California Department of Health Care Services, DAB No. 3099 (2023)

Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

California Department of Health Care Services

Docket No. A-20-7
Decision No. 3099
May 31, 2023

DECISION

California Department of Health Care Services (California) appeals a determination of the Centers for Medicare & Medicaid Services (CMS) to disallow $30,492,805 in federal financial participation (FFP) that California claimed for Targeted Case Management (TCM) services furnished from July 2003 through September 2010.[1] CMS based the disallowance on fiscal review of the TCM program in participating counties. For reasons explained below, we uphold the entire disallowance.

Legal Background

Title XIX of the Social Security Act (Act) authorizes federal grants to states for medical assistance programs known as Medicaid. Act §§ 1900-1903; 42 C.F.R. § 430.0.[2] Medicaid furnishes medical assistance to individuals in specified eligibility categories. Act §§ 1900, 1902; 42 C.F.R. § 430.0; 42 C.F.R. Part 435. Each participating state operates a Medicaid program subject to federal requirements and the state's CMS-approved state plan for medical assistance. Act § 1902; 42 C.F.R. §§ 430.10-430.16, 430.20. The state plan must provide that it will be amended whenever necessary to reflect changes in federal law, regulations, policy interpretations, or court decisions, or material changes in the state's own laws, policy, or Medicaid operations. 42 C.F.R. § 430.12(c)(1). A state plan also must provide that the Medicaid agency and, where applicable, local agencies administering the plan will "[m]aintain an accounting system and supporting fiscal records to assure that claims for Federal funds are in accord with applicable Federal requirements." *Id.* § 433.32(a). A state plan must "provide such methods and procedures relating to" payment for care and services available under the plan as may be necessary "to assure that payments are consistent with efficiency, economy, and quality of care." Act § 1902(a)(30).

1. "Medical assistance" and TCM

A state plan specifies the health care items and services that the state's Medicaid program covers. Act § 1902(a)(10); 42 C.F.R. Part 440. States must cover some categories, and may opt to cover other categories, of "medical assistance" listed in the Act. *See* Act § 1905(a); 42 C.F.R. §§ 440.210-440.225. The term "medical assistance" includes "case management services," meaning "services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services." Act §§ 1905(a)(19), 1915(g)(2)(A)(i).

The Act generally prohibits inequalities in the "amount, duration, or scope" of medical assistance that a state plan makes available to eligible individuals, Act § 1902(a)(10)(B), but TCM services became a limited exception in 1985. *Id*. §§ 1905(a)(19), 1915(g)(1); *see also Maine Dep't of Health & Hum. Servs. v. United States Dep't of Health & Hum. Servs.*, 766 F. Supp. 2d 288, 291 (D. Me. 2011), *aff'g Maine Dep't of Health & Hum. Servs.*, DAB No. 2292 (2009); *Massachusetts Exec. Off. of Health & Hum. Servs.*, DAB No. 2218, at 2 (2008), *aff'd sub nom. Massachusetts v. Sebelius*, 701 F. Supp. 2d 182 (D. Mass. 2010). As the Departmental Appeals Board (Board) has summarized:

Section 1915(g)(1) [of the Act] provides that a state may (at its option) cover case management as a Medicaid benefit for specific groups of Medicaid-eligible persons without regard to statutory requirements that Medicaid services be available statewide and be comparable (in amount, scope, and duration) for each Medicaid recipient. . . . When a state elects to cover case management as a Medicaid benefit under section 1915(g)(1), the covered services are called "targeted case management" (TCM).

Massachusetts, DAB No. 2218, at 2 (internal citation omitted).

2. Federal reimbursement for medical assistance

The Act and its implementing regulations govern the shared federal and state responsibility to fund the Medicaid program. Once CMS has approved a state plan, CMS awards quarterly grants to the state to cover the federal share of Medicaid expenditures. 42 C.F.R. § 430.30(a)(1). The quarterly payments are in "an amount equal to the Federal medical assistance percentage," or FMAP, "of the total amount expended during such quarter as medical assistance under the State plan." Act § 1903(a)(1). The FMAP varies by state, depending on state per capita income and other factors. *Id*. §§ 1903(a)(1)-(6), (g), (j), 1905(b), 1914, 1923; 42 C.F.R. § 433.10. The quarterly grant amount also depends on quarterly estimate reports, quarterly expenditure reports, and other pertinent documents. 42 C.F.R. § 430.30(a)(2); *see also* Act § 1903(d); *Bowen v. Massachusetts*, 487 U.S. 879, 883-84 (1988). The quarterly estimates are due from participating states to CMS 45 days before the beginning of each quarter and project the state's Medicaid

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funding requirements for the upcoming quarter. *See* 42 C.F.R. § 430.30(b). By contrast, the expenditure reports, due 30 days after the end of each quarter, are "the State's accounting of actual recorded expenditures," and "disposition of Federal funds may not be reported on the basis of estimates." *Id*. § 430.30(c)(1), (2).

A state may use certain types of local government funding toward paying the non-federal share of Medicaid expenditures. Act §§ 1902(a)(2), 1903(w); 42 C.F.R. §§ 433.50, 433.51. Section 433.51 provides that public funds must meet certain conditions to qualify as part of the state's share. Specifically, the public funds must be:

- "appropriated directly to the State or local Medicaid agency," or "transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control, or *certified by the contributing public agency as representing expenditures eligible for FFP under this section*"; and also must be
- non-Federal funds, or "Federal funds authorized by Federal law to be used to match other Federal funds."

42 C.F.R. § 433.51(b) (emphasis added), (c). Local government expenditures that are certified – that is, "supported with an official statement by an authorized representative of the contributing public entity confirming that the expenditures qualify as Medicaid medical assistance or other allowable Medicaid expenditures" – are called certified public expenditures (CPEs). *Alabama Medicaid Agency*, DAB No. 2716, at 2, 2 n.2 (2016) (quoting *Missouri Dep't of Soc. Servs.*, DAB No. 2589, at 6-7 (2014)).

A state makes a "claim" for FFP by submitting a request in the manner and format required by CMS program regulations, and instructions or directives issued under those regulations. 45 C.F.R. § 95.4. State and local claims must comply with established principles and standards for cost reimbursement, and during the initial years of the

disallowance period (from 2003 through 2007), Office of Management and Budget (OMB) Circular A-87 was the applicable set of federal cost principles for state and local governments. 45 C.F.R. § 92.22. The circular was amended on May 10, 2004, and in 2008 was codified as Appendix A to 2 C.F.R. Part 225. *See* 2 C.F.R. § 225.45 (Jan. 1, 2008).[3]

If a state's expenditures do not meet federal requirements, CMS may defer the state's claim for FFP or disallow reimbursement for an item or class of items. Act § 1116(d); 42

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C.F.R. §§ 430.40, 430.42. After receiving CMS's notice of a deferral, "[i]t is the responsibility of the State to establish the allowability of a deferred claim." *Id.* § 430.40(b)(2). CMS has a statutory obligation to disallow any overpaid federal Medicaid funds. Act § 1903(d)(2)(A); *see also Maine Dep't of Health & Hum. Servs.*, DAB No. 2931, at 2 (2019). When CMS determines that all or part of a claim is not allowable, CMS sends the state a disallowance letter. 42 C.F.R. § 430.42(a). The state may request reconsideration, but "[i]n all cases, the State has the burden of documenting the allowability of its claims for FFP." *Id.* § 430.42(b)(2)(ii). The state may appeal to the Board, either directly from the disallowance or after reconsideration by CMS, pursuant to the procedures in 45 C.F.R. Part 16. 42 C.F.R. § 430.42(b)(4)-(6); *see* 45 C.F.R. § 16.1; Appendix A to Part 16 at § B(a)(1).

Case Background

1. The California State Plan and TCM

California administers the state's Medicaid program, Medi-Cal, and thus "is responsible for the implementation, oversight, and monitoring of the TCM program" in the state. Cal. Ex. 37, at 1.

TCM became a covered Medi-Cal benefit effective January 1, 1995. Cal. Ex. 1, at T.1-1-1. If a local government authority (LGA) – meaning in this context a county or chartered city – elected to participate in the TCM program, then that LGA was included in the state plan and its amendments, and provided the TCM services described therein. *Id.*; *see also* Cal. Welf. & Inst. Code § 14132.44 (defining LGA); Cal. Ex. 31, at 2 n.2 ("For purposes of the TCM program, LGAs are counties and chartered cities."). On August 15, 2000, and by supplement dated September 27, 2000, California submitted for CMS approval a state plan amendment (SPA) concerning TCM services. Cal. Ex. 2, at 1-2[4]; Cal. Ex. 39, at 1-2. CMS requested and received additional information from California, and on July 18, 2001, approved SPA No. 00-013, effective retroactive to July 1, 2000. Cal. Exs. 2, 11, 39.

During the disallowance period, both SPA 95-006 (for certain groups) and SPA 00-013 (for other groups) set forth California's reimbursement methodology for TCM services that LGAs provided. Cal. Br. at 3, 8; Cal. Ex. 2, at 8-9; Cal. Ex. 3, at 1. Both SPAs expressly incorporated OMB Circular A-87 and its cost principles. *See* Cal. Ex. 2, at 6, 8; Cal. Ex. 3, at 1. By November 1 of each year, each TCM provider was required to submit to California a completed cost report on the prior fiscal year for each program under which the LGA elected to participate. Cal. Ex. 1, at T.4-1-1, T.4-5-1, T.4-5-2; Cal. Ex. 2, at 8; Cal. Ex. 3, at 1.

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Under both SPA 95-006 and SPA 00-013, LGAs received reimbursement based on a "per encounter rate." Cal. Br. at 3; *see also* Cal. Ex. 1, at T.4-2-1. The SPAs called for calculating the *current* fiscal year's per encounter reimbursement rate by dividing the *prior* fiscal year's reported TCM costs by the same *prior* year's total number of Medi-Cal and non-Medi-Cal encounters. Cal. Br. at 3; Cal. Ex. 1, at T.4-2-1; *see also* Cal. Ex. 1, at T.4-5-1; Cal. Ex. 2, at 8; Cal. Ex. 3, at 1. Specifically, SPA 95-006 stated that:

A current year per encounter rate shall be established after evaluation of the total costs of providing case management services and the total number of encounters as reflected in the prior year cost report, defined by the department. The cost report shall accumulate allowable costs for the prior fiscal year, including both direct and indirect costs, as defined in OMB Circular A87.

The per encounter rate is calculated by dividing the prior fiscal year costs of providing TCM services by the total number of encounters in that fiscal year. The per encounter rate is then multiplied by the projected number of encounters with Medicaid eligible persons to establish the total dollar amount that may be claimed in the current fiscal year.

Cal. Ex. 3, at 1. SPA 00-013 contained (with one insignificant exception) identical language.[5] Cal. Ex. 2, at 8.

Both SPA 95-006 and SPA 00-013 also imposed a yearly maximum, or "cap," on Medicaid reimbursement. Specifically, SPA 95-006 stated:

Total Medicaid reimbursement in the current year shall not exceed the product of:

1. The projected number of Medicaid encounters for the current fiscal year; and
2. The prior fiscal year costs of providing TCM services divided by the total number of encounters in that fiscal year.

The costs associated with providing TCM services in the current fiscal year in excess of the total dollar amount for which reimbursement is made, are recognized in the cost report and become part of the calculation to determine the per encounter rate for the subsequent fiscal year.

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Cal. Ex. 3, at 1. SPA 00-013 contained essentially identical language.[6] Cal. Ex. 2, at 8. In other words, the cap was "the product of the projected number of Medi-Cal encounters for the current fiscal year multiplied by the billable rate per encounter" derived from the prior fiscal year's data. Cal. Ex. 1, at T.1-1-3; *see also id.* at T.4-3-1, T.4-5-1. Any costs exceeding the cap were not reimbursable in the current fiscal year, but were recognized in the annual cost report and became part of the calculation of the billable per encounter rate for the subsequent fiscal year. Cal. Ex. 1, at T.1-1-3, T.4-3-1, T.4-7-4; Cal. Ex. 2, at 8; Cal. Ex. 3, at 1. Each LGA received a TCM approval letter that identified the per encounter rate and total reimbursement cap. Cal. Ex. 1, at T.4-3-1.

California instructed TCM providers on certifying their costs. California directed that each cost report must reflect only the allowable costs of providing TCM services as delineated in OMB Circular A-87, and that a signed certification must accompany the cost report "and attest to the cost data's validity." Cal. Ex. 1, at T.4-1-2. LGAs' completed cost reports "must be signed and dated by an appropriate LGA representative, such as a Chief Financial Officer or the TCM Program Administrator." *Id.* at T.4-5-1. The mandated, uniform certification included the certifying official's statement "under penalty of perjury that the information provided in this cost report is true and correct, based on actual costs of providing targeted case management (TCM) services." *Id.* at T.4-5-2, T.4-6-1. The certification also confirmed that the signer had "received notice that this information is to be used to establish a TCM rate that will be used as a basis to claim for federal funds." *Id.*

Once a participating LGA certified its expenditures for TCM services, California used that certification to claim FFP from CMS. Cal. Ex. 31, at 4. CMS then would reimburse approved claims to California at its FMAP rate of 50 percent. *Id.*

2. CMS's deferrals and disallowance

In 2003, CMS began expressing concerns to California, based on federal audit findings, about the funding for LGA-provided TCM services. Cal. Ex. 22, at 1. A November 17, 2003 letter from CMS deferred nearly $2.4 million in federal TCM reimbursements, and CMS began deferring quarterly claims for TCM. *Id.*; Cal. Ex. 25, at 1; Cal. Ex. 26, at 1. CMS's November 17, 2003 deferral letter told California of CMS's position that "[t]he state has not been able to provide documentation showing that the TCM payments made to all counties are allowable in accordance with 42 CFR 433.51." Cal. Ex. 22, at 1.

By June 2005, TCM-related deferrals totaled over $8 million based on claims submitted to CMS as of December 31, 2003, and CMS undertook a site review and Financial

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Management Review ("FMR") of the TCM program in San Bernardino County, a participating LGA. Cal. Ex. 17, at 1; Cal. Ex. 22, at 2. This FMR led to CMS's deferral, in September 2005, of $43,729,815 in FFP for prior period expenditures in California's TCM program. Cal. Ex. 20, at 1; Cal. Ex. 21, at 1. In a letter dated September 28, 2005, CMS stated three grounds for the deferral:

1. Some of the counties participating in both the TCM and the MAA[7] programs might have been using private funds as the State's share of the payments.

2. The State did not have procedures in place to limit certified public expenditures (CPE) claimed through these programs to actual costs.
3. Serious internal control weaknesses at the State over the TCM rate setting process raised concerns that the costs used to set the TCM rates were not reasonable, allowable, or allocable in accordance with OMB Circular A-87.

Cal. Ex. 21, at 2. CMS again stated that California had been unable "to provide documentation showing that the payments made to all counties are allowable in accordance with 42 CFR 433.51." *Id.* California met with CMS auditors on October 24, 2005, and wrote to CMS on December 27, 2005, opposing the deferral while acknowledging that a minority of TCM programs had "reimbursements exceeding budgeted costs." Cal. Ex. 20, at 1-3. In the same letter, California proposed corrective action that included tasking California's Division of Audits & Investigations with "financial oversight activities" for TCM programs including "reviewing the cost reports and reconciling the claims submitted to the cost reports." *Id.* at 4-5.

Efforts to address the 2005 FMR findings continued in 2006. The parties met and conferred on January 30, 2006. Cal. Ex. 28, at 2, 3. By letter of March 9, 2006, CMS offered to release part of the deferred sum once California accepted in writing CMS's proposed nine-step resolution plan and fulfilled three other conditions. Cal. Ex. 24, at 1-2. California unconditionally accepted only two of CMS's nine proposed action items. Cal. Ex. 28, at 2-3. The parties conferred further, with CMS explaining that "expenditures cannot be certified above the actual costs the counties are incurring for TCM because these incurred costs are the only basis for claiming FFP that would meet the regulations," particularly 42 C.F.R. § 433.51(b). CMS Ex. 32, at 1. CMS continued to defer additional FFP for TCM in 2006, on the same grounds stated in the September 28, 2005 deferral letter. *See* Cal. Ex. 23, at 1-2.

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CMS and California communicated about the deferrals for the next several years without reaching resolution. Cal. Br. at 7. On June 12, 2008, CMS gave notice that more than $55 million in federal funds were in deferral status because CMS had not received California's response to information requests. Cal. Ex. 25, at 1. CMS sought assurance that CPEs meeting federal requirements had funded all amounts claimed for TCM services and county administrative costs since 2003; otherwise, CMS would begin a disallowance action. *Id.* In September 2008, California replied that it relied on the LGAs' certifications of compliance with 42 C.F.R. § 433.51, along with administrative controls and a work plan. Cal. Ex. 29, at 1. The parties held further discussions on November 24, 2008. CMS Ex. 26, at 1. On December 5, 2008, CMS repeated that California had not supplied sufficient documentation to confirm proper funding of deferred TCM expenditures, and California's "policy to claim FFP for certified public expenditures in excess of actual cost is in violation of 42 CFR 433.51." *Id.* Therefore, unless California timely provided the requested information, CMS repeated that it would initiate a disallowance action. *Id.*

On December 16, 2008, within two weeks after CMS's most recent warning of an impending disallowance, California sent LGAs a Policy and Procedure Letter, PPL No. 08-006, which "clarifie[d] existing requirements for federal claiming for TCM Services." Cal. Ex. 31, at 1. The PPL recognized that "[a] certification that is higher than the actual cost or expenditure of the governmental unit that has generated the CPE (based on its provision of, or payment for, services to Medicaid recipients)" is "not in compliance with current federal regulations governing CPEs." *Id.* at 3. The PPL acknowledged that it "clarifies CPE requirements that have been in effect for many years." *Id.* at 8.

The parties conferred further in 2009, with CMS asking, in light of PPL No. 08-006, why California was not simply "voluntarily adjusting" amounts certified in excess of actual cost instead of forcing CMS to compute a disallowance. Cal. Ex. 33, at 1. On February 25, 2009, CMS stated that, to facilitate resolution, CMS's regional office had obtained the LGAs' cost reports documenting total costs incurred for providing Medicaid TCM services. Cal. Ex. 27, at 1-2. CMS asked California to supply promptly any additional available documentation that the deferred claims qualified as CPEs within the meaning of 42 C.F.R. § 433.51; after examining the evidence, CMS would authorize FFP for adequately supported deferred claims and disallow the rest. *Id.* at 2. In March 2009, in response to an email inquiry from California, CMS again stated that California's process "violates federal regulations because claims are being made for rate 'payments' in excess of costs actually incurred by the governmental entities involved." Cal. Ex. 34, at 1. CMS further explained, "the current claims submitted by [California] are based upon the calculated rate with no direct connection to the certification from the contributing governmental entity," and "[t]his process does not comply with federal regulations." *Id.* On April 16, 2009, California replied that it had no additional documentation to provide. Cal. Ex. 30, at 1.

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On July 20, 2010, CMS asked California to implement "a voluntary decreasing adjustment" for $18,904,602 in FFP relating to prior TCM claims that did not meet federal requirements for fiscal years 2003/2004 through 2006/2007, and to return those federal funds to CMS. Cal. Ex. 35, at 1, 2. CMS based the requested amount on the LGA cost reports and detailed how CMS made the computation. *Id.* at 1-2. If California did not make the voluntary adjustment, CMS again advised that it would proceed with a formal disallowance. *Id.* at 2. CMS directed California, if it wished to continue funding TCM expenditures through CPEs, either to fund the rate payment methodology properly in the existing state plan or submit a revised SPA, because the state's current methodology "does not comply with CMS policy for this type of funding mechanism." *Id.*

In response, California submitted California SPA 10-010 on September 30, 2010, and CMS approved it on December 19, 2013, retroactive to October 16, 2010. Cal. Ex. 36, at 1. The SPA's stated purpose was to revise the process for determining cost and claiming CPEs for county-based TCM services. *Id.*

Six calendar years after approval of SPA 10-010, on May 15, 2019, CMS issued a formal notice of disallowance of $30,492,805 in FFP that California had claimed for TCM services furnished from July 2003 through September 2010 (that is, before CMS's approval of SPA 10-010). Cal. Ex. 17, at 1. CMS explained that, since the 2005 FMR of the San Bernardino TCM program, California's own reconciliation, based on cost reports that counties submitted for state fiscal years 2003/2004 through 2009/2010, showed claims for TCM expenditures funded by county CPEs exceeded actual costs incurred, in violation of 42 C.F.R. § 433.51(b). *Id*. CMS further explained that "[s]uch amounts in excess of actual expenditures are not eligible for FFP." *Id*. The notice informed California that it had the opportunity either to request reconsideration from CMS or appeal the disallowance directly to the Board. *Id*. at 2 (citing Act § 1116(e)).

3. The Reconsideration Process

California timely asked CMS to reconsider the disallowance and revise the disallowed amount from $30,492,805 to $7,220,270 FFP, a figure California claimed was based on discussions with CMS and the cost reimbursement methodologies in SPA 10-010 as shown on an attached spreadsheet page. Cal. Ex. 37, at 1-2 and Att. A. California asserted that SPA 10-010 addressed CMS's concerns about non-compliance with 42 C.F.R. § 433.51(b), and that CMS's approval of SPA 10-010 "brought [California] into compliance with 42 C.F.R. § 433.51(b)." *Id.* at 1-2.

On August 28, 2019, CMS reaffirmed the entire $30,492,805 disallowance. CMS Ex. 38. "After careful consideration," CMS had "determined that the state did not provide any additional or new information that would cause CMS to alter its analysis in this case." *Id.* at 1. CMS stated that the disallowance period, from July 2003 to September 2010,

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preceded the October 16, 2010 effective date of the plan amendment, SPA 10-010, on which California relied. *Id.* CMS rejected the state's re-computation as inconsistent with "SPA 10-010's process for reconciliation of payments to allowable costs," even if SPA 10-010 had been in effect during the pertinent period, which it was not. *Id.* CMS determined that California had not "documented any additional allowable costs that would reduce" the overpayment. *Id.*

4. California's Appeal to the Board

California filed with the Board a timely notice of appeal and request for review (RR) that challenged CMS's disallowance on several grounds. RR at 1-2. California served discovery requests on CMS, which provided responses. Cal. Exs. 18, 19. After receiving three unopposed extensions of time, California filed an appeal brief and submitted 40 exhibits. CMS submitted a response brief and one exhibit. California filed a reply brief.

Standard of Review

The Board reviews disallowances of state claims under Title XIX of the Act (Medicaid) de novo. *Texas Health & Hum. Servs. Comm'n*, DAB No. 3066, at 7 (2022); *see also* "Appeals to Board," https://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-board/index.html <https://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-board/index.html> (last visited May 30, 2023). The Board considers a state's appeal of a disallowance (or of the unfavorable reconsideration of a disallowance) on the basis of

the documentation that the state submits and that the Board may require to support its final decision. Act § 1116(e)(2)(B). In deciding whether to uphold a disallowance or any portion thereof, the Board is bound by all applicable laws and regulations and thoroughly reviews the issues, taking into account all relevant evidence. *Id.* The state has the burden of documenting the allowability of its claims for FFP. 42 C.F.R. § 430.42(g)(1).

Analysis

California presents four primary arguments for reversing or reducing the disallowance. First, California argues that the disallowed claims were in accordance with its state plan and federal regulations. Cal. Br. at 2, 8-14. Second, California makes the related contention that CMS did not give California adequate, timely notice of CMS's contrary policy interpretation. *Id.* Third, California asserts that CMS's delay in taking the disallowance violated federal regulations and prejudiced California and the LGAs. *Id.* at 1-2, 14-16. Fourth, California contends that the disallowance is overstated, because CMS's calculation of the disallowed amount did not account for all yearly costs of the LGAs. *Id.* at 2, 16-18.

CMS counters each of California's arguments. First, CMS argues that federal law unambiguously makes FFP available only to match amounts actually expended. CMS Br.

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at 4-7. Second, CMS asserts that California had timely actual notice of the federal requirements, as the state's own documentation shows. *Id.* Third, CMS contends that the disallowance's timing did not unfairly prejudice California or affect its appeal rights, because there is no deadline for imposing a disallowance and California could have adopted legally compliant claiming practices sooner. *Id.* at 7. Fourth, CMS states that California has not demonstrated a valid basis for reducing the disallowance because CMS's calculations relied on information that California itself reported and formatted, and the time window for claiming FFP for the relevant expenditures has expired. *Id.* at 7-8.

In reply, California reiterates its primary arguments. First, California maintains that it used a "cost-based rate" that federal law does not prohibit, and that CMS approved the state plan containing this methodology and cannot negate that approval through later correspondence. Cal. Reply Br. at 1-6. Second, California maintains that CMS's documents giving notice of the actual-cost requirement were tardy and unclear. Cal. Reply Br. at 7. Third, California maintains that CMS's delay violated federal regulations and prejudiced the state. *Id.* at 7-8. Finally, California again requests that the Board at least reduce the disallowance amount due to CMS's alleged miscalculations. *Id.* at 9-10.

We begin by discussing each party's respective burden in an appeal of a Medicaid disallowance, then discuss why California has not met its burden.

1. CMS has met its initial burden to articulate the basis for the disallowance; therefore, California has the burden to prove the allowability of its claimed costs.

"In this proceeding, CMS has the initial burden to provide sufficient detail about the basis for its disallowance determination to enable the grantee to respond." *Massachusetts*, DAB No. 2218, at 11. "If the federal agency carries this minimal burden, the grantee must establish the allowability of the expenditures in dispute." *Id.*; *see also Missouri*, DAB No. 2589, at 7 (stating that "the Board has long held that states have the burden to document the allowability of the costs for which they claim federal funding," and citing decisions); *Alabama Dep't of Finance*, DAB No. 1635, at 8 (1997) (stating "the Board has repeatedly held that under the cost principles . . . a grantee has the burden of documenting the allowability of costs charged to federal funds," and citing decisions), *aff'd sub nom. Alabama v. Shalala*, 124 F. Supp. 2d 1250 (M.D. Ala. 2000); *New Jersey Dep't of Hum. Servs.*, DAB No. 899, at 4 (1987) ("Thus, as we have often stated, it is a basic principle of grants law that the grantee has the burden of documenting expenditures and their allowability," including states demonstrating entitlement to FFP). A state's burden to establish that its claims were allowable includes proving "that they reflected actual costs not estimates." *Pennsylvania Dep't of Hum. Servs.*, DAB No. 2835, at 17 (2017), *appeal voluntarily dismissed*, No. 1:18-cv-00182 (M.D. Pa. Nov. 28, 2018).

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We are satisfied that CMS's May 15, 2019 disallowance notice more than meets CMS's initial burden. CMS did not have the burden to explain in detail in its disallowance notice, as California contends, exactly why CMS concluded that the state's overpayment for TCM expenditures exceeding actual cost was $30,492,805 and not the $7,220,270 figure that California has advocated. *See* RR at 2. CMS's disallowance letter adequately identified the disallowance period as "July 2003 through September 2010" and the disallowed amount as $30,492,805, based on California's own "reconciliation between the certified claimed expenditures for TCM services provided and the actual cost based on cost reports submitted by counties for SFYs 2003/2004 through 2009/2010." Cal. Ex. 17, at 1; *see also* 42 C.F.R. § 430.42(a)(1)-(4). CMS's disallowance letter also adequately stated the factual findings underlying the disallowance: "[t]he reconciliation showed that the State claimed TCM expenditures, funded by counties' certified public expenditures (CPE), that were in excess of actual costs incurred in providing TCM services by counties." Cal. Ex. 17, at 1; *see also* 42 C.F.R. § 430.42(a)(5). The letter cited pertinent legal authorities supporting the disallowance, by stating California's claims for FFP "did not comply with 42 C.F.R. § 433.51(b)" and "[t]he legal basis for claiming most federal Medicaid reimbursement, including for TCM, is found in Section 1903(a) of the Social Security Act, 42 U.S.C. § 1396b(a)." Cal. Ex. 17, at 1; *see also* 42 C.F.R. § 430.42(a)(5). The letter clearly stated that "the State claimed FFP for CPEs that exceeded the amounts actually expended by contributing public agencies to provide services to eligible Medicaid recipients," and "[s]uch amounts in excess of actual expenditures are not eligible for FFP." Cal. Ex. 17, at 1. We find the basis for the disallowance is discernible from CMS's disallowance letter – in fact, even a much less specific letter might have sufficed – and that it therefore gave enough detail to enable California to respond.

We also observe that CMS explained the basis for its actions repeatedly, in writing and in detail, well before this dispute reached the formal disallowance stage. *See*, *e.g.*, Cal. Ex. 21 (September 28, 2005 letter from CMS); Cal. Ex. 23 (January 6, 2006 letter from CMS); Cal. Ex. 27 (February 5, 2009 letter from CMS); Cal. Ex. 32 (May 9, 2006 email from CMS). Those communications adequately conveyed CMS's position, as summarized in 2009, that California's "current CPE process violates federal regulations because claims are being made for rate 'payments' in excess of costs actually incurred by the governmental entities involved." Cal. Ex. 34, at 1. "Although the agency must always provide 'fair notice' of its regulatory interpretations to the regulated public, in many cases," including this one, "the agency's pre-enforcement efforts to bring about compliance will provide adequate notice." *General Elec. Co. v. United States Env't Prot. Agency*, 53 F.3d 1324, 1329 (D.C. Cir. 1995). We reiterate that CMS has met its minimal burden to provide sufficient detail about the basis for its disallowance determination to enable California to respond.

Because CMS has met its initial, minimal burden, the next question is whether California has borne its burden to prove that the disallowed costs were allowable. In deciding that

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issue, "[t]he Board shall be bound by all applicable laws and regulations." 45 C.F.R. § 16.14; *see also Maine*, DAB No. 2931, at 23 ("In reviewing CMS disallowances, the Board is bound by all applicable statutes and regulations and must base its decision on the evidence in the record."). "The Board therefore must uphold a decision where it is authorized by law and the non-federal party has not disproved the factual basis for the decision." *Texas*, DAB No. 3066, at 10.

We explain below why California has not disproved either the factual or legal basis for CMS's disallowance decision or shown that the disallowed costs are eligible for Medicaid reimbursement.

2. California has not borne its burden to prove that its claimed costs are allowable.

1. California has not established that its disallowed claims were in accordance with the state plan and federal regulations.

California argues that its state plan set forth a "cost-based" methodology, CMS approved the plan, and "neither the Social Security Act nor CMS' regulations required that a state claiming CPEs using a cost-based rate must reconcile to current-year costs at the end of the payment year." Cal. Br. at 8-9. California explains that it considered its per encounter rate for TCM claims "to be based on actual costs, because it was based on the actual certified costs in the year prior," and California also "considered itself to have a cost-based rate based on cost reports using OMB A-87 principles." *Id.* at 4. California contends that CMS twice has attempted, but failed, to require reconciliation to actual costs through regulation, so California reasonably believed that its rate reimbursement methodology was acceptable. *Id.* at 10-11. California emphasizes that no legal authority "expressly" or "unambiguously" requires reconciliation of CPEs to actual costs. *See, e.g.*, Cal. Br. at 2 (asserting "no statute, regulation, or policy expressly

required retrospective reconciliation to actual costs"); Cal. Reply Br. at 2 (asserting "neither Section 1903(a)(1) nor Section 433.51 expressly required reconciliation to actual costs"); *id.* at 5 (stating "no statutory or regulatory command unambiguously requires CPEs to be reconciled to actual costs").

We concur with CMS's assessment that disallowance of California's claims was required because the Act and implementing regulations make FFP available "only to match amounts expended by a State," and California submitted claims in amounts "that exceeded actual expenditures to provide services." *See* CMS Br. at 1-2. Specifically, section 1903(a)(1) of the Act authorizes FFP only in "an amount equal to the [FMAP] of the total amount *expended during such quarter* as medical assistance under the State plan." Act § 1903(a)(1) (emphasis added); *see also* CMS Br. at 2, 4; Cal. Ex. 17, at 1 (citing, in disallowance letter, to "Section 1903(a) of the Social Security Act, 42 U.S.C. § 1396b(a)"). The implementing regulation at 42 C.F.R. § 433.51 allows CPEs to count toward the State share when they are "certified by the contributing public agency as

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representing *expenditures eligible for FFP*." 42 C.F.R. § 433.51(b) (emphasis added); *see also* CMS Br. at 2, 4; Cal. Ex. 17, at 1 (stating California's disallowed claims "did not comply with 42 C.F.R. § 433.51(b)"). CMS pays FFP to "cover the Federal share of *expenditures* for services," relies on quarterly reports from participating states containing their "accounting of *actual recorded expenditures*," and requires that "disposition of Federal funds *may not be reported on the basis of estimates*." 42 C.F.R. § 430.30(a), (c)(2) (emphasis added); *see also* CMS Br. at 2-3.

In construing the terms "amount expended" and "expenditures" in the governing statute and regulations, CMS correctly gave these terms their ordinary meaning of a sum or sums actually paid out and concluded these terms unambiguously limit FFP claims to actual expenditures and CPEs to actual costs. *See* CMS Br. at 1, 4-7. The inseparable linkage of FFP to a state's quarterly "amount expended," *see* Act § 1903(a)(1), and "accounting of actual recorded expenditures," *see* 42 C.F.R. § 430.30(c)(2), inherently requires reconciliation of estimated to actual expenditures. *See California Dep't of Health Servs.*, DAB No. 1670, at 6 (1998) ("The Medicaid program uses a system of quarterly awards to make federal funds available to the states. These awards are supported by reports which *estimate* expenses for a future quarter and *verify* amounts expended for a prior quarter.") (citing 42 C.F.R. § 430.30(b) and (c)) (emphasis added).

A controlling regulation, 42 C.F.R. § 433.51, applies these standards to CPEs by requiring local governments to certify their contributed funds "as representing expenditures eligible for FFP." Therefore, California's claim that CMS unduly focuses on the word "expenditure" and "ignores the remainder of the statutory language" is mistaken. *See* Cal. Reply Br. at 4. Equally mistaken is California's insistence that its allegedly "CMS-approved methodology for *estimating* actual costs" entitles the state to "annual reimbursement *above and* below actual costs." *See* Cal. Reply Br. at 6 (emphasis added); Cal. Br. at 16 (emphasis added). The certification language that California required on LGA cost reports confirmed "under penalty of perjury that the information provided in this cost report is true and correct, *based on actual costs*," not estimates or projections, of providing TCM services. *See* Cal. Ex. 1, at T.4-5-2, T.4-6-1 (emphasis added). The certification acknowledged that the actual cost data will "be used to establish a TCM rate" for claiming federal funds – but not federal funds exceeding the federal share of actual costs. *Id.*

The SPAs incorporated the controlling federal authorities. A state plan "is a comprehensive written statement submitted by the [state] agency describing the nature and scope of its Medicaid program and *giving assurance that it will be administered in conformity with the specific requirements of title XIX*, *the regulations in [42 C.F.R.] Chapter IV*," and other applicable authorities. 42 C.F.R. § 430.10 (emphasis added). California recognizes this. *See* Cal. Reply Br. at 2. As discussed above, actual expenditures are a requirement for federal reimbursement under title XIX, *see* Act § 1903(a), and the Chapter IV regulations, *see* section 433.51, which control the SPAs at

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issue. CMS's acceptance of California's state plan did not ratify any interpretations of it that would contradict federal authorities incorporated within it. *See Arizona Health Care Cost Containment Sys.*, DAB No. 2981, at 22 (2019) (rejecting, in disallowance case, a state's contention that CMS "accepted" the approved state plan's state-licensure requirement for speech therapists, when state plan also incorporated by reference a federal regulation requiring additional professional qualifications).

California's SPAs also incorporated federal cost principles. California could use federal Medicaid grant funds only for "allowable costs," which would be "determined in accordance with the cost principles" in OMB Circular A-87. 45 C.F.R. § 92.22(b). Accordingly, California's relevant SPAs expressly incorporated the cost principles, requiring TCM providers to "provide[] documentation of services and costs in accordance with OMB A-87 principles," and report "allowable costs" for TCM "as defined in OMB Circular A87." *See* Cal. Ex. 2, at 6, 8; Cal. Ex. 3, at 1. Incorporation of the cost principles into the state plan was consistent with the mandate in section 1902(a)(30) of the Act that a state plan's methods and procedures relating to payment for services available under the plan must be "consistent with efficiency" and "economy." Act § 1902(a)(30)(A). Expressly incorporating federal authority into a state plan and requiring action "in accordance with" it binds participating governments to comply with its requirements in order to claim FFP. *See*, *e.g.*, *Arizona*, DAB No. 2981, at 25 ("[B]ecause the State plan called for school-based speech therapy services to be provided 'in accordance with' [42 C.F.R.] section 440.110, the State's expenditures for those services were eligible for FFP only if they met that regulation's conditions."). Thus, CMS appropriately cited to and relied upon OMB Circular A-87 in its deferral notices, *see* Cal. Ex. 21, at 2; Cal. Ex. 23, at 2.

The cost principles articulated in OMB Circular A-87 have undergone some amendment and relocation over time, but have remained essentially unchanged. *See Pennsylvania Dep't of Pub. Welfare*, DAB No. 2653, at 3 (2015) ("The relevant cost principles have been codified in different locations over the years but have remained unchanged in the relevant fundamental concepts."), *aff'd sub nom. Pennsylvania Dep't of Hum. Servs. v. U.S. Dep't of Health & Hum. Servs.*, 349 F. Supp. 3d 431 (M.D. Pa. 2018); *New Jersey*, DAB No. 899, at 7 n.2 ("The cost principles for state and local governments have remained substantially unchanged over many years, although their designation has changed . . . ."). "The circular established that all allowable costs must be 'necessary and reasonable for proper and efficient administration of the program, be allocable to Federal awards, and be adequately documented.'" *Massachusetts*, 701 F. Supp. 2d at 187 n.5; *see also* OMB Circular A-87 at ¶ C.1.j (1995, and 1997 and 2004 revisions); 2 C.F.R. Part 225, App. A, ¶ C.1.j. The Board has upheld a disallowance based on CMS's "persuasive" argument that the disputed costs were "unallowable under the provisions of OMB Circular A-87," and not "necessary for the proper and efficient administration of the program." *California*, DAB No. 1670, at 4-5; *see also id.* at 7.

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California has not met its burden of proving the disallowed costs were "necessary for the proper and efficient administration of the State plan as required by the cost principles," *see New Jersey*, DAB No. 899, at 4, and "reflected actual costs not estimates," *see Pennsylvania*, DAB No. 2835, at 17. On the contrary, California's submission of claims for FFP in amounts exceeding actual expenditures, in reliance on CPEs that exceeded actual costs, was not necessary or reasonable for efficient administration of the program, and was not compliant with federal cost principles. Claims for federal reimbursement based on a formulated estimation that exceeds documented current-year costs are inconsistent with federal cost principles and do not serve the Medicaid program's overall purpose, which is "to make medical assistance available to the indigent." *See New Jersey*, DAB No. 899, at 8.

California repeatedly but unpersuasively attempts to reconcile its TCM claiming practices with applicable federal law and cost principles by describing California's methodology and rates as "cost-based." *See*, *e.g.*, Cal. Br. at 3, 4, 9, 10, 11, 13; Cal. Reply Br. at 1-4, 6-8, 10. California does not define "cost-based," whether by citation to provisions in the SPAs, controlling regulations, or otherwise. California's approach appears to be "cost-based" only inasmuch as the SPAs authorize reimbursement based on a per-encounter rate, which in turn is based on "actual costs" from the *prior year's* expenses. The conceptual gap is wide and self-evident between a "cost-based" per encounter rate based on prior-year cost data and used in a projection-based rate formula, and documented current-year actual costs of rendering TCM services. Ultimately, California's position that its "cost-based" methodology entitles it to claim federal reimbursement on formulated sums that exceed actual costs is both legally unsupported and counter-intuitive.

California might have assumed that CMS's approval of SPA 00-013 (and any undeferred TCM claims submitted under it) signified CMS's knowing approval of a "rate reimbursement methodology" divorced from actual expenditures for the relevant period, *see* Cal. Br. at 11; however, California alone is accountable for any such misconception. California's premise conflicts with properly promulgated regulations of which California had notice, and state Medicaid agencies are responsible for knowing and complying with such governing legal authorities. *See Maine*, DAB No. 2931, at 9 ("States participating in Medicaid are responsible for complying with federal law and with their state plans and bear primary responsibility for Medicaid enforcement."); *Indiana Dep't of Pub. Welfare*, DAB No. 970, at 10

(1988) ("As the State Medicaid agency, it was the appellant's responsibility to know the effect of [a Medicaid] regulation" and, if necessary, to monitor compliance with it), *aff'd sub nom. Indiana by Ind. Dep't of Pub. Welfare v. Sullivan*, 934 F.2d 853 (7th Cir. 1991).

California also may have considered its interpretation of its state plan to be permissible and reasonable; however, under the SPA language and the governing and incorporated federal authorities, that belief was incorrect and not entitled to deference from the Board.

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California implies, for example, that CMS's interpretation unfairly and unreasonably limits LGAs' CPEs "to the less[e]r of their actual costs or the state plan rate." Cal. Br. at 1. Yet California never demonstrates either the reasonableness or lawfulness of the state's alternative interpretation that would entitle LGAs to reimbursement based on the *greater* of their actual costs or the formulated figure. "This Board gives deference to a state's interpretation of its own state plan" only if that interpretation "is reasonable in light of the language of the plan as a whole and the applicable federal requirements." *Missouri Dep't of Soc. Servs.*, DAB No. 1412, at 2 (1993). California's is not, and therefore we cannot and do not defer to it. *See Maine*, DAB No. 2931, at 12 n. 6 (stating that "the Board cannot and will not defer to a proposed interpretation that would be impermissible under governing federal law."). Therefore, California's objections that "no statute, regulation, or policy expressly required retrospective reconciliation to actual costs," and that California's interpretation of its own state plan was "reasonable," are unavailing. *See* Cal. Br. at 18; Cal. Reply Br. at 6. The evidence supports CMS's legal interpretation and conclusion that when California submitted claims for FFP that "exceeded what the Act authorizes, CMS was required to disallow the excess FFP." *See* CMS Br. at 5.

California has not met its burden of establishing that its disallowed claims were in accordance with the state plan and federal regulations.

2. California has not established that it lacked adequate and timely notice of CMS's interpretation of the Act and its implementing regulations.

California next alleges that it lacked adequate notice of CMS's policy limiting CPEs to actual costs. Cal. Br. at 12. More specifically, California contends that "CMS did not explain the issue to [California] until 2010." Cal. Br. at 15. We hold that these contentions lack support both factually and legally.

1. California's assertions of insufficient and untimely notice lack factual support.

The factual record does not support California's claim that CMS's policy interpretation was unclear until 2010. *See* Cal. Br. at 12-13. We recognize that the parties' written communications sometimes lacked crystalline clarity, and that ongoing discussions of complex programs and services like TCM can lead to misunderstandings. *See*, *e.g.*, *Massachusetts*, DAB No. 2218, at 35 ("[W]hile the record shows that the State had discussions with CMS about what activities could or would be claimed as TCM costs, the State did not establish . . . that CMS ever 'agreed' that those activities constituted TCM."). Yet California's own communications show that it had actual notice and understanding of CMS's position years before eventually deciding to submit a plan amendment, as CMS points out. CMS Br. at 6-7 (citing Cal. Exs. 22, 23, 26, 31, and 32).

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The record contains communications from CMS to California, long before 2010, which conveyed CMS's objections to California's methodology for claiming FFP for TCM services. For example, CMS deferral letters in 2005 and 2006 informed California that "[t]he State does not have procedures in place to limit certified public expenditures (CPE) claimed through these programs to actual costs." *See* Cal. Ex. 21, at 2; Cal. Ex. 23, at 2. By letter of March 9, 2006, CMS imposed conditions for resolving the deferral that further alerted California to the problem of "CPEs that exceeded actual Medi-Cal costs on the approved cost reports" and the need for "a formal reconciliation process to ensure that all CPEs for these TCM programs are limited to actual Medi-Cal costs." Cal. Ex. 24, at 1, 2. In May 2006, CMS further explained:

What we are saying is that expenditures cannot be certified above the actual costs the counties are incurring for TCM because *these incurred costs are the only basis for claiming FFP that would meet the regulations*. *The certification of a payment rate alone would not be considered an expenditure eligible for FFP.* In this TCM program, the State's share of

the TCM payment is satisfied by the actual costs the counties are incurring for the provision of TCM services.

Anytime an expenditure is certified that is in excess of a county's actual cost of providing TCM services, the only entity really incurring an expense is the Federal Government. At that point we are no longer reimbursing the State for part of its expenditures, we are the only one paying.

Cal. Ex. 32, at 1 (emphasis added). On December 5, 2008, CMS stated that California's "policy to claim FFP for certified public expenditures in excess of actual cost is in violation of 42 CFR 433.51." CMS Ex. 26, at 1.

The record also contains responses from California, well before 2010, which confirmed the state comprehended CMS's concerns. For example, California acknowledged in a June 8, 2005 policy and procedure letter to LGAs' TCM coordinators that CMS had begun ongoing deferrals in 2003 based in part on lack of "documentation showing that the TCM payments made to all counties are allowable in accordance with 42 CFR 433.51." Cal. Ex. 22, at 1. That letter also confirmed California's understanding that "[s]trict compliance with federal law and regulation regarding CPEs is necessary in order to minimize the risk of federal disallowances." *Id.* at 2. The letter aligned with CMS's position that CPEs must represent actual expenditures, for it advised TCM coordinators that "[a] qualifying expenditure is an expenditure that has been made for covered services," and the "amount that can be certified is the amount expended by the governmental entity." *Id.* at 3. On December 27, 2005, California admitted to CMS that some TCM programs had "reimbursements exceeding budgeted costs" and volunteered corrective action including "reviewing the cost reports and reconciling the claims submitted to the cost reports." Cal. Ex. 20, at 3-4. On December 16, 2008, California

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PPL No. 08-006 acknowledged that "[a] certification that is higher than the actual cost or expenditure of the governmental unit that has generated the CPE" is "not in compliance with current federal regulations governing CPEs." Cal. Ex. 31, at 3. The PPL further acknowledged that it "clarifies CPE requirements that have been in effect for many years." *Id.* at 8.

As these examples show, CMS gave adequate and timely notice of CMS's interpretation of applicable law and available options for resolution, and California contemporaneously acknowledged its grasp of CMS's position. CMS gave California the option in 2010 either to "submit a revised SPA *or* notify CMS that it will properly fund the rate payment methodology in the currently approved State plan." Cal. Ex. 35, at 2 (emphasis added). Although California waited until 2010 to submit a plan amendment (namely SPA 10-010) that addressed CMS's concerns, the grounds for submitting the amendment were apparent years earlier. *See* 42 C.F.R. § 430.12(c)(2) ("Prompt submittal of [state plan] amendments is necessary— (i) So that CMS can determine whether the plan continues to meet the requirements for approval; and (ii) To ensure the availability of FFP in accordance with § 430.20."). Where, as here, CMS relied on a reasonable and permissible statutory interpretation, and the state had notice of that interpretation, we have upheld the disallowance. *See*, *e.g.*, *Massachusetts*, DAB No. 2218, at 11.

Thus, California's assertion of insufficient notice of CMS's policy interpretation lacks factual support.

2. California's assertions of insufficient and untimely notice lack legal support.

California admits CMS's deferral letters stated that CPEs for TCM exceeded actual costs, but California claims this notice "was not sufficient" legally (citing *Hawaii Department of Social Services & Housing*, DAB No. 779 (1986)) because CMS cannot announce a policy with retroactive effect in a deferral. Cal. Br. at 12. California complains that CMS's attempted regulatory amendments in 2007 "created even more perplexity regarding what was required," and belie any contention by CMS that its regulations already mandated a reconciliation of CPEs to actual costs. *Id.* at 13; Cal. Reply Br. at 1-2, 5. California asserts that CMS allowed a "disconnect" between the parties to continue for several years, during which federal requirements were insufficiently clear, and CMS cannot retroactively impose a new position or reject the state plan methodology it previously approved. Cal. Br. at 12-14.

CMS counters, and the Board agrees, that *Hawaii* is distinguishable. *See* CMS Br. at 5-7. *Hawaii* involved ambiguities in federal law relating to state excise taxes. *Hawaii*, DAB No. 779, at 1, 3-5. This case, by contrast, involves "the fundamental principle that FFP is only available to match a State's expenditures," a principle that is neither ambiguous nor new. *See* CMS Br. at 5. As *Hawaii* recognized, approval of a state plan provision does

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not mean "that a state can ignore clearly applicable rules and regulations." *Hawaii* at 9. *Hawaii* also does not support California's position that CMS implicitly accepted California's methodology when "providing federal reimbursement for [California's] TCM CPE claims for 10 years (1995 through 2005)." *See* Cal. Br. at 11. The only record document California cites in factual support of this assertion, California Exhibit 11 (the state's May 25, 2001 response to a CMS informational request), does not document CMS's payment of TCM CPE claims exceeding actual costs at any time. *See* Cal. Br. at 11; *see also* Cal. Ex. 11. In *Hawaii*, by contrast, CMS "did not deny that it had provided FFP" for the disputed cost item "without question for 18 years." *See Hawaii* at 10, 15 n.9.

We consider California's reliance on *Missouri*, DAB No. 1412, to be similarly misplaced. *See* Cal. Reply Br. at 3-4. In *Missouri*, the Board upheld as reasonable a state's interpretation of state plan provisions concerning pharmacy service copayments, but only absent notice from CMS of an official interpretation to the contrary. *Missouri*, DAB No. 1412, at 2, 17; *see also id.* at 6 ("As we have previously held, absent timely and adequate notice of an agency interpretation to the contrary, a state may rely on its own reasonable interpretation of an ambiguous regulation."). As discussed above, the record evidence shows that California received timely and adequate notice that CMS's interpretation of the state plan was contrary to California's own.

The relevant legal history also does not tend to support California's assertions that the "regulatory landscape" regarding CPEs was "muddled" and "created even more perplexity regarding what was required." *See* Cal. Br. at 13. CMS issued proposed rules in January 2007, and final regulations on May 29, 2007, regarding CPEs. *See* 72 Fed. Reg. 2,236, 2,236-46 (Jan. 18, 2007) (proposed rule); 72 Fed. Reg. 29,748 (May 29, 2007) (final rule with comment period). A federal district court vacated those regulations for violating a 2007 congressional moratorium. *Alameda Cnty. Med. Ctr. v. Leavitt*, 559 F. Supp. 2d 1 (D.D.C. 2008). CMS in November 2010 restored the language in 42 C.F.R. § 433.51 to the text that was in effect before the vacated rule. *See* 75 Fed. Reg. 73,972, 73,973 (Nov. 30, 2010). The Board and both parties recognize that the restored version of section 433.51, unamended since 2010, applies to the entire disallowance period. *See* CMS Br. at 2 n.1 ("The current text of section 433.51, effective since November 30, 2010, is identical to the text that was effective until July 29, 2007," and "CMS considers the current version of the text applicable to the entire disallowance period in this case."); Cal. Br. at 13 (recognizing that "CMS proposed to amend 42 C.F.R. § 433.51" in 2007, but the proposed amendment was "struck down, remanded, and withdrawn").

Thus, throughout the disallowance period, 42 C.F.R. § 433.51 required that CPEs represent actual "expenditures eligible for FFP," and CMS's unsuccessful attempt at

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regulatory amendment in 2007 ultimately is inconsequential to this analysis.[8] Yet even if we considered these proposed regulatory amendments, we would not find that they persuasively support California's position. CMS stated in the proposed new rules that "in many instances State Medicaid agencies do not currently review the CPE submitted by another unit of government to confirm that the CPE properly reflects the actual expenditure by the unit of government for providing Medicaid services or performing administrative activities." 72 Fed. Reg. 2,236, 2,239 (Jan. 18, 2007). In CMS's assessment, "[t]hese circumstances do not serve to advance or promote the fiscal integrity of the Medicaid program," and "the proposed rule would serve to enhance the fiscal integrity of CPE practices within the Medicaid program." *Id.* CMS flagged the "important" condition that it "do[es] not constitute compliance with the Federal statute and regulation governing CPEs" to submit "[a] certification that is higher than the actual cost or expenditure of the governmental unit that has generated the CPE based on its provision of services to Medicaid recipients." *Id.* at 2,241. Thus, the proposed amendments are consistent with the policy position CMS consistently had been articulating, and continued articulating, to California. CMS's comments on the proposed amendments suggest, at most, an increasing awareness at CMS that state Medicaid agencies were not complying with federal policy, rather than any change in that policy.

Also inconsequential are California's arguments about CMS actions after the 2019 disallowance and the state of federal requirements "to this day." *See* Cal. Br. at 10-11. The Board applies the law in effect only during the years for which the disallowed FFP was claimed. *Massachusetts*, DAB No. 2218, at 10. Yet even if we were to consider CMS's proposed 2019 regulatory amendments as well, we would find that they also do not support California's position. CMS pronounced that it promulgated the 2019 regulations to "codify our practice of relying upon the cost allocation principles in federal regulations," and applicable Medicare cost principles, "as the methods and principles to identify

Medicaid program expenditures eligible to support a CPE." 84 Fed. Reg. 63,722, 63,744 (Nov. 18, 2019). While the proposed 2019 amendments thus acknowledge that CMS's policy position was not previously codified, they still tend to confirm, rather than call into doubt, that CMS had a consistent and long-standing policy and practice of requiring CPEs to comply with federal regulations and applicable cost principles.

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California also cites *Missouri*, DAB No. 2589 (2014), for the proposition that regulatory developments during the disallowance period created "perplexity" concerning applicable law, Cal. Br. at 13, but *Missouri* in fact supports CMS's position. *Missouri* addressed CMS's 2013 disallowance of $1,355,942 in Medicaid funding claimed for state fiscal years 1999 through 2001. *Missouri*, DAB No. 2589, at 1. The Board upheld the disallowance, which concerned the state's claim for FFP based on a formulated rate rather than the provider's actual costs incurred, explaining that the state's position "ignores the plain meaning of the statutory and regulatory language." *Id.* at 5-6. The Board concluded the "plain meaning" of the Act and 42 C.F.R. § 433.51 "requires CPE to be supported with an official statement by an authorized representative of the contributing public entity confirming that the *expenditures* qualify as Medicaid medical assistance or other allowable Medicaid *expenditures*," meaning "payments." *Id.* at 6-7 (emphasis added). The *Missouri* decision – issued five years before this disallowance, and involving a disallowance period preceding this one – tends to show that the legal landscape was less muddled, and CMS's position was clearer, than California contends.

Thus, California's assertion of insufficient notice of CMS's policy lacks legal support.

3. California has not shown that CMS unlawfully and prejudicially delayed taking the disallowance, or that considerations of delay can invalidate a disallowance.

California asserts that 42 C.F.R. § 430.40(c) requires CMS to determine a deferred claim's allowability within 90 days of receiving the state's response to the deferral, and that, "[i]n this case, CMS neither paid nor released any of the deferred claims within 90 days, as required by its own regulations." Cal. Br. at 14. For example, California asserts that after CMS's September 28, 2005 deferral, and California's December 27, 2005 response, CMS should have paid or disallowed the deferred funds by "March 28, 2005," but instead issued its May 15, 2019 disallowance "over 14 years late."[9] *Id*. California claims the delay was prejudicial, because if CMS had issued a timely disallowance and explanation, then California "would have immediately been made aware that CMS believed there was a disconnect between the state plan reimbursement methodology and [California's] claiming practices." *Id*. With that awareness, California purportedly would have changed its state plan methodology or funding practices promptly, "claimed an additional $19,875,957 under its modified claiming practice, and there would be no disallowance" today. *Id*. at 15. Alternatively (and somewhat inconsistently), California asserts that if CMS had issued a disallowance promptly, California "would have appealed the disallowance," ended the existing "uncertainty," and avoided years' worth of additional liability. Cal. Reply Br. at 8.

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In response, CMS "concedes that it did not pay all of the deferred claims in accordance with [42 C.F.R. §] 430.40(c)(6) because CMS and [California] continued to correspond regarding the claims with the intent to avoid a formal disallowance." CMS Br. at 7. CMS argues that California was not prejudiced, because even if CMS had paid the deferred claims after 90 days, it still could have disallowed them later. *Id.* Furthermore, CMS contends, there is no deadline for imposing a disallowance and California has been able to exercise its appeal rights. *Id.* Moreover, CMS argues again that California "had actual notice of the substantive basis for the disallowance" during the relevant period, and therefore "could have adopted claiming practices that conformed to the law" rather than waiting until 2010 to submit a conforming plan amendment. *See id.*

We find that the record supports CMS's arguments on this point. There is abundant evidence of the parties' correspondence mutually seeking to prevent a disallowance, including CMS's repeated requests for documentation supporting California's position. Significantly, the regulation that California cites actually affords CMS "90 days, *after all documentation is available in readily reviewable form*, to determine the allowability of the claim." 42 C.F.R. § 430.40(c)(5) (emphasis added). The regulation also requires the state's timely submission of that documentation. 42 C.F.R. § 430.40(c)(1) ("Within 60 days (or within 120 days if the State requests an extension) after receipt of the notice of deferral, the State must make available to the regional office, in readily reviewable form, all requested

documents and materials except any that it identifies as not being available."). The Board has held that CMS "does not violate the applicable time requirements" when, as here, the state evidently "had failed to submit, in readily reviewable form, all of the documentation and information needed to complete the Department's assessment of the State's claim" within the regulation-prescribed time period. *Pennsylvania Dep't of Pub. Welfare*, DAB No. 371, at 2-3 (1982).

Considerable record evidence indicates that California did not keep or provide CMS with fully compliant documentation of actual costs. *See*, *e.g.*, Cal. Ex. 21, at 2; Cal. Ex. 23, at 2; Cal. Ex. 24, at 2; Cal. Ex. 26, at 1. California acknowledged in its 2008 PPL No. 08-006 that CPEs "must be supported by auditable documentation that identifies the relevant category of expenditure under the State plan, and demonstrates the actual expenditures incurred by the LGA in providing services to Medicaid beneficiaries." Cal. Ex. 31, at 6. California also recognized the importance of supporting LGA documentation of TCM expenses by means of general ledger entries, invoices, contracts, and "warrants/remittance advices from the LGA that specify the payment was for TCM services," as "CMS's current guidance emphasizes the importance of such documentation." *Id.* at 6-7. Yet once CMS, on its own initiative, obtained the LGAs' cost reports, California admitted it had no further documentation to provide. Cal. Ex. 27, at 1-2; Cal. Ex. 30, at 1. California was required to "[m]aintain an accounting system and supporting fiscal records to assure that claims for Federal funds are in accord with applicable Federal requirements." 42 C.F.R. § 433.32(a). To the extent California failed to do so and did not supply such records to CMS readily on request, California

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contributed significantly to the delay of which it now complains, and we have rejected similar complaints under analogous circumstances. *See California Dep't of Health Care Servs.*, DAB No. 2204, at 10 (2008) (rejecting California's equitable argument based on 10-year period between deferral and disallowance because "California itself was responsible for much of the delay in issuing the disallowance"); *New Jersey*, DAB No. 899, at 1, 3 (upholding disallowance in part because "the State had an obligation to substantiate its claim with appropriate source documentation" and did not).

The Board observes that we have seen no record evidence that clarifies why three calendar years elapsed between California's submission of SPA 10-010 in 2010 and CMS's approval of it in 2013, or why another six calendar years passed before CMS issued its formal disallowance letter in 2019. We are not unsympathetic to California's objections to perceived delays by CMS, but the decisional record does not offer any facts from which we can draw any reasonable inferences for or against either party as to the reasons for those temporal gaps.

Even if there were such evidence, any delay by CMS in issuing the disallowance ultimately could not transform unallowable costs into allowable ones, and the Board's prior decision in *California*, DAB No. 1670 (1998), is apt authority on this point. In that case, as in this, the state argued that CMS's "unexplained delay in issuing the disallowance was excessive, prejudiced" the state, "and should result in the dismissal of the disallowance action." *Id.* at 8. In that case, as in this, the state contended that the multi-year delay between the state's response to deferral notices and CMS's ultimate disallowance "violated [CMS's] own deferral and disallowance regulations." *Id.* And in this case, as in that, we do not find that CMS's delay in issuing a disallowance prejudiced the state, because CMS "gave more than adequate notice to [the state agency] prior to the disallowance that its claims for FFP . . . were being questioned." *Id.* In this case, as in *California*, the disallowed amounts "were not allowable under federal law and cost principles," and thus "were ineligible for FFP," and "[a]ny delay by [CMS] in making its determination does not make an unallowable cost allowable and thus eligible for FFP." *Id.* at 9.

In any event, any factual disputes in the present case concerning the reasons and responsibility for the disallowance's timing are not ultimately dispositive because, as CMS correctly states, "neither the regulations nor the Act set a deadline for CMS to take a disallowance." CMS Br. at 7. The Act and regulations impose no statute of limitations or other time limit on issuance of Medicaid disallowances as a matter of law. *See Maine*, DAB No. 2931, at 23; *California*, DAB No. 2204, at 10. Accordingly, we have held that even a decade's delay in issuing a disallowance "has no legal significance." *California*, DAB No. 2204, at 10-11.

Thus, California's argument of prejudice from delay seeks essentially equitable relief that the Board cannot grant. California claims that CMS's delay deprived the state of the

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opportunity to amend its state plan immediately and claim a net sum of $19,875,957 FFP for actual program costs exceeding amounts claimed during the disallowance period. Cal. Br. at 15, 18. The implication is that CMS is estopped from making the disallowance, but California makes no showing of any element of an equitable estoppel claim, including either affirmative misconduct by CMS or reasonable reliance by California. *See Pacific Islander Council of Leaders*, DAB No. 2091, at 12 (2007) ("The Board has repeatedly acknowledged the prevailing view in the federal courts that equitable estoppel does not lie against the federal government, if indeed it is available at all, absent at least a showing of affirmative misconduct.") (citing cases); *see also Family Health Servs. of Darke Cnty., Inc.*, DAB No. 2269, at 19 (2009) ("Certainly estoppel is unavailable where the party fails to show even the traditional elements of estoppel, such as reasonable reliance.").

"[W]e do not have the authority to take into account such equitable factors as the collateral impact of a disallowance on [a state's] budget," *Maine*, DAB No. 2931, at 23, and we repeatedly have upheld disallowances against equitable arguments comparable to California's in this case. *See*, *e.g.*, *Texas*, DAB No. 3066, at 22-24, 23 n.17 (upholding disallowance and rejecting claim that state relied on CMS approval of SPA); *Pennsylvania*, DAB No. 2835, at 5-6, 13, 20 (upholding disallowance and holding CMS was not bound by alleged past acquiescence in state interpretation or estopped from assuring compliance with Medicaid statute and federal cost principles); *California*, DAB 1670, at 7 (rejecting equitable arguments against disallowance because "this Board cannot provide equitable relief" but instead "is bound by all applicable laws and regulations").

California has not shown that CMS unlawfully and prejudicially delayed in taking the disallowance, or that considerations of delay can invalidate a disallowance.

4. California has not shown that CMS's calculation overstates the disallowable amount.

California argues that "CMS' disallowance is substantially inflated because CMS did not count all of the LGAs' costs in each year in calculating the disallowance." Cal. Br. at 16. Specifically, where an LGA had more than one TCM program, CMS "disaggregated" those programs' costs to determine the allowable and disallowable costs for each, rather than netting them all into a consolidated annual total for the LGA. *Id.* at 17. According to California, federal regulation does not require that approach, and calculating the disallowance "correctly" would decrease it from $30,492,805 to $20,189,393. *Id.* at 17, 18; *see also* Cal. Reply Br. at 9.

The record supports CMS's position that, "[i]n calculating the disallowance, CMS merely relied on the information that [California] reported." *See* CMS Br. at 8. It is noteworthy that the information California ultimately provided to CMS gave a detailed accounting

for every county, and "target populations" within each county, for multiple years. *See* CMS Ex. A at 3-28, 31-52, 54-58. California decries basing the disallowance amount on the "happenstance" of separate cost reports for separate TCM programs within a single county, but California itself apparently imposed that itemized reporting requirement. *See* Cal. Ex. 1, at T.4-5-1 (requiring, in California's Provider Manual, that "[a] separate TCM cost report must be submitted by the LGA to [California] for each program under which the LGA elects to participate"). CMS's formal disallowance letter stated that CMS relied on California's "reconciliation between the certified claimed expenditures for TCM services provided and the actual cost based on cost reports submitted by counties." Cal. Ex. 17, at 1. During discovery, CMS confirmed that it calculated the disallowance by totaling tabulated amounts that California's own division of Audits & Investigations reported as reimbursement not supported by CPEs. Cal. Ex. 18, at 1.

Thus, the record supports CMS's assertion that it calculated the $30,492,805 disallowance amount in reliance on California's own tabulated data, in the format that California used for preparing it and presenting it to CMS. California may be correct that no federal regulation requires CMS's calculation of the disallowance on a line-item, per-program basis, but no federal regulation requires California's aggregated, net-per-LGA basis either. We also observe that CMS's only admitted error appears to be in California's favor, as CMS notes that, "due to an administrative oversight, CMS did not disallow" over $1,871,000 that California had reported for five counties during two fiscal years. CMS Br. at 4 n.2. California does not challenge that assertion by CMS or demonstrate any arithmetical error in the rest of CMS's calculations.

We therefore hold that California has not met its burden of proving prejudicial error in CMS's calculation of the disallowance amount, or in CMS's decision to compute unallowable amounts on a line-item basis rather than an aggregated one. *See Massachusetts*, DAB No. 2218, at 26 ("When it appears that a disallowance may include both allowable and unallowable expenditures, the State has the burden of identifying the allowable expenditures."). Given California's insufficient showing of error, we need not and do not address CMS's additional argument that the two-year time limit for claiming reimbursement under 45 C.F.R. § 95.7 has expired, or California's counterargument that recalculating the disallowance "would not implicate the claiming timeframe of 45 C.F.R. § 95.7." *See* CMS Br. at 8; Cal. Reply Br. at 10.

We hold that California has not met its burden of proving that CMS's calculation overstates the disallowable amount.

3. We decline to reach California's argument concerning intergovernmental transfers.

California argues that, "[i]f the disallowance is upheld, it should still be open to [California] to use IGTs," meaning intergovernmental transfers, "as the non-federal share

for payments equal to the difference between the certified actual costs and the state plan rate." *See* Cal. Br. at 15 n.5; *see also Alabama*, DAB No. 2716, at 2 ("The statute and regulations permit states to use, as their share, public funds transferred to the state Medicaid agency from other units of government, called intergovernmental transfers (IGTs) . . . .").

The Board need not address an issue when, as here, a party has had sufficient time, notice, and opportunity to present relevant evidence either to CMS or to the Board but has not done so. *See*, *e.g.*, *Pennsylvania*, DAB No. 2835, at 1, 11-12. California's assertion concerning IGTs consists of a single footnote, without citation to supporting record evidence or legal authority, and California makes no express request for the Board to decide this issue or grant specific relief in connection with it. Therefore, to the extent that California has attempted to raise on appeal any issue concerning TCM funding by means of IGTs, we decline to reach that issue. We decide this case based on the facts properly before us, but our decision does not preclude California and CMS from further discussing the issue of TCM funding by means of IGTs, if both parties consider such discussions permissible and worthwhile.

Conclusion

We uphold CMS's disallowance of FFP in the amount of $30,492,805.

Endnotes:

[1] Both parties have undergone name changes during the timeframe relevant to this case, but for clarity we consistently refer to the parties by their current names.

[2] We apply the substantive law in effect during the years for which the disallowed FFP was claimed. *Massachusetts Exec. Off. of Health & Hum. Servs.*, DAB No. 2218, at 10 (2008), *aff'd sub nom. Massachusetts v. Sebelius*, 701 F. Supp. 2d 182 (D. Mass. 2010).

[3] For a history of the Circular's origin and early development, *see generally Alabama v. Shalala*, 124 F. Supp. 2d 1250, 1253 (M.D. Ala. 2000), *aff'g Alabama Dep't of Finance*, DAB No. 1635 (1997). For the Circular's history after the disallowance period, *see generally Pennsylvania Dep't of Hum. Servs.*, DAB No. 2835, at 2-3, 3 n.2 (2017).

[4] For exhibits, such as Exhibit 2, which lack uniform consecutive pagination, we paginate sequentially from the first page after any exhibit cover sheet.

[5] SPA 00-013 omitted "the" from the first sentence where indicated here with brackets: "A current year per encounter rate shall be established after evaluation of the total costs of providing case management services and [] total number of encounters as reflected in the prior year cost report, defined by the department." Cal. Ex. 2, at 8.

[6] SPA 00-013 substituted the words "Targeted Case Management" in place of "TCM." Cal. Ex. 2, at 8.

[7] "MAA" stands for Medi-Cal Administrative Activities, *see* Cal. Ex. 31, at 1, or Medicaid Administrative Activities, *see* Cal. Ex. 39, at 2.

[8] In 2007, in addition to proposing regulatory amendments concerning CPEs, CMS also proposed regulatory amendments concerning TCM, in response to congressional amendment of section 1915(g) of the Act in 2005, and after previously administering TCM through sub-regulatory policy and guidance. *See Maine Dep't of Health & Hum. Servs.*, DAB No. 2292, at 3 (2009), *aff'd sub nom. Maine Dep't of Health & Hum. Servs. v. United States Dep't of Health & Hum. Servs.*, 766 F. Supp. 2d 288 (D. Maine 2011); *Massachusetts*, DAB No. 2218, at 3, 3 n.2. On December 4, 2007, CMS issued interim final regulations concerning TCM. *See* 72 Fed. Reg. 68,077; *see also* Cal. Ex. 31, at 2. However, those regulations, like the 2007 CPE regulations and with limited exceptions, were subject to congressional moratorium. *See* Pub. L. No. 110–28, § 7002(a), 121 Stat. 112, 187 (2007); *see also Maine*, DAB No. 2292, at 18 n.13; *Massachusetts*, DAB No. 2218, at 3 n.2. Those developments have no direct relevance to the parties' contentions in this appeal.

[9] The date falling 90 days after December 27, 2005, was March 27, 2006, so the disallowance actually occurred 13, not 14, years later.

/s/

Karen E. Mayberry
Board Member

/s/

Susan S. Yim
Board Member

/s/

Kathleen E. Wherthey
Presiding Board Member