Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Pennsylvania Department of Public Welfare
Docket No. A-14-105
Decision No. 2653
September 2, 2015

DECISION

The Centers for Medicare & Medicaid Services (CMS) disallowed $27,868,593 in federal financial participation (FFP) relating to the administrative costs of the home and community based waiver for persons age 60 and over (Aging Waiver) run by the Pennsylvania Department of Public Welfare (Pennsylvania or DPW) for the period from July 1, 2008 through June 30, 2009. The bulk of the disallowance involved $25,756,033 in administrative costs, largely related to administrative case management activities conducted by local agencies. CMS found that those activities were identified in the Aging Waiver to Pennsylvania's Medicaid State plan but that the related costs were not included in Pennsylvania's public assistance cost allocation plan (PACAP) as required. CMS further determined that Pennsylvania failed to establish what, if any, portion of the disallowed costs could be properly allocated to Medicaid. CMS also disallowed certain costs that were neither identified in the Aging Waiver plan nor included in the PACAP.

Pennsylvania timely appealed the disallowance. During the proceedings before the Board, Pennsylvania withdrew its appeal of the second category of costs, leaving the local agencies' administrative costs at issue.

We conclude that Pennsylvania has not shown that the disputed costs were properly allocated to Medicaid because it has not disclosed any methodology for allocating them in accordance with applicable cost principles and has not demonstrated that they were claimed in accordance with an approved PACAP. For the reasons explained further below, we uphold the remaining disallowance in full.

Legal Authorities

Medicaid Program, State Plan, and Waivers

The Medicaid program, established under title XIX of the Social Security Act (Act),[1] is jointly funded by the federal government and states to provide medical assistance to financially needy and disabled persons. Act §§ 1902(a)(10)(A), 1902(e), 1902(f); 42 C.F.R. Part 435.

Section 1903(a)(7) of the Act generally permits states to claim FFP at the 50 percent rate in costs expended by the state found necessary "for the proper and efficient administration" of the Medicaid program. Other provisions of section 1903(a) allow for claiming "medical assistance" expenditures (as defined in section 1905(a)) at a state-specific rate and at various enhanced reimbursement rates for specific activities (not involved here). Each state is responsible for funding its share of both the "medical assistance" provided under its Medicaid State plan and the costs of administering its Medicaid program. Act §§ 1902(a)(2), 1903(a), 1905(b).

Section 1902 requires each state that chooses to participate in Medicaid to develop a State plan for medical assistance. The State plan must indicate whether the program will be administered by the Medicaid State agency directly or whether the State agency will supervise the operation of the program by local agencies. Act § 1902(a)(5). State plans must also provide that the plan be in effect in all political subdivisions (statewideness under section 1902(a)(1)); that the medical assistance made available to any eligible individual not be less in amount, duration, and scope than that made available to any other such individual (comparability of services under 1902(a)(10)); and that any eligible individual may obtain assistance from any qualified provider (free choice under section 1902(a)(23)).

Section 1915(c), added in 1981, authorizes CMS "by waiver" to permit a State plan to include as medical assistance "part or all of the cost of home or community-based services . . . to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided" in a nursing facility or other institutional setting. Omnibus Budget Reconciliation Act of 1981, Pub. L. 97-35, § 2176, 95 Stat. 357, 812. Examples of services which could be included in such a home and community based care waiver include: case management services, homemaker services, home health aide services, personal care services, adult day health services, habilitation services, and respite care. Act § 1915(c)(4)(B). The provisions waived may include the requirements of

[1] The current version of the Act can be found at http://www.socialsecurity.gov/OP_Home/ssact/ssacttoc.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.

statewideness, comparability, and free choice. Act § 1915(c)(3). The Board has long recognized that "the object of the waiver authority is to provide a less costly alternative to institutional services." *Fla. Dept. of Health and Rehab. Servs.*, DAB No. 1100, at 2 (1989).

Cost Principles and Cost Allocation

The relevant cost principles have been codified in different locations over the years but have remained unchanged in the relevant fundamental concepts. Currently, a joint interim final rule for the federal government awarding agencies consolidates and makes consistent (with specified exceptions) guidance that had been contained in various Office of Management and Budget (OMB) Circulars, specifically, in regard to state governments, OMB Circular A-87. 78 Fed. Reg. 78,590 (Dec. 26, 2013).

Allocability has historically been a basic component of allowability for all costs charged to federal grants. *See Me. Dept. of Human Servs.*, DAB No. 712, at 13 (1985) (noting that allocability is a "long-standing principle well-articulated in regulations"). OMB Circular A-87 – which was codified during the period at issue in appendices to 2 C.F.R. Part 225 and was made applicable to Medicaid grants by 45 C.F.R. § 92.22 (*see* 68 Fed. Reg. 52,843 (Sept. 8, 2003)) – provides that, in order for a cost to be allowable, it must be allocable to a grant program, and costs are allocable to a cost objective only to the extent that the relative benefits of the cost accrue to that cost objective. 2 C.F.R. Part 225, App. A, ¶ C.1.b and C.3.a. Costs that are allocable to one cost objective may not be charged to other federal grants to overcome fund deficiencies or avoid legal restrictions on grant awards. *Id.*, Att. A, C.3.c. "A cost is allocable to a particular cost objective" – a cost objective is a function, organization, or activity for which costs are incurred – "if the goods or services involved are chargeable or assignable to such cost objective in accordance with relative benefits received." *Id.*, Att. A, C.3.a., B.11.

The net effect is that when a grantee such as a state incurs costs that support or benefit more than one public assistance program (federal or otherwise), the costs generally must be allocated to each program in proportion to the benefits that each derives from the activity that generated the costs. *W. Va. Dept. of Health & Human Resources,* DAB No. 2529, at 2 (2013); *Minn. Dept. of Human Servs.*, DAB No. 1869, at 4-5 (2003).

Public Assistance Cost Allocation Plans

Allocability for State agency costs in grant programs administered by the Department of Health & Human Services (HHS) must be documented in PACAPs. For many years, regulations at subpart E of 45 C.F.R. Part 95 have required states to prepare and obtain approval of PACAPs and to adhere to the methodology in their PACAPs in computing claims for FFP in State agency costs under all programs governed by the Act, including

Medicaid. 45 C.F.R. §§ 95.501, 95.502; *Or. Dept. of Human Resources*, DAB No. 729, at 14-15 & n.6 (1986) (noting that the Part 95 regulations superseded Medicare-specific regulations regarding cost allocation plans). The regulations require that the state PACAP "[d]escribe the procedures used to identify, measure, and allocate all costs to each of the programs operated by the State agency" and be compatible with the applicable accounting principles and with the relevant State plan for operation of its public assistance programs. 45 C.F.R. § 95.507(a)(1)-(3).

"State agency costs" are defined to include "all costs incurred by or allocable to the State agency except expenditures for financial assistance, medical vendor payments, and payments for services and goods provided directly to program recipients such as day care services, family planning services or household items . . . ." *Id.* § 95.505. The applicable accounting cost principles at the relevant time were found in 2 C.F.R. Part 225, Appendix A. These principles require, among other things, that State agencies claim costs for particular cost objectives (programs) only in proportion to the benefits received by such programs. The Board has long held that state Medicaid costs are allowable only if properly allocated, charged in accordance with an approved PACAP, and reasonable and necessary for proper administration of the program.

The PACAP must set out the "procedures used to identify, measure and allocate all costs to each benefiting program and activity." 45 C.F.R. § 95.507(b)(4). The PACAP must "[c]ontain sufficient information in such detail to permit" HHS Cost Allocation Services (CAS, previously the Division of Cost Allocation), in consultation with CMS, to "make an informed judgment on the correctness and fairness of the State's procedures for identifying, measuring, and allocating all costs to each of the programs operated by the State agency." *Id.* § 95.507(a)(4). The PACAP must also contain specified information including an "organization chart showing the placement of each unit whose costs are charged to the programs operated by the State agency" and a listing of all federal and non-federal programs "performed, administered, or serviced by these organizational units," with descriptions of their activities and the benefits to the federal programs. *Id.* § 95.507(b)(1)-(3).

The PACAP must state that any costs to be claimed for services provided by "a governmental agency outside the State agency" will be supported by a written agreement which must set out the services purchased, the "basis upon which the billing will be made by the provider agency (e.g. time reports, number of homes inspected, etc)," and a stipulation of billing "based on the actual cost incurred." *Id.* § 95.507(b)(6). The required statement would be waived if the costs for such services are "specifically addressed" in a state-wide, local, or umbrella/department CAP. *Id*. Where "public assistance programs are administered by local government agencies under a State supervised system," the State agency PACAP "shall also include a cost allocation plan for the local agencies." *Id.* § 95.507(b)(7).

The regulations expressly require that a state claim "FFP for costs associated with a program **only** in accordance with its approved" PACAP. *Id.* § 95.517(a) (emphasis added). Otherwise, the costs "improperly claimed will be disallowed." *Id.* § 95.519.

Standard of Review

In decisions reviewing disputed disallowances, the Board "has consistently held that a state has the burden to document the allowability and allocability of its claims for FFP." *N.J. Dept. of Human Servs.*, DAB No. 2328, at 4-5 (2010). For states, this burden was based on the requirement in the cost principles that costs claimed must "[b]e adequately documented" (2 C.F.R. Part 225, App. A, ¶ C.1.j) and on administrative requirements, including the requirement that grantees maintain accounting records supported by source documentation. *N.J. Dept. of Health*, DAB No. 2497, at 4 (2013).

Factual and Procedural Background

Organization of the State Aging Waiver

Pennsylvania's Aging Waiver permits payment for certain beneficiaries aged 60 or older who meet financial and clinical requirements to receive expanded services, including, among others, respite care, companion services, assistance with financial management, adult day care, transportation, personal care, counseling, home health care. PA Ex. 2 (Aging Waiver); CMS Ex. 18, at 1. The Aging Waiver also authorizes certain administrative activities, including some case management activities, to implement the waiver. *Id*. Pennsylvania's Aging Waiver has been in effect since initial approval effective July 1, 1995. State's Opening Brief (PA Br.) at 3. The renewal covering the costs at issue in this appeal was effective July 1, 2008. PA Ex. 2.

In earlier years, the Aging Waiver was administered by the Pennsylvania Department of Aging (PDA) under the supervision of the DPW[2] based on a memorandum of understanding (MOU). Pennsylvania reports that its long-term care system was reorganized in 2007, however, to create an Office of Long Term Living established as a joint DPW-PDA office that oversaw the Aging Waiver program during the period at issue. PA Br. at 3; PA Exs. 3 (MOU) and 4 (organizational chart).

State agency (that is, DPW) employees make eligibility determinations both for regular Medicaid long-term care and for waiver services. PA Br. at 4. At the local level, however, Area Agencies on Aging (AAAs) perform most waiver-related tasks including intake and enrollment of eligible individuals, level-of-care determinations, and

[2] Pennsylvania reports that DPW's name has been changed to the Department of Human Services. PA Br. at 2 n.1. We use the prior name for purposes of this appeal, as have the parties.

authorization of service delivery, as well as case management services and provider identification. *Id*. at 4-5. AAAs may be county agencies or nonprofits. *Id.* at 5.

IG Audit

On December 20, 2010, the IG issued a draft audit report (A-03-10-00202) recommending that Pennsylvania refund $25,756,033 in FFP for local agencies' Aging Waiver administrative costs not identified in the state PACAP and refund $2,112,560 in FFP for administrative costs not identified in the Aging Waiver or the state PACAP. CMS Ex. 18, at 8 (internal report paging).

The auditors noted that the Aging Waiver explained that DPW planned to "claim local agency administrative costs for case management, provider certification, and general administrative activities, provided those costs do not exceed a monthly rate of $262 per beneficiary," as well as "for intake services and services to transition individuals from nursing homes to home and community settings." *Id.* at 2. The AAAs would submit these local agency costs to DPW which would include them with other administrative costs related to the Aging Waiver program in its claims to CMS. *Id*.

The auditors found that the administrative costs incurred by the AAAs were unallowable because Pennsylvania "did not amend its cost allocation plan to identify the administrative costs associated with the Aging Waiver program . . . or submit a methodology for allocating them." *Id*. at 4. In addition to the cost principles cited above requiring all administrative costs to be claimed based on a methodology in an approved PACAP, the IG relied on CMS guidance issued in a December 1994 letter to State Medicaid Directors (#122094) which "clarified CMS's policy concerning State claims for administrative costs." *Id.* at 5. "CMS stated [in that letter] that an allowable administrative cost 'must be included in a cost allocation plan that is approved . . . and supported by a system which has the capability to isolate the costs which are directly related to the support of the Medicaid program from all other costs incurred by the agency.'" *Id*. at 5 (quoting State Medicaid Directors Letter #122094).

The IG noted that, even though Pennsylvania amended its PACAP to reflect the creation of the Office of Long Term Living, neither that amendment nor any other identified or included a methodology to allocate administrative costs relating to the Aging Waiver. *Id*. This omission created the possibility that costs included in the State agency's claims may have included AAA administrative costs that did not benefit the Aging Waiver program. *Id*. The IG report identified the following AAA administrative activities and costs:

> • $38,254,540 ($19,225,884 Federal share) for case management activities, which included needs assessment, care planning, and service authorization for beneficiaries to prevent institutionalization;

> • $3,827,334 ($1,913,667 Federal share) for the local agencies' administrative costs, which were calculated as the lesser of actual administrative costs or 10 percent of local agencies' care management and provider certification costs;
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> • $3,600,000 ($1,800,000 Federal share) for intake services performed by local agencies' Information and Referral personnel, who answered questions on the availability of services and programs for the elderly;
>
> • $2,515,029 ($1,257,514 Federal share) for nursing home transition services, which included providing information about availability of long term care in a variety of settings (e.g., in the home, in assisted living) and planning and coordinating beneficiaries' moves to long-term care or between alternative long-term-care settings; and
>
> • $2,424,150 ($1,212,075 Federal share) for provider certifications, by which local agencies validate that the provider meets the qualifications specified in the waiver program for the service that the provider renders.

Id. at 5-6. (The IG also questioned $346,893 in FFP for software costs incurred by DPW related to the waiver. *Id*. at 6.) In addition to the AAA administrative costs charged to the Aging Waiver, the IG questioned claims for software, a training contract, state employee salaries, and other state administrative items that were not identified in either the PACAP or the Aging Waiver, and for which no allocation methodology was submitted. *Id*.

Based on these findings, the IG recommended that Pennsylvania refund $25,756,033 in FFP for administrative costs identified in the Aging Waiver but not included in the PACAP and $2,112,560 in FFP for administrative costs identified in neither the Aging Waiver nor the PACAP. *Id*. at 8. The IG also recommended a refund of $370,978 related to a mathematical error related to a prior disallowance and advised Pennsylvania to amend its PACAP to include a detailed methodology to allocate all administrative costs relating to the Aging Waiver. *Id*.

Pennsylvania responded by letter dated March 4, 2011 to the draft IG report. PA Ex. 1, App. Pennsylvania argued that it "had an option to classify as either services or administrative costs" those local agency activities, and that it did not follow from Pennsylvania's opting to claim them as administrative, that they "lose their nature as services for cost allocation plan purposes" or their consequent exemption from inclusion in a PACAP. PA Ex. 1, App. at 2. The IG maintained that "administrative costs that might otherwise have been claimed as services" have no exemption from cost allocation requirements. PA Ex. 1, at 8.

Pennsylvania also argued that the IG had found only a "technical violation" of the cost allocation requirements which should be addressed by amending the PACAP rather than by taking a disallowance. PA Ex. 1, App. at 1, 3. The IG "revised" the report and recommendation "to set aside for CMS adjudication" the Aging Waiver administrative costs at issue here and to "continue to recommend that the State agency amend" its PACAP to "ensure that only allocable costs are claimed under the Aging Waiver program." PA Ex. 1, at 8-9.

CMS Disallowance

By letter dated June 23, 2014, CMS notified Pennsylvania of the disallowance.[3] The amount disallowed was less than the amount questioned in the audit because Pennsylvania did not dispute the finding as to $370,978 in FFP. CMS Opposition to Motion to Vacate (Dec. 10, 1994), Ex. 3. Pennsylvania did not appeal to us the disallowance amounts relating to the pilot program ($316,500) and the helpline ($25,500). PA Br. at 2 n.4.

The disallowance letter explained that administrative costs may only be claimed for Medicaid reimbursement when they are incurred "for the proper and efficient administration of the State plan." Disallowance letter at 2, *quoting* Act § 1903(a). The letter continued that such claims are allowable only when "directly related to the administration of the Medicaid program," and must be included in an approved PACAP and "'supported by a system which has the capability to isolate the costs which are directly related to the support of the Medicaid program from all other costs incurred by the agency.'" *Id.*, *quoting* State Medicaid Directors Letter #122094 (Dec. 1994).

The disallowance letter further cited the regulatory requirements for PACAPs to describe all costs claimed and the methodology for allocating them and to include a chart showing all organizational units whose costs are to be claimed and list all the programs they service as well explain how all their costs are measured and allocated, as well as to include CAPs for local government agencies administering a Medicaid program. *Id.* at 2-3, *citing* 45 C.F.R. § 95.507(b). Finally, the letter relied on Pennsylvania's obligation to comply with cost allocation principles derived from OMB Circular A-87. *Id.* at 3. CMS

[3] The disallowance letter contained two errors which CMS corrected by an errata letter dated December 4, 2014. CMS Opposition to Motion to Vacate (Dec. 10, 2014), Ex. 2. The time period was misstated as beginning July 1, 2007 and corrected to begin July 1, 2008; the program involved was misstated as PDA's Direct Care Worker Initiative and corrected to DPW's Aging Waiver. *Id.*, Ex. 2. CMS asserted that the underlying IG report and other references in the original disallowance letter made clear the intended time period and program. *Id.* at 1. By motion dated December 4, 2014, Pennsylvania requested that the disallowance be vacated without prejudice based on the errors in the disallowance letter to allow Pennsylvania to seek reconsideration by the CMS Administrator of a reissued disallowance. On January 14, 2015, Pennsylvania withdrew its motion to vacate.

concluded that, even after submitting a PACAP amendment effective for state fiscal year 2009 to describe the new organizational structure of the Aging Waiver, Pennsylvania still failed to identify the AAAs' administrative costs, show all the programs which they serviced, or describe an allocation methodology. *Id.*

This appeal ensued.

Issue

The central issue is whether Pennsylvania has demonstrated that it properly allocated the disputed administrative costs of the AAAs to the Medicaid Aging Waiver.

Analysis

Although the parties focused much briefing on whether and in what form the administrative costs of the AAAs had to be reflected in the PACAP itself, we conclude that Pennsylvania's failure here is more fundamental. We therefore begin by explaining that the essential requirement that underpins all specific content and form provisions for developing and approving PACAPs is that the state must be able to document that it has and follows a proper methodology for equitably allocating all administrative costs. We conclude that Pennsylvania has not at any point disclosed such a methodology for allocating the costs at issue to the Medicaid program despite being on notice that it needed to do so. We then explain why we conclude that Pennsylvania did also fail to meet the requirements to identify and allocate administrative costs pursuant to an approved PACAP. We next address Pennsylvania's assertions that the case management costs, despite being claimed as administrative, did not have to be covered by an approved cost allocation methodology. Finally, we consider various contentions by Pennsylvania that the disallowance should not have been taken.

1. Pennsylvania failed to meet its fundamental responsibility to demonstrate that all administrative costs claimed are properly allocable to Medicaid.

The basic requirements for cost allocation arise from cost principles mentioned above. The core concept is that a federal program may not be charged for any costs of activities from which that program does not benefit – and that when multiple programs receive some benefit from an activity, the costs of that activity should be shared in a manner that fairly reflects the relative degree to which each benefits. To comply with these restrictions, a state must develop a methodology for assigning specific costs to a particular grant program that ensures that they are allocated only to the extent that program receives relative benefits from the costs. The responsibility for developing an appropriate methodology and for documenting its application remains with the grantee. *See* 45 C.F.R. § 95.507(a) (requiring the state (grantee) to submit for approval a cost

allocation plan for the relevant "State agency"); *Mo. Dept. of Social Servs.*, DAB No. 1783, at 25 (2001) (A grantee of federal funds has the burden of documenting the allowability of its claim for federal funds, and that burden includes "demonstrating that its allocation methodology was reasonable."); *Mass. Dept. of Social Servs.*, DAB No. 1308, at 18 (1992) (stating that the regulations in 45 C.F.R. §§ 95.501-.519 "contemplate that a state is responsible for proposing an allocation method since the state has the best knowledge of its own administrative structure and organization").

CMS has argued throughout this appeal that, if Pennsylvania "knows how the disallowed costs were allocated, it has not provided that information" at any point before or during these proceedings. *See* Opening Brief of CMS (CMS Br.) at 3. CMS asserts that, instead of pointing to an equitable methodology, Pennsylvania merely argues that it was not required to allocate the disputed costs through its PACAP. *Id*. CMS's position is that, even if Pennsylvania could have understood the IG audit report and the disallowance letter as focusing on the failure to include these costs in the PACAP, Pennsylvania had ample notice and opportunity during these proceedings to at least provide an explanation of what procedures and methodology, if any, were employed to ensure that only those AAA administrative costs that were properly allocable to Medicaid were included in its claims. CMS argues that the disallowance should be upheld now because Pennsylvania has made no such showing. *Id.* at 3, 19-21.

CMS is correct. Nowhere in the record before us can we discern an explanation of how Pennsylvania determines what share of the case management and other administrative costs that the AAAs incur are properly allocated to the Aging Waiver. Pennsylvania argues that case management costs did not need to be allocated even when claimed as part of its administration of the Medicaid program (PA Reply Br. at 4-8), an argument we reject in the next section of this decision. Pennsylvania, however, never explains how any other AAA administrative costs were actually allocated. Pennsylvania makes a variety of arguments against the propriety of a disallowance in the present circumstances, which we also address later, but never directs our attention to any evidence that the disputed costs were properly allocated based on any methodology.[4]

Pennsylvania submitted the State agency's agreement with one of the AAAs which contains commitments by the AAA to allocate costs in accordance with applicable cost principles. PA Ex. 7, App. C, ¶ 3. The State agency furthermore agrees to reimburse the AAA only for administrative costs of the waiver, care management for waiver consumers, certification of providers, nursing home transition, and monitoring provider

[4] Pennsylvania argued that it should have an opportunity to develop the record through depositions, evidentiary hearing or oral argument. Feb. 19, 2015 Request to Develop the Record and for a Conference. The Board denied the requests because the information that Pennsylvania sought to develop (whether all the AAA agreements were identical and whether a CMS witness might indicate that CMS's interpretation differed at some point in the past from that presented here) was immaterial, speculative or did not require such proceedings. *See* April 1, 2015 Board Ruling (Appendix A to this Decision).

payments, and not for any other programs or costs centers, and only for those "costs incurred and validly attributable under this Agreement based on consumers served." *Id*., App. C, ¶ 1. Pennsylvania does not deny that it had the authority and duty to determine that these commitments were carried out and that any costs it passed on were properly allocated.

Clearly, the agreement reflects that Pennsylvania knew that only allocable costs should be claimed and that the AAAs might incur costs for activities not properly attributed to the Medicaid Aging Waiver.[5] Despite this evidence that both the State agency and the AAAs were well aware that the cost principles (including those governing cost allocation) applied to these agreements for the AAAs' implementation of the Aging Waiver, Pennsylvania has offered no explanation of what procedure or methodology was applied to determine which activities of the AAAs would be charged to the Aging Waiver and to what extent. Nor has Pennsylvania explained how the State agency confirmed that any such procedure or methodology was actually implemented by the AAAs.

The failure to explain the basis, procedure and/or methodology underlying what part of the AAAs' administrative costs were charged to the Medicaid program Aging Waiver is itself sufficient to uphold the disallowance at issue. *Cf. W. Va. Dept. of Health & Human Resources*, DAB No. 2529, at 3 (2013) (stating that, "[i]n general, the burden is on the entity challenging a disallowance to demonstrate that the disallowed costs are, in fact, allocable to the program in question"); *Council for Econ. Opportunities in Greater Cleveland*, DAB No. 1980, at 9 n.11 (2005) (stating that, "[i]n general, the burden is on a recipient of federal grant funds to justify both the allowability of its costs, and the methods used to allocate those costs to its federal awards"). Nonetheless, because the parties focused primarily on whether the costs were charged in accordance with an approved PACAP, we address below why we conclude that the costs were not so charged.

2. ***Pennsylvania also failed to demonstrate that the costs at issue were claimed in accordance with an approved PACAP.***

We also conclude that Pennsylvania failed to comply with the basic PACAP disclosure requirements as we explain in this section. Section 95.507(a) codifies as follows overarching requirements for developing and submitting statewide PACAPs for approval:

> The State shall submit a cost allocation plan for the State agency as required below to the Director, Division of Cost Allocation (DCA), in the appropriate HHS Regional Office. The plan shall:

[5] Moreover, Pennsylvania has not contended that the AAAs served only Aging Waiver participants or engaged only in activities that solely benefited that single program.

> (1) Describe the procedures used to identify, measure, and allocate all costs to each of the programs operated by the State agency;
>
> (2) Conform to the accounting principles and standards prescribed in Office of Management and Budget Circular A–87, and other pertinent Department regulations and instructions;
>
> (3) Be compatible with the State plan for public assistance programs . . .; and
>
> (4) Contain sufficient information in such detail to permit the Director, Division of Cost Allocation, after consulting with the Operating Divisions, to make an informed judgment on the correctness and fairness of the State's procedures for identifying, measuring, and allocating all costs to each of the programs operated by the State agency.

45 C.F.R. § 95.507(a).

Pennsylvania asserts that its Medicaid program is operated and administered by the State agency, citing a checked box in its Medicaid State plan as evidence. PA Br. at 11, *citing* PA Ex. 9, at 2. Further, Pennsylvania insists that its Aging Waiver, as part of its Medicaid program, must also be viewed as state-operated because CMS is bound to respect the State plan designation. *Id.* at 12-14. While Pennsylvania makes these assertions in the context of the argument about whether the PACAP had to include individual CAPs for the AAAs, an argument we find unnecessary to resolve as explained later, Pennsylvania never comes to grips with the implications of its "state-operated" claim for applying section 95.507(a) itself.

The plain text of the regulation demands that the PACAP describe how all costs to be claimed for programs operated by the State agency are going to be identified, measured and allocated. Since Pennsylvania says that the Aging Waiver is operated by the State agency, its costs must be described in the PACAP.

Yet Pennsylvania does not point to any description in the PACAP of the "procedures used to identify, measure and allocate" the costs of the AAAs to the Aging Waiver. Without that information, neither CAS nor CMS could reasonably be enabled to "make an informed judgment on the correctness and fairness" of those procedures. As CMS argues, the PACAP contains essentially no information to enable review of the allocation of more than $28 million in administrative costs. CMS Br. at 9-10. Pennsylvania has not provided any language from the PACAP that alerted CAS or CMS to either the use of AAAs to incur administrative costs on behalf of the State agency's operation of the

Medicaid Aging Waiver or Pennsylvania's intention to claim these costs. This failure to comply with section 95.507(a)(1) and (4) in itself suffices to support the disallowance of Pennsylvania's claim for those costs.

Although it is undisputed that the Aging Waiver itself disclosed that the AAAs would undertake administrative activities, the Waiver serves an entirely different purpose and audience than the PACAP. The Waiver describes how a state seeks approval to deviate from the normal requirements of the Medicaid State plan. Costs that deviate from the Medicaid State plan without an approved waiver would be unallowable on that basis. The Medicaid State plan and the Waiver are thus intended to explain how a state will meet the requirements of the Medicaid program. The PACAP by contrast is intended to serve as the required vehicle for addressing cross-cutting requirements for equitably allocating administrative costs incurred by states and their various components, agents and other entities that participate in multiple federal and non-federal programs. The purposes of a PACAP include ensuring that any particular federal program bear its share but no more than its share of the costs required to maintain its operation and that no costs are reimbursed from multiple sources. The PACAP is reviewed by CAS as the federal cognizant agency which consults with operating divisions, including CMS, about the impact on individual programs. This brief synopsis of the distinctions between Medicaid State plans and PACAPs highlights the reason that describing how Pennsylvania planned to operate its approved program in its Aging Waiver was no substitute for notifying CAS and CMS in the PACAP. The Aging Waiver provided no information to CAS or CMS about what costs would be incurred that might benefit multiple programs, or how they would be fairly allocated, or even where the explanation of any such procedures was to be found. Thus, Pennsylvania has failed to comply with section 95.507(a).

Pennsylvania has also failed to comply with the requirements of section 95.507(b) which delineates specific contents of an approvable PACAP as follows:

> The cost allocation plan shall contain the following information:
>
> (1) An organizational chart showing the placement of each unit whose costs are charged to the programs operated by the State agency.
>
> (2) A listing of all Federal and all non-Federal programs performed, administered, or serviced by these organizational units.
>
> (3) A description of the activities performed by each organizational unit and, where not self-explanatory an explanation of the benefits provided to Federal programs.

> (4) The procedures used to identify, measure, and allocate all costs to each benefiting program and activity (including activities subject to different rates of FFP).
>
> (5) The estimated cost impact resulting from the proposed changes to a previously approved plan. . . .
>
> (6) A statement stipulating that wherever costs are claimed for services provided by a governmental agency outside the State agency, that they will be supported by a written agreement that includes, at a minimum (i) the specific service(s) being purchased, (ii) the basis upon which the billing will be made by the provider agency (e.g. time reports, number of homes inspected, etc.) and (iii) a stipulation that the billing will be based on the actual cost incurred. This statement would not be required if the costs involved are specifically addressed in a State-wide cost allocation plan, local-wide cost allocation plan, or an umbrella/department cost allocation plan.
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> (7) If the public assistance programs are administered by local government agencies under a State supervised system, the overall State agency cost allocation plan shall also include a cost allocation plan for the local agencies. . . .

45 C.F.R. § 95.507(b).

Much of the briefing in this case, as we have mentioned, discusses whether the requirements of subsections 95.507(b)(6) and (7) applied and were met in this case. CMS alleges that the Aging Waiver component of Pennsylvania's Medicaid program was actually state-supervised and locally-administered so Pennsylvania was required to include separate CAPs for the local government AAAs in the PACAP. CMS Br. at 14. As noted above, Pennsylvania argues that its entire Medicaid program is state-operated and is therefore not required to comply with section 95.507(b)(7). CMS further asserts that Pennsylvania failed to comply with section 95.507(b)(6) because the AAA agreement did not contain the required provisions and because that section would not apply to non-governmental entities in any case. *Id.* at 10-11, *citing* PA Ex. 7. Pennsylvania responds that its PACAP contained the required statement, that the non-profit AAAs acted as instrumentalities of government, and that the agreement does contain the necessary information. PA Reply Br. at 8-12. We need not resolve the arguments about whether or how sections 95.507(b)(6) or 95.507(b)(7) apply here, however. Even were we to conclude that they apply and that Pennsylvania adequately complied with one or both provisions (a question we do not reach), we would still find that Pennsylvania did not comply with other content requirements for the PACAP in section 95.507(b)(1)-(4) on which CMS also relied.

Most obviously, section 95.507(b)(4) essentially reiterates that the "procedures used to identify, measure, and allocate **all** costs to **each** benefiting program and activity" (emphasis added) must be included in the PACAP itself. As we already discussed, Pennsylvania has not even pointed to any identification of the costs or any description of the procedures related to the AAAs' administrative costs, so their omission from the PACAP is apparent. On this basis too we find that Pennsylvania could not claim these costs in accordance with an approved PACAP because the PACAP simply contains no approved procedures for allocating these unidentified costs among all benefiting activities.

CMS contends that Pennsylvania also failed to comply with subsections 95.507(b)(1) – (3). CMS Br. at 10. Specifically, CMS argues that Pennsylvania's PACAP failed to "'identify all entities' whose costs the State is charging to the federal program, to list 'all Federal and all non-Federal programs' administered by those entities, and to explain the benefits those entities are providing to federal programs." *Id.* Pennsylvania responds that section 95.507(b)(1) refers to "**an** organizational chart (singular)" which must mean a chart only of the State agency itself, and that the references in (b)(2) and (b)(3) should be similarly read to mean only organizational units named on that limited chart. PA Reply Br. at 16-17 (emphasis in original). At a minimum, according to Pennsylvania, the regulation is ambiguous, CMS's reading is "strained," and CMS did not previously object to the omission of the AAAs or provide guidance on whether local agencies should be included in the organizational chart. *Id*.

We find that it is Pennsylvania's reading of these subsections, rather than CMS's, that is strained. The use of the singular term "organizational chart" does not necessarily imply that the chart is only to include information about a single agency, at least where a state intends to claim administrative costs for the activities of multiple organizations. In the context of section 95.507 as a whole, we find it apparent that the thrust is to require that all units at any level whose administrative costs are to be claimed by the State agency for any program which the State agency operates be identified in the chart and that the chart show how they are connected to the State agency and list their programs and activities.

Apart from any formal question of whether the chart or listing was adequate, however, we find no indication that Pennsylvania disclosed anywhere else in the PACAP the information about what federal and non-federal programs the AAAs performed, administered, or serviced and what activities they engaged in for those programs. Without that information, we fail to see how the reviewers could make an informed judgment about the reasonableness of any allocation procedures which the PACAP would use to assign the costs of those units to federal programs.[6]

[6] As CMS points out, Pennsylvania is less than logically consistent in arguing that it need not submit CAPs for the AAAs because the Aging Waiver is part of the state-operated Medicaid program and simultaneously denying that the state's organizational chart needed to include information about the placement and activities of the units performing activities for that program. CMS's Sur-reply Br. at 8.

We conclude that the costs at issue were not claimed in accordance with an approved PACAP and are therefore not allowable.

3. *Case management costs claimed as administrative costs must be included in Pennsylvania's PACAP.*

Pennsylvania argues that case management costs may simply be excluded from the requirement for the State agency to allocate the costs of program administration and to include all administrative costs in its PACAP. PA Reply Br. at 4. According to Pennsylvania, we should find that "[c]ase management is a service provided directly to program recipients, even if a State chooses to claim the expenditures for that service as an administrative cost." *Id*. Since the costs of services provided directly to recipients are expressly excluded from the definition of State agency costs required to be allocated through a PACAP by 45 C.F.R. § 95.505, Pennsylvania reasons that it was not required to include information about the costs in its PACAP. *Id.* at 3-4. Indeed, Pennsylvania suggests that, since the cost allocation regulations do not use the term "administrative cost" at all, the fact that the case management services here were claimed as administrative costs is not relevant. *Id*.

This argument is without merit. It is true, as Pennsylvania points out, that the regulations do not use the term "administrative cost." Instead, they define "State agency costs" as "all costs incurred by or allocable to the State agency" with the exception of direct services costs as quoted earlier. It follows that "State agency costs" that are not direct services costs must be "administrative costs." Moreover, longstanding guidance to states has consistently established that when costs for activities that are characterized as case management are claimed as administrative costs, they are subject to cost allocation procedures. And, as Pennsylvania expressly acknowledges, the State Medicaid Manual (SMM) § 4302.2(G) "says . . . that States must include case management activities in a cost allocation plan if they are being claimed as an administrative cost," as does the preamble to interim final case management regulations. PA Reply Br. at 5, *citing* 72 Fed. Reg. 68,077, 68,088 (Dec. 4, 2007); P. Ex. 19 (containing SMM § 4302.2(G)). Further, while some case management activities may indeed be direct services, those case management activities which directly relate to "the proper and efficient administration of the Medicaid State plan," which are "commonly referred to, by States and others, as 'administrative case management,'" may be claimed as administrative costs but must be "specified" in the state's PACAP.[7] 72 Fed. Reg. at 68,087-88. The preamble also prohibits a state from claiming as administrative case management any costs that "are an integral part or extension of a direct

[7] These administrative case management activities may include eligibility determinations, intake and screening, outreach and utilization review. 72 Fed. Reg. at 68,088.

medical service." *Id.* at 68,088. Thus, the fact that some claimed administrative costs may be associated with case management services provided directly to Medicaid recipients does not alter their identity as administrative costs for allocability purposes. Pennsylvania cannot now, having claimed the AAA case management costs as administrative, assert that they are actually direct medical services to justify omitting them from its PACAP.

In short, Pennsylvania presented the case management activities of the AAAs in implementing the Aging Waiver as administrative costs not as services to individual recipients. If that characterization was inaccurate, the costs could only be claimed as medical assistance under the Medicaid State plan, but Pennsylvania has neither argued nor shown that they qualified as medical assistance under that plan. If the characterization was accurate, the case management costs are State agency costs which must be allocated in order to determine what share was necessary for the proper and efficient administration of Medicaid in Pennsylvania. The PACAP approval process provides the way for CMS to determine whether the costs are necessary.[8]

The case management costs incurred by the AAAs and claimed as administrative costs by the State agency are unallowable because they were required to be but were not included in Pennsylvania's PACAP.

4. *Pennsylvania's remaining contentions are unpersuasive.*

Pennsylvania argues that (1) CMS was obligated to pursue its concerns through the State plan compliance procedures of 45 C.F.R. Part 430.60 et seq.; (2) CMS was precluded from taking a disallowance by a "Best Practices" guide issued by CAS; and (3) CMS should not prevail here because it failed to explain why it departed from its own past administrative practice relative to the Aging Waiver. PA Br. at 9. We reject all of these arguments.

a. This dispute does not arise under State plan conformity procedures.

On the first point, Pennsylvania's position is that the dispute about whether its Aging Waiver is state-operated means that CMS's action "raises a state plan conformity issue." PA Br. at 11-12. Pennsylvania suggests that the Board may not hear the disallowance

[8] Pennsylvania cites to a footnote in the Board's decision in *Missouri Department of Social Services*, DAB No. 1304, at 4 n.6 (1992), but that decision provides no support for Pennsylvania's argument that when claiming case management costs as administrative costs, rather than direct services costs, it is not required to follow the cost allocation requirements for administrative costs. The *Missouri* footnote merely addressed whether Missouri was precluded from using the time measurement system it developed for administrative costs to also determine costs incurred by employees providing case management services directly under a waiver. That is not an issue here, and the issue that is presented here – whether Pennsylvania can claim case management costs as administrative costs but not include them in its PACAP – was not presented in *Missouri*.

where the heart of the dispute is whether a Medicaid State plan provision is invalid. *Id.* Rather, Pennsylvania argues, CMS should be required to proceed under 45 C.F.R. Part 213 where CMS could adjudicate whether the challenged provision had become obsolete in state practice or was inconsistent with federal regulations, pursuant to 42 C.F.R. § 430.35. *Id.*

We have already concluded that this case is about whether the administrative costs are properly allocated under the PACAP, not about whether the Medicaid State plan substantially complies with federal law (a determination which, as CMS notes, would carry potential serious consequences for state program funding). CMS Br. at 16. Accordingly, we need not address this argument further. We also note that even if the current action could be accurately viewed as raising a State plan conformity issue, the Third Circuit treated review by the Board as "sufficient to meet the hearing requirements" for plan conformity disputes. *N.J. Dept. of Human Servs.*, DAB No. 259, at 20 (1982). The Board has long recognized that the Secretary has discretion to "determine that a particular set of circumstances requires only a 'disallowance' when, arguably, a finding of noncompliance would also have been possible." *Id.* at 18.

b. Administrative guidance on PACAP amendments does not preclude this disallowance.

Pennsylvania argues that a statement taken from a 2007 DCA (now CAS) manual for review of PACAPs precludes CMS from taking a disallowance in the present case. PA Br. at 16-18. Pennsylvania quotes this provision:

> If as a result of a review or from other information obtained, it is determined that a State agency failed to amend its cost allocation plan as required by 45 CFR 95.509, the DCA will notify the State that an amended plan is required and that disallowances will be made if it is not submitted within a reasonable period of time. This notification will indicate why the plan needs to be amended, request the State to review not only the sections of the plan that are in question but also the overall plan to identify any other changes that may be required, and specify a reasonable due date for submission of the amended plan. If the amended plan or an acceptable justification for an extension is not submitted by the due date, disallowances will be made . . . .

PA Br. at 17, *quoting* PA Ex. 12. Pennsylvania then notes that it was not informed that local CAPs were required prior to the IG audit and that thereafter it "promptly submitted" a revised PACAP. *Id.* at 17-18. Therefore, Pennsylvania concludes, the procedures in the quoted provision bar a disallowance. *Id.* at 18. Further, Pennsylvania asserts that the

manual is entitled to deference and that regulations allow for retroactive amendment of a PACAP to "'prevent significant inequity'" or to address a finding that the PACAP is "'materially incomplete.'" PA Reply Br. at 18, *citing and quoting* 45 C.F.R. § 95.515(a).

On its face, the manual provision nowhere bars or precludes disallowances of administrative costs that a state seeks to claim without including them in an approved PACAP, but, instead, warns states that failure to amend when required will result in disallowances. Instructions in a manual to take disallowances if a state does not timely amend a plan cannot be read to override regulations authorizing disallowances for failure to claim costs in accord with an approved cost allocation plan, especially since the manual provisions do not have the force of law that applies to regulations.

In any case, the manual provision has no application to the dispute before us. Section 95.509(a) requires states to "promptly amend" their PACAPs when specific events occur. The events include legal or organizational changes making procedures outdated, discovery of a material defect, amendment of the state program plan, or other changes making the allocation basis or procedures invalid. 45 C.F.R. § 95.509(a). Neither party has alleged that any of the listed events took place. The dispute here is over whether Pennsylvania erroneously claimed reimbursement for certain administrative costs which were not described in its PACAP and for which it has not provided a valid allocation methodology. States are not obliged to claim all possible administrative costs, but are required to include all such costs they seek to claim in the PACAP with the required information about allocation methodology. Pennsylvania's failure to include the administrative costs at issue in its PACAP did not make the PACAP defective. Instead, the failure meant that Pennsylvania could not properly allocate the costs to Medicaid.

It is true that section 95.517(a) does permit retroactive application of PACAP amendments when, among other circumstances, that is "needed to avoid a significant inequity to either the State or the Federal Government."[9] Despite Pennsylvania's attempt to argue that the Board should allow it to submit a retroactive amendment (PA Reply Br. at 18), the case before us as it now stands does not present any issue about approval or effective date of a PACAP amendment. CMS asserts (and Pennsylvania has not shown otherwise) that Pennsylvania has not requested a retroactive effective date for any PACAP amendment and has not submitted any amendment that would allocate AAA case management costs. CMS Sur-reply Br. at 10. In fact, according to CMS, Pennsylvania amended its Aging Waiver in 2012 to treat case management as a service. *Id*. This decision does not prejudge whether any approvable amendment might be submitted or what effective date might be appropriate, although we do note CMS's comment that,

[9] CMS argued that sections 95.517 and 95.519 not only authorize but mandate a disallowance (CMS Br. at 17), but this assertion overstates the situation since, as noted in the text, CMS does have other discretionary authority.

once Pennsylvania "devises a fair allocation method, it must then demonstrate it has a valid basis for 'back-casting' that method to a prior period" to justify a retroactive effective date. *Id.*

c. Pennsylvania failed to show that the disallowance taken here was inconsistent with prior CMS practice or guidance.

Pennsylvania states that, since "the inception of its Aging Waiver," it "claimed the administrative costs of the AAAs without being required to include those costs" in its PACAP. PA Br. at 6, 20. While Pennsylvania acknowledges that "it is possible for [Pennsylvania] to have been in violation of the cost regulations for so many years," Pennsylvania speculates that "the 'more plausible hypothesis' is that CMS did not think those regulations applied to the Aging Waiver in the way it now says." *Id.* at 21, *citing Christopher v. SmithKline Beecham Corp.*, 132 S.Ct. 2156 (2012).

Aside from the fact that Pennsylvania's theory about CMS's state of mind has no evidentiary support, the circumstances in *SmithKline* case were entirely different. Pennsylvania's descriptions of CMS as announcing a new interpretation "preceded by a very lengthy period of conspicuous inaction" and as creating an acute "potential for unfair surprise," may fit the circumstances at issue in *SmithKline* but fly wide of the mark here. PA Br. at 20. *SmithKline* involved Department of Labor (DOL) regulations that dealt with the application of overtime rules for outside salespersons to pharmaceutical company representatives. DOL advanced a new interpretation to explain not considering those representatives as exempt salespersons, and the Court declined to defer to an interpretation announced for the first time in a brief which it considered "flatly inconsistent" with the underlying statute. 132 S.Ct. at 2169. The Court noted that 90,000 pharmaceutical sales representatives presently do well-known work in a manner "not materially changed for decades" and like that of "quintessential outside salesmen," and concluded that "[o]ther than acquiescence, no explanation for the DOL's inaction is plausible," if DOL understood the regulation as it now argued. *Id*. at 2168.

In contrast, the cost allocation requirements we apply here on their face plainly inform the states that all administrative costs to be claimed under federal grants must be disclosed in a PACAP with sufficient detail to allow the agencies to make informed judgments about whether the allocation methodologies being used are proper and approvable. We thus disagree that the present case involves CMS articulating a "novel interpretation of its regulations" for the first time in in an enforcement proceeding. PA Br. at 21, and cases cited therein. The cost allocation regulations at issue are longstanding and our application of them here has not required any new interpretation of their terms.

While Pennsylvania may debate whether it was required to include individual local agency CAPs and/or maintain compliant agreements with the local agencies, it has pointed to nothing novel about the fundamental obligation of identifying costs and disclosing allocation methodologies. Nor can there be any question that CMS (and CAS) have long enforced the requirements to identify and disclose allocation methodologies compliant with the cost principles for all administrative costs, as is evident from years of Board jurisprudence. *See, e.g., N.J. Dept. of Human Servs.,* DAB No. 2328, at 5 (2010) (upholding a disallowance of costs not claimed in accordance with an approved cost allocation plan); *Mont. Dept. of Family Servs.*, DAB No. 1266, at 2 (1991) (upholding a disallowance of FFP claims that were "not consistent with" an approved cost allocation plan); *Kan. Dept. of Social & Rehab. Servs.*, DAB No. 1349, at 7-10, 14 (1992) (upholding the disallowance of an FFP claim that had been calculated based on unapproved cost allocation methodology), *aff'd, Kan. ex rel. Sec. of Social & Rehab. Servs.*, 859 F. Supp. 484 (D. Kan. 1994).

Moreover, as CMS points out, it is not reasonable to attribute to CMS a knowing tolerance of Pennsylvania's apparent practice of claiming the AAAs' administrative costs while failing to disclose them in its PACAP. CMS Br. at 21. CMS calculates that the disallowed costs "represent only 0.2% of DPW's total FFP for the audit period" and points out these claims were not readily apparent to CMS because they were bundled in a line item on the expenditure claims form entitled simply "Other Financial Participation." *Id., citing* CMS Ex. 5. The fact that Pennsylvania's claiming practices were not identified in the PACAP obviously makes it less likely that CMS made a judgment that the practices were acceptable and now changed its mind, rather than that it became aware of them only as a result of the IG audit. While CMS was certainly notified in the Aging Waiver that the AAAs would be undertaking administrative activities, as we have said, that notice did not provide any information about how the costs of those activities would be identified and allocated; nor would that information necessarily be expected in a routine waiver application. We find no support for Pennsylvania's suggestion that CMS has applied the cost allocation regulations in any manner that could reasonably have caused it any unfair surprise.

According to Pennsylvania, the cost allocation requirements should be interpreted in light of the instructions for preparing Medicaid waiver applications, which do not advise states that they must file PACAP amendments. PA Br. at 6, 21. Pennsylvania points to nothing in the waiver instructions indicating that obtaining a waiver of certain specific Medicaid requirements would somehow permit states to deviate from the overarching requirements for cost allocation which affect all federal programs. *See generally* PA Ex. 17 (CMS "Instructions, Technical Guide and Review Criteria" for an "Application for a 1915(c) Home and Community-Based Waiver [Version 3.5]" (Release Date: January 2008)). As Pennsylvania itself put it, "the process established by CMS contemplates that waiver

administrative costs will be claimed in the same way as other Medicaid administrative costs." PA Br. at 18. The way that Medicaid administrative costs have always been claimed is through an approved PACAP methodology. The waiver instructions do not alter the cost allocation requirements in any way.

Conclusion

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

/s/
Sheila Ann Hegy

/s/
Constance B. Tobias

/s/
Leslie A. Sussan
Presiding Board Member