Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Iowa Department of Human Services
Docket No. A-10-71
Decision No. 2378
May 2, 2011

DECISION

The Iowa Department of Human Services (DHS) appealed a May 10, 2010 determination by the Centers for Medicare & Medicaid Services (CMS) to disallow $671,759 in federal funding claimed by the State of Iowa's Medicaid program during federal fiscal year (FFY) 2003. CMS issued the disallowance based on findings of an audit performed by the United States Department of Health and Human Services' Office of Inspector General (OIG). The audit investigated whether DHS had properly claimed, as costs of Medicaid program "administration," the salary and related costs of skilled professional medical personnel (SPMP). The OIG found, and CMS concurred, that some activities for which the claimed SPMP costs were incurred did not meet federal funding requirements. The following two audit findings account for most of the disallowance: (1) certain SPMP activities that were classified as Medicaid "administration" were in fact "direct medical services" and therefore not allowable as Medicaid administration; and (2) other claimed SPMP activities were not allowable at the enhanced federal matching rate applicable to SPMP expenditures because the activities did not require the knowledge or skills of a medical professional.

For the reasons discussed below, we sustain CMS's decision to disallow $671,759 in federal reimbursement.

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. Act § 1901. The program is jointly financed by the federal and state governments and administered by the states. Act § 1903; 42 C.F.R. § 430.0. Each state administers its Medicaid program in accordance with broad federal requirements and the terms of its "plan for medical assistance" (State Plan), which must be approved by CMS on behalf of the Secretary of Health and Human Services (HHS). Act § 1902; 42 C.F.R. §§ 430.10-430.16. A state with an approved Medicaid plan is eligible to receive federal matching funds, also known as "federal financial participation" (FFP), for a percentage of the Medicaid program expenditures it makes in accordance with the State Plan. Act § 1903; 42 C.F.R. §§ 433.10(a), 433.15(a).

Most Medicaid program expenditures are for "medical assistance," a term that refers to the broad categories of medical services that a state is authorized to provide under its State Plan. Act § 1905(a). In addition, state Medicaid programs make expenditures for various administrative activities or functions, such as program outreach, preadmission screening, claim processing, and utilization review. *See* 42 C.F.R. § 433.15.

The Medicaid statute authorizes FFP for administrative expenditures "found necessary by the Secretary for the proper and efficient administration of the State plan." Act § 1903(a)(2), (7). For most administrative expenditures, the FFP (or federal matching) rate is 50 percent. *See* 42 C.F.R. § 433.15(a)(7), 432.50(b); State Medicaid Manual (CMS Pub. 45) § 2500.5.[1] The Medicaid statute authorizes a higher rate of reimbursement – 75 percent – for certain administrative activities performed by skilled professional medical personnel (SPMP). In particular, section 1903(a)(2)(A) of the Act states that the federal government "shall pay to each state with a plan approved under this title" –

> an amount equal to 75 per centum of so much of the sums expended . . . (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to compensation or training of skilled professional medical personnel, and staff directly supporting such personnel, of the State agency or any other public agency.

In 1985, CMS issued regulations, codified mostly in 42 C.F.R. Part 432, that implement section 1903(a)(2)(A). 50 Fed. Reg. 46,652, 46,655, 46,663-64 (Nov. 12, 1985). These regulations define SPMP to include "physicians, dentists, nurses, and other specialized personnel who have professional education and training in the field of medical care or appropriate medical practice and who are in an employer-employee relationship with the Medicaid agency." 42 C.F.R. § 432.2. In addition, the regulations, in section 432.50(d)(1), specify various criteria for obtaining FFP for SPMP expenditures at the enhanced rate. Two of those criteria are: (1) the SPMP expenditures must be "for activities that are directly related to the administration of the Medicaid program, and as such do not include expenditures for medical assistance"; and (2) the SPMP must be "in positions that have duties and responsibilities that require professional knowledge and skills." *Id.* § 432.50(d)(1)(i), (iii).

On their face, the criteria in section 432.50(d)(1) for claiming enhanced rate reimbursement apply only to SPMP employed by the state Medicaid agency. Section 432.50(d)(2), however, states that the "[t]he rate of 75 percent FFP is available for staff of *other public agencies* if the requirements specified in paragraph (d)(1) of this section are met and the public agency has a written agreement with the Medicaid agency to verify that these requirements are met." (Italics added.) In addition, section 432.50(c)

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[1] The State Medicaid Manual is available at http://www.cms.gov/Manuals/PBM/list.asp.

provides that "FFP is prorated for staff time that is split among functions reimbursed at different rates," and that "[r]ates of FFP in excess of 50 percent" – such as the rate for SPMP – "apply only to those portions of the individual's working time that are spent carrying out duties in the specified areas for which the higher rate is authorized."

The preamble to the 1985 SPMP regulations states that the purpose of enhanced rate reimbursement "is to encourage State agencies to employ personnel who have the professional medical expertise necessary to develop and administer Medicaid programs that are medically sound as well as administratively efficient." 50 Fed. Reg. at 46,655. The preamble goes on to list the following as examples of SPMP functions that would meet the criteria for enhanced rate reimbursement: (1) "Acting as a liaison on the medical aspects of the program with providers of services and other agencies that provide medical care"; (2) "Furnishing expert medical opinions for the adjudication of administrative appeals; (3) "Reviewing complex physician billings"; (4) "Providing technical assistance and drug abuse screening on pharmacy billings"; (5) "Participating in medical review or independent professional review team activities; (6) "Assessing the necessity for and adequacy of medical care and services provided, as in utilization review"; and (7) "Assessing, through case management activities, the necessity for and adequacy of medical care and services required by individual recipients." *Id.* at 46,656. The preamble further "note[s] that none of these functions includes the provision of medical care and services," and that "[p]rovision of medical care and services would always be considered medical assistance rather than administration." *Id.*

Case Background

DHS administers Iowa's Medicaid program. From July 1, 2002 through June 30, 2003, DHS had three agreements with the University of Iowa Hospitals and Clinics (UIHC), a publicly funded academic medical center, to obtain administrative services supporting Iowa's Medicaid program. The first agreement was between DHS and UIHC's Department of Pediatrics and Center for Disabilities and Development.[2] DHS Ex. 13, at 153. The second and third agreements were between DHS and the Child Health Specialty Clinics, an organization affiliated with UIHC's Department of Pediatrics and funded by Title V of the Act. DHS Ex. 12, at 136-37; DHS Ex. 13, at 168; DHS Br. at 6. As explained in greater detail below, the purpose of the three agreements was to outline the conditions under which UIHC employees, including SPMP, would perform administrative functions (such as referral, outreach, eligibility determination, and case management) that facilitated the delivery of medical care to Medicaid-eligible children, especially children with severe disabilities and complex medical needs. All three agreements were incorporated into Iowa's approved State Plan. DHS Ex. 12, at 135; DHS Ex. 13, at 150.

[2] A third party to this agreement was the Department of Child Psychiatry at UIHC. DHS Ex. 12, at 153. No costs associated with that department are at issue in this case.

For work performed by SPMP under the interagency agreements, UIHC submitted payment vouchers to DHS that listed quarterly personnel and travel costs for SPMP and supporting staff. DHS Ex. 7, at 76; DHS Ex. 4, at 26. In turn, during FFY 2003, DHS claimed FFP at the 75 percent rate for these and other SPMP costs. DHS Ex. 4, at 26-29.

The OIG subsequently audited the FFY 2003 SPMP claims to determine whether SPMP costs reported by UIHC, the state Medicaid agency (DHS), and one Iowa public school district met the applicable requirements for federal reimbursement. *See* DHS Ex. 7, at 77. The audit focused on two general issues: (1) whether the audited SPMP costs were properly characterized as costs of Medicaid "administration"; and (2) if those costs were for Medicaid administration, whether they were properly claimed at the 75 percent federal matching rate. *Id.* at 77-78.

The OIG determined that $671,759 in claimed FFP for SPMP costs did not meet applicable reimbursement requirements. DHS Ex. 7, at 79. That overall determination was based on the following findings:

State Agency	Claimed Costs of Unallowable Activities	OIG's Reason for Disallowance
(1) Department of Pediatrics and Centers for Disabilities and Development	$355,100	SPMP costs were incurred for activities that were "an integral part of or related to" direct medical services and were not for Medicaid administration.
(2) Department of Pediatrics and Centers for Disabilities and Development	$47,586	Organizations' indirect costs were unallowable because the related FFP claims for SPMP costs were unallowable.
(3) Child Health Specialty Clinics	$236,459	Personnel costs were not reimbursable at the enhanced rate for SPMP because the employees' services did not require medical knowledge and skills.
(4) Child Health Specialty Clinics	$ 5,034	Travel costs were unallowable.
(5) School District A	$11,643	Claimed costs were for activities that did not require medical knowledge and skills; payment vouchers were inaccurate.
(6) DHS	$15,937	Claimed costs were for activities performed by a person who was not an employee of DHS.

Concurring with the audit findings, CMS disallowed $671,759 in FFP for FFY 2003. P. Ex. 11. DHS then filed this appeal.

DHS's appeal does not challenge the disallowance of DHS's or School District A's costs. *See* Table Rows 5 and 6. In addition, DHS concedes that CMS properly disallowed $15,862 of indirect costs of the Department of Pediatrics and Centers for Disabilities and Development. *See* Table Row 2; DHS Br. at 3. DHS also concedes that CMS properly disallowed $18,668 in personnel costs claimed for "parent consultants" at CHSC. *See* Table Row 3; DHS Br. at 13. Consequently, the issues before the Board relate to the following cost amounts and categories:

- $355,100 in personnel costs of the Department of Pediatrics and Centers for Disabilities and Development;

- $ 31,724 (or $47,586 minus $15,862) in indirect costs of the Department of Pediatrics and Centers for Disabilities and Development;

- $ 217,791 (or $236,459 minus $18,668) in personnel costs of the Child Health Specialty Clinics; and

- $5,034 in travel costs of the Child Health Specialty Clinics.

In support of its appeal, DHS submitted an initial brief ("DHS Br.") and appeal file containing 16 numbered exhibits. Thereafter, CMS filed a response brief ("Response Br."), and DHS filed a reply ("Reply Br.").

During the initial round of briefing, DHS requested an evidentiary hearing. The Board granted the request and established a schedule under which the parties were permitted to submit written direct testimony of their witnesses, and then either conduct in-person cross-examination and submit post-hearing briefs, or, alternatively, submit supplemental briefs. In accordance with that schedule, DHS submitted written direct testimony from four UIHC employees: Elayne Sexsmith, Administrator of the Center for Disabilities and Development; Jane Caswell, a nurse clinician specialist in the Department of Pediatrics; Doris Montag, Assistant Director of Finance & Operations for the Department of Pediatrics; and Christina Trout, an advanced practice nurse in the Department of Pediatrics. CMS elected not to submit written direct testimony or cross-examine DHS's witnesses. After CMS notified the Board of that election, the parties submitted supplemental briefs. *See* CMS's Supplemental Brief on the Merits, dated March 25, 2011 ("CMS Supp. Br."); Appellant's Response Brief dated March 25, 2011 (DHS Final Br.).

Discussion

The uniform administrative requirements for grants to states place on a state the burden of documenting the allowability and allocability of costs for which reimbursement is claimed. See 45 C.F.R. §§ 74.50-74.53 (1999); *Texas Health and Human Services Commission*, DAB No. 2235, at 4 (2009); *Maine Dept. of Human Resources*, DAB No. 2292, at 9 (2009) (holding that when a disallowance is supported by audit findings, the

grantee has the burden of showing that the findings are legally or factually unjustified). The Board has held that this burden "is heavier when FFP is being claimed . . . at an enhanced rate, requiring a clear showing that all claimed costs meet applicable reimbursement requirements[.]" *Montana Dept. of Public Health*, DAB No. 2020, at 8 (2006). As we explain below, while DHS presented evidence that shows that many of the functions performed qualified as Medicaid administrative activities requiring the knowledge and skills of the SPMP who performed them, DHS did not carry its burden of proof to show that either all or some identifiable part of the disallowed costs met the applicable requirements.

1. *Personnel costs at UIHC's Department of Pediatrics and Center for Disabilities and Development ($355,100)*

For the period at issue, DHS claimed $355,100 in FFP for personnel costs (i.e., salaries and fringe benefits) of SPMPs in the Department of Pediatrics (DOP) and Center for Disabilities and Development (CDD). *See* DHS Ex. 4, at 26; DHS Ex. 7, at 84, 86. These costs were purportedly incurred for activities specified in DHS's interagency agreement with DOP and CDD. *See* DHS Br. at 6. Under that agreement, DOP and CDD agreed to provide "Medicaid administrative activities for children age 0 to 21 years as an agent for [DHS] to assure the availability, accessibility, coordination, and appropriate utilization of preventive and remedial health care resources to Medicaid beneficiaries and their families (where appropriate) in the State of Iowa." DHS Ex. 13, at 155. In exchange, DHS agreed to reimburse UIHC for the "federal share of actual and reasonable costs for Medicaid administration provided by its staff based upon a time-accounting system which is in accordance with the provisions of OMB [Office of Management and Budget] Circular A-87 and 45 C.F.R. Part 74 and 95." *Id.* at 154. CMS does not deny DHS's allegation that it approved the interagency agreement.

To comply with the contractual provision mandating reimbursement based on a "time-accounting system," UIHC used time studies intended to quantify the work hours spent by SPMP performing Medicaid administrative activities as well as the hours spent on activities eligible for FFP at the enhanced rate. *See* DHS Ex. 7, at 76. In these studies, employees reported how they spent their work hours using the 10 activity codes in Appendix A to the interagency agreement. DHS Ex. 13, at 155, 162; Montag ¶ 12; Montag Attachment 3. These codes define – with general criteria and often with illustrative examples – various categories of SPMP and non-SPMP activities and indicate whether those activities are "claimable" (eligible for FFP as Medicaid administration) or "not claimable" (ineligible for FFP as Medicaid administration). DHS Ex. 13, at 162. Code 9 indicates that it was to be used to designate "direct client care, service, or treatment" and further indicates that such activities are "not claimable" as Medicaid administration. *Id.* at 165.

The OIG disallowed all of the claimed SPMP costs for DOP and CDD, concluding that these costs had been incurred for activities that "were an integral part of" or an

"extension of" a "direct medical service" and for that reason were ineligible for FFP as costs of Medicaid administration. DHS Ex. 7, at 81. In support of that conclusion, the OIG quoted the following passage from the CMS publication *Medicaid and School Health: A Technical Assistance Guide* (August 1997) (referred to herein as the "1997 Technical Assistance Guide"):

> Expenses cannot be claimed as administration if they are an integral part or extension of a direct medical or remedial service, such as patient follow-up, patient assessment, patient education, counseling, development of the medical portion of an IEP [individualized education program] or IFSP [individualized family service plan], or other physician extender activities. Such services are properly paid for as part of the payment made for the medical or remedial services.

DHS Ex. 7, at 86 (quoting DHS Ex. 15, at 243). The OIG also based its conclusion on "documentation" provided by UIHC and on audit interviews with SPMP employed at DOP and CDD. *Id.* at 81. According to the OIG, "a majority" of the SPMP reported in their audit interviews that they had coded, as Medicaid administration, activities that, in the OIG's view, constituted direct medical services or integral parts or extensions of direct medical services. *Id.*; *see also* DHS Ex. 4, at 30. Those activities, said the OIG, included updating a patient chart, writing a report concerning a direct medical service, and other "pre- and post-visit patient activities."[3] DHS Ex. 7, at 81.

In this appeal, DHS expresses no conceptual disagreement with the principle that a state may not, for purposes of claiming FFP, classify direct services (or integral parts or extensions of direct services) as Medicaid administration; this principle reasonably follows from the general regulatory prohibition against claiming "medical assistance" as an administrative cost and is necessary to prevent duplicate program payment for the same activities. *See* 42 C.F.R. § 432.50(d)(1)(i); 50 Fed. Reg. at 46,656 (stating that the "[p]rovision of medical care and services would always be considered medical assistance rather than administration"). Rather, DHS contends that the OIG mischaracterized the claimed SPMP activities as direct medical or remedial services or as integral parts or extensions of those services. According to DHS, those activities – all of which, it says, were performed days, weeks, or months before or after a Medicaid-eligible child's inpatient or outpatient visit to UIHC for diagnosis, treatment, or rehabilitation – were allowable as Medicaid administration because they met CMS's definition of "administrative case management." Final Br. at 1, 3-4 (stating that the "[t]he crux of the issue in this appeal is whether the *case management and care coordination* activities"

[3] The OIG goes too far to the extent it suggests that merely being "related to" or "resulting from" a direct service makes an activity ineligible to be claimed as an administrative cost. *See* DHS Ex. 7, at 86. Such a position is hard to reconcile with the longstanding interpretation that Medicaid administration may include activities such as utilization review of medical services.

performed by SPMP were allowable as Medicaid administration). In support of that contention, DHS points to the 1997 Technical Assistance Guide, which states that "[c]ase management can be provided as an activity found necessary for the proper and efficient administration of a state's Medicaid plan," and that case management is an "activity which assists individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of an individual." *See id.* at 2-3 (quoting DHS Ex. 15, at 245). DHS also points to CMS's May 2003 Medicaid School-Based Claiming Guide ("2003 Claiming Guide"), which states that "administrative case management" may be eligible for FFP as Medicaid administration and defines case management as involving "the facilitation of access and coordination of services covered under the state's Medicaid program."[4] DHS Ex. 14, at 26. A model activity code in the 2003 Claiming Guide (entitled "Referral, Coordination, and Monitoring of Medicaid Services") provides several examples of allowable administrative case management, *id.* at 215-16, and DHS quotes five in particular:

- Making referrals for and/or coordinating medical or physical examinations and necessary medical/dental/mental health evaluations;

- Providing follow-up contact to ensure that a child has received the prescribed medical/dental/mental health services covered by Medicaid;

- Coordinating the delivery of community based medical/dental/mental health services for a child with special/severe health care needs;

- Coordinating the completion of the prescribed services, termination of services, and the referral of the child to other Medicaid service providers as may be required to provide continuity of care; and

- Providing information to other staff on the child's related medical/dental/mental health services and plans.

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[4] While relying on the 2003 Claiming Guide, DHS nonetheless contends that the OIG improperly applied "administrative claiming standards" found in the Guide that did not exist during the period covered by the interagency agreement. DHS Br. at 7. That contention is factually baseless, however. The 1997 Technical Assistance Guide, which the 2003 Claiming Guide replaced, sets out the essential standard that the OIG expressly applied to disallow the DOP/CDD costs – namely, that Medicaid administration does not include activities that are direct medical services or "integral to or an extension of" direct medical services. DHS does not point to any differences between the 1997 and 2003 publications that were material to the audit findings at issue in this appeal. Moreover, the provisions from the claiming guides on which DHS relies simply incorporate and apply longstanding guidance in section 4302 of CMS's State Medicaid Manual (SMM) concerning the type of administrative function – administrative case management – that DHS asserts was performed by the SPMP at DOP and CDD. *See* DHS Ex. 14, at 192 (noting that examples of allowable administrative case management activities are found in SMM 4302.2(G)); SMM §§ 4302(A), 4302.2(G)(2) (rev'd Dec. 1991).

Final Br. at 4-5. DHS contends that the written direct testimony of its witnesses "establishes that the SPMP claiming activities which CMS is challenging are *exactly* the above listed types of services that are identified as permissible case management services." Final Br. at 3, 5. These activities, DHS asserts, allowed Medicaid-eligible children, especially those with disabilities or complex medical needs, to receive as many medical services as possible in their home communities in lieu of receiving those services at greater cost in Iowa City, and that a "great deal of coordination and education with local community providers and the families" was needed to support the community-based care. *Id.* at 5. Furthermore, the SPMP's activities, DHS asserts, "fulfilled the purpose of administrative claiming which was to "ensure the best possible medically sound outcomes for Medicaid clients and to ensure efficient administration of the program by coordinating care and avoiding duplication of services." *Id.* at 3.

In evaluating DHS's argument, we begin by repeating the requirement that an administrative cost is allowable only to the extent that it is "necessary for the proper and efficient administration" of the State Plan. *See Illinois Dept. of Public Aid*, DAB No. 2022, at 12 (2006) (discussing that requirement). As indicated, Iowa's State Plan incorporated the interagency agreement between DHS and UIHC. The agreement's stated purpose was to "ensure more efficient administration of the State Medicaid Plan" by enlisting DOP and CDD to perform "administration activities" to "assure the *availability, accessibility, coordination*, and appropriate utilization" of health care provided to Medicaid-eligible children. DHS Ex. 13, at 153, 157 (italics added). In general, case management, as CMS defines it, involves activities whose primary purpose is to promote or facilitate the "availability" or "accessibility" of medical care and to "coordinate" a patient's contact with the medical community to ensure that he or she receives prescribed care and treatment. *See* DHS Ex. 14, at 215. CMS does not deny that any such activities, if performed pursuant to the agreement, were necessary for the proper and efficient administration of the State Plan. In addition, the interagency agreement states that the services provided under the agreement would not be construed as "targeted case management" eligible for federal funding as medical assistance.[5] *Id.* at 155.

[5] A state may classify case management as either (1) an administrative activity or (2) "medical assistance" under a statutory provision (section 1905(a)(19) of the Act) that permits states to provide program recipients an optional Medicaid benefit known as "targeted case management." DHS Ex. 15, at 245-47 (stating that "[i]n establishing a unique Medicaid program, each state has the flexibility to provide case management type services" in various ways, including "as an administrative activity necessary for the proper and efficient administration of a State's Medicaid plan" or "as a medical service under the authority of section 1905(a)(19) of the Act"); DHS Ex. 14, at 193, 215 (stating that "[w]hile some case management activities may fall within the scope of both administrative and targeted case management, a state may not claim the same costs both as targeted case management and administrative case management"); *Massachusetts Dept. of Health and Human Services*, DAB No. 2218, at 2-3 (2008) (discussing targeted case management), *aff'd, Commonwealth of Massachusetts v. Sebelius*, 701 F. Supp.2d 182 (D.Mass. 2010). The OIG did not find, and CMS does not contend, that any of the audited SPMP activities in fact constituted targeted case management under Iowa's State Plan.

Given these circumstances, we agree with DHS that the SPMP activities at issue here are allowable as Medicaid administration if, as DHS alleges, they meet the definition of administrative case management. As we now explain, however, DHS's evidence fails to demonstrate that all of the activities for which FFP was claimed constituted allowable case management and not direct services.

DHS's case rests heavily on the testimony of Doris Montag, Assistant Director for Finance & Operations for DOP. She testified that SPMP at DOP and CDD provide two "distinct" services: (1) "direct patient care," which consists of "medical consultation for diagnosis and treatment of pediatric specialty conditions," "psychological testing and counseling," and "rehabilitation therapies"; and (2) "specialized care coordination and ongoing follow-up services [hereinafter referred to simply as care coordination] for children with complex medical conditions." Montag ¶ 2. According to Ms. Montag, direct patient care "occurs within the medical setting of the outpatient clinic, a procedural or treatment room, or within the inpatient hospital setting." *Id.* ¶ 4. These services, she said, "include activities that a physician, or other licensed professional has provided under supervision, such as review of patient and family, social, and medical history, review of medical systems, physical evaluation, diagnosis, medical decision-making, . . . the development of treatment plans and recommendations[,] . . . the documentation of the medical visit, normal follow-up with laboratory, radiology or related tests ordered during the visit and distribution of the visit report with recommendations to the referring physician, or primary care physician if requested by the family." *Id.* ¶ 9.

On other hand, said Ms. Montag, "care coordination" typically occurs "away from the medical setting" in SPMP's offices and is typically conducted by phone conversations with parents, caregivers, school personnel, physicians, therapists, pharmacists, durable medical equipment vendors, and insurance companies. Montag ¶¶ 4-5. Ms. Montag further described care coordination as activities that "precede and follow the direct care visits during the weeks prior to, or months following, the medical consultation." *Id.* ¶ 5. According to Ms. Montag, care coordination prior to a patient's outpatient or inpatient visit involves "securing extensive medical information, preparation of genetic pedigrees to determine family risks, and determination of appropriate pre-visit tests with subsequent scheduling." *Id.* ¶ 11. Following the patient visit, said Ms. Montag, care coordination involves "coordination of the treatment plan, monitoring of ongoing status between visits and frequent phone call support, and counseling or guidance with parents, community resource agencies, day care providers and physicians to ensure the child's health outcome." *Id.*

Ms. Montag testified that when SPMP were "directly involved in the delivery of patient specific care associated with a psychologist, therapist[,] or physician's billable service, they coded Direct Care," and that "use of the Direct Care codes captured the time spent in a specific patient visit or encounter in the procedure room or inpatient hospital care." Montag ¶¶ 4, 9. She further explained that care coordination provided before and after the patient's inpatient or outpatient visit or treatment episode was "independent from the

physician visit" and "outside the scope of the physician's direct billable services." In addition, Ms. Montag testified that SPMP "were trained to record their direct patient care activities under the designated code for Direct Client Care . . . as specified within" those organizations' interagency agreement with DHS. *Id.* ¶ 12. As part of that training, said Ms. Montag, SPMP were given "translator" sheets (Attachments 1 and 2 to her testimony) which indicated how specific activities were to be coded by SPMP in their time sheets. *Id.*

Ms. Montag's testimony as a whole is not persuasive. She suggests that SPMP at DOP and CDD ordinarily coded a patient-specific activity as Medicaid administration when the activity preceded or followed the patient's inpatient or outpatient visit at UIHC and/or was performed in the SPMP's office. However, whether an activity is properly coded as Medicaid administration does not depend on the timing and setting of the activity but on the nature of its relationship to the medical care or treatment received by the patient, whether the state's Medicaid program reimburses the provider for the activity as part of a billable service, and whether the activity is, in fact, "necessary for the proper and efficient administration" of the state Medicaid plan (which, here, incorporates the terms of the interagency agreement between DHS and UIHC). *See Illinois Dept. of Public Aid* at 12. Ms. Montag implicitly recognizes that direct services can include some activities, such as "normal follow-up" of tests ordered during the patient's visit, or distribution of the visit report, that would not necessarily occur during the course of an inpatient or outpatient visit at UIHC and which could occur after the visit in a different setting. Montag ¶ 9.

Neither Ms. Montag's testimony nor other evidence clearly or adequately addresses what activities are ordinarily included in the Medicaid reimbursement for services furnished to inpatients or outpatients at DOP and CDD. DHS also failed to satisfactorily explain how, or to what extent, Iowa's Medicaid program pays for some non-physician practitioner services furnished by DOP and CDD. As indicated, Ms. Montag identified the services ordinarily included in payment for *physician services* under the American Medical Association's billing code handbook, known as Current Procedural Terminology (CPT). Montag ¶ 9. She later acknowledged that "most" of the licensed SPMP at CDD use some CPT billing codes (*id.* ¶ 10), which suggests the possibility that non-physician SPMP coded, as Medicaid administration, activities that could have been or were reimbursed through Medicaid payment to those practitioners.[6] Neither Ms. Montag's testimony nor other evidence in the record ruled out that possibility by identifying which non-physician SPMP (if any) were able to bill Medicaid in their own right and by clearly specifying the types of services billed by those practitioners.

[6] The record indicates that SPMP involved in administrative cost claiming included physician assistants, nurse practitioners, and psychologists. *See* DHS Ex. 4, at 42-43.

Even if we assume, for the sake of argument, that Iowa's Medicaid payment system did not regard pre- and post-visit SPMP activities as integral parts or extensions of a direct service, DHS's position is still untenable because it failed to prove that the SPMP at DOP and CDD *actually* coded their activities in a manner consistent with Ms. Montag's distinction between "direct patient care" and pre- and post-visit "care coordination." Although Ms. Montag testified that SPMP were trained to designate direct services (as she defined them) under the proper activity code (code 9), she did not expressly attest – based on interviews of SPMP or her personal review of timesheets and other relevant source documentation – that all of the *disallowed* activities were, in fact, pre- and post-visit care coordination. Other evidence in the record places this in question.

As indicated, the OIG interviewed SPMP at DOP and CDD and asked them to describe the types of activities they coded as Medicaid administration during the relevant period. The OIG generated two lists of the activities described by the SPMP (one for DOP and one for CDD), and those lists are included in DHS Exhibit 4. On their face many of the listed activities – such as patient rounds, interpreting laboratory results, discussing test results with patients over the phone, charting, working on treatment plans, writing discharge summaries, assessing children's nutrition needs, scoring screening tests, writing reports, genetic counseling, "preparing for clinic," and assisting with insulin adjustments over the phone – could be an integral part of providing treatment, rather than case management. *Compare* DHS Ex. 4, at 30-31 with DHS Ex. 14, at 215 (CMS model activity code for administrative case management). Ms. Montag acknowledged that many of these activities are ordinarily included in a payment for "physician services." Montag ¶ 9 (acknowledging that direct services include the "normal follow-up with laboratory, radiology, or related tests ordered during the visit," "development of treatment plans and recommendations," "documentation of the patient visit," and "distribution of the visit report" to the referring or primary care physician).

The activity lists generated by the OIG , based on descriptions by SPMP who actually performed the activities, amount to findings that support CMS's disallowance determination. Accordingly, the burden is on DHS to show that those findings were baseless or incorrect. *Maine Dept. of Human Services* at 9. DHS did not meet that burden. DHS presented no evidence, for example, that the OIG inaccurately or incompletely reported how SPMP described their activities or that those activities (as reported by the OIG) were not, in fact, part of the disallowed claims for FFY 2003. Nor did DHS produce documentary or other evidence showing that the purpose of the listed activities, or the context in which they were performed, rendered them allowable as administrative case management. Under their agreement with DHS, DOP and CDD were obligated to maintain "appropriate records and documents" of costs incurred under the agreement. DHS Ex. 13, at 155. DHS produced no patient case records or other documentation to verify that SPMP's reported time was *actually* spent performing allowable case management.

DHS witnesses Elayne Sexsmith and Jane Caswell testified that, as UIHC employees, they performed certain activities that arguably met the definition of administrative case management, such as arranging for the delivery of community-based health care for medical diagnosis or treatment, providing clinical and treatment information to local physicians to ensure that the patients received appropriate and optimal care, and monitoring the care actually provided. *See, e.g.*, Caswell ¶¶ 5-6; DHS Ex. 14, at 215-16 (¶¶ 5, 8, 9-11). However, without time sheets and other contemporaneous records, we cannot possibly verify that these employees' allowable activities were actually claimed during the period in question and disallowed, much less quantify what part of the disallowance is attributable to those activities.

These witnesses discussed other activities they considered to be "care coordination," such as gathering and reviewing a child's medical and other records in preparation for an inpatient or outpatient visit at UIHC. *See, e.g.*, Sexsmith ¶¶ 4-5. However, DHS fails to explain how or why these activities meet CMS's definition of administrative case management, and the available evidence raises questions about whether they were, instead, integral to a direct service. For example, Elayne Sexsmith's testimony describes the data collection and review she performed prior to a child's visit at UIHC as "important to understand the starting point" for an evaluation and states that these pre-visit activities were "required" to begin the process of formulating a plan of treatment. Sexsmith ¶ 5. Yet, Ms. Montag admitted that a direct physician service includes a review of a patient's family, social, and medical history and development of the patient's treatment plan and recommendations. Montag ¶ 9.

DHS suggests that the disallowance should be overturned because the claimed SPMP costs were identified using the approved administrative activity codes in Appendix A of the interagency agreement, specifically codes 3 and 5, and because the 1997 Technical Assistance Guide did not require time study participants to provide a narrative explanation of the activity performed. DHS Br. at 9, 10; Final Br. at 7-8. Code 3 – entitled "Skilled Medical Professional Assessment, Case Planning, and Follow-Up – states that it captures, among other activities, "interpreting results of screenings, assessments, examinations and evaluations *which may be needed to make a clinical determination* of the nature and extent of the individual's health related condition as well as the kinds of treatment or care needed to improve his/her health outcome." DHS Ex. 13, at 163 (italics added). The code also states that it covers the "development" of a plan of care or treatment "*designed to correct or ameliorate*" a health condition. *Id.* In addition, code 5 ("Skilled Medical Professional Consultation/Anticipatory Guidance") states that it covers, among other things, "[a]ttending case conferences or multi-disciplinary teams to assess and evaluate individual needs and treatment plans" and "[a]dvising high risk individuals with complex health need about the causes and prevention of active and communicable diseases and of high-risk behaviors that lead to disease or poor health outcomes." *Id.* at 164.

Such activities could conceivably constitute direct medical services (or integral parts or extensions of those services) depending on the context in which they are performed, the scope of any applicable medical assistance benefit, and Medicaid payment policies for the medical practitioners and institutions involved in the resident's care. *See*, *e.g.* Montag ¶ 9 (admitting, for example, that development of a treatment plan to treat a condition is part of a direct service); DHS Ex. 15, at 243 (stating that "patient education" services may be considered integral parts of a direct service); SMM § 4302.2(H) (noting that elements of case management may, depending on the terms of the governing state plan, be furnished as medical assistance under the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit pursuant to sections 1905(a)(4)(B) and 1915(r) of the Act, instead of as administrative case management). Given that codes 3 and 5 did not spell out the contexts in which the activities they described would be performed or could be considered allowable as Medicaid administration, it was incumbent on DHS in this proceeding to provide evidence (which it did not do) verifying that the SPMP activities coded under these activity codes were not, as the OIG found, direct services or integral parts or extensions of direct services. As parties to the interagency agreement, DHS and UIHC were obligated to apply the approved time-accounting methodology in a manner consistent with the agreement's purpose, which was to obtain and pay for Medicaid "administrative activities" (not medical assistance). That meant ensuring that SPMP's use of codes 3 and 5 was consistent with the injunction in code 9 not to claim costs of direct services.

Moreover, the translator sheets that Ms. Montag testified were used to train time study participants do not appear to be fully consistent with the descriptions in the interagency agreement and do not provide any assurance that SPMP refrained from coding direct services as Medicaid administration. Like the activity codes, the translator sheets do not precisely spell out the distinction between direct services and Medicaid administration or explain how that distinction was to be understood and applied in the context of the SPMP's work with Medicaid-eligible children. *See* Montag Attachments 1 and 2. For each activity code (except code 9), the sheets give a few examples of discrete activities to which the code may be assigned. However, none of the activities are placed in a context that would enable the coder to distinguish properly an administrative activity from a direct service. For example, the translator sheet for CDD instructs the SPMP to code "writing/dictating patient reports" and development of a treatment plan under code 3. Montag Attachment 1. Yet, Ms. Montag admitted that writing of visit reports and development of a treatment plan were parts of direct services. Montag ¶ 9. The same translator sheet also places "Theraplay," and "other 'non-billable' direct patient care activities" under code 3, but DHS provides no explanation of how these activities could be considered the topic of assessment, care planning, and follow-up to which code 3 was intended to apply.

We recognize the possibility that some disallowed activities met the literal criteria of code 3 and 5 for designation as Medicaid administration. However, we do not think that the interagency agreement permits a mechanistic use of the codes, without differentiation

according to the context in which the coded activities were performed, to support claims that are clearly inconsistent with the agreement's purpose – which was to obtain and pay for Medicaid administrative activities. In that vein, the parties were obligated to ensure that use of codes 3 and 5 was consistent with the injunction in code 9 not to claim costs of activities that are reimbursed as direct medical services.

2. *Indirect costs of the Department of Pediatrics and Center for Disabilities and Development ($31,724)*

For the period at issue, DHS claimed $47,586 in FFP for indirect costs allocated to SPMP activities for which the DOP and CDD submitted payment vouchers. DHS claimed these indirect costs at the enhanced FFP rate of 75 percent. Because CMS found that the SPMP activities were unallowable as Medicaid administration, CMS disallowed all of the claimed indirect costs. *See* DHS Ex. 7, at 82, 89; DHS Ex. 4, at 27-28.

Conceding that the enhanced matching rate is inapplicable to indirect costs,[7] DHS asserts that the indirect costs claimed for DOP and CDD should be allowed at the 50 percent rate "[i]n the event that the DAB determines" that the related SPMP activities constituted reimbursable Medicaid administration. DHS Br. at 13. In the previous section, we determined that DHS did not meet its burden to show that the activities performed by SPMP at DOP and CDD were eligible for FFP as Medicaid administration.

The Board has held that a "[a] grantee's entitlement to reimbursement for indirect costs is premised on its entitlement to reimbursement for the direct costs with which those indirect costs are associated." *Florida Dept. of Health and Rehabilitative Services*, DAB No. 821, at 19 (1987); *see also New Jersey Dept. of Human Services*, DAB No. 1143, at 5 n. 5 (1990). DHS has not alleged any grounds that would justify not applying that principle to the indirect costs at issue here. Because those indirect costs were allocable to direct costs that we have held were properly disallowed, we sustain the disallowance of $47,586 in indirect costs.

3. *Personnel costs of UIHC's Child Health Specialty Clinics ($217,791)*

CMS disallowed $217,791 in FFP for claims for services provided during the audit period by UIHC's Child Health Specialty Clinics (CHSC). The $217,791 represents the difference between the 75 percent rate available for SPMP activities and the 50 percent

[7] FFP at the enhanced rate "is available in expenditures for salary or other compensation, fringe benefits, travel, per diem, and training . . . ." 42 C.F.R. § 432.50(a).

rate available for other Medicaid administrative activities.[8] The OIG's final report explained that the OIG "disallowed the enhanced portion of the claim because most activities performed by personnel did not require their medical knowledge and skills." DHS Ex. 7, at 87. In addition, the OIG determined that the activities performed by the CHSC nurses did not require specialized knowledge and skills because the same activities were performed by "parent consultants." *Id.* An OIG response to a DHS information request listed examples of activities which CHSC staff said, in interviews with the OIG auditors, they had coded as SPMP activities, but which the OIG found did not require SPMP knowledge and skills. These examples were:

- Care coordination (not involving direct patient care)
- Waiver and EPSDT Care conferences (not involving direct patient care)
- Travel to care conferences
- Follow-up with kids on IH waiver (not involving direct patient care)
- Identifying referrals and other outreach activities
- Helping client and family fill out assessment forms (not involving direct patient care)

DHS Ex. 4, at 32.

For the reasons explained below, we uphold this part of the disallowance, but we do not adopt all of the conclusions stated by the OIG and CMS. To help the reader understand why our analysis differs in some respects from the OIG findings and CMS's arguments, we first set out the interagency agreement between DHS and CHSC and explain the home and community-based waiver program to which it relates. We then discuss DHS's evidence and why we consider it insufficient to show that all, or a particular part, of the claim is reimbursable at the 75 percent rate.

During the time period at issue here, the Iowa State Plan approved by CMS incorporated an interagency agreement between DHS and the CHSC. DHS Ex. 12, at 135-149. The interagency agreement states that the parties entered into the agreement to define the parties' responsibilities with respect to "assessment, planning, and care coordination activities related to recipients of the Home and Community Based III and Handicapped (HCBC-IH) Waiver of the Iowa Medical Assistance Program (Title XIX)." *Id.* at 137. The agreement explains: "These children have severe chronic illness, depend on technology assistance for daily life support or have complex health needs requiring many community services." *Id.*

[8] The auditors also recommended disallowance of $18,668 in FFP that represents the difference between the 50 percent FFP rate and the 75 percent FFP rate for costs of "parent consultants." DHS does not dispute this part of the disallowance. Contrary to what CMS suggests, however, this amount is included in the $62,110 that DHS conceded was not allowable.

The interagency agreement provides for CHSC to employ staff that "can provide DHS with technical assistance and consultation regarding children, under the age of 21, with complex health care needs." DHS Ex. 12, at 137. For these children, a "designated CHSC nurse consultant" was to "assist DHS as needed" in activities listed in the agreement, including: referring families to the HCBS-IH Waiver program, explaining the program to families, assisting parents in completing the "HCBS Assessment form," identifying Waiver services and providers, and facilitating communication between the Waiver client, family, and providers of involved agencies. *Id.* at 138. In addition, for purposes of administration and quality assurance for the HCBS-IH Waiver program, designated CHSC staff were to assist DHS, as needed or requested, in activities such as serving as a liaison between health care providers and families, identifying personnel and resources to provide Waiver services, participating "as a health consultant at care conferences," assisting "in developing and updating a coordinated plan of care for the HCBS-IH Waiver program child requiring such services," and providing "input and consultation at the annual interdisciplinary team meeting for the child." *Id.* An attachment to the interagency agreement shows what percentage of their time individual nurse consultants were expected to spend on activities under the interagency agreement and shows the related costs being claimed at the 75 percent rate. *Id.* at 148-149.

Under Medicaid regulations, in order to obtain approval for an HCBS waiver, a state must provide various assurances to CMS. Among other things, a state must assure that, absent the waiver, the recipients would need institutional care in a hospital, nursing facility (NF), or intermediate care facility for the mentally retarded (ICF/MR). 42 C.F.R. § 441.302(g). A state must provide for initial and periodic evaluations of the recipient's need for the level of care of a NF or an ICF/MR in the near future unless he or she receives home or community-based services.[9] 42 C.F.R. § 441.302(c). The state must provide CMS certain information, such as information about the form used to make the required evaluation of the need for the services. 42 C.F.R. § 441.303.

In addition, the regulations require a state to assure it will inform the recipient of "any feasible alternatives" available under the waiver. 42 C.F.R. §§ 441.302(d). A waiver request must provide that services will be furnished under a written plan of care subject to approval of the Medicaid agency and must describe who will be responsible for developing the plan of care. 42 C.F.R. § 441.301(b).[10] Services available under the waiver can include "habilitation services," which are defined in section 1915(c)(5)(A) of

[9] Clients admitted to an ICF/MR must be in need of "active treatment," with admission based on a preliminary evaluation that includes valid assessments of functional, developmental, behavioral, social, health and nutritional status to determine if the facility can provide for the client's needs. 42 C.F.R. § 483.440(b). Patients with mental retardation or mental illness admitted to an NF are subject to the pre-admission screening requirements in sections 483.126 and 483.128.

[10] The preamble to the final rule explained that states had flexibility regarding who would develop the plan and the process for state agency approval of the plan. 46 Fed. Reg. 48,532, 48,534 (Oct. 1, 1981).

the Act as services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings.

To try to rebut the OIG's finding that the parent consultants performed the same activities as the CHSC nurse consultants, DHS relies on the following statements in the written testimony of Doris Montag, the Assistant Director of the DOP:

> 14. The Child Health Specialty Clinics employed both skilled and non-skilled staff to perform care coordination work. However, there is a distinct difference in the nature of the work done by the two groups. The Position Descriptions for Parent Consultants (non-skilled) and Staff Nurses (skilled) are attached. [Montag Attachment 4, 5].
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> 15. Nursing staff was responsible for tasks associated with the nursing care needs of the children served. They assessed the health, developmental and social status of children, made referrals for services and coordinated with health care providers in the local communities to assure that the health care needs of the child were being met. The activities required the competencies of nursing training.
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> 16. In contrast, the Parent Consultants worked primarily with the families of the children to provide parental peer to peer support, to educate and encourage parents to secure referrals for the needed services and to introduce families to local services available for their child. . . . While these roles do require training and familiarity with community resources and disease processes, they do not require nursing or other SPMP competencies.

CMS argues that "although the written direct testimony of Doris Montag asserts that nursing competencies were required to assess the 'health, developmental and social status of children,' the actual duties of the staff nurses as described in a position description bring that conclusion into question." Response Br. at 10. CMS asserts: "Developmental and social status assessments simply do not require medical training." *Id.* at 11. According to CMS, the "list of duties serves to support the OIG's conclusion that the majority of activities were outreach, general administrative, or assistance to access services – activities not requiring medical expertise." *Id.* at 11.

In our view, DHS's evidence is sufficient to show that the mere fact that parent consultants might perform activities similar to those in which the nurse consultants were engaged does not necessarily mean those activities did not require the knowledge and skills of a SPMP. Moreover, CMS's broad assertion that developmental and social status assessments do not require medical training is unsupported by any citation and is inconsistent with the record as a whole and with longstanding Medicaid policy. As DHS asserts, such training may be required in assessing children with complex health needs, such as the waiver children addressed in the interagency agreement. As CMS recognized

in approving the interagency agreement, moreover, "assessment" in the context of Iowa's HCBS waivers refers to evaluating whether a child would require institutional-level services if the child does not receive waiver services and whether and what alternative waiver services are feasible for a particular child to safely meet the child's health care needs.

Medicaid policy has long recognized that "medical care assessments," such as those done by registered nurses as part of a review of the level of care needed by an individual recipient, qualify as SPMP activities. *West Virginia Dept. of Welfare*, DAB No. 372, at 8 (1982), *citing* Medical Assistance Manual. More recently, the preamble to the final rule implementing revised SPMP requirements listed examples of SPMP activities that include: participating in medical review or independent professional review team activities; assessing the necessity for and adequacy of medical care and services provided, as in utilization review; and assessing, through case management activities, the necessity for and adequacy of medical care and services required by individual recipients. 50 Fed. Reg. at 46,656.

The fact that CMS approved, as part of the State Plan, an interagency agreement listing specific activities for which the state intended to claim the 75 percent rate when provided by a nurse consultant, as needed or as requested by DHS, for HCBS-IH waiver children indicates that CMS recognized that the listed activities might require the knowledge and skills of a nurse consultant ***when actually provided in that context***. On the other hand, DHS still has to show that the activities the CHSC coded as SPMP activities, and for which it claimed federal reimbursement, were the activities described in the interagency agreement and otherwise met federal cost claiming requirements. Ms. Montag's written testimony and the position description submitted as an attachment to that testimony are insufficient to establish that all of the activities claimed were such activities. Ms. Montag testified that CHSC staff were responsible for "tasks associated with the nursing care needs of the children served" which "required the competencies of nursing training." Montag ¶ 15. What is absent from her testimony and DHS's evidence as a whole, however, is any assurance that the ***only*** tasks coded as SPMP activities were ones that were associated with the nursing care needs of the children served. Nor does DHS's evidence provide any assurance that the activities coded as SPMP activities were only those provided, pursuant to the interagency agreement, to the type of children receiving or potentially eligible for HCBS-IH waiver services.

As DHS points out, the position description submitted with Ms. Montag's testimony indicates that the primary stated duty of the staff nurses at CHSC was to "triage and assess the nursing needs of children with special health care needs, plan and coordinate care based on needs, and evaluate effectiveness of care provided." Montag Attachment 4. Not all children with "special" health care needs, however, have the ***complex*** health care needs or other characteristics that do or might qualify them for HCBS waiver services. Moreover, CHSC staff interviewed by the OIG indicated that activities they coded as SPMP included "Waiver and EPSDT Care conferences." DHS Ex. 4, at 32. EPSDT is

the acronym for the Early and Periodic Screening, Diagnosis, and Treatment a state must provide to Medicaid children. 42 C.F.R. Part 441, subpart B. While some EPSDT children might have the kind of complex health care needs that would make them eligible for the HCBS waiver programs, not all such children would need that level of care. Yet, DHS presented no testimony from the CHSC staff who were interviewed by the OIG or other evidence that would support a conclusion that the staff coded care conferences as SPMP activities only when participating in a care conference pursuant to the interagency agreement.

Also, we note that the attachment to the interagency agreement identified only partial FTEs (full-time equivalents) for identified staff members as eligible for the 75 percent rate. This appears to recognize that the identified individuals were performing some tasks that did not require nurse competencies and/or were not performed pursuant to the agreement. Since the OIG report refers to coding of the CHSC staff time, we assume some coding was occurring. The interagency agreement with CHSC did not, however, specify any allocation method. In the absence of any evidence to the contrary, we must assume that the coding directions to the CHSC staff were the same as for other UIHC staff from CDD and DOP, and therefore subject to the problems we identified above with respect to the other categories of cost.

As explained above, a state claiming FFP at an enhanced rate has the burden to document that all of the requirements for the enhanced rate are met. While DHS's evidence is sufficient to show that it reasonably thought that tasks performed by the CHSC nurses pursuant to the interagency agreement would qualify for that rate when provided to waiver children such as those with complex health needs, the evidence in the record is insufficient to show that ***all*** of the CHSC activities for which it claimed FFP at the enhanced 75 percent rate in fact were provided for such children. Absent documentation of the activities coded as SPMP activities that connects them to the activities described in the interagency agreement, moreover, we are unable to determine the percentage of the claim that was for allowable SPMP activities.

4. *Travel costs of UIHC's Child Health Specialty Clinics ($5,034)*

For the period at issue, DHS claimed $15,101 in FFP for travel costs incurred by CHSC personnel. *See* DHS Ex. 4, at 28 (table). DHS claimed these costs at the 75 percent matching rate for SPMP. *Id.* CMS determined, however, that the claimed travel costs, while allowable as Medicaid administration at the 50 percent matching rate, were ineligible for enhanced rate reimbursement because the travel-related activities did not require medical skills or knowledge. DHS Ex. 4, at 24; DHS Ex. 7, at 82, 89. Accordingly, CMS disallowed $5,034 of the claimed CHSC travel costs, an amount equal to the difference between a claim for those costs at the 75 percent FFP rate and a claim at the 50 percent rate. DHS Ex. 4, at 28 (table); DHS Ex. 7, at 89.

DHS's appeal briefs do not identify or discuss any of the travel episodes for which the disallowed costs were incurred. In addition, DHS submitted no evidence – such as travel orders, receipts, meeting notes and agendas, or employee testimony – documenting the claimed travel or verifying the need for SPMP involvement. We note that DHS's December 22, 2005 response to the OIG's draft audit report identified and sought to justify enhanced rate claims for some of the travel costs, *see* DHS Ex. 7, at 106, but DHS's appeal briefs do not cite or incorporate that discussion. DHS merely contends in this appeal that "[i]n the event that the DAB determines that SPMP at CHSC could properly claim at the enhanced rate, the travel costs associated with those same individuals should be allowed at the enhanced rate." DHS Br. at 15.

In the previous section, we determined that DHS did not meet its burden to show what part of CHSC's personnel costs were properly claimed at the enhanced rate. For that reason, and because DHS has not sought to justify enhanced rate reimbursement for any specific travel cost, we sustain the disallowance of $5,034 in CHSC travel costs.

Conclusion

For the reasons discussed above, we sustain CMS's May 10, 2010 decision to disallow $671,759 in FFP for the state of Iowa's Medicaid program.

/s/
Sheila Ann Hegy

/s/
Leslie A. Sussan

/s/
Judith A. Ballard
Presiding Board Member