Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

SUBJECT: Minnesota Department of Human Services
Docket Nos. A-07-51
A-07-80
A-07-121
Decision No. 2122

DATE: October 25, 2007

DECISION

The Minnesota Department of Human Services (Minnesota, State) appealed determinations by the Centers for Medicare & Medicaid Services (CMS) disallowing a total of $5,094,000 in federal financial participation (FFP) that Minnesota claimed under the Medicaid program for the period July 1, 2005 through December 31, 2006. Based on our de novo review, we find that the factual premises on which CMS based its disallowance 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 analysis and background.

Summary

Minnesota claimed FFP for payments made to Metropolitan Health Plan (MHP) for capitation payments for managed care services to be provided to Medicaid eligible enrollees under CMS-approved waivers or state plan provisions. MHP is a non-profit entity, established and operated by Hennepin County, Minnesota, that qualifies as a managed care organization (MCO). CMS disallowed what it said was the part of the capitation payments intended to cover graduate medical education (GME) costs. CMS found that MHP, after receiving the monthly capitation payments, paid the amount intended to cover GME costs to Hennepin County Medical Center (HCMC), a hospital operated by Hennepin County, and that HCMC then returned those funds to the State. CMS asserts, among other things, that Minnesota should have assured that MHP retained the funds, and that, instead, the funds were transferred to HCMC, which then transferred the funds back to the State to

use for non-Medicaid purposes. According to CMS, the payments from MHP to HCMC were donations and the payments to Minnesota from HCMC were applicable credits, and, therefore, Minnesota's expenditures had to be reduced accordingly. CMS also argues that, since the GME funds were returned to Minnesota, either the payment rates were not actuarially sound or MHP did not actually receive the actuarially sound amount.

Minnesota argues that the payments to MHP were made in accordance with the CMS-approved waivers (and the CMS-approved contract with MHP) to recognize higher than usual costs of GME for MHP enrollees, as determined through an actuarially sound method. Minnesota also argues that it was not required to offset the payments from HCMC to the State against its Medicaid expenditures because those payments constituted protected intergovernmental transfers under section 1903(w)(6)(A) of the Act, since they were derived from local property taxes, as required by State law. Minnesota asserts that CMS is retroactively applying new restrictions on intergovernmental transfers published in 2007, contrary to both the Administrative Procedure Act and legislation precluding CMS from applying those restrictions. CMS responds that it is basing the disallowance on existing law, specifically, sections 1903(a)(1) and 1903(m) of the Act and applicable cost principles.

Based on our de novo review of the record, we reverse the disallowance since the record does not support the factual findings on which the disallowance determinations relied. First, CMS's assertion that the funds paid to MHP were returned to the State by HCMC is not supported by the record. Instead, the payments from HCMC to the State were mandated payments, from a unit of local government, and CMS now concedes that the funds transferred were derived from local property taxes. This fact is not irrelevant, as CMS now suggests. As the disallowance letter acknowledges (and other CMS statements confirm), section 1903(w)(6) protects intergovernmental transfers derived from local property taxes from treatment as either impermissible donations or applicable credits. Moreover, the amounts transferred from HCMC to the State were not diverted to non-Medicaid purposes, but were required under State law to be appropriated to the administrative control of the State Medicaid agency to be used for Medicaid purposes. The funds transferred from HCMC to Minnesota met all applicable requirements to qualify as the non-federal share of Medicaid expenditures.

Minnesota also established that it is not reasonable to infer that the payments to MHP were not actuarially sound merely because MHP made payments to HCMC, which made intergovernmental

transfers. In proposing the GME payment amount, Minnesota provided assurances from a qualified actuary, supported by documentation and accepted by CMS, that the capitation payments, including the adjustment for GME costs, were actuarially sound. Also, Minnesota's evidence shows that HCMC in fact incurs higher GME costs than other hospitals, and CMS provided no evidence to the contrary. Traditionally, GME costs are recognized in rates for services provided by teaching hospitals such as HCMC, and the payments to HCMC from MHP to recognize those costs were consistent with the terms of the approved waivers, the approved contract with MHP, and applicable CMS policy. CMS's reliance on a recent court decision and a recent Board decision to support its position is misplaced since those cases are distinguishable.

Since we conclude that the CMS disallowances were based on erroneous factual premises, we do not reach Minnesota's argument that CMS is improperly applying new policy retroactively.

Legal Background

The federal Medicaid statute, title XIX of the Social Security Act (Act), provides for joint federal and state financing of medical assistance for certain needy and disabled persons. Act §§ 1901, 1903.[1] Each state that chooses to participate administers its own Medicaid program under broad federal requirements and the terms of its own "plan for medical assistance," or state plan, which must be approved by CMS on behalf of the Secretary of Health and Human Services. Act § 1902; 42 C.F.R. §§ 430.10-430.16. Once the state plan is approved, a state becomes entitled to receive federal reimbursement, or "federal financial participation" (FFP), for "an amount equal to the Federal medical assistance percentage . . . of the total amount expended . . . as medical assistance under the State plan." Act § 1903(a). Section 1905(a) of the Act defines the term "medical assistance" as "payment of part or all of the cost" of specified services and care when provided to Medicaid-eligible individuals under the state plan.

Capitation payments made to managed care organizations pursuant to an approved waiver may also be considered "medical assistance"

[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.

for purposes of reimbursement under section 1903(a)(1) of the Act. Act §§ 1115(a)(2), 1915(c)(1). State waiver programs must be approved by CMS. In addition, states may now operate managed care programs under a state plan amendment approved under section 1932 of the Act, without obtaining a waiver, if the requirements of section 1903(m) are met.

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 percent to 83 percent of the cost of medical assistance, depending the state's per capita income and other factors. 42 C.F.R. § 433.10 (2001). Minnesota's FMAP during the relevant time period was 50%. CMS Br. at 5. 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 (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 impermissible types of taxes and donations.[2] Section 1903(w)(6) prohibits the Secretary from restricting states' use of certain state and local tax funds, in the form of an intergovernmental transfer or certified public expenditures, as the state's non-federal share and provides that the funds that may not be restricted shall not be considered to be an impermissible tax or donation.

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 certain Medicaid services by 42 C.F.R. § 447.272.[3] However, neither section 1902(a)(30)(A) of the Act

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[2] 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).

[3] For each type of health care facility (i.e.,

(continued...)

nor the UPLs in 42 C.F.R. Part 447 apply to payments to MCOs, which are subject to different safeguards. See 67 Fed. Reg. 40,989, 40,991 (June 14, 2002).

Specifically, section 1903(m) of the Act provides:

> (2)(A) . . . no payment shall be made . . . to a State with respect to expenditures incurred by it for payment (determined under a prepaid capitation basis or under any other risk basis) for services provided by an entity . . . unless –-
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> * * *
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> (iii) such services are provided for the benefit of individuals eligible for benefits . . . in accordance with a contract between the State and the [managed care] entity . . . under which prepaid payments to the entity are made on an actuarially sound basis . . . .

The Department has implemented this provision through regulations at 42 C.F.R. Part 438. 42 C.F.R. § 438.1(b). The CMS Regional Office must review and approve all MCO contracts. 42 C.F.R. § 438.6(a). When the contract is a risk contract, payment is made using capitation rates that must be actuarially sound. 42 C.F.R. § 438.6(c)(2). A "capitation payment" is --

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

42 C.F.R. § 438.2. A capitation payment is made to an MCO for each individual enrolled under the managed care contract. 42

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[3](...continued)
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. Within each group of facilities, the regulation calls for separate aggregate UPLs to be calculated for state government-owned or operated facilities, non-state government-owned or operated facilities, and privately-owned and operated facilities. Id.

C.F.R. § 438.2. The regulations define the term "actuarially sound capitation rates" and specify the elements a state must apply in setting rates (or explain why they are not applicable) and the documentation a state must provide to support the rates set. 42 C.F.R. § 438.6(c). The regulations also address "special contract provisions," which also must be "computed on an actuarially sound basis." 42 C.F.R. § 438.6(c)(5). These regulations contain the following requirement:

> If a State makes payments to providers for graduate medical education (GME) costs under an approved State plan, the State must adjust the actuarially sound capitation rates to account for the GME payments made on behalf of enrollees covered under the contract, not to exceed the aggregate amount that would have been paid under the approved State plan for FFS [fee-for-service]. States must first establish actuarially sound capitation rates prior to making adjustments for GME.

42 C.F.R. § 438.6(c)(5)(v). Under a risk contract, the total amount the state pays to an MCO for carrying out the contract provisions is a medical assistance cost, and FFP is available for periods during which the contract meets the requirements of part 438 and is in effect. 42 C.F.R. §§ 438.802, 438.812.

Grants to States, including Medicaid, are subject to the cost principles in Office of Management and Budget (OMB) Circular A-87. 45 C.F.R. § 92.22(b). 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.[4]

Minnesota's Managed Care Program

Minnesota operates several managed care programs under federal waivers or as part of its state plan. Minnesota's managed care program for individuals under age 65 is known as the Minnesota's Prepaid Medical Assistance Project Plus (PMAP+) and is operated under Waiver Number 11-W-00039/5, approved by CMS under section 1115 of the Act. Under a separate section 1915b waiver, Minnesota operates managed care for seniors in a program called

[4] 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).

Minnesota Senior Care. Affidavit of Sandy Burge (Burge Aff.), ¶¶ 3, 4.

MHP is one of the MCOs that has a contract with Minnesota to provide managed care services to Medicaid enrollees. MHP is an enterprise initiative of Hennepin County and a not-for-profit, state-certified health maintenance organization. Id., ¶ 5. MHP was established in 1983 to provide the traditional patients of HCMC and community clinics with access to managed care. CMS Ex. 3. HCMC is a teaching hospital operated by Hennepin County and provides GME that includes eight free-standing residency programs for 280 resident physicians. MN Reply Br. at 5, n. 4.

In 2001, the Minnesota Legislature enacted a law providing for an increase in the capitation payments made to the MHP in recognition of higher than average GME costs. 2001 Minn.Laws, 1st Sp.Sess., ch. 9, art 2, sec. 45. This law increased MHP's annual capitation payments by approximately $6,800,000 annually. Since then, Minnesota has paid MHP the increased capitation rates pursuant to its federally-approved waivers and managed care contracts. Burge Aff., ¶ 6. The approved GME adjustment amounts vary according to the age and category of enrollee. See, e.g., Burge Aff, Ex. E, App. II-A (2006 rates).

Starting in 2001, Hennepin County was required to make payments of $2,066,000 per month as part of that county's contribution toward the non-federal share of medical assistance expenditures, an increase of $566,000 per month (or $6,792,000 per year) over the $1,500,000 per month previously required. CMS Ex. 4, at 1. Since August 1, 2005, Minnesota law has required Hennepin County to make monthly payments to the State in the amount of $566,000, as part of that county's contribution toward the non-federal share of medical assistance expenditures. Minn. Stat. § 256B.19. In 2005, CMS's Chicago Regional Office conducted a review of Minnesota's supplemental payments to hospitals and payments for medical education made in fiscal years 2003 and 2004. In early 2005, Minnesota was asked to provide detailed information regarding its capitation payments, including information on transfers and the source of payment for the non-federal share of Medicaid expenditures. Affidavit of Ann Berg (Berg Aff.) ¶¶ 3,4. In response to this request and similar requests from CMS as part of its review of the Minnesota Senior Care waiver, Minnesota provided CMS with information about Minnesota's capitation payments for GME and the flow of funding for the payments. Id., ¶ 6. One of the funding flow charts prepared for the waiver and submitted to the regional reviewer showed funding of the non-federal share of $6.8 million in payments for GME

coming from Hennepin County flowing through the State to MHP and then to providers under contract with MHP. Id., Ex. A, at 5.

CMS approved the Minnesota Senior Care waiver on March 16, 2005. Burge Aff., ¶ 6. On May 3, 2005, CMS approved Minnesota's request for a three-year extension of the PMAP+ waiver, including the GME payments, for the period July 1, 2005 through June 30, 2008. Id., ¶ 7, Ex. A. On September 14, 2005, CMS approved the Operational Protocol for that waiver, setting forth the GME payments, including the payment to MHP. Id., ¶ 7, Ex. C.

Minnesota also submitted its annual managed care contracts with MHP to CMS, and each contract (including the contracts for calendar years 2005, 2006, and 2007) identified the adjustment to the capitation rate for MHP to recognize its higher GME costs. Id., ¶ 9; Affidavit of Karen Peed (Peed Aff.), ¶ 2. Minnesota also submitted with each contract a checklist (called a "Financial Review Checklist for At-Risk Capitated Contracts Rate Setting") that addressed each of the required elements for approval and specifically mentioned the GME adjustment. Burge Aff., ¶ 10 and Ex. F, at 8; Ex. G, at 8. CMS approved each contract, notifying Minnesota that the contracts with MHP meet "applicable Federal contracting requirements of 42 Code of Federal Regulations 438 including the capitated ratesetting requirements . . . ." Id., ¶ 11, Exs. H, I; Peed Aff., ¶ 2.

CMS's 2005 Review

In September 2005, CMS's Regional Office sent Minnesota a Draft Report of Financial Management Review of Medical Education Payments and Supplemental Payments to Inpatient Hospitals, addressing payments for State fiscal years 2003 and 2004. Berg Aff., ¶ 7, Ex. B. The Draft Report found that "the State is making payments to the Metropolitan Health Plan which are not entirely true expenditures" based on the following rationale:

> Our review disclosed that the State made additional monthly payments of $566,000 to the Metropolitan Health Plan in 2004. However, it was discovered that the entire amount of the payment was IGT'd from HCMC to the State in order for the payment to be made. This is in contradiction of Section 1903(w)(6) of the Social Security Act, which limits transfers of these types to the non-Federal share of the payment amount. Also, since the entire amount of the payment was given to the State, the payment did not reflect the net expenditure by the State.

Id. at 4. The Draft Report did not propose a disallowance, but recommended that Minnesota "should no longer claim FFP for the portion of the payments to the Metropolitan Health Plan for which more than the non-Federal share of such payment is being IGT'd from HCMC to the State." Id. The Draft Report did not cite any legal authority for the conclusions that section 1903(w)(6) limits transfers to the non-federal share of a particular payment and that the payment did not reflect the net expenditure.

Minnesota responded to the Draft Report by letter dated October 28, 2005. Berg Aff., Ex. C. Among other things, Minnesota explained that State law required Hennepin County to pay the State $566,000 per month as part of its share of the non-federal share of medical assistance costs in general. Minnesota also pointed out Minnesota did not make "additional monthly payments" to MHP each month, but instead "pays a per capita amount per individual enrolled in the [Medicaid] program, which varies based on age, gender, and other factors." Id. at 2.[5] The total monthly capitation payments to MHP are approximately $6 million per month, Minnesota said. Id. The CMS Regional Office did not respond to Minnesota's October 28, 2005 letter or issue a final review report.

The Disallowance Determinations

On December 6, 2006, the CMS Regional Administrator issued a notice disallowing $3,296,000 in FFP Minnesota claimed for capitation payments that it made to MHP from July 1, 2005 through June 30, 2006. Minnesota appealed (Docket No. A-07-51). Subsequently, the Regional Administrator issued two more disallowances, one for $849,000 in FFP for the period July 1, 2006 through September 30, 2006, and one for $849,000 in FFP for the period October 1, 2006 through December 31, 2006. Minnesota appealed (Docket Nos. A-07-80 and A-07-121), and the Board consolidated the three cases.

The basis for the disallowances was that the amount disallowed "represents the amount of the capitation payment made to MHP that

[5] The significance of this variation is that the total amount paid to MHP each month as a result of the GME add-on would vary (unless the ages and categories of Medicaid enrollees in MHP each month stayed exactly the same). There is no indication in the Draft Report that the reviewer examined what part of the actual capitation payments made to MHP in 2003 to 2004 each month represented the GME add-on, nor that CMS made such an analysis for the disallowance period at issue.

is returned by MHP to Hennepin County Medical Center, the entity that funded the capitation payment" and that, as a result, "we have concluded that there was no actual expenditure eligible for federal financial participation under section 1903(a)(1) or 1903(m) of the Act. Disallowance Ltr. of 12/8/2006, at 1. The disallowance letter stated that an "expenditure" does not arise within the meaning of section 1903(a)(1) of the Act from a transaction that is in the nature of a loan.

According to the disallowance letter, the "arrangement that is described above, in which part or all of the claimed payment is returned without consideration, appears to be in the nature of a loan rather than a payment that is retained by the service provider for its own purposes," and Minnesota "has not established that the returned funds were a payment for value received, were pursuant to a permissible tax, **or** were a protected intergovernmental transfer made from State or local tax revenues that were made available to pay for the State share of Medicaid expenditures." Id. (emphasis added). The letter cited OMB Circular A-87 for the proposition that costs must be net of "applicable credits" and that no profit is intended under federal grants. "Since in this case the county is receiving funds from the health plan as a result of the transaction of the State paying the health plan," the letter stated, "these payments constitute an 'applicable credit' that must be used to offset allowable Medicaid costs before seeking FFP (See DAB Decision 779)" and also the financing arrangement "illustrates an unallowable profit that flows to the State agency under its grant program." Id. at 2. Finally, the letter concluded that, "[s]ince MHP did not retain the full capitation rate claimed as an expenditure by the State, it does not appear that the full capitation payment amount in the contract was required under an actuarially sound basis," as required by section 1903(m)(2)(A)(iii) of the Act, or, alternatively, "MHP was not actually receiving that actuarially sound rate under the contract because it was required to return some or all of the rate." Id.

Minnesota's appeal

On appeal, Minnesota asserts that the payments from HCMC to Minnesota were "derived from local taxes" since State law in effect during the disallowance period required that any intergovernmental transfer from a county entity come from local property tax revenue. See Minn. Stat. § 256B.20(1). Minnesota also cites evidence that HCMC is a division of Hennepin County with access to county tax funds and that the transfers from HCMC to the State came from a fund that includes local property taxes. Berg Aff. ¶ 6; CMS Ex. 6. Thus, Minnesota argues, HCMC's monthly

payments to the State are protected intergovernmental transfers under the provisions of the Act and CMS regulations addressing non-federal share, not applicable credits or unallowable profit. Minnesota further argues that its evidence shows that the capitation payments it made to MHP were actuarially sound and that nothing in section 1903(m)(2)(A)(iii) of the Act or its implementing regulations imposes a requirement that an MCO "retain" the capitation payment for it to be considered actuarially sound. Minnesota also disputes CMS's assertion that the transfers from HCMC to the State were diverted to non-Medicaid purposes. Minnesota provided evidence that State law required that the amounts appropriated for its "medical assistance fund" include all of the amounts from intergovernmental transfers. Affidavit of Marty L. Cammack (Cammack Aff.) ¶ 4.

According to Minnesota, CMS's disallowance is based on a new legislative rule, not promulgated through notice and comment rulemaking, that is a significant departure from CMS's former, long established and consistent practice.[6] Minnesota argues that CMS is imposing, without rulemaking or adequate notice to states, a restriction on intergovernmental transfers inconsistent with section 1903(w)(6) of the Act and is imposing a restriction on capitation payments that is inconsistent with section 1903(m) of the Act.

While Minnesota's appeal was pending, this Department published a proposed and then an interim final rule that would, among other things, limit Medicaid reimbursement to providers operated by

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[6] Minnesota cites a statement made by a CMS Deputy Administrator in response to an Office of Inspector General (OIG) report as evidence that CMS has itself admitted that rulemaking would be necessary before CMS could require states to assure that local government providers retain the Medicaid payments that they receive. MN Br. at 20-21, citing MN Ex. A. Minnesota also points to a Government Accountability Office (GAO) report to Congress in 2004 that questioned some Medicaid funding practices, but noted that current law does not limit payments to public providers to actual costs. Id. at 21, citing MN Ex. B. Minnesota also points out that CMS has previously declined in several rulemakings to regulate intergovernmental transfers, determining instead to address what it saw as excessive payments to public providers by making changes to the UPLs because "States, counties, and cities have developed their own unique arrangements for sharing in Medicaid costs." Id. at 22, quoting 65 Fed. Reg. 60,151.

units of government to actual costs and provide that, in general, payment methodologies must permit a provider to receive and retain the full amount of the total computable payment for services furnished under the approved State plan or waiver provisions. 72 Fed. Reg. 2236 (Jan. 18, 2007); 72 Fed. Reg. 29,748 (May 29, 2007). The Department determined to make this rule effective prospectively, on July 30, 2007 (except that the actual cost provision would not apply to non-institutional providers until after a transition period). Id. Before the effective date, however, Congress passed a law, effective May 25, 2007, precluding the Secretary from taking "any action (through promulgation of regulation, issuance of regulatory guidance, or other administrative action)" to "finalize or otherwise implement" the provisions of the January proposal or similar provisions or to "promulgate or implement any rule or provision restricting payments for graduate medical education under the Medicaid program." Pub. L. 110-28, § 7002(a). Thus, Minnesota now also argues that the disallowance is inconsistent with this law, because CMS is applying the provisions of the new rule.

CMS's Position on Appeal

CMS asserts, in response, that it is not applying the new rule but is relying instead on the law as in effect during the disallowance period, specifically, sections 1903(a)(1) and 1903(m) of the Act and OMB Circular A-87. CMS says this reliance is consistent with the new statutory restriction, which does not prohibit the Secretary from enforcing the law in effect on the date of enactment.

According to CMS's brief, "it is irrelevant that, under State law, Hennepin County's return payments to the State are derived from local property taxes." CMS Br. at 17. CMS says that the payments were derived from a provider-related donation, and this is controlling. CMS also says now that it is irrelevant that State law requires use of intergovernmental transfers from local governments for Medicaid purposes. CMS continues to rely on OMB Circular A-87 for the proposition that Minnesota received an "applicable credit" and an unallowable profit.

CMS does not deny that it approved Minnesota's waivers and the MHP contracts providing for the GME adjustments to the capitation payments, but says CMS did not have the same information then that it has now about the transfers. CMS's initial brief also says CMS is relying on the terms of MHP's approved contracts as requiring MHP to "retain" the part of the capitation payments that represents the GME adjustment (although later briefs modified this position). CMS also argues that its position here

is supported by the Eighth Circuit's decision in a related Minnesota case and the Board's decision in an Alaska case.

Analysis

As noted above, we do not reach the issue of whether CMS here is improperly applying new policy retroactively since we conclude that CMS's disallowance determinations were based on erroneous factual premises and that the facts now conceded by CMS are not irrelevant under existing law, as CMS now argues.

Below, we first address why the fact that the funds paid from HCMC to the State were derived from local property taxes precludes treatment of the payment as an applicable credit or as a donation. We then address the issues of whether the payments from Minnesota to MHP were actuarially sound and what was required by the contract Minnesota had with MHP. We also explain why we disagree with CMS that Minnesota profited from the transactions or diverted funds to non-Medicaid purposes. Finally, we explain why we determine that CMS's reliance on the recent court and Board decisions is misplaced.

> *The payments from HCMC to Minnesota were protected intergovernmental transfers, properly recognized as non-federal share.*

Section 1903(w) of the Act 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.
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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 also passed a provision requiring that CMS 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).

As a result of these statutory provisions, this Department 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, so long as the 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 . . . ." 42 C.F.R. § 433.51; see 57 Fed. Reg. 55,118 (Nov. 24, 1992). This is the rule applicable to the disallowance period.

Based on the record before us, we find that the transfer from HCMC to Minnesota is a protected intergovernmental transfer and qualifies as the non-federal share under the applicable regulation. It is undisputed that HCMC, as an entity of Hennepin County, is a "unit of government" within the meaning of section 1903(w)(6). See also, 72 Fed. Reg. at 29,832 (recognizing that a county hospital qualifies as a unit of local government, regardless of its status as a service provider). Moreover, as noted above, in response to the State's assertions and evidence regarding the source of the transfer from HCMC to the State, CMS concedes that the "payments to the State are derived from local property taxes." CMS Br. at 17. Further, there is no dispute that HCMC funds were public funds, and CMS does not deny that State law required the funds transferred from HCMC to be included in the State appropriation for medical assistance. This last fact is not irrelevant, as CMS now alleges, but shows that the funds were transferred to the administrative control of the Medicaid State agency, as required by section 433.51 of the regulations governing non-federal share. It also shows that the funds were not diverted to non-Medicaid purposes, contrary to what CMS's arguments suggest.

CMS now suggests that, despite its concession that the transfer from HCMC was derived from local property taxes, we should find that the HCMC payment to Minnesota was not a protected intergovernmental transfer. CMS points out that section 1903(w)(6)(A) of the Act states that "the Secretary may not restrict States' use of funds where such funds are derived from State or local taxes . . . unless the transferred funds are derived by the unit of government from donations . . . that would

not otherwise be recognized as the non-federal share under this section." According to CMS, the "unless" clause means that section 1903(w)(1)(A)(on provider-related donations) "trumps" section 1903(w)(6)(A), and therefore, section 1903(w)(6)(A) is irrelevant. CMS Reply Br. at 10-11. As we discuss in the next section, however, the record shows that the payment from MHP to HCMC was a contractual payment to recognize HCMC's expected costs for GME, so CMS's characterization of that payment (in the disallowance determination) as a voluntary donation or a loan, rather than a payment for value received, is not warranted on the record here. Perhaps in recognition that MHP did receive value from HCMC in the form of hospital services, CMS's reply brief now asserts that the payment from HCMC to Minnesota was a "voluntary donation."[7] Id. That payment, however, was required by State law.

In any event, CMS's position in its reply brief that the provider-related donations provisions in section 1903(w)(1)(A) "trump" section 1903(w)(6) has no merit. CMS does not explain how the transfers here could have been both derived from local property taxes and derived from donations, nor cite any regulation restricting intergovernmental transfers CMS would consider to be derived from both sources. As Minnesota points out, moreover, section 1903(w)(6)(B) of the Act provides that "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." Yet, CMS does not attempt to reconcile that provision with its position that the provider-related donation provisions "trump" section 1903(w)(6)(A). Finally, CMS's position is inconsistent with this Department's explanation of section 1903(w)(6), and with the Regional Administrator's disallowance determination. The preamble to the 2007 final rule explains that --

> the purpose of the provider tax and donation restrictions in general was to prevent situations in which the health care provider contributed a non-federal share of claimed expenditures but was essentially repaid through Medicaid or other payments. The provision at section 1903(w)(6)(A) of the Act is based on the

[7] We note that, while CMS cites the regulatory definition of "provider-related donation," it provides no analysis of its regulations governing when donations must be used to reduce Medicaid expenditures to explain how the requirements would apply to the alleged donation here to make it impermissible.

> rationale that such repayment does not occur when the health care provider uses state or local tax funding for its contribution.

72 Fed. Reg. at 29,758 to 29,759. Also, the preamble to the proposed rule describes section 1903(w)(6)(A) as an "exception" to the provider-related donation provisions. 72 Fed. Reg. 2236, 2238 (Jan. 18, 2007). Viewing section 1903(w)(6)(A) as an exception to the provider-related donation provisions (which gives effect to section 1903(w)(6)(B)) cannot, however, be reconciled with the position in CMS's reply brief that the provider-related donation provisions "trump" section 1903(w)(6)(A) and make it irrelevant. Moreover, the Regional Administrator's initial disallowance determination clearly indicated that, if Minnesota showed either that there was "value received" (i.e., no donation) or that the funds were a protected intergovernmental transfer from local tax revenues that were made available to pay for the State share of Medicaid expenditures, CMS would consider the requirements of section 1903(a)(1) to be met. Disallowance Ltr. of 12/8/2006, at 1. Under CMS's new position, any finding of an impermissible provider-related donation would be controlling.

Since we find that the payments to Minnesota from HCMC were protected intergovernmental transfers (and therefore CMS could not restrict their use), we also reject CMS's arguments that the State's capitation payments to MHP had to be offset by the amount transferred by HCMC to the State because section 1903(a)(1) of the Act provides FFP only for "net expenditures" after offset of any "applicable credit" under OMB Circular A-87. As Minnesota points out, this Board said in Georgia that if a payment to a state was a protected intergovernmental transfer then it would not properly be treated as an "applicable credit."[8]

Ultimately, CMS's argument boils down to the continued assertion that there was a "recycling" of funds because the payments from the State were "associated with" the payments to the State. CMS says that, "regardless of the source of Hennepin County's payments to Minnesota, the fact remains that MHP passes its

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[8] This conclusion in Georgia was based on the Board's decision in Oregon Dept. of Human Resources, DAB No. 1298, at 10 (1992), which in turn noted that CMS's predecessor agency (HCFA) 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." CMS does not argue that this conclusion was in error.

$566,000 payment for higher medical education costs to the county-owned hospital, HCMC, and State law requires the county to return that very amount to the State." Id. CMS points to county records describing both a credit and a debit in the amount of $566,000 as "MA IGT2 Fund Entries for MHP" as evidence that the payments received from MHP were "associated" with the County's payment to the State. CMS Br. at 12, citing CMS Ex. 10. CMS also points out that a response to questions from the then Manager of the Federal Relations Unit in Minnesota's Office of the Medicaid Director described HCMC's $566,000 monthly payment as the "medicaid education payment." Id., citing Berg Aff., Ex. A, at 7.[9] This evidence might raise a question about the source of the transfers from HCMC to Minnesota, but CMS's concession that the transfers were "derived from local property taxes" makes it unreasonable to continue to infer from this evidence that HCMC was simply "returning" the GME funds back to the State, rather than retaining them to cover GME costs and making a protected intergovernmental transfer.[10] While "association with" Medicaid

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[9] That the two payments were associated in the minds of county and state officials is not surprising, given that the Minnesota legislature made a corresponding increase in the amount of the non-federal share Hennepin County was required to provide at the same time it was proposing to recognize the higher than usual GME costs being incurred and that, but for the recognition of these costs in the capitation rates, the County would have had to cover them. Also, since both MHP and HCMC are County entities, both transactions are reasonably characterized as intergovernmental transfers (or IGTs).

[10] We also note that the county records for 2005 on which CMS relies for its assertion that HCMC was "returning" the GME payments to the State show that, for some months, HCMC made the intergovernmental transfer to the State before it received the GME payment from MHP. CMS Ex. 5. CMS submitted no records for the 2006 quarters at issue here. In any event, however, having conceded that the funds transferred from HCMC to the State were derived from local property taxes, CMS cannot reasonably assert that the funds HCMC received from MHP each month were the same funds that HCMC transferred to the State. We also note that CMS's "recycling" argument assumes, without any support, that $566,000 of the total capitation payments MHP received each month represented GME adjustments. This assumption is not warranted since the adjustment amounts varied according to the age and category of enrollee. See, e.g., Burge Aff., Ex. E, App. II-A (2006 rates). Variations in the numbers and types of enrollees

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payments would be relevant to whether HCMC's payment to the State could be treated as either an applicable credit or a provider-related donation, it is not enough to justify such treatment when, as here, the payment to the State is a protected intergovernmental transfer.

Finally, CMS's apparent position that mere association of the payments from the State to MHP with the payments from HCMC is sufficient to render them unallowable is inconsistent with past CMS actions. First, while CMS claims that it did not have complete information prior to re-approving the waivers and MHP contracts under which the GME payments were made, Minnesota provided undisputed evidence that it had timely submitted to CMS a chart about the GME payment to MHP that shows an intergovernmental transfer from Hennepin County as the source of the non-federal share of the GME adjustment. Berg Aff. ¶ 6 and Ex. A, at 5. Yet, CMS approved the waivers and twice approved the contract with MHP setting capitation rates that included the adjustment for GME. Second, the CMS reviewer in his Draft Report did not state that the "association" of the two payments required a reduction in expenditures claimed, but only questioned whether more than the non-federal share of the amounts MHP was paid for GME could qualify as a protected intergovernmental transfer. Third, under the applicable, existing regulations on non-federal share, CMS has approved state plans making supplemental payments to a public provider contingent on the public provider making an intergovernmental transfer to cover the non-federal share of the payments. See, e.g., Georgia, supra. Finally, while the regulations governing managed care specifically precluded states from funding incentive payments to MCOs from intergovernmental transfers, the regulations did not so limit payments to MCOs for GME, even though CMS was clearly was aware that states might use such transfers to fund the payments and indicated that it planned "to study existing Medicaid GME payment arrangements and may issue additional policies in the future." 67 Fed. Reg. at 41,004-05.

In sum, since the payments from HCMC to Minnesota were protected intergovernmental transfers, the State's expenditures for medical assistance may not properly be reduced on the theory that there was an applicable credit or a provider-related donation.

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[10](...continued)
in any month would thus affect how much MHP actually received each month as a result of the GME adjustments.

> *The adjustments to the capitation payments to recognize higher than usual GME costs were actuarially sound, and the payments from MHP to HCMC under their agreement for services are consistent with the approved waivers and MCO contracts.*

It is undisputed here that the monthly payments Minnesota made to MHP were capitation payments, at the approved capitation rates, for Medicaid eligible individuals who were MHP enrollees. CMS determined nonetheless that the payments did not represent valid Medicaid expenditures based on the rationale that, since MHP could afford to make the monthly payments to HCMC and HCMC could transfer an equal amount of funds to the State, this means that the capitation payments were not "actuarially sound."

The Part 438 regulations define "Actuarially sound capitation rates" as rates that–

> (A) Have been developed in accordance with generally accepted actuarial principles and practices;
> (B) Are appropriate for the populations to be covered, and the services to be furnished under the contract; and
> (C) Have been certified as meeting the requirements of this paragraph (c), by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

42 C.F.R. § 438.6(c)(1)(i). As indicated above, adjustments for GME are considered "special contract provisions." Thus, while the capitation rate calculated before any adjustment must be actuarially sound, the adjustments must also must be "computed on an actuarially sound basis." 42 C.F.R. § 438.6(c)(5).

Minnesota presented undisputed evidence that it complied with the requirements of Part 438 with respect to certifying and documenting that its rates (including the GME adjustment) were actuarially sound and that CMS had approved them. (See our discussion at page 8 with citations, e.g., Burge Aff., Exs. H, I.) CMS does not challenge that evidence but now asserts that its approval is "irrelevant" because it did not then have all the information it has now about the transfer of funds.

We disagree that the CMS approval is irrelevant. In promulgating the requirements for MCOs, this Department explained that it was not applying a UPL to capitation payments because, by reviewing the process used in setting actuarially sound rates under a risk contract, CMS would fulfill its responsibilities to the fiscal

integrity of the Medicaid program. 67 Fed. Reg. at 40,991-98. Having provided by regulation what it means for capitation payments to be actuarially sound and having accepted Minnesota's documentation based on historical GME costs, CMS cannot now reasonably reject that evidence without any evaluation of what it (or other evidence based on historical costs and/or actuarial principles) in fact shows. CMS made no finding and presents no evidence that HCMC did not in fact historically incur higher than usual GME costs, nor did CMS find that, when evaluated using actuarially sound methods, those costs would not support the adjustments made to MHP's capitation rates.

CMS found alternatively, however, that, even if the capitation rate was sound, "MHP was not actually receiving that actuarially sound rate" because "MHP did not retain the full capitation rate." CMS Ex. 1, at 2. Minnesota pointed out in response that it did make the full payments to MHP and that it did not exert any administrative control over how MHP used the funds to meet its MCO contract obligations. Thus, Minnesota argued that, since there is no applicable requirement that the MCO "retain" the payments, CMS was improperly applying a new policy retroactively. CMS responded in its initial brief that its basis for saying that MHP had to retain the funds is that it was required by MHP's contracts with Minnesota. CMS Br. at 15. For this argument, CMS points to language in the contracts describing the payments as an "add-on that recognizes higher than average medical education costs that shall be retained by the MCO." See Burge Aff., Ex. D, at 3 and Ex. E, at 3. Minnesota argues that CMS's position that this description meant that MHP could not use the funds to pay a service provider is an unreasonable interpretation of the contract.

We agree that it would be unreasonable to interpret the contract as precluding the payment from MHP to HCMC, for the following reasons. First, the contract statement must be considered in context. In addition to the GME payment adjustments at issue here, Minnesota also had approval to make some payments for basic GME costs that were "carved out" of the capitation payments and placed in a trust fund (called the "MERC") to be distributed by the State to the sponsoring institutions that incurred the costs. Berg Aff., Ex. A; Burge Aff., Ex. C, at 28; Affidavit of David R. Johnson (Johnson Aff.) ¶ 3.[11] In contrast, the GME payments to

[11] Although generally a state agency must ensure that no payment is made to a provider other than the MCO for services available under an MCO contract, payments for GME are an

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MHP for the adjustment at issue here were not carved out and placed in the MERC trust fund. Minnesota presented evidence that its intent in drafting the contract was only to distinguish the two types of payments for GME. Peed Aff. ¶ 4.

Second, as discussed above, Minnesota presented evidence that its charts presented as part of the approval process showed that the additional GME payments would flow through MHP to the providers, just as the basic GME amounts put in the MERC trust fund would go to those incurring the costs, not to the MCOs. In light of this, CMS could not reasonably have thought at the time of approval that, by using the word "retain," the contract meant that MHP would not use the funds to cover providers' GME costs.

Third, capitation payments are to be based on historical fee-for-service costs of providing covered Medicaid services. GME is not itself "medical assistance." Instead, 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. See, e.g., 72 Fed. Reg. 28,930, 28,931 (May 23, 2007).[12] Thus, the expectation would be that the GME adjustments would not be retained by MHP to cover its own costs, but would be retained by MHP to reimburse the teaching hospital or hospitals that incurred the unusually high GME costs. Minnesota presented evidence that MHP paid HCMC pursuant to its provider agreement "in recognition of HCMC's higher than average GME costs." Johnson Aff. ¶ 3. CMS not only presents no evidence to the contrary, but acknowledges that "CMS has no reason to question whether HCMC incurs medical education costs." CMS Reply Br. at 3.

Finally, as Minnesota points out, CMS does not explain how a contract requirement that MHP "retain" the funds would work when, by accepting the monthly capitation payments as a prepayment, MHP becomes obligated to provide services to its enrollees, including

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[11](...continued)
exception. 42 C.F.R. § 438.60. While Minnesota opted to make other GME payments directly to other providers, rather than depending on the MCOs to make the payments, Minnesota would not have the same concern about whether MHP would pass on to HCMC amounts intended to its GME costs, given the relationship of MHP and HCMC to Hennepin County.

[12] In the cited document, CMS proposed to change this practice, but CMS specifically says here that "the propriety of claiming FFP for GME costs is not at issue." CMS Br. at 6, n. 3.

services for which it must contract with other providers. Indeed, in its reply brief, CMS now says it does not maintain that the contracts between the State and MHP prohibit MHP from paying subcontract providers for GME costs. CMS Reply Br. at 4. Instead, CMS now says that the problem is that the payments here "pertained to GME costs in name only." Id. CMS's only basis for this assertion is its view that the funds were "returned" to the State, a premise that is inconsistent with the conceded fact that the funds transferred to the State were derived from local property taxes.

Thus, we find that the payments from MHP to HCMC were consistent with the approved waiver and contracts and that CMS's reliance on section 1903(m) of the Act as a basis for the disallowances is misplaced.

CMS's arguments that FFP is available only if MHP expended the payments from Minnesota on medical education are based on erroneous premises.

CMS's brief also relies, for its position that Minnesota's payments to MHP "for GME" were not "amounts expended as medical assistance" under section 1903(a)(1) of the Act, on the dictionary definition of "expend" as "to make use of for a specific purpose; utilize." CMS Br. at 19-10, citing Merriam Webster's Collegiate Dictionary (10th Ed., 1993) at 408. CMS says that, in order to qualify for FFP, Minnesota's increased capitation payments for above-average medical costs must be 'use[d] . . . for [the] specific purpose' actually described in the approved section 1915 demonstration project, and the State's contracts with the MCO (and documents related to those contracts)." Id. at 10. CMS also says that Minnesota's suggested definition of "expenditure" (as "the act or process of paying out; disbursement; a sum paid out") ignores section 1903(a)(1), which refers to amounts "expended as medical assistance," since the funds paid MHP were intended as to be used for medical education, but were not used for that purpose.

We note that CMS has never officially adopted the definition of "expend" it now wishes us to apply (and that definition arguably conflicts with the definition of "expenditure" in the State Medicaid Manual for purposes of timely filing of claims and in Department regulations). State Medicaid Manual, 2560.4; 45 C.F.R. § 92.3 (definitions of "accrued expenditures" and "outlays (expenditures)"). Even accepting the definition CMS now proposes, however, we would not find CMS's argument persuasive.

The bases for Minnesota's claims for FFP are the sections of the Act (cited above) that provide that certain capitation payments for managed care may be considered "amounts expended as medical assistance" for purposes of section 1903(a)(1). The implementing regulations recognize the projected costs of medical education as adjustments to the amount of capitation payments, not as a separate item of covered medical assistance. Including a particular type of cost in calculating a capitation payment rate does not necessarily mean that the MCO's spending, once it has received the capitation payment, is limited to the costs recognized in setting the rate. To the contrary, the preamble to the final MCO rule recognized that the mix of services used in setting the rate might be different from the services actually provided by the MCO. 67 Fed. Reg. at 41,003. As Minnesota points out, moreover, a monthly capitation payment is made for each Medicaid enrollee, irrespective of whether that enrollee receives any services.

Finally, the undisputed evidence discussed above shows that MHP did, in fact, use the funds to recognize the GME costs HCMC was expected to incur in providing services to MHP enrollees.

The disallowed amount does not represent an unallowable profit.

CMS also found that the expenditure by Minnesota is not allowable because this Department's Guide to implement OMB Circular A-87 (referred to as ASMB C-10) states that "profit remains unallowable." CMS Ex. 1, at 2, citing ASMB C-10, at 1-6. CMS's theory that Minnesota had a profit from the "flow of funds" was initially premised on its "applicable credits" and "return of funds" theories, which we have rejected above on factual grounds.

We also note that the OMB Circular A-87 provision from which the statement in ASMB C-10 is derived states that "[p]rovision for profit or other increment above cost is outside the scope of this Circular." OMB Circular A-87, Att. A, A.1. Thus, whether a state received a "profit" under a grant program is determined by examining whether a state received more than its allowable costs. Since we find that the capitation payments to MHP did constitute net expenditures to the State allowable under section 1903(a)(1), we find no "profit" to Minnesota.

CMS's determination also suggests that Minnesota had a profit because the funds transferred from HCMC to the State went into the State's General Fund, from which the State could divert them to non-Medicaid purposes. Minnesota provided evidence, however, that the factual premise in CMS's brief is erroneous. That

evidence establishes that, under State law, funds that are appropriated to the medical assistance account to cover Medicaid expenditures must include all intergovernmental transfers local governments are required to make under state law. Cammack Aff. ¶ 4. CMS does not dispute this evidence nor provide any evidence that state law was not followed, instead calling the evidence irrelevant. Nor does CMS proffer any other basis on which we could find that Minnesota, which is the grantee here, had any profit.

CMS says here that it is not relying on the policy of its 2007 rule that providers owned or operated by governments receive no more than their actual costs of providing services to Medicaid eligible individuals. Yet, by arguing that there was no value received from MHP for its payments to HCMC, CMS also suggests that Hennepin County may have improperly profited from the payments at issue. In our view, however, the record does not support a finding of any unallowable profit to the County. The County's role here is not as a subrecipient of grant funds, but as a service provider, and the applicable rules are those governing capitation payments. Capitation payments are prepaid amounts based on estimates of costs and, while an MCO generally bears the risk that the services will cost more than the capitation payments, the regulations do not exclude the possibility that they will cost less. Nor do current rules exclude entities contracting with an MCO from receiving advance payments or from realizing some profit.

In any event, there was no finding here that in fact the County profited. While it is conceivable that the GME payment amounts projected from historical costs attributable to Medicaid patients enrolled in MHP could have been higher than the actual costs HCMC incurred in 2005 and 2006 for those enrollees (for example, if the amount of the services provided to the patients or the per-patient GME costs were reduced), CMS has provided no reason to believe there would be any significant reduction, and it is also possible the actual costs were higher than the projected amount. Moreover, CMS's disallowance effectively assumes that the <u>entire amount</u> intended to recognize GME costs is an unallowable profit -- an assumption that is wholly unwarranted given how the rates were established and approved.

CMS's reliance on recent decisions by 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 its disallowances: the Eighth Circuit Court

of Appeals decision in Minnesota v. Ctrs. for Medicare & Medicaid Servs., No. 06-3263 (8th Cir. July 31, 2007) and this Board's decision in Alaska Dept. of Health and Social Services, DAB No. 2103 (2007). These cases are both distinguishable, however.

The Eighth Circuit decision upheld CMS's disapproval of a State plan amendment in which Minnesota proposed to increase the amount of supplemental payments it made to county nursing facilities. CMS based its disapproval on 1902(a)(30)(A) of the Act, which requires 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 were within the applicable UPL was sufficient to show that they met the requirements of section 1902(a)(30)(A). CMS is not relying on section 1902(a)(30)(A) for the disallowance here, however.[13] As noted above, neither section 1902(a)(30)(A) nor the UPLs apply to capitation payments to MCOs. Instead, in implementing the MCO regulations, the Department determined that the requirement that capitation rates be actuarially sound was sufficient protection for the integrity of the Medicaid program.

In the plan disapproval case, moreover, CMS knew that Minnesota intended to fund the non-federal share of supplemental payments to nursing facilities with intergovernmental transfers from the counties that owned the facilities, but said that "the State's use of IGTs [intergovernmental transfers] was not the basis for disapproval" of the plan amendment. CMS Ex. 11 (Hearing Officer's Recommended Decision) at 5.

In any event, this case is in an entirely different posture than the plan disapproval case with respect to the facts. As CMS acknowledges, the Board's review is de novo, and we find that the facts were not as CMS found them in its disallowance determinations. In contrast, the Eighth Circuit applied a substantial evidence standard to uphold CMS's plan disapproval, primarily based on Minnesota's failure to submit information sought by CMS to assure that the payments at issue there were not excessive.

The Board's decision in Alaska is also distinguishable. In that case, CMS raised no issue about whether funds transferred to a

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[13] CMS's reliance on the Ninth Circuit's decision in Alaska Dep't of Health and Social Servs. v. Centers for Medicare & Medicaid Servs., 424 F.3d 931 (9th Cir. 2005) is misplaced for similar reasons.

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 in fact 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 2001 preamble statement to a rule implementing changes to the UPLs that stated 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. 3147, 3175-76 (January 12, 2001). That statement, however, appeared in a discussion of the diversion of Medicaid funds to non-Medicaid purposes, a key issue in the Alaska case. Here, however, the transferred funds were required to be used for Medicaid purposes and the payments to MHP (and on to HCMC) were consistent with the approved waivers and contracts. Under those contracts, moreover, MHP was entitled to receive prepaid capitation payments. Thus, MHP was not expected to have already incurred costs that the payments would "offset" – a situation different from fee-for-service payments to meet a facility's claims for services it has already provided.

In sum, CMS's reliance on these cases is misplaced.

Conclusion

For the reasons stated above, we reverse the disallowances. Based on our de novo review, we find that the factual premises on which CMS based its disallowance 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.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Judith A. Ballard
Presiding Board Member