Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

SUBJECT: Massachusetts Executive Office of Health and Human Services
Docket No. A-08-83
Decision No. 2218

DATE: December 31, 2008

DECISION

The Massachusetts Executive Office of Health and Human Services (State), which administers Massachusetts's Medicaid program, appealed a March 20, 2008 determination by the Centers for Medicare & Medicaid Services (CMS) to disallow $86,645,247 in federal Medicaid reimbursement for services performed by social workers employed by the Massachusetts Department of Social Services (MDSS) during federal fiscal years (FFYs) 2002 and 2003. The State characterized those services, which MDSS performed on behalf of Medicaid-eligible children, as "targeted case management." However, an audit by the United States Department of Health and Human Services' Office of Inspector General (OIG) concluded that the services did not meet the Medicaid program's definition of case management and thus were ineligible for federal reimbursement. The findings of the OIG audit are the bases for CMS's disallowance.

In this proceeding, the State had the burden of proving that the disallowance of reimbursement was for services that met the Medicaid definition of case management. We conclude that the State failed to carry this burden and for that reason uphold the disallowance in its entirety.

Legal Background

The federal Medicaid statute, title XIX of the Social Security (Act),[1] authorizes a program in which the federal government

[1] Title XVIII of the Social Security Act can be found at http://www.ssa.gov/OP_Home/ssact/title18/1800.htm. Each section

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provides financial assistance to participating states to assist them in furnishing health care to needy and disabled persons. Act § 1901. Each state administers its own Medicaid program subject to federal requirements and the terms of its "plan for medical assistance" (state plan), which must be approved by CMS on behalf of the Secretary of Health and Human Services (HHS). Act § 1902; 42 C.F.R. §§ 430.10-430.16. Once its state plan is approved, a state becomes entitled to receive federal reimbursement, or "federal financial participation" (FFP), for a specified percentage of the amounts it spends on "*medical assistance* under the State plan." Act § 1903(a) (italics added).

Section 1905(a) of the Act specifies the categories of medical assistance — e.g., hospital services, physician services, nursing facility services — that a state Medicaid program may or must cover. Section 1905(a)(19) provides that the term "medical assistance" includes "case management services (as defined in section 1915(g)(2))."

During FFYs 2002 and 2003 (the period covered by the disallowance), section 1915(g)(2) provided in its entirety:

> For purposes of this subsection, the term "case management services" means services which will assist individuals eligible under the plan in gaining access to needed medical, social, education, and other services.

Section 1915(g)(1) provides that a state may (at its option) cover case management as a Medicaid benefit for specific groups of Medicaid-eligible persons without regard to statutory requirements that Medicaid services be available statewide and be comparable (in amount, scope, and duration) for each Medicaid recipient. For example, a state may elect to cover case management for a group of persons based on their geographic location or on their participation in non-Medicaid educational or social service programs. See Massachusetts Exhibit ("M. Ex.") 2, at 1. When a state elects to cover case management as a Medicaid benefit under section 1915(g)(1), the covered services are called "targeted case management" (TCM).

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[1](...continued)
of the Act on that website contains a reference to the corresponding United States Code chapter and section.

Congress enacted section 1915(g) in 1985 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA), Pub. L. No. 99-272, § 9508, 100 Stat. 82. Between 1985 and 2007, CMS issued no regulations to implement section 1915(g).[2] Instead, CMS implemented the statute through sub-regulatory policy and guidance published in a Medicaid program manual and policy letter.

During or prior to 1991, CMS issued section 4302 of the State Medicaid Manual (SMM), entitled *Optional Targeted Case Management Services – Basis, Scope and Purpose*. CMS Ex. B. The SMM is "an official medium by which [CMS] issues mandatory, advisory, and optional Medicaid policies and procedures to the Medicaid State agencies." SMM, *Foreword*.[3]

Section 4302 states that case management services under section 1915(g)(2) are services "furnished to assist an individual in gaining or coordinating access to needed services." CMS Ex. B (SMM § 4302.2(G)(1)). Section 4302 further states:

> Although FFP may be available for case management activities that identify the specific services needed by an individual, assist recipients in gaining access to these services, and monitor to assure that needed services are received, *FFP is not available for the cost of these specific services* unless they are separately reimbursable under Medicaid.

Id. (italics added). This instruction distinguishes between case management – which are services to help a person gain access to needed medical, educational, and social services – and the needed

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[2] On December 4, 2007, CMS issued interim final regulations regarding targeted case management. 72 Fed. Reg. 68,077. Congress subsequently imposed a temporary moratorium on those regulations, with an exception for certain regulations that implement 2005 changes to the statutory definition of case management. See Pub. L. No. 110-252, § 7001(a)(3)(A), (B)(i), 122 Stat. 2388. The 2007 regulations are not at issue in this appeal.

[3] A copy of the SMM's *Foreword* was not included in the parties' exhibits. The State Medicaid Manual is available on CMS's internet website at http://www.cms.hhs.gov/Manuals/PBM/list.asp.

services themselves (sometimes referred to as "underlying" or "direct" services). The instruction indicates that direct or underlying services do not constitute TCM and are ineligible for Medicaid reimbursement unless they are covered as a Medicaid benefit under the state plan.

In January 2001, CMS issued State Medicaid Director Letter (SMDL) No. 01-013. M. Ex. 2. The letter purported to clarify HHS policy on Medicaid reimbursement of TCM when TCM is provided to persons who participate in or receive services under other (non-Medicaid) federally financed social or educational programs, such as programs funded under title IV-B (child and family services), title IV-E (foster care and adoption assistance), and title XX (social services block grant) of the Act.

SMDL 01-013 covers three general subjects: (1) the definition of "case management services"; (2) whether services provided to individuals ineligible for Medicaid, or eligible but not part of the target population, constitute TCM; and (3) the applicability of Medicaid third party liability rules to FFP claims for TCM. M. Ex. 2, at 1. Principally relevant here is the definition of case management services, about which SMDL 01-013 states in part:

> [A]ctivities commonly understood to be allowable [as Medicaid case management] include: (1) *assessment* of the eligible individual to determine service needs, (2) *development of a specific care plan*, (3) *referral* and related activities to help the individual obtain needed services, and (4) *monitoring and follow-up*. . . . In general, allowable activities are those that include assistance in accessing a medical or other service, but do not include the direct delivery of the underlying service.

Id. at 2 (italics added).[4] Repeating a principle set out in SMM

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[4] SMDL 01-013 describes each of the four categories of allowable TCM as follows:

> Assessment: This component includes activities that focus on needs identification. Activities include assessment of an eligible individual to determine the need for any medical, educational, social, and other services. . . .

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§ 4302, SMDL 01-013 emphasizes that "direct services" do not constitute Medicaid case management and are thus "unallowable":

> Medicaid case management services *do not include payment for the provision of direct services (medical, educational, or social) to which the Medicaid eligible individual has been referred*. For example, if a child has been referred to a state foster care program, any activities performed by the foster care case worker that relate directly to the provision of foster care services cannot be covered as case management. Since these activities are a component of the overall foster care service to which the child has been referred, the activities do not qualify as case management.

Id. (italics added).

In 2005, Congress enacted section 6052 of the Deficit Reduction Act of 2005 (DRA), Pub. L. No. 109-171, 120 Stat. 93-95. It

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> Care Planning: This component builds on the information collected through the assessment phase and includes activities such as ensuring the active participation of the Medicaid-eligible individual and working with the individual and others to develop goals and identify a course of action to respond to the assessed needs of the Medicaid eligible individual. . . .
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> Referral & Linkage: This component includes activities that help link Medicaid eligible individuals with medical, social, [and] educational providers and/or other programs and services that are capable of providing needed services. . . .
>
> Monitoring/Follow-up: This component includes activities and contacts that are necessary to ensure the care plan is effectively implemented and adequately addressing the needs of the Medicaid eligible individual. The activities and contacts may be with the Medicaid eligible individual, family members, providers, or other entities. . . .

M. Ex. 2, at 2.

appears that section 6052(a)(2) incorporated the essence of SMDL 01-013's guidelines into section 1915(g)(2)'s definition of case management. As a result of section 6052, section 1915(g)(2) currently provides that case management includes: "*Assessment* of an eligible individual to determine service needs, including activities that focus on needs identification, to determine the need for any medical, educational, social, or other services; "*Development of a specific care plan* based on the information collected through the assessment"; "*Referral* and related activities to help an individual obtain needed services"; and "*Monitoring and follow-up activities*[.]" DRA § 6052(a)(2)(A)(ii) (italics added). In addition, mirroring the guidance first given in SMM § 4302, section 1915(g)(2) currently provides that case management does not include the "direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred."[5] Id. § 6052(a)(2)(A)(iii).

Case Background

The Massachusetts Department of Social Services (MDSS)[6] employs

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[5] In addition to supplementing the statutory definition of case management, section 6052 added the following provision to section 1915(g):

> (4)(A) In accordance with section 1902(a)(25) [of the Act], Federal financial participation only is available under this title for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program.
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> (B) A State shall allocate the costs of any part of such services which are reimbursable under another federally funded program in accordance with OMB Circular A-87 (or any related or successor guidance or regulations regarding allocation of costs among federally funded programs) under an approved cost allocation program. DRA § 6052(a)(4)(B).

[6] Effective July 2008, the MDSS was renamed the Department of Children and Families (http://www.mass.gov/ Eeohhs2/docs/

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social workers and others who provide services focused on child abuse and neglect, foster care, adoption, and domestic violence. M. Ex. 1 (OIG Report at 1). In 1994, the State issued (and CMS approved) state plan amendment (SPA) 94-017, which authorizes Medicaid coverage of TCM services performed by MDSS employees. M. Ex. 3. According to SPA 94-017, the "target group" for these services are Medicaid-eligible children who are "reported to [MDSS] as potentially abused or neglected, or are receiving services from the [MDSS] after being determined to either be at risk of abuse or neglect or substantiated as being abused or neglected children." Id.

SPA 94-017 provides the following definition of the services covered by MassHealth (the State's Medicaid program) as TCM:

> Targeted case management is a set of interrelated activities under which the responsibility for locating, coordinating, and monitoring appropriate services for an individual rests with a specific person within the case management provider agency. The purpose of case management is to assist individuals in gaining access to needed medical, social, and other services.
>
> Case management will include:
>
> 1. collection of assessment data;
> 2. development of an individualized plan of care;
> 3. coordination of needed services and providers;
> 4. home visits and collateral contacts as needed;
> 5. maintenance of case records; and
> 6. monitoring and evaluation of client progress and service effectiveness

M. Ex. 3.

In May 2006, the OIG issued a report on its audit of $197,718,235 in expenditures by MassHealth on services that MassHealth claimed were for TCM pursuant to SPA 94-017. M. Ex. 1.[7] The services in

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[6](...continued)
dss/dept_name_change.pdf). MDSS is a department or agency within the Massachusetts Executive Office of Health and Human Services.

[7] Department of HHS, Office of Inspector General, *Review of*
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question were performed by MDSS social workers during FFYs 2002 and 2003 on behalf of Medicaid-eligible children. Id. (OIG Report at 2). The audit's objective was to verify that the expenditures were for "allowable Medicaid TCM services." Id.

According to the OIG's audit report, MDSS charges MassHealth for TCM using a rate that is applied to each month in which a Medicaid-eligible child receives at least one TCM service. M. Ex. 1 (OIG Report at 5). The TCM rate is derived from the results of a Random Moment Time Study (RMTS) in which the social workers' time (and associated salary costs) are allocated to various "cost centers" (or cost categories). Id. An instruction manual governs the conduct of a RMTS and defines the scope of each cost center. See CMS Ex. A; M. Ex. 13. For each cost center, the RMTS instruction manual provides an "activity code" which describes the types of social worker activities that the cost center is supposed to capture. Id. Both parties submitted RMTS manual excerpts containing the activity codes relevant to this case. Id.

MDSS determined the TCM rate for FFYs 2002 and 2003 based on salary costs allocated to 25 cost centers. M. Ex. 1 (OIG Report at 5 & Appendix B). The OIG found that 16 of those 25 cost centers reflected costs of "direct services" – more specifically, costs of furnishing MDSS's child protective services – rather than costs of services that assisted Medicaid-eligible children in gaining access to medical, educational, or social services. Id. (OIG Report at 6 & Appendix B (columns with the heading "unallowed")). The OIG also observed that many of the services whose costs were included in the TCM rate (and charged to Medicaid) "were authorized under other Federal programs to assist children and families," including programs funded under titles IV-B, IV-E, and XX of the Act. Id. (OIG Report at 6). The OIG found that "although [MDSS] allocated the costs of services to Title IV-E before allocating any costs to Medicaid, it did not allocate any services to Title IV-B or Title XX, both of which provide Federal funding to State child protection programs." Id.

Based on these findings, the OIG concluded that MassHealth had been charged for TCM in FFYs 2002 and 2003 based on a rate that

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[7](...continued)
Targeted Case Management Services Rendered by the Massachusetts Department of Social Services During Federal Fiscal Years 2002 and 2001, A-01-04-00006 (May 2006).

reflected costs of direct services. M. Ex. 1 (OIG Report at 3, 6). As a result, said the OIG, the State had overstated the amount of allowable TCM expenditures in its FFP claims for those years. Id. To determine the amount of the overstatement, the OIG recalculated the State's TCM rate for FFYs 2002 and 2003 after excluding salary costs that it found were for direct services. Id. (OIG Report at 6). Based on those recalculations, the OIG determined that the State's reported TCM expenditures for FFYs 2002 and 2003 had been overstated by $171,147,058, resulting in payment to the State of $86,645,347 in unallowable FFP. Id.

On March 20, 2008, CMS issued a notice of disallowance of $86,645,347 in FFP for FFYs 2002 and 2003. The notice states that the amount disallowed was for expenditures by the State on "direct social services, such as child protection and welfare services." In addition to citing section 1915(g)(2) of the Act, the notice of disallowance cites SMDL 01-013's statement that case management does not include direct services, such as foster care and child welfare services. The notice also states that SMDL 01-013's "interpretation" was "directly supported by language in the Congressional committee report accompanying the original authorization of case management that emphasized that case management services under section 1915(g) must not duplicate payments made to public agencies or private entities under other program authorities for the same purpose." Finally, the notice of disallowance states that the State's claim for FFP in direct services was inconsistent with certain provisions of Office of Management and Budget (OMB) Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*.

On April 17, 2008, the State filed a notice of appeal with the Board, asserting that the disallowance was "erroneous as a matter of law" and was also "arbitrary and capricious." On June 9, 2008, the State filed its initial brief ("M. Br.") and 13 supporting exhibits. CMS filed a response brief ("Resp. Br.") and six exhibits ("CMS Ex.") on July 11, 2008. On July 28, 2008, the State filed a reply brief ("Reply Br.") to which it attached one additional exhibit.[8] Thereafter, the parties submitted

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[8] The additional exhibit attached to the reply brief is a June 2005 report by the U.S. Government Accountability Office, entitled *Medicaid Financing: States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight*, GAO-05-748 (June 2005). CMS did

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additional correspondence on August 1, August 7, August 15, and August 22, 2008.

Discussion

We preface our discussion by noting that we apply the law in effect during FFYs 2002 and 2003, the years for which the disallowed FFP was claimed. Unless otherwise indicated, when we refer to the "statutory definition of case management," we mean the definition in section 1915(g)(2) as it existed before the 2005 DRA.

In its opening brief, the State objects to the disallowance on three general grounds. First, it contends that CMS's reliance on SMM § 4302, SMDL 01-013, and OMB Circular A-87 was improper.[9] M. Br. at 9-20. According to the State, these authorities were, for various reasons, either legally invalid or inapplicable to the circumstances described by the OIG auditors. Id. Urging us to ignore the sub-regulatory guidance issued by CMS concerning the proper scope of TCM, the State asserts that "[a]t all times relevant to the Disallowance, the statutory definition" of case management in section 1915(g)(2) "constituted the only legally binding description of case management services." Id. at 7.

Second, the State contends that the disallowance should be overturned because the OIG and CMS failed to investigate and verify that the disputed MDSS services fell outside the statutory definition of case management. M. Br. at 7-9. Finally, the State contends that, in fact, all of the disallowed FFP at issue was for services that met the statutory definition of case management. Id. at 21.

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[8](...continued)
not object to the submission of this additional exhibit.

[9] Although the March 20, 2008 notice of disallowance does not cite or allude to SMM § 4302, CMS relies on this provision in its response to the State's appeal. Response Br. at 10 n.4. The State does not object to CMS's reliance on SMM § 4302, and we have held that a federal agency may revise the basis for a disallowance on appeal as long as the opposing party is given an adequate opportunity to respond to the change in position, as happened here. Wisconsin Dept. of Health and Social Services, DAB No. 696 (1985); New Hampshire, DAB No. 1862, at 10 n.5.

CMS responds that SMM § 4302 and SMDL 01-013 represent reasonable and permissible interpretations of section 1915(g)(2), of which the State had notice, and that it properly relied on those interpretations in issuing the disallowance. See Response Br. at 3-12. CMS also attempts to justify its reliance on OMB Circular A-87. Id. at 2.

For the reasons below, we conclude that section 1915(g)(2), SMM § 4302, and SMDL 01-013 constitute sufficient and valid legal bases for the disallowance, and that the State failed to carry its burden of proving that the disallowed FFP was for case management as defined in section 1915(g)(2).

1. *The State has the burden of showing that the disallowed FFP was for services that met the definition of case management in section 1915(g)(2) of the Act.*

In this proceeding, CMS has the initial burden to provide sufficient detail about the basis for its disallowance determination to enable the grantee to respond. Delaware Dept. of Health and Social Services, DAB No. 1166, at 10 (1990); 45 C.F.R. § 74.90(c)(2). If the federal agency carries this minimal burden, the grantee must establish the allowability of the expenditures in dispute. Delaware, DAB No. 1166, at 10; Wisconsin Dept. of Health and Social Services, DAB No. 1121, at 12 (1989). When a disallowance is supported by audit findings, the grantee typically has the burden of showing that those findings are legally or factually unjustified. Wisconsin, DAB No. 1121, at 15-16; Indiana Dept. of Public Welfare, DAB No. 970, at 6-7 (1988).

Relying on the findings of the May 2006 audit, CMS indicates in its response brief that the disallowance concerns expenditures claimed to be for TCM but which do not (in its view) meet the definition of case management in section 1915(g)(2) or the interpretation of that definition in SMM § 4302 and SMDL 01–013. Response Br. at 3-12. This is a facially adequate basis for the disallowance because the expenditures claimed to be for TCM are eligible for FFP only if they are for services that meet the statutory definition of case management.[10]

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[10] See Act §§ 1903(a) (requiring the federal government to reimburse a share of any amount expended by a state as "medical

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Because CMS adequately articulated the basis for its disallowance, the burden is on the State to establish that the disallowed FFP was for allowable Medicaid expenditures under the state plan. More particularly, the State must prove that the expenditures for which it claimed FFP were for services that met the then-existing statutory definition of case management.

2. *In SMM § 4302 and SMDL 01-013, CMS interpreted the statutory definition of case management as excluding "direct services," and that interpretation is entitled to deference*.

The Board is, of course, bound by applicable statutes and regulations. 45 C.F.R. § 16.14. Less formal rules or guidelines, including CMS interpretations of the Medicaid statute and regulations contained in CMS program manuals and policy letters, are not binding on the Board. However, in appropriate circumstances, the Board defers to such interpretations. Alaska Dept. of Health and Social Services, DAB No. 1919, at 14 (2004). The Board will defer if the interpretation is reasonable and the grantee had adequate notice of the interpretation or, in the absence of notice, did not reasonably rely on its own contrary interpretation. Id.

In FFYs 2002 and 2003, the controlling statute, section 1915(g)(2), defined "case management" as "services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services." In discussing the scope of the case management benefit, SMM § 4302, whose issuance predates SPA 94-017 (the state plan provision which authorized coverage of TCM by MassHealth), states:

> Although FFP may be available for case management activities that identify the specific services needed by an individual, assist recipients in gaining access to these services, and monitor to assure that needed services are received, FFP is not available for the cost of these specific services unless they are separately reimbursable under Medicaid.

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[10](...continued)
assistance"), 1905(a)(19) (defining "medical assistance" to include "case management" as defined in section 1915(g)(2)).

CMS Ex. B (SMM § 4302.2(g)(1)). This passage advised the states that while services to help a Medicaid recipient identify, obtain, and monitor the provision of needed medical, educational, and social services are allowable as TCM, the underlying needed services – "direct services" in Medicaid program jargon – are not TCM and may be reimbursed only if covered under another (non-TCM) Medicaid benefit.

SMDL 01-013 reiterates that interpretation and provides an illustration:

> Medicaid case management services *do not include payment for the provision of direct services (medical, educational, or social)* to which the Medicaid eligible individual has been referred. For example, if a child has been referred to a state foster care program, any activities performed by the foster care case worker that relate directly to the provision of foster care services cannot be covered as case management. Since these activities are a component of the overall foster care service to which the child has been referred, the activities do not qualify as case management.

M. Ex. 3 (italics added).

The State maintains that any reliance on interpretive statements in SMM § 4302 and SMDL 01-013 is improper because CMS issued them without using the notice-and-comment rulemaking procedures of the Administrative Procedure Act (APA), 5 U.S.C. § 553.[11] M. Br. at

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[11] The State suggests that by relying on the interpretation of 1915(g)(2) in SMM § 4302 and SMDL 01-013, CMS "exceeded its statutory authority," pointing to the fact that some CMS guidance, including the instruction regarding "direct services," was ultimately codified by Congress in 2005. M. Br. at 13-15, 19; see also DRA § 6052(a)(2)(A)(iii) (stating that case management does not include the "direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred"). This suggestion is meritless. As the agency entrusted to administer Medicaid at the federal level, CMS may issue interpretative rules or guidance, such as section 4302 and SMDL 01-013, to fill gaps or resolve ambiguities in the statutory scheme. Cf. Morton v. Ruiz, 415 U.S. 199, 231 (1971) ("The power of an administrative agency to

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19. APA notice-and-comment procedures apply only to "substantive" rules (also known as "legislative" rules); they do not apply to "interpretative rules, general statements of policy, or rules of agency organization, procedure, or practice." 5 U.S.C. § 553(b); Lincoln v. Vigil, 508 U.S. 182, 196 (1993). Interpretative rules are "issued by an agency to advise the public of the agency's construction of the statutes and rules which it administers." Chrysler Corp. v. Brown, 441 U.S. 281, 302 n.31 (1979) (quoting the Attorney General's Manual on the Administrative Procedure Act (1947)).

SMM § 4302 states that it implements section 1915(g)(2) of the Act (and other provisions) and "provide[s] clarification" of those provisions. CMS Ex. B (SMM § 4302(D)). By clarifying what falls *outside* section 1915(g)(2)'s definition of case management — namely, direct services — section 4302 and SMDL 01-03 clearly function, at least in part, as interpretative rules; they purport to advise states and the public of CMS's understanding of a statutory term ("case management") that it applies in administering the Medicaid program.[12] See Shalala v. Guernsey Memorial Hospital, 514 U.S. 87, 99 (1995) (holding that a guideline published in a CMS program manual was a "prototypical example of an interpretive rule issued by an agency to advise the public of its construction of the statutes and rules it administers").

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[11](...continued)
administer a congressionally created program necessarily requires the formulation of policy and the making of rules to fill any gap left, implicitly or explicitly, by Congress."). Since CMS's instruction regarding direct services was a legally valid interpretative rule, Congress's subsequent codification merely evidenced its approval of CMS's interpretation; it did not retroactively transform the instruction into an invalid (for want of notice-and-comment rulemaking) legislative rule.

[12] The SMM's *Foreword* states that it "makes available to all State Medicaid agencies . . . informational and procedural material needed by the States to administer the Medicaid program." That material includes "instructions" for implementing provisions of the Act. The Foreword goes on to state that "[i]nstructions are official interpretations of the law and regulations, and, as such, are binding on Medicaid State agencies," and that "[t]his authority is recognized in the introductory paragraph of State plans."

Because the prohibition on claiming of direct services as TCM is an interpretative rule, it is not invalid for lack of adherence to notice-and-comment rulemaking procedures. Furthermore, that prohibition is a reasonable interpretation of section 1915(g)(2) because the statutory definition of case management expressly covers only services that help a Medicaid recipient "gain access" to needed medical, educational, and social services, not the needed services themselves. The State does not contend that it lacked timely notice of that interpretative rule, nor does it contend that the rule is substantively unreasonable.[13] Because we find that the prohibition on claiming direct services as TCM is a reasonable interpretation of the governing statute, we defer to that interpretation and proceed to determine whether it, along with the applicable statutory language, supports the disallowance.[14]

3. *The State has not carried its burden of proving that the disallowed FFP was for case management as defined in section 1915(g)(2).*

The rate that MDSS charged MassHealth for TCM services in FFYs 2002 and 2003 was based on salary costs assigned to various cost centers (i.e., cost categories). The OIG concluded that some of these cost centers captured salary costs of direct services, not costs of TCM, and thus had been improperly included in the calculation of the TCM rate. According to the OIG, the improperly included cost centers were: (1) Protective intake; (2) Case management; (3) Preparation for and participation in legal proceedings; (4) Referrals to the district attorney; (5) Child placement; (6) Investigative efforts; (7) Services for children with special needs; and (8) All other permanency planning activities. M. Ex. 1 (OIG Report, Appendix B).

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[13] Rather than claiming that it was unaware of SMM § 4302 and SMDL 01-013 prior to the disallowance period, the State suggests that their contents were not detailed or clear enough for it to know or expect that particular MDSS services would be found unallowable. Reply Br. at 2 ("neither the SMDL nor the SMM provided EOHHS with notice that all or any of its TCM claims were improper."). We address this contention later.

[14] Our decision rests only on that part of SMDL 01-013 that bars TCM claiming of direct services. We need not decide whether other guidelines or pronouncements in this document are valid interpretations of the Medicaid statute.

Having found that MassHealth made expenditures based on a faulty TCM rate, the OIG – and ultimately CMS – concluded that a portion of the State's claims for FFP in those expenditures was excessive and subject to disallowance. The OIG determined the amount of the disallowance by recalculating MDSS's TCM rate for FFYs 2002 and 2003 and excluding the above-listed cost centers – which we will call the "excluded cost centers" – from that rate recalculation.

In light of the OIG's findings and the State's legal posture in this proceeding, our primary task is to determine whether the State has proven that the salary costs assigned to the excluded cost centers were for TCM, not for direct services (as the OIG found). The State contends that all of those costs were for services that met the statutory definition of Medicaid case management. M. Br. at 20-24.

a. The "protective intake" cost center

We first consider the "protective intake" cost center. According to the State, protective intake constitutes the "first step in the process of developing a child's service plan and involves assessing and reassessing the child's service needs." M. Br. at 22. The State further asserts that protective intake "include[s] helping enrollees gain access to needed medical, social and other services, and specifically may include collection of assessment data, home visits and collateral contacts as needed, in accordance with activities described in the SPA." Id. at 23.

The OIG described protective intake differently. Protective intake, said the OIG –

> includes investigative efforts to prevent or eliminate the removal of a child from his or her home. These efforts include receipt and screening of reports of abuse and investigations to determine whether there is reasonable cause to believe that a child has been or may be abused or neglected.

M. Ex. 1 (OIG Report, Appendix A).

The OIG's description is consistent with the protective intake cost center's RMTS activity code, which states in relevant part:

> Protective Intake (Receipt, Screening and

> Investigation)
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> This activity code is for *investigative efforts to prevent or eliminate the need for removal of children from their homes* for all cases where a removal of a child from his or her home has not occurred (but such a removal is, to the caseworker, a reasonable possibility in the absence of preventive services) . . . . The conduct of the following activities are among those investigative efforts to prevent or eliminate the need for removal of a child from his or her home:
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> 1. Receipt and screening to determine, based upon the facts in a report of suspected abuse or neglect whether there is or may be reasonable cause to believe that a child(ren) has been abused or neglected or may be at the risk of being abused or neglected by a caretaker . . . .
>
> 2. Investigation to determine if there is reasonable cause to believe that a child(ren) has been or may have been abused or neglected or may be at risk of being abused or neglected by a caretaker and to protect the child(ren) from further abuse or neglect . . . .

CMS Ex. A at 4 (italics in original). The OIG's description of protective intake is also consistent with MDSS Policy #86-015R, entitled *Protective Intake.* That policy indicates that protective intake is the initial step of a state-mandated child protective services process.[15] See M. Ex. 13. The policy

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[15] Protective intake is the initial step of a process mandated by state law. Chapter 119 of the Massachusetts General Laws requires MDSS to institute a process for protecting at-risk children that includes the following elements: (1) investigating and evaluating a report of child abuse or neglect; (2) evaluating the household of the child named in the report; (3) determining the risk of physical or emotional injury to any other children in the same household; (4) taking immediate temporary custody of the child if the agency has reasonable cause to believe that removal is necessary to protect the child from further abuse or neglect; (5) offering to the family about whom there is a substantiated case of child abuse or neglect "appropriate social services" to prevent further injury to the child and preserve and stabilize

(continued...)

explains that protective intake consists of (1) "*screening* all reports" of suspected abuse or neglect, and (2) "*investigating* screened-in reports" of suspected abuse or neglect. Id. (italics added). "The purpose of screening," says the policy, "is to determine, based upon the facts in the report, whether there is or may be reasonable cause to believe that a child(ren) has been abused or neglected or may be at risk of being abused or neglected by a caretaker." Id. Screening, says the policy, is "part of the process which determines the Department's subsequent actions and intervention with the family," actions that could include removal of the child from the home. Id. The purpose of "investigation" is similar: "to determine if there is reasonable cause to believe that a child(ren) has been or may have been abused or neglected or may be at risk of being abused or neglected by a caretaker and to protect the child(ren) from further abuse or neglect." Id. Like screening, investigation is part of the process which "determines the nature of the Department's involvement with the family." Id.

In our view, the relevant RMTS activity code and MDSS policy #86-015R support the OIG's finding that protective intake is a direct social service, a component of a process that is focused on identifying and protecting vulnerable children. See infra n.15. "Screening" and "investigation," the two elements of protective intake, serve to substantiate (or rule out) a "report" of abuse or neglect. Their apparent chief purpose is not to help the Medicaid-eligible child, in the words of section 1915(g)(2), "gain access" to medical, educational, and social services. Rather, their purpose is to provide the child protective services social worker and agency with information that enables them to determine whether further protective intervention is needed — such as placement of the child outside the home — and, if possible, to "prevent or eliminate the need for removal" of the child from the home.

We have no reason to believe that protective intake in this instance served any other purpose. According to SPA 94-017,

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[15](...continued)
family life; (6) notifying the district attorney of the results of the investigation and of the service plan, if any, developed for the child and the child's family; and (7) notifying appropriate persons in the event that the report of abuse and neglect has not been substantiated. Mass. Gen. Laws ch. 199, § 51(B).

which authorized Medicaid coverage of TCM in Massachusetts, the Medicaid-eligible children who received protective intake in SFY 2002 and 2003 had been "reported" to MDSS as "potentially abused or neglected." M. Ex. 3. Upon receiving the "reports" of abuse or neglect, MDSS initiated the child protective services process by performing protective intake in order to determine the validity of those reports. See M. Ex. 7 (indicating that children in the target population are "screened" for risk of abuse or neglect).

Although it is clear that the disallowance rests on the content of relevant RTMS activity codes, the State has failed to present an argument about why the screening and investigative activities described in the protective intake activity code ought to be classified as case management instead of direct services. M. Br. at 22-23. Without citing or referring to that activity code, the State merely asserts that protective intake includes the types of activities specified in SPA 94-017, such as "collection of assessment data," "home visits," and "collateral contacts as needed." Id. at 23. While these types of activities may be some of the means by which screening and investigation are undertaken, they do not in themselves constitute case management unless they directly and substantially serve the purposes of case management. SPA 94-017 states that the "[t]he purpose of case management is to assist individuals in gaining access to needed medical, educational, or social services." The State has not explained or demonstrated *how* the activities captured by the protective intake cost center directly and substantially serve that purpose.

The State suggests that protective intake is case management because it is the "first step" in identifying the need for medical, educational, and other services deemed necessary to prevent or eliminate placement of the child outside the home. M. Br. at 22; M. Ex. 1 (OIG Report, Appendix D, at 11). However, the relevant RMTS activity code does not mention activities focused on identifying a child's service needs. CMS Ex. A at 4. According to that code, the focus of protective intake is on ascertaining the risk of harm to the child. Identifying service needs is the focus of the "Development of service plans" cost center, see id. at 6, which the OIG retained in its recalculation of the TCM rate for FFYs 2002 and 2003.

We realize that, in a generic sense, the screening and investigative activities described in the protective intake activity code arguably help the Medicaid-eligible client gain

access to a social service because protection from abuse or neglect is a social service and because protective intake, as the initial step in the child protective services process, helps ensure that a vulnerable child and the child's family receive the services needed to keep the child safe. But virtually every social welfare program has a screening, investigative, or other similar process whose purpose is to verify that a prospective program participant needs, is eligible for, or is otherwise appropriate to receive, the program's services. We see nothing in section 1915(g)(2)'s text or legislative history to indicate that the statutory definition of case management was intended to cover such a process. As the conference report to the legislation that established section 1915(g) indicates, case management is "commonly understood" as a "system under which responsibility for *locating, coordinating, and monitoring a group of services* rests with a designated person or organization." CMS Ex. E (citing the conference report passage concerning section 9508 of the 1985 COBRA, Public Law 99-272) (italics added). In other words, case management is a unique and distinct activity that involves comprehensive management of an individual's need for a range of services. The State recognized this in SPA 94-017, where it stated that TCM is a "set of interrelated activities under which the *responsibility for locating, coordinating, and monitoring appropriate services rests with a specific person* within the case management provider agency." M. Ex. 3 (italics added). The State has not persuaded us that protective intake is concerned with locating, coordinating, and monitoring a group of services needed by the Medicaid recipient, nor has it demonstrated that any of the disallowed services were performed by MDSS employees with "responsibility" for that managerial function.

For these reasons, we concur with the OIG's finding that protective intake, as described in the relevant activity code, is a direct service, not TCM. Because we find that the activity code used by the State to allocate salary costs to the protective intake cost center describes activities that do not meet the statutory definition of case management, we have no basis to disturb the OIG's conclusion that salary costs allocated to that cost center were improperly included in the TCM rate for FFYs 2002 and 2003.

b. <u>The "case management" cost centers</u>

We turn next to the two cost centers labeled "case management."

One of these case management cost centers relates to "pre-placement" activities that occur before a child is removed from his or her home. CMS Ex. A at 5-6. The second case management cost center relates to "post-placement" activities that occur after the child is removed from the home. Id. at 13-14.

In its report, the OIG distinguished case management for TCM purposes from the activities captured by the case management cost centers:

> Th[e] [case management] cost center should be distinguished from Medicaid "TCM" as used in this report. "Case management," as used by [MDSS], largely includes services that represent the day-to-day provision of services by social workers, such as "initial case assignment, subsequent case assignment, and on-going casework activities." These direct services should be distinguished from TCM services, which focus on assessment, referral, and monitoring and include "assessment of the beneficiary to determine service needs, development of a specific care plan, referral to needed services, and monitoring and followup of needed services." [quoting SMDL 01-013]

M. Ex. 1 (OIG Report at 5 n.3). The OIG's view is supported by the RMTS activity codes corresponding to the case management cost centers. For example, the activity code for pre-placement case management states:

> **This activity code is for general case management and case supervision activities for all cases where a removal of a child from his or her home has not occurred** (**but such removal is, to the caseworker, a reasonable possibility in the absence of preventive services**) and includes all *intact family* cases which can be so described. This activity is generally equivalent to *initial case assignment, subsequent case assignment*, and *ongoing casework* activities as described in the Case Practice Policy and Procedures Manual. The conduct of the following activities are among those defined as case management and supervision.
>
> 1. When a case is opened, . . . the establishment of a case record and the initial assignment of a case to be continuously handled by an individual

caseworker. Activities include signature and dating of the Record of Case Assignment and completion of an ASSIST Worker Assignment Event, etc. . . .

2. Assignment of an ongoing case to a social worker or to a supervisor. Activities include the documentation of the necessity for a reassignment, documentation in the ongoing dictation, advising the family of a reassignment, signature and dating of the Record of Case Assignment, completion of an ASSIST Worker Assignment Event, etc. . . .

3. Maintenance of contact with the family and with collaterals as indicated in the family's service plan, and activities will include determination of which family members and collaterals should be contacted on an ongoing basis, determination of the frequency, location and method of contacts, etc. . . .

4. Arrangement for social worker-client contacts and child-family visitation schedules for all cases with children in placement, monthly visits with children, placement resources, parents, and siblings, etc. . . .

* * *

6. Supervision supporting ongoing casework through discussion of family dynamics, treatment planning, service delivery, agency mandate, and caseload priorities. Activities include scheduling, preparing for and documenting regularly scheduled supervisor-supervisee discussions. . . .

7. Documentation, consisting of the entry into the family's case record of information and materials pertaining to the Department's and provider's activities on behalf of the family and the family's interaction with the Department and providers. Activities include the ongoing dictation regarding contacts with the family or collaterals, inclusion into case records of data necessary for subsequent court action, etc. . . .

Id. at 5-6 (emphasis added, italics in original).

The State has made no showing that the above-quoted passage can reasonably be interpreted as describing allowable TCM, nor has it supplied any evidence that the activities described *in fact or practice* met the Medicaid definition of case management. On its face the passage contains no words or phrases – such as "helping" or assisting a child "find," "locate," or get "access" to "needed medical, social, education, and other services" – that clearly or expressly signal that it was intended to capture TCM. Furthermore, the words in bold strongly suggest that this passage, which appears in virtually identical form in the activity code for "post-placement" case management, identifies administrative activities (e.g., case assignment, establishing and maintaining MDSS-family contact, arranging child-family visitation schedules, documenting MDSS-family interaction) that are performed in response to, or in conjunction with, a determination by a MDSS social worker that a child is at risk of abuse or neglect. While it is conceivable that some time study participants used the code to report some activities that supported, directly or indirectly, the provision of allowable TCM, neither the language of the passage nor any argument made or evidence supplied by the State persuades us that the OIG erred in concluding that the case management cost centers captured direct services, not TCM.[16]

The two case management activity codes identify one other group of activities that requires analysis. Paragraph five of those codes states:

> 5. *Assisting clients, on an ongoing basis, in identifying and obtaining available services to meet assessed needs*. Activities include specifying services to be provided in the family's service plan, determining what services are appropriate and available, providing assistance to the client in obtaining services either by making a referral or by providing information on how the

[16] Our analysis below with respect to the activities described in paragraph five of the case management activity codes differs somewhat from our analysis here with respect to paragraphs one through four, six, and seven of those codes. However, we conclude that the State has not met its burden to show that the OIG erred with respect to paragraph five as well.

> client can obtain the service directly, completing service authorizations, etc. . . .

CMS Ex. A at 5, 13 (italics added). These activities do seem to be focused on helping a person gain access to needed medical, educational, and social services. However, it is unclear what percentage, if any, of the salary costs assigned to the case management cost centers for FFYs 2002 and 2003 were for activities described in paragraph five. Indeed, the State has introduced no evidence from which we could verify that costs assigned to the case management cost centers were for helping clients locate and obtain services to meet assessed needs. Instead, the State has extravagantly claimed that *all* salary costs assigned to the case management cost centers were allowable (see M. Br. at 23), when it is apparent from the relevant activity codes that some of the services captured by those cost centers were direct services.

Moreover, it is conceivable that the amount of allowable costs captured by paragraph five of the case management activity codes was insignificant, or even zero, because the criteria in paragraph five overlaps criteria in other activity codes that, on their face, are more tightly focused on capturing allowable case management activities and whose corresponding cost centers were retained in the OIG's TCM rate recalculation.[17] Like paragraph five, the activity codes for the two "referral to services" cost centers describe activities to help Medicaid-eligible clients locate and obtain health care and other social services. CMS Ex. A at 2-3, 10-11. The State has made no attempt to distinguish the services described in paragraph five (whose costs were excluded from the OIG's rate recalculation) from the services captured by the referral-to-services cost centers (whose costs

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[17] The OIG stated it was "unable to express an opinion" about the allowability of costs retained by the OIG in the TCM rate recalculation for FFYs 2002-2003. M. Ex. 1 (OIG Report at 3). As a result, the Medicaid expenditures associated with those costs were not disallowed. The retained costs had been allocated to the cost centers known as "Referral to services," "Development of service plans," and "Case reviews." Id. (OIG Report, Appendix B ("No Opinion" column)). The OIG stated that although those costs appeared to reflect "allowable TCM services under existing policy, our audit work identified a significant risk that the services may have already been reimbursed under other Federal programs." Id. (OIG Report at 3).

were retained in the rate recalculation).

Assuming for the sake of argument that the case management cost centers captured allowable costs in FFYs 2002 and 2003 (and there is not sufficient evidence that they actually did), the State needed to rule out the possibility of duplicate federal payments. SMM § 4302 accurately states:

> In authorizing States to offer case management services, Congress recognized that there was some potential for duplicate payments because the same or similar services have often been provided by other programs or under the Medicaid program itself. H. Rep. No. 453, 99th Cong., 1st Session 546 (1985), [the conference report] which accompanies [section 9508] of P.L. 99-272, emphasizes that payment for case management services under § 1915(g) must not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

CMS Ex. B.[18] The OIG found that although MDSS had allocated a portion of salary costs to the title IV-E program (foster care and adoption assistance), it had not allocated any such costs to the title IV-B and title XX programs, which, according to the OIG, also provide federal funding to state child protection programs. M. Ex. 1 (OIG Report at 6).

In response to the OIG's apparent concern about duplicate federal payments, the State provided the declaration of MDSS Budget Director David O'Callaghan, who stated: "At all times relevant to this matter DSS allocated its costs, specifically including TCM costs, among the above Federal grants [title IV-E, IV-B, XIX, and XX] ***in a manner*** intended ***to assure*** that no given dollar was allocated to more than one Federal grant and no claim for Federal

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[18] The conference report to the 1985 COBRA states in relevant part:

> The conferees expect that the Secretary will assure that payments made for case management services under this section [1915(g) of the Act] do not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

CMS Ex. E (131 Cong. Rec. H13093-H13102, 1985 WL 724562).

reimbursement under a Federal grant duplicated any claim for reimbursement under any other Federal grant." M. Ex. 10 (italics and emphasis added). This statement does not adequately address the OIG's concern because neither Mr. O'Callaghan nor the State in its briefs specified the factual basis for his "assurance" that duplicate payments did not occur. Mr. O'Callaghan stated that costs were allocated "in a manner" intended to assure that Medicaid was not improperly charged but failed to describe the "manner" in which the allocation occurred for specific costs. In addition, the record contains insufficient information about MDSS's federal funding sources and the activities or programs financed by those funding sources.

In light of these circumstances, the fact that paragraph five of the "case management" activity codes describes activities that arguably fit within the definition of TCM is not dispostive. This fact merely indicates a *possibility* that *some* of the disallowed costs associated with the case management cost centers – cost centers that, according to the relevant activity codes, captured *both* unallowable and allowable costs – were allowable. When it appears that a disallowance may include both allowable and unallowable expenditures, the State has the burden of identifying the allowable expenditures. Ohio Dept. of Human Services, DAB No. 858, at 8-10 (1987) (refusing to modify a disallowance when the State failed to offer evidence – "contemporaneous source documentation" – that identified or quantified the amount of allowable "maintenance costs" that may have been included in the disallowance of certain "pass-through" costs). Here, the State has not met that burden because it has not presented any evidence that identifies and quantifies the allowable costs assigned to the case management cost centers, if indeed there are any.

c. The remaining excluded cost centers

The remaining excluded cost centers are entitled "Preparation for and participation in legal proceedings," "Referrals to the district attorney," "Child placement," "Investigative efforts," "Services for children with special needs," and "All other permanency planning activities." See M. Ex. 1 (Appendix B). Like protective intake and case management, these other excluded cost centers have activity codes that appear to describe direct, child protective services – namely, activities whose immediate and primary aim is not to help a child gain access to needed medical, educational, and other social services, but to protect

vulnerable children and place them in a safe living environment. See, e.g., CMS Ex. A at 4 (stating that the activity code for the cost center called "preparation for and participation in judicial proceedings" is "for the preparation for and participation in judicial determinations, court proceedings or voluntary placement agreements regarding removals of children from their homes and placement into substitute care"); id. at 5 (stating that the activity code for "referrals to the district attorney" is "for notification and provision of information to the appropriate District Attorney and local law enforcement authority if certain specific conditions have resulted from abuse or neglect").[19] The State has not indicated how or why these activity codes should in these circumstances be read as descriptions of case management. To the extent that some of these activity codes can be read as capturing *both* direct services and TCM, the burden was on the State to identify and quantify the allowable TCM costs allocated to the corresponding cost centers for FFYs 2002 and 2003. Ohio Dept. of Human Services. The State provided no such evidence.

Instead of offering evidence sufficient to meet its burden of proof, the State complains that the OIG and CMS failed to verify the nature of the services whose costs were excluded from the OIG's TCM rate recalculation. M. Br. at 7-9. Relying on Massachusetts v. Secretary of HHS, 816 F.2d 796 (1st Cir. 1987), aff'd in part and rev'd in part sub nom., Bowen v. Massachusetts, 487 U.S. 879 (1988), the State asserts that in order to determine whether a particular service constitutes reimbursable "medical assistance," there must be "'an inquiry into the *nature of the*

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[19] Although the activity codes for "services for children with special needs" and "all other permanency planning services" refer to the MDSS employee as a "caseworker," the apparent purpose of those activities is to facilitate the placement of a child in a permanent living arrangement. This view is confirmed by the State's own comments to the draft OIG report and by an MDSS policy statement cited in those comments. See M. Ex. 1 (OIG Report, Appendix D at 15 & n.40 (stating that the activities captured by the "permanency planning" codes are "related to the arrangement for and entry into adoption assistance agreements or alternative placements" or "related to permanency planning other than the arrangement of special needs adoption agreements"); M. Ex. 13 (three-page document with the heading "Exhibit 8"). The State has pointed to no other evidence supporting its claim that the activities captured by these two activity codes meet the statutory definition of case management.

services, not just into what they are called or who provides them.'" Id. at 7 (quoting Massachusetts v. Secretary of HHS, 816 F.2d at 804)). According to the State, the OIG and CMS failed to ascertain or inquire about the "nature" of the services excluded from the TCM rate recalculation, or to determine whether those services met the statutory definition of case management. Id. at 9. The State asserts that the disallowance is based merely on a finding about who provided the services in question (MDSS social workers) and the title of the cost centers to which salary costs were allocated, rather than upon the "nature of the services themselves." Id. at 9, 21-22.

The factual premise of this argument – that the OIG (and by extension CMS) failed to inquire about the nature of the services charged to Medicaid as TCM – is unfounded. As discussed, MDSS salary costs were assigned to cost centers based on the results of time studies in which employees used activity codes (corresponding to each cost center) to record how they spent their time. The activity code for each cost center described in detail the types of activities properly allocable to the cost center. Thus, a salary cost was allocated to one of the cost centers included in the TCM rate if the activity which generated the cost was of the type or kind described in the cost center's activity code.

In judging whether a cost center had been properly included in the TCM rate, the OIG examined the cost center's activity code to determine whether it described activities that met the Medicaid definition of case management.[20] If the services described by an activity code did not (in its view) meet that definition, then the OIG excluded the cost center from its recalculation of the TCM rate. Because the OIG excluded a cost center from the TCM rate recalculation if its activity code described services that did not constitute case management under section 1915(g)(2), the OIG's decision to exclude the cost center from the recalculation, and the resulting disallowance, was in fact based on the "nature of the services."

If the State is suggesting that the auditors should have examined source documentation to verify the unallowability of each and every MDSS activity captured by an excluded cost center, we

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[20] The OIG provided a summary of the services associated with each activity code in Appendix A of its May 2006 report. M. Ex. 1.

reject that suggestion. To require such an inquiry would impose an unreasonable administrative burden and unduly frustrate CMS's legitimate effort to ensure that federal Medicaid dollars are spent properly. The courts and the Board have held that a disallowance may be based on statistical sampling and other reliable auditing techniques that do not involve review of individual costs or expenditures. See, e.g., New York Dept. of Social Services, DAB No. 1134, at 8-9 (1990) (citing cases). In this case, the disallowance was based on review and application of rate determination methods that the State itself used to claim the disallowed FFP.

In summary, we conclude that the State has failed to carry its burden of proving that the disallowed FFP was for services that met the statutory definition of case management.

4. *The State's other contentions provide no basis for overturning or modifying the disallowance.*

We find no merit in, or need not reach, the State's other contentions. First, the State suggests that it should not be held accountable for the unallowable expenditures because the guidance to states in SMM § 4302 and SMDL 01-013 was not detailed or clear enough about the kinds of activities that would be disallowed. M. Br. at 19; Reply Br. at 2 ("neither the SMDL nor the SMM provided EOHHS with notice that all or any of its TCM claims were improper."). However, both clearly indicated that a direct social service needed by the Medicaid recipient could not be claimed as TCM. The State does not assert that this instruction caused confusion or uncertainty with respect to the child protective services captured by the excluded cost centers.[21] If the State had any doubt about the instruction's

[21] In its reply brief, the State suggests that SMDL 01-013 may have caused or contributed to confusion which resulted in the disallowance. In support of this suggestion, the State points to a 2005 General Accountability Office (GAO) report which indicates that CMS had admitted that SMDL 01-013 "contained problems and errors that caused confusion regarding appropriate TCM claims when non-Medicaid state claims were involved." Reply Br. at 3 (citing *Medicaid Financing: State's Use of Contingency Fee Consultants to Maximize Federal Reimbursements Highlights Need For Improved Federal Oversight*, GAO No. GAO-05-748, at 31 n.43 (June 28, 2005)). However, we see nothing in the GAO report

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meaning or scope, it was obligated to obtain clarification from CMS before submitting its FFP claims for TCM. See Missouri Dept. of Social Services, DAB No. 2184, at 29 (2008) ("good faith includes seeking guidance where the state is aware of an apparent ambiguity or uncertainty" in the agency's legal interpretation).

The State further contends that SMDL 01-013 was an improper basis for the disallowance because CMS failed to comply with the provisions of 5 U.S.C. § 801 et seq., commonly known as the Congressional Review Act (CRA), when it issued SMDL 01-013. M. Br. at 12-13. The CRA was enacted in section 251 of the Contract With America Advancement Act, Pub. L. No. 104-121, § 251, 110 Stat. 847, 868-74. The CRA provides that before an agency "rule" can take effect, the federal agency promulgating the rule shall submit to each house of Congress and to the Comptroller General a report containing (1) a copy of the rule, (2) a concise general statement relating to the rule, including whether it is a major rule, and (3) the proposed effective date of the rule. 5 U.S.C. § 801(a)(1). Assuming arguendo that SMDL 01-013 is a "rule" within the meaning of the CRA, the State has not presented evidence that CMS did not comply with the CRA; it asserts only that "[t]here is no public record that CMS submitted the SMDL to each House of Congress and the Comptroller General." M. Br. at 13. Absent evidence to the contrary, we presume that CMS properly discharged its statutory responsibilities with respect to SMDL 01–013. Cf. FCC v. Schreiber, 381 U.S. 279, 296 (1965) (administrative agencies are entitled to presumption that they will act properly and according to law); U.S. Postal Serv. v. Gregory, 534 U.S. 1, 10, 122 S.Ct. 431, 151 L.Ed.2d 323 (2001) ("[A] presumption of regularity attaches to the actions of Government agencies ....").

The State also argues that CMS improperly invoked OMB Circular A-87. M. Br. at 15-19. We need not reach this argument because we conclude that CMS had other sufficient legal grounds for the disallowance (the statutory text, SMM § 4302, and SMDL 01-013).

Next, the State contends that the disallowance should be overturned "[t]o the extent CMS relie[d] on" Medicaid's third-party liability provisions. M. Br. at 20. Because CMS in this

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[21](...continued)
which indicates that the noted "problems and errors" touch on the basis for the disallowance here, which is that FFP was claimed for direct services.

proceeding did not rely on Medicaid third party rules to support the disallowance, we need not address the State's arguments about their applicability.

The State further asserts that it did not begin to claim FFP for TCM until almost two years after CMS approved SPA 94-017 (in 1994). M. Br. at 4. Between 1994 and 1996, says the State, it "participated in numerous meetings and phone calls and exchanged numerous letters" with its consultant, MDSS, and CMS Region I employees in order to "identify and confirm the specific activities that CMS agreed were TCM activities provided by [MDSS]." Id.; see also M. Ex. 1 (OIG Report, Appendix D, at 5-6). The State further asserts that its communication with CMS about TCM claiming continued after 1996. M. Br. at 5. As a result of these contacts, says the State, CMS was, prior to the disallowance period, "well familiar" with the activities that the State was claiming as TCM, yet CMS continued to pay the State's TCM claims and never informed the State that SPA 94-017 was "non-compliant in any way."[22] Reply Br. at 4. "[G]iven the facts of this case," says the State, "it would be unsupportable and improper to impute to [the State] actual knowledge of anything that would lead it to conclude that it was acting in any way other than in full compliance with federal law, as reflected by the Medicaid statute itself, as well as CMS's actions and policy issuances." Id.

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[22] To the extent that this assertion can be construed as a request that we overturn the disallowance on the ground that the unallowable expenditures were made in accordance with the State's CMS-approved state plan, we reject that request because it is unsupported by any analysis or argument. The State has not attempted to explain how or why the social worker services described in the RMTS activity codes for the excluded cost centers can be regarded as satisfying the coverage criteria in SPA 94-017, which expressly incorporated key portions of the statutory definition of case management as well as language from the conference report to the 1985 legislation that enacted section 1915(g)(2). Compare M. Ex. 3 (defining case management as "activities under which the responsibility for locating, coordinating, and monitoring appropriate services for an individual rests with a specific person" and as activities which "assist individuals in gaining access to needed medical, social, and other services") with Act § 1915(g)(2) and CMS Ex. E (1985 conference report).

This argument appears to rest on a factual claim that CMS was aware of or had approved the State's disallowed claiming practices.[23] However, the evidence submitted by the State fails to substantiate that claim. The State relies heavily on the declaration of Dennis Bothamley, a private consultant who assisted the State in developing its TCM rate. M. Br. at 4-5. Bothamley asserted in his declaration that he participated in meetings with CMS employees in 1995 and 1996 to "familiarize CMS Region I with the targeted TCM activities of DSS case managers and the case notes documenting the TCM activities that DSS case managers perform as set forth in [SPA 94-017]." M. Ex. 5. Bothamley stated that, during two or three consecutive days in 1995, two CMS Region I employees named Blake and Briggs (identified by Bothamley as "Medicaid financial experts") reviewed case notes from three MDSS field offices and "asked questions as to the nature of each discrete activity." Id., ¶ 3. However, the case notes reviewed were not described by Bothamley or made part of the record; thus, it is unclear whether any of the case notes reviewed were for services captured by the excluded cost centers.

Bothamley further asserted that he met with Briggs and another CMS employee named Harold Finn, whom Bothamley identified as a "Medicaid policy and state plan expert," on January 19, 1996 to discuss protective intake. M. Ex. 5, ¶ 2. However, Bothamley did not specify what representations he made to those employees about protective intake during that meeting or its role, if any (as of January 1996), in the TCM rate calculation. M. Ex. 5, ¶ 3.

Bothamley went on to state that around this same time (early 1996), he provided a copy of MDSS's "random moment time study (RMTS) categories" to CMS employee Blake, and that he later met with Blake "to explain which of the 48 RMTS categories were

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[23] The State's request that we overturn the disallowance based on its claim that CMS approved or agreed to the inclusion of problematic cost centers in the TCM rate sounds like a request for equitable estoppel, but the State does not allege that the elements for estoppel were satisfied. In any event, the Board lacks authority to grant equitable relief, and CMS could not be estopped in any event absent a showing of affirmative misconduct, which the State has not tried to make. Nebraska Dept. of Health and Human Services, DAB No. 2177 (2008); Pacific Islander Council of Leaders, DAB No. 2091 (2007).

performed by DSS TCM case managers" and "which of the DSS case manager activities would qualify as TCM under the six TCM categories listed in the approved TCM State Plan [SPA 94-017]." M. Ex. 5, ¶ 4. According to Bothamley, Blake "asked questions about the nature of the RMTS activities identified as TCM" but "raised no concerns." Id.

From an evidentiary standpoint, the statements about Bothamley's contacts with Blake in early 1996 are problematic. First, the State did not submit a copy of the document that Bothamley says he provided to Blake during that period. The document presumably identified the name or title of the RTMS activity categories, or activity codes, that MDSS employees used to report their time.[24] However, it is unclear whether that document included the definitions and criteria for each code, and if it did, whether those definitions and criteria were the same as those used to determine the TCM rate for the period at issue in this case (FFYs 2002 and 2003). Second, although Bothamley stated that he told Blake which activity categories would be reflected in the TCM rate, his declaration does not say what those categories were. Third, it is unclear that Blake actually reviewed the documents furnished to him or passed them on to colleagues. We cannot conclude, based on this evidence, that CMS knew, prior to the disallowance period, that the specific activities found by the OIG to be unallowable were being claimed as TCM.

According to the State, three other exhibits indicate that CMS knew about the inclusion of protective intake (and other disallowed cost categories) in the TCM rate prior to the disallowance period. M. Br. at 4-5 (citing M. Exs. 4, 6, and 7). The first two exhibits contain letters dated January 25 and February 15, 1996 from the State to CMS. The January 25 letter discusses various issues concerning the methodology used by MDSS to develop the TCM rate. M. Ex. 6. One of those issues was a request by CMS that MDSS develop two TCM claiming rates: one for Medicaid recipients of "unopened protective intake," and one for all other Medicaid recipients in the target group. M. Ex. 6. The February 15 letter summarizes the results of discussions

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[24] An RMTS "observation form" on page one of the RMTS Instruction Manual lists 47 (not 48) activity categories, or activity codes, including the ones at issue in this case – i.e., protective intake, case management, referrals to district attorney, preparation for or participation in legal proceedings, etc. See CMS Ex. A.

between CMS and the State about various TCM "billing" issues, including "how a billable incident of TCM [would] be identified" and the definition of the "target population." M. Ex. 7. The third exhibit, a 1998 memorandum from MDSS to the Massachusetts Division of Health Care Finance and Policy (MDHCFP), contained a request by MDSS for MDHCP's approval of proposed TCM rates. M. Ex. 4. MDSS's rate proposal conformed with CMS's request to separate the TCM rate into one rate for "unopened protective intake" cases and another for all other cases. Id.

These documents have the same critical deficiency as the State's other evidence: they fail to show that CMS knew about the inclusion in the TCM rate of *specific activities described in the RMTS activity codes* at issue here.[25] For example, although the documents indicate or suggest that CMS was aware that the State's TCM rate reflected a category of costs called protective intake, they do not establish that CMS was aware of the nature of the activities being claimed as protective intake in 2002 and 2003.

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[25] In its discussion of protective intake, the State asserts:

> ***Where*** (1) protective intake activities ***fit squarely*** within the scope of the TCM provisions of the Medicaid statute in effect during the relevant period, ***and*** (2) CMS had ***actual knowledge*** beginning in 1994 that Massachusetts's TCM rate included the protective intake cost center and with such knowledge consistently and over a period of years made FFP payments to the state on its expenditures for protective intake activities, CMS's decision now to disallow [the State's] TCM expenditures in 2002 and 2003 because they include activities categorized as protective intake is unsupportable.

M. Br. at 23 (bold and italics added). This contention fails at the outset because, as we have discussed, the State has not shown that protective intake "fits squarely" within the statutory definition of case management. Assuming for the sake of argument that CMS did have "actual knowledge" prior to FFY 2002 that the State was claiming FFP for the kinds of protective intake activities later found unallowable by the OIG, a fact that the record does not substantiate, the State does not assert a *legal* justification (estoppel, for example) for overlooking the claiming of expenditures that are, on this record, unallowable under the applicable statute.

Finally, the State points to a January 18, 2001 memorandum from the Branch Chief of CMS Region I's Division of Medicaid and State Operations. M. Br. at 6 n.9 (citing M. Ex. 8). The memorandum concerned proposed revisions by the State to MDSS's cost allocation plan. M. Ex. 8. The memorandum states that certain unspecified cost "items" that MDSS wanted or intended to claim as Medicaid "administrative" costs "may be captured in the Targeted Case Management (TCM) program." Id. However, the evidentiary value of this memorandum is negligible at best because it fails to specifically identify the cost "items" in question, indicate whether those items were ultimately included in the TCM rate calculation, or indicate that CMS became aware of the inclusion of the unspecified items in the TCM rate.

Assuming for the sake of argument that Blake, Briggs, Finn, or some other CMS employees became aware in the 1990s that protective intake and other cost centers later excluded by the OIG were being included in the State's TCM rate calculation, there is no evidence that these or any other CMS employees, *with knowledge of the definitions or descriptions for each code*, had "agreed" that their inclusion in the TCM rate calculation was consistent with the applicable Medicaid statute and CMS's interpretation of that statute.

In sum, while the record shows that the State had discussions with CMS about what activities could or would be claimed as TCM costs, the State did not establish that CMS knew, prior to the fiscal years covered by the disallowance, that activities described in the above-discussed RMTS activity codes (as they appear in the record before us) were being charged to Medicaid as TCM; nor did the State establish that CMS ever "agreed" that those activities constituted TCM.

Conclusion

For the reasons stated above, we affirm the disallowance of $86,645,347 in FFP for expenditures that the State claimed were for targeted case management services in FFYs 2002 and 2003.

/s/
Judith A. Ballard

/s/
Constance B. Tobias

/s/
Sheila Ann Hegy
Presiding Board Member