Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

West Virginia Department of Health and Human Resources
Docket No. A-13-31
Decision No. 2536
September 20, 2013

DECISION

The West Virginia Department of Health and Human Resources (West Virginia or State) appeals a November 21, 2012 determination by the Centers for Medicare & Medicaid Services (CMS) to disallow $22,806,230 in federal financial participation (FFP). The State sought that FFP for payments that its Medicaid program made for certain school-based health services (SBHS) furnished to Medicaid-eligible children during state fiscal years (SFYs) 2001, 2002, and 2003.

West Virginia's Medicaid program pays for SBHS using per-unit rates (*e.g.*, dollars per student encounter) that, in turn, are based on school districts' costs of providing the covered services. Initially, the State's payment rates for SBHS, and corresponding FFP claims for SFYs 2001 through 2003, reflected only the school districts' salary and fringe benefit expenses. Later, the State increased the rates for those years to reflect two additional categories of school district costs ("operating" and "indirect costs"), made additional payments to the school districts based on the rate increases, and claimed FFP for the additional payments.

The basis for CMS's disallowance is a finding by the Department of Health & Human Services (HHS) Office of Inspector General (OIG) that West Virginia violated its approved Medicaid plan by including operating and indirect costs in its calculation of SBHS payment rates. We conclude, however, that the adjustment of SBHS rates for SFYs 2001 through 2003 in order to reflect those costs, and the claiming of FFP based on the adjusted rates, were authorized by West Virginia's Medicaid plan and consistent with the State's reasonable interpretation of that plan. For that reason, we reverse the disallowance in its entirety.

Legal Background

Under Medicaid, a program created under title XIX of the Social Security Act (Act),[1] federal financial assistance is available to states that provide health care to persons with low income and resources. Act §§ 1901, 1902(a)(10); 42 C.F.R. § 430.0. Within constraints established by title XIX (and its corresponding regulations), states that participate in Medicaid have considerable flexibility to determine program eligibility, the scope of covered health benefits, and payment levels for medical services. 42 C.F.R. § 430.0.

In order to participate in Medicaid, a state must have a "State plan" that is approved by the Secretary of Health & Human Services (Secretary). Act § 1901. A State plan is a "comprehensive written statement . . . describing the nature and scope" of a state's Medicaid program and "giving assurance that it will be administered in conformity with the specific requirements of title XIX," the regulations implementing that title, and other "applicable official issuances" of the Secretary. 42 C.F.R. § 430.10. In general, a State plan must specify or describe the healthcare services covered under the state's Medicaid program, the groups of persons eligible for coverage, and "the policy and the methods to be used in setting payment rates for each type" of covered service. *See* Act § 1902(a)(10); 42 C.F.R. §§ 430.12(a), 435.10(b), and 447.201(b) (citation for the quoted passage).

A state with an approved State plan is eligible to receive federal matching funds, also known as FFP, for "medical assistance under the State plan."[2] Act § 1903(a)(1). "Medical assistance" is defined in the Medicaid statute to mean the state's payments for covered "care and services." *Id.* § 1905(a). Medical assistance may include a state's payments for healthcare services provided by public school employees to Medicaid-eligible children. *See Texas Health and Human Servs. Comm.,* DAB No. 2187, at 2 (2008). In order to be eligible for FFP, a state's payments for covered healthcare services

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

[2] Payments for certain services that fall within the definition of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) are eligible for FFP regardless of whether they are specified in the State plan. *See* Act § 1905(r)(5) (providing that the EPSDT benefit covers "[s]uch other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan"). In general, the EPSDT benefit covers comprehensive diagnostic, prevention, and treatment services that are provided to Medicaid-eligible children who are under 21 years of age. Act §§ 1905(a)(4)(B), 1905(r); *Texas Health & Human Servs. Comm.*, DAB No. 2235, at 2-3 (2009).

must be made in accordance with applicable standards, methods, or procedures contained in the State plan. *Texas Health and Human Servs. Comm.*, DAB No. 2404, at 15-17 (2011); *New Jersey Dept. of Human Servs.,* DAB No. 1143, at 5 (1990).

Case Background

As we later explain, this appeal is related to an earlier disallowance appeal decided by the Board in 2011, *West Virginia Dept. of Health & Human Resources*, DAB No. 2365 (2011), *aff'd,* 899 F. Supp.2d 477 (S.D. W.Va. 2012). The facts relevant to both appeals are essentially the same.[3]

In the late 1990s, the State decided that it wanted its Medicaid program to cover certain SBHS for Medicaid-eligible "special needs" students in public schools.[4] WV Ex. 23, ¶ 5; CMS Ex. 8, ¶ 5. Toward that end, the State developed payment rates for each of the seven categories of services that it wanted to cover, rates that were intended to reimburse the schools' "actual cost of providing" the services.[5] WV Ex. 23, ¶¶ 5-6; CMS Ex. 8, ¶¶ 5-6.

The State developed the SBHS rates with the help of the Pacific Health Group (PHG), a private consulting firm, and the West Virginia Department of Education. WV Ex. 23, ¶ 14. At the time, the State's Department of Education did not have a fully functioning cost reporting system in place that was capable of generating complete statewide data on school districts' costs. *Id.*, ¶ 12. In order to estimate school districts' expected costs of providing the covered services, PHG conducted a paper survey of West Virginia school districts to obtain relevant cost (and other) data. CMS Ex. 8, ¶ 6; WV Ex. 4, at 4-5 & App'x A; WV Ex. 23, ¶ 14. The cost data obtained in these surveys consisted of salary and fringe benefit expenses incurred during SFY 1999 for school employees who

[3] In support of its current appeal, the State submitted a May 3, 2013 declaration by Richard Brennan, Coordinator of Program and Revenue Alternatives for the West Virginia Department of Health and Human Resources. WV Ex. 23. CMS submitted a June 22, 2010 declaration by Mr. Brennan which the State submitted for the record in its prior appeal to the Board. CMS Ex. 8 (declaration in Board Docket No. A-10-44).

[4] The special needs students were children who had been found disabled under the Individuals with Disabilities Education Act, 20 U.S.C. § 1400. *See* WV Ex. 23, ¶ 5.

[5] Those seven categories of SBHS were: (1) health needs assessment and treatment planning (triennial assessment); (2) health needs assessment and treatment planning (annual assessment); (3) personal care services (half-day); (4) personal care services (full-day); (5) specialized transportation (vehicle); (6) specialized transportation (aide); and (7) care coordination. CMS Ex. 2, at 10-11. The record indicates that the State's Medicaid program already covered other types of school-based services, including nursing services, psychological evaluations and counseling, and physical, occupational, and speech language therapy. *See* WV Ex. 4, at 3.

performed health-related services for special education students. WV Ex. 23, ¶ 15; CMS Ex. 2, at 6. Based on that data, PHG calculated a statewide-average per-unit payment rate for each of the school-based services that it planned to cover. WV Ex. 23, ¶ 16; WV Ex. 4, at 4-6; CMS Ex. 2, at 6, 10.

In the course of its rate development work, the State consulted with CMS (then known as the Health Care Financing Administration)[6] about the submission of a State plan amendment that would authorize Medicaid coverage of SBHS for special education students. WV Ex. 23, ¶¶ 5-6; WV Ex. 4, at 16. During the consultation process, CMS asked the State for its assurance that payment rates for SBHS would not exceed the school districts' costs of providing the services in question. WV Ex. 23, ¶ 6; WV Ex. 4, at 16.

In February 2000, PHG made a slide presentation to CMS, entitled "Calculation of Final Rates for Special Education Medicaid-Reimbursable Services," which specified the payment rates that the State intended to use for those services (once an appropriate State plan amendment was approved by CMS) and how those rates were calculated.[7] WV Ex. 4; CMS Ex. 1, at 1, 17. One slide outlined various issues that CMS had raised during a November 1999 meeting and indicated that the State would submit an appropriate State plan amendment that would be "drafted in accordance with [CMS] recommendations." WV Ex. 4, at 16.

During the first quarter of 2000, the State submitted a proposed State plan amendment (SPA) to CMS for its approval. WV Ex. 23, ¶ 6. The amendment, designated SPA 00-01, specified the categories of school-based services that the State proposed to cover under its Medicaid program and indicated that payment for those services would be "fee-for-service" using "interim rates" based on "statewide historical costs." WV Ex. 6; *compare* WV Ex. 5 (proposed CMS modification to section 4.19-B) *with* WV Ex. 7 (page 6 of section 4.19-B, setting out approved language for SBHS). After discussing the proposed amendment with State officials and PHG, CMS asked the State to revise it to state that the "costs" used to calculate the payment rates would "not . . . exceed actual, reasonable costs and must be cost settled on an annual basis." WV Ex. 6 (Apr. 28, 2000 mem. of J. Hubik, CMS State Rep. for W. Va., stating that "I [Hubik] requested that the State modify its proposed SPA to require annual cost settlements and to limit reimbursement to actual cost"); WV Ex. 5 (Mar. 14, 2000 email from N. Antlake, DHHR Counsel, to D. Combs, DHHR, discussing J. Hubik's "comments" to the proposed SPA).

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[6] We will refer to the federal Medicaid agency as CMS, regardless of the period being discussed.

[7] Each party submitted a copy of the slide presentation, but the copies are not identical. CMS's version, for example, is missing the fourth page of the presentation, while the State's version is missing the 17th page. *See* WV Ex. 4; CMS Ex. 1.

The State agreed to the modification, and on May 12, 2000, CMS approved the proposed amendment (as modified) with an effective date of January 1, 2000. WV Ex. 7. For each newly covered school-based service, SPA 00-01 indicated that "reimbursement" – that is, payment to the school district – would be made as follows:

> Reimbursement . . . shall be fee-for-service. Reimbursement interim rates are based on statewide historical costs for [each service]. . . . Costs not to exceed actual, reasonable costs and must be cost settled on an annual basis.

WV Ex. 7 (Att. 4.19-B, pages 14 ("School Health Services – Specialty Transportation") and 6 ("Personal Care," "Health Needs Assessment and Treatment Planning," and "Care Coordination")).

Using interim SBHS rates that reflected only salary and fringe benefit costs ,the State paid its school districts for covered SBHS furnished between January 1, 2000 and June 30, 2003 (SFYs 2001 through 2003). *See* WV Ex. 20, at 2; WV Br. at 5-6. The State also claimed and received $33,599,094 in FFP for the SBHS payments that it made based on the February 2000 rates. CMS Ex. 2, at 21 (total under "Original Paid" column); WV Ex. 20, at 2.

During 2003, the State began the process of conducting final settlements of SBHS costs for the fiscal years at issue in this appeal. WV Ex. 23, ¶ 17; WV Br. at 5-6. For that purpose (and others), the State relied on the work of another private consulting firm, the Public Consulting Group, Inc. (PCG). [8] WV Ex. 23, ¶ 18. PCG reviewed the rate development work that preceded the approval of SPA 00-01 and determined that the interim rates (developed based only on the survey data for salary and fringe benefits) did not reflect two categories of school district costs – operating costs and indirect costs[9] – that were, according to PCG, generally "allowable" under Office of Management and Budget (OMB) Circular A-87.[10] CMS Ex. 2, at 3-4, 6. PCG concluded that the exclusion of operating and indirect costs from the payment rate calculations had resulted in school districts receiving reimbursement that was less than their "actual" or "full" costs of

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[8] Evidence in the record indicates that the State "had a contract with PCG that enabled DHHR to use PCG for a range of tasks in the federal reimbursement programs, including several projects that involved technical capability or resources that DHHR did not have in-house" and that the settlement of SBHS costs "fell within the broad scope of work under the PCG contract." WV Ex. 23, ¶ 18.

[9] As used here, the term "operating costs" includes expenses for supplies, rent, maintenance and repair, and related capital and debt service costs; "indirect" costs are those incurred for a joint purpose or objective, such as centralized administrative or business support. WV Ex. 23, ¶ 8; WV Ex. 20, at 5-6.

[10] OMB Circular A-87, which is codified in the Code of Federal Regulations, sets forth general principles for determining costs that are eligible for federal funding under federal grants, contracts, and other awards. 2 C.F.R. Part 225, App. A, ¶ A.1.

providing covered SBHS. *Id.* According to the State, the West Virginia Education Information System (WVEIS), a cost reporting and tracking system, was not fully capable of generating complete and accurate statewide cost data until 2002. Consequently, only after that point, did the State have actual data on the full range of costs incurred. WV Br. at 5-7 (and record citations therein). Using this data on actual costs, PCG recalculated the February 2000 rates to include operating and indirect costs (as well as updated salary and fringe benefit data),[11] a process that yielded higher rates for all seven categories of SBHS specified in SPA 00-01. *Id.* at 7-8 (¶¶ 6-7); WV Ex. 20, at 2-3. PCG also recommended that the State make "retroactive payments" to the school districts for SFYs 2001 through 2003 based on the "revised" rates and claim FFP for those payments. CMS Ex. 2, at 9.

In accordance with PCG's recommendation, the State made additional payments to the school districts based on what it called its "final" SBHS rates for SFYs 2001 through 2003 – that is, the rates "developed based on the WVEIS data on actual costs, including operating and indirect costs, as well as updated salary and fringe benefit costs." WV Ex. 23, ¶ 7; WV Br. at 6-7. In September 2003 and May 2005, the State submitted "supplemental" FFP claims for those payments. WV Ex. 20, at 2; WV Br. at 6-7. The total amount of supplemental FFP claimed for SFYs 2001 through 2003 based on the final SBHS rates was $39,413,198. WV Ex. 20, at 2.

In 2005, the OIG initiated an audit that led to the issuance of two reports concerning the September 2003 and May 2005 supplemental FFP claims. *See* WV Br. at 7-12 (and exhibits cited therein). The issue addressed in the first report was whether FFP claimed for SFY 2001 should be disallowed on the ground that the State had failed to comply with the two-year timely claims rule in section 1132(a) of the Act. WV Ex. 17, at 2.

Section 1132(a) requires that an FFP claim for state expenditures be filed within two years after the quarter in which the expenditures are made but also provides for certain exceptions to that rule, including one for an "adjustment to prior year costs." The OIG concluded that approximately $2.5 million in FFP should be disallowed for SFY 2001 because the claim for that amount was untimely under section 1132(a) and did not represent or reflect an adjustment to prior year costs meeting the statutory exception. WV Ex. 17, at 5. CMS concurred with that conclusion and disallowed $2,298,329 for the period October 1, 2000 through June 30, 2001. DAB No. 2365, at 6. The State appealed, and the Board sustained the disallowance, indicating that the "sole question" before it was whether an "adjustment to interim payment rates for SBHS to include the overhead and indirect costs of providing those services" constituted an adjustment to prior year costs. *Id.* at 13.

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[11] PCG proposed other adjustments to the SBHS rate calculations that are not at issue in this appeal. *See* CMS Ex. 2, at 6-7.

The second OIG report, issued in 2011, led to the disallowance being contested in this appeal. The issue addressed in that report was whether West Virginia's Medicaid plan permitted the supplemental FFP claims filed by the State in September 2003 and May 2005. WV Ex. 20, at 3. Noting that "[f]or 3 years, from July 1, 2000 through June 30, 2003, [West Virginia] received Federal funding [for SBHS] based on claims submitted using reimbursement rates based solely on salaries and fringe benefits," the OIG found that the inclusion of operating and indirect costs in the calculation of "revised" payment rates for those years violated the State plan "as interpreted by the State and approved by CMS." *Id.* at 5.

In accordance with that finding, the OIG recalculated the SBHS rates supporting the September 2003 and May 2005 FFP claims by removing operating and indirect costs from the cost pools upon which the rates were based. WV Ex. 20, at 4, 5-6. Applying its recalculated rates to the units of SBHS claimed by the State for SFYs 2001 through 2003, the OIG concluded that the federal government had improperly provided $22,806,230 in FFP for SBHS for those years and recommended that CMS disallow that amount.[12] *Id.* at 4, 6. CMS concurred and, in November 2012, issued a disallowance of $22,806,230 in FFP for the period October 1, 2001 through September 30, 2003. WV Ex. 21.

The State then filed this appeal. It argues that the State plan permitted adjustment of the "interim" SBHS rates to reflect operating and indirect costs. WV Br. at 16-17, 17-21. "So long as the adjustments were timely made and did not result in reimbursement that exceeded 'actual, reasonable costs' of providing SBHS," says the State, it "had discretion to include cost components not included in its interim rates [such as operating and indirect costs] when it conducted the final cost settlements." *Id.* at 18. The State submits that the "decision to include operating and indirect costs when it performed final settlements of its initial interim SBHS rates" is consistent with its interpretation and application of its State plan as well as with OMB Circular A-87, CMS policy, and Board precedent. *Id.* at 21-26, 26-30.

CMS responds that the content of the February 2000 slide presentation, coupled with the State's use of only salaries and fringe benefits in its interim rates used to claim FFP for SFYs 2001 through 2003, show that the State interpreted its Medicaid plan as allowing only salary and fringe benefit costs to be considered in setting or adjusting SBHS rates. Response Br. at 11-13, 17, 19-23. CMS also contends that the inclusion of operating and indirect costs in the SBHS rate calculations constituted a material change to the approved payment methodology in SPA 00-01 and that federal Medicaid regulations required the

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[12] This amount does not include the $2.3 million in FFP that CMS ultimately disallowed for SFY 2001 based on the State's failure to comply with the two-year rule in section 1132(a). *See* WV Ex. 20, at 3 (indicating that the OIG examined federal reimbursement totaling $70,713,963, an amount that excluded $2,298,329 in FFP that the OIG had recommended disallowing in its prior audit report).

State to amend the State plan in order to implement that change and claim FFP based on it. *Id.* at 15-16. In addition, CMS argues that the factual circumstances here are "indistinguishable" from those in *Colorado Dept. of Health Care and Policy Financing*, DAB No. 2057 (2006), a decision in which the Board sustained a disallowance of "retroactive" FFP claims for SBHS. *Id.* at 2-3, 17-19. Finally, CMS asserts that findings by the Board in the State's prior (2011) disallowance appeal preclude any decision in favor of the State in this appeal. *Id.* at 13-14, 24. For the reasons discussed below, we find CMS's arguments to be without merit.

Discussion

West Virginia is eligible for FFP in its payments for SBHS only if those payments were made in accordance with the standards, methods, and procedures specified in its approved Medicaid plan.[13] In view of that limitation and CMS's stated justification for the disallowance, there are two key, interrelated questions in this appeal. First, did the State plan permit the State to calculate SBHS payment rates based on school districts' operating and indirect costs (in addition to the districts' salary and fringe benefit costs)? Second, assuming the answer to the first question is yes, did SPA 00-01 authorize the State to adjust the final SBHS rates in order to account for operating and indirect costs after making interim payments that did not include them and to make supplemental payments based on the adjusted rates for SFYs 2001, 2002, and 2003?

SPA 00-01, the governing State plan provision, does not directly address either issue. However, by its plain terms, SPA 00-01 does clearly authorize a retrospective payment methodology: the amendment says that, for a given quarter, West Virginia will pay school districts for SBHS based on "interim" (or provisional) rates reflecting "statewide historical" costs, then perform a cost settlement in order to determine final rates for the quarter. *See* DAB No. 2365, at 2-3, 4. The amendment does not prescribe a particular formula for calculating SBHS rates, nor does it specify the categories of costs that may or must be included in a payment rate calculation. SPA 00-01 merely requires that the costs reflected in a payment rate be actually incurred by school districts to deliver SBHS and be "reasonable." Furthermore, SPA 00-01 does not (with one immaterial exception[14])

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[13] *See* Act § 1903(a)(1) (making FFP available for "medical assistance *under the State plan*" (italics added)); 42 C.F.R. §§ 430.10 (providing that the State plan is the basis for FFP in a state's Medicaid program) and 447.201(b) (requiring that the State plan specify the methods used to set payment rates for covered services); *Massachusetts Dept. of Public Welfare*, DAB No. 867 (1987) ("states must follow the methods and standards set out in their state plans for all facilities to obtain FFP"); *Louisiana Dept. of Health and Hospitals*, DAB No. 2350, at 7 (stating that the Medicaid statute and regulations "make FFP available only in payments made according to the approved methodology" set out in the State plan).

[14] The only limitation imposed by SPA 00-01 on cost settlement is a requirement that settlement be performed on an "annual basis." Because CMS does not cite this requirement as a basis for the disallowance, we need not discuss it further.

describe or limit the scope of the cost settlement process. For example, the amendment does not say that final rates may reflect only the categories of costs used to calculate the interim rates. SPA 00-01 merely instructs the State to "cost settle" its SBHS rates using "actual" and "reasonable" costs.

When a State plan is ambiguous or silent about an issue, the Board ordinarily defers to a state's *reasonable* interpretation of the plan.[15] In deciding whether a state's interpretation of a State plan provision is reasonable, the Board has articulated the following guidelines:

> . . . [T]he Board will consider whether the state's proposed interpretation gives reasonable effect to the language of the plan as a whole. The Board will also consider the intent of the provision. A state's interpretation cannot prevail unless it is reasonable in light of the purpose of the provision and program requirements. Lacking any documentary, contemporaneous evidence of intent, the Board may consider consistent administrative practice as evidence of intent. The importance of administrative practice is in part determining whether the state in fact was applying an official interpretation of a plan provision or has advanced an interpretation only as an after-the-fact attempt to justify acting inconsistently with or simply ignoring its plan.

South Dakota Dept. of Social Services, DAB No. 934, at 4 (1988); *see also Texas Health and Human Resources Comm.*, DAB No. 2404, at 17-18 (quoting and relying on *South Dakota*). "The Board developed this approach [to analyzing State plan ambiguity] for circumstances in which a state has flexibility in what state plan provisions to adopt, particularly with respect to reimbursement methodologies." *Louisiana Dept. of Health and Hospitals*, DAB No. 2350, at 9 (2010).

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[15] *Texas Health and Human Resources Comm.*, DAB No. 2404, at 17 (the "the Board ordinarily defers to a state's *reasonable* interpretation of ambiguous State Plan language" (italics in original)); *New Jersey Dept. of Human Resources*, DAB No. 2107, at 6 (2007) (the Board "generally defer[s] to the state's interpretation of the plan's language if that interpretation is reasonable, 'gives effect to the language of the plan as a whole, and is supported by evidence of consistent administrative practice'" (*quoting Colorado Dept. of Health Care and Policy Financing*, DAB No. 2057, at 10)); *Kansas Health Policy Authority*, DAB No. 2255, at 18 (2009) (deference is accorded to a state's interpretation of its Medicaid plan "so long as that interpretation is an official interpretation and is reasonable in light of the language of the plan as a whole and the applicable federal requirements"); *Louisiana Dept. of Health and Hospitals*, DAB No. 1542 (1995) (when a federally approved state plan "does not specify any particular method for calculating" payment rate amounts or adjustments, "any *reasonable* method should be acceptable" (italics added)), *aff'd*, *Louisiana Dept. of Health & Hospitals v. HHS*, No. 96-441 (AET) (D. N.J. Feb. 11, 1997).

The State asserts that it has always interpreted SPA 00-01 as (1) authorizing payment for SBHS based on school districts' operating and indirect costs and (2) permitting a retrospective adjustment of SBHS rates to include such costs. The amendment's text does not rule out either element of that interpretation. Regarding the first element, SPA 00-01 does not, as we earlier noted, specify the categories of costs that may (or must) be reflected in the rates. The amendment states that costs must be "actual" and "reasonable," but neither of those limitations excludes operating and indirect costs by definition or implication. Including operating and indirect costs is consistent with federal cost principles for grants to state and local governments in OMB Circular A-87.[16] *See* 2 C.F.R. Part 225, Att. B, ¶¶ 25, 26, & 37 (identifying various cost items as allowable, including "[m]aterials and supplies," building and equipment rental, and maintenance and repair) & Att. A, ¶ D.1 (indicating that that the "total cost" of a federal award includes "an allocable portion of allowable indirect costs"); *cf. Medicare Provider Reimbursement Manual,* CMS Pub. 15-1 (setting out principles of "reasonable cost" reimbursement for the Medicare program and defining "reasonable cost" in section 2102.1 (of Part 1) as "tak[ing] into account both direct and indirect costs of providers of services" and further stating that the "intent of the [Medicare] program" is that "providers are reimbursed the actual costs of providing high quality care"). Furthermore, the State introduced evidence, not rebutted by CMS, that its interpretation of SPA 00-01 is consistent with its interpretation or implementation of other (non-SBHS) cost-based payment provisions to capture a Medicaid provider's *total* actual costs of providing a service. *See* WV Ex. 23, ¶¶ 8-11 (stating that "[i]t has always been [the State's] practice to capture full allowable incurred costs, including operating and indirect costs, during cost settlement in order to reimburse the total, actual costs of providing Medicaid services that are reimbursed on a cost basis"). The State's cost reimbursement practices in these other areas support the State's interpretation of the cost-based reimbursement provision in SPA 00-01. *Cf. New York Dept. of Social Servs.*, DAB No. 151, at 7, 9 (1981) (holding that it was "appropriate to look to relevant State law and practices" to assess the reasonableness of the State's view about whether the State plan permitted a "fee schedule" to be adjusted retroactively in order to recognize categories of costs that had been omitted from the original fee schedule amounts).

As for the second element of the State's interpretation, it is consistent with the retrospective rate methodology authorized by SPA 00-01, which permits retroactive adjustment of SBHS rates but places no limit in the scope of the adjustment (other than that supporting costs be "actual" and "reasonable"). The "cost settlement" language in

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[16] CMS does not dispute that operating and indirect costs reflected in the State's payments for SBHS for SFYs 2001 through 2003 were actually incurred to provide those services, nor does it contend that those costs were not "reasonable" under applicable principles for determining allowable costs.

SPA 00-01 was included at CMS's insistence, yet CMS failed to produce contemporaneous evidence that the language's intended meaning is anything other than what the State contends it means. CMS has also failed to establish that the State violated any accepted cost settlement principles in determining final SBHS payment rates.

Not only is the State's interpretation consistent with applicable State plan language, it is reasonable in light of the circumstances surrounding the development and use of the initial interim rates. The State presented unrebutted evidence that it had always intended to base its SBHS rates on *total* statewide costs of providing SBHS, an intention that is not inconsistent with the amendment's open-ended language (permitting the inclusion of costs "not to exceed" actual and reasonable costs) and with the State's administration of other cost-based payment methodologies. *See* WV Ex. 23, ¶¶ 9-10, 12. However, when the State developed the initial interim rates, it did not have "historical cost experience" regarding any of the school-based services that it intended to cover under SPA 00-01. CMS Ex. 8, ¶ 6; WV Ex. 4, at 4 (indicating that the rates reflected "data for which reimbursement occurs today"). Not until late 2002 or 2003 did the State have a management information system in place (namely, the WVEIS) that was capable of "extract[ing] the necessary elements to determine total SBHS costs and develop rates that reflected total costs." WV Ex. 23, ¶ 12. Only then was the State able to obtain complete and reliable cost data relevant to the services covered by SPA 00-01. Under these circumstances, the State was not unreasonable in waiting until it had amassed adequate cost experience with respect to the newly covered SBHS before attempting to incorporate operating and indirect costs into the applicable payment rates.

It is true that the State did not include any estimate or placeholder to reflect future inclusion of operating and indirect costs in developing the initial interim rates. The State explains that the absence of prior experience and data in 1999 and 2000, and an abundance of caution in avoiding any excess interim payments that might lead to a disallowance later, let it to"conservatively" calculate its initial interim rates (*see* WV Ex. 23, ¶ 7). This approach had the effect of causing the rates to understate total actual costs , but we do not view this decision as evidencing a commitment by the State not to include total actual costs in calculating reimbursement rates as it generally does in implementing other cost-based reimbursement methodologies once the relevant data became available.

In *New York Department of Social Services*, the Board considered whether Medicaid payments to publicly operated intermediate care facilities for the mentally retarded (ICF/MRs) – payments based on an annual "fee schedule" – could be retroactively increased in order to account for types of costs that were not included in the calculation of the fee schedule payment rates (as well as to correct for an annual six-month lag in applying newly established fee schedule rates). DAB No. 151, at 4-6. In accordance with New York law, fee schedule amounts were intended to capture "the actual costs incurred" by ICF/MRs to provide their Medicaid-covered services. *Id.* at 7. New York explained, however, that its fee schedules for ICF/MR were developed using cost

estimates and projections of service utilization rather than "actual allowable costs and actual patient days." *Id.* at 7. During the relevant period, New York had a statute which required that fee schedules be based "on the costs of services, care, treatment, maintenance, overhead, and administration" and authorized the relevant state agency to establish rates "which assure maximum recovery of such costs." *Id.* at 3. New York's State plan did not indicate whether retroactive payment adjustments were permitted; it merely stipulated that the method of reimbursement for ICF/MRs would be a "fee schedule." *Id.* at 2. The Board concluded that there was nothing in federal or state law or in the record that "exclude[d] the possibility of retroactive adjustment" of fee schedule amounts, and it further found that "given the State statutory requirements," it would be "illogical to assume that the State would deliberately set up a reimbursement methodology that would not capture all possible allowable costs." *Id.* at 7, 9.

Like New York's fee schedule payment system for ICF/MRs, SPA 00-01 contemplated that providers (that is, school districts) would ultimately receive reimbursement for Medicaid-covered services based upon the actual costs incurred to provide those services. And while New York had a statute that permitted the relevant state agency to establish fee schedule payments that assured "maximum recovery" of costs, West Virginia had – and still has – a statute (enacted in 1990) that *requires* it to "maximize federal reimbursement" for the Medicaid-covered services in question, W.Va. Code § 18-2-5b(a),[17] and that also requires the creation of a "school health services advisory committee" whose mission is to advise the State on ways "to ensure that the school-based medicaid service providers bill for and receive "*all the medicaid reimbursement to which they are entitled*," *id.* § 18-2-5b(b) (italics added). Finally, like New York, West Virginia did not have complete, reliable cost information when it initially set payment rates for the covered services and was able to acquire that information only after providers had actually incurred costs to provide the services. For these reasons, we find that the State acted reasonably to include previously unidentified – but otherwise allowable – categories of costs in its final SBHS rates, just as the Board found New York reasonably made retroactive adjustments to account for costs not reflected in its fee schedules.

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[17] Section 18-2-5b(a) of the West Virginia code provides:

> The state board [of education] shall become a medicaid provider and seek out medicaid eligible students for the purpose of providing medicaid and related services to students eligible under the medicaid program and to maximize federal reimbursement for all services available under the Omnibus Budget Reconciliation Act of one thousand nine hundred eighty-nine [Pub. L. No. 101-239], as it relates to medicaid expansion and any future expansions in the medicaid program for medicaid and related services for which state dollars are or will be expended[.]

Among other things, the 1989 federal law cited in this provision strengthened the Medicaid coverage available to children under the EPSDT benefit. Pub. L. No. 101-239, § 6403, 103 Stat. 2262 (1989).

In short, we conclude that the State's interpretation of SPA 00-01 is reasonable and entitled to deference and reject CMS's arguments to the contrary. CMS asserts that its approval of SPA 00-01 was "based on the SBHS methodology West Virginia had submitted to CMS" in its February 2000 slide presentation. Response Br. at 12. Pointing to the title of the presentation ("Calculation of Final Rates for Special Education Medicaid Reimbursable Services"), CMS asserts that the State identified its "final" SBHS rates – rates that reflected only salaries and fringe benefits – then made payments and claimed FFP based on those rates for almost three years afterward. *Id.* According to CMS, the February 2000 presentation and use of the rates consistent with that presentation as initial interim rates "are evidence that West Virginia historically interpreted its State Plan to include only the costs of salaries and fringe benefits for SBHS." *Id.* CMS asserts that the State's current interpretation of SPA 00-01 is inconsistent with that historical interpretation and for that reason deserves no deference. *Id.* at 18.

The trouble with this argument is that, notwithstanding the use of the word "final" in the slide presentation's title, the February 2000 rates were not, in fact, "final" under the State plan. CMS approved SPA 00-01 shortly after the slide presentation, but the actual language of the state plan amendment does not use the word "final" or refer to any specific formula for setting final rates. Furthermore, the slide presentation itself states that the analysis done for rate development was limited but that "any refinement of existing rates will occur in the next phase of the project." WV Ex. 4, at 4. Thus, CMS could not have concluded that no further changes could occur. Instead, the amendment plainly indicates that, for a given cost period, the State would initially pay for SBHS services based on "interim" rates subject to retrospective adjustment. Although SPA 00-01 may have been unclear about the nature and scope of the State's cost settlement authority, the State retained considerable discretion and flexibility to decide how to finalize its SBHS payment rates for SFYs 2001 through 2003 and what types of costs to include in calculating those rates. The actions taken by the State in 2003 in response to PCG's recommendation represented the State's **initial** exercise of that discretion based on actual cost experience for the seven school-based services covered by SPA 00-01. Therefore, we agree with the State that the most relevant evidence of the State's understanding or interpretation of SPA 00-01 are its efforts in 2003 and 2005 to finalize SBHS rates for SFYs 2001 through 2003. *Cf. Texas Health and Human Servs. Comm.*, DAB No. 2176, at 11 (stating that "a state does not violate or act inconsistently with its state plan merely because it exercises discretion conferred by the plan"). Focusing on the State's actual cost settlement practices during those years is appropriate because "[u]nder a retrospective system, . . . what is ultimately considered expended in accordance with the state plan . . . is determined by the state plan rate-setting methodology for establishing final rates." *District of Columbia Dept. of Human Servs.*, DAB No. 1617, at 27 n.12 (1997).

There is no dispute that, from the first determination of final rates under SPA 00-01, the State incorporated operating and indirect costs into the SBHS rate calculations, that the interim rates established thereafter consistently included those costs and that the actual amounts of those costs were included in reconciliation of all subsequent final cost settlements. WV Ex. 23, ¶¶ 19-20, 24. These circumstances constitute relevant evidence of the State's historical interpretation of SPA 00-01. Thus, we reject CMS's contention that the payment rate adjustments to include those costs for SFYs 2001 through 2003 were inconsistent with that interpretation.

CMS asserts that the retrospective adjustments of the SBHS rates for SFYs 2001 through 2003 were not, in fact, "cost settlements" reflecting "the difference between estimates and settled actual costs" but, rather, an "attempt to add two entirely new categories of costs – operating and indirect costs – at the direction of PCG outside of the annual cost settlement process."[18] Response Br. at 20. However, the State plan is silent about how the final "cost-settled" rates would be calculated, and CMS presented no evidence that the State's cost settlement process deviated from some normal or typical process for settling costs of school-based providers. We also agree with the State that "[t]he non-restrictive language of the State Plan is broad enough to encompass a cost settlement process that updates SBHS rates to include cost information," such as the cost data relating to the newly covered school-based services, "that was not readily available when interim rates were developed." Reply Br. at 15. The initial interim rates were based purely on cost estimates not derived from any actual or historical cost experience relating to the services covered by SPA 00-01. In contrast, the rate adjustments proposed by PCG and implemented in 2003 were based on actual cost experience (from SFY 2001) relating to those covered services.

CMS contends that the Board "specifically found" in the State's prior disallowance appeal "that the adjustments at issue here were not consistent with the concept of 'cost settlement' as that term is usually understood'" and were "inconsistent with" and "not contemplated by" the payment methodology laid out in SPA 00-01. Response Br. at 10-11, 13-14, 20 (*quoting* DAB No. 2365, at 8). CMS asserts that these prior findings "largely determine[ ] the ultimate issue in the instant case . . . ." *Id.* at 10-11. We find this argument to be without merit. The Board's previous findings were made in support of its resolution of an entirely different legal issue. The "sole question before [the Board]" in the State's prior appeal was whether a disallowed FFP claim based on an adjustment to the State's **interim** SBHS rates to include additional estimated costs met the regulatory definition of an "adjustment to prior year costs," and, therefore, fell within an exception to the timely claims provision. DAB No. 2365, at 6. The Board has held

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[18] We see no significance in the role that PCG played in the cost settlement process. The validity of the adjustments stands or falls on the reasonableness of the State's interpretation of SPA 00-01 and whether the actions and calculations supporting the supplemental FFP claims are consistent with that interpretation.

that, to constitute an "adjustment to prior year costs" for purposes of the exception, an adjustment must be consistent with the state plan methods and procedures for determining rates. The untimely adjustments to the interim SBHS rates did not meet that test. The State did not show that that the concept of "cost settlement" in its State plan would have put CMS on notice that entirely new categories of costs excluded from the interim rates might be added to the calculation of rates years later. Such a difference in how rates are calculated is not merely the unavoidable consequence of making interim payments based on estimates that must later be reconciled when actual costs are calculated.

In contrast, the dispositive legal issue in this case is whether the State could, consistent with a reasonable interpretation of its state plan, revise the costs included in its rate calculations based on its evolving experience and collection of actual cost data. What is significant here is that the State included the actual operating and indirect costs the first time the State calculated any final SBHS rates based on actual costs from the relevant cost reporting period. While the change in the categories of costs on which the rate is calculated was not merely an inevitable part of the usual cost settlement process for retroactive payment systems nor expressly contemplated in the state plan language, we do not find anything in the state plan that precluded the state from making such a change going forward. The fact that it did make this change from its first opportunity and did so consistently in all its later rate calculations convinces us that the change reflected a reasonable interpretation of the state plan. Also, the State timely claimed the expenditures resulting from the corresponding adjustments to the interim rates for later periods, so it did not need to show that an exception to the timely claims provisions applied.

We also find CMS's contention that this case is factually indistinguishable from the circumstances in *Colorado Department of Health Care and Policy Financing* to be without merit. In that case, CMS approved a 1997 State plan amendment which stated that SBHS payment rates would be determined "according to Department formula." DAB No. 2057, at 3. The amendment did not specify the formula, but two years later, in a September 10, 1999 letter, Colorado's Medicaid agency proposed a formula and asked CMS to approve it. *Id.* Although the formula was never approved by CMS or incorporated into Colorado's Medicaid plan, Colorado continued to use the formula for the next four to five years to calculate its Medicaid payment rates for SBHS. *Id.* at 3-5, 13. Then, in 2005, the state Medicaid agency unilaterally made various changes to the formula, such as "including additional costs and changing some of the algebraic processes." *Id.* at 4, 10. Based on those changes, Colorado recalculated its SBHS payment rates for 2003 and 2004 and submitted FFP claims for the additional payments that resulted from the rate recalculations. *Id.* at 4. CMS disallowed those claims, and the Board upheld the disallowance. *Id.* at 4-6. The Board found that the formula that Colorado had proposed in September 1999, coupled with the use of that formula to claim FFP for SBHS, were "evidence of Colorado's historical interpretation and application of"

the 1997 State plan amendment. *Id.* at 6. The Board also found that the "retroactive" FFP claims for 2003 and 2004 were "based on a methodology . . . not described in the" 1997 State plan amendment, were "not consistent with Colorado's interpretation" of the amendment, and were unallowable for those reasons.[19] *Id.* at 9.

A material difference between *Colorado* and the appeal now before us is that unlike the State plan amendment in Colorado, SPA 00-01 established a retrospective payment methodology that expressly authorized SBHS payment rate adjustments based on more complete data about actual costs. In *Colorado,* the disallowance and the Board's decision were based in part on the fact that the relevant State plan amendment did not provide for retrospective adjustment of SBHS payment rates. DAB No. 2057, at 5, 16. Another important difference is that, unlike Colorado, West Virginia did not deviate from a specific rate formula that it identified as the State-plan-authorized payment methodology. The State plan amendment in *Colorado* expressly stated that SBHS rates would be calculated according to a "formula" which Colorado would (and did) later specify. SPA 00-01, on the other hand, did not specify or even refer to a "formula" for calculating SBHS costs; it merely stated that SBHS would be paid under an interim rate that would be later be subject to retrospective adjustment during a cost settlement process whose contours were left to the State to define. For these reasons, we conclude that *Colorado* does not dictate the outcome here.

Finally, CMS contends that the inclusion of operating and indirect costs in the calculation of SBHS payment rates for SFYs 2001 through 2003 constituted a "material modification" to the SBHS rate methodology that required amendment of the State plan in order to become effective. Response Br. at 15-16. In support of that assertion, CMS relies on 42 C.F.R. § 430.12(c)(ii), which says that a State plan "must provide that it will be amended whenever necessary to reflect . . . [m]aterial changes in State law, organization, or policy, or in the State's operation of the Medicaid program." *Id.*

We disagree that the State was obligated to amend its State plan to permit the inclusion of operating and indirect costs in its SBHS rates. SPA 00-01 expressly authorized the State to finalize its cost-based "interim" rates, subject only to the requirements that the rates be based on "actual" and "reasonable" costs. The recalculation of SBHS rates to include operating and indirect costs was part of the State's effort to finalize those rates for SFYs 2001 through 2003 to reflect the actual costs incurred. We have concluded that the State's implementation of its cost settlement authority for those years constituted its

[19] The Board stated that it gave no deference to Colorado's interpretation of the 1997 State plan amendment as permitting the 2005 revisions to the SBHS rate methodology because the interpretation was, in the Board's view, inconsistent with Colorado's "prior interpretation" of the amendment "as evidenced by its letter of September 10, 1999 and its prior administrative practice" of applying the formula specified in that letter. DAB No. 2057, at 10.

historical interpretation of SPA 00-01. Because the disputed rate recalculations do not violate the express terms of SPA 00-01 and are consistent with the State's reasonable interpretation of that amendment, they cannot fairly be characterized as a "material change" in State law, organization, policy, or program operation.

Conclusion

For the reasons discussed above, the Board reverses CMS's November 21, 2012 disallowance of $22,806,230 for the period October 1, 2001 through September 30, 2003.

/s/

Judith A. Ballard

/s/

Leslie A. Sussan

/s/

Stephen M. Godek
Presiding Board Member