Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

SUBJECT: Pennsylvania Department of Public Welfare
Docket No. A-09-9
Decision No. 2281

DATE: November 10, 2009

DECISION

The Pennsylvania Department of Public Welfare (DPW) appealed a determination by the Centers for Medicare & Medicaid Services (CMS) disallowing $2,569,407 in federal Medicaid funding DPW claimed for payments made to ACPA of Pennsylvania (ACPA), a managed care organization, for services provided under a contract for calendar year (CY) 2005. DPW identified $4.8 million paid under that contract as an overpayment after it had already received the $2,569,407 federal share from CMS. CMS determined that this overpayment was subject to statutory and regulatory provisions giving a state 60 days after discovery of an overpayment to a Medicaid provider to refund the federal share of the overpayment. Here, DPW did adjust the federal share within 60 days of determining it had overpaid ACPA, but then repaid the $4.8 million to ACPA. DPW then reclaimed the federal share, which CMS disallowed.

According to DPW, it repaid ACPA after determining that it had erroneously identified the $4.8 million as an overpayment. There was no overpayment, ACPA says, because a settlement agreement with ACPA established final payment rates for CY 2005 that were within the range of actuarially sound rates that DPW could pay for managed care services. CMS does not dispute that DPW was precluded by the settlement agreement from recovering the $4.8 million from ACPA but maintains that DPW has not shown that the $4.8 million did not represent an overpayment.

For the reasons discussed below, we conclude that DPW has not shown that the $4.8 million did not represent an overpayment

subject to the federal government's right to a refund of the federal share. Accordingly, we uphold the disallowance.

Legal Background

The federal Medicaid statute, title XIX of the Social Security Act (Act), provides for joint federal and state financing of medical assistance for certain needy and disabled persons. Act §§ 1901, 1903. Each state that chooses to participate administers its own Medicaid program under broad federal requirements and the terms of its own "plan for medical assistance," or state plan, which must be approved by CMS on behalf of the Secretary of Health and Human Services. Act § 1902; 42 C.F.R. §§ 430.10-430.16. Once the state 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 . . . of the total amount expended . . . as medical assistance under the State plan." Act § 1903(a). Section 1905(a) of the Act defines the term "medical assistance" as "payment of part or all of the cost" of specified services and care when provided to Medicaid-eligible individuals under the state plan.

Sections 1902(a)(2), 1903(a) and 1905(b) of the Act require states to share in the cost of medical assistance and in the cost of administering the approved state plan. The rate of federal financial participation (FFP) that a state receives in its expenditures for medical assistance is called the federal medical assistance percentage (FMAP), and generally ranges from 50 percent to 83 percent of the cost of medical assistance, depending on the state's per capita income and other factors. 42 C.F.R. § 433.10 (2001).

Capitation payments made to a managed care organization (MCO) pursuant to an approved waiver may be considered "medical assistance" for purposes of reimbursement under section 1903(a)(1) of the Act. Act §§ 1115(a)(2), 1915(c)(1). State waiver programs must be approved by CMS. In addition, states may operate managed care programs under a state plan amendment approved under section 1932 of the Act, without obtaining a waiver, if the requirements of section 1903(m) are met.

Section 1903(m) of the Act provides:

> (2)(A) . . . no payment shall be made . . . to a State with respect to expenditures incurred by it for payment (determined under a prepaid capitation basis or under any

> other risk basis) for services provided by an entity . . . unless –-
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> (iii) such services are provided for the benefit of individuals eligible for benefits . . . in accordance with a contract between the State and the [managed care] entity . . . under which prepaid payments to the entity are made on an actuarially sound basis . . . .

The Department has implemented this provision through regulations at 42 C.F.R. Part 438. 42 C.F.R. § 438.1(b). The CMS Regional Office must review and approve all MCO contracts. 42 C.F.R. § 438.6(a). One type of MCO contract is a "risk contract," under which the contractor "[a]ssumes risk for the cost of the services covered under the contract" and "[i]ncurs loss if the cost of furnishing the services exceeds the payments under the contract." 42 C.F.R. § 483.2. When the contract is a risk contract, payment is made using capitation rates that must be actuarially sound. 42 C.F.R. § 438.6(c)(2). A "capitation payment" is --

> a payment the State agency makes periodically to a contractor on behalf of each recipient enrolled under a contract for the provision of medical services under the State plan. The State agency makes the payment regardless of whether the particular recipient receives services during the period covered by the payment.

42 C.F.R. § 438.2. A capitation payment is made to an MCO for each individual enrolled under the managed care contract. 42 C.F.R. § 438.2. The regulations define the term "actuarially sound capitation rates" and specify the elements a state must apply in setting rates (or explain why they are not applicable) and the documentation a state must provide to support the rates set. 42 C.F.R. § 438.6(c). Under a risk contract, the total amount the state pays to an MCO for carrying out the contract provisions is a medical assistance cost, and FFP is available for periods during which the contract meets the requirements of Part 438 and is in effect. 42 C.F.R. §§ 438.802(a), 438.812(a).

Subsection 1903(a) of the Act provides for payments to states for medical assistance. Subsection (d)(1) provides for estimating in advance of each quarter the amount a state will expend for medical assistance and administrative costs. Subsection 1903(d)(2) provides:

> (A) The Secretary shall then pay to the State . . . the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.
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> (C) For purposes of this subsection, when an overpayment is discovered, which was made by a State to a person or other entity, the State shall have a period of 60 days in which to recover or attempt to recover such overpayment before adjustment is made in the Federal payment to such State on account of such overpayment. . . .
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Subpart F of 42 C.F.R. Part 433 "sets forth the requirements and procedures under which States have 60 days following discovery of overpayments made to providers for Medicaid services to recover or attempt to recover that amount before the States must refund the Federal share of these overpayments to CMS, with certain exceptions."[1] 42 C.F.R. § 433.302. As used in Subpart F, the term "discovery (or discovered)" means "identification by any State Medicaid agency official or other State official, the Federal Government, or the provider of an overpayment, and the communication of that overpayment finding or the initiation of a formal recoupment action without notice as described in § 433.316." 42 C.F.R. § 433.304.

The term "overpayment" means "the amount paid by a Medicaid agency to a provider which is in excess of the amount that is allowable for services furnished under section 1902 of the Act and which is required to be refunded under section 1903 of the Act." 42 C.F.R. § 433.304. A state "must refund the Federal share of overpayments at the end of the 60-day period following discovery . . . whether or not the State has recovered the overpayment from the provider."[2] 42 C.F.R. § 433.312(a)(2).

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[1] Section 433.304 defines the term "provider" as "any individual or entity furnishing Medicaid services under a provider agreement with the Medicaid agency." DPW does not dispute that its contract with the MCO constituted a provider agreement for purposes of this definition.

[2] The one exception to this requirement is not applicable here.

The regulations also provide:

> If the amount of an overpayment is adjusted downward after the [State] has credited CMS with the federal share, the [State] may reclaim the amount of the downward adjustment" if the downward adjustment "is properly based on the approved State plan, Federal law and regulations governing Medicaid and the appeals processes specified in State administrative policies and procedures.

42 C.F.R. § 433.320(c).

Factual Background

The following facts are undisputed.[3] DPW had a contract with ACPA for the provision of services under its Medicaid managed care program. The contract, which was approved by CMS, provides that DPW will notify ACPA if base capitation rates will be risk adjusted to reflect the health status of enrollees; the notice must be given at least six months prior to the effective date. DPW Response to Order to Develop Record, Attachment B, at 3b-3, and Attachment C, at 3b-3. A dispute arose under the contract regarding certain risk adjusted rate factors for the CY 2005 contract period. ACPA's appeals to DPW's Bureau of Hearings and Appeals were resolved by a Stipulation of Settlement signed in October 2006. DPW Ex. 4. In the Stipulation, DPW agreed to increase the medical assistance payment amount for CY 2005 (the "Settlement Period") by $11.2 million. Id. ¶ 2. DPW was not precluded from offsetting against this amount "any amount which may be due from Appellant to DPW for a period other than the Settlement Period[.]" Id. ¶ 2(a), (b). However, DPW and ACPA agreed that the Stipulation resolved "any matters which relate to Appellant's payment rates" for the Settlement Period as well as "[a]ll issues relating to Appellant's MA [medical assistance] payment rates for services provided to MA recipients" for the Settlement Period. Id. ¶ 3(a), (b).

At the same time the Stipulation was being finalized, DPW calculated that ACPA owed it $4.8 million for the CY 2005

[3] This statement of the undisputed facts is taken largely from the Order to Develop the Record issued by the Presiding Board Member, which set out the undisputed facts as they then appeared from the record.

contract period. DPW Ex. 2, at 1; DPW Br. at 2.[4] DPW recovered this amount from ACPA but then reversed the recovery. DPW Br. at 2. Prior to reversing the recovery, DPW refunded $2,569,407, the federal share of the $4.8 million, to CMS. DPW then reclaimed the $2,569,407 on its quarterly expenditure report for the quarter ending September 30, 2007. DPW Ex. 1.

CMS initially deferred DPW's claim for $2,569,407 FFP in the $4.8 refunded to ACPA. DPW Ex. 1. CMS requested "additional information related to the basis for the contract stipulation and the subsequent contract adjustments as they relate to ACPA's approved contract and the actuarially certified rate methodology approved by CMS." Id. In response to CMS's request, DPW explained the basis for the Stipulation in part as follows:

> The stipulation provides for a total payment to ACPA of $11.2 million. This represents a negotiated amount (approximately $1.5 million less than claimed by ACPA) based on Risk Adjusted Rate (RAR) factors that ACPA disputed. Given the basis for ACPA's dispute under the contract and the fact that the settlement payment would keep ACPA's capitation payments within the certified rate ranges, the Department settled the dispute[.]

DPW Ex. 2, at 1. DPW further explained that it recouped the $4.8 million from ACPA based on its calculation of "other RAR adjustments relating to the 2005 contract period." Id. According to DPW--

> this amount was then paid back to ACPA because of the 2005 contract stipulation that provides settlement of 'all issues relating to Appellant's Medical Assistance (MA) payment rates for services provided to MA recipients for the period January 1, 2005 through December 31, 2005[.]'

Id. at 1-2.

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[4] Although both parties refer to the amount in question as $4.8 million, it appears from another document submitted by DPW that the precise amount was $4,858,097.15. DPW letter dated 8/28/09, attached memorandum from Director, Office of Budget, DPW.

DPW also stated that it was attaching to its response "information regarding the payments to ACPA that show the amounts as not deviating from the actuarially certified rate methodology approved by CMS (see attached capitation payment worksheet)." Id. at 2. In response to the Board's inquiry, CMS did not dispute that it had received this information and that the information showed that the payments were based on rates within the range certified as actuarially sound.

By letter dated September 4, 2008, CMS notified DPW that it was disallowing the previously deferred claim for $2,569,407 FFP. DPW Ex. 3. CMS cited as authority for the disallowance the provisions in section 1903(d)(2)(C) and (D) of the Act and 42 C.F.R. § 433.312(a)(2) providing that a state must refund the federal share of overpayments whether or not the state has recovered the overpayment from the provider. CMS also noted that paragraph 6 of the Stipulation states that the Stipulation "is [not] binding on any other state agency or any federal agency." CMS continued: "Though DPW was precluded from recouping the $4.8 million contract adjustment from ACPA, the fact is DPW identified that ACPA had been overpaid according to their contract and so DPW is obligated to pay CMS the federal share of that overpayment." Id. at 1.

Analysis

This case presents the issue of whether DPW has provided a sufficient basis for finding that, although DPW itself originally identified the $4.8 million as an overpayment, this was not in fact an overpayment. In a case presenting an analogous issue -- whether the Health Care Financing Administration, CMS's predecessor agency, could reasonably rely on state audit findings, the Board stated that "[t]he state has the burden of showing that it has revised its findings, specifically that it has changed its determination and found that funds previously identified as overpayments were in fact expended for medical assistance." Alaska Dept. of Health and Social Services, DAB No. 1452, at 5 (1993). Although DPW did not identify the $4.8 million overpayment at issue here as part of audit findings, it took the necessary steps to recover that amount from ACPA and to adjust the federal share. Thus, this was a considered finding by someone in a position of authority. As discussed below, we conclude that DPW has not met its burden to show that it changed its determination and found that the $4.8 million was properly paid as medical assistance. DPW had ample opportunity to make such a showing in response to CMS's

deferral and in the Board proceedings in its appeal of the disallowance, but did not do so.

DPW maintains that it was precluded from determining that it overpaid ACPA for CY 2005 because the Stipulation set the final payment amount under the CY 2005 managed care contract. However, the Stipulation was binding only on DPW and ACPA, the parties to the Stipulation. Thus, whether DPW could properly recover the $4.8 million from ACPA is irrelevant to whether DPW made an overpayment in that amount for federal purposes. Whether the $4.8 million constituted an overpayment depends instead on whether or not the $4.8 million was paid to ACPA in accordance with the approved managed care contract for the year in question.

DPW does not specifically identify any way in which the rate adjustments on which DPW based its determination of the $4.8 million overpayment were inconsistent with the CY 2005 contract. As indicated above, the excerpts DPW submitted from the approved contract include provisions that permit DPW to determine whether rates need to be risk adjusted and that make rate adjustments valid only if DPW gave ACPA six months notice. DPW has not alleged, or shown, that it did not follow these contract provisions in making the rate adjustments related to the $4.8 million overpayment. Indeed, DPW presented no specific information or evidence regarding what risk adjusted rate factor or factors it used to calculate this overpayment, how this calculation was made, or why the calculation should not be considered reliable. Furthermore, DPW admitted that its overpayment determination did not involve the rate adjustments at issue in the appeals resolved by the Stipulation.

DPW also argues that its overpayment determination was erroneous because the Stipulation sets a final payment amount for CY 2005 that is based on rates within the range of actuarially sound rates approved by CMS. DPW's argument appears to be that any amount within this range was necessarily allowable as medical assistance. We disagree. Once DPW determined a rate adjustment amount in accordance with its CMS-approved contract, the adjusted rate must be used to establish what payments are allowable for federal purposes. If DPW chose to make certain rate adjustments permitted by its contract with ACPA to better reflect the expected costs of the services provided and followed the correct procedures under the contract for doing so, DPW cannot now disavow the result on the ground that the amount ultimately paid to ACPA might otherwise have been allowable.

Accordingly, we conclude that DPW has not shown that the $4.8 million did not represent an overpayment.

Conclusion

For the reasons stated above, we uphold the disallowance in full.

_____/s/_____
Sheila Ann Hegy

_____/s/_____
Constance B. Tobias

_____/s/_____
Judith A. Ballard
Presiding Board Member