Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

SUBJECT: California Department of Health Care Services
Docket No. A-08-93
Decision No. 2204

DATE: October 20, 2008

DECISION

The California Department of Health Care Services (California, CDHCS) appealed the decision of the Centers for Medicare & Medicaid Services (CMS) disallowing federal financial participation (FFP) in the amount of $2,514,227 claimed by California under the Medicaid program. The claims were for capitation payments that California made to a health maintenance organization (HMO), Molina Medical Centers (Molina), from May 1, 1997 through June 19, 1997. CMS found that Molina was not in compliance with a provision of the Act then in effect requiring that less than 75 percent of individuals enrolled in an HMO with a risk comprehensive contract be eligible for Medicare or Medicaid (case mix requirement). CMS disallowed the difference between the amount paid by California to Molina under its risk contracts and what Molina would have been paid if it had been a non-risk contractor. On appeal, Molina argues that CMS did not document that Molina failed to comply with the case mix requirement, that this requirement should not be enforced in view of its subsequent repeal, and that the disallowance should be set aside for equitable reasons. For the reasons set out below, we uphold the disallowance.

Legal Background

The federal Medicaid statute, title XIX of the Social Security Act (Act), authorizes a program that furnishes medical assistance

to low-income individuals and families as well as to blind and disabled persons.[1] Act § 1901. Each state operates its own Medicaid program in accordance with broad federal requirements and the terms of its Medicaid state plan. Act §§ 1902(a)(10), 1905(a); 42 C.F.R. Part 435. A state receives federal reimbursement for a share of its Medicaid program expenditures. Act §§ 1903(a), 1905(a).

CMS advances funds to a state on a quarterly basis, based on the federal share of the estimated cost of the program. Act § 1903(d). CMS reviews a state's estimate for a quarter, as well as the state's quarterly expenditure reports for prior quarters. In computing a grant award, CMS may adjust the state's estimate and may also adjust the amount of the award to reflect any overpayment or underpayment which was made to the state in any prior quarter. Id. Such adjustments may include amounts for which payment is deferred or disallowed. 42 C.F.R. § 430.30(d). The regulations at 42 C.F.R. § 430.40 set forth the mechanism pursuant to which the CMS Regional Administrator may question a claim and defer payment of it. Section 430.40(a) provides for deferral of a claim or any portion of a claim within 60 days after CMS's receipt of a Quarterly Statement of Expenditures that includes the claim. Section 430.40(b) provides that, within 15 days after excluding the claim from a state's grant award, "the Regional Administrator sends the State a written notice of deferral that . . . [r]equests the State to make available all the documents and materials the regional office then believes are necessary to determine the allowability of the claim." If the Regional Administrator later determines that the deferred claim is not allowable, he may issue a disallowance without paying the claim. 42 C.F.R. § 430.40(e). Payment of a deferred claim does not preclude a subsequent disallowance based on the results of an audit or financial review. 42 C.F.R. § 430.40(d).

This case involves a deferral and a later disallowance based on section 1903(m)(2) of the Act, which was implemented in 42 C.F.R. § 434.26 (1996). Section 1903(m)(2) was repealed effective June 20, 1997. Public Law No. 105-33, §§ 4703(a), 4710(b)(2). Section 1903(m)(2) applied to HMOs such as Molina that furnished services under "risk comprehensive contracts." 42 C.F.R.

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[1] The current version of the Social Security Act can be found at www.ssa.gov/OP_Home/ssact/comp-ssa.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section.

§ 434.26. The services provided under such a contract must be either inpatient hospital services and any one of five other specified services, or any three or more of the five specified services. 42 C.F.R. § 434.21(b). Under such a contract, it is possible that the contractor may incur a loss because the cost of providing services may exceed the payments made by the state to the contractor for those services. 42 C.F.R. § 434.2.

Section 1903(m)(2)(A) provided in pertinent part:

> Except as provided in [subparagraph (C)], no payment shall be made under this title to a State with respect to expenditures incurred by it for payment (determined under a prepaid capitation basis or under any other risk basis) for services provided by any entity (including a health insuring organization) which is responsible for the provision (directly or through arrangements with providers of services) of [certain specified services] unless–
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> > (i) the Secretary has determined that the entity is a health maintenance organization . . . ;
> > (ii) less than 75 percent of the membership of the entity which is enrolled on a prepaid basis consists of individuals who (I) are insured for benefits under part B of title XVIII [Medicare] or for benefits under both parts A and B of such title, or (II) are eligible to receive benefits under this title [Medicaid];
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> > * * * * *

Section 1903(m)(2)(C) provided:

> Subparagraph (A)(ii) shall not apply with respect to payments under this title to a State with respect to expenditures incurred by it for payment for services by an entity during the three-year period beginning on the date of enactment of this subsection or beginning on the date the entity qualifies as a health maintenance organization (as determined by the Secretary), whichever occurs later, but only if the entity demonstrates to the satisfaction of the Secretary by the submission of plans for each year of such three-year period that it is making continuous efforts and progress toward achieving compliance with subparagraph (A)(ii).

Case Background

The history of this case is documented by a series of letters between the parties, most of which were provided by CMS to California. In some cases, the letters refer to other correspondence between the parties which is not included in the record.

On March 28, 1997, the Health Care Financing Administration (HCFA), CMS's predecessor, wrote to California (then the California Department of Health Services (DHS)) in reference to a request by Molina for an extension of a waiver of the case mix requirement for its Medicaid HMO contracts.[2] HCFA stated that although it was unaware that any formal request to waive the case mix requirement had been made in the first instance, it would not withhold FFP in capitation payments made by California to Molina for the maximum time for which a waiver could have been granted - three years from the beginning of the contract period. According to HCFA, that three-year period would expire on March 31, 1997 for the Sacramento County contract and on April 30, 1997 for the remaining contracts. HCFA stated that, for periods subsequent to the expiration of the three-year maximum waiver period, California must document Molina's compliance with the case mix requirement or contract with Molina on a non-risk basis. CDHCS Ex. 1, at 1. In a letter dated April 17, 1997, CMS reiterated that it would not withhold FFP for the original contract periods but stated that, commencing with the expiration of these contracts, "any State payments made to [Molina] on a risk basis will not be eligible for Federal matching funds." CDHCS Ex. 4, at 1.

On April 25, 1997, California wrote to HCFA's central office setting forth actions that California was taking or planned to take "over the next 90 days" to convert its contracts with Molina to non-risk contracts that were not subject to the case mix requirement. CDHCS Ex. 5, at 1. California also noted that it had been orally assured by regional HCFA staff that FFP would be paid "for any short transition period that might be needed" to implement its plans. Id. at 3. HCFA in turn advised California on May 7, 1997 that it had no discretion to extend a waiver of the case mix requirement beyond three years. CDHCS Ex. 8.

On May 9, 1997, HCFA responded to a May 7, 1997 letter from California "outlining Molina Medical Centers' (MMC) intent to merge with Universal Care Health Plan in an effort to come into

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[2] HCFA was renamed the Centers for Medicare & Medicaid Services in 2001. See 66 Fed. Reg. 35, 437 (July 5, 2001).

compliance with the 75/25 case mix requirement" and requesting a waiver of the requirement "to cover the transition period during which MMC anticipates the completion of the merger." CDHCS Ex. 9, at 1. HCFA reiterated that it had no discretion to extend a waiver of the case mix requirement beyond three years. HCFA also stated that "there is insufficient information in the letter of intent between MMC and Universal Care to determine the purpose and appropriateness of a proposed merger." Id.

On December 11, 1997, HCFA's Region IX office notified California that it was recommending that the Central Office defer $9,232,655 for managed care capitation payments made to Molina after the three-year waiver periods had expired. CDHCS Ex. 10, at 1-2.

On May 20, 1998, California responded to HCFA's deferral notice, requesting that HCFA reconsider taking any disallowance, "especially in view of the repeal" of the case mix requirement. CDHCS Ex. 11, at 1. California also asked HCFA to consider recalculating the potential disallowance on several grounds. Id. at 2-3.

On December 24, 2003, California wrote to CMS, noting that CMS had recently brought to California's attention "several long outstanding deferral issues," including the deferral of its claim for capitation payments to Molina. CDHCS Ex. 12, at 2. California requested "an exemption from the federal deferral timelines" on the ground that "both CMS and CDHS need to conduct further research and determine status of the . . . deferrals." Id. at 1, 3.

On January 30, 2004, CMS advised California that it was approving its request for relief from the deferral timeline, stating that "[w]e will not make a determination of allowability on these deferrals until you have had an opportunity to provide additional supporting material." CDHCS Ex. 13, at 1.

On November 9, 2007, California wrote to CMS stating that it had been informed that CMS was preparing to issue a disallowance based on the December 11, 1997 deferral and stating its objections to such an action. California also argued that even if CMS properly disallowed $2.5 million (the recalculation proposed by California on May 20, 1998), CMS owed California interest on "almost $7 million in federal funds" that "CMS has been holding" since 1998. CDHCS Ex. 14, at 1-2.[3]

(continued...)

On March 27, 2008, CMS notified California that it had recalculated the disallowance as suggested by California on May 20, 1998 and was disallowing $2,514,227 FFP. CMS stated that there was no statutory or regulatory authority for extending the waiver of the case mix requirement beyond the three-year period. CMS further stated that the legislation repealing the case mix requirement did not grant retroactive relief from the rule. Letter dated 3/27/08 from Associate Regional Administrator, Division of Medicaid & Children's Health, CMS, to Chief Deputy Director of Health Care Programs, CDHCS (e-mailed by California to Board on 5/8/08).

Discussion

California argues for reversal of the disallowance on several grounds, which we discuss in turn below.

CMS was not required to produce evidence that Molina failed to meet the case mix requirement.

California argues first that "there is no indication that Molina really was factually out of compliance with the 75/25 rule[.]" CDHCS Br. at 7. According to California, CMS failed to follow the procedures in 42 C.F.R. § 430.40 for deferring and disallowing a claim which might have produced documentation of Molina's noncompliance. California argues that after providing notice of the deferral, HCFA did not request additional information in order to resolve questions about the allowability of the claim. California also points out that HCFA never conducted an audit or financial review before disallowing the claim, contending that this contravened section 430.40(d). In this connection, California also cites section 430.32(a), which states that CMS determines whether a state is complying with federal requirements and state plan provisions "through analysis of the State's policies and procedures, on-site review of selected aspects of agency operation, and examination of samples of individual case records."

This argument misapprehends where the burden of establishing compliance with the case mix requirement lies. As the Board has previously held, "[a] state seeking FFP bears the burden of showing that its claims are 'allowable' (satisfy applicable reimbursement requirements[.]" See Illinois Dept. of Public Aid, DAB No. 2021, at 16 (2006), citing New York State Dept. of

(...continued)

[3] California did not pursue this argument on appeal.

Health, DAB No. 1636 (1997). Thus, once HCFA questioned whether Molina complied with the case mix requirement, the burden was on California to show that Molina was in compliance with this requirement. None of the correspondence in the record contains any indication that California was taking the position that Molina complied with the case mix requirement, however. California instead merely argued for an extension of the three-year waiver period, in effect conceding that Molina did not in fact comply with the case mix requirement.[4]

We are not persuaded that the deferral process requires CMS to elicit information that will support a disallowance, as California appears to argue. The deferral process affords the Regional Administrator the opportunity to request additional information before deciding whether to pay or disallow a claim; however, nothing in the deferral regulations requires the Regional Administrator to request such information before disallowing a claim. Similarly, section 430.40(d) did not require an audit or financial review before California's claim could be disallowed. Section 430.40(d) on its face applies only where a claim has been paid following a deferral, while it appears that California's claim was never paid. See CDHCS Ex. 14 (11/9/07 letter asserting that CMS owed California interest on funds "wrongfully withheld since 1998").[5] In any event, we conclude that CMS had a sufficient basis for disallowing the claims here without taking all of the steps listed in section 430.32(a). California had in effect conceded that Molina did not meet the case mix requirement, and CMS had identified the claims associated with payments to Molina, reviewed California's

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[4] We note also that California did not avail itself of the opportunity to file a reply to CMS's brief, which alleged that California never asserted until it brought this appeal that Molina met the case mix requirement. CMS Br. at 7, n.4.

[5] CMS's March 27, 2008 disallowance letter requests California to "make a decreasing adjustment in [the amount of the disallowance] on line 10B of your next Quarterly Statement of option to retain the disputed funds. . . by notifying the Regional Administrator in writing no later than 30 days after the date this letter is received." 3/27/08 letter at 3. This language, which is standard in disallowance letters, implies that California was paid, but is contradicted by California's own assertion to the contrary in November 2007. Thus, it appears that CMS included this standard language in error.

response to the deferral, and adjusted the disallowed amount accordingly.

California also argues that CMS should have made "findings with respect to if and when" Molina's plan to come into compliance with the case mix requirement by merging with another HMO was implemented. CDHCS Br. at 7. As indicated above, the burden of showing compliance rested on California, not CMS. However, California does not even allege, much less document, that Molina implemented its plan and achieved compliance for all of its contracts before the end of the disallowance period. Indeed, California requested an extension of the three-year waiver period in order to permit Molina to implement its plan.[6] CDHCS Ex. 9. Moreover, since section 1903(m)(2)(C) required an annual demonstration that an entity "is making continuous efforts and progress toward achieving compliance" with the case mix requirement as a condition of a three-year waiver, it is not reasonable to read the statute as permitting such efforts to excuse an entity's failure to comply following the end of the waiver period.

The repeal of the case mix requirement is not a basis for excusing Molina's failure to meet this requirement.

California argues that it should not be penalized for "technical non-compliance with a repealed requirement" which "[o]bviously . . . was not important to the orderly administration of Medicaid." Id. As indicated above, section 1903(m)(2) was repealed effective June 20, 1997. CMS took the repeal into account in recalculating the disallowance so that it covers only the period through June 19, 1997.

We conclude that the repeal of the case mix requirement is not a basis for excusing Molina's failure to meet this requirement. California does not point to any evidence that Congress intended to excuse noncompliance prior to the effective date of the repeal. Moreover, we infer that this was not Congress' intent based on the fact that Congress provided a special effective date for the repeal (June 20, 1997) that was earlier than the general

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[6] In a letter to HCFA dated May 20, 1998, California referred to "efforts undertaken by DHS and Molina to avoid a disallowance by restructuring affiliations with other health plans which enabled Molina to meet the 75/25 standard, by June 1, 1997 in Los Angeles County[.]" CDHCS Ex. 11, at 1. California's recalculated disallowance amount, which CMS accepted, took this into account. Id., Attachment C.

effective date of the legislation. Compare Public Law No. 105-33, § 4710(b)(2) and § 4710(a). If Congress had intended the repeal to be retroactive to the period here, it would have so specified instead of setting the June 20, 1997 special effective date for the repeal. Thus, section 1903(m)(2) applies to the period at issue here, and we have no authority to waive it. See 45 C.F.R. § 16.14 (the Board is "bound by all applicable laws and regulations").

California's arguments based on equitable considerations have no merit.

California argues that the disallowance should be set aside based on equitable considerations. California argues specifically that the disallowance was unreasonable because HCFA did not provide "a reasonable transition period covering the disallowance period for Molina to achieve compliance with the 75/25 rule." CDHCS Br. at 7. According to California, it was "impossible" for Molina to "restructure the managed care programs" in several counties within the three days from the date of HCFA's March 28, 1997 letter denying California's request for an extension of the three-year waiver period to the end of that period on March 31, 1997.[7] Id. California also argues that the disallowance is inequitable because it will lead to a recoupment from Molina by California that will have an adverse effect on Molina's stock price and business operations "grossly disproportionate to its underlying amount[.]" Id. at 9, citing CDHCS Ex. 15 (Declaration of Mark L. Andrews (General Counsel of Molina's parent company)). California argues further that the disallowance should be set aside "[d]ue to the ten year delay in making a determination regarding this matter," which resulted in the loss of "evidence in the form of documents and testimony." CDHCS Br. at 7-8.

None of these arguments are persuasive. As noted above, the Board is not authorized to excuse noncompliance with applicable statutes. See also West Virginia Dept. of Human Resources, DAB No. 2185, at 20 (2008) ("This claim for equitable relief is not a proper basis for overturning a disallowance because the Board lacks authority to grant such relief."), citing, inter alia, 45 C.F.R. § 16.14.

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[7] California indicates in its appeal brief that the waiver period ended on March 31, 1997 for "at least three counties." CDHCS Br. at 7. However, California did not previously dispute that the waiver period ended on this date only for the Sacramento County contract and on April 30, 1997 for the contracts with the remaining counties.

Moreover, we disagree that HCFA failed to provide a reasonable transition period for Molina to come into compliance with the case mix requirement. The plain language of section 1903(m)(2)(C) provides for a maximum waiver period of three years. California (and Molina) had constructive notice of this waiver period from the statute. Thus, Molina had three years, not three days, to come into compliance with the case mix requirement. Moreover, California can hardly complain that HCFA did not provide a reasonable transition period since HCFA waived the case mix requirement for the maximum three-year period even though neither California nor Molina had submitted a formal waiver request and Molina did not submit annual plans to demonstrate that it was "making continuous efforts and progress toward achieving compliance" with the case mix requirement, as required by section 1903(m)(2)(C).

In addition, any adverse effect on the price of Molina's stock would not be a direct result of the disallowance, but would result only if California seeks to recover the disallowed payments from Molina and Molina has not set aside funds to cover those payments despite being aware of the issue. However, whether California recovers any of the disallowance from Molina is a matter between California and Molina. We note that California's contract with Molina provides that "DHS may recover the amounts disallowed by DHHS by an offset to the capitation payment made to the Contractor" and provides that "[i]f recovery of the full amount at one time poses a financial hardship on the Contractor, DHS at its discretion may grant a Contractor's request to repay the recoverable amounts in monthly installments over a period of consecutive months not to exceed six (6) months." CDHCS Ex. 16. California cannot reasonably maintain that the disallowance should be reversed on the basis of financial hardship to Molina when California and Molina contractually agreed that any financial hardship would be addressed only by extending the period for repayment by Molina to six months (and even then only at California's discretion).

Finally, we reject California's equitable argument based on the ten-year period between the deferral and the disallowance. California itself was responsible for much of the delay in issuing the disallowance since it made a request in December 2003 for an "exemption" from the deferral timelines. California did not allege that, prior to that time, it had asked CMS to either pay or disallow the claim. In any event, the applicable regulations contain no statute of limitations or other time limit on the issuance of Medicaid disallowances. 42 C.F.R. § 430.42. Thus, in and of itself, the ten-year delay in issuing the

disallowance has no legal significance. The Board has held that generally a disallowance may be considered untimely only if a grantee can prove prejudice that is "attributable to the loss of records resulting from their innocent loss or destruction after expiration of the record retention period." California Dept. of Health Services, DAB No. 1490, at 8 (1994), quoting California Dept. of Social Services, DAB No. 855, at 3 (1987).[8] California does not assert, however, that it at one time had records establishing compliance with the case mix requirement which were innocently lost or destroyed due to the passage of time. Indeed, it is unlikely that California ever had such records since California did not assert until this appeal that Molina was in compliance with the case mix requirement and since the clear implication of California's correspondence with HCFA and CMS prior to the disallowance is that the requirement was not met.

Conclusion

For the reasons explained above, we uphold the disallowance in full.

/s/
Stephen M. Godek

/s/
Constance B. Tobias

/s/
Judith A. Ballard
Presiding Board Member

[8] The record retention period for grants such as Medicaid is generally three years from the date of the state's submission of the last expenditure report for the federal fiscal year. 45 C.F.R. § 92.42(b), (c)(1); see also 42 C.F.R. § 433.32(b). However, it is arguable that California was required to retain any records relating to Molina's compliance with the case mix requirement until resolution of the deferral action. See section 92.42(b)(2) ("[i]f any litigation, claim, negotiation, audit or other action involving the records has been started before the expiration of the 3-year period, the records must be retained until completion of the action and resolution of all issues which arise from it[.]").