Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

SUBJECT: Minnesota Department of Human Services
Docket Nos. A-07-53
A-08-43
Decision No. 2157

DATE: March 4, 2008

DECISION

The Minnesota Department of Human Services (Minnesota, State) appealed two determinations by the Centers for Medicare & Medicaid Services (CMS) disallowing a total of $19,748,684 in federal financial participation (FFP) that Minnesota claimed under the Medicaid program at title XIX of the Social Security Act (Act). Based on the evidence in the record before us on review, we find that the factual premises on which CMS based its determinations were erroneous and that no disallowance is warranted under the facts here. Since we reverse the disallowances on factual grounds, we do not reach Minnesota's allegations that CMS was improperly applying new law retroactively. Below, we first summarize our decision and then provide more detailed background and analysis.

Summary

Minnesota's approved State plan provides for annual supplemental payments to county-owned nursing homes. CMS determined that State supplemental payments made in May 2006 and May 2007 were not made pursuant to the approved State plan since Minnesota made the payments to the counties in which the nursing homes were located instead of to the nursing homes. CMS also found that the nursing homes never received the State supplemental payments to use for the care of Medicaid recipients. Instead, according to CMS, the counties returned most of the funds to the State. CMS determined that the funds transferred to the State by the counties were donations or applicable credits that reduced the expenditures in which FFP is available.

Minnesota responds that the State supplemental payments were appropriately made to the counties, as permitted by the Medicaid

regulations and State plan. Minnesota also argues that the transfers from the counties to the State were, as State law required, derived from local property taxes and appropriated for Medicaid purposes, not diverted to non-Medicaid purposes. According to Minnesota, it was not required to offset the counties' payments to the State against its Medicaid expenditures because those payments constituted protected intergovernmental transfers within the meaning of section 1903(w)(6)(A) of the Act.

Based on our de novo review of the record, we find that the State's payments directly to the counties for nursing facility services provided by county-owned facilities to Medicaid recipients were expenditures for medical assistance consistent with the approved State plan. The evidence shows that the counties held both the nursing home licenses and properly executed assignments from the nursing homes for the counties to receive the supplemental payments directly. The assignments were specifically authorized by federal regulation and provided for in the State plan. The evidence also shows that the counties were responsible for care in the nursing homes and incurred allowable costs for nursing facility services the homes provided. The assignments thus were valid, contrary to what CMS found, and the payments to the counties reimbursed them for costs of nursing facility services, a type of medical assistance.

Moreover, State law required that the counties' payments to the State be derived from local property tax revenue, and there is no evidence that any county ever violated this law. The evidence provided by Minnesota shows that the counties had such tax revenue available. CMS points to the similarity in the timing and amount of the transactions in 2006. Minnesota's evidence regarding those transactions, however, shows that it would have been impossible for some counties to have used the funds received from the State as supplemental payments for their transfers to the State and that it is highly improbable that the others did (even assuming county officials might ignore the State law regarding the source of the funds). CMS's disallowance determination relied on evidence that the timing of the supplemental payments in earlier years (2003 and 2004) was such that it was possible in those years that the same funds were simply "recycled" back to the State, but even this evidence (regarding transactions that are not at issue here) does not directly address the source of the funds transferred from the counties to the State.

Indeed, despite being asked to clarify its position, CMS does not clearly dispute Minnesota's assertion that the transfers to the State were derived from local property taxes, instead arguing

that the source of the transferred funds is irrelevant. The significance of the source, however, is twofold. First, it means that the supplemental payments were not, as CMS found, simply being returned to the State. Instead, the counties had those funds available to offset their costs incurred for nursing facility services, and likely did use the funds for that purpose since the aggregate amounts Medicaid paid for the services were less than what Medicare would have paid. Second, as CMS has long recognized, county payments to a state that are protected intergovernmental transfers may not be treated as provider-related donations or applicable credits that reduce Medicaid expenditures.

Furthermore, the uncontradicted evidence presented by Minnesota shows that the transfers from the counties to the State were appropriated for Medicaid purposes, not diverted to non-Medicaid purposes, as CMS alleges. CMS's concerns about the integrity of the Medicaid program are misplaced, therefore, and its other arguments in support of the disallowances are without merit.

Accordingly, we reverse the disallowances.

Legal Background

The federal Medicaid statute, found in title XIX of the Act,[1] provides for joint federal and state financing of medical assistance for certain needy and disabled persons. Act §§ 1901, 1903. Each state that chooses to participate administers its own Medicaid program under broad federal requirements and the terms of its own "plan for medical assistance," or state plan, which must be approved by CMS on behalf of the Secretary of Health and Human Services. Act § 1902; 42 C.F.R. §§ 430.10-430.16.[2] (If a state plan or plan amendment is disapproved, the state may seek reconsideration by the CMS Administrator, whose decision is the final decision of the Secretary and is subject to review by the federal court of appeals for the circuit in which the state is

[1] The current version of the Social Security Act can be found at www.ssa.gov/OP_Home/ssact/comp-ssa.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. Also, a cross reference table for the Act and the United States Code can be found at 42 U.S.C.A. Ch. 7, Disp Table.

[2] Except where noted, we cite to the 2005 Code of Federal Regulations since the cited regulations that appear there were in effect during the period in question here.

located. Act § 1116(a) and (b); 42 C.F.R. Part 430, subpart D.) Once the state plan is approved, a state becomes entitled to receive federal reimbursement, or FFP, for "an amount equal to the Federal medical assistance percentage . . . of the total amount expended . . . as medical assistance under the State plan." Act § 1903(a). Section 1905(a) of the Act defines the term "medical assistance" as "payment of part or all of the cost" of specified services and care when provided to Medicaid eligible individuals under the state plan. This definition includes "nursing facilities services" in the list of covered services.

Sections 1902(a)(2), 1903(a) and 1905(b) of the Act require states to share in the cost of medical assistance and in the cost of administering the approved state plan. The rate of FFP that a state receives in its expenditures for medical assistance is called the federal medical assistance percentage (FMAP), and generally ranges from 50 to 83 percent of the cost of medical assistance, depending on the state's per capita income and other factors. 42 C.F.R. § 433.10. Minnesota's FMAP during the relevant time period was 50%. CMS Br. at 3. The non-federal share that states must provide in order to receive FFP is sometimes referred to as the state share. 42 C.F.R. § 433.51. Section 433.51(a) provides that "[p]ublic funds" which are "transferred from other public agencies" to the State Medicaid agency "may be considered as the State's share in claiming FFP[.]" Of the state share, not less than 40 percent must consist of "financial participation by the State." Act § 1902(a)(2). The latter provision has been viewed as authorizing local sources to contribute up to 60% of the state share. See, e.g., H.R. Rep. No. 1096, at 37, 102nd Cong., 2nd Sess. 1992.

Section 1903(w)(1)(A) of the Act requires that the total expenditures for medical assistance in which a state claims FFP must be reduced by the amount of revenues that the state receives from health care providers in the form of certain types of taxes and donations.[3] Section 1903(w)(6) contains an exception to the restrictions on provider-related donations that permits states to use certain state and local tax funds as the state's non-federal share without having to reduce claims for FFP. This section provides in relevant part:

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

> (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.
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> (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.) At the same time, Congress passed a provision requiring the Secretary to engage in notice and comment rulemaking prior to implementing any changes in the treatment of public funds as the source of the non-federal share. Pub. L. No. 102-234, § 5(b). The Secretary then determined to retain the regulatory provision from 42 C.F.R. § 433.45 (redesignated as section 433.51), which permits use of "public funds" as the state share of Medicaid, including funds "transferred from other public agencies . . . to the State or local agency and under its administrative control . . . ." 42 C.F.R. § 433.51; see 57 Fed. Reg. 55,118 (Nov. 24, 1992).

Section 1902(a)(19) of the Act requires a state plan to "provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interest of the recipients." In addition, under section 1902(a)(30)(A) of the Act, a state plan must "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary . . . to assure that payments are consistent with efficiency, economy, and quality of care. . . ." This section serves as the basis for "upper payment limits" (UPLs) established for the Medicaid program by 42 C.F.R. § 447.272. For each type of health care facility (i.e., hospitals, nursing facilities and intermediate care facilities) the UPL is the aggregate amount that can be reasonably estimated would have been paid to that group of

facilities for those services under Medicare payment principles. Section 447.272; see also Georgia Dept. of Community Health, DAB No. 1973, at 3 (2005). Non-state government-owned or operated facilities (government facilities that are neither owned nor operated by the state, such as county-owned facilities) are one of the groups for which a separate, aggregate UPL applies to nursing facility services. Id.

Case Background[4]

In 1993, the Minnesota legislature enacted a law requiring that--

> [b]eginning in 1994, the commissioner shall pay a nursing home payment adjustment on May 31 after noon to a county in which is located a nursing home that, on that date, was county-owned and operated, with the county named as licensee by the commissioner of health[.] The adjustment shall be an amount equal to $16 per calendar day multiplied by the number of beds licensed in the facility on that date.

MN Br. at 4, quoting Minn. Stat. § 254B.431, subd. 23(a) (copy at CMS Ex. 3). Minnesota's State plan amendment providing for an annual supplemental Medicaid payment in the amount specified in this law was approved by CMS's predecessor agency, the Health Care Financing Administration (HCFA). MN Ex. 4. Minnesota submitted another State plan amendment to CMS following the enactment in 2002 of a law providing that, in addition to the payment previously authorized, the Commissioner "shall pay to a nursing facility" $29.55 per day, multiplied by the number of licensed beds. MN Br. at 4, quoting Minn. Stat. § 256B.431, subd. 23(c); MN Ex. 5. CMS approved a State plan amendment providing for both supplemental payments – SPA 02-08 – effective March 1, 2002 after Minnesota documented that the amendment complied with UPL requirements. MN Ex. 6. SPA 02-08 provides in pertinent part as follows:

> SECTION 19.080 Disproportionate share nursing facility payment adjustment.
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> A. On May 31 of each year, the Department shall pay a disproportionate share nursing facility payment adjustment after noon on that day to a nursing home

[4] The following facts appear from the record and are not disputed. Additional undisputed facts are identified in the Analysis section as appropriate.

> that, as of January 1 of the previous year, was county-owned and operated, with the county named as licensee by the Commissioner of Health, had over 40 beds and had medical occupancy in excess of 50 percent during the reporting year ending September 30, 1991. The adjustment shall be an amount equal to $16 per calendar day multiplied by the number of beds licensed in the facility as of September 30, 1991. These payments are in addition to the total payment rate established under Section 17.000.
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> B. Beginning in 2002, in addition to the payment in item A, the Department shall pay to a nursing facility described in item A a disproportionate share nursing facility payment adjustment on May 31 in an amount equal to $29.55 per calendar day multiplied by the number of beds licensed in the nursing facility on May 31. The provisions of item A apply.
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> C. Payments in items A and B are limited by the Medicare upper payment limits for non-state, government-owned or operated nursing facilities.

MN Ex. 5 (underscoring omitted).[5]

In May 2006, Minnesota made supplemental Medicaid payments calculated in accordance with SPA 02-08. The payments, which totalled $19,019,859, were made via electronic transfer directly to 13 counties, each of which owned and operated a nursing home that met the criteria in SPA 02-08. MN Ex. 8, ¶¶ 10-12.

Minnesota claimed FFP in the $19,019,859 of supplemental payments made to the counties. CMS disallowed $9,509,930 (the amount of FFP payable at the State's FMAP rate of 50%) by letter dated December 8, 2006. The disallowance determination, signed by the CMS Regional Administrator, sets out the following grounds for the disallowance:

- The payments were inconsistent with section 1903(a)(1) of the Act. "Since the funds in question were not paid

[5] CMS disapproved a subsequent State plan amendment reflecting a third supplemental payment provided for by the Minnesota legislature in 2003. CMS's disapproval was upheld on appeal. Minnesota v. Ctrs. for Medicare & Medicaid Services, 495 F.3d 991 (8th Cir. 2007). We discuss later CMS's suggestion that the court's decision is dispositive here.

to medical providers, and were returned directly to the State Agency by the counties, there were no actual expenditures made to medical providers. The funds remained under the administrative control of the State even when temporarily transferred to the counties."

- Under section 2560.4.G.1 of CMS's Medicaid Manual, "[n]o expenditure occurs when there is no payment or accounting transfer made specifically to the accounts of the governmental provider."

- While section 447.10(e) of 42 C.F.R. permits payment to be made in accordance with a reassignment to a government agency, "there is no documented reassignment [from the nursing homes to the counties] with respect to the expenditures at issue" and "the term 'reassignment' must be interpreted in light of the provisions of section 1903(w) of the Act to exclude donations and thus cannot include the circumstances here, where "there was no indication of an exchange of value to support a reassignment, even if there had been a documented reassignment."

- Even assuming there was an expenditure, "the State Agency's claimed expenditure was in excess of the actual expenditure" because it failed to "take into account the refund or return of funds from the county" as required by Office of Management and Budget (OMB) Circular A-87.

- "While certain transfers from local governmental entities back to the State are protected from treatment as either a donation or applicable credit under section 1903(w)(6)(A) [of the Act], that protection extends only to transfers 'derived from state and local taxes . . .' and does not include transfers of funds derived from Medicaid payments from the State agency. Therefore, with respect to the claimed expenditures at issue, the return or refund of some or all of the funds from the county would not be protected and are appropriately considered either as an applicable credit or provider-related donation that reduces the claimed expenditure consistent with OMB Circular A-87 or section 1903(w)(1)(A) of the Act."

- "Section 1905(b) [of the Act] sets out a very specific formula for determining federal and state share of Medicaid expenditures. Claimed expenditures that do not account for returns or refunds of payments . . .

effectively violate that formula by triggering federal payment for amounts in excess of the actual expenditure incurred by the State."

- "Section 1903(i)(17) of the Act states that payments shall not be made 'with respect to any amount expended for roads, bridges, stadiums, **or any other item or service not covered under a State plan**.' Since some or all of the claimed expenditures at issue here are required to be returned to the State Agency, the payment is effectively not being made for nursing facility services (or any other covered service) as required by the approved State plan. Instead, the payment is available to be used for other purposes, including items or services not covered under the State plan."

MN Ex. 1, at 1-3 (emphasis in original).

Minnesota appealed. This appeal was assigned Docket No. A-07-53. After receiving the parties' submissions in the appeal, the Board issued an Order to Develop the Record, asking CMS to clarify its position regarding the funds transferred to the State. CMS responded, and Minnesota filed a reply.

Meanwhile, on November 17, 2007, CMS issued a new determination, based on exactly the same grounds, disallowing $10,238,754 in FFP for supplemental payments Minnesota made in May 2007 to counties for nursing facility services. Minnesota appealed. This appeal was assigned Docket No. A-08-43. The Board's acknowledgment letter noted that the issues presented appear to be the same and proposed to consolidate the two appeals. Neither party objected or sought to present additional evidence.

Analysis

We note at the outset that it is undisputed that the county nursing homes provided nursing facility services to eligible Medicaid recipients and that the nursing homes met the criteria in SPA 02-08 to qualify for State supplemental payments. Nor does CMS deny that generally payments for nursing facility services provided to eligible Medicaid recipients that are made according to the State plan are expenditures for "medical assistance" under section 1905(a) of the Act. The key issues here are whether Minnesota violated its State plan by making the payments to the counties and whether the State's expenditure claims should be reduced by the amount of the supplemental payments based on one of the grounds cited by CMS.

Below, we first discuss why we conclude that SPA 02-08 permitted the State to make the supplemental payments to the counties rather than to the nursing homes. Next, we discuss why we find that the counties used the State supplemental payments for costs associated with the services provided by the nursing homes. We then discuss why we conclude that payments made by the counties on the same date as the counties received the State supplemental payments were not a return of the supplemental payments in the form of a provider-related donation or an applicable credit, but were instead protected intergovernmental transfers. Finally, we explain why we conclude that CMS's reliance on recent court and Board decisions is misplaced.

1. SPA 02-08 did not require that the supplemental payments be made directly to the nursing homes.

CMS argues in its brief that the State supplemental payments were not made in accordance with the approved State plan because the plan provides for payments to the nursing homes while the State payments were made to the counties in which those nursing homes were located. In CMS's view, by "nursing home," the approved State plan can mean only the "bricks and mortar plus staff" institution in which the services are provided. CMS Br. in Response to State Reply, at 15. CMS's position cannot be sustained on the record before us, however.

First, Minnesota asserts without contradiction that the counties or one of their subdivisions were the actual nursing home licenseholders. MN Br. at 11, citing MN Ex. 12 (Affidavit of Margaret J. Jacques, Att. A (copies of counties' licenses)). The State plan provision for supplemental payments to nursing homes for which the county was the licensee is intended to implement the 1993 State law directing that the supplemental payments be made to the county that holds the nursing home license. In light of this legislation, Minnesota could reasonably interpret its State plan as permitting payment directly to the county, even if, as CMS asserts, the nursing home and the county licenseholder are "legally distinct entities" (CMS Br. at 27). This interpretation is also consistent with State law providing that Medicaid payments are to be made to the "vendor," who is defined to include "any person or persons furnishing, within the scope of the vendor's respective license . . . nursing home and convalescent care . . . ." MN Reply Mem. at 14, citing Minn. Stat. §§ 256B.03, subd. 1 and 256B.02, subd. 7. CMS cites nothing in the history of the State plan or its implementation by Minnesota indicating that any different interpretation was intended.

In any event, there is evidence in the record that the nursing homes assigned the State supplemental payments to their county owners.[6] As the Regional Administrator's determination recognizes, Medicaid regulations expressly permit a provider to assign its right to payment to a government agency or entity. MN Ex. 1, at 2, citing 42 C.F.R. § 447.10(e). Section 4.21 of the approved State plan also permits such reassignment.[7]

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[6] According to Minnesota, all of the supplemental payments were made "pursuant to a reassignment of the payments to the counties." MN Ex. 8 (Cammack Affidavit), ¶ 12. For nine of the 13 counties, the payments were made pursuant to assignments executed in 1994 by the nursing home administrators. The assignments directed Minnesota to deliver all payment adjustments made under Minn. Stat. § 256B.431, subd. 23, to the county owners. Id., ¶¶ 14-15 and Att. A. Also in 1994, two nursing homes returned forms to Minnesota with banking information for the county in which they were located in order to permit the State to make the payment adjustments to the counties. Id., ¶ 16 and Att. B. One nursing home sent a letter to Minnesota with the county's banking information. Id., ¶ 17 and Att. C. Minnesota was unable to locate documentation for the remaining nursing home, but we infer an assignment was made since Minnesota clearly took steps to obtain documentation from all of the county nursing homes and had the relevant banking information for all of the counties. Minnesota asserts without contradiction, moreover, that "[t]he nursing homes have not withdrawn their assignments and authorizations, nor have they instructed Minnesota to pay any portion of the supplements directly to them." MN Br. at 14, citing MN Ex. 8, at ¶¶ 21-22.

[7] As indicated above, both disallowance letters stated that there is no documented reassignment with respect to the expenditures at issue. Based on the evidence before us, however, we make a contrary finding. The disallowance letters also state that even if there had been a documented reassignment, it would be invalid since there was "no exchange of value" provided by the counties. CMS's brief says it is not questioning the legal validity of the assignments but rather making the point that the nursing homes' reassignments constituted provider-related donations because the nursing homes did not receive anything of value from the counties in exchange for the assignment of the nursing homes' right to reimbursement. CMS Br. at 28, n.9. As discussed later, however, this point is also based on an incorrect factual premise.

CMS also argues that making the supplemental payments directly to the counties violates section 2560.4.G.1. of its State Medicaid Manual, which provides in part that "[e]xpenditures for services are made in the quarter in which any State agency made a payment to the service provider" (emphasis added). However, the purpose of this section is to specify when an expenditure occurs. Nothing in its language indicates that a county licenseholder could not constitute the service provider for purposes of determining whether a state has made an expenditure. Moreover, the manual provision must be read in light of the regulations, which specifically permit assignment to a governmental entity.

2. The counties incurred costs for the care of Medicaid recipients in the nursing homes.

CMS also found that the State supplemental payments to the counties were not used for the care of the Medicaid recipients in the nursing homes. CMS inferred this from the fact that the payments were not made directly to the nursing homes, but provided no evidence regarding how the funds were, in fact, used.

Minnesota points out that State law authorizes counties to establish nursing homes to provide care and treatment to their elderly and disabled residents and requires that a county nursing home be established, operated and maintained by the county board or an administrative board that is under the control of the county. MN Reply Mem. at 14-15, citing Minn. Stat. §§ 376.55, subd. 1 and 2, and 376.58, subd. 1; see, also, Minn. Stat. § 376.58, subd. 3 (authorizing a county administrative board to "establish, operate and maintain a county nursing home . . . ."). As noted above, the counties or one of their subdivisions were the actual nursing home licenseholders. State law makes the licensee of a nursing home "responsible for its management, control, and operation" as well as "for the quality of care rendered and for compliance with laws and rules relating to the safety and sanitation of nursing homes, or which otherwise relate directly to the health, welfare, and care of residents." MN Br. at 12, quoting Minn. Rule 4658.0050, subp. 1 and 2 (2005). Minnesota also cites to subparagraph 3 of this rule, which it says makes the licensee "responsible for providing an adequate and competent nursing home staff, for maintaining professional standards in the care of residents and operation of the home, for providing the facilities, equipment and supplies needed for the residents, and for providing evidence of adequate financing and the proper administration of funds." MN Br. at 12.

Since each county was ultimately responsible for the provision of nursing home services, it is unreasonable to infer that the

counties did not use the State supplemental payments to offset the costs of caring for Medicaid recipients in the nursing homes based merely on the fact that the payments went directly to the counties.

Minnesota also asserts that the counties provided "direct and indirect financial support to their nursing homes." MN Reply Mem. at 12. By way of example, Minnesota submitted affidavits from an official in each of four counties averring that the county provided direct appropriations of county property tax revenue to the county-owned nursing home in the year in question. MN Exs. 13-16. The appropriations totalled over $2 million in 2006, which Minnesota alleges was close to the amount of the State supplemental payments received by the counties. MN Reply Mem. at 12. One of the affidavits specifies that the appropriations were for an operations subsidy, psychiatric services and information systems services, and a capital expense subsidy. MN Ex. 14. Three of the affidavits also support Minnesota's contention that the counties provided other financial support to the nursing homes, alleging that the nursing home is located on county-owned property and pays no rent or property tax to the county or city government. MN Exs. 14-16. CMS does not dispute that the counties' expenditures could be considered in determining costs of providing covered nursing facility services to eligible Medicaid recipients in the county nursing homes.

Minnesota does not identify the precise amount of costs incurred by the counties for Medicaid services to nursing home residents. However, it is unlikely that the State payments exceeded the actual costs incurred since, before CMS approved SPA 02-08, Minnesota documented that the State payments would not result in total payments which exceeded the applicable UPL. (CMS also found that the additional supplemental payment proposed in 2003 would not have violated the UPL. CMS Ex. 11, at 8.) Indeed, CMS states that its disallowance letter "neither states nor implies that the State's expenditures do not qualify for FFP because the supplemental payments for county-owned and operated NFs exceed the costs actually incurred by the service providers." CMS Br. in Response to State's Reply Br. at 6. In addition, Minnesota alleges, and CMS does not dispute, that this is not "a situation where some county-owned nursing homes are being paid substantially less so others can receive excess payments" since "[a]ll county-owned nursing homes [received] the supplemental payments." MN Reply Mem. at 14. Thus, Minnesota was not circumventing the intent of the revised UPL regulations, which grouped facilities to avoid such cost-shifting. See 66 Fed. Reg. 3148, 3165 (Jan. 12, 2001).

In any event, contrary to what CMS argues, Minnesota need not establish that the full amount of the State payments was actually used for the care of Medicaid recipients in the nursing homes. See CMS Br. in Response to State Reply, at 9. At the time the State supplemental payments were made, there was no requirement in place that actual costs be documented in order for payments to nursing homes to be allowable as medical assistance. Instead, the longstanding practice in Medicaid has been to permit states to reimburse providers using prospective rates that are estimates based on average historical costs of facilities in a particular class, without any requirement to retrospectively adjust to actual costs. See 41 Fed. Reg. 27,300, 27,303 (July 1, 1976). (The prospective rates were intended to give providers an incentive to keep costs down. 41 Fed. Reg. at 27,303.) Indeed, CMS admits that it "understood that, in approving the underlying SPAs, it was authorizing annual supplemental payments to the NFs [nursing facilities] that were not based on each provider's actual costs incurred." CMS Br. in Response to State's Reply at 7. Thus, Minnesota was entitled to FFP in the State supplemental payments regardless of the precise amount that was expended for care of the Medicaid recipients in the nursing homes.

For the same reason, Minnesota need not track how the State supplemental payments were used. Nursing facilities submit Medicaid claims after furnishing the services, and payments are intended as reimbursement for costs the facility incurred in providing the services. See, e.g., 42 C.F.R. §§ 447.45, 447.250. Thus, the counties were entitled to the payments regardless of how they use the funds.

3. The payments made by the counties to the State were not a return of the State supplemental payments but rather were intergovernmental transfers derived from local property tax revenue.

CMS asserts that the State supplemental payments were merely returned by the counties to the State. According to CMS, the State funds never really left the State's control but were instead "'parked' very briefly in the county governments' accounts before nearly the same payment amounts" were returned to the State. Thus, in CMS's view, the counties "recycled" the State supplemental payments to the State as provider-related donations that section 1903(w)(1)(A) of the Act requires be used to reduce a state's claim for Medicaid FFP. CMS Br. at 16-17.[8]

[8] CMS acknowledges that the total amount paid by the (continued...)

However, Minnesota asserts that the counties' payments to the State were made pursuant to State law requiring each county to make a contribution toward the cost of Minnesota's Medicaid program on May 31 of each year and to use property tax revenue to meet this financial obligation. MN Br. at 6, 18, citing Minn. Stat. §§ 256B.19, subd. 1d, and 256B.20(1); MN Reply Mem. at 9-10.[9] CMS does not clearly dispute the State's assertion that the funds were derived from local property taxes, even after the Board directed CMS to clarify whether it was disputing the assertion. CMS alleges no reason to believe county officials

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[8](...continued)
counties to the State in 2006 was $135,851 less than the amount of the State payments. CMS nevertheless argues that the entire amount should be disallowed because "the counties did not direct even the $135,851 . . . to the NFs for the provision of services to Medicaid eligibles." CMS Br. at 18. However, CMS made no finding that would support this assertion.

[9] Minn. Stat. 256B.19, subd. 1d, provides:

> (a) In addition to the percentage contribution paid by a county under subdivision 1 [repealed prior to 2006], the governmental units designated in this subdivision shall be responsible for an additional portion of the nonfederal share of medical assistance cost[.]

Paragraphs (b) through (d) require that "each of the governmental units designated in this subdivision shall transfer before noon on May 31 to the state Medicaid agency an amount equal to the number of licensed beds in any nursing home owned and operated by the county on that date, with the county named as licensee, multiplied by" specified amounts. Minn. Stat. § 256B.20(1) provides:

> The board of county commissioners of each county shall annually set up in its budget an item designated as the county medical assistance fund and levy taxes and fix a rate therefor sufficient to produce the full amount of such item, in addition to all other tax levies and tax rate, however fixed or determined, sufficient to carry out the provisions hereof and sufficient to pay in full the county share of assistance and administrative expenses for the ensuing year . . . .

CMS does not dispute Minnesota's assertion that the taxes to which this section refers are property taxes.

would ignore State law. Instead, CMS merely says that the evidence "does not definitively establish the source of the counties' return payments to the State." CMS Response to Order at 3.

CMS's evidence is certainly not dispositive of the source of the funds transferred to Minnesota from the counties in 2006 and 2007. CMS originally relied on evidence from 2003 and 2004, although the transactions for those years are not before us. CMS Br. at 17, citing CMS Exs. 12-13. CMS also relies on the requirement in State law that the transfers to and from the counties be made on the same date to support its position that the funds (or nearly the same amounts) were "returned." CMS does not specifically assert that the same funds were returned to the State, however, and made no finding for any county, even for 2003 or 2004, that the funds transferred to and from the county came from the same account or that a county account charged for a transfer did not have sufficient funds derived from local property taxes to cover that transfer.

Moreover, any inference about the source of the funds that might be drawn from the fact that the transactions occurred on the same date is undercut not only by the State law requiring that county transfers come from local property taxes, but also by the State's uncontradicted evidence. That evidence shows that all of the counties made their transfers to the State before noon on May 31, 2006. MN Ex. 8 (Affidavit of Martin L. Cammack) at ¶ 7. The evidence also shows that the earliest any county could have possibly accessed the funds received as supplemental payments from the State on that date was 10:00 a.m. and that some counties could not access them until as late as 3:00 p.m. MN Ex. 8, ¶¶ 9 and 10. Counties that could not access the payments from the State until after noon surely could not have transferred those same funds before noon. Moreover, we doubt that county accounting processes would have permitted any county to have initiated and completed the process of transferring funds to the State between 10 a.m. and noon on May 31, 2006 or, alternatively, to have authorized obligation and electronic transfer of funds before 10 a.m. based merely on an expectation that the county might receive the supplemental payments from the State in time to cover the transfer. Indeed, since State law provided for the supplemental payments to the counties to be made after noon, no county official could have reasonably expected that funds from the supplemental payments would be available to cover a transfer to the State that was required to be completed before noon.

Finally, Minnesota provided evidence that all of the counties had local property taxes sufficient to cover the transfers. MN Ex.

25. Minnesota also explained that May 31 was chosen as the date for the counties to make their intergovernmental transfers because property taxes are payable on or before May 16th of each year and interest on a late payment is doubled if the payment is delayed beyond May 31st. MN Reply to CMS Response to Order at 3, citing Minn. Stat. § 279.01, subd. 1.

Given the availability of sufficient property tax revenues, the State law requiring counties to use those revenues as non-federal share, and the evidence that it would have been impossible for some counties and improbable for others to have instead transferred funds derived from the supplemental payments back to the State, we conclude that counties' payments to the State were derived from local property taxes. Therefore, the payments were protected intergovernmental transfers under section 1903(w)(6) of the Act.[10]

CMS nevertheless argues in its brief that the counties' payments to the State must be considered provider-related donations because the provider-related donations provision in section 1903(w)(1)(A) "trumps" section 1903(w)(6). CMS Br. in Response to State's Br. at 13. This Board rejected that argument in Minnesota Dept. of Human Services, DAB No. 2122 (2007), as inconsistent with section 1903(w)(6)(B) of the Act and with the explanation of both provisions in the preamble to a rule published in 2007. See 72 Fed. Reg. 29,748, 29,758 to 29,759 (Jan. 18, 2007). Indeed, the Regional Administrator's determinations here (including the second determination, which was issued three weeks after the Board had issued DAB No. 2122) acknowledge that if the transfers from the counties to the State were derived from local taxes, they would not be considered donations. This view is, moreover, consistent with section 433.51(a), which permits use of "public funds" as the state share of Medicaid.

CMS does not cite to any applicable regulation (or even a policy issuance) that would deny treatment as a protected intergovernmental transfer based on the fact that the timing and amount of the transfer is similar to the amount and timing of a payment from a state to the governmental unit making the

[10] Minnesota also provided uncontradicted evidence that the percentage of the state share funded by local sources did not exceed that permitted by section 1902(a)(2) of the Act. MN Br. at 7, citing MN Ex. 10 (Affidavit of Christine Bronson), ¶ 2 (local government funds accounted for less than 11% of non-federal share in state fiscal years 2004 - 2006).

transfer. CMS's response to the Board's Order disavows any intent to restrict intergovernmental transfers, asserting that CMS is not stopping the counties from transferring the funds to Minnesota. The effect of adopting CMS's position here would, however, be to restrict the use of intergovernmental transfers from counties as non-federal share whenever the timing and amounts of the transfers were similar to the timing and amount of any Medicaid payments to the counties.

In response to the Order, CMS's main argument is that it is irrelevant here whether the transferred funds were derived from local property taxes because of the "indisputable absence of a bonafide expenditure for medical assistance," as required by section 1903(a)(1) of the Act. CMS Response to Order at 3.[11] Minnesota disputes CMS's position that there was no expenditure for medical assistance, however. Minnesota argues that the counties incurred costs related to the ownership and operation of nursing homes providing nursing facility services to Medicaid recipients and that the payments for those services were made in accordance with the approved State plan. We have already determined that Minnesota supported these arguments with persuasive evidence and, therefore, rejected CMS's contentions that the State plan requires payments "to" nursing facilities and that there was no valid reassignment of the right to payment. We conclude, for the same reasons, that the supplemental payments were bonafide expenditures for medical assistance.

We also reject CMS's argument that Minnesota admitted that the counties here made provider-related donations. CMS Br. at 21, citing CMS Ex. 8 (MN letter dated 11/19/03 responding to CMS's questions regarding the later proposed State plan amendment), at 2. Minnesota merely stated that "providers owned and operated by local government, by definition, have financial interactions that could be considered 'redirection' of funds." Id. On its face,

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[11] CMS also argues in its response that, if the source of the funds were dispositive, that would "be tantamount to requiring CMS to demonstrate in its disallowance notices that the agency could literally trace the very same dollar bills (i.e., dollar bills with the same serial numbers) as they moved in the small circle form Minnesota to the counties and then back to the State" and that "it is inconceivable that Congress would have imposed such a requirement." CMS Response to Order at 5. Nothing in our decision (or Minnesota's arguments) requires tracing dollar bills by their serial numbers. The plain wording of section 1903(w)(6)(A), however, protects intergovernmental transfers "derived from" local property taxes.

however, this statement does no more than acknowledge that someone might view a county as redirecting Medicaid funds to non-Medicaid purposes, even though the transaction had a different purpose. Nothing in the statement concedes that any of these transactions constitutes an impermissible "donation."

5. The counties' payments to the State did not constitute an applicable credit.

CMS argues as an alternative basis for the disallowance that the county payments to the State constitute an applicable credit. Under the cost principles, "applicable credits," or "those receipts or reduction of expenditure-type transactions that offset or reduce expense items allocable to Federal awards as direct or indirect costs," generally must be subtracted from claims for federal funding. OMB Circular A-87, Att. A, ¶¶ C.1.i, C.4.[12] CMS takes the position in its brief that "the refunds of the supplemental payments constitute 'applicable credits' under OMB Circular A-87, which must be deducted from the claimed expenditures in question." CMS Br. at 30.

The Board considered the question of whether intergovernmental transfers constitute an applicable credit in Georgia Dept. of Community Health. The Board there stated that "the exception in section 1903(w)(6) permitting state Medicaid agencies to receive transfers of state and local tax funds is analogous to Board holdings recognizing that such taxes and other fees of general applicability that states typically use to fund their operations are not applicable credits that reduce a state's net expenditures in which the state claims FFP." Georgia at 18. According to the Board, "[v]iewing those fees as third party recoveries and applicable credits . . . would render meaningless a state's ability to raise revenues, as all monies received by a state from its populace through the power of taxation would potentially be 'applicable credits'." Georgia at 19, citing Oregon Dept. of Human Resources, DAB No. 1298, at 14-15 (1992). Oregon in turn noted that HCFA (CMS's predecessor agency) had "conceded in prior Board cases that if funds qualify as state's share, then they are not subject to the applicable credit cost principle requirements." DAB No. 1298, at 6. Consistent with these prior decisions and CMS's previous concessions, CMS's disallowance determinations state that transfers from local governmental

[12] OMB Circular A-87 is made applicable by 45 C.F.R. § 92.22(b). In 2005, the provisions of OMB Circular A-87 were relocated to the Code of Federal Regulations at 2 C.F.R. Chapter II. 70 Fed. Reg. 51,910 (Aug. 31, 2005).

entities to the State are protected from treatment as applicable credits if the transfers are derived from state or local taxes.

We found above that the counties' payments to the State were derived from local property taxes. Accordingly, we find that these payments were not applicable credits.

6. The funds were not diverted to non-Medicaid purposes.

CMS also argues that, because the counties' payments to the State were deposited in the State's General Fund, they were "available for any use, including those not 'covered under a State plan'," in violation of section 1903(i)(17) of the Act. CMS Br. at 21.

This argument has no merit. State law requires that a county's contribution be credited to a State treasury account "from which medical assistance payments to vendors shall be made." See MN Br. at 6, quoting Minn. Stat. § 256B.041, subd. 2. Minnesota's Financial Operations Director explained that, pursuant to this law, "[a]n amount equal to the local governments' contributions is included in the Legislature's appropriation to the Medical Assistance Account from the General Fund." MN Ex. 8 (Cammack Affidavit), ¶ 6. Similarly, Minnesota explained in a letter to CMS in 2003 that a county's payment "is deposited in the General Fund, which funds the Medical Assistance Account, which pays for the nonfederal share of most Medical Assistance expenditures, including all payments to nursing homes, including the rate add-on at section 20.080 of the state plan." CMS Ex. 6, at 6. This procedure provides adequate assurance that the counties' payments were available only for Medicaid costs.

There is, moreover, no basis for CMS's further suggestion that 45 C.F.R. § 74.23 required that the counties' payments to the State be identified with the supplemental payments in question here. See CMS Br. in Response to State's Reply Br., at 12.[13] CMS points to nothing in the provisions on cost sharing or matching in section 74.23 (or elsewhere) that requires that cash contributions must be identified with specific expenditures in

[13] CMS says section 74.23 was made applicable by 42 C.F.R. § 430.30(e). Section 430.30(e), however, contains an exception for the cost sharing and matching provisions previously codified in subpart G of 45 C.F.R. Part 74 and later recodified in section 74.23. In 2003, moreover, 45 C.F.R. Part 92 (rather than Part 74) was made applicable to entitlement grants such as Medicaid. 68 Fed. Reg. 52,843 (Sept. 8, 2003).

order to meet a non-federal share requirement. CMS's State Medicaid Manual (at section 2600 and 2600.1) merely requires a state to certify that state and local funds are available to cover the non-federal share of its projected expenditures.

7. CMS's reliance on recent decisions of the Eighth Circuit and the Board is misplaced.

CMS sought and received an opportunity to submit an additional brief in this case to address what it said were two recent decisions supporting the disallowance: the Eighth Circuit Court of Appeals decision in Minnesota v. Ctrs. for Medicare & Medicaid Services, and this Board's decision in Alaska Dept. of Health and Social Services, DAB No. 2103 (2007), *reconsideration denied*, Ruling No. 2008-1, dated October 15, 2007.

These cases are both distinguishable, however. The Eighth Circuit decision upheld CMS's disapproval of a State plan amendment in which Minnesota proposed a third supplemental payment to county nursing homes. CMS based its disapproval on the requirement in section 1902(a)(30)(A) of the Act that payments for care and services under the State plan be consistent with "efficiency, economy, and quality of care." The key legal issue in the case was whether the fact that the proposed supplemental payments would not cause the total aggregate payments to exceed the applicable UPL was sufficient to show that the payments met the requirements of section 1902(a)(30)(A) of the Act. CMS is not relying on section 1902(a)(30)(A) for the disallowance here, however. Moreover, whereas here CMS relies primarily on the use of intergovernmental transfers from the counties that owned the nursing homes, the proposed hearing decision adopted by the CMS Administrator and appealed to the Eighth Circuit said that "the State's use of IGTs [intergovernmental transfers] was not the basis for disapproval" of the plan amendment at issue there. CMS Ex. 11, at 5; see also MN Ex. 7 (Decision of the Administrator) at 6-7, 13.

Moreover, the court found that CMS properly disapproved the proposed State plan amendment based on Minnesota's failure to provide information requested by CMS "regarding the ultimate use of the Medicaid funds requested by the state, including the use of the funds by the county-owned nursing homes." 495 F.3d at 999. Here, however, CMS approved the State plan amendment at issue (providing for the supplemental payments authorized by State law in 2002). CMS does not allege that Minnesota failed to provide all requested information prior to that approval, and Minnesota here provided evidence that the State supplemental

payments were applied to the costs of providing nursing facility services, consistent with the approved State plan.

In sum, the disallowances here present different legal issues and different facts than those addressed in the Eighth Circuit decision.

The Board's decision in Alaska is also distinguishable. In that case, CMS raised no issue about whether funds transferred to a state from a unit of local government were a protected intergovernmental transfer. The basis for the Board's decision in Alaska was that the state's claims were not for supplemental payments to private hospitals authorized by the State plan as reimbursement for inpatient hospital services, but that, instead, under the agreements between the State and the hospital, the funds were used for other types of services, not covered by Medicaid, or for an "administrative fee." As CMS points out, in rejecting Alaska's argument that it had no notice that its arrangements were not permissible, the Board did cite to a statement in the preamble to the 2001 rule implementing changes to the UPLs that it was the agency's intent that under the new UPL regulations Medicaid payments claimed as nursing home or other institutional services expenditures "will in fact be paid to and retained by those facilities to offset the costs they incurred in furnishing Medicaid services to eligible individuals." Alaska at 7, citing 66 Fed. Reg. at 3175-76. That statement, however, appeared in a discussion of the diversion of Medicaid funds to non-Medicaid purposes, a key issue in Alaska. As discussed above, there was no such diversion here. Moreover, the Board specifically stated in Alaska that if a provider "has applied non-Medicaid funds to cover the costs of services to Medicaid eligibles and is entitled to additional retrospective payments under a State plan for those services, the additional funds become the [provider's] funds to disburse for whatever purposes are consistent with its governing policies." Alaska at 23. This describes the situation here, where the State supplemental payments were used to reimburse the counties for costs associated with furnishing services to Medicaid eligibles in the nursing homes. Thus, CMS's reliance on Alaska is also misplaced.

Conclusion

For the foregoing reasons, we reverse the disallowance in full.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Judith A. Ballard
Presiding Board Member