

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

Pennsylvania Department of Human Services
Docket No. A-16-50
Decision No. 2883
July 26, 2018

DECISION

The Pennsylvania Department of Human Services (State) appealed a January 7, 2016 decision by the Centers for Medicare & Medicaid Services (CMS) to disallow \$48,789,786 in federal financial participation (FFP) for Pennsylvania's Medicaid program. The State claimed the disallowed FFP for "personal care" and "personal assistance" services furnished to Medicaid recipients under Pennsylvania's Home and Community-Based Waiver for Individuals Aged 60 and Over (Aging Waiver) during state fiscal year (SFY) 2009. CMS determined the disallowance amount based on the results of an audit of a random sample of 100 paid coverage claims billed to the Aging Waiver. After reviewing documentation submitted by the State (including service providers' timesheets and "service orders" issued by the entities that administered the Aging Waiver), CMS found that the State had failed to substantiate the allowability of 46 of the 100 audited sample claims.

In this appeal, the State does not challenge CMS's audit methods or assert that CMS improperly projected its sample findings to the relevant universe of paid Medicaid claims for SFY 2009. Instead, the State takes issue with CMS's findings that certain sample claims were unallowable under the Aging Waiver. More specifically, the State contends that documentation it provided during the audit and during this appeal substantiates the allowability of 38 of the 46 sample claims rejected by CMS.

For the reasons outlined below, we sustain CMS's findings of unallowability with respect to 29 of the 38 contested sample claims; reverse CMS's finding of unallowability with respect to nine contested claims; rule on various discovery and evidentiary matters; and remand the case to CMS to recalculate the disallowance amount.

LEGAL BACKGROUND

Title XIX of the Social Security Act (Act),¹ the federal Medicaid statute, 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. A state that operates a Medicaid program in accordance with federal requirements and the terms of its federally approved “State plan for medical assistance” is entitled to FFP (that is, federal matching funds) for a percentage of its Medicaid program expenditures. Act §§ 1902(a), 1903(a); 42 C.F.R. § 430.30. Those expenditures consist largely of payments to health care providers that furnish covered services to program beneficiaries. Act § 1905(a).

Under section 1915(c) of the Act, a state Medicaid program may obtain from CMS a “waiver” of certain federal requirements to enable that program to provide “home or community-based services” to persons who would otherwise need Medicaid-funded institutional care. 42 C.F.R. §§ 430.25(c)(2), 440.180, 441.300. The types of home or community-based services that may be provided under a section 1915(c) waiver include case management, home health aide services, respite care, “personal care services,” and “[o]ther services requested by the agency and approved by CMS as cost effective and necessary to avoid institutionalization.” *Id.* § 440.180(a)-(b); *see also* Act § 1915(c)(4)(B). Services that are provided in accordance with an approved section 1915(c) waiver, and which meet other applicable federal requirements, constitute “medical assistance” eligible for FFP. Act § 1915(c)(1) (providing that a state may treat home or community-based services as “medical assistance” under the State plan); 42 C.F.R. §§ 430.25(c)(2) (stating that a section 1915(c) waiver allows a state to include home or community-based services as “medical assistance” that is “reimbursable under the State plan”) and 440.2(b) (stating that, subject to limitations in 42 C.F.R. Part 441, FFP is “available in expenditures under the State plan for medical or remedial care and services as defined in” 42 C.F.R. Part 440, subpart A – care and services which include home or community-based waiver services as defined in section 440.180 of that subpart).

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

A state must claim FFP for its Medicaid program expenditures in accordance with program regulations, instructions, or other directives. *See* 42 C.F.R. § 430.30(a)(2), (c); 45 C.F.R. § 95.4 (defining “claim” as a request for FFP in the “manner and format required by” applicable program regulations and “instructions or directives issued thereunder”). CMS’s State Medicaid Manual² contains longstanding guidance and instructions for submitting and substantiating FFP claims.³ State Medicaid Manual (SMM) §§ 2497, 2500.

CASE BACKGROUND

The State provides eligible Medicaid beneficiaries with home and community-based services under its CMS-approved Aging Waiver. CMS Ex. 11, at 1, 4, 8. The features, terms, and requirements of the Aging Waiver, as they existed during SFY 2009, are set forth in the waiver application that the State submitted, and CMS approved, for that fiscal year. PA Ex. 2. (For simplicity, we discuss the waiver’s terms and requirements using the present tense – as if the SFY 2009 version of the Aging Waiver were still in effect.)

The Aging Waiver authorizes various categories of home and community-based services – e.g., “home health,” “respite,” “community transition,” “TeleCare” – and specifies the “applicable limitations” for each service category. PA Ex. 2, at 3, 37 *et seq.* In accordance with 42 C.F.R. § 441.301(b)(1)(i), the Aging Waiver states that “[a]ll waiver services” must be furnished “pursuant to” a “participant-centered service plan” which (1) contains information about the participant’s health, personal care, nutritional, and other needs; (2) describes the “waiver services [to be furnished] to the participant, their projected frequency[,] and the type of provider that furnishes each service”; and (3) specifies “the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant.” *Id.* at 5, 85-86; *see also* 42 C.F.R. § 441.301(b)(1)(i) (providing that a section 1915(c) waiver must provide that home and community-based services be provided “[u]nder a written person-centered service plan . . . that is based on a person-centered approach and is subject to approval by the Medicaid agency”). The Aging Waiver further states that a service plan must be “based on written assessments or other

² The State Medicaid Manual, CMS Pub. 45, is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>. The State submitted relevant sections of the manual as exhibits to the appeal file. PA Exs. 3-4.

³ The manual also communicates official CMS policies and legal interpretations relating to the availability of FFP for a state Medicaid program’s expenditures for medical assistance and program administration. SMM, Forward, ¶¶ A-B; *Ga. Dep’t of Cmty. Health*, DAB No. 2521, at 2 n.2 (2013) (noting that the State Medicaid Manual is a vehicle for communicating federal Medicaid policies and procedures to state Medicaid programs).

documentation that supports the participant’s need for each Waiver and Non-Waiver funded service in order to address the full range of individual needs.” PA Ex. 2, at 85. In addition, the Aging Waiver states that FFP “is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.” *Id.* at 6.

Among the home and community-based services authorized by the Aging Waiver is “personal care,” defined by the waiver application as follows:

Personal Care is a range of assistance to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the participant to perform a task related to personal hygiene or functional activities of daily living. This can include bathing, skin care, mouth care, dressing, grooming, toileting, ambulation and transfer, change of position or turning the participant, feeding, medication assistance with self-administration, observation, instruction to informal care givers. Personal care may include the provision of supplemental housekeeping as long as the primary service rendered is for the ‘hands-on’ care. Personal Care services can be provided in either a quarter hour or shift.

PA Ex. 2, at 44. The Aging Waiver also authorizes “personal assistance,” a category of services similar to personal care.⁴ *Id.* at 61. Like personal care, personal assistance is “aimed at assisting the individual to complete tasks of daily living that would be performed independently if [the individual] had no disability.” *Id.* Despite that similarity, the waiver application subjects personal care and personal assistance to different service-delivery standards and requirements. For example, the Aging Waiver requires that personal care be managed by a licensed home health or home care agency,⁵ whereas personal assistance may be either “provider managed” or “participant directed.” *Id.* at 44, 62. Elaborating on those terms, the waiver application explains that personal assistance may be delivered under either (1) an “Agency Model,” which makes the

⁴ Personal assistance is authorized by the Aging Waiver in accordance with 42 C.F.R. § 440.180(b)(9), which permits a state to provide “[o]ther services,” besides those specified in paragraphs (1) through (8) of section 440.180(b), “that are requested by the [state] and approved by CMS as cost effective and necessary to avoid institutionalization.”

⁵ The Aging Waiver also requires that personal care be supervised by a registered nurse and delivered by a “certified personal care aide,” “registered nurse aide,” or an individual with at least “[t]wo years of professional work experience in a health care related capacity.” PA Ex. 2, at 44-45. Personal assistance, on the other hand, does not require supervision by a registered nurse. *Id.* at 61-63. In addition, the credentialing and experience requirements for personal assistance “attendants” are less stringent than they are for personal care aides. *Id.* at 62-63.

qualified home health or home care agency responsible for hiring, paying, and supervising the “attendant” who renders the authorized hands-on assistance; or (2) a “Consumer Employer Model,” which allows the waiver participant to assume responsibility for “hir[ing], fir[ing], schedu[ing], and supervis[ing]” the attendant. *Id.* at 61.

During SFY 2009, the Aging Waiver was administered by 52 Area Agencies on Aging (AAAs) under contract with the State. *Id.* at 10. AAAs were responsible for enrolling Medicaid beneficiaries in the waiver program, performing “level of care” assessments (to decide whether a waiver participant would otherwise be eligible for Medicaid-funded institutional care), developing a waiver participant’s service plan in collaboration with the participant, certifying providers of waiver services, and authorizing services. *Id.* at 10-12, 83. AAA “care managers” are expected to enter and maintain information about participants’ level-of-care evaluations and service plans (including plan updates or revisions) in a database known as the Social Assistance Management System (SAMS). *Id.* at 31, 85-87, 144. (The Aging Waiver application alludes to a “standard service plan form,” *id.* at 86, but neither party proffered or discussed such a form.)

In 2010, CMS performed a Financial Management Review (an audit) of personal care and personal assistance services provided under the Aging Waiver during SFY 2009. CMS Ex. 11, at 1, 4; CMS Ex. 13, ¶ 8. As part of that review, CMS’s auditors randomly selected 100 claims from a universe of paid SFY 2009 claims that billed the Aging Waiver for personal care and personal assistance. CMS Ex. 11, at 6, 13; CMS Ex. 13, ¶¶ 9-10. The auditors then examined documentation submitted by the State in support of each sample claim. CMS Ex. 11, at 13; CMS Ex. 13, ¶¶ 10-11. That documentation included, to the extent provided, service orders issued by AAAs to home care agencies as well as timesheets and similar records showing the dates and hours reportedly worked by the agencies’ employees on behalf of the waiver participants named on the claims. CMS Ex. 4; CMS Ex. 11, at 13.

CMS issued the findings of its financial management review in a February 4, 2014 report.⁶ CMS Ex. 11. CMS found that, despite having received “ample time and multiple opportunities” to provide supporting documentation, the State had provided “insufficient” documentation for almost one-half of the sample claims. *Id.* at 13. The February 2014 report noted the following “examples” of documentation deficiencies: “(1) timesheets [of the service provider] not signed by the recipient of services, (2) timesheets not supporting the hours claimed, (3) no service order detail to indicate the

⁶ The report is titled: “Pennsylvania: Review of Personal Care Services in the Home and Community Based Aging Waiver, State Fiscal Year 2009, Control No. 03-FA-2010-PA-02-F, Final Report.” CMS Ex. 11.

types of services to be performed, (4) time sheets not demonstrating what services were conducted and other information provided did not demonstrate services provided, and (5) no documentation provided at all.” *Id.* From its sample findings, CMS projected that the State had received \$48,789,786 in FFP for unallowable personal care and personal assistance services during SFY 2009. *Id.* at 14.

Based on its financial management review findings, CMS notified the State on January 7, 2016 that it was disallowing \$48,789,786 in FFP for Pennsylvania’s Medicaid program on the ground that the State “did not comply with Federal requirements when it failed to provide sufficient supporting documentation to demonstrate the allowability of Personal Care Services expenditures claimed under” the Aging Waiver during SFY 2009. (CMS evidently used the term “personal care” to encompass claims seeking payment under the Aging Waiver for both “personal care” and “personal assistance.”)

The State timely appealed the disallowance to the Board. Before the State submitted its opening brief and exhibits, and in response to a discovery request, CMS produced documents showing its audit methods and how it had calculated the disallowance amount based on the sample findings. *See* CMS Exs. 2, 7, 9, 12. With some exceptions, CMS also produced copies of claim-related documentation furnished by the State to CMS’s auditors. CMS Ex. 16-96; CMS Ex. 13, ¶¶ 11-12.

CMS found 46 of the 100 sample claims unallowable. CMS Ex. 4. The State contests 38 of the 46 adverse findings. PA Exs. 1 and 13. The parties have submitted documents, separate from their briefs, stating their views regarding the allowability of each contested sample claim. CMS’s claim-by-claim contentions are found in a chart (cited herein as “CMS Chart”) appended to its April 3, 2017 response brief. The State’s claim-by-claim contentions are found in State Exhibits 1 and 13.

ANALYSIS

In this appeal, the State’s overarching contention is that CMS “applied novel and stringent documentation standards which were not in effect” when the contested claims were paid, and that CMS “never communicated to the States the level of detail or adequacy of documentation that it would require to substantiate that the [personal care and personal assistance] services were properly provided.” State’s Opening Brief (PA Br.) at 8-14. The State submits that section 2500 of the State Medicaid Manual is the only authority cited by CMS that “provides guidance to the States on the level of documentation that must be kept to support” a claim for FFP, and that the documentation it provided to support the contested sample claims complied with that guidance. *Id.* at 10.

CMS responds that the State had adequate notice of its obligation to substantiate the allowability of services billed to the Aging Waiver, and that the documentation required to support the State's case is "dictated by" applicable conditions for allowability, including the requirement that a waiver service be provided pursuant to an approved service plan. *See* CMS's Response Brief (Response Br.) at 9-10, 11-12, 14, 16. According to CMS, the documentation submitted by the State did not contain information called for by the State Medicaid Manual and failed to show that the billed services met basic conditions for allowability. *Id.* at 11-13, 14, 16.

We consider these opposing views concerning the adequacy of the State's documentation in part A of this section. In part B, we rule on CMS's request to exclude from the appeal record documents submitted by the State with its June 19, 2017 reply brief; and in part C, we respond to the State's contention that CMS improperly altered its rationale(s) for the disallowance. Then, in part D, we review the available documentation for each of the 38 contested sample claims and decide whether it suffices to establish the claim's allowability under the Aging Waiver. Finally, in part E, we respond to the State's request to make available unredacted copies of two CMS Financial Management Review Guides.

A. A state Medicaid agency's obligation to substantiate the allowability of its claims for FFP

A state Medicaid program is subject to uniform grant administration requirements issued by the Department of Health and Human Services (HHS) under title 45 of the Code of Federal Regulations. *See* 45 C.F.R. § 75.101(a), (b). When the disallowed expenditures at issue in this case were made, the HHS grant administration requirements applicable to state government grantees were found in 45 C.F.R. Part 92 (Oct. 1, 2008).⁷ Those requirements obligate a state to ensure that accounting records of expenditures for which it seeks FFP are "supported by such source documentation as cancelled checks, paid bills, payrolls, time and attendance records, . . . , etc." *Id.* § 92.20(b)(6) (Oct. 1, 2008); *see also id.* § 75.302(b) (requiring the "non-Federal entity" to have "[r]ecords that identify adequately the source and application of funds for federally-funded activities" and that are "supported by source documentation"). The applicable grant administration regulations also state that "[g]rant funds may be used only for . . . [t]he *allowable costs*"

⁷ HHS's grant administration requirements are presently codified in 45 C.F.R. Part 75, which supersedes 45 C.F.R. Part 92. 45 C.F.R. § 75.104(b).

of a grantee and further require that a determination of a grantee’s allowable costs accord with “cost principles” issued by the Office of Management and Budget (OMB). *Id.* §§ 92.20(b)(5), 92.22(a)(1), (b) (Oct. 1, 2008) (italics added); *see also id.* §§ 75.100(c), 75.400, 75.401(a).⁸

Under OMB cost principles, a state expenditure is an allowable cost (eligible for FFP) only if it meets certain general criteria. One general criterion is that a claimed expenditure “[c]onform to any limitations or exclusions set forth in [the cost] principles, Federal laws, terms and conditions of the Federal award, or other governing regulations as to types or amounts of cost items.” 2 C.F.R. Part 225, App. A, ¶ C.1.d (Jan. 1, 2008); *see also* 45 C.F.R. § 75.403(b) (containing similar language). Another criterion for allowability is that a cost be “adequately documented.” *Id.*, App. A, ¶ C.1.j (Jan. 1, 2008); 45 C.F.R. § 75.403(g).

Federal Medicaid regulations notify states of their obligation to maintain, and if necessary produce, documentation substantiating the allowability of claimed program expenditures. Title 42 C.F.R. § 433.32, for example, states that a state plan “must provide that the Medicaid agency and, where applicable, local agencies administering the plan will . . . [m]aintain an accounting system and supporting fiscal records to assure that claims for Federal funds are in accord with applicable Federal requirements.” In addition, a section of the regulations that authorizes Medicaid disallowances states that “[i]n all cases, the State has the burden of documenting the allowability of its claims for FFP.” 42 C.F.R. § 430.42(b)(2)(ii).

CMS’s State Medicaid Manual echoes and elaborates on the just-mentioned regulatory requirements. SMM § 2497.1 (in effect since 1987) states that “[e]xpenditures are allowable [eligible for FFP] only to the extent that, when a claim is filed, [the state Medicaid agency has] adequate supporting documentation in readily reviewable form to assure that all applicable Federal requirements have been met.” PA Ex. 3.

In light of the above-mentioned regulations and agency guidance, the Board has long held that, if a federal grantor agency “provide[s] sufficient detail about the basis for its [disallowance] determination to enable the grantee to respond” (a minimal showing that was made with respect to all of the contested sample claims, including those that we

⁸ In 2008 and 2009, the OMB cost principles applicable to state governments – titled “Cost Principles for State, Local, and Indian Tribal Governments” – were codified in appendices to 2 C.F.R. Part 225. See 70 Fed. Reg. 51,910 (Aug. 31, 2005). In late 2013, OMB consolidated the cost principles contained in various “circulars” into a single set of uniform cost principles (applicable to all types of non-federal entities) under 2 C.F.R. Part 200. 78 Fed. Reg. 78,590 (Dec. 26, 2013). HHS and other federal departments and agencies adopted (in whole or part) the uniform cost principles in late 2014. 79 Fed. Reg. 75,872 (Dec. 19, 2014). HHS’s adoption of the uniform cost principles is codified in 45 C.F.R. Part 75 and became effective on December 26, 2014. *See* 2 C.F.R. § 300.1; 45 C.F.R. §§ 75.106, 75.110(a).

ultimately find allowable), then the burden shifts to the grantee (the non-federal party) to substantiate the existence and allowability of the questioned expenditures. *Me. Dep't of Health & Human Servs.*, DAB No. 2292, at 9 (2009), *aff'd*, *Me. Dep't of Human Servs. v. U.S. Dep't of Health & Human Servs.*, 766 F. Supp. 2d 288 (D. Me. 2011); *see also* *Mass. Exec. Office of Health & Human Servs.*, DAB No. 2218, at 11 (2008) (describing the federal agency's burden as "minimal"), *aff'd*, *Mass. v. Sebelius*, 701 F. Supp.2d 182 (D. Mass. 2010); *Kan. Dep't of Social and Rehab. Servs.*, DAB No. 1408, at 7 (1993) (holding that it was the "State's obligation to document the allowability of its claims for [the disputed] services, not [CMS]'s obligation to show their unallowability by showing that the patients were harmed"); *Neb. Dep't of Social Servs.*, DAB No. 1494, at 3 (1994) (noting the Board's consistent holding that "a state has the burden of documenting the existence and allowability" of its claimed costs).

The State contends that the documentation it provided to support the contested sample claims – including service orders issued by AAAs and service providers' time records – should be found adequate in part because CMS has not issued rules specifying the types, form, and content of documentation necessary to support Medicaid payment for personal care or similar services. PA Br. at 8-13; Reply at 3-6, 10. Responding to the audit's findings that service orders often failed to specify the types of personal care or personal assistance authorized, the State asserts that the service order had a limited "authorization" function; that the order typically contained enough information to carry out that function; that it was unnecessary, as a matter of waiver program administration, for the service order to specify "details" about what types of personal care or personal assistance had been authorized because the service provider would have received a copy of the waiver participant's service plan, which contained those details; and thus a payment claim for personal care or personal assistance should not be found unallowable merely because of "lack of detail" in the service order. PA Br. at 7-10; PA Ex. 2, at 87 (stating that a service plan was "distributed by the Care Manager to the participant and . . . providers of service"). In addition, the State suggests that its burden of proof in this case was met if its documentation sufficed to "authorize a claim for payment through [its] Medicaid Management Information System." PA Ex. 13, at 5; *see also* Reply at 8.

These points overlook what the State's documentary evidence must show when a claim for FFP in a medical assistance expenditure is questioned. The issue here is not whether the State complied with requirements concerning the form or content of time records, or whether a service order effectively transmitted the AAA's authorization for services, or whether the State's Medicaid program received all of the information necessary to process a service provider's payment claim. Rather, the issue before us is whether the totality of the documentary evidence produced by the State verifies that the services billed to the waiver were actually performed and *met the conditions for allowability*

under the Aging Waiver and other applicable federal requirements. *N.Y. State Dep't of Health*, DAB No. 2637, at 8 (2015) (agreeing with New York that it was appropriate to consider the “totality of the documentation” in deciding whether a Medicaid service claim met applicable legal requirements); *Md. Dep't of Health & Mental Hygiene*, DAB No. 2090, at 4 (2007) (indicating the state’s burden was to document that claimed expenditures were allowable – that is, provided in accordance with applicable requirements). Those conditions included the requirement that a service billed to the Aging Waiver be authorized and delivered in accordance with a service plan developed for the service recipient. Simply put, the State’s documentation, whatever form(s) it took, must provide reasonable assurance that the contested claims were made in compliance with the waiver’s requirements.

It is not enough for the State to say that there were (in SFY 2009) no federal regulations or policies spelling out documentation requirements for personal care or other waiver services. The conditions for allowability adequately notified the State that it needed to collect and preserve in its records all the information necessary to support its FFP claims. Furthermore, Medicaid regulations, and the Aging Waiver itself, obligated the State to institute rules, procedures, or systems to ensure that it generated, kept, or had access to documentation substantiating the allowability of an FFP claim if called upon to do so. *See* 42 C.F.R. § 433.32 (requiring the state Medicaid agency or its agents to “[m]aintain an accounting system and supporting fiscal records to assure that claims for Federal funds are in accord with applicable Federal requirements,” to “[r]etain records for 3 years from the date of submission of a final expenditure report[,]” and to “[r]etain records beyond the 3-year period if audit findings have not been resolved”) and § 441.302(b) (requiring a state Medicaid agency to “assure financial accountability for funds expended for home and community-based services”); PA Ex. 2, at 139, 140, 145 (specifying the “methods,” procedures, or systems to be instituted to ensure the “integrity of payments that have been made for waiver services” – including “monitoring of financial records that document the need for and the cost of services provided under the waiver” and establishing a “process for validating provider billings” that includes “mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant’s approved service plan; and, (c) [when] the services were provided”).

We later discuss whether the documentation provided by the State in relation to the particular claims at issue met these standards.

B. Objections to exhibits submitted with the State’s reply brief

After CMS filed its response brief, the State sought a five-week extension of time in which to submit a reply. Doc. 42, DAB Dkt. No. A-16-50. The State said that it needed extra time to “determine if additional electronic documentation from the archived SAMS

[Social Assistance Management System] database might be responsive and helpful” and to retrieve any such documentation. *Id.* CMS opposed the request for two reasons. First, it contended that SAMS data is “irrelevant” because it is “substantively and qualitatively inadequate to demonstrate that the personal care services at issue were, in fact, ‘authorized’” by an AAA. *Id.* Second, CMS asserted that it had given the State “multiple opportunities” (prior to this administrative litigation) “to provide the missing data to document the allowability of [its] claims.” *Id.*

The Board granted the requested extension on the condition that, “if the reply includes additional data or exhibits, the State should explain why the material was not submitted with the initial brief and appeal file.” *Id.* The Board also said it might grant CMS an opportunity file a surreply to respond to any additional data or exhibits submitted by the State. *Id.*

The State timely filed its reply brief as well as 10 additional exhibits – numbered 13 through 22. In response to the Board’s directive to state why it had not submitted the additional exhibits with its opening brief, the State said, without further elaboration, that “[a] few of the exhibits contain additional sample case documentation that the State determined may be relevant after receiving [CMS]’s brief and chart of alleged sample case errors[,]” while “[t]he remainder of the exhibits address issues raised by the CMS brief.” Reply at 2.

CMS sought, and the Board granted, an opportunity to file a surreply, which CMS filed three weeks after the State filed the reply. CMS asked the Board in the surreply to exclude State Exhibits 13-21 because the State had failed to justify its failure to submit those materials earlier and for various other reasons (irrelevance, lack of foundation). Surreply at 3-4. We rule on CMS’s exclusion request as follows:

State Exhibit 13, titled “Reply Analysis of Sample Cases Found in Error,” is essentially an addendum to the reply brief, summarizing the State’s position concerning the allowability of each contested sample claim. The exhibit responds to contentions made by CMS in its response brief and attached chart and provides legal and record citations pertinent to each claim. In its reply brief, the State explains that the short arguments in the chart should be read in conjunction with the arguments in the reply brief (much as CMS treated the chart attached to its response brief to which these arguments respond). Reply Br. at 1. Because we treat State Exhibit 13 as part of the reply and as useful reference material (not as evidence per se), and because CMS does not contend that arguments within State Exhibit 13 go beyond addressing points made in CMS’s response brief and chart, we make that document part of the record of this appeal.

State Exhibit 14 is a table listing contested sample claims. For each listed claim, the table indicates the name of the waiver participant, the procedure code used to identify the billed services, a description of the documentation deficiency identified by CMS's auditors, the amount of the claim, and the service model (agency-managed or consumer-directed) under which the billed services were delivered. This document purports to be a summary of information contained in other exhibits. It does not purport to constitute evidence of any fact that bears upon the allowability of a sample claim. We exclude it because the State has not provided the foundation normally required to demonstrate that a summary exhibit (which is in the nature of secondary evidence) is appropriate and reliable – such as showing that the underlying documents or items are so voluminous as to make summary helpful to the Board and that the summary itself is an accurate representation of those underlying exhibits.

State Exhibit 15 is a December 2016 “Informational Bulletin” issued by CMS and titled “Strengthening Program Integrity in Medicaid Personal Care Services.” State Exhibit 16 is a copy of section 11600 of the State Medicaid Manual, which deals with Medicaid claims processing. Both documents are official federal agency publications available to the public.⁹ They serve to provide convenient copies in the record of sources to which the State could properly cite, whether or not the copies were proffered. They provide relevant authorities on the legal issue of whether they establish documentation standards or policies applicable to the contested waiver service claims. For these reasons, we admit Exhibits 15 and 16.

State Exhibit 17 is an April 5, 2017 email from the State's lawyer to CMS's lawyer. The email states that CMS's response brief “appears to shift from relying upon alleged defects in service orders to alleged defects in service plans” and asks CMS's lawyer to indicate whether that alleged shift “constitute[s] an amendment of the disallowance[.]” Although the State is entitled to argue, and does argue (*see* Reply at 12-13 and our analysis in part C below), that CMS's response brief improperly introduced new grounds for the disallowance, the email is not proof of any relevant or material fact. Whether or not CMS altered its rationale for the disallowance is a legal question that we resolve based on our own review of pertinent documents, including the notice of disallowance and CMS's response brief. We therefore exclude State Exhibit 17 from the record.

State Exhibit 18 is a timesheet relating to sample claim 12. With respect to that claim, CMS cited the absence of a timesheet for the first time in the chart attached to its response brief. *See* CMS Exs. 4 and 6 (alleging no lack of a timesheet) and CMS Chart (case no. 12, asserting that the State did not “provide any documentation that the services

⁹ The State Medicaid Manual is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>. The December 2016 Informational Bulletin is available at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib121316.pdf>.

at issue were actually provided”). Therefore, the State had no prior opportunity to respond to this allegation. Our consideration of this document also does not unfairly prejudice CMS because it had an opportunity in the surreply to discuss the document’s content and materiality. We admit State Exhibit 18.

State Exhibits 19 and 20 are, respectively, a Government Accountability Office (GAO) report about Medicaid Personal Care Services, and a second GAO report consisting of written congressional testimony by a GAO official about the same topic. State Exhibit 22 is a November 2012 report issued by the HHS Office of Inspector General and titled, “Personal Care Services: Trends, Vulnerabilities, and Recommendations for Improvement.” Like State Exhibit 15, these federal government publications are available to the public (on the authoring organizations’ websites) and could have been cited or discussed by the State as relevant official materials, even if they had not been offered as exhibits to the appeal file. In addition, the State relied on the exhibits to rebut certain points first made by CMS in its response brief. *See* Reply at 2, 5. CMS had an opportunity to respond to any aspect of the materials which it considered significant to our consideration, and did so. *See* Surreply at 8-9 (explaining why State Exhibits 19, 20, and 22 do not constitute “authoritative guidance” applicable to the sample claims). For these reasons, we deny CMS’s request to exclude State Exhibits 19, 20, and 22.

State Exhibit 21 contains extracts from the State’s Social Assistance Management System (SAMS) and a declaration from an employee of the Pennsylvania Office of Long-Term Living, the state agency that administered the Aging Waiver during SFY 2009. These SAMS extracts purport to show “service order special instructions” relating to sample claims 33, 89, and 91. The declaration identifies the extracts as reflecting information stored in the SAMS. Our order granting an extension to the State required the State to explain why any additional evidence it might submit with its reply brief had not been submitted earlier and also stated that we might provide CMS an opportunity to respond in an additional surreply brief. *See* May 15, 2017 email from Board staff attorney to counsel for the State and CMS. The State did provide an explanation, albeit one we find less than satisfying because it is not explicit about why the State only recognized the potential relevance of these materials after CMS’s briefing.¹⁰ It is true, however, that the documents in this exhibit are highly relevant to CMS’s asserted grounds (stated in the chart appended to the response brief) for rejecting sample claims 33, 89, and 91. Our role in cases conducted under 45 C.F.R. part 16 provides us sufficient discretion and authority to ensure that we have before us the information needed to reach a sound decision. *See, e.g.,* 45 C.F.R. §§ 16.9 (In order to promote development of the record, the Board

¹⁰ The State acknowledged the request for an explanation, but states merely that “[a] few of the exhibits contain additional sample case documentation that the State determined may be relevant after receiving the Agency’s brief and chart of alleged sample case errors.” Reply at 2. The State also expressly consented to CMS filing a surreply to respond to the new exhibits. *Id.*

“may, at the time it acknowledges [the] appeal or at any appropriate later point, request additional documents or information,” and may “take such other steps as the Board determines appropriate to develop a prompt, sound decision.”) and 16.13 (The Board has the power “to order or assist the parties to submit relevant information.”). Admitting this exhibit promotes a complete record of relevant evidence to permit us to correctly analyze the sample claims at issue. Its admission does not unfairly prejudice CMS: it had an opportunity to discuss the evidence’s substance and materiality in the surreply, and it does not allege that the timing of the evidence’s submission precluded it from offering counter-evidence. We therefore admit State Exhibit 21.

In sum, we exclude State Exhibits 14 and 17 and admit State Exhibits 13, 15, 16, and 18-22.

C. CMS’s alleged revision to the legal grounds for disallowance

In their work papers, CMS’s auditors noted that certain sample claims were supported by service orders that “lack details describing services ordered” and timesheets that “only delineate time spent[.]” CMS Ex. 4. Pointing to these findings, the State submits that CMS cited “completely new [documentation] errors” in its response brief and chart, and in doing so revised the rationale(s) for the disallowance and imposed “burdensome new documentation demands in mid-litigation.” Reply at 12, 13.

These assertions are meritless for a number of reasons. First, the January 7, 2016 notice of disallowance, rather than the auditors’ work papers, is the proper baseline for judging whether CMS revised or supplemented the grounds for disallowance. The State does not allege any inconsistency between the disallowance notice and CMS’s response brief and chart. The State is also vague about what it understood to be CMS’s rationale for the disallowance, as stated in its January 7, 2016 notice, and about how it thinks CMS changed or supplemented that rationale. The State alludes to CMS’s contention that billed services had not been “authorized” under an approved service plan, Reply at 12, but the State does not argue that this position was not reasonably apparent from the disallowance letter.

Even if CMS somehow revised the basis for the disallowance at the response-brief stage, that fact does not preclude CMS from relying on the new or amended ground. The Board has long held that the federal agency may revise the basis for a disallowance during the Board proceeding as long as the grantee receives an adequate opportunity to respond to the change in position. *Or. Dep’t of Human Servs.*, DAB No. 2208, at 12-13 (2008). Here, based on its assertion that CMS’s response brief and chart “might be construed by the Board as amending the basis of the disallowance,” the State requested additional time

in which to file its reply and to obtain additional evidence supporting the sample claims. The Board granted that request, and the State does not claim that the extra time it received to gather additional supporting documentation and prepare the reply was inadequate. Nor does the State show that it was deprived of access to specific supporting evidence as a direct or indirect result of CMS revising its grounds for the disallowance.

As for the State's assertion that CMS made "new documentation demands," the State does not specify what additional documentation it thinks CMS demanded. CMS in fact made no such demands during this appeal. It merely argued throughout that the documentation provided by the State during the audit and this appeal failed to demonstrate the contested claims' allowability under the Aging Waiver. In any event, as discussed earlier, the issue before us is not whether the State satisfactorily complied with demands for particular types of documents, or whether the individual documents provided by the State complied with some state or federal form-and-content requirements. The question before us is whether the State met its obligation to *have available* contemporaneous records that a reasonable reviewer would find sufficient to verify its compliance with applicable federal requirements for reimbursement of its section 1915(c) waiver expenditures. The audit which resulted in the disallowance entailed a review of any claim-related documentation that the State was able and willing to provide. The auditors found, upon initial review, that the submitted documentation did not contain information necessary to verify that certain claims were proper under the Aging Waiver. CMS Ex. 11, at 13. The State had an additional opportunity following that initial review to locate records containing the missing information and to present them to the auditors. *Id.* The State also had more than ten months from the date CMS responded to the State's discovery request (April 11, 2016) to the deadline for filing its opening brief (February 28, 2017) to assemble evidence of its compliance with applicable federal requirements. We also admitted State Exhibit 18 because it was offered to rebut a disallowance ground (namely, the absence of a timesheet supporting sample claim 12) that CMS asserted for the first time in its response brief. In short, the State had a fair opportunity to make its case on the appeal's dispositive issues with any documentation that could establish the allowability of its claims.

D. Allowability of the contested sample claims

We now review the documentary evidence produced by the State for each contested sample claim and decide whether it suffices to establish the claim's allowability under the Aging Waiver. We conclude that the State provided sufficient evidence of allowability for nine of those claims, which we identify with an asterisk. The other claims remain inadequately documented and therefore unallowable.

Sample Claim 1

Sample claim 1 sought Medicaid payment for 40 units (quarter-hours) of personal care allegedly furnished to a waiver participant from April 1 through April 3, 2009. CMS Ex. 5, at 1; PA Ex. 10. During this proceeding, CMS was unable to produce copies of the documentation reviewed by its auditors concerning this claim. *See* Response Br. at 4; CMS Ex. 15, ¶ 10. However, the State furnished a copy of a service provider’s timesheet showing hours worked by a personal care aide during April 2009. PA Ex. 10, at 1. Although the timesheet – the only piece of documentation in the record for this claim – shows the name of waiver participant, the name of the personal care aide, and the dates and hours reportedly worked by the aide, CMS contends that the claim is insufficiently documented because the timesheet does not specify the type(s) or “nature” of the personal care provided.¹¹ CMS Chart (case no. 1). The timesheet produced by the State, says CMS, “shows only that the provider delivered 16.5 hours of some kind of services to the beneficiary during the week at issue.” *Id.* CMS submits that its “basic supporting documentation requirements” in SMM § 2500.2(A) obligate the State to document both the “nature” and “extent” of the services provided.”¹² *Id.* CMS also emphasizes that personal care encompasses a range of assistance – including help with bathing, skin care, toileting, dressing, grooming, ambulation, transfers, feeding, and meal preparation. *Id.* Without some evidence of what types of personal care were delivered, says CMS, it is “impossible to verify” that the billed services “were actually authorized . . . in accordance with a service plan[.]” Response Br. at 12-13.

The State responds that CMS regulations, policies, and guidance do not require a service provider’s timesheet (or other time record) to specify the nature or types of personal care performed during each shift. PA Br. at 9-14; Reply at 3-6. The State agrees (PA Br. at 3) that SMM § 2500.2(A) applies to set a documentation standard – which is that documentation of a billed service should reflect (among other information) the “nature,

¹¹ CMS’s auditors rejected the claim in part because “the services provided are undocumented as the timesheets delineate only the time spent” but also because the timesheet was not signed by the personal care aide whose time is reported on the document. CMS Ex. 10, at 2; CMS Ex. 4, at 1. CMS does not press the latter point in this appeal. *See* CMS Chart (case no. 1). The timesheet was signed by the waiver participant and contains a handwritten notation that the personal care aide’s supervisor had “verified” the reported hours. PA Ex. 10, at 1.

¹² SMM § 2500.2(A) provides the following guidance about the documentation that should be provided to support a claim for FFP in a Medicaid service:

Your supporting documentation includes as a minimum the following: date of service, name of recipient, Medicaid identification number, name of provider agency and person providing the service, nature, extent, or units of service, and the place of service. Do not report estimated amounts. . . .

extent, *or* units of service.” SMM § 2500.2(A) (italics and emphasis added). The State submits that, because the just-quoted provision “speaks in a disjunctive,” the standard is satisfied as long as the state has documented the “units of personal care service provided,” as the timesheet for sample claim 1 does. PA Br. at 4. “Contrary to CMS’ assertion as to what constitutes ‘minimum’ requirements,” says the State, “there is no additional conjunctive requirement that the nature of the specific personal care tasks performed on a specific day be recorded.” *Id.*

Like the points we discussed in part A of this section, the State’s argument regarding sample claim 1 ignores the fact that its documentation needed to verify compliance with applicable conditions for allowability, including the requirement that waiver services be furnished pursuant to an approved service plan. The timesheet alone provides no assurance of compliance with that requirement. There needed to be some evidence that the waiver participant had a service plan calling for the provision of personal care in accordance with which the services were provided. The record contains no such evidence. The State did not provide a copy of the plan itself (assuming the waiver participant had one), or a service order based on the plan, or any other evidence from which we can infer that the services reflected on the timesheet (whatever their nature) were included in a service plan approved prior to the billed dates of service.¹³ The State was responsible for having “mechanism(s) to assure” that a service billed to the waiver and reflected in the State’s FFP claim was included in a participant-centered service plan developed and approved by the AAA. PA Ex. 2, at 144. The State did not submit evidence demonstrating that such mechanisms were in place when sample claim 1 was billed to the Aging Waiver or explain how such mechanisms, had they been implemented, would permit an inference that sample claim 1 satisfied the Aging Waiver’s service-plan requirement absent documentation to that effect.

We reject the State’s cramped reading of SMM § 2500.2(A) as requiring the State to document either the nature of a billed service, or the number of hours worked by the service provider, but not both. In our view, the phrase “nature, extent, or units of service” must be read in conjunction with the waiver’s provisions concerning the content of an individual service plan. More specifically, SMM § 2500.2(A) and the waiver must be read as requiring documentation of sufficient detail to enable CMS to determine that the billed units of service were for the types of waiver services specified in the participant’s service plan. Moreover, the word “units” in the phrase “nature, extent, or units of service” cannot be read apart from the words “of service” to mean that a state

¹³ It appears that the auditors reviewed a service order associated with this claim (*see* CMS Ex. 5, at 1), but the State does not indicate why it failed to produce its own copy or argue that CMS’s inability to produce that document precludes a finding that the billed services were not “authorized.”

must report only time spent with a waiver participant. While “units” speaks to quantification, “of service” speaks to substance which, in the context of waiver services, must be the nature of the service furnished. Thus, we conclude that the State’s “either-or” interpretation is not correct and that CMS is not required to find a service eligible for FFP when a provider documents the units of time spent with a Medicaid or waiver participant without also specifying the nature of the service(s) performed during that time.¹⁴ We note that the timesheet produced by the State for sample claim 1 does not state that the provider had rendered “personal care,” much less document the types of personal care furnished on each date.

We also reject, for reasons discussed in part A, the State’s suggestion (*see* PA Ex. 1, at 1) that a state carries its burden to substantiate the allowability of a paid Medicaid service claim if its documentation reflects all of the information specified in SMM § 2500.2(A). Nowhere does that provision indicate that the specified information (“date of service, name of recipient, Medicaid identification number, name of provider agency and person providing the service, nature, extent, or units of service, and the place of service”) is *sufficient* to establish an expenditure’s allowability. To the contrary, the manual indicates that this information is merely the “minimum” that should be documented, and that a state must have evidence of compliance with *all* conditions for allowability. SMM §§ 2500.2(A) (stating that “supporting documentation includes as a minimum” certain information) and 2497.1 (stating that “[e]xpenditures are allowable only to the extent that, when a claim is filed, you have adequate supporting documentation to assure that all applicable Federal requirements have been met”).

The State cites various other CMS publications to support its views concerning the scope of its documentation obligation. Those publications include: an August 2015 CMS “booklet” titled “Personal Care Services: Preventing Medicaid Improper Payments” (PA Ex. 5); the December 2000 “Regional Office Protocol for Conducting Full Reviews of State Medicaid Home and Community-Based Services Waiver Programs” (PA Ex. 7); the February 2002 “Title XIX Financial Management Review Guide #13: Home and Community-Based Services (HCBS) Waivers” (CMS Ex. Ex. 97); and the November 2009 “Title XIX Financial Management Review Guide #26: Medicaid Personal Care Services Excluding Waiver Services” (CMS Ex. 1). None of these publications purport to establish policies concerning the types or quality of documentation sufficient to

¹⁴ Our decision does not rule out the possibility of CMS, in a given instance, concluding, based on a totality of the documentation available to it, that it is able to determine that the provider furnished services consistent with an individual’s service plan even though the provider documented only units of service. However, that is different from holding that the SMM language on which the State relies requires CMS to find FFP allowable where that is the only documentation provided.

establish the allowability of a personal care or other section 1915(c) waiver service. The August 2015 CMS booklet, for example, merely indicates general types of information (identity of the personal care aide, dates and hours of service) that a *service provider* should keep to support a Medicaid *payment claim* for personal care, which may be only a subset of the information that a *state* must document to support a *claim for FFP* in that service.¹⁵ PA Ex. 5, at 5. In addition, the Regional Office Protocol and February 2002 Review Guide refute the notion that documenting the quantity of time spent with a waiver participant is sufficient: both publications indicate that CMS expects a state to have access to records showing both the “services provided” (what was done) and the “units of service” (quantity of time spent with the Medicaid recipient). CMS Ex. 97, at 12; PA Ex. 7, at 50. In addition, both Financial Management Review Guides indicate that CMS expects a state to document that the billed services were furnished in accordance with a service or care plan. CMS Ex. 1, at 19; CMS Ex. 97, at 13.

We conclude, for the reasons just stated, that the State did not substantiate the allowability of sample claim 1.

Sample Claim 7

Sample claim 7 sought Medicaid payment for personal care allegedly furnished to the waiver participant from October 1 through October 31, 2008. CMS Ex. 5, at 1. The documentation provided to CMS during the audit included a service order issued by the AAA to the home care agency that submitted the claim.¹⁶ CMS Ex. 6, at 1. The auditors found that the claim’s allowability was insufficiently documented because the service order “lacks details describing the services ordered,” a finding that CMS reaffirmed in the chart appended to its response brief. CMS Ex. 4, at 1; CMS Chart (case no. 7). We need not address that finding, or evaluate the evidence offered to rebut it,¹⁷ because CMS identifies a second, adequate ground upon which to uphold the unallowability finding – namely, the State’s failure to produce timesheets or other records verifying that the billed services were actually performed. *Cf.* 45 C.F.R. § 92.20(b)(6) (Oct. 1, 2008) (requiring

¹⁵ CMS accurately observes that the “purpose [of the August 2015 CMS booklet] is to educate Personal Care Service providers” and “not to provide guidance to state Medicaid programs regarding documentation requirements.” Response Br. at 19-20 (italics and emphasis omitted).

¹⁶ During this proceeding, CMS was “unable to locate” a copy of the service order reviewed by its auditors. Response Br. at 4; CMS Ex. 15, ¶ 10. The State does not contend that CMS’s inability to produce the order bars an adverse finding concerning the claim’s allowability.

¹⁷ That evidence included information extracted from the State’s Social Assistance Management System (SAMS) database. PA Ex. 8, at 2.

that accounting records of activities financed by federal awards be supported by appropriate source documentation, such as “paid bills” and “time and attendance records”); *N.J. Dep’t of Human Servs.*, DAB No. 2415, at 27-29 (2011) (upholding the disallowance of expenditures when the state’s documentation failed to substantiate that the claimed services “were actually rendered”).

The State submits that CMS’s “decision to raise a new timesheet error at the response brief stage is unreasonable and prejudicial.” PA Ex. 13, at 1. However, as we noted earlier, a grantor agency may raise new grounds for a disallowance finding during the Board proceeding as long as the grantee receives an adequate opportunity to respond to the change in position. *Or. Dep’t of Human Servs.* at 12-13. Here, the State had an opportunity in the reply brief to respond to CMS’s assertion that it had no timesheets or other documentation that the billed services were actually performed.

The State suggests that this opportunity was illusory. It asserts that “[t]imesheets are provider-level records, not state records” and that the provider’s record-retention period for the timesheets “has long expired.” PA Ex. 13, at 1-2. We find these assertions unpersuasive. The fact that timesheets are generated and kept by the service providers is immaterial because the State’s own regulations afford it access to Medicaid providers’ records. 55 Pa. Code § 1101.51(e) (stating that Medicaid service “[p]roviders shall make . . . records readily available for review and copying by State and Federal officials or their authorized agents”). Furthermore, the State cannot at this stage – years after CMS initiated the financial management review – plead that the service provider’s four-year record-retention obligation has expired.¹⁸ The State Medicaid Manual instructs states to maintain, or have access to, supporting documentation *when it files its claim for FFP* in the provider’s services. SMM § 2500.2(A) (PA Ex. 4) (calling for the state Medicaid agency to “[r]eport only expenditures for which all supporting documentation, in readily reviewable form, has been compiled and which is immediately available when the claim is filed”); *id.* § 2497.2 (PA Ex. 3) (requiring a state to “maintain and have readily available for audit” the “documentation necessary to support the allowability of the claim” for FFP); *D.C. Dep’t of Health*, DAB No. 2219, at 3-4, 6 (2008) (citing the instruction that a state agency have supporting documentation available when the FFP claim is filed). In addition, Medicaid program regulations advise states that they are expected to have supporting documentation at hand in the event that CMS questions the allowability of claimed expenditures. 42 C.F.R. § 430.40(b)(2) (authorizing CMS to ask a state to “make available all the documents and materials the regional office then

¹⁸ Section 1101.51(e) of title 55 of the Pennsylvania Code states that “[p]roviders shall retain, for at least 4 years, unless otherwise specified in the provider regulations, medical and fiscal records that fully disclose the nature and extent of the services rendered to MA [medical assistance] recipients”

believes are necessary to determine the allowability of” a deferred FFP claim). In light of those provisions, the State should have recognized the need to compile documentation of sample claim 7’s allowability no later than early 2010, when CMS initiated its financial management review. Hence, the proper time for obtaining the service provider’s documentation was the audit period (which substantially overlapped the provider’s record-retention period),¹⁹ and not the three-week period between the filing of CMS’s response brief and the State’s deadline for filing the reply. The State does not contend that it lacked reason to know during the financial management review that the provider’s records might be needed to support this sample claim.

We conclude, therefore, that the State did not substantiate the allowability of sample claim 7.

Sample Claims 8 and 9

Sample claim 8 sought Medicaid payment for personal care allegedly furnished to a waiver participant from July 1 through July 31, 2008. CMS Ex. 5, at 1. Sample claim 9 sought payment for personal care allegedly furnished to another waiver participant from July 1 through July 31, 2008. CMS Ex. 5, at 1. Both claims have the same problem as sample claim 7: the State did not produce time records verifying that the billed services were actually furnished on the dates of service noted on the claims. For that reason, we uphold the findings that sample claims 8 and 9 claims are unallowable under the Aging Waiver.

Sample Claim 11

Sample claim 11 sought Medicaid payment for 36 units of personal assistance allegedly furnished to the waiver participant from January 1 through January 3, 2009. CMS Ex. 5, at 2; PA Ex. 9. CMS found the claim unallowable on two grounds. First, CMS noted that the service order “fails to describe details concerning particular services ordered.” CMS Chart (case no. 11). Second, CMS asserts that a timesheet produced by the State “document[s] only total time spent” and does not specify the types of personal assistance provided, “making it impossible to verify” that the waiver recipient received “authorized” services. *Id.*

¹⁹ The record indicates that CMS initiated its financial management review in March 2010 and did not issue the final report of that review until February 2014. CMS Ex. 11, at 2, 9.

The first ground is valid and sufficient to uphold CMS's unallowability finding regarding sample claim 11. To be allowable under the Aging Waiver, personal assistance (like other services covered by the waiver) must be furnished pursuant to a participant-centered service plan approved by the AAA. PA Ex. 2, at 5, 102, 148. For this sample claim, the only evidence of an approved service plan is an extract from the Social Assistance Management System (SAMS), accompanied by a State employee's declaration.²⁰ PA Ex. 8. According to the declaration, the SAMS extract reflects the contents of a service order issued by the AAA to a home care agency on behalf of the waiver participant. *Id.* at 1. According to the SAMS extract, the service order was for 12 units (quarter hours) of personal assistance per day during the month of January 2009, to be billed to the Aging Waiver under procedure code W1792. *Id.* at 2. There is no information in the SAMS extract about the type(s) of personal assistance needed by the waiver participant or authorized by the AAA. *Id.*

Two points merit emphasis here. First, the State suggests that an AAA's service order (the document whose content is purportedly memorialized in the SAMS extract) is not the waiver participant's service plan, though a service order may reflect information contained in the service plan. PA Ex. 13, at 5 (distinguishing the service order from the service plan and stating that the home care agency would have possessed a copy of the service plan that provided "more specific detail on care"); Reply at 7 (stating that a "service order is an administrative document issued by Area Agencies on Aging . . . to formally authorize the provision of Medical personal care services following approval of the service plan"). According to the State, the service order is merely an "authorization document" and "was not the sole, or even the primary, device for communicating the service plan content." PA Ex. 13, at 2; Reply at 8-9. Even if that is so, the State needed to produce some evidence that the waiver participant actually had a service plan which identified his or her unmet needs (relating to health, hygiene, nutrition, safety, and other areas), the services approved by the AAA to meet those needs, and the "projected frequency" of the approved services. PA Ex. 2, at 5, 85-87; *see also* 42 C.F.R. § 441.301(c)(2) (stating that a "person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need . . .").

Second, as the Aging Waiver indicates, the terms "personal care" and "personal assistance" denote various types of services whose availability depends on the waiver participant's assessed unmet daily living needs, as documented in a service plan. *See* PA Ex. 2, at 44 (noting that "[p]articipants are assessed for [personal care] services,

²⁰ It appears that CMS's auditors reviewed a service order relating to sample claim 11, but CMS was unable to produce a copy of that document in this proceeding. *See* CMS's Response Brief (Response Br.) at 4; CMS Ex. 15, ¶ 10; CMS Ex. 4, at 1. Again, the State does not contend that CMS's inability to produce certain documents reviewed by the auditors bars an adverse finding concerning the claim's allowability.

frequency of services[,] and duration of services based upon needs [that] are identified and documented in the participant’s plan of care”), 61-62 (indicating that the objective of personal assistance is helping the waiver participant complete daily living tasks that he could perform independently but for his “disability”), and 88 (stating that a waiver participant’s “Care Manager facilitates the completion of the ISP by *matching services to all identified needs* in the assessment” (italics added)); 42 C.F.R. § 441.301(c)(2)(xii) (stating that a written service plan must “[p]revent the provision of *unnecessary or inappropriate* services and supports” (italics added)). Therefore, regardless of the mechanism used by the State to authorize a provider’s services, the State needed to show that the authorization responded to specific daily living needs identified in an approved service plan, and that the provider’s payment claim was consistent with the service plan’s provisions regarding the “type, scope, amount, duration and frequency” of services. 42 C.F.R. § 441.301(c)(2)(xiii)(A) (indicating that a service plan should identify “specific and individualized assessed need[s]”); PA Ex. 2, at 102 (referencing the State’s assurance of compliance with the requirement that services be “delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan”).

As noted, the SAMS extract for sample claim 11 indicates that the AAA authorized 12 daily units of undifferentiated personal assistance. The extract is inadequate proof that the service order was based on a participant-centered service plan, as it fails to describe the waiver participant’s unmet daily living needs or specify the types of personal assistance that the AAA decided were appropriate to help the participant meet those needs. The absence of that information is especially significant because, according to the Aging Waiver, the SAMS database was the AAAs’ repository for service-plan information. PA Ex. 2, at 86-88, 144 (“Service plan information is managed in the SAMS System.”). The State does not explain why such information was not included in the SAMS extract for sample claim 11.

On top of those shortcomings, the State provided no evidence that the AAA gave a copy of the waiver participant’s service plan (assuming she had one), or some other document reflecting the plan’s content, to the service provider. In addition, the provider’s time record (PA Ex. 9) does not, as CMS asserts, disclose the nature of the personal assistance delivered. These circumstances create additional uncertainty about whether the billed services were provided under an approved service plan.

It is important to note that the State does not disagree that a service plan must specify the types of personal care or personal assistance needed by the waiver participant. Nor does the State dispute that waiver expenditures for personal care and personal assistance are allowable only to the extent that they were for the types of personal care or personal assistance specified in an approved service plan. Instead, the State suggests that the

dispute concerning sample claim 11 is merely a disagreement about what information a proper service order should contain. Reply at 8 (asserting that the service order needed to contain only “the information necessary” for the provider to bill and receive program payment); PA Ex. 13, at 2 (stating that there is no requirement that a service order include the “kind of detail” that might appear in a service plan). However, as we explained in part A of this section, this line of argument sidesteps the dispositive issue, which is whether the documentation produced by the State, whatever it might happen to be, is reliable evidence that the contested claim meets the requirements for federal reimbursement.

The State submits that CMS improperly “reframe[d] its regulatory requirements for personal care services to insist that the State produce an auditable paper . . . showing that personal care service delivery conformed to the personal care service plan.” Reply at 9. “[C]onformity between personal care plans and personal care services,” says the State, “is assured through quality assurance reviews, and not through a paper trail of detailed service orders and timesheets.” *Id.*

We see no impropriety by CMS. The “conformity” cited by the State is an express condition for allowability under the Aging Waiver. PA Ex. 2, at 6 (stating that FFP would not be claimed “for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan”) and 102 (discussing the State’s assurance that services will be “delivered in accordance with the service plan”). CMS may therefore properly insist that the State produce documentation verifying compliance with that condition. The State cites no law, and we are unaware of any, to support its vague suggestion that CMS must rely exclusively upon the existence, or even results, of federal or state quality assurance reviews, rather than other types of audits, to ensure that a state’s FFP claims include only those expenditures that meet the applicable waiver requirements. *Cf.* 42 C.F.R. §§ 430.32-.33 (providing for federal program reviews and audits) and 430.42(a)(5) (indicating that disallowance may rest on “audit” or “financial review” findings). Further, as we have noted, the State here has not produced any evidence of the nature or results of its quality assurance reviews that might substantiate this or other claims at issue.

In a footnote, the State asserts that CMS “has not questioned the content or existence” of any service plan. Reply at 9 n.6. We are not certain what the State means by this. In several instances CMS expressly, and validly, questions whether services billed to the waiver were “authorized” by the AAA. *See* Response Br. at 14 (noting that CMS had found the documentation “insufficient . . . [to] demonstrate compliance” with that and other applicable federal requirements). Because authorization must be based on a service plan, the State was obliged in these instances to present some evidence of a relevant service plan’s existence and content.

Finally, the State implies that it has no obligation to demonstrate that the billed personal assistance services were included in the waiver participant's service plan because the services were delivered under the "consumer employer model." PA Ex. 13, at 2-3. Under that model, says the State, the waiver participant "knew what was in his [service] plan *because he developed his own plan for services* and had possession of it." *Id.* at 3 (italics added). The italicized phrase in the preceding sentence is inaccurate. While a waiver participant under the consumer-employer model hires and supervises the service provider, and may possess a copy of the service plan or know its content, the AAA is mainly responsible for developing the service plan, with input from the waiver participant. PA Ex. 2, at 3 (stating that "AAA Care Managers are responsible for Service Plan development with input from the participant" and "ensure that participants are receiving care and services to prevent institutionalization in accordance with 42 CFR Section 441.301"). Furthermore, a waiver participant's possession of the service plan in no way diminishes the State's obligation to demonstrate that the billed services were provided in accordance with the plan. *See* PA Ex. 2, at 144-45 (requiring the State to have a "process for validating provider billings" to "assure that all claims for payment are made only . . . when the service was included in the participant's approved service plan" and to maintain "[r]ecords documenting the audit trail of adjudicated claims (including supporting documentation) . . . for a minimum period of 3 years as required in 45 CFR § 92.42").

Based on the foregoing analysis, we conclude that the State provided insufficient evidence that services billed to the Aging Waiver in sample claim 11 were authorized or provided pursuant to a participant-centered service plan, as the waiver requires. We therefore sustain CMS's finding that sample claim 11 is unallowable under the Aging Waiver.

Sample Claim 12

Sample claim 12 sought Medicaid payment for 160 units (quarter-hours) of personal assistance allegedly furnished to the waiver participant from December 8 through December 12, 2008. CMS Ex. 5, at 2. In support of that claim, the State produced a service order which indicates that an AAA authorized a home care agency to provide personal assistance to the waiver participant for a six-month period beginning on July 1, 2008. PA Ex. 11. The service order specifies the permitted service "frequency" (40 hours per week) and the procedure code (W1792) to be used for billing personal assistance to the Aging Waiver. *Id.* The service order does not, however, describe the waiver participant's unmet daily living needs or identify the nature or type(s) of personal assistance authorized. *Id.* As our analysis of sample claim 11 indicates, a service order lacking such information is insufficient evidence that the billed services were provided pursuant to a participant-centered service plan, as the Aging Waiver requires.

The State produced a timesheet for this claim. It shows hours worked by a “personal care attendant” on the billed dates of service (PA Ex. 18) but does not specify the types of personal assistance rendered on those dates. The timesheet is immaterial because there is nothing on its face confirming that the attendant rendered services included in the waiver participant’s service plan (assuming that a plan was in place on the billed dates of service).

Accordingly, we conclude the State did not meet its burden of substantiating the allowability of sample claim 12 under the Aging Waiver.

*Sample claim 16

Sample claim 16 sought Medicaid payment for nine hours, or 36 units (quarter-hours), of personal care allegedly furnished to a waiver participant. CMS Ex. 5, at 2; CMS Ex. 16, at 1. As submitted by the service provider, the claim indicates that the billed services were performed on August 9, 2008. *Id.*

CMS determined that the provider’s “timesheets do not support the billed amounts because they fail to document that *any* personal care services were provided *on August 9, 2008*, let alone 36 units of services.” CMS Chart (case no. 16 (italics added)). The State responds that the claim “has a technical invoicing error in that the dates of service should have been for 9 hours between August 11, 2008 through August 15, 2008” rather than for nine hours on August 9, 2008. PA Ex. 1, at 3.

Although CMS asserts that the State provided “no evidence” of an invoicing error, there is some evidence of such an error in the documentation reviewed by CMS’s auditors. That evidence includes:

- *a printout of the results of a Medicaid claims database inquiry* showing that for August 2008, the provider submitted, and the State paid, three distinct claims for personal care furnished to the waiver participant: one claim for 12 hours of service for August 1 through August 8; a second claim for nine hours for August 9; and a third claim for three hours for August 18 (CMS Ex. 16, at 7) – a total of 24 hours for the month of August²¹;

²¹ The provider’s billing rate for personal care was \$5.15 per service-unit (per quarter-hour). CMS Ex. 5, at 2. According to the printed results of the claims database inquiry, the provider billed the Aging Waiver \$247.20 for 12 hours, or 48 units, of personal care for August 1 through August 8; \$185.40 for nine hours, or 36 units, for August 9; and \$61.80 for three hours, or 12 units, for August 18. CMS Ex. 16, at 7.

- *the service provider's timesheets for August 2008* (CMS Ex. 16, at 22-27), which show that it rendered 12 hours of personal care from August 1 through August 8; nine hours from August 11 through August 15; and three hours on August 18 – a total of 24 hours;
- *a state employee's handwritten notes* (CMS Ex. 16, at 7) describing an apparent error by the service provider in entering dates of service on the *second* claim (for nine hours of personal care).

We find this documentation sufficient to conclude that the nine hours of personal care billed to the Aging Waiver in sample claim 16 were, in fact, furnished to the waiver participant during August 2008, and that the service provider made a clerical error (on its second claim for that month) in reporting the dates of service for those nine hours. In other words, sample claim 16 should have been for nine hours of personal care from August 11 through August 15, rather than for nine hours on August 9. Apart from questioning whether the billed services were in fact provided on the recorded date, an issue that we resolve in the State's favor, CMS does not allege another ground on which to find the claim unallowable.

We therefore conclude that sample claim 16 is allowable under the Aging Waiver.

*Sample Claim 21

Sample claim 21 sought Medicaid payment for 332 units (quarter-hours) of personal care allegedly furnished to a 94 year-old waiver participant from March 1 through March 29, 2009. CMS Ex. 5, at 3; CMS Ex. 21, at 1-2. In support of that claim, the State produced an AAA's service order, a copy of which the State obtained from the service provider, a home care agency. CMS Ex. 21, at 9-10. The service order, which indicates that it was effective during March 2009, instructed the home care agency to help the waiver participant with bathing, dressing, grooming, meal preparation, and light housekeeping. *Id.* at 10. The order also specifies the frequency with which the services were to be delivered (every Tuesday and Thursday, and every other Sunday and Friday) and the number of service units to be provided during each home visit (either 28 or 16 units depending on the day). In addition to the service order, which CMS found to be adequate (*see* the discussion in the CMS Chart regarding sample claim 7), the State produced the home care agency's "invoices" (dated soon after the billed dates of service) showing the name and address of the waiver participant, the name of the home care agency employees who reportedly rendered care to the waiver participant, and the dates and hours worked by those employees. CMS Ex. 21, at 11-18.

CMS contends that sample claim 21 is inadequately documented because the invoices fail to specify the type of personal care provided (e.g., assistance with bathing dressing, grooming, etc.) during the hours billed, “making it impossible to verify whether the services provided were, in fact, authorized.” CMS Chart (case no. 21).

The State’s documentation for sample claim 21 establishes that an AAA authorized specific personal care services, and that the home care agency received the service order and thus knew which services its aides were supposed to provide. In addition, the State’s documentation confirms that the billed services were performed during the service order’s authorization period (March 2009). There is no allegation by CMS that the provider billed in excess of the authorized frequency or quantity. Nor does CMS allege that the types of personal care ordered were not included in the waiver participant’s service plan. Hence, the question before us – as to this and similar claims for which there is documented authorization for specific types of personal care and evidence that personal care was delivered in authorized amounts and at authorized frequencies – is whether to infer from these circumstances that the types of personal care provided on the billed service dates correspond to one or more of the authorized activities despite the absence of an activity log or other record showing precisely what types of personal care were rendered during a home visit. While more detailed documentation would be desirable to confirm that the aides limited themselves to the specific types of authorized personal care, we conclude that the documentation collectively suffices to show that the aides were actually providing services in accordance with an approved service plan on the billed dates of service.

We therefore reverse CMS’s finding that sample claim 21 is unallowable under the Aging Waiver.

*Sample Claim 22

Sample claim 22 sought Medicaid payment for 736 units (quarter-hours) of personal care allegedly furnished to an 82 year-old waiver participant from March 1 through March 31, 2009. CMS Ex. 5, at 3; CMS Ex. 22, at 1. In support of that claim, the State produced an AAA’s service order for March 2009, a copy of which the State obtained from the service provider, a home care agency. CMS Ex. 22, at 6-7. The order instructed the home care agency to provide “daily” assistance with “all” activities of daily living and “medication management,” and to escort the participant to the physician’s office three times per week. *Id.* at 7. CMS does not allege that the services ordered for the dates shown were inconsistent with the waiver participant’s service plan. In addition to the service order, the State produced timesheets for the billed dates of service showing the

name and address of the waiver participant, the name of the home care aide(s) who reportedly rendered the billed services, and the hours worked on each date. The timesheets were signed by both the personal care aide and the waiver participant and confirm that the billed services were performed during the service order's authorization period (March 2009). *See* CMS Ex. 22, at 8-9, 15-18, 21-24, 27-30, 34-37.

The documentation provided for sample claim 22 is comparable to – and given the signatures perhaps even stronger than – the evidence that we found sufficient to establish sample claim 21's allowability. Accordingly, we conclude that the State has substantiated the allowability of sample claim 22.

Sample Claim 23

Sample claim 23 sought Medicaid payment for 168 units (quarter-hours) of personal care allegedly furnished to the waiver participant from August 1 through August 31, 2008. CMS Ex. 5, at 3; CMS Ex. 23, at 1. In support of that claim, the State produced a service order issued by an AAA and activity logs completed by a personal care aide indicating the nature of the care provided during each service visit. CMS Ex. 23, at 20-26. CMS found the claim to be inadequately documented because the service order "lacked sufficient details describing the services ordered." CMS Chart (case no. 23). "[B]ecause the service order merely provides a blanket authorization" for unspecified types of personal care, says CMS, "the [S]tate has failed to demonstrate that the services were provided in accordance with the state authorization." *Id.*

On its face the service order authorized eight hours per day (40 hours per week) of "hands on" personal care and "house keeping" for August 2008 (and other months), to be billed under procedure code W1700. The order does not, however, describe the waiver participant's unmet daily living needs or specify the types of personal care authorized. In addition, the procedure code noted on the service order does not (in this instance and all others) differentiate among the various types of personal care services that may be authorized based on a participant's assessed needs.

For the reasons explained in our analysis of sample claim 11, a service order lacking information about the waiver participant's unmet daily living needs or the types of personal care authorized is insufficient proof that the AAA authorized the billed services pursuant to a participant-centered service plan. The State notes that the provider "would have had a copy of the service plan that provided more specific detail on care." PA Ex. 13, at 5. Even if that is true, it was the State's obligation to maintain and produce the plan, or some other contemporaneous record reflecting the plan's content, in the event that CMS questioned the claim's allowability. PA Ex. 2, at 145 (requiring the State to

maintain “[r]ecords documenting the audit trail of adjudicated claims (including supporting documentation) . . . for a minimum period of 3 years as required in 45 CFR §92.42”) and 89 (stating that the AAA case manager would maintain “[w]ritten copies or electronic facsimiles of service plans . . . for a minimum period of 3 years as required by 45 CFR §92.42”).

For these reasons, we sustain CMS’s finding that sample claim 23 is unallowable under the Aging Waiver.

Sample Claim 31

Sample claim 31 sought Medicaid payment for 268 units (quarter-hours) of personal care allegedly furnished to the waiver participant from December 1 through December 31, 2008. CMS Ex. 5, at 4; CMS Ex. 31, at 1. In support of that claim, the State produced a service order issued by an AAA and timesheets signed by a personal care aide. CMS Ex. 31, at 11-15. CMS determined that the claim was unallowable because the timesheets fail to indicate what types of personal care were furnished during the hours billed, and because the service order “authorizes large quantities of personal care services (8 and 14 hours at a time) with absolutely no description or direction to the provider about what type of personal care services the state expected the provider to deliver to the beneficiary.” CMS Chart (case no. 31).

As CMS asserts, the AAA’s service order does not describe the waiver participant’s unmet daily living needs or specify the types of personal care that the AAA decided were appropriate to help the participant meet those needs. The order merely authorizes a daily number of “personal care hours” (Monday through Friday) to be billed under the appropriate procedure code. CMS Ex. 31, at 11-12. As we explained in our analysis of sample claim 11, a service order that fails to identify the participant’s unmet daily living needs or the types of personal care authorized is insufficient proof that the billed services were provided pursuant to a participant-centered service plan. The State submitted no other evidence that the billed services satisfied that requirement.²²

We therefore conclude that the State failed to establish that sample claim 31 is allowable under the Aging Waiver.

²² The timesheets for sample claim 31 make no reference to a service plan and do not disclose the types of personal care delivered on the billed dates of service.

*Sample Claim 33

Sample claim 33 sought Medicaid payment for 444 units (quarter-hours) of personal care services allegedly furnished to a waiver participant from June 1 through June 30, 2008. CMS Ex. 5, at 4; CMS Ex. 33, at 1. In support of this claim, the State initially (during the audit) produced timesheets signed by a personal care aide, activity logs (signed by both the personal care aide and the waiver participant) indicating the nature of the services provided by the aide during each service visit, and a service order issued by an AAA to the home care agency that employed the personal care aide. CMS Ex. 33, at 7-26, 28-30, 32. For the service dates at issue, the service order authorized the home care agency to furnish 16 units of personal care Monday through Friday, and 12 units on Saturday and Sunday. *Id.* at 28-29.

CMS determined that the claim was unallowable because the service order “lacked sufficient details describing the services ordered.” CMS Chart (case no. 33). “Given that there is no description [in the service order] of the particular types of personal care services authorized,” says CMS, “there is no way for the state to demonstrate that the services actually provided were indeed authorized under the service order and there is no way for the state to demonstrate that the *authorized services* were actually provided.” *Id.* (italics in original).

Responding to that finding, the State submitted with its reply brief a record extracted from the SAMS, the electronic database used by the AAA care managers to store service-plan content and other “information from the collaboration between the [waiver] participant and the [AAA] Care Manager.” PA Ex. 2, at 86-87, 144; PA Ex. 21, at 1-2. The SAMS record indicates, in the “Service Instructions” (or “PCA_SO_DESC” or service-order description) field, that the AAA had assessed the waiver participant named in sample claim 33 as needing help with bathing, hygiene, toileting, dressing, transfers, feeding, and meal preparation – the types of personal care that, according to the provider’s activity logs, were actually performed on the billed dates of service. PA Ex. 21, at 4; CMS Ex. 33, at 7-16, 30. That record also reflects a “Service Begin Date” of June 1, 2008 and the number of “Units Ordered” (444, an amount consistent with the number of units billed). Because the SAMS was used by AAA care managers to create a contemporaneous record of service-plan content (*see* PA Ex. 2, at 86), and because that record in this instance confirms that personal care was authorized to help the waiver participant during June 2008 with specific daily living needs (described in the “service instructions” field), we find the SAMS record and the service order to be sufficient evidence that the AAA authorized the billed services pursuant to an approved service plan.²³

²³ There is no allegation by CMS that the service provider billed the Aging Waiver in excess of the frequency or service-unit limits specified in the service order.

We therefore conclude that the State has substantiated the allowability of sample claim 33.

Sample Claim 35

Sample claim 35 sought Medicaid payment for 88 units (quarter-hours) of personal care allegedly furnished to a waiver participant during November 2008. CMS Ex. 5, at 4; CMS Ex. 35, at 1. In support of that claim, the State produced a service order issued by an AAA and activity logs (signed by both the waiver participant and a personal care aide) indicating the types of personal care furnished during each visit. CMS Ex. 35, at 4-7, 12. CMS submits that the sample claim is unallowable because the “services provided do not match the services authorized since the personal care worker was authorized to provide 16 different types of principal beneficiary care services and yet, in fact, merely pushed the resident in a wheelchair and billed for multiple unauthorized housekeeping services.” CMS Chart (case no. 35).

The record supports CMS’s position. Effective November 4 (all dates are from 2008), the service order authorized the provision of eight units (or two hours) of personal care on Tuesdays, Thursdays, and Saturdays (or six hours per week) in order to help the waiver participant with bathing, grooming, and dressing.²⁴ CMS Ex. 35, at 12. However, according to the November activity logs, the personal care aide did not provide those types of assistance. Instead, the aide helped the participant with “ambulation” (the participant apparently used a wheelchair), washed clothes, prepared meals, shopped for groceries, and performed light housekeeping. CMS Ex. 35, at 7. The AAA did not clearly authorize those activities as Aging Waiver services. In the “comments” section, the service order states that “[c]onsumer needs assistance with bathing, grooming and dressing.” *Id.* at 12. There is no comparable statement on the order that the participant needed help with “ambulation.” *Id.* In addition, the service order does not mention clothes washing, meal preparation, grocery shopping, or housekeeping.²⁵

²⁴ The waiver participant was hospitalized on November 23 and discharged on November 25, and the service order was updated to reflect those events: the order directed the home care agency to suspend services “effective 11/24/08” and “[r]esume services effective 11/25/08.” CMS Ex. 35, at 12. The service order also authorized eight units of personal care for Wednesday, November 29 (in lieu of the regularly scheduled visit for Thursday, November 30). *Id.*

²⁵ Even if housekeeping had been authorized, that service would not be allowable. The Aging Waiver states that “[p]ersonal care may include the provision of *supplemental housekeeping* as long as the *primary service* rendered is for the ‘hands-on’ care.” PA Ex. 2, at 44 (italics added). This means (as we note in our discussion of sample claim 41) that the waiver covers housekeeping as “personal care” or “personal assistance” only if it is performed during the same visit (or, at minimum, on the same day) as an authorized “primary” service. In this instance, according to the service provider’s activity logs, none of the housekeeping performed on the billed dates of service was provided on the same day as an authorized primary service. *See* CMS Ex. 35, at 4 (entry for Nov. 26), 5 (entries for Nov. 4 and Nov. 6), 6 (entries for Nov. 11, Nov. 13, and Nov. 15), and 7 (entries for Nov. 18, Nov. 20, and Nov. 22).

Below the service order's "comments" is a list of services (e.g., bath, foot care, hair wash, etc.) that are explicitly identified as billable "personal care" under procedure code W1700. Although "assist[ance] with ambulation" appears on top of the list, that particular service, unlike the others, is not labeled as billable personal care, raising a question about whether the AAA had authorized that service to be provided under the Aging Waiver. The State did not clarify or explain this aspect of the service order. *See* PA Ex. 13, at 6-7. In any case, assistance with ambulation – unlike bathing, grooming, and dressing – is not documented on the service order as one of the waiver participant's assessed needs.

We therefore conclude that the State did not substantiate the allowability of sample claim 35.

*Sample Claim 36

Sample claim 36 sought Medicaid payment for 12 units (quarter-hours) of personal care allegedly furnished to a 93 year-old waiver participant on June 26, 2008. CMS Ex. 5, at 4; CMS Ex. 36, at 1. In support of that claim, the State produced the service provider's "daily visit log" for June 28, 2008 and a "SAMS Consumer Service Order Report" which indicates that the AAA had authorized the provider to help the participant three times per week with bathing, dressing, grooming, toileting, and other daily living activities. CMS Ex. 36, at 2, 7, 11-12.

CMS's auditors rejected the sample claim on the ground that the AAA's service order, which appears on the top of the SAMS Consumer Service Order Report, "lacks details describing the services ordered." CMS Ex. 4, at 2. However, the service order does contain those details. *See* CMS Ex. 36, at 11-12. CMS does not defend the auditors' finding, nor does it contend that the service provider's time records were inadequate or that the number of billed service units exceeded the number authorized. CMS does not allege that the services ordered for the dates shown were inconsistent with the waiver participant's service plan.

There is, however, an issue about whether there was a valid service authorization in effect during the billing period. The State concedes that the Service Order Report shows that the AAA's authorization "expired in 2007." PA Ex. 1, at 6. The State also admits that it "has not retained paper evidence of an extension of the service order . . ." PA Ex. 13, at 7. Nonetheless, the State submits that the AAA extended the authorization through at least June 2008 (when the billed services were provided) and that "electronic confirmation" of an extension is reflected on pages three and four of CMS Exhibit 36, which, the State says, are screenshots from its Home and Community Service Information System (HCSIS). *Id.*; PA Ex. 1, at 6.

According to CMS, the screenshots are from the State's PROMISE system, to which Medicaid providers submit payment claims and which show "only what the provider billings were." CMS Chart (case no. 36). However, the acronym "HCSIS" appears on top of both screenshots, and one of them also shows that service "units" were "authorized" for the waiver participant for June 2008. CMS Ex. 36, at 3-4. Furthermore, the Aging Waiver indicates that data from the SAMS – where AAA case managers store service-plan information – are transferred to the HCSIS daily, and that the PROMISE system checks the HCSIS in order to "verify the necessary information (verifies provider, unit, service on the service plan) on the participant's service plan before approving the claim for payment." PA Ex. 2, at 31, 85-86, 88, 144-45. In light of that information, and the absence of any suggestion by CMS that AAAs had, or were required to have, uniform or standard procedures for issuing or documenting service extensions or reauthorizations), the HCSIS screenshots suffice to demonstrate that the AAA's 2007 authorization for personal care continued in effect during June 2008, when the billed services were provided.

Accordingly, we reverse the unallowability finding regarding sample claim 36.

Sample Claim 41

Sample claim 41 sought Medicaid payment for 188 units (quarter-hours) of personal care allegedly furnished to a waiver participant from March 16 through March 31, 2009. CMS Ex. 5, at 5; CMS Ex. 41, at 1. For that two-week period, an AAA authorized a home care agency to provide the waiver participant with the following types of personal care:

- "assisting with toileting and laundry completion" (to help the recipient "maintain personal hygiene"),
- "bathing assistance" upon the recipient's request (to help the recipient "maintain personal hygiene"),
- "assisting with transfers and walker/wheelchair usage,"
- "assisting with house cleaning/dish washing,"
- "preparing any meals requested by" the recipient,
- "assist[ing] with shopping," if requested,
- "provid[ing] caregiver relief by monitoring consumer from 1:30-4:30PM, 5 days/wk, while family members' work schedules over-lap."

CMS Ex. 41, at 6.

CMS contends that the services billed under sample claim 41 are unallowable because the home care agency's "activity sheet" (*id.* at 7) shows that, "instead of performing . . . principal personal care services [such as assisting with personal hygiene] which were authorized under the [AAA's] service order, the provider and beneficiary improperly used the personal care service benefit solely for housekeeping services" (CMS Chart, case no. 41). Review of the activity sheet confirms that only unspecified "housekeeping" services were provided to the waiver participant during the latter half of March 2009. Under the Aging Waiver, "supplemental housekeeping" may be billed as personal care only if the waiver participant also received a "primary service" involving "hands-on" care. PA Ex. 2, at 44. The provider's activity sheet shows no such primary service was provided to the waiver participant during the two-week period for which the claim was submitted (March 16 through March 31, 2009). CMS Ex. 41, at 7.

According to the State, "[t]he fact that only housekeeping was provided on certain days, does not make the services for those days unallowable so long as the other services were provided on other days." PA Ex. 13, at 8. As a factual matter, the State failed to make any showing that the other services were actually provided on other days. Furthermore, the State does not point to any language in the Aging Waiver that can be reasonably read to allow payment for housekeeping furnished on days on which no primary service was delivered.

The State asserts that it "cannot show that that other services were provided on other days without the provider timesheets surrounding the review period"; that it "did not copy the surrounding timesheets"; and that "the record retention period for such provider records has long expired." PA Ex. 13, at 6. Assuming for argument's sake that those additional records would have helped to establish the claim's allowability, the State should have secured them during the course of the financial management review (*see* the discussion above concerning sample claim 7).

For these reasons, we sustain CMS's determination that sample claim 41 is unallowable under the Aging Waiver.²⁶

²⁶ The State asserts, in the alternative, that housekeeping may be covered under the Aging Waiver as "personal assistance" (rather than as "personal care") but fails to elaborate on that point. P. Ex. 13, at 6. Under the waiver, housekeeping is covered as personal assistance only to the extent that it is "*incidental* to the care furnished" or "essential to the health and welfare of the individual rather than the individual's family." PA Ex. 2, at 62. The State does not allege that the housekeeping billed under sample claim 41 met either of those conditions and, as we have concluded, there is no evidence of any care to which the housekeeping services could arguably be incidental.

Sample Claim 43

Sample claim 43 sought Medicaid payment for 24 units (quarter-hours) of personal care allegedly furnished to a waiver participant on April 2 and April 9, 2009. CMS Ex. 5, at 5; CMS Ex. 43, at 1, 7. In support of this claim, the State produced a service order issued by an AAA and a daily “activity sheet,” signed by the waiver participant. CMS Ex. 43, at 6-7. The activity sheet shows the hours worked by a personal care aide but indicates that the only service provided was “light housekeeping.” CMS Ex. 43, at 7.

For this reason, we sustain CMS’s finding that sample claim 43 is unallowable under the Aging Waiver.

Sample Claim 44

Sample claim 44 sought Medicaid payment for 300 units (quarter-hours) of personal care allegedly furnished to a waiver participant from February 1 through February 15, 2009. CMS Ex. 5, at 5; CMS Ex. 44, at 1. In support of that claim, the State produced a service order issued by an AAA to a home care agency and that agency’s “Daily Service Record” (a timesheet) for the first 19 days of that month. CMS Ex. 44, at 7-9. Based on that documentation, CMS determined that the claim was unallowable because the service order “lacked sufficient details describing the services ordered.” CMS Chart (case no. 44).

As CMS alleges, the service order does not specify either the types of personal care services authorized or the unmet daily living needs that the services were intended to address. CMS Ex. 44, at 6. As we explained in our discussion of sample claim 11, a service order lacking such information is insufficient proof that the billed services were furnished pursuant to an approved participant-centered service plan.²⁷ The State submitted no other evidence that the billed services were included in, and delivered in accordance with, an approved service plan.

The State therefore failed to substantiate the allowability of sample claim 44 under the Aging Waiver.

*Sample Claim 57

Sample claim 57 sought Medicaid payment for 32 units (quarter-hours) of personal assistance allegedly furnished to a waiver participant during January 2009. CMS Ex. 5, at 7; CMS Ex. 57, at 1, 9. In support of the claim, the State produced an AAA’s service

²⁷ The Daily Service Record does not reference a service plan or disclose the nature of the personal care delivered on the billed dates of service.

order, a copy of which the State obtained from the home care agency, as well as timecards and other records showing the hours reportedly worked by a home care attendant on January 19, January 25, and January 27, 2009. CMS Ex. 57, at 6, 9, 13-14.

CMS asserts that sample claim 57 is unallowable because the service order “fails to specify what type of personal care services were authorized[.]” CMS Chart (case no. 57). To the contrary, the order pertaining to the service dates in question expressly authorized assistance with “bathing, dressing, grooming, incontinent care as needed, as well as med[ication] set up and reminder.” CMS Ex. 57, at 6. CMS does not assert that the services specified are inconsistent with the waiver participant’s individual service plan.

CMS also asserts that the State’s documentation is insufficient because the time records do not specify the type(s) of personal assistance furnished, only the hours spent with the waiver participant, “making it impossible to verify whether the services provided were, in fact authorized.” CMS Chart (case no. 57). However, the documentation provided for this sample claim is comparable to the evidence that we found sufficient to establish sample claim 21’s allowability.

Accordingly, we conclude that the State has substantiated the allowability of sample claim 57.

*Sample Claim 59

Sample claim 59 sought Medicaid payment for 32 units (quarter-hours) of personal assistance allegedly furnished to a waiver participant on October 11, 2008. CMS Ex. 5, at 7; CMS Ex. 59, at 1, 12. In support of the claim, the State produced a document titled “SAMS Consumer Service Plan,” which identifies the types of personal assistance authorized (namely, help with bathing, dressing, grooming, toileting, and other tasks) during this time period as well as a timecard and other records showing the hours worked by a home care attendant on October 11, 2008. *Id.* at 8-9, 12, 16-17.

CMS contends that the State’s documentation is insufficient because the service provider’s time records do not specify the type(s) of personal assistance furnished, only the time spent with the waiver participant, “making it impossible to verify whether the services provided were, in fact authorized.” CMS Chart (case no. 59). However, the documentation provided for this sample claim is comparable to the evidence that we found sufficient to establish the allowability of sample claims 21 and 57.

Accordingly, we conclude that the State has substantiated the allowability of sample claim 59.

Sample Claim 60

Sample claim 60 sought Medicaid payment for 105 units (quarter-hours) of personal assistance allegedly furnished to a waiver participant from August 1 through August 31, 2008. CMS Ex. 5, at 7; CMS Ex. 60, at 1. In support of this claim, the State produced a document titled “Provider Service Request”²⁸ as well as timecards and other records showing the hours worked by a home care attendant during August 2008. CMS Ex. 60, at 7, 10-14.

CMS contends that the State’s documentation is insufficient because the time records do not specify the type(s) of personal assistance furnished, only the hours spent with the waiver participant, “making it impossible to verify whether the services provided were, in fact authorized.” CMS Chart (case no. 60). CMS also asserts that the service order “provides no description of the type of services authorized[.]” *Id.*

As CMS asserts, the time records do not specify the services rendered. CMS Ex. 60, at 11-14. Moreover, the AAA’s service order – the Provider Service Request form – does not specify the type(s) of personal assistance authorized or the waiver participant’s unmet daily living needs. CMS Ex. 60, at 7. As we explained in our discussion of sample claim 11, a service order lacking such information is insufficient proof that the billed services were authorized or provided pursuant to an approved participant-centered service plan. The Provider Service Request does refer to a “care plan” in effect during the billing period, but the State did not produce a copy of the plan or some other evidence of its content.

Because it provided insufficient evidence that the AAA authorized the billed services pursuant to an approved service plan, the State has not met its burden to establish the allowability of sample claim 60.

Sample Claim 63

Sample claim 63 sought Medicaid payment for 89 units (quarter-hours) of personal assistance furnished (under the consumer-employer model) to a waiver participant from March 15 through March 31, 2009. CMS Ex. 5, at 7; CMS Ex. 63, at 1. In support of that claim, the State produced timecards and other records showing the hours purportedly

²⁸ The service request refers to an attached “MA-51” medical evaluation form, but that document is not part of the record.

worked by the home care attendant on behalf of the waiver participant during March 2009. CMS Ex. 63, at 8-15. But, as CMS notes in the chart appended to its response brief, the State did not produce any document by which CMS could verify that the billed services were authorized in accordance with a service plan approved by the AAA.

For that reason, we hold that the State did not substantiate the allowability of sample claim 63 under the Aging Waiver.

Sample Claim 65

Sample claim 65 sought Medicaid payment for 424 units (quarter-hours) of personal assistance allegedly furnished to a waiver participant from January 1 through January 31, 2009. CMS Ex. 5, at 7; CMS Ex. 65, at 1. In support of the claim, the State produced an AAA's service order as well as timecards and other records showing the hours purportedly worked by a home care attendant during January 2009. CMS Ex. 65, at 7-8, 14-21. CMS contends that the State's documentation is insufficient because the time records do not specify the type(s) of personal assistance furnished, only the hours spent with the waiver participant, "making it impossible to verify whether the services provided were, in fact authorized." CMS Chart (case no. 65). CMS also asserts that the service order does not specify the types of personal assistance authorized by the AAA. *Id.*

As CMS asserts, the AAA's service order does not specify the type(s) of personal assistance authorized or the waiver participant's unmet daily living needs.²⁹ CMS Ex. 65, at 7-8. As we explained in our discussion of sample claim 11, a service order lacking such information is insufficient proof that the billed services were provided pursuant to an approved participant-centered service plan. The State submitted no other evidence that the billed services were included in, and delivered in accordance with, an approved service plan.³⁰

The State therefore failed to substantiate the allowability of sample claim 65 under the Aging Waiver.

²⁹ The time records supporting this sample claim do not specify the type(s) or nature of the personal assistance provided. CMS Ex. 65, at 14-21.

³⁰ The documents produced by CMS include a service plan form, but the form is not filled out. CMS Ex. 65, at 9.

Sample Claim 66

Sample claim 66 sought Medicaid payment for 327 units (quarter-hours) of personal assistance allegedly furnished to a waiver participant from October 1 through October 31, 2008. CMS Ex. 5, at 8; CMS Ex. 66, at 1. In support of the claim, the State produced an AAA's service order and timecards and other records showing hours worked by a home care attendant during January 2009. CMS Ex. 66, at 8-9, 11-20. CMS contends that the State's documentation is insufficient because the time records do not specify the type(s) of personal assistance furnished, only the hours spent with the waiver participant, "making it impossible to verify whether the services provided were, in fact authorized." CMS Chart (case no. 66). CMS also asserts that the AAA's service order does not specify what types of personal assistance were authorized by the AAA. *Id.*

The service order produced by the State authorizes the home care agency's "coordination" service (billed under procedure code W7341), not the personal assistance services themselves (billed under procedure code W1792). CMS Ex. 66, at 1, 8. There is no other documentation verifying that the billed services were authorized pursuant to an approved participant-centered service plan. In addition, the time records supporting this sample claim do not specify the type(s) or nature of the personal assistance provided. CMS Ex. 66, at 11-20.

The State therefore failed to substantiate the allowability of sample claim 66 under the Aging Waiver.

Sample claims 67-68, 77-84, 88, and 90

The nature of the documentation supporting sample claims 67-68, 77 through 84, 88, and 90 is the same in each instance. In support of these claims, the State submitted service orders issued by AAAs and time records kept by the service providers. *See* CMX Ex. 67, at 10, 13-19 (sample claim 67); CMS Ex. 68, at 8-9, 11-14, 17-24 (sample claim 68); CMS Ex. 73, at 9, 11-13 (sample claim 77); CMS Ex. 74, at 8-11, 15 (sample claim 78); CMS Ex. 75, at 7-11, 14-15 (sample claim 79); CMS Ex. 76, at 6-12 (sample claim 80); CMS Ex. 77, at 6-16 (sample claim 81); CMS Ex. 78, at 7-14 (sample claim 82); CMS Ex. 79, at 6-13 (sample claim 83); CMS Ex. 80, at 6-11 (sample claim 84); CMS Ex. 84, at 6-16 (sample claim 88); CMS Ex. 86, at 6-9 (sample claim 90). However, as CMS asserts, the AAA's service order in each instance fails to specify the type(s) of personal care or personal assistance authorized or the waiver participant's unmet daily living needs, and there is no other evidence that the billed services were included in, and delivered in accordance with, an approved service plan.

For these reasons (as more fully outlined in our discussion of sample claim 11), we affirm CMS's finding that sample claims 67, 68, 77 through 84, 88, and 90 are unallowable under the Aging Waiver.

*Sample Claim 89

Sample claim 89 sought Medicaid payment for 96 units (quarter-hours) of personal care allegedly furnished to a waiver participant from November 3 through November 27, 2008. CMS Ex. 5, at 10; CMS Ex. 85, at 2. During the audit, the State produced a service order issued by an AAA to the home care agency that submitted the claim. CMS Ex. 85, at 6. The order authorized the agency to furnish eight units of personal care, three times per week (Mondays, Wednesdays, and Thursdays) for the month of November 2008 – a total of 96 units for that month. *Id.* In addition to the service order, the State produced timesheets showing the dates and hours worked by a personal care aide on behalf of the waiver participant (whose name and address appear on the top of those documents) during November 2008. *Id.* at 7-8. The timesheets are signed by both the personal care aide and the waiver participant, the latter who certified that the services were performed in a “satisfactory manner.” *Id.* The timesheets show that the service provider delivered services according to the schedule specified in the service order. *Id.*

In the chart attached to the response brief, CMS contends that the State's documentation is insufficient because the “service order lacks details describing the services ordered.” CMS Chart (case no. 89). “Given that there is no description [in the service order] of the particular types of personal care services authorized,” says CMS, “there is no way for the state to demonstrate that the services actually provided were indeed authorized under the service order and there is no way for the state to demonstrate that the *authorized services* were actually provided.” *Id.* (italics in original).

Responding to that finding, the State submitted with its reply brief a SAMS record relating to the waiver participant. That record indicates – in the “Service Order Special Instructions” (or “PCA_SO_DESC”) field – that the AAA had assessed the waiver participant as needing help with certain daily living activities, including hygiene, skin care, dressing, transfers, and housekeeping. PA Ex. 21, at 2. The extract also reflects (in the “SO Eff Date” and “SO Exp Date” fields) that the “instructions” were effective during November 2008. *Id.* Consistent with our findings concerning sample claims 21 and 33, we find that the SAMS record – in particular its articulation of the resident's unmet daily living needs – is sufficient evidence that the billed personal care services were authorized and furnished to address specific needs documented in a participant-centered service plan. CMS does not allege that the services ordered for the dates shown were inconsistent with the waiver participant's service plan. Accordingly, we reverse CMS's finding that sample claim 89 is unallowable under the Aging Waiver.

*Sample Claim 91

Sample claim 91 sought payment for 56 units (quarter-hours) of personal care allegedly furnished to the waiver participant from February 5 through February 25, 2009. CMS Ex. 5, at 10; CMS Ex. 87, at 2. During the audit, the State produced a service order issued by an AAA to the home care agency that submitted the claim. CMS Ex. 87, at 6. The order authorized the agency to furnish 14 units of personal care on Thursday of each week during February 2009 – a total of 56 units for that month. *Id.* In addition to the service order, the State produced timesheets showing the dates and hours worked by a personal care aide on behalf of the waiver participant (whose name and address appear on the top of those documents) during February 2009. *Id.* at 7-8. The timesheets are signed by both the personal care aide and the waiver participant, the latter who certified that the services were performed in a “satisfactory manner.” *Id.*

CMS contends that the State’s documentation is insufficient because the “service order lacks details describing the services ordered.” CMS Chart (case no. 91). “Given that there is no description [in the service order] of the particular types of personal care services authorized,” says CMS, “there is no way for the state to demonstrate that the services actually provided were indeed authorized under the service order and there is no way for the state to demonstrate that the *authorized services* were actually provided.” *Id.* (italics in original).

Responding to that finding, the State submitted with its reply brief a SAMS record which indicates – in the “Service Order Special Instructions” (or “PCA_SO_DESC”) field – that the AAA had assessed the waiver participant as needing help with certain daily living activities, including hygiene, skin care, feeding, dressing, and housekeeping. PA Ex. 21, at 3. That record also indicates (in the “SO Eff Date” and “SO Exp Date” fields) that the AAA’s service instructions were effective during February 2009. *Id.* Consistent with our findings concerning sample claims 21 and 33, we find that the SAMS record – in particular its articulation of the resident’s unmet daily living needs – is sufficient evidence that the billed personal care services were authorized and furnished to address specific needs documented in a participant-centered service plan. CMS does not allege that the services authorized for the dates shown were inconsistent with the waiver participant’s service plan. Accordingly, we reverse CMS’s finding that sample claim 91 is unallowable under the Aging Waiver.

Sample Claim 92

CMS submits, and the State does not dispute, that sample claim 92 sought payment under the Aging Waiver for “grass cutting.” CMS Chart (case no. 92). The records produced by the State for this claim show that the AAA authorized grass-cutting to be billed as

“personal assistance.” CMS Ex. 88, at 2, 4-6, 11-12. CMS contends that this activity does not constitute personal assistance, as defined in the Aging Waiver. CMS Chart (case no. 92).

The Aging Waiver defines personal assistance services to include:

- “Providing assistance to the participant with eating, bathing, dressing, personal hygiene, and other activities of daily living (ADL).”
- “Assistance with the preparation of meals”;
- “Such *light housekeeping* chores as bed making, dusting, and vacuuming, *and other activities of daily living* which are incidental to the care furnished or which are *essential to the health and welfare of the individual* rather than the individual’s family”;
- “Health maintenance activities . . . , such as bowel and bladder routines, ostomy care, catheter, wound care and range of motion as indicated in the Individual Service Plan (ISP)”;
- “Routine wellness services to enable adequate nutrition, exercise, keeping of medical appointments and all other health regimens related to healthy living activities.”

PA Ex. 2, at 61-62 (italics added).

The State suggests that grass-cutting is “light housekeeping . . . essential to the health and welfare of the” waiver participant (PA Ex. 2, at 62) because “[i]f grass is not cut, the lawn becomes a haven for vermin[,]” and “municipal authorities” might cite the participant for creating a “nuisance . . . that might ultimately result in her eviction” (PA Ex. 1, at 15; PA Ex. 13, at 17). We reject that suggestion. Light housekeeping is defined in the Aging Waiver as a type of “daily living” activity. Grass-cutting is not a daily living activity, and we do not believe that it can fairly be called “*housekeeping*” (as opposed to yard maintenance). Furthermore, the State proffered no evidence, only its lawyer’s speculation, that grass-cutting was “essential” to the waiver participant’s “health and welfare.” The available documentation does not tell us what, if any, health needs, risks, or related concerns prompted the AAA to authorize that service for the waiver participant. *See* CMS Ex. 88.

Consequently, we conclude the State did not meet its burden to substantiate the allowability of sample claim 92.³¹

E. *The State is not entitled to unredacted versions of CMS's Financial Management Review Guides.*

During the discovery phase of this appeal, CMS withheld two Financial Management Review Guides (one dated February 2002, the other November 2009), asserting that they were protected from disclosure under the deliberative process privilege. The State asked the Board to compel production of the Review Guides. The Board initially granted that request but later, in response to CMS's motion for reconsideration, directed CMS to provide the Review Guides for *in camera* review. Based on that review, the Board provided the State with redacted versions of the Review Guides. *See* Feb. 7, 2017 Ruling on Request for Reconsideration. Although it concluded that the Review Guides were not privileged, the Board redacted information that it found to be "entirely and plainly irrelevant" to the parties' dispute, including "internal CMS communication and coordination protocols, review steps and procedures that were not taken or followed to reach the conclusions supporting the challenged disallowance, and other information unresponsive to the State's assertion of need." *Id.* at 8. The State now contends that the redactions were an "abuse of discretion" and asks the Board to release unredacted versions of the Review Guides. PA Br. at 14.

We find insufficient cause to modify or reverse our prior rulings concerning the Review Guides. A review of the redactions does not change our view that the excluded information (relating to internal audit and communication processes and procedures) is wholly irrelevant to the material issues that we resolve in this appeal. The Board may exclude irrelevant or immaterial information from the record of this proceeding. *See* 45 C.F.R. § 16.11 (the "Presiding Board Member generally will admit evidence unless it is determined to be clearly irrelevant, immaterial or unduly repetitious"); 5 U.S.C. § 556(d) (an agency "as a matter of policy shall provide for the exclusion of irrelevant, immaterial, or unduly repetitious evidence").

Relying on a judicial discovery ruling under the Federal Rules of Civil Procedure, the State asserts that "[i]rrelevant information in otherwise relevant documents should be released unless the producing party offers a persuasive reason for why such information should be withheld." PA Br. at 15 (citing *In re Takata Airbag Prods. Liab. Litig.*, 2016

³¹ The State asserts that in evaluating the allowability of sample claim 92, we must defer to its "interpretation of ambiguous language" in the Aging Waiver. PA Ex. 13, at 17. However, the State does not point to any such language.

Westlaw 1460143 (S.D. Fla. March 1, 2016)). However, the Federal Rules of Civil Procedure do not govern this proceeding (*see* Appellate Div. Practice Manual) and while the Board sometimes finds them to be instructive, the State provides no good reason why we should apply them in this case.

The State says that it “can likely obtain the unredacted documents” through a Freedom of Information Act (FOIA) request. PA Br. at 16. That fact is insignificant here because, as we stated in our initial ruling on the State’s discovery motion, “the breadth of discovery before the Board is not co-extensive” with the availability of documents under FOIA. June 14, 2016 Ruling on Motion to Compel Discovery at 4 n.2.

The State cites one two-line redaction on page 11 of the February 2002 Review Guide as “particularly troublesome.”³² PA Br. at 15-16. The cited redaction appears as follows:

Determine whether the claims documentation includes the following to support the claim in accordance with section 2500 of the State Medicaid Manual ([REDACTED]):

- a. Date of service;
- b. Medicaid identification number;
- c. Name of waiver consumer;
- d. Services provided;
- e. Units of service;
- f. Amount and date of payment; and
- g. Location where services provided.”

CMS Ex. 97, at 13. Because the redaction appears in the middle of a passage that discusses documentation of waiver service claims, we disclose the redacted material, which states: “The State would retain the same information in addition to the current contract/provider agreement[.]”³³ That sentence merely reveals CMS’s expectation, communicated in the State Medicaid Manual, that a state will possess contemporaneous documentation of certain facts supporting a service provider’s claim for payment under a section 1915(c) waiver. The passage as a whole does not help the State, for reasons outlined in part A of our analysis. Like the State Medicaid Manual, the passage does not specify the evidence *sufficient* to establish a state’s eligibility for FFP in its section 1915(c) waiver expenditures, nor does the passage purport to define or limit the State’s obligation to obtain and produce such evidence in response to a disallowance.

³² The State does not point to any similarly “troublesome” redactions in the November 2009 Review Guide.

³³ A version of CMS Exhibit 97 without the discussed redaction will be included in the electronic record as an attachment to the Board’s decision, along with the cited discovery ruling.

CONCLUSION

For the reasons outlined above, we affirm CMS's unallowability findings regarding the audited sample claims except for sample claims 16, 21-22, 33, 36, 57, 59, 89, and 91. Regarding those nine claims, we hold that the State met its burden to substantiate their allowability under the Aging Waiver.

Because this decision is partially favorable to the State, we remand the case to CMS to recalculate the disallowance amount and issue a revised disallowance determination. If it believes that CMS has erred in recalculating the disallowance amount, the State may appeal the recalculation issue (and that issue only) to the Board in accordance with 45 C.F.R. Part 16.

_____/s/
Sheila Ann Hegy

_____/s/
Constance B. Tobias

_____/s/
Leslie A. Sussan
Presiding Board Member