Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

SUBJECT: Maine Dept. of Health and Human Services
Docket No. A-09-12
Decision No. 2292

DATE: December 24, 2009

DECISION

The Maine Department of Health and Human Services (DHHS or State), which administers Maine's Medicaid program, appealed a March 20, 2008 determination by the Centers for Medicare & Medicaid Services (CMS) to disallow federal reimbursement for certain expenditures made by the State's Medicaid program during federal fiscal years (FFYs) 2002 and 2003. CMS issued the disallowance based on findings of an audit performed by the United States Department of Health and Human Services' Office of Inspector General (OIG). The audit examined whether the State had properly claimed federal reimbursement for expenditures on "targeted case management" (TCM). The State provides TCM services as a Medicaid benefit to certain groups of eligible children. The OIG found that a substantial portion of the State's TCM reimbursement claims for FFYs 2002 and 2003 were excessive and failed to comply with federal requirements and the terms of its Medicaid plan. Based on the OIG audit findings, CMS disallowed $29,759,384 of federal reimbursement for the State's Medicaid program for FFYs 2002 and 2003.

In this appeal, the State did not meet its burden to prove that the disallowed expenditures were allowable Medicaid expenditures.[1] We therefore affirm CMS's disallowance of

[1] The record of this appeal includes the following submissions: the State's opening brief and exhibits ("M. Br." and "M. Ex."), CMS's response brief and exhibits ("CMS Br." and

(Continued . . .)

$29,759,384 in federal Medicaid reimbursement for FFYs 2002 and 2003, subject to CMS's assessment of an apparent error in one of 604 findings by the OIG concerning social worker services reviewed by the OIG during its audit and any adjustment to the disallowance necessitated by the results of that assessment.

Legal Background

The federal Medicaid statute, title XIX of the Social Security Act (Act),[2] authorizes a program in which the federal government 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. During the period at issue in this case (FFYs 2002 and 2003), section 1905(a)(19) of the Act provided that the

(Continued . . .)
"CMS Ex."); and the State's reply brief ("Reply Br."). On July 23, 2009, after submission of the reply brief, the Board issued an Order to Develop the Record (ODR). In response to that order, the parties filed additional briefs ("State Response to ODR" and "CMS Response to ODR") and some additional unnumbered exhibits. One of the additional exhibits submitted by CMS is a document entitled "HHS Office of Inspector General, Office of Audit Services Response to the Departmental Appeals Board Order to Develop the Record" ("OIG Response to ODR").

[2] Title XIX of the Social Security Act can be found at http://www.ssa.gov/OP_Home/ssact/title18/1800.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section.

statutory term "medical assistance" included "case management services" as defined section 1915(g)(2) of the Act. 42 U.S.C. § 1396d(a)(19) (2000). In turn, section 1915(g)(2) defined "case management services" to mean "services which will assist individuals eligible under the plan in gaining access to needed medical, social, education, and other services." 42 U.S.C. § 1396n(g)(15) (2000).

In 2005, Congress enacted the Deficit Reduction Act of 2005 (DRA), which amended section 1915(g)(2). See Pub. L. No. 109-171, § 6052, 120 Stat. 93-95. Prior to enactment of the DRA, CMS implemented the statutory definition of "case management" with guidance published in section 4302 of the State Medicaid Manual (SMM) and in State Medicaid Directors Letter (SMDL) 01-013. Massachusetts Executive Office of Health and Human Services, DAB No. 2218, at 3 (2008); see also CMS Ex. B (SMM § 4302); M. Ex. 5 (SMDL 01-013).

Among other things, CMS's guidance sought to clarify what types of services could properly be found to constitute case management for Medicaid purposes. SMM § 4302 "distinguishes between case management – which are services to help a person gain access to needed medical, educational, and social services – and the needed services themselves (sometimes referred to as 'underlying' or 'direct' services)." Massachusetts at 3-4. SMM § 4302 further indicates that direct or underlying services do not constitute TCM and are ineligible for federal Medicaid reimbursement unless they are designated separately as a Medicaid benefit under the state plan. Id. at 4. SMDL 01-013 elaborates on the guidance in SMM § 4302, stating that "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." M. Ex. 5. For example, SMDL 01-013 states that "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." Id.

A State's Medicaid expenditures are subject to the standards in Office of Management and Budget (OMB) Circular A-87, now codified at 2 C.F.R. Part 225, App. A. See Michigan Dept. of Community Health, DAB No. 2225, at 3 (2009) (and authorities cited therein). OMB Circular A-87 provides that a cost or expenditure is "allowable" (eligible for reimbursement) under a federal "award" (such as a Medicaid grant) only if it is, among

other things, "allocable to" that award. 2 C.F.R. Part 225, App. A, ¶ C.I.b.

Case Background

The Maine Office of Child and Family Services (OCFS), a component of DHHS, provides various welfare services, including foster care, adoption, and other child protective services.[3] CMS Ex. 6 (OIG Report at 1-2). OCFS also provides TCM services on behalf of Medicaid-eligible children who (1) are referred to OCFS by law enforcement, medical, educational, or other professionals for investigation into whether they have been abused or neglected, or (2) are receiving services from OCFS after having been found by OCFS to have been abused or neglected or at risk of being abused or neglected. Id.; see also M. Ex. 3, at 26, 27. For each month that OCFS provides a Medicaid-eligible child with at least one TCM service (a period that the OIG refers to as a "beneficiary-month"), the State's Medicaid program pays OCFS a fixed amount (or rate) for all TCM services provided to the child during that month. See M. Ex. 6 (OIG Report at 2 and n.1). The State, in turn, seeks federal Medicaid reimbursement for the monthly TCM payments that it makes to OCFS. During the relevant period, Maine's state plan provided that "all payment rates for case management services" would be (with two irrelevant exceptions) "cost based." CMS Ex. A.

In December 2007, the OIG issued a report detailing the results of an audit of the State's federal reimbursement claims for TCM expenditures in FFYs 2002-2003. M. Ex. 6 (hereafter cited as "OIG Report").[4] In general, the OIG concluded that the State had overstated the amount of Medicaid-allowable TCM expenditures by $44,213,815 for those two fiscal years. OIG Report at 8. The OIG further concluded that the "cause" of the overstated claims

[3] The OIG refers to OCFS by a slightly different name – the *Bureau* of Child and Family Services. See M. Ex. 6. CMS refers to that agency as the "*Office* of Child and Family Services," as do we in this decision.

[4] U.S. Dept. of Health and Human Services, Office of Inspector General, *Review of Medicaid Targeted Case Management Services Provided by the Maine Bureau of Child and Family Services During Federal Fiscal Years 2002 and 2003*, A-01-05-00004 (December 2007).

was the State's failure to "establish procedures to ensure that Medicaid TCM costs were reasonable, allowable, and allocable, in accordance with Federal requirements." Id. The following is a summary of the findings and methods upon which the OIG based its conclusions.

On its Medicaid expenditure reports, the State claimed to have spent $26,360,407 for TCM in FFY 2002, and $30,240,693 for TCM in FFY 2003 – for a total of $56,601,100. See OIG Report at 3; CMS Ex. F (Att. D, pg. 3, line for "Maine BCFS TCM Reimbursement"). Accounting records for DHHS's Regional Social Services Account (RSSA) were the source of the State's TCM claims for FFYs 2002-2003. OIG Response to ODR at 1. In reviewing those accounting records, the OIG found that OCFS had spent only $46,610,115 to provide services – *both TCM and non-TCM* – to Medicaid beneficiaries in FFYs 2002 and 2003. OIG Report at 5. That amount was $9,990,985 less than the amount that the State claimed as TCM expenditures *alone* during those two years. In light of this discrepancy, the OIG determined that the State had claimed reimbursement for "excess costs" of $9,990,985. Id. Accordingly, the OIG subtracted $9,990,985 from the State's TCM claims for FFYs 2002 and 2003, as shown on line 2 of table I.[5]

Table I

		(a) FFY 2002	(b) FFY 2003	(c) Unallowable
1	Total TCM Claimed	26,360,407	30,240,693	
2	***subtract*** *Excess Costs*	4,293,220	5,697,765	9,990,985
3	Remainder	22,067,187	24,542,928	

Next, the OIG found that $12,070,279 of the $56,601,100 in claimed TCM expenditures for FFYs 2002 and 2003 were unallowable because they constituted "administrative costs" of operating

[5] The figures in columns (a) and (b) of Table I are found in CMS Exhibit F, Attachment D, page 3 in the lines entitled "Maine BCFS TCM Reimbursement" and "Reimbursement in excess of costs to provide TCM to Medicaid eligible clients."

OCFS programs and were "not related to a specific medical assistance [Medicaid] service." OIG Report at 6-7. The OIG explained:

> These [administrative] costs were related to the overall operation of [OCFS] and the administration of all Federal awards that [OCFS] received. Examples included clerical salaries, mileage, unfunded retirement liability, and cellular phone service. Because these costs were not related to a specific medical assistance service but rather were "administrative costs of services or programs to which Medicaid beneficiaries are referred," they were not eligible as TCM costs.

Id. at 7 (quoting SMM § 4302(G)(1)). Thus, the OIG subtracted an additional $12,070,279 from the State's TCM claims for FFYs 2002 and 2003, as shown on line 4 of table II.[6]

Table II

		(a) FFY 2002	(b) FFY 2003	(c) Unallowable
1	Total TCM Claimed	26,360,407	30,240,693	
2	***subtract*** *Excess Costs*	4,293,220	5,697,765	9,990,985
3	Remainder	22,067,187	24,542,928	
4	***subtract*** *Admin Costs*	5,957,562	6,112,717	12,070,279
5	Remainder	16,109,625	18,430,212	

[6] The figures in columns (a) and (b) on line 4 of table II are found in CMS Exhibit F, Attachment D, page 3 in the line entitled "Salary and other costs related administrative activities."

Next, applying the guidance in SMM § 4302 and SMDL 01-013, the OIG found that $22,152,551 of the claimed TCM expenditures for FFYs 2002 and 2003 were for salaries and related costs of providing unallowable "direct services" (e.g., adoption or foster care services). OIG Report at 6; CMS Ex. F, at 1. Accordingly, the OIG subtracted another $22,152,551 (in addition to the $9,980,985 in excess costs and $12,070,279 in administrative costs) from the State's TCM claims for FFYs 2002 and 2003, as shown on line 6 of table III.[7]

Table III

		(a) FFY 2002	(b) FFY 2003	(c) Unallowable
1	Total TCM Claimed	26,360,407	30,240,693	
2	***Subtract*** *Excess Costs*	4,293,220	5,697,765	9,990,985
3	Remainder	22,067,187	24,542,928	
4	***Subtract*** *Admin Costs*	5,957,562	6,112,717	12,070,279
5	Remainder	16,109,625	18,430,212	
6	***subtract*** *Salary Costs of Direct Services*	9,805,331	12,347,220	22,152,551
7	Remainder	6,304,294	6,082,992	
8	Total Unallowable Costs (column c)			44,213,815

The amount shown on line 6 of table III was based on an estimate of how OCFS social workers spent their time. The OIG derived that estimate by randomly selecting 100 beneficiary-months from

[7] The figures in columns (a) and (b) on line 6 of table III are found in CMS Exhibit F, Attachment D, page 3 in the line entitled "Allocated the salary cost based on direct services."

the 64,126 beneficiary-months for which the State had submitted TCM claims for FFYs 2002-2003. See OIG Report at 6; OIG Response to ODR at 6. The OIG reviewed documentation (case notes) of 604 discrete services provided during those months to 99 different Medicaid-eligible children, 76 of whom were enrolled in Maine's foster care program. OIG Report at 6; see also CMS Ex. F at 1 & Att. A. Based on that review, the OIG concluded that OCFS social workers spent 52 percent of their time in FY 2002 and 61 percent or their time in FY 2003 performing "direct services" (such as foster care or adoption assistance) or other services that did not constitute TCM. OIG Report at 6. The OIG used these percentages to calculate the amount of social worker salary costs incurred for direct services during FFYs 2002 and 2003, as shown on line 6 of table III.

In sum, of the $56,601,100 in TCM expenditures claimed by the State for FFYs 2002 and 2003, the OIG concluded that expenditures of $44,186,699 were unallowable and thus ineligible for federal reimbursement. See line 8 of table III. The expenditures that the OIG determined to be unallowable were: $9,990,985 in "excess costs" (i.e., expenditures not reflected in DHHS accounting records) (see OIG Report at 5); $12,070,279 in OCFS administrative costs (id. at 6-7); and $22,152,551 in costs of providing direct services (id. at 8). The OIG was unable to express a firm opinion about the allowability of the remaining claimed TCM expenditures (which totaled $12,378,285) but did not recommend their disallowance.

Concurring with the OIG's findings, CMS issued a disallowance for $29,759,384 in federal Medicaid reimbursement – $29,759,384 being the federal share of the $44,186,699 in Medicaid expenditures that the OIG found to be unallowable. M. Ex. 1. The State then timely appealed CMS's disallowance determination to the Board.

Following submission of the State's reply brief, the Board issued an Order to Develop the Record. The order required the parties to supplement their briefing and evidence concerning two subjects: (1) administrative costs; and (2) the statistical methods used by the OIG to support its development of new TCM rates for FFYs 2002 and 2003. The parties filed concurrent responses to the Board's order. The order allowed a party to reply to the other's response. CMS filed a reply to the State's response; the State did not file a reply to CMS's response.

Discussion

In an appeal of a federal agency's disallowance determination, the federal agency has the initial burden to provide sufficient detail about the basis for its determination to enable the grantee to respond. Massachusetts at 11. If the federal agency carries this burden, then the grantee (here, the State) must show that the disputed expenditures are allowable. Id. "When a disallowance is supported by audit findings, the grantee typically has the burden of showing that those findings are legally or factually unjustified." Id. (citing prior Board decisions).

In this case, the OIG's audit findings are the bases for CMS's disallowance. Those findings are clearly identified and explained in the OIG's December 2007 report and in material submitted by CMS in this appeal (see, e.g., CMS Ex. F). We thus hold that CMS met its burden to provide sufficient detail about the basis for the disallowance. The State was therefore obligated to demonstrate that the audit findings are, in fact, incorrect. The State did not meet that burden, as we discuss below. (We have organized the discussion below around the three categories of claimed expenditures that the OIG found to be unallowable: (1) "excess costs"; (2) administrative costs; and (3) costs of direct services.)

1. *There is no basis in the record to revise the OIG's finding that the State's TCM claims for SFY 2002-2003 included $9,990,985 in "excess costs."*

The State objects to the OIG's finding that the State's TCM claims for FFYs 2002 and 2003 included $9,990,985 in "excess costs" (i.e., costs not reflected in the State's accounting records) on the ground that those claims were based on reimbursement rates that CMS and the State had agreed to in 1996. M. Br. at 10-11. According to the State, CMS approved TCM reimbursement claims based on the negotiated rate for several years prior to the audit period. Id. "In paying for case management services at the agreed-upon rate," says the State, it "justifiably relied on the agreement it reached with [CMS] and on [CMS]'s conduct in conformity with that agreement over the next several years." Id. at 11 (citing Hawaii Dept. of Social Services, DAB No. 779 (1986)).

We reject this contention. There is no evidence in the record that CMS negotiated or approved the TCM payment rates used by the State during the relevant time period. In addition, the

State does not cite – or rely upon – any legal principle that would authorize the Board to accept the allegedly negotiated rates without confirming that those rates complied with the state plan requirement that TCM rates be "cost-based." A State's expenditures are eligible for federal Medicaid reimbursement only if they are made in accordance with the state plan. Act § 1903(a) (authorizing FFP in the "total amount expended under the State plan as medical assistance" (emphasis added)); 42 C.F.R. § 430.10 (indicating that an approved state plan serves as the basis for claiming FFP in the state's Medicaid program); Colorado Dept. of Health Care and Policy Financing, DAB No. 2057, at 1-2 (2006) ("To receive FFP, a state must claim the costs of medical assistance in accordance with its approved State plan"); New Jersey Dept. of Human Resources, DAB No. 115, at 1 (1980) (noting that the state plan provides the basis for claiming FFP). Because the burden was on the State to justify its TCM reimbursement claims, the State needed to demonstrate that the payment rates supporting those claims were cost-based, as the state plan required. Cf. 42 C.F.R. § 447.203(a) (requiring a state Medicaid agency to "maintain documentation of payment rates and make it available to HHS upon request").

According to the OIG Report, the State's TCM claims for FFYs 2002 and 2003 were based on payment rates of between $864 and $899 per beneficiary-month. OIG Report at 2. The OIG found that the State had failed to justify those rates during the audit, and the State does not dispute that finding. OIG Report at 2; CMS Ex. F, at 2. The State also failed in this proceeding to prove that those rates were based on the cost of providing allowable TCM services. The only evidence that the State submitted in support of its payment rates were the documents in Exhibit 2-A to its response to the Order to Develop the Record. These documents purport to summarize how, for various targeted populations of Medicaid-eligible children and families, the State calculated its monthly per-client TCM rates for state fiscal year 1996 (July 1, 1995 through June 30, 1996). According to the documents in Exhibit 2-A, the State's rates reflected a determination that OCFS social workers spent 90.17 percent of their time providing "matchable" (Medicaid allowable) case management services to Medicaid clients. In support of that determination, the State furnished (in Exhibit 2-A) a table of data that purports to show the results of a "social worker time study analysis."

These documents are clearly insufficient to meet the State's burden. First, they do not indicate that the rate calculations

shown were, in fact, the basis for the State's TCM claims for FFYs 2002 and 2003. The State did not submit a declaration from a knowledgeable program official in order to authenticate Exhibit 2-A or to verify the accuracy and relevance of the information it contains. Second, the record provides no objective basis upon which to evaluate a critical element of the rate calculations – namely, the assumption that OCFS social workers spent approximately 90 percent of their time performing allowable TCM services. According to Exhibit 2-A, the State based that assumption on the results of a time study of OCFS social workers. However, we have no way to determine the validity of those results because the State submitted no evidence of how the study was conducted or the criteria used by its authors to allocate social worker time among allowable and unallowable objectives. Moreover, there is no evidence that the State made the time study results – along with the study's source documentation – available to the OIG for its audit.[8]

For all these reasons, we accept the OIG's finding that the State's TCM claims for FFYs 2002 and 2003 included $9,990,985 in "excess costs."

2. *The State failed to establish that the administrative costs questioned by the OIG were allowable Medicaid costs.*

In its initial brief, the State asserted that it was difficult or "impossible" to determine how the OIG determined that the State's TCM claims for FFYs 2002 and 2003 included $12,070,279 in unallowable administrative costs. M. Br. at 12-13. "At the

[8] A time study is a type of cost allocation methodology. State agencies that administer public assistance programs, including Medicaid, must submit their cost allocation methodologies to HHS's Division of Cost Allocation (DCA) for approval. See 45 C.F.R. § 95.507; Texas Health and Human Services Commission, DAB No. 2136, at 6 n.4 (2007) (citing OMB Circular A-87, Att. D, ¶ E.1.); Kansas Dept. of Social and Rehabilitation Services, DAB No. 2056, at 6 (2006) (discussing the requirements in 45 C.F.R. Part 95, subpart E for public assistance cost allocation plans). The State does not claim that it obtained DCA's approval for any cost allocation methodology related to TCM.

very least," said the State, "CMS should be required to explain how it reached the $12 million figure." Id. at 13.

In its Order to Develop the Record, the Board asked CMS to "provide a fuller explanation of how the OIG determined the amount of administrative costs that were excluded from its calculation of the new TCM rates." ODR at 1-2. In response, CMS submitted a detailed explanation, authored by the OIG's Office of Audit Services, of the data and methods used to identify the disallowed administrative costs. OIG Response to ODR at 1-3. The OIG explained that it reviewed accounting records of OCFS's Regional Social Service Account (RSSA) as well as payroll summaries for various categories of OCFS employees whose salaries and costs were recorded in the RSSA. Id. at 1. From these records, the OIG identified two broad categories of unallowable administrative costs. Id. at 1-2. The OIG referred to the first category as "miscellaneous administrative costs." Id. at 1. Those miscellaneous costs included telephone allowances, cellular phone service, vehicle rent and mileage, air fare, office supplies, furniture, and meals. Id. The second category of unallowable costs identified by the OIG consisted of salaries and fringe benefits for OCFS employees who were not identified in the state plan as providers of TCM services. Id. at 1-2. The employees in that category included clerk-typists, community care workers, human services aides, paralegal assistants, and others. Id. at 2. The OIG noted that the State's payroll summaries and accounting records "did not reconcile" and that salary costs shown in the RSSA were not categorized by job title. Id. Consequently, the OIG used an additional estimation method to determine the amount of unallowable salaries and fringe benefits. Id. at 2-3.

The State has not questioned the OIG's and CMS's explanation for the audit finding concerning administrative costs. We thus conclude that CMS (through the OIG) adequately explained the basis for its finding that the State's TCM claims included $12,070,279 in unallowable administrative costs.

Turning to the merits of that finding, the State contends that the administrative costs identified by the OIG are potentially allowable because the state plan provides that payment rates will be "cost based" without distinguishing between direct and indirect costs. M. Br. at 12. The State submits that because state and federal law contemplate that TCM services will be provided by state welfare or social service agencies, it follows that the administrative costs of those agencies must be reflected in the payment for those services. M. Br. at 12.

Furthermore, says the State, the Medicaid statute and regulations do not prohibit states from building into their TCM rates the cost of administrative activities that make those services possible. Id.

We read these contentions to say that the administrative costs of a state agency are eligible for federal Medicaid reimbursement to the extent that they support the provision of allowable (Medicaid-covered) TCM services. We need not decide whether, or how, FFP may be claimed for such administrative costs because the State has not alleged, much less proved, that the particular administrative costs identified by the OIG as unallowable – i.e., the "miscellaneous" costs, and the salary costs and fringe benefits of employees whom the state plan did not designate as TCM providers – were incurred, in whole or part, to support the provision of allowable TCM services.[9]

In its response to the Board's Order to Develop the Record, the State asserts that a portion of OCFS administrative costs from FFYs 2002 and 2003 were allocated to the title IV-E program. State Response to ODR at 2. The State goes on to say that "CMS may not disallow administrative costs that were not charged to Medicaid," implying that CMS disallowed expenditures that had been charged to the title IV-E program and were not included in the State's TCM claims for FFYs 2002 and 2003. Id.

These assertions, it is important to note, were made before the State received the OIG's response to our questions regarding administrative costs. The State did not question or dispute any aspect of that explanation or otherwise explain why its contentions regarding administrative costs continued to be relevant and persuasive in light of the OIG's detailed response to our order. The State also failed to submit evidence

[9] "All administrative costs (direct and indirect) are normally charged to Federal awards [including Medicaid grants] by implementing the public assistance cost allocation plan," which, as noted in the previous footnote, must be approved by HHS's Division of Cost Allocation. OMB Circular A-87, Att. D, ¶ A. The State furnished no evidence that it allocated OCFS administrative costs to Medicaid based on an approved cost allocation plan.

demonstrating that CMS had disallowed expenditures that were not charged to its Medicaid program.[10]

For these reasons, we accept CMS's finding that the State's TCM claims for FFYs 2002 and 2003 included $12,070,279 in unallowable administrative costs.

3. The OIG's findings that certain activities performed by OCFS social workers constituted direct services (rather than TCM) are not erroneous.

The State questions the OIG's analysis of the 100 sample beneficiary-months (claims) from the two-year audit period. See M. Br. at 5-10. As indicated, the OIG stated that it reviewed case notes for 604 discrete services provided during those 100 months. (Copies of the case notes are found in CMS Exhibit G.) For each service reviewed, the OIG rendered a judgment about whether it met the Medicaid definition of case management. In the majority of instances, the OIG found that the documented service constituted a direct social service (such as foster care), rather than TCM. See CMS Ex. F, Att. A (left column of spreadsheet).

After receiving a draft of these findings, the State's consultant, David Zentner, reviewed the case notes for the sample services. M. Ex. 7 (Zentner, D., "Review of 100 Case Narratives to Determine Extent of Case Management Services Provided to Foster Care Children in the State of Maine," April 24, 2006). Like the OIG, the State's consultant rendered a judgment about whether each sample service satisfied Medicaid's definition of case management. See id. (attached spreadsheet).

[10] Along with its response to the Board's Order to Develop the Record, the State submitted, as Exhibit 1-A, worksheets that purport to show the amount of OCFS costs allocated to title IV-E for the audit period. State Response to ODR at 1. The State provided no meaningful explanation of the worksheets, and we see nothing in them indicating that CMS disallowed federal reimbursement for expenditures that were charged to the title IV-E program and not included in the State's TCM claims for FFYs 2002 and 2003. The State also provided no declaration to authenticate the worksheets or to describe the source of their data.

In many instances, the consultant disagreed with CMS's determination that a service was a direct service (rather than TCM). M. Ex. 7, at 3, 4 (and spreadsheet). In a comparatively smaller number of instances – 79 to be exact – the consultant noted that the allowability of the service "would likely be in dispute and therefore [the service] may not qualify as a case management service." Id. Finally, in 57 instances, the consultant conceded that the documented service was unallowable as TCM. Id. Thus, for 133 (79 plus 57) sample services – 23 percent of the total – the State's consultant did not dispute the OIG's finding of unallowability or conceded that the documentation did not conclusively refute that finding.

Nonetheless, relying partly on its consultant's findings, the State now contends that all of the sample services deemed unallowable by the OIG are in fact allowable. M. Br. at 5-7. The State submits that the disputed services met the pre-DRA definition of case management in section 1915(g)(2) of the Act as well as the definitions of that term in the state plan and state regulations. Furthermore, the State submits that in the absence (during FFYs 2002 and 2003) of any *federal regulations* interpreting section 1915(g)(2)'s "broad" definition of case management, it properly relied on its own interpretations of section 1915(g)(2) in its state plan and regulations, instead of on CMS's interpretation in SMM § 4302 and SMDL 01-013. Id. at 6-7. In addition, the State asserts that the record does not disclose the criteria used by the OIG to determine that a particular service was unallowable as TCM. State Response to ODR at 5.

We reject these contentions for following reasons.

First, contrary to the State's assertion, the record clearly identifies the criteria used by the auditors to evaluate the 604 sample services. The OIG's audit report states that auditors used the interpretive guidance in SMDL 01-013 to determine whether a sample service constituted TCM. OIG Report at 11; see also CMS Ex. F at 1.

Second, the State has not explained in any detail how its reliance on the state plan or regulations might reasonably have caused it to reach different conclusions than CMS about the allowability of the sample services. See M. Br. at 5-10. For example, the State has not identified or discussed any specific examples of activities that CMS found unallowable but that met the State's definition(s) of case management. We note also that the State's own consultant, while he admitted taking a "broader

view of what constitutes targeted case management services than that of OIG," claimed to have reviewed each documented service to determine whether it constituted case management "as defined in federal law and federal written interpretations," not as defined in the state plan or state regulations. M. Ex. 7, at 1, 3.

Third, the State has not persuaded us that it was legally impermissible for CMS to require adherence to the interpretive guidance in SMM § 4302 and SMDL 01-013. Federal Medicaid regulations require that state plans give effect to valid interpretations of federal law issued by CMS. See 42 C.F.R. § 420.12(c)(1)(i) (stating that a state plan "must provide that it will be amended whenever necessary to reflect . . . [c]hanges in federal law, regulations, policy interpretations, or court decisions"). Moreover, the Board has consistently held that it will apply "any reasonable and permissible interpretation by CMS of ambiguous [federal] statutory language if CMS's interpretation was timely published in the *Federal Register* or, failing that, if the state had actual and timely notice of the interpretation." Alaska Dept. of Health and Social Services, DAB No. 1919, at 15 (2004). The State does not claim that it lacked timely notice (constructive or actual) of the interpretive guidance in SMM § 4302 and SMDL 01-013. We note that SMM § 4302, which expressed the view that section 1915(g)(2) precluded claims for direct services, was issued during or prior to 1991, at least 10 years before the audit period. Massachusetts at 3. The State does not allege that it was unaware of that prohibition when it developed its state plan and TCM rates.

If the State is contending that it understood its approved state plan (and related regulations) as authorizing Medicaid reimbursement for *something more* than what CMS's guidance permitted, the State has submitted no evidence that it actually held such a view when it submitted the disputed TCM claims. Although the State invokes the principle which accords deference to a state's interpretation of its own Medicaid plan (see M.Br. at 6), that principle is inapplicable here. "Generally, the Board gives deference to a state's interpretation of its own state plan, so long as that interpretation is an official interpretation and is reasonable in light of the language of the plan as a whole and the applicable federal requirements." Kansas Health Policy Authority, DAB No. 2255 (2009). Here, the State is not claiming to interpret or rely on an ambiguous provision of its state plan. Rather, the State is claiming that its state plan provided a reasonable interpretation of a federal

statute (section 1915(g)(2)), and that it acted in accordance with that interpretation. In any event, the State does not contend that its state plan or regulations could reasonably be interpreted to authorize TCM claims for the types of services that the OIG found to be unallowable.[11] The State also does not explain how its state plan and regulations could lawfully supercede federal law or a federal agency's interpretation of federal law of which it had adequate notice.

The State's substantive objection to CMS's interpretation of section 1915(g)(2) lacks foundation. The State contends that CMS's interpretation is unreasonable because it "adds restrictions to case management services that are found nowhere in the Medicaid statute" and is generally "inconsistent with the broad definition of case management contained in the law."[12] M. Br. at 7 (emphasis added). However, the State does not specify what the allegedly impermissible "restrictions" are, and the State's arguments overlook the fact that Congress, in the DRA, essentially ratified CMS's interpretation of section

[11] The State's regulations state that case management "consists of intake/ assessment, plan of care development, coordination/advocacy, monitoring, and evaluation." CMS Ex. 3 (section 13.01 of the Maine Medical Assistance Manual). Although these services are the type of services that may qualify as TCM, depending on the context in which they are rendered, they are, under CMS's interpretation of the governing statute, unallowable as TCM if they relate directly to the provision of a social service to which the Medicaid recipient has been referred. We see nothing in the state's regulations which expresses a contrary view.

[12] The State further objects to SMDL 01-013 because it does not state that it disapproves of the terms of previously approved state plans, implying that SMDL 01-013 is inconsistent with the state plan's definition of case management. M. Br. at 7. We find no merit to this objection. The State cites no authority for the proposition that it may decline to follow a federal interpretive rule of which it had adequate notice when that rule conflicts with its state plan but does not expressly disapprove of conflicting state plans. In any event, the State produced no evidence, such as declarations from state agency officials, that it actually understood its state plan as being in conflict with SMDL 01-013.

1915(g)(2).[13] Furthermore, the Board has held that SMM § 4302 and SMDL 01-013 reasonably interpreted the statutory definition of case management as excluding "direct services," such as foster care and adoption services. Massachusetts at 12-14.

Our next reason for upholding the audit findings regarding the 604 sample services is that the State produced insufficient documentation that those services actually met the federal definition of case management. CMS's interpretive guidance describes four general categories of allowable case management services: assessment, care planning; referral & linkage; and monitoring/follow-up. M. Ex. 5 (SMDL 01-013). The guidance further states in relevant part:

> 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. In the case of foster care programs, we view the following activities as part of the direct delivery of foster

[13] As amended by the DRA, section 1915(g)(2) 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." 42 U.S.C. § 1396n(g)(2)(A)(iii) (2006). The State contends that a post-DRA moratorium imposed by Congress on CMS regulations concerning case management "suggest[s] that CMS's interpretation of the statute, as contained in [SMDL 01-013] . . . does not express the intent of Congress." M. Br. at 8. This contention lacks merit. As we noted in Massachusetts at 3 n.2, the moratorium left in place regulations that implemented statutory changes to section 1915(g) contained in section 6052 of the DRA. Those changes modified the statutory definition of case management to incorporate the essence of the guidance from SMDL 01-013. See Massachusetts at 5.

> care services and therefore may not be billed to Medicaid as a case management activity. The following list is intended to be illustrative and not all inclusive: research gathering and completion of documentation required by the foster care program, assessing adoption placements, recruiting or interviewing potential foster care parents, serving legal papers, home investigations, providing transportation, administering foster care subsidies, and making placement arrangements. During the State plan approval process, [CMS] will provide guidance to determine Medicaid billable activities.

Id. (italics added).

In this case, the target population for TCM services included Medicaid-eligible children who had been abused or neglected or were at risk of abuse or neglect. The State does not deny that those children were referred to OCFS for foster care, adoption, and other child protective services. Consequently, activities that directly relate to those services do not, under CMS's valid interpretation of section 1915(g)(2), constitute Medicaid case management.

Applying the relevant statutory definition and interpretive guidance, we reviewed the case notes for the sample services that the OIG found to be unallowable in order to ascertain any error in the findings that the OIG made. With one exception (discussed later), we discovered no error. In most instances, the relevant case notes clearly describe the provision of foster care, adoption, or other direct social services (e.g., overseeing or assessing foster care or adoption placements, recruiting potential foster care parents, supervising family visitations, mediating or monitoring custody conflicts, assisting in legal proceedings) and otherwise fail to indicate that the social worker was engaged in the type of activities – assessment, care planning, referral-and-linkage, and monitoring – considered allowable as TCM.

In a handful of instances, the documentation suggests that the social worker may have performed a Medicaid-allowable service. However, in those few instances, we could not verify the services' allowability as TCM because the context in which they were performed was unclear. For example, some of the documentation indicates that case workers helped to arrange transportation for their foster care clients. See, e.g., CMS Ex. G (tab 9). Arranging transportation to help a Medicaid

recipient gain access to a needed service may constitute case management. However, we could not determine from the case notes whether the transportation-related activities were part of the social worker's responsibilities for providing foster care, or were performed in order to help the child gain access to a medical, educational, or other non-foster care service. The State could have provided evidence to resolve that ambiguity, such as information concerning the requirements and operation of the non-Medicaid programs administered by OCFS social workers, the responsibilities of OCFS social workers under those programs, or additional information about the services received by the Medicaid-eligible child. However, the State did not provide that information – or any other evidence to explain the context in which the case notes were written. Consequently, we lacked any benchmarks or criteria for making the critical distinction in the relatively few cases in which the primary nature or purpose of the documented service was unclear.

According to the State, the OIG's finding that more than half of social workers' time was spent on non-TCM activities "simply does not reflect the reality" of OCFS's "day-to-day operations." State Response to ODR at 5. For example, says the State, the OIG's finding "fails to recognize that most direct services provided to children at risk of abuse or in foster care were provided by private agencies that contract with the Department for that purpose." Id. We find no merit in this contention because the State neither provided evidence about the "reality" of OCFS's "day-to-day operations" nor explained how or why that reality would affect the results of the audit. Furthermore, generalizations such as this are insufficient to overcome the OIG's very specific findings regarding the 604 sample services.

The State asserts that the conflict between the consultant's and the OIG's findings regarding the sample services is "due to the very subjective nature of the OIG's interpretation of the narrative entries." M. Br. at 9. According to the State, activities deemed by the OIG to be direct services "could as easily" be found to meet the definition of case management.[14]

[14] One example of this, says the State, is the activity described on page six of the OIG's audit report. M. Br. at 10. However, that activity was an effort by the social worker to place the Medicaid-eligible child in an adoptive home. OIG Report at 6. That activity is clearly a direct service – that is, an OCFS service to which the child had been referred because

(Continued . . .)

Id. at 10. We reject the suggestion that ambiguity in the documentation – such that a service "could as easily be found" allowable as not – should be resolved in the State's favor. The State has the burden of persuasion concerning the allowability of its expenditures. Ambiguous documentation is insufficient to meet that burden, especially when a party with that burden has access (as the State had) to evidence that might clarify the ambiguity but failed to present that evidence.

The State contends that in only two of the 100 sampled beneficiary-months did the consultant find that no TCM services were provided in the month. M. Br. at 9. "This is significant," the State says,

> because case management services were paid at a monthly rate . . . [I]f any case management activity occurred during the month, [BCFS] was justified in charging the monthly rate. Therefore, charges for case management services in each month were justifiable in 96% of the cases reviewed.

Id. This contention is meritless because, as discussed, the social workers' case notes do not support the consultant's view that activities deemed unallowable by the OIG were allowable as TCM. Even if the consultant correctly found that TCM activities were absent in only two of the 100 sample months, such a finding is immaterial because the sample findings were not used to disallow any claims or determine the percentage of all claims that were in fact unallowable. Instead, as the OIG indicated in its response to the Board's Order to Develop the Record, the sample findings were used to determine the percentage of time spent by OCFS social workers on allowable TCM services, findings that were in turn used to calculate new, monthly, "cost-based" TCM payment rates for FFYs 2002 and 2003. OIG Response to ODR at 6. Those rates were then applied to each and every one of the beneficiary months in the universe of TCM claims for FFYs 2002 and 2003, *regardless* of whether an allowable TCM service had been provided in that month. Id. ("even if OIG reviewed a TCM beneficiary month and determined that it contained no allowable TCM Services, the related monthly TCM claim or claims

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(Continued . . .)
the child had been identified as having been abused or neglected (or potentially abused or neglected).

were ultimately re-priced using the OIG's TCM monthly service rate and some reimbursement potentially allowed").

We found one apparent, albeit minor, error in the OIG's findings. In sample 36 (CMS Ex. G, tab 36), the OIG reviewed a May 5, 2003 case note, which stated: "Received and reviewed CHCS treatment team notes re: [N.S.] dated 4/24/03[.]" The OIG did not find this activity unallowable, indicating that it constituted "medical monitoring." CMS Ex. F, Att. A, at 6 (count no. 272). In the same sample, the OIG reviewed a May 1, 2003 case note whose content was essentially identical to the May 5 case note (see CMS Ex. G, tab 36), yet the OIG found the May 1 activity to be unallowable. Nothing on the face of these two case notes indicates why the auditors would have treated the services differently. The inconsistency – which implicates a single service of only 15-minute duration in a population of 604 sample services, many of which were considerably longer than 15 minutes – might affect the calculation of the disallowance amount but does not affect the legal basis for the disallowance. Furthermore, the State has not cited the inconsistency on appeal as a reason to reject the audit findings or to reverse the disallowance. Accordingly, we uphold the disallowance despite the apparent error regarding sample 36. Nonetheless, we instruct CMS to assess the actual impact of the apparent error on its calculation of the disallowance amount, make any appropriate adjustment based on that assessment, and inform the State of the results of the assessment.

4. *The State did not meet its burden of proving that the OIG's sampling techniques were invalid or inappropriate.*

In its initial brief, the State contended that the OIG's method of selecting the 100 sample claims was of "questionable validity," asserting that "[t]he tiny percentage of the entries reviewed by OIG compared to the size of the universe of record entries and the substantial amount of the resulting disallowance . . . on their face call into question the appropriateness of the auditing technique and the sufficiency of the sample size employed." M. Br. at 2, 14. The State further contended that prior Board decisions and the Board's Practice Manual obligated CMS in this appeal to demonstrate that the sampling technique and sample size were appropriate. Id. at 14. "At the very least," said the State, "CMS should be put to the task of demonstrating the reliability of OIG's sample and that its techniques complied with generally accepted auditing standards and was appropriate to use in this case." Id. at 13.

In its Order to Develop the Record, the Board asked CMS to "describe or explain the method that auditors used to draw the sample of 100 beneficiary-months" and to "submit evidence that the OIG's sampling and other statistical methods were appropriate." ODR at 3. In addition, the Board asked CMS to "explain to what extent, if any, the auditors shared with the State information about their sampling method prior to this appeal and, if so, the extent to which the State raised issues about the method after receiving the information." Id. In response to the Board's queries, the OIG stated:

> The OIG's sample of 100 beneficiary months was selected from a population of the 64,126 beneficiary months containing paid TCM services totaling $56,601,100 that were provided from 10/1/2001 through 9/30/2003 by the Maine BCFS. OIG extracted these billable beneficiary months processed by the State agency from the CMS Medicaid Statistical Information System which contained 64,250 monthly TCM claims. The beneficiary months in the population were determined by grouping the TCM monthly claims by beneficiary number and dates of service. The resulting 64,126 beneficiary months were then numbered sequentially and selected for review based on the random numbers generated by the OAS statistical sampling software. Every item in the population had an equal chance of being selected and therefore auditor bias was eliminated. As a result, OIG had no evidence, nor did the State agency provide any evidence, that the sample did not reflect the population from which it was drawn. Furthermore, the OIG's estimation methodology was approved by its Director of Quantitative Methods, an expert in statistics.
>
> Because the State Agency claimed TCM services using a beneficiary month as the billable unit (i.e. a bundled rate), each TCM monthly claim contained an unknown number of TCM services representing an unknown amount of time. OIG therefore drew the random sample of 100 TCM beneficiary months to determine the amount of time spent by BCFS staff on potentially allowable TCM services. OIG did not utilize the sample to disallow TCM monthly claims. The time information collected was used as part of the OIG's calculation of a TCM monthly service rate. OIG re-priced all 64,250 monthly TCM claims using their TCM monthly service rate. Therefore, even if OIG reviewed a TCM

> beneficiary month and determined that it contained no allowable TCM services, the related monthly TCM claim or claims were ultimately re-priced using the OIG's TCM monthly service rate and some reimbursement potentially allowed (Appendix). OIG adopted this methodology to provide the most conservative calculation possible given the data available to them. OIG did not construct a confidence interval or the related precision level of the statistical estimate because OIG did not project the results of its review of the 100 sample items to the population of 64,126 beneficiary months.

OIG Response to ODR at 6. Although the State had an opportunity to respond to this justification of the OIG's statistical and auditing methods, the State did not do so.

In its response to the Board's Order to Develop the Record (filed concurrently with the OIG's response), the State suggests that the appropriate universe for the sampling was the number of "service episodes" (86,212) that occurred during the two-year audit period, rather than the number of beneficiary-months (64,126) claimed during that period. State Response to ODR at 3. The State further asserts that it consulted Dr. Jay Yoe, DHHS's Director of Quality Improvement, who, the State says, has "expertise in statistical analysis in the social sciences." Id. According to the State,

> Dr. Yoe calculated that, to obtain a 95% confidence level with a margin of error of 2% and a response distribution of 50%, the auditors would have had to review a sample of 2,336 service episodes. It was Dr. Yoe's opinion that, given the significant financial impact of the decision resulting from the selection of the sample's parameters, imposing a 2% margin of error was unwarranted.

Id.

We reject these assertions because the State submitted no evidence to support its objection to the OIG's methods. Most notably, the State did not submit Dr. Roe's curriculum vitae or a declaration expressing the opinion attributed to him. The State submitted only the brief summary quoted above, with no explanation of relevant statistical terminology and no description of the method or principles that Dr. Yoe relied upon to determine that the appropriate sample size was 2,336 service

episodes. Moreover, it is unclear from the State's opinion summary whether Dr. Yoe had full and accurate information about the OIG's sampling method and how the sample findings were used in this case. Dr. Yoe's opinion, assuming that the State accurately summarized it, certainly does not account for, or reflect a consideration of, the explanation and justification submitted by the OIG in response to the Board's Order to Develop the Record. For example, the opinion that a larger sample was necessary to obtain a 95 percent confidence interval does not respond to the OIG's position that constructing a confidence interval was unnecessary because the sample findings were not "projected" to the population. Finally, the State presented no evidence to suggest that the sample of 100 beneficiary-months was, in any material respect, unrepresentative of the relevant population for purposes of estimating the percentage of time spent by OCFS social workers on TCM and non-TCM activities.

In its response to the Order to Develop the Record, the OIG asserts that it "shared its methodology with State agency officials informally throughout the audit and formally on two separate occasions before this appeal." OIG Response to ODR at 6. The State did not dispute that assertion (or question the adequacy of any other part of the OIG's response to our order), nor did the State allege that it (or its consultant) protested the OIG's sampling method during the audit. We note that the OIG performed the sampling precisely because the State had not developed or implemented its own methodology to allocate employee salary costs among allowable and unallowable objectives. Such a methodology was necessary to ensure that the State's TCM rates complied with the requirement in OMB Circular A-87 that the costs charged to Medicaid are in fact "allocable to" that program. Given these circumstances and the State's evidentiary burden, it was incumbent on the State to do more than assert undeveloped and unsubstantiated objections to the OIG's statistical and auditing methods.

Conclusion

We sustain CMS's legal basis for the October 8, 2008 disallowance of federal reimbursement for the State's Medicaid program. We also uphold the amount of the disallowance ($29,759,384), subject to CMS's assessing whether the apparent error in sample 36 (as discussed on pages 22 of this decision) requires an adjustment in the disallowance amount. If CMS determines that an adjustment to the amount is necessary, it shall make the adjustment and inform the State of its determination. Should the State disagree with the amount of any

adjustment, it may file an appeal limited to that issue within 30 days of receiving notice of CMS’s determination.

/s/
Judith A. Ballard

/s/
Constance B. Tobias

/s/
Sheila Ann Hegy
Presiding Board Member