Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

SUBJECT: District of Columbia Department of Health
Docket No. A-08-72
Decision No. 2219

DATE: December 31, 2008

DECISION

The District of Columbia Department of Health's Medical Assistance Administration (MAA) appealed the determination of the Centers for Medicare & Medicaid Services (CMS) disallowing federal financial participation (FFP) totalling $20,000,000 claimed by MAA as Medicaid costs. Of that amount, $15,000,000 was claimed for rehabilitative services provided from October 1, 1999 through September 30, 2003, and $5,000,000 was claimed for case management services provided from October 1, 2002 through September 30, 2003. MAA claimed the costs as increasing adjustments to prior period costs on its quarterly expenditure report for the quarter ended December 31, 2005. MAA had previously claimed and received approximately $108 million FFP for the same services.

CMS disallowed the claim for both types of services on the ground that MAA failed to submit adequate supporting documentation during the deferral process. For the reasons explained below, we uphold the disallowance in full.

Legal Background

The federal Medicaid statute, title XIX of the Social Security Act (Act), authorizes a program that furnishes medical assistance to low-income individuals and families as well as to blind and disabled persons. Act § 1901.[1] The program is jointly

[1] The current version of the Social Security Act can be found at www.ssa.gov/OP_Home/ssact/comp-ssa.htm. Each section of the Act on that website contains a reference to the corresponding

(Continued. . .)

financed by the federal and state governments and administered by the states. Act § 1903; 42 C.F.R. § 430.0. Each state administers its Medicaid program in accordance with broad federal requirements and the terms of its "plan for medical assistance," which must be approved by CMS on behalf of the Secretary of Health and Human Services. Act § 1902; 42 C.F.R. § 430.10 - 430.16. The state plan must specify the medical items and services covered as "medical assistance" under the state's program. Act § 1902; 42 C.F.R. § 430.10. The state plan must also describe or specify the policies, methods, and standards used to set payment amounts or rates for covered services. 42 C.F.R. §§ 447.201(b), 447.252(b). Payments to providers must be made at rates determined in accordance with the methods and standards in the plan. See 42 C.F.R. § 447.253(i).

A state plan may include rehabilitative services and case management services as part of the medical assistance provided by the state to eligible individuals. Act §§ 1905(a), 1905(a)(13), 1915(g)(1). "Rehabilitative services" include-

> any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level.

Act § 1905(a)(13); see also 42 C.F.R. § 440.130(d). "Case management services" are--

> services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services.

Act § 1915(g)(2). Section 1915(g)(1) permits a state to limit (or target) the provision of case management services to certain groups of individuals.

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.

Once CMS has approved a state plan, it makes quarterly grant awards to the state to cover the federal share of the state's expenditures under the plan. 42 C.F.R. § 430.30(a)(1). "The amount of the quarterly grant is determined on the basis of information submitted by the State agency (in quarterly estimate and quarterly expenditure reports) and other pertinent documents." 42 C.F.R. § 430.30(a)(2). Section 1132(a) of the Act provides for federal reimbursement for a Medicaid program expenditure only if the state files a claim within two years after the quarter in which it makes the expenditure, unless certain exceptions apply. See also 45 C.F.R. § 95.7.

Section 430.40 of 42 C.F.R. sets forth the mechanism pursuant to which the CMS Regional Administrator may question the costs claimed on a quarterly expenditure report and defer payment. Section 430.40(a) provides for deferral of a claim or any portion of a claim within 60 days after CMS's receipt of the quarterly expenditure report. Section 430.40(b)(1) provides that, within 15 days after excluding the claim from a state's grant award, "the Regional Administrator sends the state a written notice of deferral that"—

(i) Identifies the type and amount of the deferred claim and specifies the reason for deferral; and
(ii) Requests the State to make available all the documents and materials the regional office then believes are necessary to determine the allowability of the claim.

The regulation further states that "[i]t is the responsibility of the State to establish the allowability of the deferred claim." 42 C.F.R. § 430.40(b)(2). The state is then required to "make available to the regional office, in readily reviewable form, all requested documents and materials except any that it identifies as not being available." 42 C.F.R. § 430.40(c)(1). "If the State does not provide the necessary materials within the specified time, the Regional Administrator disallows the claim." 42 C.F.R. § 430.40(c)(4). Otherwise, "after all documentation is available in readily reviewable form," the Regional Administrator determines the allowability of the claim. 42 C.F.R. § 430.40(c)(5).

Consistent with section 430.40, section 2500.5 of CMS's State Medicaid Manual (SMM) states that FFP "is available only for allowable actual expenditures" and directs states to "[r]eport only expenditures for which supporting documentation, in readily reviewable form, has been compiled and which is immediately

available." See also SMM § 2497.1 ("Expenditures are allowable only to the extent that, when a claim is filed, you have adequate supporting documentation to assure that all applicable Federal requirements have been met.")[2]

Furthermore, the uniform administrative requirements for grants to states place on a state the burden of documenting the allowability and allocability of costs for which reimbursement is claimed. See reporting and record retention requirements at 45 C.F.R. §§ 92.40-42; see also Oklahoma Health Care Authority, Ruling No. 2008-4, at 4 (2008), citing California Dept. of Health Services, DAB No. 1606 (1996) ("It is a fundamental principle that a state has the initial burden to document its costs and to show that its claim for reimbursement is proper.")

Factual Background

Effective July 1, 1999, CMS approved amendments to the District of Columbia's state Medicaid plan providing for two new service categories: "Case Management for Abused or Neglected Children" (State Plan Amendment (SPA) 99-08) and "Rehabilitative Services for Children Who Have Been Abused or Neglected" (SPA 99-09). MAA Exs. A and B. SPA 99-08 provides that case management services will be paid at an "interim rate" with an annual adjustment of the claims to reflect actual costs incurred. MAA Ex. A at 6-7.[3] SPA 99-09 provides that rehabilitative services "shall be reimbursed through a cost based fee schedule." MAA Ex. B at 10.

MAA, the single state agency, arranged for the District of Columbia's Child and Family Services Administration (CFSA) to provide the services covered by the two state plan amendments. Based on cost information provided by CFSA, MAA initially claimed a total of approximately $108 million FFP for case management services and rehabilitative services provided from October 1, 1999 through September 30, 2003. See CMS Br. at 5, citing CMS Ex. 5. MAA later filed a claim for an additional $20

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[2] The current version of the SMM, which can be accessed at http://www.cms.hhs.gov/Manuals/, indicates that these provisions were in effect during the period in question.

[3] We cite to the page numbers added by the parties, not the page numbers on the original documents.

million FFP for the same services on its quarterly expenditure report for the quarter ended December 31, 2005. See MAA Ex. K at 4. According to MAA, the previous payments for both case management services and rehabilitative services had been based on interim rates, and the additional $20 million claim was for increases to the interim rates based on the actual costs CFSA had expended in providing the services. Id. at 1.

By letter dated April 10, 2006, CMS notified MAA that it was deferring the claim for $20 million FFP. MAA Ex. I. The letter stated that "[i]n accordance with Title 42 CFR §430.40, we are requesting that the District provide documentation in support of the validity of these claims . . . ." [4] Id. at 2. In response to this request, MAA submitted eight reports of audits of the cost reports for CFSA based on which MAA calculated the increased payment rates. The audits were conducted by Bert Smith & Co., an independent auditing firm, at MAA's request. See CMS Br. at 6. The auditors issued separate audit reports in September 2005 for MAA's rehabilitative services program (referred to in the audit reports as "the Rehab Option Program") for each fiscal year (FY) from FY 2000 through FY 2003. See MAA Exs. D (FY 2000), E (FY 2001), F (FY 2002), and G (FY 2003). The auditors also issued separate audit reports for MAA's case management program (referred to in the audit reports as the "Targeted Case Management program") for the same fiscal years. See CMS Ex. E (FY 2002), MAA Ex. H (FY 2003) (both issued November 2005). (The audit reports of case management services for FYs 2001 and 2002 are not included in the record.) The auditors took a sample of claims for individual services and calculated adjusted payment rates for each year in question after subtracting from the cost pools used to calculate the rates the amounts of some of the sample claims they determined were improper.

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[4] The deferral notice erroneously states that the $20 million "represents claims for FFP related to cost settlements for targeted case management services[.]" CMS Ex. I at 1. However, CMS clarified in a May 25, 2007 letter to MAA that the deferral relates to the audit findings that "claims made for targeted case management (TCM) services and rehabilitative services could not be supported." MAA Ex. J at 1 (emphasis added).

In a letter dated February 29, 2008, CMS notified MAA that it was disallowing the entire $20 million claim because the Bert Smith & Co. audit reports were inadequate to support the claim and CMS was "unable to determine from the information provided if any portion of your claim is allowable[.]" MAA Ex. K at 4.[5]

Analysis

MAA challenges the disallowance on two principal grounds. First, MAA argues that, contrary to what the auditors found, none of the costs on the cost reports were unallowable. Second, MAA argues that even if there were some unallowable costs, CMS improperly disallowed the entire claim on the mistaken premise that "a few spoiled apples ruin the entire barrel of apples[.]" MAA Reply Br. at 10. In MAA's view, moreover, in stating that it was unable to determine if any portion of the claim was allowable, CMS ignored its "duty to state valid reason(s) for a disallowance." Id. at 9. MAA asks that the Board remand the case to CMS to determine what portion of the $20 million is allowable or that the Board itself make this determination. See MAA Br. at 31.

Contrary to what MAA's arguments suggest, however, the disallowance is valid regardless of whether specific costs in the cost pools audited by Bert Smith & Co. were unallowable. As the applicable regulations and the State Medicaid Manual make clear, MAA was required to have supporting documentation for this claim in readily reviewable form when the claim was filed. MAA was also required to produce the supporting documentation for CMS's review if CMS so requested during the deferral process, as CMS did here. In response to CMS's request, MAA produced only the Bert Smith & Co. audit reports.

While the audits were presumably based on documentation provided by CFSA (which the auditors apparently reviewed for a sample of

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[5] CMS also advanced two other grounds for the disallowance (both challenged by MAA): 1) that the claim was not filed within the two-year period specified in section 1132 of the Act and did not fall within the exception for adjustments to prior year costs, and 2) that the rehabilitative services portion of the claim was purportedly based on a reimbursement methodology other than the methodology in the approved state plan. See MAA Ex. K at 2-3; CMS Br. at 7-10.

service claims), the audit reports are not themselves supporting documentation for MAA's claim for FFP. MAA claimed the $20 million FFP for the same services for which it was previously reimbursed in order to reflect actual costs later reported by CFSA, which MAA said exceeded the costs used to calculate the interim rates for the services. Thus, to support the $20 million claim, MAA would need to provide documentation showing that the actual costs were higher than the costs reimbursed through the interim rates. The audit reports, however, provide no basis for determining whether the claim represents actual increased costs. Even if MAA were able to show that all of the costs in the cost pools used to recalculate the rates were allowable, that would not establish the extent, if any, to which the actual costs exceeded the costs reimbursed through the interim rates.

Moreover, even if the Bert Smith & Co. audit reports somehow showed that the claim was based on actual increased costs, CMS would have been justified in declining to rely on the reports. As CMS's disallowance letter notes, both the case management services and rehabilitative services audits identified problems including insufficient documentation, duplicate payments, ineligible recipients, and quality problems (i.e., services not provided in accordance with applicable requirements). MAA Ex. K, at 2-3. For example, the auditors found that some claims for individual services in the sample they took were missing invoices and other supporting documentation for rehabilitative services expenditures, court orders showing that the recipient was determined to be either abused or neglected, case plans required to be developed to address the child's assessed needs, or evidence of contact by the social worker providing case management services. See, e.g., MAA Ex. D at 6, Finding 2000-2; id. at 7, Finding 2000.4; MAA Ex. F at 8, Finding 2002.7; MAA Ex. H at 8, Finding 2003.2. However, the auditors subtracted from the cost pools used to calculate payment rates only the amounts of some of the claims for which they identified problems. In addition, although the auditors reviewed only a sample of claims for individual services, they did not project the results of their review to the universe of claims. Moreover, some audits did not review sample claims for compliance with requirements for which the auditors identified problems in other years. Furthermore, the auditors themselves reported that they might not have identified all problems with the cost information since there were material weaknesses in the design or operation of CFSA's internal control over compliance

with Medicaid laws and regulations. See, e.g., MAA Ex. H, at 7. Thus, the audits significantly understated the amount of unallowable costs in the cost pools.[6]

MAA's arguments on appeal only reinforce this conclusion. Attempting to justify the auditors' failure to subtract the amounts of all individual claims with identified problems or to project the sample results to the universe of claims, MAA states that the sample was not "statistically valid." MAA Br. at 28; see also id. at 27. MAA also criticizes other aspects of the audits as follows:

- MAA contends that the auditors "used a subjective, undefined standard to determine the sufficiency" or adequacy of documentation for rehabilitative services. MAA Br. at 15-16.

- MAA contends that the audit finding that case plans were missing for more than half the sampled rehabilitative services claims in FY 2002 was based on a misinterpretation of the state plan as requiring that case plans be revised every six months. Id. at 20.

- MAA contends that the auditors improperly relied only on entries in CFSA's computer system to determine whether there was sufficient documentation for case management and rehabilitative services, such as invoices for claims, information to support case managers' encounters with recipients, and case plans. Id. at 21-22, 28.

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[6] For example, CMS asserts without contradiction that as a result of the auditors' self-imposed limitations, the auditors subtracted from the cost pools only 0.04% of the costs of individual claims for rehabilitative services for FYs 2000-2003 that the auditors found lacked supporting documentation, although "[t]he sample results suggest that over 50% of those claims may have been unallowable[.]" CMS Br. at 15. Similarly, the auditors subtracted no costs to account for the 76% of claims that the auditors found lacked adequate case plans. Id. at 17.

- MAA contends that the audit finding that there were duplicate costs "rests on the auditor's refusal to understand the allocation methodology."[7] Id. at 23.

- MAA contends that "the auditor's finding that 98% of sampled files contained no documentation to substantiate abuse or neglect is inconceivable and signifies unreliable auditing." Id. at 26.

MAA cannot reasonably argue that CMS should have accepted the audits as adequate to document the claim when MAA itself admits that the audits are unreliable.

Notwithstanding MAA's failure to provide supporting documentation during the deferral process, we note that there might have been a basis for reversing part or all of the disallowance if MAA had provided supporting documentation during the proceedings before the Board, as permitted by the Board's procedures. See 45 C.F.R. § 16.8(a)(1) (providing for the submission of an "appeal file containing the documents supporting the claim"). However, MAA failed to provide to the Board any of the underlying documentation for the increased rates on which the claim was based. Indeed, MAA failed to provide any documentation to the Board regarding even the audit findings that it disputes, although MAA itself recognizes that documentation would be necessary to resolve most of these disputes and allegedly located some relevant documentation. See MAA Ex. M (affidavit of CFSA administrator stating that, in preparation for this appeal, he led a search for documentation, including case plans and court orders, identified by Bert Smith & Co. as missing or inadequate, and succeeded in locating some of this documentation).

In light of MAA's failure to provide any supporting documentation for its $20 million supplemental claim for case management and rehabilitative services when requested by CMS and on appeal to the Board, it would be unreasonable to remand the appeal and give MAA yet another opportunity to provide supporting documentation. We therefore conclude that the entire claim is unallowable based on MAA's failure to document the claim. We need not, therefore, address CMS's additional bases

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[7] MAA does not explain what that methodology was or how it would make a difference.

for disallowing the claim as untimely or inconsistent with the approved state plan, or determine whether the claim was otherwise unallowable.

Conclusion

Based on the foregoing analysis, we uphold the disallowance in full.

/s/
Judith A. Ballard

/s/
Constance B. Tobias

/s/
Leslie A. Sussan
Presiding Board Member