Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Colorado Department of Health Care Policy and Financing
Docket Nos. A-14-57 and A-14-58
Decision No. 2640
June 5, 2015

DECISION

The Centers for Medicare & Medicaid Services (CMS) disallowed $12,064,042 in federal financial participation (FFP) claimed by the Colorado Department of Health Care Policy and Financing (HCPF) for expenditures on Medicaid "outstationing." The term "outstationing" refers to efforts that enable persons to apply for Medicaid at locations other than welfare offices.

The expenditures for which CMS denied FFP relate to outstationing activities performed during calendar years 2000 through 2006 at facilities operated by the Denver Health & Hospital Authority (Denver Health), a political subdivision of the state of Colorado. Denver Health incurred costs to perform the outstationing activities, then obtained reimbursement for those costs from HCPF, which administers Colorado's Medicaid program. Two reimbursement mechanisms were used. One involved retrospective payments to Denver Health from Colorado's general fund; each of the retrospective payments at issue was made five (or more) years after the calendar year in which Denver Health incurred the costs for which it was being reimbursed. The second reimbursement mechanism required Denver Health to certify its outstationing-related costs as expenditures eligible for FFP; the FFP obtained by HCPF for those expenditures was then passed back to Denver Health.

Between 2006 and 2011, HCPF submitted FFP claims for both the retrospective payments and Denver Health's certified public expenditures. CMS justifies the disallowance of those claim on two principal grounds. First, it contends that the claims were time-barred by 1132(a) of the Social Security Act (Act),[1] which requires that a claim for FFP in a state expenditure be filed within two years after the calendar quarter in

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

which the state makes the expenditure. Second, CMS contends that the disallowance was proper under 45 C.F.R. § 95.517 because HCPF did not claim FFP for the outstationing expenditures in accordance with a cost allocation plan approved by the Department of Health and Human Services (HHS).

For reasons explained below, we hold that all of the disallowed FFP claims are time-barred under section 1132(a) of the Act. In addition, we hold that claims relating to outstationing activities performed at least during calendar years 2000 through 2004 were also properly disallowed because they were not prepared and submitted in accordance with an HHS-approved cost allocation plan.

I. Legal Background

The federal Medicaid statute, title XIX (sections 1901-1946) of the Act, authorizes a program that furnishes medical assistance to low-income individuals and families. The program is administered by each state in accordance with an HHS-approved Medicaid State plan. Act §§ 1902, 1903; 42 C.F.R. § 430.0. A state with an approved State plan is eligible to receive federal matching funds, or FFP, for a percentage of the Medicaid program expenditures it makes in accordance with the plan. Act § 1903; 42 C.F.R. §§ 430.30(a), 433.10(a), 433.15(a).

Section 1902(a)(55) of the Act requires a Medicaid State plan to "provide for receipt and initial processing of [Medicaid] applications" at locations other than local welfare offices. The purpose of that requirement is "to make the Medicaid application process more accessible to low-income pregnant women, infants, and children." 59 Fed. Reg. 48,805, 48,806 (Sept. 23, 1994). The CMS regulations which implement section 1902(a)(5) require states to provide these groups with an opportunity to apply for Medicaid at "outstation locations" that must include "disproportionate share hospitals" (DSH) and "Federally-qualified health centers" (FQHC) that participate in the Medicaid program. 42 C.F.R. § 435.904(c). In accordance with the statute, each outstation location must provide for "the receipt and initial processing" of Medicaid applications.[2] *Id.* § 435.904(d)(1). *Id.* § 435.904(d)(2). That function may be performed by DSH or FQHC employees, entities under contract with the DSH or FQHC, state employees (whether or not employed by the state Medicaid agency), and others. *Id.* § 435.904(e)(3); *see also* 59 Fed. Reg. at 48,807; CO Ex. 4 (State Medicaid Director Letter #01-008), at 6-7.

[2] "'Initial processing' means taking applications, assisting applicants in completing the application, providing information and referrals, obtaining required documentation to complete processing of the application, assuring that the information contained on the application form is complete, and conducting any necessary interviews." 42 C.F.R. § 435.904(d)(2).

Expenditures made to provide initial processing of Medicaid applications at outstation locations (including expenditures for salaries, fringe benefits, travel, training, equipment, and space) are considered costs of Medicaid program "administration." 59 Fed. Reg. at 48,808. Such expenditures are eligible for FFP at the 50 percent rate. *Id.* (*citing* Act § 1903(a)(7), which authorizes FFP for state expenditures "found necessary by the Secretary [of Health & Human Services] for the proper and efficient administration of the State plan").

The FFP rate is sometimes called the "Federal share" of a state's allowable Medicaid expenditures. 42 C.F.R. § 433.10. In order to finance the "State share" of FFP-eligible Medicaid expenditures, a state may, in certain circumstances, rely on funds expended by a public agency other than the state Medicaid agency. *See* 42 C.F.R. § 433.51. In order for such expenditures to be used as State share, they must be "certified by the contributing public agency as representing expenditures eligible for FFP" (and meet other requirements). *Id.* § 433.51(b), (c).

Medicaid FFP is disbursed to states in quarterly awards. 42 C.F.R. § 430.30(a). A state claims FFP by filing a Medicaid statement of expenditures (form CMS-64) within 30 days after the end of each quarter. *Id.*, § 430.30(c)(1). This quarterly statement of Medicaid expenditures, or QSE, is an "accounting of [the State's] actual recorded [Medicaid] expenditures" which the state believes are entitled to FFP. *Id.* § 430.30(c)(2).

II. Case Background[3]

Denver Health is an integrated healthcare network that includes a hospital (Denver Health Medical Center), FQHCs, and school-based health centers. CO Ex. 49, ¶ 7. During calendar years 2000 through 2006, Denver Health provided for the receipt and initial processing of Medicaid applications at numerous outstation locations. *Id.* ¶¶ 7, 8. In performing that function, Denver Health incurred costs that included: (1) salaries and related compensation of employees who staffed the outstation locations; (2) indirect costs (which were assigned using a "step-down" allocation process); (3) reimbursement of the Denver County Human Services Department, whose employees apparently helped with the initial processing of Medicaid applications; and (4) payments in 2005 and 2006 to a contractor named Chamberlin Edmonds & Associates. *Id.*, ¶¶ 8, 17-19, 22.

[3] We use the following abbreviations in citing to the appeal record: "CO Br." (HCPF's initial brief); "Response Br." (CMS's response brief); "Reply Br." (HCPF's reply brief); "CO Ex." (HCPF Exhibit); and "CMS Ex." (CMS Exhibit).

Section 2505-10-8.700.8 of title 10 of the Colorado Code of Regulations – section 8.700.8 for short – authorizes HCPF to reimburse both "freestanding" and "hospital-based" FQHCs for their Medicaid outstationing costs. (For discussion purposes, we assume that the Denver Health facilities whose outstationing activities are implicated by the disallowance were all hospital-based FQHCs.)

Section 8.700.8 has undergone revisions since 2005. As of 2005, the regulation directed HCPF to "reimburse FQHCs for reasonable costs associated with accepting applications to determine Medicaid eligibility" subject to both a "reasonable cost-per-application limit" and a total reimbursement cap of "$60,000 per facility per year for all administrative costs associated with outstationing activities." 10 CCR § 2505-10-8.700.8.A (2005) (CO Ex. 8). In order to receive reimbursement, FQHCs were required to submit "annual logs of applicant information to [HCPF]." *Id.* § 8.700.8.B. In addition, hospital-based FQHCs were required to "submit the administrative and general pass through direct costs associated with outstationing activities on an extra line on the Medicaid Cost Report (related to Worksheet A – Trial Balance)." *Id.* § 8.700.8.C.2. (This means that hospital-based FQHCs were required to report their outstationing costs on an appropriate worksheet of the parent hospital's cost report, which a hospital must file annually with a Medicare program contractor and whose data is used by both the Medicare program and Colorado's Medicaid program for various purposes, including determining the amount of Medicare payment due and calculating Medicaid reimbursement rates.[4]) Section 8.700.8 stated that reimbursement of hospital-based FQHCs would be in the form of an "annual lump sum retrospective payment." *Id.* § 8.700.8.C.2.

In a letter dated April 5, 2005, HCPF notified CMS of its concern that the existing reimbursement formula (which capped reimbursement at $60,000 per facility) was not adequate to cover Denver Health's outstationing costs and that it was considering changing the formula to fully reimburse those costs:

> For the period ending 12/31/2003, Denver Health Medical Center operated 19 Outstation locations and reported $4.118 million in Outstationing related costs. The reimbursement under the current formula allowed for only $1.140 million ($60,000 multiplied by 19 facilities) in compensation. The result was $2.978 million in uncompensated costs, which [Denver Health] absorbed. Because Denver Health Medical Center services the largest

[4] *See* 10 CCR § 2505-10-8.700.6.C.4 (requiring hospital-based FQHCs to "submit separate cost centers and settlement worksheets for primary care services and non-primary care services on the Medicare Cost Report for their facilities"); CO Ex. 49, ¶¶ 12-13; CO Ex. 39, at 8; Provider Reimbursement Manual, CMS Pub. 15-1, Pt. 2, Ch. 28, § 2807 (instructions for Worksheet A of a hospital cost report), available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html.

> volume of Medicaid and low-income clients in the state, and that they are the only provider which qualifies as a FQHC and Disproportionate Share Hospital, the Department believes there is justification to reimburse this provider up to 100% of administrative costs relating to Outstationing. The increased reimbursement proposed by the Department would allow reimbursement for the $2.978 million in uncompensated costs, of which $1.489 million represents the State's share and the remaining $1.489 million represents the federal share . . . .

Id. at 1. HCPF asked CMS to "confirm that FFP [would be] available for 100% of administrative costs for services related to Outstationing when those funds are distributed back to a qualified facility providing the service on behalf of the Department and that no formal amendment to the State Plan is necessary to establish this reimbursement formula." *Id.* at 2.

In its May 25, 2005 response to the April 5 letter, CMS wrote:

> . . . FFP is available to match expenditures incurred by the State for administrative activities related [to outstationing activities] . . . at the 50 percent rate. Because activities related to outstationing constitute administrative functions and are not part of a medical services . . ., the State is not required to have a reimbursement methodology for these activities in the State Plan. As long as the methodology used by the State to reimburse these providers meets the general cost allocation principles of OMB Circular A-87 and ASMB C-10, such reimbursement methodology may cover 100% of the administrative costs for services directly attributable to outstationing such as salaries, fringe benefits, travel, training equipment and space.

CO Ex. 10.

After receiving CMS's guidance, HCPF "obtained a supplementary budget allocation" from the Colorado legislature and in 2006 amended section 8.700.8 "so that [it] could pay Denver Health additional FFP for eligible expenditures not reimbursed" under the pre-existing reimbursement formula. CO Ex. 38, at 4. As amended in 2006, section 8.700.8 stated that "[f]or any FQHC Medicaid cost report audited and finalized after July 1, 2005," Denver Health's FQHCs "shall receive *additional federal financial participation* for eligible expenditures [for outstationing] that are not reimbursed" under the reasonable-cost-per-application methodology that capped total reimbursement at $60,000 per facility. 10 CCR § 2505-10-8.700.B (2006) (italics added) (CO Ex. 13). Section 8.700.8 (as amended in 2006) further stated that in order to receive the additional

reimbursement, Denver Health's FQHCs "shall provide the State's share of the outstationing payments by certifying [to HCPF] that the audited administrative costs associated with outstationing activities are eligible medical expenditures under 42 C.F.R. Section 433.51." *Id.*

Hence, as amended in 2006, section 8.700.8 continued to authorize reimbursement for Denver Health's outstationing costs under the reasonable-cost-per-application methodology (up to a maximum of $60,000 per facility). To the extent Denver Health's outstationing costs exceeded the reimbursement available under that methodology, section 8.700.8 authorized additional reimbursement for the excess costs. Reimbursement of the excess costs was in the form of passed-through FFP – that is, the federal share of any outstationing costs that Denver Health certified as "expenditures eligible for FFP" in accordance with 42 C.F.R. § 433.51(b). (Expenditures certified under section 433.51 are known as "certified public expenditures" or CPE.)

In 2009, HCPF amended its outstationing regulation again. *See* CO Ex. 50, ¶ 12. As amended in that year, section 8.700.8 stated that "[h]ospital-based FQHCs shall receive [FFP] for reasonable costs associated with assisting clients in the Medicaid application process." 10 CCR § 2505-10-8.700.8.B (2009) (CO Ex. 22). In order to receive FFP, the FQHCs were required to "provide the State's share of the outstationing payment by certifying that the audited administrative costs associated with outstationing activities are eligible Medicaid expenditures under 42 C.F.R. Section 433.51." *Id*. The 2009 version of section 8.700.8 severed Denver Health's reimbursement from the reasonable-cost-per-application methodology, requiring that reimbursement be entirely in the form of passed-through FFP for costs that Denver Health certified as public expenditures.[5] *See* CO Ex. 49, ¶ 16. Section 8.700.8 continued to require hospital-based FQHCs to report their outstationing costs on the parent hospital's cost report. 10 CCR § 2505-10-8.700.8.C.2 (2009) (CO Ex. 22).

For its Medicaid outstationing activities during calendar years 2000 through 2004, Denver Health was reimbursed in accordance with the amendment to section 8.700.8 that took effect in 2006. *See* CO Ex. 49, ¶ 15; CMS Ex. 50, ¶ 11. In other words, for each of those years, Denver Heath received a lump sum retrospective "outstationing payment" from Colorado's general fund equal to $60,000 multiplied by the number of its facilities

[5] Reimbursement for Medicaid outstationing costs incurred by freestanding FHQCs remained subject to a "reasonable cost-per-application limit" up to a maximum of $60,000 per facility. 10 CCR § 2505-10-8.700.8.A (2009) (CO Ex. 22).

that performed Medicaid outstationing activities. *Id*. In addition, Denver Health received passed-through FFP for outstationing costs that exceeded the retrospective payment and that it certified as public expenditures eligible for FFP.[6] *Id.*

For its outstationing activities during calendar years 2005 and 2006, Denver Health received reimbursement in accordance with the amendment to section 8.700.8 that took effect in 2009. CO Ex. 49, ¶ 16; CO Ex. 50, ¶ 12. In other words, Denver Health received reimbursement equal to the federal share of outstationing costs that it had certified as public expenditures; the reimbursement for those two years did not include any lump sum retrospective payments. CO Ex. 49, ¶ 16.

For each calendar year in question, the following table shows the method(s) used by HCPF to reimburse Denver Health for Medicaid outstationing activities performed during the year (columns 1 through 5), the total Medicaid outstationing "expenditures" claimed by HCPF for that year (column 6), the federal share of the claimed expenditures (column 7), and the year in which HCPF claimed the expenditures on its Medicaid QSE(s) (column 8):

TABLE 1[*]

(1) Year	(2) Outstation Facilities	(3) Method of Reimbursement	(4) Per-Facility Payments	(5) Denver Health's CPE	(6) Total Expenditures Claimed by HCPF for Medicaid Outstationing	(7) Federal Share of Total Outstationing Expenditures	(8) Year the Federal Share Was Claimed
2000	24	$60K-per-facility retrospective payment ***plus*** FFP for CPE	$1,440,000	$523,919	$1,963,919	$981,960	2006
2001	24	$60K-per-facility retrospective payment ***plus*** FFP for CPE	$1,440,000	$1,089,128	$2,529,128	$1,264,564	2006
2002	24	$60K-per-facility retrospective payment ***plus*** FFP for CPE	$1,440,000	$920,661	$2,360,661	$1,180,331	2007

[6] For example, for calendar year 2000, Denver Health received a retrospective outstationing payment totaling $1,440,000 ($60,000 multiplied by 19 outstation facilities). *See* CO Br., Appendix A. In addition, Denver Health received FFP (at the 50 percent rate) for $523,919 in outstationing costs that were not reimbursed by the retrospective payment and which it certified as public expenditures eligible for FFP. *Id.*

(1) Year	(2) Outstation Facilities	(3) Method of Reimbursement	(4) Per-Facility Payments	(5) Denver Health's CPE	(6) Total Expenditures Claimed by HCPF for Medicaid Outstationing	(7) Federal Share of Total Outstationing Expenditures	(8) Year the Federal Share Was Claimed
2003	21	$60K-per-facility retrospective payment ***plus*** FFP for CPE	$1,260,000	$2,830,904	$4,090,904	$2,045,452	2008
2004	20	$60K-per-facility retrospective payment ***plus*** FFP for CPE	$1,200,000	$3,184,968	$4,384,968	$2,192,484	2009
2005	n/a	FFP for CPE	$0	$3,476,521	$3,476,521	$1,738,261	2010
2006	n/a	FFP for CPE	$0	$5,325,059	$5,325,059	$2,662,530	2011

*The information in this chart is taken from Appendix A of HCPF's initial brief. According to HCPF, the total federal share of Medicaid outstationing expenditures claimed by HCPF for calendar years 2000 through 2006 – that is, the sum of the figures in column 7 – is $1,539 more than the disallowance amount calculated by CMS. Neither CMS nor HCPF has asked the Board to adjust the disallowance amount to account for this discrepancy.

Column 1: Calendar year in which Denver Health performed Medicaid outstationing activities

Column 2: Number of Denver Health facilities that performed Medicaid outstationing activities during the calendar year

Column 3: HCPF's method(s) of reimbursing Denver Health for Medicaid outstationing: (1) a lump sum retrospective payment equal to $60,000 multiplied by the number of Denver Health facilities that performed Medicaid outstationing activities during the calendar year; *and/or* (2) passed-through FFP for Denver Health's certified public expenditures (CPE)

Column 4: The amount of the lump sum retrospective payment to Denver Health for Medicaid outstationing activities (equal to the figure in column 2 multiplied by $60,000)

Column 5: The amount of Denver Health's certified public expenditures (CPE) for outstationing

Column 6: Total expenditures claimed by HCPF for Medicaid outstationing for the calendar year (equal to the sum of the figures in columns 4 and 5)

Column 7: The federal share of total expenditures claimed with respect to Medicaid outstationing activities during the calendar year (equal to 50 percent of the figure in column 6)

Column 8: Year in which HCPF claimed FFP for the expenditures in column 6

As this table shows, there was a five-year (or longer) lag between the calendar year in which Denver Health performed Medicaid outstationing activities and the year in which HCPF claimed FFP for "expenditures" related to the calendar year's outstationing activities. According to HCPF, the delay was the result of the process used to identify, allocate, and audit Denver Health's outstationing costs. CO Br. at 8-13. That process is described in the declarations of Peggy Burnette, Denver Health's Chief Financial Officer (CO Ex. 49), and Nancy Dolson, director of HCPF's Special Financing Division (CO Ex. 50).

The cost determination process for a given calendar year began with Denver Health's submission of its annual cost report to its Medicare contractor. CO Ex. 49, ¶ 13. According to Peggy Burnette, Denver Health submitted its cost report by the last day of the fifth month following the end of the calendar year. *Id.* (The calendar year is Denver Health's Medicare cost reporting period.)
After reviewing and approving the cost report, the Medicare contractor issued a Notice of Program Reimbursement (NPR), which is the Medicare program's statement of the amount of Medicare payment due a provider for the relevant cost reporting period. CO Ex. 49, ¶ 13; *see also* 42 C.F.R. § 405.1803. Denver Health used its cost report and "finalized" NPR to calculate its outstationing costs for the calendar year, then forwarded its calculation to Office of the State Auditor, which reviewed and audited the calculation. CO Ex. 49, ¶¶ 12-13.

After receiving the findings of the State Auditor, HCPF asked Denver Health to certify the audited outstationing costs for the calendar year as public expenditures for Colorado's Medicaid program. *Id.*, ¶ 13. At about the same time (according to Nancy Dolson), the state of Colorado made a retrospective outstationing payment to Denver Health for the calendar year (as noted, the retrospective payments were made only with respect to calendar years 2000 through 2004). CO Ex. 50, ¶ 13; *see also* CO Ex. 52, ¶¶ 2-4. "Once the certification [of public expenditures] was on hand and any general fund transfer had been made, HCPF claimed FFP on the QSE for the quarter in which the State received certification or the quarter immediately following. The federal share of the claim based on Denver Health's certification was then transferred to Denver Health." CO Ex. 50, ¶ 13.

For each calendar year's outstationing activities, the following table shows (in columns 1-3) what HCFP considers to be key dates in the cost determination and reimbursement process. The table also indicates (in column 4) when HCPF submitted FFP claims (QSEs) that reported the expenditures associated with the calendar year's outstationing activities.

TABLE 2

(1) Year	(2) NPR Date	(3) Certification Date	(4) Date of Lump Sum Retrospective Outstationing Payment	(5) QSE Date
2000	10/03/2005	06/15/2006	08/14/2006	06/30/2006 for CPE 09/30/2006 for the lump sum retrospective payment

(1) Year	(2) NPR Date	(3) Certification Date	(4) Date of Lump Sum Retrospective Outstationing Payment	(5) QSE Date
2001	01/30/2006	06/15/2006	08/14/2006	06/30/2006 for CPE 09/30/2006 for the lump sum retrospective payment
2002	08/16/2005	06/20/2007	06/11/2007	06/30/2007
2003	08/07/2006	06/25/2008	06/23/2008	06/30/2008
2004	01/09/2009	06/25/2009	06/15/2009	06/30/2009
2005	12/05/2008	04/07/2010	[redacted]	06/30/2010
2006	06/25/2010	05/09/2011	[redacted]	06/30/2011 and 09/30/2011

Column 1: Calendar year in which Denver Health provided Medicaid outstationing services

Column 2: The dates on which HCPF alleges Denver Health received "finalized NPRs on which Denver Health based the calculation and certification of its outstationing costs" (CO Br., Appendix A, n.2)

Column 3: The date that HCPF says it made a lump sum retrospective outstationing payment to Denver Health (equal to the number of Denver Health facilities that performed outstationing activities during the calendar year multiplied by $60,000).

Column 4: The date that Denver Health certified its public expenditures to HCPF

Column 5: The quarter end-date of the QSE on which HCPF claimed FFP for expenditures relating to the calendar year's outstationing activities

By letter dated July 30, 2013, CMS notified HCPF that it was disallowing $2,692,324 in claimed FFP for expenditures relating to Medicaid outstationing activities performed by Denver Health during calendar year 2006. CO Ex. 36. In a separate letter also dated July 30, 2013, CMS notified HCPF that it was also disallowing $10,677,539 in claimed FFP for expenditures relating to Medicaid outstationing activities performed by Denver Health during calendar years 2000 through 2005. CO Ex. 37.

HCPF filed a request for reconsideration, but CMS upheld its initial disallowance determinations. However, to account for "decreasing adjustments" that HCPF made to some of the disallowed FFP claims, CMS reduced the disallowance amounts slightly – from $2,692,324 to $2,664,513 with respect to the claims associated with calendar year 2006, and from $10,667,539 to $9,399,529 with respect to the claims associated with calendar years 2000 through 2005. *Id.* The sum of these revised disallowance amounts is $12,064,042, the amount in controversy.

III. Discussion

In its July 30, 2013 notice letters, CMS specified several grounds for disallowing HCPF's outstationing-related FFP claims. However, CMS relies on only three of those grounds in this appeal. In particular, CMS contends that all of the disallowed claims (relating to calendar years 2000 through 2006) are time-barred by section 1132(a) of the Act. Response Br. at 26-33. CMS also contends that the claims were subject to disallowance under 45 C.F.R. § 95.517 because they were not prepared and submitted in accordance with an HHS-approved cost allocation plan. *Id.* at 16-26. In addition, CMS contends that a portion of the claimed outstationing expenditures – namely, contingency fee payments made by Denver Health to Chamberlin Edmonds & Associates (CEA) during 2005 and 2006 – do not meet the allowability criteria in CMS Regional Information Letter 4-03 (CO Ex. 5). *Id.* at 33-35. (HCPF estimates that it claimed $1.098 million as the federal share of its payments to CEA. *See* CO Br. at 36 n.17.)

Because the first ground fully supports the total disallowance of FFP relating to the seven calendar years at issue (2000 through 2006), and because the second ground provides additional support for disallowing the claimed FFP relating to five of those calendar years (2000 through 2004), we do not need to address CMS's contention regarding the contingency fee payments to CEA.

A. *The disallowed FFP claims are barred because they were not filed within the two-year period specified in section 1132(a) of the Act and 45 C.F.R. § 95.7.*

With exceptions irrelevant here, section 1132(a) of the Act states that an FFP claim "with respect to an expenditure made during any calendar quarter by the State" is barred unless it is filed within two years after the end of that quarter. The regulation implementing section 1132(a) states that the federal government "will pay a State for a *State agency expenditure*" only if a "claim . . . for that expenditure" is filed "within 2 years after the calendar quarter in which the State agency made the expenditure." 45 C.F.R. § 95.7 (italics added)

For purposes of the Medicaid program (title XIX of the Act), the regulations in 42 C.F.R. Part 95 define the term "State agency" to mean "any agency of the State, including the State Medicaid agency or State Child Health Agency, its fiscal agents, a State health agency, or any other State or local organization *which incurs matchable expenses*." 45 C.F.R. § 95.4 (italics added)

The Part 95 regulations also specify when CMS "consider[s]" a State agency expenditure to have been "made." Of relevance here is section 95.13(d), which states that CMS "consider[s] a State agency's *expenditure for administration* . . . under title[ ] . . . XIX . . . to have been made in the quarter payment was made by a State agency to a private

agency or individual; or in the quarter to which the costs were allocated in accordance with the regulations for each program." 45 C.F.R. § 95.13(d) (italics added). The same regulation also provides that "non-cash expenditures such as depreciation" are treated as having been "made in the quarter the expenditure was recorded in the accounting records of any State agency in accordance with generally accepted accounting principles." *Id.*

As it must, HCPF acknowledges (*see* CO Br. at 18-19) that the two-year claiming period specified in section 1132(a) is triggered by a "State agency *expenditure*." HCPF asserts that the "relevant expenditures" in this case consisted of: (1) "payments from the State to Denver Health" (that is, lump sum retrospective outstationing payments from Colorado's general fund to Denver Health pursuant to the reasonable-cost-per-application methodology that capped Denver Health's reimbursement at $60,000 per facility); and (2) actual outstationing costs that Denver Health certified as public expenditures eligible for FFP. CO Br. at 21.

HCPF contends that its FFP claims with respect to Denver Health's certified public expenditures were timely because they were filed "based on the dates on which it allocated and certified" Denver Health's outstationing costs. CO Br. at 22 n.11. In addition, HCPF contends that its FFP claims with respect to the lump sum retrospective payments were timely because they were filed on the QSE for the quarter in which each payment was made. Reply Br. at 4. For clarity, we address these two contentions separately.

1. The claims for FFP in Denver Health's certified public expenditures

In presenting its argument on the timeliness issue, HCPF assumed – and we agree[7] – that Denver Health was a "State agency" (a public entity that "incurs matchable expenses") and that the "second prong" of 45 C.F.R. § 95.13(d) therefore "governs" application of the two-year rule in this case. CO Br. at 19. The second prong of section 95.13(d) states that an expenditure for Medicaid administration occurs in the "quarter to which the costs were allocated in accordance with the regulations for each program."

Denver Health's certified outstationing expenditures indisputably are – and were claimed by HCPF as – "State agency expenditures" for Medicaid administration. Under the second prong of section 95.13(d), Denver Health is deemed to have made those expenditures in a quarter "to which the costs were allocated[.]" In this context, "the costs" are those which Denver Health incurred to provide outstationing activities and

[7] CMS also agrees that the second prong of section 95.13(d) governs here and, therefore, also viewed Denver Health's actions as those of a State agency.

which it certified as Medicaid program expenditures. Thus, in order to decide whether the two-year rule bars the FFP claims with respect to those costs (or expenditures), the second prong of section 95.13(d) requires us to identify the periods *to which* they were allocated.

For each calendar year from 2000 through 2006, Denver Health reported costs associated with outstationing on its annual hospital cost report in accordance with section 8.700.8 of Colorado's regulations.[8] *See* CO Ex. 35, at 3 (indicating that Denver Health's outstationing costs were determined using cost report "data"). Because a provider's cost report is a statement (derived from the provider's system of accounting) of its actual costs of the accounting period for which the report is prepared, *see* 42 C.F.R. §§ 413.20 and 413.24, a reasonable assumption is that any outstationing costs reflected in Denver Health's cost report for a particular calendar year were costs allocated to that year.

HCPF is silent about the allocation of Denver Health's outstationing costs. HCPF does not allege or demonstrate that those costs were allocated under Denver Health's system of accounting to periods other than calendar years 2000 through 2006. Nor does HCPF contend that Medicaid program regulations required or resulted in a different allocation. We therefore hold that, for purposes of the two-year rule, Denver Health's certified public expenditures for Medicaid outstationing were "made" during the calendar years with which the expenditures are identified. We assume that Denver Health made any outstationing expenditures allocated to a calendar year during the fourth quarter of that year since such an assumption is most favorable to HCPF. To comply with the two-year rule, HCPF needed to claim FFP with respect to that quarter's expenditures within two years after the end of the quarter. It did not do so, as shown above in Table 1.

HCPF relies on *Nebraska Department of Health and Human Services*, DAB No. 2177 (2008), but this decision supports our conclusion. At issue in that case were costs incurred by school districts to help administer Nebraska's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, a component of the state's Medicaid program. In accordance with interagency agreements between the school districts and the Nebraska Medicaid agency, the school districts sought reimbursement for their EPSDT-related costs by submitting quarterly invoices to the Nebraska Medicaid agency. DAB No. 2177, at 5. The invoices had to be submitted within one year after the quarter to which the costs related. *Id.* In addition, a school district had to certify that its cost reporting for the invoiced quarter was based on "expenditures" reflected in its accounting system and that federal funds were not used. *Id.* In turn, the Nebraska Medicaid agency

[8] For example, according to a document which summarizes Denver Health's outstationing cost calculation for calendar year 2004, Denver Health incurred total "actual outstationing costs" of $4,407,358 during that year. The source cited for that figure is a line in Worksheet B of Denver Health's hospital cost report (form CMS-2252-96).

agreed to "reimburse the school districts the Title XIX federal share of actual and allowable costs for ESDT administration provided by [school district] staff . . . ." *Id.* at 4 (internal quotation marks omitted).

On September 14 and 15, 2004, the Nebraska Medicaid agency reimbursed the school districts for invoiced costs of the period from October 1, 1999 through August 31, 2002. *Id.* at 6. Two months later, the Nebraska Medicaid agency filed a QSE seeking FFP for the reimbursement amount. *Id.* CMS disallowed the claim, finding that it was untimely under section 1132(a) of the Act and 45 C.F.R. § 95.7. *Id.* at 7. In defense of the disallowance, CMS argued that the Nebraska Medicaid agency needed to claim FFP for the school districts' EPSDT-related costs within two years after the school districts incurred the costs, not within two years of the date that the Nebraska Medicaid agency reimbursed the school districts. *Id.* at 8. The Nebraska Medicaid agency, on the other hand, argued that its payments to the school districts on September 14 and 15, 2004 were the relevant "expenditures" and that the two-year claiming period commenced on those dates. *Id.* at 7.

The Board found that the school districts were "State agencies" – public entities that incurred matchable expenses – for purposes of applying the two-year rule. *Id.* at 9. Based on the "interagency agreements and official policies," the Board also found that when the Nebraska Medicaid agency reimbursed a school district for [Medicaid] administrative costs, it was "not making matchable (FFP-claimable) expenditures but merely passing to the school district the federal share of those expenditures." *Id.* (emphasis in original). For that reason, the Board held that the two-year filing period relevant to its FFP claim did not begin in September 2004 (when the Nebraska Medicaid agency reimbursed the school districts). *Id.* at 9-10. Applying the second prong of section 95.13(d), the Board further held that the expenditures relevant to that claim were "made" in the period from October 1, 1999 through August 31, 2002. *Id.* at 10-11. That period, the Board explained, was the one to which the school districts had allocated their EPSDT-related costs. *Id.* Because the Nebraska Medicaid agency's FFP claim was filed more than two years after that period, the Board upheld the disallowance.

Like the school districts in *Nebraska*, Denver Health incurred matchable expenses (costs) for Medicaid administration, then submitted an accounting of those costs which allocated them to specific cost reporting periods (namely, calendar years 2000 through 2006). And like the Nebraska Medicaid agency, HCPF treated Denver Health's allocated costs as the State's share of expenditures for Medicaid administration. In accordance with *Nebraska's* holding, those costs are considered expenditures for Medicaid administration that were "made" during the periods to which they were allocated.

HCPF asserts that *Nebraska* rejected the view that expenditures for Medicaid administration are made when a State agency provides services, incurs costs, and pays their employees. Reply Br. 6. HCPF also argues that *Nebraska* held that "the State had two years from the filing of the invoice to claim FFP." CO Br. at 21. HCPF misreads *Nebraska*.

HCPF appears to have read the Board's statement that "[t]he *preparation* of the invoices by the school districts for submission to [the Nebraska Medicaid agency] effectively constitutes the recording of the expenditures by a state agency" as meaning that the expenditure occurred in the quarter when the invoices were prepared. DAB No. 2177, at 11 (italics added). That statement, however, immediately follows these sentences:

> [W]hen the school district submits the . . . invoice to [the State Medicaid agency] *for a given quarter*, it represents that the EPSDT administrative costs shown on the invoice are allowable Medicaid program costs that are recognized, in its system of accounting *as costs incurred during that quarter*. In other words, the school district, a State agency, represents that the costs are *allocable* to Medicaid and to the calendar quarter *for* which it has prepared the invoice.

Id. at 10-11 (italics added). The Board's point was that, by preparing the invoice, the school district recorded the quarter to which the expenditure was allocable. The school district *made* the expenditure in the quarter to which it was allocated. The allocation is demonstrated not by the date when the school district issued paychecks (which might be after the period when then they were earned, for example) but by the date to which the school district allocated the costs in its accounting system (which might be, for example, to the school year in which they were earned).[9] The invoices amount to a recording in the accounting system identifying the quarter to which the costs are allocable, but the timing of preparing the invoice is irrelevant in determining the quarter to which the costs are allocated, *i.e.*, the quarter *for* which the invoice is prepared.

[9] State agency expenditures made to private providers differ from the State's claiming of its own administrative costs in a number of ways which affect when an expenditure is considered to have been made. The federal agencies may reasonably be concerned that a state agency may seek to maximize its FFP by controlling when it chooses to make payments for some of its own costs or by assigning the costs to different time periods for different purposes. Hence, the regulations, as noted, require state agency expenditures to be claimed for the quarter to which they are allocated in the state agency's own accounting records. Payments to private providers for services, by contrast, are treated as expenditures for the quarter in which the payment is made. 45 C.F.R. § 95.13(b). Similarly, under the first prong of section 95.13(d), payments for administration or training made to private providers are considered expenditures when the payment is made.

Thus, the Board held in *Nebraska*:

> It is undisputed that the contested disallowance relates to EPSDT administrative costs that Nebraska's school districts allocated — based on accounting records, time study results, and other data. For that reason, and because Nebraska recognizes a school district's invoiced AOCM costs as the state's share of expenditures on EPSDT administration, we conclude, *in accordance with section 95.13(d), that the disallowance in this case was for expenditures "made" from October 1, 1999 through August 31, 2002* [that is, the period in which the school districts incurred costs to perform EPDST administration]. Because Nebraska's FFP claim for those expenditures was not filed within two years after the end of the quarter in which they were made, CMS properly disallowed the claims as untimely under section 1132(a) of the Act.

DAB No. 2177, at 11 (italics added, footnote omitted).

HCPF asserts that it "claimed FFP [for Denver Health's certified public expenditures] within two years of the dates on which Denver Health 'invoiced' [HCPF] (i.e., when it notified [HCPF] of its costs and certified them)" following the extensive auditing process described in the Dolson and Burnette declarations." CO Br. at 21. As explained, *Nebraska* did not hold that the two-year period for filing an FFP claim began on the date a school district submitted an invoice. Rather, in accordance with the second prong of section 95.13(d), the Board held that the two-year filing period commenced at the end of the accounting periods to which the school districts had allocated their costs of Medicaid administration. DAB No. 2177, at 10-11.

HCPF also suggests that the two-year period for claiming Denver Health's certified public expenditures did not begin until Denver Health not only "determined the proper allocation of its outstationing costs to Medicaid ('in accordance with the regulations for [that] program') *but also* certified its costs based on audited and finalized cost report." CO Br. at 21 (italics added). However, HCPF does not tie that position to any relevant statutory or regulatory language. By the plain language of sections 95.7 and 95.13, the two-year period is triggered by a State agency "expenditure." Those regulations do not say that an expenditure is considered "made" on the date that is audited, allocated, or certified. The relevant language in section 95.13(d) states that an expenditure is made in the period "to which" a State agency's costs are allocated, not on some date when the State agency identifies, allocates, or certifies its allowable costs.

Moreover, Denver Health's certification under 42 C.F.R. § 433.51 is not in any sense an expenditure. The certification is merely Denver Health's official confirmation to CMS that previously made expenditures are eligible for FFP under Colorado's Medicaid plan and 42 C.F.R. § 433.51. *Mo. Dept. of Social Servs.*, DAB No. 2589, at 5-7 (2014)

(holding that the certification required by section 433.51 is an "official statement by an authorized representative of the contributing public entity confirming that the expenditures qualify as . . . allowable Medicaid expenditures"). In other words, certified public expenditures do not become expenditures when they are certified; rather, certification is an after-the-fact process that ensures that the expenditures being claimed have met the requirements to be allowable.[10]

HCPF suggests that it did not intentionally or negligently delay the submission of its FFP claims but merely took reasonable steps to ensure they were accurate and proper. The motives or reasons for HCPF's delayed claiming are irrelevant. There is nothing in the applicable statute and regulations that permits the Board to toll the application of the two-year rule pending the conclusion of a state's efforts (even diligent ones) to identify, allocate, and audit its FFP-eligible costs.

In *Ohio Department of Human Services*, DAB No. 1177 (1990), the State agency argued that the two-year period in section 1132(a) did not begin until the federal agency clarified its position about the allowability of the claimed expenditures under the title IV-E program. The Board rejected that position:

> As applicable here, the regulations provide a two-year time period beginning with the quarter following the quarter to which the costs were allocated. There is simply no provision in the regulations for expanding this time frame based on when the Agency may clarify its position on the allowability of particular expenditures in policy announcements, regulations or any other policy making vehicles. Aside from lacking support in the language of the regulation itself, such a position on its face would be confusing and difficult to implement since it would require a modification in the two-year period every time that the Agency modified or clarified its position on the allowability of any category of cost.

DAB No. 1177. The Board further noted that the federal agency's actions did not make it "impossible" for the state agency to file a timely claim and that "[a] state can always file a claim even if it believes that the [federal] Agency will dispute the allowability of the claim." *Id.*

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[10] HCPF points out that it could not claim FFP (for costs not reimbursed by the per-facility payments) "in the absence of a valid certification of actual costs from Denver Health." Reply Br. at 7. It is true, of course, that 42 C.F.R. § 433.51(b) required HCFP to have Denver Health's certification in hand before it could claim FFP based on its expenditure of non-federal public funds. But there is nothing in section 433.51 that could be construed as changing how the two-year rule – a separate legal requirement – is applied. That rule requires a state to claim FFP with respect to a State agency expenditure within two years of when the expenditure is "made," not within two years of the date that the State agency certifies the expenditure pursuant to section 433.51(b).

Just as the state agency in *Ohio* argued that the two-year claiming period did not commence until the federal agency clarified the allowability of costs that the state agency sought to claim, HCPF is contending here that the two-year period did not start until it was confident it had the certifications CMS would require to show that Denver Health's costs were eligible for FFP. We find no merit in this contention. As we held in *Ohio*, a state's perceived need for such assurance does not render the two-year period inapplicable or affect the determination of when an expenditure is made.

Moreover, based on the record before the Board, there is no reason to believe that circumstances outside the state of Colorado's control made it "impossible" for HCPF to file a claim for Denver Health's certified outstationing expenditures within the prescribed two-year period. In its April 5, 2005 letter to CMS, HCPF stated that Denver Health's outstationing costs for the year ending December 31, 2003 were $4.118 million. CO Ex. 9. This information was provided to CMS more than one year before Denver Health obtained what HCPF calls the hospital's "finalized" NPR for calendar year 2003. HCPF ultimately claimed FFP for a slightly higher amount – $4.180 million – for calendar year 2003 (a figure that HCPF lowered slightly to $4.090 million in response to the disallowance). These circumstances suggest that HCPF had all the information it needed (based on data that Denver Health was obligated to supply in its annual cost report) to file a reasonably accurate FFP claim with respect to calendar year's outstationing activities within two years afterward. Such a claim could then have been adjusted, as necessary, to appropriately account for the results of audits and other events that might have affected the relevant cost calculations. *See Ga. Dept. of Cmty. Health*, DAB No. 2521, at 3 (2013) (discussing the use of adjustments that either increase or decrease claims submitted for "prior periods"), *rev'd on other grounds, Ga. Dept. of Cmty. Health v. HHS*, ___ F. Supp. 3d, ___, 2015 WL 554903 (D. D.C. 2015).

In any event, the two-year rule does not permit us to consider the alleged impracticality of filing timely claims in complex cost accounting situations. Under the FFP claiming process established by the Medicaid statute, regulations, and program instructions, the state Medicaid agency is responsible for having accounting systems and procedures in place to enable it to develop and submit claims within the two-year period established by Congress. 42 C.F.R. § 433.32 (requiring agencies that administer the State plan to "[m]aintain an accounting system and supporting fiscal records to assure that claims for Federal funds are in accord with applicable Federal requirements"); SMM § 2497 (explaining, in general, a state's burden to have documentation sufficient to show that a

claim satisfies all applicable federal requirements); *Georgia Dept. of Cmty. Health*, DAB No. 2521, at 23 (stating that the "onus is on a state to have cost accounting and other financial systems in place to ensure that it makes a complete, supportable, and *accurate* claim for a current or prior quarter").[11]

In light of the foregoing analysis, we conclude that HCPF's claims for FFP in Denver Health's certified public expenditures were subject to disallowance under section 1132(a) of the Act and 45 C.F.R. § 95.7.

2. The claims for FFP in the lump sum retrospective payments

As our factual summary indicates, for each calendar year from 2000 through 2004, a lump sum retrospective payment, drawn from the state of Colorado's general fund, was made to Denver Health to reimburse costs that it had incurred during the year to perform outstationing activities. The retrospective payment was equal to the number of Denver Health-affiliated facilities (presumably, FQHCs) that performed Medicaid outstationing activities during the year multiplied by $60,000. State regulation required Denver Health to identify its outstationing costs on its annual cost report in order to obtain the retrospective payment. *See* 10 CCR § 2505-10-8.700.8.C (2006) (CO Ex. 13).

HCPF provided the following information about the dates of the retrospective payments and the dates on which HCPF filed its claims for FFP in those payments:

Table 3

Calendar Year in Which Outstationing Activities Were Performed	Amount of Lump Sum Retrospective Payment	Date of the Lump Sum Retrospective Payment to Denver Health (per the Dolson Declaration, CO Ex. 52, ¶¶ 2-4)	Quarter-ending Date of the QSE on Which the Lump Sum Retrospective Was Claimed
2000	$1,440,000	8/14/2006	9/30/2006
2001	$1,440,000	8/14/2006	9/30/2006
2002	$1,440,000	6/11/2007	6/30/2007

[11] In a footnote, HCPF states that while it "continues to believe that it has timely submitted all claims at issue here," it has asked CMS to exercise its authority under 45 C.F.R. § 95.19 to grant a "good cause" waiver of the two-year requirement based on alleged "delays of CMS's contractor . . . in finalizing [Denver Health's] cost reports." CO Br. at 22 n.11. Our decision here does not affect any action that CMS may take (or may have taken) on HCPF's waiver request.

Calendar Year in Which Outstationing Activities Were Performed	Amount of Lump Sum Retrospective Payment	Date of the Lump Sum Retrospective Payment to Denver Health (per the Dolson Declaration, CO Ex. 52, ¶¶ 2-4)	Quarter-ending Date of the QSE on Which the Lump Sum Retrospective Was Claimed
2003	$1,260,000	6/23/2008	6/30/2008
2004	$1,200,000	6/15/2009	6/30/2009
TOTAL	**$6,780,000**	[redacted]	
Federal Share	**$3,390,000**		

In light of this information, which shows that HCPF filed FFP claims with respect to the retrospective payments during the quarter in which those payments were made, HCPF asserts that those claims were "indisputably timely." Reply Br. at 4. We disagree with this assertion because it ignores the legally relevant program expenditures.

As noted, the two-year rule for filing FFP claims applies to "State agency expenditures" – that is, the "matchable" expenses of a state or local organization. 45 C.F.R. § 95.4 (defining the term "State agency"). Although HCPF asserts that Denver Health made State agency expenditures to provide Medicaid outstationing, *see* CO Br. at 19 n.10, HCPF does not plainly assert that *it* made State agency expenditures when it made or authorized the retrospective lump sum payments to Denver Health.[12] More importantly, in asserting that its FFP claims with respect to those payments were timely filed, HCPF ignores what it concedes is the governing regulatory provision – the second prong of section 95.13(d).

As previously stated, the second prong of section 95.13(d) states that CMS "consider[s]" a "State agency's expenditure for [Medicaid] administration . . . to have been made . . . in the quarter to which the costs were allocated in accordance with the regulations for each program." On its face, the provision equates a "State agency's expenditure for [Medicaid] administration" and the "allocated" costs of carrying out that program function. In view of the record before us, those costs cannot be anything other than the outstationing expenses incurred by Denver Health (a State agency) and identified on its costs reports as allocated to the calendar years for which those reports were submitted to the Medicare contractor. HCPF does not suggest any other way in which section 95.13(d) can or should be interpreted and applied in these circumstances. Accordingly, we hold that the State agency expenditures which triggered the two-year claiming period in this case were the costs that Denver Health incurred to perform Medicaid outstationing

[12] If it had made such an assertion, of course, we would have expected HCPF to explain how it would be legally sufficient under the laws governing claims for FFP to identify one state agency for purposes of the CPE claims and a different state agency for purposes of the claims for the lump sum retrospective payments.

activities, not the retrospective payments that reimbursed those costs. Whether or not Denver Health's costs were reimbursed by retrospective payments, section 95.13(d) requires that we treat them as State agency expenditures "made" in the periods to which they were allocated.

We would reach the same result even if we treated the lump sum retrospective payments as the operative State agency expenditures. The second prong of section 95.13(d) requires us to treat those expenditures as having been "made . . . in the quarter [or other period] to which the costs were allocated." Because the record indicates that "the costs" – that is, the expenses reimbursed by the retrospective payments – were allocated to calendar years 2000 through 2004, the retrospective payments (State agency expenditures) are deemed to have been made during those calendar years.

Our holding is consistent with *New York State Department of Social Services*, DAB No. 1129 (1990). In that case, the New York Medicaid agency was a party to a contract under which a New York county undertook to administer a Medicaid demonstration project. The county, in turn, delegated administrative functions to a non-profit corporation. The county reimbursed the non-profit's costs, then billed the New York Medicaid agency, which paid the county and then claimed FFP for the billed expenses. The Health Care Financing Administration (CMS's predecesssor) disallowed the claim as untimely under section 1132(a) of the Act. The Board described the dispositive issue in the appeal as follows:

> The sole issue . . . is when the expenditure was made under the regulation [section 95.13(d)]. If the expenditure was made when [the county] paid for the administrative expenses of the [non-profit corporation], then the claim was clearly too late under the statute and regulation. If the expenditure was made when the State [Medicaid Agency] paid [the county], then it was within the two-year period and was timely.

The Board found that the county operated as a "State agency." Based on that finding, the Board concluded that the matchable expenditure was made when the county "paid the administrative costs of the [non-profit corporation] in operating the [Medicaid demonstration project]" and not when the New York Medicaid agency reimbursed the county. Under that holding, when a state or local organization, like Denver Health, undertakes to perform Medicaid administration and incur matchable expenses on behalf of the state Medicaid program, the expenses incurred by that State agency to carry out that function are the "State agency expenditures" which trigger the running of the two-year claiming period.

In short, HCPF's FFP claims with respect the lump sum retrospective payments – shown in Table 3 – were substantively claims for FFP in State agency expenditures that are deemed by section 95.13(d) to have been made during calendar years 2000 through 2004. Each of those FFP claims was filed five or more years after the end of the calendar year to which it relates. We therefore conclude that these FFP claims are barred by section 1132(a) of the Act and 45 C.F.R. § 95.7.

B. *The disallowed FFP claims relating to outstationing activities performed during calendar years 2000 through 2004 are subject to disallowance on the additional ground that they were not prepared and submitted in accordance with an HHS-approved cost allocation plan.*

CMS disallowed the claimed outstationing expenditures for the additional reason that "the state did not have an approved CAP [cost allocation plan] that detailed how HCPF identified, measured, and allocated the costs associated with Denver Health's outstationing program." Response Br. at 16; *see also* CO Ex. 36, at 1; CMS Ex. 37, at 1. For the reasons stated below, we conclude that the absence of an approved CAP is an additional basis for disallowing FFP for the outstationing costs for at least calendar years 2000 through 2004.[13]

Claims for FFP for Medicaid administrative costs must not only be timely filed; they must also be prepared and submitted in accordance with an approved CAP. 45 C.F.R. § 95.501. A CAP is a "narrative description of the procedures that the State will use in identifying, measuring, and allocating all State agency costs incurred in support of all programs administered or supervised by the State agency." *Id.* § 95.505. A CAP must "[d]escribe the procedures to identify, measure, and allocate all costs to each of the

[13] With CMS approval, HCPF amended its CAP effective July 1, 2010 to include a specific method for allocating outstationing costs. CO Exs. 30 (§ IV.F) and 34. Since the claims for all of the calendar years at issue except for 2005 and 2006 were filed before the CAP amendment took effect, the costs for those years could not have been claimed in accordance with the CAP methodology, even if the claims were timely filed, which we have concluded they were not. HCPF argues that outstationing expenditures that relate to calendar years 2005 and 2006 and that were reported on QSEs filed after July 1, 2010 (the effective date of the CAP amendment) were claimed in accordance with its CAP, as section 95.517(a) requires. *See* CO Br. at 31; Reply Br. at 17. CMS urges us to reject that contention, asserting that "the relevant CAP is the one that was in effect at the time the costs were incurred," rather than the CAP that was in effect at the time the FFP claim was filed. Response Br. at 25 (*citing Mo. Dept. of Social Servs.*, DAB No. 1021 (1989)). Since we have concluded that FFP is not allowable for any of the calendar years at issue (including 2005 and 2006) because the expenditures were not timely claimed, we need not resolve this issue, but we do note that even if we accepted HCPF's argument and the assumption on which it is based, this would affect the disallowance amount only as to calendar year 2005 and 2006 outstationing costs.

programs operated by the State agency." *Id.* § 95.507(a)(1); *Ill. Dept. of Children and Family Servs*., DAB No. 1422 (1993) (finding that the state's claim for FFP must reflect the application of an appropriate cost allocation methodology described in its CAP). The purpose of the CAP is to assure that where a state agency incurs administrative costs that benefit multiple Federal and/or state programs, a claim for FFP under a particular Federal program includes only the share of those costs appropriately allocated to that program. *W. Va. Dept. of Health & Human Resources*, DAB No. 2529, at 2 (2013). As the Board said in *West Virginia*, "[t]his means that when a state incurs costs that support or benefit more than one public assistance program, the costs generally must be allocated to each program in proportion to the benefits that each derives from the activity that generated the costs." *Id*. at 3 (*quoting Minn. Dept. of Human Servs*., DAB No. 1869, at 4-5 (2003)). With an exception for certain proposed CAPs that is not relevant here, "[a] state must claim FFP for costs associated with a program only in accordance with its approved [CAP]." 45 C.F.R. § 95.517(a). Claims for FFP for administrative costs that are not claimed in accordance with the approved CAP methodology are subject to disallowance. *Id.* § 95.519; *W. Va. Dept. of Health & Human Resources* at 4-5 (disallowing title IV-E training costs).

HCPF does not deny that its CAP for claiming Medicaid administrative costs did not include a specific methodology for identifying, measuring or allocating outstationing costs prior to the amendment that took effect on July 1, 2010. *See* CO Br. at 24-25. HCPF argues, however, that the allocation of its outstationing costs was covered by a general provision in its pre-amendment CAP for "Outside Costs." *Id.* at 26. The pre-amendment CAP provision states that when services are provided by a governmental agency outside HCPF, those outside costs "will be supported by a written agreement which includes at least": (1) a "[d]escription of specific services being purchased"; (2) "[d]elineation of the billing mechanism"; (3) a "[s]tatement that billing will be based on actual costs incurred"; and (4) "[t]ime reporting for a statistically valid sample of employees." CO Ex. 3 (Fiscal Year 2000 Public Assistance CAP, § IV.E).

HCPF argues that this provision is equivalent to the statement required under 45 C.F.R. § 95.507(b)(6) for outside governmental agencies whose administrative costs are not addressed by a specific CAP methodology. Section 95.507(b)(6) provides that for such situations a CAP "shall contain . . . [a] statement stipulating that wherever costs are claimed for services provided by a governmental agency outside the State agency, that they will be supported by a written agreement that includes, at a minimum (i) the specific service(s) being purchased, (ii) the basis upon which the billing will be made by the provider agency (e.g. time reports, number of homes inspected, etc.) and (iii) a stipulation that the billing will be based on the actual cost incurred." Section 95.507(b)(6) further states, "This statement would not be required if the costs involved are specifically addressed in a State-wide cost allocation plan, local-wide cost allocation plan, or an

umbrella/department cost allocation plan." *See also N.J. Dept. of Human Servs.*, DAB No. 2328, at 5 (2010) (upholding a disallowance of costs of Medicaid activities by a governmental agency outside the Medicaid State agency because the State's CAP did not include an allocation method for those costs and the written agreement the State agency relied on did not meet the requirements in 45 C.F.R. § 95.507(b)(6)). HCPF asserts that it had a written agreement with Denver Health meeting both the requirements of its CAP provision and the requirements for written agreements in section 95.507(b)(6) and, therefore, did not need to have a specific methodology in its CAP for identifying, measuring and allocating outstationing costs.[14]

CMS states that it "might agree with HCPF's argument that its CAP did not need a specific section covering outstationing costs *if* there was evidence that HCPF actually had a written agreement with Denver Health that satisfied the requirements in 45 C.F.R. § 95.507(b)(6)."[15] Response Br. at 18 (italics in original). However, CMS goes on to state that HCPF did not submit any such written agreement. CMS concludes that the Board here, as in *New Jersey*, should uphold the disallowance because of the absence of either a CAP allocation methodology for the claimed outstationing costs or a written agreement meeting the requirements of the regulation.

[14] HCPF also asserts CMS did not advise it prior to the disallowance that it needed a provision for identifying, measuring and allocating these costs in its CAP. CO Br. at 9. CMS disputes that it never expressed its concern about this issue prior to the disallowance but also says whether it did or did not is irrelevant because the regulations in subpart E of 45 C.F.R. Part 95 gave HCPF constructive notice of the need to claim costs through an approved CAP. Response Br. at 23. CMS is correct about the irrelevance. In *West Virginia Department of Health and Human Resources*, the Board held that the Subpart E regulations gave constructive notice of this legal obligation when rejecting the state's "vague suggestion that it had insufficient time – or inadequate notice of its obligation – to formulate an acceptable methodology prior to submitting claims for . . . training costs." DAB No. 2529, at 9; *accord Kan. Dept. of Social & Rehab. Servs.*, DAB No. 1349 (1994) (holding that the Subpart E regulations gave a state "notice that its Title IV-E claims should be calculated in accordance with a CAP approved by DCA"), *aff'd, Kan. El rel. Sec. of Social & Rehab. Servs. v. Shalala*, 859 F. Supp. 484 (D. Kan. 1994). We also reject HCPF's suggestion that CMS effectively told HCPF it did not need a CAP when it informed HCPF in May 2005 that it did not need to amend its Medicaid State plan in order to begin reimbursing Denver Health for 100 percent of its outstationing costs. Reply Br. at 9 (*citing* CO Ex. 10). A State plan and a CAP are separate and distinct documents. The Medicaid State plan describes the Medicaid program services the State provides while a CAP is a financial plan used for allocating administrative costs among funding sources for multiple programs. Moreover, as HCPF acknowledges, *id.*, the cited CMS letter (CO Ex. 10) expressly provided that any methodology used by a state must "meet[ ] the general cost allocation principles of OMB Circular A-87 . . .," and those principles include CAP requirements. *See* 2 C.F.R. Part 225, Appendices A (¶ F.2) and D (Jan. 1, 2013).

[15] CMS also states that a "CAP does not need to describe the procedures for allocating costs claimed for services provided by a Governmental agency outside of the state Medicaid agency if it includes [the statement required by section 95.507(b)(6)]." Response Br. at 17.

We agree with CMS that the record contains no written agreement that complies with the requirements of section 95.507(b)(6). Thus, we need not decide whether the CAP statement on which HCPF relies obviates the need for a CAP allocation methodology specific to Medicaid outstationing services. Although HCPF states that Denver Health had such a written agreement with HCPF "[a]t all times relevant to the disallowance," HCPF does not cite to any document in the record that even arguably constitutes a written agreement containing all of the information required by the regulation. CO Br. at 26-28; Reply Br. at 10. HCPF asserts that the "written agreement was comprised of Denver Health's provider agreement and, when it became a Medical Assistance site, its contract with HCPF, each of which incorporated and reflected Denver Health's agreement to the provisions of § 8.700.8 of the State's Medical Assistance regulations and of federal outstationing rules." Reply Br. at 10. However, the only exhibits cited by HCPF in support of this statement are the first three pages of a 26-page 2006 contract between Denver Health and HCPF and a paragraph in a declaration by Nancy Dolson, HCPF's Special Financing Director. *Id*., *citing* CO Exs. 14 and 50. Neither exhibit demonstrates the existence of a written agreement meeting the requirements of section 95.507(b)(6).

It should go without saying that an exhibit containing only the first three pages of a 26-page contract has minimal, if any, evidentiary value with respect to determining the substance and intent of the document as a whole. But beyond that, while the excerpt discusses the scope of services to be provided and procedures for processing medical assistance applications and determining eligibility for Medicaid, it does not, as CMS notes, "discuss the billing mechanisms or state that billings will be based upon actual costs" as required for the written agreements addressed in section 95.507(b)(6). Response Br. at 18. Nor does the contract excerpt "incorporate or reflect Denver Health's agreement to the provisions of § 8.700.8 of the State's Medical Assistance regulations and . . . federal outstationing rules" as HCPF contends, arguing, in effect, that a reference to those rules would compensate for the absence of billing mechanisms in the written agreement itself.[16] Reply Br. at 10. The language from the excerpted contract refers only generally to abiding by federal and state laws, regulations and directives and does not even refer specifically to the provisions of section 8.700.8 much less incorporate those provisions by reference.

[16] CMS asserts that "it is unreasonable for HCPF to argue that the requirement for a written agreement is satisfied by the existence of a state agency regulation" because a regulation "is not a written agreement that memorializes the negotiated terms of the parties' duties and obligations." Response Br. at 18. We agree with CMS that the regulations themselves do not constitute written agreements. However, we need not and do not decide here whether incorporating rules that substantively meet the requirements of section 95.507(b)(6) into an otherwise sufficient written agreement might satisfy the requirements of section 95.507(b)(6) because, as we discuss, there was no such incorporation here and the alleged incorporating language addresses a process that is substantively very different from the process addressed in the regulations.

Moreover, the language in the excerpt on which HCPF relies does not relate substantively to the provisions of section 8.700.8. Section 8.700.8 addresses the process by which freestanding and hospital-based FQHCs submit logs of applicant information and cost reports and receive reimbursement for the costs of the outstationing services they provide. *See* CO Exs. 8, 13, 22. The excerpt states only that Denver Health will adhere to federal and state laws in the "conduct [of] all eligibility duties and activities as described [in the contract] . . . ." CO Ex. 14, at 2. In other words, the statement about following state and federal laws relates to the administrative performance of outstationing activities designed to determine applicant eligibility not to the way Denver Health reports or seeks reimbursement for its outstationing costs.

The Dolson declaration also is not evidence of a written agreement meeting the requirements of section 95.507(b)(6). The paragraph of the Dolson declaration cited by HCPF merely states that Denver Health is "reimbursed according to a methodology set forth in state regulation," an apparent reference to the provisions of section 8.700.8. CO Ex. 50, ¶ 6. Ms. Dolson also states that Denver Health "has a longstanding provider agreement with the State that was in effect during calendar years 2000 through 2006" and that "Colorado's standard Medicaid provider agreement" requires compliance with "all applicable" federal and state laws and guidelines and that "[t]he [provider] agreement that Denver Health signed would have contained the same provisions." *Id*. However, Ms. Dolson does not state that either the provider agreement or any other written agreement incorporates the provisions of section 8.700.8, and Colorado has not submitted a copy of any of Denver Health's provider agreements. Moreover, as with the contract excerpt discussed above, Ms. Dolson's statements about compliance with federal and state laws and guidelines are far too general to serve as evidence that the provider agreement or any other "written agreement" specifically incorporates the provisions of section 8.700.8.

The contract excerpt – which is the only document that HCPF claims is a written agreement – does not meet the requirements of section 95.507(b)(6) for other reasons. As CMS indicates, while the excerpt discusses the scope of services to be provided and procedures for processing medical assistance applications and determining eligibility for Medicaid, it does not, as CMS notes, "discuss the billing mechanisms or state that billings will be based upon actual costs" as required for the written agreements addressed in section 95.507(b)(6). Once again HCPF attempts to cure this shortcoming by arguing that Denver Health's provider agreement and Medical Assistance site contract incorporate the state's rules governing the process for outstationing service providers to submit cost reports and obtain reimbursement from HCPF for the costs of their outstationing activities. Reply Br. at 10-11. However, as discussed above, the only "written agreement" provided by HCPF (the 2006 site contract) does not specifically incorporate those rules but makes only a general assertion about complying with federal and state laws when performing the outstationing activities described in the contract. *See* CO Ex. 14, at 2. Similarly the declaration cited by HCPF states only that "Colorado's standard Medicaid provider agreement requires that providers comply with all applicable

provisions of the Social Security Act, federal and state laws, regulations and guidelines, and Department rules." CO Ex. 50, ¶ 6. Thus, assuming for purposes of our decision that HCPF could identify, measure and allocate its outstationing costs using a written agreement meeting the requirements of section 95.507(b)(6), we conclude that it has not shown it had such a written agreement.

HCPF suggests that there was no violation of CAP requirements because the claimed outstationing costs were entirely allocable to the Medicaid program. *See* CO Br. at 30 (asserting that the retrospective payments did not raise allocability concerns because the payments were significantly below Denver Health's total costs); Reply Br. at 13 (asserting that there was no need to allocate outstationing costs because Denver Health "used a single application process"). We need not determine whether, or what extent, Denver Health's outstationing costs were allocable to non-Medicaid programs because the Board has held consistently that the requirement to claim FFP through a CAP "'applies even where costs are determined to be directly applicable to a single state agency program' in order to ensure that all costs are distributed on a 'consistent basis.'"[17] *W. Va. Dept. of Health & Human Resources* at 6 (*quoting Ill. Dept. of Children and Family Servs.*, DAB No. 1422 (1993)). If HCPF intended to allocate all of Denver Health's outstationing costs to Colorado's Medicaid program, it needed to specify its method for doing so in an approved CAP. *Cf. Ill. Dept. of Children & Family Servs.*, DAB No. 2022, at 3 (2002) (holding that the regulations in 45 C.F.R. Part 95, subpart E "require, as a prerequisite for allocating . . . costs to Medicaid, that the allocation methodology *be approved*," and that because the state did not have approval to allocate certain costs, "either in whole or in part, it could not reasonably expect reimbursement" (italics added)), *aff'd, Ill. Dept. of Healthcare & Family Servs. v. HHS*, 2008 WL 877976 (N.D. Ill. 2008). HCPF did not do so – either directly in the CAP's text or indirectly through an inter-agency agreement that met the requirements of section 95.507(b)(6) – until it proposed the CAP amendment that took effect on July 1, 2010.

[17] However, we note that evidence submitted by HCPF indicates that programs other than Medicaid (including the State Children's Health Insurance Program and Colorado Indigent Care Program) may have benefitted from Denver Health's outstationing activities. *See* CO Ex. 49, ¶ 9 (indicating that eligibility determinations for these non-Medicaid programs were made on the basis of information collected by Denver Health during the Medicaid intake process); CMS Ex. 1, at 3 (¶ 5) (specifying the programs that received Denver Health's "facilitated enrollment services").

Conclusion

We sustain the disallowance of $12,064,042 in FFP claimed by HCPF for expenditures relating to Medicaid outstationing activities performed by Denver Health during calendar years 2000 through 2006.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Sheila Ann Hegy
Presiding Board Member