

Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Alabama Medicaid Agency
Docket No. A-13-98
Decision No. 2716
June 30, 2016

DECISION

The Alabama Medicaid Agency (Alabama) appealed the Center for Medicare & Medicaid Services' (CMS's) determination disallowing \$72,056,075 in federal financial participation (FFP) that Alabama claimed under the Medicaid program as supplemental payments to nine county-owned, hospital-based nursing facilities during the period October 2005 through October 2007. The supplemental payments were in addition to the facilities' normal reimbursement for providing Medicaid services and were planned to represent the difference between the Medicaid reimbursement and the higher reimbursement paid under Medicare principles.

CMS disallowed the supplemental payments on several grounds, all relating to the fact that 96.5 percent of the supplemental payments to the nursing facilities in which Alabama claimed FFP were in fact removed from the nursing facilities' accounts and returned to Alabama within days after Alabama issued the payments.¹

Alabama argues that, under the applicable regulation, the funds taken from the nursing facilities could then be counted as part of the state share of Medicaid expenditures. States are required to contribute to Medicaid expenditures in order to claim FFP for the federal share in those expenditures. As we explain, States are permitted to use funds from local government entities (such as counties and county-owned healthcare providers) as a source of some of the state share of Medicaid subject to statutory and regulatory limitations.

For the reasons explained below, we conclude that, based on the transactions shown on this record, Alabama had no actual expenditures eligible for FFP in the amounts of the supplemental payments taken from the nursing facilities, and we sustain the disallowance.

¹ During the appeal, CMS reduced the disallowance to \$69,534,112, the federal share of the 3.5% of the supplemental payments not taken from the nursing facilities, on the ground those amounts were allowable Medicaid expenditures made pursuant to Alabama's state Medicaid plan.

Legal Background

The Medicaid program, established by title XIX of the Social Security Act (Act), provides for joint federal and state financing of medical assistance for certain needy persons. *See also* 42 C.F.R. § 430.0. States that participate in Medicaid must observe broad federal requirements and the terms of their state Medicaid plans as approved by CMS on behalf of the Secretary of the Department of Health and Human Services (HHS). Act § 1902; 42 C.F.R. §§ 430.10 - 430.16. A state with an approved State plan is eligible to receive federal matching funds, or FFP, in “an amount equal to the Federal medical assistance percentage,” or FMAP, “of the total amount expended . . . as medical assistance under the State plan” Act § 1903(a)(1). The FMAP is the rate of FFP that a state receives in its expenditures for medical assistance and generally ranges from 50 percent to 83 percent of the cost of medical assistance, depending on the state’s per capita income and other factors. 42 C.F.R. § 433.10. The parties agree that Alabama’s FMAP was 69.51% during FY 2006, 68.85% during FY 2007, and 67.62% during the first quarter of FY2008. CMS Brief (Br.) at 22; Alabama Br. at 27 n.*, citing 69 Fed. Reg. 68,370, 68,372 (Nov. 24, 2004), 70 Fed. Reg. 71,856 (Nov. 30, 2005), 71 Fed. Reg. 69,209, 69,210 (Nov. 30, 2006).

The non-federal share of Medicaid funding that states must incur to receive FFP is generally referred to as the state share. *See* 42 C.F.R. § 433.51. The statute and regulations permit states to use, as their share, public funds transferred to the state Medicaid agency from other units of government, called intergovernmental transfers (IGTs), and certain expenditures of public funds for allowable Medicaid costs by units of government other than the state Medicaid agency, called certified public expenditures (CPEs).²

Section 1903(w)(1)(A) of the Act requires that the total Medicaid expenditures in which a state claims FFP be reduced by the amount of revenues the state receives from health care providers in the form of certain types of taxes and donations from health care providers,

² An IGT “is a mechanism by which states use local, rather than state, dollars to fund the state share of Medica[id] expenditures” that is “specifically sanctioned by the Medica[id] Act, which grants states the flexibility to fund up to 60% of their share of Medica[id] expenditures with local dollars.” *Alaska Dep’t of Health & Soc. Servs. v. Ctrs. for Medicare & Medicaid Servs.*, 424 F.3d 931, 936 (9th Cir. 2005). CPEs are expenditures of “public funds . . . certified by the contributing public agency as representing expenditures eligible for FFP” under the Medicaid program. 42 C.F.R. § 433.51. To qualify as CPEs such expenditures must be “supported with an official statement by an authorized representative of the contributing public entity confirming that the expenditures qualify as Medicaid medical assistance or other allowable Medicaid expenditures.” *Mo. Dep’t of Soc. Servs.*, DAB No. 2589, at 6-7 (2014).

thus forbidding their use as the state share.³ Section 1903(w)(6) of the Act, however, protects a state's ability to use IGTs and CPEs from or by units of government that are health care providers if the funds "are derived from State or local taxes," unless the funds also derive from the impermissible provider taxes and donations barred by section 1903(w)(1)(A).

The regulation addressing state use of IGTs and CPEs to fund the state share provides:

Public Funds as the State share of financial participation.

(a) Public Funds may be considered as the State's share in claiming FFP if they meet the conditions specified in paragraphs (b) and (c) of this section.

(b) The public funds are appropriated directly to the State or local Medicaid agency, or are transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control, or certified by the contributing public agency as representing expenditures eligible for FFP under this section.

(c) The public funds are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds.

42 C.F.R. § 433.51.⁴

Factual Background

I. Origin of the supplemental payments program

In 1999, CMS (then called the Health Care Financing Administration, or HCFA) approved an amendment Alabama proposed to its state Medicaid plan, called state plan amendment (SPA) 99-02, providing (among other provisions) that "each rural government-owned hospital based nursing facility may be paid an enhanced payment not to exceed Medicare upper limits in the aggregate." Alabama Ex. 9, at 3. The enhanced payments (also called supplemental payments) were in addition to the standard Medicaid

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).

⁴ Different regulations governing of IGTs and CPEs were in effect for part of the disallowance period. Those rules were proposed in January 2007, published as final in May 2007, and vacated by a federal district court in May 2008 as having been issued in violation of a statutory moratorium, and neither party has argued that they apply here. 72 Fed. Reg. 2236, 2246, 2247 (Jan. 18, 2007) (proposed rule), 72 Fed. Reg. 29,748 (May 29, 2007) (final rule with comment period); *Alameda Cnty. Med. Ctr. v. Leavitt*, 559 F. Supp. 2d 1 (D.D.C. 2008). CMS in November 2010 restored the language of 45 C.F.R. § 433.51 (previously 433.45) that had been in effect prior to the vacated rule, that is, the language quoted above. 75 Fed. Reg. 73,972, 73,973 (Nov. 30, 2010).

reimbursement the nursing facilities received for services they rendered to Medicaid beneficiaries. The added payments were generally intended to offset the burden on facilities that treated a large number of needy patients and to ensure continued access to care for Medicaid recipients. The amounts of the supplemental payments were meant to represent the difference between the standard Medicaid reimbursement rate they were paid, and the higher reimbursement provided for the same services that would have been available under the federal Medicare program at title XVIII of the Act. *See, e.g.*, 66 Fed. Reg. 3148 (Jan. 12, 2001) (higher Medicare-level reimbursement permitted “to non-State public hospitals to recognize the higher costs of inpatient and outpatient services in public hospitals”).⁵

Alabama made the supplemental payments from an “enhancement pool . . . calculated by subtracting the rate paid by Medicaid to each nursing facility in the state from the rate which would have been paid using Medicare payment principles.” Alabama Ex. 9, at 3-4. “After calculating an enhancement pool based on cost reports and the difference between the rate paid by Medicaid and the rate that Medicare would have paid, the pool was divided between qualifying nursing facilities based on each facility’s number of Medicaid resident days.” Alabama Br. at 5. Alabama then “transferred the enhanced payments, including the State and Federal share, to the eligible nursing facilities on a monthly basis.” Alabama Ex. 13, at 16.

After CMS approved SPA 99-02, Alabama and eight of the nine county-owned nursing facilities participating in the supplemental payments program agreed that the facilities would retain at least 3.5% of the supplemental payments. This agreement is reflected in an August 13, 1999 letter from the General Counsel of the Alabama Hospital Association (Hospital Association) to the Commissioner of the Alabama Medicaid Agency “memorializing conversations between Alabama Medicaid and the qualifying nursing facilities.” Alabama Br. at 5. The letter states that Alabama “has received approval from HCFA for a change in the State Plan for an Enhancement Program for rural governmental hospital / nursing homes” and that “[t]he rural governmental Hospital / Nursing Homes participating in the new Federal Enhancement Program approved by HCFA . . . have asked that the agreement between Medicaid and the Nursing Homes be memorialized.”

⁵ CMS has long permitted facilities providing inpatient services to receive such enhanced or supplemental Medicaid payments determined by calculating an “aggregate” upper payment limit pool for each group of facilities based on ownership (privately-owned, state government-owned or operated, and non-state government-owned or operated, such as those owned or operated by county government) that may not exceed the amount that can be reasonably estimated would have been paid under Medicare payment principles. *See, e.g.*, Alabama Ex. 11, at 8; 42 C.F.R. § 447.272(b) (2001, 2015); 66 Fed. Reg. 3175 (Jan. 12, 2001) (providing that “aggregate Medicaid payments to a group of facilities . . . may not exceed the upper payment limit,” which “refers to a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles”).

Alabama Ex. 10, at 2. The letter explains the agreement as “[t]he Hospital / Nursing homes shall retain at least three and one half percent (3.5%) of any funds which are made available from this new program.”⁶ *Id.*

In January 2005, CMS informed Alabama that IGTs from public providers could fund the state share of Medicaid costs only if (among other conditions) the IGTs did not exceed the state share and were funded with state or local taxes. CMS Exs. 15, at 2; 23, at 1. During 2007, CMS and Alabama discussed a proposed amendment to Alabama’s state Medicaid plan (SPA 05-009) that would have provided for Alabama to use CPEs by the nursing facilities, instead of IGTs, to fund the state share. CMS Exs. 8, at 4-5; 23-30. Alabama subsequently withdrew the section of the SPA that provided for CPEs, which was not included in the version of the SPA that CMS approved in 2010. CMS Exs. 8, at 5-6; 31, at 2; 33.

We next review how Alabama actually conducted its supplemental payment program during the time frames at issue.

II. Alabama’s supplemental payments program during FY2006

For at least the first year of the disallowance period, federal FY 2006, Alabama (*i.e.*, the state Medicaid agency) deposited in the nursing facilities’ bank accounts both the state and federal shares of the supplemental payments. As per the agreement memorialized in the August 13, 1999 letter, the nursing facilities were permitted to retain at least 3.5% of the deposited funds. Within several days after the purported supplemental payments were deposited, however, 96.5% of the payments were transferred from each nursing facility’s bank account back to Alabama in two transactions. CMS Br. at 14-16; Alabama Br. at 8-9; Alabama Ex. 11, at 12. Accordingly, in practice, the nursing facilities were permitted to retain no more than 3.5%.

Each month during FY2006, Alabama’s Chief Financial Officer (CFO) sent directly to each of the nine county nursing facilities involved a letter that “specified the date and amount of the Supplemental Payment the nursing home would receive from EDS, the company that administered financial transactions for Alabama Medicaid.” CMS Br. at 14-15, citing (*e.g.*) CMS Ex. 10, at 1-12; CMS Ex. 11; CMS Ex. 12, at 1-5; CMS Ex. 13 at 1-2; and CMS Ex. 14; *see also* Alabama Br. at 8 (“[o]nce a month, Alabama Medicaid

⁶ One of the nine county hospital nursing facilities that received the supplemental payments, Coosa Valley Nursing Facility, was not listed in the letter memorializing the agreement with Alabama. Alabama Ex. 10. Alabama does not dispute, however, that this facility, like the others, received supplemental payments, of which 96.5% was transferred from the facilities’ bank account to the State Medicaid agency. *See* CMS Ex. 12 (Alabama Medicaid letters notifying Coos Valley Nursing Facility of supplemental payments and transfers).

instructed its fiscal agent, EDS, to make an enhanced payment to each of the qualifying facilities via the regular Medicaid provider payroll” and “would also send a monthly letter to each qualifying nursing facility detailing the enhanced-payment amount that the facility would receive that month”). Each letter also informed the facilities specifically how much of the amount deposited would be withdrawn for the State and when the withdrawals would be taken out of the accounts. In all letters in the record, the amount to be withdrawn was approximately 96.5% of the amount deposited. For example, a letter dated January 6, 2006 from Alabama’s CFO to the Administrator of Bibb Medical Center Hospital and Nursing Home, one of the participating facilities, states:

A publicly owned nursing home enhancement payment will be on your next provider payroll from EDS on January 12, 2006. Your facility’s enhancement is \$663,086.

A transfer in the amount of \$202,175 will be made from your pre-designated account on January 17, 2006. Another transfer in the amount of \$437,703 will be made from your pre-designated account on January 18, 2006.

CMS Ex. 11, at 1; *see also, e.g.*, CMS Exs. 10, at 1-12; 12, at 1-6; 13, at 1-2; 14, and Alabama Ex. 16 (monthly letters from Alabama Medicaid to nursing facilities). The sum of the two amounts transferred from the nursing facility’s account and returned to Alabama, \$639,878, is 96.5% of the payment just deposited. Thus, in each instance, after EDS conducted these transactions, as EDS had informed the facility it would do, the facility’s account was left with only the remaining 3.5% of the claimed supplemental payment, the minimum amount that the facilities were told they would retain pursuant to the agreement memorialized in the August 13, 1999 letter from the Hospital Association. Alabama Ex. 10.

Alabama does not dispute that the amounts transferred out of the nursing facilities’ bank accounts totaled approximately 96.5% of each total payment to the same facility. The withdrawals, moreover, were each taken from the same bank accounts into which the purported supplemental payments were deposited. CMS Br. at 16, citing CMS Exs. 18, 20, 22; *see* Alabama Br. at 9 (“Acting on behalf of the qualifying nursing facilities, the Hospital Association facilitated the IGTs by withdrawing amounts from the qualifying facilities’ designated bank accounts and depositing the amounts into Alabama Medicaid’s account.”). The parties do dispute whether it was the State’s own fiscal agent or the Hospital Association that transferred the funds out of the nursing facilities’ accounts and to the State agency. *See* CMS Br. at 15; Alabama Reply at 17. The State does not, however, deny or provide any evidence contesting CMS’s assertions that, in each instance, the sum withdrawn from the nursing facility’s account was later credited to the benefit of the State agency.

III. Alabama's supplemental payments program from November 2006 on

Beginning in November 2006, although Alabama continued to claim FFP in the total amount of the supplemental payments (comprising the federal and state shares), the amounts transferred to and withdrawn from the nursing facilities' bank accounts constituted only the federal share of the payments, i.e., 68.85% of the total purported supplemental payments Alabama claimed in FY2007 at the then-applicable FMAP. Alabama reported the remaining state share of the payments as CPEs incurred by the nursing facilities. *See* Alabama Br. at 11 (“Beginning in November 2006 and continuing through October 2007, the qualifying facilities did not make IGTs to Alabama Medicaid. Instead, Alabama Medicaid recorded CPEs equal to the non-federal share of the total computable enhanced payment each month for the qualifying facilities.”); *see also* CMS Br. at 25 (“Starting November, 2006 through the first month of FY2008, each Putative IGT represented exactly 65.35% of the total expenditures for which Alabama claimed FFP (which was equivalent to a combination of the Supplemental Payment and putative CPE for each month).”)⁷

CMS in its brief alleged, and Alabama in reply did not dispute, that the nursing facilities continued to retain only 3.5% of the total supplemental payments in which Alabama claimed FFP, but the chain of transfers became more complicated. Instead of the funds the nursing facilities received being transferred back to Alabama Medicaid as IGTs, they were transferred to private PHPs or “Prepaid Health Plans” that “acted as fiscal agents for Alabama Medicaid” which “used the PHPs to distribute both the hospitals’ fee-for-service (per diem) base payments and their DSH [disproportionate share hospital] payments.” CMS Ex. 42, at 2 (Decl. of CMS senior financial policy advisor); *see also* Alabama Reply at 18 (acknowledging that “the recipient nursing facilities transferred monies to private PHPs during a portion of the disallowance period”).

A February 22, 2007 “PHP Management Memorandum” from the CFO of the Hospital Association to the Administrator of the Greene County Hospital and Nursing Home, which owned one of the nursing facilities at issue, explains the changes to the process as follows:

⁷ Alabama reports that October 2006 was “a transition month [between IGTs and CPEs] in which one IGT was made to Alabama Medicaid by each of the qualifying nursing facilities.” Alabama cites the example of Clay County Nursing Home, which “received an enhanced payment of \$446,124 from Alabama Medicaid on its October 13, 2006 provider payroll The [Alabama] Hospital Association withdrew \$138,968 from Clay County’s designated account on October 16, 2006, and credited Alabama Medicaid with that amount.” Alabama Br. at 10. The amount withdrawn from the account was 31.15% of the total payment, equivalent to Alabama’s state share percentage for FY2007. *See* CMS Br. at 22; Alabama Br. at 27 n.*. Neither party alleges that a transition month affected the bases for or the amount of the disallowance.

As an example, public nursing facilities were receiving an enhanced payment from [Alabama] Medicaid and transferring 96.5% of that payment to [Alabama] Medicaid during fiscal year 2006. In fiscal year 2007, that facility will receive a payment from [Alabama] Medicaid that represents 68.85% of the calculated payment. In turn, an intra-fund transfer equal to 65.35% of the calculated payment will be made to the PHPs. This transfer will take place on the Monday following the first check write each month (Tuesday in the case of banking holidays).

CMS Ex. 21, at 1.

Alabama did not dispute that all of the funds the PHPs transferred to their member hospitals were Medicaid funds, and that Alabama reduced its other Medicaid payments to the PHPs by approximately the amounts of the funds transferred from the county nursing facilities. CMS Ex. 42, at 3-5. Thus, to the extent the nursing facilities transferred funds to the PHPs, those funds replaced funds that Alabama Medicaid would otherwise have transferred directly to the PHPs.

IV. The disallowance

CMS's initially disallowed FFP in the payments in a letter dated January 30, 2013. The letter explained that the claimed expenditures "were not true supplemental payments" because "the majority of the funds remained under the administrative control of the state even when temporarily transferred to the nursing facilities." Alabama Ex. 1, at 1-2.

CMS also determined that Alabama should only be able to claim "net expenditures" and the funds taken from the facilities were "applicable credits" that should offset the amount of the supplemental payments in which Alabama claimed FFP; the transferred funds were not IGTs protected by section 1903(w)(6) of the Act because they did not derive from state or local taxes; claiming expenditures without accounting for returns of the payments violated the formula for state and federal shares set out in section 1905(b) of the Act; and the transfer of funds to Alabama effectively violated section 1903(i)(17) of the Act barring payments "with respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under a State plan" because the payments are not effectively reimbursing nursing or other services. *Id.* at 1-2.

Alabama requested reconsideration by CMS, which sustained the disallowance on May 24, 2013. Alabama Exs. 2, 3. Alabama appealed to the Board, and the case was stayed for over a year at the parties' request while they engaged in both discovery and settlement discussions.

Analysis

We sustain the disallowance because we conclude, under the specific facts of this case, that (1) Alabama did not incur any costs in the amount of the supplemental payments taken from the nursing facilities' accounts within days after they were deposited and returned to Alabama or used for Alabama's benefit, and (2) Alabama has not shown that the nursing facilities had allowable Medicaid expenditures in amounts equal to the state share of the supplemental payments that Alabama ceased depositing in the facilities' bank accounts that qualified as CPEs. We accordingly need not reach CMS's further arguments that IGTs and CPEs must derive from state or local taxes to fund the state share of Medicaid expenditures. Moreover, we reject Alabama's arguments that CMS was precluded from taking this disallowance based on the legislative history protecting the use of certain IGTs and CPEs as state share of Medicaid expenditures.

I. Alabama did not incur expenditures when it moved funds into and out of the nursing facilities' accounts.

The particular circumstances of this case show that Alabama had no actual expenditures in the funds moved into and then taken from the facilities' accounts (and thus incurred no Medicaid costs) because the nursing facilities never had actual ownership, control, or use of the funds that briefly resided in their bank accounts before being transferred back to Alabama, or used for Alabama's benefit. This is apparent from the nursing facilities' prearranged consent to the removal and timing of the transfers from their accounts (96.5% of the payment amounts withdrawn days after the payments and without any intervening use of the transferred funds by the facilities); the nature of the transactions (in which Alabama Medicaid or its agents transferred the funds directly into and out of the facilities' predesignated bank accounts based on a prior agreement only assuring the nursing facilities that they would retain at least 3.5%); and the source of the supplemental payments (Medicaid payments that included federal reimbursement). Absent such actual dominion over the funds, the nursing facilities could not transfer them to the state Medicaid agency as IGTs to be used as the state share in claiming FFP.

We do not address whether supplemental payments in the amounts at issue might have been permissible had they actually constituted expenditures; and we conclude that CMS properly allowed FFP in the amount of the supplemental payments that actually were made to the nursing facilities for their use and benefit, i.e., the 3.5%. We find no substance, however, to the claim that the other 96.5% of the funds constituted supplemental payments as that term is used in the Medicaid program.

Alabama argues that it had expenditures in the amount of the transferred funds under "the everyday meaning of the word 'expenditure'" as "to pay out" that it says the Board has previously applied. Alabama Br. at 22, citing *Fla. Dep't of Health & Rehab. Servs.*, DAB No. 884 (1987). An analogy may illustrate why we find no actual expenditures

occurred in the transactions at issue. The quintessential expenditure is the exchange of money paid for goods or services received. If an individual asks a bystander to hold the individual's wallet briefly and then return it, no value is exchanged in either direction. If the first person offers the holder a tip of one dollar (or of 3.5% of the funds in the wallet) so long as the rest is returned unused, the tip paid is consideration for the service and constitutes an expenditure, but the money remaining in the wallet when it is returned has not been expended. In short, even an "everyday" understanding of the word "expenditure" would not lead a reasonable person to conclude that such an interaction constituted an expenditure. A careful review of the circumstances shown in the record establishes that the nursing facilities essentially stood in the position of holding funds and returning them to the State Medicaid agency in exchange for a tip of 3.5% of the funds.

A. The transfers out of the nursing facilities' accounts were not voluntary.

Most notably, the transfers of funds from the nursing facilities' bank accounts to Alabama (or, beginning in FY2007, to the PHPs on Alabama's behalf) were not voluntary actions by the nursing facilities as Alabama asserts. Alabama Br. at 17-19 (asserting that the transfers "were done voluntarily by the nursing facilities" which "were under no legal obligation to make such transfers"). Instead, the record shows that removal of 96.5% of the payments was effectively a precondition for the facilities' retention of the remaining 3.5%. Notwithstanding that the agreement between Alabama and the nursing facilities states that the facilities would keep "at least" 3.5% of each payment, Alabama does not allege, nor does the record show, any instance of a facility being permitted to retain more than 3.5% of a payment. Alabama Ex. 10, at 2. Alabama also does not allege any instance of any facility making use of any of the transferred funds during the time they were in the facility's account. While the language of the letter memorializing the agreement between Alabama Medicaid and the facilities, read in isolation from the overall facts of the supplemental payments program, might be read to contemplate the possibility of facilities retaining more than 3.5% of the supplemental payments, in practice that did not occur. Indeed, the monthly letters from the Alabama CFO to the facilities informing them of the amounts of the payments to and transfers out of their accounts, which in all cases were approximately 96.5% and 3.5%, respectively, are evidence that the facilities were effectively required to consent to the transfer of the 96.5% in order to keep the 3.5% of the payments. *See* CMS Exs. 10, at 1-12; 11; 12, at 1-6; 13, at 1-2; 14; Alabama Ex. 16 (monthly letters from Alabama Medicaid to nursing facilities).

The effectively mandatory nature of the facilities' agreement to permit removal of most of the supposed supplemental payments by Alabama is further made evident in letters that Alabama sent to the nursing facilities after the start of FY2007. Alabama had then begun reducing the deposits in the nursing facilities' bank accounts to the federal share of the payments (which were then transferred to the PHPs) and claiming the state share never paid to the facilities as CPEs. The letters, from the CFO of the Alabama Medicaid

Agency, informed the facilities that “the payment is now just the federal share of the total computed payment,” and that “[t]his means that your facility will **no longer be required to transfer** the non-federal share” to Alabama. Alabama Ex. 26 (letter of Nov. 7, 2006 to Clay County Hospital & Nursing Home administrator) (emphasis added); *see* identical language in other letters at CMS Exs. 10, at 14-24; 12, at 7-12; 13, at 4. It is thus apparent that both parties understood the arrangement throughout to require the facilities to consent to the return transfers.

Alabama’s assertion that the nursing homes “were under no legal obligation to make such transfers,” Alabama Br. at 19, also misses the point. The element that makes allowing Medicaid’s agent to remove the bulk of the funds put in the facilities’ account not truly voluntary is not a statutory obligation or even a clear contractual obligation to do so. It is instead the clear course of dealing from the initial contract with the Hospital Association, through the EDS instruction letters, through the various iterations of the transfer methodology, with always the same outcome, a net 3.5% supplement to each facility. While Alabama points to the “continued reliance on nursing facilities’ initial authorization forms” as evidence that participation by the facilities was consensual (Alabama Reply at 17 n.3, citing Alabama Exs. 44, 45), the point is not that the facilities were coerced or misled into permitting the withdrawals. The point is that the circumstances as a whole clearly show that, once they accepted any supplemental payment, the facilities were never in fact provided an option about how much of the payment would be taken out of their accounts. The passive role played by the facilities in the movement of the funds in and out of the accounts is one marker that the transactions were essentially not voluntary in nature.

Further, Alabama has not alleged any instance of a nursing facility that received a supplemental payment electing *not* to permit the return of the funds (amounting to some 96.5% of the total payment in which Alabama claimed FFP) to Alabama (or the forwarding of that amount to the PHPs), or of a facility making some other use of the funds. Nor has Alabama suggested that the facilities had any option to receive the share of the supplemental payments that they would retain without also authorizing the balance to be transferred into and promptly back out of their bank accounts. The written authorizations for the withdrawals sent by the nursing facilities to the Hospital Association and the related Hospital Association memorandum thus do not render the payments “voluntary” in the context of Alabama’s practice, which was to effectively condition receipt of payments on consent to the transfers. Even assuming the participation of the nursing facilities and the Hospital Association in the supplemental payment program overall was consensual, which CMS has not disputed, this does not make the return of 96.5% of the Medicaid funds voluntary. For nursing facilities to consent to participate in a program to obtain a small supplemental payment from the State upon agreeing to receive and then permit immediate recapture of a larger sum simply does not amount to a voluntarily undertaking to pay the larger sum to the State.

To return to our analogy, when the bystander holding the wallet returns it, the bystander has not made a voluntary payment of the money in it because the money inside the wallet never belonged to the bystander. The terms of the agreement did not provide the bystander with the use and ownership of the money, but rather provided for payment of a tip for holding and returning the remaining money intact. In other words, the bystander in the analogy, and the nursing facilities in this case, are merely temporary custodians of the funds received (very temporary in the case of Alabama's nursing homes) and the return of the funds held to their source is not a voluntary transfer of their own funds.

Alabama also argues that there is no requirement that an IGT be voluntary, because “the Board has noted [that] CMS has previously ‘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.’” Alabama Br. at 19, citing *Minn. Dep’t of Human Servs.*, DAB No. 2122, at 18 (2007) (Alabama’s emphasis). Alabama also cites the statement, in the legislative history of Public Law No. 102-234, that IGTs or CPEs “‘may be mandated by State law’ or ‘be undertaken . . . on a voluntary basis.’” Alabama Reply at 18, citing H.R. Rep. No. 102-310, at 15 (1991) (Alabama Ex. 37). Neither a State law mandate nor a voluntary undertaking by the facilities occurred here. We do not hold, in any case, that only voluntary transfers are permissible IGTs. Instead, the non-voluntary nature of the transfers from the nursing facilities’ bank accounts is one factor that, coupled with the ephemeral presence of the funds in the bank accounts and their being taken from the federally-financed supplemental payments, demonstrates that the facilities never had actual possession of the transferred funds.

Additionally, a crucial factual distinction shows that Alabama’s reliance on *Minnesota* is misplaced. In *Minnesota*, CMS “conceded that the funds transferred from [the county hospital] to the State were derived from local property taxes” DAB No. 2122 at 17, n.10. The Board thus found that the funds transferred from the county hospital “were protected intergovernmental transfers” under section 1903(w)(6) that qualified as the non-federal share under the applicable regulation at section 433.51. *Id.* at 13, 14, 16. As we discuss below, the protection of section 1903(w)(6) did not apply here and would not apply even if we were to find that Alabama had actual expenditures in the funds transferred from the facilities’ bank accounts.

Thus, even assuming that the facilities voluntarily elected to participate in the supplemental payments program, it is not disputed that those that did participate, without exception, transferred almost all of the funds back to Alabama or to the PHPs in order to receive 3.5% (and in no case any more than 3.5%) of the payments. Hence, only the 3.5% constituted amounts that were in addition to the reimbursement they otherwise received for providing Medicaid services. This record does not support Alabama’s claim

that the transfers of funds from the nursing facilities back to Alabama were voluntary. Moreover, as we explain next, the circumstances as a whole demonstrate that the 96.5% of the payments transferred back to Alabama was never actually under the control of or available for the use of the nursing facilities.

B. The brief period of time that the transferred funds were in the nursing facilities' bank accounts, and their derivation from federal funds, are further evidence that the facilities did not have actual possession of the funds.

The letters from the Alabama CFO to the facilities informing them of each month's supplemental payments also stated that the amounts equal to 96.5% of the payments would be removed from the facilities' bank accounts, typically four days later (but always within 3-10 days), in two withdrawals on either the same day or the following days as the payment. CMS Exs. 10, at 1-12; 11; 12, at 1-6; 13, at 1-2; 14. As noted above, Alabama has not asserted that nursing facilities receiving the purported supplemental payments ever made any use of the funds during the few days they were present in facility bank accounts.

The record also shows that the funds transferred out of the nursing facilities' bank accounts to Alabama (or, after November 2006, used for Alabama's benefit) derived from the purported supplemental payments to the facilities rather than from any independent source. As noted earlier, the transferred funds were, in all instances, withdrawn from the same bank accounts into which the payments had been deposited several days earlier, and without any intervening use of the funds by the facilities. This alone indicates the likelihood that the same funds first deposited were the funds then returned. The origin of the transferred funds in the purported supplemental payments is also confirmed by the February 22, 2007 memorandum from the Hospital Association CFO, which states that "public nursing facilities were receiving an enhanced payment from [Alabama] Medicaid and transferring 96.5% **of that payment** to [Alabama] Medicaid during fiscal year 2006." CMS Ex. 21, at 1 (emphasis added).

None of this changed when, in FY2007, the transfers were made instead to the PHPs rather than directly back to the Alabama Medicaid agency. Alabama does not dispute CMS's assertions and evidence that the funds transferred to the PHPs replaced funds that Alabama Medicaid itself would otherwise have paid directly to the PHPs, thus effectively constituting a transfer to Alabama. CMS Ex. 42, at 3-5; *see also* Alabama Reply at 18 (noting, and not disputing, "that the recipient nursing facilities transferred monies to private PHPs during a portion of the disallowance period" and CMS's argument "that transfers by the nursing facilities to PHPs constitute 'Putative IGTs' to Alabama

Medicaid”). Again, as with the earlier transfers made directly back to Alabama, the nursing facilities never effectively received the funds ostensibly paid to them by being passed through their bank accounts but instead in all cases actually used for Alabama’s benefit to reduce Alabama’s Medicaid expenditures.

We also note that the payments transferred to the nursing facilities included federal reimbursement and indeed, beginning in November 2006, consisted exclusively of the federal share of the supplemental payments, and the earlier purported supplemental payments consisted, at least in part, of federal reimbursement.⁸ The regulations expressly forbid the use of any federal funds as part of the state share of Medicaid funding, unless authorized by federal law to be used to match other federal funds, which Alabama does not assert was the case here. 42 C.F.R. § 433.51(c). Thus, to the extent the purported supplemental payments consisted of funds derived from federal funds, they could not be claimed as expenditures for further federal reimbursement. As evidence that federal funds were included in the transfers to the nursing facilities, CMS points again to the February 22, 2007 Hospital Association memorandum to show that facilities were provided Medicaid funds of which they retained only 3.5% during FY 2006, and thereafter the payments were reduced to only the federal share of the Medicaid funds, while the facilities continued to keep only 3.5% of the total supplemental payments in which Alabama claimed FFP. CMS Br. at 16, 35, citing CMS Ex. 21. A review of the amounts of the payments clearly demonstrates that the federal share was included in the pre-2007 payments. In other words, the purported supplemental payments were not State expenditures at all to the extent that the funds were transferred back to the State and further were not reimbursable expenditures to the extent they were made with funds already received by the State from federal reimbursement.

CMS asserts that Alabama effectively admitted that the funds transferred from the nursing facilities included the “same federal funds” as in the supplemental payments originally transferred to the facilities. CMS Br. at 16, 35. CMS bases this assertion on the statement from the February 22, 2007 Hospital Association memorandum quoted above that the facilities “were receiving an enhanced payment from [Alabama] Medicaid and transferring 96.5% **of that payment** to [Alabama] Medicaid” CMS Ex. 21, at 1 (emphasis added). Alabama attempts to distance itself from the statement in the memorandum on the ground that the Hospital Association is a private trade association not a state entity. Alabama Reply at 15-16. Nevertheless, we note that the Hospital Association memorandum reflects the role it played as intermediary between the State and the nursing facilities and Alabama does not indicate that it ever notified the Hospital Association or the facilities that the representation in the memorandum was inaccurate.

⁸ We need not attempt to determine the amount of the claims at issue that might reflect such impermissible use of federal funds, since we conclude that the claims are unallowable in their entirety for the reasons discussed in the text.

Alabama does not dispute the substance of the information in the memorandum, and Alabama's efforts to discount the credibility of the memorandum are not convincing, given Alabama's previous descriptions of the central role the Hospital Association played in implementing the supplemental payments program. According to Alabama, the Hospital Association "worked with" Alabama "to communicate with its members regarding the new payment program;" sent the August 13, 1999 letter to Alabama memorializing conversations between Alabama Medicaid and the qualifying nursing facilities; sent the facilities instructions for authorizing the transfers; and withdrew the transferred funds from the facilities' bank accounts and credited those amounts to Alabama. Alabama Br. at 5, 9, 19; Alabama Reply at 17.

Indeed, Alabama appears to acknowledge that the transfers were made from the purported supplemental payments, by arguing that a longstanding and permissible source of IGTs in addition to state and local tax revenues was "revenue received by governmental providers for services rendered" Alabama Br. at 22; *see also* Alabama Reply at 10 ("reimbursement received for services provided"). Alabama apparently intends to convey that supplemental payments may constitute further reimbursement for services the nursing facilities have provided. We need not resolve whether or when actual revenue received by a public provider for services rendered may serve as a permissible (or protected) source of IGT funds. In this case, we simply find that the nursing facilities did not **receive payment** at all for services rendered in the form of supplemental payments beyond the 3.5% which they retained. As the facilities never acquired actual ownership and control of the transferred funds, those funds could not constitute revenue for services they rendered.

II. Alabama's arguments that CMS was barred from disallowing its claims based on various legislative actions protecting certain sources of state share do not alter our conclusion that the state did not incur expenditures in the disallowed claims.

A. *Applicable credits*

Alabama's arguments are intended to rebut CMS's determination that, even if the payments to the nursing facilities were expenditures by the State, then the return transfers from the facilities to the State were "applicable credits" that would have to be offset before any claim for FFP would be allowable.⁹ Disallowance Notice at 2. Alabama

⁹ Cost principles in effect at the time of the supplemental payments define "applicable credits" as "receipts or reduction of expenditure type transactions that offset or reduce expense items allocable to Federal awards as direct or indirect costs" that must be deducted from claims for FFP. 2 C.F.R. Part 225 (2006) (70 Fed. Reg. 51,910 (Aug. 31, 2005)) (codifying Office of Management and Budget Circular A-87), App. A, ¶¶ C.1.i, C.4.a.

argues that the “applicable credit” provision does not apply because the nursing facilities were transferring “public funds” which may legitimately serve as state expenditures for Medicaid reimbursement. Alabama Br. at 21-22.

As we have explained already, the circumstances and nature of the transactions here do not in fact constitute expenditures under any commonsense understanding of that word. It is thus not necessary to make findings as to whether the return of 96.5% of the transferred funds to the State agency amounted to a credit offsetting an expenditure of those funds in the initial transfer. The Board’s *Florida* decision, which Alabama cites, is inapplicable and irrelevant. Alabama Br. at 22, citing *Fla. Dep’t. of Health & Rehab. Servs.* The questioned expenditure in that case was a use allowance on equity capital invested in plant, property, and equipment related to patient care and the approved state Medicaid plan defined that use allowance as an allowable cost for non-profit providers. DAB No. 884, at 1. The cost principles have long recognized use allowances as representing allowable costs of the use of grantee-owned property (for which grantees may not charge rent). *See, e.g.*, OMB Circular A-87 (1995), Att. B, ¶ 15, published at 60 Fed. Reg. 26,484 (May 17, 1995). A use allowance recognizes that there has effectively been an expenditure in the nature of depreciation of a capital asset used in a federal grant program. Nothing in that decision supports the idea that a temporary transfer of funds with an obligation to promptly return them is an allowable expenditure.

Since there were no expenditures by the State (and no actual possession by the nursing facilities), it follows that there is nothing against which to net any applicable credits under the facts of this case.

B. Permissible and protected IGTs

Alabama further argues that (1) the transferred funds taken out of the nursing facilities qualified as permissible IGTs under the state share regulation, 42 C.F.R. § 433.51, and (2) the disallowance violates section 5(b) of Public Law No. 102-234, which bars CMS from taking action that “changes the treatment . . . of public funds as a source of State Share” in that regulation (previously at section 433.45(a)) except through notice-and-comment rulemaking. As explained below, neither argument is valid.

1. State share regulation

As an initial matter, we find no dispute that, as we stated above, the transferred funds were not protected IGTs (or CPEs) under section 1903(w)(6)(A) of the Act because Alabama has not shown that they “derived from State or local taxes” as required by that provision prohibiting CMS from “restrict[ing] States’ use of funds . . . as the non-Federal share of [Medicaid] expenditures” where “such funds are derived from State or local taxes . . . transferred from . . . units of government within a State” While Alabama stated that “[m]ost of” the county government entities that owned the nursing facilities

“received tax revenues during the disallowance period,” it did not assert that the transferred funds derived from state or local taxes, and did not respond to CMS’s citation of evidence on appeal that the counties did not receive sufficient state or local tax revenues to have covered the transfers from the nursing facilities to Alabama. Alabama Br. at 8; CMS Br. at 27-34. Thus, the Act’s prohibition in section 1903(w)(6)(A) on restricting IGTs derived from state or local taxes as the state share of Medicaid expenditures does not bar the disallowance.

Alabama instead relies on section 433.51 for the propositions that state share funds need not derive from state and local taxes (because that regulation has no express requirement as to the source of “public funds”) and that “public funds” may be “considered as the State’s share in claiming FFP” if the public funds “are transferred from other public agencies” to the state Medicaid agency “and under its administrative control” and “are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds.” 42 C.F.R. § 433.51; Alabama Br. at 20-21, 25; Alabama Reply at 2-6, 14-15. Alabama argues that the funds transferred from the nursing facilities “were ‘public funds’ within the meaning of that regulation” because “units of local government owned and operated the qualifying nursing facilities” and “the transfers from the qualifying nursing facilities’ bank accounts were deposited in Alabama Medicaid’s account and under its administrative control.” Alabama Br. at 21.

This circular argument does not benefit Alabama, as the regulation does not define “public funds” but merely addresses only when their use as state share is permissible.¹⁰ Alabama appears to maintain that the transferred funds were “public funds” solely because the nursing facilities were units of government. Even if we were to agree that any funds the State received from a government entity (that do not derive from the provider taxes and donations prohibited by section 1903(w)) are public funds (a question we do not reach), we would not conclude that the funds transferred from the nursing facilities qualified as public funds. We could not reach such a conclusion because, as we found above, the facilities had neither possession nor use of the funds. Section 433.51 expressly requires that the public funds be transferred to “the administrative control” of the state Medicaid agency. This requirement implies that the funds must have been previously under the administrative control of the transferring public agency. That requirement is not met here, where the nursing facilities never had administrative control of the funds.

¹⁰ Neither party asserted that the statute or regulations define the term “public funds” for the purpose of the state share regulation, and we are not aware of an applicable definition.

2. Congressional rulemaking requirement

Alabama argues that “CMS seeks to accomplish through its disallowance that which Congress” – in section 5(b) of Public Law No. 102-234 – “prohibited the federal agency from doing over two decades ago: namely, change the treatment of public funds as a source of the non-federal share using a procedure other than notice-and-comment rulemaking.” Alabama Br. at 17. Alabama characterizes CMS’s position that “public funds” must derive only from state and local taxes to qualify as IGTs under section 433.51 as “a radical change in the treatment of public funds” that is barred by section 5(b) absent notice and comment rulemaking. Alabama Reply at i, 3, *see* CMS Br. at 35 (“the regulatory understanding of public funds must encompass the statutory requirement that they be derived from state or local taxes”). We need not decide whether this is an accurate statement of CMS’s position or, if so, whether we find it legally sound because, as explained earlier, our decision does not rest on a conclusion that all public funds must derive from state or local taxes.

Moreover, we do not agree that section 5(b) barred CMS from disallowing the funding scheme here based on the legislative history so extensively recounted by the parties. Alabama casts the history of congressional actions, in the 1990s and in 2007, as simply rejecting or delaying various efforts by CMS to restrict or limit in different ways the permissible sources of the state share of Medicaid expenditures. *See* Alabama Br. at 2-4, 11-15, 20-21. Alabama states that Public Law No. 102-234 was partly triggered by CMS’s interim final rules, issued in 1990 and 1991, imposing “a ‘net expenditure’ requirement whereby [Medicaid] expenditures claimed by a State would be ‘reduced by the revenues derived from either donations or other voluntary payments made by or on behalf of health care providers.’” *Id.* at 3, quoting 56 Fed. Reg. 46,380, 46,386 (Sept. 12, 1991). Similarly, according to Alabama, Public Law No. 110-28, § 7002(a)(1)(A) (May 25, 2007), blocked regulations proposed by CMS in January of that year to limit IGT (and CPE) sources to governmental entities “with ‘generally applicable taxing authority’” and require providers “to ‘retain the full amount of the total computable payment provided to them for services furnished under the approved State plan’” Alabama Br. at 11-12, 14, citing 72 Fed. Reg. 2236, 2246, 2247 (Jan. 18, 2007) (proposed rule).

Alabama’s account of the interactions between legislative and regulatory initiatives over the years is one-sided.¹¹ Nothing even in Alabama’s historical account, however, suggests that states had used, or Congress intended to protect, financing arrangements like the one here, in which funds transferred to public providers from a state agency are virtually immediately withdrawn from those providers’ banking accounts by prior agreement and returned to the state agency. We see no evidence Congress intended that the mere temporary passage of funds through the bank accounts of providers that never had any use or control of the funds converted them to “public funds” that the state Medicaid agency could then recover and count as the state share without restriction.

Moreover, the CMS actions which Congress did reject or postpone involved much more restrictive rules than the disallowance here involves. Public Law No. 102-234 constituted a nuanced response including *protections* for states’ abilities to fund their Medicaid programs with IGTs derived from state and local taxes, but also imposing significant *restrictions* on states’ use of taxes and donations from health care providers. As we sustain the disallowance on grounds other than that the transfers did not derive from state and local taxes, we conclude that the lengthy and complex history of this provision in no way precludes the present disallowance.

C. CMS prior statements

Alabama also relies on a statement in the preamble to a 1992 interim final rule (after passage of Public Law No. 102-234) that until CMS adopted regulations “changing the treatment” of IGTs, “States may continue to use, as the State share of medical assistance expenditures, transferred or certified funds derived from *any* governmental source (other than impermissible taxes or donations derived at various parts of the State government or at the local level).” Alabama Br. at 20, citing 57 Fed. Reg. 55,118, 55,119 (Nov. 24, 1992) (Alabama’s emphasis). The issue in this case, however, is not whether county nursing facilities may *never* constitute a “governmental source” of public funds for use as state share, a position which CMS does not argue in any event. Instead, the issue for us is whether the nursing facilities in this case were, in any meaningful sense, the “source” from which the state share was “derived,” and we have concluded they were not.

¹¹ Alabama ignores legislative history showing difficult debates balancing state budget strains with concerns about potentially “abusive Medicaid funding schemes.” CMS Br. at 3. Indeed, Public Law No. 102-234 in 1991 imposed some aspects of the very “net expenditure requirement” CMS sought to implement through its 1990 and 1991 interim final rules. As the Board has explained, the history of that law “demonstrates that a principal reason Congress limited states’ use of provider taxes and donations was that states were shifting an increasingly larger portion of their Medicaid expenses to the federal government” and that Congress, after passing several earlier moratoria on CMS issuing new regulations on provider taxes and donations, “came to accept CMS’s view that some states’ use of provider taxes and donations had increased the federal government’s share of Medicaid costs without an increase in services, and that some states were ‘gaming’ the system to reap windfalls that they used for non-Medicaid expenses.” *Ga. Dep’t of Cmty. Health*, DAB No. 1973, at 12-13 (2005).

Alabama also points to CMS's responses to recommendations by the HHS Office of the Inspector General (OIG) in three 2001 reports concerning enhanced payments by Alabama (Alabama Ex. 11), North Carolina (Alabama Ex. 12), and six states including Alabama (Alabama Ex. 13). Alabama states that CMS "categorically rejected OIG's suggestion" that CMS require "that a provider must 'retain' enhanced payments in order for those payments to qualify for FFP," on the ground that CMS did "not have the authority to prescribe how facilities are to use the Medicaid payments they receive from state Medicaid agencies" and that "[o]nce a Medicaid payment is made to a medical provider, the funding is then available to that provider to use as the provider sees fit." Alabama Br. at 22, quoting Alabama Exs. 12, at 17; 13, at 33 respectively.

Again these CMS comments are neither binding nor even on point given our resolution of the case. CMS's response to the more relevant report, the one on enhanced payments in Alabama, does not contain the comments quoted by Alabama from the two other states' reports.¹² OIG found, as have we, that the nursing facilities retained only 3.5% of the payments designated to them as enhanced payments. Alabama Ex. 11, at 12-13. OIG reported that State officials said this percentage "was arrived at via a negotiation process between the State and the nursing facilities." *Id.* at 12.¹³ OIG described Alabama's use of the enhanced payments and IGTs as a "financial windfall" and as creating a "recycling effect" of multiple draws on federal funds. *Id.* at 16. OIG's recommendation was that CMS should require the payments to the nursing facilities be based on the facilities' "financial need" and be "paid directly to the targeted nursing facilities for direct health care services for Medicaid residents." *Id.* at 17. As to **that** recommendation, CMS agreed in principle but stated that it would require regulatory change which it did not then have sufficient resources to pursue. *Id.* at 18. The present disallowance does not involve CMS requiring that the nursing facilities show financial need or that payment be made "directly" for direct services to Medicaid residents. Our resolution is based on the failure to transfer the funds to the nursing facilities' use and control in any practical sense.

CMS's responses to the other OIG reports are even less relevant. In North Carolina's report, OIG recommended CMS should "require state plans to contain assurances" that supplemental payments to hospitals "will be retained by the hospitals and used to provide services to Medicaid eligible individuals." Alabama Ex. 12, at 17. CMS did not concur

¹² OIG's primary concern was that upper payment limits for enhanced payments were calculated in a manner that allowed some public providers to receive far more than private providers and far more than their actual costs of services as a means of obtaining federal participation in expenditures in public nursing facilities beyond that provided for by the state's FMAP. Alabama Ex. 11, at 5-6, 9-11. CMS largely concurred and issued new regulations concerning upper payment limits. *Id.* at 17-22.

¹³ We note that this report further confirms the evidence that the nursing facilities had committed to permit 96.5% to be cycled through their accounts and returned as part of the agreement brokered by the Alabama Hospital Association.

because it lacked authority to tell the hospitals how to use payments they receive from Medicaid reimbursement. *Id.* CMS did not tell the nursing facilities here how to use funds received from Medicaid as reimbursement for services, and in fact these were not funds received by the facilities nor were the funds reimbursement for services. In the multi-state report, OIG recommended that CMS require states seeking FFP to “demonstrate that the enhanced payments were actually made available to the facilities and that the facilities used the funds to furnish Medicaid-approved services” Alabama Ex. 13, at 33. It is true, as Alabama points out, that CMS commented that “[o]nce a Medicaid payment is made to a medical provider, the funding is then available to that provider to use as the provider sees fit.” *Id.* But Alabama failed to quote the immediately preceding language in CMS’s comment: “We concur with the first part of this recommendation. It is current policy that states must make an expenditure in order for FFP to be available.” *Id.* That is precisely the basis for our upholding this disallowance, i.e., that the state did not make an expenditure because the funding was **not available** to the facilities for them to use as they saw fit.

III. Alabama has not shown that the nursing facilities had allowable Medicaid expenditures that qualified as CPEs.

As stated earlier, beginning in November 2006, Alabama reduced the amount of the supplemental payments it deposited in the nursing facilities’ accounts by the amount of the state share of each payment, and then claimed the state share as a CPE. Alabama Br. at 11, 23, citing Alabama Exs. 21, 24-26, Ex. M to Ex. 35; CMS Br. at 19-25. CMS argues that Alabama’s state Medicaid plan does not provide for CPEs to fund the supplemental payments, that the claimed CPEs were not certified as allowable Medicaid expenditures by an “official statement by an authorized representative of the contributing public entit[ies],” and that the claimed CPEs exceeded the nursing facilities unreimbursed costs and “represented expenditures by the nursing homes for which the nursing homes had already been reimbursed by CMS.” CMS Br. at 36-37.¹⁴

We sustain the disallowance related to the CPEs because Alabama has not shown the required certification that the unreimbursed expenditures the nursing facilities made were allowable Medicaid services. Thus, Alabama did not carry its evidentiary burden. *See, e.g., Mo. Dep’t of Soc. Servs.*, DAB No. 2589, at 7 (2014), citing *Utah Dep’t of Health*, DAB No. 2462, at 21 (2012), and *N.Y. State Dep’t of Soc. Servs.*, DAB No. 204, at 5 (1981) (Board has long held that states have the burden to document the allowability of the costs for which they claim federal funding).

¹⁴ As with the IGTs, CMS also asserts that the CPEs did not derive from state or local taxes and were thus not protected from disallowance by section 1903(w)(6) of the Act. Alabama responds (as with the IGTs) that the nursing facilities made CPEs based on the “public funds” language of the state share regulations at section 433.51. We have already discussed why these arguments are unfounded and unnecessary given our resolution of the case.

Section 433.51 of the regulations permits states to include in the state share public agencies' expenditures of public funds that are "certified by the contributing public agency as representing expenditures eligible for FFP under this section [the Medicaid program]" if the public funds "are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds." Section 1903(w)(6) of the Act protects those CPEs (like IGTs) derived from state and local taxes, if they are not derived from prohibited provider taxes and donations. The Board has stated that "the plain meaning of the language of section 1903(w)(6) of the Act and 42 C.F.R. § 433.51 requires CPE[s] to be supported with an official statement by an authorized representative of the contributing public entity confirming that the expenditures qualify as Medicaid medical assistance or other allowable Medicaid expenditures." *Mo. Dep't of Soc. Servs.* at 7-8.

Alabama says "the nursing facilities' uniform cost reports from the previous year" constituted its certification. Alabama Br. at 23. Those reports "required that the officer or administrator of the facility sign the cost report and certify" that the cost report "is a true, correct, and complete report prepared from the books and records of the provider(s) in accordance with applicable Alabama Medicaid Reimbursement Principles. . . ." *Id.* at 23-24, citing Ex. K to Alabama Ex. 35 (Decl. of Ala. Acting Comm'r).

Alabama provides as an example a three-page cost report for one facility for one fiscal year. Ex. K to Alabama Ex. 35. The organization of the cost report implies that the provider claims Medicaid costs on a per-bed-day rate. *See also* Alabama Br. at 5 (enhancement pool of aggregate supplemental payments "was divided between qualifying nursing facilities based on each facility's number of Medicaid resident days").¹⁵ The document bears the notarized signature of the facility Administrator, who certifies "to the best of my knowledge and belief" the document "is a true, correct, and complete report prepared from the books and records of the provider(s) in accordance with applicable Alabama Medicaid Reimbursement Principles, except as noted." Ex. K to Alabama Ex. 35.

The cost report is not adequate as a certification of public expenditures eligible as the state share for several reasons. For one thing, the content of the certificate relates only to the accuracy of the cost information in the report and does not certify that particular expenses incurred by the facility constitute "expenditures eligible for FFP." More

¹⁵ Thus, the report shows the number of "Beds Available" at the beginning and end of the period, the "Resident Days Available," "Resident Days Utilized," and resulting "Percent of Occupancy." *Id.* at 1. The resident days for each month are broken down into "Medicaid Days," "Medicare Days," "All Other," and "Holding Bed Paid Days," along with a figure for "Available Bed Days." *Id.* at 2. Finally, total expenses, total equity capital, and total resident days are recorded. *Id.* at 3.

fundamentally, the report and certification do not provide any assurance, as required for use as state share, that the reported costs were not otherwise reimbursed. That is to say, nothing in the exhibit shows that expenditures by the nursing facility that were being used as state share were incurred in addition to, and did not duplicate, costs that the nursing facility claimed for federal reimbursement – a basic and obvious requirement for the costs to be allowable as CPEs. Alabama nowhere explains how it could determine which, if any, of the reported “bed days” were not already included in the facility’s Medicaid reimbursement. Alabama identified no other document in the record that would establish that the nursing facilities expended the amounts claimed as CPEs for allowable Medicaid costs in which Alabama did not claim FFP. The cost report expenditures thus were not shown to be related to or available for counting as state share of the purported supplemental payments.

Alabama instead relies on the Board decision in *Missouri* as holding “a government provider’s use of cost reports to certify public expenditures consistent with legal authority.” Alabama Br. at 25, citing DAB No. 2589, at 12. *Missouri* in that case cited CMS’s approval of a Virginia state Medicaid plan amendment that “provided for the state agency to draw down FFP ‘to cover unreimbursed Medicaid costs for inpatient services provided by non-state government owned hospitals [i.e., hospitals owned or operated by a unit of government other than the state] as certified by the provider through cost reports.’” DAB No. 2589, at 12 (emphasis and brackets in original). According to Alabama, the Board “distinguished Virginia’s use of cost reports from Missouri’s attempt to use the private hospital’s cost reports ‘because a government owned hospital may serve as a ‘contributing public agency’ within the meaning of’ the public-funds regulation.” Alabama Br. at 25, citing DAB No. 2589, at 12.

Alabama’s reliance on *Missouri* is misplaced. We do not conclude in this case that the county nursing facilities were ineligible to serve as contributing public agencies nor do we conclude that public agencies may never provide the required certifications through their cost reports. In *Missouri*, however, the Board made clear that the approved Virginia plan amendment “provided for the state agency to draw down FFP ‘to cover *unreimbursed* Medicaid costs’” for inpatient services. DAB No. 2589, at 12, quoting Mo. Ex. 25, at 120 (Va. SPA) (emphasis added); *see also Neb. Dep’t of Health & Human Servs.*, DAB No. 2177, at 5 (2008) (certification that “sufficient state funds have been expended to comply with the Medicaid non-federal matching requirements” also certified that “[a]ll federal funds were excluded” and that “[t]he claim is not a duplicate of any other claim for reimbursement”). *Missouri*’s cost reports were inadequate primarily because the representations and information included in the cost reports were not made “by an official of any government entity.” DAB No. 2589, at 12. Alabama’s cost report is inadequate not because of who certified it but because of what it does **not** certify, i.e., that the expenditures were for Medicaid costs not already reimbursed.

Alabama also cites an email and a draft internal CMS memorandum from a CMS financial specialist as allegedly showing that Alabama began using CPEs “[a]t CMS’s urging” and that the CPE system “complied with federal requirements.” Alabama Br. at 9-10, 23, citing Alabama Exs. 21, 24. We disagree with this characterization of the documents, neither of which shows that CMS encouraged or permitted the use of CPEs not based on certifications meeting the applicable content requirements.

We accordingly conclude that Alabama has not shown that the nursing facilities incurred CPEs in amounts equal to the state share of the supplemental payments that Alabama did not deposit into the facilities’ bank accounts.

Conclusion

For all of the reasons stated above, we sustain the disallowance of \$69,534,112 in Medicaid FFP in the supplemental payments.

_____/s/
Sheila Ann Hegy

_____/s/
Constance B. Tobias

_____/s/
Leslie A. Sussan
Presiding Board Member