Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

SUBJECT: West Virginia Department of Health and Human Resources
Docket No. A-08-41
Decision No. 2250

DATE: May 26, 2009

The West Virginia Department of Health and Human Resources (DHHR) appealed a decision by the Centers for Medicare & Medicaid Services (CMS) to disallow $634,525 in federal Medicaid funds. The disallowance stems from a lawsuit filed by West Virginia (State) against Dey, Inc. (Dey) and other pharmaceutical manufacturers. The lawsuit alleged that the defendants had fraudulently manipulated their drug prices and that, as a result, public insurance programs, including the State's Medicaid program, had overpaid for the defendants' drugs. Dey settled the case, agreeing to pay the State $850,000. Later CMS determined that because the State's lawsuit had sought reimbursement for unallowable expenditures for which the State had received federal Medicaid funds, the federal government was entitled to a share of those proceeds. Accordingly, CMS issued the challenged disallowance in order to recoup a share of the settlement proceeds. During this appeal, CMS lowered the disallowance amount from $634,525 to $446,607.

As we discuss below, this appeal presents essentially the same issues as those decided by the Board in a prior disallowance appeal filed by DHHR. In West Virginia Dept. of Health and Human Resources, DAB No. 2185 (2008), the Board held that under section 1903(d)(2) of the Social Security Act (Act) and Office of Management and Budget (OMB) Circular A-87, the federal government was entitled to a share of funds obtained by the State in settling a lawsuit against the manufacturers of the drug Oxycontin. Similarly, we conclude here, based on these same legal authorities, that the federal government is entitled to a share of the Dey settlement proceeds. In addition, we conclude that CMS properly determined that approximately 67 percent of the Dey settlement proceeds is allocable to the State's Medicaid program. Based on these conclusions, we sustain the disallowance of $446,607 of federal Medicaid funds.

Background

1. *Applicable legal authority*

The federal Medicaid statute, title XIX of the Act, authorizes a program that furnishes medical assistance to certain needy and disabled persons. Act § 1901. The program is jointly financed by the federal and state governments and administered by the states. Act § 1903; 42 C.F.R. § 430.0. Each state administers its own Medicaid program pursuant to broad federal requirements and the terms of its "plan for medical assistance," which must be approved by CMS on behalf of the Secretary of Health and Human Services (HHS). Act § 1902; 42 C.F.R. §§ 430.10-430.16. Once its Medicaid plan is approved, a state becomes entitled to receive federal reimbursement, or federal financial participation (FFP), for "an amount equal to the Federal medical assistance percentage [FMAP] . . . of the total amount expended . . . as medical assistance under the State plan." Act § 1903(a) (emphasis added). "Medical assistance" means "payment of part or all of the cost" of specified care and services provided to Medicaid-eligible individuals. Act § 1905(a). The FMAP is the percentage of the state's medical assistance expenditures for which FFP is paid. 42 C.F.R. § 433.10.

FFP is available only for "allowable" Medicaid expenditures. See 42 C.F.R. §§ 430.40, 430.42(a). OMB Circular A-87, made applicable to the Medicaid program by 45 C.F.R. §§ 74.27 and 92.22, provides that an expenditure or other "cost" is allowable if, among other things, it is "necessary and reasonable for proper and efficient performance and administration of Federal awards." 2 C.F.R. Part 225, App. A, ¶ C.1.a. When a state Medicaid agency pays a medical provider "in excess of the amount that is allowable" for the provider's services, the state Medicaid agency has made an "overpayment" which must be refunded to the federal government, via a reduction in FFP, under section 1903(d)(2) of the Act (requiring that payment of FFP be "reduced . . . to the extent of any overpayment . . . which the Secretary determines was made" to the State in any prior quarter).[1] See

[1] States have the primary responsibility to prevent improper Medicaid payments and to identify and recover overpayments when they occur. New Jersey Dept. of Human Services, DAB No. 1469, at 7 (1994). The Act and regulations provide that once an overpayment is discovered, a state has 60 days in which to recover or attempt to recover the overpayment before the Secretary of Health and Human Services may adjust FFP

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also 42 C.F.R. §§ 433.300, 433.304 (definition of "overpayment); West Virginia Dept. of Health and Human Resources, DAB No. 2185, at 2 (2008) (citing Arkansas Dept. of Human Services, DAB No. 717, at 6-7 (1986)).

OMB Circular A-87 provides that expenditures or other costs for which a state program may receive a federal "award" (such as a Medicaid grant) consist of the program's allowable direct costs, plus the program's allocable share of allowable indirect costs, "less applicable credits." 2 C.F.R. Part 225, App. A, ¶ D.1. "Applicable credits refer to those receipts or reduction of expenditure-type transactions that offset or reduce expense items allocable to Federal awards as direct or indirect costs." Id., ¶ C.4.a. "To the extent that such credits accruing to or received by the governmental unit relate to allowable costs," they must be "credited to the Federal award either as a cost reduction or cash refund, as appropriate." Id. In short, an applicable credit reduces the amount of a program expenditure or cost for which FFP may be claimed. See Maine Dept. of Health and Human Services, DAB No. 2168, at 10 (2008) (holding that employers' contributions to a state-run health insurance program on behalf of Medicaid recipients were applicable credits that should have been deducted from Maine's Medicaid FFP claims). Likewise, "[a] state that has received an applicable credit but not reduced its allowable costs claimed" under a federal grant program "has received an overpayment of FFP." California Dept. of Finance, DAB No. 1592, at 6 (1996).

2. *Background of DHHR's current Board appeal*

In October 2001, the State sued Dey and other drug manufacturers in state court, alleging that the defendants had "deliberately and fraudulently overstated" the "average wholesale prices" (AWPs) used by the State to determine the amounts it pays pharmacies, physicians, and other providers for prescription drugs. WV Ex. 3, ¶ 2; see also WV Ex. 2, ¶¶ 1-2. The State brought the suit on behalf of three state agencies: DHHR, which administers the State's Medicaid program[2]; the West Virginia Public Employees

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to account for the overpayment. Act § 1903(d)(2)(C); 42 C.F.R. § 433.312(a).

[2] According to the amended complaint, DHHR performs this administrative function through its Bureau for Medical Services. WV Ex. 2, ¶ 3.

Insurance Agency (PEIA), which funds health insurance for the State's employees; and the Workers' Compensation Division (WCD) of the West Virginia Bureau of Employment Programs (BEP), which covers the cost of drugs provided to eligible injured or disabled workers. WV Ex. 3, ¶¶ 7, 19, 21-22; see also Reply Br. at 10-11. According to the State's initial and amended complaints, in an effort to increase sales and garner market share, the defendants reported "artificially inflated" AWPs for various drugs in industry drug pricing compendia while simultaneously charging pharmacies, physicians, and other medical providers less than the published AWPs for those drugs. WV Ex. 3, ¶¶ 24-47; WV Ex. 2, ¶¶ 15-21. As a result of this alleged practice, said the State, Medicaid and other public health insurers paid providers "excessive" amounts for the defendants' drugs because those insurers used AWPs reported in industry pricing compendia to establish payment levels. WV Ex. 3, ¶¶ 39, 41-42; WV Ex. 2, ¶¶ 18-19. The State's amended complaint states that "[f]or one year alone, from July, 1999 to June, 2000, Medicaid paid almost $1.7 million for the drugs identified in Appendix A, of which almost $650,000 was overpaid based upon the inflated AWPs." WV Ex. 3, ¶ 20.

Based on these and other allegations, the State pled multiple causes of action, the first of which was for violation of West Virginia's Fraud and Abuse in the Medicaid Program statute, W. Va. Code § 9-7-1 et seq. WV Ex. 3, ¶¶ 48-54. In support of this cause of action, the State alleged that "[d]efendants [had] engaged in a fraudulent scheme which allowed providers to obtain inflated payments from Medicaid based upon a falsely inflated AWP." Id., ¶ 50.

In May 2004, more than two years after the suit was filed, but prior to discovery and trial, the State settled with Dey. WV Exs. 4-5. In exchange for the State releasing all claims or causes of action based on "Covered Conduct,"[3] Dey agreed to pay

[3] Section II.C of the parties' Settlement Agreement and Release states that the "alleged conduct and transactions referenced in Paragraph II.(B) are hereinafter referred to as the 'Covered Conduct.'" WV Ex. 4, at 2. Paragraph II.B states in relevant part:

> [T]he STATE claims that DEY "manipulated" the price for its drugs published by various industry drug pricing compendia so that DEY could "market the spread" between the price listed as the "average wholesale price" in

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the State $850,000, $100,000 of which was to be deposited in the Consumer Protection Fund of the Office of the West Virginia Attorney General to be used at the Attorney General's discretion for consumer protection purposes. WV Ex. 4, at 4-5. The settlement separately required Dey to pay the State another $250,000 for attorneys' fees and other costs incurred by the State for legal work performed by its outside (private) attorneys. Id. at 4. According to DHHR, the State's case against the remaining defendants ultimately went to trial, after which judgment was entered for the defendants. WV Br. at 1 n.1.

Based on the settlement, the state court overseeing the lawsuit entered an Agreed Dismissal Order signed by the parties. WV Ex. 5. The dismissal order states in relevant part:

> Whereupon those parties [the State and Dey] jointly moved the court to dismiss all claims asserted in the above-styled civil action by the State of West Virginia against Dey, Inc., with prejudice, the same having been settled by the parties therein. The Court therefore **ORDERS** [that] all claims asserted in the above-styled action by the State of West Virginia against Dey, Inc, are hereby dismissed with prejudice as being fully compromised, settled and agreed.

Id. at 1 (emphasis in original).

On November 23, 2007, after reviewing the settlement and underlying pleadings, CMS issued a notice of disallowance of $634,525 in Medicaid FFP. CMS Ex. 1. Emphasizing that the lawsuit against Dey had alleged harm to the State's Medicaid program, CMS asserted in the disallowance notice that a portion of the Dey settlement proceeds constituted a recovered Medicaid overpayment, and thus the federal government was entitled to recover its contribution to the overpayment under section 1903(d)(2) of the Act. Id. at 1. CMS also asserted that the

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> such compendia, on which STATE agencies have chosen to base their reimbursements to pharmacies and other health care institutions, and the price at which pharmacies and other providers were able to obtain DEY's drugs on the open market.

Id.

settlement proceeds constituted an applicable credit under OMB Circular A-87 which must be applied to reduce the amount of Medicaid FFP claimed or received by the State. Id. CMS calculated the disallowance by applying the State's FMAP against the entire settlement amount of $850,000. In other words, CMS initially allocated 100 percent of the Dey settlement proceeds to Medicaid in calculating the disallowance amount.

DHHR filed a timely appeal of the disallowance, which the Board stayed pending issuance of its decision in DAB No. 2185. After issuing that decision, the Board lifted the stay, and the parties submitted written legal arguments and documentary evidence relating to the November 23, 2007 disallowance at issue here. In its response brief, CMS notified the Board and DHHR that it had reduced the disallowance from $634,525 to $446,607. CMS based this reduction on a determination that approximately 67 percent of the Dey settlement proceeds (not 100 percent, as CMS initially determined) is properly allocable to the State's Medicaid program.

3. *DHHR's prior appeal and DAB No. 2185.*[4]

As here, DHHR's prior appeal grew out of a lawsuit alleging harm to the Medicaid program and other public health insurers. The State alleged in that lawsuit that the defendants — drug manufacturers and marketers — had engaged in a marketing campaign that misrepresented the appropriate uses, risks, and safety of Oxycontin. DAB No. 2185, at 5-6. As a result of that conduct, alleged the State, Oxycontin had been "inappropriately prescribed and used, unnecessarily putting people at risk of addiction[.]" Id. at 5. The State further alleged that the Medicaid program had incurred "excessive and unnecessary" expenses because Medicaid recipients had been "inappropriately and unnecessarily prescribed Oxycontin." Id. at 11. As a remedy for the defendants' alleged conduct, the State demanded "restitution and reimbursement" for expenditures on Oxycontin and expenditures associated with the diagnosis and treatment of Oxycontin addiction. Id. at 6, 11.

The litigants settled the case before trial. DAB No. 2185, at 6. In exchange for the State releasing its claims against the defendants — including claims of injury to the State's Medicaid

[4] This account is a summary only and should not be read as modifying in any way the Board's decision in DAB No. 2185.

program — the defendants agreed to pay $10 million to the Consumer Protection Fund of the Office of the West Virginia Attorney General for medical and law enforcement education and training. Id. The state court approved the settlement and ordered the plaintiffs' attorneys' fees and expenses to be paid from the settlement proceeds. Id. at 7.

More than two years after the settlement, CMS issued a notice of disallowance for $4.1 million as the federal government's share of the Oxycontin settlement proceeds due to harm allegedly sustained by the State's Medicaid program as a result of the defendants' alleged misconduct. DAB No. 2185, at 7. The notice of disallowance indicated that CMS had set the amount of the disallowance by "equitably distributing" or allocating the $10 million in settlement proceeds among the three state agencies named as plaintiffs in the lawsuit. Id.

In the ensuing appeal, the Board addressed two issues: (1) was the federal government legally entitled to a share of the Oxycontin settlement proceeds? and (2) if so, did CMS allocate a proper share of that money to the State's Medicaid program? DAB No. 2185, at 9-10.

The Board concluded that to the extent the Oxycontin lawsuit demanded reimbursement from the defendants for excessive or unnecessary — and hence unallowable — Medicaid expenditures resulting from the defendants' alleged misconduct, the settlement proceeds constituted a recovered Medicaid overpayment. DAB No. 2185, at 13. Because the State had previously obtained FFP for that overpayment, said the Board, the federal government was entitled to a share of the recovered overpayment under section 1903(d)(2) of the Act.[5] Id. The Board also held that the Oxycontin settlement proceeds constituted an applicable credit under OMB Circular A-87 because they effectively reduced the Medicaid program's overall cost of providing medical and health services (such as prescription drugs and substance abuse treatment) to Medicaid recipients. Id. at 17-18.

[5] To the extent that the State had received money to settle claims for reimbursement of *allowable* medical assistance expenditures, the Board held that the federal government was entitled to a share of those proceeds under section 1903(d)(3) of the Act, which permits CMS to recoup the federal share of recovered medical assistance payments by a state's Medicaid program. DAB No. 2185, at 13-16.

In addition, the Board rejected DHHR's argument that it was improper for CMS to claim a share of the Oxycontin settlement proceeds because no part of those proceeds were paid to, or used by, the state Medicaid agency but instead were paid into the Attorney General's Consumer Protection Fund and used for non-Medicaid purposes. DAB No. 2185, at 19. The Board held that the State as a whole, not merely DHHR, is accountable for the administration of its Medicaid program and "thus, it does not matter which state agency received the settlement proceeds, or that the proceeds have already been used for non-Medicaid purposes." Id. at 19. The Board also rejected the argument that CMS unreasonably delayed issuing the disallowance, noting that the Board lacks the authority to grant equitable relief, and that the applicable statute and regulations impose no time limit on the issuance of a disallowance. Id. at 19-20.

Concerning the allocation issue, the Board found that CMS had failed to "articulate a sufficient basis" for the allocation and noted CMS's admission that the allocation failed to account for payment of the State's attorneys' fees and expenses out of the settlement. For these reasons, the Board remanded the case to CMS to recalculate the disallowance and to review any additional evidence and argument submitted by the State about what would constitute a proper distribution.[6] Id.

Discussion

The ultimate legal questions to be resolved in this appeal are the same as those decided in DAB No. 2185. First, we must decide whether the federal government is legally entitled to some portion of the Dey settlement proceeds. If the answer to that question is yes, we must then determine whether CMS has allocated an appropriate amount of the Dey settlement proceeds to the Medicaid program.

1. *CMS is entitled to a share of the Dey settlement proceeds.*

The material facts of the current appeal are essentially the same

[6] The parties apparently did not reach an agreement on remand because DHHR recently filed an appeal of a "Revised Determination of Disallowance Amount" issued by CMS on March 20, 2009.

as those addressed in DAB No. 2185. In both cases, the State sued corporate defendants, alleging that their misconduct had caused unnecessary or excessive Medicaid expenditures. In both cases, the State's lawsuit sought reimbursement for those Medicaid expenditures. In both cases, one or more defendants paid the State a sum of money to settle the lawsuit. And in both cases, CMS identified section 1903(d)(2) and the applicable credit provision of OMB Circular A-87 as the legal bases for its decision to recoup a share of the settlement proceeds.

DHHR contends here that section 1903(d)(2) and OMB Circular A-87 are inapplicable in these circumstances. WV Br. at 6, 7. DHHR further contends that it never received any portion of the Dey settlement proceeds and that "[b]y charging West Virginia's DHHR with an overpayment based on settlement dollars the agency never received, CMS attempts to import an income tax concept into the law governing state plans for medical assistance." Id. at 8. In addition, DHHR contends that CMS acted inequitably because it "waited" three and one-half years after the settlement before issuing the disallowance. Id. at 8.

DHHR offers no legal analysis to support these contentions. Instead, it refers us to arguments it made previously. WV Br. at 6, 7. DHHR also acknowledges that the Board rejected these contentions in DAB No. 2185.[7] Id. at 6, 7. DHHR articulates no reason to question the legal reasoning in DAB No. 2185, however, and we see no legally significant differences between the State's receipt of the Dey settlement proceeds and its receipt of the Oxycontin settlement proceeds. Based on our analysis of CMS's authority in DAB No. 2185, which we incorporate by reference, we conclude that CMS is entitled to recoup a share of the Dey settlement proceeds and that those proceeds also constitute an applicable credit that must be applied to reduce the amount of expenditures for which FFP is available.

DHHR makes two other contentions that DAB No. 2185 did not address but which we find meritless. First, DHHR contends that

[7] We note that in the prior appeal, DHHR conceded that the Oxycontin settlement proceeds constituted an applicable credit if any portion of those funds were paid to settle claims for reimbursement of Medicaid expenditures. DAB No. 2185, at 18. DHHR does not explain why that concession on the legal consequences of a settlement paid in relation to Medicaid expenditures is not equally applicable here.

CMS had no basis to find that the Dey settlement proceeds constituted recovered Medicaid overpayments because the settlement "was based exclusively on alleged price manipulation, not overpayment." Reply Br. at 2, 11. In other words, the State suggests that the settlement did not resolve claims that the defendants' conduct resulted in, or caused its Medicaid program to make, unallowable expenditures for Dey's drugs.

This contention is factually unsupported. The settlement agreement indicates that the State released Dey from "any civil or administrative claim, action, suit or proceeding . . . the STATE has or may have or could assert in the future under any source of law for the Covered Conduct" (emphasis added). The Covered Conduct, according to section II.C of the settlement agreement, was Dey's alleged drug price manipulation, as described in section II.B of that agreement. See infra n.3 (quoting section II.B). According to the State's amended complaint, the claims made by the State with respect to the Covered Conduct were causes of action, both statutory and common law, seeking restitution or reimbursement of what the State's pleadings called "inflated" or "excessive" expenditures, or "overpayments," by Medicaid and other public health insurers as a result of the Covered Conduct. See WV Ex. 3, ¶¶ 50, 54, 62-63, 69, 73, 77. For example, count I of the amended complaint, alleging violation of the State's Medicaid fraud statute, states that Dey's conduct had "caused the State and its public agencies to pay excessive costs" for the defendants' drugs, "injuring the State and its public agencies." WV Ex. 3, ¶¶ 48-54 (emphasis added). Thus, it is clear that the settlement agreement resolved claims that Dey's misconduct had resulted in or caused Medicaid overpayments. Any doubt as to the scope of the settlement is dispelled in the "Agreed Dismissal Order," signed by the court and the settling parties, which states that "all claims" asserted in the State's civil action had been dismissed "with prejudice, the same having been settled by the parties herein." WV Ex. 5, at 1 (emphasis added).

Second, DHHR contends that because the State's case against Dey did not proceed to the discovery or trial phases of the litigation, there is "no evidentiary basis" for the proposition that the settlement proceeds constitute a recovered Medicaid overpayment. Reply Br. at 7. DHHR also contends that CMS has "an absolute duty to do at least some reasonable investigation before it issues a disallowance; it cannot, as a matter of law, simply assume that the bare allegations of an Amended Complaint contain all the information necessary for it to take" a disallowance. WV Br. at 8.

We reject these contentions. The State's amended complaint plainly states claims for reimbursement of Medicaid overpayments resulting from the alleged manipulative pricing of Dey's drugs. See, e.g., WV Ex. 3, ¶¶ 39-40, 45. The settlement agreement shows that the State received $850,000 from Dey to settle those reimbursement claims. WV Ex. 4. These documents are sufficient evidence that a portion of the settlement proceeds represents a recovered Medicaid overpayment. Whether the State could have proved its Medicaid overpayment claims against Dey at trial is irrelevant. By compromising those claims prior to trial and judgment, the State effected a recovery of Medicaid overpayments for Dey's drugs. Moreover, we are unaware of any legal authority that requires CMS to independently confirm that there is an evidentiary basis for an overpayment identified by the state Medicaid agency before issuing a disallowance to recoup the federal share of that overpayment. As we noted earlier, states have the primary responsibility to identify and recover overpayments.

2. *CMS allocated an appropriate amount of the Dey settlement proceeds to West Virginia's Medicaid program.*

   a. CMS used a reasonable method to allocate approximately 67 percent of the Dey settlement proceeds to Medicaid, and the State has not presented any other method for allocating the proceeds or calculating the disallowance.

CMS's disallowance notice states that the amount of the disallowance was equal to $850,000 multiplied by West Virginia's FMAP. Thus, CMS initially allocated all $850,000 of the Dey settlement proceeds to the Medicaid program. See Response Br. at 23. In its initial appeal brief, DHHR contended that this allocation "completely disregard[ed] the fact that the Attorney General brought the lawsuit to recover losses sustained not only by the DHHR" (the state Medicaid agency) but by other state agencies or non-Medicaid programs. WV Br. at 4. CMS subsequently announced that it had reduced the disallowance based on a determination that approximately 33 percent of the Dey settlement proceeds is allocable to non-Medicaid programs and that approximately 67 percent of those funds is allocable to Medicaid. See Response Br. at 1. CMS presented the following rationale for that allocation.

According to CMS, "the heart of the State's suit against Dey were fraud allegations concerning the pricing of its drug albuterol."

Response Br. at 23. In a September 22, 2003 memorandum (evidently prepared by the State's attorneys), the State estimated that the damages attributable to Dey's allegedly fraudulent pricing of albuterol were $1,416,033.82. CMS Ex. 11. Spreadsheets attached to the September 22, 2003 memorandum break down this total by state agency as follows: DHHR's estimated damages were $952,152.57; PEIA's were $146,033.82; and WCD/BEP's were $317,544.25, for a total of $1,416,033.82. DHHR's estimated damages of $952,152.57 are 67.2408 percent of the total estimated damages attributable to Dey. Thus, CMS reasons, it is appropriate to allocate 67.2408 percent of the $850,000 in Dey settlement proceeds, or $571,546.80, to the Medicaid program. Multiplying $571,546.80 by West Virginia's FMAP at the time of the settlement (78.14%) yields a disallowance amount of $446,607. CMS therefore lowered the disallowance from $634,525 to $446,607.

DHHR does not challenge CMS's calculations or present a method of its own for calculating the disallowance. Instead, DHHR contends that the allocation "cannot be sustained" because the September 22, 2003 memorandum and spreadsheets contain only damage "estimates" along with "caveats" that some data were "incomplete," of questionable reliability, or based on "assumptions" or "extrapolations." WV Br. at 9-10. These criticisms suggest a belief that CMS was obligated to justify its allocation with mathematical precision or certainty. However, absent complete or perfect information, an allocation need only have some reasonable basis. Cf. School Board of Seminole County, DAB No. 1238 (1991) (finding that "[i]n the absence of complete time distribution records," the federal agency was "reasonable in relying on the existing records to establish [an employee's] time distribution between the two programs"). Because CMS's allocation rests on the State's own damages estimate in preparation for litigation, an estimate that in turn was based on a substantial volume of claims and reimbursement data supplied by the affected programs,[8] and because there is no indication in the memorandum and spreadsheets that the estimates were seriously flawed or substantially overstated the alleged relative loss to Medicaid, we conclude

[8] The September 22, 2003 memorandum states that the damages estimates were based on "available data from the client agencies and information about reimbursement methods used in each program to calculate the overcharge attributable to AWP." CMS Ex. 11. "Where possible," states the memorandum, the authors "extrapolat[ed] from this data to approximate data with regard to periods for which data is currently unavailable." Id.

that a reasonable basis exists for CMS to allocate approximately 67 percent of the Dey settlement proceeds to Medicaid.

Because CMS proffered a facially appropriate basis for the allocation, DHHR had the burden here to demonstrate that the allocation was inappropriate. See Massachusetts Executive Office of Health and Human Services, DAB No. 2218, at 12 (2008) (finding that the burden shifted to the appellant once CMS "adequately articulated the basis" for the disallowance). DHHR clearly did not meet that burden. Given that mathematical certitude is not required in these circumstances, DHHR's assertions that the damages estimates are based to an extent on imperfect data, "assumptions," and extrapolation are insufficient absent some proof or demonstration that the assumptions or extrapolations are unreasonable, or that more complete or accurate data would likely have decreased the percentage amount of damages allocated to the Medicaid program. DHHR has supplied no such proof or demonstration, and proposed no alternative allocation, even though it has access to claims data and other relevant source documentation. Indeed, DHHR fails to discuss the actual methods or data used by the State's lawyers to generate the damages estimates or otherwise explain how or why, or to what extent, those methods and data may have distorted CMS's allocation.

DHHR asserts that the State's "methodologies and assumptions . . . presumably failed the reliability test at trial" (of the claims against the non-settling defendants), Reply Br. at 10, but provides no evidence that its damages estimates were ever scrutinized at trial. DHHR also points to language in the memorandum stating that "[i]t would not be difficult to modify the above methodology or assumptions or to use new or different data from the agencies." CMS Ex. 11. Even if that proposition is true, however, it does not prove that the estimates were inadequately supported or substantially inaccurate, only that the State could have used different methods and assumptions to calculate its damages (for the State's benefit, presumably). Furthermore, the September 22, 2003 memorandum states that "[t]he damages estimate is most complete for Medicaid." CMS Ex. 11.

For the reasons discussed, we conclude that CMS reasonably relied on the State's September 22, 2003 memorandum and spreadsheets to determine the amount of the Dey settlement proceeds properly allocable to Medicaid. We further conclude that CMS allocated an appropriate percentage (approximately 67 percent) of those proceeds to Medicaid.

b. CMS properly treated the $100,000 paid by Dey to the West Virginia Attorney General's consumer protection fund as part of the settlement proceeds for purposes of calculating the disallowance.

DHHR contends that the $100,000 paid by Dey to the West Virginia Attorney General's consumer protection fund "should be considered a legitimate cost of obtaining the settlement" and therefore not be included in CMS's disallowance calculation. WV Br. at 5-6. More specifically, the State asserts that these funds should be treated as costs of legal work performed by attorneys of the West Virginia Attorney General's office in the lawsuit against Dey. Reply Br. at 8.

We see no factual basis to conclude that the funds paid to the Attorney General's consumer protection fund represent a "cost of obtaining the settlement." There is no evidence that the consumer protection fund financed the State's lawsuit against Dey, and the settlement agreement states that the money paid to the fund was to be used for purposes that do not include reimbursing the State for attorneys' fees or other legal costs — i.e., "solely for consumer protection purposes." WV Ex. 4, at 4. Furthermore, the Settlement Agreement had a separate provision for attorneys' fees, requiring Dey to make a payment of $250,000 (in addition to the principal $850,000 settlement payment) to cover attorneys' fees incurred by the State "in filing and pursuing this lawsuit and in bringing the settlement about[.]" Id.

In support of its request that $100,000 be treated as a cost of obtaining the settlement, DHHR cites section 3907 of CMS's State Medicaid Manual and Washington State Department of Social and Health Services, DAB No. 1561 (1996). Neither is relevant or applicable here. Section 3907 sets forth guidelines for reimbursement of Medicaid in "third party liability" (TPL) cases, which are governed by section 1902(a)(25) of the Act. The Board decision in Washington also concerns reimbursement in the TPL context. This case involves recovery of an overpayment under section 1903(d), not a TPL recovery under section 1902(a)(25).

Conclusion

In this decision, we conclude that the federal government was entitled to a share of the Dey settlement proceeds. We also conclude that CMS had an appropriate basis for determining that the federal government's proper share of the settlement proceeds was 67.2084 percent. Based on these conclusions, we sustain the

disallowance of Medicaid FFP in the amount of $446,607.

/s/
Judith A. Ballard

/s/
Leslie A. Sussan

/s/
Sheila Ann Hegy
Presiding Board Member