Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Pennsylvania Department of Public Welfare
Docket No. A-14-106
Decision No. 2631
April 13, 2015

DECISION

The Pennsylvania Department of Public Welfare (Pennsylvania) appeals the Centers for Medicare & Medicaid Services (CMS)'s determination disallowing $3,001,536 in federal financial participation (FFP) Pennsylvania claimed as Medicaid administrative costs over the period 1996-2011. Pennsylvania claimed payments it made to a contractor that provided training to nursing facilities on reducing the use of restraints, as part of a CMS-approved restraint reduction initiative. CMS determined that the disallowed costs are not necessary for the proper and efficient administration of the Medicaid program as required of Medicaid administrative costs by applicable law and cost principles. CMS cited a 1994 letter to State Medicaid Directors (1994 State Medicaid Directors Letter (SMDL)) providing that claims for Medicaid administrative costs may not include the overhead costs of operating a provider facility, such as the supervision and training of providers, and that Medicaid administrative costs do not include the costs of medical assistance services that providers furnish to Medicaid recipients.

For the reasons explained below, we sustain the disallowance.

Legal background

The Medicaid program and cost principles

The Medicaid program, established under title XIX of the Social Security Act (Act), is jointly funded by the federal government and states to provide medical assistance to financially needy and disabled persons. Act §§ 1902(a)(10)(A), 1902(e), 1902(f); 42 C.F.R. Part 435.[1] Each state that chooses to participate administers its own Medicaid program under broad federal requirements and the terms of its "plan for medical assistance" (state plan), which must be approved by CMS on behalf of the Secretary of

[1] The current version of the Social Security Act can be found at http://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 title and section.

the Department of Health and Human Services (HHS). Act § 1902; 42 C.F.R. Part 430. Once the state plan is approved, a state becomes entitled to receive FFP for a percentage of its program-related expenditures.

Most Medicaid program expenditures are for "medical assistance," a term that refers to the broad categories of medical services that a state is authorized to provide under its state plan. *Iowa Dep't of Human Servs.*, DAB No. 2378, at 2 (2011), citing Act § 1905(a). In addition, state Medicaid programs make expenditures for various administrative activities or functions, such as program outreach, preadmission screening, claim processing, and utilization review. *Id*., citing 42 C.F.R. § 433.15; Act § 1903. The Act specifies different types of administrative activities for which FFP is available at rates from 50% to 100%, and then provides, as relevant here, 50% FFP in other "amounts expended … as found necessary by the Secretary for the proper and efficient administration of the State plan." Act § 1903(a)(7). The regulations similarly provide FFP at various rates for costs of specified activities and at 50% for "[a]ll other activities the Secretary finds necessary for proper and efficient administration of the State plan[.]" 42 C.F.R. § 433.15(a)(7).

Cost principles for state and local governments in effect at the time of the disallowed claims similarly require that allowable costs must be "necessary and reasonable for proper and efficient performance and administration" of the grant program. 2 C.F.R. Part 225 (OMB Circular A-87), App. A, ¶ C.1.a. In addition, a program cost is allowable only if it is "allocable" to that program, meaning that it is charged to the program "in accordance with relative benefits received." *Id*. at ¶¶ C.1.b, C.3.a.

In decisions reviewing disputed disallowances, the Board "has consistently held that a state has the burden to document the allowability and allocability of its claims for FFP." *N.J. Dep't of Human Servs.*, DAB No. 2328, at 4-5 (2010) (citations omitted). For states, this burden was based on the requirement in the cost principles that costs claimed must "[b]e adequately documented," 2 C.F.R. Part 225, App. A, ¶ C.1.j, and the administrative requirements, including the requirement that grantees maintain accounting records supported by source documentation, 45 C.F.R. § 92.20(b). *N.J. Dep't. of Health*, DAB No. 2497, at 4 (2013).

The 1994 State Medicaid Directors Letter (SMDL)

CMS's predecessor, the Health Care Financing Administration (HCFA), issued the 1994 SMDL on December 20, 1994 "to reiterate our long-standing policy on allowable administrative costs."[2] Pennsylvania Exhibit (PA Ex.) F, at 1. The letter states that "[w]e

[2] We use the acronym HCFA in quotations from older decisions and documents which use it.

have consistently held that allowable claims … must be directly related to the administration of the Medicaid program" and that "[a]n allowable administrative cost: … may not include the overhead costs of operating a provider facility, such as the supervision and training of providers." *Id*. at 1, 4-5 (emphasis added). The 1994 SMDL provides a non-exclusive list of the types of administrative costs "necessary for the proper and efficient administration of the State plan" when included in approved cost allocation plans: "Medicaid eligibility determinations; Medicaid outreach; Prior authorization for Medicaid services; Medicaid Management Information System development and operation; Early and Periodic Screening, Diagnostic, and Treatment administration; Third Party Liability activities; and Utilization review." *Id*. at 2.

The 1994 SMDL also advises that allowable Medicaid administrative costs do not include the costs of medical assistance services provided to Medicaid recipients:

> An allowable administrative cost … cannot be an integral part or extension of a direct medical or remedial service, such as patient follow-up, patient assessment, patient education, counseling (including pharmacy counseling), or other physician extender activities. Such services are properly paid for as part of the payment made for the medical or remedial service. Because Medicaid providers have agreed to accept service payment as payment in full, such providers may not claim an additional cost as administrative cost under the State plan.

Id. at 4-5 (emphasis added).

Factual background

In 1993 CMS Region III initiated a project to reduce the rate of physical restraint usage in nursing homes, following legislation and regulations providing nursing home residents the right to freedom from physical or chemical restraints imposed for discipline or convenience. PA Ex. B; 42 C.F.R. § 483.13(a). A restraint reduction task force created in Pennsylvania included at least one CMS representative and representatives from the Pennsylvania Department of Health, providers and other stakeholders. PA Exs. B, C, D; PA Ex. 3.

Pennsylvania implemented the "Pennsylvania Restraint Reduction Initiative" (PARRI) "for the purpose of providing direction, training and support to long term care facilities which desire to reduce their use of physical restraints." CMS Ex. 12, at 27. The Pennsylvania Department of Public Welfare, the state Medicaid agency, awarded a grant in July 1996 to the Pennsylvania County Commissioner's Association which in turn awarded a grant or contract to Kendal Outreach LLC. CMS Ex. 12 (original PARRI grant document). The training project began in 1996 (official kick-off September 1996).

CMS Ex. 4 (audit workpapers). Kendal initially trained nursing home staff at four nursing home training sites and expanded to 26 nursing home sites as training sites for the rest of the Pennsylvania nursing homes. PA Ex. 5; CMS Ex. 13 (PARRI background information from Kendal).

Pennsylvania funded the Kendal contract through its "Medicaid intergovernmental transfer (IGT) process" until 2006, and then from civil money penalties CMS collects from sanctioned nursing homes. PA Brief (Br.) at 4, citing PA Ex. 4; CMS Ex. 1; CMS Ex. 5, at 2. Pennsylvania did not specifically identify the PARRI payments to Kendal on the CMS form that state Medicaid agencies use to report costs but instead included the payments among larger amounts claimed as "Other Financial Participation." CMS Ex. 14, at 2 (audit workpapers); PA Br. at 6.

The disallowance followed a July 2012 report of an audit by the HHS Office of Inspector General of Pennsylvania's claims for Medicaid administrative costs for provider training under PARRI (OIG audit report). PA Ex. E; CMS Ex. 11. Based on the OIG audit, CMS determined that:

- The PARRI's purpose is "to assist providers in their compliance with long term care certification requirements and to improve the quality of care in nursing facilities, not to assist with the effective administration of the Medicaid program."
- The claimed costs "were for the training of nursing home providers and not for the administration of the Medicaid program."
- The PARRI contract costs "do not constitute general administrative costs of the Medicaid program [but] constitute nursing facility overhead costs since the training was intended to support and augment the inservice training for nursing facilities and to enhance the quality of service delivery at nursing facilities."
- "[T]he administrative costs claimed in connection with [PARRI] … were [thus] not necessary and reasonable for the proper and efficient performance and administration of the State's Medicaid program."

Disallowance Letter at 1-3. The disallowance letter cites Act § 1903(a)(7) (50% FFP in Medicaid costs "found necessary by the Secretary for the proper and efficient administration" of the State plan) and 2 C.F.R. Part 225 (OMB Circular A-87), App. A, ¶ C.1.a (allowable costs must be "necessary and reasonable for proper and efficient performance and administration" of the grant program). *Id*. at 2. The disallowance letter also cites the 1994 SMDL statement "that allowable administrative costs do not include 'the overhead costs of operating a provider facility, such as the supervision and training of providers.'" *Id*. CMS disallowed $3,001,536 in FFP claimed for the period July 1, 1996 through June 30, 2011. *Id*.

The record consists of the parties' briefs and exhibits, including exhibits Pennsylvania submitted with its reply brief and another exhibit, a CMS notice of final rulemaking from the Federal Register, that Pennsylvania submitted two days later with a "Submission of Supplemental Authority." CMS in response requested leave to file a surreply brief, which it submitted with the request. Pennsylvania then submitted a "Limited Objection to Sur-Reply" stating that Pennsylvania "does not object to the Agency's sur-reply brief to the extent it addresses new issues raised in the State's reply" but that the only new issue raised "was that it is entitled to an inference that the Agency approved FFP for the [PARRI]." Pennsylvania did not request an opportunity to respond to CMS's surreply.

Since Pennsylvania submitted additional documentation and made new arguments with its reply, it is appropriate to permit CMS to respond. *See* 45 C.F.R. § 16.8(c) (permitting appellant to submit "a short reply" to the respondent's brief and supplement to the appeal file). Accordingly, the Board grants CMS's request and accepts the surreply into the record. Pennsylvania is not prejudiced by the admission of the surreply since it does not raise any issues Pennsylvania did not already have an opportunity to address.

Analysis

Pennsylvania does not dispute receiving the 1994 SMDL, which CMS issued not long before PARRI and which informed states they could not claim provider training as Medicaid administrative costs. Pennsylvania also does not deny that the disallowed claims were for the costs of training nursing facility staff on reducing the use of restraints in caring for residents, some of whom may have been Medicaid recipients. *See* PA Br. at 5-6 (Kendal's "work over the audit period" included doing on-site and off-site "training to nursing homes," including training provider staff on restraint reduction).[3] Pennsylvania nonetheless argues that the Kendal contract payments were allowable Medicaid administrative costs, despite the 1994 SMDL, for several reasons. Pennsylvania argues that the 1994 SMDL does not prohibit its claims, is inconsistent with other issuances permitting Medicaid funding for provider training, and is invalid. Pennsylvania also argues that the Board should infer that CMS approved Medicaid FFP for the contract payments. Finally, Pennsylvania argues that grants administration policies bar CMS from disallowing costs claimed for years prior to the periods for which Pennsylvania was required to retain records.

[3] Pennsylvania reports that Kendal's "actual work over the audit period consisted of: (1) providing phone consultations to nursing homes; (2) doing on-site training visits to nursing homes; (3) providing teleconference/web training to nursing homes, (4) and providing offsite training to nursing homes at centralized locations." PA Br. at 6, citing PA Ex. 7 (Log of Activities). Pennsylvania asserts that Kendal's work under the contract "also included consultation with nursing homes on difficult individual cases, and this activity is not training and is plainly allowable," an argument we address below. *Id*. at 16 n.8.

None of these arguments demonstrate that the Kendal contract payments were allowable Medicaid administrative costs or provides a basis for reversing the disallowance. As we explain below, the 1994 SMDL continued prior policy that medical assistance costs are not administrative costs and is consistent with Board holdings prior to the 1994 SMDL.

I. The Kendal contract payments were unallowable as Medicaid administrative costs under the 1994 SMDL, which reiterated existing CMS policy that the Board cited in upholding previous disallowances of provider training costs.

We note two points central to our analysis. First, the 1994 SMDL does not bar any Medicaid FFP in the costs of provider training, but only prohibits states from claiming provider training as a Medicaid *administrative* cost – a cost of administering their state Medicaid plans. It limits allowable administrative costs to those incurred in a state's administration of its plan and excludes the costs of medical assistance services furnished by providers. *See* PA Ex. F at 5 (allowable administrative costs "cannot be an integral part or extension of a direct medical or remedial service [which is] properly paid for as part of the payment made for the medical or remedial service"). It also indicates that provider training may be considered a component of medical assistance rather than an activity of the state agency in administering its Medicaid plan. *See id*. (allowable administrative costs "may not include the overhead costs of operating a provider facility, such as the supervision and training of providers").

Second, the prohibition in the 1994 SMDL on states claiming provider training and other medical assistance costs as costs of administering their Medicaid state plans was not a new policy. Even before CMS issued the 1994 SMDL "to reiterate our long-standing policy on allowable administrative costs," *id*. at 1, the Board had upheld CMS's exclusion of provider training costs from allowable Medicaid administrative costs that states could claim for administering their state plans. Those holdings, in which the Board applied the law and regulations to facts similar to this case, apply here.

In *New York State Department of Social Services*, DAB No. 1146 (1990), the Board upheld the disallowance of the state's claims for Medicaid administrative FFP in the costs of different types of training the state Medicaid agency funded and provided, through contractors, to personnel in county or city nursing homes, hospitals, and homeless shelters that provided direct services to Medicaid recipients.[4] CMS disallowed the claims on the ground that the state was obliged to treat the costs as medical services costs properly claimed through the per diem services rates by which the facilities were paid for medical assistance services. The Board found that:

[4] Training provided to nursing home personnel dealt with working with the mentally impaired; training for hospital personnel "was designed to implement a model curriculum in discharge planning," and the nature of the training provided in homeless shelters "was not clear from the record." DAB No. 1146, at 3.

- The nature of the training showed "that the training was not directly related to administration of the State plan, but was instead related to facility responsibilities" as it "focused on direct service responsibilities of the facilities, not on elements related to [state Medicaid] plan administration."
- The training was "apparently designed to improve the quality of direct services provided by the facility employees trained, and not to improve the quality of the State's administration of the Medicaid program."
- Although the provider staff who received training "may interact with the Medicaid program and may have to provide services which meet Medicaid standards, they perform these functions in the course of facility operation, not in the course of administering the State plan."
- The state "did not connect the training to the State's objectives in administering its State plan[.]"

DAB No. 1146, at 6-8 (emphasis added). The Board thus concluded that it was "reasonable … for HCFA to conclude that costs of training intended to affect services provided are services costs" that "were related to service delivery rather than [Medicaid] program administration so that they could be claimed for FFP only by means of the rate-setting mechanism established for reimbursement of the costs of facility services." *Id*. at 2, 8.

The Board again held that provider staff training was related to the provision of medical assistance and was not a Medicaid administrative cost in *New York State Department of Social Services*, DAB No. 1252 (1991), where the state again claimed contract payments for training of staff in health care facilities as Medicaid administrative costs. The Board pointed out that "[v]ery few of the trainees had a direct employment relationship with the State Medicaid agency, and … there is nothing in the record to establish that these employees had direct administrative responsibilities for the Medicaid program." The Board moreover stated that "[w]hile the trainees … may have worked in the administration of the delivery of health care, this is not tantamount to the administration of the State's Medicaid program." DAB No. 1252, at 7 (emphasis added).

The rationale in the *New York* cases particularly applies here, where it is not disputed that the training helped facilities comply with limitations on restraint use in the regulations governing the quality of care that facilities provide to their residents. 42 C.F.R. § 483.13(a). As in the *New York* cases, the training "focused on direct service responsibilities of the facilities, not on elements related to [state Medicaid] plan administration" and was "not directly related to administration of the State plan, but was instead related to facility responsibilities." DAB No. 1146, at 7. The training was also "apparently designed to improve the quality of direct services provided by the facility employees trained, and not to improve the quality of the State's administration of the Medicaid program." *Id*. at 7-8.

Thus, the PARRI training Kendal provided to nursing facilities and their staff was not related to Pennsylvania's administration of its state Medicaid plan, and Pennsylvania's payments to Kendal for the training were not allowable Medicaid administrative costs.[5]

Pennsylvania also asserts that Kendal's work under the contract "also included consultation with nursing homes on difficult individual cases, and this activity is not training and is plainly allowable." PA Br. at 16 n. 8. CMS, however, did not rely solely on the 1994 SMDL language on provider training as grounds for the disallowance but also cited language in the Act and cost principles underlying the differentiation of the costs of medical assistance from a state's costs of administering its Medicaid state plan. *See* Disallowance Letter at 2 (citing Act § 1903(a) and stating that a purpose of PARRI is to "to improve the quality of care in nursing facilities, not to assist with the effective administration of the Medicaid program"). Pennsylvania did not identify the amount it claimed was allowable on this basis or provide documentation relating to the alleged consultations. Even if Pennsylvania had established that some of the disallowed claims were for such consultations, Pennsylvania did not provide any explanation for why we should view consulting on the care of individual patients as integral to administering the state Medicaid program rather than as part of the delivery of health care. Therefore, Pennsylvania has provided no basis for reversing the disallowance to that extent.

Pennsylvania has thus not met its grantee's burden to demonstrate that the its claims were allowable Medicaid administrative costs.

II. That CMS may permit states to recover some provider training costs through provider reimbursement rates for medical assistance provides no grounds to reverse the disallowance.

Pennsylvania argues it should be able to claim the Kendal contract payments as Medicaid administrative costs because CMS permits states to claim provider training costs as medical assistance costs through provider reimbursement rates. Pennsylvania cites a CMS 2011 "Informational Bulletin" advising states on how some "provider-related training costs may be considered in the development of the rate of payment for medical services." PA Ex. G at 4-5. As Pennsylvania recognizes, the Informational Bulletin

[5] We also note that the record indicates that Pennsylvania claimed all of the Kendal contract payments as Medicaid administrative costs and did not allocate to Medicaid only the portion of the costs attributable to serving Medicaid recipients, as required by the cost principles then in effect. CMS Ex. 14, at 3 (audit workpapers stating Pennsylvania first "estimated that the total cost of the PARRI dating back to 1996 was approximately $6 million" and then determined that "Total Expenditures for the PARRI were $6,001,929.31"); 2 C.F.R. Part 225, App. A, ¶¶ C.1.b, C.3.a (allowable cost must be "allocable" to the federal program, meaning charged "in accordance with relative benefits received" by the program). CMS did not cite Pennsylvania's apparent failure to allocate the PARRI costs to Medicaid as a ground for the disallowance, instead basing the disallowance on its determination, with which we agree, that none were allowable administrative costs.

cautions that such training costs "may not be claimed separately by the Medicaid agency as an administrative expense." *Id*. at 4; PA Br. at 14. Pennsylvania argues, however, that it had to claim the Kendal contract payments as administrative costs because the nursing facilities did not pay for the training and thus could not include its costs in their Medicaid reimbursement rates. PA Br. at 12 ("since these allowable costs are incurred through a state-level contract they cannot be claimed through the ratesetting process" but "must be submitted as administrative costs"). Pennsylvania asks, "[w]hat rational basis is there for reimbursing … training when paid for by a provider, but not when the State makes the payment?" PA Reply at 9.

The Board in the *New York* cases explained the rationale for reimbursing provider training and other medical assistance costs only through provider reimbursement rates and not as administrative costs of the state Medicaid agency. The Board also rejected the same argument Pennsylvania makes here.

In DAB No. 1146, the Board observed that "[u]nless the rate system is utilized, a state cannot meet its responsibility to determine whether the rates are 'reasonable and adequate to meet the costs [that] must be incurred by efficiently and economically operated'" providers, as was then required under Act § 1902(a)(13)(A) and is currently required by 42 C.F.R. § 447.253(b)(1) in setting rates for hospitals and long term care facilities. DAB No. 1146, at 9. More recently, the Board has noted that "the principle that a state may not, for purposes of claiming FFP, classify direct services (or integral parts or extensions of direct services) as Medicaid administration … reasonably follows from the general regulatory prohibition against claiming 'medical assistance' as an administrative cost and is necessary to prevent duplicate program payment for the same activities." *Iowa Dep't of Human Servs.* at 7 (2011) (upholding disallowance of administrative FFP in salary and related costs of skilled professional medical personnel in provider facilities). *See also Ga. Dep't of Med. Assistance*, DAB No. 1413, at 10 (1993) ("reimbursement through use of a facility's rate allocates to Medicaid only the services costs attributable to Medicaid recipients, and not those attributable to Medicare or private pay residents of the facility").

In DAB No. 1252, the Board cited DAB No. 1146 as finding that provider training costs related to medical assistance "are allocable only to facility services, and not to the administration of the State Medicaid plan," and held that "[e]ven if the State is unable as a practical matter to factor these costs into the rate-setting process for the facilities, the State cannot characterize these costs as Medicaid administration for its own convenience." DAB No. 1252, at 8, *citing* DAB No. 1146, at 8-9. The Board in DAB No. 1146 held that New York's argument "that, as a practical matter, it had no other way to recover these costs," as Pennsylvania argues here, "cannot change the character of the costs to justify claiming them as administrative costs." DAB No. 1146, at 8. That

Pennsylvania funded the training so that the providers themselves did not incur the costs in their provision of medical assistance does not change the nature of the training as provider training or otherwise convert it into an administrative activity.

III. Pennsylvania's assertion that the Kendal contract costs were not part of the providers' overhead costs does not establish that the costs were allowable administrative costs.

Pennsylvania makes a convoluted argument to the effect that the Informational Bulletin "makes clear that provider training costs like those at issue here are not 'overhead costs'" and also argues that the Kendal contract costs are not "overhead" under a definition of the term applied in a case involving a dispute between an employer, a manufacturer of farm and industrial equipment, and unions concerning damages resulting from a strike allegedly called by the unions without following certain procedures, to include the procedures in the collective bargaining agreement with the employer. PA Br. at 15; PA Reply at 6, citing *United Elec., R. & M. Workers v. Oliver Corp*., 205 F.2d 376 (at 387) (8th Cir. 1953). Pennsylvania argues that the costs are thus allowable administrative costs because the 1994 SMDL "prohibits only the claiming of provider training costs that are facility overhead costs." PA Reply at 6.

This argument ignores the full meaning and context of the 1994 SMDL. Regardless of the definition of "overhead" Pennsylvania cites (PA Reply at 6), the 1994 SMDL expressly includes provider training as an example of overhead costs. Furthermore, the 1994 SMDL does not exclude provider training from Medicaid administration solely on the basis that it is "overhead," in isolation from the rest of the letter. As discussed above, the exclusion of provider training from Medicaid administration reflects the longstanding principle, based on sections 1905(a) and 1903(a) of the Act and 42 C.F.R. § 433.15 and applied in the *New York* and *Iowa* decisions, that a state may not claim costs of medical assistance rendered by providers as the state agency's Medicaid administrative cost. Contrary to what Pennsylvania suggests in its brief (PA Br. at 13-14), moreover, the 2011 Informational Bulletin does not purport to address the claiming of Medicaid administrative costs, nor does it use the term "overhead." The bulletin instead distinguishes between costs "associated with requirements that are prerequisite to being a qualified Medicaid provider," which "are not reimbursable by Medicaid," and "costs associated with maintaining status as a qualified provider," which "may be included in determining the [provider's] rate for services." PA Ex. G at 4, cited at PA Br. at 13. Nothing in the bulletin may reasonably be read as indicating that provider training costs that may not be included in determining the provider's rate for services may somehow be claimed as administrative costs of the state Medicaid agency. On the contrary, the Informational Bulletin directly states that the subject training costs "may only be included as part of the rate paid for the service and may not be claimed separately by the Medicaid agency as an administrative expense."

IV. Pennsylvania's argument that the 1994 SMDL was an invalid substantive rule provides no basis to reverse the disallowance.

Pennsylvania argues that the 1994 SMDL is invalid because it is a substantive rule that CMS was required to promulgate through notice and comment rulemaking. PA Br. at 16-17. CMS responds that the 1994 SMDL "is a policy statement, not a rule" subject to that requirement. CMS Br. at 22. We need not and do not address Pennsylvania's argument because the 1994 SMDL was binding on Pennsylvania in any event.

The Board has long held "that where a statute or regulation is subject to more than one interpretation, the federal agency's interpretation is entitled to deference as long as the interpretation is reasonable and the grantee had adequate and timely notice of that interpretation or, in the absence of notice, did not reasonably rely on its own contrary interpretation." *Md. Dep't of Human Res., et al.*, DAB No. 1949, at 17-18 (2004), *aff'd sub nom. N.Y. State Office of Children & Family Servs.* v. *U.S. Dep't of Health & Human Servs.' Admin. for Children & Families*, 556 F.3d 90 (2nd Cir. 2009), citing *Alaska Dep't of Soc. & Health Servs.*, DAB No. 1919, at 14 (2004) (citations omitted). To the extent the Act's limitation of Medicaid *administrative* costs to those "found necessary by the Secretary for the proper and efficient administration" of the state Medicaid plan (Act § 1903(a)(7)) could be deemed ambiguous for not specifically addressing provider training, CMS resolved any ambiguity in the 1994 SMDL. The 1994 SMDL's reiteration of CMS's policy, upheld by the Board, that provider training (like other components of medical assistance) is not a Medicaid administrative cost is reasonable, for the reasons discussed above and in the *New York* and *Iowa* decisions.

Pennsylvania does not dispute that it received the 1994 SMDL but asserts it "reasonably relied upon its interpretation of the term 'overhead costs of operating a provider facility' [in the 1994 SMDL] to exclude state-level advanced training of provider personnel." PA Br. at 15-16, citing *Mass. Exec. Office of Health & Human Servs.*, DAB No. 2218, at 12 (2008), *aff'd, Mass. v. Sebelius*, 701 F.Supp.2d 182 (D. Mass. 2010). Pennsylvania, having had notice of the 1994 SMDL, was bound by its terms. In any event, Pennsylvania did not provide evidence that it claimed the payments to Kendal as administrative costs based on any contrary interpretation of the 1994 SMDL. Pennsylvania has also not provided evidence that it had, and relied on, a prior interpretation of the Act and regulations to the effect that the training of Medicaid providers was necessary for Pennsylvania's proper and efficient administration of its state Medicaid plan.

V. Pennsylvania has shown no basis to infer that CMS permitted Pennsylvania to claim the costs of PARRI training as Medicaid administrative costs.

Pennsylvania argues that the Board should reverse the disallowance based on the ground that CMS might have agreed to permit Pennsylvania to claim FFP in the PARRI costs. Pennsylvania concedes it "cannot locate any records indicating whether CMS agreed to support the PARRI through the matching process" because "any correspondence or file notes that existed have long since been destroyed." PA Br. at 4-5. Pennsylvania nonetheless argues that the Board "should draw an inference that [CMS] approved the State claiming FFP for the costs of the Kendal Company contract," because the Board denied discovery from CMS on that issue and because, according to Pennsylvania, the "circumstances surrounding the claim suggest that CMS might have agreed to provide Medicaid matching."[6] *Id*. at 11; PA Reply at 4.

The circumstances Pennsylvania alleges are that CMS Region III staffers "were actively involved in the PARRI Task Force and its pursuit of funding"; that CMS "has always been quite familiar with how the [PARRI] contract was being funded" and "paid the State's claim for the Kendal Company contract for nearly twenty years without questioning it"; and that CMS staff "could have reasonably interpreted" the law "to allow the Kendal contract costs" because the 1994 SMDL involves "the somewhat flexible concept of provider 'overhead'" and is not "a clear and unambiguous regulation." PA Br. at 4, 11; PA Reply at 3. Pennsylvania also argues that the "adverse witness rule" that "'a party's failure to call a witness under its control who could testify as to material facts permits a tribunal to draw an adverse inference against the part[y] in control of the witness'" requires the Board to infer that CMS approved FFP in the Kendal contract costs. PA Reply at 3, citing *In re Evangeline Refining Co.*, 890 F.2d 1312 (5th Cir. 1989). Pennsylvania criticizes CMS for failing to produce any declaration from a former CMS employee who was on the PARRI task force from its inception until 2014.

Pennsylvania's arguments are unsupported speculation that misrepresent the full context of the 1994 SMDL. As discussed above, the 1994 SMDL did not advance a new view of provider training based solely on a "flexible" concept of overhead but reiterated existing policy that claims for Medicaid administrative costs could not include costs of medical assistance. CMS issued the 1994 SMDL shortly before the PARRI task force met and not long after the Board, in the *New York* cases, had sustained disallowances of claims for administrative FFP in provider training costs on the grounds that they were medical assistance. The 1994 SMDL then expressly included provider training as an example of

[6] On November 3, 2014, the Board denied discovery on the grounds that Pennsylvania had not explained why the information sought was necessary to resolve the dispositive issue and was relying on conjecture.

overhead. All of these circumstances make it highly unlikely that CMS would have permitted Pennsylvania to claim the costs of the PARRI provider training as Medicaid administrative costs. Pennsylvania identifies no credible reason why CMS would have done so following the *New York* decisions which, although taken in a different CMS region, represented the final decision of the Secretary in those cases.

Pennsylvania also does not dispute that its claims for administrative costs did not identify the Kendal contract payments, which were included among larger amounts identified on the claim form as "Other Financial Participation." CMS Ex. 14, at 2; PA Br. at 6. This calls into question Pennsylvania's attempt to assign probative weight to CMS's failure to have taken this disallowance earlier. Contrary to what Pennsylvania argues, the 2014 testimony of a CMS official before Congress to the effect that CMS reviews "every line" of claim forms does not make it likely that CMS was previously aware of the specific nature of the claims because the line in question here did not identify the costs as provider training. PA Reply at 3-4, citing PA Ex. 10.

Moreover, the PARRI task force minutes Pennsylvania cites to show that CMS was aware of how the PARRI was being funded could instead support an inference that CMS did not approve administrative FFP for PARRI. PA Br. at 4, citing PA Ex. 4. The minutes significantly make no mention of claiming Medicaid FFP for the PARRI project. Finally, Pennsylvania does not specifically assert that any records showing CMS approval of administrative FFP ever actually existed, and does not identify particular state laws or regulations pursuant to which any such records might have been destroyed.

Given the absence of any support in the record for the claim that CMS might have agreed to permit Pennsylvania to claim the provider training costs as Medicaid administrative costs, despite CMS's existing policies and the Board decisions to the contrary, we need not address the parties' dispute over the precise meaning and application of the adverse witness rule.

VI. The HHS Grants Administration Manual (GAM) does not bar the disallowance.

GAM § 1-105-60(C)(3)(a)(1), under the heading "Time Period for Computing Disallowances," states "the computation of the disallowance will cover … the period the organization is required to retain records under applicable records retention requirements," with exceptions for extending (or shortening) the period, such as for retroactive claims or cases of fraud or deliberate misrepresentation.[7] PA Ex. 8, at 19.

[7] The GAM is no longer available on the HHS website and (as noted in Board decisions) has been replaced by a Grants Policy Statement and a series of Grants Policy Directives. CMS does not argue that the GAM is not applicable here, is no longer effective or does not apply to at least some of the disallowance period.

Regulations in effect during the disallowance period generally required that records pertinent to an award be retained for three years from the date of submission of the expenditure report or quarterly/annual financial report as applicable, with exceptions including when an audit is started before the end of the three-year period. *See, e.g.*, 45 C.F.R. §§ 74.21(1980); 92.42(b) (1997).

Pennsylvania argues that the GAM provision "bars CMS from extending the instant disallowance to a period before April 1, 2008," based on OIG's notification to Pennsylvania on July 26, 2011 that it would conduct an audit entrance conference. PA Br. at 3 n.2, 9. Pennsylvania argues that it is "well established" by the Board and federal courts that the GAM "is binding agency policy," because the Board and courts have "cited the GAM in federal-state disallowance matters." *Id*. at 9, citing *Mass. Exec. Office for Admin. & Fin.*, DAB No. 1034 (1989); *Mass. v. Sullivan*, 803 F. Supp. 475 (D. Mass. 1992) (reversing and remanding DAB No. 1034); and *S. Mut. Help Ass'n, Inc. v. Califano*, 574 F.2d 518 (D.C. Cir. 1977).

The GAM does not bar this disallowance. As CMS noted, the Board in *Community Health and Counseling Services*, DAB No. 557, at 7 (1984), held that the GAM provision "does not state that for *all* disallowances, the computation will *only* cover the period of time records are required to be retained" (emphasis added). The Board essentially held that the GAM provision did not bar the disallowance where records in fact exist to support the computation of the disallowance, so the grantee is not prejudiced by the passage of time. *See also Pa. Dep't of Pub. Welfare*, DAB No. 582, at 10 (1984) (citing DAB No. 557), *rev'd and remanded on other grounds, Pa. Dep't of Pub. Welfare v. Heckler*, No. 85-0643 (M.D. Pa. Sept. 18, 1986). The Board has also held, regarding the record retention requirements in the regulations, that a grantee is not excused from producing relevant documentation unless it shows that specific documents actually existed, were retained for the requisite period, and then were innocently destroyed. *Ca. Dep't of Health Servs*., DAB No. 1240, at 14 (1991). Pennsylvania has not alleged that any destruction of records prevents accurate calculation of the disallowance amount, and the record shows that the amount of the disallowance (FFP claimed) was determined by Pennsylvania. CMS Ex. 5, at 2-3 (audit workpapers). Instead, Pennsylvania appears to assert only that theoretically some missing records might show CMS approval to claim the Kendal contract payments as Medicaid administrative costs, which is an assertion we rejected as unsupported and speculative.

VII. Other CMS issuances and regulations Pennsylvania cites are not applicable and do not demonstrate that the Kendal contract costs are allowable Medicaid administrative costs.

Pennsylvania cites several CMS issuances and statements in regulations that, Pennsylvania asserts, permit FFP in provider training costs contrary to the 1994 SMDL and thus support its argument that the Board should infer that CMS approved Medicaid

funding for the PARRI. None support Pennsylvania here. In general, Pennsylvania takes isolated statements out of context and ignores other parts of the issuances reiterating the long-standing policy that states may not claim the costs of medical assistance as administrative costs. We address each issuance below.

A. An unidentified HHS issuance addressing state outreach activities to older adults and disabled individuals as Medicaid administrative costs

Pennsylvania cites what it describes as a "policy clarification issued in connection with the Aging and Disability Resource Center (ADRC) program" that, Pennsylvania claims, "says that training costs that are not part of provider overhead are allowable as administrative costs" under Medicaid.[8] Pennsylvania states that this "guidance … say[s] … that 'functional screen training time' is an example of an allowable administrative cost claimed by Wisconsin under ADRC." PA Reply at 7-8, citing PA Ex. 12.

Pennsylvania does not accurately describe this issuance, which nowhere states that provider training costs may be directly claimed as Medicaid administrative expenses. The issuance makes clear that ADRCs are state and local governmental entities, and that "screen training" refers to training staff of these governmental entities in screening and prescreening clients for eligibility for various services including Medicaid. PA Ex. 12. Permitting states to claim FFP for such activities appears consistent with the 1994 SMDL's inclusion, among examples of allowable administrative costs in CMS-approved cost allocation plans, of activities such as Medicaid eligibility determinations and Medicaid outreach. PA Ex. F at 2. As Pennsylvania notes, the ADRC guidance states that allowable Medicaid administrative costs "must not include the overhead costs of operating a provider facility or otherwise include costs of a direct service to beneficiaries," which is also consistent with the 1994 SMDL's reiteration of the policy that the costs of medical assistance services are not allowable as Medicaid administrative costs. *Id*. The costs of training state or local government employees in screening potential Medicaid recipients are not at issue here.

[8] A website of the HHS Administration on Aging (AOA) indicates that ADRC is a "collaborative effort" of AOA and CMS "to streamline access to long-term care" by supporting "State efforts to develop 'one-stop shop' centers in local communities that help older adults and individuals with disabilities make informed decisions about their service and support options and serve as the single point of entry to the long-term care system." http://www.eldercare.gov/Eldercare.NET/Public/About/Aging_Network/ADRC.aspx (Accessed Apr. 10, 2015).

B. A regulation governing the reporting of training and administrative costs incurred by Medicaid state agencies

Pennsylvania argues that "the regulation at 42 C.F.R. § 432.55(b)(4) clearly authorizes FFP for the hiring of experts to develop and conduct special programs" and "authorize[s] the State to contract for consultants to handle special projects." PA Br. at 15; PA Reply at 8. Pennsylvania cites this regulation to support its argument that the training costs were not overhead addressed by the 1994 SMDL. *Id.*

Part 432, "State Personnel Administration," authorizes FFP in training expenditures at various rates of FFP including, as relevant here, 50% for "all other staff of the Medicaid agency or other public agencies providing services to the Medicaid agency." 42 C.F.R. § 432.50(b)(6). The section Pennsylvania cites addresses only the reporting of such costs and does not authorize administrative FFP in the costs of contracts that are not directly related to the State's administration of its Medicaid program and that are between parties that do not include the state Medicaid agency.

C. A regulation that reimburses nursing aide training as administrative costs

Pennsylvania argues that CMS "has not acted consistently here" because its regulation at 42 C.F.R. § 483.158 permits "[t]he basic training of nursing facility clinical care … excepting only doctors, nurses, and a few others" to be "reimbursed as an administrative cost . . . ." PA Reply at 9. Pennsylvania's premise is not valid because the Act itself, not solely the regulation, authorizes the cost of "nursing aide training and competency evaluation programs" to be claimed as Medicaid administrative costs. Act § 1903(a)(2)(B). The Board thus rejected this same argument in DAB No. 1146 on the ground that section 1903(a)(2)(b) is a "unique reference to reimbursement of nursing aide training as an administrative cost (without reference to other training)" and "a specific statutory exception to the normal treatment of training costs for facility staff[.]" DAB No. 1146, at 6-7.

D. A school-based training provision

Pennsylvania cites two sentences in a 57-page May 2003 CMS "Medicaid School-Based Administrative Claiming Guide" referring to "other administrative activities not associated with a covered Medicaid medical service which may be covered in schools" which "include Medicaid outreach, facilitating Medicaid eligibility determinations, medical/Medicaid related training and general administration[.]" PA Ex. 11, at 4. Pennsylvania argues that this shows that CMS "allows administrative cost claiming for provider training in public schools." PA Reply at 9. That statement, even in isolation, does not support Pennsylvania. Some of the activities listed correspond to the examples

of allowable administrative costs in the 1994 SMDL. PA Ex. F at 2 (Medicaid eligibility determinations, Medicaid outreach). The Claiming Guide also is consistent with the longstanding principle that medical assistance may not be claimed as Medicaid administration. It states that "[e]xpenditures for direct school-based health services that are within the scope of Medicaid coverage and furnished to Medicaid eligible children may be claimed as 'medical assistance' and are not within the scope of the administrative claims discussed in this guide" and that "[a]ctivities that are considered integral to, or an extension of, the specified covered service are included in the rate set for the direct service, and therefore they should not be claimed as an administrative expense." PA Ex. 11, at 2, 11.

E. Preamble to a case management rule

Pennsylvania cites language in an excerpt from the preamble to a 2009 final rule CMS published in the Federal Register on topics including "Partial Rescission of Case Management Interim Final Rule," which Pennsylvania describes as "discussing allowable Medicaid administrative costs and mentioning training[.]" PA Submission of Supp. Auth. (Jan. 14, 2015). The preamble includes "training" among "examples of allowable administrative activities" ("Medicaid eligibility determinations and re-determinations; Medicaid intake processing; Medicaid preadmission screening for inpatient care; prior authorization for Medicaid services; utilization review; Medicaid outreach; training; transportation; and referral activities"). 74 Fed. Reg. 31,183, 31,193 (June 30, 2009).

Like other CMS issuances on which Pennsylvania relies, the preamble is consistent with the 1994 SMDL in that it advises (again) that medical assistance is not Medicaid administration. Indeed, the next paragraph of the preamble cites the 1994 SMDL as having advised that "a State may not claim costs as administration if the activities are an integral part or extension of a direct medical service." *Id*. Pennsylvania cites nothing in the preamble indicating that the "training" listed among allowable administrative activity refers to the training of providers who furnish medical assistance, the costs of which are not allowable administrative costs.

Thus, none of the issuance Pennsylvania cites vitiate the prohibition in the 1994 SMDL on claiming provider training costs as Medicaid administrative costs or the policy that administrative costs do not include the costs of medical assistance.

Conclusion

For the reasons stated above, we uphold the disallowance.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Susan S. Yim
Presiding Board Member