Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

SUBJECT: California Department of Health Services
Docket Nos. 90-190
90-235
90-252
91-93

DATE: March 20, 1992

RULING ON REQUEST FOR RECONSIDERATION OF DAB NO. 1285

The California Department of Health Services requested reconsideration of the Departmental Appeals Board's decision in California Dept. of Health Services, DAB No. 1285, issued on December 19, 1991. That decision dealt with California's entitlement to federal funding under Title XIX (Medicaid) of the Social Security Act (Act).

California claimed these funds for the costs of targeted case management (TCM) services for developmentally disabled people, a covered service under its Medicaid state plan. The Health Care Financing Administration (HCFA) disallowed California's claims on the grounds that the services were provided "without charge" to all developmentally disabled citizens of California and therefore were not reimbursable under sections 1902(a)(17)(B) and 1905(a) of the Act.

In DAB No. 1285, the Board concluded that HCFA's determination that these services had been provided "without charge" was not consistent with HCFA's definition of "without charge" in its State Medicaid Manual. We also found that the State had notice of the Manual provisions and had relied on the definition in seeking HCFA's approval of the related State plan amendment. However, since California did not prove that it had satisfied the requirements of this definition, the Board could not fully resolve the issues which had been raised concerning the allowability of California's claims. The Board therefore remanded the case to HCFA for further review under the terms of DAB No. 1285.

California now requests the Board to alter the remedy provided in DAB No. 1285. Specifically, it requests

the Board release the deferrals of California's claims and require HCFA to pay California the federal funds at issue pending HCFA's review of California's practices.

Below, we discuss the result in DAB No. 1285, California's arguments, and the reasons for our conclusion that California is not entitled to the remedy it seeks.

The Board's Decision

DAB No. 1285 dealt with the allowability of California's claims for TCM services for developmentally disabled people. These services were provided through a network of state-funded, non-profit corporations. The users of these TCM services were not charged for them and had no obligation to pay for them.

Section 1905(a)(19) of the Act authorizes TCM as a Medicaid service. In addition to including TCM as a covered Medicaid service, Congress also enacted a unique provision concerning Medicaid funding of state-funded TCM services.[1] Section 8435 of Public Law 100-647. In DAB No. 1285 the Board concluded that the first sentence of this section precluded HCFA from denying funding for TCM services on the grounds that a state is required to provide TCM services under state law or that a state is paying for TCM services from non-federal funds. However, the Board also concluded that under the second sentence, payment of such claims is not required by the first sentence if the services are provided "without charge."

HCFA argued that the term "without charge" meant that individuals incur no cost for the TCM service and have no obligation to pay for the service. However, in DAB No. 1285, the Board concluded that "without charge"

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[1] The relevant portion of that section reads:

> The Secretary of Health and Human Services may not . . . deny payment to a State for [TCM] services . . . on the basis that a State is required to provide such services under State law or on the basis that the State had paid or is paying for such services from non-Federal funds before or after April 7, 1986. Nothing in this section shall be construed as requiring the Secretary to make payment to a State . . . for such case-management services which are provided without charge to the users of such services.

should be construed in accordance with the definition HCFA promulgated in its State Medicaid Manual.[2] Under that definition of "without charge," the Board determined that services were not "without charge" if third party reimbursement for the services was sought even though no individual incurred a cost for such services.

While California provided some evidence on the issue of whether in fact California sought third party reimbursement, the Board found that evidence insufficient. However, since this issue emerged in the course of Board proceedings, the Board concluded that California should have a further opportunity to demonstrate that it sought third party reimbursement for these services and that therefore they were not provided "without charge." Thus, the Board remanded the case.

California's Reconsideration Request

The regulatory provision at 45 C.F.R. §16.13 expressly authorizes the Board to reconsider its decisions "where a party promptly alleges a clear error of fact or law."[3] California alleged in its Request for Reconsideration that the Board erred in DAB No. 1285 by allowing HCFA to

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[2] The text of section 5340 reads:

> Services without charge, for purposes of Medicaid, means that no individual or family is charged for medical care, and third party reimbursement is not sought.

[3] Requests to reconsider are directed to an agency's discretion. Braswell Motor Freight Lines, Inc. v. United States, 275 F.Supp. 98, 103 (W.D. Tx. 1967), aff'd 389 U.S. 569 (1968) (stating that "It is well settled that petitions for rehearing or further hearing are addressed to the discretion of the administrative agency and that denial of such petitions is not open to question unless in clear abuse of discretionary authority."); N.L.R.B. v. Fort Vancouver Plywood Co., 604 F.2d 596, 601 (9th Cir. 1979), cert. denied, 445 U.S. 915 (1980) (stating that "The administrative law judge has considerable discretion in the grant or denial of a motion to reopen."); Duval Corp. v. Donovan, 650 F.2d 1051, 1054 (9th Cir. 1981) (stating that "A petition for reconsideration by an administrative agency is addressed to that body's discretion. Denial of such a petition should be overturned only upon a showing of the clearest abuse of discretion.").

retain these funds pending HCFA's review pursuant to the Board's remand.

California advanced three arguments in support of its position that it is entitled to the use of the funds pending HCFA's decision on remand. First, it argued that the basis of HCFA's deferral has been determined to be without justification. Second, it argued that the remand was improper because it was based upon the consideration of incompetent material in the record. Third, it argued that a more equitable resolution should have been employed because the remand inures to the exclusive benefit of HCFA and the exclusive detriment of California.

Discussion

As a preface to our discussion of California's arguments, we note that the Board has consistently held that grantees have the burden of proving that their claims are allowable. California Dept. of Health Services, DAB No. 1095 (1989); New York State Dept. of Social Services, DAB No. 673 (1985). In DAB No. 1285, the Board concluded that California had not met this burden. Under 45 C.F.R. Part 16, the Board has a broad range of options in handling such cases. See 45 C.F.R. 16.13. Here, the Board could have kept this case open for further development of this issue or remanded the case to HCFA for further development. The fact that the Board decided to remand the case does not change the status of the funding in question: the Board did not determine that California was entitled to receive the funds. Thus, a remand was clearly within the Board's authority and, in our view, appropriate under the circumstances.

As we explain below, none of California's arguments persuades us that we erred in remanding or that the consequences of the remand are inequitable.

1. The basis for HCFA's deferral has not been determined to be without justification and California is not entitled to these funds pending a final determination on allowability.

Title XIX provides for the payment of federal monies to states to aid in financing state medical assistance programs. Since many states might have difficulty financing a Medicaid program even if subsequently reimbursed by the federal government, HCFA advances funds to a state on a quarterly basis, based on the federal share of the estimated cost of the program. Section

1903(d). HCFA 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, HCFA 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 a deferral mechanism pursuant to which the HCFA Regional Administrator may question a claim and defer payment of it. The deferral could be of an amount included in a state's estimate, or on its quarterly expenditure report. If the Regional Administrator then determines that the deferred claim is not allowable, he may issue a disallowance without paying the claim. 42 C.F.R. §430.40(e). Therefore, where a disallowance is preceded by a deferral, the state does not receive the money pending resolution of the dispute.

Alternatively, HCFA may disallow claims which have already been paid to a state. In these circumstances, the state then has the option of retaining the funds or returning the funds pending a final determination as to the allowability of the claim. Section 1903(d)(5) of the Act. If the state retains the funds, it is liable for interest if the claim is finally determined to be unallowable. Id.

In this case, the disallowances at issue were preceded by deferrals and HCFA never advanced California these funds. In its Request for Reconsideration, California argued that, because the Board had determined that HCFA's grounds for its initial deferrals were invalid, the Board should release the deferrals and require HCFA to pay California this money. In support of its argument, California cited section 1903(d)(5) of the Act.

For the following reasons, we disagree with California's argument:

- California has mischaracterized the scope of DAB No. 1285 by saying that the Board completely overruled HCFA's construction of section 8435 and the basis of HCFA's disallowance of these funds. Central to HCFA's deferral and disallowance was HCFA's finding that these services were provided "without charge" and therefore it was not compelled to pay for them under section 8435. In fact, the Board adopted HCFA's construction of section 8435 that HCFA was not

required by that section to pay these claims if the services were provided "without charge." Since the Board determined that California had not established that these services were not "without charge," the original and central issue in this dispute remained unresolved, i.e., whether these services were provided "without charge."

- Further, the matter before the Board is HCFA's disallowance of these costs, not its prior deferral. Under 42 C.F.R. §430.40(b)(5), the Regional Administrator may issue a deferral but must subsequently either pay the State or disallow the claims. The State may then appeal the disallowance. 42 C.F.R. §430.40(e)(2); 45 C.F.R. Part 16, App. A, §B(a)(1).

- California did not cite any authority for the proposition that a state is entitled to Medicaid funds pending resolution of a dispute about their allowability. Rather, the purpose of the deferral mechanism is to enable HCFA to decline to pay claims when it determines prior to payment that there are questions as to its allowability.

- Section 1903(d)(5) does not establish a state's entitlement to funds pending resolution of a dispute. The relevant portion of section 1903(d)(5) states that "the amount of the Federal payment in controversy shall, at the option of the State, be retained by such state or recovered by the Secretary pending a final determination with respect to such payment amount." (Emphasis added.) (Under section 1903(d)(5), if a state opts to retain the payment, the state must pay interest on the claim if it is finally disallowed.) Section 1903(d)(5) sets forth a state's options where a payment has been advanced to the state. As HCFA has notified the states in section 2502.5 of the State Medicaid Manual, section 1903(d)(5) does not apply in deferrals where no funds have been paid and there are therefore no funds to "retain."

Therefore, we conclude that there is nothing in the Act or regulations which requires HCFA to advance California the deferred funds pending a final determination about their allowability.

2. The Board's remand was not based upon the consideration of incompetent material in the record.

The Board initially issued a preliminary analysis and order to develop the record in this case. In the preliminary analysis the Board raised the question of whether these services should be considered to have been provided "without charge" under HCFA's definition of that term in the State Medicaid Manual.

California responded that the services were not provided "without charge" because it had implemented a system for "charging" third parties for such services. In support of this representation California filed an affidavit of the Chief of the Title XIX Section, Community Services Division, California State Department of Developmental Services. She described the process by which third party reimbursement from health insurance carriers was sought for TCM services. Attached to her affidavit were "Targeted Case Management Procedures" which set forth instructions on how Regional Centers and the State Agency were to process TCM claims for recipients who had medical insurance.

In response, HCFA pointed out that this affidavit did not contain any information about when such a third party recovery system had been implemented and did not represent that third party recovery actions were taken during the period at issue (March 31, 1988 through June 30, 1990). In fact, since the affiant represented in her affidavit that she prepared these procedures in the spring of 1989, the terms of her affidavit raised the question of whether these procedures were used for claims during the entire period at issue.

In its request for reconsideration, California argued that (1) it introduced evidence in response to the preliminary analysis which established that California was seeking third party reimbursement; (2) HCFA introduced no evidence which would controvert California's evidence; (3) the statements of HCFA's counsel were not evidence; and (4) therefore, the Board's remand was based on incompetent evidence.[4]

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[4] In its request for reconsideration, California quoted language from the preliminary analysis that "there is nothing in the present record that would establish that California is not seeking third party reimbursement for TCM services." California than argued

(continued...)

For the following reasons, we reject California's argument. First, California ultimately had the burden of proof on the issue of whether third party reimbursement was sought for these services. The only evidence California proffered on its actual practices in seeking third party reimbursement was the Chief's affidavit. As counsel for HCFA pointed out, that affidavit was insufficient because it contained no allegation as to the time period during which California initiated these third party efforts. Therefore, the Board did not rely on HCFA's counsel's statement as evidence, but rather on the inherent inadequacy of California's proof. California did not meet its burden on this issue in this case.

Second, as the Board made clear in the decision, the question of whether California sought third party reimbursement for these services turns on whether it complied with its State plan, the Act, and standards promulgated by HCFA. This is a question of broad scope which is best examined in the first instance by program officials who are familiar with the standards and the operation of California's Medicaid program. It is certainly not one the Board can resolve on the basis of a deficient affidavit and previous representations of California officials concerning their future intentions in the area of third party reimbursement.

3. The remedy employed by the Board does not inure to HCFA's sole benefit and is not inequitable.

California argued that the remand issued in DAB No. 1285 inured solely to HCFA's benefit and was inequitable. California maintained that the Board failed to explain the facts underlying its choice of a remand. Specifically, it argued that since only six percent of its TCM Medicaid recipients have insurance, the Board's remedy unfairly denies California access to the funds for the 94 percent of recipients who have no

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[4](...continued)
that no further evidence was introduced between the preliminary analysis and DAB No. 1285 which would change this conclusion. However, the fact that the record did not support HCFA's position does not mean that the opposing evidence was sufficient to meet the State's burden of documenting that it was seeking third party reimbursement. Thus, this observation in the preliminary analysis does not result in California's prevailing in the final decision.

insurance. Given the distribution of insured and uninsured, California argued that it would been more equitable to let California have the money while HCFA conducted its review of the State's third party practices.

We disagree for the following reasons. First, the decision does not inure solely to HCFA's benefit. In DAB No. 1285, the Board modified the terms of a very large disallowance. According to California, it will ultimately be able to demonstrate to HCFA that it has complied with the third party reimbursement requirements. Assuming this is accurate, California will have won substantial sums pursuant to this decision. By remanding to HCFA, the Board gave the parties an opportunity to informally resolve the third party issue, rather than requiring more formal presentations which may prove time-consuming and unnecessary.

Second, in arguing that only six percent of the recipients are affected by third party recovery requirements and DAB No. 1285, California misconstrued the decision. The Board's ruling was that the State must show that it met applicable requirements related to third party reimbursement. The question whether the State's third party recovery efforts met applicable requirements is a threshold issue for funding for all the payments for TCM services, irrespective of whether there was a liable third party.[5] California's suggestion that the decision unfairly denies it access to the money for 94 percent of its claims is misleading and is not a basis to order HCFA to pay these claims at this time.

Third, the Board did explain the remedy it chose and how the remedy was related to the facts of the case. California pointed to the language in the decision stating that "we conclude that HCFA may not disallow these claims for FFP on the basis of the present record." However, in the next sentence the Board wrote that "we also conclude that California did not establish that it is entitled to the disallowed funds." As the Board explained: California's evidence was insufficient as to the issue of "without charge"; since the question of third party reimbursement arose in the course of Board's consideration of this case, it was most equitable to allow California to demonstrate that it sought third

[5] We also note that there may be some recipients who are uninsured but for whose services a third party tortfeasor may be liable.

party reimbursement for these services; the question of whether California had done so involved review of its obligations under its State plan, the Act, and HCFA policies; and this was the type of review that was must appropriately conducted by program officials. While one consequence of the remand is that HCFA continues to hold the funds, California identified no authority for its position that it is entitled to use of the funds pending a determination on their allowability.

Based on the foregoing discussion, we conclude that California did not allege any error of law or fact which would warrant modifying DAB No. 1285.

Cecilia Sparks Ford[6]

Norval D. (John) Settle

Judith A. Ballard
Presiding Board Member

[6] Ms. Ford has been substituted on the panel for Mr. Teitz for purposes of this ruling. Mr. Teitz died in January 1992.