Virginia Department of Medical Assistance Services, DAB No. 3108 (2023)

Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Virginia Department of Medical Assistance Services

Docket No. A-19-34
Decision No. 3108
August 23, 2023

DECISION

The Virginia Department of Medical Assistance Services (Virginia or "the State"), which administers Virginia's Medicaid program, has appealed a June 26, 2018 determination by the Centers for Medicare & Medicaid Services (CMS) disallowing $57,972,975 in federal financial participation (FFP) for that program. Virginia claimed the disallowed FFP for Medicaid payments to two state-owned institutions for mental diseases – Piedmont Geriatric Hospital (Piedmont) and Catawba Hospital (Catawba) – for inpatient services to individuals age 65 or older during calendar years 2006 through 2010. CMS determined that the payments were ineligible for FFP because neither facility had demonstrated its compliance with Medicare special conditions of participation (CoPs) applicable to psychiatric hospitals during the relevant years; specifically, "[c]ertification surveys were not performed by [CMS] . . . due to the two hospitals failing to apply for certification as psychiatric hospitals," and the two hospitals were in fact "certified as acute care and sub-acute care hospitals." Va. Ex. 1, at 1.

In this appeal, the State contends that CMS has no valid grounds for the disallowance determination because Piedmont and Catawba were not required to be surveyed and certified as Medicare psychiatric hospitals in order to receive Medicaid FFP payments for inpatient services to patients age 65 years of age or older. Alternatively, the State contends that Piedmont and Catawba met the Medicare special CoPs through compliance with substantially similar state requirements. For the reasons and bases set out below, we affirm the disallowance.

Legal Background

The federal Medicaid statute, Title XIX of the Social Security Act (Act), authorizes federal grants to states that provide "medical assistance" (that is, health insurance benefits) to low-income persons and families. Act §§ 1901, 1903; 42 C.F.R. § 430.0. Each state administers its own Medicaid program subject to broad federal requirements in Title XIX and its "plan for medical assistance," commonly referred to as the "state plan." Act § 1902; 42 C.F.R. §§ 430.10-430.16.

A state with a federally-approved Medicaid plan becomes entitled to federal matching funds, known as FFP, for a percentage of the expenditures it makes for "medical assistance" and associated administrative costs under the state plan. Act § 1903(a); 42 C.F.R. §§ 430.0, 430.10-.15, 430.30; State Medicaid Manual (SMM)[1] § 2497.

1. Medical assistance

Section 1905(a) of the Act defines reimbursable "medical assistance" as "payment [by the state Medicaid program] of part or all of the cost" of specified categories of "care and services" that must or may be provided to Medicaid-eligible individuals under the state plan. *See also N.J. Dep't of Human Servs.*, DAB No. 2780, at 2 (2017). Such care and services include, for example, inpatient hospital services, physicians' services, and nursing facility services. Act § 1905(a)(1), (4), (5).

2. Medical assistance exclusion: IMD exclusion

Section 1905(a)(30) of the Medicaid statute states that, "except as otherwise provided in paragraph (16)," the term "medical assistance" does not include "payments with respect to care or services for any individual who has not attained 65 years of age who is a patient in an institution for mental disease (IMD)." Act § 1905(a)(30)(B).[2] This provision is known as the IMD exclusion.[3] For purposes of the IMD exclusion, section 1905(i) of the Act defines an "institution for mental diseases" as a "hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services."[4] Regulations implementing the statute's provisions

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concerning the availability of FFP and the IMD exclusion were in effect when Virginia received the FFP payments at issue in this case. *See* 42 C.F.R. § 435.1009 (Oct. 1, 2011); 42 C.F.R. § 435.1009 (Oct. 1, 2006); 42 C.F.R. § 435.1008 (Oct. 1, 2005).[5]

Congress enacted the IMD exclusion to prevent the use of federal Medicaid funds to pay for services that have traditionally been the responsibility of state and local governments. *See Conn. Dep't of Income Maintenance v. Heckler*, 471 U.S. 524, 533 (1985) (persons with mental diseases); *N.J. Dep't of Human Servs.*, DAB No. 1549, at 9 (1995) (noting that one purpose of the IMD exclusion is "to ensure that Medicaid funds are not used to finance care that has traditionally been the responsibility of state governments"), *aff'd, N.J. Dep't of Human Servs. v. United States,* No. 96-441 (AET) (D. N.J., Feb. 11, 1997); *Pa. Dep't of Pub. Welfare*, DAB No. 1042, at 7 (1989) (stating that the IMD exclusion was enacted "based on a general congressional belief that care in mental institutions was a traditional state responsibility and on a general distrust of the effectiveness and efficiency of care in IMDs").

3. Exceptions to the IMD exclusion

a. The 65-or-older benefit (section 1905(a)(14))

On its face the IMD exclusion, as specified in section 1905(a)(30) of the Medicaid statute, does not apply to care and services furnished to IMD patients who are 65 years of age or older. The Medicaid statute elsewhere provides, in section 1905(a)(14), that the term medical assistance includes "*inpatient hospital* services . . . for individuals 65 years of age or over in an institution for mental diseases." (emphasis added). This category of medical assistance (which we refer to as the 65-or-older benefit) is further defined in 42 C.F.R. § 440.140(a) as "services provided under the direction of a physician . . . in an institution for mental diseases that meets the requirements specified in [42 C.F.R.] § 482.60 (b), (c) and (e)"[6] for that institution to participate in the Medicare program as a "psychiatric hospital."

Section 482.60 – provisions of which are incorporated by the regulatory definition of the 65-or-older benefit – provides that a "psychiatric hospital" must meet the conditions of Medicare participation in 42 C.F.R. §§ 482.1-.57 (except section 482.24) that are applicable to all hospitals, as well as the "special" conditions in 42 C.F.R. §§ 482.61 (standards relating to clinical records) and 482.62 (standards relating to staffing). The special conditions were adopted to help ensure that psychiatric hospitals provide "active

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treatment" (and not merely custodial care) to their Medicare and Medicaid patients. 51 Fed. Reg. 22,010, 22,031, 22,033 (June 17, 1986). In summary, the availability of FFP for inpatient hospital services furnished in an IMD to patients 65 years or older "is conditioned on the facility meeting the special Medicare conditions of participation for psychiatric hospitals specified in 42 C.F.R. § 482.60." *N.Y. State Dep't of Social Servs.*, DAB No. 1051, at 2 n.1 (1989).

These requirements have applied to Medicaid for quite some time. In 1977, the Medicaid regulations underwent recodification, with the first phase being effective October 1, 1978. *See* 43 Fed. Reg. 45,176 (September 29, 1978). At that time, 42 C.F.R. § 449.10(b)(14) became 42 C.F.R. § 440.140, and defined the 65-or-older benefit as "inpatient hospital services provided under the direction of a physician . . . in . . . [a]n institution for mental diseases that meets the requirements under [M]edicare, §§ 405.1035 and 405.1036 . . . ." (These provisions were the predecessors to current sections 482.30 and 482.60.) *See* 43 Fed. Reg. at 45,178, 45,227. In 1986, CMS moved the Medicare hospital CoPs, including the two special psychiatric hospital CoPs, from 42 C.F.R. Part 405, "Medicare Programs," into 42 C.F.R. Part 482, "Standards and Certification." 51 Fed. Reg. at 22,010 ("These regulations revise[d] the requirements that hospitals must meet in order to participate in the Medicare *and Medicaid* programs (Titles XVIII and XIX of the Social Security Act).") (emphasis added); *see also* 42 C.F.R. § 482.1(a)(5) (implementing section 1905(a) of the Medicaid statute, such as the section's provision defining the 65-or-older benefit, and stating that Medicaid regulations interpreting section 1905's provisions "specify that hospitals receiving payment under Medicaid must meet the requirements for participation in Medicare").[7] In 1999, 42 C.F.R. Parts 482-498 were redesignated as Subchapter G. *See* 64 Fed. Reg. 66,234, 66,279 (Nov. 24, 1999).

In summary, the regulations found in 42 C.F.R. Part 482 specify licensing, quality of care, safety, and other requirements that institutions must meet in order to participate in Medicare as "hospitals" or "psychiatric hospitals" (Medicare CoPs and special CoPs).

b. The under-21 benefit (section 1905(a)(16))[8]

By operation of the "except-as-otherwise-provided" clause in section 1905(a)(30) of the Act, an exception to the IMD exclusion exists for "inpatient psychiatric hospital services for individuals under age 21" – a category of medical assistance specified in section 1905(a)(16)(A), further defined in section 1905(h), and implemented by 42 C.F.R. §§ 440.160 and 441.151. *See also* 42 C.F.R. § 435.1009(a)(2).

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Section 1905(h) of the Medicaid statute defines "inpatient psychiatric hospital services for individuals under age 21" in relevant part as "inpatient services which are provided in an institution (or distinct part thereof) which is a *psychiatric hospital* as defined in section 1861(f) [of the Medicare statute] or in another inpatient setting that the Secretary has specified in regulations." Act § 1905(h)(1)(A) (emphasis added). Section 1861(f) of the Medicare statute defines the term "psychiatric hospital" to mean an institution that, *inter alia*, meets Medicare conditions of participation for hospitals in section 1861(e)(3) through (9), as well as requirements for "clinical records . . . as the Secretary finds to be necessary to determine the degree and intensity of the treatment provided to" Medicare beneficiaries, and "staffing requirements as the Secretary finds necessary for the institution to carry out an active program of treatment for individuals who are furnished services in the institution." Act § 1861(f)(2)-(4).

The language of section 440.160 in effect during the majority of the audit period (October 4, 2006, through September 30, 2010) reads as follows:

"Inpatient psychiatric services for individuals under age 21" means services that –

(a) Are provided under the direction of a physician;

(b) Are provided by –

(1) A psychiatric hospital or an inpatient psychiatric program in a hospital, accredited by the Joint Commission on Accreditation of Healthcare Organizations, or

(2) A psychiatric facility which is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Council on Accreditation of Services for Families and Children, the Commission on Accreditation of Rehabilitation Facilities, or by any other accrediting organization, with comparable standards, that is recognized by the State.

(c) Meet the requirements in § 441.151 of this subchapter.

42 C.F.R. § 440.160 (Oct. 1, 2009). Effective Oct. 1, 2010, section 440.160(b)(1) was modified to read:

(1) A psychiatric hospital that undergoes a State survey to determine whether the hospital meets the requirements for participation in Medicare as a psychiatric hospital as specified in § 482.60 of this chapter, or is accredited by a national organization whose psychiatric hospital accrediting

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program has been approved by CMS; or a hospital with an inpatient psychiatric program that undergoes a State survey to determine whether the hospital meets the requirements for participation in Medicare as a hospital, as specified in part 482 of this chapter, or is accredited by a national accrediting organization whose hospital accrediting program has been approved by CMS.

75 Fed. Reg. 50,042, 50,418 (Aug. 16, 2010).

To summarize, a state may not use federal Medicaid dollars to pay for services furnished to an inpatient of an IMD age 21 to 64. 42 C.F.R. § 435.1009(a)(2); *Mo. Dep't of Social Servs.*, DAB No. 2677, at 2 (2016). Under the 65-or-older benefit, a state Medicaid program may cover, as medical assistance, inpatient hospital services furnished in an IMD that meets, among other requirements, Medicare conditions of participation applicable to psychiatric hospitals. *New York*, DAB No. 1051, at 2 n.1 (noting that "FFP under Medicaid for inpatient psychiatric hospital services for individuals over the age of 65 is conditioned on the facility meeting the special Medicare conditions of participation for psychiatric hospitals specified in 42 C.F.R. § 482.60"). A state Medicaid program may also cover, as medical assistance, inpatient psychiatric hospital services furnished to an individual under 21 years old in a facility that meets the Medicare statute's definition of a "psychiatric hospital" (or in some "other inpatient setting that the Secretary has specified in regulations" (Act § 1905(h)(1)(A)).

4. Certification of facilities to participate in Medicaid

The certification process is completely separate from the process used to determine whether a facility is an IMD. They are different determinations which involve different considerations. *See Ind. Dep't of Pub. Welfare*, DAB No. 1294, at 9 (1992). Section 1905(a) of the Act provides that "medical assistance" (Medicaid) payments may be applied to various hospital services. Regulations interpreting those provisions specify that hospitals receiving payment under Medicaid must meet the requirements for participation in Medicare (except in the case of medical supervision of nurse-midwife services). *See* 42 C.F.R. §§ 440.10 and 440.165.

Under Medicare, a hospital may be certified as a "hospital" or a "psychiatric hospital." *See* Act § 1861(e) and 1861(f) (defining the terms "hospital" and "psychiatric hospital," respectively); *see also* 42 C.F.R. §§ 482.11-.57 (hospital conditions of participation) and §§ 482.60-.62 (psychiatric hospital conditions of participation). To be certified as a psychiatric hospital, a facility must meet enhanced staffing and record-keeping standards. *Id*. §§ 482.60-.62. For facilities that participate in both Medicare and Medicaid, the state certification serves as a recommendation to the CMS Regional Office. *Id*. § 488.12.

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In addition to the regulations, CMS's State Medicaid Manual (SMM) and State Operations Manual (SOM), CMS Pub. 100-07,[9] address the requirements and processes for ensuring the standards are met for participating in Medicare and Medicaid:

- "When services are furnished through the types of institutions approved for Medicare, the Medicare institutional standards must be met for Medicaid as well." SMM § 2084.B;
- "Section 1864(a) of the Act directs the Secretary to use the State health agencies (SAs) or other appropriate agencies to determine whether health care institutions meet standards. This helping function is termed provider certification." SMM § 2084.1; s*ee also* SOM § 1002 (Rev. 1, effective May 21, 2004);
- "Each State Medicaid agency enters into an interagency agreement with the certifying SA establishing the determination-making function of the certifying SA and providing for the application of Federal certification standards and procedures." SMM § 2084.3(A);

- "[T]he State [must] use the agency responsible for . . . licensing [health institutions] to determine whether institutions meet all applicable Federal health standards for Medicaid participation, subject to validation by the Secretary." SOM § 1002 (citing Act §§ 1902(a)(9)(A) and 1902(a)(33)(B)).
- "To participate in Medicare *and Medicaid*, a psychiatric hospital must meet the special medical records and special staffing requirements (*See* 42 CFR §§ 482.61, 482.62)." SOM § 2718A (Rev. 1, effective May 21, 2004) (emphasis added) (submitted in CMS Ex. 1, at 2).

a. Demonstrating compliance with special psychiatric CoPs

To be certified as Medicaid providers, hospitals must meet the requirements for participation in Medicare. *See* Act § 1905(a); 42 C.F.R.§ 482.1(a)(5). Thus, a hospital's certification status in the Medicare program determines its certification status in the Medicaid program. Medicare/Medicaid certification is ordinarily a two-step process involving both the state health agencies and CMS. Generally, certification of a provider's compliance with Medicare participation requirements is based on state agency surveys. *See* 42 C.F.R. §§ 488.1 (defining the term "certification"), 488.11, 488.12. First, the state agency responsible for the health facility licensure collects an extensive range of information concerning the facility's staff, physical plant, and services. The

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certification review is conducted pursuant to detailed federal forms which require the state survey agency to examine virtually every aspect of how the facility conducts its business. *See id.* § 488.26. The CMS Regional Office has the final authority to determine whether a facility should be certified. *Id.* §§ 488.11, 488.12; *see also* SOM § 1008.

Alternatively, a provider may demonstrate such compliance based on the survey and recommendation of a national accrediting organization (AO), such as The Joint Commission (formerly known as the Joint Commission on Accreditation of Healthcare Organizations), whose accreditation program is approved by CMS. *See* 42 C.F.R. §§ 488.4, 488.5. If the provider "demonstrates full compliance with all of the accreditation program requirements of the [AO]'s CMS-approved accreditation program," then CMS may grant "deemed status" to the provider – that is, certify the provider for Medicare participation based on the AO's recommendation. *Id*. §§ 488.4(a)(1), 488.1 (defining "deemed status"); *see also* Act § 1865(a)(1). In summary, a facility meets applicable requirements when it is *surveyed for, and certified as complying with*, the requirements. *See* 42 C.F.R. §§ 482.1, 488.1, 488.10 and 488.12.

The SOM in effect during the audit period set forth procedures for demonstrating compliance with the Medicare special CoPs applicable to psychiatric hospitals. Section 2718A explains that a facility demonstrates it meets the special psychiatric CoPs by undergoing a specialized survey, performed by surveyors who have heightened credentials focused on psychiatric care. CMS Ex. 1. Specifically, these surveys can only be performed "by board-certified psychiatrists and Masters-prepared psychiatric nurses, and, if necessary, Masters-prepared psychiatric social workers." *Id*. at 2. All State-owned and operated psychiatric hospitals are to be surveyed by CMS contract specialist surveyors to the extent possible, depending on availability and the scope of the program. *Id*. Section 2718C states that "CMS surveyors are responsible for the opening conference, the survey of the two special conditions, 42 CFR 482.61 and 482.62, and the exit conference." *Id.* at 3.

The SOM's former Appendix AA,[10] titled "Psychiatric Hospitals – Interpretive

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Guidelines and Survey Procedures," explained the extensive survey protocol required to determine compliance with the two special psychiatric CoPs. *See* CMS Ex. 2. Appendix AA affirmed that active treatment is crucial to determining whether a psychiatric hospital is entitled to Medicare and Medicaid payment, stating: "Active treatment is an essential requirement for inpatient psychiatric care. . . . The patient is in the hospital because it has been determined that the patient requires intensive, 24 hour, specialized psychiatric intervention that cannot be provided outside the psychiatric hospital." *Id.* at 35 (element B125). The concept of active treatment does not apply in general hospitals. Accordingly, the survey protocols for such hospitals do not address whether a facility is providing active treatment to its patients. *See* CMS Ex. 2. Part II of the former Appendix AA divided the two special CoPs into 61 elements, from B98 through B158. *Id.* at 17-59. Surveyors must consider all of these elements when determining whether a facility complies with the special CoPs. *See id.* at 11 (Part I), 17-59 (Part II).

b. Eligibility for FFP

An "inpatient" is "a patient who has been admitted to a medical institution as an inpatient on recommendation of a physician . . . and who . . . [r]eceives room, board and professional services in the institution for a 24-hour period or longer." 42 C.F.R. § 440.2(a)(1). Except as limited in Part 441, FFP is available in expenditures under the State plan for medical or remedial care and services as defined in subpart A (sections 440.1 through 440.185). *Id.* § 440.2(b). While some provisions in Part 441 prohibit FFP for services furnished to institutionalized individuals, those prohibitions do not apply to an individual age 65 or older in an IMD. *See id.* §§ 441.11(c)(2), 441.13(a)(2). Part 441, subpart C, implements section 1905(a)(14) of the Act, which authorizes State plans to provide for inpatient hospital services "for individuals age 65 or older in an institution for mental diseases," and sections 1902(a)(20)(B) and (C) and 1902(a)(21), which prescribe the conditions a state must meet to offer these services. *Id.* § 441.100.

SMM § 2497.1 indicates that FFP "is only available for allowable actual expenditures made on behalf of eligible recipients for covered services *rendered by certified providers.*" (emphasis added.)

Factual Background

As noted, the dispute in this appeal concerns disallowance of FFP for Medicaid payments by Virginia to Piedmont and Catawba Hospitals, both state-owned institutions, for inpatient hospital services provided to individuals age 65 or older.

During the audit period (calendar years 2006 through 2010), Piedmont and Catawba provided long-term inpatient psychiatric treatment for geriatric patients, most of whom were Medicaid-eligible, and many of whom were dually eligible for Medicare and Medicaid. Virginia Brief (Va. Br.) at 3; CMS Br. at 13. During the audit period,

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Piedmont and Catawba were participating in both Medicare and Medicaid – as acute care hospitals in Medicare, and as IMDs in Medicaid. Va. Br. at 4; CMS Br. at 4, 14.

In addition, during the audit period, Piedmont and Catawba Hospitals:

- were operated by the Virginia Department of Behavioral Health and Developmental Services (VDBHDS);
- were not licensed as hospitals pursuant to statute (Va. Code § 32.1-124) exempting hospitals owned or operated by the Commonwealth from such licensing[11];
- were accredited as hospitals by The Joint Commission;
- were considered IMDs[12]; and
- requested reimbursement from Medicaid for inpatient psychiatric services.

Va. Br. at 4; CMS Br. at 14.

On May 4, 2011, the Department of Health and Human Services Office of the Inspector General (OIG) notified Virginia of a nationwide survey to determine "whether psychiatric hospitals met appropriate conditions of participation (CoP) prior to receiving Medicaid service and DSH [disproportionate share hospital] payments" from 2001 to 2011. Va. Ex. 3. The OIG noted that it had "identified four government-owned hospitals in Virginia where CoP compliance [could not] be established based on . . . current information." *Id*. On April 17, 2012, the OIG notified Piedmont and Catawba of its intent to conduct an audit to determine whether the State properly claimed FFP for payments to the hospitals for inpatient psychiatric services furnished from January 1, 2006 through December 31, 2010. Va. Ex. 4(a). The OIG conducted the audit and

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provided draft reports, and Virginia provided comments on April 7, 2014.[13] The OIG released its final audit reports on July 10, 2014. *See* Va. Ex. 5 (Report on Medicaid Payments to Piedmont); Va. Ex. 6 (Report on Medicaid Payments to Catawba).

The OIG concluded that during the audit period (excluding a four-month interlude in 2007, discussed in the next paragraph), Virginia improperly claimed $36,903,169 in FFP for Medicaid payments to Piedmont for inpatient hospital services furnished to 65-or-older patients, and $17,395,647 in FFP for payments to Catawba for the same category of services. Va. Ex. 5, at ii, 2-3; Va. Ex. 6, at ii, 2-3. The basis for these conclusions was that neither Piedmont nor Catawba had demonstrated compliance with the two Medicare special CoPs during the audit period, as neither had been "specially surveyed by qualified health care professionals to demonstrate [such] compliance." Va. Ex. 5, at 4-5; Va. Ex. 6, at 4-5.

The OIG further found that the State had claimed additional amounts of potentially unallowable FFP for services rendered by Piedmont and Catawba to 65-or-older patients during the four-month period from June 28, 2007 through October 26, 2007. Va. Ex. 5, at i-ii, 2-3; Va. Ex. 6, at i-ii, 2-3. The OIG referred to this four-month period as the "regulatory gap period."[14] *Id.* The additional amounts of FFP associated with that period totaled $2,462,157 for Piedmont and $1,212,002 for Catawba. *Id.*

Based on these findings, the OIG recommended that Virginia:

- refund $54,298,816 in FFP claimed for inpatient hospital services furnished by Piedmont and Catawba to patients 65 or older "on dates outside the regulatory gap period" (that is, $36,903,169 claimed for Piedmont's 65-or-older inpatient services for calendar years 2006 through 2010 excluding the regulatory gap period, plus $17,395,647 claimed for Catawba's services for the same services and time period excluding the regulatory gap period);
- work with CMS to determine whether the State should refund an additional $3,674,159 of FFP claimed for inpatient hospital services furnished by the hospitals to patients 65 or older during the regulatory gap period (that is, $2,462,157 claimed for Piedmont's services plus $1,212,002 for Catawba's services); and

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- ensure that Virginia claims federal reimbursement for Medicaid payments for inpatient hospital services provided to patients age 65 o r older in IMDs only if those IMDs can demonstrate compliance with the Medicare special CoPs.

Va. Ex. 5, at 5; Va. Ex. 6, at 5.

During the audit period (2006 through 2010), The Joint Commission had a CMS-approved accreditation program for facilities or institutions requesting Medicare participation as hospitals but *not* for those requesting participation as psychiatric hospitals. *See* CMS Ex. 5, at 8 ("[A]lthough 42 C.F.R. [§] 488.6 permits [a psychiatric hospital] to [participate in Medicare] via deemed status, to date no AOs have applied for CMS recognition of a psychiatric hospital accreditation program."). CMS did not approve The Joint Commission as a national AO for psychiatric hospitals until February 2011. *See* 76 Fed. Reg. 10,598 (Feb. 25, 2011); Va. Ex. 15.

For certification purposes, CMS considers accreditation under a CMS-approved Medicare accreditation program only where the AO has recommended deemed status. *See* 42 C.F.R. § 488.1 (definition of "deemed status"); SOM § 2003C.[15] "[I]t is not sufficient for a health care facility seeking Medicare participation to document that it is accredited; it must document that a CMS-recognized AO has accredited it under its recognized deemed status program and that the AO has recommended that CMS grant the facility certification via deemed status." *See* CMS Ex. 5, at 5-6. Because there were no CMS-recognized "deemed status" programs for psychiatric hospitals during the audit period, The Joint Commission's accreditation of Piedmont and Catawba hospitals did not include recommendations that CMS certify them as meeting the Medicare special CoPs via "deemed status." CMS submits, and Virginia does not dispute, that while both Piedmont and Catawba were accredited as "hospitals," neither hospital was certified as meeting the special CoPs for psychiatric hospitals during the audit period. *See* CMS Br. at 22; Va. Br. at 9, 17.

On August 1, 2014, after receiving both final OIG audit reports, the Virginia Secretary of Health and Human Resources (HHR) sent a letter to the CMS Administrator. Va. Ex. 16. The letter explained that after receiving the draft OIG reports, but prior to the final reports being issued, Virginia sought to "ensure compliance going forward" by asking the state survey agency to survey the two hospitals for the two "special conditions," but that when the survey agency took action to schedule the surveys CMS directed it to stop. *Id*. at 1-2. The letter also referred to a conference call between personnel from three state agencies and CMS, during which the Virginia representatives stated they were seeking to

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ensure compliance with requirements applicable to psychiatric hospitals.[16] *Id*. at 2. The letter characterized CMS as being "perplexed by the existence of facilities that are both psychiatric hospitals and medical hospitals," and indicated that CMS directed Virginia to "put its request in writing to the Certification and Enforcement Branch in the Philadelphia Regional Office." *Id*. The letter concluded by stating that the State's efforts to ensure compliance had been frustrated by CMS and that it sought "direction on how to resolve this." *Id*.

Virginia asserts that CMS did not respond to its August 1, 2014 letter until September 27, 2017, and that CMS's letter with that date "again[17] failed to mention anywhere that a hospital needs to be surveyed and certified as a psychiatric hospital in order to receive Medicaid reimbursement and did not address the state's inability to get the hospitals certified or suggest a way forward" for Virginia. Va. Br. at 6 (citing Va. Ex. 17).

CMS disagrees with Virginia's representation that CMS did not respond to the State's correspondence until 2017. CMS Br. at 16. CMS asserts that it responded to the State's August 1, 2014 correspondence in an October 9, 2014 letter, a copy of which it submitted as CMS Exhibit 3. Virginia did not object to the submission of this document or submit a reply brief. The October 9, 2014 response clearly indicated that section 1861(e) of the Act requires that a hospital that "primarily provides 'care and treatment of mental diseases'" may participate in the Medicare program only as a psychiatric hospital as defined in section 1861(f) of the Act, and that section 1861(f) of the Act requires a psychiatric hospital to meet certain requirements above and beyond the standard requirements for a hospital in order to participate in Medicare. CMS Ex. 3,at 1 (quoting section 1861(e)). The response also provided clear guidance as to what actions needed to be taken for both hospitals to continue to participate in Medicare:

- The Medicare enrollment status of both Piedmont and Catawba must be changed to psychiatric hospitals;
- The hospitals must take action to demonstrate they meet the psychiatric CoPs;
- Because both Piedmont and Catawba participate in Medicare on the basis of being accredited by The Joint Commission, the Virginia survey agency is not

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- able to assess the hospitals' compliance with the special psychiatric CoPs. This must be handled through The Joint Commission;
- The Philadelphia Regional Office of CMS was prepared to work with both hospitals and The Joint Commission in order to resolve the issue as expeditiously as possible.

Id. at 1-2.

CMS further asserts that its September 27, 2017 letter was in fact a response to a "second request" from Virginia, dated September 30, 2016. *See* CMS Br. at 17 n.8 (citing CMS Ex. 4).[18] The September 30, 2016 document, titled "Technical Assistance Request from Virginia on IMD Rules," does not specifically confirm receipt of the October 9, 2014 response, but it does state, "Thank you for your willingness to help make sure Virginia is on the right track." CMS Ex. 4. The next documented correspondence is the Notice of Disallowance.

The Notice of Disallowance (NOD), dated June 26, 2018 (a little less than four years after the OIG issued its final reports), notified Virginia that CMS was disallowing $57,972,975 in FFP for Medicaid payments to Piedmont and Catawba for inpatient hospital services furnished to individuals age 65 or older in IMDs from January 1, 2006, through December 31, 2010. Va. Ex. 1. The NOD stated: "This disallowance is one of several that we are issuing after a thorough review of pending potential disallowance items. Because of their age, we have taken the opportunity to carefully review the issues and ensure that the disallowance actions are appropriate." *Id*. at 1. CMS determined that Virginia's FFP claims for those services were unallowable because Piedmont and Catawba had not been "surveyed for compliance with [the Medicare special] CoPs" and had not otherwise demonstrated such compliance. *Id*. at 2. CMS also determined that because the Medicare CoPs for psychiatric hospitals did not change as a result of CMS's inadvertent omission of 42 C.F.R. §§ 482.61 and 482.62 from a 2007 rulemaking, Virginia's payments to Piedmont and Catawba for inpatient hospital services furnished to 65-or-older patients from June 28 through October 25, 2007 (the so-called regulatory gap period) were unallowable. *Id*.

The NOD addressed Virginia's audit response that although the hospitals had not obtained "federal certification," its Medicaid payments to the hospitals for 65-or-older patients were entitled to FFP because surveys performed during the audit period to verify

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compliance with state requirements demonstrated compliance with the Medicare special conditions of participation for psychiatric hospitals. *Id*.; *see also* Va. Ex. 5, Appendix (April 7, 2014 letter). CMS disagreed, stating that Virginia had not produced any survey documents and had not demonstrated what the state surveyors reviewed. Va. Ex. 1, at 2. CMS concluded that the premise underlying Virginia's argument, — that facilities do not need to obtain federal certification to claim federal payment, but need only show that they meet the requirements for certification — is incorrect and would be administratively unworkable. *Id*.

On October 23, 2018, CMS denied Virginia's request for reconsideration of the disallowance, affirming the disallowance for the reasons stated in the NOD.[19] *See* Va. Ex. 2. Virginia then timely filed its notice of appeal to challenge the disallowance in accordance with 45 C.F.R. Part 16 and 42 C.F.R. § 430.42(f).

Standard of Review

The Board is authorized to review specified "final written decisions," including "disallowances" under title XIX of the Act (Medicaid). 45 C.F.R. Part 16, App. A, ¶¶ A, B(a)(1). The Board must sustain a disallowance "if it is supported by the evidence submitted and is consistent with the applicable statutes and regulations." *W. Va. Dep't of Health & Human Res.*, DAB No. 2185, at 20 (2008) (citing 45 C.F.R. §§ 16.14, 16.21). In decisions reviewing disputed disallowances of FFP for a state's Medicaid program expenditures, the Board "has consistently held that a state has the burden to document the allowability and allocability of its claims for FFP" once CMS has set out a lawful basis for its action. *N.J. Dep't of Human Servs*., DAB No. 2328, at 4-5 (2010) (citations omitted).

Analysis

It is undisputed that throughout the audit period, the hospitals at issue participated in Medicare, not as psychiatric hospitals, but as acute care hospitals. Furthermore, for the purpose of the issues before us, it is undisputed that the hospitals were IMDs, focused on inpatient treatment for geriatric mental illnesses, primarily providing inpatient long-term psychiatric services to individuals age 65 or older, and also providing acute care to those same patients as needed. Va. Br. at 3; CMS Br. at 13. The disallowance involved requests for FFP for Medicaid payments for these inpatient long-term psychiatric hospital services.

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Virginia asserts that the Act is silent as to whether inpatient services provided in an IMD to individuals age 65 or older are "psychiatric services" as well as to whether an IMD furnishing such services must meet the Medicare requirements for a psychiatric hospital, and thereby challenges CMS's interpretation of section 1905(a) to include these requirements. Va. Br. at 7. Moreover, Virginia asserts that CMS interprets services provided in an IMD to be "psychiatric services" such that an IMD must meet the Medicare special CoPs for psychiatric hospitals pursuant to 42 C.F.R. § 440.140. *Id*. at 7-8. Virginia contends that an IMD need not be a psychiatric hospital under Medicare to be eligible to receive FFP for Medicaid payments. *Id*. at 9. Alternatively, Virginia argues that "Medicare certification" is not required, that a hospital need only show "substantial compliance" with the Medicare special CoPs, and that both Piedmont and Catawba were "substantially compliant" with those conditions as a result of being compliant with "substantially similar" Virginia requirements. *Id*. at 18-27.

CMS asserts that Virginia admits that during the audit period, Piedmont and Catawba were psychiatric hospitals that participated in Medicare as acute care hospitals. CMS Br. at 4, 14. With regard to Virginia's argument that the hospitals did not need to be certified, but only had to show "substantial compliance" with the Medicare special CoPs, CMS asserts:

- The hospitals had to be certified for compliance with the Medicare special CoPs;
- Virginia demonstrated only that the hospitals were subject to the state requirements but produced no survey findings establishing that the hospitals complied with those requirements;

- The state requirements lack critical elements of the Medicare special CoPs.

Id. at 4. Therefore, CMS asserts that even if certification was not required, which CMS disputes, the FFP claims would still be unallowable because Virginia failed to show the hospitals "substantially complied" with the Medicare special CoPs. *Id*. at 4-5.

We begin by discussing the parties' respective burdens in this appeal: CMS bears the initial burden to articulate the basis for the disallowance; and Virginia bears the ultimate burden to prove that the disallowed Medicaid expenditures are allowable (that is, eligible for FFP). We then discuss why Virginia has not met its burden of proof, based in part on its acknowledgement that Piedmont and Catawba provided inpatient long-term psychiatric services to individuals age 65 or older during the audit period.

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1. CMS has met its initial burden to articulate the basis for the disallowance; Virginia has the burden to demonstrate the allowability of its claimed costs.

In cases proceeding under 45 C.F.R. Part 16 such as this one, the Board has stated that the awarding federal agency *first* must articulate the basis for its decision such that the non-federal party can understand the issues raised by the agency's decision. *See, e.g.*, *Mass. Exec. Off. of Health & Hum. Servs.*, DAB No. 2218, at 11 (2008), *aff'd*, 701 F. Supp.2d 182 (D. Mass. 2010); *Me. Dep't of Health & Hum. Servs.*, DAB No. 2292, at 9 (2009), *aff'd*, 766 F. Supp.2d 288 (D. Me. 2011); *Mo. Dep't of Soc. Servs.*, DAB No. 2994, at 6 (2020) (and cited cases). If the federal agency meets that burden, which the Board has consistently described as *minimal*, then the non-federal party bears the burden to demonstrate that the federal agency's decision was wrong. *See Mass. Exec. Off.* at 11.

We are satisfied that CMS's NOD was sufficient to meet CMS's initial burden. As noted above, the notice explained that the disallowance was based on the results of the OIG's audit. Va. Ex. 1, at 1. Indeed, the NOD cited the OIG's findings that claims for inpatient hospital services for individuals age 65 or older in IMDs were not in accordance with federal requirements because the IMDs (Piedmont and Catawba) had not demonstrated compliance with the Medicare special CoPs during the audit period. *Id*. The Board has determined that federal agencies may meet their initial burden of proof in appeals of determinations arising from audit findings by sufficiently explaining in their decisions that the decisions were based on audit findings. *See Int'l Educ. Servs., Inc.*, DAB No. 3055, at 12 (2021) (rejecting the award recipient's argument that a disallowance and withholding of a non-competing continuation award following an OIG audit were insufficiently specific, because the decisions "provided sufficient information about the bases for the decisions to enable [the award recipient] to respond during the appeal"), *request for reconsideration docketed*, Docket No. A-22-35 (Feb. 1, 2022).

With CMS having met its initial, minimal burden, the question becomes whether Virginia has met its burden to prove that the disallowed costs were allowable. Board review under the Part 16 procedures is generally limited to resolving disputes about material facts and deciding whether the appealed decision is consistent with applicable law and regulations. The Board therefore must uphold a decision where it is authorized by law and the non-federal party has not disproved the factual basis for the decision. *See* 45 C.F.R. § 16.14 (captioned "How Board review is limited" and stating that the Board is "bound by all applicable laws and regulations"); *see also S.A.G.E. Commc'ns Servs.*, DAB No. 2481, at 5-6 (2012) ("The Board must uphold a disallowance" when it is "authorized by law" and its "factual basis" has not been "disproved.").

Virginia does not expressly assert that CMS failed to meet its initial burden, nor does it challenge the factual basis for the disallowance. Instead, Virginia asserts that "Medicare certification" is not required, that a hospital need only show "substantial compliance" with the Medicare special CoPs, and that both Piedmont and Catawba were "substantially

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compliant" as a result of being compliant with Virginia requirements that were "substantially similar" to the federal CoPs. Va. Br. at 9-27. We reject Virginia's arguments and explain below why Virginia has not shown that the disallowed Medicaid payments to Piedmont and Catawba are eligible for federal Medicaid reimbursement.

2. Piedmont and Catawba were required to meet the Medicare special CoPs under 42 C.F.R. §§ 482.60 through 482.62.

The legal background section above identified that 42 C.F.R. § 440.140 has a long history. A review of that history reveals that the language regarding compliance with particular provisions at issue in this appeal, namely the requirement for certification under the Medicare CoPs and special CoPs for psychiatric hospitals, has been substantively unchanged since at least 1977. We summarize the relevant changes in the discussion below.

a. Regulatory changes

In September 1977, Part 405 (Federal Health Insurance for the Aged and Disabled) of Title 20 of the Code of Federal Regulations (C.F.R.) was recodified under the newly created Chapter IV of Title 42 for the new Health Care Financing Administration (HCFA), created by the Departmental Reorganization Order published on March 9, 1977 (42 Fed. Reg. 13,262). *See* 42 Fed. Reg. 52,826 (Sept. 30, 1977). The preamble language for the 1977 rulemaking indicated the recodification "will bring together in a single chapter the regulations governing the three major programs of [HCFA] . . . [and] will make the regulations more accessible and preclude the confusion that exists because of codification under three different chapters under three different titles [Medicare, Medicaid, and Professional Standards Review Organizations]."[20] *Id*.; *see also* 42 Fed. Reg. 65,112 (Dec. 29, 1977).

In 1978, additional changes were made to the Medical Assistance Program regulations in Title 42. *See* 43 Fed. Reg. 45,176 (Sept. 29, 1978). The preamble language for the 1978 rulemaking stated:

These regulations reorganize and redesignate, with clarifying editorial changes, the current regulations for the [M]edicaid program (title XIX of the Social Security Act). No policy changes have been made in the existing regulations. Those regulations will now be systematically and intensively reviewed for possible revisions . . . .

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* * * *

This document contains all [M]edicaid regulations currently in 42 [C.F.R.] chapter IV, subchapter C . . . includ[ing] all new [M]edicaid regulations and revision published as final rules during the last few months.

Id. The effective date of the changes was October 1, 1978. *Id.*

In 1978, Section 440.140(a)(ii) required that IMDs meet the requirements under §§ 405.1035 (except for admission and utilization reviews) and 405.1036 (psychiatric hospitals). *Id*. at 45,227. Section 405.1036 required that psychiatric hospitals be in substantial compliance with §§ 405.1037 (special medical records requirements) and 405.1038 (special staffing requirements). *See* 31 Fed. Reg. 13,424, 13,439-13,440 (Oct. 18, 1966) (reflecting these requirements as previously codified in Title 20 of the Code of Federal Regulations); 42 Fed. Reg. 52,826 (recodifying the contents of 20 C.F.R. Part 405 under 42 C.F.R. Subchapter B, Part 405).

Finally, in 1986, the regulations involving the hospital CoPs in Medicare and Medicaid programs were revised. *See* 51 Fed. Reg. 22,010. The Medicare CoPs were contained in 42 C.F.R. Part 405, which were also applicable to Medicaid participation pursuant to §§ 440.10(a)(3) and 440.20(a)(3). *Id.* A new Part 482 was added, titled "Conditions of Participation for Hospitals." *Id.* at 22,011, 22,042. Some existing provisions were redesignated to this new section. Relevant to this case, new section 482.1(a)(3) stated:

Section 1905(a) of the Act provides that "medical assistance" (Medicaid) payments may be applied to various hospital services. Regulations interpreting those provisions specify that hospitals receiving payment under Medicaid must meet the requirements for participation in Medicare (except in the case of medical supervision of nurse-midwife services. See §§ 440.10 and 440.165 of this chapter.).

Id. at 22,042.

While the verbiage and organization of the Medicare special CoPs in sections 482.60-.62 have been modified, the substantive requirements of meeting basic hospital functions, optional hospital services, and requirements for psychiatric hospitals incorporated by reference remained the same. Accordingly, for Piedmont and Catawba to be

eligible for FFP for inpatient hospital services furnished under the 65-or-older benefit, they were required to meet the Medicare special CoPs, which in turn required the facilities to have been surveyed and certified as demonstrating compliance with the special CoPs.

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b. Conditions of participation for inpatient hospital services in an IMD participating in Medicaid

As noted above, Virginia contends that the Act is silent about whether inpatient services for individuals age 65 or older are "psychiatric services" and about whether an IMD furnishing such services must meet the Medicare participation requirements for a psychiatric hospital, and therefore Virginia asserts that CMS erroneously interprets services provided in an IMD to be "psychiatric services" such that an IMD must meet the Medicare special CoPs for psychiatric hospitals pursuant to 42 C.F.R. § 440.140. *Id*. at 7, 12-13. To the extent Virginia's assertions could be viewed as a challenge to the validity of section 440.140 of the regulations, the Board's governing regulations provide that "the Board shall be bound by all applicable laws and regulations." 45 C.F.R. § 16.14. The Board has consistently held that it is bound to apply the duly promulgated regulations of the Secretary. *Ca. Dep't of Social Servs*., DAB No. 1959, at 7 (2005).

We do not view Virginia's appeal as challenging the validity of any Medicaid program regulations. Rather, we construe Virginia's challenge to be directed at the process by which a state must demonstrate that an IMD "meet[s] the standards" to be eligible to participate in Medicaid. Virginia asserts that an IMD need not be accredited or certified as a psychiatric hospital under Medicare to be eligible to receive FFP for Medicaid payments, "since they were not billing Medicare for inpatient psychiatric services." Va. Br. at 9, 13.

Additionally, Virginia asserts that "CMS acknowledged that there was confusion around the impact of Joint Commission accreditation of psychiatric hospitals." Va. Br. at 5. According to Virginia, the confusion stemmed from CMS answers to Frequently Asked Questions (FAQs) appended to an October 17, 2008 Survey and Certification Memorandum entitled "Accreditation and its Impact on Various Survey and Certification Scenarios."[21] *Id.* at 5 n.6. Virginia asserts that, in those answers, CMS "acknowledged confusion as a result of accrediting organizations offering certification for provider types, like psychiatric hospitals, that CMS had not recognized for purposes of deeming." *Id.* Virginia further asserts that in answers to FAQs appended to a May 6, 2011 Survey and Certification Memorandum entitled "Approval of Deeming Authority of the Joint Commission for Psychiatric Hospitals" (Va. Ex. 15), CMS suggested that hospitals had been relying on Joint Commission accreditation for purposes of meeting the Medicare special CoPs for psychiatric hospitals based only on compliance with the Medicare CoPs for acute-care hospitals. Va. Br. at 5 n.6 (quoting a statement by CMS from May 2011

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FAQs that "effective February 25, 2011, the Joint Commission can no longer accredit and recommend a psychiatric hospital for deemed status based on compliance with the hospital CoPs (A tags) alone" (Va. Ex. 15, at 4)). We find Virginia's interpretation erroneous for a number of reasons.

First, the 2008 FAQ response denied that a facility accredited by an AO could always seek Medicare participation via "deemed status," pointing out that a facility must document that a CMS-recognized AO has accredited the facility under the AO's recognized deemed status program and has recommended that CMS grant the facility certification via deemed status. *See* Oct. 17, 2008 Mem. at 5-6. This response corresponds with the language in 42 C.F.R. § 488.1 and section 2003C of the State Operations Manual. The May 6, 2011 Memorandum announced that the approval of deeming authority of The Joint Commission for Psychiatric Hospitals provided "an accreditation option which previously did not exist." *See* Va. Ex. 15 at 1, 3. The 2011 FAQ response indicated that any *psychiatric hospital currently accredited and deemed* by The Joint Commission for the hospital CoPs will be considered deemed for both the hospital CoPs and the special CoPs. *Id*. at 4, Q-1. The language Virginia relies on has no bearing on Piedmont or Catawba as there is no evidence that, prior to 2012, they were ever accredited by The Joint Commission with recommendation to CMS for certification as psychiatric hospitals. The *only* Joint Commission accreditations for Piedmont and Catawba during the audit period were as acute care hospitals.

We agree with Virginia that the Act does not define "inpatient hospital services in an IMD" and that no authority specifically states that an IMD must participate as a psychiatric hospital under Medicare to be eligible to receive FFP for Medicaid payments. However, these conclusions are not dispositive to the issue before us. The issue here is not whether Piedmont and Catawba were participating in Medicare as "psychiatric hospitals," but whether they were eligible to receive FFP for Medicaid payments for inpatient hospital services to individuals age 65 and over in an IMD during the audit period. In order to be entitled to FFP for Medicaid payments for inpatient hospital services furnished in an IMD to individuals 65 years or older, the State must demonstrate that the IMD met the Medicare special CoPs when the services were provided. 42 C.F.R. §§ 440.140(a) (defining "inpatient hospital services for individuals age 65 or older in [IMDs]" as "services provided under the direction of a physician . . . in an [IMD] that meets the requirements" for participation in Medicare as a psychiatric hospital) and 440.2(b) (providing that FFP "is available in expenditures" for "services as defined in" Part 440); *see also N.Y. State Dep't of Social Servs.*, DAB No. 678, at 5 (1985) (stating that under the predecessors to 42 C.F.R. § 440.140, FFP is available for services in an IMD only if the IMD meets Medicare standards for psychiatric hospitals).

The Board addressed this issue in *New Jersey Department of Human Services*, DAB No. 513 (1984), although neither party cited to that decision. *New Jersey* involved disallowances for inpatient services provided to both individuals age 65 or older, and

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individuals under age 21, in an IMD. While the regulations cited in *New Jersey* have been modified and re-codified since 1984, the language at issue here remains substantially the same, as indicated in the historical review above.

In *New Jersey*, the Board found that the Act did not define "inpatient hospital services for individuals age 65 or older in an IMD" but acknowledged that "[a]s with other medical services included in the original Medicaid amendments of 1965, 'inpatient hospital services' is defined in the regulations." DAB No. 513, at 3. Specifically, 42 C.F.R. § 440.140(a)(1)(ii) defined "inpatient hospital services for individuals age 65 or older in an IMD" as services that "meet[ ] the requirements under Medicare, § 405.1035 and § 405.1036 of this chapter" – namely, utilization review and Medicare special CoPs for psychiatric hospitals.[22] *Id.* at 1, 3. The decision cited to section 1102 of the Act, stating the Secretary's authority expressly includes the responsibility of implementing the Act and to make and publish such rules and regulations as may be necessary to the efficient administration of the Secretary's functions, and held the Medicaid regulations in question were promulgated under the authority of section 1102. *Id*. at 4.

Furthermore, *New Jersey* held:

[W]e find that the State has not shown that the regulations are not "reasonably related" to the enabling legislation and not necessary to the efficient administration of the Medicaid program. In addition, the regulations can be viewed as an interpretation of the phrase "inpatient hospital services" in the Medicaid amendments to the Act, and we would find that interpretation reasonable.

Id. at 4 (citing *Thorpe v. Housing Authority of the City of Durham*, 393 U.S. 268, 280-81 (1969) ("The Supreme Court, faced with a similar general implementation provision, has held that the validity of a circular promulgated under that provision will be sustained so long as it is 'reasonably related to the purposes of the enabling legislation.'")).

As previously noted, the legislative history indicates that Congress intended for Medicaid to support the provision of services that "cover only active care intended to cure patients in [mental and tuberculosis] hospitals and not to cover custodial care." *See* Act §§ 1902(a)(20), (21); *see also* S. Rep. No. 89-404, at 26, 40 (June 30, 1965), *reprinted in* 1965 U.S.C.C.A.N. 1943, 1987 (dated June 30, 1965). This same intent is found in the original language of section 405.1036(a):

The conditions of participation for psychiatric and tuberculosis hospitals are similar to those for other hospitals, though differing in some respects due to their different purpose. To provide assurance that the program while

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paying for active treatment in psychiatric and tuberculosis hospitals would avoid paying for care that is merely custodial, the conditions of participation require that the hospital be accredited by the Joint Commission on Accreditation of Hospitals, that its clinical records be sufficient to permit the Secretary to determine the degree and

intensity of treatment furnished to beneficiaries, and that it meet staffing requirements the Secretary finds necessary for carrying out an active treatment program.

31 Fed. Reg. at 13,439-40.

New Jersey addressed the regulations given the statutory scheme and legislative history:

First, inpatient hospital services for IMDs and tuberculosis hospitals would be similar in many respects to inpatient services for hospitals generally. The Secretary would therefore use Medicare statutory standards which (unlike those for Medicaid) spell out in some detail requirements for inpatient hospital services.

Second, IMDs providing inpatient psychiatric hospital services have a purpose different, though related, from institutions solely providing hospital care. . . .

* * * *

. . . There is no indication in the legislative history of the 1965 amendments that Congress intended Medicaid to support a lesser standard of quality of care than the Medicare program provided. It was, therefore, reasonable for the Secretary to use the Medicare provisions to define under Medicaid inpatient hospital services for persons age 65 or older in an IMD. Moreover, adoption of Medicare standards for inpatient hospital services for the aged in IMDs promotes efficiency by permitting a hospital to be certified to participate in both the Medicare and Medicaid programs by meeting one set of standards.

DAB No. 513, at 5.

Like the Board in *New Jersey*, we find that the regulations requiring compliance with the CoPs and special CoPs for inpatient hospital services to individuals age 65 or older in an IMD to be reasonably related to the enabling legislation. As addressed above, the requisite standards have not substantively changed; only the location of where that language can be found in the regulations has changed.

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Virginia also relies on the fact that "inpatient psychiatric hospital services to individuals under age 21" is defined in the Act and implementing regulations and that those authorities require that such services be provided in a "psychiatric hospital" or an inpatient psychiatric program in a hospital. Va. Br. at 12-13 (citing Act §§ 1905(a)(16) and 1905(h), and 42 C.F.R. § 440.160(b)(1) (Oct. 1, 2009)). Virginia argues the distinction between the language in those provisions explicitly requiring the services be provided in a psychiatric hospital, and the absence of such language in section 1905(a)(14) of the Act and 42 C.F.R. § 440.140, "must inform the proper interpretation of the regulations issued by CMS implementing these provisions" where "no such linkage was established by Congress." *Id*. at 12.

We again cite to *New Jersey,* which explained that the 1972 amendments to the Act providing for coverage of inpatient psychiatric hospital services to individuals under the age of 21 were a result of a conflict between the House and Senate versions of the bill, where the House version contained no provision for this coverage and the Senate version authorized coverage in an accredited institution providing active care and treatment such as the services provided by a psychiatric institution in the Medicare program. DAB No. 513, at 5 (citing S. Rep. No. 1230, 92nd Cong., 2nd Sess. 281 (1972)). The Conference Report (H.R. Rep. No. 1605, 92nd Cong., 2nd Sess. 65 (1972)) set specific limitations on the Senate bill, which are now codified in section 1905(h) of the Act and 42 C.F.R. § 440.160. *Id.* The decision in *New Jersey* again relied on the legislative history to conclude that the "historical development of the Act created differing regulatory requirements to meet the different service needs of different age populations," and "[t]here is no indication in the legislative history that Congress either rejected the standards imposed by the regulations on IMDs providing inpatient services to the older age population or disavowed the substantive bases for the distinct statutory requirements." *Id*. at 6.

Additionally, while the statute may not define "inpatient hospital services in an IMD," the statute's definition of an IMD is unambiguous – a "hospital, nursing facility, or other institution of more than 16 beds, ***that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases***, including medical attention, nursing care, and related services." *See* Act § 1905(i) (emphasis added). In order to meet the Medicare requirements for participation as a psychiatric hospital, a facility has to be primarily engaged in treating the mentally ill. Act

§ 1861(f). Thus, such facilities would have the overall character of facilities established and maintained for the care and treatment of persons with mental diseases, within the regulatory and statutory IMD definition. The services to persons over age 65 in an IMD would inherently include psychiatric services. Finally, the guidelines for determining whether an institution is an IMD include "whether the facility specializes in providing psychiatric/psychological care and treatment." *See* SMM § 4390.C.4.

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Lastly, Virginia's argument that Piedmont and Catawba were not required to meet the Medicare standards for psychiatric hospitals because they were not billing Medicare for inpatient psychiatric services (Va. Br. at 9) obscures the issue. The regulations require that "hospitals receiving payment under Medicaid must meet the requirements for participation in Medicare." *See* 42 C.F.R. § 482.1(a)(5). These requirements address many aspects, including inpatient hospital services in IMDs. Previous Board decisions have held that a facility which meets the applicable standards may be certified as a Medicaid provider. *See N.Y. State Dep't of Social Servs.*, DAB No. 1441, at 3-4, 14 (1993); *N.Y. State Dep't of Social Servs.*, DAB No. 1528, at 6 (1995) (both citing 42 C.F.R. § 482.1), *aff'd, N.Y. v. HHS*, No. 95 CIV. 10258 JSM, 1997 WL 610771 (S.D. N.Y. Sept. 30, 1997). Thus, CMS may properly disallow any expenditures for services furnished by a facility which is not properly certified. *New York*, DAB No. 1441, at 2, 14. Regardless of whether Piedmont and Catawba billed Medicare, the State was required to establish that the IMDs had been certified as compliant with the Medicare special CoPs to be eligible for FFP in the claimed Medicaid payments for inpatient hospital services rendered in those facilities to 65-or-older individuals.

3. Virginia has provided no evidence demonstrating that Piedmont and Catawba met the special psychiatric CoPs during the audit period.

Virginia concedes that the Act requires state agencies "to set health standards (consistent with all applicable federal requirements) and to determine compliance with Medicaid on participation requirements," but asserts that "neither the statute nor the regulations require the state to utilize the Medicare certification process in determining compliance." Va. Br. at 17. Virginia further asserts that "meeting the requirements" of the Medicare special CoPs only requires "substantive compliance, not formal certification." *Id.* at 13 n.25. We disagree. Virginia's position ignores the regulatory language requiring that a facility meet applicable requirements when it is *surveyed for, and certified as complying* with, the applicable requirements. *See* 42 C.F.R. §§ 482.1, 482.10, 488.1, 488.10 and 488.12. Furthermore, SMM § 2497.1 indicates that FFP is only available for allowable actual expenditures made on behalf of eligible recipients for covered services *rendered by certified providers.* Finally, SMM §§ 2084.1, 2084.3, and SOM § 1002 indicate that Medicaid providers must be certified as meeting all federal certification standards and procedures to participate in Medicaid (citing Act §§ 1902(a)(9)(A), 1902(a)(33)(B)).

Virginia provides a side-by-side comparison of the state's requirements and the Medicare special CoPs contained in sections 482.61 and 482.62, asserting that they are "substantially similar." Va. Br. at 18-24. CMS disagrees, asserting that the State's requirements lack important provisions in the special psychiatric CoPs, listing numerous substantive differences as well as pointing out that one of the policy documents upon which the State relies was not issued until mid-way through the audit period, and another was issued four years after the audit period closed. CMS Br. at 24-25 (referencing Va. Ex. 20 and Va. Ex. 24).

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We need not do our own comparison of the details of the state and federal requirements to determine if they are "substantially similar," because even if they were, Virginia has not provided evidence to establish that the hospitals were surveyed and found compliant with those requirements during the audit period. There is no evidence in the record that any Virginia agency surveyed, certified, or made any other determination that Piedmont or Catawba complied with those requirements during the audit period. More importantly, there is no evidence that any accrediting organization surveyed Piedmont or Catawba during the audit period to determine whether either one met the special CoP requirements in Part 482, subpart E, let alone certified the hospitals' compliance to the state Medicaid agency or to CMS. The requirement for survey and certification is not simply a technical requirement. Instead, its "purpose is to ensure that the services provided by a facility are of the type and quality which Congress intended to fund under title XIX [Medicaid]," *New York*, DAB No. 1441, at 13-14, and "funding is not available in the absence of a finding that a facility is in compliance." *New York*, DAB No. 678, at 7.

The State also asserts:

[N]ot once [since 1972] has CMS questioned the hospitals' actual compliance with the participation requirements. There is no allegation that the hospitals do not meet the special CoPs applicable to IMDs that furnish these psychiatric services. Indeed, as described in detail below, the Commonwealth has presented evidence that the hospitals were, in fact, compliant with the requirements.

Va. Br. at 17. Again, Virginia obscures the issue, and sidesteps the fact that demonstrating compliance requires a certification after a survey by qualified personnel. Virginia has offered no evidence of any relevant "compliance determination," and the audit finding that there was no survey or certification, the basis for CMS's disallowance, rebuts Virginia's undocumented assertion that the hospitals met the conditions of participation. We also disagree with Virginia's contention that the fact that Piedmont was "reviewed and found compliant with the special CoPs soon *after* the disallowance period" demonstrates that "its policies and practices . . . are substantially equivalent to the federal requirements" and that both hospitals "met the requirements" of the special CoPs during the disallowance period because they met Virginia's standards. Va. Br. at 24-25 (emphasis added, internal quotation marks omitted); *see also* Va. Ex. 12. The "unannounced full resurvey" by The Joint Commission was conducted in August 2012, some 20 months ***after*** the end of the audit period and is not retroactively applicable to the audit period. *See* Va. Ex. 12, at 1. Moreover, there is no similar "review and finding of compliance" for Catawba. The fact remains that there is no documented evidence that either hospital was in compliance with the Medicare special CoPs during the audit period.

Virginia argues that actions by CMS since 2004, noted in the factual background section, "delayed" and "prevented [the State] from getting a Medicare survey of compliance with

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the special CoPs," and this "is further reason to allow DMAS to present state compliance and post-audit surveys as evidence of meeting the requirements at sections 482.61-.62." Va. Br. at 25. The 2004 "actions" Virginia relies on include CMS's action to convert the hospitals' participation status in the Medicare program from "long-term care" hospitals (LTCHs) to acute-care hospitals, and subsequent events that resulted from that event. In response to the conversion of the hospitals' participation status, a state employee in the "Provider Reimbursement Division" asked an individual within CMS (no further details were provided as to what position the CMS employee held or what division they worked in) about the "implication of this change for Medicaid reimbursement," specifically:

[M]y current understanding is that as long as these hospitals meet the definition of IMDs, which they clearly do, [V]DMAS must treat them as IMDs, and must pay them under the methodology applicable to IMDs, regardless of their status with Medicare. This would preclude Virginia Medicaid from treating these hospitals as short stay acute care hospitals. Could you please confirm if this understanding is correct.

See Va. Ex. 9. The response back was, "Yes, this is correct. From a Medicaid prespective [sic], CMS would follow the reimbursement methodology in your state plan for IMDs." *Id*. CMS's response to this argument asserted that "[i]f Virginia was looking for information regarding certification, it should have contacted either the State survey agency or CMS's Division of Survey and Certification." CMS Br. at 17-18 n.10. As CMS correctly states, the burden of ensuring compliance with the regulations and demonstrating entitlement to FFP rests on Virginia. *Id*.

We disagree with Virginia that these 2004 actions "delayed" and "prevented the [State] from getting a Medicare survey of compliance with the special CoPs." The question asked after the hospitals' participation status change was whether the state should pay the IMDs in accordance with the State Plan. The question was based on the premise that "the hospitals clearly met the definition of IMDs." The answer indicated that CMS would follow the state plan. The response in no way changed or relieved the State from meeting its obligation to ensure that the hospitals complied with applicable conditions of Medicaid participation for IMDs, which the State bore all along. And, in our view, the Virginia employee did not specifically pose a question about the conditions of participation and CMS therefore had no reason to, and did not, specifically address the conditions of participation in its response. So, to the extent Virginia's argument based on the 2004 email exchange may be construed as implying that Virginia reasonably read CMS's response to mean that Virginia need not do anything in order to ensure the hospitals were surveyed and certified in accordance with the authorities, we reject that implication.

Accordingly, there is no evidence to establish that Piedmont and Catawba demonstrated compliance with the Medicare special CoPs during the audit period.

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4. The delay in conducting the audit and issuing the disallowance does not bar the disallowance.

Virginia also asserts CMS's decision to issue the disallowance "six years after the start of the audit (four years after the OIG released its report and up to twelve years after the expenditures were made)" is inequitable, prejudicial, an abuse of discretion, and violates the Administrative Procedure Act. Va. Br. at 28.

Regarding the cumulative time between Medicaid payments for which FFP was disallowed and CMS's disallowance determination, the Board has previously held that an agency's delay in taking a disallowance does not invalidate the disallowance. *See Tenn. Dep't of Human Servs*., DAB No. 1054, at 12 n.8 (1989) (and cases cited therein). Virginia's position is also premised, in part, on its assertion that the language in section 440.140 *alone* does not mention accreditation or Medicare certification, and on CMS's "fail[ure] to mention" that "a hospital needs to be surveyed and certified as a psychiatric hospital in order to receive Medicaid reimbursement." Va. Br. at 6, 13. Virginia contends that it "engaged in a protracted, good faith effort to work with CMS to resolve the hospital compliance issues raised by the OIG audit." *Id.* at 26. Virginia recounts its post-audit efforts to request a survey to ensure compliance as well as their efforts to reach out to the CMS Regional Administrator in 2014 "requesting guidance on how to pursue or survey or otherwise resolve the compliance issue." *Id*. Virginia concludes that "in the face of confusion over application of the rules and years of good faith efforts by the Commonwealth to ensure compliance, CMS has chosen to issue a very belated and significant disallowance that will deprive the behavioral health system of badly needed resources." *Id*. at 27.

The record supports that any confusion about the application of the rules resided only with Virginia personnel. Section 440.140 clearly established the applicability of the Medicare special CoPs to IMDs that furnish inpatient hospital services. Part 488 provides mechanisms by which a state must ensure or verify an IMD's compliance with those conditions – namely, state agency surveys and accreditation programs of national accrediting organizations (such as The Joint Commission). In August of 2012, Piedmont received a complete resurvey by The Joint Commission, which by then had a CMS-approved accreditation program to survey hospitals for compliance with the Medicare special CoPs, and was later certified as a psychiatric hospital in December 2012. *See* Va. Exs. 12 and 16. This was almost two years before the Virginia Secretary of Health and Human Resources letter to the CMS Regional Administrator "requesting guidance on how to pursue or survey or otherwise resolve the compliance issue." Virginia had the answer to how to resolve the compliance issue, so there was no need for the 2014 letter. Furthermore, contrary to Virginia's claim that CMS failed to mention the survey and certification requirements for an IMD to participate in Medicaid and be eligible for FFP, both the 2014 and 2017 post-audit correspondence from CMS identified the need for IMDs to "meet the applicable conditions of participation" and referred Virginia to

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statutory, regulatory and program guidance. *See* Va. Ex. 17; CMS Ex. 3. Finally, the record does not support the conclusion, asserted by Virginia, of "years of good faith efforts . . . to ensure compliance." Va. Br. at 27. As stated previously, the record is devoid of any evidence of demonstrated compliance with the CoPs by either hospital during the audit period.

Virginia further asserts that federal uniform audit requirements require a federal awarding agency to release a "management decision" within six months of receiving an audit report. Va. Br. at 29 (citing 2 C.F.R. § 200.521 (Jan. 1, 2014) (superseding OMB Circular A-133 eff. December 26, 2013)). CMS responds that this requirement, as it existed in OMB Circular A-133 during the audit period, applies only to "single state audits" (meaning, an audit conducted pursuant to the Single Audit Act, 31 U.S.C. § 7501 *et seq*.) and does not apply to the OIG audit at issue here. *See* CMS Br. at 29 (citing OMB Circular A-133, Part B, § __.200(a) and Part D, § __.400(c)(5), in effect during the audit period). CMS further indicates that even if the OMB Circular A-133 provision was relevant, the "six-month time frame is an administrative goal, not a statute of limitations," and that Board precedent holds that CMS's failure to issue a disallowance within six months of an audit report is not a basis for rescinding a disallowance. CMS Br. at 29 (citing *Mich. Dep't of Health & Human Servs., Office of Child Support*, DAB No. 2868, at 7 (2018)). Finally, CMS asserts that the

authority to issue a Medicaid disallowance is found in 42 C.F.R. § 430.42(a), and nothing in the provisions cited by Virginia overrules this authority or prevents CMS from pursuing a disallowance if the agency fails to issue a decision within six months of an audit report. *Id*.

We agree that the NOD in this case is not a "management decision" within the parameters of Circular A-133, as it was based on an OIG audit, not a single state audit. Furthermore, as CMS correctly indicates, the Board has held that CMS's failure to issue a disallowance within six months of an audit report is not a valid basis for rescinding a disallowance. *See Michigan*, DAB No. 2868, at 7 (citing *Md. Dep't of Human Res*., DAB No. 519, at 2-4 (1984) (stating "there is no statute of limitations or laches which can be applied against the federal government unless it is specifically provided for by Congress")).

Lastly, while Virginia correctly asserts that "[t]his is not a case involving fraud or misconduct" (Va. Br. at 30), it is a case involving non-compliance with Medicare and Medicaid statutes and regulations. CMS properly imposed the disallowance in this case based on longstanding provisions in the Act and implementing regulations, both of which "'contain no statute of limitations or other time limit on the issuance of Medicaid disallowances.'" *Ill. Dep't of Healthcare & Family Servs.*, DAB No. 2863, at 17 (2018) (quoting *Ca. Dep't of Health Care Servs*., DAB No. 2204, at 9 (2008)), *vacated and remanded on other grounds*,489 F. Supp. 3d 801 (N.D. Ill. Sept. 25, 2020); *see also Ca. Dep't of Health Servs*., DAB No. 1007, at 7 (1989) ("[The Health Care Financing Administration, CMS's predecessor,] is not limited by statute or regulations in the

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amount of time it may take in issuing a disallowance."). Furthermore, the Board's regulations make clear that we must uphold a disallowance if it is supported by the evidence and is consistent with the applicable statutes and regulations. 45 C.F.R. §§ 16.14, 16.21. Thus, the delay in issuing the disallowance has no legal significance. Accordingly, we sustain the disallowance.

5. Virginia's claim for equitable relief is not a proper basis for reversal.

Virginia asserts that the delay in issuing the disallowance was unfairly prejudicial because when it was notified that the claims at issue may be unallowable, the three-year document retention period had already expired for the earliest years of the audit period. Va. Br. at 28. To establish a defense based on a document retention period, the Board has required states to show that: 1) specific documents relevant to the disallowance actually existed; 2) they were retained for the full record retention period; 3) they were innocently destroyed by the state; and 4) their loss prejudiced the state. *California*, DAB No. 1007, at 8; *see also California*, DAB No. 2204, at 11 ("[G]enerally, a disallowance may be considered untimely only if a grantee can prove prejudice that is attributable to the loss of records resulting from their innocent loss or destruction after [the] expiration of [any applicable] record retention period." (internal quotation marks omitted)). Moreover, the grantee's burden of proof on this issue is high. A grantee must make the required showing "by substantial evidence." *California*, DAB No. 1007, at 8. And, in asserting prejudice, the non-federal party is not given the benefit of "presumption that [it] kept pertinent records and retained them for the requisite period." *N.Y. City Human Resources Admin.*, DAB No. 1199, at 11 (1990) (citation omitted).

In this case, Virginia has not specifically asserted or produced documentation that the required certifications for Piedmont or Catawba Hospitals ever existed for the audit period. Indeed, the most reasonable conclusion based on the record is that documents concerning the required certifications for the audit period never existed, because Virginia's stated position is that "Medicare certification" is not required for IMD services for individuals age 65 or older, and that "the absence of certification is not indicative of a failure to meet those standards." Va. Ex. 5, at 18; Va. Ex. 6, at 18. We therefore need not further address the application of record retention requirements in this case.

Finally, Virginia also asserts that lengthy, retroactive repayment periods in the Medicaid disallowance context require a state to pay back federal funding that has long since been spent puts an extreme strain on state taxpayers to fund the repayment. Va. Br. at 29. Virginia also argues that state taxpayers will have difficulty funding this repayment. *Id*. However, "the burden or financial hardship which repayment might cause the grantee is not relevant to our consideration of whether grant costs are allowable." *Juniata Cnty. Child Care and Development Servs., Inc*., DAB No. 2089, at 5 (2007).

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To the extent Virginia asks the Board to provide some other type of equitable relief, the Board is not authorized to grant equitable remedies. *See, e.g., Mental Health Ass'n of Oregon*, DAB No. 2590, at 9 (2014) ("The Board has no authority to waive a disallowance on the basis of equitable principles."); *P.R. Dep't of Health*, DAB No. 2385, at 29 (2011) (and cases cited therein); *River East Econ. Revitalization Corp*., DAB No. 2087, at 12 (2007) ("general claim of 'equity' . . . is not available as a basis for dispensing federal funds"); *The Children's Center, Inc*., DAB No. 2506, at 8 (2013) ("The Board is not authorized to reverse a disallowance based on equity."); *Camden Cnty. Council on Econ. Opportunity*, DAB No. 881, at 7-8 (1987) ("The Board is bound by all applicable laws, and can not invent equitable remedies without a basis in law.").[23]

6. CMS's inadvertent omission of the Medicare special CoPs from the Code of Federal Regulations for a four-month period in 2007 did not negate Virginia's obligation to demonstrate the hospitals' compliance with those conditions during that period.

In a March 30, 2007 final rule, effective June 28, 2007, CMS promulgated Medicare participation requirements for transplant centers and codified them in 42 C.F.R. Part 482, Subpart E, where the Medicare special conditions of participation for psychiatric hospitals were already codified. *See* 42 C.F.R. Part 482, subpart E (Oct. 1, 2006); 72 Fed. Reg. 15,198, 15,273-78. However, rather than stating that the new requirements were being added to Subpart E, the final rule's preamble stated that "Part 482 is amended by revising subpart E to read as follows," with the revised Subpart E including the new transplant-center requirements but omitting the Medicare special conditions of participation for psychiatric hospitals. 72 Fed. Reg. at 15,273-78. CMS corrected the error four months later, on October 26, 2007, adding the Medicare special conditions for psychiatric hospitals (sections 482.60 through 482.62) back into Subpart E of Part 482. *See* 72 Fed. Reg. 60,787 (Oct. 26, 2007). CMS explained that it was correcting its "technical error," and that it had intended to add the organ transplant CoPs and to retain the special psychiatric conditions "without change." *Id*. Additionally, CMS did not delay the effective date for 30 days, stating "[w]e are not making any changes to our existing regulations, but reinstating provisions that have previously been approved and were unintentionally omitted from the final rule that appeared in the March 30, 2007 Federal Register (72 FR 15198)." *Id*.

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In its audit reports, the OIG noted:

CMS made a technical error when it issued regulations for Medicare transplant center CoP in 2007. Effective June 28, 2007, it inadvertently omitted certain regulations for Medicare CoP relevant to this audit. CMS formally reinstated the omitted regulations effective October 26, 2007. Despite the omission, CMS's implementing guidance remained in effect from June 28 through October 25, 2007 (the regulatory gap period).

Va. Ex. 5, at ii; Va. Ex. 6, at ii.

Virginia asserts that as a result of this inadvertent omission, the Medicare special psychiatric CoPs were not in effect from June 28 through October 2007 when CMS "'amended' subpart E to 'add' these requirements." Va. Br. at 31-32. Accordingly, Virginia asserts that $2,462,157 of the disallowed payments to Piedmont, and $1,212,002 of the disallowed payments to Catawba, should be found allowable as they are attributable to this so-called "regulatory gap period."[24] *Id*. In support of that contention, Virginia relies on a portion of the language in 44 U.S.C. § 1510(e), which states, "The publication of the documents in the Federal Register is prima facie evidence of the text of the documents and their legal effect." *Id.* at 31. CMS responds that the inadvertent omission did not include any notification that the Medicare special CoPs were being deleted, as would be required under the Administrative Procedure Act (APA), and therefore the omission had no legal effect. CMS Br. at 31.[25]

Virginia's contention is clearly erroneous. The complete language in 44 U.S.C. § 1510(e) states:

The codified documents of the several agencies published in the supplemental edition of the Federal Register under this section, as amended by documents subsequently filed with the Office and published in the *daily issues of the Federal Register* shall be prima facie evidence of the text of the documents and of the fact that they are in effect on and after the date of publication. (emphasis added).

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The Code of Federal Regulations is prima facie evidence of the text of the original documents. 44 U.S.C. § 1510(e). The Federal Register serves as a daily supplement to the Code of Federal Regulations. Each document that is subject to codification and published in a daily issue shall be keyed to the Code of Federal Regulations. 1 C.F.R. § 5.5. The Code of Federal Regulations is kept up to date by the individual issues of the Federal Register. *These two publications must be used together to determine the latest version of any given rule. See Wiggins Brothers, Inc. v. Dep't of Energy*, 667 F.2d 77, 89 (Temporary Emergency Court of Appeals 1981), *cert denied*, 456 U.S. 905 (1982).

Here, the March 30, 2007 issue of the Federal Register clearly identified that new requirements for transplant centers were being *added* to Subpart E, and the proposed additional sections were numbered 482.68 - 482.104, which would logically follow the existing sections 482.60 -.62 dealing with psychiatric hospitals. *See* 72 Fed. Reg. 15,273. Furthermore, the language in the October 1, 2006 daily Federal Register clearly indicated that Part 482 was being *amended* but did not specifically assert that sections 482.60-.62 were being repealed, deleted, or omitted. The final rules for sections 482.60-.62 were published in both the daily Federal Register and the Code of Federal Regulations. The Medicare CoPs and special CoPs for hospitals were properly published prior to the inadvertent omission in 2007. We find that the omission of the special conditions in the March 2007 final rule had no legal effect because that rulemaking did not purport to withdraw those conditions.

Additionally, during this four-month period, section 482.1 continued to include the language that "hospitals receiving payment under Medicaid must meet the requirements for participation in Medicare" (42 C.F.R. § 482.1(a)(5) (Oct. 1, 2007)), and section 2718A of the State Operations Manual continued to state that "[t]o participate in Medicare and Medicaid, a psychiatric hospital must meet the special medical records and special staffing requirements." CMS Ex. 1, at 2. As discussed earlier, the regulations establishing Medicare CoPs for hospitals have included language requiring that hospitals receiving payment under Medicaid must meet the Medicare CoPs for quite some time.

Furthermore, since 1978, 42 C.F.R. § 440.140 has defined inpatient hospital services for individuals age 65 or older in IMDs as "services provided under the direction of a physician for the care and treatment of recipients in an institution for mental diseases that meets the requirements specified in § 482.60(b), (c), and (e) of this chapter [or in that section's predecessors, sections 405.1036-.1038]" (defining the Medicare CoPs for hospitals and special CoPs for psychiatric hospitals). The Secretary not only identified the necessary medical and staffing requirements in the regulations, but also in Appendix AA to CMS's State Operations Manual. *See* CMS Ex. 2.

Finally, we agree with CMS that Virginia has neither claimed nor demonstrated that it actually believed that between June and October of 2007, the special conditions did not apply and acted in accordance with that belief. *See, e.g., Alliance for Cannabis*

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Therapeutics v. D.E.A., 15 F.3d 1131, 1136 (D.C. Cir. 1994) ("To establish a claim under [5 U.S.C. § 552(a)(1)], . . . the litigant must show that 'he was adversely affected by a lack of publication or that he would have been able to pursue an alternative course of conduct' had the information been published."). The evidence in the record supports that Virginia never complied with the special CoPs before the audit, and that it was only after Virginia received the draft audit report, which discussed CMS's inadvertent error, that Virginia asserted the special CoPs were not in effect during the regulatory gap period. *See* Va. Ex. 5, at 17; Va. Ex. 6, at 17. Even assuming for the moment Virginia was aware of the March 30, 2007 final rule and read it to mean that sections 482.60-.62 were not in force, such a reading would not have been reasonable in the absence of formal notice of such action and when corresponding SOM provisions remained undisturbed. Furthermore, Virginia still asserts the special CoPs do not apply. Having already determined that neither hospital complied with the requirements of the special CoPs during the audit period, we find that the State's FFP claims for inpatient hospital services furnished by Piedmont and Catawba to 65-or-older individuals from June to October 2007 are unallowable.

Conclusion

We sustain CMS's June 26, 2018 disallowances of $18,607,649 for Catawba and $39,365,326 for Piedmont, totaling $57,972,975.

Endnotes

[1] The SMM is publicly-available at https://www.cms.gov/regulations-and-guidance/guidance/manuals/paper-based-manuals-items/cms021927 <https://www.cms.gov/regulations-and-guidance/guidance/manuals/paper-based-manuals-items/cms021927> (last visited August 15, 2023).

[2] When the disallowed FFP claims and disallowance determination in this case were made, the IMD exclusion was found in paragraph (29) of section 1905(a). Paragraph (29) was redesignated as paragraph (30) by Public Law 115-271, approved on October 24, 2018. *See* Act § 1905 (endnote 170); Pub. L. 115–271, § 1006(b)(2)(B), 132 Stat. 3894, 3914.

[3] The IMD exclusion is reflected in other paragraphs of section 1905(a) that specify the scope of reimbursable medical assistance. *See* Act § 1905(a)(1) ("inpatient hospital services (other than services in an institution for mental diseases)"); 1905(a)(4)(A) ("nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older"); and 1905(a)(30)(B) (which provides an exception to the exclusion for substance abuse and recovery services provided pursuant to a state plan amendment for certain patients in an institution for mental diseases).

[4] This definition was added to the statute in 1988. Pub. L. 100–360, § 411(k)(14)(A), 102 Stat. 798. Prior to that, the regulations contained a similar definition which until 1991 did not include the 16-bed requirement. *See* 56 Fed. Reg. 8,854 (Mar. 1, 1991). The regulations currently indicate that whether an institution is an IMD is "determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such." 42 C.F.R. § 435.1009 (Oct. 1, 2005); 42 C.F.R. § 435.1010 (Oct. 1, 2011).

[5] Section 435.1008 was redesignated and amended as section 435.1009, and the prior section 435.1009 was redesignated as section 435.1010 by 71 Fed. Reg. 39,225 (July 12, 2006).

[6] We note that section 440.140(a)(1) says "(e)," but there is no section (e). This should be section (d).

[7] In 1986, section 482.1(a)(5) was initially designated as subparagraph (a)(3). 51 Fed Reg. at 22,042. In 1995, it was re-designated as subsection (a)(5). 60 Fed. Reg. 50,439, 50,442 (Sept. 29, 1995).

[8] The disallowance in this case does not involve beneficiaries under age 21. However, Virginia relies on the differing language contained in the two exceptions in their arguments, which will be addressed below.

[9] The current State Operations Manual is publicly-available at https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms1201984 <https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms1201984>.

[10] Appendix AA was part of the original release of the SOM, a paper-based manual (CMS Pub. 7), later converted to an internet-only-manual, publicly-available at https://web.archive.org/web/20031204055708/http://www.cms.hhs.gov/manuals/pub07pdf/AP-a.pdf - PDF <https://web.archive.org/web/20031204055708/http:/www.cms.hhs.gov/manuals/pub07pdf/ap-a.pdf> </disclaimer.html> (*see* pp. 193-260). After the time frame relevant to this appeal, Appendix AA was modified in 2014 and 2015, but those modifications have no impact on this case. Effective February 20, 2020, Appendix AA was incorporated into Appendix A, titled "Survey Protocol, Regulations and Interpretive Guidelines for Hospitals," and the Psychiatric Hospital Survey Module is now contained within Appendix A. *See* CMS Pub. 100-07, Transmittal 200 (Feb. 21, 2020), available at https://www.cms.gov/files/document/r200SOMA.pdf - PDF <https://www.cms.gov/files/document/r200soma.pdf>. Appendix A (publicly-available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf - PDF <https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/som107ap_a_hospitals.pdf>) repeatedly refers to the previously separate Appendix AA and continues to refer to seven tasks contained in Appendix AA with broken hyperlinks. The "Interpretive Guidelines" section for 42 C.F.R. §§ 482.60-.62 is incomplete, indicating for several requirements that "guidance is pending and will be updated in future releases." We will refer to the specific provisions using CMS Exhibit 2.

[11] VDBHDS outlines operational requirements for state-owned hospitals that are part of the public behavioral health system. Va. Br. at 16. While the Virginia Department of Health (VDH) is generally charged with defining and enforcing such requirements, the State had a regulatory structure parallel to VDH licensing for state-owned hospitals that are part of Virginia's public mental health system and operated by VDBHDS. *Id.* VDBHDS works with VDH in its role as the state agency responsible for conducting Medicare surveys for such hospitals, to the extent applicable. *Id.* Furthermore, the state relies on AOs, including The Joint Commission, to assess the hospitals. *Id.*

[12] The record contains no evidence of when and by whom these facilities were determined to be IMDs. CMS does not dispute that both facilities were IMDs but asserts "Virginia misrepresented to CMS that Piedmont and Catawba were acute care hospitals." CMS Br. at 30, 33.

[13] The record does not include the OIG's draft reports, nor does it establish when Virginia received them. However, the final reports include, in an appendix, Virginia's written response to the draft reports dated April 7, 2014.

[14] June 28, 2007, was the effective date of a Federal Register rulemaking that amended 42 C.F.R. Part 482 but inadvertently omitted 42 C.F.R. §§ 482.61 and 482.62 (containing the two Medicare special CoPs applicable to psychiatric hospitals) from the rule's text. October 26, 2007, was the effective date of the Federal Register rulemaking that corrected the error. *See* 72 Fed. Reg. 15,198, 15,273-78 (March 30, 2007) and 72 Fed. Reg. at 60,787-89 (Oct. 26, 2007).

[15] This provision is publicly-available at https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/som107c02.pdf - PDF <https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/som107c02.pdf> (last visited August 15, 2023).

[16] It is unclear if the conference call was before or after the state agency was directed to stop their efforts to schedule a survey.

[17] We believe Virginia's use of the word "again" might refer to communications between the State and CMS in 2004 after CMS terminated the long-term-care-hospital (LTCH) status of both hospitals, which Virginia asserts "prevented [the State] from getting a Medicare survey of compliance with the special CoPs." Va. Br. at 25. This issue is addressed later in the decision.

[18] CMS's brief does not indicate the manner in which Virginia's second request was made. The purported second request is not on letterhead or addressed to a particular person at a particular location, and there is no signature block. CMS Ex. 4. There is contact information for an individual at VDMAS listed at the bottom, with a name, email address and phone number. *Id.*

[19] The record contains the CMS denial but not Virginia's request for reconsideration.

[20] Delegations of Authority both accompanying and subsequent to the Departmental Reorganization Order transferred responsibility for the Medicare program from the Social Security Administration to the [HCFA]; and for the Medicaid program, from the Social and Rehabilitation Service to the [HCFA]. *See* 42 Fed. Reg. 13,262.

[21] The October 17, 2008 Survey and Certification Memorandum, entitled "Accreditation and its Impact on Various Survey and Certification Scenarios," can be found at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/scletter09-08.pdf - PDF <https://www.cms.gov/medicare/provider-enrollment-and-certification/surveycertificationgeninfo/downloads/scletter09-08.pdf> (last visited August 15, 2023). The May 6, 2011 Memorandum is Va. Ex. 15.

[22] Sections 405.1035 and 405.1036 are now codified in 42 C.F.R. §§ 482.30 and 482.60.

[23] Virginia does not expressly assert that laches applies, or that equitable estoppel lies against CMS. However, the Board has stated that laches is generally inapplicable against the federal government. *See, e.g., Md. Dep't of Human Resources*, DAB No. 519, at 4 (1984); *Ky. Cabinet for Human Resources*, DAB No. 957, at 5 (1988) (citing *Ga. Dep't of Med. Assistance*, DAB No. 798 (1986)). Moreover, even accepting that estoppel *could* lie against CMS in these cases, Virginia has not established the elements of estoppel, to include affirmative misconduct by CMS and detrimental reliance by Virginia. *See Ky. Cabinet* at 5 ("While it is not clear that the federal government can ever be estopped, it certainly cannot be in the absence of affirmative misconduct" by government officials.); *Heckler v. Cmty. Health Servs. of*

Crawford Cnty., 467 U.S. 51, 59 (1984) (setting out the elements of estoppel). "Failure to question costs earlier is not grounds for estoppel; inaction is not affirmative misconduct." *Ca. Dep't of Health Servs.*, DAB No. 1139, at 11 (1990); *see Ky. Cabinet* at 5 (same).

[24] The Board has not addressed this specific issue, but previously noted a regulation which CMS had inadvertently omitted from the Code of Federal Regulations and subsequent technical correction, but did not state a position on the legal significance of the inadvertent omissions. *See Batavia Nursing and Convalescent Ctr.*, DAB No. 1904, at 61 n.55 (2004), *aff'd,* 129 F. App'x 181 (6th Cir. 2005).

[25] The Administrative Procedure Act (APA) requires federal agencies to publish a notice of proposed rulemaking in the Federal Register, and to notify the public of "either the terms or substance of the proposed rule or a description of the subjects and issues involved." 5 U.S.C. § 553(b)(3). The APA defines "rule making" to include "formulating, amending, or repealing a rule." *Id.* § 551(5).

/s/

Constance B. Tobias
Board Member

/s/

Susan S. Yim
Board Member

/s/

Karen E. Mayberry
Presiding Board Member