DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

MAY 0 2 2014

Ms. J. Ruth Kennedy
Medicaid Director
Department of Health and Hospitals
628 N 4th Street
P.O. Box 91030
Baton Rouge, LA 70821-9030

Dear Ms. Kennedy:

I am responding to your request to approve Louisiana State Plan Amendments (SPAs) 13-23, 13-25, and 13-28. The Centers for Medicare & Medicaid Services (CMS) received SPAs 13-23 and 13-25 on June 27, 2013, with proposed effective dates of June 24, 2013. SPA 13-28 was received on July 12, 2013, with a proposed effective date of October 1, 2013. The amendments propose to provide for supplemental Medicaid inpatient hospital payments and disproportionate share hospital (DSH) payments to private hospitals participating in public-private partnerships. Because Louisiana did not establish that the overall arrangements would be consistent with sections 1902(a)(2), 1902(a)(4), 1903(a), and 1903(w) of the Social Security Act (the Act), I am unable to approve Louisiana SPAs 13-23, 13-25, and 13-28.

As explained in more detail below, the issue is that Louisiana did not establish that the arrangements were consistent with the restrictions on claims for federal Medicaid funding when a state receives donations from, or imposes taxes on, providers or provider-related entities. To the extent that the arrangements would not be consistent with those restrictions, effectively there would be insufficient non-federal contributions to support the proposed claims for federal funding. Therefore, CMS could not determine that the proposed state plan amendments were a sound basis for claims for federal financial participation (FFP). This disapproval action is about specific financial transactions related to the Cooperative Endeavor Agreements (CEAs) and the associated Medicaid payments for which FFP is sought; it is not about how Louisiana manages its charity care system.

Section 1903(w) of the Act generally places limitations on the use of provider-related donations and taxes as funding sources for expenditures claimed by states as the basis for federal financial participation (FFP). Among these limitations, as set forth in implementing regulations at 42 CFR 433.54, expenditures are not allowable, and FFP is not available, to the extent that the state receives provider-related donations and there is a "hold harmless arrangement" under which providers (or the provider class) could be effectively repaid for a provider-related tax or donation through any direct or indirect payment, offset, or waiver. These would be "non-bona fide" provider-related donations. A hold harmless arrangement is defined to include circumstances in which an increased Medicaid payment is conditional on the receipt of a donation.

Limitations on provider-related donations are relevant because the supplemental and DSH payments made under the SPAs appear to be linked to the CEAs that provide, among other things, for donations of payments from privately owned hospitals (characterized as advance lease payments, but that appear to be provider-related donations) that are returned to the private hospitals in the form of increased Medicaid payments. This would constitute a hold harmless arrangement. Specifically, SPA 13-23 would provide for supplemental Medicaid payments for inpatient hospital services to privately owned hospitals participating in CEAs in New Orleans and Lafayette. SPAs 13-25 and 13-28 would provide for DSH payments to privately owned hospitals participating in CEAs in New Orleans, Lafayette, Houma, Lake Charles, Shreveport, and Monroe. These hold harmless arrangements would trigger the limitations on provider-related donations; specifically, they would require a reduction in allowable expenditures, and in FFP that could be claimed.

The SPAs at issue would not comply with the requirements of sections 1902(a)(2) and 1902(a)(4) of the Act. Section 1902(a)(2) of the Act requires that the state plan provide for the non-federal share of expenditures under the state plan, from either state or local funding. Because the SPAs at issue propose to claim for FFP without adjustment to reflect unallowable expenditures, they would result in a non-federal share that would be insufficient to meet the requirements of section 1902(a)(2). Moreover, section 1902(a)(4) of the Act requires that the state plan comply with methods of administration as are found necessary by the Secretary for the proper and efficient operation of the plan. Among the implementing regulations for section 1902(a)(4) of the Act is the requirement at 42 CFR 430.10 that a state plan contain all information necessary for CMS to determine that the plan can be approved to serve as a basis for FFP in the state program. Because the state has not established that the supplemental payments are not part of a hold harmless arrangement that would result in a reduction in FFP, we cannot conclude that the SPAs are consistent with section 1902(a)(4) and the implementing regulations at 42 CFR 430.10.

The restrictions on provider-related donations are also relevant to a determination of whether the SPAs at issue comport with the broad principles of the federal-state partnership embodied in section 1903(a) of the Act, because they indicate circumstances in which the federal government would pay more than its share of the net expenditures, after accounting for claimed expenditures that are effectively repaid by the provider-related donations.

The agreements provide for annual facility and equipment leases along with a payment that the state has called advance lease payments. These advance lease payments are not usual and customary industry payment arrangements, and are linked to the CEA which is also linked to the increased Medicaid payments. As a result, these payments are, in effect, provider-related donations that are repaid through a hold harmless arrangement and thus are non-bona fide provider-related donations. The state indicated that the base lease payments are based on fair market value appraisals done by independent third-party professionals in the field of hospital valuation, and thus appear to comport with normal business practices. The advance lease payments do not appear to be justified in the same way. University Hospital and Clinics-Lafayette and Lafayette General Medical Center are under one CEA, and have made an advance lease payment of $15.8 million, and University Medical Center Management Corporation-New Orleans and Louisiana Children's Medical Corporation are under another CEA and have made

advance lease payments of $250 million. The information submitted by the state indicates that these advance lease payments are in excess of the fair market value of the leased property. The state describes the advance lease payments as "an upfront, good faith gesture on the part of private partners required by the state in an effort to objectively express each private partner's interest in and commitment to consummating the underlying relationship contemplated in the CEA." However, we are not aware of any other examples of advance lease payments of this magnitude in the state's ordinary course of business. As such, they appear to be a non-bona fide provider related monetary donation from the private hospitals to the state or related governmental entity.

The non-bona fide provider related donations are directly linked to higher Medicaid payments. Only providers that agree to participate in a CEA are eligible to receive the additional Medicaid and DSH payments under the proposed SPAs. The hospitals that sign the CEA agreements receive supplemental inpatient hospital payments capped at their Medicaid charge levels and DSH payments at 100 percent of net uncompensated care cost, whereas other private hospitals are paid less for inpatient care and at lower percentages for uncompensated care. The payments are made in lump sums that assume that the private hospitals participating in the CEAs will provide similar levels of Medicaid and uninsured care as was previously provided by the public charity care hospital system notwithstanding that the pattern of care might be different. For instance, SPA 13-23 proposes that supplemental payments of $23.7 million FFP would be paid to University Hospital and Clinics-Lafayette and Lafayette General Medical Center, as an entity with a CEA, for state fiscal year (SFY) 2014. The SPA proposes that supplemental payments of $42.2 million FFP would be made to University Medical Center Management Corporation-New Orleans and Louisiana Children's Medical Corporation, as an entity with a CEA, in SFY 2014. Additionally, SPAs 13-25 and 13-28 propose that six hospitals, which have entered in CEAs with LSU, including the facilities proposed to receive supplemental payments under SPA 13-23, would qualify for combined DSH payments of $297 million FFP in SFY 2014.

As a result, we cannot conclude that the proposed SPAs provide a basis for FFP in the state program. Additionally, the state has not established that the proposed payments are not part of a hold harmless arrangement and we are unable to determine that the financing arrangements are consistent with 1903(w) of the Act or 42 CFR 433.54.

For these reasons, after consulting with the Secretary as required by 42 CFR 430.15, I am disapproving the SPAs.

If you are dissatisfied with this determination, you may petition for reconsideration within 60 days of the receipt of this letter, in accordance with the procedure set forth in federal regulations at 42 CFR 430.18. Your request for reconsideration should be sent to: Ms. Barbara Washington, Centers for Medicare & Medicaid Services, Center for Medicaid and CHIP Services, 7500 Security Boulevard, Mailstop S2-26-12, Baltimore, Maryland 21244-1850.

If you have any questions or wish to discuss this determination further, please contact:
Mr. Bill Brooks, Associate Regional Administrator, Centers for Medicare & Medicaid Services, Region 6, 1301 Young Street, Room 833, Dallas, Texas 75202.

Sincerely,

Marilyn Tavenner

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