BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGS ON REFERRAL BY THE COMMISSIONER OF HEALTH AND SOCIAL SERVICES

In the Matter of	)	
	)	OAH No. 13-1649-MDA
C CARE SERVICES	)	
_____	)	

DECISION

I. Introduction

This case involves a regulation under which the Office of Rate Review (ORR) reduces the reimbursement rate of Medicaid providers if they fail to timely submit audited financial data. C Care Services (C Care) did not submit its 2012 financial data on or before the due date. As a result, ORR imposed a 20% rate reduction. C Care appealed that reduction.

A hearing was held on two separate dates, March 7 and April 17, 2014. On the first date, C Care was assisted by a lay representative, Marc Korn. On the second date, C Care was represented by an attorney. The ORR was represented by counsel on both hearing dates.

Based on the applicable law and the evidence presented at the hearing, the ORR properly imposed a rate reduction because of C Care's late report.

II. Facts

C Care provides a variety of services to Medicare recipients in Alaska. It bills the state over $11 million a year for these services.[1] C Care acknowledged at the hearing that it uses a calendar year as its fiscal year, and that it did not file its 2012 financial information on or before September 30, 2013. On October 1, 2013, ORR sent C Care a notice stating that the financial information had not been received, and that if it was not received by November 1, 2013, a 20% rate reduction could be imposed.[2] If not received

> a letter will be sent to you after the November 1st deadline, specifying the amount that your rates will be reduced, the date [on] which the reduction will go into effect, and a means to appeal the reduction in your rates.[3]

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1 Record at 20.
2 Record at 1.
3 Record at 1 – 2.

On November 4, 2013, a second notice was sent informing C Care that it would have a rate reduction of 20%, effective December 1, 2013.[4] C Care appealed that reduction, noting that there were problems with the current Medicaid payment system, and that there had been several blackout periods during the prior sixty days.[5]

The Department of Health and Social Services had intended to implement its new Medicaid Management Information System on October 1, 2013.[6] The new system replaced the prior, 20-year-old system.[7] As part of the transition between systems, a planned "blackout period" began at 4:00 pm on September 16 and continued through September 30, 2013.[8]

As it turned out, there were numerous problems with the implementation of this new system.[9] In a letter dated February 18, 2014, the ORR acknowledged that some of the problems limited the ability to timely file annual financial information.

> Many providers rely on remittance advices and claims reports that are generated by the MMIS system to comply with the annual reporting requirements specified above. Unfortunately, these aspects of the MMIS system are not adequate for providers to rely on at this time for completing their annual reports.[10]

Because the MMIS was not adequate for providers to rely on, the ORR informed providers that the rate reduction would not be enforced for specific time periods beginning March 1, 2014, depending on the provider's fiscal year.[11] The ORR's decision not to enforce the rate reduction did not apply to C Care's 2012 report, which had been due on September 30, 2013. C Care's audited financial information was not submitted until February 25, 2014.[12]

III. Discussion

A. Rate Reduction Regulations

As a condition of being a provider of certain Medicaid services, C Care Services agreed to comply with ORR's accounting and reporting requirements.[13] Providers are

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4 Record at 5.
5 Record at 11.
6 Exhibit 7, letter from DHSS dated July 15, 2013.
7 *Id.*
8 *Id.*
9 *See* Exhibit 11 (list of problems from December 16, 2013 Enterprise Production Status Meeting).
10 Exhibit 13.
11 *Id.*
12 Record at 13
13 7 AAC 145.531(a).

required to submit a report no later than nine months after the end of their fiscal year.[14] For providers such as C Care, who use a calendar year as their fiscal year, the report would be due by September 30. This report must include

> audited financial statements completed in accordance with generally accepted auditing standards (GAAS) or generally accepted government auditing standards (GAGAS)[.[15]]

A provider who does not submit its report when due is subjected to a rate reduction. For providers receiving $200,000 or more in annual Medicaid payments, there is a 20% rate reduction effective 30 days after the report was due, which continues in effect until the completed report is received by ORR.[16]

B. The Commissioner Has Discretion Not To Impose A Rate Reduction

The first legal question for consideration is whether there is any discretion not to impose a rate reduction. In *In re A. Care Coordination*,[17] the Commissioner held that there was no discretion to allow a hardship exemption and not impose a rate reduction. This case focused on the cost of providing audited information, and the impact that added cost would have on small providers. The regulation requires small providers to either provide the required information, or accept a rate reduction.[18] The Commissioner held that an administrative appeal was not the proper forum to challenge that regulation.[19] However, *A. Care Coordination* did not discuss whether there could ever be circumstances that justified an exception to the general rule that a rate reduction would be imposed.

The ORR's own actions suggest its belief that there is some discretion. First, while the regulation states that the rate reduction goes into effect 30 days after the financial information was due, the November 4 letter to C Care gave it an extra 30-day grace period.[20] Second, after problems occurred implementing the MMIS, the ORR granted blanket exemptions from the rate reduction.[21] Clearly, the ORR believes it has the authority to delay or waive the rate reduction when a provider has not filed its financial information.

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14 7 AAC 145.531(e).
15 7 AAC 145.531(e)(2).
16 7 AAC 520(l)(2)(A).
17 OAH No. 13-0935-MDR (Commissioner of Health and Social Services 2014).
18 7 AAC 145.520(l)(1).
19 *In re A. Care Coordination*, OAH No. 13-0935-MDR, page 3.
20 Record at 5 (reduction began on December 1 rather than November 1).
21 Exhibit 13.

Enforcing a valid regulation "can be illegal when there are unusual circumstances that make such adherence highly unreasonable."[22] In this case, C Care has asserted that the problems with implementing the MMIS contributed to the delay in filing its financial information. The implementation of a new MMIS is an unusual circumstance, as is the degree of problems encountered during that implementation. C Care argued that the Department of Health and Social Services' actions significantly contributed to its delay in submitting its financial information. If true, it would be highly unreasonable to penalize C Care for something caused by the same Department that is imposing the penalty.[23]

C. Imposing A Rate Reduction Is Not Unreasonable In This Case

The ORR argued that whether imposing the reduction was unreasonable should be reviewed under an abuse of discretion standard. That standard might apply when an appellate court reviews the final agency decision, but it is not applicable at this stage. The Commissioner is not required to defer to decisions and interpretations of the individual divisions or offices within the Department of Health and Social Services.[24] The question here is not whether the ORR abused its discretion, but whether the problems with the MMIS caused or significantly contributed to C Care's delay in submitting its financial information.

C Care's owner, Cecilia DeLeon, testified about her efforts to submit her financial information. From her 2011 audit, she knew the type of information the auditors would require before they began their work. She also knew it would take the auditors up to six weeks to complete their work. Ms. DeLeon testified that in 2013, C Care relied on the MMIS for the reports the auditor would need. That is because her internal system was not designed to track the information the ORR wanted reported.[25] Ms. DeLeon was also informed that the MMIS system would be unavailable during the last two weeks in September.[26]

In order for C Care to submit its financial audit by the due date of September 30, 2013, Ms. DeLeon knew or should have known that she would need to download reports from the MMIS by mid-August so her auditors would have time to compete their work. She

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[22] *State v. Valley Hospital Association*, 116 P.3d 580, 586 (Alaska 2005).

[23] The ORR is a subordinate unit of the Department of Health and Social Services.

[24] *See In re Martin Ferrell*, OAH No. 06-0582-COL (Commissioner of Commerce, Community and Economic Development 2007), page 7, n. 26.

[25] In its letter of February 18, 2014, the ORR acknowledged that many providers relied on the MMIS system to prepare their annual reports. Exhibit 13. C Care's intent to rely on this system was not unreasonable.

[26] Exhibit 7.

should have obtained these reports long before the September blackout period, and long before the problems with the new MMIS that began in October. Ms. DeLeon delayed obtaining those reports. At first, she was working to complete the 2011 audit. She also testified that she was worried that the auditors she used for 2011 would raise a concern about the financial strength of the company. There was some suggestion during the hearing that this was based on delays in getting paid by the Department during October of 2013. It is not clear, however, how those October delays could have been the cause of her decision to delay beginning the audit work, because that delay began much earlier.

In any event, Ms. DeLeon did switch auditing firms. She testified that she was planning to access the MMIS in October so that the audit could be completed by December. She stated that she was counting on the one month grace period to avoid the rate reduction in October, and hoping she would get her financial information submitted without having more than one month of reduction. Instead, she was not able to file her audited financial information until late February of 2014. Even with the two months' grace period she was allowed, she had nearly three months of rate reduction instead of the one month she planned to incur.

Even though there were still problems accessing information on the MMIS on February 18, 2014, C Care was able to submit its report in February. However, Ms. DeLeon asserted that because of the problems with the MMIS, her staff was focused more on getting bills submitted so they could meet C Care's payroll obligations. In addition, she had to gather accounts receivable information to obtain short-term financing while waiting for delayed state payments. C Care's efforts were focused on maintaining cash flow so that it could continue to operate, rather than on obtaining the information the auditors needed.[27]

It is likely that problems with the MMIS contributed to the length of time it took C Care to complete its report, but those problems did not cause the initial delay. Instead, that delay was caused by Ms. DeLeon's decision to defer gathering the information she needed for the audit. She was aware that she was required to submit her financial information on or before September 30, 2013. She knew there would be a blackout period for two weeks before that information was due, and she knew her auditors would need information from the MMIS system at least six weeks prior to the due date. Instead of obtaining the needed

[27] Testimony of Ms. DeLeon.

information in advance, C Care made a business decision to submit its financial information late, counting on a grace period to avoid being penalized by its late filing. Under these circumstances, even though the problems with the MMIS caused additional delay, it was not *highly unreasonable* for the ORR to comply with 7 AAC 145.520 and impose the 20% rate reduction.

D. The Applications To The Centers For Medicare & Medicaid Services Do Not Preclude Imposition Of A Rate Reduction

C Care's second argument is related to Medicaid participation applications submitted by the State of Alaska to the federal government. There are several applications, one for each type of Medicaid program. All of these applications have a provision which, according to C Care, prohibits imposition of a rate reduction. For example, the Home and Community-Based Services Waiver application has a provision titled "Provider Retention of Payments." For this provision, the application states "Providers receive and retain 100 percent of the amount claimed to CMS for wavier services."[28] C Care argued that providers subject to a rate reduction would only receive 80% of the amount claimed. According to C Care, the rate reduction regulation violates the State's agreement with the federal government and is, therefore, unenforceable.

Ms. DeLeon testified that she was unaware of this provision when she decided to delay submitting her financial information. Thus, she cannot claim that C Care relied on this when she made that decision. In addition, to the extent C Care's interpretation is correct, it would be up to the federal government to enforce that provision. C Care is not a party to that agreement, and there is no indication that C Care is an intended third-party beneficiary.

Next, the evidence in the record does not support C Care's interpretation. Randall Schlapia, an ORR audit supervisor, explained that the state is reimbursed by CMS for a portion of the amount the state pays for Medicaid and Medicare services. When the state pays a provider $100, it submits a claim for that amount to CMS, and receives a portion of that amount in reimbursement.[29] The provision relied on by C Care explains that the full $100 will be received and retained by the provider. If a provider is subject to a 20% rate

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[28] Exhibit 2 (Appendix I: Financial Accountability I-3 Payment (6 of 7)). CMS stands for the Centers for Medicare & Medicaid Services.

[29] The percentage reimbursed by the federal government varies depending on the service being reimbursed.

reduction, then the amount submitted to CMS would also be reduced by 20%. In the example above, the state would only claim $80, which is still the full amount received and retained by the provider.[30] Accordingly, there is nothing inconsistent between the application provisions and a 20% rate reduction.

IV. Conclusion

C Care Services was aware well in advance that it was required to file its 2012 audited financial information on or before September 30, 2013. It knew the information its auditors would ask for to prepare the financial report. C Care made a decision not to gather the necessary information for its report prior to September of 2013. Its report was late because of that decision. Accordingly, even though the implementation of the new MMIS caused additional delay, it was not highly unreasonable to impose the 20% rate reduction required by regulation.[31]

Dated this 7th day of May, 2014.

Signed
Jeffrey A. Friedman
Administrative Law Judge

Adoption

The undersigned, by delegation from of the Commissioner of Health and Social Services, adopts this Decision, under the authority of AS 44.64.060(e)(1), as the final administrative determination in this matter.

Judicial review of this decision may be obtained by filing an appeal in the Alaska Superior Court in accordance with Alaska R. App. P. 602(a)(2) within 30 days after the date of this decision.

DATED this 5th day of June, 2014.

By: *Signed*
Signature
William J. Streur
Name
Commissioner
Title

[This document has been modified to conform to the technical standards for publication.]

[30] Testimony of Mr. Schlapia.

[31] The ORR has delayed imposition of the rate reduction pending the outcome of this hearing. This decision does not address whether or how the ORR will implement the rate reduction retroactively. *See In re A. Care Services*, OAH No. 13-0935-MDR, page 3.