Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Pennsylvania Department of Human Services
Request for Reconsideration of Decision No. 2883
Ruling No. 2019-3
June 20, 2019

RULING ON REQUEST FOR RECONSIDERATION

In a memorandum filed on October 1, 2018, the Centers for Medicare & Medicaid Services (CMS) requested that Board Decision 2883 (July 26, 2018) be reconsidered.[1] The Pennsylvania Department of Human Services (State) objects to CMS's request. The Board will grant a request to reconsider its decision only if the request shows that the decision is based on a "clear error of fact or law." 45 C.F.R. § 16.13. As we discuss below, CMS has not shown any such error.

The Board's Decision

Board Decision 2883 reviewed 38 disputed sample claims. CMS found these claims unallowable out of an audit total of 100 sample claims for payment under Pennsylvania's Aging Waiver for "personal care" and "personal assistance" allegedly furnished to Medicaid recipients. The Board upheld CMS's conclusions that 29 of the claims were unallowable.

The Board found that nine of the 38 claims that it reviewed were allowable (eligible for payment) under the Aging Waiver. Those nine are identified in the Board's decision as claim numbers 16, 21, 22, 33, 36, 57, 59, 89, and 91.

[1] In its response to CMS's reconsideration request, the State contends that: (1) the Board "lacks jurisdiction" to reconsider its decision because section 1116 of the Social Security Act (42 U.S.C. § 1316) "imposes an absolute 60-day deadline for a party to request reconsideration"; (2) CMS's reconsideration request was not filed by the statutory deadline; and (3) the Board lacks authority to extend the deadline. These points overlook some pertinent history. On September 24, 2018, CMS counsel, citing "significant family issues," asked the Board to extend the 60-day period for filing a reconsideration request by one-week (from September 24 to October 1, 2018). In support of that request, CMS counsel informed the Board that she had asked the State's lawyer, Mr. Manne, if the State had any objection to the extension and that Mr. Manne told her that the State did not object. The Board proceeded to grant the extension, and the State filed its reconsideration request by the extended deadline. The State does not deny it could have raised (but did not raise) its so-called "jurisdictional" objection in response to the State's extension request. We therefore decline to entertain the objection at this stage.

CMS's reconsideration request

CMS asks us to reconsider our decision as to six of the nine sample claims that we determined were allowable (sample claims 21, 22, 57, 59, 89, and 91). Request for Reconsideration (RR) at 1-2. CMS specifically states that it does not request reconsideration of the other three allowable claims. *Id*. at 1 n.1. Despite that statement, CMS goes on to present lengthy argument about a seventh claim, i.e. sample claim 33. *Id.* at 7-9. CMS does not specifically ask for reconsideration of that claim in its argument, but lists the claim as one for which reconsideration is sought in its conclusion. *Id*. at 10.

Below, we address first CMS's asserted basis for seeking reconsideration of the six listed claims. We then explain why CMS's arguments present no clear error of fact or law. Instead, they merely seek to relitigate the issues resolved in the Board's decision.

We then discuss CMS's contentions about sample claim 33. CMS does not identify any clear error and does not even request reconsideration, and we find no reason to revisit our decision as to this claim.

CMS's arguments for reconsideration regarding sample claims 21, 22, 57, 59, 89, and 91

CMS continues to assert that the allowability of sample claims 21, 22, 57, 59, 89, and 91 was inadequately documented, and argues that the Board erroneously found to the contrary. RR at 2-7.

For each of these claims for which CMS now reiterates its assertions of unallowability, the Board found that the evidence of record included at least:

1) a service order or other evidence indicating that an Area Agency on Aging (AAA) had authorized a home care agency to furnish personal care or personal assistance to the waiver participant during the period covered by the claim; and

2) timesheets, timecards, invoices, or other records showing the days and hours worked by the home care agency's employee(s) on the waiver participant's behalf during the period covered by the claim.

See DAB No. 2883, at 27-29, 36-38, 41-42.

According to CMS, the available documentation was nevertheless inadequate because it did not specify "the particular type" or types of personal care or personal assistance delivered by the home care agency, making it "impossible to determine" whether the agency had properly billed its services to the Aging Waiver. RR at 2. CMS calls the Board's findings regarding sample claims 21, 22, 57, 59, 89, and 91 "inconsistent with the fundamental principle of grants management that a grantee has the burden to document that the costs were actually incurred and that they represent allowable costs, allocable to the grant." RR at 1-2, 6.

CMS also alleges that the questioned findings are not compatible with the Board's rejection of sample claims 92 and 43. RR at 2-3, 5, 7. The Board found that the service records underlying sample claims 92 and 43 documented that unallowable services ("grass cutting" and "housekeeping") had been billed to the Aging Waiver. CMS asserts that sample claims 92 and 43 illustrate that sample claims 21, 22, 57, 59, 89, and 91 "could very well have included" unallowable services and that it was therefore "crucial" for the State to produce records showing the nature of the services actually performed for the waiver participant. RR at 3-4, 5.

Analysis of CMS's contentions regarding sample claims 21, 22, 57, 59, 89, and 91

These contentions reveal no factual or legal error by the Board with respect to sample claims 21, 22, 57, 59, 89, and 91, much less any "clear" error. For each of those claims, the available documentation established that:

1) the named waiver recipient had a service plan, developed by an AAA, calling for services (such as bathing, dressing, feeding) that met the Aging Waiver's definition of personal care and personal assistance;
2) the AAA authorized a home care agency to furnish those services to the waiver participant during the period covered by the claim;
3) one or more employees of the home care agency rendered services at the waiver recipient's home during that period; and
4) the frequency and hours of service reflected in the claim were consistent with the frequency and hours authorized by the AAA.

In view of those documented facts, the Board reasonably inferred that the home care agency faithfully followed the approved service plan and delivered authorized personal care or personal assistance on the dates in question. CMS does not cite any statute,

regulation, or Board precedent precluding the Board from drawing that particular factual inference. Moreover, we see nothing about claims 92 or 43 which suggests that the inference is substantively unreasonable.[2]

The fact that CMS's auditors themselves approved comparably documented claims also indicates the inference is reasonable. For example, auditors approved sample claim 58 based on an AAA's service order that authorized the home care agency to deliver certain types of personal assistance covered by the Aging Waiver plus timesheets which specified only the days and hours worked by the home care agency's employee(s) on the waiver participant's behalf. CMS Ex. 58; CMS Ex. 4, at 2.

CMS's arguments regarding sample claim 33.

CMS also objects to the Board's finding that sample claim 33 is allowable. RR at 7-9. Sample claim 33 sought payment under the Aging Waiver for personal care furnished during June 2008. DAB No. 2833, at 31. The claimed services included help with bathing, dressing, hygiene, skin care, meal preparation, and eating. *Id.*; CMS Ex. 33, at 7-15. CMS rejected the claim because the service order issued by the AAA, while it authorized three to four hours of daily personal care for June 2008 (or a total of 444 quarter-hour "units" of personal care for the month), did not specify the "particular types of personal care services authorized." Chart attached to CMS's Response Brief; CMS Ex. 4, at 2; CMS Ex. 33, at 28.

In response, the State submitted information extracted from the Social Assistance Management System (SAMS), a database that the Board found had been "used by AAA care managers to create a contemporaneous record of service-plan content." DAB No. 2883, at 5, 13, 31. On its face the SAMS extract shows – in the "Service Begin Date," "Units Ordered," and "Service Instructions" fields – that starting June 1, 2008, 444 units of personal care (the amount reflected in the AAA's service order) had been authorized to help the waiver participant meet specific daily living needs, including bathing, dressing, skin care, hygiene, meal preparation, and "feeding." P. Ex. 21, at 4. The SAMS extract

[2] Although the service at issue under claim 92 was ineligible for payment under the Aging Waiver, it was one that the AAA had authorized the home care agency to provide. *See* CMS Ex. 88, at 11-12. It is unclear whether the service at issue under sample claim 43 (housekeeping) was authorized because, while the AAA's service order called upon the home care agency to furnish "personal care" (a term that the Aging Waiver defined to include "supplemental housekeeping"), the order did not specify the types of personal care needed by the waiver participant. CMS Ex. 43, at 6; P. Ex. 2, at 44. In other words, neither of these claims proves that service providers instructed to provide specified care were including unapproved, unallowable care activities in their services if they did not list which of the needed services were provided during each hour of care.

also identifies the waiver participant's care manager, whose name also appears on the service order. *Id.*; CMS Ex. 33, at 28. Based on the service order and SAMS extract, the Board found that the AAA had "authorized" the claimed services "pursuant to an approved service plan." DAB No. 2883, at 31.

CMS now contends that the SAMS extract is "not sufficient to demonstrate the allowability" of the claimed services because it does not confirm that "the *provider knew at the time of service what services were authorized* such that the authorization was contemporaneous with the provision of services." RR at 8 (italics added). By this statement we understand CMS to mean that the State needed to provide documentation that the AAA had communicated the substance of the waiver participant's service plan to the home care agency either before or during the relevant claim period (June 2008). However, no such evidence was needed to establish the claim's allowability in these circumstances.

As CMS indicated in the underlying proceeding, the issue it raised concerning sample claim 33 was whether the services "actually provided were indeed authorized under the service order" (*see* Chart attached to CMS's Response Brief). The SAMS extract shows that the waiver participant's care manager "ordered" the provision of various types of personal care for June 2008. The home care agency's "Client Care" records for June 2008 indicate that the types of personal care provided to the waiver participant (and billed to the Aging Waiver) were the types of personal care authorized for that month. This information is sufficient proof that the services "actually provided were indeed authorized . . . ." The information also supports an inference that the home care agency correctly understood what types of personal care had been authorized for that month.

CMS asserts that the SAMS extract "does not document which of the personal care services authorized were authorized for particular weeks during the relevant time period" and does not specify "the number of hours per week for which the particular service was authorized." RR at 8-9. However, CMS does not explain why such information was necessary to verify the allowability of the claimed services. CMS does not suggest, for example, that the information was needed to prevent billing of unnecessary services or excessive service hours.

Furthermore, CMS's own auditors approved sample claims based on service orders that did not subdivide authorized hours by service type or include a weekly service schedule. *See, e.g.*, CMS Ex. 89, at 7 (service order(s) for sample claim 93); CMS Ex. 90, at 11-12 (service order(s) for sample claim 94); CMS Ex. 4, at 4 (indicating that auditors found documentation for sample claims 93 and 94 to be adequate). In addition, most of the

authorized services billed under sample claim 33 (e.g., dressing, bathing, toileting, meal preparation, feeding) addressed the waiver recipient's *daily* living needs, and so it is reasonable to infer that the care manager had authorized those services to be provided during each week of the relevant billing or authorization period (June 2008). P. Ex. 21, at 4; *see also* P. Ex. 2, at 44, 61 (describing personal care and personal assistance as helping a person complete tasks of "daily living"). As for the remaining authorized services, the "service instructions" extracted from the SAMS adequately specified their frequency as "daily," "weekly," "monthly," or "as needed." P. Ex. 21, at 4.

Finally, noting that a state Medicaid program is expected to have "readily available" documentation to support its claims for FFP,[3] CMS contends that the SAMS extract for sample claim 33 deserved no evidentiary weight because it could have been, but was not, provided to CMS's auditors in 2010. RR at 9. According to CMS:

> The Board allowed Pennsylvania to submit these summary data sheets *over CMS' objections in 2017*, many years after the dates of services (i.e., between July 1, 2008 through June 30, 2009).[4] Such a lengthy period of time between the dates of service and the time of the submission of the summary data raises serious questions about whether the SAMS summary data extracts submitted in 2017 constitute the same data that existed between July 1, 2008 through June 30, 2009.
>
> . . . . Within this context where Pennsylvania had a duty to have supporting documentation for its claims readily available and it failed to do so multiple times prior to the appeal, it should not be allowed to submit *second hand* summary information years after the services at issue were provided given the dubious nature of the contemporaneity.

Id. at 9 (italics added).

---

[3] CMS has communicated that expectation in regulations that authorize CMS to defer and disallow FFP claims for Medicaid expenditures and in provisions of the State Medicaid Manual (SMM) that discuss the FFP claiming process. *See* 42 C.F.R. § 430.40(b)-(c) (requiring a state to "make available" to CMS, "in readily reviewable form," documents and materials supporting a deferred claim for FFP and permitting CMS to disallow the deferred claim if the state does not provide "necessary materials"); DAB No. 2883, at 8, 20 (citing and quoting from SMM §§ 2497.1, 2497.2 and 2500.2(A)).

[4] The audit sample evidently included claims for services performed during the last six months of state fiscal years 2008 (January 1 through June 30, 2008). *See* DAB No. 2883, at 32, 33 (discussing sample claims 33 and 36); CMS Ex. 5, at 2 (sample claim 17).

The preceding passage implies that CMS questioned the reliability of the SAMS extract in the underlying proceeding. It did not.

The State proffered that document with its June 19, 2017 reply brief. CMS objected to the proffer on the ground that the SAMS extract should have been filed with the State's "appeal request." CMS's July 10, 2017 Surreply at 5. CMS did **not** contend that the document was inadmissible, or suggest that its information merited no weight, because of the "lengthy period of time" between the proffer (June 19, 2017) and the dates of service (in June 2008). Nor did CMS make such points with respect to the SAMS extracts proffered with the State's opening brief.

In light of CMS's failure to challenge the reliability of or weight to be accorded the SAMS document in the underlying proceeding, we need not decide whether – as CMS seems to suggest – the Board was somehow obliged to exclude, ignore, or discount this documentary evidence merely because the State failed to produce it during a pre-disallowance audit. Moreover, we note that CMS does not address how its suggestion might be affected by the Board's statement in *D.C. Dept. of Health*, DAB No. 2219, at 9 (2008) that, "[n]otwithstanding [the grantee's] failure to provide supporting documentation during the deferral process," a "basis for reversing" the disallowance might have existed had the grantee submitted supporting documentation during the Board appeal. In addition, CMS does not point to anything on the face of the SAMS extract for sample claim 33 that raises questions about the document's reliability, and CMS fails to justify its characterization of the SAMS database as containing "second hand" information. The "second hand" label implies that relevant information stored in the SAMS did not come from a trustworthy or knowledgeable source. However, CMS takes no issue with the Board's finding (DAB No. 2883, at 31) that such information was entered by waiver participants' care managers, the persons directly responsible for formulating and approving waiver participants' service plans. Because CMS does not dispute that care managers used the SAMS to record information about waiver participants' approved service plans, and because CMS did not raise any concerns in the underlying proceeding about the authenticity, accuracy, or "contemporaneity" of information extracted from that database, the Board committed no error in assigning weight to the SAMS extract relating to sample claim 33.

Conclusion

Based on the foregoing analysis, we deny CMS's request for reconsideration.

/s/
Sheila Ann Hegy

/s/
Constance B. Tobias

/s/
Leslie A. Sussan
Presiding Board Member