Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Arizona Health Care Cost Containment System
Docket No. A-17-70
Decision No. 2824
October 2, 2017

DECISION

Arizona Health Care Cost Containment System (Arizona), the state agency that operates the Medicaid program in the state of Arizona, appeals a determination by the Centers for Medicare & Medicaid Services (CMS) to disallow $11,716,850 in federal financial participation (FFP) for the period from January 1, 2004 through September 30, 2008, for school-based administration costs associated with providing health-related services to Medicaid-eligible schoolchildren under the federal Individuals with Disabilities Education Act (IDEA). The U.S. Department of Health and Human Services' Office of the Inspector General (OIG) audited Arizona's FFP claims for school-based administration costs for the period from January 1, 2004 through September 30, 2008. Based on the OIG's January 2013 audit report, which found that Arizona's use of random moment time study (RMTS), a statistical sampling methodology, to allocate school-based administrative costs to Medicaid did not fully comply with applicable requirements. CMS determined that, of the $30,545,822 in FFP claimed, Arizona improperly claimed $11,716,850. The Board upholds the disallowance of $11,716,850.

I. Legal Background

Title XIX of the Social Security Act (Act)[1] authorizes the Medicaid program, which furnishes medical assistance to low-income individuals and families as well as to blind and disabled persons. Act §§ 1901-1903; 42 C.F.R. § 430.0. A state with an approved "State plan for medical assistance" is eligible to receive federal matching funds – that is, FFP – for its costs in administering the state plan. Act §§ 1902, 1903; 42 C.F.R. §§ 430.30(a), 433.10(a), 433.15(a). FFP-eligible costs include (in addition to payments

[1] The current version of the Act can be found at https://www.ssa.gov/OP_Home/ssact/ssact-toc.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. Also, a cross-reference table for the Act and the United States Code can be found at 42 U.S.C.A. Ch. 7, Disp Table.

for covered medical care) expenditures for Medicaid program "administration." The federal Medicaid statute authorizes FFP at a rate of 50 percent for activities the Secretary of Health & Human Services finds necessary for the proper and efficient administration of the state plan. Act § 1903(a)(7). (Costs of certain administrative activities, not relevant here, are eligible for FFP at rates higher than 50 percent.)

A state Medicaid agency, such as Arizona, must comply with the cost principles in Office of Management and Budget (OMB) Circular A-87, "Cost Principles for State, Local, and Indian Tribal Governments." 2 C.F.R. Part 225 (2004-2013) (codifying OMB Circular A-87); 45 C.F.R. § 74.27(a) (2003). To be allowable, a cost must be necessary and reasonable for the proper and efficient performance and administration of federal awards and must be allocable to federal awards. OMB Circular A-87, App. A, ¶ C.1.a, b. A program cost is allowable if it is allocable to the award. *Id.* ¶ C.1.b. A cost is allocable to a particular cost objective if the goods or services involved are chargeable or assignable to such cost objective in accordance with relative benefits received. *Id.* ¶ C.3.a.

The state agency must document the allowability of its claims for FFP. *Id.* ¶ C.1.j. "In an appeal of a federal agency's disallowance determination, the federal agency has the initial burden to provide sufficient detail about the basis for its determination to enable the grantee [i.e., the non-federal party] to respond." *Me. Dept. of Health & Human Servs.*, DAB No. 2292, at 9 (2009), *aff'd*, *Me. Dept. of Human Servs. v. U.S. Dept. of Health & Human Servs.*, 766 F. Supp. 2d 288 (D. Me. 2011). If the federal agency carries this burden, which is "minimal," then the non-federal party must show that the costs are allowable. *Mass. Exec. Office of Health & Human Servs.*, DAB No. 2218, at 11 (2008), *aff'd*, *Mass. v. Sebelius*, 701 F. Supp. 2d 182 (D. Mass. 2010); *see also Pa. Dept. of Pub. Welfare*, DAB No. 2669, at 4 (2015) and *Pa. Dept. of Pub. Welfare*, DAB No. 2653, at 5 (2015) (in addressing the standard of review, stating, in both decisions, that the state or non-federal party must document its claims for FFP in accordance with applicable cost principles and administrative requirements). Moreover, "[w]hen a disallowance is supported by audit findings, the grantee [or non-federal party] typically has the burden of showing that those findings are legally or factually unjustified." DAB No. 2218, at 11, citing *Wisconsin Dept. of Health and Soc. Servs.*, DAB No. 1121, at 15-16 (1989) and *Indiana Dept. of Pub. Welfare*, DAB No. 970, at 6-7 (1988).

CMS has issued the *Medicaid School-Based Administrative Claiming Guide*, dated May 2003 (2003 Guide).[2] It explains how to allocate school-based administrative costs so that states claim only costs that are eligible for federal Medicaid reimbursement.

II. Case Background

A. *Random Moment Time Study*

The claims for FFP at issue here were for reimbursement of the costs of school-based administrative activities in support of Medicaid-covered health-related services provided to children under IDEA. Act § 1903(c). The school-based health program permits children to receive health services within the school. To determine the federal share of such costs, Arizona used a statistical sampling method called random moment time study, under which a selected sample of school employees were surveyed at randomly selected workday moments to report the time they spent on Medicaid and non-Medicaid activities. Information in the RMTS reports, or observation forms, were used to calculate the percentage of time devoted to Medicaid activities (i.e., statewide Medicaid percentage), which was used to calculate the amount of FFP Arizona claimed as its school-based administrative costs. Ex. 9, at AZ 158-AZ 159. Federal regulations recognize the use of random moment sampling as an acceptable method for allocating costs to federal awards when employees work on multiple activities not allocable to a single federal award. *See* 2 C.F.R. Part 225, App. B, 8.h(6).

B. *OIG audit findings*

This case began with the OIG's nationwide audit of state Medicaid agency contingency fee arrangements with consultants for claiming school-based administrative costs. By letter dated October 20, 2008, the OIG informed Arizona that it intended to audit its contingency fee arrangements, and that the audit period will include federal payments made from January 1, 2004 through June 30, 2008. The OIG asked Arizona to produce

[2] The 2003 Guide is of record as Arizona's Exhibit 1 (of 14 exhibits). Arizona's 14 exhibits, marked Exhibits 1 through 14 and submitted with its opening brief (AZ Br.), are paginated sequentially from "AZ 001" through "AZ 208." CMS filed its response brief (CMS Response), but no exhibits. Arizona filed a reply brief (AZ Reply). The parties cite to the exhibits using the numbers designated by Arizona. We do the same. E.g., Ex. 1, at AZ 002. Arizona also submitted a four-page Appendix 1, paginated "AZ 387" through "AZ 390," with its opening brief. Arizona describes Appendix 1 as "Other state methodologies that currently exclude non-responses." AZ Br. at v. Appendix 1 appears to be an excerpt from a larger document, but Arizona does not identify the source of it. Appendix 1 purports to identify 14 states that use the RMTS methodology and whose claiming plans permit the exclusion of certain types of responses under certain circumstances.

for inspection certain documents identified in a list provided with the letter. Ex. 6, at AZ 109, AZ 111-AZ 112. Among those documents were Arizona's and its contractor Maximus, Inc.'s policies, procedures, manuals and guidelines related to claiming Medicaid school-based administrative activities and reviewing and monitoring school-based administrative claims for federal reimbursement, and the quarterly amount claimed by Arizona for FFP for Medicaid school-based administrative costs. *Id.* at AZ 111, AZ 112. By letter dated March 11, 2011, the OIG informed Arizona that it had revised its audit objective to include Arizona's claiming of such costs. Ex. 8, at AZ 143. The OIG also stated that the audit scope would include Local Education Agency (LEA) administrative costs claimed from January 1, 2004 through September 30, 2008. *Id.* Thus, the OIG extended the audit period by one quarter, for a total of 19 quarters.

In January 2013, the OIG issued its audit report, titled *Arizona Improperly Claimed Federal Reimbursement for Medicaid School-Based Administrative Costs* (Report No. A-09-11-02020). Ex. 9. The OIG reviewed Arizona's claims for $61,091,772 for the audit period. Of $61,091,772, Arizona claimed $30,545,822 as the federal share. *Id.* at AZ 159. The OIG determined that Arizona "did not always" maintain required documentation to support its RMTS methodology used to allocate school-based administrative costs, and that the methodology "was not fully consistent" with federal requirements. *Id.* at AZ 161. The OIG found that $11,716,850 was not allowable. *Id.*

In sum, the OIG found:

- For 2 of 19 quarters (i.e., first quarter of calendar year 2004; second quarter of calendar year 2005), Arizona did not maintain documentation to support (1) the universes of total available moments in time and RMTS participants and/or (2) the sample of random moments for selected participants. For the first quarter of 2004, Arizona provided the OIG copies of 3,559 completed RMTS observation forms (i.e., the sample results), but not the data files to support the sample universe determination and the sample selection. For the second quarter of 2005, Arizona provided the OIG copies of 3,730 completed observation forms, but did not provide a data file to support the sample universe determination. According to the OIG, Maximus indicated that it could not locate the data files and, without them, the OIG could not verify whether the observation forms were for the sample items selected for the two quarters.[3] The OIG determined that $5,421,711 of the unallowable $11,716,850 was attributable to the failure to maintain such documentation.

[3] The only basis the OIG cited for recommending disallowance of the costs claimed for the two quarters was the failure to maintain required documentation. The OIG did not evaluate the sampling methodology for the two quarters. Ex. 9, at AZ 163. Moreover, the OIG indicated that it could not determine the sample size or the number of discarded sample items for the two quarters due to lack of documentation and thus did not have sufficient information to revise the statewide Medicaid percentages for the two quarters. *Id.* at AZ 173.

- For the remaining 17 quarters, the OIG determined that the RMTS methodology was "not fully consistent with Federal requirements" for two reasons:

  (1) Arizona inappropriately discarded sample items when calculating the statewide Medicaid percentages for each quarter. Of the 34,400 sample items related to observation forms sent to the statewide RMTS participants for the 17 quarters, Arizona discarded 6,754 items when calculating the percentages. Of the 6,754 discarded items, 3,192 were for non-responses,[4] and 3,562 were forms that were not complete or had inaccurate information, such as no activity codes or description, or no signature or date, or were completed by someone other than the selected participant. According to the OIG, Arizona should have retained the discarded items in the sample and coded them as non-Medicaid activities. Because Arizona discarded the items, it could not prove that the discarded items were for Medicaid school-based administrative activities. Also, by discarding the items, Arizona reduced the sample size, which resulted in higher statewide Medicaid percentages, and consequently increased federal reimbursement.

  The OIG recalculated the statewide Medicaid percentage for the 17 quarters by including the discarded items in the sample and treating them as non-Medicaid activities "unless the observation forms indicated otherwise." For discarded forms, the OIG treated the items as Medicaid activities "if the forms indicated that the activities were related to Medicaid." Using the revised percentages, the OIG determined that $6,295,139 was not allowable for the 17 quarters.

  (2) The OIG also determined that the RMTS methodology did not meet acceptable statistical sampling standards because the universes from which the sample items were selected were "incomplete" or "incorrect" for various reasons, such that the methodology yielded statistically invalid results. E.g., for 12 of the 17 quarters, not every sample item in the universe had an equal chance of being

[4] A "non-response" simply means that the employee selected to complete an observation form for a randomly-selected workday moment to report the time he or she spent at the pre-determined moment on Medicaid and/or non-Medicaid activities *did not actually return the form*. A "non-response" does not mean that there was nothing to report. Thus, a non-response essentially means that a specific data point – the time a particular employee spent at a pre-determined moment on Medicaid and/or non-Medicaid activities – was not collected and thus was not available to be coded as Medicaid time versus non-Medicaid time. States have an incentive to favor data results that potentially could augment Medicaid-chargeable time in relation to non-Medicaid-chargeable time and consequently the federal share they could claim. CMS therefore may reasonably be concerned about collecting and accounting for all relevant random moment sampling data, Medicaid and non-Medicaid related, because data not collected and accounted for (such as non-responses) could be disproportionately associated with non-Medicaid time. Requiring the inclusion of all sampled moments (in other words, not discarding non-responses as well as incomplete or inaccurate responses) while presuming that uncollected data or incomplete or inaccurate data were not chargeable to Medicaid seeks to correct for this incentive.

> selected. The OIG stated that it was not able to determine which portion of the claim would have been allowable if complete or correct universes had been used to calculate the statewide Medicaid percentages. Therefore, the OIG said, it would "set aside" $18,828,972 (i.e., $30,545,822 claimed minus $11,716,850) for "CMS resolution."

Id. at AZ 161-AZ 166, AZ 171-AZ 173. (The "set aside" amount is not the subject of dispute on appeal.)

The OIG also determined that, overall, Arizona lacked "adequate controls" to ensure that it maintained all required documentation to support the methodology employed and that the methodology was consistent with all federal requirements. One such lapse in control was the failure to exercise oversight authority to ensure that Maximus, Arizona's contractor, maintained all required supporting documentation. *Id.* at AZ 166.

C. *CMS's disallowance and denial of reconsideration*

After considering Arizona's March 4, 2013 letter responding to the OIG's audit findings (Ex. 10), CMS issued a notice of disallowance, dated October 20, 2016, informing Arizona that it was disallowing $11,716,850 in FFP claimed for school-based administrative costs in accordance with the OIG's audit findings. Ex. 11. With respect to the first quarter of 2004 and second quarter of 2005, CMS stated that, based on Section II of Arizona's Administrative Policies and Procedures, Arizona's contract with Maximus, which "operationalized" Arizona's school-based program, and Maximus's record retention policy, the applicable record retention period was five years, and that Arizona was responsible for ensuring that the subject sampling records were retained for five years. *Id.* at AZ 183-184. In any case, CMS concluded, Arizona was responsible for substantiating its claims for the two quarters. *Id.* at AZ 184.

As for the remaining 17 quarters, CMS stated, in part:

> [S]tates must comply with OMB [Circular] A-87 requirements . . . CMS's [2003 Guide] describes the treatment of time study non-responses on page 41. While the Guide states that ". . . all non-responses should be coded non-Medicaid," it also includes language suggesting that oversampling can be used to substitute responses for non-responses, as follows: ". . . many schools oversample and/or factor in a non-response rate in their time study methodology." By not conclusively stating that all non-responses must be coded as non-Medicaid, the Guide recognizes that there could be alternate methodologies to address non-responses that do not require coding them as non-Medicaid. However, such alternate methodologies would still need to be statistically valid, reviewed and approved by CMS, and included in the state's claiming guide.

Id. CMS also acknowledged Arizona's development of its own claiming plan in 2004, but said that the 2004 plan did not permit the exclusion of non-responses. It wrote:

> [Arizona's] 2004 . . . plan did not permit the exclusion of any responses because the plan did not contain a non-response protocol explicitly allowing for such treatment. For any plan without such a protocol, CMS expects the state to include all responses in the time study results, and to code invalid responses (including non-responses) as non-Medicaid.

Id.[5]

By letter dated December 14, 2016, Arizona asked CMS to reconsider its disallowance, arguing, inter alia, that: CMS's 2003 Guide did not specifically preclude exclusion of non-responses; CMS failed to timely act on Arizona's request for approval of its 2004 plan; in its disallowance, CMS wrongly attempted to rely on an unannounced, retrospective interpretation of unclear 2003 Guide language about how non-responses should be treated; and that, despite Arizona's inability to produce sampling data for two quarters, there is no basis to question that Arizona had processed the claims for those two quarters as it had for the remaining 17 quarters. Ex. 12. By letter dated February 14, 2017, CMS reaffirmed its disallowance, stating that Arizona "has not provided any new or additional information that would overturn the findings of fact on which the disallowance is based." Ex. 13, at AZ 204.

III. Discussion

Arizona appeals the disallowance pursuant to section 1116(e) of the Act. *See also* 42 C.F.R. § 430.42(f). In subsection A below, we address the issue of applicable burden of proof and standard of review by the Board. We then address, in subsections B and C, Arizona's arguments about the disallowance of $6,295,139 and $5,421,711 and explain why Arizona has not proven that the FFP of $6,295,139 and $5,421,711 was allowable.

[5] Arizona reportedly prepared its 2004 plan (dated January 2004) when it retained Maximus to process its claims for school-based administrative costs and submitted the plan to CMS on March 23, 2004. Exs. 2; 3, at AZ 100. CMS did not approve the 2004 plan as drafted. In October 2008 Arizona submitted a revised claiming plan for CMS approval. After additional revisions, Arizona resubmitted its plan on May 3, 2010, which CMS approved on June 7, 2010. AZ Br. at 4; Ex. 7 (approved 2010 plan). Most of Arizona's arguments concern certain language in the 2003 Guide and CMS's alleged inaction on the request for approval of the 2004 plan. We will discuss these matters in detail later.

A. *Arizona has the burden to prove that the disallowed FFP is allowable.*

Arizona states that in its opening brief it explained why the disallowance of $11,716,850 was "arbitrary and capricious," but CMS merely responded with an "argument of less than three pages that fails to defend CMS against *any* of [Arizona's] arguments." AZ Reply at 1 (emphasis in original); AZ Br. at 7 (quoting 5 U.S.C.A. § 706(2)(A) and (E) and stating that "[t]he Board reviews CMS's disallowance to determine whether it was 'arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law' or 'unsupported by substantial evidence.'"). Arizona thus appears to take the position that CMS effectively conceded any argument advanced by Arizona to the extent CMS did not in Arizona's view rebut it in its response brief.

Arizona also asserts that the October 20, 2016 disallowance determination does not clearly and specifically state CMS's rationale for disallowing $6,295,139. According to Arizona, the rationale is "brief, conclusory, and vague" (*id.* at 8) and "differs considerably from the OIG's recommendation" since, "[o]ther than the amount OIG calculated, CMS adopted almost none of OIG's reasoning" (*id.* at 12); *see also id.* at 15 (similar argument). Arizona says that since the disallowance "does not incorporate OIG's audit report" and CMS "accepts some of OIG's arguments and ignores others," the disallowance "thus stands on its own, and the issue is whether the facts and legal grounds stated in the [disallowance] justify" the disallowance. AZ Reply at 2.

Arizona mistakes the standard for review at the Board for that established for courts reviewing administrative action under the Administrative Procedure Act (APA), 5 U.S.C. § 706 *et seq*. Section 706 of the APA provides for courts to "hold unlawful and set aside agency action, findings, and conclusions found to be" "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law" and "unsupported by substantial evidence" after a hearing on the record. 5 U.S.C. § 706(2)(A), (E). The Board, however, is not a court; it is an appellate adjudicative body in an administrative appeal process. Moreover, disallowance appeals before the Board are not hearings "on the record" as that concept is defined in the APA.

As set out above, in these proceedings, once CMS has explained the basis for a disallowance with sufficient clarity, the state agency bears the burden of substantiating that the FFP it claims is allowable. Furthermore, where, as here, the disallowance is based on audit results, the state agency must show that those findings are not justified. Thus, the question is not whether CMS has conceded any disputed point in Arizona's favor by not effectively rebutting Arizona's arguments. Rather, the initial question is whether CMS has carried its initial burden to provide sufficient rationale for the disallowance. If so, the ultimate question becomes whether Arizona has met its burden to show that it properly claimed the FFP.

We conclude that CMS has indeed carried its "minimal" initial burden, i.e., it has articulated its bases and rationale for disallowing the FFP as claimed with sufficient clarity such that Arizona has the burden to substantiate the amounts claimed. In its 2016 disallowance, CMS clearly stated that the basis for disallowing $11,716,850 in FFP, the exact amount the OIG recommended that Arizona should refund, was the OIG's January 2013 audit report, and then discussed in some detail the audit results. Ex. 11, at AZ 182-AZ 184; Ex. 9, at AZ 153. In its February 14, 2017 denial of reconsideration, CMS reiterated that it was affirming the disallowance of $11,716,850 based on the OIG's audit findings. Ex. 13.

We also disagree with the suggestion that to the extent CMS did not expressly incorporate certain OIG audit findings into its disallowance determination, CMS is later constrained in pursuing recovery of the disallowance. Arizona contends that CMS effectively waived the right to pursue any argument derived from the OIG's findings unless expressly reiterated in the determination. Arizona cites no supporting authority on point. Arizona was afforded advance notice and opportunity to review and respond to the OIG's findings on which CMS later based its disallowance determination both in response to the draft and final reports, and did so both times. Ex. 9, at AZ 174-AZ 177 (response to the draft report, appended to the final report as Appendix D); Ex. 10 (response to the final report). Given that background, we are not persuaded that Arizona was confused in any way about the bases of CMS's action or that Arizona has lacked a full opportunity to respond to those bases in this proceeding.

B. *CMS properly disallowed the FFP of $6,295,139.*

1. *Arizona's Arguments*

Arizona does not deny excluding non-responses, or inaccurate or complete responses, to calculate the statewide Medicaid percentages as the OIG found.[6] Arizona maintains, however, that CMS's disallowance rests only on CMS's interpretation of language in the 2003 Guide which Arizona portrays as subjective, unannounced, and retrospective in nature. Ex. 14 (notice of appeal), at AZ 208; AZ Br. at 6, 8-9. Arizona implies that the 2003 Guide did not unambiguously preclude the exclusion of non-responses. In particular, Arizona points to CMS's "brief, conclusory, and vague" statement in its 2016 disallowance (Ex. 11) that "CMS expects [Arizona] to include all responses in the time study results, and to code invalid responses (including non-responses) as non-Medicaid." AZ Br. at 8, 9-10. CMS, Arizona says, could have clearly expressed such an expectation

[6] According to the OIG, excluding non-responses and observation forms with missing or inaccurate information, i.e., discarding sample items, reduces the sample size and could result in a higher statewide Medicaid percentage and thus a higher federal reimbursement. Ex. 9, at AZ 159.

earlier in its 2003 Guide, but did not do so. *Id*. According to Arizona, CMS "admit[ted]" in its 2016 disallowance that the 2003 Guide was "not clear" (*id.* at 10), as CMS said: "'By not conclusively stating that all non-responses must be coded as non-Medicaid, the Guide recognizes that there could be alternate methodologies to address non-responses that do not require coding them as non-Medicaid.'" *Id.*, quoting Ex. 11, at AZ 184. Because the 2003 Guide language was not clear and CMS did not publish the interpretation of it on which it relies prior to this disallowance, Arizona says, CMS's reliance on the 2003 Guide presents due process concerns. *Id.* at 21; AZ Reply at 3 (similar argument). Therefore, says Arizona, no deference is due to CMS's interpretation of the 2003 Guide. AZ Br. at 17, 23-24.

Arizona submitted its own draft claiming plan in 2004 (Ex. 2) – which the 2003 Guide permitted states to do so long as the state plan is a statistically valid plan that CMS ultimately approves (AZ Br. at 10, citing Ex. 1, AZ 044) – proposing to exclude as invalid certain types of forms.[7] Arizona says that it submitted its 2004 plan to CMS with the intention to submit any claims using the methodology proposed in 2004, but CMS did not approve it or disapprove it, or ask questions about it. *Id.* at 10-11. When Arizona asked about the status of CMS's review of the 2004 plan, CMS indicated only that it "look[ed] good" though with some questions, and that CMS would rely on Arizona's statement that the plan was in accordance with the 2003 Guide. *Id.* at 19; Ex. 3, at AZ 099 (November 2004 emails). Thereafter, according to Arizona, CMS failed to act for years. In April 2008, Maximus recommended that Arizona *no longer* exclude non-responses (Ex. 4), and Arizona agreed with Maximus's recommendation to treat non-responses "prospectively" as non-Medicaid items (Ex. 5). AZ Br. at 11. Arizona avers that CMS did not take issue with Arizona's claiming practices, which "only stopped when [Arizona] – not CMS – raised a question about inconsistent actions CMS seemed to be taking in other states" in terms of how non-responses are to be treated for sampling purposes. *Id.*[8] Thus, Arizona says, CMS "simply did not get the job done" and now wrongly "expects [Arizona] to pay a penalty for [its] failure." *Id.*

Arizona also claims that it acted reasonably in using its own methodology after giving CMS an opportunity to review Arizona's methodology, since the 2003 Guide did not require prior CMS approval of a state's methodology and Arizona could not wait indefinitely to submit its claims. *Id.* at 22. Moreover, Arizona's interpretation of the

---

[7] Arizona's *Medicaid Administrative Claiming Program Guide*, dated January 2004, marked "DRAFT – Pending CMS Approval," states, in part: "Forms that cannot be validated, due to missing or inaccurate information, or failure to return the updated form will be marked invalid. Once all invalid forms have been extracted from the sample pool of observation forms, all valid forms are included in the tabulation." Ex. 2, at AZ 072-AZ 073.

[8] Arizona maintains that CMS has approved 14 state methodologies that do not treat non-responses or incomplete or inaccurate responses as non-Medicaid events. AZ Br. at 19-20, citing Appendix 1.

2003 Guide as permitting the "discarding [of] non-responses so long as no one instructed persons with few Medicaid activities not to respond" was also reasonable in light of CMS's failure to take any definitive action on Arizona's 2004 plan. *Id.* Arizona says, "Failure to question [Arizona's] methodology or tell [Arizona] its treatment of non-responses and incomplete or inaccurate responses could not be approved strongly suggests CMS had no reason in 2004 to disapprove [Arizona's] methodology." *Id.* at 19. Arizona claims that it understood that CMS would tell Arizona if it disapproved of Arizona's methodology, but "[n]o issue was raised regarding the claims already submitted until OIG notified [Arizona] in 2011 of its intent to audit the claims" and thus Arizona reasonably relied to its detriment on CMS's inaction on the 2004 plan. *Id.* at 22. It says, CMS effectively "allowed" Arizona to "use its interpretation" "for four years." *Id.* at 11. In any event, CMS later approved a revised Arizona plan (in 2010), which does permit the exclusion of certain types of responses under certain circumstances, and Arizona has been excluding non-responses and inaccurate responses consistent with the approved 2010 plan as it had done in 2004. *Id.* at 19-20, citing Ex. 7, at AZ 122.

Arizona argues that the 2003 Guide does not on its face make clear that CMS would expect Arizona to include all invalid responses and code them as non-Medicaid merely because Arizona's 2004 plan did not include a protocol explicitly allowing for exclusion of non-responses. *Id.* at 9, 15-16. First, Arizona argues, CMS does not cite any authority for determining that Arizona's method was impermissible, does not identify a standard showing that its method produces statistically invalid results, and fails to otherwise explain why Arizona's methodology was insufficient. *Id.* at 16. Second, while Arizona suggests that CMS "implies" that a more explicit explanation for Arizona's methodology might have resulted in CMS's finding Arizona compliant, CMS did not explain what part of Arizona's plan was unclear or what information Arizona could have given to make its explanation more explicit. *Id.* Third, CMS's rationale is "suspect" given that CMS could have disapproved of or questioned the 2004 plan, but did not do so. *Id.* at 16-17. In particular, a CMS analyst merely told Arizona that the 2004 plan "look[ed] good" though CMS had some questions, but CMS never actually raised any question about how Arizona was treating the sample items now in dispute. Ex. 3, at AZ 099 (November 2004 email from CMS to Arizona). Fourth, the 2004 plan's description of how Arizona would treat non-responses was no less explicit than the statement in the approved 2010 plan that "[n]on-responsive moments, moments not returned or not accurately completed and subsequently resubmitted by the school district will not be included in the results unless the return rate for valid moments is less than 85" percent, and no less explicit than provisions in many other states' plans. AZ Br. at 17, quoting Ex. 7, at AZ 122 and citing Appendix 1.

Arizona also contests the OIG's reasoning for its recommendations, while raising no specific disputes about the OIG's audit methods. Arizona first asserts that the OIG made an "unfounded" and "fatally flawed" "assumption" that removing non-responses reduces sample size, in turn resulting in higher statewide Medicaid percentages, which in turn leads to higher reimbursement. *Id.* at 13. Not only does Arizona contend that neither the OIG nor CMS has shown that removing non-responses is *per se* impermissible, it denies that the record contains any proof that the non-responses Arizona allegedly discarded disproportionately represented non-Medicaid services. Contrary to the OIG's view, says Arizona, discarding non-responses or incomplete or inaccurate responses from individuals who provided no Medicaid-related services would have the opposite effect and decrease federal reimbursement. *Id.* Moreover, Arizona says that for the OIG to fault Arizona for not proving that the discarded items were for reimbursable activities is inconsistent with CMS's theory that all non-responses must be coded as non-Medicaid items and ignores that these items were discarded precisely because they lacked complete or accurate information (i.e., they were not "non-responses"). OIG did not explain how Arizona could have sorted such non-responses between Medicaid and non-Medicaid activities or why, if it were indeed possible, OIG did not do so as part of its audit. *Id.* at 14. Lastly, Arizona points out that the 2003 Guide advises, "No completed responses should be deleted or ignored," which, according to Arizona, clearly implied that incomplete forms may be deleted. *Id.*, citing Ex. 1, at AZ 044. CMS relied on the OIG's calculations, but said nothing about whether CMS in fact interpreted its 2003 Guide as described either in 2004 or since then. *Id.* at 15.

2. *Arizona has not shown that it actually interpreted 2003 Guide language to mean that non-responses may be excluded and then reasonably relied on that interpretation to its detriment.*

In general, the Board defers to a federal agency's interpretation of the authorities under which it implements its program as long as the agency's interpretation is reasonable and the non-federal party has had timely and adequate notice of that interpretation or did not rely to its detriment on another reasonable interpretation. *See, e.g., Blackfeet Tribe*, DAB No. 2675, at 11 (2016), citing *Missouri Dept. of Soc. Servs.*, DAB No. 2184, at 2 (2008). Arizona claims that CMS has admitted the instructions in the 2003 Guide about how to handle non-responses were vague. The questions thus posed include whether Arizona actually interpreted the 2003 Guide language to mean that non-responses may be excluded and, if so, whether Arizona reasonably relied on that interpretation (i.e., whether such an interpretation was a reasonable and permissible alternative).

The 2003 Guide states, in part:

> To ensure an adequate number of responses, many schools oversample and/or factor in a non-response rate in their time study methodology. Under this methodology, oversampled responses are sometimes substituted for responses not received. However, oversampled responses should not be substituted for completed responses in which there are no or few reported Medicaid activities in order to increase the Medicaid reimbursable portion of the claim. No completed responses should be deleted or ignored. Another potential problem is employees who are instructed to not complete the time study if they typically do not perform many Medicaid activities. To avoid this, all non-responses should be coded to non-Medicaid time study codes. In addition, codes should be established to fully account for vacations, sick time, lunch hours, and other paid time not at work.

Ex. 1, at AZ 045 (emphasis added). CMS appears to have acknowledged that this language does not say that no non-response may ever be excluded, or that every non-response must be coded as non-Medicaid without fail. Instead, CMS explains, "By not conclusively stating that all non-responses must be coded as non-Medicaid, the Guide recognizes that there could be alternate methodologies to address non-responses that do not require coding them as non-Medicaid." Ex. 11, at AZ 184.

Nevertheless, the underlined sentence certainly articulates that coding non-responses as non-Medicaid is at least an appropriate method of furthering important goals of statistical sampling to calculate federal reimbursement, i.e., to ensure statistical validity, and to safeguard against practices that could skew sampling results and, possibly, result in claims for a federal share to which states may not be fully entitled.[9] In context, CMS could reasonably interpret the underlined sentence to mean that non-responses are to be

[9] Relevant to this point, the 2003 Guide states:

> In the past, federal agencies have generally accepted minimal documentation of time study random moment sampling. However, circumstances under which school-based administrative activities are sampled for purposes of FFP under the Medicaid program differ. In other instances, the costs to be distributed are generally federally reimbursable and the results of the sample only determine the percentage of the costs that are directed to each federal program. In contrast, when sampling is conducted to determine [FFP] under the Medicaid program for the costs of school-based administrative activities, the vast majority of the costs are not federally reimbursable. Therefore, it is critically important for additional documentation to be maintained, in order to verify the appropriateness of the claims in terms of allowability and allocability and to limit the risk of the federal government.

Ex. 1, at AZ 041.

coded as non-Medicaid to minimize the possibility that the federal share calculation could be derived in part on non-Medicaid activities or time without regard to whether the specific situations mentioned (such as oversampling) were present. Moreover, we do not consider the fact that CMS recognized the possibility that some alternative methodologies for handling non-responses (other than coding them all as non-Medicaid) could be acceptable necessarily means that CMS must accept any such state methodology without a showing that the methodology had in some other way addressed the concerns raised by excluding them rather than coding them as non-Medicaid. We therefore are not inclined to view the language as vague as Arizona asserts it is, because the most reasonable reading is that the default, *in general*, is that non-responses should not be excluded.[10]

On this point, we note that the evidence Arizona has offered strongly suggests that Arizona's own contractor interpreted the 2003 Guide language to mean that non-responses are not to be discarded. In its April 22, 2008 letter to Arizona, Maximus included the above-quoted language with the words "all non-responses should be coded to non-Medicaid time study codes" underlined, and stated that Arizona "treats 'non-responses' differently than the CMS Guide requires. In particular, [Arizona] permits the omission of non-responses from the sampling as long as the State obtains a statistically valid number of forms in each quarter." Ex. 4, at AZ 102-AZ 103. Maximus also stated, "Until recently, neither CMS nor [OIG] has made an issue of this. However, in recent reviews of school based Medicaid administrative claiming methodologies in several states, CMS has identified 'non-responses' as an issue that must be addressed consistent with the CMS Guide." *Id.* at AZ 103. Maximus did provide its understanding that the 2003 Guide language was a new requirement instituted in 2000 on which stakeholders had not had an opportunity to comment and suggested that the methodology Arizona was using was consistent with other federal guidance, with which the 2003 Guide language could be viewed as in conflict, but still recommended that, "absent specific approval by CMS to use a different methodology than the methodology described in the CMS Guide, [Arizona] follow the requirements described in the CMS Guide." *Id.* at AZ 103-AZ 104. In response, Arizona commented that "there appears to be some basis for continuing to use the current methodology for addressing non-responses," but agreed to proceed with Maximus's recommendation "to treat non-responses (i.e., instances where an observation for[m] is not returned) as non-Medicaid claimable activities by coding them to non-Medicaid time study codes," but only to do so "prospectively." Ex. 5, at AZ 107.

[10] The 2003 Guide language does not specifically address how to treat incomplete or inaccurate responses. Thus, it would not be reasonable to say that the language is vague as to such responses.

This 2008 exchange between Maximus and Arizona suggests that the impetus for Arizona stopping the exclusion of non-responses was that CMS raised concerns about how states using time study sampling were treating non-responses. It also suggests that Maximus and Arizona believed that there was some basis for excluding non-responses. However, it does not indicate that Arizona (or Maximus) questioned the meaning of the relevant 2003 Guide language at that time or relied on some different understanding of the language than that put forward by CMS. Maximus interpreted it to mean that non-responses are not to be excluded absent CMS approval,[11] and Arizona nowhere disagreed with that interpretation.

Also, it would be unreasonable to interpret the words "all non-responses should be coded to non-Medicaid time study codes" to mean that non-responses (or incomplete or inaccurate responses) indeed may be excluded whenever a state chooses to do so. The apparent purpose of this language, read in context of the full quoted paragraph, is to avoid the possibility that states would discard certain types of responses, such as incomplete responses, for which they know that little or no Medicaid time is associated, or which they have reason to believe are likely to be for non-Medicaid time. Here, excluding non-responses altogether left open the possibility that some of the forms not returned could have been assigned to employees who had little or no Medicaid time, thus skewing the sampling in a way that could favor the state.

In its March 2004 email transmitting its January 2004 draft plan to CMS for approval, Arizona expressly assured CMS that it prepared the plan "in accordance with the CMS May 2003 Guide." Ex. 3, at AZ 100. Nothing indicates that Arizona found the 2003 Guide unclear, or suggests Arizona then had any particular interpretation of the relevant 2003 Guide language. Arizona has not submitted any evidence dated between May 2003 (date of the 2003 Guide) and March 2004 indicating that it considered and interpreted, or questioned as unclear, the 2003 Guide language.

We conclude that Arizona did not in fact rely on a particular interpretation of the 2003 Guide in excluding non-responses without receiving approval from CMS.

[11] The OIG appears to have similarly construed that Arizona's protocol at that time was not consistent with CMS guidance that does not expressly authorize discarding of samples as it said: "[T]he 2004 State guide included incorrect guidance that allowed Maximus to discard sample items." Ex. 9, at AZ 162.

3. *CMS did not unreasonably interpret the 2003 Guide after the fact and then disallow the FFP claimed based on that interpretation.*

We disagree that CMS made an unannounced, after-the-fact interpretation of the 2003 Guide language in 2016. In its 2016 determination, CMS did state that it "expects the state to include all responses in the time study results, and to code invalid responses (including non-responses) as non-Medicaid." Ex. 11, at AZ 184. However, that statement, in context, did not announce some new policy understanding. CMS referenced Arizona's 2004 draft plan, Arizona's representations about discarding non-responses under that plan, and the OIG's earlier adverse findings. *See* Ex. 9, at AZ 175; Ex. 10; Ex. 11, at AZ 184. CMS then said that it understood that Arizona's 2004 plan "did not permit the exclusion of any responses because the plan did not contain a non-response protocol explicitly allowing for such treatment" and, where a state's plan did not include such an explicit protocol, CMS "expects" the state to include non-responses. Ex. 11, at AZ 184. Thus, we construe CMS's statement to simply explain that the inclusion of non-responses is the norm – which is reasonable to say in light of the 2003 Guide language – where no CMS-approved state plan that permits alternative treatment of non-responses is in place.

4. *Arizona discarded responses when the guidance then in effect did not specifically permit such action and without CMS approval and, as a result, could not later prove that the claims were in fact allowable.*

Arizona insists that it acted reasonably in excluding non-responses pursuant to its 2004 plan despite the lack of CMS's approval of that plan as drafted in light of CMS's inaction on the request for approval of that plan. Arizona's argument suggests an erroneous assumption that its ability to submit compliant claims for the period covered by the audit somehow turned on CMS's action, one way or the other, on the 2004 plan. It did not. We reject the assertion that the fault lies with CMS for inaction on the 2004 plan.

As discussed, the 2003 Guide does not generally permit the exclusion of non-responses, though, as we said, a reasonable interpretation of the relevant language therein, particularly in view of the parallel goals of statistical validity and claim integrity, would be that the exclusion of non-responses may be permissible with an approved protocol to support it. As also discussed, Arizona's contractor – which evidently handled all of the claims that were audited – interpreted the 2003 Guide to mean that non-responses were not to be excluded and recommended that Arizona conform to it, and Arizona agreed with that recommendation. Arizona's 2004 plan proposed to exclude certain types of forms that cannot be validated due to missing or inaccurate information, or failure to return the updated form, from the sampling pool. Ex. 2, at AZ 072- AZ 073. Importantly, there is no dispute that CMS never approved the 2004 plan, as drafted. It is also undisputed that, on November 5, 2014, CMS confirmed that it had not approved that plan and that until such time CMS approved it, CMS was relying on Arizona's assurance

that its plan conformed to the 2003 Guide.[12] But Arizona's 2004 plan did not conform to the 2003 Guide because its proposal to exclude certain types of responses considered invalid essentially sought approval to deviate from the general rule of including all responses. The evidence moreover shows that CMS did not approve any plan submitted by Arizona until June 2010, after the audit period.[13] Thus, Arizona's continued exclusion of non-responses for the 2004-2008 claims included in the audit period – which was clearly a conscious choice as shown by Maximus's 2008 letter (Ex. 4) and Arizona's 2008 response (Ex. 5) – was in no way sanctioned by CMS. Arizona has not cited any applicable authority, or approved guidance in effect at the relevant time, that permitted such action.

Arizona argues it acted appropriately in using its own methodology (i.e., applying its interpretation of its own 2004 plan) with respect to the audited claims because the 2003 Guide "permitted states to use alternative methodologies so long as a state submitted a statistically valid plan prior to implementation and CMS ultimately approved it." AZ Br. at 10, citing Ex. 1, AZ 044.[14] Arizona says that, although the 2003 Guide does not require CMS approval of a state plan before implementation, Arizona nevertheless submitted its own plan for approval in March 2004, "months before it intended to submit any claims under the methodology." *Id.*

Arizona's argument wrongly presumes that its use of its own methodology in the absence of CMS action on the 2004 plan was justifiable. We disagree. Arizona does not dispute that CMS must approve a state's plan. CMS never approved Arizona's 2004 plan. Arizona moreover does not take into consideration something fundamental – that the RMTS methodology used, regardless of whether a state drafted it, must be *statistically valid*. The 2003 Guide provides:

---

[12] On November 5, 2014, an individual representing Arizona emailed CMS to ask about the status of review of the 2004 plan. Ex. 3, at AZ 099. Later that day, CMS's representative responded that he had forwarded the guide to the "CO" (presumably, Central Office) and indicated that he himself had not had an opportunity to "review it closely – but other staff indicated it looks good, but they have a few questions." *Id.* He then wrote, "Until such time as we formally approve [Arizona's] plan we are relying on your statement in the transmittal e-mail that says [Arizona's] program was prepared in accordance with the May 2003 CMS Guide." *Id.*

[13] The approved 2010 plan provides, in part, that non-responsive moments, moments not returned or not accurately completed and subsequently resubmitted by the school district will not be included in the results unless the return rate for valid moments is less than 85 percent. Ex. 7, at AZ 122.

[14] Exhibit 1, page AZ 044 (page 40 of the 2003 Guide) does not include specific language that supports what Arizona says about the 2003 Guide, though there is no dispute that CMS permits states to draft their own plans. But CMS approval of a state plan is an entirely different matter.

> Flexibility is afforded, within the bounds of statistical validity. However, *the validity and reliability of the sampling methodology must be acceptable to CMS*. That is, the state must include details of how its time study methodology will be validated.

Ex. 1, at AZ 045 (emphasis added). Since CMS never approved Arizona's 2004 plan, *as drafted*, it is reasonable to infer that CMS had concerns or reservations. Indeed, as noted, when asked for a status of review of the 2004 plan, in November 2004, CMS responded tentatively, and said nothing to indicate approval of the 2004 plan as drafted. Ex. 3, at AZ 099. In this regard, we also note that the version of Arizona's plan that CMS eventually approved in June 2010 was a revised version of the plan, first submitted in October 2008 and resubmitted with revisions on May 3, 2010. AZ Br. at 4. While the approved plan does permit the exclusion of non-responses, it includes specific, and more detailed, language concerning the treatment of non-responses that differs materially from the draft 2004 plan, to ensure a valid sample size. The 2010 plan provides, in part:

> [Arizona] will require an 85% return rate. Non-responsive moments, moments not returned or not accurately completed and subsequently resubmitted . . . will not be included in the results unless the return rate for valid moments is less than 85%. If the return rate of valid moments is less than 85% then, non-returned moments will be included and coded as a non-allowable. To ensure that enough moments are received to have a statistically valid sample, Arizona will over sample at a minimum of fifteen percent (15%) more moments than needed for a valid sample size.

Ex. 7, at AZ 122. This language, approved by CMS, not found in the 2004 plan, strongly suggests that CMS had concerns about a matter relevant to statistical validity that the 2004 plan did not adequately or specifically address.[15]

Arizona further represents that it has been excluding "non-responses and inaccurate responses," as it had in 2004, in accordance with the 2010 plan, implying that despite the lack of CMS approval of the 2004 plan, it effectively complied with the 2010 plan, which was later approved, all along for purposes of the audited 2004-2008 claims. AZ Br. at 19-20. We have reason to question this representation. As noted, Arizona's 2004 plan

[15] On a related point, the 2003 Guide requires that the time study "must reflect all of the time and activities (whether allowable or unallowable under Medicaid) performed by employees participating in the Medicaid administrative claiming program" and "must entail careful documentation of all work performed by certain school staff over a set period of time and is used to identify, measure and allocate the school staff time that is devoted to Medicaid reimbursable activities." Ex. 1, at AZ 012. Generally, excluding forms that were not fully completed for one reason or another (no signature), as the OIG determined Arizona had done, would raise questions about whether that action was consistent with the 2003 Guide's requirement that the study must "capture 100 percent" of time. *Id.*

and its 2010 plan differ materially. The former permits exclusion of forms determined invalid because they cannot be validated, due to missing or inaccurate information, or failure to return the updated form, from the sampling pool. Ex. 2, at AZ 072-AZ 073. The latter requires an 85% return rate to ensure a valid sample size and permits exclusion of certain types of moments unless doing so would yield an invalid sample size (i.e., less than 85% return rate). Ex. 7, at AZ 122. These material differences raise a legitimate, and unanswered, question about whether Arizona in fact treated non-responses for the audited claims in such a way as to ensure a minimum return rate with respect to the 2004-2008 claims as Arizona apparently claims it had, when there is no dispute that the plan that requires an 85% return rate had not been approved until June 2010.[16] Arizona has not produced evidence showing that it has treated non-responses for the 2004-2008 claims consistent with 2010 guidance CMS eventually approved. In any case, in the end, as discussed, with respect to the audited 2004-2008 claims, it is more important that the discarding of non-responses, or inaccurate or incomplete responses, was not sanctioned by the 2003 Guide, nor approved by CMS at the time, and Arizona has not cited any other authority, or guidance approved and in effect during the relevant period, permitting such action.

Lastly, Arizona has made some statements raising questions about whether it actually discarded non-responses (and possibly incomplete and inaccurate responses also) for *all* claims covered by the audit period (January 2004-September 2008). In its May 8, 2008 letter to Maximus agreeing with Maximus's recommendation to treat non-responses as non-Medicaid claimable activities by coding them to non-Medicaid time study codes, written almost five months before the end of the audit period, Arizona stated that it would agree to modify the current methodology "prospectively." Ex. 5, at AZ 107. But elsewhere, Arizona suggested that it modified its methodology even earlier. Ex. 12 (reconsideration request), at AZ 193 (representing that, on Maximus's recommendation, Arizona "immediately changed it methodology, beginning with claims submitted for December 2007" to conform to CMS's "interpretation") and AZ 199 (footnote 2, similar representation). Arizona also stated that it submitted its methodology to CMS on March 23, 2004 "months before any claims were first submitted to CMS using this methodology," which could raise the question whether, in the early part of 2004 (within the audit period), Arizona had *not* excluded certain types of responses. Ultimately, however, we conclude that Arizona has not come forward with any relevant proof that any of the disallowed claims were not, as a factual matter, properly disallowed for improperly excluding non-responses or incomplete or inaccurate responses.

[16] As we said, Appendix 1 appears to be an excerpt from another, larger document. Because Arizona has not submitted the source document itself let alone identified it, we accord it minimal weight. Nonetheless, based on what little information Appendix 1 provides, it appears to indicate that 14 states have plans that require an 85% return rate, which, as a general matter, raises a question about whether CMS has in fact been as inconsistent in its position on how states should treat non-responses as Arizona claims. AZ Br. at 11, 19-20, citing Appendix 1. As discussed, CMS eventually approved Arizona's plan that also includes an "85% return rate" provision.

5. *Arizona's arguments asserting flaws in OIG's reasoning have no merit.*

Arizona asserts that the OIG's rationale that removing non-responses reduces sample size, resulting in higher statewide Medicaid percentages and higher reimbursement, is flawed, and that discarding non-responses or incomplete or inaccurate responses from individuals who provided no Medicaid-related services would have the opposite effect. AZ Br. at 13. Arizona presumes that all of the responses it discarded were of individuals who provided *no* Medicaid services – something it has not proven. That aside, the assertion of flawed OIG reasoning is belied by the plain fact that, here, based on the OIG's findings, removal of non-responses (and incomplete or inaccurate responses) evidently resulted in over-claiming, or higher reimbursement. Arizona has not satisfactorily explained why the OIG's reasoning is nevertheless flawed under these circumstances. Moreover, it is not the OIG's responsibility to show that removing non-responses or incomplete or inaccurate responses per se maximizes Medicaid claims, or to prescribe a workable methodology for Arizona to sort Medicaid responses from non-Medicaid responses. *Id.* at 13, 14; Ex. 1, at AZ 049 (2003 Guide, stating that the school-based administrative claiming program must be supported by a system that is capable of isolating costs directly related to the support of the Medicaid program from all other costs incurred by the school and which the state will claim as administrative costs). Arizona, not the OIG or CMS, must prove that discarding responses did not result in over-claiming of Medicaid reimbursement.

Also with respect to OIG's finding that Arizona improperly discarded incomplete responses, Arizona asserts that the 2003 Guide's statement that "[n]o completed responses should be deleted or ignored" (Ex. 1, at AZ 045) "clearly impl[ied]" that incomplete forms may be deleted. AZ Br. at 14. In context, that statement reasonably may be read simply as an instruction that states should not substitute over-sampled responses for completed responses in which there are no or few reported Medicaid activities so as to possibly increase the federally reimbursable portion. *See* Ex. 1, at AZ 045. Moreover, it is not reasonable to interpret the statement that no completed responses should be deleted or ignored to mean that *in*complete forms may then be freely deleted or ignored.

C. *CMS properly disallowed FFP of $5,421,711 for the first quarter of 2004 and the second quarter of 2005, for failure to maintain required documentation.*

1. *Arizona failed to maintain documentation to substantiate its claims.*

Arizona first asserts that it is not at fault for its (or Maximus's) inability to produce documentation for the two quarters because it had no reason to know that the OIG would audit its claims for Medicaid school-based administrative costs until March 11, 2011, six and seven years, respectively, after the quarters in question, when the documents were no

longer available. AZ Br. at 24-25, citing Ex. 8, AZ 143 (OIG's March 11, 2011 notice of "intention to conduct an audit of Medicaid school-based administrative costs claimed by . . . Arizona"). Arizona says that the OIG's letter dated October 20, 2008 indicated it would review only the Medicaid contingency fee arrangements for school-based administrative costs claimed from January 1, 2004 to June 30, 2008 and, thus, did not indicate that Arizona might need to produce the sampling records. *Id.* at 25, citing Ex. 6; AZ Reply at 9-10 (asserting that, among the list of requested documents attached to the 2008 letter, the only item "even tangentially related to the claims was a request for an Excel file of the *amounts* [Arizona] had claimed in 2004-08").

Arizona also raises alternative arguments about its failure to maintain documents. According to Arizona, it was required to maintain documents for only three years. AZ Br. at 25-26, referring to Ex. 10, AZ 179 (Arizona's March 4, 2013 letter to CMS in response to OIG's audit report, relying on 45 C.F.R. § 92.42(b)(1), (c) in support of its position that it was required to retain documents for three years); *id.* at 26, citing 45 C.F.R. § 75.361. Arizona also charges CMS with wrongly attempting to hold it to an "irrelevant" five-year document retention requirement based on Arizona's "administrative policies" and "contract with Maximus," and "Maximus's own record retention policy," asserting that, if Maximus violated its contract with Arizona to retain documents for five years after the end of a contract, "that is a matter between [Arizona] and Maximus" and as such no contract provision on the retention of documents was "incorporated into any obligation to CMS by any authority CMS has cited." *Id.* at 26.

Arizona's arguments fail. We first reject the argument that the scope of audit as announced in the OIG's October 20, 2008 letter was limited to a review of consultant fee arrangements so as not to have given Arizona any reason to know that it may have to produce documents supporting school-based administrative cost claims. As a recipient of federal funding, Arizona is subject to compliance reviews and therefore may be required to produce such documentation. *See* Act § 1902(a)(27). In its 2008 letter, OIG clearly stated two audit objectives: first, to determine the extent to which Arizona had contracted with consultants to pay contingency fees; second, to examine the "*impact of these arrangements on the submission of improper claims to the Federal Government*." Ex. 6, at AZ 109 (emphasis added). Thus, while the audit apparently began with a focus on review of contingency fee arrangements, the larger audit objective as announced in October 2008 plainly was to determine whether federal funds were properly claimed, thus implicating sampling documents that substantiate the FFP claimed for school-based administrative costs. We note, also, that the list appended to the OIG's 2008 letter included a request for documents worded in such a way that reasonably may be construed to include such sampling documents. *Id.* at AZ 112 ("Quarterly amount claimed by [Arizona] for [FFP] for Medicaid school-based administrative expenditures (in an Excel

file)"). The OIG's March 11, 2011 audit notice (Ex. 8) reinforced the earlier notice of the core audit objective to ascertain whether claims for FFP were properly made, and extended the audit period by one quarter to 19 quarters, i.e., to include the third quarter of 2008.

We also reject Arizona's arguments to the effect that it was not obligated to retain the subject records beyond three years for the reasons set out below.

Pursuant to section 1902(a)(4) of the Act and the implementing regulation at 42 C.F.R. § 431.17(b), Arizona must "maintain or supervise the maintenance of the records necessary for the proper and efficient operation of" their state plans, including "[s]tatistical, fiscal, and other records necessary for reporting and accountability as required by the Secretary." 42 C.F.R. § 431.17(b); *see also id.* § 433.32 (requiring that a state plan must provide that the state Medicaid agency, and, as applicable, local agencies administering the plan, maintain an accounting system and supporting fiscal records to ensure that claims for federal funding comply with applicable requirements) and OMB Circular A-87, App. A, ¶ C.1.j (claims must be "adequately documented"). These basic documentation principles are incorporated into the 2003 Guide. *See* Ex. 1, at AZ 041-AZ 042. Of note, the 2003 Claiming Guide instructs that the state agency is required to "maintain/retain adequate source documentation to support the Medicaid payments for administrative claiming." *Id.* at AZ 041. Thus, there is no question that the sampling records for the two quarters are records subject to applicable documentation maintenance requirements.

Also, applicable here, under 42 C.F.R. § 433.32(b), "[a] State plan must provide that the Medicaid agency and, where applicable, local agencies administering the plan will . . . [r]etain records for 3 years from date of submission of a final expenditure report[.]"[17] In addition, as relevant here, by statute, the state agency must file a claim for FFP "within the two-year period which begins on the first day of the calendar quarter immediately following such calendar quarter." Act § 1132(a); *see also* 45 C.F.R. §§ 95.7 (stating, in part, that the time limit for claiming expenditures made after September 30, 1979 is "within 2 years after the calendar quarter in which the State agency made the expenditure"), 95.19 (exceptions to claiming time limits not shown to be applicable here). The regulations in 45 C.F.R. Part 95, subpart A set out the provisions for when an expenditure is considered to have been made for purposes of determining when the claiming period starts. Notably, under subsection 95.13(d), a state agency's expenditure for administration costs is considered to have been made in the quarter the payment was actually made by the state agency.

[17] We note, however, that under 42 C.F.R. § 433.32(b) and (c) state plans must provide that the state Medicaid agency retain records for three years from the date of submission of a final expenditure report, but also that it retain records beyond that three-year period "if audit findings have not been resolved."

Accordingly, in general, the administrative expenditures for the first quarter of calendar year 2004 and the second quarter of calendar year 2005 are considered to have been made in those quarters. Arizona has not argued, or produced evidence showing, that they were actually made at a different time. The claims for FFP based on the administrative expenditures for those two quarters, then, must have been made within two years after the expenditures, i.e., just after the first quarter of calendar year 2006 and just after the second quarter of calendar year 2007.[18] Arizona has not asserted, or produced evidence, showing that it filed its claims for FFP for those two quarters earlier than those dates. In the absence of such evidence, we assume that it filed the claims for the quarters at the end of the applicable two-year period. Based on the two-year claiming period and applying the three-year records retention provision of 42 C.F.R. § 433.32(b), Arizona should have retained the documentation in question for each of the two quarters through the first quarter of calendar year 2009 and the second quarter of calendar year 2010 (i.e., five years after the quarters), which fell *after* the OIG's October 2008 notice of intent to audit to determine whether FFP was properly claimed. Thus, the documents in question should have been retained and produced on October 30, 2008, the date on which the OIG said it would visit Arizona to conduct an entrance conference to review Arizona's records. *See* Ex. 6, at AZ 109.

We note that, while Arizona takes issue with CMS's position that Arizona should have retained its records for five years based on Arizona's administrative policies, contract with Maximus, and Maximus's own records retention policy, asserting that these items are "irrelevant," AZ Br. at 26, Arizona's own plan as drafted in 2004, which Arizona claims to have reasonably applied, provided that Maximus will retain time study observation records "for a period no less than five (5) years from the claim quarter." Ex. 2, at AZ 078. The CMS-approved plan (2010) stated that documentation must be retained for the "minimum federally required time period" of "three years unless there is an outstanding audit" (citing 42 C.F.R. § 433.32), but also that "[t]he State's requirement is for LEAs to maintain MAC [Medicaid Administrative Claiming] Program documentation for five years or until such time all outstanding audit issues and/or exceptions are resolved." Ex. 7, at AZ 126. Thus, both of Arizona's plans setting out a five-year retention policy evidently took into consideration the two-year period for claiming and the three-year document retention requirement. If Arizona and Maximus were applying its 2004 plan going forward as Arizona represents they were, then, presumably, they should have retained the records for the two quarters through the first quarter of 2009 and the second quarter of 2010 (five years after each "claim quarter"). In

[18] On the issue of the two-year filing limit, the 2003 Guide provides that states should consider the expenditure reporting cycle. "The expenditure is not considered 'filed' until it is received by CMS on the CMS-64 Expenditure Report, which is required to be filed 30 days after the end of a reporting quarter." Ex. 1, at AZ 051.

any case, ultimately, it is Arizona, not Maximus, that bears the burden to maintain documents necessary for substantiating its claims for FFP and, as necessary, to supervise any consultant it retains to perform claiming functions. Therefore, it is irrelevant whether CMS had any involvement in the contract between Arizona and Maximus, or that Maximus, rather than Arizona itself, "lost" the documents to support the claims for the two quarters (AZ Reply at 9).

2. Arizona cites no legal basis that would obligate CMS to reduce the disallowed amount of $5,421,711 for the two quarters in proportion to the amount disallowed for the remaining 17 quarters, and the disallowed amount does not represent a punitive sanction for failure to maintain documentation.

Arizona argues that, even if the disallowance of $5,421,711 were "legally justified, the amount bears no rational relationship to the number of claims that likely would have been disallowed on their merits had the supporting documents been available for review." AZ Br. at 26. It says that, if any amount claimed for the two quarters should be disallowed due to failure to retain documentation of the universe for the claims, that amount at most should be an amount proportional to the percentage of claims disallowed for the 17 quarters for which Arizona did maintain documentation. That is, since the amount disallowed for the 17 quarters was $6,295,139, which Arizona says is 25% of $25,124,111[19] that could have been allowed for the 17 quarters (with documentation), CMS should disallow $1,355,427, which represents 25% of $5,421,711 disallowed for the two quarters (without documentation). *Id.* at 26-28. Arizona avers that disallowing the full $5,421,711 would be an "unreasonable," "unduly punitive," and "substantial" sanction "for losing documents." *Id.* at 26, 28.

Arizona mischaracterizes the disallowance as a punitive sanction for failure to maintain documents. A disallowance of FFP for failure to substantiate the claims is not intended to punish the state agency. The issue is whether federal funds have been properly paid to a claimant in accordance with applicable requirements. *See Ca. Dept. of Health Servs.*, DAB No. 1490, at 12-13 (1994) (rejecting the argument that Medicaid disallowance of FFP for failure to comply with certain federal nursing home reform requirements amounted to a punitive sanction disproportionate to noncompliance); *see also River East Economic Revitalization Corp.*, DAB No. 2087, at 13 (2007) ("A disallowance is a matter of grants management, and is not in the nature of punishment.").

[19] Arizona derived $25,124,111 by subtracting $5,421,711 (amount disallowed for two quarters without documentation), from the total federal share claimed, $30,545,822. AZ Br. at 27.

Arizona's request for reduction of a "punitive" disallowance amount suggests a belief that the disallowance amount is disproportionately high where it has, it says, provided the Medicaid services in question and has submitted reimbursable claims despite its inability to later produce documents related to the two quarters. AZ Br. at 27 ("No one suggests [Arizona] submitted claims it did not believe were properly reimbursable . . . ."), 29 ("no one questions that Medicaid services were provided to eligible children in schools during 2004-08"). However, because a disallowance is not a penalty, questions of excessiveness or proportionality are irrelevant. The disallowance represents CMS's determination that Arizona has not produced the underlying RMTS sample universe records for the two quarters – which Arizona concedes – and therefore has not substantiated its claims for those quarters. In any case, Arizona cites no authority that would obligate CMS to reduce the disallowance amount for the two quarters in proportion to the amount disallowed for the remaining 17 quarters. We are not aware of any such authority.

Arizona suggests that CMS should bear some responsibility for the disallowance based on audit outcomes to the extent that CMS should have or could have identified, but did not identify, irregularities in Arizona's claims at the outset. AZ Br. at 27 ("When it reimbursed the . . . claims, CMS apparently noted nothing deficient or peculiar about the claims from the two quarters in question."), 28 ("CMS should be required to show some reason" why Arizona did not meet requirements "before disallowing them wholesale."). We have already rejected what we construe as Arizona's attempt to disavow its responsibility for substantiating its claims in reliance on an inaccurate understanding of the burden of proof. And, where, as here, the disputed disallowance was based on audit findings, the question is not what CMS could have done at the outset on the claims as then submitted; the question is whether the party claiming federal funds has in fact substantiated the claims where, as here, the audit on which CMS based a disallowance determination found that the claims were not substantiated. Arizona has not carried its burden to show that the audit findings were not substantiated.

Lastly, to the extent that Arizona's request for a reduced disallowance may be construed as a request for equitable relief, the Board has no authority to grant such relief. *Ca. Dept. of Health Care Servs.*, DAB No. 2204, at 9 (2008); *W. Va. Dept. of Health and Human Resources*, DAB No. 2185, at 20 (2008); *see also River East Economic Revitalization Corp.* at 12 ("general claim of 'equity' . . . is not available as a basis for dispensing federal funds").

Conclusion

The Board sustains CMS's determination to disallow $11,716,850.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Susan S. Yim
Presiding Board Member