Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

SUBJECT: Pennsylvania Department of Public Welfare
Docket No. A-07-23
Decision No. 2244

DATE: April 27, 2009

DECISION

The Pennsylvania Department of Public Welfare (DPW, State) appealed a determination by the Centers for Medicare & Medicaid Services (CMS) disallowing federal financial participation (FFP) in the amount of $15,070,548 claimed under the Medicaid program for family planning services provided by managed care organizations (MCOs) during the period October 2000 through February 2004. DPW claimed FFP at the enhanced rate of 90% (instead of the State's lower federal medical assistance percentage rate) available for expenditures for family planning services. CMS based the disallowance on an HHS Office of Inspector General (OIG) audit finding that DPW overstated the amount of the capitation payments made by DPW to MCOs that was attributable to family planning services.

As explained in detail below, we conclude that: 1) DPW failed to show that CMS approved the methodology DPW used to identify the payments it made to MCOs for family planning services, 2) the methodology DPW used is unreasonable on its face, and DPW has not established that that methodology is nevertheless reasonable in light of other information and circumstances, and 3) DPW did not show any valid basis for questioning whether the OIG properly calculated the amount of the disallowance. Accordingly, we sustain the disallowance in full.

The record for this decision includes the parties' briefs and other submissions regarding DPW's motion to compel discovery and CMS's responsive motion for summary disposition; the transcript

of an oral argument on those motions; and the parties' briefs and exhibits on the merits, which include a sur-reply from each party. With its reply brief, DPW submitted a request for an evidentiary hearing which CMS opposed. We explain later why we deny DPW's hearing request.

Legal Background

The federal Medicaid statute, title XIX of the Social Security Act (Act), authorizes a program that furnishes medical assistance to low-income individuals and families as well as to blind and disabled persons. Act § 1901.[1] A state that administers a Medicaid program pursuant to an approved plan is entitled to FFP for a percentage of the expenditures it makes in operating the program. Act § 1903(a). For most Medicaid expenditures, the federal government provides FFP at a rate known as the "federal medical assistance percentage" (FMAP). Act §§ 1903(a)(1), 1905(b). The State's FMAP during the relevant period was about 54 percent. PA Ex. 2 (OIG audit report) at i (internal numbering).

For certain categories of expenditures, the Act authorizes FFP at a rate greater than the FMAP. As relevant here, section 1903(a)(5) of the Act authorizes FFP at the rate of 90 percent for expenditures "attributable to the offering, arranging, and furnishing . . . of family planning services and supplies." CMS's disallowance determination states that although "the Act does not specifically require enhanced Federal funding for family planning services provided through managed care delivery systems, CMS has permitted States to claim these costs." DPW Ex. 1, at 1.

DPW alleges that CMS's "legal standard" for determining whether a state has properly allocated capitation payments to family planning services is whether the state's methodology is reasonable. DPW Br. at 7-9, citing DPW Ex. 3, at 11-12 and 44-45. CMS has not disputed that this is the applicable standard.

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[1] The current version of the Social Security Act can be found at www.ssa.gov/OP_Home/ssact/comp ssa.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. Also, a cross reference table for the Act and the United States Code can be found at 42 U.S.C.A. Ch. 7, Disp Table.

See CMS Br. at 5. The Board applied this standard in another case involving family planning services, holding that where the State lacked a "reasonable method" to "distinguish costs for family planning from costs for other services," "the State [was] not entitled to FFP at the enhanced rate beyond that allowed by [CMS]." New York State Dept. of Social Services, DAB No. 1284, at 7 (1991).

A grantee bears the burden of documenting the allowability of its claims for federal funding. See, e.g., Kansas Dept. of Social and Rehabilitation Services, DAB No. 2056, at 5 (2006), citing Nebraska Health and Human Services System, DAB No. 1660 (1998), West Virginia Dept. of Human Services, DAB No. 1107 (1989), and 45 C.F.R. 92.20 (standards for financial management systems). This burden is "especially heavy" when FFP is being claimed at an enhanced rate, "requiring a clear showing that all claimed costs meet applicable reimbursement requirements[.]" Illinois Dept. of Public Aid, DAB No. 2021, at 16-17 (2006), aff'd, Illinois Dep't of Healthcare & Family Servs. v. U.S. Dep't of Health & Human Servs., Nos. 06 C 6402, 06 C 6412, 2008 WL 877976 (N.D.Ill. Mar. 28, 2008); see also Illinois Dept. of Children and Family Services, DAB No. 1530, at 43 (1995) (a state must "meet a higher standard of proof to justify a claim at an enhanced rate. Otherwise, a state might improperly try to shift costs to programs, or parts of programs, with enhanced funding.").

Factual Background

The record reflects the following core undisputed facts. (Additional undisputed facts are identified later in the decision where relevant.) Prior to 1997, medical assistance was provided to Medicaid recipients on a fee-for-service basis throughout Pennsylvania, and DPW claimed 90% FFP in all expenditures for family planning services. Beginning in 1997, DPW required Medicaid recipients in 25 of its 67 counties to obtain medical assistance through MCOs. Although DPW later made plans to make enrollment in MCOs mandatory in all 67 counties, it never implemented those plans.

DPW paid for the services provided by MCOs through capitation payments that were not based on actual expenditures for the services provided. Thus, in the counties that had changed to providing medical assistance through MCOs, DPW no longer received "fee-for-service encounter data" identifying the expenditures for family planning services. CMS Br. at 1; see also CMS Br. at 2, 5, 10; DPW Ex. 1, at 2. Medicaid recipients

in some non-managed care counties could choose to obtain medical assistance either through MCOs (referred to as voluntary managed care) or on a fee-for-service basis. CMS Br. at 5.

By letter dated April 19, 2001, DPW wrote to CMS's Regional Office staff that DPW was "in the process of developing a methodology to identify family planning services provided to the managed care population" and requested "a meeting to provide documentation about this process or to answer questions about this methodology."[2] DPW Ex. 4, at 1. According to DPW's letter, DPW "will develop a 'Family Planning Percentage or Factor' to be applied against Pennsylvania Medicaid Physical Health (PH) managed care premium payments to determine the amount of premium payments eligible for 90 percent federal financial participation (FFP)." Id. The letter continues: "A key factor in developing the 'FP Factor' is assuring that the methodology represents family planning costs associated with populations eligible to enroll in managed care[.]" Id. (emphasis added). The letter then states that the purpose of developing the family planning factor is "to determine what proportion (presented as a simple percentage factor or Per Member Per Month amount) or amount of managed care premiums related to the provision of family planning services in order to claim 90 percent FFP for the identified portion of premiums." Id. The letter presents the following formula:

> **Numerator**: Total fee-for-services family planning expenditures for recipients eligible to enroll in managed care for a target timeframe.
>
> **Divided by:**
>
> **Denominator:** Total fee-for-service expenditures for recipients eligible for enrollment in managed care for services covered by managed care, as used in the managed care rate setting process for a target timeframe

Id. at 2 (emphasis in original). The letter also identifies "Processing Assumptions" including that the numerator of the family planning factor would include "family service

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[2] CMS was previously named the Health Care Financing Administration (HCFA). See 66 Fed. Reg. 35,437 (July 5, 2001). We use CMS in this decision unless we are referring to the "HCFA 64" claiming form in use at the time in question.

expenditures for recipients in each of the five service categories covered by the managed care plans ("TANF, Healthy Beginnings, SSI with Medicare, SSI without Medicare, and Federal GA"). Id.

DPW met with CMS's Regional Office staff on May 18, 2001 to present its methodology. See DPW Ex. 4, at 8; DPW Ex. 5, at 13. At that meeting, Regional Office staff requested that DPW change the methodology to calculate a separate family planning factor for each service category. See id. DPW presented a revised methodology making the change requested at a second meeting with Regional Office staff on July 12, 2001. See DPW Ex. 5, at 13. In developing the five separate family planning factors, DPW determined that 82.66% of its capitation payments were for individuals who were enrolled in Medicaid because they qualified for TANF.[3] DPW Ex. 2, App. A at 1.

An undated document titled "Federal Claim for Enhanced Federal Financial Participation For Family Planning Portion of Health Choices Physical Health Managed Care Payments" for the "Claim Period: February 1, 1997-March 31, 2001" contains the same descriptions of the numerator and denominator of the family planning factor (identified as the "Formula for development of **Family Planning Ratio(s)**") as DPW's April 1, 2001 letter, except that it specifies the "target timeframes" for the numerator and denominator ("a base year prior to implementation of managed care" and "the first year of managed care operation," respectively).[4] DPW Ex. 4, at 8 (bolding in original). The base year selected was State fiscal year 1996 (July 1, 1995 through June 30, 1996). Id. at 9.

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[3] TANF is the acronym for "Temporary Assistance for Needy Families," the title IV-A program that provides cash assistance to families with dependent children.

[4] Consistent with the title, this document includes a list showing the amounts of DPW's "Family Planning Managed Care Claim" for the period 2/1/97–3/31/01. DPW Ex. 4, at 13. In addition, the document includes some documentation supporting that claim. DPW Ex. 4, App. A-I. CMS does not argue, however, that the description of the methodology pertained only to the claim for the period 2/1/97 – 3/31/01 and not future claims.

DPW first submitted a claim for family planning services purportedly using this methodology on July 30, 2001.[5] See DPW Ex. 5, at 13. DPW ultimately claimed a total of $102,926,476 FFP for the period October 1, 2000 through February 2004. See DPW Ex. 2 (audit report), App. A at 1.

The OIG issued a report in January 2006 which found that DPW "did not claim family planning service costs in accordance with its CMS-approved methodology."[6] DPW Ex. 2, at 4. According to the OIG--

> Pennsylvania included in the numerator of the family planning factor calculations claims for beneficiaries not eligible to enroll in its managed care program. This was contrary to its CMS-approved methodology, which defined the numerator as "total fee-for-service family planning expenditures for recipients eligible to enroll in managed care." Pennsylvania's managed care program operated in only 25 of its 67 counties.

Id. (emphasis added).[7] The OIG recalculated the family planning factors and determined that, "[b]y claiming these ineligible family planning costs at the enhanced 90-percent rate rather than at its FMAP rate of about 54 percent, Pennsylvania received $15,070,548 in unallowable Federal reimbursement" for the period October 2000 through February 2004. Id. at 6.

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[5] DPW's claim for periods prior to federal fiscal year 2001 was disallowed as untimely. DPW appealed the disallowance to the Board, but the case was settled. See DPW Br. at 2; DPW Ex. 5, at 8-12.

[6] The OIG did not explain how it determined what the "CMS-approved methodology" was. Both parties agree that no approval was documented in writing.

[7] The OIG also found that DPW "improperly included non-family-planning services in the numerator of the family planning factor calculations." Id. at 5. DPW asserts that the finding was in error but states that "[t]his misstatement on the part of OIG has no impact on their computation of the alleged disallowance, since that computation was made without regard to the" data that DPW used in the numerator. DPW Br. at 4-5.

Analysis

DPW does not dispute the OIG's finding that DPW used family planning expenditures for all 67 Pennsylvania counties, that is, statewide data, instead of data for only the mandatory managed care counties in the numerator of the family planning factor.[8] In addition, DPW acknowledges that its use of statewide data in the numerator "overstate[d] the State's family planning expenditures relating to the 25 mandatory managed care counties[.]" DPW Br. at 11; see also DPW Reply Br. at 3. DPW argues, however, that the methodology it used to calculate the claims was reasonable "[j]udged by both the circumstances and the information available to the parties in 2001," when CMS approved DPW's proposed methodology. DPW Br. at 10, 12. DPW further asserts that, contrary to what the OIG found, it followed the approved methodology when it calculated the claims using statewide data in the numerator of the family planning factor. Since CMS determined that the methodology was reasonable at the time it approved the methodology, DPW argues, CMS is bound by its approval "under federal grant law" even if the methodology is unreasonable in hindsight. DPW Reply Br. at 2-3.

CMS denies that it approved the methodology DPW actually used to calculate the claims, asserting that when its Regional Office staff approved the proposed methodology, they did not understand that DPW intended to use statewide data in the numerator of the family planning factor. CMS argues that in any event, it is irrelevant whether CMS approved the use of statewide data in the numerator. Specifically, CMS argues that it is not precluded from disallowing DPW's claims since the claims were not for family planning services eligible for enhanced funding.

Whether CMS would be precluded from taking a disallowance once it has approved a state's methodology for identifying managed care family planning costs is a question that we need not reach here. As explained in the first section of our analysis, we conclude that DPW has not shown that CMS approved the methodology DPW actually used to calculate the claims. Moreover, as explained in the second section of our analysis, we conclude that the methodology DPW used is unreasonable on its

[8] For convenience, we refer to a single family planning factor since the relevant computations were the same for each of the five family planning factors developed by DPW.

face and that DPW has not shown that that methodology is nevertheless reasonable in light of other information and circumstances. CMS therefore properly determined that the claims were not eligible for enhanced funding.

DPW also argues that even if a disallowance is warranted, the OIG's recalculation of the family planning factor is subject to question, so that further development of the record or a remand with respect to the disallowance amount is required. As explained in the last section of our analysis, we conclude that DPW has not shown any valid basis for questioning the accuracy of the OIG's recalculation. Accordingly, we uphold the disallowance in full.

I. DPW has not shown that CMS approved the methodology DPW actually used to calculate the claims.

Although CMS does not dispute that its Regional Office staff had authority to, and did in fact, approve DPW's proposed methodology (as the OIG found), CMS asserts that the proposed methodology that was approved was not the same methodology actually used by DPW to calculate its claim. In particular, CMS asserts that, consistent with the formula specified in the proposed methodology, the CMS Regional Office staff who approved the proposed methodology "understood that the numerator and denominator of the family planning ratio were going to be comparable, meaning that the data for both figures would relate to the same population." CMS Br. at 10, citing CMS Exs. 5-7 (declarations of three Regional Office staff).[9]

DPW admits that, in calculating its claims, it did not follow the formula for the family planning factor specified in its proposed methodology. That is, DPW admits that it used family planning expenditures for Medicaid recipients in all 67 Pennsylvania counties in the numerator of the family planning factor instead of family planning expenditures for only Medicaid recipients in the 25 mandatory managed care counties. DPW argues, however, that CMS should have understood that DPW planned to use statewide data in the numerator (notwithstanding the formula) from a statement later in the proposed methodology

[9] As explained below, we do not rely on these declarations in reaching our conclusion that DPW has not shown that CMS approved the methodology DPW used to calculate its claims.

regarding what data source was used to develop the numerator. DPW points to the statement in its proposed methodology that "[t]he Numerator was developed by summarizing gross family planning service expenditures reported on the HCFA 64 for the period 7/1/95-6/30/96" as showing that DPW's proposed methodology for determining the family planning factor was something other than set out in the formula. See, e.g., DPW Br. at 3, citing DPW Ex. 4, at 5 (internal page numbering).[10] The "HCFA 64" is the form used by states to report expenditures claimed for FFP on a quarterly basis. DPW asserts that the expenditures on the HCFA 64 to which this statement refers would necessarily be the family planning expenditures for all 67 Pennsylvania counties. DPW Br. at 3-4; CMS Br. at 10. DPW asserts that it should have been clear from this reference to the HCFA 64 expenditures that DPW meant to use statewide data in the numerator, and that CMS in approving the proposed methodology must have approved the use of that data.

We are not persuaded that it is clear from the statement about using the HCFA 64 that DPW meant to use statewide data in the numerator, however. That statement does not expressly state that the numerator was equal to total gross family planning service expenditures reported on the HCFA 64. Instead, it

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[10] The language on which DPW relies appears on page 10 of DPW Exhibit 4, which DPW included in its appeal file in response to the Board's request for "a copy of the proposed methodology that includes all of its attachments" (see Board Rulings dated 8/25/08, at 4). CMS does not deny that the document in DPW Exhibit 4 is the proposed methodology that CMS Regional Office staff approved. Since that document expressly refers to DPW's May 18, 2001 meeting with Regional Office staff, we assume that it is the document provided by DPW to Regional Office staff at DPW's second meeting with Regional Office staff on July 12, 2001. We cannot determine from the record whether the document provided to Regional Office staff at the first meeting on May 18, 2001 stated that the HCFA 64 was used to develop the numerator. DPW's argument (discussed later) that CMS's policy change on filing deadlines for enhanced claims left DPW no time to obtain more accurate data suggests that the statement about the HCFA 64 appeared only in the document provided at the second meeting since the policy change was formally announced after the first meeting.

states that the numerator "was developed by summarizing" these expenditures. This language could arguably be read as indicating that these expenditures would be used simply as a starting point for identifying the family planning expenditures for Medicaid recipients in the mandatory managed care counties.

Even if the statement about using the HCFA 64 was meant to convey that family planning expenditures for all 67 Pennsylvania counties were used in the numerator, this would be completely at odds with the formula's description of the numerator as family planning expenditures "for recipients eligible to enroll in managed care," which DPW concedes refers only to recipients in the 25 mandatory managed care counties. Nothing in the proposed methodology explains how the statement, read as DPW proposes, and the formula can be reconciled. Nor is there any explanation in DPW's April 19, 2001 letter to CMS's Regional Office staff, which contains the same formula as the proposed methodology subsequently presented to CMS and states that "[a] key factor in developing the 'FP Factor' is assuring that the methodology represents family planning costs associated with populations eligible to enroll in managed care" (DPW Ex. 4, at 1 (emphasis added)). The letter also contains a list of "Data Sources Used" which includes, in addition to the HCFA 64 reports, the William M. Mercer, Inc. Health Choices Physical Health Data Books for three "zones" which encompass only the mandatory managed care counties, and there is no indication as to how any of the data sources were used. DPW Ex. 4, at 2. Thus, contrary to what DPW argues, it is not clear from the proposed methodology that DPW intended to use statewide data in the numerator of the family planning factor.

DPW also argues, however, that any ambiguity in the proposed methodology would have been resolved by information and circumstances of which CMS was aware at the time CMS approved the proposed methodology. According to DPW, the information and circumstances showed that it was reasonable to use statewide data in the numerator and CMS must therefore have concluded that the proposed methodology provided for the use of statewide data in the numerator. DPW alleges specifically that CMS knew that DPW was not going to claim enhanced funding for family planning services provided to Medicaid recipients who resided outside the 25 mandatory managed care counties and were eligible to enroll

in DPW's "voluntary managed care program."[11] DPW Br. at 5; see also DPW Br. at 11 and DPW Reply Br. at 4. In addition, DPW alleges that CMS knew that approximately 80% of TANF families, who DPW says were the most likely users of family planning services, lived in the mandatory managed care counties. See State's Response to Agency's Motion for Summary Disposition and Agency's Opposition to Discovery at 2. DPW Br. at 5, 11. Finally, DPW alleges that CMS knew that DPW had to file its claims for enhanced funding in family planning services quickly since CMS notified State Medicaid Directors July 3, 2001 that all claims for enhanced FFP filed after that date would be considered separate from earlier claims for the same expenditures at the regular rate and must meet the two-year claims filing limit in section 1132 of the Act (unless a specified exception applied).[12] DPW Br. at 10, citing DPW Ex. 5, at 7.

However, DPW has not proffered any evidence showing that CMS had knowledge of any of the foregoing information or circumstances, much less that CMS understood from them that DPW intended to use statewide data in the numerator of the family planning factor.[13]

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[11] The formula for the planning factor refers to Medicaid recipients "eligible to enroll" or "eligible for enrollment" in "managed care" without distinguishing between mandatory and voluntary managed care. This language indicates that DPW could have used the proposed methodology to file claims for both eligible residents in the mandatory managed care counties and eligible residents in the remaining counties, which suggests that CMS would not have known from the formula that DPW was not going to claim funding at the enhanced rate for the latter. In any case, the formula required that DPW use consistent data in the numerator and the denominator.

[12] DPW states that it had advance notice of this issuance through the "grapevine" (DPW Br. at 10), but does not say when it received such notice. The Board decision on which this issuance is expressly based, New Jersey Dept. of Human Services, DAB No. 1655, was issued on April 20, 1998.

[13] As we discuss in the next section of our analysis, moreover, DPW's arguments that the foregoing information and circumstances made it reasonable for DPW to use statewide data in the numerator are highly speculative and/or beyond the authority of the Board to consider.

DPW submitted a declaration from one individual claiming to have been "involved with submission of the State's family planning factor methodology to the Agency." DPW Ex. 6 (Declaration of Gary L. Weaver), at 1 (unnumbered). Mr. Weaver asserts that "[a]t the time the [family planning] factor was submitted to the Agency, the State believed the factor to be reasonable since approximately 80% of the clients eligible for family planning services resided in the 25 counties." Id. at 2 (unnumbered). Mr. Weaver also asserts that DPW "used the CMS-64 data" because "[a]t the time the factor was submitted, the State could not easily ascertain the family planning claims data with respect to only the 25 mandatory managed care counties." Id. These assertions indicate possible DPW rationales for using statewide data in the numerator of the family planning factor (although Mr. Weaver does not refer to DPW's decision not to claim enhanced FFP for family planning expenditures attributable to the voluntary managed care population). However, these assertions do not show that CMS had knowledge of any of these rationales or approved the use of statewide data in the numerator based on them. Indeed, absent from the declaration is any allegation that Mr. Weaver or any other DPW representative told CMS when the proposed methodology was under discussion that DPW was using statewide data in the numerator or why.

DPW nevertheless seeks an evidentiary hearing regarding CMS's understanding of DPW's proposed methodology. In particular, DPW maintains that it has a right to cross-examine CMS's declarants regarding their assertions that they did not understand that DPW meant to use statewide data in the numerator of the family planning factor. As just discussed, however, DPW has not produced any evidence that this was CMS's understanding. Moreover, DPW has not offered to produce any witnesses of its own at a hearing or produced any other evidence to establish its assertions about what CMS understood. It is unnecessary for us to consider the declarations CMS submitted since the burden of documenting that the methodology used to identify family planning expenditures was reasonable rests on DPW, not CMS. Accordingly, we strike CMS's declarations from the record. Since we do not admit or rely on the declarations, DPW has no right or need to cross-examine the declarants. We therefore deny DPW's hearing request.

II. The methodology DPW used to calculate the claims is unreasonable on its face, and DPW has not established that that methodology was nevertheless reasonable in light of other information and circumstances.

The purpose of DPW's proposed methodology is to distinguish between DPW's expenditures for family planning services provided by MCOs to Medicaid recipients and DPW's expenditures for other services provided by MCOs to that population. The proposed methodology specifies a formula for a family planning factor which consists of the ratio of fee-for-service family planning expenditures for Medicaid recipients eligible to enroll in managed care to all fee-for-service expenditures for Medicaid recipients eligible to enroll in managed care. To determine the amount of capitation payments attributable to family planning services, the capitation payments are multiplied by this ratio. This methodology reflects the assumption that the proportion of family planning expenditures to all expenditures for Medicaid recipients is the same whether the expenditures are reimbursed on a fee-for-service basis or a capitation basis.

DPW deviated from the specified formula by using in the numerator of the ratio expenditures for Medicaid recipients in all 67 Pennsylvania counties, not just the 25 counties in which DPW required Medicaid recipients to enroll in managed care. At the same time, DPW followed the formula with respect to the denominator, using expenditures for Medicaid recipients in the 25 mandatory managed care counties. Thus, while the numerator of the ratio in the specified formula is a subset of the denominator, the numerator DPW used pertained to a broader population than the denominator. The logic of applying this altered ratio to the capitation payments to determine the amount attributable to family planning services is not apparent since, unlike the ratio set out in the proposed methodology, the altered ratio does not reflect the proportion of fee-for-service family planning expenditures to all fee-for service expenditures.

In another case involving the disallowance of FFP claimed for family planning services, the state identified family planning services provided by health clinics based on the ratio of total hours for that category of services to total hours for all services, but used actual encounter data for the numerator and data from a sample for the denominator. The Board observed that where the numerator and denominator are determined by "inconsistent" methods, "the results are skewed." North Carolina Dept. of Human Services, DAB No. 1025, at 12 (1989). The Board proceeded to find that use of the ratio overallocated costs to family planning services and upheld a disallowance based on CMS's recalculation of these costs.

As in North Carolina, the numerator and the denominator DPW used in its family planning factor are inconsistent (although for a different reason) and the resulting ratio is illogical. Since the ratio is larger than it would be if the data used in the numerator and the denominator were for the same population, this skews the results and overstates the amount of capitation payments attributable to family planning services. Thus, the methodology used by DPW is on its face unreasonable.

DPW acknowledges that the use of statewide data in the numerator "would overstate the State's family planning expenditures relating to the 25 mandatory managed care counties[.]" DPW Br. at 11. DPW argues, however, that the Board should find that the methodology DPW used to calculate the claims was nevertheless reasonable in light of the same information and circumstances DPW cites to support its position that CMS approved that methodology. First, DPW asserts that its claims understated the total amount expended by DPW for family planning services provided by MCOs to Medicaid recipients since DPW did not file any claims for Medicaid recipients outside the mandatory managed care counties who could voluntarily enroll in managed care. Second, DPW suggests that the fee-for-service family planning expenditures for the 67 Pennsylvania counties DPW used in the numerator did not exceed fee-for-service family planning expenditures for the 25 mandatory managed care counties by as much as it might appear because approximately 80% of the most likely users of family planning services, i.e., TANF families, lived in those 25 counties. According to DPW, to the extent that statewide expenditures exceeded expenditures for only the 25 counties, this "overstatement" was "roughly cancelled out" by the "understatement" relating to unclaimed expenditures for the voluntary managed care population. DPW Br. at 11.

This argument is highly speculative, as DPW appears to recognize when it states that the overstatement and the understatement were "roughly cancelled out" (emphasis added). DPW alleges that there were "tens of thousands" of Medicaid recipients who were eligible to voluntarily enroll in managed care (State's Response to Agency's Motion for Summary Disposition and Agency's Opposition to Discovery at 2) but provides no documentation of the actual number of such recipients or the amount of family planning expenditures attributable to them. In addition, while DPW provided a "Statewide Managed Care Map" and a December 2006 table showing the number of Medicaid eligibles in each county who received TANF payments (DPW Exhibit 5, at 14-16) to show that most of the statewide expenditures were for individuals in the mandatory managed care counties, that documentation is far

from adequate. The table does not pertain to the disallowance period; thus, DPW's reliance on it is questionable. But even if 80% of the TANF recipients during the disallowance period resided in the mandatory managed care counties, as DPW alleges, it does not necessarily follow that 80% of the statewide expenditures were made for Medicaid recipients in the mandatory managed care counties. Instead, the difference depends on the relative per capita expenditures for family planning services for Medicaid recipients in the managed care counties and for the non-managed care counties. As discussed in the last section of our analysis in connection with another argument, DPW does not provide any support for its assertion that the per capita expenditures were higher in the mandatory managed care counties.

Moreover, even if we could determine the amount of any unclaimed expenditures, it is well-established that it is impermissible for a state to offset different expenditures against unallowable costs that were timely claimed when the former expenditures can no longer be timely claimed. See, e.g., New Mexico General Services Dept., DAB No. 1876, at 9 (2003)(to allow offset "would be to open a back door to claims evading timely filing requirements which would leave federal budget outlays uncertain indefinitely" and "would mean the additional charges would never pass through the normal claiming process . . . that assure[s] that expenditures are proper under the particular federal grants involved"). Thus, the Board has no authority to reduce the disallowance by the amount of any such unclaimed expenditures.[14]

DPW argues further that the methodology it used was reasonable in light of the limited time it had in which to file timely claims for enhanced funding under CMS's July 3, 2001 policy. According to DPW, it "did not have the leisure to spend months or years analyzing data" to identify the expenditures specified in the numerator of the formula but "had to use an existing source."[15] DPW Br. at 10. However, DPW undercuts its argument

[14] For the reasons explained in the previous section, we do not reach the question whether CMS might have had discretion to consider whether DPW's methodology was reasonable in light of the unclaimed expenditures for the voluntary managed care population.

[15] DPW contends that the OIG likely spent "hundreds of person-hours" recalculating the family planning factor, and states that DPW would "want to develop the record on this issue"

(Continued . . .)

when it acknowledges that it "could have used" the same data source for the family planning expenditures in the numerator of the family planning factor as it used for the denominator of the family planning factor—the expenditures reported in the Mercer data books for the mandatory managed care counties. DPW Br. at 10. In an apparent attempt to justify not using the Mercer data books for the numerator, DPW then asserts that they excluded pharmacy services. DPW does not explain why this exclusion made use of the Mercer data books inappropriate for the numerator but not the denominator, however.

Even if DPW could not have timely filed its claims without using statewide expenditures in the numerator of the planning factor, we cannot find on this basis that the methodology DPW used was reasonable. DPW's argument is in effect an equitable argument as to which the Board can grant no relief. See Municipality of Santa Isabel, DAB No. 2230, at 10 (2009), and cases cited therein ("The Board is bound by applicable laws and regulations . . . . 45 C.F.R. § 16.14. Thus, the Board has no authority to waive a disallowance based on equitable principles.").

Accordingly, DPW has not established that the methodology DPW used, although unreasonable on its face, was nevertheless reasonable in light of other information and circumstances.

III. DPW has not established that there is any basis for questioning the accuracy of the OIG's recalculation of the family planning factor.

DPW argues that if the Board finds that DPW was not justified in calculating the family planning factor as it did, the Board should remand the case for a "recomputation" of the disallowance. DPW Reply Br. at 8. In the cover letter to its reply brief, DPW also requests, apparently in the alternative, an evidentiary hearing "to elicit testimony from representatives of the Office of Inspector General as [to] data they used to recompute the numerator." Letter dated 1/6/09 (incorrectly dated 1/6/08).

(Continued . . .)
in order to prove that DPW could not have accurately identified the expenditures specified in the formula in time to meet the filing deadline. DPW Br. at 10, n.10. As our discussion below indicates, however, such record development would be pointless.

DPW asserts in particular that "the OIG numerator is highly improbable" because, in DPW's view, it reflects a "consumption rate of family planning services per individual in largely rural non-managed care counties [that] is between 1.4 to 2.3 times that of the managed care counties." DPW Br. at 6; DPW Reply Br. at 6. According to DPW, it "defies common sense" that "Medicaid recipients residing in rural counties (with relatively few doctors and hospitals) consum[e] much more of the State's family planning [services] than recipients in the mandatory managed care counties." DPW Br. at 6.

DPW's argument is not persuasive. DPW explains that it computed the alleged consumption rates by dividing family planning costs by the number of Medicaid recipients. See DPW Reply Br. at 6, n.2. Thus, as CMS points out, DPW is really comparing the cost per capita for family planning services in the managed care and non-managed care counties, not the relative consumption or utilization of services. See CMS Sur-Reply Br. at 2. According to CMS, it "would not be surprising" if the per capita cost of family planning services in the non-managed care counties was higher than in the managed care counties, as DPW asserts the OIG's recalculation shows. Id. at 3. DPW does not point to any basis for its premise that the per capita cost should have been higher in the managed care counties.

In any event, DPW's calculation of the per capita costs allegedly indicated by the OIG's expenditure figures is questionable. CMS observes that "DPW's estimate is rough" since "DPW used population data from 2006, but cost data from 2001 through 2004." Id. In addition, CMS notes that DPW concludes in its example at note 2 of its reply brief that the per capita cost was 1.67 (not 2.3) times higher in the managed care counties than in the non-managed care counties. Id. at 3. DPW does not challenge CMS's observations other than to speculate that "there were no significant geographical distribution changes between 2004 and 2006." DPW Reply at 6, n.2. We conclude that DPW's "consumption rate" argument, like its argument that the statewide expenditures used in the numerator of the family planning factor were not significantly different from expenditures for the 25 mandatory managed care counties, lacks factual support, and that DPW has not shown that OIG's recalculated numerator is "highly improbable."

DPW points to nothing else that indicates any material flaw in the OIG's recalculation. DPW claims that the OIG workpapers "do not enumerate the specific steps" that the OIG took "to generate its computations." DPW Reply Br. at 7. The procedures that the

OIG used to recalculate the numerator of the family planning factor are described in the OIG audit report and summarized in several of CMS's submissions. The OIG report states that the auditors started their review with a database of fee-for-service claims with at least one family planning diagnosis code for Medicaid beneficiaries statewide for the period July 1, 1995 through June 30, 1996. The database contained 313,180 claims totaling $21,940,162 and was generated by DPW (at the OIG's request) by querying its paid claims file. See DPW Ex. 2, at 4, and n.5. According to CMS--

> [t]he OIG separated out the non-managed care county claims and reported them on workpaper B.2.23. That left 190,043 managed care county claims costing $13.2 million. Of those 190,043 claims, the OIG then found 1,674 multiple service claims – those that had a family planning and a non-family planning component – and reported them on spreadsheet B.2.20. . . . Also on B.2.20, the OIG allocated the cost of the multiple service claims between family planning and non-family planning services, using the allocation percentages to which CMS and DPW had previously agreed. The OIG concluded that $4.0 million of the multiple-service claims were for non-family planning services, and subtracted this amount from the $13.2 million, finding that DPW had presented $9.2 million in managed care county family planning claims.

CMS letter dated 1/8/09, at 1; see also Respondent's Motion for Summary Disposition and Opposition to Petitioner's Discovery Motion at 5. On its face, this procedure appears logical, and DPW, which received copies of all the spreadsheets, does not identify any missing steps or other information that is needed to understand the calculation. Indeed, DPW previously advised the Board that "the State's consultant feels he has enough information to understand the OIG's computations." 8/24/07 e-mail from DPW to Board staff.[16]

[16] This advisory occurred after the Board had given DPW three weeks to confer with its consultant to determine whether he needed any information regarding the audit process beyond that provided in the audit workpapers on a CD-ROM that counsel conceded he had received from the OIG one and one-half years earlier. See Tr. at 4-6, 10-11, 51. DPW thus had ample time before it filed its reply brief to seek any clarification.

DPW also raises some questions about whether the $21.9 million claims database used by the OIG included non-family planning expenditures, or whether the OIG looked at only a subset of the expenditures in this database. See DPW Br. at 6, n.3. DPW acknowledges that it supplied the database to the OIG, however. See DPW Reply Br. at 7. If DPW had questions about whether the database in fact included only family planning expenditures, DPW had the ability to check that itself.

DPW also asserts that "a reasonable method" of recalculating the family planning factor "would be simply to reduce the numerator by the percentage of the State's caseload or population that is attributable to the non-managed care counties." DPW Br. at 13. Since we find no basis for questioning the accuracy of the OIG recalculation, however, there is no reason to substitute or modify, based on raw population numbers, a methodology that is based on actual claims data and that has not been shown to contain any material flaws.

Accordingly, we conclude that DPW has shown no basis for either an evidentiary hearing or a remand with respect to the OIG's recalculation of the family planning factor.

Conclusion

For the foregoing reasons, we uphold the disallowance in full.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Sheila Ann Hegy
Presiding Board Member