Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Utah Department of Health
Docket No. A-11-122
Decision No. 2462
June 8, 2012

DECISION

The Utah Department of Health (Utah) appealed a determination by the Centers for Medicare & Medicaid Services (CMS) disallowing $9,687,795 in federal financial participation (FFP) Utah claimed under the Medicaid program. Utah's claims were for expenditures it incurred from July 1, 2000 through December 31, 2007 for FlexCare, part of Utah's Long Term Care Managed Care (LTC-MC) program. CMS determined that Utah's payments to its FlexCare contractors exceeded the applicable upper payment limits (UPLs). CMS also determined that Utah had improperly claimed administrative costs at the FFP rate that applies to medical assistance, rather than the lower rate that applies to administrative costs.

Utah argues that all of the Medicaid recipients enrolled in the FlexCare program would have been receiving nursing facility services if they had not received FlexCare services, and therefore Utah reasonably treated the Medicaid rates Utah paid for nursing facility services as the applicable UPLs for FlexCare payments. Alternatively, Utah argues that the Board should remand the disallowance to CMS to recalculate the disallowance amount.

For the reasons stated below, we conclude that the plain language of the applicable regulations required that the UPLs for FlexCare payments be set using what Medicaid would have paid for the services actually furnished to FlexCare enrollees, rather than the rates set for nursing facility services the enrollees otherwise would have received. We also conclude that, in the absence of better data from Utah, CMS's calculations used to determine the disallowance amount were reasonable. Accordingly, we uphold the disallowance of the full amount.

Legal Background

Title XIX of the Social Security Act (Act) establishes the Medicaid program, authorizing federal grants to any state that has submitted, and had approved by the Secretary of Health and Human Services, a state plan for medical assistance.[1] CMS administers the Medicaid program on behalf of the Secretary. "Medical assistance" is defined in section 1905(a) of the Act. Among other things, section 1905(a) lists services that may or must be covered under a state's Medicaid plan. FFP is available in amounts expended as medical assistance under an approved state plan at a rate called the "Federal medical assistance percentage" (FMAP). Act § 1903(a)(1); 42 C.F.R. §§ 440.2(b) (definitions of services for FFP purposes) and 400.203 (defining the term "services" for purposes of Medicaid). FFP is also available for amounts found necessary for the proper and efficient administration of a Medicaid state plan, generally at a 50% rate. Act § 1903(a).

State plan requirements in section 1902(a) of the Act include the following:

- paragraph (1) requires that the plan be in effect in all political subdivisions (statewideness);
- paragraph (10) requires that the medical assistance made available to any eligible individual not be less in amount, duration, and scope than that made available to any other such individual (comparability of services); and
- paragraph (23) requires that any eligible individual may obtain assistance from any qualified provider (freedom of choice).

Section 1915(a) of the Act provides, among other things, that a state shall not be deemed to be out of compliance with these three state plan requirements "solely by reason of the fact" that the state has –

> entered into a contract with an organization which has agreed to provide care and services in addition to those offered under the State plan to individuals eligible for medical assistance who reside in the geographic area serviced by such organization and who elect to obtain such care and services from such organization . . . .

[1] The current version of the Act can be found at http://www.socialsecurity.gov/OP_ Home/ssact/ssact.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section.

In other words, section 1915(a) allows a state to enter into certain contracts that otherwise would cause the state to be out of compliance with the provisions on statewideness, comparability of services, and freedom of choice and to be subject to a compliance enforcement action under section 1904 of the Act. UT Ex. 12, at 5 (CMS 2007 guide on Long-Term Care Capitation Models). For example, section 1915(a) permits a state to offer a voluntary Medicaid managed care program that would otherwise be unavailable in a state that provides services on a fee-for-service basis. Other provisions of section 1915 authorize the Secretary to actually waive specified state plan requirements and to require recipients to participate in a waiver program.

Prior to 2002, provisions in Medicaid regulations at 42 C.F.R. Part 434 set out state Medicaid agency responsibilities and requirements for contracts with health maintenance organizations and prepaid health plans. In 2002, new regulations at 42 C.F.R. Part 438 were promulgated to govern managed care entities and to set out the conditions for FFP in payments made by a state to an entity providing managed care services. Part 438 became effective August 13, 2002 and was to be fully implemented by one year from the effective date of the regulation. 67 Fed. Reg. 40,989, 41,072 (June 14, 2002).

The Part 438 regulations require review and approval by the CMS regional office of all contracts with a Managed Care Organization (MCO), a Prepaid Inpatient Health Plan (PIHP), or a Prepaid Ambulatory Health Plan (PAHP), including those risk and nonrisk contracts that, on the basis of their value, are not subject to the more stringent prior approval requirement in section 438.806. 42 C.F.R. § 438.6(a). The definitions at section 438.2 include the following:

> *Nonrisk contract* means a contract under which the contractor—
>
> (1) Is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits specified in § 447.362 of this chapter; and
>
> (2) May be reimbursed by the State at the end of the contract period on the basis of the incurred costs, subject to the specified limits.

The UPL requirement specified at 42 C.F.R. § 447.362 for nonrisk contracts has been in effect since 1983 and was not changed in the 2002 rulemaking. 48 Fed. Reg. 54,013, 54,025 (Nov. 30, 1983). That UPL provision states:

> Under a nonrisk contract, Medicaid payments to the contractor may not exceed—
>
> (a) **What Medicaid would have paid**, on a fee-for-service basis, for the services **actually furnished** to recipients: plus

> (b) The net savings of administrative costs the Medicaid agency achieves by contracting with the plan instead of purchasing the services on a fee-for-service basis.

(Emphasis added.)

Prior to the promulgation of the Part 438 regulations in 2002, the term "nonrisk" was defined as follows:

> *Nonrisk* means that the contractor is not at financial risk for changes in the cost or utilization of services provided for in the payment rate agreed upon at the beginning of the contract period. Under a nonrisk contract, the State agency may make retroactive adjustment during and at the end of the contract period so that the contractor is reimbursed for costs actually incurred, subject to the upper limit of payment established in § 447.362 of this chapter, or any lower limit specified in the contract.

42 C.F.R. § 434.2 (2001). The preamble to the 2002 rulemaking explained:

> The chief incentives to accepting a risk contract and seeking to contain costs is that the contractor keeps any "savings" that are obtained, for instance, by achieving a lower utilization of inpatient services than that of FFS providers in the area. In the case of nonrisk contracts, since the limit is based on services actually furnished, there are no "savings."

48 Fed. Reg. at 54,019.

With a limited exception not applicable here, FFP is "not available for a State's expenditures for services that are in excess of the amounts allowable" under 42 C.F.R. Part 447, subpart F. 42 C.F.R. § 447.304(c). Subpart F includes the UPL for nonrisk contracts. Also, the Part 438 regulations specify that the total amount paid under a risk contract is a medical assistance cost, but that, under a nonrisk contract—

> (1) The amount the State agency pays for the furnishing of medical services to eligible recipients is a medical assistance cost; and
>
> (2) The amount the State agency pays for the contractor's performance of other functions is an administrative cost.

42 C.F.R. § 438.812.

Factual Background

Except as indicated below, the following facts are undisputed. Utah created its Long-Term Care, Managed Care (LTC-MC) program to allow Medicaid recipients living in nursing facilities the option of moving into home- or community-based settings instead of remaining in nursing facilities. The LTC-MC program had two components: (1) primary- and acute-care services (which Utah referred to as "physical services"), and (2) long-term care (LTC) services. The first component consisted of all non-LTC medical services that are covered under Utah's state Medicaid plan. This component was operated under a section 1915(b) waiver through contracts first with United Healthcare of Utah (United Healthcare), and later under contracts with the University of Utah Hospital and Clinics (Healthy U) and Molina. Utah refers to these as its "underlying" contracts.

In 1999, Utah sought CMS approval for the LTC component of its program (called FlexCare) under section 1905(a) of the Act. The correspondence between CMS and Utah at that time indicated that FlexCare was to be operated under a subcontract between United Healthcare and Heritage Management, Inc. UT Ex. 5. CMS approved the program initially in 1999. Later, Utah began providing FlexCare services under its contract with Healthy U, which used Valley Mental Health to provide the FlexCare component.

The FlexCare program served only certain counties in Utah. Originally it was available for any Medicaid-eligible recipient in one of those counties who was aged 65 or older or an adult with substantial physical disability and who resided in a Medicaid-certified nursing facility (other than an Intermediate Care Facility for the Mentally Retarded) or was to be discharged from a hospital into a nursing facility. Utah later restricted enrollment to individuals who had resided in a nursing facility for at least 90 days. Covered services included nursing facility services, 24-hour supported living alternatives, home health services, personal care services, physical environment modifications, specialized medical equipment, assistive technology devices, personal emergency response systems, respite care, and adult day care.

Utah initially set the FlexCare premiums (monthly capitation payments) at the average statewide nursing home rate per patient day for that year multiplied by the number of patient days in the month. After several years, Utah began to negotiate premium amounts based on the prior year's experience with FlexCare services and costs. When nursing home rates rose in 2005, Utah did not incorporate this increase into the FlexCare premiums.

At least as early as 2004, CMS began raising questions about whether Utah's managed care contracts were consistent with federal requirements, including the UPL provision, and seeking from Utah "encounter" data about the nature and amount of services furnished under the contracts to use in calculating UPLs. Utah apparently provided such

data with respect to the physical services component of the contracts (and returned $6 million in FFP claimed under those contracts). Utah did not, however, provide encounter data for FlexCare.

As a result of communications with CMS about the authorities under which Utah was operating various programs, Utah revised its LTC-MC program. Utah continued to operate the physical services component under section 1915(b) authority. The FlexCare component, however, was replaced by a New Choices program under a section 1915(c) waiver that CMS approved effective June 1, 2006.

In 2006, the Department of Health and Human Services (HHS) Office of the Inspector General (OIG) initiated an audit of LTC-MC costs claimed by Utah, issuing an audit report in May 2009. UT Ex. 13. The OIG found that Utah did not have "policies and procedures to ensure that the State agency could support that it was paying equal to or less than the upper payment limits, pursuant to 42 CFR § 447.362." *Id.* at 5. Because Utah could not ensure that its claims were equal to or less than the UPLs, the OIG said, it was unable to express an opinion on the allowability of the $27,432,527 in federal reimbursement Utah had claimed for FlexCare services. *Id.* The OIG set aside that amount and recommended that Utah work with CMS to resolve the allowability of the claims. *Id.* at ii.

On August 1, 2011, CMS issued a notice to Utah disallowing $9,687,795 in FFP Utah had claimed for FlexCare expenditures for the period July 1, 2000 through December 31, 2007. UT Ex. 17. The notice stated that, because of a lack of supporting documentation from Utah, CMS had "developed an alternative methodology to identify an overpayment dollar value less than the OIG's $27,432,527 set aside value." *Id*. at 1-2. The disallowance letter explained that CMS's methodology included the following:

- CMS's use of Utah's 9/24/2009 Form CMS-372, which provided documentation for the first year of the New Choices, section 1915(c) waiver program.
- CMS's understanding that enrollees and services provided under the New Choices Waiver were equivalent to those in the historical LTC-MC FlexCare program.
- CMS's application of the "cost per day to the number of enrollees in the program which was calculated based on the Form CMS-372 data for the New Choices Waiver as factors for LTC-MC Flexcare program."
- CMS's adjustment for a 9% administrative fee, similar to other nonrisk contracts Utah operated.

Id.

Analysis of factual disputes

The contracts for FlexCare services were nonrisk contracts.

The OIG found generally that Utah had used nonrisk contracts for its LTC-MC program, but an Appendix to the audit report (at 6) indicates that FlexCare was under a risk contract from April through June 2003. CMS's disallowance calculations also exclude that period, identifying the contract as a risk contract in that period. UT Ex. 19, 5th Column.

Utah's brief asserts that for the first two years of FlexCare, from July 2000 until July 2002, the underlying contracts that Utah had with various managed care organizations such as United Healthcare were risk contracts. UT Br. at 32. In support, Utah cites to the excerpt in its Exhibit 8 from the contract with United Healthcare, which states: "This Contract is a risk contract as described in 42 CFR 447.361." *Id.* This one-page excerpt from the contract in Utah Exhibit 8 is not sufficient to establish that the UPL for nonrisk contracts did not apply to FlexCare payments during the periods for which the disallowance was taken.

First, the one-page excerpt indicates it is from a contract effective July 1, 2001, so it would not cover the first year (July 2000 through June 2001) during which Utah asserts it had a risk contract. Second, in light of the record as a whole, we do not consider the mere fact that the underlying contract effective July 1, 2001 was self-described as a risk contract subject to the UPL for risk contracts then in section 447.361 sufficient to establish that the underlying contract was, in fact, a risk contract. The contract addenda in the record that relate specifically to FlexCare also refer to "risk sharing" and to section 447.361, but they contain a provision for **retroactive adjustment** of payments to cover any costs the contractor incurs in excess of the capitated premium payments. UT Ex. 4; *see also* UT Ex. 9 (describing the LTC services component as a "full-risk payment arrangement," but nonetheless providing for retrospective adjustment if costs exceed payment). Such retroactive adjustment is the essential characteristic of a nonrisk contractual arrangement.

Utah did, also, submit a declaration from the former State Medicaid Director that states that, at the outset, the underlying contracts were risk contracts, which then were revised and became nonrisk contracts in July 2002. UT Ex. 21 (Deily Declaration), ¶ 17. This statement does not undercut the OIG's finding that FlexCare was operated under nonrisk contracts, however. In context, the statement refers to the underlying contracts with the health maintenance organizations, such as United Healthcare, that operated under a section 1915(b) waiver. The declaration goes on to acknowledge that a "different

addendum" to the contract "covered the long-term care services at issue here" and specified that Utah would pay a capitated premium in advance, but "would retroactively adjust annual payments to contractors if claim costs exceeded premiums." *Id.*; UT Exs. 4, 9.

Utah concedes that the FlexCare contract addenda provided for retroactive adjustments to reimburse contractors for costs incurred, but argues that the addenda were not "stand-alone nonrisk contracts." UT Br. at 32. In our view, the OIG and CMS correctly found that Utah had nonrisk contracts for purposes of the UPL provision in the first years of the program even if the "underlying" contracts were risk contracts (which Utah did not prove). The addendum and subcontract did stand alone from the "underlying" contract in several important respects. They provided for different amounts to be paid for different services under a program component authorized under a different statutory provision. Moreover, the record indicates that Utah originally issued a separate request for proposals for the LTC program, entering into the sole source contract with United Healthcare only after receiving only one proposal in response. UT Ex. 4, 3rd page. The happenstance that Utah contracted for services under FlexCare by amending an existing contract rather than entering into a new, separate contract should not allow Utah to circumvent the UPL applicable to payments under a contract in which the contractor does not assume the risk that the costs will be more than the capitation payments.

The retroactive adjustment provision in the addendum to the contract between Utah and United Healthcare effectively meant that, with respect to the FlexCare component, the contract was not, in fact, a risk contract, but was a nonrisk contract. Although we do not have in the record a copy of each contract under which FlexCare operated, Utah's own exhibits indicate that it entered into cost settlements with the contractors for each of the periods at issue, which supports an inference that a retroactive adjustment provision continued to apply. UT Ex. 22, ¶ 4. Thus, we find that all of the contracts at issue (which does not include the period April to June 2003) were nonrisk contracts with respect to FlexCare and that FlexCare payments were subject to the UPL for nonrisk contracts.

CMS did not approve all of the relevant contract provisions.

The OIG report also found that, although CMS had approved the implementation of the FlexCare program under section 1915(a) by approving the contract Utah submitted in 1999, Utah had "modified the LTC-MC program and executed contracts with other contractors," presumably meaning contractors other than United Healthcare. UT Ex. 13, at 2. The OIG reported that, according to CMS officials, CMS withheld approval of those other contracts because of a lack of compliance with the regulations. *Id.*

Utah did not challenge this assertion in its initial brief. In response to CMS's assertion that it did not approve the FlexCare contracts after the first year, however, Utah replied that CMS's assertion was wrong. UT Reply Br. at 7. In support, Utah submitted a declaration by Michael Hales, Utah's Director of the Division of Medicaid and Health Financing, who was also Assistant Director from 2003 to 2005. UT Ex. 31 (Hales Declaration). Utah also submitted copies of correspondence with CMS, both as Exhibit A to the Hales Declaration and as Utah Exhibit 27.

The Hales Declaration states:

> In 1999, CMS approved Utah's contracts with United, Healthy U, and Molina, each of which had FlexCare long-term care components operating under the authority of Section 1915(a). The United contract ran through the end of 2002, when Utah and United ended their relationship. The Healthy U and Molina contracts ran from July 1, 1999 until December 31, 2005. CMS re-approved the Healthy U and Molina contracts in 2002. The State at all times understood that it was operating FlexCare under its original grant of authority. In March 2005, as part of discussions with CMS regarding the approval of an amendment to the managed care contracts changing from risk to nonrisk, CMS first raised the issue of whether Section 1915(a) was the appropriate authority under which FlexCare should operate and encouraged the State to look at a "combination" Section 1915(b), (c) waiver. At CMS's urging, Utah split off FlexCare from the other managed care contracts. CMS then approved the contracts for physical health only under the Section 1915(b) authority (retroactive to January 1, 2006), and the State replaced FlexCare with a new Section 1915(c) waiver.

UT Ex. 31, ¶ 8.

The first assertion in this statement – that each of the three underlying managed care contracts had FlexCare components – is inconsistent with the contemporaneous documentary record. The 1999 documents clearly indicate that Utah originally implemented the FlexCare component of the LTC-MC program only through its contract with United Healthcare and its subcontract with Heritage Management, Inc. UT Exs. 2-5; UT Ex. 27 (9/27/99 letter from CMS). The only contract provision in the record regarding any other contractor's operation of FlexCare is an addendum to the Healthy U contract with an effective date of **January 1, 2003.** UT Ex. 9. A document prepared by Tad Purser suggests a possible earlier date, by indicating that, beginning in July 2002, all FlexCare payments were made to Healthy U to provide services through Valley Mental Health. UT Ex. 22 (Ex. A). Mr. Purser is Financial Manager of the Utah Medicaid program's Bureau of Financial Services and was previously an auditor with the Bureau. *Id.* at 1. Even if we accept the document prepared by Mr. Purser as sufficient to show

that FlexCare was operated by Healthy U as early as **July 2002**, however, that document is inconsistent with Mr. Hales' assertions to the effect that FlexCare was under the Healthy U contract as early as 1999 and that the Molina contract also had a FlexCare component.

Furthermore, Mr. Hales' assertion that the contract with Healthy U ran from 1999 until December 2005 is irrelevant. The issue is whether the contract component for FlexCare program was **approved** by CMS, not whether a contract was in effect between the parties. The documents to which the Hales Declaration refers as showing CMS's approval in 2002 do show approval of an amendment to the United Healthcare contract effective July 1, 2001 to permit a prorated premium for the LTC component, and approval of an amendment to move the FlexCare program to Healthy U effective June 1, 2002. UT Ex. 27, at 4, 6. The other documents on which the Hales Declaration relies to show CMS approval are insufficient to show such approval, however. One of the 2002 documents is for a different project (the Dual Diagnosis Pilot Project), and another approves amendments with no clear relationship to FlexCare. *Id.* at 3, 5. Two of the three post-2002 approval letters relate only to Molina's section 1915(b) waiver contract. *Id.* at 8, 10. The other letter is an April 2006 letter approving Healthy U's section **1915(b) waiver** program under a contract effective January 1, 2006. *Id.* at 9. No mention is made in that letter about the FlexCare program under section 1915(a), and by then Utah had been advised to separate it from the section 1915(b) waiver contract.

While CMS apparently approved moving FlexCare to the Healthy U contract in 2002, that approval was relevant at most until April 2003, given that Utah's own evidence shows it changed to a risk contract for FlexCare for the period April 2003 through June 2003. UT Ex. 24. Moreover, the Hales Declaration admits that the change to the Healthy U contract in 2003 to make it again a nonrisk, rather than a risk contract caused CMS to raise questions. CMS's evidence indicates that at least by 2005 CMS did not consider Utah to have an approved contract for FlexCare services under the section 1915(a) waiver. CMS Ex. 3, at 1 (8/12/05 email from Hales to CMS indicating no contract was in place between Healthy U and Valley Mental Health); CMS Ex. 4, at 7 (7/01/05 letter from CMS to Utah indicating Utah did not currently have an approvable 1915(a) contract and had previously been informed that its contracts were not consistent with the regulations); CMS Ex. 5, at 1 (CMS Memorandum of 7/12/05 regarding contract amendments not compliant with regulations); CMS Ex. 7. Yet, Utah continued to claim FFP in FlexCare payments to Healthy U/Valley Mental Health as late as December 2007. UT Ex. 24.

We do not need to definitively decide the periods for which Utah had CMS approval, however. CMS is not disallowing the costs at issue here on the basis of lack of contract approval, but merely indicated that it could have disallowed the full amount of FFP claimed for any period of nonapproval, rather than using its alternative methodology to calculate a UPL and a lower disallowance amount.

Utah did commit to provide encounter data for FlexCare.

The parties also disagree about whether Utah's commitment in 2005 to provide encounter data encompassed data for FlexCare or was limited to encounter data for the section 1915(b) waiver programs. Encounter data are claims records that detail the costs paid by a managed care organization that has contracted to provide Medicaid services. CMS used Utah's failure to provide encounter data or comparable data as a reason why CMS had to use an alternative methodology to calculate UPLs for the period at issue.

Mr. Hales avers that Utah agreed to provide CMS with encounter data for physical health services provided under the section 1915(b) contracts, and that in his 2006 emails to CMS in CMS Exhibit 9, he was referring **only** to encounter data for those physical health services. UT Ex. 31, ¶ 5. He also avers that the data referred to in CMS Exhibit 10, a report from Gail Rapp, Assistant Director of the Utah Division of Medicaid and Health Financing, are the encounter data for the physical health component of the section 1915(b) contracts, which data Utah provided to CMS in 2007. *Id.*, ¶ 7. According to Mr. Hales, Utah believed it was unnecessary to obtain encounter data for FlexCare "because the long-term care component was not paid for on a cost basis." *Id.*, ¶ 6.

Mr. Hales' statement that he was referring only to the physical services component of the contracts in his 2006 emails at CMS Exhibit 9 is not credible, given that the first email from CMS in the series of emails reminded Utah that it had to assure that the UPL test was met, not only for the Molina and Healthy U contracts, but for "all other Long Term Care contracts that exist" and that, as mentioned in previous discussions, use of the nursing facility rate "is not an appropriate or allowable UPL assurance." CMS Ex. 9, at 2. Moreover, the Rapp report, dated March 16, 2007, contains nothing that limits her discussion of encounter data to the physical health component of the LTC-MC program. CMS Ex. 10.

Even if Utah intended these later documents to refer only to more limited encounter data, moreover, that does not mean that Utah had not previously committed to providing such data. In 2005, Mr. Hales wrote to CMS after it had raised issues regarding compliance with the UPL in section 447.362 for non-risk contracts. CMS Exs. 6, 7. He indicated that Utah assumed that compliance meant that Utah had calculated the UPL, determined whether the amount paid the plans exceeded the UPL, and recouped any overpayments. CMS Ex. 7, at 1. He indicated that among Utah's actions to comply with the UPL requirement would be to receive "all historical encounters from health plans" by October 15, 2005 and then to price the encounters and complete UPL calculations by November 30, 2005. *Id.*

In addition, we note that any belief by Utah that obtaining encounter data for FlexCare was unnecessary because it "was not paid for on a cost basis" would be unreasonable in light of the retroactive adjustment provision, providing for an upward adjustment if costs exceeded the premium payments.

Analysis of legal arguments

In this section, we first address the legal arguments Utah made regarding the UPL provision applicable to nonrisk contracts, including its arguments about why the nursing facility rates should be used in calculating the UPL. We then address Utah's arguments about CMS's calculation of the disallowance amount.

The UPL provision for nonrisk contracts is not ambiguous.

As indicated above, the UPL for nonrisk contracts is what "Medicaid would have paid, on a fee-for-service basis, for the services actually furnished to recipients," plus an allowance for administrative cost savings.

According to Utah, in applying this UPL provision to FlexCare, "it is necessary to confront the fact that, during the time FlexCare operated, there was no fee-for-service equivalent for many of the individual services offered under the program." UT Br. at 13. Utah points out that section 1915(a) of the Act authorizes states to contract with organizations for services "in addition to those offered under the State plan" and that "many of the individual services FlexCare offered were not covered by the State plan." *Id.* at 13-14. Utah concludes from this that the UPL provision cannot be applied literally to its program.

We disagree. Since Utah's Medicaid program simply would not have paid on a fee-for-service basis for additional services not covered by the state plan, those services are irrelevant to the calculation of the UPL for a nonrisk contract under the plain terms of section 447.362. The plain language of that section permits a state to include in the UPL calculation **only** amounts that Medicaid "would have paid." Moreover, section 447.362(a) plainly refers to what Medicaid would have paid for "services actually furnished." The term "services" is defined for purposes of the Medicaid program to mean "the types of medical assistance specified in section 1905(a) of the Act and defined in subpart A of part 440" of 42 C.F.R. 42 C.F.R. § 400.203. Part 440, in turn, provides that (subject to the limits in part 441) FFP is "available in expenditures under the State plan for medical or remedial care and services as defined in this subpart." 42 C.F.R. § 440.2(b).

Reading the term "services" in subsection 447.362(a) to mean only services covered under the Medicaid program and the state plan is also consistent with the context, given the wording of subsection 447.362(b). Subsection (b) includes in the UPL calculation

savings "the Medicaid agency achieves by contracting with the plan instead of purchasing **the services** on a fee-for-service basis." (Emphasis added.) The term "the services" in subsection (b) clearly refers back to the services actually furnished under the contract mentioned in subsection (a), therefore confirming that section 447.632 is using the term "services" to mean only those services the Medicaid agency would have otherwise purchased on a fee-for-service basis.

Given that the additional, non-covered services are irrelevant to the UPL calculation, the fact that Utah had not established a fee-for-service rate for those services simply does not matter, and the UPL language can be applied literally, contrary to what Utah argues. The UPL can be calculated by determining which of the services actually furnished under the contract qualify as Medicaid-covered services under the state plan and what amount Utah's Medicaid program would have paid for those services if purchasing them on a fee-for-service basis.

Section 1915(a) permitted Utah to enter into a contract for services, including for additional services, without being found out of compliance with the section 1902(a) requirements regarding state-wideness, comparability of services, and freedom of choice. Contrary to what Utah's argument suggests, however, the issue is not whether Utah was authorized to enter into a contract for additional services. Rather, the issue is the extent to which FFP is available in payments under the contract. When the contract is a nonrisk contract, FFP is not available in payments that exceed the nonrisk UPL.

We also note that Utah points to nothing in section 1915(a) specifically stating that any non-state plan, "additional services" that may be included in a contract under section 1915(a) constitute "medical assistance" for which **FFP** is available under section 1903(a) of the Act. In contrast, some other provisions of the Act specify that certain amounts (other than the costs of room and board) may qualify as "medical assistance" when a state has a waiver program under one of those provisions. *See, e.g.,* Act §§ 1915(c)(1), 1915(d)(1), and 1915(e)(1).[2]

Utah's arguments about the meaning of section 447.362 have no merit.

Utah asserts that CMS has "acknowledged" that section 447.362 cannot be applied literally to FlexCare because there was no fee-for-service program comparable to the package of services provided to FlexCare participants. UT Br. at 14. The June 24, 2005

[2] Even under a section 1915(c) home- and community-based services waiver, the statute excludes from medical assistance amounts paid as room and board. Yet, the record indicates that FlexCare did pay some room and board costs. UT Ex. 14, 5th page; CMS Ex. 5, at 2. Utah does not explain how room and board could be considered an additional **service** within the meaning of section 1915(a), much less how it would be considered to be "medical assistance" for which FFP would be available.

email on which Utah relies for this argument, however, addresses the issue of plan **administrative** costs that have no fee-for-service parallel for purposes of determining a state's administrative cost savings. UT Ex. 10. Nothing in the email suggests that CMS thought the UPL provision for nonrisk contracts was ambiguous with respect to how to calculate what Medicaid would have paid for the **services** actually furnished under the contract. Indeed, even with respect to administrative costs, the email refers only to "plan administration directly related to the provision of state plan services." *Id.* Thus, it is consistent with reading the phrase "services actually furnished" to mean only the state plan services furnished under the contract, not the additional, non-covered services.

The fact that there were no established Medicaid fee-for-service payment rates for the **additional** services provided under the contracts merely reflects the fact that those services were not covered by the state plan. (For example, Utah was using FlexCare funds to provide some care to recipients residing in institutions that did not meet Medicaid certification requirements, and to pay for expenses such as moving costs that are not healthcare related. UT Exs. 11, 15.) Since Medicaid would not have paid anything for the additional, non-covered services on a fee-for-service basis, the plain language of section 447.362 excludes any costs of those services from the UPL calculation. Thus, even assuming that the package of services provided by a nursing facility is the closest "equivalent" to the package of services provided by FlexCare, as Utah asserts, that assumption is irrelevant for purposes of calculating the UPL, except to the extent nursing facility services were actually furnished under the contract.

Contrary to what Utah argues, the lack of any CMS guidance documents on "how to calculate the upper payment limit under § 447.362 when there is no fee-for-service equivalent under the State plan" does not suggest that a state retains some discretion in identifying the UPL in these circumstances. UT Br. at 22. The lack of such guidance is consistent with CMS's position that services for which there is no fee-for-service equivalent under a state plan are not included in the calculation.

Similarly, the fact that CMS approved the initial FlexCare contract in 1999 without raising any question about the UPL (despite the fact that Utah did not provide any information about fee-for-service equivalents) does not undermine CMS's position here, as Utah contends. UT Br. at 22. That action is consistent with CMS's position that the only relevant services for calculating the UPL in section 447.362 are services covered under the state plan.

In a footnote, Utah suggests that because there was no precise fee-for-service equivalent to the FlexCare services during the period the program operated, it is questionable whether the UPL provision applies at all. UT Br. at 14 n. 7. We disagree. By its own terms, the UPL applies to all nonrisk contracts. Utah points to nothing in the wording or history of the UPL provision that would make it inapplicable to a nonrisk contract merely because that contract includes additional services not covered under the state plan.

Utah suggests further that, if no FFP is available under a section 1915(a) contract for services offered in addition to those under the state plan, then CMS approval of the contract is "meaningless." UT Reply Br. at 4. We disagree. Approval by CMS of managed care contracts is required for many reasons, including to ensure that applicable procurement standards are met and that recipients are protected.

Utah also argues that CMS's development of an "alternative methodology" to calculate the disallowance "confirms that a literal reading of the regulation applicable to nonrisk contracts is not workable in connection with FlexCare and that a nonliteral application of the rules is legally permissible." UT Br. at 14. Utah does not deny, however, that it has never provided CMS with information about the services actually furnished to FlexCare enrollees. The reason CMS needed to develop an alternative methodology was because of Utah's failure to provide such information, not because of any ambiguity in the UPL provision. *See, e.g.,* UT Ex. 17, at 1 (disallowance letter stating that CMS developed its methodology because of "a lack of supporting documentation from the State agency").

Utah further suggests that the disallowance is at odds with the regulatory history of UPLs for capitated contracts, citing changes to the regulations applying to risk contracts. UT Br. at 24. One of the changes that Utah cites, however, merely eliminated a different upper limit based on what third party payors were paying for comparable services under comparable circumstances. 48 Fed. Reg. at 54,015. The other change was to base the UPL for **risk** contracts on actuarially sound rates – i.e., the change made in 2002.

As Utah points out, part of the rationale for this later change was that some states were finding it increasingly difficult to provide information on what the fee-for-service costs would have been for populations that had been on managed care for many years. 66 Fed. Reg. 6228, 6234 (Jan. 19, 2001). Despite this difficulty, however, the rulemaking made no corresponding change to the UPL for **nonrisk** contracts in section 447.362 – the provision that is at issue here. This may have represented a policy judgment that states that had not moved to risk contracts were more likely to have the requisite information, but whatever the reason, the nonrisk UPL remained unchanged and applicable to Utah's nonrisk contracts.

Utah's argument, moreover, ignores other parts of the preamble to the 2002 rulemaking that undercut Utah's position. Although the UPL for risk contracts was amended to refer to actuarially sound rates, the rulemaking also implemented a limit on payments a state could make based on a provision setting risk corridors in a risk contract. A risk corridor is a "risk sharing mechanism in which States and contractors share in both profits and losses under the contract outside of a predetermined threshold amount . . . ." 42 C.F.R. § 438.6(c)(1)(v). The 2002 rulemaking enacted section 438.6(c)(5)(ii), which provides:

> If risk corridor arrangements result in payments that exceed the approved capitation rates, these excess payments will not be considered actuarially sound to

> the extent that they result in total payments that exceed **the amount Medicaid would have paid, on a fee-for-service basis, for the State plan services actually furnished** to enrolled individuals, plus an amount for [plan] administrative costs directly related to the provision of these services.

(Emphasis added.) The preamble explained this provision as follows:

> In considering the commenters' concerns, we have determined that a more appropriate outer limit on the actuarial soundness of payments under a risk corridor methodology would be a limitation based on **what Medicaid would spend for the specific services utilized**, plus an amount to cover the managed care plan's reasonable administrative costs. Such a limit would be similar to the "non-risk upper payment limit" in § 447.362, except for the recognition of administrative costs. The reason we did not simply adopt the rule in § 447.362 is because the amount allocable to administrative costs under that section of the regulations is not based on a managed care entity's reasonable administrative costs, but rather on the amount the Medicaid agency "saves" in its administrative costs by not having to pay fee-for-service claims for the beneficiaries enrolled in the managed care plan. We believe this amount is likely to be much lower than even the administrative costs of a well run managed care organization.
>
> Thus, we are revising the requirement in proposed § 438.814 to impose an upper limit on payments under risk corridors that is based on "what Medicaid would have paid on a fee for service basis for the services actually furnished to recipients" plus an allowance for the managed care plan's reasonable actual administrative costs. This limit reflects the fact that a risk corridor extended to its ultimate extreme would become a nonrisk contract, and that the rule governing FFP in nonrisk contracts (with the modification noted) is the most logical limit to apply. We are also moving this requirement to § 438.6(c)(5) in order to have all of the payment provisions in one subpart of this rule.

67 Fed. Reg. at 41,070; *see also* 42 C.F.R. § 438.6(c)(4)(providing that rates for risk contracts must be based on state plan services).

We also note that Utah does not claim that it did not have information about the fee-for-service rates it would have paid for the state plan services provided under the contract. Instead, the difficulty was that Utah could not (or chose not to) produce data about the services actually furnished.

In sum, Utah's arguments about how to apply the UPL for nonrisk contracts have no merit.

Utah's reliance on 2009 CMS guidance is misplaced.

With its reply brief, Utah submitted a copy of guidance CMS issued in 2009, which Utah says allows managed care plans to offer services that are "in lieu of (or as a substitute for) more costly contracted State plan services" under a section 1915(a) contract. UT Reply Br. at 5-6, citing UT Ex. 28. The guidance indicates that the point of "in lieu of services" is to allow contractors to replace State plan services with more cost-effective services. UT Ex. 28. Utah argues:

> If CMS is correct that Section 1915(a) does not directly authorize federal financial participation for services not covered by a State plan (as it argued in its answering brief), then Utah was technically paying for the "more costly" State plan service (i.e., care in a nursing facility) even though the managed care plans that operated FlexCare were authorized to provide home and community-based services in lieu of that service. In this circumstance, the upper payment limit must be the fee-for-service rate for the State plan service for which the State is technically contracting, *i.e.*, the nursing home rate.

UT Response to CMS Surreply at 6-7.

This argument has no merit. The excerpt from the CMS 2009 guidance submitted as Utah Exhibit 28 deals with setting capitation rates and states at the outset that "[s]ervices comprising the capitation rate must be included and approved in the State Plan, approved under section 1915(b)(3) authority, or approved under section 1115." UT Ex. 28, at 3rd page. The excerpt notes that a state could not require a Medicaid recipient to accept more cost-effective "in lieu of services" in place of more costly state-plan covered services, but could, **in the rate development process**, "account for the expected cost and utilization of 'in lieu of' services **as a proxy** for the cost of approved State plan services in a contract." *Id.* at 4th page (emphasis added). That a state could base a capitation **rate** on a lower cost service does not automatically transform that service into a service "for which Medicaid would have paid on a fee-for-service basis" within the meaning of the UPL provision at section 447.362. Nor does it authorize a state to calculate the UPL by substituting the fee-for-service rate applicable to a **more costly** service for the amount, if any, Medicaid would have paid for a service actually furnished.

The guidance does note that certain services could be provided as "in lieu of" services through a contract offered under section 1915(a) without a waiver under section 1915(c). UT Ex. 28, at 6th page. Nothing in the guidance, however, interprets the UPL provision to include "in lieu of" services in the UPL calculation even if Medicaid would not have paid for them at all under fee-for-service arrangements.[3]

> *The fact that amounts per recipient per day paid to the FlexCare contractor did not exceed the average per-day rate for nursing facility services does not establish that Utah's payments under the contract did not exceed the UPL.*

Utah argues that its evidence shows that the payments to FlexCare did not exceed the amounts Medicaid would have paid if nursing facility services were provided to the FlexCare enrollees. According to Utah, the average nursing facility rates should be used for the UPL calculation because the recipients would have been receiving nursing facility care if they had not been in the FlexCare program and because the average per diem nursing facility rates are the only Medicaid fee-for-service rates for a package of services comparable to the services provided under FlexCare.

The key problem with Utah's argument is that, by its plain terms, section 447.362 requires use of the Medicaid fee-for-service amounts (i.e. what Medicaid would have paid) for services **actually furnished**. Utah concedes that, except for a small percentage of the FlexCare enrollees (as we discuss below), the services actually furnished were not nursing facility services but were instead alternative services such as personal care services, physical environment modifications, and home health services.

In addition, there appears to be a significant flaw in Utah's proposed calculation to show its FlexCare payments per day did not exceed the amount Medicaid would have paid for a day of nursing facility care. Utah calculated the average per day amounts paid to the FlexCare contractors each year based on its cost settlements with the contractors. UT Ex. 24; UT Ex. 22, ¶ 4. The contract provisions in the record indicate that any amounts paid by Utah to the contractor would be **net** of other applicable revenue received by the contractor, including amounts paid by Medicaid recipients (for example, from supplemental security income payments in excess of $45) and third party liability payments. *See, e.g.,* UT Ex. 9, at 1. In contrast, Utah used "Medicaid nursing home **revenue** per patient day" (which it says represents the average daily **rates** Utah paid to nursing homes for care of Medicaid patients for each year listed) as a per day UPL. UT Ex. 24; UT Ex. 22, ¶¶ 4, 5. The nursing facility rate, however, would **not** always be

[3] Utah's reliance on UT Exhibit 26 is also misplaced. That exhibit is an excerpt from CMS's State Medicaid Manual that applies only to comprehensive risk contracts.

equivalent to what "Medicaid would have paid" for the nursing facility services on a fee-for-service basis. Medicaid would not have paid for amounts that were the responsibility of the recipient or a liable third party. 42 C.F.R. §§ 447.50-447.59; 447.82; 435.832(a); 433.135 *et seq*.

Even if one could reasonably use the unreduced average nursing facility rate as "what Medicaid would have paid" for nursing facility services, moreover, Utah's calculation would be flawed. By using a figure for the contract payments that was net of other applicable revenues but using the nursing facility amounts that were not reduced to account for other revenue sources, Utah is, in effect, comparing apples and oranges. Thus, Utah's analysis does not, as it alleges, show that its payments did not exceed a UPL based on treating nursing facility rates as the closest fee-for-service equivalent.

Despite its claims that it treated the daily nursing facility rate as the UPL, moreover, Utah presented no **contemporaneous** evidence that it in fact interpreted section 447.362 to permit it to do this. Instead, Utah relies on the Deily Declaration, signed on January 12, 2012, which states that there "was no question in our minds that the daily nursing rate was the applicable upper payment limit." UT Ex. 21, ¶ 34. This statement is not only unreliable because it was made well after the fact, but it also lacks any indication that Utah had, in fact, timely analyzed the wording of section 447.362 and relied on its reading of that wording.[4]

We also note that Utah first prepared calculations using the average nursing facility rates in 2008. UT Ex. 22 (Purser Declaration), ¶ 3. This was well after the time periods in question and after Utah was unable to provide encounter data for the FlexCare program. As discussed above, the evidence as a whole shows that, when CMS raised questions about the UPL, Utah committed to provide historical encounter data that would have permitted calculation of a UPL based on services actually furnished. This evidence undercuts Mr. Deily's assertion about Utah's view on how to calculate the UPL.

Even if Utah did in fact read section 447.362 to permit it to use the nursing facility rate in calculating the UPL, moreover, that reading would not matter here. Such a reading is not a reasonable one, given the plain reference in that section to services "actually furnished."

Utah argues that, in reviewing the 1999 contract, CMS did not require "client-specific encounter data" but only suggested that such data would be "helpful." UT Reply Br. at 11, citing UT Ex. 3. This argument, however, ignores the fact that, in response to CMS's

[4] What little contemporaneous evidence there is, moreover, suggests that Utah erroneously thought in 1999 that the UPL for risk contracts then in section 447.361 applied. UT Ex. 1, at 3; UT Ex. 4, Att. F-1, at 5.

questions about the 1999 proposed contract addendum, Utah assured CMS that it would work with the contractor and subcontractor "to obtain client specific encounter data for enrollees," and that Utah had amended the contract to require contractor participation in data collection and reporting efforts. UT Ex. 4, at 6. The subcontract between United Healthcare of Utah and Heritage Management, Inc. does specifically require Heritage to maintain and to submit encounter data. CMS Ex. 2, at 2, 4, 8.[5] Moreover, after part 438 became effective, Utah was required to obtain a certification from any prepaid inpatient health plan (PIHP) that it would have encounter data. 42 C.F.R. § 438.604. Since FlexCare included institutional services, it would be considered a PIHP under the part 438 regulations. 42 C.F.R. § 438.2.

Utah contends that it made a deliberate effort to avoid increasing costs through increased Medicaid enrollments once long-term care options outside of nursing homes became available through its FlexCare program and to ensure its program was "budget neutral." UT Br. at 18-19. Budget neutrality is indeed a feature of some waiver programs, including the 1915(b) waiver under which Utah operated the non-FlexCare component of its LTC-MC program. The mere fact that FlexCare may have been budget neutral does not help Utah here, however. Utah had clear notice that its FlexCare payments under the contracts had to meet the UPL requirement in section 447.362 in order for FFP to be available and that the UPL was to be calculated based on what Medicaid would have paid for services actually furnished under the contracts. Utah could not reasonably think that the UPL could be calculated using the costs of nursing facility services that it **avoided** furnishing by reason of the contracts, rather than the costs of services actually provided.

More generally, Utah argues that its efforts to move Medicaid recipients out of nursing facilities into community programs were consistent with initiatives by the then Secretary of HHS and with the Supreme Court's decision in *Olmstead v. L.C. ex rel. Zimring,* 527 U.S. 581 (1999). Under *Olmstead*, unnecessary institutionalization of individuals with disabilities constitutes discrimination under the American with Disabilities Act. States may not deny community placement to a disabled individual if such placement is appropriate, not opposed by the individual, and can be accommodated to meet individual needs. The issue here is not, however, whether moving recipients into community-based programs is a good idea. Instead, the issue is the extent to which federal Medicaid funds are available for the costs of those programs when a state chooses to provide them under a nonrisk contract authorized by section 1905(a), rather than under a risk contract or a nonrisk contract authorized by a different section of the Act.

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[5] The contract attachment for FlexCare services also required United Healthcare to provide utilization reports, and Utah assured CMS that it would provide such data "in a format consistent with the federal 372S report used in the Home and Community Based Services waiver program." UT Ex. 4, at 5-6; UT Ex. 2, at 5. That report form breaks down the costs of the services by service type and the number of participants receiving the service. UT Ex. 15.

CMS reasonably calculated the UPLs using data from the New Choices program.

To calculate a UPL for each year in question and to determine what part of the expenditures Utah claimed for FFP were unallowable as amounts in excess of the UPLs, CMS looked at utilization data for services Utah provided under its New Choices program in the first year after that program replaced the FlexCare program. Based on that data, CMS derived an average cost of $77 per day for New Choices services. Utah argues that CMS's methodology is flawed in several respects.

First, Utah argues, use of the New Choices data is inconsistent with the wording of the regulation, which refers to amounts Medicaid would have paid for the services. Obviously, Utah argues, this must mean services provided in the same period when the services were furnished, not to services furnished at a later date. UT Br. at 21. Moreover, Utah contends, this is the only practical reading of the regulation because Utah "could not have limited FlexCare payments by looking to the cost of New Choice services because New Choices did not exist at that time." *Id.*

CMS's use of the New Choices data, however, was not based on an interpretation of the UPL regulation as calling for use of payments made in a later year. Rather, because Utah was unable or unwilling to provide either encounter data or comparable data to determine what services were actually furnished to enrollees, CMS determined that the program that replaced FlexCare could provide data that would serve as a **proxy** for the data Utah failed to produce and would permit CMS to **estimate** reasonable UPLs for the period in question. CMS points out that, absent some data to document that Utah's payments for FlexCare were not in excess of the applicable UPL, CMS could have disallowed all of the FFP Utah claimed in those payments. As CMS argues, Utah had the burden of documenting the allowability of its costs, but did not do so. *See, e.g.,* 42 C.F.R. §§ 431.17, 433.32, and 45 C.F.R. §§ 74.62, 92.20.

Utah argues, however, that CMS's methodology "disregards key differences between FlexCare and the New Choices waiver program." UT Br. at 28. According to Utah, the number of enrollees in FlexCare grew steadily, but slowly, from fewer than 50 participants in the first year to over 600 participants in late 2006. Utah argues that, because FlexCare was an innovative program, "any fee-for-service equivalent in this period would likewise have begun as a new program with rates reflecting the higher costs associated with an inexperienced startup." *Id.* By the time the New Choices waiver program was in effect, Utah argues, the services were well-established, efficient, and cost effective, reflecting seven years of FlexCare experience, and any fixed costs were spread over many more participants than was the case with FlexCare in the early years. *Id*.

This argument is not persuasive, for several reasons. First, it is entirely speculative. Utah presented no evidence to support its theory that costs under the New Choices program would have been lower than the costs under FlexCare for the same services.

Second, even assuming that Utah is correct that some efficiencies from having more participants might have tended to reduce average costs in later years, that would not, by itself, show that CMS's use of the later year's costs was unreasonable. Generally, costs are expected to increase in time because of inflation. Indeed, Utah's own figures it used to compare FlexCare costs per patient day to average nursing facility rates generally show an upward trend in both FlexCare costs and nursing facility rates. UT Ex. 22 (Ex. A). Thus, CMS's use of average per patient costs from later years is, at the very least, just as likely to have overstated the UPLs for the years at issue as to have understated the UPLs.

Utah also argues that CMS's calculation disregards differences in services offered under the two programs. The Deily Declaration attests that the New Choices program does not offer the following services that were furnished to FlexCare participants: services provided in nursing homes and services that help participants secure appropriate and safe housing environments, provide relocation assistance, and cover certain durable medical equipment and pharmacy costs. UT Ex. 21, ¶ 36. Utah would have us conclude from this that "the cost per day of the bundle of FlexCare services was presumably higher than the average daily cost of New Choices services, making the $77 per day figure an inappropriate reference point for FlexCare." UT Br. at 29.

This argument is also unpersuasive. First, other than nursing facility services (which a state must include in its state plan), the additional services furnished by FlexCare but not by New Choices were not necessarily state plan services properly included in calculation of a UPL for a nonrisk contract. Absent any showing (or even an assertion) by Utah that services such as relocation assistance were state plan services for which Medicaid would have paid, the fact that they were furnished to FlexCare participants but not to New Choices participants is irrelevant for purposes of determining a reasonable UPL. Second, since Utah provided no information regarding how many FlexCare recipients received these additional FlexCare services or what they cost (other than with respect to nursing facility services), we have no way of adjusting CMS's calculations to account for them, even if we thought such adjustments were warranted. We also note that the excerpt from the 2003 contract with Healthy U states that pharmacy is **not** a covered service in the premium rate but that pharmacy claims would be paid by Utah on a fee-for-service basis. UT Ex. 10, at 2. If pharmacy services were not provided under the contracts, then they also should not be included in the UPL calculations for those contracts, even if they were furnished to FlexCare participants on a fee-for-service basis.

With respect to nursing facility services, Utah argues that the disallowance amount should be reduced by 6.7% (or $649,082) because, under FlexCare, 6.7% of enrollees were receiving care in nursing facilities, whereas under the New Choices program, no enrollees were in nursing facilities. Utah did present some evidence regarding the costs of providing those services to FlexCare enrollees. Utah Exhibit 25 is a spreadsheet listing nursing facilities, payment periods, payment amounts, and days of service from 2000 to 2005, and showing $2,301,412.69 in total expenditures and 23,227 total days of

service, for an average daily rate of $99.08. Utah also submitted, with its reply brief, the declaration of Tonya Hales, Director of Utah's Bureau of Authorization and Community Based Services. UT Ex. 30. Ms. Hales says that she helped prepare the spreadsheet, using data from the program manager at Valley Mental Health, a subcontractor of Healthy U, but removing some data "documenting miscellaneous payments that Valley Mental Health paid for services provided outside of nursing homes so that the data in the spreadsheet reflect payments made for nursing home care." *Id*., ¶ 6. She also attests that, based on her experience administering the program, she understands that "the percentage of patient days FlexCare paid for nursing home care in 2006 and 2007 is similar to the percentage of patient days paid from 2000 to 2005," that is, the 6.7% figure Utah provided for the period 2000 to 2005. *Id.*

CMS declined to accept Utah's data as sufficient to show that its calculations should be adjusted. CMS pointed out, among other things, that it did not have assurance that Utah's calculations were accurate, in the absence of specifics about what data Utah removed from the data provided by Valley Mental Health.

Based on our analysis, we conclude that the evidence submitted by Utah is insufficient to show that CMS's method of determining a UPL was unreasonable or that we should remand for some adjustment to the calculations. Aside from the question about what data were removed, we find Utah's spreadsheet questionable in several respects. First, Utah did not explain why Valley Mental Health would have information about nursing facility services for FlexCare enrollees in the years when Valley Mental Health was not operating the FlexCare program, but Heritage Management was operating the program under a subcontract with United Healthcare. Thus, we have no assurance that the payments included in the spreadsheet were all for FlexCare enrollees. We also note that Utah did not explain why Valley Mental Health had relevant data for nursing facility services but not for other state plan services for the period it did operate the FlexCare program.

Second, Utah's calculation of patient days appears to be based on the assumption that a payment to a nursing facility for a period of time (usually a month, but sometimes a shorter period) represented payment for services only for the number of days within that period. That is a reasonable assumption if the payment was for services furnished to only one FlexCare enrollee, but is not a reasonable assumption if more than one enrollee was in the facility during that period. Yet, Utah presented no evidence that each payment was for only one enrollee, and the spreadsheet contains unexplained discrepancies. For example, the spreadsheet shows that Evergreen Canyons facility was paid $6,043.20 for September 2003 and $3,122.32 for October 2003, but the spreadsheet treats each of these payments as though it were payment for 30 days of service. UT Ex. 25, at 4th page. It seems highly unlikely that the facility was paid almost twice as much for 30 days of service in September as for 30 days in October. Similar discrepancies appear in other spreadsheet lines, such as those for 2003 payments to Murray Care Center and Infinia. *Id.* at 6th page. Other inconsistencies appear on the spreadsheet as well. For example, a

payment of $2,618.72 to Federal Heights made in September 2003 is treated as representing only **5** days of service, but another payment of $1,812.96 in the same month is treated as representing **30** days of service, and a payment in July 2003 of $6,244.64 is treated as representing **31** days of service. *Id.* at 5th page. Because there is no logical and consistent correspondence between the amounts paid to a facility for services and the number of days of service Utah assigned to a payment, we do not consider the spreadsheet to be reliable evidence of the average per day cost of nursing facility services for the relevant period. If, as appears possible, the spreadsheet generally understates the days of service, then that would mean that the average per day amount is overstated.

Moreover, Utah seeks an adjustment that would reduce the disallowance amount by 6.7%, the percentage of patient days it says FlexCare paid for nursing facility services. Even assuming we accepted Utah's evidence as sufficient to establish that nursing facility services to FlexCare enrollees averaged $99.08 per day (which we do not), that would at most mean that 6.7% of the patient days cost $22.08 more than the $77 **average** per day cost CMS used. It would not establish that the **total** disallowance amount was overstated by 6.7%, as Utah alleges.

In sum, Utah has not established on the record before us that any adjustment to CMS's UPL calculations is required.

Conclusion

For the reasons stated above, we uphold the full amount of the disallowance.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Judith A. Ballard
Presiding Board Member