Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

New Jersey Department of Human Services
Docket No. A-15-70
Decision No. 2737
September 22, 2016

DECISION

The New Jersey Department of Human Services (New Jersey) appeals a March 30, 2015 determination by the Centers for Medicare & Medicaid Services (CMS) disallowing $50,063,977 federal financial participation (FFP) for Medicaid disproportionate share hospital (DSH) payments that New Jersey made to five hospitals for state fiscal years (SFYs) 2003 through 2007 (July 1, 2002 through June 30, 2007). CMS based the disallowance on Office of Inspector General (OIG) Audit Report No. A-02-09-01017, which concluded that for one or more years of the relevant period, each of the five hospitals did not meet the one percent minimum Medicaid inpatient utilization rate (MIUR) required to receive Medicaid DSH payments pursuant to section 1923(d)(3) of the Social Security Act (Act).[1]

On appeal, New Jersey does not dispute that the DSH payments made to the five hospitals identified in the OIG report are not allowable. New Jersey argues, however, that the disallowance should be reduced because it made timely claims, not questioned by the OIG or CMS, for which it did not previously obtain FFP due to the statutory limit on federal reimbursement for DSH payments to institutions for mental disease (IMDs). Specifically, New Jersey asserts that the portion of the disallowance that represents the federal share of payments to the two IMDs identified in the report ($45,011,013) should be subtracted from the disallowance because New Jersey "'overclaimed' IMD DSH payments by several hundred million dollars over the audit period," and CMS deferred the excess claims. NJ Br. at 2. In addition, New Jersey contends that the OIG and CMS have not shown that the payments to the two IMDs identified in the audit report were among the IMD DSH payments for which the state received FFP, rather than among the unreimbursed claims that exceeded the IMD DSH caps.

[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. Also, a cross-reference table for the Act and the United States Code can be found at 42 U.S.C.A. Ch. 7, Disp Table.

For the reasons discussed below, we conclude that CMS properly determined that New Jersey's claims for DSH payments to the five hospitals identified in the OIG report are unallowable because the hospitals did not meet the MIUR necessary to qualify as DSHs during the specified periods. We further conclude, however, that the record supports New Jersey's contentions that it timely claimed FFP for all of its IMD DSH payments, which substantially exceeded the IMD DSH caps, and that CMS deferred federal funding for the claimed expenditures that exceeded the IMD DSH caps but has not to date disallowed those claims. In addition, the record does not establish whether the payments to the IMDs identified in the report were among the claims for which CMS provided FFP or among the claims that were deferred.

Accordingly, we remand this matter for CMS to review New Jersey's timely claims for DSH payments to IMDs that met the DSH eligibility requirements during the relevant period and to determine whether those claims are otherwise allowable and payable. CMS should recalculate the disallowance amount associated with the two IMDs identified in the audit report, permitting New Jersey to retain FFP only for allowable and payable IMD DSH claims up to the IMD DSH caps. To the extent necessary to recalculate the disallowance, CMS should consider evidence as to whether the unallowable claims related to the hospitals at issue here were previously reimbursed in whole or in part under the IMD DSH cap. CMS should issue a written determination stating the revised disallowance amount. If New Jersey disagrees with CMS's determination, it may appeal that determination to the Board in accordance with the procedures in 45 C.F.R. Part 16.

I. Legal Background

The Medicaid program, established under title XIX of the Act, provides medical assistance for certain low-income individuals. States that participate in Medicaid must observe broad federal requirements and the terms of their Medicaid state plans, as approved by CMS. Act § 1902; 42 C.F.R. §§ 430.0 - 430.20. Once CMS has approved a state plan, it makes quarterly awards to the state to cover the federal share of expenditures. Act § 1903(a); 42 C.F.R. § 430.30(a)(1). The amount of the quarterly award is determined on the basis of information submitted by the state in quarterly estimate and quarterly expenditure reports and other pertinent documents. 42 C.F.R. § 430.30(a)(2). When CMS determines that a claim or portion of claim is not allowable, CMS "promptly sends the State a disallowance letter that includes" specific information relating to the state's claimed expenditures, CMS's findings of fact, the legal grounds for the disallowance, and the procedures for the state to request reconsideration or to appeal the disallowance. *Id.* § 430.42.

In 1981, Congress amended the Act to provide that in establishing Medicaid hospital payment rates, states must "take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs ...." Pub. L. No. 97-35 § 2173(a)(1)(B)(ii), 95 Stat. 357, 808 (1981), codified at Act § 1902(a)(13)(A)(iv).

Section 1923 of the Act ("Adjustment in Payment for Inpatient Hospital Services Furnished by Disproportionate Share Hospitals") requires each Medicaid state plan to provide for "an appropriate increase in the rate or amount of payment" for "inpatient hospital services" to compensate DSHs that incur atypical costs in furnishing services to a disproportionate number of indigent patients. Act § 1923(a)(1)(B). These increases in payments are referred to as DSH "payment adjustments."

In order to receive DSH payment adjustments, a facility must be classified as a DSH. Section 1923(b) provides for hospitals that meet certain requirements to be "deemed" DSHs. The Act also permits a state to identify other hospitals as DSHs so long as they meet minimum specified criteria. Relevant here, section 1923(d)(3) provides that no hospital may be defined or deemed as a DSH unless it has a MIUR of not less than one percent. The MIUR, expressed as a percentage, is the number of inpatient days of care furnished to Medicaid-eligible patients during a given period divided by the total number of inpatient days of care provided during that period. Act § 1923(b)(2).

Since the early 1990s, Congress has developed several different types of limitations on federal reimbursement for DSH expenditures. After DSH expenditures increased dramatically in the late 1980s, Congress amended the Act in 1991 to provide for an annual "DSH allotment" for each state, limiting the aggregate amount of federal reimbursement that a state may obtain for DSH expenditures. Pub. L. No. 102-234 § 3, 105 Stat. 1799 (1991). Section 1923(f) of the Act provides that FFP shall not be paid to a state for "any payment adjustment made under this section for hospitals in a State for quarters in a fiscal year in excess of the [DSH] allotment for the State for the fiscal year. . . ."[2] The implementing regulation at 42 C.F.R. § 447.297(d)(2) provides that if "CMS determines that at any time a State has exceeded its final DSH allotment for a Federal fiscal year, FFP attributable to the excess DSH expenditures will be disallowed." CMS publishes the annual state DSH allotment amounts in preliminary and final form in the *Federal Register* each year. 42 C.F.R. § 447.297(c), (e).[3]

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[2] For the period covered by the audit report, a state's DSH allotment was based on the greater of the preceding year's DSH allotment (increased by the percentage change in the consumer price index for all urban consumers for the previous federal fiscal year) or 12 percent of the total amount of expenditures under the state plan for medical assistance during the previous fiscal year. Act § 1923(f)(3).

[3] Congress further provided for hospital-specific limits on FFP for DSH payment adjustments under section 13621(b) of the Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, 107 Stat. 312. In general, the statute limits FFP for DSH payments based on the amount of the uncompensated costs incurred by each DSH in providing services to individuals who are eligible to receive Medicaid or who have no health insurance or other source of third-party coverage. Act § 1923(g). The hospital-specific limitations are not at issue here.

Within the state allotment is a separate, lower limit or cap on FFP for DSH payments to IMDs and other mental health facilities, which Congress enacted under the Balanced Budget Act of 1997, Pub. L. No. 105-33 § 4721, 111 Stat. 513 (1997). States are generally prohibited from using federal Medicaid funds to pay directly for the costs of inpatient services furnished to persons aged 22 through 64 years old who are patients of IMDs. Act § 1905(a)(14), (16); *Mo. Dept. of Social Servs*., DAB No. 2161, at 6, n.3 (2008) (citing legal authorities). The purpose of the "IMD exclusion" is to prevent states from using federal funds to supplant state financing of mental health hospitals, which states historically operated and funded. DAB No. 2161, at 6, n. 3 (citing legal authorities). A state Medicaid program may nevertheless make claims and receive FFP for DSH payments to IMDs and other mental health facilities that qualify for payments. In the mid-1990s, however, Congress became concerned that extensive use of the DSH payment authority could allow states to shift the costs of operating mental health facilities from states to the federal government. U.S. Gov't Accountability Office, GAO/HEHS-98-52, Medicaid: Disproportionate Share Payments to State Psychiatric Hospitals 10 (1998). Responding to that concern, the 1997 legislation added section 1923(h) to the Act, providing for annual statewide IMD DSH limits, which CMS also publishes annually in the *Federal Register.*[4]

II. Case Background

This appeal arose from an OIG audit of the DSH payments that New Jersey claimed for SFYs 2003 through 2007, for which the federal government provided $3,104,648,159 FFP.[5] NJ Ex. 4, at 1-2. The audit objective was to determine whether New Jersey claimed DSH payments in accordance with federal DSH eligibility requirements. *Id.* To accomplish the objective, the OIG obtained from New Jersey a list of the 109 hospitals that received DSH payments; reviewed New Jersey's Quarterly Medicaid Statements of Expenditures (Form CMS-64) and the Hospital Cost Reports (CMS-2552-96) submitted by each hospital for the relevant periods; and obtained New Jersey's MIUR calculations for the hospitals. *Id.* at 2.

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[4] A state's IMD DSH limit is the lesser of the state's total DSH expenditures attributable to FFY 1995 for payments to IMDs and other mental health facilities or the applicable percentage of the state's 1995 total DSH allotment. Act § 1923(h)(1). The "applicable percentage" is the lesser of the percentage of DSH payments made for IMDs in federal fiscal year 1995 or a percentage established by statute. Act § 1923(h)(2). New Jersey's "applicable percentage" for its IMD DSH cap is 32.66% because 32.66% of its DSH payments in 1995 were made to IMDs. NJ Ex. 6, ¶ 3.

[5] New Jersey's SFY begins July 1 and ends June 30; the federal fiscal year (FFY) spans October 1 through September 30.

The OIG issued its final report in November 2012, after it solicited and reviewed New Jersey's responses to a May 2012, draft report. NJ Exs. 3, 4. The final report concluded that New Jersey had claimed DSH payments totaling $100,127,954 ($50,063,977 FFP) for five hospitals that did not meet federal eligibility requirements for DSH payments during one or more of the years covered by the audit because they had MIURs of less than one percent. NJ Ex. 4, at 3, App.A. The five hospitals identified were: 1) Saint Barnabas Behavioral Health; 2) Buttonwood Hospital (Buttonwood); 3) Hudson County Psych Hospital/Meadowview Psychiatric Hospital/Hudson County (Meadowview); 4) Healthsouth Garden State Rehab; and 5) Mount Carmel Guild. *Id.* at App. A. Two of the five hospitals identified in the report, Buttonwood and Meadowview, are IMDs. The audit report noted that New Jersey had "contended that valid claims for DSH payments to other hospitals throughout the State exceeded the State's DSH allotment during a portion of our audit period" and, consequently, "these claims should be considered as an offset to the unallowable DSH payments associated with" the OIG's findings. *Id.* at 3. The OIG stated, however, that New Jersey "provided no specific evidence to support an offset," but also stated that New Jersey "may directly address the offset of excess claims with CMS." *Id.* 4 and n.5. After the OIG issued the final audit report, New Jersey and CMS representatives discussed the offset issue but did not reach resolution on the matter.

On March 30, 2015, CMS issued a notice of disallowance to New Jersey in the amount of $50,063,977 FFP based on the OIG's final audit report. CMS stated that it had reviewed the findings and concurred with the OIG that New Jersey had claimed DSH payments totaling $100,127,954 ($50,063,977 federal share) for the five hospitals identified in the report that did not meet federal requirements for DSH payments during the relevant periods. New Jersey timely appealed the disallowance.

III. Analysis

A. New Jersey's claims for the DSH payments made to the five hospitals identified in the OIG report are not allowable.

As explained above, sections 1923(b)(2) and 1923(d)(3) of the Act provide that no hospital may be deemed or determined to be a DSH unless it has a MIUR of not less than one percent. In this case, the OIG and CMS determined that, during one or more of the fiscal years covered by the OIG audit, the five hospitals identified in the report failed to meet the MIUR requirement. The OIG determined that the ineligible DSH payments made to the identified hospitals totaled $100,127,954, with a federal share of $50,063,977. NJ Ex. 4, at 3.

New Jersey's appeal does not dispute CMS's determination that the claims for FFP for the DSH payments associated with the five hospitals identified in the OIG report were not allowable because the hospitals did not meet the minimum MIUR required to qualify as

DSHs during the relevant periods. We therefore sustain without further discussion CMS's determination that the DSH payments to the five hospitals identified in the OIG report did not qualify for federal reimbursement.

B. New Jersey timely claimed all IMD DSH expenditures; CMS disallowed only those relating to the payments to the two IMDs identified in the audit report; and the record does not establish which IMD DSH expenditures were previously reimbursed.

New Jersey argues on appeal that the disallowance should be reduced by $45,011,013 -- the amount associated with the payments to Buttonwood and Meadowview, the two hospitals identified in the report that are IMDs – because New Jersey "made timely claims for DSH expenditures, not questioned by CMS or the OIG, that were sufficient to justify the amount of federal funds claimed." NJ Br. at 1-2. New Jersey states (and CMS does not deny) that its longstanding practice in claiming FFP for DSH expenditures has been to make claims on its Medicaid quarterly report for all DSH expenditures attributable to that quarter, regardless of whether the claims would exceed, or already had exceeded, its DSH allotment. *Id*. at 5; NJ Ex. 7 (Declaration of Robert Durborow), ¶¶ 4-6. New Jersey states that the purpose of this practice was to ensure that it had timely, sufficient and valid expenditures to justify the FFP that it received in the event of a later deferral or disallowance related to DSH expenditures. *Id.* For the period at issue, New Jersey submitted its quarterly reports into the CMS Medicaid Budget and Expenditure System (MBES), an electronic platform, which, New Jersey alleges, "allowed the State to enter claims for FFP over its DSH cap." *Id.*; NJ Ex. 7, ¶ 6.

The parties submitted joint stipulations of facts in this case which state as follows:

> 4. For each FFY at issue, [New Jersey] claimed FFP for DSH funding in excess of its annual IMD DSH cap as calculated by CMS and published in the Federal Register.
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> 5. For FFY 2002, [New Jersey] claimed expenditures of $410,445,652 for DSH payments to IMDs, which would have entitled it to $205,222,827 in FFP absent the IMD cap. [New Jersey] received only the amount up to its IMD cap of $178,628,772. Thus, [New Jersey] had $26,594,055 in claimed but unreimbursed FFP for FFY 2002.

> 6. For FFY 2003, [New Jersey] claimed expenditures of $425,303,602 for DSH payments to IMDs, which would have entitled it to $212,651,803 in FFP absent the IMD cap. [New Jersey] received only the amount up to its IMD cap of $170,737,825. Thus, [New Jersey] had $41,913,978 in claimed but unreimbursed FFP for FFY 2003.
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> 7. For FFY 2004, [New Jersey] claimed expenditures of $417,546,844 for DSH payments to IMDs, which would have entitled it to $208,773,425 in FFP absent the IMD cap. [New Jersey] received only the amount up to its IMD cap of $178,685,231. Thus, [New Jersey] had $30,088,194 in claimed but unreimbursed FFP for FFY 2004.
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> 8. For FFY 2005, [New Jersey] claimed expenditures of $446,615,751 for DSH payments to IMDs, which would have entitled it to $223,307,878 in FFP absent the IMD cap. [New Jersey] received only the amount up to its IMD cap of $178,685,231. Thus, [New Jersey] had $44,622,647 in claimed but unreimbursed FFP for FFY 2005.
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> 9. For FFY 2006, [New Jersey] claimed expenditures of $486,250,496 for DSH payments to IMDs, which would have entitled it to $243,125,250 in FFP absent the IMD cap. [New Jersey] received only the amount up to its IMD cap of $178,685,231. Thus, [New Jersey] had $64,440,019 in claimed but unreimbursed FFP for FFY 2006.
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> 10. For FFY 2007, [New Jersey] claimed expenditures of $501,318,898 for DSH payments to IMDs, which would have entitled it to $250,659,450 in FFP absent the IMD cap. [New Jersey] received only up to the amount of its IMD cap of $178,685,231. Thus, [New Jersey] had $71,924,219 in claimed but unreimbursed FFP for FFY 2007.

NJ Ex. 6 (Stipulations of New Jersey Department of Human Services and CMS, July 2015). *See also*, NJ Ex. 7, ¶¶ 5-6 (stating that during the relevant period, New Jersey used the MBES to enter the CMS-64 reports claiming all DSH expenditures; CMS would pay FFP up to the respective limit and then defer the federal funding that exceeded the limit).

Based on the parties' stipulations, the amount of New Jersey's unreimbursed IMD DSH claims for each year at issue (converted into New Jersey's SFYs) and the amount of FFP that the OIG and CMS associated with the payments to Meadowview and Buttonwood are set forth in the chart below:

	SFY 2003	SFY 2004	SFY 2005	SFY 2006	SFY 2007
IMD-DSH Cap	$172,710,562	$176,698,380	$178,685,231	$178,685,231	$178,685,231
IMD-DSH Claims	$210,794,559	$209,743,019	$219,674,265	$238,170,907	$248,775,900
Unreimbursed Expenditures	$38,083,997	$33,044,639	$40,989,034	$59,485,676	$70,090,669
CMS Disallowance for Buttonwood and Meadowview	$8,854,474	$7,449,784	$7,693,436	$9,973,186	$11,040,133

NJ Ex. 4, App. A; NJ Br. at 12-13.[6] As reflected in the chart, the record supports New Jersey's contention that its timely, unreimbursed IMD DSH claims exceeded the amount of the claims that the OIG and CMS associated with Buttonwood and Meadowview for each year of the relevant period.

New Jersey further asserts that the "OIG report assumes without explanation that the disallowed costs [associated with Buttonwood and Meadowview] are among the federal funds paid to the State" for DSH payments to IMDs rather than among the DSH payment claims for which New Jersey was not reimbursed because they exceeded the annual IMD DSH limits. NJ Br. at 11, n.3. Likewise, CMS's March 30, 2015 disallowance determination does not address the basis for CMS's apparent conclusion that New Jersey previously received FFP for the Buttonwood and Meadowview claims and, consequently, must return those funds to the federal government.

Even though New Jersey's opening brief raised the question whether the claims for the DSH payments to Buttonwood and Meadowview were even among the claims for which the state received FFP, CMS still has not explained why it reached the apparent conclusion that it had in fact reimbursed New Jersey for the Buttonwood and

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[6] New Jersey converted the FFY amounts identified in the stipulation into SFY amounts by taking 75% from the identified FFY and 25% from the prior year. CMS did not question New Jersey's method of converting the FFY amounts to SFYs. NJ Br. at 12, n.4. The amounts of CMS's disallowances for Buttonwood and Meadowview are consistent with the OIG's calculations. NJ Ex. 4, App. A.

Meadowview DSH payments. (Conversely, the record also does not show that the payments to Buttonwood and Meadowview were among the claims that were not reimbursed because they exceeded the IMD DSH caps.) Thus, for purposes of this case, we conclude that the record before the Board does not establish that New Jersey received federal reimbursement for the IMD DSH payments that New Jersey made to Buttonwood or Meadowview during the audit report period.

New Jersey argues that, under these circumstances, it should not be required to return questioned federal funds because sufficient valid, unreimbursed federal claims have been shown to exist to "offset, dollar for dollar, the questioned expenditures." NJ Br. at 14. CMS contends that an offset is inappropriate for reasons we discuss in the next section.

C. Neither the regulation at 45 C.F.R. § 95.7 nor the Board's decision in New Jersey Department of Human Services, DAB No. 1652 (1998), bar an offset in these circumstances.

While the parties' stipulations of facts establish that New Jersey's unreimbursed IMD DSH claims for each year at issue exceeded the amount of FFP associated with the payments to Meadowview and Buttonwood, CMS argues that the Board's decision in an earlier case, *New Jersey Department of Human Services*, DAB No. 1652 (1998), precludes the offset that New Jersey seeks in this appeal.

CMS states that the Board's earlier decision addressed and rejected New Jersey's contention that DSH payments exceeding an allotment may be treated as allowable but not payable in order to preserve the State's ability to claim the excess costs "should other claims counted against the allotment later be disallowed on other grounds." CMS Br. at 2. CMS contends, "States still are not allowed to claim FFP for expenditures over the cap." *Id.* at 4. CMS further asserts that 45 C.F.R. § 95.7, which provides for a two-year time limit on Medicaid claims, "controls the outcome of this case." CMS Br. at 7. Specifically, section 95.7 provides that a state in general may not obtain federal reimbursement on claims submitted more than two years after the calendar quarter in which the state made the expenditure. CMS indicates that New Jersey may not submit claims for its previously unreimbursed IMD DSH payments well after the two-year claim periods expired.[7]

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[7] 45 C.F.R. § 95.19 provides that the time limit at section 95.7 does not apply to —
(a) Any claim for an adjustment to prior year costs.
(b) Any claim resulting from an audit exception.
(c) Any claim resulting from a court-ordered retroactive payment.
(d) Any claim for which the Secretary decides there was good cause for the State's not filing it within the time limit.

As explained below, we conclude that the Board's reasoning in DAB No. 1652 and 45 C.F.R. § 95.7 do not apply to bar the relief that New Jersey seeks in this appeal. The earlier New Jersey case involved appeals of four CMS written disallowance determinations for Medicaid DSH payments that exceeded New Jersey's DSH allotments for the periods covered by those disallowance determinations. On appeal of CMS's determinations, New Jersey did not deny that its disallowed claims exceeded the relevant allotments. Rather, the "only issue raised by New Jersey as to the amounts [CMS] found exceeded the applicable allotment limits was whether disallowance was the correct procedure to handle the excess amounts…."[8] DAB No. 1652, at 5. New Jersey argued then "that the excessive claims should not be disallowed, but rather 'treated as allowable but not payable,' so as to remain potentially claimable if other payments made within the allotment limit [were] disallowed in the future." *Id.* at 1, 5. New Jersey alternatively argued that CMS "be barred from asserting the two-year timely claims limitation against New Jersey if New Jersey [sought] to use these claims as 'replacement' for any later disallowed DSH payments previously counted against its allotment." *Id.* at 7.

The Board determined in DAB No. 1652 that New Jersey's concern about how CMS might in the future handle resubmitted claims, should claims counted against the allotments later be disallowed, was at that time "speculative and not ripe for resolution." *Id*. at 2; *see also id.* at 7-8 ("the requested relief relating to possible replacement DSH claims is denied because it would be premature and based on mere speculation."). The Board explained that its authority "does not provide for deciding hypothetical disputes in advance." *Id.* at 8. In addition, the Board noted, 42 C.F.R. § 447.297(d)(2) "mandate[s] that FFP attributable to excess DSH payments be disallowed 'at any time' that [CMS] determines the allotment has been exceeded," and there "is no specific provision for an interim determination of "allowable but not payable" claims.[9] *Id.* at 6. Accordingly, the Board concluded, CMS's final written determinations "correctly disallowed the excess DSH claims." *Id.* at 8. With respect to New Jersey's concern that CMS might in the future rely on the two-year timely claims limitation to prevent New Jersey from using the claims at issue as "replacement claims" for any later disallowed DSH payments previously counted against its allotments, the Board noted that CMS's brief stated that "nothing precludes New Jersey 'from resubmitting claims for DSH payments in the event room under the cap does become available.'" *Id*. at 8, quoting CMS Br. at 12.

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[8] The Board's decision in the earlier case refers to the federal Health Care Financing Administration (HCFA), CMS's predecessor agency.

[9] Section 447.297 relates to statewide annual DSH allotments; CMS has not issued regulations specifically addressing the IMD DSH limits.

Accordingly, contrary to CMS's argument, the Board did not need to address or decide in DAB No. 1652 the issue of how to treat other claims already filed by a state for DSH expenditures which were not reimbursed because they exceeded the applicable DSH cap in the event that a later disallowance of reimbursed DSH claims created room under the cap.

In contrast with the 1998 case, the issue presented in this case is not hypothetical. Rather, in this case, New Jersey seeks to use prior, timely-filed IMD-DSH claims to support the federal reimbursement that it received for IMD DSH payments up to the amount of the annual IMD DSH limits. New Jersey does not ask for a determination that its prior claims exceeding the IMD DSH caps be classified as "allowable but not payable."

More important, in this case, CMS **did not** disallow any of New Jersey's timely DSH claims that exceeded its IMD limits for SFYs 2003-2007 upon New Jersey's submissions of its claims. As noted above, 42 C.F.R. § 430.42(a) provides that when CMS determines that "a claim or portion of claim is not allowable," CMS is to "promptly send[] the State a disallowance letter" that specifies the grounds for the disallowance and the opportunities for the state to seek reconsideration or to appeal the disallowance. Here, the record does not show, and CMS does not assert, that CMS previously issued any such disallowance letters. To the contrary, the declaration of New Jersey's Management Improvement Specialist and Manger of Financial Reporting states that CMS did not previously take disallowances on the IMD DSH claims that exceeded the IMD limits, "but rather deferred all federal funding associated with DSH claims that exceeded the statutory cap for IMDs." NJ Reply at 2, citing NJ Ex. 7, ¶ 6.

We also note that CMS's brief states that in 2012 it created a new form, CMS-64.9I, for states "to record additional expenditures over the limit" with the intention that this mechanism would thereafter "allow CMS *to forego issuing deferrals* for excess expenditures." CMS Br. at 4 (emphasis added). This statement is consistent with New Jersey's assertion that, for the pre-2012 period at issue here, CMS deferred New Jersey's claims for FFP exceeding its IMD limits but never took disallowances.

Because CMS did not previously disallow any of New Jersey's timely IMD claims for the relevant period, the unreimbursed claims that exceeded the IMD DSH caps remained pending. Therefore, there is no issue in the present case about whether New Jersey may "re-submit" any claims following the OIG audit or March 2015 CMS disallowance. Accordingly, the two-year filing limit at 45 C.F.R. § 95.7 does not preclude the disallowance reduction that New Jersey seeks in this particular case. Nevertheless, we recognize that the pending claims were deferred based solely on the IMD DSH cap before the disallowance of claims for DSH payments to the ineligible hospitals created room

under the IMD DSH cap. As a result, CMS may not have had an opportunity to ascertain whether the pending claims are otherwise allowable, and hence payable to the extent room now exists under that cap. Therefore, as we next explain, the matter must be remanded to CMS for further action.

D. Remand to CMS

In light of New Jersey's timely claims, we remand this matter to CMS for further action. On remand, CMS should evaluate whether New Jersey's timely claims for DSH payments to IMDs that met the DSH eligibility requirements during the relevant periods were allowable and payable. CMS should reduce the disallowance amount associated with the two IMDs identified in the OIG report to permit New Jersey to retain FFP for all allowable and otherwise payable IMD DSH expenditures that do not exceed the IMD DSH limits. To the extent necessary to its redetermination, CMS should consider whether any disallowed amounts are included in previously reimbursed claims which would therefore require return of FFP. CMS should issue a written determination stating the revised disallowance amount. If New Jersey disagrees with CMS's determination, it may appeal that determination to the Board in accordance with the procedures in 45 C.F.R. Part 16.

IV. Conclusion

For the reasons explained above, we conclude that CMS properly determined that New Jersey's claims for the DSH payments made to the five hospitals identified in the OIG report were not allowable. We further conclude that New Jersey timely claimed all of its IMD DSH expenditures; that those claims are still pending and have not been determined at this point to exceed the available IMD DSH limits; and that the record does not show that the disallowed costs were among the funds previously provided to New Jersey. We therefore remand this matter to CMS for further action consistent with the instructions above.

/s/
Sheila Ann Hegy

/s/
Constance B. Tobias

/s/
Leslie A. Sussan
Presiding Board Member