**Department of Health and Human Services**
**DEPARTMENTAL APPEALS BOARD**
**Appellate Division**

Missouri Department of Social Services
Docket No. A-14-15
Decision No. 2589
September 4, 2014

# DECISION

The Missouri Department of Social Services (Missouri) appeals the September 10, 2013 determination by the Centers for Medicare & Medicaid Services (CMS). CMS disallowed $1,355,942 in Medicaid funding that Missouri claimed for state fiscal years (SFY) 1999, 2000, and 2001. The disallowance relates to payments that Kansas City, Missouri (Kansas City) made to Children's Mercy Hospital (Children's Mercy), a private, non-profit entity. Missouri claimed the payments as certified public expenditures (CPE) for graduate medical education (GME). CMS based the disallowance on an audit report issued in 2007.

For the reasons stated below, we sustain the disallowance.

## 1. Background

### *A. Statutes and regulations governing CPE claims*

The Medicaid program, established under Title XIX of the Social Security Act (Act), is jointly funded by the federal government and states to provide medical assistance to individuals who meet certain eligibility categories under the statute and regulations.[1] Act §§ 1902(a)(10)(A), 1902(e), 1902(f), 1928; 42 C.F.R. Part 435. Each state that chooses to participate administers its own Medicaid program under broad federal requirements and the terms of its "plan for medical assistance" (state plan), which must be approved by CMS on behalf of the Secretary of the Department of Health and Human Services (HHS). Act § 1902; 42 C.F.R. §§ 430.10 - 430.16.[2]

[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 42 U.S.C.A. Ch. 7, Disp Table.

[2] The editions of the regulations we cite in this decision are those in effect during the SFY 1999-2001 period unless indicated otherwise.

Each state must ensure that it can fund its share of both the "medical assistance" provided under its state plan and the costs of administering its Medicaid program. Act §§ 1902(a)(2), 1903(a), 1905(b). Section 1905(a) of the Act defines "medical assistance" as "payment of part or all of the cost" of covered services and care when provided to Medicaid-eligible recipients under the state plan. The rate of federal financial participation (FFP) that a state receives for medical assistance expenditures is called the federal medical assistance percentage, which generally ranges from 50 percent to 83 percent of the cost of medical assistance, depending on the state's per capita income and other factors. Act §§ 1903(a)(1), 1903(g), 1905(b); 42 C.F.R. § 433.10. The federal share for Medicaid administrative costs does not vary by state and is 50 percent for most administrative functions. Act §§ 1903(a)(2) –(5), 1903(a)(7); 42 C.F.R. § 433.15.

The Act and regulations permit states to use general state funds and other resources, including certain types of local government funding, to finance the non-federal share of Medicaid expenditures. Act §§ 1902(a)(2), 1903(w); 42 C.F.R. Part 433, subpart B. Together, these funds are sometimes referred to as the "state share." 42 C.F.R. § 433.51. The Act and regulations also specify that certain types of revenues may not count as the state share. Section 1903(w)(1)(A) of the Act requires the total medical assistance expenditures for which a state claims FFP to be reduced by the amount of revenues that the state receives from health care providers in the form of impermissible types of taxes and donations.[3] Section 1903(w)(6) prohibits the Secretary from restricting states' use of certain state and local tax funds, in the form of intergovernmental transfers or CPE, as the state share.

The related regulation at 42 C.F.R. § 433.51 provides that public funds may be counted as state share in several circumstances, including if the funds are "certified by the contributing public agency as representing expenditures eligible for FFP . . . ." 42 C.F.R. § 433.51(b).[4]

The regulations define a "claim" to mean a "request for [FFP] in the manner and format required by [the federal agency's] program regulations, and instructions or directives issued thereunder." 45 C.F.R. § 95.4.

[3] Section 1903(w) of the Act was enacted as part of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, Public L. No. 102-234, 105 Stat. 1793 (Dec. 12, 1991).

[4] The regulation providing for CPE to be considered state's share predated the enactment of section 1903(w) of the Act. The regulation was formerly designated at 42 C.F.R. § 433.45 and was redesignated at 42 C.F.R. § 433.51 in 1992. *See* 57 Fed. Reg. 55,138 (Nov. 24, 1992).

*B. Medicaid funding for GME*

The Act and regulations do not expressly authorize states to use Medicaid FFP to finance GME (training new physicians at teaching hospitals and other institutions). *See* 72 Fed. Reg. 28,930, 28,932 (May 23, 2007). CMS nevertheless historically permitted states to use Medicaid FFP for GME "in recognition of the flexibility afforded to states in designing Medicaid service and payment systems."[5] *Texas Health & Human Servs. Comm'n,* DAB No. 2404, at 2-3 (2011), citing *Utah Dept. of Health*, DAB No. 2131, at 3-4 (2007) (and authorities cited therein).

CMS permitted states to finance GME as a component of payments for hospital services provided to Medicaid patients, consistent with the payment methodologies in their approved state plans. 72 Fed. Reg. at 28,932-33; DAB No. 2131, at 3-4; *see also Minnesota Dep't of Human Servs.*, DAB No. 2122, at 21 ("the cost principles for setting reimbursement rates for hospital services recognize GME costs as a cost of patient care that may be included in determining a reasonable reimbursement amount for those services").

*C. Missouri's state plan provisions for enhanced GME payments*

Missouri's state plan for SFYs 1999-2001 provided for three types of GME payments. First, GME costs were included as a part of the per-diem rates for fee-for-service Medicaid recipients. Mo. Ex. 13. Second, Missouri paid hospitals a Medicaid GME "add-on" for Medicaid clients covered under managed care plans. Mo. Ex. 5. Third, and at issue here, the state plan provided for annual "enhanced" GME payments to be made to certain providers, including acute care children's teaching hospitals. Mo. Exs. 7, 12.

To be approved by CMS, Missouri's enhanced GME payment methodology had "to relate Medicaid payments for GME to Medicaid's share of the increased costs of providing services in a hospital with a GME training program." Mo. Exs. 18, at 80; 19, at 82.[6] To meet this requirement, Missouri computed the enhanced payments by applying an inflationary factor to "the Medicaid proportionate share of the aggregated approved GME amount" in a base year "as determined on the Medicare cost report" of each

[5] In 2007, CMS issued a proposed rule to "clarify that costs and payments associated with [GME] programs are not expenditures for medical assistance that are federally reimbursable under the Medicaid program." 72 Fed. Reg. 28,930 (May 23, 2007). Congress subsequently imposed moratoria on further action on the proposed rule. Pub. L. 110-28, § 7002(a)(1)(C), 121 Stat. 187 (May 25, 2007); Pub. L. No. 110-252, § 7001(a)(1), 122 Stat. 2387 (June 30, 2008). While the moratoria expired, the Secretary never finalized the rule.

[6] The cited exhibit page numbers refer to the consecutive page numbers of Missouri's appeal file.

eligible hospital. Mo. Ex. 19, at 83. Missouri's enhanced GME payment provision, one version of which was effective June 29, 1999, and a second version of which was effective June 2, 2000, directed Missouri to make the payments at the end of each fiscal year. Mo. Exs. 7, 12.

Missouri's state plan amendments providing for enhanced GME payments also stated that for a hospital that "has cash subsidies," the "share of the enhanced GME payment to a hospital . . . shall come from funds certified by the hospital." *Id.*

*D. The Office of Inspector General audit*

In May 2004, the HHS Office of Inspector General (OIG) began an audit of Missouri's Medicaid payments for GME. Mo. Br. at 10. The OIG issued its audit report in August 2007, concluding that payments Kansas City made to Children's Mercy that Missouri claimed as non-federal share CPE for GME for the SFY 1999-2001 period "did not fully comply" with federal law or Missouri's approved state plan. Mo. Ex. 30, at 166, 170.

Specifically, the OIG determined, because CPE under section 1903(w)(6)(A) of the Act and 42 C.F.R. § 433.51(b) "are for Medicaid eligible expenditures, the certification must be made after the money has been paid for services (i.e., expended)." *Id.* at 169 (emphasis by OIG). In addition, the OIG determined, "because FFP is available only for certified public expenditures, the certification must be made before the State uses those expenditures as a basis for claiming FFP." *Id.* (emphasis by OIG). The OIG stated that in 2004, during the audit, Kansas City executed certifications relating to the payments it made to Children's Mercy for SFYs 1999-2001, but Kansas City had not certified the expenditures before Missouri claimed FFP for them, contrary to federal law. *Id.* at 172.

The OIG further found that Children's Mercy did not certify the funds for all of the years audited, as required by Missouri's state plan. The OIG noted that for SFY 2001, Children's Mercy submitted a copy of its contract with Kansas City and "asked that the contract serve as the [hospital's] certification for that State FY." *Id.* "Because the State plan amendment did not specify how hospitals were to certify funds," the OIG concluded, "we could not determine whether the hospital's request was an acceptable form of certification." *Id.*

In addition, the OIG explained, according to the contract between Kansas City and Children's Mercy, the funds claimed as CPE were provided for "inpatient and outpatient health [care] to the indigent children of Kansas City, Missouri without regard to any other consideration or payments received by the [hospital] from others for such health care." *Id.* While the OIG "recognize[d] that some of the services provided with these funds may have qualified as GME," it was unable to determine what part of the contract payments was used to finance GME. *Id.* at 172-73.

Based on these conclusions, the OIG recommended that Missouri refund to the federal government "$1,355,942 in GME overpayments to the hospital during State FYs 1999 through 2001. . . ." *Id.* at 173.

*E. The CMS disallowance*

On September 10, 2013, CMS issued the determination disallowing $1,355,942 in FFP claimed by Missouri for enhanced GME payments for SFYs 1999-2001. Based on the OIG audit report, CMS concluded that the documentation provided by Missouri to support the claimed CPE did not meet the certification requirements of 42 C.F.R. § 433.51(b) and section 1903(w)(6)(A) of the Act. Mo. Ex. 35. CMS also determined that the payments did not satisfy Missouri's state plan provision requiring the hospital to certify the funds. *Id.*

2. **Analysis**

*A. The plain meaning of the language of section 1903(w)(6) of the Act and 42 C.F.R. § 433.51 requires CPE to be supported by an official statement confirming that the public funds represent allowable Medicaid expenditures.*

Missouri argues that CMS's determination "is based entirely on form over substance." Mo. Br. at 20. According to Missouri, neither section 1903(w)(6) of the Act nor 42 C.F.R. § 433.51 includes any requirements for the content or form of a CPE. Mo. Br. at 18. Missouri asserts that the regulation "does not even expressly require that the certification be in writing." Mo. Reply at 3. Missouri notes that in 2007, CMS amended section 433.51 to "require that CPEs be 'supported by auditable documentation in a form approved by the Secretary that,' among other things, '[i]dentifies the relevant category of expenditures under the State plan.'" *Id.* at 4; 72 Fed. Reg. 2236, 2246 (Jan. 18, 2007)(proposed rule); 72 Fed. Reg. 29,748, 29,833 (May 29, 2007)(final rule with comment period). The rule required the local agency to certify that a payment is eligible for FFP as a particular type of Medicaid service. *Id.* Missouri points out that CMS did not seek to add these requirements until after the period at issue here and that, in any event, the rule was since vacated. *Id.*; 75 Fed. Reg. 73,972 (Nov. 30, 2010).

Missouri also asserts that the amounts claimed were not intended to reflect, nor need they be tied to, the actual costs that Children's Mercy incurred in educating its medical residents. Mo. Br. at 13; Mo. Reply at 6, citing 72 Fed. Reg. at 29,768. Rather, Missouri argues, "the claimed payments from Kansas City to Children's Mercy" reflect the government agency's actual costs and "are intended to be 'in an amount equal to the Medicaid State plan rate . . . for the service,' *i.e.,* the amount to which Children's Mercy was entitled under the enhanced GME payment formula in Missouri's state plan." Mo. Br. at 13; Mo. Reply at 6.

Missouri's contention that section 1903(w)(6) of the Act and 42 C.F.R. § 433.51 do not include any requirements for the content of a certification of public expenditures ignores the plain meaning of the statutory and regulatory language. As summarized above, section 1903(w)(6) of the Act and section 433.51 of the regulations provide that only under certain conditions may funding from a unit of state or local government be used as the non-federal share of Medicaid expenditures in claiming FFP. Section 1903(w)(6) provides in relevant part:

> (A) Notwithstanding the provisions of this subsection, the Secretary may not restrict States' use of funds where such funds are derived from State or local taxes . . . transferred from or **certified by units of government within a State as the non-Federal share of expenditures under this title**, regardless of whether the unit of government is also a health care provider . . . unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under this section.
>
> (B) For purposes of this subsection, funds the use of which the Secretary may not restrict under subparagraph (A) shall not be considered to be a provider-related donation or a health care related tax.

(Emphasis added.) The regulation at 42 C.F.R. § 433.51 provides:

> (a) Public funds may be considered as the State's share in claiming FFP if they meet the conditions specified in paragraphs (b) and (c) of this section.
> (b) The public funds are appropriated directly to the State or local Medicaid agency, or transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control, **or certified by the contributing public agency as representing expenditures eligible for FFP** under this section.
> (c) The public funds are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds.

(Emphasis added.)

The language in the statute and regulation highlighted above establishes that, in order to qualify as non-federal share, CPE must be "certified by" the contributing governmental entity as "expenditures under [Title XIX]," or "expenditures eligible for FFP." The plain meaning of the verb, "to certify" is "to say officially that something is true, correct, or genuine;" "to say officially that something or someone has met certain standards or requirements;" or "to attest authoritatively as being true or as represented or as meeting a standard." http://www.merriamwebster.com/dictionary/certify. "Expenditures under this title" and "expenditures eligible for FFP" are payments for which a state is entitled to receive federal funding under the Medicaid Act and regulations. Thus, the plain meaning

of the language of section 1903(w)(6) of the Act and 42 C.F.R. § 433.51 requires CPE to be supported with an official statement by an authorized representative of the contributing public entity confirming that the expenditures qualify as Medicaid medical assistance or other allowable Medicaid expenditures.

This requirement is not merely a formality, as Missouri implies, but is consistent with a state's responsibility to "[m]aintain an accounting system and supporting fiscal records to assure that claims for Federal funds are in accord with applicable Federal requirements." 42 C.F.R. § 433.32(a). Based on this or similar provisions, the Board has long held that states have the burden to document the allowability of the costs for which they claim federal funding. *See, e.g., Utah Dep't of Health*, DAB No. 2462, at 21 (2012); *New York State Dep't of Social Servs.*, DAB No. 204, at 5 (1981). In light of this responsibility and the context in which states may use CPE to support claims for Medicaid FFP, it would be unreasonable to interpret the term "certified" as permitting a certification to be an oral rather than a written statement. In any event, Missouri has not argued or provided evidence that the reason why it failed to provide any written certification made prior to the audit was that it interpreted the regulation to permit oral certification. Nor did Missouri assert that a Kansas City official had made a formal oral statement before the audit confirming that the public funds represented allowable Medicaid expenditures.

We agree with Missouri that the statutory and regulatory language does not specify that a certification of public expenditures must include particular wording (such as "eligible for FFP"), be documented on a specific form, account for actual costs incurred by the service provider, or identify the specific category of Medicaid costs funded by the CPE, as would have been required under CMS's 2007 regulatory revision. Nevertheless, as discussed above, the statute and regulation in effect during the period at issue plainly imposed on Missouri a responsibility to support the CPE claims with an official statement by an authorized Kansas City representative confirming that the payments made to Children's Mercy for SFYs 1999-2001 represented allowable Medicaid expenditures. Such evidence would provide necessary assurance that Missouri had met its obligation to fund its share of allowable Medicaid costs for the care and services provided under its state plan.

### *B. Missouri's documentation does not constitute certification by a public official that the public funds represented allowable Medicaid expenditures.*

Missouri submitted three groups of documents which it asserts show "that Kansas City made a public expenditure to Children's Mercy, which independently and together are sufficient to support the State's claim of a CPE." Mo. Br. at 13. Applying the requirements of section 1903(w)(6)(A) of the Act and section 433.51 of the regulations to that evidence, we conclude that Missouri's documentation is not sufficient to support its CPE claims for the reasons explained below.

i. Annual contracts between Kansas City and Children's Mercy

Missouri argues that annual contracts between Kansas City and Children's Mercy under which Kansas City made the payments at issue are sufficient to support the CPE claims. Missouri asserts that the "contracts were signed by both the local unit of government, Kansas City, and the hospital, and they specify the purpose (inpatient and/or outpatient hospital services for indigent children) and amount of the payment." Mo. Br. at 13. According to Missouri, these documents "suffice as valid certifications of the local expenditures at issue" and show that the payments that Kansas City made to Children's Mercy constituted "'cash subsidies' within the meaning of [Missouri's] state plan amendment for enhanced GME." Mo. Br. at 9, 13.[7]

The contracts are not the kind of official statements of certification discussed above. In addition, the terms of the contracts belie Missouri's characterization of the nature of the payments and fail to show what, if any amount, of the payments that Kansas City made to Children's Mercy represented allowable Medicaid expenditures. The contracts covering the May 1, 1998 to April 30, 2000 period included a "Scope of Work" provision, which stated that the "purpose" of the agreements was for Children's Mercy "to provide inpatient and outpatient health [care] to the indigent children of Kansas City, Missouri without regard to any other consideration or payments received by [Children's Mercy] from others for such health care." Mo. Exs. 1, at 5; 2, at 14. An "Addendum to General Provisions" in the contracts further provided that the "work listed in the Scope of Work is only indicative of the work to be performed . . . and serve[s] as a basis" for Children's Mercy "to carry out such work as is necessary to fulfill the objective of this contract, and is not to be narrowly construed as being the only items for which" Children's Mercy "was responsible." Mo. Exs. 1, at 4; 2, at 12. The contracts also stated that Children's Mercy would "bill the City" on a monthly basis, and that **"[r]eimbursement** shall occur following submittal by" Children's Mercy "of **documented expenditures** which the City deems acceptable." Mo. Exs. 1, at 2, 4; 2, at 10, 12 (emphasis added). (Each agreement specified a total payment amount that would not be exceeded. Mo. Exs. 1, at 2; 2, at 10.)

The terms of the contracts covering the May 1, 1998 to April 30, 2000 period thus do not confirm or provide assurance that the payments made by Kansas City constituted "cash subsidies" for Medicaid-covered hospital services or other allowable Medicaid expenditures that could be used for enhanced GME payments under Missouri's state plan.

[7] Missouri asserted in its reply brief that CMS did "not dispute that Kansas City provided cash subsidies to Children's Mercy for the years in question." Mo. Reply at 1. We note that while CMS did not dispute that Kansas City made payments to Children's Mercy, CMS's brief does not indicate that CMS considered the payments to be "cash subsidies." Rather, CMS argued that "nothing in the record indicates the City's payments represented expenditures for services allowed under the Missouri state plan." CMS Br. at 6-7.

Rather, the contract language shows that the payments constituted reimbursement for an amorphous array of "inpatient and outpatient health" care that Children's Mercy furnished to "indigent" children and other "such work as [was] necessary to fulfill" the contract objective.

The contract for the May 1, 2000 to April 30, 2001 period also fails to show that the payments Kansas City made to Children's Mercy under that agreement represented reimbursement for Medicaid covered inpatient or outpatient hospital services or other expenditures that were eligible for FFP. The "Scope of Services" provision of that contract provided that in exchange for monthly payments from Kansas City, Children's Mercy would –

> maintain and operate an ambulatory general clinic, offering services in general medicine, including such laboratory and surgical procedures which are necessary in such treatment and which can be accommodated by existing facilities; to arrange by cooperative agreement with other medical providers for treatment of patients that cannot be provided by the Contractor; and to prescribe and supply to patients medicines necessary in the treatment of illness.

Mo. Ex. 11, at 54. Under the contract's "Compensation Schedule," moreover, Children's Mercy "certifie[d] that it [would] utilize $40,668.00 of the $3,846,415.00 [in total payments under the contract] for the sole purpose of funding a new or expanded public health related prevention program(s) and no other. . . ." *Id.* at 58. Nowhere in the contract (or in any other record evidence) is there even an indication that the ambulatory clinic services or public health related prevention programs for which Children's Mercy received payments from Kansas City for SFY 2001 constituted Medicaid medical assistance or administrative expenditures eligible for FFP.

Furthermore, the contracts' definition of the term "indigent" to include a "person who is a member of a family unit whose income falls within the current [federal] income poverty guidelines" suggests that some of the individuals who received services provided under the agreements were not Medicaid recipients. Mo. Exs. 1, at 5; 2, at 14; 11, at 54. Missouri itself acknowledges that while children who were members of family units whose income fell within federal income poverty guidelines would have included Medicaid recipients, the population of individuals who met the family income criterion of the definition of "indigent" also included children ineligible for Medicaid. Mo. Reply at 3 ("all children under the federal poverty level are covered by Medicaid unless they are non-qualified or undocumented aliens").

In addition, while Children's Mercy had to account for payments under the contracts on a cost reimbursement basis, Missouri provided no documentation to show that any of the amounts paid under the agreements were in fact used as reimbursement for allowable Medicaid expenditures. Accordingly, we reject Missouri's contention that the annual contracts suffice to support Missouri's CPE claims.

ii. Kansas City's 2004 attestations

The next group of documents on which Missouri relies to support its CPE claims is a set of attestations executed in September 2004 in response to the OIG audit. Each attestation is signed by Kansas City's Director of Health and states that its purpose "is to confirm that during" one of the years at issue, Kansas City paid a specific sum "in local funds including a Health Levy to Children's Mercy Hospital for indigent children health care services." Mo. Ex. 24. All of the attestations include a parenthetical statement: "(We understand that a portion of this amount was claimed as the non-federal share of a Medicaid expenditure to the hospital for [GME] . . . and that the federal share of the amount claimed was reimbursed to Children's Mercy . . . .)" *Id.*

These attestations fall far short of the kind of official statement of certification by an authorized representative that the plain language of the statute and regulation anticipates. Like the contracts between Kansas City and Children's Mercy, the attestations fail to show what, if any, amounts of the payments that Kansas City made to Children's Mercy represented allowable Medicaid expenditures, eligible for FFP, as required by the plain language of section 1903(w)(6)(A) of the Act and 42 C.F.R. § 433.51. Each attestation identifies the total amount of payments that Kansas City made to Children's Mercy for each SFY at issue: $3,761,000 for SFY 1999; $3,805,747 for SFY 2000; and $3,846,415 for SFY 2001. Mo. Ex. 24. Like the contracts, however, the attestations do not specify what, if any, amounts of these total annual payments represented expenditures for Medicaid covered services provided to Medicaid recipients, even though Missouri claimed FFP based on Children's Mercy allegedly receiving Medicaid "cash subsidies" for enhanced GME payments in the specific amounts of $547,593 for SFY 1999; $847,476 for SFY 2000; and $842,799 for SFY 2001. Mo. Ex. 3, at 19-23. Moreover, the parenthetical statement in each attestation merely confirms that Missouri *claimed* a portion of the total annual payments from Kansas City to Children's Mercy as Medicaid non-federal share for GME; it does not establish that Missouri properly did so. The lack of wording in the attestations reflecting the statutory and regulatory requirements is particularly striking given the context in which the attestations were made --- in response to the OIG's questioning whether Missouri's CPE claims were adequately documented to show that the public funds represented allowable Medicaid expenditures.

As noted above, the OIG and CMS also concluded that the 2004 attestations were untimely. According to the OIG, the statutory and regulatory use of the past tense and past participle of the verb "to certify" to describe the funding (i.e., "certified by units of

government," "certified by the contributing public agency," and "certified public expenditures") means that "the certification must be made before the State uses those expenditures as a basis for claiming FFP." Mo. Ex. 30, at 169. CMS also points out that the State Medicaid Manual (SMM) clearly instructs states that expenditures "are allowable only to the extent that, when a claim is filed, [the state has] adequate supporting documentation to assure that all applicable Federal requirements have been met." CMS Pub. 45, § 2497.1.[8] The instructions state that for a claim to be "fully documented," "all supporting documentation must . . . be immediately available" when the state files the FFP claim, that is, "complete documentation in readily reviewable form must be in [the state's] possession." *Id.* §§ 2497.2, 2497.4. The instructions reiterate that when a state files an FFP claim, "it must be supported by sufficient documentation to assure that the expenditure was made on behalf of an eligible recipient for covered services rendered by a certified provider." *Id.*

Reading the language of the CPE statute and regulation to require the contributing government entity to certify the funds before the state may claim the expenditures is thus reasonable and consistent with CMS's longstanding instructions. Moreover, Missouri does not point to any provision in the Act, regulations, or CMS guidance that led it to believe that when it filed its quarterly statements of expenditures it could reasonably claim the non-federal share of the enhanced GME payments if Kansas City had not already certified the payments and the state itself had paid Children's Mercy only the federal share of the enhanced GME payment amounts. Accordingly, in addition to concluding that the 2004 attestations were invalid because they failed to confirm that the payments from Kansas City to Children's Mercy were for allowable Medicaid costs, we conclude that the OIG and CMS reasonably determined that the attestations were untimely.

iii. Children's Mercy cost reports

The third set of documents that Missouri submitted as purporting to support its CPE claims includes Children's Mercy cost report excerpts and "Institutional Reimbursement Unit" (IRU) database printouts, which "reflect and retain the figures that were reported" as "cash subsidies" or "government appropriations" in the cost reports for the years at issue. Mo. Br. at 14-15. Missouri provided with these documents "supplemental communications" to show how much of the total amounts of "cash subsidies" or "government appropriations" paid to Children's Mercy were attributable to payments from Kansas City. *Id.*

[8] The current version of the SMM, which can be accessed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html, indicates that these provisions were in effect during the period in question.

Missouri asserts that the cost report documents satisfy both federal certification requirements and the requirement in its state plan that the state share of an enhanced GME payment "shall come from funds certified by the hospital." Mo. Br. at 14, citing Mo. Exs. 7, 12. Missouri asserts that cost reports include a certification by the hospital that the information provided in them is true, correct and complete. Mo. Br. at 15. In addition, Missouri contends that cost reports "have repeatedly been accepted by CMS as a basis for CPEs." *Id.* citing 72 Fed. Reg. at 29,770; Mo. Ex. 25 (2005 Virginia state plan amendment.)

We conclude that the cost report documentation fails to meet the requirements of section 1903(w)(6)(A) of the Act and section 433.51 of the regulations. Most obviously, the documents were not authored or executed by an official of any government entity. Rather, the information and representations in the cost reports were provided by the hospital. In addition, like the contracts and attestations, the cost reports and related documents fail to indicate what, if any, amount of payments that Children's Mercy received from Kansas City and reported as "cash subsidies" or "government appropriations" represented allowable Medicaid expenditures, eligible for FFP.

We reject Missouri's assertion that CMS has repeatedly accepted cost reports "as a basis for CPEs." Mo. Br. at 15. The *Federal Register* page cited in Missouri's brief includes CMS's responses to (1) a comment that the 2007 proposed regulatory revision would place an administrative burden on states if they were required to periodically audit and review CPEs and (2) a comment recommending that CMS modify the regulation to allow a payment and corresponding CPE based on a current cost report without any reconciliation process. 72 Fed. Reg. 29,769-29,770. The responses discuss states' use of cost reports to audit and review CPE practices and to reconcile costs, but do not address the use of cost reports to certify public expenditures.

Furthermore, the Virginia state plan amendment cited by Missouri is inapposite. That amendment provided for the state agency to draw down FFP "to cover unreimbursed Medicaid costs for inpatient services provided by non-state <u>government owned</u> hospitals [i.e., hospitals owned or operated by a unit of government other than the state] as certified by the provider through cost reports." Mo. Ex. 25, at 120 (emphasis added). The Virginia state plan amendment is consistent with the CPE statute and regulation because a government owned hospital may serve as a "contributing public agency" within the meaning of section 433.51. The Virginia state plan provision is thus distinguishable from the circumstances presented in this case, which involve a private hospital receiving public funds from a government entity.

Accordingly, we conclude that the cost report documentation, 2004 attestations, and annual contracts between Kansas City and Children's Mercy neither independently nor together suffice to support Missouri's claimed CPE for the SFY 1999-2001 period.

3. **Conclusion**

For the reasons discussed above, we sustain the disallowance.

/s/
Sheila Ann Hegy

/s/
Leslie A. Sussan

/s/
Judith A. Ballard
Presiding Board Member