim within that limit. In this context, an "expenditure" means a Medicaid payment by the state to a health care provider. 45 C.F.R. § 95.13(b).

According to Georgia, its $90 million claim relates to provider payments that were made prior to June 30, 2005 and which were later deemed to constitute overpayments or other amounts owed to Georgia (and reflected in Georgia's June 30, 2005 provider receivables balance). *See* Ga. Br. at 1 ("stating that its request for $90 million was "related to provider receivables" that it had credited to CMS). With respect to those expenditures, Georgia's $90 million claim is clearly untimely. Georgia does not suggest that the claim was made "with respect to" any expenditures other than the pre-June 30, 2005 provider payments.[14]

Georgia emphasizes that it timely reported the provider payments in question on QSEs submitted prior to June 30, 2005. However, that fact does not render the two-year limit inapplicable to its 2009 claim for $90 million. The Medicaid regulations and State Medicaid Manual establish a grant award process that requires states to verify that federal Medicaid funds are expended for purposes and at levels consistent with the state plan and federal requirements and to ensure that the appropriate federal matching rate is applied to eligible expenditures. *See* 42 C.F.R. § 430.30-.35; SMM § 2497.4 (stating that a claim "must be supported by sufficient documentation to assure that the expenditure was made on behalf of an eligible recipient for covered services rendered by a certified provider"). As explained earlier, that process permits, and in some instances requires, a state to make retroactive "adjustments" on a QSE concerning claims made on a previous quarter's QSE. *See, e.g.*, SMM § 2500(A)(1) (instructing a state that is "unable to develop and

[14] The claim is untimely even if the relevant expenditures were made in 2005, as the schedule supporting line 10.B of the June 2009 QSE seems to indicate. CMS Ex. 4, at 5 (line 1A).

document a claim for expenditures on a current basis" to "withhold it until the actual amount, supported by final documentation, has been determined" and to report the amount on a future QSE as a "prior period adjustment"). This ongoing adjustment process may result in a state making multiple claims, on different or successive QSEs, concerning a quarter's expenditures for a particular category of medical assistance (hospital services, for example) or program administration.

Assume, for example, that a state makes $10 million in expenditures on inpatient hospital services during quarter one (Q1) and submits a QSE for Q1 that seeks FFP for those expenditures at the 60 percent matching rate. If the state determines later (after filing the QSE for Q1) that it was eligible for FFP for those expenditures at a higher matching rate (say, 70 percent), then the state may request additional FFP (up to the 70 percent rate) for the Q1 expenditures by making an appropriate increasing adjustment – one that increases the amount of FFP requested for the expenditures made during the prior quarter on inpatient hospital services – on a subsequent QSE. In that circumstance, the request for additional FFP (as a consequence of applying the higher federal matching rate) would be barred by the two-year rule unless it was filed within the two-year period established by section 1132(a), even if the underlying expenditures were reported on a prior quarter's QSE. *See, e.g., Connecticut Dept. of Social Services*, DAB No. 1982 (2005).[15]

In general, the requirement to file a claim within the two-year limit applies to any FFP request, whether it is the initial claim for a quarter's expenditures or some prior-period adjustment concerning them. *See, e.g.*, *Connecticut v. Schweiker*, 684 F.2d at 982 (noting that prior to enactment of the timely claims limits, states regularly claimed FFP for previously unreported expenditures incurred in earlier quarters, and the absence of any time limits on such "prior-period adjustments," which "are, in effect, claims for reimbursement for earlier expenditures," made it "difficult for HHS to plan and administer the budget"). In other words, section 1132(a) not only bars 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

[15] In *Connecticut* and in *New Jersey*, DAB No. 1655 (1998), the states had timely requested FFP for certain expenditures at some rate. Each state later determined that it was entitled to FFP for those expenditures at a higher rate and requested additional reimbursement based on the higher rate more than two years after the quarters in which the expenditures were made. The Board held in these cases that the request for additional FFP based on the higher rate was a claim subject to the two-year rule, rejecting the states' argument that the rule did not apply because the state's second claim did not report any additional expenditures and because timely claims had already been made for the expenditures at the lower rate.

unless the request falls within an exception recognized in the applicable statute and regulations. In practical terms, this means that, unless a statutory exception applies, 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.

Here, Georgia's claim for $90 million for the quarter ending June 30, 2009 was the last in a series of prior-period adjustments concerning Medicaid provider payments (expenditures) reflected in Georgia's June 30, 2005 provider receivables balance. Those provider payments were made at various times between 1988 and 2005, and the record indicates that Georgia requested and received FFP for those payments prior to June 30, 2005. *See* Ga. Ex. 19 ¶ 10. For a large percentage of those provider payments (mainly the advance payments made as a result of MMIS problems), Georgia credited back to CMS the federal share prior to June 30, 2005, having determined that the payments constituted, or should be treated as, overpayments under the 60-day rule. *Id.* ¶ 7. Georgia presumably performed the pre-June 30, 2005 crediting – totaling approximately $37.4 million, according to Georgia – by entering decreasing adjustments to its previously-submitted-and-approved claims for the same expenditures. *See* CMS Ex. 6 ¶ 3 (discussing the procedures for refunding the federal share of an overpayment on the QSE). In addition to the provider payments for which Georgia had refunded the federal share prior to June 30, 2005, the provider receivables balance as of that date reflected provider payments for which Georgia had received FFP but not yet refunded the federal share (which was approximately $7.6 million). Ga. Ex. 19 ¶ 10.

After June 30, 2005, Georgia made decreasing adjustments concerning the provider payments reflected in the June 30, 2005 provider receivables balance when it credited CMS with $45 million on the September 2005 QSE and an additional $45 million on the June 2006 QSE. Each credit was reflected in the amount reported on the schedule (CMS-64p) supporting line 10.B of the QSE, which is designated for decreasing adjustments, and was identified as relating to payments for inpatient hospital services.[16] *See* Ga. Exs. 8, 10; Ga. Br. at 10-11; SMM § 2500.1(B) (instructions for line 10.B). By twice including $45 million in its calculation of a decreasing adjustment for those services, Georgia signaled to CMS (in the absence of a contrary explanation) that it was reducing prior-period claims for that medical assistance category. Georgia concedes that the $45 million credits were prior-period adjustments relating to the pre-June 30, 2005 provider

[16] Georgia explained that the credits were entered on the QSEs in this manner because it believed that the "bulk" of the advance provider payments reflected in the June 30, 2005 provider receivables balance had been made to hospitals for inpatient hospital services. Ga. Ex. 19 ¶ 16.

payments when it asserts that the "[t]he ultimate effect [of the $45 million credits] was to increase the amount of reported [60-day] provider overpayments, *thereby refunding to CMS a second and third time the federal share* for the same provider overpayments that Georgia had already refunded on a quarterly basis from 1988 through 2005."[17] Reply Br. at 11 (italics added). Moreover, as discussed below, Georgia did not identify the decreasing adjustments as refunds of provider overpayments that might later be reclaimed. Thus, the decreasing adjustments at issue here are analogous to the decreasing adjustment in *Ohio Dept. of Human Resources*, DAB No. 1595 (1996), which the Board found constituted a withdrawal of an earlier FFP claim.

Finally, Georgia's claim for $90 million on the June 2009 QSE was another prior-period adjustment (this one an increasing adjustment) with respect to the same pre-June 30, 2005 provider payments. Georgia implicitly acknowledged this fact when its witness indicated that the claim represented "prior period adjustments for inpatient hospital services" and when it noted on the June 2009 QSE that the claim was "an adjustment to 60 day receivables," referring to provider payments reflected in Georgia's June 30, 2005 provider receivables balance. Ga. Ex. 19 ¶ 16; Ga. Ex. 13; CMS Ex. 4, at 1. Thus, the expenditures at issue – that is, the provider payments made prior to June 30, 2005 – were no longer included in the amount of FFP that Georgia had previously reported for prior quarters, and the FFP request with respect to those expenditures on the June 2009 QSE was untimely.

CMS originally argued that the $90 million claim relates to Medicaid program expenditures that were reported on the September 2005 and June 2006 QSEs but that were offset by the $45 million credits in calculating "net expenditures" on line 11 of the QSEs' Summary Sheets. Response Br. at 17-18. According to CMS, the September 2005 and June QSEs did not represent a "claim" for any expenditures that were offset (or netted out) by the $45 million credits because it is the "total on Line 11 [that is, total net expenditures] that constitutes the request for payment of FFP." *Id.* at 17. CMS asserts that the request for $90 million on the June 2009 QSE was Georgia's initial – but untimely – attempt to claim FFP with respect to those netted-out expenditures. *Id.* at 18-19. We disagree.

As explained above, the relevant expenditures – that is, the expenditures "with respect to" which the $90 million claim was made – are the provider payments made on or before June 30, 2005 and reflected in the June 30, 2005 provider receivables balance. CMS does not cite any legal authority to support its argument that the $90 million claim was made

[17] As indicated, a portion of the June 30, 2005 provider receivables balance that was transferred to the QSE as decreasing adjustments on the September 2005 and June 2006 QSEs reflected pre-June 30, 2005 provider payments for which Georgia had not refunded the federal share as of June 30, 2005. As for those provider payments, the decreasing adjustments represented the first and second refunds of the federal share.

with respect to netted-out expenditures on the September 2005 and June 2006 QSEs. *See* Response Br. at 17 (pointing only to the declaration of a CMS Financial Management Group employee, CMS Ex. 6 ¶ 3, who did not cite any legal authority). Furthermore, 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 is inconsistent with the regulatory definition of a claim and the content and function of a QSE. When a state submits a QSE, it certifies that the amounts reported on the supporting schedules were actually made, supported by documentation, and are eligible for FFP (that is, made in accordance with the state plan and applicable federal requirements). *See* CMS Ex. 2, at 1 (cover sheet of form CMS-64 certifying that the information on the Summary Sheet and "Supporting Schedules" is "correct"). 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. SMM § 2500(A)(1). Contrary to CMS's assertions here, the QSE's Summary Sheet, on which line 11 appears, does not operate to present a single, unified "claim" for 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. *See* SMM §§ 2500.1(B), 2600(C).

In short, the record shows that the $90 million claim was submitted "with respect to" the pre-June 30, 2005 provider payments and increased the amount of FFP that had previously been requested for those payments in the manner and format required. It therefore had to be filed within two years after the quarter in which those expenditures were made. The claim was not filed within that period, and so it is barred under section 1132(a).

3. *Georgia's claim for $90 million on the June 2009 QSE was not a reclaiming of FFP based on a downward adjustment of overpayments.*

Georgia contends that if the Board determines that its request for $90 million on the June 2009 QSE is a "claim" (as we have just determined), then it is exempt from the two-year limit under 42 C.F.R. § 433.320(c), a provision in CMS's provider overpayment regulations. PA Comments at 7. Under those regulations, a state must refund the federal share of a provider overpayment within a specified period. However, in certain circumstances, a state may "reclaim" a previously refunded federal share. Section 433.320(c) states:

> If the *amount of an overpayment is adjusted downward* after the [state] agency has credited CMS with the Federal share, the agency may reclaim the amount of the downward adjustment on the [QSE]. Under this provision –
>
> (1) Downward adjustment to an overpayment amount previously credited to CMS is allowed only if it is properly based on the approved State plan, Federal law and regulations governing Medicaid, and the appeals resolution processes specified in State administrative policies and procedures;
>
> (2) *The 2-year filing limit for retroactive claims for Medicaid expenditures does not apply*. A downward adjustment is not considered a retroactive claim but rather a reclaiming of costs previously claimed.

42 C.F.R. § 433.320(c) (italics added). Hence, this regulation provides that when there has been a "downward adjustment" to the amount of a provider overpayment meeting the requirements of section 433.320(c)(1), a state may reclaim FFP that was previously refunded to CMS on account of the overpayment without regard to the two-year limit in section 1132(a).

Georgia contends that section 433.320(c) is applicable to its claim for $90 million "because the amount Georgia seeks to recover is tied to provider receivables" for which Georgia previously refunded the federal share. Ga. Br. at 21, 23. That contention, says Georgia, is supported by the following chain of facts:

- The $45 million credits on the September 2005 and June 2006 QSEs (the impetus for its $90 million claim) relate to provider overpayments reflected in Georgia's June 30, 2005 provider receivables balance;

- "Over 80% [of the total amount erroneously credited to CMS] corresponds directly to the federal share for 60-day provider receivables [as of June 30, 2005] that Georgia had already credited to CMS on a quarterly basis from 1988 to June 30, 2005";

- This crediting was done "pursuant to" section 433.320(a), which gave Georgia 60 days to recover or attempt to recover an overpayment before it was required to refund the federal share; and

- The federal share of the cumulative balance of 60-day receivables "was refunded again" when the $45 million credits were erroneously included on the September 2005 and June 2006 QSEs.

Reply Br. at 9-10; *see also* Ga. Br. at 22-23. Georgia asserts that because the $90 million claim relates to provider overpayments for which it had refunded the federal share prior to June 30, 2005, the two $45 million credits "*must be regarded as upward adjustments to previously credited overpayment amounts,*" and the subsequent $90 million claim is properly regarded as a "*downward adjustment* to those same previously credited overpayment amounts" within the meaning of section 433.320(c).[18] PA Comments at 8 (italics added); *see also* Ga. Br. at 2-3, 22-25; Reply Br. at 8-10.

We disagree that the $45 million credits on the September 2005 and June 2006 QSEs must be regarded as refunds of – or as upward adjustments to refunds of – the federal share of provider overpayments. The evidence shows that Georgia did not classify the credits on those QSEs as overpayment refunds.[19] Even if the credits were overpayment refunds, it does not follow that the attempt to reverse them *must be* a "reclaiming" of FFP under section 433.320(c).[20] That regulation clearly provides that a state may reclaim the previously refunded federal share of an overpayment without regard to the two-year limit only if there has been a "downward adjustment" of the amount of a provider overpayment itself. *See also* 54 Fed. Reg. 5452, 5457 (Feb. 3, 1989) (stating that a state may reclaim the federal share "*to the extent that the State subsequently makes a downward adjustment* . . . ." (italics added)). A downward adjustment is a finding or determination by a state that a provider is entitled to receive a Medicaid payment (or a portion of a Medicaid payment) that the state earlier identified as improper, excessive, or otherwise unallowable under the state plan or federal requirements. *See* 42 C.F.R. § 433.320(c)(1) (stating that a downward adjustment is allowed "only if it is properly based on the approved State plan, Federal law and regulations governing Medicaid, and the appeals resolution processes specified in State administrative policies and procedures).

[18] We note, and Georgia recognizes, that this argument is inapplicable to the provider receivables for which Georgia had *not* refunded the federal share as of June 30, 2005. Ga. Br. at 23.

[19] A refund of the federal share of a provider overpayment is made on schedule CMS-64.9o, which supports line 10.C of the QSE's Summary Sheet. *See infra* footnote 8; CMS Ex. 6 ¶ 4. Georgia did not enter the credits in question on this schedule. Instead, Georgia entered the credits as prior-period adjustments on schedules supporting line 10.B, which reports the total of decreasing adjustments that are <u>not</u> audit adjustments or overpayment refunds. Ga. Exs. 8, 10 (Form CMS-64.9P).

[20] Georgia does not point to any section of the June 2009 QSE which indicates that its claim for $90 million stemmed from downward adjustments of overpayments.

Although Georgia's claim for $90 million relates generally to 60-day provider receivables for which Georgia refunded the federal share, there is no evidence that Georgia ever downwardly adjusted the amount of any underlying provider overpayments within the meaning of section 433.320(c), much less that any such downward adjustments met the requirements of (c)(1). In other words, there is no evidence that at any point after refunding the federal share of the provider payments that were found to constitute overpayments, Georgia determined – as a result of an "appeals resolution" or some other formal or informal administrative process – that any of those payments to providers were in fact allowable under the state plan and federal requirements.[21] Moreover, Georgia has emphasized that the purpose of the $90 million claim was not to reclaim FFP for previously identified provider overpayments but to reverse the erroneous crediting on the September 2005 and June 2006 QSEs. Tr. at 9. Because the $90 million claim does not reflect a downward adjustment of the amount of provider overpayments, section 433.320(c) does not apply to that claim.

In responding to the Board's Preliminary Analysis, Georgia contends that "if the mistaken credits and Georgia's attempt to recover them are characterized as adjustments to expenditures, then, under subsection (c)(2), recovery of the credits would constitute reclaiming, or downward adjustment to previously credited overpayment amounts, to which the two-year claiming limit does not apply." *See* Mar. 14, 2013 Reply of Ga. Dept. of Cty. Health on Prelim. Analysis (PA Reply) at 5. In support of that contention, Georgia asserts that subsection (c)(2) "does not say 'the 2-year filing limit for retroactive claims does not apply to downward adjustments described in [subsection] (c)(1)'" but states simply, without limitation, that "'[t]he 2-year limit for retroactive claims . . . does not apply.'" *Id.* (*quoting* 42 C.F.R. § 433.320(c)(2)).

This argument is without merit. Georgia overlooks key portions of section 433.320(c)'s text as well as the regulation's structure. The text which prefaces subsections (c)(1) and (c)(2) says that a state may "reclaim" (that is, request FFP for) the "amount of a downward adjustment" to an overpayment. 42 C.F.R. § 433.320(c) (stating that "[i]f the amount of an overpayment is adjusted downward after the [state] agency has credited CMS with the Federal share," then the state "may reclaim the amount of a downward adjustment"). The preface then points directly to subsections (c)(1) and (c)(2) with the words "[u]nder this provision," clearly implying that the subsections specify the conditions or circumstances under which a state may reclaim the federal share of a

[21] Georgia argues that the exemption to the two-year limit in section 433.320(c)(2) is not confined to downward adjustments that occur as a result of an "appeals resolution" process. Ga. Br. at 25; Reply Br. at 9. We need not address this argument because we find no evidence that Georgia downwardly adjusted the overpayments relating to Georgia's claim for $90 million through *any type* of administrative process.

downward adjustment outside of timely claims restrictions. Subsection (c)(1) prescribes when a "downward adjustment to an overpayment amount" is "allowed," and subsection (c)(2) says that a "reclaiming" of a downward adjustment can occur without regard to the two-year limit "for retroactive claims," noting that a "downward adjustment" is considered a "reclaiming" and not a retroactive claim. By distinguishing a "retroactive claim" subject to the two-year limit from a "downward adjustment" – a term that section 433.320's preface associates with the "amount of an overpayment" meeting the conditions in subsection (c)(1) – subsection (c)(2) plainly indicates that the exemption to the two-year rule applies only when a state's claim represents a downward adjustment as defined in subsection (c)(1).

We see nothing in section 433.320(c)'s text, preamble, or drafting history which indicates that subsection (c)(2) was intended to implement a broader policy that the two-year limit not apply whenever a state previously reported costs on a QSE, regardless of any adjustments on a later QSE, with respect to those expenditures. Interpreting this provision more narrowly, moreover, makes sense. For refunds of overpayments made under the 60-day rule and properly identified as such on the QSE, CMS is on notice that a state is not definitively withdrawing its earlier request for FFP, but doing so only pursuant to the 60-day rule, so CMS can take the possibility of downward adjustments to overpayment amounts under the regulation into account in planning its budget. That rationale does not apply to the amounts at issue here.

Georgia further contends that even if section 433.320(c) is inapplicable by its own terms, the Board should hold that the regulation "applies by analogy" because Georgia is attempting to reclaim FFP with respect to expenditures that were previously and timely claimed, just as a state would do if it made a downward adjustment to an overpayment and then reclaimed the amount of the downward adjustment. Tr. at 14. The Board has no authority to broaden a regulation to cover circumstances that a state considers in some way analogous, however. The Board is bound by the terms of applicable statutes and regulations. 45 C.F.R. § 16.14. Consequently, we may hold that section 433.320(c) applies only if that regulation can plausibly be interpreted to cover the claim's circumstances. Georgia has not shown that section 433.320(c)'s scope or meaning is uncertain or ambiguous (either inherently or applied to its circumstances), nor has it offered a plausible construction of the regulation's text that would allow us to find that its $90 million claim constitutes a reclaiming of a downward adjustment. Georgia has also not shown that CMS adopted or that Georgia reasonably relied on an interpretation of section 1132(a) of the Act or the implementing regulations as meaning that once a state had timely reported particular expenditures at some point, then the state could simply "reclaim" the expenditures at any time, no matter what the nature of any decreasing adjustment the state had made on a later QSE with respect to those expenditures.

4. *Georgia's other arguments regarding the applicability of the two-year limit are unpersuasive.*

Georgia makes other interrelated arguments concerning the applicability of the two-year limit, none of which we find persuasive.

First, Georgia suggests that the Board has not properly framed the dispositive issue. That issue, according to Georgia, is not its eligibility to claim, receive, or use federal funds (*i.e.*, FFP) but its right to recover "state funds" erroneously credited to the federal government. Ga. Br. at 25-26 (asserting that "CMS in essence is declining to return the State's money"); PA Comments at 6 (stating that the "[t]he real question is not what affirmative right the State has to reclaim its own funds, but rather what right CMS has to keep the State's funds"). Georgia asserts that neither section 1132(a) nor any provision of the Medicaid statute or regulations authorizes CMS to retain $90 million of Georgia's money. Ga. Br. at 26.

Georgia also contends that section 1132(a)'s legislative purpose – to enable HHS to know its financial obligations for each fiscal year within a reasonable time after the end of the year – is not served by applying the two-year limit in this case:

> CMS furthers that legislative purpose when it applies the two-year claiming limit to a State's untimely claim for FFP for an expenditure that the State incurred over two years before and neglected to claim. CMS would be unable to ascertain its obligations for a fiscal year that ended more than two years earlier if it permitted States to file such late expenditure claims. CMS does not advance the legislative purpose by applying the limit to deny recovery of amounts CMS received from the State to which CMS was never entitled (amounts that are in essence State funds). A State's reclaiming of amounts it erroneously over-credited to CMS does not create an unanticipated "obligation" to provide FFP. . . .

Ga. Br. at 17-18; *see also* Reply Br. at 2-3 (stating that "requests for a return of erroneous credits do not impose on CMS unanticipated obligations to reimburse a state for the federal share of stale expenditures").

We reject these arguments because they are based on the premise, which we rejected above, that Georgia's request for $90 million was not a "claim" subject to the two-year rule. We also disagree with the suggestion that Georgia merely sought to recover "state funds" on the June 2009 QSE. When Georgia included $45 million in decreasing adjustments on the September 2005 and June 2006 QSEs, it was not refunding state funds but instead reducing claims for federal funds provided in advance of the quarter.

Similarly, when it included $90 million on its June 2009 QSE, Georgia was not seeking a return of state funds but was making a claim against the FFP award for the quarter ending June 30, 2009. These increasing and decreasing adjustments did not result in a transfer of "state funds" but merely decreased the amount of Georgia's claims for FFP.

We also disagree with Georgia's suggestion that its $90 million claim did not impose an "unanticipated obligation" on the federal government. Assuming it was timely, the claim imposed an "obligation" because the federal government would have been obligated to provide (or approve the provision of) $90 million to Georgia for the current quarter if the expenditures associated with that claim were allowable under the Act and State plan. Furthermore, Georgia did not give any reason why CMS should have expected or planned for a $90 million funding request in mid-2009 with respect to expenditures that were made four or more years before and for which Georgia had made unqualified decreasing adjustments. Georgia itself did not discover the basis for the $90 million claim until 2008, and CMS was not alerted to that discovery until mid-2009. *See* Ga. Ex. 19 ¶ 15; CMS Ex. 7 ¶ 4. From the perspective of a federal budget planner, Georgia's $90 million claim on the June 2009 QSE was no different from any other untimely claim (not covered by an exception): it was made "with respect to" state Medicaid expenditures that occurred several years before, the very type of claim that Congress intended to foreclose in enacting the two-year limit. *New York State Dept. of Social Servs.*, DAB No. 521, at 8 (1984) (stating that the purpose of the two-year limit is "to prevent the state from coming in many years after expenditures are made and claiming FFP").

Georgia contends that the disallowance is in conflict with CMS "policy" expressed in the preamble to the final rule which adopted the provider overpayment regulations in 42 C.F.R. Part 433, subpart F. Reply Br. at 12. Georgia points, in particular, to a passage of the preamble which states that those regulations "do not contemplate States refunding more than the amount due the Federal Government." *Id.* (*quoting* 54 Fed. Reg. at 5455). According to Georgia, the same principle should be applied to a request seeking a return of "inadvertently credited" funds. Ga. Br. at 24-27; *see also* Reply Br. at 1, 8, 12, 23 (stating that the "disallowance is inconsistent with . . . CMS's own statement [in the preamble to the overpayment regulations] that the federal government should not keep more than the State legitimately owes"). We reject this argument because there is no hint in the preamble that the quoted passage was intended to be either an interpretation of the statutory or regulatory provisions establishing the two-year limit or a policy explaining how CMS will treat FFP claims that are based on belatedly discovered claiming errors.

The passage merely prefaced a reminder that if a state refunded the federal share of an overpayment under the 60-day rule, the state was not required to make a second refund when it actually collected the overpayment from the provider.[22] The preamble language merely indicates that states are not expected to make the sort of mistakes that Georgia made here – it does not suggest any provision to accommodate such incorrect excess refunds by exempting claims for them from the usual timeliness requirements.

While asserting that it does not seek an equitable remedy, Georgia contends that general equitable principles, such as prevention of unjust enrichment, should guide how the Board interprets and applies the two-year limit in these circumstances. Reply Br. at 13; *see also* Ga. Br. at 2 (asserting that "[t]he Medicaid statute and regulations cannot be read to permit" a result in conflict with those principles). Georgia also points to some court decisions in which courts have required the federal government to return funds that it was not entitled to have or received in error. Ga. Br. at 28-30.

In general, the Board has no authority to render a decision based upon equitable principles alone. *See New Jersey Dept. of Human Servs.*, DAB No. 2497, at 8 (2013); *Arizona Health Care Cost Containment System*, DAB No. 1569 (1996); *New Jersey Dept. of Human Servs.*, DAB No. 1142 (1990). The Board is, as mentioned, bound by applicable statutes and regulations. Those laws – applied in the context of a Medicaid grant award process that permits states ample opportunity to develop, verify, and adjust FFP claims – require us to uphold the disallowance for reasons discussed earlier.

Even if equitable principles were relevant, it is not obvious how they should factor into an analysis of section 1132(a)'s meaning or applicability given federal and state interests at stake. Congress arguably struck an equitable balance of those interests by enacting exceptions to the two-year limit and by permitting states to petition the Secretary of HHS to waive the limit upon a showing of "good cause," a remedy analogous to equitable tolling, which requires a showing that the untimely filing was due to circumstances

[22] The relevant paragraph of the preamble states:

> These regulations [42 C.F.R. Part 433, subpart F] do not contemplate States refunding more than the amount due the Federal Government. *Therefore, States should not report on the Form HCFA-64 any collections made on overpayment amounts for which the Federal share has been previously refunded.* In addition, if a State has refunded the Federal share of an overpayment as required by these regulations and the State subsequently makes recovery by reducing future provider payments by a discrete amount, the State should not reflect that reduction in its claim of Federal financial participation.

54 Fed. Reg. at 5455 (italics added).

beyond a litigant's control. *Compare Sandvik v. United States*, 177 F.3d 1269, 1271 (11th Cir. 1999) ("Equitable tolling is appropriate when a movant untimely files because of extraordinary circumstances that are both beyond his control and unavoidable even with diligence.") and 45 C.F.R. § 95.22 (defining good cause to mean "lateness due to circumstances beyond the State's control").

Furthermore, Georgia does not come to us without fault. This case arose because of deficiencies in Georgia's internal accounting system. *See* CMS Ex. 6 ¶ 9 (indicating that CMS staff "learned through . . . meetings [with Georgia's staff] that Georgia's errors started with deficiencies in its internal accounting system"). That system: (1) caused a large amount of FFP to be credited erroneously to CMS on the September 2005 QSE, (2) caused an *identical* error to be made less than one year later, and (3) failed to detect the errors afterward. Only after an outside audit in 2008 uncovered problems with Georgia's accounting system did Georgia discover the errors. Due to Georgia's inability to prevent or detect the errors, more than three years elapsed between the first claiming error and Georgia's attempt to correct it. Moreover, the large volume of provider receivables was the result of Georgia's persistent failure to implement a functional system for making and tracking accurate payments to providers, causing it to adopt the system of ad hoc advance payments.

Nothing in the text or legislative history of section 1132 leads us to conclude that Congress intended to permit, without time constraint, claims based on the belated discovery of QSE errors that are within a state's power to prevent. Section 1132(b) suggests quite the opposite in fact by precluding a finding of "good cause" when the failure to file a claim within the specified two-year period "is attributable to neglect or administrative inadequacies[.]" That rule is a sensible one because states are in the best position to verify the accuracy and legal validity of their claims and to make necessary retrospective corrections in a timely manner. *Cf. Minnesota Dept. of Human Services*, DAB No. 1791 (2001) ("The State is in the best position to take prompt action to determine whether its expenditures for health care were made on behalf of individuals eligible for Medicaid and to make any retrospective corrections in a timely manner.").

In short, we cannot reasonably interpret section 1132(a) in the manner that Georgia seeks. Our conclusion is consistent with the Board's longstanding holding that the two-year limit's exceptions be construed narrowly in light of section 1132(a)'s purpose. *Kansas Health Policy Authority*, DAB No. 2216, at 4 (2008). To reiterate, the two-year limit's purpose is enable the federal government to know its funding obligations with respect to a quarter within a reasonable time afterward and thereby facilitate timely budget planning. A state frustrates that purpose when it belatedly seeks FFP to rectify a prior quarter's claiming errors that it failed to detect within the two-year time limit applicable to the expenditures at issue. Under the grant award process established by the Medicaid statute, regulations, and program instructions, the onus is on a state to have cost accounting and other financial systems in place to ensure that it makes a complete,

supportable, and *accurate* claim for a current or prior quarter. *Cf.* SMM § 2497 (explaining, in general, a state's burden to have documentation sufficient to show that a claim satisfies all applicable federal requirements). That burden necessarily requires that errors which affect the amount a state may properly claim under a quarterly award be detected and corrected within the prescribed two-year period (unless one of the statutory or regulatory exceptions applies).

Conclusion

For the reasons set out above, we affirm CMS's June 30, 2011 determination to disallow Georgia's claim for $90,050,230 in FFP on its QSE for the quarter ending June 30, 2009.

/s/
Judith A. Ballard

/s/
Leslie A. Sussan

/s/
Stephen M. Godek
Presiding Board Member