Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Pennsylvania Department of Human Services
Docket No. A-15-111
Decision No. 2710
June 3, 2016

DECISION

The Pennsylvania Department of Human Services (State), which administers Pennsylvania's Medicaid program, claimed $36,268,423 in federal financial participation (FFP) for expenditures by county mental health agencies on Mental Health Administrative Case Management (MH-ACM) during state fiscal years (SFYs) 2011, 2012, and 2013. The State characterized the claimed expenditures as costs of Medicaid administration.

The Centers for Medicare & Medicaid Services (CMS) disallowed FFP for those expenditures. In doing so, CMS found that the formula used by the State to allocate MH-ACM expenditures between Medicaid and other programs did not "identify an accurate number" of Medicaid-eligible clients served by the county mental health agencies that provide MH-ACM services. July 21, 2015 Notice of Disallowance at 2. As a result, said CMS, the State's claims for FFP in those expenditures did not meet applicable legal requirements, including cost principles for allocability and the statutory requirement that an expenditure be "necessary . . . for the proper and efficient administration" of the State's Medicaid program. *Id*., *citing* 42 U.S.C. § 1396b(a)(7). CMS made additional findings, including that the State's FFP claims reflected expenditures that were categorically unallowable as costs of Medicaid administration.

The State has appealed the disallowance, contending that its methodology for allocating county-level MH-ACM expenditures was included in Pennsylvania's Public Assistance Cost Allocation Plan (PACAP) approved by CMS. The State thus portrays the disallowance as an "improper challenge to . . . approved PACAP provisions." State's Opening Brief (Pa. Br.) at 15. The State insists that the disallowed expenditures were allocated to Medicaid in a manner "consistent with" its PACAP. State's Reply Brief (Reply Br.) at 4. CMS denies that Pennsylvania properly followed the PACAP methodology. CMS's Response Brief (Response Br.) at 6, 12-13, 23-24.

When, as here, CMS disallows FFP based on concerns about how a state allocated its administrative expenditures among federal and non-federal programs, the state must demonstrate that the allocation methodology it used was consistent with its PACAP and was implemented in a manner which ensured that expenditures charged to the Medicaid program met all requirements for federal reimbursement. We find that the State has not carried that burden in this appeal.

The State admits that it did not collect information on whether clients receiving the MH-ACM services were Medicaid eligibles, as opposed to those who were uninsured or covered by General Assistance (GA) or other State-only funded programs. Nevertheless, the State argued that it interpreted its PACAP to allow it to use the number of clients receiving all mental health services through Medicaid in place of the number of Medicaid eligibles receiving MH-ACM services. Further, according to the State, the numbers are effectively equivalent since those who receive mental health services are assumed to have first received MH-ACM services as a "front door" to accessing the mental health system. As explained below, the State's calculations were inconsistent with the PACAP methodology; its claims of an alternative interpretation of that methodology appear to be after-the-fact rationalizations that do not represent a plausible reading in context; the assertion that the number of Medicaid eligibles receiving mental health services is equivalent to the number of Medicaid eligibles receiving MH-ACM services is unsupported on this record; the use of the State approach, even if permitted by the PACAP, would not be consistent with cost principles and applicable requirements; and the other arguments offered by the State to justify its claims are without merit.

For these and other reasons, we sustain the disallowance in its entirety.

Applicable legal authorities

A state Medicaid program providing medical insurance to financially needy and disabled persons must be operated in accordance with federal requirements. 42 U.S.C. § 1396 *et seq.* Those requirements include the terms of the state's federally approved Medicaid State plan, *id.* § 1396a(a), and provisions of title XIX (sections 1901 *et seq.*) of the Social Security Act (Act).

Under section 1903(a) of the Act, 42 U.S.C. § 1396b(a), a state Medicaid program is eligible to receive FFP in a share of its program-related expenditures. Most Medicaid program expenditures are for "medical assistance," a term which refers to the broad categories of medical items and services (such as inpatient hospital care or physician services) that the state is authorized (and in some cases required) to provide and pay for under the terms of its State plan. *Id.* § 1396d(a). The federal share of medical assistance expenditures is set for each state. *Id.* § 1396d(b).

Other state Medicaid program expenditures support administrative functions, such as medical claim processing and utilization review. *Id.* § 1396b(a)(2)-(7). Apart from specific enhanced rates not relevant here, FFP at a rate of 50 percent is authorized in section 1903(a)(7) of the Act for "[a]ll other activities the Secretary [of Health & Human Services] finds necessary for proper and efficient administration of the State plan." *Id.* § 1396b(a)(7); *see also* 42 C.F.R. § 433.15. Longstanding CMS policy recognizes that "administrative case management" – which, in the Medicaid context, refers to activities that help Medicaid applicants or recipients obtain and coordinate access to Medicaid-covered services – may be necessary for Medicaid program administration. CMS Ex. 1 (Dec. 20, 1994 letter to State Medicaid Directors from the Health Care Financing Administration); *Pa. Dept. of Public Welfare*, DAB No. 2669, at 18-19 (2015).

Federal regulations in 45 C.F.R. Part 95 require a state to specify in its PACAP the procedures "for equitably allocating administrative costs incurred by states and their various components, agents and other entities that participate in multiple federal and non-federal programs." *Pa. Dept. of Public Welfare*, DAB No. 2653, at 13 (2015); *see also* 45 C.F.R. § 95.501, 95.503, 95.507. Those regulations also require a state to claim "FFP for costs associated with a program **only** in accordance with" an approved PACAP. 45 C.F.R. § 95.517(a) (emphasis added). Otherwise, the costs "improperly claimed will be disallowed." *Id.* § 95.519.

In claiming FFP for MH-ACM expenditures, the State was also subject to federal "cost principles" for determining "allowable" costs. 45 C.F.R. § 92.22 (Oct. 1, 2013); *Pa. Dept. of Public Welfare*, DAB No. 2669, at 3 (2015). When the expenditures at issue in this case were made (SFYs 2011 through 2013), the applicable cost principles were found in Office of Management Budget Circular A-87 ("Cost Principles for State, Local, and Indian Tribal Governments"), which was codified in 2 C.F.R. Part 225.[1] 45 C.F.R. § 92.22(b) (Oct. 1, 2013).

Under these cost principles, a state expenditure is allowable only if it meets certain basic criteria. 2 C.F.R. Part 225, Appendix A, ¶ C.[2] One criterion is that an expenditure must be "allocable to" the federal program. *Id.*, Appendix A, ¶ C.1.b. Allocability means that when expenditures (or the goods or services purchased with the expenditures) serve multiple "cost objectives" (a cost objective can be a program, organization, function, or activity), then the expenditures must be charged to those objectives "in a manner that

[1] In late 2013, OMB consolidated the content of OMB Circular A-87 and several other circulars into a single set of uniform cost principles. 78 Fed. Reg. 78,590 (Dec. 26, 2013). HHS and other federal departments and agencies adopted (in whole or part) the uniform cost principles in late 2014. 79 Fed. Reg. 75,872 (Dec. 19, 2014). HHS's adoption of the uniform cost principles is codified in 45 C.F.R. Part 75 and became effective on December 26, 2014. *See* 2 C.F.R. § 300.1; 45 C.F.R. §§ 75.106, 75.110(a).

[2] We cite throughout this decision to the January 1, 2013 edition of 2 C.F.R. Part 225.

fairly reflects the relative degree to which each [cost objective] benefits" from the expenditures. DAB No. 2653, at 9; 2 C.F.R. Part 225, Appendix A, ¶ C.3.a (stating that a cost is "allocable to a particular cost objective if the goods or services involved are chargeable or assignable to such cost objective in accordance with relative benefits received").

Factual and case background

1. *Medicaid and mental health services in Pennsylvania counties*

In Pennsylvania, most Medicaid recipients receive covered health care under a managed care program called HealthChoices; the rest receive coverage under a fee-for-service system.[3] *See* CMS Ex. 11, at 1 (indicating that "[a]s of July 2011, over 80 percent of all Medicaid beneficiaries were enrolled in some form of managed care"). HealthChoices has two components: one provides medical coverage (for physical conditions); the second component covers "behavioral health" services – that is treatment for mental health and substance abuse problems. *Id.* at 1.

During the fiscal years at issue in this case, in addition to its Medicaid program, the State operated a GA program to provide a State safety net of medical and mental health benefits to low-income adults who were not eligible for Medicaid. *See* 62 Pa. Stat. § 403.2; 55 Pa. Code § 141.61. GA benefits were funded entirely with state funds, that is the federal government did not provide FFP for any GA expenditures. 55 Pa. Code § 1101.21 (defining GA as a program funded solely with state funds).

The parties' dispute arises from the intersection of Pennsylvania's Medicaid program and community mental health system. We therefore sketch out how mental health services are delivered to individuals in need in Pennsylvania. In accordance with the State's Mental Health and Mental Retardation Act of 1966 (1966 Act), *codified in* 50 Pa. Stat. § 4101 *et seq.*, Pennsylvania's community mental health system is county-based, administered by offices of county government. Pa. Ex. 3, at 4; CMS Ex. 3, at 9. The 1966 Act requires that counties offer various mental health services, including short-term inpatient care, outpatient care, specialized rehabilitation and training, aftercare for persons released from state and county facilities, and, particularly relevant here, "unified procedures for intake for all county services and a central place providing referral services and information." 50 Pa. Stat. § 4301(d). Most of these legally-mandated

[3] Pennsylvania operates HealthChoices as authorized by CMS under section 1915(b) of the Act, 42 U.S.C. § 1396n(b). *See* CMS Ex. 11, at 2.

services are delivered by community-based providers under contract with the counties. CMS Ex. 3, at 9. The county systems are overseen by the Pennsylvania Department of Human Services' Office of Mental Health and Substance Abuse Services (OMHSAS). *See* 50 Pa. Stat. § 4201.

Counties operate their community mental health systems in part with "base" funds appropriated by the state legislature and allocated by OMHSAS. Pa. Ex. 3, at 1; 55 Pa. Code § 4300.136. Counties use these funds to meet their obligations under the 1966 Act. CMS Ex. 25, at 1; 55 Pa. Code §§ 4300.154, 4300.158(a). Certain other money is allocated as "categorical" funds, meaning that their use is dedicated to supporting specific activities, functions, or populations. Pa. Ex. 25, at 1; 55 Pa. Admin. Code § 4300.155(a) (stating that that "[c]ategorical funding is the identification of a certain dollar amount in a county mental health . . . allocation to be used for a specific component of the county program"). For example, categorical allocations support the State's Behavioral Health Special Initiative, a safety net program for "people without health insurance who require drug or alcohol treatment services." Pa. Ex. 12; *see also* CMS Ex. 14, at 1.

In addition to administering the community mental health system, many of Pennsylvania's counties manage the behavioral health component of HealthChoices. Under that program, a county may enter into a contract with the State to provide Medicaid enrollees in that jurisdiction with mental health and drug and alcohol treatment services through a risk-based managed care plan. CMS Ex. 11. As a HealthChoices contractor, a county may operate a HealthChoices behavioral health plan directly. Pa. Ex. 19, at pg. vii (defining the term "County Operated BH-MCO") and pg. 1 (indicating that a county which "demonstrate[s] capacity to meet the standards and requirements for" the HealthChoices program is provided "the first opportunity to enter into a capitated [risk-based] contract with" the State). However, most counties with HealthChoices contracts apparently subcontract the day-to-day operation of their behavioral health plans to non-public managed care organizations (MCOs) while retaining oversight of the plan. *See* CMS Ex. 11, at 3 (identifying the managed care organizations associated with counties' Healthchoices behavioral health plans); Pa. Ex. 19, at 39 (stating that a HealthChoices Primary Contractor "oversees and is accountable for any functions and responsibilities it delegates" to an MCO or other subcontractor). A county's HealthChoices behavioral health plan is funded, not with allocated base funds, but with periodic "capitation" payments made by the State for each plan enrollee.[4] *See* Pa. Ex. 19, at pgs. vi, 2, 65.

[4] A capitation payment constitutes payment for the provision of "In-Plan Services, whether or not the Member received the services during the period covered by the [payment]." Pa. Ex. 19, at pgs. vi, 10; *see also id.* at pgs. 19-22 (defining the scope of required "In-Plan Services" under a HealthChoices behavioral health plan).

2. *Administrative case management in the county mental health programs*

In correspondence with CMS, the State has stated that "all persons needing publicly funded mental health services," whether or not eligible for Medicaid, "must access those services through the county mental health program." CMS Ex. 25, at 4. County mental health offices function (in part) as gatekeepers – performing "intake" (*e.g.*, conducting an initial interview and assessment of the person requesting assistance, developing a care plan, and making necessary "referrals"), determining financial "liability" (the responsibility of public or private insurance, or the client personally, for the cost of needed services), and "authorizing" services that are covered by Medicaid or other programs financed in whole or part by state funding. *Id.* at 2; Pa. Ex. 3, at 2, 3, 4-5. The State has described these activities as the "front door" to the community mental health system. Reply Br. at 5.

Each county mental health program reports its expenditures on an annual Income and Expenditure (I&E) report. CMS Ex. 25, at 2. The I&E report categorizes these expenditures by "cost center." *Id.* Each cost center captures the expenditures made for a different category of mental health service or administrative function performed by the county or by an organization under contract with the county. *Id.*; *see also* CMS Ex. 14, at 13 (I&E Report for Erie County showing cost centers for, among other services and functions, "Administrative Management," "Crisis Intervention," "Community Services," and "Day Treatment"). In addition, each cost center identifies the various funding sources (*e.g.*, "base allocation," "categorical funding") or "revenues" (such as medical assistance) supporting the reported expenditures. CMS Ex. 21, at 2; CMS Ex. 14, at 13. HealthChoices capitation payments are *not* reported on the I&E report. *See* CMS Ex. 22, Part A, at 32.

The cost center relevant to this case is called "Administrative Management." An OMHSAS policy bulletin defines the Administrative Management cost center as follows:

> The Administrative Management cost center applies to those activities and administrative functions undertaken by [county] staff in order to ensure intake into the county mental health system and the appropriate and timely use of available resources and specialized services to address the needs of individuals seeking assistance. **Services are available for all persons who have a mental health diagnosis** . . . for the purposes of facilitating and monitoring a person's access to mental health services and community resources. The activities include, but are not limited to:
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> a. Processing of intake into the Base Service Unit;
> b. Verification of disability;
> c. Liability determination;
> d. Authorization for services;

e. Monitoring of service delivery through review of evaluations, progress notes, treatment/service plans, and other written documentation of services;
f. Maintenance of records and case files;
g. On an occasional and situational basis, administrative case managers may provide some direct service to individuals as described below:

1. Coordination of service planning with state mental hospitals and other out-of-home placement facilities with other systems;
2. Provision of supportive listening and guidance in problem-solving to consumers, their families and significant others;
3. Contact with family, friends, school personnel and significant others to develop or enhance the consumer's natural support network;
4. Advocacy efforts to improve consumers' life situations, promote consumer choice, improve services, eliminate stigma, etc.

Pa. Ex. 2, at 9 (bold added; underlining in original). Examples of I&E reports submitted by CMS indicate that, during the relevant fiscal years, expenditures reported in the Administrative Management cost center were financed by counties' "base allocations" and by "categorical funding." CMS Ex. 14, at 13.

3. *Federal claims for county mental health administrative case management*

Beginning in January 2002, the State began to claim Medicaid FFP for expenditures reported in the Administrative Management cost center of the counties' annual I&E reports. CMS Ex. 3, at 6, 22. The State identified the claimed expenditures as having been made for mental health administrative case management and claimed them as costs of Medicaid administration.[5] *Id.* at 6, 26. Since MH-ACM services were available to all persons with a mental health diagnosis in the county, it was necessary to determine the share of the expenditures attributable to Medicaid that might be properly allocated to the Medicaid program.

[5] Pennsylvania's counties provide other types of case management (such as "intensive case management") that are covered as medical assistance under Pennsylvania's State plan. See CMS Ex. 3, at 9, 10.

In 2007, the Department of Health & Human Services' Office of Inspector General (OIG) issued a report concerning its audit of the State's FFP claims for the MH-ACM (mental health administrative case management) expenditures of Allegheny County (Pennsylvania) during FYs 2002 and 2003. CMS Ex. 3. The OIG found that the claims failed to comply with federal law because the State had not amended its Public Assistance Cost Allocation Plan (PACAP) to specify the method and procedures for identifying, measuring, and allocating county-level MH-ACM expenditures to the Medicaid program. *Id.* at 4, 5, 6. Accordingly, the OIG recommended that CMS direct the State to amend its PACAP to specify its procedures for allocating and claiming those expenditures. *Id.* at 6. The State objected to the recommendation stating it had already added some general language to the PACAP, reading as follows: "In accordance with a request from the OIG, we are including this reference that the Department of Public Welfare claims administrative case management expenditures **associated with the medical assistance eligible clients** in the counties." *Id*. (emphasis added). CMS commented that it did not believe further amendment was necessary and that requiring submission of separate amendments for all the counties would be administratively burdensome. *Id*. Nonetheless, the State proposed, and CMS accepted, the following further amendment to its PACAP:

> The Department of Public Welfare (DPW) claims administrative case management (ACM) **expenditures associated with the Medical Assistance (MA) eligible clients** in the counties. The ACM functions performed by County Mental Health (MH) staff are defined as those necessary for intake into the community mental health system and **directly connected to determining eligibility for and authorizing mental health services covered by the Medicaid State Plan**. The expenditures for these activities are necessary for the proper and efficient administration of the State plan and as such are eligible for fifty percent Federal match pursuant to section 1903(a)(7) of the Act. DPW calculates the ACM claim using actual expenditures from annual "Income and Expenditure" reports submitted by the County MH offices, instructions for which are provided to the counties yearly. **General Assistance clients are eliminated from the numbers of persons determined MA eligible at the time of the service delivery and the unduplicated number of MA eligible persons served for each county is converted to a percentage which is applied against the actual expenditure data.**

CMS Ex. 13 (emphasis added); *see also* Pa. Ex. 16 (email correspondence between the State and CMS).

Three elements of this provision are important for our later discussion. First, the provision indicates that the State would claim FFP only for the MH-ACM expenditures "associated with" Medicaid-eligible clients of county mental health offices. Second, the

provision stipulates that MH-ACM expenditures necessary for Medicaid administration are those "directly connected with" helping a Medicaid-eligible client gain access to "mental health services covered by the Medicaid State plan." Third, the PACAP calls on the State to calculate, for each county, a "percentage" of "persons served" who are unduplicated Medicaid eligibles (i.e., MA eligibles remaining after eliminating those on GA) and to apply that percentage against "actual expenditure data." The actual expenditure data would be county expenditures reported in the Administrative Management cost center of the counties' annual I&E reports.

4. *History of the present disallowance*

In 2013 and 2014, CMS performed "financial reviews" that resulted in the deferral of FFP claims for county MH-ACM expenditures made during SFYs 2011 through 2013. *See* CMS Ex. 24. In correspondence with the State about the deferral, CMS expressed various concerns about the allowability of those expenditures. Pa. Ex. 3. One concern was that the State could not, for each county, identify the "number of actual" Medicaid-eligible persons who received (or benefited from) MH-ACM services. *Id.* at 3. According to CMS, the State had relied on an "estimate" of that number to calculate Medicaid's share of counties' MH-ACM expenditures – an estimate which reflected an assumption that "everyone receiving FFS [fee-for-service] or MC [managed care] behavioral health services also received case management." *Id.*

In a November 6, 2013 letter responding to the deferral, the State alleged that its methodology for quantifying the portion of the MH-ACM expenditures charged to the Medicaid program "specifically identifies the number of Medicaid eligibles that receive case management" and further explained:

> . . . [T]he only [MH-ACM] costs being claimed [for FFP] are those listed in the Administrative management cost center that primarily pertain to intake and liability determination. The ratio, or percentage, of MA [Medicaid] eligibles compared to the universe of all individuals who received services, by county, is applied to the expenditures in the Administrative Management cost center to determine the Medicaid reimbursable amount by county. By applying the percentage, [MH-ACM] expenditures for non-MA eligible individuals, the uninsured, and underinsured are not claimed.

CMS Ex. 25, at 4, 6.

After considering the State's response to the deferral, CMS disallowed the claimed MH-ACM expenditures for SFYs 2011 through 2013, stating that they were "not necessary for the proper and efficient administration of the Medicaid program as required by section

1903(a)(7) of the Act" or had been charged to Pennsylvania's Medicaid program in violation of federal cost principles. July 21, 2015 Notice of Disallowance at 2. More particularly, CMS found:

- The "formula" used to calculate Medicaid's share of a county's MH-ACM expenditures "fail[ed] to identify an accurate number of Medicaid eligibles served," and as a result the State's FFP claims included MH-ACM expenditures that were "not directly related to a Medicaid state plan or waiver service." *Id.* at 2.

- Some of the claimed MH-ACM expenditures were for state-funded services, including those furnished "exclusively" to the uninsured, that "were not necessary and reasonable for the proper and efficient administration of the Medicaid program." *Id.* at 3.

- The State's FFP claims improperly included "operating costs" of the county mental health agencies. *Id.* at 3.

- Some portion of the claimed MH-ACM expenditures duplicated managed care capitation payments for which the State had already claimed and received FFP. *Id.* at 4.

On September 18, 2015, the State filed its notice of appeal in this case, stating, among other things, that CMS was "challenging as erroneous a cost allocation methodology that it approved in the State's Public Assistance Cost Allocation Plan." Notice of Appeal at 1.

5. *Proceedings in this case*

The Board acknowledged its receipt of the State's appeal in a letter dated October 1, 2015. In that letter, the Board, recognizing the apparent complexity of the issues raised by the disallowance, granted the State 60 days (30 more than the normal) – or until November 30, 2015 – to file its initial merits brief and supporting evidence. (The deadline was later extended, at the State's request, to December 7, 2015.) The Board also directed CMS to produce (1) "copies of any reports from the reviews referenced in the July 21, 2015 disallowance notice that have not already been provided to the appellant" and (2) "copies of any worksheets or other audit papers that explain how the disallowance amount was calculated[.]" Board acknowledgment at 2.

On November 16, 2015, the State filed a motion to compel discovery from CMS and asked the Board to stay the briefing schedule pending disposition of the motion. (The State also filed a motion to dismiss, which the Board denied.) The State's discovery motion alleged that CMS had not complied with the Board's earlier instruction to

produce certain reports and audit papers. The State also sought "additional discovery," including the production of "documents that relate to the negotiation and approval" of the relevant PACAP provision.

The Board directed CMS to respond to the State's discovery motion (which CMS did),[6] but for various reasons, including the State's admission that it was prepared to file its opening brief by the December 7, 2015 deadline, denied the request to stay the briefing schedule.

The State filed its opening brief and appeal file on December 7, 2015. After CMS filed its response brief, the State filed a reply brief together with a request for a "conference with the Board to discuss the need for further record development." State's Request for a Conference and Evidentiary Hearing (Jan. 31, 2016) at 1. We rule on these requests later in this decision.

Discussion

In its merits briefs, the State objects to each of the four grounds for disallowance articulated by CMS in its July 21, 2015 disallowance notice. The first ground concerns how the State determined the portion of each county's MH-ACM expenditures to allocate to the Medicaid program. Our analysis focuses most heavily on that ground because our conclusion that the State failed to follow the allocation methodology in its PACAP and violated applicable law in calculating its claims for MH-ACM expenditures is sufficient in itself to support the entire amount of the disallowance. We also briefly address the other three grounds for disallowing some portions of the claims, and we reject additional arguments raised by the State challenging whether the Board proceeding is the proper venue to resolve these disputes. Finally, we rule on the outstanding State requests.

1. *The claims at issue were inconsistent with the methodology in Pennsylvania's PACAP and also violate applicable cost principles and legal requirements.*

    a. Claims for FFP must be consistent with the methodology in the PACAP and with other applicable requirements.

As explained earlier, states must specify in their PACAPs how they will allocate administrative costs for entities participating in multiple federal and non-federal programs and may only claim FFP for such costs in accordance with that PACAP. *Pa. Dept. of Public Welfare*, DAB No. 2653, at 13 (2015); 45 C.F.R. §§ 95.501, 95.503,

[6] In its December 3, 2015 response to the discovery motion, CMS asserted (at page 4) that it had "fully complied" with the Board's October 1, 2015 production order and further represented that it had "sent appellant an electronic copy of its entire file on the Medicaid Disallowance at issue."

95.507, 95.517(a). Furthermore, those claims must also comport with applicable cost principles and federal requirements to be allowable. *Pa. Dept. of Public Welfare*, DAB No. 2669, at 3 (2015). Furthermore, administrative costs allocated to Medicaid are subject to a specific statutory limitation, making them eligible for FFP only to the extent they are "necessary" for the "proper and efficient administration" of the Medicaid program. 42 U.S.C. § 1396b(a)(7). A state's allocation method must ensure that an FFP claim does not include administrative costs that violate that limitation. *Cf. N.J. Dept. of Human Servs.*, DAB No. 1801, at 3 (2001) (holding that an approved cost allocation plan "is not an unalterable 'contract' binding the parties," and that "[c]osts claimed in accordance with the plan still must be allowable under the applicable cost principles, regulations, and law and are still subject to any administrative or statutory limitations" (internal quotation marks omitted)).

In short, a state Medicaid program's administrative costs are allowable only if the costs were "properly allocated, charged [to Medicaid] in accordance with an approved PACAP, and reasonable and necessary for the proper administration of the program." DAB No. 2653, at 4. Thus, even if we had found (which we do not, as explained below) that the State followed the general methodology in the PACAP, we would have to consider as well the questions raised by CMS about whether the PACAP methodology was applied in a manner inconsistent with the governing legal principles.

We also note that, once CMS questioned whether the county-level MH-ACM expenditures were claimed in a manner consistent with the PACAP and applicable law, the State had the burden in this proceeding to demonstrate their allowability. *Id.* at 5, 9-10; *see also* 42 C.F.R. § 430.42(b)(2)(ii) (stating that "[i]n all cases, the State has the burden of documenting the allowability of its claims for FFP"). In other words, the State needed to show, not only that it followed its PACAP, but that the methodology it applied was "reasonable" and resulted in an allocation that complied with the federal cost principles and other legal conditions for allowability. DAB No. 2669, at 8 (noting that "apart from" complying with PACAP requirements in 45 C.F.R. Part 95, the State was required to "demonstrate . . . . that some reasonable methodology was used to allocate" the disallowed administrative costs); DAB No. 2653, at 9-10 (citing prior Board decisions and stating that the state needed to show it "follow[ed] a proper methodology for equitably allocating all administrative costs").

Applying these requirements, we begin (in subsection b) by looking at the applicable allocation methodology which the State included in its approved PACAP. We then consider (in subsection c) what the State actually did in allocating the MH-ACM expenditures at issue, which we find inconsistent with the PACAP methodology. In subsections d through e, we consider the State's various arguments that it nevertheless followed a reasonable interpretation of the methodology specified in its PACAP and that the counties' MH-ACM expenditures were properly allocated to Medicaid as a result.

b. The PACAP methodology required the State to calculate, for each county, the percentage of Medicaid-eligible MH-ACM clients.

As set out in the background section, the PACAP description of the allocation method provides for the allocation of MH-ACM expenditures "associated with the Medical Assistance (MA) eligible clients in the counties" which are "necessary for the proper and efficient administration of the State plan." CMS Ex. 13. The portion to be allocated for 50% FFP is to be calculated "using actual expenditures" from county I&E reports, by eliminating GA clients from "the numbers of persons determined MA eligible," at the time of the service delivery," and converting the remaining "unduplicated number of MA eligible persons served for each county" to a percentage of persons served which is then "applied against the actual expenditure data."[7] *Id*. CMS has not made any allegation that the methodology set out in the PACAP was unacceptable but instead has strongly challenged whether the State actually followed that methodology in the disputed claims.

On its face, the PACAP methodology appears to call for figuring out what percentage of the clients served by each county's MH-ACM program were Medicaid-eligible, separated from those eligible for State GA funding only. Yet the State has expressly admitted that it "**did not maintain a count of individuals utilizing Medicaid funded MH-ACM services during the claim period**." PA Ex. 18, ¶ 4 (declaration of Susan Snyder, director of OMHSAS's Division for Budget and Administrative Services) (emphasis added). We therefore begin by considering whether the PACAP indeed anticipated these core data being collected in order to implement its allocation methodology.

A close reading of the terms of the methodology reinforces this expectation. First, the expenditures to which this methodology was to be applied were entirely MH-ACM services, so it is reasonable to presume that all the terms in the methodology related to those services rather than to other mental health services. Second, the PACAP makes clear that only those MH-ACM expenditures "associated with" Medicaid-eligible clients will be claimed, so the calculations to be performed must be understood as those reasonably related to identifying those expenditures rather than to those expenditures associated with other services.

[7] In the PACAP, MA refers to "medical assistance" clients eligible for services **either** under the State's Medicaid program **or** its GA program (that is, wholly state-funded aid to persons who are not eligible for Medicaid). *See* 55 Pa. Code § 1101.21 (definitions of "MA,", "GA," and "Medicaid"). According to the PACAP, the first step in deriving a county's Medicaid allocation "percentage" is identifying the total number of "persons determined MA eligible" (*i.e.*, the number of mental health clients determined eligible for MA under **either** Medicaid or GA), then subtracting the number of GA clients (GA "clients are eliminated from the numbers of persons determined MA eligible") – leaving only Medicaid-eligible persons served as the basis for calculating the Medicaid percentage.

Third, the percentage of Medicaid-eligible clients (MA-eligibles minus GA-eligibles) is to be applied against the county's pooled expenditures for MH-ACM administrative costs from the Administrative Management cost center on its annual I&E report. Given this methodology in the PACAP, it is evident that "persons served" by the county's MH-ACM program constitutes the allocation (or distribution) "base." An allocation base is used to accumulate the total relevant expenditures to then distribute in a manner intended to measure the relative benefits of those costs to Medicaid and other cost objectives or programs. The selection of an appropriate base for distribution of pooled costs is a matter of considering "cause-and-effect or other logical factor" which is reasonably related to the measurement of relative benefits.[8] *Teaching and Mentoring Communities, Inc.*, DAB No. 2636, at 9 (2015). Since the number of clients receiving MH-ACM services is likely to directly impact the expenditures to provide those services (or certainly at least to bear a strong logical relationship to the magnitude of the costs involved in service delivery), the PACAP methodology proposed to use persons served as an appropriate allocation base to distribute those costs across the programs benefitting from the MH-ACM activities.

We thus conclude that the language of the PACAP read as a whole expresses a planned methodology in which the relevant "persons served" are the clients who received an MH-ACM service (such as intake) during the relevant reporting period. It follows that the percentage of unduplicated "[Medicaid-]eligible persons served" must mean the percentage of distinct individual clients **who received MH-ACM services** (during the relevant reporting period) **who were also Medicaid-eligible** at the time they received those services.

This methodology from the PACAP is consistent with longstanding CMS policy, which calls for verifiably accurate allocations of MH-ACM costs in particular. Section 4302.2 of CMS's State Medicaid Manual (last revised in 1991) states that "[w]hen FFP is claimed for any functions performed as case management administrative activities under § 1903(a) . . ., **documentation must clearly demonstrate** that the activities were provided to Medicaid applicants or eligibles, and were in some way connected with determining eligibility or administering services covered under the State plan." Pa. Ex. 9 (emphasis added). Similarly, a December 20, 1994 State Medicaid Director Letter (SMDL) issued by CMS states that "with regard to any allowable administrative claim, payment [that is, FFP] may only be made for the percentage of time which is **actually attributable to Medicaid eligible individuals**." CMS Ex. 1, at 1-2 (emphasis added). The 1994 SMDL also cautions states that any cost allocation methodology for administrative case management costs must have the "**capability to isolate** the costs which are directly related to the support of the Medicaid program from all other costs incurred by the [state] agency." *Id*. at 6 (emphasis added).

[8] For example, an allocation base might be square footage used by different programs when allocating rental costs or staff activities as assessed by a random moment time study when allocating personnel costs.

We conclude that the PACAP required the State to be able to determine for each county for each relevant period what percentage of those receiving MH-ACM services were eligible for Medicaid in order to allocate the county's expenditures for administrative management of those services. Given that the State has frankly acknowledged that it does not have the information needed to determine the actual number of persons receiving MH-ACM services who are Medicaid-eligible, we turn next to considering how the State says it actually derived the claims at issue.

c. The State's calculations of the Medicaid percentage are inconsistent with the PACAP methodology.

The Board has held that the "first step in demonstrating that administrative costs have been properly allocated, once a disallowance has called that into question, is for the state to explain the methodology used for allocating the costs." *Pa. Dept. of Public Welfare*, DAB No. 2669, at 7. To do so here, the State offered an email and spreadsheet authored by Susan Snyder, explaining how it actually determined Medicaid's share of a county's MH-ACM expenditures. CMS Ex. 12. She reports that the State calculated the percentage of persons served for each county by first obtaining the unduplicated number of **Medicaid-eligible residents in the county who received a Medicaid-covered behavioral health service** (whether that service was provided under HealthChoices or on a fee-for-service basis) during the reporting period. That number was divided by the total number of unduplicated **persons who received either a Medicaid-covered behavioral health service or an MH-ACM service** during that same period. *Id*. at 2.

The State then converted this county-specific ratio to a percentage and multiplied the percentage by total expenditures in the Administrative Management cost center on the county's I&E report. *See* CMS Ex. 25, at 3; CMS Ex. 20, Part C, at 25. The State multiplied that product by 50 percent (the FFP rate for administrative expenditures) and included the result in its FFP claim. *Id.*

On its face, the ratio used by the State to determine the Medicaid percentage is inconsistent with Pennsylvania's PACAP, which called on the State to determine, for each fiscal period, the proportion of each county's MH-ACM recipients who were Medicaid-eligible when they received MH-ACM services. In other words, the PACAP called for a ratio whose denominator was the number of persons who received MH-ACM services during the fiscal period, and whose numerator was the number of those MH-

ACM recipients who were Medicaid-eligible when they received the MH-ACM services.[9] In her declaration, Ms. Snyder candidly admits that "[t]he ratio the State used to allocate Medicaid vs. non-Medicaid costs . . . in this case utilizes the number of persons receiving Medicaid-funded behavioral health services in both the numerator and denominator. It does not use the number of individuals utilizing Medicaid-funded Mental Health-Administrative Case Management services during the claim period." Pa. Ex. 18, ¶ 4.

It is apparent that the State used a ratio inconsistent with the PACAP because, as it now effectively admits, it simply lacked the data to effectuate the PACAP methodology. While the State claims to know the total unduplicated number of persons in each county who received "base-funded" MH-ACM services during each of the relevant fiscal years, the State acknowledges that it does not have data on the number of persons from that group who were Medicaid-eligible "at time of service." CMS Ex. 12, at 2 (describing columns E and F of the spreadsheet). Ms. Snyder's email states that the number of MH-ACM recipients who were Medicaid-eligible was "unknown" because the State did "not yet have" the necessary "person level encounter data on the AM [Administrative Management] recipients." *Id.*; *see also* Pa. Ex. 18, ¶ 4 (no count maintained of "individuals utilizing Medicaid funded MH-ACM services during the claim period").

We conclude that the State's actual allocation methodology was inconsistent with its PACAP. We next consider the State's arguments for why the claims should nevertheless be allowable.

d. <u>The State's alternative calculation method is not permissible</u>.

Despite its failure to calculate the Medicaid percentage using the ratio called for in the PACAP, the State suggests, on various grounds, that its allocation of MH-ACM expenditures satisfied applicable requirements. To begin with, the State suggests that its formula yielded good "estimates" of the proportion of a county's MH-ACM clients who were Medicaid-eligible. *See* Pa. Br. at 6 (acknowledging CMS's complaint that the ratio produced a mere "estimate" of the percentage of Medicaid-eligibles who received MH-

[9] Neither the denominator nor the numerator used in the State's ratio correspond to these values. The numerator of the State's ratio is the number of Medicaid eligibles in the county who (during the fiscal period) *received Medicaid-covered behavioral health services* during the fiscal year, as distinct from the number of Medicaid eligibles who *received MH-ACM services* (the value called for by the PACAP). And the denominator of the State's ratio is the sum of Medicaid eligibles who received Medicaid-covered behavioral health services during the fiscal period and the number of other distinct persons (Medicaid-eligible or not) who, though they had not received Medicaid-covered behavioral health services during that period, had received MH-ACM services. As noted, the PACAP required the denominator to reflect only the total number of persons who received MH-ACM services during the fiscal period.

ACM but responding that "the whole process of cost allocation involves estimates").[10] Ms. Snyder explained that the State's formula was based on the "assumption" that every person who received a Medicaid-covered behavioral health service during a fiscal year, whether through HealthChoices or the fee-for-service delivery system, *also* received an MH-ACM service from a county during that year. CMS Ex. 12, at 2 (discussing columns C and D of spreadsheet). The State's position is that this assumption justifies substituting the Medicaid-eligible recipients of behavioral health services for Medicaid eligibles who received MH-ACM in the PACAP ratio. However, the State offered no documentary evidence – or even a reasoned argument based on the structure and functioning of county mental health systems – to prove that the assumption is reasonable.

The only evidence on this point offered by the State was again Ms. Snyder's declaration stating:

> It is my opinion based upon my years of experience with the Pennsylvania behavioral health service system that **most** individuals receiving Medicaid fee-for-service or Medicaid managed care services **first** received MH-ACM costs because MH-ACM is the "front door" to the State's behavioral health system.

Pa. Ex. 18, ¶ 5 (emphasis added). This opinion serves more to undercut than support the blanket assumption on which the State's calculations depend.

First, "most" does not mean "all," and the validity of the State's calculations is based on the assertion that *all* persons who received Medicaid-covered services received a base-funded MH-ACM service in the same year. Second, Ms. Snyder's opinion does not assert that it was reasonable to assume that a person's receipt of a Medicaid-covered service in one year necessarily means that the person also received an MH-ACM service **during the same year,** which would be necessary for the State to reasonably use its

[10] The State's comment distorts the allocation process. An appropriate allocation methodology does permit a grantee to receive federal participation in activities that provide shared benefits to federal programs and other activities without the often-costly effort that would be required to attempt to trace each cost incurred directly to the benefitting program. Thus, for example, here the PACAP methodology would relieve the State of tracing precisely what MH-ACM services each individual Medicaid recipient received and then what expenditures the county incurred to provide that specific service, by permitting the pooling of joint or common expenditures and using a percentage to essentially represent an estimate of the average cost of the MH-ACM services received by Medicaid recipients (and hence benefiting the Medicaid program). The flexibility thus created by an appropriate allocation methodology, however, is premised on the accuracy of the information used to apply it and cannot justify piling on estimates and assumptions in place of the data called for by the methodology.

formula in place of the one required by the PACAP.[11] The statement also leaves unanswered other questions, such as why some clients might not be aware of and go directly to their assigned HealthChoices plan to obtain services without first contacting the county program.[12] Finally, her statement overall is weak and lacks specifics. For example, she does not say that she based it on any personal examination or knowledge of relevant county-level data or clarify whether it pertains to the fiscal years at issue. She also does not give any reason to assume that every person who received MH-ACM services necessarily went on to receive Medicaid behavioral health services the same year, which would also be implicit in the theory that the number of those receiving Medicaid behavioral health services is equivalent to the number of Medicaid eligibles who received MH-ACM services.

Notwithstanding its failure to show that it accurately determined the percentage of MH-ACM recipients in a given year who were Medicaid-eligible when served, the State submits that the disallowance should be overturned because its ratio is "consistent with the vague language of the PACAP." Reply Br. at 6. The State says that it "interprets" the PACAP's phrase "numbers of persons determined MA eligible at the time of the service delivery" (after elimination of GA clients) to mean "the number of Medicaid eligible persons receiving behavioral health services, rather than those only receiving MH-ACM services," and the term "service" to mean a Medicaid-covered behavioral health service. *Id.* at 5. However, the State does not show that it actually interpreted the

[11] According to the State, county MH-ACM is the set of activities that opens the "front door" to a county's community mental health programs and contracted treatment providers. CMS Ex. 25, at 3. Even if we assumed that a client must "first" enter through the "front door" to receive behavioral health services, nothing demonstrates that the client may not continue to receive such services in future time periods without re-entering the system through the county MH-ACM doorway. Thus, a Medicaid-eligible person who receives intake and other services necessary to connect him with appropriate treatment providers might continue to receive Medicaid-covered care from those providers in a subsequent year without further involvement of, or coordination by, county MH-ACM staff.

[12] It is unclear why Medicaid eligibles who are members of HealthChoices behavioral health plans that are required to play a substantial role in authorizing, coordinating, and otherwise facilitating access to services needed by their members would repeatedly need county MH-ACM intake or authorization services. *See* Pa. Ex. 19, at 11, 21-22. The State did not explain how the county-administered or supervised HealthChoices behavioral health plans and the county mental offices who furnish "base-funded" MH-ACM services interact. Evidence in the record suggests that Medicaid eligibles may automatically be assigned to their local behavioral health plans prior to any request for such services. Pa. Ex. 19, at 11 (stating that plan "[m]embers are enrolled in the BH-MCO [behavioral health managed care organization] operating in their county of residence on or after being determined eligible for Medical Assistance").

plan in this way or relied on this interpretation and fails to explain how these interpretations could be reasonable in light of the provision's context and purpose. Instead, we find it difficult to reconcile these purported interpretations with the rest of the methodology in the PACAP.[13]

The State also offers no evidence that it relied upon its so-called interpretations when it proposed the relevant PACAP provision or developed the disallowed FFP claims. Indeed, Ms. Snyder acknowledges that she had no personal involvement in the developing of the processes for these claims and that the individuals who were involved have left the State agency. Pa. Ex. 18, ¶ 2 (also stating she based her declaration only on "a reasonable inquiry"). The State proffers no documentary evidence of any such interpretation contemporaneous with either the PACAP amendment or the period of the claims at issue. The most telling evidence that these interpretations are little more than post hoc rationalizations, moreover, comes from the previously-mentioned State spreadsheet contained in CMS Exhibit 12. The spreadsheet purports to show data elements relating to the State's calculation of the Medicaid percentage. One of the spreadsheet's columns is expressly designated to capture the number of MH-ACM recipients who were Medicaid-eligible **at the time they received MH-ACM services**. The presence of this column clearly implies that the State understood that it was supposed to allocate MH-ACM expenditures based on the actual number of Medicaid-eligible persons who received MH-ACM in a given fiscal year, rather than on a proxy number derived by assumptions. Yet that column is left blank.

Further evidence of the State's true understanding of cost allocation methodology can be found in a 1996 policy, issued by the State to county mental health offices, titled "Procedures for Claiming Federal Reimbursement on Administrative Costs for Medicaid Funded MH Services." CMS Ex. 20, Part A, at 20. That bulletin, which the State does not dispute was still in effect during the relevant fiscal periods, instructs county mental health programs to "document," as appropriate, either "the *actual* percentage of service or

[13] For example, if, as the State contends, the term "service" in the PACAP methodology meant any Medicaid-covered behavioral health service, then the PACAP would require the State to also calculate the "numbers of persons determined MA eligible at the time of . . . delivery" of any Medicaid-covered behavioral health services. In other words, the State's interpretation results in an odd instruction to determine how many persons already receiving Medicaid services are Medicaid eligible. Furthermore, if, as the State alleges, the PACAP authorized it to calculate the allocation percentage based on the number of persons in the county who received any Medicaid-covered behavioral health service (not those who received MH-ACM services), then it would follow that the State would also need to determine the total number of persons who received **any publicly funded behavioral health service** (whether or not paid for by Medicaid) during the same period. Yet the State does not argue that the PACAP required it to compute the latter number. Most importantly, the State's purported interpretations would essentially remove from the PACAP any meaningful proportional relationship between the county's MH-ACM expenditures and their benefit to Medicaid as opposed to other community mental health programs.

percentage of clients eligible to earn federal revenue" in order to determine the expenditures "eligible for [federal] reimbursement" and to maintain "[s]upporting documentation to substantiate reporting methods and reimbursements[.]" *Id.* at 22 (emphasis added).[14]

The State's 1996 policy – particularly the instruction to quantify the "actual . . . percentage of clients eligible to earn federal revenue" – is consistent with our reading of the PACAP language and with CMS policy in the State Medicaid Manual cited earlier requiring clear documentation that case management activities are claimed only for services to Medicaid applicants or Medicaid eligibles. Given that the relevant PACAP provision was negotiated and approved against the backdrop of the policies requiring accurate identification of MH-ACM expenditures associated with Medicaid eligibles, and given that the PACAP expressly called on the State to determine "numbers" of Medicaid eligibles served by county MH-ACM services, the State should have harbored no uncertainty about the information it needed to use – namely, data on the number of Medicaid-eligible persons who received MH-ACM services – to calculate the Medicaid percentage. And, as noted earlier, the State's own data collection forms suggest it did understand the meaning of the PACAP provision but simply failed to ensure that the necessary data were collected in practice. This conclusion is further bolstered by Ms. Snyder's statement that the State did not "yet" have the data (CMS Ex. 12, at 2), implying again that the State knew what data were needed to perform the calculations contemplated by a reasonable reading of the PACAP methodology but had simply not succeeded so far in collecting the information.

The State's assertion in its reply brief that the Medicaid percentages it calculated for each county were "the only reasonable" ones it could "construct with the data in its possession" does nothing to support the State's case. Reply Br. at 6. The State cannot use the unavailability or inadequacy of its own data as a basis for claiming FFP. Medicaid program regulations require states to create and maintain documentation and data sufficient to justify their FFP claims. 42 C.F.R. § 431.17(b)(2) (requiring that State plans provide for the maintenance of "[s]tatistical, fiscal, and other records necessary for reporting and accountability as required by the Secretary"); *id.* § 433.32(a) (requiring states to "[m]aintain an accounting system and supporting fiscal records to assure that claims for Federal funds are in accord with applicable Federal requirements"). Compliance with that requirement necessarily entails "creating and maintaining records adequate to document the actual distribution of activity among the federal and state

[14] Although it does not expressly mention "administrative case management," the 1996 bulletin does not in any case purport to contain an exhaustive list of the categories of the administrative cost to which it applies. CMS Ex. 20, Part A, at 21 (noting, for example, that "[d]irect administrative costs" that may be "apportioned" to Medicaid "generally include, **but are not limited to**" costs of various county functions or offices (emphasis added)).

programs." *Mich. Dept. of Social Servs.*, DAB No. 1211, at 6 (1990). In this case, it was the State's responsibility to ensure that county mental health programs collected and maintained data sufficient to document the "actual distribution of [MH-ACM] activity" among the counties' Medicaid-eligible and non-Medicaid-eligible clients. The State failed to meet that responsibility, admitting that it did not "maintain a count of individuals utilizing Medicaid funded MH-ACM services during the claim period." Pa. Ex. 18, ¶ 4.[15]

e. The State's remaining arguments for allowability have no merit.

The State's other points are unsupported, immaterial, or unclear. The State contends, for example, that a Medicaid percentage derived from a ratio equal to the number of Medicaid-eligible persons who received MH-ACM services divided by the total number of persons who received those services (that is, a percentage derived according to the plain language of the PACAP methodology as we read it) "makes no sense because it fails to recognize that MH-ACM services involve primarily outreach, intake, and eligibility determinations" and that "[i]ndividuals who are eligible for Medicaid at the time of MH-ACM delivery generally do not need those services." Reply Br. at 4-5.

The State does not show that the county mental health programs performed "outreach" and "eligibility determinations" as those terms are generally understood, and indeed State and county program records do not use those terms.[16] Instead, MH-ACM services provided by county mental health staff consist of such functions as: "processing of intake," which includes "assessments, development of a care plan[,] and referral to services"; "verification of disability"; "[a]uthorization for services"; "liability determination" (that is, determination of financial responsibility); and "[m]onitoring of service delivery." CMS Ex. 25, at 2, 4-5. The State does not explain why Medicaid-

[15] Even if we accepted (which we do not) the State's claim that the PACAP was ambiguous about the methodology, we note that the State would not be permitted to simply use any formula or data it wished, because it still must allocate costs in a manner which ensures compliance with statutory and regulatory requirements, including federal cost principles. *Cf. Mich. Dept. of Social Servs.*, DAB No. 370, at 4 (1982) (federal agency approval of a cost allocation plan "does not constitute an approval for the charging of costs in a manner inconsistent with applicable statutes and regulations"). The State retains the burden to "document the appropriateness of" the methodology it uses, *id.* at 9, and to demonstrate that it produced a "proper allocation," *Mass. Dept. of Public Welfare*, DAB No. 335, at 10 (1982) (sustaining a disallowance where the state applied its approved allocation method "in a manner which could not have resulted in a proper allocation of costs"). The State has not done that because it has not shown that the allocation ratio it calculated for each county accurately reflects the portion of the county's MH-ACM expenditures devoted to serving Medicaid-eligible clients.

[16] We see nothing in the record indicating that county mental health offices make or participate in making determinations about a person's **eligibility for Medicaid** (as distinct from determining whether a Medicaid-eligible person satisfies Medicaid coverage criteria to receive specific mental health services). Ms. Snyder merely declares without explanation that "the MH-ACM services claimed by the counties are qualitatively different from the targeted case management services that managed care organizations deliver to their clients." Pa. Ex. 18, ¶ 6.

eligible persons seeking behavioral health assistance would not need those services regardless of whether they have already been determined eligible for Medicaid when receiving them. Furthermore, the State's position is difficult to square with the State's reliance on the previously discussed assumption that **all** persons who receive a Medicaid-covered mental health service **also** receive an MH-ACM service during the same reporting period. If those who are eligible for Medicaid generally do not need MH-ACM services, how can they also all receive those services?

The State further asserts that its formula for calculating the Medicaid percentage (based on the number of Medicaid eligibles who received a behavioral health service) was intended to "follow individuals who received MH-ACM services to see . . . [i]f [those services] resulted in an individual obtaining Medicaid eligibility." Reply Br. at 5. The State cites no evidence that its allocation ratio served that purpose. Nothing in the State's formula called for tracking when the Medicaid recipients receiving behavioral health services obtained their Medicaid eligibility or how that related to whether or when they had received MH-ACM services. Moreover, the State does not explain why any intention to follow such individuals into the behavioral health system would be relevant to determining what share of the MH-ACM expenditures benefited the Medicaid program (the purpose of the PACAP methodology).

The State also contends that CMS "took no action to question" its allocation methodology for seven years and that "CMS [now] seeks to change the rules of the game retroactively, by saying that the methodology the state adopted to implement the PACAP is improper." Reply Br. at 3. That argument implies that CMS somehow knew of and permitted the State's approach despite its inconsistency with the approved PACAP methodology. The State produced no evidence that CMS was aware of that approach prior to the financial reviews that led to the disallowance. Nor has the State identified any retroactive rule change by CMS. We read the disallowance here as merely enforcing compliance with longstanding statutory and regulatory requirements, including section 1903(a)(7) of the Act and the allocability cost principle in OMB Circular A-87.

Moreover, any alleged prior tolerance by CMS would in any case be legally immaterial. Absent the necessary conditions for estoppel (*e.g.*, affirmative misconduct, detrimental reliance), which are not alleged to exist, a federal agency's inattention to a grantee's FFP claiming practices, or even a past policy or practice of non-enforcement, does not preclude the agency from issuing a disallowance to enforce applicable statutory and regulatory requirements. *Ga. Dept. of Human Resources,* DAB No. 870, at 9-14 (1987); *Mich. Dept. of Social Servs.*, DAB No. 1211, at 6; *Tenn. Dept. of Human Servs.*, DAB No. 1054, at 9-12 (1989).

f. We conclude that the MH-ACM expenditures were not properly allocated and therefore the Medicaid claims are not allowable.

To summarize, the county-level MH-ACM expenditures at issue in this appeal would be allowable only if they were claimed in accordance with Pennsylvania's PACAP, were allocated to Medicaid in accordance with "relative benefits received," and were "necessary" for Medicaid program administration. The State has failed to demonstrate that any of these requirements was satisfied. The PACAP required the State to allocate MH-ACM expenditures to Medicaid using the percentage of a county's MH-ACM clients who were eligible for Medicaid at the time they received MH-ACM services. The State did not follow this methodology. It did not use the allocation percentage called for by the PACAP because it did not know the number of each county's MH-ACM clients who were Medicaid-eligible. Instead, the State apportioned MH-ACM expenditures using a formula that produced an **estimate** of the percentage of a county's MH-ACM clients who were Medicaid-eligible. Any validity of that estimate, moreover, would depend entirely on factual assumptions whose accuracy and reliability the State has failed to substantiate. Because the State has not shown that it accurately quantified the share of each county's MH-ACM expenditures associated with Medicaid-eligible clients, there is no basis upon which we can hold that those expenditures were "allocable to" Medicaid (as required by federal cost principles) or necessary for Medicaid program administration (as required by section 1903(a)(7) of the Act).

2. *The State also improperly included in its claims expenditures that were categorically unrelated to helping persons gain access to Medicaid-covered services and which therefore could not be allocated to Medicaid.*

In addition to the concerns CMS raised about how the percentage of persons served was calculated, concerns which we determined in the preceding section to be well-founded, CMS also identified issues about some of the expenditures included in the pool itself. July 21, 2015 Notice of Disallowance at 3.

As discussed, the State apportioned each county's MH-ACM expenditures to Medicaid by applying an allocation percentage to the expenditures that the county pooled in the Administrative Management cost center of its annual I&E report. The record indicates that some of the expenditures pooled in the Administrative Management cost center were made using so-called "categorical" funds – state funds provided to the counties for specific mental-health-related programs (apart from those core community mental health programs and services that counties were legally obligated to provide under the 1966 Act). *See, e.g.*, CMS Ex. 14, at 13 (Administrative Management column). According to CMS, Pennsylvania's Medicaid program was charged (via application of the State's allocation percentage) for categorical expenditures relating to the following state programs: the Behavioral Health Special Initiative (BHSI); the Community Hospital

Integration Projects Program; the Southeast Integration Projects Program; Student Assistance Program (SAP) Services; Specialized Mental Health Services (SMHS); and the Direct Care Worker Initiative. *Id.*; Response Br. at 9.

CMS's position is that the allocation to Medicaid of any share of a county's categorical expenditures is unallowable because the expenditures support wholly state-funded, non-Medicaid assistance programs and are therefore "necessarily not reasonable and necessary for the proper and efficient administration of the Medicaid program." Response Br. at 8. In response, the State emphasizes that those programs incur costs of "intake and other related services that [were] properly charged to the administrative management line of the [counties'] I&E reports" and were therefore appropriately reflected in the disallowed FFP claims. Pa. Br. at 11. The State also asserts that CMS "has not cited any statute or regulation prohibiting the State from claiming MH-ACM costs under the cited programs." *Id.*

The record substantiates CMS's concern about the allocability of the categorical expenditures. According to a webpage submitted by the State, BHSI, one of the categorical programs whose expenditures were charged to Medicaid, is a "safety net" program for "people **without health insurance** who require drug or alcohol treatment services." Pa. Ex. 12 (emphasis added). The webpage further states that BHSI performs case management functions that include referral of clients to a "licensed drug and alcohol provider in the BHSI provider network." *Id.* Based on this limited information, no portion of MH-ACM expenditures funded by the BHSI program may be charged to the Medicaid program. According to the Pennsylvania's PACAP, MH-ACM expenditures are "necessary" for Medicaid program administration only to the extent that they help **Medicaid** clients get access to **Medicaid-covered** services. The BHSI program by definition helps **non-Medicaid-eligible** clients get treatment that is not covered by Medicaid (due to the clients' Medicaid ineligibility). When the State applied its allocation percentage to the BHSI expenditures, a portion of those expenditures was charged to Medicaid even though the expenditures conferred no apparent benefit to Medicaid and were not "necessary" for Medicaid program administration.[17] *See Ca.*

[17] The State submitted a guide for CAP development to suggest some costs associated with a state-only program may potentially be eligible for FFP. The costs to which that guide refers, however, involve the use of a single, concurrent eligibility determination process for entry into all programs and even in such cases the common costs of shared eligibility determination activities must be allocated properly. Pa. Ex. 10 (U.S. Dept. of Health & Human Servs., "Cost Principles and Procedures for Developing Cost Allocation Plans and Indirect Cost Rates for Agreements with the Federal Government: Implementation Guide for OMB Circular A-87") (April 8, 1997) at ¶ 2-14 (discussing allocation of "common costs" of determining persons' eligibility for federal and state-only programs when application and eligibility determinations occur concurrently). As we have said already, the costs at issue here do not include program eligibility determinations but rather identifying the responsible party and providing service authorization, referrals and care monitoring. Pa. Ex. 2, at 9 (defining the Administrative Management cost center to include costs of "[l]iability determination" for services, but not mentioning costs of program eligibility determinations).

Dept. of Benefit Payments, DAB No. 160, at 6 (1981) (holding that the federal agency "was not unreasonable in requiring the State to eliminate from [a cost pool] costs which are unallowable to any federal program because the State had not shown that its method of allocating costs excluded the unallowable costs from claims for FFP").

According to the State, it "does not matter that some [MH-ACM] services may be for uninsured persons because Agency policy allows as an administrative expense the costs of assisting non-Medicaid eligible individuals." Pa. Br. at 11. As evidence of that supposed policy, the State cites a passage from a November 2007 CMS rulemaking concerning "targeted case management," which States may cover as medical assistance under their State Medicaid plans. *Id.* (*citing* Pa. Ex. 8). The cited passage states that, while "[c]ase management as medical assistance under the State plan cannot be used to assist an individual, who has not **yet** been determined eligible for Medicaid, to apply for or obtain this eligibility[,] . . . **[t]hose activities may be an administrative expense of the State's operation of its Medicaid program**, rather than a medical assistance service." 72 Fed. Reg. 68,077, 68,082 (Dec. 4, 2007) (emphasis added).

That passage does not help the State. It specifies only one type of activity performed for the benefit of an uninsured person that "may" qualify as allowable Medicaid administration – helping a person "apply for or obtain" Medicaid eligibility. 72 Fed. Reg. at 68,082. There is no evidence, however, that county mental health offices expended BHSI funds for that purpose during the relevant fiscal years. *See* CMS Ex. 2, at 9 (identifying the types of activities whose costs are accumulated in the Administrative Management cost center). Furthermore, as we have repeatedly explained, the PACAP does not define allowable MH-ACM expenditures to include costs of processing Medicaid applications or helping a person apply for or obtain Medicaid eligibility.

SAP is another program whose case management functions do not, based on the record before us, satisfy the conditions for allocability. According to a fact sheet submitted by the State, Pa. Ex. 15, the program helps schools build "SAP teams" (whose members include school staff and "liaisons from community alcohol and drug and mental health agencies") that are trained to identify students with substance abuse and mental health problems and to help those students and their families find the services to address those problems and remove other barriers to learning. The case management functions performed by SAP teams include "assist[ing] in linking [a] student to in-school and/or community based services and activities" (for example, by "recommend[ing] a drug and alcohol or mental health assessment"). Pa. Ex. 15, at 2.

The State has not demonstrated that any disallowed SAP-funded MH-ACM expenditures were associated with Medicaid-eligible children. *See* Pa. Br. at 11; Reply Br. at 10. Even if it had done so, the State would also have had to show that the MH-ACM activities paid for with SAP funds met other criteria for allowability, as defined in CMS policy and the State's PACAP. The State made no attempt to do so. In particular, the

State submitted no evidence that SAP funds paid for "necessary" Medicaid administrative functions, such as "intake" to the county mental health system or "determining eligibility for" or "authorizing mental health services covered by the Medicaid State Plan." CMS Ex. 13.

The State similarly failed to demonstrate the allocability of other categorical expenditures, such as those under the Community Hospital Integration Projects Program (CHIPP) and the Direct Care Workers Initiative (DCWI). CHIPP, as well as the Southeast Integration Projects Program, support the transition of state mental hospital patients to community-based settings.[18] *See* CMS Ex. 25, at 2; Pa. Ex. 13. Some of these expenditures for these programs raise additional concerns in that the activities apparently involved do not seem to be Medicaid-covered services. Under the State's PACAP – and longstanding CMS policy – costs of helping a person obtain or coordinate non-Medicaid services are unallowable, even if the person is Medicaid-eligible. CMS Ex. 1, at 4-5 ("Allowable administrative costs do not include gaining access to or coordinating non-Medicaid services even if such services are health-related."); Pa. Ex. 9 (State Medicaid Manual § 4302.2, stating that "documentation must clearly demonstrate" that activities claimed as administrative case management activities were "provided to Medicaid applicants or eligibles, **and** were in some way connected with determining eligibility or administering **services covered under the State plan**" (emphasis added)). The State has offered no evidence that its allocation formula operated to ensure that Medicaid was not charged for MH-ACM expenditures devoted to administering non-Medicaid-covered services.

The DCWI, administered by the Pennsylvania Department of Aging (PDOA), provides funds to help local agencies recruit and retain "direct care workers." CMS Ex. 7, at 11. Direct care workers provide care and personal assistance to the elderly, chronically ill, or disabled. *Id.* It is obvious, and the State concedes (*see* Pa. Br. at 9), that the DCWI by design does not provide "case management" to persons needing mental health services. Rather, the DCWI finances the recruitment and training of health and personal care workers.

In a letter responding to CMS's deferral, the State alleged that some counties "use Direct Care Worker funds to pay for staff that perform intake and other (MH-ACM) services." CMS Ex. 25, at 3. The State also alleged that a county that wants to use DCWI funds for MH-ACM services must submit a plan to OMHSAS and obtain its approval to use those

[18] For example, CHIPP funds in some counties were used to provide community-based mental health services, such as social rehabilitation, community employment and community residential services. CMS Ex. 15 (FY2011-2012 I&E Report for Cumberland/Perry counties) at 5-10. These services do not appear to be covered by Medicaid in those counties. *See* CMS Ex. 11, at 2 (identifying covered mental health services under HealthChoices).

funds for that purpose. *Id.* In addition, the State alleged that county plans to use DCWI funds for MH-ACM services are "on file with OMHSAS." *Id.* However, in this appeal, the State did not elaborate on, or present evidence to back up, these allegations. It did not, for example, submit copies of any county plans for using DCWI funds to pay for MH-ACM services or provide any other documentary evidence verifying that those funds were expended to help Medicaid eligibles gain access to Medicaid-covered services. Given the absence of any supporting documentation, we need not address whether such plans would be relevant to the allowability of the costs.

In sum, the record substantiates CMS's concern that MH-ACM expenditures financed with categorical funds and assigned to Medicaid by pooling into the Administrative Management cost center were not properly allocable to Medicaid at all. The State did not allay that concern in this proceeding. It offered essentially no evidence demonstrating that MH-ACM activities supported by categorical funding benefitted Medicaid and were otherwise necessary for the proper and efficient administration of Medicaid. We therefore conclude that the portion of the disallowed expenditures relating to the counties' categorical programs is unallowable on this ground (as well as the ground discussed in the preceding section).

3. We need not resolve the remaining bases for the disallowance.

CMS asserts that **no** "operating costs" incurred by the counties (even to provide MH-ACM services to Medicaid-eligible clients) may be allocated to Medicaid by any method other an indirect cost rate. Response Br. at 10, 19-21. CMS also alleges that the State "essentially double-dipp[ed] with respect to Mental Health ACM costs for Medicaid Managed Care beneficiaries." *Id.* at 10. According to CMS, the capitation payments to the counties for HealthChoices were "intended to be the sole source of reimbursement for any and all allowable costs," including MH-ACM costs associated with the counties' Medicaid managed care enrollees. *Id.* at 23.

The record does not provide an adequate legal or factual basis to resolve these issues. Given that our prior discussion provides sufficient basis to uphold the entire disallowance, we will not delay the proceedings to develop the record further.

4. The State's "jurisdictional objections" are meritless.

In its reply brief, the State asserts what it calls "jurisdictional objections." First, citing 42 C.F.R. § 430.60, the State contends that CMS's arguments "raise a state plan dispute not subject to Part 16 procedures before the Board." Reply Br. at 3, n.4. In two recent appeals involving Pennsylvania's Medicaid program, the State attempted to recast CMS's disallowance of administrative costs as a "State plan dispute." The Board rejected the

contention in both instances. *Pa. Dept. of Public Welfare*, DAB No. 2669, at 21; *Pa. Dept. of Public Welfare*, DAB No. 2653, at 17-18. Its reasons for doing so, which we briefly summarize in the following paragraph, apply equally to this case.

Section 430.60, the regulation cited by the State, affords a state the right to appeal – under hearing procedures found in 42 C.F.R. Part 430, subpart D – a decision by CMS "to disapprove State plan material (under §430.18) or to withhold Federal funds (under §430.35), because the State plan or State practice in the Medicaid program is not in compliance with Federal requirements." 42 C.F.R. § 430.60(a). In this case, CMS has not taken any action against the State under either section 430.18 or section 430.35. In other words, CMS had made no determination that Pennsylvania's State plan, or implementation of that plan, is not in conformity with federal law. The dispute in this case is not about how the State has implemented its Medicaid plan but about whether the State claimed FFP for administrative costs in violation of its own PACAP, the federal cost principles, section 1903(a)(7) of the Act, and other federal requirements. That dispute is clearly subject to the Board's Part 16 appeal process. *See* 45 C.F.R. Part 16, Appendix A, ¶ B(a)(1) (authorizing Board review of disallowances under Medicaid and other mandatory grant programs).

Second, the State contends that the disallowance has been improperly "used to circumvent a process for disapproving," and subsequently amending, a flawed PACAP. Reply Br. at 3 n.4. In support of that contention, the State points to a statement by CMS, in response to a discovery request, that Pennsylvania's PACAP is "so general that it has little relevance to CMS's determination that the Mental Health Administrative Case Management costs at issue were allowable." CMS's Opposition to Appellant's Discovery Requests (Dec. 4, 2015) at 6. Characterizing this statement as an "admission that the . . . PACAP should be amended," the State asserts that a disallowance is "not the proper method of challenging a PACAP that is determined to be in need of amendment," and that CMS "must afford the State an opportunity to amend its PACAP prior to going to a disallowance." Reply Br. at 3 n.4 (*citing* 45 C.F.R. §§ 95.509).

This contention likewise fails to render the disallowance unlawful (or this proceeding improper). CMS has not formally disapproved the State's PACAP or asked the State to amend it. Title 45 C.F.R. § 95.509 requires a state to "promptly amend" a PACAP when specific events occur. Neither party alleges that one or more these events has occurred. Furthermore, the Board has held that any available process for challenging the sufficiency of a PACAP or correcting its deficiencies does not preclude CMS from disallowing administrative costs that do not meet legal criteria for federal reimbursement. *Pa. Dept. of Public Welfare*, DAB No. 2669, at 22; *Pa. Dept. of Public Welfare*, DAB No. 2653, at 19. Any inadequacy of its PACAP cannot serve to relieve the State of its

obligation to allocate costs in accordance with federal cost principles and other legal requirements, and an opportunity to amend the PACAP prospectively would not change the fact that the State did not meet that obligation with respect to the counties' MH-ACM expenditures at issue here.

5. *The State has not justified its request for an evidentiary hearing*.

Concurrently with the submission of its reply brief, the State requested a conference "to discuss further proceedings and the need for an evidentiary hearing" during which it could present witness testimony and additional documentary evidence. Request for Conference and Evidentiary Hearing (Req. for Conf.) at 1. The State said that an evidentiary hearing was necessary "due of the complexity of the **documentation issue** raised by [CMS]." *Id.* (emphasis added). According to the State, CMS in its response brief made "demands for documentation" with respect to the issues raised in the disallowance notice (Reply Br. at 3) – demands to which it cannot meaningfully respond "within the framework of the time-compressed paper-driven process of the normal Part 16 adjudication procedures" (Req. for Conf. at 2).

We find the State's hearing request to be deficient on a number of levels. First, it mischaracterizes the record. Contrary to the State's allegation, CMS did not make "demands for documentation." CMS simply argued that the State did not carry its burden to document the allowability of the claimed expenditures.

Second, the hearing request does not satisfy Board criteria. The Board's Practice Manual states that a hearing request should identify the potential witnesses (including their titles, if applicable) and give a brief summary of the nature of their expected testimony. *Appellate Div. Practice Manual*,[19] "When and why would an evidentiary hearing be held?" The State's hearing request identified no potential witnesses, by name or title, much less the nature of any particular witness's expected testimony.

The Board's Practice Manual also states a hearing request should "identify the issues or material facts in dispute the resolution of which it believes would be significantly aided by an evidentiary hearing, or explain how the party otherwise expects an evidentiary hearing to enhance the Board's decision-making." *Id.* With respect to the issues we have addressed in this decision, the State has not identified specific, material factual disputes that we need further witness testimony to resolve.

[19] The Practice Manual is available at http://www.hhs.gov/dab/divisions/appellate/practicemanual/manual.html

The State asserts that it "could rebut the Agency's challenge" by producing additional documentary evidence, such as "cost allocation plans for each county, single audit reports, spreadsheets showing how costs flowed up into the Income and Expenditure reports, and declarations from county fiscal staff." Req. for Conf. at 2. However, cost allocation plans, financial and accounting records, and employee declarations are material that, under Board procedures, a party is expected to present during the normal briefing process if the party chooses to rely on such documents to support its case. No evidentiary hearing is required to receive them (unless the opposing party seeks to cross-examine a declarant), and nothing precluded the State from presenting any evidence that it felt would support its claims. Moreover, the State does not say precisely how any such additional evidence would respond to or resolve *specific* arguments or factual disputes.

Concerning the validity of the assumptions used in its cost allocation methodology, the State suggests that a "study" could be performed to answer the "empirical question" of "[w]hether most people receiving behavioral health services under Medicaid also received MH-ACM services." Req. for Conf. at 1-2. That suggestion amounts to asking the Board to independently investigate an issue about which the State had the obligation to develop and present evidence. The State's "study" proposal is also a concession that currently no evidence exists to support its assumptions even though it has relied on them throughout this proceeding to dispute CMS's basis for taking the disallowance. This concession simply adds to the reasons we stated earlier for rejecting the State's assumptions.

The State contends that CMS put the State in the position of being unable to mount a more robust case in its initial appeal submission, asserting that CMS's response brief was the "first [place] that CMS . . . explained in an understandable manner precisely what it believes is wrong with the State's allocation methodology." Reply Br. at 3. The chief problem with that methodology, as discussed earlier, was that it apportioned MH-ACM expenditures based on an unsubstantiated assumption rather than on direct evidence about the number of MH-ACM recipients who were Medicaid-eligible. The record shows that CMS notified the State about that problem at least as early as February 2014. Pa. Ex. 3, at 3. In addition, the July 21, 2015 disallowance notice advised the State that its allocation ratio was flawed because it did not reflect "an accurate number of Medicaid eligibles served" by MH-ACM. July 21, 2015 Notice of Disallowance at 2. And the State's notice of appeal and opening brief expressed no confusion or uncertainty about what CMS had found wrong about its allocation methodology.

For all these reasons, we deny the State's request for an evidentiary hearing.

Conclusion

For the reasons explained above, we uphold CMS's July 21, 2015 determination to disallow $36,268,423 for Pennsylvania's Medicaid program.

/s/
Sheila Ann Hegy

/s/
Constance B. Tobias

/s/
Leslie A. Sussan
Presiding Board Member