Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

SUBJECT: Texas Health and Human Services Commission
Docket Nos. A-07-101
A-07-127
A-08-16
Decision No. 2136

DATE: December 6, 2007

DECISION

The Texas Health and Human Services Commission (Texas or HHSC) appealed determinations by the Centers for Medicare & Medicaid Services (CMS) disallowing claims for indirect costs incurred by the Texas Department of Transportation (TX-DOT), which operates the Medicaid non-emergency transportation program. CMS determined that the claims were overstated because, in determining the amount of indirect costs allocable to Medicaid, Texas had applied the approved indirect cost rate for TX-DOT to a direct cost base that inappropriately included payments to the transportation providers. The total disallowance is of $2,966,601 in federal financial participation (FFP): $2,415,981 for the period October 1, 2003 through December 31, 2006, $258,613 for the period January 1, 2007 through March 31, 2007, and $292,007 for the period April 1, 2007 through June 30, 2007.

Texas asserts that TX-DOT's federally approved indirect cost rate allows for including payments to the transportation providers in calculating indirect costs. Texas also asserts that, since CMS in several related cases took the position that the payments for transportation services did not qualify as "medical assistance" and had to be claimed as administrative costs, consistency requires that those costs not be eliminated from the direct cost base to which the approved indirect cost rate is applied.

For the reasons stated below, we conclude that Texas could not properly apply the approved indirect cost rates for TX-DOT to a direct cost base including payments for medical transportation services. Not only would including such payments in a direct cost base potentially be inequitable to the Federal Government, but, more important, Texas did not show that such costs were a

cost element included in the direct cost base used to calculate the rates. Accordingly, we uphold the disallowance.

Factual background

The following facts are undisputed. HHSC is the single State agency for Medicaid. Since 1975, the Texas Medicaid State Plan has provided for payment for "authorized medical transportation furnished to eligible recipients as a Title XIX benefit by approved transportation providers both private and public" either based on a negotiated reasonable charge per trip under an "assurance contract" or "based on reasonable charges not to exceed the rates established by the Single State Agency" under a payment-per-trip contract. CMS Ex. A. Prior to 1994, the medical transportation program was operated by the Texas Department of Health under the supervision of HHSC, but in 2004, the Texas legislature revised provisions governing health and human services to give HHSC even greater authority and control, reorganizing the HHSC agencies into four new departments. HB 2292, 78th Legislature, Regular Session, 2003. This legislation also required HHSC to enter into an interagency contract with TX-DOT to "assume all responsibilities of the Texas Department of Health and the [HHSC] relating to the provision of transportation services for clients of eligible programs." Id. TX-DOT was authorized to "contract with any regional transportation provider or with any regional transportation broker for the provision of public transportation services." Id. This law resulted in transfer of the Medicaid transportation program to TX-DOT. Since 2004, TX-DOT has operated call centers that receive client requests for transportation services, arrange for the transportation on a per-trip basis, and assign a unique confirmation number; TX-DOT then processes claims from transportation contractors based on the confirmation numbers.

On January 18, 2006, the Dallas Regional Office of CMS notified Texas that CMS was deferring the FFP claimed for administrative expenditures for "Indirect Cost - Client" by the HHSC on behalf of TX-DOT. The letter indicated that, through discussions with Texas officials, the Regional Office had discovered that "the State significantly changed their transportation program." TX Ex. B, at B-1. The letter also reported that, during these discussions, TX-DOT staff had stated that "the Federal Highway Administration, the cognizant agency, approved their indirect cost rates for State FY 2006, which is 2.23 percent." Id. at B-2. According to the deferral letter, Texas had applied this approved indirect cost rate "to the Medical assistance payments as well as direct costs," based on its belief that Office of Management and Budget (OMB) Circular A-87 authorized it to apply

its approved indirect cost rate "to any costs." Id. The deferral letter determined that the "medical assistance payments (Title XIX funds) are excluded in the direct base cost calculation of TX-DOT's approved indirect cost rate" and listed reasons why CMS had determined that the rate should not be applied to the "medical assistance" payments. CMS subsequently issued the disallowance determinations at issue here.

Legal background

Medicaid, established under title XIX of the Social Security Act (Act), is a program in which the federal government and states share the cost of providing necessary medical care to financially needy and disabled persons. Sections 1901, 1903 of the Act.[1] Each state establishes and administers its own Medicaid program subject to various federal requirements and the terms of its "plan for medical assistance" (state plan), which must be approved by the Secretary of Health and Human Services (Secretary). Section 1902 of the Act. Once the state plan is approved, a state becomes entitled to receive FFP for a percentage of its program-related expenditures. FFP is available at the "federal medical assistance percentage" rate for expenditures for "medical assistance under the State plan," at special rates for certain services or administrative costs, and at a 50 percent rate for the remainder of expenditures "found necessary by the Secretary for the proper and efficient administration of the State plan." Section 1903(a) of the Act.

Section 1905(a) of the Act defines "medical assistance," in general, as payment of part or all of the cost of the listed services (which a state either must or may cover in its state plan) when provided to the specified eligible individuals (recipients). Section 1905(a)(28) of the Act (formerly section (a)(27)) provides that "medical assistance" includes "any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary." Medicaid regulations specify that transportation may be either medical

[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.

assistance or an administrative cost. Specifically, 42 C.F.R. § 440.170(a) provides:

> *Transportation.* (1) "Transportation" includes expenses for transportation and other related travel expenses determined to be necessary by the agency to secure medical examinations and treatment for a recipient. (2) Transportation, as defined in this section, is furnished only by a provider to whom a direct vendor payment can appropriately be made by the agency. If other arrangements are made to assure transportation under § 431.53 of this subchapter, FFP is available as a administrative cost.

For purposes of the Medicaid fee-for-service program, the term "provider" means "an individual or entity furnishing Medicaid services under an agreement with the Medicaid agency" unless the context indicates otherwise. 42 C.F.R. § 400.203. The term "Medicaid agency" or "agency" means the "single State agency administering or supervising the administration of a State Medicaid plan" unless the context indicates otherwise.

Medicaid grants are subject to the cost principles of OMB Circular A-87. 45 C.F.R. §§ 92.4, 92.22. OMB Circular A-87 is now codified in 2 C.F.R. Part 225.

OMB Circular A-87 provides that the total cost of federal awards is "comprised of the allowable direct cost of the program, plus its allocable portion of allowable indirect costs, less applicable credits." Att. A., ¶ D.1. 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 the relative benefits received." Att. A, ¶ C.3.a. "Direct costs" are "those that can be identified specifically with a particular final cost objective." Att. A., ¶ E.1. "Indirect costs" are "those: (a) incurred for a common or joint purpose benefiting more than one cost objective, and (b) not readily assignable to the cost objectives specifically benefitted, without effort disproportionate to the results achieved." Att. A, ¶ F.1; Att. E, A.1.[2]

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[2] As the Circular recognizes, there "is no universal rule for classifying certain costs as either direct or indirect under every accounting system" and a "cost may be direct with respect to some specific service or function, but indirect with respect to the Federal award or other final cost objective." Att. A,

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OMB Circular A-87 sets out requirements for developing and submitting cost allocation plans and indirect cost rate proposals. Attachment E addresses state and local indirect cost rate proposals.[3] Indirect costs are normally charged to federal awards by the use of an indirect cost rate. "Indirect cost rate" is a "device for determining in a reasonable manner the proportion of indirect costs each program should bear" and "is the ratio (expressed as a percentage) of the indirect costs to a direct cost base." Att. E, ¶ B.2. "Base" means "the accumulated direct costs (normally either total direct salaries and wages or total direct costs exclusive of any extraordinary or distorting expenditures) used to distribute indirect costs to individual Federal awards." Att. E, ¶ B.4. Thus, for example, if the direct cost base were $100,000 and total indirect costs were $25,000, the indirect cost rate would be 25 percent.

There are several types of indirect cost rates. The rates at issue here are "fixed rates." Fixed rates are determined in advance based on estimates, and then the difference between the estimated costs and the actual allowable costs of the period covered by the rate is carried forward as an adjustment to the rate computation of a subsequent period. Att. E, ¶ B.

There are also several methods for computing indirect cost rates. The "simplified method" may be used where a governmental unit's department or agency has only one major function or where all of its major functions benefit from the indirect costs to approximately the same degree. The provisions for the simplified method state that the "distribution base may be (1) total direct costs (excluding capital expenditures and other distorting items, such as pass-through funds, major subcontracts, etc.), (2) direct salaries and wages, or (3) another base which results in an equitable distribution method." Att. E, ¶ C.2.c. (Emphasis added.) Option 1 is generally referred to as a modified total direct cost base. Where a grantee agency's indirect costs

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¶ D.2. In general, however, costs must be accorded consistent treatment and "may not be assigned to a federal award as a direct cost if any other cost incurred for the same purpose in like circumstances has been allocated to the Federal award as an indirect cost." Att. A, ¶ C.1.f.

[3] Attachment C addresses negotiation and approval of central services cost allocation plans. Attachment D and subpart E of 45 C.F.R. Part 95 address Public Assistance Cost Allocation Plans.

benefit its major functions in varying degrees, use of a "multiple allocation base method" may be required. Att. E, ¶¶ C.1.b. and C.3. Under this method, costs are accumulated into separate cost groupings (that is, pools of expenses that are of like character in terms of the functions they benefit); each grouping (or indirect cost pool) is then allocated to benefitted functions by means of a distribution base which "best measures the relative benefits." Id. The same three options for distribution bases are listed for this method as for the simplified method. Att. E, ¶ C.3.e. In selecting cost elements or related factors for a distribution base, various actual conditions should be taken into account, including whether the cost element or related factor is "common to the benefitted functions during the base period." Att. E, ¶ C.3.c. If conditions exist where a particular award is "carried out in an environment which appears to generate a significantly different level of indirect costs," a "special indirect cost rate" should be developed for that award.

State and local departments or agencies that seek to claim indirect costs under federal awards must prepare indirect cost rate proposals and supporting documentation and timely submit them to the federal agency designated as the "cognizant agency" for that department or agency. Att. E, ¶ D. The cognizant agency reviews the proposal, may negotiate some changes, and then ultimately approves an indirect cost rate (or issues a determination disapproving the proposed rate). Att. E, ¶ E. The Circular provides that "[o]nce a rate has been agreed upon, it will be accepted and used by all Federal agencies unless prohibited or limited by statute." Att. E, ¶ E.1.

The Federal Highway Administration of the Department of Transportation is the cognizant agency for TX-DOT, and the Department of Health and Human Services (HHS), specifically, the HHS Division of Cost Allocation (DCA), is the cognizant agency for the HHSC. 51 Fed. Reg. 552.[4]

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[4] DCA also is responsible for approving public assistance cost allocation plans submitted pursuant to OMB Circular A-87, Attachment D, and 45 C.F.R. Part 95, subpart E. State agencies administering public assistance programs, including Medicaid, must submit to DCA for approval narrative descriptions of their allocation methodologies, so that DCA can evaluate "the appropriateness of the proposed groupings of costs (cost centers) and the related allocation bases." OMB A-87, Att. D, ¶ E.1.

HHS DCA also has government-wide responsibility for implementing OMB Circular A-87. DCA's "Implementation Guide for Office of Management and Budget Circular A-87" (referred to as ASMB C-10) discusses use of "modified total direct costs" as the distribution base for indirect costs. ASMB C-10 explains that modified total direct costs "exclude 'any extraordinary or distorting expenditures,' usually capital expenditures, subawards, contracts, assistance payments (e.g., to beneficiaries), and provider payments." ASMB C-10, at ¶ 6.2.2 (emphasis added).

ASMB C-10 states that the "direct cost base is used to distribute indirect costs to individual Federal awards, i.e., an indirect cost rate must be applied to a direct cost base in order to determine the amount of indirect costs." Id. ASMB C-10 also states that once a rate is "recognized" for purposes of an award, then it may be applied "to the applicable base of the allowable direct costs incurred during award performance." Id. at ¶ 6-16 (emphasis added). In Colorado Dept. of Health Care and Policy Financing, DAB No. 2057 (2006) (cited by both parties here), the Board described how an indirect cost rate is determined and stated that the "resulting indirect cost rate is then customarily applied to a direct cost base comprised of the same cost elements that were used in the base to calculate the indirect cost rate." DAB No. 2057, at 14. In other words, the "applicable" base for purposes of determining the indirect costs allocable to a particular award is one comprised of the cost elements used to determine the rate in the first place.[5]

Analysis

Whether Texas properly included the costs of transportation services in the direct cost base is not determined by whether the costs are administrative costs or medical assistance.

[5] The reason the Board said in Colorado that the rate is "customarily" applied to the same cost elements is that there are some awards for which the approved indirect cost rate may not be applied to the direct cost base to determine allowable indirect costs because there are regulatory limits on the amount of indirect costs that will be allowed. As ASMB C-10 notes, federal agencies usually determine at the time of an award whether to recognize and use indirect cost rates established for a particular recipient by its cognizant agency. ASMB C-10, at ¶ 6.2.2.

On appeal, Texas noted that in separate disallowances that were the subject of related appeals, CMS had asserted that the payments TX-DOT made for transportation services did not qualify as "medical assistance," and therefore that FFP was available only at the 50 percent rate available for Medicaid administrative costs. According to Texas, if its payments to transportation providers "will be treated as a Medicaid administrative expense rather than a Medicaid provider payment for the purpose of claiming FFP, those payments should also be treated as a Medicaid expense for the purpose of inclusion in the direct cost base to which an indirect cost base is applied." TX Br. at 2-3. In support, Texas cited to the principle in OMB Circular A-87 regarding consistent treatment of like costs as either direct or indirect.

In its response brief, CMS cited the Board decision in the related disallowances, Texas Health and Human Services Commission, DAB No. 2114 (2007), arguing that the Board decision categorized the payments made by TX-DOT as "provider payments" and that it is "clear that the payments at issue in this case are either 'provider payments' or 'assistance payments' as contemplated by both OMB Circular A-87 and its implementation guide (ASMB C-10)." CMS Br. at 7.

We first note that CMS's description of the Board's holding in DAB No. 2114 is not entirely accurate. In that decision, the Board concluded that, prior to June 1, 2006, the transportation services were furnished by "providers to whom a direct vendor payment [could] appropriately be made by the [State] agency" but that, after that date, some of the services were furnished under brokerage contracts, with no direct vendor payment appropriately made from any state agency to the entity that actually provided the service. Having concluded that part of the claims at issue were allowable as "medical assistance" expenditures, under the existing approved plan, the Board upheld the disallowance determinations in part and reversed them in part, in an amount to be determined pursuant to the Board's instructions in its decision.[6]

[6] The Board further concluded that Texas had established that, under the medical transportation program (even as administered by TX-DOT), recipients had the freedom of choice of providers that was required for Texas to receive FFP in payments for the services at the higher rate for medical assistance expenditures. The decision also noted that Texas may be entitled to an additional lump sum payment of FFP for the services

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In any event, whether the transportation services provided under contracts between TX-DOT and providers or brokers qualify as "medical assistance" or only as administrative expenditures under Medicaid is not determinative of the issue presented here. Texas does not deny that the payments for transportation services were made either directly to the providers who contracted with TX-DOT or indirectly to the providers through the brokers who contracted with TX-DOT. Thus, we find that CMS reasonably characterized them as "provider payments" within the meaning of ASMB C-10. In addition, the payments could reasonably be considered contract costs, since the payments were made pursuant to the contracts between TX-DOT and the providers or brokers.

As Texas points out in its reply brief, however, the provisions in the Circular and in ASMB C-10 on which CMS relies do not state that costs of provider payments (or contracts) must always be excluded from a direct cost base, but only that they are "normally" or "usually" excluded. TX Reply Br. at 1. The Circular indicates that the reason for excluding such costs is either that they are "distorting" or that including them would otherwise be inequitable. Texas asserts that ASMB C-10 indicates that the determination about whether to exclude costs from the direct cost base used to calculate an indirect cost rate is "based upon an assessment of the degree to which the funds reflect an expenditure of resources by the primary recipient." TX Reply Br. at 2. In support, Texas cites to a note to an illustration in ASMB C-10 regarding "flow through funds" that are "provided to a primary recipient and subsequently passed through to another organization which actually performs the program for which the funds are provided." TX Reply Br. at 2, quoting note (a) to Illustration 6-1 in ASMB C-10. The note explains that such funds are excluded from direct costs for purposes of the rate computation because "the primary recipient's involvement is generally limited to monitoring and oversight" of flow through funds, and the funds do not "reflect the expenditure of resources" by the primary recipient. Id. Texas asserts that TX-DOT is not limited to monitoring and oversight of the "provider payments" since, when a Medicaid recipient who needs non-emergency transportation calls a TX-DOT employee in a call center operated by TX-DOT, "TX-DOT staff verifies the eligibility of the recipient, determines the type of transportation that is

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provided under brokerage contracts if CMS approves a proposed Texas plan amendment authorizing such contracts and if the plan amendment has an effective date during the disallowance period.

needed by the recipient, and arranges for the transportation to be provided." Id.

Although we agree with Texas that there may be some circumstances where including some costs of contracts or provider payments in a direct cost base might be appropriate, the rationale Texas offers here is not persuasive. The fact that TX-DOT performs functions such as responding to requests for transportation services and arranging for the transportation to be provided does reflect an expenditure of resources by TX-DOT. Texas does not explain, however, why the indirect costs of those efforts were not fully recognized by applying the indirect cost rate to a direct cost base that included the salaries and wages of the staff performing those functions, costs of materials, and other administrative-type costs incurred by TX-DOT. Texas separately claimed indirect costs computed by applying the indirect cost rates to such administrative expenses, and CMS allowed them. CMS Br. at 8, n. 6.[7] Texas does not claim that TX-DOT incurs any costs for actually transporting Medicaid recipients, nor assert that the payments for transportation services are a type of cost element that was common to other TX-DOT functions during the relevant period. Thus, including the payments for transportation services in the direct cost base could be distorting and inequitable to the Federal Government, as CMS asserts.

We do not need to resolve this issue definitively, however. CMS says that it is not arguing that the indirect cost rate was calculated incorrectly, but only that the rate was applied inappropriately to the medical assistance payments. More important, as we discuss next, we conclude that Texas did not show that the indirect cost rate agreement between TX-DOT and its cognizant agency in fact permitted Texas to allocate costs to Medicaid using a direct cost base that included the payments to contractors for the transportation services.[8]

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[7] Although Texas does not argue that HHS had recognized TX-DOT's indirect cost rate in advance (for example, by approving a public assistance cost allocation plan referring to that rate), CMS says that it did not disallow the indirect costs determined by applying the TX-DOT rate to administrative expenses since CMS "chose to recognize the cognizant agency's indirect cost rate . . . ." Id.

[8] In a footnote, CMS suggests without support that the payments to providers were, by definition, not "direct" costs. CMS Br. at 9, n. 8. To the extent the services were provided to

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Texas did not show that payments from TX-DOT to providers or brokers were included in its approved indirect cost rates for use in charging indirect costs to federal awards.

As indicated above, we are not in this case reviewing an indirect cost rate proposal to determine whether to approve that proposal or to set a different indirect cost rate. It is undisputed here that TX-DOT had, during the period at issue, indirect cost rates that were approved by its cognizant agency. CMS has accepted the approved indirect cost rates as applied to TX-DOT's direct administrative costs, but says that it is not proper to apply those rates to the payments for transportation services because the direct cost base used to compute the rates did not include such payments.

To support its assertion that the direct cost base for TX-DOT's approved rates did not include payments for transportation services, CMS provided a copy of the TX-DOT indirect cost proposal for the period September 1, 2003 through August 31, 2004, that is, State Fiscal Year (SFY) 2004. CMS Ex. D. According to CMS, if the payments for transportation services had been included in the direct cost base used to compute the indirect cost rate, they would have appeared as a "medical/health related" entry in the indirect cost rate proposal, specifically, in the first column of either page 10 or page 11 of the proposal, CMS Exhibit D. CMS Br. at 9.

Texas replies that its Exhibit E "shows that the provider payments **are** included in the direct cost base used in calculating the indirect cost rate under the Approved Indirect Cost Rate Plan for State Fiscal Year 2006." TX Reply Br. at 5 (emphasis in original). Texas does not deny that payments to TX-DOT contractors for transportation services were not included in the historical costs used to calculate the applicable indirect cost rate for SFY 2004, nor does it claim that such costs were included in the base used to calculate the applicable rate for SFY 2005. Instead, Texas maintains that the "medical assistance expenses for transportation were considered part of the direct

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Medicaid recipients, however, they would have been specifically identifiable with the Medicaid program. Such payments are a type of cost normally charged directly to a program, as indicated by the fact that ASMB C-10 mentions provider payments as an element of direct costs that might need to be excluded from modified total direct costs in computing an indirect cost rate.

cost base even though the historical data generally used to estimate those expenses was not available to TX-DOT at the time the proposed indirect cost plan was prepared." Id. Texas says this position "is based on TX-DOT's interpretation that in the proposed plan historical costs are used to estimate costs for a future period but the indirect cost rate is calculated from the estimates rather than the actual historical costs." Reply Br. at 5. Texas argues that "[e]stimated costs may also include any new cost elements for which there is no historical cost data," and "[a]djustments are made in subsequent periods to account for differences between actual costs and over-estimates or under-estimates." Id. According to Texas, TX-DOT's interpretation that the costs of medical transportation services were considered part of the direct cost base in the SFY 2004 proposal is supported by the inclusion of the historical cost data for those expenses in the indirect cost rate plan for SFY 2006. Texas argues that the circumstances of this case are comparable to those addressed in the Board's decision in University of California, DAB No. 763 (1986), even though the process for establishing the indirect cost rate in that case was different. That case involved an interpretation of what cost elements were included in a direct cost base, Texas says, and therefore supports its view that the State's interpretation of its plan should be accepted.

Texas also argues that CMS's assumption that payments for transportation services would have appeared as a "medical/health related" entry in the indirect cost proposal is incorrect. According to Texas, "[s]ince the expenditures are reported by 'District/Division/Office' and the medical transportation program is within the Public Transportation Division, the program's expenditures are included in the Public Transportation expenditures." TX Reply Br. at 3-4. In support of its assertion that payments for transportation services were included in the direct cost base for SFY 2006, Texas compares the $62,704,758 TX-DOT reported for "Public Transportation Projects" in the SFY 2004 proposal (at page D-67 of CMS Exhibit D) with the $124,284,774 TX-DOT reported for "Public Transportation Projects" in the SFY 2006 proposal (at page C-8 of Texas Exhibit C). Texas points out that the transmittal letter for the SFY 2004 proposal says that the proposed rates were "computed from actual expenditures in the fiscal year ending August 31, 2002, with projected increases in direct and indirect cost for fiscal years 2003 and 2004." CMS Ex. D, at D-3. Since the medical transportation program did not "fully transfer" to TX-DOT until March 2004, Texas says, the "actual expenditures reflected in this document could not include any of the medical transportation program expenditures." TX Reply Br. at 3. According to Texas,

the fact that the $124,284,774 reported in the SFY 2006 proposal is $61,580,016 greater than the amount reported in the SFY 2004 proposal is "primarily attributable to medical transportation expenditures, including provider payments." Id. at 4. Texas cites its Exhibit E as showing that the $124,284,774 was included in the calculation of the indirect cost rate for SFY 2006.[9]

We conclude that Texas did not show that payments for Medicaid transportation services were included in any direct cost base used to compute TX-DOT's indirect cost rates applicable to the disallowance period. The mere fact that a state may consider estimated cost increases in computing an indirect cost rate based on historical costs does not establish that the SFY 2004 and 2005 rates in fact included estimated payments for transportation services. In fact, the TX-DOT proposal for SFY 2004 indicates that the "Projected Direct Cost" for SFY 2004 for Public Transportation was determined by applying an estimated 6.02% increase to the actual SFY 2002 direct costs for Public Transportation. CMS Ex. D, at D-11. The same percentage increase was used to project increases for other Divisions' direct costs and for indirect costs. Id. Since the same factor was used for all costs, it likely reflects projected inflation. In any event, Texas provided no evidence that the projected increase for Public Transportation related in any way to adding projected costs of transportation services to the actual SFY 2002 expenditures.

With respect to the indirect cost rate for SFY 2006, Texas is correct that the documents show a dramatic increase in the direct costs of Public Transportation used to compute that rate compared to the direct costs used to calculate the SFY 2004 rate. For the following reasons, however, we do not agree with Texas that this demonstrates that payments for transportation services were included in the direct costs used to compute the SFY 2006 rate:

- While Texas asserts that the increase is "primarily attributable to medical transportation services," Texas submitted no evidence to support this assertion. The only information regarding the $124,284,774 shown by the excerpt from the SFY 2006 indirect cost rate proposal submitted by Texas is that the figure is based on actual expenditures incurred during SFY 2004 and is from

[9] Texas describes its Exhibit E as "an excerpt from TX-DOT's Approved Indirect Cost Rate Plan for State Fiscal Year 2006, the same document from which Appellant's Exhibit C is an excerpt." TX Reply Br. at 4.

Account 74, Public Transportation Projects. TX Ex. C, at C-8. Texas asserts that the Public Transportation Division was responsible for the medical transportation program, but Texas provided no evidence (such as a declaration from someone in that division or from someone who prepared the indirect cost proposal) that payments for transportation services in SFY 2004 were charged to the account for Public Transportation Projects or even that the medical transportation program was considered a "project" of the division.[10]

- Given the potential cost of public transportation projects, we cannot reasonably say that the only plausible explanation of the increase from 2002 to 2004 in actual direct costs for such projects is that payments for medical transportation services were included.

- Texas says that the medical transportation program was not fully transferred to TX-DOT until March 2004, well into SFY 2004. Yet, the percentage increase over SFY 2004 actual direct costs used to project direct SFY 2006 costs for the Public Transportation Division was the same as the percentage increase used for other divisions. TX Ex. E. If the direct costs for SFY 2004 included payments for medical transportation services, but TX-DOT knew that the program was not fully implemented until March 2004 (well into the fiscal year), one would have expected the projected increases in direct costs for SFY 2006 to have taken this into account in a way that would be reflected in the proposal.

- Texas provided no evidence that it informed its cognizant agency, the Federal Highway Administration, that payments for medical transportation services were being included in the direct cost base for SFY 2006. Given the nature and amount of the payments and the guidance in ASMB C-10 that provider payments are usually excluded from modified total direct costs, TX-DOT would

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[10] Elsewhere, the proposal distinguishes "projects or jobs," for which the direct costs are taken from the "respective project ledger of . . . (TxDOT's financial accounting system) segments 72 through 79," from "non-project or non-job type activities." TX Ex. C, at C-3.

> likely have mentioned that it was including this new cost element in the distribution base if it was, in fact, seeking approval for departing from the usual practice of excluding such costs.

To the extent Texas is relying on the Board's decision in University of California to mean that we should defer to Texas's "interpretation" of what was included in the direct cost base, that reliance is misplaced. First, in the University of California case, the Board accepted the interpretation advanced by the University of a statement in the Negotiation Agreement regarding what patient care costs were excluded from the direct cost base because that interpretation was consistent with the wording, structure, and history of the Negotiation Agreement, and because the University had presented evidence showing that the patient care costs at issue had in fact been included in the direct cost base used to compute the indirect cost rate. Here, Texas has not shown that TX-DOT included costs of payments for medical transportation in the direct cost base used to compute the rates for the disallowance period although it is TX-DOT that has access to the information about the costs underlying its indirect cost rate proposal.

Second, Texas has not here pointed to any language in a Negotiation Agreement or an indirect cost proposal that TX-DOT interprets as permitting it to include payments for transportation services in the direct cost base used to distribute indirect costs to federal awards.[11]

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[11] Excerpts from the TX-DOT indirect cost rate proposal for SFY 2004 submitted by CMS do indicate that TX-DOT had a "philosophy" that cost recovery of general and administrative costs should be the same "regardless of whether contract or state forces are utilized to do a job or function." CMS Ex. D, at D-9. The transmittal letter for the indirect cost proposal for SFY 2004 therefore states that "'pass-through' expenditures continue to be included in direct cost[s] in our indirect cost plan and indirect cost[s] are distributed to 'pass-through' projects in our accounting system." Id. at D-3. The letter goes on to say, however, that "we do not bill any federal programs for indirect cost on 'pass-through' projects." Id. Thus, even if the payments for medical transportation had been included in the account for Public Transportation Projects and therefore in the direct cost base used to calculate the indirect cost rate for SFY 2004, we question whether the Federal Highway Administration's approval of the rate could reasonably be considered approval for

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Finally, while it appears that the indirect cost rates for TX-DOT were fixed rates, so that carry forwards from earlier periods were permitted, Texas apparently misunderstands the nature of the carry forwards permitted. As shown in the indirect cost rate proposals, the amounts carried forward from prior periods were "Indirect Cost Variances" determined by comparing the total indirect costs that were incurred in each period with the indirect costs "applied." CMS Ex. D, at D-81 to D-84; TX Ex. E. Permitting carry forward of any over- or underrecovery of indirect costs resulting from use of a fixed rate is far different from permitting a state to unilaterally change the direct cost base used to distribute indirect costs among benefitting activities during the rate period.

In sum, we conclude that Texas could not properly apply the approved indirect cost rates for TX-DOT to a direct cost base including payments for transportation services since Texas did not show that such costs were a cost element included in the direct cost base used to calculate the rates.

Conclusion

For the reasons stated above, we uphold the disallowance of $2,966,601 in FFP Texas claimed as indirect costs of medical transportation services.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Judith A. Ballard
Presiding Board Member

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charging the indirect costs associated with those accounts to federal funds.