Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Colorado Department of Health Care Policy and Financing
Docket No. A-09-121
Decision No. 2343
November 10, 2010

DECISION

The Colorado Department of Health Care Policy and Financing (Colorado) appeals the August 3, 2009 determination of the Centers for Medicare & Medicaid Services (CMS) disallowing $3,324,269 in Medicaid federal financial participation (FFP). Colorado claimed the FFP for supplemental payments made to prepaid inpatient health plans (PIHPs) operating under the Colorado Medicaid Mental Health Capitation and Managed Care Program. The payments were made for the period August 13, 2003 through September 30, 2004. CMS disallowed the FFP on the grounds that the payments were not made pursuant to PIHP contracts that had been reviewed and approved by CMS, as required under 42 C.F.R. § 438.6(a), and because the payments failed to meet the requirements at 42 C.F.R. § 438.6(c) governing risk contracts.

For the reasons explained below, we uphold the disallowance. First, we conclude that the supplemental payments were not eligible for FFP under 42 C.F.R. § 438.6 because they were not recognized under any PIHP contracts that had been reviewed and approved by CMS. Second, we conclude that CMS has not abused its discretion in determining to deny Colorado's request for retroactive review and approval of contract ratifications and a retrospective actuarial certification for the supplemental payments. CMS has several reasonable grounds for denying Colorado's request, including Colorado's failure to timely disclose the supplemental payments; the lateness of the request; and the lack of proof that Colorado's claims were not duplicative of costs for which the PIHPs had already received payment.

Legal Authority

The Medicaid program, established under title XIX of the Social Security Act (Act), provides medical care to financially needy and disabled persons.[1] The federal

[1] The current version of the 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.

government and states share the funding of program costs. Sections 1901, 1903 of the Act. Each state establishes and administers its own Medicaid program, subject to various federal requirements and the terms of its "plan for medical assistance" (Medicaid state plan), which must be approved by the Secretary of the Department of Health and Human Services (HHS). Section 1902 of the Act; 42 C.F.R. §§ 430.10-430.16. Once a state plan is approved, the state becomes entitled to receive FFP for its "medical assistance" expenditures (payments for covered medical care under the Medicaid plan). Section 1903(a)(1) of the Act. Section 1915(b) of the Act authorizes the Secretary to grant waivers that allow states to implement managed care delivery systems.

States may provide Medicaid services to eligible recipients through certain types of managed care plans. *See, e.g.*, sections 1903(m), 1905(t), and 1932 of the Act. The regulations at 42 C.F.R. Part 438 set forth the requirements, prohibitions and procedures for providing services through different types of managed care entities, including PIHPs.[2] Section 438.2 defines a PIHP to mean an entity that—

> (1) Provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates;
> (2) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and
> (3) Does not have a comprehensive risk contract.

A "capitation payment" is a payment that the state "makes periodically to a contractor on behalf of each recipient enrolled under a contract for the provision of medical services under the State plan." *Id.*

The regulation at 42 C.F.R. § 438.6(a) states:

> The CMS Regional Office must review and approve all . . . PIHP . . . contracts, including those risk and nonrisk contracts that, on the basis of their value, are not subject to the prior approval requirements in § 438.806.

Section 438.6(c)(2)(i) requires all "payments under risk contracts and all risk-sharing mechanisms in contracts" to be "actuarially sound." Section 438.6(c)(2)(ii) requires each contract to "specify the payment rates and any risk-sharing mechanisms, and the actuarial basis for computation of those rates and mechanisms." In addition, the state must provide documentation of, among other things, the actuarial certification of the capitation rates and an assurance that the payment rates are "[b]ased only upon services covered under the State plan . . . ." 42 C.F.R. § 438.6(c)(4). "Under a risk contract, the total amount

[2] The regulations cited in this decision were in effect during the relevant period, August 13, 2003 through September 30, 2004.

that the State agency pays for carrying out the contract provisions is a medical assistance cost" for which FFP is available. 42 C.F.R. § 438.812(a).

Background

This is the second appeal in which Colorado has requested that the Board reverse a CMS disallowance of FFP claimed for supplemental payments made to mental health assessment and services agencies (MHASAs) operating as PIHPs under the Colorado Medicaid Mental Health Capitation and Managed Care Program. Previously, in *Colorado Dept. of Health Care Policy and Financing*, DAB No. 2085 (2007), the Board upheld the CMS disallowance of supplemental payments for the period October through November 2004 on the grounds that those payments were inconsistent with the contract and administrative approval requirements at sections 438.6(a) and 438.6(c) of the regulations.

In 1995 Colorado implemented the Colorado Medicaid Mental Health Capitation and Managed Care Program under a section 1915(b) waiver. Under the program, Colorado contracted with MHASAs operating in discrete geographic areas to provide mental health services to Medicaid recipients. Colorado made monthly capitation payments to the MHASAs for enrolled recipients in the MHASAs' geographic areas. Colorado states that it developed the initial capitation rates using fiscal year 1994-1995 Medicaid fee-for-service (FFS) data of state plan services provided by community mental health centers and individual mental health providers that billed Medicaid. P. Br. at 11.

According to Colorado, the costs of certain mental health services furnished by child placement agencies (CPAs) to foster care children were inadvertently excluded from the initial capitation rates because payment for these services historically had been made "outside of Colorado's Medicaid fee for service (FFS) framework." *Id.* Specifically, Colorado states, since the 1970s county departments of social services retained CPAs to provide foster care placement and maintenance services, including some therapeutic services. Historically, the counties directly contracted with and paid the CPAs fixed amounts for these services. Consequently, Colorado states, the "payments generated no FFS data." *Id.*

According to Colorado, in 1998 the State incorporated the "medically necessary county-funded services provided to CPA children . . . into the capitated rates." P. Ex. 12, at 2. At that time, Colorado states, the counties stopped making payments directly to the CPAs and directed funds to the Colorado Department of Health Care Policy and Financing. County funding for the services, however, remained fixed. Colorado states that due to subsequent, unanticipated increases in MHASA enrollment, the fixed amount of county funding was insufficient to meet the counties' payment obligations. Consequently, Colorado states, Colorado and the MHASAs "orally agreed to amend the contracts." P. Ex. 15, at 2. Pursuant to the parties' agreement, Colorado contends, beginning in April 2001 Colorado "removed the funding attributable to the counties from the capitation rates" and began to make separate, supplemental payments to the MHASAs using the

"fixed county funds." P. Ex. 12, at 2. From April 2001 through November 2004, the MHASAs received $24,000,947 in supplemental payments, of which $12,227,602 was FFP. P. Ex. 9, at i.

Colorado submitted, and CMS reviewed and approved, contracts between Colorado and the MHASAs establishing capitation rates, and actuarial certifications supporting those rates, for the periods July 1, 2003, through June 30, 2004; and July 1, 2004, through December 31, 2004. CMS Ex. 1, ¶ 2.

According to CMS, CMS first learned that Colorado was making supplemental payments over and above payments at the approved capitation rates during a site review of the Colorado Medicaid Community Mental Health Services Program in April 2004. CMS Ex. 1, ¶ 3. By letter to CMS dated October 8, 2004, Colorado confirmed that it was making the supplemental payments. CMS Ex. 1, ¶ 4. In November 2004, CMS asked Colorado to stop making the supplemental payments. *Id.* In April 2005, CMS notified Colorado that CMS would defer $487,390 in FFP that Colorado had claimed as supplemental payments for CPA services for October through November 2004. DAB No. 2085, at 3. In November 2005, CMS issued a notice of disallowance for those payments. *Id.*

In May 2007, the Board upheld the disallowance for October through November 2004, concluding that the supplemental payments for that two-month period were neither recognized under the MHASA capitation rate contracts that CMS had reviewed and approved, nor under any supplemental contracts approved by CMS. DAB No. 2085. The Board noted that while the parties appeared to agree that section 438.6(a) did not preclude retroactive consideration and approval by CMS of supplemental contracts addressing the additional payments, Colorado had never presented any such contracts for review. *Id.* at 5-6.

CMS thereafter asked the HHS Office of Inspector General (OIG) to review the supplemental payments made before October 1, 2004. In October 2008, the OIG issued its final report, "Review of Colorado Medicaid Mental Health Capitation and Managed Care Program," No. A-07-06-04067. P. Ex. 9. The OIG found, among other things, that the supplemental payments made from August 13, 2003 through September 30, 2004 "were not fully consistent with Federal and State requirements" and that $3,324,269 in FFP was unallowable because Colorado did not obtain CMS's approval of contracts covering the supplemental payments for that period. *Id.* at ii.

On August 3, 2009, CMS issued a determination disallowing $3,324,269 in FFP claimed by Colorado for "unallowable supplemental payments made from August 13, 2003 through September 30, 2004." In support of its determination, CMS cited the OIG audit report findings. CMS further stated that Colorado failed to submit for CMS approval contracts addressing the supplemental payments, as required under section 438.6(a). CMS further noted that "all risk contracts must meet" the requirements at section 438.6(c) of the regulations. *Id.* Colorado timely appealed CMS's determination.

Analysis

I. CMS properly determined that the supplemental payments were not eligible for FFP under 42 C.F.R. § 438.6.

As noted, section 438.6(a) of the regulations requires that the CMS Regional Office review and approve the PIHP contracts into which a state enters for the administration of its Medicaid managed care program. As part of the contract review and approval process, the state must provide documentation evidencing that PIHP payments: 1) are based on actuarially sound capitation rates developed in accordance with generally accepted actuarial principles; 2) are appropriate for the populations to be covered and the services to be furnished under the contract; 3) are based only on services covered under the state plan (or costs directly related to providing these services); and 4) have been certified as meeting the requirements of section 438.6(c) by qualified actuaries. 42 C.F.R. § 438.6(c); DAB No. 2085, at 4; 67 Fed. Reg. 40,989, at 40,998 (2002). By reviewing the documentation and "the process used in setting the rates under a risk contract," CMS fulfills its "regulatory responsibilities to the fiscal integrity of the Medicaid program" and ensures "that States have considered all relevant factors in this process." 67 Fed. Reg. at 40,998.

Section 438.6 of the regulations was published in the *Federal Register* on June 14, 2002, and states were given until August 13, 2003 to come into compliance with it. 67 Fed. Reg. 40,989, 41,072. Thus, Colorado had more than one year's notice before it was required to submit for CMS review and approval contracts or contract amendments to support all of its payments to the MHASAs, including payments outside of the established capitation rates. Colorado does not deny that, notwithstanding the notice provided, the supplemental payments it made to the MHASAs for the period August 13, 2003 through September 30, 2004 were neither recognized under the MHASA contracts in effect for that period, nor provided for in any written amendments to those contracts. Indeed, Colorado acknowledged to the OIG during the course of the audit that while it "did not intend . . . to circumvent federal regulations . . . at worst, the Department's existing payment structure merely failed to conform to the regulatory requirements implemented by 42 C.F.R. § 438.6 in August 2003." P. Ex. 5, at 3.

Accordingly, in the absence of approved contract amendments addressing the supplemental payments, we conclude that CMS properly determined that FFP is not available for the supplemental payments made for the period August 13, 2003 through September 30, 2004.

II. CMS has not abused its discretion in denying Colorado's request for retroactive review and approval of contract "ratifications" and a retrospective actuarial certification.

A. The Parties' Arguments

Colorado concedes that "42 C.F.R. § 438.6 requires CMS approval of PIHP and other contracts, including supplemental payments [contracts]," but argues that "the rule does not prohibit retroactive approval." P. Br. at 3. On appeal, Colorado "now submits ratifications and actuarial certification of the payments that formed the basis of the disallowance." P. Br. at 24, citing P. Exs. 15, 16. Colorado asks the Board to "direct CMS to consider such documentation for approval" because, Colorado argues, the supplemental payments were necessary and proper, and based on actuarially sound rates. *Id.* at 23. Colorado also contends that it has provided the OIG and CMS evidence showing that the MHASAs and Colorado "modified the payment terms" of their approved contracts by oral agreement, "removing the capitated rate portion provided by the participating counties for CPA services, and paying that portion instead by lump sum . . ." *Id.* at 19. Colorado further asserts that its actions "enabled [the State] to achieve savings in furtherance of the intent of 42 C.F.R. § 438.6." *Id.* at 3.

Colorado also contends that at various times it has "requested permission to submit contract revisions for the supplemental payments," but that "CMS has not permitted" Colorado to submit the amendments. *Id.* at 10-11. Colorado argues that "CMS did not and does not have substantial bases on which to deny retroactive review." P. Reply at 1. To support its argument, Colorado cites the Board's decision in *Iowa Dept. of Human Services*, DAB No. 1340 (1992). *Id.* at 2. In that case, the Board held that CMS had considerable discretion in determining whether to grant retroactive approval of Medicaid drug utilization review services contracts, but "may not deny retroactive approval based on unsubstantiated conclusions or on bases so insubstantial that the decision fairly can be described as capricious." *Id.* at 7-8, quoting *Virginia Dept. of Medical Assistance*, DAB No. 1195, at 11 (1990), quoting *Alabama Dept. of Human Resources*, DAB No. 939, at 7 (1988). Where an HHS agency has the discretion "to grant approval after-the-fact," the Board then stated, "the agency may not merely rely on the lack of prior approval per se to deny retroactive approval; the agency must articulate a reasonably persuasive substantive basis for denying such approval." P. Reply at 2, quoting DAB No. 1340, at 1. Here, Colorado argues, "CMS failure to afford retroactive review would amount to a refusal based simply on failure to obtain prior approval." *Id.* at 2. Consequently, Colorado contends, CMS's actions have been "arbitrary and capricious." *Id.* at 1.

In response, CMS does not deny that it has the authority under section 438.6 to review and approve PIHP contracts on a retroactive basis. CMS argues, however, that in this case, review and approval of Colorado's June 2010 "Contract Ratification" and retrospective actuarial certification is not warranted. CMS contends that it "has the discretion to deny [a request for] retroactive review and approval of contracts as long as it can articulate a substantive basis for doing so." CMS Br. at 1-2, 8, citing DAB No. 1195,

at 11, quoting DAB No. 939, at 7. Here, CMS argues, there are multiple grounds supporting its decision, including Colorado's failure to timely disclose to CMS the alleged oral agreements between the State and the MHASAs regarding the supplemental payments; "the extreme passage of time in this case;" and "the lack of proof that Colorado's removal of the CPA-related services from the capitated rate did not result in duplicate payments." P. Br. at 8.

B. The Standard of Review

The standard of review of a decision committed to an agency's discretion is whether the decision was arbitrary, capricious, an abuse of discretion or otherwise not in accordance with the law. *River East Economic Revitalization*, DAB No. 2087 (2007). The Board previously has applied this standard to decisions committed to the discretion of an HHS operating division by regulation or policy. *Id.* at 7, and cases cited therein. The Board has not considered the applicability of this standard in the context of a CMS decision to deny a grantee's request for retroactive approval of an amendment to a previously approved Medicaid managed care contract. However, as noted above, both parties here appear to agree that we should be guided by the standard articulated in prior decisions on retroactive approval. In those cases, the Board has held that the agency has "considerable discretion" to deny the request. DAB No. 1195, at 11, quoting, DAB No. 939, at 7. The agency, however, "may not deny retroactive approval based on unsubstantiated conclusions or on bases so insubstantial that the decision fairly can be described as capricious." *Id.*

For the reasons discussed below, we conclude that CMS has grounds for denying Colorado's request for retroactive review and approval that are substantiated by the record and rest on substantial bases that reflect legitimate concerns about Medicaid program integrity.

C. Discussion

1. Colorado failed to timely disclose the alleged oral agreements it had with the MHASAs and unreasonably delayed the submission of written contract amendments necessary to support the supplemental payments.

CMS argues that Colorado's request for review of the "contract ratification" and retrospective actuarial certification should be denied because Colorado failed to timely disclose any oral agreements it had with the MHASAs regarding the supplemental payments and unreasonably delayed the submission of the written contract amendments required under section 438.6. The record supports denial of retroactive approval on these grounds. As noted, Colorado did submit, and obtain CMS's approval of, MHASA contracts for the period August 13, 2003 through September 30, 2004. P. Ex. 15; CMS Ex. 1, ¶ 2. Those contracts provided for payment of specified capitation rates for specified mental health services, with certifications that those rates were actuarially sound. *Id.* CMS thus reasonably understood that the MHASA payments under the

approved capitation rates covered all medically necessary mental health services provided under Colorado's Medicaid mental health managed care program.

Colorado did not disclose to CMS any oral agreements with the MHASAs to make supplemental payments outside of the approved capitation rates until years after it began to make those payments in April 2001. Indeed, while Colorado states that it "did not obscure the supplemental lump sum payments," it does not deny that CMS did not learn of the payments until April 2004, when CMS "happened upon" information discovered during a program site visit. P. Reply at 5; CMS Br. at 8-9; CMS Ex. 1, at ¶ 3. Colorado states that the evidence "indicates that as early as October 8, 2004, [it] did disclose the changes incidental to the supplemental payments." P. Reply at 5. That date, however, followed the site visit and was more than 13 months after Colorado was required to come into full compliance with section 438.6.

During the Board proceedings addressing CMS's disallowance of the supplemental payments made for the period October through November 2004, Colorado indicated that it "would be willing to submit at a future date a supplemental contract for CMS's consideration." DAB No. 2085, at 5. The Board found that Colorado's offer to submit a contract for retroactive approval at some future date was not a sufficient ground for overturning the disallowance then on appeal. However, the Board observed that CMS "seem[ed] to agree that retroactive consideration of approval is possible." *Id.* The Board's May 2007 decision thus made clear that "Colorado was obliged after the deadline for compliance (August 13, 2003) to request approval for supplemental contracts covering CPA costs for any subsequent period after the deadline," and that CMS considered retroactive review of contract amendments under section 438.6 possible. *Id.* Nevertheless, Colorado failed thereafter to submit for CMS's review either written contract amendments or the actuarial certification needed to support the supplemental payments for the period August 13, 2003 through September 30, 2004.

Colorado attributes its failure to CMS. P. Br. at 11, 16, 21-22. Colorado states that it made clear in its March 28, 2008 response to the OIG's January 2008 draft audit report that it was "in the process of preparing contracts for CMS review and approval." P. Ex. 5, at 3; P. Br. at 20-21. Colorado adds that it also offered "to discuss the rate calculation . . . and submit actuarial certification to obtain CMS approval." P. Br. at 7, citing P. Ex. 5, at 4. Colorado now asserts that it did not submit these documents because CMS "did not permit [Colorado] to do so and instead requested additional information and documentation pertaining to explanation of the original and revised capitation rates and breakdown of monthly payments to the MHASAs." P. Br. at 21, citing P. Ex. 7. Colorado adds that "CMS did not respond to or accept" Colorado's offer to discuss the rate calculation and to submit the actuarial certification. P. Br. at 7, citing P. Ex. 5, at 4. Colorado also contends that CMS's February 3, 2009 response to the final OIG audit report, "again failed to recognize the Department's request to submit agreements for the supplemental payments to CMS for approval." P. Br. at 22, citing P. Ex. 11. "In fact" Colorado argues, "CMS has at no time indicated that it would agree to review memorializations to the contractual changes to payment methodologies." P. Br. at 22-23.

Thus, Colorado argues that CMS's "failure to afford retroactive review" is arbitrary, elevates form over substance, and is "effectively base[d] . . . solely on the fact that prior approval ha[s] not been obtained." P. Reply at 2-4.

The record does not support these allegations. First, we note, Colorado has failed to explain why, in the months immediately following the issuance of the Board's May 2007 decision, it did not submit for CMS approval any written contract amendments for the supplemental payments made prior to October 2004. The OIG's January 2008 draft audit report thus recommended that the August 13, 2003 through September 2004 supplemental payments be disallowed because Colorado had not obtained CMS's approval of contracts providing for those payments. P. Ex. 4, at 5. Furthermore, Colorado's March 28, 2008 response to the draft report stated that for "the period from August 2003 to September 2004," Colorado was "in the process of making contract amendments and obtaining revised certification letters to correct the rate calculation, *and will submit them to CMS for approval*." P. Ex. 5, at 5 (emphasis added). Nothing in Colorado's response indicated that Colorado was awaiting a response from CMS before completing and submitting the promised documents. Nor is there evidence that CMS told Colorado in response to the March 28, 2008 letter that CMS would refuse to review such documents.

Moreover, the April 11, 2008 letter to Colorado requesting evidence about how Colorado had developed the capitation and supplemental payment rates could not reasonably be understood as barring Colorado from submitting to CMS the documents that Colorado had indicated were forthcoming. Notably, the letter requesting the information was sent by the OIG, not CMS. P. Ex. 6. Furthermore, the evidence about the MHASA capitation and supplemental payment rates was not required in lieu of necessary written contract amendments and actuarial certification. Rather, as discussed in greater detail below, the requested evidence was necessary to verify Colorado's representations about the costs used to calculate the rates and to ensure that the supplemental payments were not duplicative of compensation to the MHASAs for CPA services under the approved capitation rates. Accordingly, the OIG's final audit report noted that Colorado had "said that it was in the process of submitting revised contracts to the State Controller for approval." P. Ex. 9, at ii. Yet, as of the October 2008 issuance of the final report, Colorado had yet to submit the documents that, more than six months earlier, it said it was preparing.

In addition, CMS certainly is not arbitrary in now asserting that it should not be compelled to undertake a retroactive review when, at this late date, Colorado has yet to submit actual written contract amendments signed by the parties in support of the payments. Instead, Colorado proffers a document titled "Request for Contract Ratification," dated June 10, 2010. P. Ex. 15. That document refers to two sets of contracts with the MHASAs, one set with an original contract date of May 15, 2001 (with the exception of one contract dated July 5, 2001); and the other set with an original contract date of September 1, 2003. *Id.* at 1. The document then sets forth a list of "factual recitals," essentially reiterating Colorado's ongoing contentions about the history

of the supplemental payments, including Colorado's contention about oral agreements to remove payments for CPA services from the capitation rates for the period beginning "April 1, 2001 and continuing until the end of the Contracts' terms on September 30, 2004, . . . and instead make prospective fixed sum payments outside of the capitation rate for the CPA services." *Id.* at 2. The document asserts that the "amendment to the Contracts was evidenced by contemporaneous written communications between the Parties and by the Parties' conduct during the remaining term of the Contracts." *Id.* The document then includes a statement that the facts stated therein "are true and correct" and "fairly represent[] the agreement of the Parties." *Id.* at 3. The document next provides that, based on the representations in the document, "the Colorado Department of Health Care Policy and Financing hereby requests that the Colorado State Controller . . . acknowledge his or her ratification of the amendment of the Original Contracts as set forth above." This statement is followed by the signature of the Department's Executive Director and a signed statement by the State Controller ratifying "the amendments to the Contracts, as described . . . above." *Id.* at 3-4.

Colorado apparently intends the "Request for Contract Ratification" to serve as a substitute for the written PIHP contract amendments required for CMS to review and approve under section 438.6. P. Br. at 26. Aside from the issue of whether ratification of oral agreements could ever substitute for written contract amendments, the submission of this document raises the question why Colorado has not produced written amendments, signed by all of the parties to the original contracts, which, years ago, Colorado stated it would provide. Moreover, neither the "contract ratification" nor Colorado's briefs explain why, if the oral agreements were in effect as of April 2001, the provisions of the oral agreements were not memorialized in writing in the contracts entered into on May 15, 2001, or later.

Furthermore, Colorado has never produced the alleged "contemporaneous written communications between the Parties" evidencing the oral agreement for the supplemental payments. The only "contemporaneous" documentation in the record regarding the supplemental payments consists of financial transaction forms and letters from Colorado requesting that a Colorado contractor process the supplemental payments. P. Ex. 7, Att. 6. The language in the letters suggests that there was some agreement to make "flat rate" payments to the MHASAs and supports the idea that there had been some problem with using "the number of Foster Care eligibles as a proxy" for payments. *Id.* It also suggests, however, that the supplemental payment amounts were determined based on the available funding from the counties, not on the costs of the CPA services. The county funding would not necessarily relate to the cost of the CPA services or even to the amounts Colorado alleges it "removed" from the capitation rates.

Colorado's failures described above are substantiated by the record. Alone, they provide a basis for the Board to conclude that CMS's refusal to do retroactive review is not arbitrary, capricious, or an abuse of discretion. Moreover, without the necessary documentation, CMS could not timely determine whether the payments were necessary

and proper, and thus discharge its responsibility to ensure the fiscal integrity of the Medicaid program.

2. Colorado has failed to show that the supplemental payments did not duplicate payments for the CPA services under the approved capitation rates.

We further conclude that CMS has a substantial basis for denying Colorado's request for retroactive review because Colorado has failed to establish that the supplemental payments did not duplicate payment to the MHASAs for services already covered under the approved capitation rates. The question of duplicate payments for the same services was addressed in the Board's 2007 decision. The Board then noted that "as part of the approval process," it would not be enough for Colorado to document retroactively "the actuarial soundness of the payment for the CPA services," since the approved contracts "still purport[] to cover these very services." DAB No. 2085, at 6. As CMS previously stated, this fact led it "to question whether the State [would] actually [be] paid twice for the CPA services, once in the capitated rate and once in the supplemental payment." *Id.*

The issue of duplicate payments for the same services was again raised during the OIG's audit of the supplemental payments made prior to October 2004. On several occasions Colorado was asked for evidence to verify its claim that the payments were not duplicative, including evidence that the part of the capitation payments associated with the CPA services was removed from the capitation rates beginning in April 2001. P. Ex. 6, at 1; P. Ex. 9, at ii-iii, 6; P. Ex. 11. Most notably, in its April 11, 2008 letter to Colorado, the OIG specified that evidence was needed to show, among other things, how the original capitation rates were calculated; how the revised capitation rates were calculated, "showing the amounts removed from the capitated rates and an explanation of how these reductions were calculated;" and a breakdown of the monthly MHASA payments and "explanation of how each payment was calculated." P. Ex. 6.

In response, Colorado provided a July 1, 2008 letter that summarized in general how Colorado developed the original and revised capitation rates and how it derived the supplemental payment amounts but did not address the OIG's specific questions, such as how the reductions were calculated and how the MHASA payments were calculated. P. Ex. 7. Colorado included with the letter several other documents, but again, none of these documents addressed the OIG's specific questions. The only documentation from the disallowance period that Colorado provided consisted of the above-described financial transaction forms and transmittal letters requesting that a Colorado contractor process the financial transaction requests for "MHASAs CPA payments." P. Ex. 7, at 6. The OIG determined that none of the submitted materials constituted evidence that "the costs associated with the mental health services provided to foster care children in CPAs were removed from the capitation rates." P. Ex. 9, at 6. Consequently, the OIG concluded that there was insufficient support for the contention that "the costs of providing the mental health services to foster care children in CPAs were reimbursed only once and therefore that all Federal requirements had been met." *Id.*

CMS now argues that Colorado has yet to produce the evidence necessary to establish that the supplemental payments did not duplicate payments under the approved capitation rates. CMS Br. at 9-10. CMS adds that it "also remains unclear just what services are included in the carved out CPA rate" since "Colorado has not provided CMS with an itemized representation of those charges." *Id.* at 9. CMS notes that the chart that Colorado created to illustrate its "Foster Care Capitation Rate Development" purports to show that "the removal of the CPA rate lowered the foster care capitation rate beginning in April 2001." CMS Br. at 10; P. Br. at 14. CMS argues, however, that the figures in the chart "do not appear to be supported by the actual FFS data that established the portion of the MHASA rate that needed to be part of the supplemental payment." CMS Br. at 10. Moreover, CMS contends, the June 10, 2010 retrospective actuarial certification that Colorado presents "does not address the capitated rate and does not rule out the possibility of duplicated charges." *Id.*

In its reply, Colorado contends that CMS's reliance on the duplicate payments issue as a basis for denying retroactive review is unreasonable and improper. The issue, Colorado asserts, "was never identified by the OIG" or CMS as a basis for disallowing the supplemental payments made for the August 13, 2003 through September 30, 2004 period. Colorado states that the duplicate payments issue was identified by the OIG only "with respect to the time period of April 1, 2001 to August 12, 2003." P. Reply at 6. "Despite the fact [that] duplicate payments were never in issue in this case," Colorado states, the July 1, 2008 letter and attachments provided "reasonable support that its actions had not resulted in duplicate charges." *Id.* at 6-7. "CMS opposition to considering such information," Colorado contends, "supports the conclusion that CMS prejudged the request to submit the contract changes for retroactive review." *Id.* at 7.

Colorado's arguments have no merit. As noted, the question of duplicate payments for the same services has been repeatedly raised, including during the course of the appeal addressing the October through November 2004 supplemental payments. Notably, the approved MHASA contracts addressed in that appeal were in effect during the latter part of the disallowance period now at issue, which ends on September 30, 2004. CMS Ex. 1, at ¶ 2 ("CMS reviewed and approved capitated rate contracts . . . for periods covering July 1, 2003, through June 30, 2004, and July 1, 2004 through December 31, 2004."); P. Ex. 4, at 5, n.8. In addition, according to the OIG's final audit report, Colorado acknowledged to the auditors that the contracts "required the MHASAs to provide all mental health services to all Medicaid-eligible recipients." P. Ex. 9, at 6. Even assuming that this statement is referring only to the contracts in effect for the period prior to August 13, 2003, the record indicates that those contracts were in effect for at least part of the August 13, 2003 through September 30, 2004 disallowance period as well. CMS Ex. 1, at ¶ 2. Thus, while the OIG audit report discusses the duplication issue in the context of discussing supplemental payments made prior to the disallowance period on appeal, the audit findings are clearly relevant to the disallowance period at issue in this appeal. Colorado evidently understood this since it addressed the issue in its initial brief, as well as later. P. Br. at 20. Moreover, despite the fact that CMS clearly raised the duplication issue in its response brief in this case, Colorado did not provide any evidence

with its reply that the relevant contracts did not, in fact, require the MHASAs to provide all covered mental health services to all enrollees, including Foster Care children, in exchange for the capitation payments at the original contract rates.

Furthermore, the OIG auditors and CMS reasonably did not consider the materials that Colorado produced in July 2008 to be documentation that, in fact, the costs of CPA services had been removed from the capitation rates. Most significantly, the "Foster Care Capitation Rate Development Chart" on which Colorado has repeatedly relied to support its characterizations of the development of the rates and removal of CPA costs is not reliable evidence. The chart shows that in April 2001 the capitation rates decreased. P. Br. at 14; P. Ex. 7, Att. 3, at 2; P. Ex. 15, at 6. The chart further shows that the "total rates" (i.e., the Foster Care capitation rate plus the supplemental CPA rate) paid to the MHASAs after April 2001 were less that the capitation rates in effect prior to that period. *Id.* The chart does not, however, evidence what costs associated with the mental health services provided to foster children in CPAs were removed from the capitation rates, nor does it establish that the overall payments to the MHASAs declined (and resulted in savings to Colorado and the federal government) because the CPA services were paid outside of the capitation rates. As CMS states, the reasons for the overall decline in the total payment rates made to the MHASAs since 2001 could have been "any number of factors, none of which are available for the review and consideration by the Board." CMS Br. at 10. Indeed, Colorado's more detailed "Foster Care Rates History Sheet" attributes "additional rate cuts in Q4 FY00-01 and FY01-02" to the "results of the competitive bidding process," and the additional cuts in "FY03-04 and FY04-05" to "service cuts." P .Ex. 7, Att. 2.

Moreover, we agree with CMS that a June 10, 2010 retrospective actuarial certification proffered by Colorado in this case does not rule out the possibility that the supplemental payments duplicated charges incorporated into the capitation rates. That certification is expressly limited to the "CPA add-on rates" and "is only intended for the CPA eligible population." P. Ex. 16.

Finally, without documentation showing that the costs of the CPA services were in fact removed from the capitation rates, there is no assurance that the alleged amended contracts would satisfy the regulatory requirements, including the requirement that the capitation rates be actuarially sound. Nor is there any assurance that what Colorado did resulted in a savings to the federal government, as Colorado alleged.

Accordingly, we conclude that the record supports CMS's contention that Colorado failed to show that the supplemental payments would not duplicate reimbursement to the MHASAs under the approved capitation rates. This alone is a substantial basis for denying Colorado's request for retroactive review.

Conclusion

Based on the foregoing analysis, we uphold the August 3, 2009 CMS determination disallowing $3,324,269 in Medicaid FFP claimed by Colorado for the August 13, 2003 through September 30, 2004 period.

_____/s/_____
Sheila Ann Hegy

_____/s/_____
Leslie A. Sussan

_____/s/_____
Judith A. Ballard
Presiding Board Member