Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Pennsylvania Department of Human Services
Docket No. A-15-50
Decision No. 2835
November 30, 2017

DECISION

The Centers for Medicare & Medicaid Services (CMS) disallowed $26,142,278 in federal financial participation (FFP) relating to county-level costs for operating Pennsylvania's MR2176 Consolidated Waiver (Consolidated Waiver) and providing targeted case management for individuals waiting to enter the Consolidated Waiver program, for the period from October 1, 2012 through September 30, 2013. CMS contends that the costs at issue are unallowable because the Pennsylvania Department of Human Services (previously known as the Pennsylvania Department of Public Welfare and referred to herein as Pennsylvania or State) failed to include them in its Public Assistance Cost Allocation Plan (PACAP) or to explain how it allocated the costs to the federal Medicaid program. Moreover, CMS questions whether some of the costs are allowable at all under the Medicaid program even if they were allocated properly.

Many of the issues in this case are similar to those raised in prior cases in which Pennsylvania challenged, and the Board sustained, disallowances of FFP for costs incurred by its counties in administering aspects of its Medicaid program without providing information to CMS about the costs or its methods for allocating them. In those cases, the Board fully rejected arguments analogous to those made in this appeal. We address those arguments more briefly in this decision, referring to the fuller discussions elsewhere when appropriate. To the extent issues arising from the challenged disallowance are unique to this case, including whether the statewide disallowance may properly be based on detailed review of two counties' costs and whether some counties' claims were improperly based on estimates rather than actual costs, we provide more detailed discussions where necessary to resolve the dispute before us.

After the briefing period closed in this case, Pennsylvania asked the Board to either conduct extensive additional record development or remand the case to CMS for further review. We decline to do either, concluding that Pennsylvania had ample time, notice, and opportunity to present any relevant evidence either to CMS during the lengthy deferral, disallowance and reconsideration processes or to us during the pendency of this proceeding.

For the reasons explained below, we conclude that Pennsylvania has not shown that the disputed county-level costs were allocated to the federal Medicaid program in accordance with applicable legal requirements. We therefore uphold the disallowance in full.

Applicable Legal Authorities

The Medicaid program is jointly funded by the federal government and the states to provide medical assistance to financially needy and disabled persons. Social Security Act (Act)[1] §§ 1901, 1902(a)(10)(A); 42 C.F.R. § 430.0. Section 1903(a)(7) generally provides FFP at a 50 percent rate for state expenditures "necessary . . . for the proper and efficient administration" of the Medicaid program, also called "administrative costs." The rate for FFP in "medical assistance" expenditures (defined in section 1905(a)), by contrast, varies by state. Each state is responsible for funding its share of "medical assistance" and administrative costs. Act §§ 1902(a)(2), 1903(a), 1905(b).

Section 1902 requires that each state participating in Medicaid develop a State plan for medical assistance. The State plan must indicate whether its program will be administered by the State Medicaid agency directly or whether the State agency will supervise the operation of the program by local agencies. Act § 1902(a)(5). State Medicaid plans must be in effect in all political subdivisions (a principle known as "statewideness" established under section 1902(a)(1)); must provide 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 must allow any eligible individual to obtain assistance from any qualified provider ("free choice" under section 1902(a)(23)). States may obtain waivers to deviate from these principles in some circumstances, as Pennsylvania has done for the Consolidated Waiver program to serve an intellectually disabled population. *See* PA Exs. 1-2.

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"). Federal cost principles in OMB Circular A-87 – codified during the period at issue in appendices to 2 C.F.R. Part 225 (Jan. 1, 2012) and made applicable to Medicaid grants by 45 C.F.R. § 92.22(b) (Oct. 1, 2012) (*see* 68 Fed. Reg. 52,843 (Sept. 8, 2003)) – have long provided that, in order for a cost to be allowable, it must be allocable to a grant program, and that

[1] The current version of the Social Security Act can be found at http://www.socialsecurity.gov/OP_Home/ssact/ssact.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 https://www.ssa.gov/OP_Home/comp2/G-APP-H.html.

costs are allocable to a "cost objective" only to the extent that the relative benefits of the cost accrue to that cost objective.[2] 2 C.F.R. Part 225, App. A, ¶¶ C.1.b., C.3.a. Costs 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. Hence, state costs that benefit more than one public assistance program (federal or otherwise) must generally 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).

States must document the allocability of all State agency costs (defined as "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 . . . .") in approved PACAPs setting out the methodology used. 45 C.F.R. §§ 95.501, 95.502, 95.505; *Or. Dept. of Human Resources*, DAB No. 729, at 14-15 & n.6 (1986) (noting that the Part 95 regulations superseded prior Medicare-specific regulations regarding cost allocation plans). State PACAPs must "[d]escribe the procedures used to identify, measure, and allocate all costs to each of the programs operated by the State agency" and must be compatible with the applicable accounting principles and with the relevant State Medicaid plan. 45 C.F.R. § 95.507(a)(1)-(3). The PACAP must set out the "procedures used to identify, measure and allocate all costs to each benefiting program and activity . . . ." *Id.* § 95.507(b)(4). In addition, 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 include 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).

[2] In late 2014, the Part 92 regulations and the codification of OMB Circular A-87 in 2 C.F.R. Part 225 were superseded by the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards published in 45 C.F.R. Part 75. *See* 79 Fed. Reg. 75,872, 75,875-76 (Dec. 19, 2014). The disallowed costs at issue in this case were incurred prior to the 2014.

The PACAP must affirm that any costs to be claimed for services provided by "a governmental agency outside the State agency" will be supported by a written agreement setting 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 that billing will be "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 statewide, 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 regulations provide that "the costs improperly claimed will be disallowed." *Id*. § 95.519.

Case Background

This case is one of a series of appeals of disallowances taken by CMS after 2010 audits by the Department of Health and Human Services Office of Inspector General (IG) discovered that Pennsylvania had been claiming FFP in the costs of local entities that were administering components of the State's Medicaid program without demonstrating that those costs were properly allocable to Medicaid. The IG findings originally dealt with the State's Aging Waiver, but they triggered CMS to review other similar administrative cost claims, including those at issue here. CMS Br. at 8-9; CMS Ex. 5.

Prior Board decisions addressed CMS's disallowance of administrative costs under the Pennsylvania Aging Waiver (*Pa. Dept. of Public Welfare*, DAB No. 2653 (2015) and *Pa. Dept. of Public Welfare*, Ruling 2016-2 (2016)) and under the State's Non-Emergency Medical Transportation Program (*Pa. Dept. of Public Welfare*, DAB No. 2669 (2015)).

The Consolidated Waiver program involves home and community-based services provided to severely intellectually disabled recipients who might otherwise require institutional care. PA Exs. 1 and 2. The program is operated by "administrative entities." PA Br. at 3-4. Under the State Medicaid plan, such entities could be private, but in operation, the State uses only county mental health/intellectual disability programs as administrative entities for the Consolidated Waiver. *Id*.; PA Ex. 1, at 4. The State agency retains overall responsibility while delegating to the counties the "operational and administrative functions." PA Ex. 1, at 4. Each county has an agreement with the State. *Id*. Pennsylvania represents that each agreement employed one of two preprinted forms in effect during the relevant period. PA Br. at 4; PA Exs. 3 and 4.

Pennsylvania submitted excerpts from the PACAP that applied during the relevant period. PA Exs. 7, 11. These excerpts show that the PACAP included a statement that the State had agreements with any non-State governmental entities and identified the State agency component (Office of Developmental Programs) involved with the Consolidated Waiver. It is undisputed that the PACAP did not include any mention of the county agencies, their role in administering waiver programs, or discussion of whether or by what method(s) the costs of their activities would be allocated to Medicaid.

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 is based on the requirement in federal cost principles that costs claimed must "[b]e adequately documented" (2 C.F.R. Part 225, App. A, ¶ C.1.j.) and on grant administration requirements, including the requirement that grantees maintain accounting records supported by source documentation. *N.J. Dept. of Health*, DAB No. 2497, at 4 (2013).

Analysis

1. *Pennsylvania did not identify any allocation methodology for claiming the disallowed costs in accordance with its PACAP as required.*

CMS's primary reason for disallowing the funds at issue was that Pennsylvania had not complied with regulatory requirements to claim FFP for its costs of operating the Medicaid program "only in accordance with its approved" PACAP. Sept. 18, 2014 Disallowance Letter at 1-2, citing 42 C.F.R. § 433.34 and 45 C.F.R. §§ 95.515, 95.517, 95.519. CMS explained that Pennsylvania did not submit an amendment to its PACAP to cover these costs until September 25, 2013 (after the costs at issue were deferred) and that the amendment (if ultimately approved) could not be effective for any claims incurred prior to October 1, 2013 (the first quarter following submission). *Id*. at 2, citing 45 C.F.R. § 95.515. Pennsylvania generally denies that the requirements to have and disclose an allocation methodology apply to its claims for costs incurred by counties under the Consolidated Waiver, offering several arguments for either exempting the costs from cost allocation provisions entirely or accepting the PACAP's reference to agreements with the counties as adequate compliance with those provisions. None of these arguments has any merit.

To begin with, Pennsylvania contends that it was not required to include information about county-level costs because its Medicaid plan indicated that the program was "state-administered." PA Br. at 9-14, citing PA Exs. 8, 9. According to Pennsylvania, CMS has long known of and accepted the state-administered status of Pennsylvania's Medicaid

program and CMS should be bound by that acceptance. *Id*. at 11-13. CMS does not dispute that Pennsylvania's Medicaid program is state-administered, but denies that such status somehow implies that Pennsylvania could claim county-level costs of administering the Consolidated Waiver without including those costs in the PACAP and disclosing how they would be allocated. CMS Br. at 18-20. CMS listed the myriad activities to be performed by county-level administrative entities in operating the Consolidated Waiver to serve intellectually-disabled Medicaid-eligible residents (as delineated in the State's waiver application). *Id*. at 7-8, citing PA Ex. 1, at 16-17; PA Ex. 2, at 16-17. Moreover, CMS alleges that the same administrative entities perform many other activities and services that are not directed at waiver-eligible individuals or that are provided under non-Medicaid programs. CMS Br. at 7 and n.6. Given that Pennsylvania counties were responsible for such broad administrative activities, and that those activities incurred costs that overlapped many cost objectives (waiver and non-waiver-related), according to CMS, it is evident that attributing any of these costs to Medicaid would require allocation. Nevertheless, says CMS, Pennsylvania failed to identify any county-level costs of the Consolidated Waiver in its PACAP and failed to explain what methods it would use to allocate an appropriate share of those costs to Medicaid.

Pennsylvania denies none of CMS's allegations about the activities of the county administrative entities. Instead, Pennsylvania asserts that its omission of any methodology for determining which costs of those entities could be charged to Medicaid as State agency costs was the result of its own interpretation of cost allocation requirements, which, it asserts, CMS must have shared in the past since CMS did not previously disapprove Pennsylvania's PACAP. PA Br. at 17-19; PA Reply Br. at 2-4. CMS responds that the issue before the Board is not whether Pennsylvania's PACAP was acceptable but whether these particular costs were claimed in accordance with the PACAP that Pennsylvania submitted and CMS approved. CMS Br. at 21-22.[3]

The State's position is precisely what the Board repeatedly rejected in its prior Pennsylvania decisions, the reasoning of which we adopt and apply here as well. *See Pa. Dept. of Public Welfare*, DAB No. 2669, at 6-12, and citations therein. To summarize, the cost allocation requirements, throughout the relevant time frame and long before, have always placed the burden on the grantee to ensure that claims comply with cost principles, which include allocability of all costs. Thus, the Board explained that –

[3] We therefore again reject Pennsylvania's attempts to recast these disallowances as "plan conformity" disputes which involve findings that a State's Medicaid plan or its implementation is not in substantial conformity with federal requirements, findings which CMS has not made here. DAB No. 2653, at 16-17; Act § 1904; 45 C.F.R. Part 213.

> [T]he "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." DAB No. 2653, at 9. The state is responsible for developing and documenting an appropriate methodology to ensure that specific costs of administering a program are allocated in a manner compliant with the applicable requirements. *See* 45 C.F.R. § 95.507(a) (requiring submission of PACAP for "State agency" costs); *Mass. Dep't 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").

DAB No. 2669, at 6. Where it is clear (and in this case, it is undisputed) that the components involved incur costs relating to multiple programs, the state should have clearly understood that it must have a methodology in place to ensure that Medicaid-related costs are separated out.

Here, the PACAP neither identified which county-level costs Pennsylvania intended to claim under the Consolidated Waiver nor explained the methodology by which the costs would be allocated. Moreover, as in the prior cases, Pennsylvania has not responded to repeated opportunities to demonstrate that some appropriate methodology was in place to allocate the costs of county administrative entities beyond asserting that the counties themselves are required to have cost allocation plans. DAB No. 2669, at 8; PA Ex. 15, at 2 (O'Leary Decl.). Pennsylvania has not, for example, provided examples of any county cost allocation plans to show how the costs at issue are passed to Medicaid, or even provided explanations of the methodology or methodologies used. Absent such a showing here, as in the prior cases, we "do not see how Pennsylvania could claim to show that all the costs were properly allocated." DAB No. 2669, at 9.

Pennsylvania argues that following bare statement in its PACAP sufficed to establish that any county-level costs were properly allocated:

> In accordance with 45 CFR 95.507(b)(6), costs that are claimed for services provided by a governmental agency outside the state agency 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.

PA Ex. 7; PA Br. at 13-15. Pennsylvania asserts that the form agreements it completed with the county administrative entities met each of these requirements, in that they "itemize the services being purchased" (citing PA Ex. 3, at 15-17, and P. Ex. 4, at 16-18); specify the "basis upon which payment is made," i.e. that funds are "advanced in an amount 'necessary to comply with the requirements outlined' in the agreement and the State reviews advance payments against 'actual expenditures'" (citing PA Ex. 3, at 18-19 and P. Ex. 4, at 20); and require billing upon actual cost since the agreements provide for the State review process and then require any excess administrative funds to be returned to the State at the end of the agreement term (citing PA Ex. 3, at 44, and PA Ex. 4, at 46). PA Br. at 14.

Pennsylvania points to nothing in the PACAP itself that disclosed what services the State actually intended to purchase from governmental agencies outside the State agency, indicated that those services included the administrative operations of county entities under the Consolidated Waiver, or informed CMS what methodology would be used to allocate the costs or where that methodology could be found. In other words, the PACAP merely stated that conforming agreements would exist if services were purchased but did not anywhere explain whether the State actually planned to purchase some of its administrative activities from non-State entities. Pennsylvania acknowledges that the only reference to the Consolidated Waiver in the PACAP "contained no detail on county costs," but that is an understatement. As far as appears in the record, the PACAP did not even indicate that costs for that program would be claimed for any administrative activities outside the account codes listed, which appear to all be State agency components. PA Br. at 17; PA Ex. 11.

As the Board has repeatedly explained, the requirement to have conforming agreements with governmental entities outside the State agency before submitting claims for their service costs is only one of the applicable requirements. *See, e.g.*, DAB No. 2669, at 9-11. For example, the rest of subsection 95.507(b) requires that a State agency PACAP include the following additional 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).
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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) (italics added). As we have said, Pennsylvania has not demonstrated that its PACAP either described the activities performed by county administrative entities under the Consolidated Waiver or explained the procedures used to identify, measure or allocate their costs.

Pennsylvania assures us that, even though it "uses agreements in lieu of submitting local agency cost allocation plans," the CAPs prepared by those counties "classified as 'major local governments'" would independently be required to undergo federal review and others would be subject to audit requirements.[4] PA Br. at 14. Pennsylvania contends that these counties' cost allocation plans would need to be provided with the State agency PACAP only if Pennsylvania's overall Medicaid program were state-supervised (instead of state-administered), which it is not.

The dichotomy presented is a false one, however. Section 95.507(b)(7) clearly requires inclusion of county or other local-agency CAPs with the PACAP in a state-supervised system. It does not necessarily follow that a state never needs to include local agency CAPs in the PACAP when its Medicaid program overall is state-administered and the state chooses to have some of its public assistance programs administered by local government agencies, as Pennsylvania has done with its county agencies administering the Consolidated Waiver. Regardless of whether Pennsylvania should have included the county-level CAPs with its PACAP under section 95.507(b)(7), moreover, Pennsylvania plainly should have included information meeting the requirements of section 95.507(b)(1) through (4). DAB No. 2669, at 11. Nothing in those subsections suggests a distinction between the information required about the roles of other state-level entities and the roles of county-level entities, simply referring to the activities of all "costs" or each "unit." Yet, the PACAP failed to even notify CMS of the existence of county-level administrative costs which the State planned to allocate to Medicaid or to explain at any level of detail how the allocation would be performed.

[4] Pennsylvania does not identify which counties were so classified or explain how the federal government would be informed of cost allocation methodologies of non-major county agencies. Nor has Pennsylvania produced any of the county cost allocation plans, either directly to CMS outside of the PACAP or before the Board in these proceedings. Pennsylvania's position amounts to expecting the federal government to rely on the State's review of its counties' methodologies for assurance that the State is charging an appropriate share of the costs to the federal government.

Pennsylvania contends that the Board previously agreed with the State's view that the PACAP did not need to identify the county-level costs or allocation methodology at all, so long as it included the statement that it had the kinds of agreements required by section 95.507(b)(6). PA Br. at 13. This contention relies on a statement in *New Jersey Department of Human Services*, DAB No. 2328, at 6 (2010), that a PACAP "need not describe the procedures for allocating costs claimed for services provided by a governmental agency outside the state Medicaid agency if the CAP includes a statement" in compliance with paragraph (b)(6). Pennsylvania relies on this passing statement in the legal background of the *New Jersey* decision while entirely ignoring the actual holdings of the case which undermine Pennsylvania's position.

New Jersey's Medicaid agency (known as DMAHS) sought to claim some of the costs of a separate (i.e., non-Medicaid) state agency (an ombudsman office, referred to in the decision as OOIE) for providing investigations of abuse involving Medicaid-eligibles. DAB No. 2328, at 1, 3-4. New Jersey did not include the information about these costs in its PACAP but alleged that it was not required to do so because it had a 1991 agreement with the ombudsman agency that complied with section 95.507(b)(6). *Id.* at 5. The Board concluded that the 1991 agreement did not satisfy section 95.507(b)(6), explaining as follows:

> Section 95.507(b)(6) requires that an agreement to purchase the services whose costs are to be allocated specify the services "being purchased." In the 1991 agreement, however, DMAHS did not agree to purchase specific services from OOIE. DMAHS merely agreed to bill Medicaid for the cost of any investigations that OOIE conducted in Medicaid cases. Furthermore, even if that billing agreement could be considered a purchase of services (and we conclude it cannot), OOIE did not agree to conduct a specified number of such investigations, or indeed any such investigations at all. Section 95.507(b)(6) also requires that the agreement specify the basis upon which billing will be made by the outside agency. In this case, the agreement states only that OOIE will report the cost of the investigations "based upon generally accepted cost accounting principles," a statement so general as to be effectively meaningless. Moreover, nothing in the agreement indicates that Medicaid will be billed based on actual costs incurred, as also required by section 95.507(b)(6).

Id. Viewed in these terms, Pennsylvania's preprinted agreements with the county agencies are even further removed from the kind of discrete purchase agreements envisioned by the Board as compliant with section 95.507(b)(6) than the agreements rejected in *New Jersey*. Pennsylvania's agreements in effect delegate to the county agencies overall operation of waiver activities and provide for quarterly advances of funds needed to carry them out, contingent on the State budget, and merely reserve to the

State "the right to review advance installments against actual expenditures at any time, and to make appropriate adjustments in subsequent advances." PA Ex. 3, at 18-19. Contrary to the State's contentions, the reservation of authority to review advances does not amount to a guarantee that claims will only reflect actual costs. The specific services to be provided are left open to vagaries of appropriations and of county planning.

Moreover, we see nothing in the agreements (and Pennsylvania identifies nothing) that speaks to how the State will identify the share of county expenditures for administration that benefits Medicaid. Instead, the State reserves to itself an ability to "evaluate increases and decreases in the [county agency] workload" and then to adjust its own allocation to the counties based on State appropriations. PA Ex. 3, at 19. If the State does not appropriate enough money to cover all activities the county agencies are to perform under the agreement, the State will notify the county agencies of how to prioritize their efforts. *Id*. Plainly, these are open-ended arrangements in which the State decides how much money to provide to the counties and what administrative services to underwrite with none of the kind of controls that the regulations require for a purchase agreement from a vendor agency for predefined quantities of services at actual cost with a specified basis for determining the billing units which would ensure only services benefitting Medicaid were billed.

In contrast, New Jersey provided an explanation of its method for determining how much of the OOIE costs to allocate to Medicaid, which was to apply the percentage of investigations involving Medicaid-eligibles to the total costs of OOIE's activities. DAB No. 2328, at 6. The Board found this methodology to be "inconsistent with" federal cost principles, however, because, among other things, New Jersey failed to document that the percentage of investigations corresponded to the share of overall OOIE activities benefitting Medicaid since OOIE performed functions other than investigations. *Id*. at 6-7.

In short, New Jersey's claims for the activities of its ombudsman office were properly disallowed on multiple grounds, including the absence of an allocation methodology in the approved PACAP and the non-qualification of New Jersey's agreements even assuming that the agency service purchase agreement provision (section 95.507(b)(6)) would be an exception to the requirement to specify the methodology in the PACAP. *Id*. at 5. Pennsylvania's agreements with its county mental health agencies are, for the reasons discussed earlier, even further from qualifying as agency service purchase agreements under section 95.507(b)(6).

The New Jersey decision also did not need to resolve whether compliance with section 95.507(b)(6) would obviate the requirement for any description of methodology in the PACAP in the situation where the agreements covered discrete purchases of services for actual cost but somehow included services not directly benefitting Medicaid and

therefore requiring allocation. We do not need to resolve that question now either, nor need we reach the issue that we declined to reach in prior Pennsylvania cases of whether the actual county CAPs had to be supplied along with the PACAP. *See, e.g.*, DAB No. 2669, at 11, 23-34; DAB No. 2653, at 9-11, 14, 21. It is sufficient to conclude that the administrative costs incurred by county agencies in operating the Consolidated Waiver during the period at issue were not claimed in accordance with the approved PACAP given that no methodology ensuring that the claims were properly allocated was either disclosed in the PACAP or documented before us.

The present case is controlled by the same fundamental principles the Board reiterated in a case involving similar facts involving a different Pennsylvania waiver program also operated by county-level entities:

> 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).

DAB No. 2653, at 21. The same conclusion applies here. We next explain why Pennsylvania's arguments in the nature of affirmative defenses do not alter the outcome.

2. *CMS is not precluded from requiring Pennsylvania to document that its county-level costs are allocable to Medicaid under its PACAP based on alleged prior notice to CMS.*

Pennsylvania portrays the disallowance here, and in the related cases, as flying in the face of decades of practice by CMS in knowingly permitting Pennsylvania to claim for county-level administrative costs without requiring it to identify those costs in its PACAP or provide any documentation as to how they were allocated to Medicaid. *See, e.g.*, PA

Br. at 17-19; PA Reply Br. at 3 ("What has almost certainly occurred here is in an unarticulated change in the interpretation and/or application of the cost allocation regulations by the Agency, and not [a] decades-long excusable oversight . . .").

Pennsylvania in essence cobbles together information it disclosed in its Medicaid State plan and Consolidated Waiver to try to demonstrate that CMS had knowledge of the participation of county agencies in its implementation, and then presumes that knowledge would have led CMS to question the PACAP if the claims for county costs were not in compliance. *See* PA Br. at 16; PA Reply Br. at 2-4, 13-14. However, mere knowledge of the county agencies' participation implies no knowledge of whether or by what method Pennsylvania would seek to have Medicaid participate in its counties' administrative costs. *See* DAB No. 2653, at 13 (Medicaid waiver plans serve "an entirely different purpose and audience than the PACAP."). The complete absence of any reference in the PACAP to county costs[5] implies, if anything, the reverse – that the State does not intend to make such claims. For similar reasons, we find unpersuasive Pennsylvania's contention that, because CMS did not previously find the PACAP unacceptable, CMS must have changed its mind recently after having accepted Pennsylvania's views about not having to identify its counties' waiver-related costs at in its PACAP or to provide any explanation of an allocation methodology because CMS did not previously find the PACAP unacceptable. *See, e.g.,* PA Br. at 3, 16, 17-18; PA Reply Br. at 3-4. Nothing in the PACAP would have given CMS a reason to assume that it formed the basis for county-level claims for administration of the waivers. Nor has the State shown any reason that its inclusion of such costs in prior quarterly expenditure reports (QERs) identified them in any manner that would have caused CMS to be aware that county-level administrative costs were subsumed in the State's waiver administration costs. Moreover, that some of the counties may independently submit their own CAPs for federal review, as Pennsylvania asserts, does not obviate the need for the State to inform the federal government whether and how the State plans to seek reimbursement for county-level operation of aspects of its Medicaid program. Finally, even assuming CMS had reason to question the PACAP earlier than it did, Pennsylvania points to no authority for the proposition (if this is what it is suggesting) that this would estop CMS from taking the current disallowance to assure compliance with the Medicaid statute and federal cost principles.

[5] Pennsylvania attempts to negate this implication by arguing that it "is not as if the State's PACAP was totally silent on the issue of county-level costs," pointing out that one page contains a reference to "'Community Programs (Medicaid Waiver)' under the cost allocation provisions for the Office of Developmental Programs (ODP)." PA Reply Br. at 13-14, citing PA Ex. 11. If anything, this brief reference to the community programs under a Medicaid waiver suggests that the costs to be allocated for those community programs were those of the State ODP office. Pennsylvania identifies no reference in the PACAP to the county-level agencies, not even a mention that it had agreements with them that would cover waiver costs chargeable to Medicaid.

3. *Pennsylvania has not shown that any of the costs at issue were claimed as direct service costs rather than administrative costs.*

Pennsylvania also suggests that some of the costs at issue should be considered as having been incurred for direct services rather than for program (or waiver) administration, despite the fact that Pennsylvania seeks to claim them at the rate applicable to administrative costs, not at the rate for medical expenditures for direct services to recipients. PA Br. at 6-8. This contention too is a rehash of analogous arguments made and rejected in the prior Board cases relating to Pennsylvania's attempt to claim county-level costs as costs of administering Medicaid waiver programs. *See, e.g.*, DAB No. 2669, at 16-20; DAB No. 2653, at 16-17.

Pennsylvania points out that the PACAP only needs to explain how State agency costs are allocated and argues that these do not include "services . . . provided directly to program recipients." PA Br. at 6, quoting the definition of "State agency costs" in 45 C.F.R. § 95.505. Pennsylvania describes the costs it now characterizes as direct services as "administrative costs for targeted case management services for individuals who are Medicaid eligible and waiting to be enrolled in a waiver." *Id.* at 4. The full definition of "State agency costs" includes "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 . . . ." 45 C.F.R. § 95.505. This fuller context highlights that allowable, allocable costs claimed by the State are to be treated as State agency costs by default with the exceptions being for medical expenditures and services and items to be given to individual recipients (such as cash, furniture, day care, etc.).

CMS has historically recognized that certain activities, including "case management," may either be carried out at a level intended to benefit the overall operation of the Medicaid program or directed more to the individual benefit of program recipients. CMS Br. at 12, citing CMS Ex. 1, at 6. CMS has provided some flexibility for states to determine whether particular case management costs are considered as in the nature of medical expenditures or as administrative costs of program operation. As the Board explained in one of the prior cases in which Pennsylvania attempted the same argument, however, "longstanding guidance to states," along with a preamble to interim final case management regulations, have "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." DAB No. 2653, at 16, citing State Medicaid Manual (SMM) § 4302.2(G) and 72 Fed. Reg. 68,077, 68,088 (Dec. 4, 2007) (preamble to interim final case management regulations). Further, while some case management activities provided to individual recipients may indeed be direct services, 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,'" are to be claimed as administrative costs and must be "specified" in the state's PACAP. DAB No. 2653, at 16 (footnote omitted), quoting 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 medical service.'" *Id.* at 16-17, quoting 72 Fed. Reg. at 68,088.

The State disingenuously suggests that CAS guidance defining "administrative costs" to exclude "payments to third parties in compensation for services or goods provided directly to program recipients" means that an expenditure "otherwise classified" as administrative is "nonetheless exclude[d] . . . from cost allocation if it is a payment for services provided directly to program recipients." PA Br. at 7, quoting PA Ex. 5, at 78 (CAS's "Best Practices Manual for Reviewing Public Assistance Cost Allocation Plans"). The guidance neither says nor means any such thing. As with the regulatory definition, Pennsylvania distorts the definition by truncating it. The actual definition of administrative costs in the guidance is as follows: "<u>All costs allocated or incurred by the State agency</u> except expenditures for financial assistance, medical vendor payments and payments to third parties in compensation for services or goods provided directly to program recipients. These State agency costs <u>include all administrative costs, both direct and indirect,</u> incurred in support of the various programs administered or supervised by the State agency." PA Ex. 5, at 78 (emphasis added). The real import of this definition is to make clear that references to "administrative costs" are basically equivalent to references to "State agency costs" and include everything claimed as operational costs by the State agency or on its behalf except the direct payment for medical or other services directly provided to individual program recipients.

In this context, it is apparent that the instructions in the longstanding 1994 State Medicaid Director Letter (SMDL) advising states that every administrative cost "'must be included in a cost allocation plan that is approved by'" CMS, is not, as Pennsylvania contends, an "invalid legislative rule" conflicting with government-wide cost allocation principles. PA Br. at 7-8, quoting PA Ex. 6, at 6 (1994 SMDL). To the contrary, it is a routine application of those very principles to the question of distinguishing the kinds of case management that are provided to specific Medicaid recipients as a medical expenditure from the kinds that are part of operating the program effectively and therefore are administrative costs that must be included in approved cost allocation plans. And it is an application of which Pennsylvania has had actual notice for more than 30 years. As the Board has said, "Pennsylvania cannot now, having claimed the . . . costs as administrative, assert that they are actually direct medical services to justify omitting them from its PACAP" or failing to explain their allocation. DAB No. 2653, at 17.

4. *Pennsylvania has not shown that the claims were entirely based on actual costs.*

CMS alleged in the disallowance letter that certain Consolidated Waiver costs claimed by Pennsylvania were not actual expenditures but only estimates, specifically the salary costs reported for Cumberland and Perry counties and the total administrative costs for Philadelphia County. Sept. 18, 2014 Disallowance Letter at 3. Pennsylvania contends that, while it permitted county agencies to submit quarterly reports based on estimates, it required reconciliation to actual expenditures and return of any excess funds from the counties. PA Br. at 4, 21-22. In support, Pennsylvania submits the declaration of a state budget analyst affirming that the counties did submit annual reports for the periods at issue reconciling the estimated quarterly report amounts to actual expenditures. PA Ex. 15, at 1 (O'Leary Decl.). Moreover, Pennsylvania asserts that the practice of estimates and reconciliation, unlike the "systemic concerns" raised by other issues, "may be unique" to the counties reviewed and therefore should not be "extrapolated" to other counties' costs. PA Br. at 22.

Pennsylvania compares its submission of estimated county administrative costs on its QERs to CMS to the practice of making interim payments to providers that are later reconciled to actual costs, noting that 45 C.F.R. § 95.4 recognizes adjustments to prior year costs for payments made under an "interim rate concept." PA Br. at 21-22; PA Reply Br. at 17. Pennsylvania acknowledges that "42 C.F.R. 430.30(c)(2) requires that States claim their actual costs,"[6] but denies that this requirement precludes "provider payment systems that include interim or estimated claims subject to reconciliation." PA Reply Br. at 17-18. Pennsylvania's argument is inapposite because the claims at issue were for state administrative costs, not provider payments, and the counties here acted as agents of the State in administering the Consolidated Waiver program, not as vendors selling services to the State. Furthermore, as CMS points out, Pennsylvania failed to show that any reconciliation later done by the State to costs claimed by the counties was reflected in any adjustment to prior year costs on any QER that Pennsylvania submitted. CMS Br. at 30.

Because we have found the disallowance sustainable on other grounds, however, we need not resolve the factual disputes about whether all counties employed similar estimating practices or what part of the disallowed funds represented improper estimates. We also need not address the contention that CMS should not "extrapolate" the disallowance beyond the counties which were specifically reviewed. PA Br. at 22. The disallowance is not extrapolated, in any statistical sense. CMS alleged a failure to document that any

[6] Indeed, the QER contains an express statement by the State that certifies that "[t]he expenditures included in this report are based on the state's accounting of actual recorded expenditures, and are not based on estimates." *See, e.g.*, CMS Ex. 8 at 1 ¶ 3.

of the county agency costs at issue were claimed in accordance with an approved cost allocation plan or methodology. After notice of this allegation, Pennsylvania did not come forward with evidence that any of its county agency costs were properly claimed or that material distinctions existed in the cost allocation practices relating to different counties. Since we uphold the disallowance on the overarching grounds, it is not necessary to explore the State's vague claims that the use of estimates for FFP claiming "may be unique" to the two counties tested (PA Br. at 22) or perhaps to five counties, as Pennsylvania later says that its due diligence revealed (PA Reply Br. at 18). As we have said, the burden was on Pennsylvania to establish that its claims were allowable, including that they reflected actual costs not estimates.

5. *Pennsylvania is not entitled to further record development or to remand for further proceedings before CMS.*

Pennsylvania first requested in its reply brief that the Board conduct a "hearing or some other form of evidentiary record development to prove" that CMS made an "unarticulated change in [its] interpretation and/or application of the cost allocation regulations by [CMS]." PA Reply Br. at 3-4. CMS filed a surreply brief denying that any change in interpretation or application of the longstanding cost allocation provisions had occurred or required further record development. As CMS noted, the Board had, at that point, already rejected a similarly speculative request to somehow develop the record to determine if CMS once had a different interpretation of the requirements such that states were not required to provide information about how costs of administrative activities delegated to local government entities were allocated to Medicaid. CMS Surreply Br. at 1; DAB No. 2653, at 20 (Pennsylvania's "theory about CMS's state of mind has no evidentiary support," and the Board's application of the cost principles to Pennsylvania's circumstances "has not required any new interpretation of their terms").

In seeking reconsideration of DAB No. 2653, Pennsylvania pointed to a 2007 internal memorandum in which a regional official of CMS responded to a draft of an unrelated IG report recommending that Pennsylvania include all its county cost allocation plans with its PACAP by expressing concern that this would be "administratively burdensome" to include all 67 county plans. *Pa. Dept. of Public Welfare*, Ruling 2016-2, at 7. Pennsylvania proffered this same document to us after the close of briefing, reiterating its request for unspecified further record development because the 2007 comment "appears to confirm our assertion that the Agency has silently shifted its interpretation regarding cost allocation plan requirements." Sept. 8, 2015 letter from the State to the Board with attached Appendix B. CMS objected to this contention, pointing out that the comment was merely an "internal" response regarding "particular Medicaid claims," not a policy statement, and that Pennsylvania was informed in the same document to which the comment was attached that CAS (the entity charged with reviewing PACAPs) did not agree with it. Oct. 1, 2015 letter from CMS to the Board.

Pennsylvania's repeated requests for record development appear to seek to use Board proceedings to undertake a fishing expedition to try to generate evidence to show some inconsistency in policy or interpretation for which the State has shown no basis apart from the fact that these disallowances took place only after an IG audit focused on the issue of county-level administrative claims being allocated to Medicaid without an approved methodology to do so. In any case, as we have discussed above, both in this case and in the prior decisions, the Board has not needed to reach the question of whether all 67 county-level cost allocation plans should have been included with the PACAP, so it is irrelevant whether CMS's thinking on that question has varied. Pennsylvania has not shown any variation in the expectation that states must demonstrate that their claims are based on reasonable and approved allocation methodologies. In these cases, as we discuss next, Pennsylvania has had ample opportunities to make such a demonstration and has failed to do so.

In the alternative, Pennsylvania seeks a remand to allow it to "amend its cost allocation plan retroactively to cure the PACAP defects now perceived by the Agency." PA Reply Br. at 4; *see also* PA Br. at 16-17. By way of authority for such an action, Pennsylvania points to a Board decision – *Kansas Department of Social and Rehabilitation Services*, DAB No. 2056 (2006) – in which a disallowance was remanded to allow a state to resubmit to the predecessor of CAS (known as DCA) an approvable PACAP amendment and suggests following that procedure here since CMS "is asserting that Pennsylvania's PACAP is materially incomplete." PA Reply Br. at 4. As the Board explained in a prior decision involving Pennsylvania, *Kansas* is inapposite. *See* DAB No. 2669, at 22 n.10. The Board held in *Kansas* that the Social Security Administration was not precluded from disallowing claims made under an approved cost allocation plan but that DCA was the proper entity to determine if the existing plan was materially incomplete after full disclosure of information the state had not shown was provided in the approval process, and to determine if the state would be required to retroactively amend the existing plan. In the present case, CMS has not argued, and the Board has not found, that Pennsylvania's PACAP is materially incomplete. Pennsylvania did not claim in accordance with the existing approved PACAP because it omitted any information about identifying or allocating county-level administrative costs of the Consolidated Waiver. We find no basis for a remand. In any case, Pennsylvania has not shown that the Board has authority to order retroactive approval of a revised PACAP, and the Board did not do so in *Kansas*.

More generally, in its reply brief, Pennsylvania suggests that it could "supply the Board with county cost allocation plans, single audit reports, invoices, spreadsheets, and the like" but declines to do so because the Board is "not the Agency's auditor" and because CMS allegedly "did not request the kind of documentation it now seeks prior to issuance of the disallowance letter." PA Reply Br. at 9. According to Pennsylvania, the documentation would be "more appropriately addressed on remand," should

Pennsylvania prevail before the Board. *Id*. CMS responds that it has asked the State for all supporting documentation regarding allocation of the county-level costs when it issued the first deferral notice in April 2013 and continued to request documentation with each later deferral. CMS Surreply at 2, citing CMS Ex. 18, at 3 and CMS Ex. 7, at 4. Even had Pennsylvania somehow not understood prior to its appeal that CMS was seeking documentation of how the counties' costs were allocated, the State should have been clear about this after the Board instructed the parties to include in their appeal files "all documents which would assist the Board in making findings of fact on disputed issues . . . ." March 10, 2015 Acknowledgment of Notice of Appeal at 3. The Board rejected a similar claim from Pennsylvania in denying reconsideration of DAB No. 2653, pointing out that in that case, as here, Pennsylvania sought to deflect the need to meet its burden of demonstrating that its claims were properly allocated:

> From the outset, Pennsylvania has sought to focus this case entirely on the question of where, i.e., in what documents, the relevant allocation methodology had to be described. Certainly, it is true that Pennsylvania and CMS were in dispute on this point. CMS plainly argued that not only must a proper allocation methodology be shown to have existed, to have been disclosed and to have been applied, but also that, if the methodology was contained in county-level CAPs, those CAPs should have been included with the State PACAP. Nevertheless, we find it clear that CMS throughout this proceeding also asserted that Pennsylvania had failed to explain its methodology at all. Therefore, Pennsylvania should have known that, at a minimum, the explanation of its allocation methodology should have been presented to the Board.

DAB Ruling 2016-2, at 5. We conclude that Pennsylvania could have supplied evidence of the relevant allocation methodologies to CAS, to the IG, to CMS, or, ultimately, to us. While the Board should not have to serve as auditor in the first instance, the Board offered Pennsylvania yet another venue in which to show its compliance with cost allocation requirements. We see no justification for remanding this matter to provide further opportunities to submit documentation which Pennsylvania should have proffered long ago.

We deny Pennsylvania's requests for further proceedings or remand.

Conclusion

For the reasons explained above, we uphold the disallowance in its entirety.

/s/
Sheila Ann Hegy

/s/
Constance B. Tobias

/s/
Leslie A. Sussan
Presiding Board Member