Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

West Virginia Department of Health and Human Resources
Docket No. A-14-17
Ruling No. 2014-2
March 25, 2014

RULING ON CMS'S REQUEST FOR RECONSIDERATION

The Centers for Medicare & Medicare Services (CMS) asks the Board to reconsider its September 20, 2013 decision, *West Virginia Dept. of Health & Human Resources*, DAB No. 2536 (2013), which we refer to as Decision 2536. The Board may grant a request for reconsideration if a party promptly alleges a "clear error of fact or law." 45 C.F.R. § 16.13. CMS's reconsideration request falls well short of meeting that standard. CMS primarily contends that certain findings and conclusions contained in an earlier, related Board decision, *West Virginia Dept. of Health & Human Resources*, DAB No. 2365 (2011) (which we refer to as Decision 2365) should have been treated as binding or preclusive in the subsequent appeal that resulted in Decision 2536. That contention is wholly unconvincing because Decisions 2365 and 2536 rest on different bodies of evidence that were used to make different factual findings that, in turn, were relevant to different issues of law.

CMS also questions our reliance on evidence in the record even though CMS failed to discredit or rebut that evidence; raises issues that are immaterial or were not raised in CMS's pre-decision brief; and makes contentions that inaccurately characterize our findings. CMS also argues that we improperly resolved an ambiguity in the applicable Medicaid State plan amendment in favor of West Virginia (the "State") even though CMS failed to produce evidence of its own understanding of the amendment when it was drafted and approved. For these reasons, which we elaborate below, we deny CMS's request for reconsideration.

Discussion

The issues in Decisions 2365 and 2536 originated from CMS's approval of State plan amendment (SPA) 00-01, which authorized the State's Medicaid program to cover and pay for seven categories of school-based health services (SBHS) based on payment rates for each unit of service. Following the approval of SPA 00-01 in May 2000, the State paid for the covered SBHS using payment rates that had been presented to CMS in a February 2000 slide presentation. The rates presented to CMS in February 2000 reflected

estimates (derived from 1999 data) of salary and fringe benefit costs incurred by school districts to provide SBHS. In 2003, the State retroactively increased the SBHS rates to reflect two additional types of costs – indirect and operating costs.

In Decision 2365, we decided the issue of whether claims for federal financial participation (FFP) based on the State's retroactive rate adjustments had been filed within the two-year period specified in section 1132(a) of the Social Security Act and, if not, whether those claims (which related to SBHS performed from October 1, 2000 through June 30, 2001) fell within the definition of an "adjustment to prior year costs," a statutory exception to the two-year filing rule. Decision 2365 expressly noted that it was not addressing whether the rate adjustments for SBHS were, in fact, "allowable" under SPA 00-01 "but whether, having chosen to omit [operating and indirect costs] from its initial rate development process, West Virginia may wait until after the timely claims deadline passes and then seek to add them retrospectively to its rates as an adjustment to prior year costs." DAB No. 2365, at 12.

In contrast, Decision 2536 did not address the issue concerning the timeliness of the State's FFP claims (which covered SBHS performed from July 1, 2001 through June 30, 2003). Instead, the dispositive issue was whether the retroactive rate adjustments were allowable – that is, authorized by SPA 00-01 and consistent with other applicable cost reimbursement requirements.[1] *See* DAB No. 2536, at 1, 8, 15 (stating that the "dispositive legal issue in this case is whether the State could, consistent with a reasonable interpretation of its state plan, revise the costs included in its rate calculations based on its evolving experience and collection of actual cost data"). In Decision 2536, we concluded that the adjustments – which accounted for costs that are generally allowable under federal cost reimbursement principles[2] – were permissible because they were consistent with the State's reasonable interpretation of SPA 00-01. *Id.* at 1, 9-13. Accordingly, we reversed disallowances of FFP that the State had timely claimed on the basis of those adjustments.

In support of our holding in Decision 2536, we found that SPA 00-01 authorized a retrospective payment rate methodology under which the State would establish and use "interim" rates (based on "statewide historical costs") to pay for SBHS, rates that would

[1] *See General Principles for Determining Allowable Costs*, 2 C.F.R. Part 225, Appendix A, ¶ C.1. (Jan. 1, 2013) (setting forth the "[f]actors affecting allowability of costs," including the requirement that a cost "[c]onform to any limitations or exclusions set forth in [the General Principles, formerly issued as Office of Management and Budget Circular A-87], Federal laws, terms and conditions of the Federal award, or other governing regulations as to types or amounts of cost items"); *Arizona Health Care Cost Containment System*, DAB No. 1569 (1996) (stating that a state's Medicaid expenditures "must be made in accordance with a State plan in order to be allowable").

[2] *See* the citations to 2 C.F.R. Part 225 and the Medicare Provider Reimbursement Manual on page ten of Decision 2536.

later be "*cost settled* [that is, adjusted retrospectively in order to account for actual cost experience] on an annual basis." *See* DAB No. 2536, at 5 (quoting SPA 00-01), 8. We also found that, until late 2002 or 2003, the State did not have a management information system in place that was capable of "'extract[ing] the necessary elements to determine total SBHS costs and develop rates that reflected total costs'" and that "[o]nly then was the State able to obtain complete and reliable cost data relevant to the services covered by SPA 00-01." *Id.* at 8 (*quoting* WV Ex. 23, ¶ 12). We further found that although SPA 00-01 "may have been unclear about the nature and scope of the State's cost settlement authority, the State retained considerable discretion and flexibility to decide how to finalize [that is, to "cost settle"] its SBHS payment rates for SFYs 2001 through 2003 and what types of costs to include in calculating those rates." *Id.* at 13. We also agreed with the State that the "nonrestrictive language" of SPA 00-01 was "broad enough to encompass a cost settlement process" that updates SBHS rates to incorporate cost information "that was not readily available when interim rates were developed" because of the lack of relevant historical cost experience. *Id.* at 14. In addition, we found that the disputed retroactive adjustments to the interim rates were the product of just such a process – incorporating operating and indirect costs into the rate calculations based on actual cost experience for the SBHS covered by SPA 00-01. *Id.* Finally, we concluded that the State's efforts in 2003 and 2005 to finalize its SBHS rates (which included the retroactive adjustments to reflect operating and indirect costs) "represented the State's **initial** exercise" of the broad discretion conferred by SPA 00-01 and, as such, were the most relevant evidence of the State's interpretation of SPA 00-01. *Id.* at 13 (emphasis in original); *see also id.* at 16-17 (stating that "implementation of [the State's] cost settlement authority for [SFYs 2001 through 2003] constituted its historical interpretation of SPA 00-01").[3]

1. *The Board committed no clear error of law in failing to give certain findings in Decision 2365 preclusive effect in the proceeding that resulted in Decision 2536.*

CMS's chief argument in its request for reconsideration is that Decision 2536 is in irreconcilable conflict with Decision 2365, most notably concerning the issue of whether the disputed retroactive adjustments constituted "cost settlement." *See* Request for Reconsideration (RR) at 17-29. CMS asserts that Decision 2536 "cannot stand given that it relies principally on factual and legal conclusions which directly contradict" conclusions

[3] CMS asserts that the "record undermines any claim that West Virginia actually relied on that interpretation in claiming SBHS." RR at 15. This assertion overlooks our prior finding that the State's "historical" interpretation of the State plan was evidenced by actions it took prior to the administrative litigation – namely, its "efforts in 2003 and 2005 to finalize SBHS rates for SFYs 2001 through 2003." DAB No. 2536, at 13, 16.

made in Decision 2365. RR at 18. CMS submits that the findings in Decision 2365 should have been accorded binding or preclusive effect in the second case under the doctrine of collateral estoppel and that "all of the elements" of that doctrine have been met with respect to those findings. RR at 28.

The Board committed no clear error of law in failing to give Decision 2365 collateral estoppel effect because CMS did not invoke the doctrine in its pre-decision briefing. *See Puerto Rico Dept. of Health*, DAB Ruling No. 2011-5 (Sept. 30, 2011) (declining to reconsider a decision based on issues that could have been – but were not – presented to the Board before it issued its decision); *see also Georgia Pacific Consumer Products, LP v. Von Drehle Corp.*, 710 F.3d 527, 533 (4th Cir. 2013) (stating that a party may waive defenses of claim and issue preclusion if they are not timely asserted), *cert. denied,* 134 S. Ct. 393 (2013).

Furthermore, CMS's argument is untenable on its merits, for at least two reasons. First, as the State accurately demonstrates in its response to CMS's reconsideration request, there was evidence in the record of the second appeal that we did not have during the first case, including a previously omitted page from the February 2000 slide presentation which suggested that the SBHS rates were not "final" (as the title of the presentation indicated) but subject to retrospective adjustment. *See* Response Br. at 2-3 (*citing* WV Exs. 4 (at 4), 5-6).

Second, not only did we consider different bodies of evidence in the two cases, our findings in the prior case resolved different legal issues. In Decision 2365, we found that the disputed retroactive adjustments were not "contemplated" by the State's rate-setting system (as established in SPA 00-01). DAB No. 2365, at 8. CMS submits that this finding addressed "precisely the same legal issue at bar in the instant administrative appeal." RR at 27. We disagree. In Decision 2365, our finding that the adjustments were not contemplated by the State's rate-setting system resolved the issue of whether that system was structured in such a way that it put CMS on notice of the possibility that adjustments to the interim rates would be claimed outside the two-year period specified in section 1132(a) of the Act as "adjustments to prior year costs." *See* DAB No. 2365, at 12 (stating that "[t]he issue before us is not whether operating and indirect costs are allowable under SPA 00-001 . . . but whether, having chosen to omit them from its initial rate development process, West Virginia may wait until after the timely claims deadline passes and then seek to add them retrospectively to its rates as an adjustment to prior year costs"). That finding did not resolve the dispositive issue before us in the second appeal – namely, whether the State reasonably interpreted SPA 00-01 as permitting these adjustments *assuming they were timely claimed*. Indeed, we expressly stated in Decision 2365 that our decision was *not* addressing that issue when we stated that SPA 00-01 "is

silent with regard to whether operating and indirect costs would be reimbursed or included in either the interim or final rate."[4] DAB No. 2365, at 8. In other words, Decision 2365 expressly left open the possibility that the disputed rate adjustments – if performed and claimed within the applicable two-year period – might be judged permissible. Because the issues addressed by the Board were not, as CMS asserts, "exactly" the same, our findings and conclusions in Decision 2365 were not binding or preclusive in the subsequent appeal.

2. *The Board correctly held that the SBHS rates presented to CMS in February 2000 were not "final."*

Apart from positing the preclusive effect of Decision 2365, CMS contends that the holding in Decision 2536 rests on "a series of incorrect factual determinations and legal conclusions." RR at 2-3. First, CMS contends that the Board ignored the fact that the SBHS payment rates presented to CMS in February 2000 by the State's consultant were described as "final" in the title of the consultant's slide presentation. RR at 5-7. CMS asserts that the February 2000 slide "presentation itself gives **no** indication of planned adjustment or material change" and that the presentation's "vague mention of possible unspecified refinement of the rates at some unspecified date in the future fails to undercut the clear language of the rate submission which is unequivocally labeled 'Final.'" RR at 6 (emphasis in original).

We previously rejected this argument (or a variant of it) in Decision 2536, finding that the argument is flatly contradicted by SPA 00-01, which expressly characterized the proposed SBHS rates as "interim" – that is, provisional and subject to later retrospective adjustment. DAB No. 2536, at 13. Whether or not a payment rate is subject to retrospective adjustment is an issue that is ordinarily controlled by the language of the State plan. *Cf.* 42 C.F.R. § 447.201(b) (providing the State plan "must describe the policy and methods to be used in setting payment rates for each type of service included in the State's Medicaid program"). When the applicable State plan language is ambiguous, the Board may consider extrinsic evidence to help discern the plan's meaning. However, in this instance, it was unnecessary for us to consider such evidence

[4] CMS suggests that our holding in Decision 2536 is foreclosed by the decision of the United States District Court which affirmed Decision 2365, *West Virginia Dep't of Health & Human Resources v. U.S. Dep't of Health & Human Servs.*, 899 F. Supp.2d 477 (S.D.W.Va. 2012). *See* RR at 18-19. However, the district court did not make its own findings of fact; it merely reviewed the findings of the Board in order to determine whether they were supported by substantial evidence. Because we reject the argument that the findings in Decision 2365 have preclusive effect (for the reasons stated in the text above), there is no basis to conclude that the court decision that merely affirmed those findings has such effect.

because SPA 00-01 clearly indicates that the SBHS rates presented to CMS in February 2000 – rates that accurately identified in SPA 00-01 as being based on "statewide historical costs" (rather than actual costs) – were *not* "final." CMS does not explain how or why our reliance on the State plan's language to resolve this particular factual issue was improper.

CMS asserts that we "ignore[d] the fact that *CMS did, in fact, understand* the 2000 SBHS rates submission to be 'Final.'" RR at 6. However, in its response to the State's opening brief and appeal file, CMS did not allege that it understood the rates to be final when it approved SPA 00-01. Because CMS did not raise this factual issue earlier (or explain why it could not have done so), the issue cannot be a basis for finding that we committed a clear error of law. *New Hampshire Dept. of Health and Human Servs.*, Ruling No. 2012-2 (Oct. 14, 2011) (noting that "reconsideration in general will not be granted to address an issue that could have been raised before, but was not . . . ." (internal quotation marks omitted)).

In any event, we do not see any persuasive evidence in the record to support CMS's allegation that it understood the 2000 SBHS rates to be "final" (assuming we would actually consider such evidence to construe the applicable State plan language). The February 2000 slide presentation, the document upon which CMS chiefly relies, was not authored by CMS but by the State's consultant. The word "final" appears only in the presentation's title, and none of the slides which follow indicate that that word was intended to describe a feature of the ultimately approved payment rate methodology. *See* CMS Ex. 4, at 17 (indicating that the "new billing codes" would be "implemented" in conjunction with a "complete[d] SPA amendment" but without indicating the proposed or expected elements of that amendment). Furthermore, the slide presentation was written and presented prior to the modification by CMS of any proposed State plan language then under consideration, and so the presentation clearly could not have been an interpretation of the State plan language ultimately approved in SPA 00-01. In addition, CMS did not offer the declaration of any employee with personal knowledge of the agency's views or deliberations regarding the proposed rates or of the negotiations leading to the approval of SPA 00-01. CMS cites the declaration of a CMS associate regional administrator (RR at 6, citing CMS Ex. 7, at 3-4), but that person did not testify about the agency's contemporaneous understanding of SPA 00-01 when it was approved in May 2000 or, for that matter, quote or parse its language. Instead, he focused on what CMS believed to be *the State's* interpretation of SPA 00-01. Finally, throughout these proceedings, the interim rates shown in the slides were described as being based on estimates from historical costs, rather than actual costs, and CMS could not have reasonably thought that rates based on these estimates were "final" as that term is used in a retrospective rate-setting system.

3. *The Board committed no clear error in disregarding the role of the State's consultant.*

CMS next contends that we mischaracterized the role of the State's consultant, Pacific Consulting Group (PCG), concerning the disputed retroactive adjustments. RR at 7-9. Pointing to the Board's finding (DAB No. 2536, at 5) that the State relied on PCG's work to finalize its SBHS rates for SFYs 2001-2003, CMS asserts that PCG was not, in fact, hired to perform or make recommendations regarding payment rate settlements; instead, says CMS, PCG's contractual role was to help the State "maximize" the acquiring of federal Medicaid matching funds ("revenue maximization"). *Id.* CMS asserts that our finding concerning PCG's role was based on the "self-serving" declaration of Richard Brennan and ignored contrary evidence in the PCG report itself, which, CMS says, "revealed that the PCG contract was a 'contingency contract' with West Virginia which was ultimately for the purpose of finding new sources of federal Medicaid dollars." *Id.* at 8-9 (citing CMS Ex. 6, at 11).

Much if not all of this argument presupposes that we made a definitive finding of fact about what role PCG was hired to perform concerning FFP claiming for SBHS. There is no such finding in Decision 2536, however, and thus we did not mischaracterize PCG's role. We merely accurately noted there was evidence that the settlement of SBHS costs "fell within the broad scope of work" under PCG's contract with the State and that the State reasonably interpreted SPA 00-01 as authorizing the disputed rate adjustments recommended by PCG.[5] *See* DAB No. 2536, at 5 n.8, 9-12. More notably, we found "no significance in the role that PCG played," stating that the "validity of the adjustments stands or falls on the reasonableness of the State's interpretation of SPA 00-01 and whether the actions and calculations supporting the supplemental FFP claims are consistent with that interpretation." *Id.* at 14 n.18. CMS does not dispute our finding about the issue's lack of materiality.

In its argument concerning PCG's role, CMS relies on documents which it now belatedly seeks to have admitted into the record. *See* RR at 8 n.1 (proposing the admission of CMS Exhibits 9-11). According to CMS, these documents establish that PCG's contractual role was, in fact, to maximize federal Medicaid revenue and not to cost settle the State's SBHS rates. *Id.* at 8-9. However, CMS did not explain why it failed to submit these documents in the proceedings leading to Decision 2536. For that reason, we will not admit them into the record. Even if we admitted the documents, they would not affect

[5] We further note that there is nothing in SPA 00-01 that precluded the State from relying on the recommendations of a consultant to determine final (or cost-settled) SBHS rates.

our analysis in Decision 2536 because CMS does not point to anything in the documents that undermines our observation that cost settlement fit within the contract's "broad scope of work" and because the issue of whether PCG was hired to settle the SBHS rates is (as we mentioned) immaterial in any event.

4. *The Board did not clearly err in finding that the disputed retroactive adjustments were part of cost settlements made on an annual basis.*

Next, CMS argues that we erroneously found that the disputed retroactive rate adjustments constituted "cost settlements." RR at 9-12. In reaching that conclusion, says CMS, the Board overlooked that "cost settlement" is a term of art with a generally accepted meaning. RR at 10. According to CMS, the rate adjustments were not cost settlements "within the generally accepted meaning of the term" because they did not involve a "reconciliation" of interim payments and actual costs. *Id.* (citing a regulation, 42 C.F.R. § 413.64(f), that sets out principles of "reasonable cost" reimbursement for the Medicare program). Furthermore, CMS contends that we ignored that SPA 00-01 "specifically refers to '<u>annual</u> cost settlement.'" RR at 10 (emphasis in original). CMS asserts that the State's retroactive adjustment of three years of SBHS costs cannot possibly constitute an "annual" cost settlement. RR at 10-11.

Contrary to CMS's suggestion, we considered and applied the generally accepted meaning of "cost settlement" – namely, a process that reconciles the interim payments made for a covered service (payments based on prospective estimate of the costs of providing the service) and the *actual costs incurred* to provide the service in order to determine a final payment rate. *See Louisiana Dept. of Health & Hospitals*, DAB No. 2350, at 9 (2010) (stating that in a cost settlement, "interim payments are reconciled to actual costs and final payment is made"). We specifically found that the State had engaged in a process to determine final SBHS rates that reflected actual, reasonable costs for each of the three fiscal years in question. DAB No. 2536, at 13, 14 (finding that the actions taken by the State to finalize its rates were based on "actual cost experience" for SBHS). The State performed that process in accordance with its interpretation of SPA 00-01 as permitting final rates to reflect any actual costs that met the definition of "reasonable" costs under Medicare principles. *See* WV Ex. 23, ¶¶ 8-11, 19-20. That interpretation is consistent not only with State plan's language (and the State's reasonable interpretation of that language), as we explained in our decision (DAB No. 2536, at 9-13), but with the Medicare "reasonable cost" regulations cited by CMS, which provide that a retroactive adjustment to determine final payment (that is, a cost settlement) involves computing "the amount of the provider's *total allowable cost* . . . for the reporting year" – that is, the reasonable costs actually incurred during the relevant accounting period to provide the covered service. 42 C.F.R. § 413.64(f)(1) and (3) (italics added); *see also id.* § 413.9(c)(3) (providing that the "reasonable cost basis of

reimbursement contemplates that the providers of services would be reimbursed the actual costs of providing quality care however widely the actual costs may vary from provider to provider and from time to time for the same provider").

CMS does not dispute that for SFYs 2001 through 2003, the State computed final payment rates for SBHS based on *actual* reasonable *costs* of providing those services – including indirect and operating costs – and that those actual-cost-based rates were used to determine final payment amounts for the services. In turn, the final payment amounts were reconciled against the amounts previously paid and claimed for the services based on the interim rates (which reflected *estimated* costs of providing the services) in order to determine the additional amounts of FFP claimable for those services. Because the retroactive rate adjustments were used to effect a reconciliation of estimated and actual costs to determine final payments for SBHS, CMS's argument that our holding is inconsistent with an accepted definition of cost settlement is meritless.

As for CMS's argument that the rate adjustments were invalid because the State did not perform cost settlements annually, we note first that the term used by CMS to press this argument – "annual cost settlement" – does not appear in SPA 00-01. Instead, SPA 00-01 states that SBHS payment rates should be "cost settled on an annual basis." WV Ex. 7. CMS appears to read that phrase to require the State to perform a cost settlement *during each year*. However, the phrase could arguably be read to require the State to determine final SBHS rates *for each year* or each year's worth of cost data, without regard to when the settlement for any given year should be commenced or completed.[6] It is unnecessary to resolve this apparent ambiguity because CMS's argument fails to identify a clear error of law or fact by the Board. In Decision 2536, we did not construe the meaning of the phrase "cost settled on an annual basis," nor did we determine whether the retroactive adjustments had been made "on an annual basis." Instead, we merely noted that the "only limitation imposed by SPA 00-01 on cost settlement is a requirement settlement be performed on an 'annual basis'" and that it was unnecessary to discuss that requirement because CMS did not cite it as a basis for the disallowance. Because the issue of whether the SBHS rates had been cost settled on an annual basis was

[6] In support of its argument regarding the timing of the cost settlements, CMS relies on Office of Inspector General audit notes (proposed CMS Exhibit 12) that it now seeks to introduce into the record. *See* RR at 11 n.2. We reject the belated request to admit this evidence because CMS has not explained why it could not have been submitted before the Board issued Decision 2536. The notes do not, in any event, resolve the apparent ambiguity in SPA 00-01. CMS points to notes of an August 24, 2005 meeting attended by, among others, a deputy commissioner of the State's Medicaid agency. According to those notes, the deputy commissioner indicated that the State "did not do the cost reports or settlements every year for SHBS," and that "[i]t should have been done every year, but because of numerous staff turnover it wasn't done." These notes make no reference to SPA 00-01, however, nor do they indicate whether the deputy commissioner believed that the State plan *legally required* SBHS settlements to be performed each year or whether he merely thought that the settlements "should have been done every year" in order to promote administrative efficiency or to conform with state practices in settling other types of Medicaid or non-Medicaid costs.

never raised or addressed, and because CMS does not deny that it failed to raise the issue earlier, there is no basis to find that we committed a clear error concerning the issue. The Board has consistently held that issues or arguments that could have been presented to the Board before it issued its decision, such as CMS's contention that the State failed to perform its cost settlements on an "annual basis," are inappropriate grounds upon which to reconsider the decision. *New Hampshire Dept. of Health and Human Servs.*, Ruling No. 2012-2; *Puerto Rico Dept. of Health*, Ruling No. 2011-5 (Sept. 30, 2011).

What remains of CMS's cost settlement argument (in light of the preceding discussion) is a complaint that the State performed its payment rate reconciliation using categories of reasonable costs that were not already reflected in the interim rates. But, as we found, SPA 00-01 did not indicate specifically what types of costs could be considered in setting interim SBHS rates or finalizing those rates, referring only to "reasonable" costs. DAB No. 2536, at 8-9. CMS made no finding that the operating and indirect costs at issue here are not "reasonable" costs within the meaning of SPA 00-01. Furthermore, CMS pointed to no generally accepted cost settlement principle or practice that precluded the State from finalizing rates based on previously omitted categories of reasonable costs. In short, SPA 00-01 left the design and scope of the cost settlement process to the State's discretion, and there is no evidence in the record of any limitation on that discretion.

5. *The Board did not improperly rely on the statements in a declaration provided by the State's employee.*

Next, CMS contends that we erroneously found that the State had always intended to base its SBHS rates on *total* statewide costs of providing SBHS. RR at 12-13. In support of that finding, the Board cited unrebutted statements to that effect in the declaration of Richard Brennan. DAB No. 2536, at 11. CMS now contends that Mr. Brennan's statements are "self-serving" or are insufficient proof of the State's intentions because "Mr. Brennan was not even involved with the SBHS rates at the time" (late 1999 and early 2000).[7] RR at 12-13. We disagree.

[7] In a related vein, CMS suggests that the State was obligated but failed to give CMS notice in 1999 or 2000 of its intention to base its SBHS rates on "total statewide costs" of providing those services. RR at 12. However, CMS does not cite a statute, regulation, or legal principle to support that view, *see* RR at 12, nor (as we noted in Decision 2536) did CMS produce any evidence that when it approved SPA 00-01, it understood that amendment to limit the types of "actual, reasonable" costs that the State could consider in setting or "cost settling" SBHS payment rates. Having drafted or approved open-ended language that gave the State wide discretion in designing and implementing its payment rate methodology for SBHS, subject only to the limitation that final SBHS rates be based on actual and reasonable costs, CMS is not in a position to complain that the State fully exercised that discretion. *Cf. Texas Health and Human Servs. Comm.*, DAB No. 2176, at 11 (stating that "a state does not violate or act inconsistently with its state plan merely because it exercises discretion conferred by the plan").

We inferred that Mr. Brennan was in a position to know the State's intention from his employment history with the West Virginia Department of Health and Human Resources – which included service as "Director of Rate Setting and Cost Evaluation" – and his statement, under penalty of perjury, that his testimony was "based on [his] personal knowledge, on [his] discussions with other DHHR personnel and consultants from [PCG], and on [his] review of documents that [he saw] in connection with the performance of [his] current and previous duties." WV Ex. 23, ¶ 2. CMS does not point to any evidence that impeaches Mr. Brennan's credibility or rebuts his testimony, and CMS did not seek to cross-examine him. It merely asserts that his testimony was "self-serving" – a label that, if applied indiscriminately, would disqualify the testimony of any witness who testified on behalf of his or her employer. Given these circumstances, we cannot agree that our reliance on his testimony was a clear error of fact or law.

6. *CMS's argument that SPA 00-01 was not ambiguous concerning the retroactive payment rate adjustments does not reveal a clear error of fact or law in Decision 2536.*

Drawing on its earlier contentions, CMS contends that we erred in finding that SPA 00-01 was ambiguous concerning the validity of the disputed retroactive adjustments. RR at 13-17. Asserting that the "plain language" of SPA 00-01 "permits retrospective adjustments only where they reflect 'annual cost settlement,'" CMS takes us to task for framing the key interpretive issue (whether SPA 00-01 permitted the State to adjust SBHS payment rates retroactively to incorporate indirect and operating costs) with "painstaking specificity" and "then proceed[ing] to determine that the State Plan is ambiguous simply because the State Plan does not explicitly prohibit this particular type of adjustment." RR at 13 (emphasis in original). "By the Board's logic," says CMS, "if the State claimed reimbursement for expensive conferences in Wheeling, West Virginia, the State Plan would be ambiguous with regard to whether an adjustment to include reimbursement for expensive conferences in Wheeling simply because it is not explicitly prohibited by the State Plan." *Id.*

This argument mischaracterizes our analysis and simply fails to identify any clear factual or legal error in Decision 2536. We did not, as CMS suggests, frame the dispositive issue in a way that preordained the result. Rather, applying our longstanding precedent which accords deference to a State's reasonable interpretation of State plan language, we analyzed whether the State had reasonably construed broadly worded language in SPA 00-01 in order to determine final payment amounts for SBHS for which the State had little or no previous cost experience and for which the State had not previously applied a retrospective payment rate methodology. CMS's assertion that our reading of SPA 00-01 would permit Medicaid payment for "expensive conferences" overlooks that such payment would be subject to the reasonableness criterion, a well-defined principle of

federal cost reimbursement. *See, e.g.*, 2 C.F.R. Part 225, Appendix A, ¶ C.2 (Jan. 1, 2013); 42 U.S.C. § 1395(x) (defining "reasonable cost" for purposes of the Medicare program); 42 C.F.R. Part 413 (setting out principles of "reasonable cost" reimbursement for Medicare).

CMS's various contentions boil down to the proposition that when CMS approved SPA 00-01, the phrase "cost settled on an annual basis" in SPA 00-01 had a clear, adequately defined meaning, derived from law or accepted Medicaid cost reimbursement practices, that the State should have known and understood as barring it from incorporating categories of reasonable costs that were not reflected in the interim rates. As the record and our discussion above shows, CMS failed to present evidence of what that phrase permitted or forbade in this context or demonstrate that the incorporation of additional categories of reasonable costs into the calculation of final SBHS rates was inconsistent with federal cost reimbursement principles (*e.g.*, OMB Circular A-87, as codified in 2 C.F.R. Part 225) or accepted cost settlement practices. *See* DAB No. 2536, at 11 (finding that CMS "failed to produce contemporaneous evidence that the . . . intended meaning [of the cost settlement language in SPA 00-01] is anything other than what the State contends it means" and that CMS "failed to establish that the State violated any accepted cost settlement principles in determining final SBHS payment rates"). Moreover, CMS takes no issue with our finding that the State was "not unreasonable in waiting until it had amassed adequate cost experience with respect to the newly covered SBHS before attempting to incorporate operating and indirect costs into the applicable payment rates." *Id.* at 11.

7. *CMS fails to show that the Board clearly erred in distinguishing or relying on its past decisions.*

CMS also contends that the circumstances in this case are "exactly like" the circumstances in *Colorado Dept. of Health Care and Policy Financing*, DAB No. 2057 (2006), in which the Board sustained a Medicaid disallowance of "retroactive" FFP claims for SBHS. RR at 29. Decision 2536 distinguished *Colorado*, but CMS makes no attempt to show that the distinctions we drew are legally immaterial. Moreover, CMS does not question our reliance on *New York Dept. of Human Resources*, DAB No. 151 (1981), the decision that we found to be more factually analogous to the present factual circumstances than *Colorado*. DAB No. 2536, at 11-12. Accordingly, we see no basis to support CMS's implicit assertion that we misapplied, or failed to apply, relevant case law.

8. *The Board properly rejected CMS's contention that the disputed retroactive adjustments constituted a material change to the State's payment rate methodology for SBHS.*

Finally, throughout its request for reconsideration, CMS asserts or implies that by retroactively adjusting the SBHS rates to reflect additional categories of costs, the State effectively modified the payment rate methodology described in SPA 00-01 without advance notice to, or the prior approval of, CMS in violation of 42 C.F.R. § 430.12(c)(ii). *See, e.g.*, RR at 7 (asserting that the State sought CMS approval for a "material unilateral change to [its] reimbursement scheme only after the fact" (emphasis in original)). This argument (which we rejected in Decision 2536, at 16) rests on the assumption that the retroactive adjustments did not, in fact, constitute a cost settlement of the February 2000 SBHS rates but instead were "unilateral" changes to "final" rates accepted by CMS during the state plan amendment process. *See id.* at 6-7. As explained above, we committed no clear error in finding that the adjustments were part of the cost settlement of *interim* rates for SFYs 2001 through 2003 and consistent with the State's reasonable interpretation of SPA 00-01. Because the adjustments were authorized by SPA 00-01, there is no basis to find that they constituted a material change to the approved payment rate methodology. Although a state needs CMS approval to change a Medicaid payment rate methodology, it does not need prior CMS approval to make retroactive rate adjustments pursuant to an approved State plan that authorizes such adjustments.

Conclusion

Because CMS has not identified a clear and material error of fact or law in Decision 2536, we deny its request for reconsideration.

/s/
Judith A. Ballard

/s/
Leslie A. Sussan

/s/
Stephen M. Godek
Presiding Board Member