Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

VIA ELECTRONIC MAIL ONLY

April 23, 2015

Bill Brooks
Centers for Medicare and Medicaid Services
Division of Medicaid and Children's Health Operations
Dallas Regional Office
1301 Young Street, Suite 833
Dallas, TX 75202

RE: LA SPA TN 14-0041 RAI Response
Nursing Facilities Reimbursement Methodology Supplemental Payments

Dear Mr. Brooks:

Please refer to our proposed amendment to the Medicaid State Plan submitted under transmittal number (TN) 14-0041 with a proposed effective date of November 22, 2014. The purpose of this SPA is to amend the provisions governing the reimbursement methodology for nursing facilities to adopt provisions for supplemental Medicaid payments to qualifying non-state, government-owned or operated nursing facilities that enter into an agreement with the department. We are providing the following additional information as requested in your RAI correspondence dated March 26, 2015.

SIGNED AGREEMENTS

1. On February 18, 2015, CMS received the State's response to our Informal Request for Additional Information (IRAI). We understand that the State disagrees with our listing the non-state governmental nursing facilities for FFY 2015 on the Attachment 4.19-A page 9m.

   In a telephone conversation, CMS was advised that Hospital Service Districts would be buying private nursing homes. CMS has concerns that such financial arrangements meet the definition of non-bona fide provider donations as described in federal statute and regulations.

   Detailed information needs to be provided to determine whether the dollar value of the contracts between private and public entities have any fair market

valuation. There can be no transfer of value or a return or reduction of payments reflected in these agreements.

If the state is proposing to make supplemental payments to any or all of the current five NSGO NFs, the state must provide, for those facilities, copies of all signed, or under consideration, Cooperative Endeavor Agreements, lease agreements, Intergovernmental Transfers (IGTs), management agreements, MOUs, management contracts, loan agreements, and any other agreements that would present the possibility of a transfer of value between any two entities. The qualifying NFs must be identified in the state plan. Please submit the revised plan pages for our review.

A similar submission will be required should the state propose to qualify additional NSGO NFs for supplemental payments. CMS expects to review all future non-state governmental NF funding arrangements in Louisiana to insure compliance with SMDL#14-004 issued on May 9, 2014. CMS will carefully review these future arrangements. CMS will require a revised State plan for each new non-state NF.

Whether the State is a party to the financial arrangement or not, the State is ultimately responsible to ensure that the funding is appropriate. The State would be responsible for refunding any FFP if CMS finds the funding source inappropriate.

Response:
In the future, should a non-state governmental entity (NSGO entity), such as a hospital service district (HSD), desire to own or operate a nursing facility (NF) or an additional NF, the NF will undergo a change of ownership (CHOW) whereby the NSGO entity will become the owner and/or operator of the NF, making the NF a non-state government owned and/or operated nursing facility (NSGO NF).

As defined in 42 C.F.R. §433.54 and described in State Medicaid Director Letter (SMDL) 14-004 (May 9, 2014), a non-bona fide provider donation is a donation made directly or indirectly by a provider to a State or unit of government, that is determined to have a direct or indirect relationship to Medicaid payments, as a result of the donations being returned to the provider under a "hold harmless" provision or practice, such as: (1) the payment amount from the unit of government being positively correlated to the donation from the provider; (2) any or all of the payment amount from the unit of government varying based on the amount of the donation from the provider; or (3) the unit of government receiving the donation from the provider, guarantees the return of any portion of the donation to the provider through a payment. This is <u>not</u> what is being proposed by the Department.

As stated in paragraph #1 of this response, the NSGO entity becomes the owner and/or operator of the NSGO NF. Any financial arrangements between a NSGO entity and the former owner of the NF will not result in a non-bona fide provider donation, as no funds will be donated to the NSGO entity in return for a supplemental payment. Rather, any services or real or tangible property the former NF owner provides or transfers to the NSGO entity would be compensated based upon the fair market value of such services or property. In addition, there would be no "hold harmless" provision, as there would not be a positive correlation

between the services and property the former NF owner provides to the NSGO entity and the supplemental payments; the supplemental payments would not be conditioned on the former NF owner providing any services to the NSGO entity; and there would not be a guarantee that the former NF owner will see a return of any services or property provided to the NSGO entity through a supplemental payment. Rather, any compensation paid by the NSGO entity to the former NF owner for services or property related to the NSGO NF would be fair market value compensation for such services or property.

There are no Cooperative Endeavor Agreements (CEAs), lease agreements, Intergovernmental Transfers (IGTs), management agreements, Memorandums of Understanding (MOUs), management contracts, loan agreements, and any other agreements, neither signed nor under consideration, that would present the possibility of a transfer of value between any two entities. Due to the initial stages of this SPA, these agreements and relationships have not yet been developed.

We respectfully disagree with the suggestion that there will be multiple revisions to the State Plan whenever additional NFs might be added to the proposed program. The Department understands it is responsible for ensuring that the funding arrangements are appropriate, consistent with the SPA and relevant federal laws and therefore, as part of the Department's review of the CHOWs, the Department will carefully scrutinize the CHOWs and the CHOW questionnaire responses (see below #11) to determine whether the proposed new licensed and certified provider meets federal and state criteria as a NSGO entity.

Additional Questions from the State's response to the IRAI

2. In IRAI response for Question 1 – CMS still has only the hypothetical number for the budget impact which is based on estimates of 75 and 100 facilities for 2015/2016. How did the State estimate that in 2015, 75 facilities would qualify as NSGO and seek agreements to receive supplemental payments?

   Response:
   The number "75" was only an estimate. The Department did not discuss the programs directly with any NFs to determine the degree of interest by the NFs to enter into a CHOW transaction with a NSGO entity which then the NSGO will enter into agreements to qualify to receive supplemental payments. As we stated in our IRAI response for Question 1, as there are currently only five NSGO NFs eligible under transmittal number (TN) 14-0041, it would be more accurate to provide a FFP determination for only the five NSGO NFs that are currently eligible under TN 14-0041. Please see attached Exhibit A for the budget impact based on only five NSGO NFs for 2015/2016.

3. In IRAI response for Question 5 – The state's proposed language requires that NSGO entities must enter into an "agreement" with the Department to participate and qualify for a Medicaid supplemental payment. What is the purpose of the agreement and will this be a standard template agreement? Have any NSGO entities entered into such an agreement

with the Department? If yes, please provide a copy of the agreement. If no agreements have been executed, please provide a copy of the agreement document.

Response:
The Department proposed this language to be more specific on how a provider qualifies for supplemental payments. This agreement is to ensure that the NSGO entity that owns and/or operates the NSGO NF voluntarily agrees to make the IGT and also qualifies for Medicaid supplemental payments. This agreement will be a standard template agreement. At this time, no NSGO NFs have entered into an agreement with the Department; however, a copy of the draft agreement can be provided to CMS once completed.

4. In IRAI response for Question 6 – Does the State expect that the five current NSGO facilities will seek to enter into an agreement to receive supplemental payments?

Response:
Yes, the state does expect that the five current NSGO facilities will seek to enter into an agreement to receive supplemental payments.

5. In IRAI response for Question 10 – Please clarify the last sentence of the State's response. It states "In addition, supplemental payments will provide resources that enhance services on the continuum of care between rural hospitals and nursing facilities in order to improve coordination of care, transfer/discharge relationships, and reduce hospital readmissions." What are the enhanced services? How will the State monitor the reduction of hospital readmissions?

Response:
The supplemental payments will provide resources which will allow the NSGO NFs to enhance the services they already provide, thereby improving quality of care and survey and inspection results. As NFs have different areas of quality improvement needs, NSGO NFs will seek to improve quality through individualized programs and initiatives. Some quality initiatives include:

- **improving medication management and use of antipsychotic medication to ensure that they are used appropriately and any continued use of these medications is carefully monitored; and**
- **increasing NSGO NFs Registered Nurse (RN) staffing ratios.**

The additional resources will also allow the NSGO NFs to provide new enhanced services. Some additional examples of enhanced services or quality initiatives that will be implemented, based upon what is needed for better patient care, also include:

- **emergency preparedness training;**
- **efficiency and processes training; and**
- **wound care programs or certifications.**

All of these enhanced, new services will allow the NFs to improve the overall goal of quality of care, as well as reduce hospital readmissions.

In addition, any relationship between the NSGO NF and any NSGO entity will give the NSGO NF the opportunity to conduct and implement best practices regarding quality reviews, inspections and care improvement, as well as exchange expertise, in an effort to improve overall care.

The State will monitor the reduction of hospital readmissions using CMS data.

6. In IRAI response for Question 11 – Do the five NSGO facilities only serve Medicaid patients? Are any of the five facilities facing precarious financial conditions?

Response:
No, these five NSGO NFs do not serve Medicaid patients only; however, these five NSGO NFs have high Medicaid populations averaging approximately 73 percent of residents. The five NSGO NFs are not in precarious financial conditions, but do operate on tight margins. In addition, Louisiana's median NF reimbursement rate for all payor sources is one of the lowest compared to all states, as demonstrated by a Genworth Study (please see attached Exhibit B); and Louisiana's NF Medicaid reimbursement rate is one of the lowest in the nation. These supplemental payments will provide additional resources for better patient care.

7. In IRAI response for Question 12 – What is the patient mix of the current five non-state nursing facilities? What is the percentage of Medicaid patients that are in these five non-state nursing facilities? What evidence or documentation does the State have that a private nursing facility will have the same high acuity needs versus a non-state nursing facility?

Response:
The five NSGO NFs serve Medicare, Medicaid, and Private Pay populations, with Medicaid composing approximately an average of 73 percent of the total population.

All Louisiana NFs have high acuity needs as demonstrated by total activities of daily living (ADLs). Louisiana NF patients requiring assistance with activities of daily living, or total ADLs, are greater than the national average and are the 14th highest as compared to all states. In addition, Louisiana has the second highest proportion of people, age 65 and over, with any disability. The high number of elderly individuals living in poverty, coupled with the high levels of individuals that require nursing care and help with numerous ADLs, presents high acuity patients in all NFs (public and private).

8. In IRAI response for Question 13 – Please provide details on how payments will positively impact quality of care.

Response:
These payments will impact quality of care by improving the relationships between the NSGO NFs and their hospital partners, specifically with regard to coordinating care, transferring and discharging patients, and reducing hospital readmissions. NSGO NFs and their hospital partners will utilize each entity's expertise to further

refine, improve, and expand services for better patient care. In addition, NSGO NFs and their hospital partners will mutually assist each other with conducting quality reviews, inspections, and surveys in order to continually evaluate and improve quality of care.

NSGO NFs will have a greater opportunity to undertake more capital projects and implement individual quality initiatives determined to be most important to their individual facility and resident population and for which they would not otherwise have funding. These additional funds will allow NSGO NFs to develop programs tailored to specific Medicaid patient needs, such as:

- **additional educational opportunities and training for staff to improve staff services and staff-patient relationships;**
- **wound care and certification; and**
- **improving and updating the NFs current services such as medication management and RN staffing ratios.**

As also addressed in our response to #5, above, the possibilities to improve quality of care are greatly enhanced with the opportunities afforded by these supplemental payments.

9. In IRAI response for Question 18 – CMS expected the State to be more specific in this question. For example, the base rate is $150 per diem and the supplemental payment will increase that payment by $75? Please review question#18 and provide a more specific response.

Response:
Louisiana's average Medicaid per diem rate for the five NSGO NFs is $156. The supplemental payment is expected to increase rates for the five NSGO NFs by an average of $39 per day.

10. In IRAI response for Questions 24 through 27 – Is the State indicating that HSDs can acquire nursing homes?

Response:
Yes. According to Louisiana law, HSDs have the authority to own or operate nursing facilities, including by acquisition.

11. In IRAI response for Question 31 – What does the following phrase mean? "In the future, the ownership of the property and equipment of any potentially eligible NSGO NF will be reviewed as part of the change of ownership". Please explain the financial transactions, leases, and agreements the state expects will occur between the HSD and the private nursing home to effect the change of ownership. For instance, will the private nursing home be purchased for fair market value?

Response:
In the event a NF undergoes a CHOW with a NSGO entity that results in a NSGO NF that is potentially eligible for supplemental payments, the Department will

review such CHOW. As part of its review, the Department will ask the NSGO entity to complete a questionnaire where the NSGO entity will describe the ownership of the facility, operations, property and equipment. The questionnaire has not yet been developed, but will likely ask the preparer to answer questions and submit supporting documentation regarding:

- **the relationship between the previous owner and the new NSGO entity owner of the NF;**
- **whether the CHOW transaction is a bona fide sale or lease arising from an arm's length transaction between unrelated parties;**
- **whether the NF is owned or directly operated by a NSGO entity and whether the NSGO entity is the holder of the NF license and the signatory on the provider agreement;**
- **whether the NSGO entity is exercising governance over the NF;**
- **whether the NSGO entity that operates the NF has obligations to fund the NF's expenses, liabilities, and has ultimate liability for the operation of the NF;**
- **whether the NSGO entity that operates the NF has the ability to fund the NF; and**
- **whether the NSGO entity has the ability to make a permissible IGT.**

Such questionnaire and resulting answers will ensure that the NF's owner is an NSGO that "owns or operates" the NF for licensure and certification purposes, and that the NSGO entity agrees to comply with any other standards for the program. In addition, the questionnaire will require the individual completing the questionnaire to certify that the information provided is true, accurate and complete and that all representations have been adequately disclosed, thereby placing ultimate liability for rates calculated in the questionnaire, on the preparer.

The Department is unsure what financial transactions, leases, and agreements will occur between a NSGO entity and a private NF to affect the change of ownership, as these have not yet occurred. However, as part of the Department's review, it will carefully analyze all agreements and financial arrangements as part of its questionnaire.

12. In IRAI response for Question 42 – When the State notes that the funds will come from the non-state government entities; does that mean the funds will come from the HSD or from the NF? It does not appear that new funds will be raised by the HSD.

Response:
The current five NSGO NFs themselves, or the HSDs governing them, will be the NSGO entities funding the IGT. In the event HSDs own or operate NSGO NFs in the future, the HSD will make a permissible IGT and fund it. The HSDs have the ability to fund the IGT under state law as the HSDs are political subdivisions that have the authority to levy taxes and issue bonds. They also have authority to acquire other health care entities, such as nursing facilities.

Please consider this a formal request to begin the 90-day clock. We trust that this additional information will be sufficient to result in the approval of the pending plan amendment. We look forward to negotiating with CMS to ensure approval.

As always, we appreciate the assistance of Tamara Sampson in resolving these issues. If further information is required, you may contact Darlene A. Budgewater at Darlene.Budgewater@la.gov or by phone (225) 342-3881.

Sincerely,

J. Ruth Kennedy
Medicaid Director

JRK/DAB/MVJ

Attachments (2)

c: Ford Blunt
Darlene Budgewater
Tamara Sampson

Louisiana Upper Payment Limit Calculation
Non-State Government Owned or Operated
Medicare/Medicaid Payment Differential
For State Fiscal Year 2015 (July 1, 2014 - June 30, 2015)

(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J) = (E)+(F)+(G)+(H)+(I)	(K) = (D) - (J)	(L)	(M) = (L) * 20%	(N)	(O) = (L)+(M)+(N)	(P) = (K) +(O)
					Medicaid Payments Outside of Per Diem Rate						Adjustments to Payment Differential				
CMS #	Medicaid Provider Number		[1] Total Calculated Medicare Reimbursement for Medicaid Receipients	[2] Calculated Medicaid Reimbursement (From Per Diem)	[3] Calculated Medicaid Specialized Care Reimbursement	[4] Calculated Medicaid Leave Day Reimbursement	[5] Calculated Medicaid Private Room Conversion Reimbursement	Other Medicaid Supplemental Payments	Total Medicaid Reimbursement	Total Medicare to Medicaid Payment Differential Prior to Adjustments	[6] LESS: RX	[6] PLUS: Medicaid Pharmacy Rebate (Claw-back)	[7] LESS: Lab / X-Ray	Total Payment Differential Adjustments	Total Medicare to Medicaid Payment Differential
V56001	0051840		$ 2,936,281	$ 2,220,558	$ -	$ 3,329	$ -	$ -	$ 2,223,887	$ 712,394	$ (386,508)	$ 77,302	$ (257)	$ (309,463)	$ 402,931
E16015	0051137		$ 2,532,542	$ 1,643,421	$ -	$ 429	$ -	$ -	$ 1,643,850	$ 888,692	$ (320,297)	$ 64,059	$ -	$ (256,238)	$ 632,454
L29002	0051000		$ 5,864,593	$ 4,220,847	$ -	$ 12,029	$ -	$ -	$ 4,232,876	$ 1,631,717	$ (794,874)	$ 158,975	$ (50)	$ (635,949)	$ 995,768
N34003	0051200		$ 5,150,138	$ 3,876,692	$ -	$ 1,176	$ -	$ -	$ 3,877,868	$ 1,272,270	$ (699,316)	$ 139,863	$ -	$ (559,453)	$ 712,817
S45001	0051617		$ 3,933,539	$ 2,645,583	$ -	$ 5,808	$ -	$ -	$ 2,651,391	$ 1,282,148	$ (499,846)	$ 99,969	$ (91)	$ (399,968)	$ 882,180

Total Annual Differential/Fiscal Impact **$ 3,626,150**

NOTES:

(1): Calculated Medicare Reimbursement for Medicaid recipients were established using December 31, 2013 MDS assessments multiplied by Medicaid paid claims days (dates of payment 5/1/2013 - 4/30/2014).

(2): Nursing facility calculated Medicaid reimbursement was created using the 7/1/2014 Medicaid provider reimbursement rates multiplied by Medicaid paid claims days (dates of payment 5/1/2013 - 4/30/2014)

(3): Specialized care reimbursement is paid outside of the standard per diem rate as an add-on payment to the current facility per diem rate. The established specialized care add-on per diems (TDC, NRTP-R & NRTP-C) were multiplied by Medicaid paid claims for specialized care days from the State's MMIS system for the period of 5/1/2013 - 4/30/2014 (dates of payment) to determine total specialized care reimbursement for SFY 2015.

(4): Allowable Medicaid Leave days were established using Medicaid paid claims for leave days from the State's MMIS system for the period of 5/1/2013 - 4/30/2014 (dates of payment) multiplied by the 7/1/2014 Medicaid Leave day rates to establish Medicaid Leave day reimbursement for SFY 2015.

(5): Private Room Conversion (PRC) Medicaid days were established utilizing reviewed/audited 2012 Medicaid Supplemental cost reports (CRYE 1/1/2012 - 12/31/2012). The 2012 cost reporting information was annualized to account for short year cost reports. Allowable PRC Medicaid days were multiplied by the PRC incentive payment amount of $5 per allowable day to established the total estimated Medicaid PRC reimbursement for SFY 2015.

(6): The calculated Pharmacy (RX) differential was initially established using State reports from 9/30/2004. These amounts have been trended forward using the SNF Market Basket (without Capital) index published by Global Insights. Inflation has been calculated from 9/30/2004 to the midpoint of SFY 2015 (12/31/2014). The Medicare Pharmacy Rebate is estimated at 20% of the Pharmacy (RX) differential.

(7): The estimated Lab/X-Ray differential was established using State generated reports of expense for the quarter ended 12/31/2013. This amount was inflated to the mid-point of the state year (12/31/14).

Median Cost of Care for Long Term Services and Supports in 2014

State	Homemaker Services (hourly rate)	Home Health Aid (hourly rate)	Adult Day Health Care (daily rate)	Assisted Living Facility (monthly rate)	Nursing Home Semi-Private Room (daily rate)	Nursing Home Private Room (daily rate)
Oklahoma	$18	$20	$60	$3,082	$145	$158
Louisiana	$14	$15	$55	$3,156	$152	$161
Missouri	$19	$19	$75	$2,500	$145	$164
Arkansas	$17	$17	$72	$2,850	$155	$171
Kansas	$18	$19	$70	$3,730	$160	$175
Texas	$18	$18	$35	$3,523	$139	$180
Iowa	$22	$22	$55	$3,418	$169	$185
Georgia	$17	$18	$60	$2,500	$180	$192
South Dakota	$22	$22	$72	$3,110	$186	$194
Alabama	$16	$16	$25	$2,894	$188	$196
Tennessee	$17	$18	$55	$3,465	$185	$198
South Carolina	$18	$18	$50	$2,874	$185	$200
Utah	$21	$21	$47	$3,061	$173	$200
Nebraska	$21	$23	$50	$3,298	$189	$202
Illinois	$20	$21	$67	$3,805	$170	$205
Mississippi	$16	$17	$63	$2,900	$204	$210
Montana	$20	$21	$82	$3,300	$201	$216
Kentucky	$19	$20	$63	$3,264	$200	$220
North Carolina	$17	$18	$51	$2,940	$203	$225
New Mexico	$18	$19	$95	$3,500	$201	$227
Virginia	$18	$19	$61	$3,990	$211	$231
Arizona	$19	$20	$78	$3,150	$197	$233
Idaho	$18	$19	$96	$3,275	$219	$233
Indiana	$18	$20	$70	$3,724	$199	$235
Ohio	$19	$19	$52	$3,971	$208	$239
Wyoming	$20	$20	$84	$3,090	$216	$242
Minnesota	$23	$26	$72	$3,403	$228	$243
Nevada	$20	$22	$71	$3,250	$229	$246
Florida	$18	$19	$60	$3,000	$230	$251
Colorado	$21	$22	$64	$3,313	$217	$252
North Dakota	$25	$25	$57	$3,105	$241	$257
Michigan	$19	$20	$70	$3,200	$241	$260
Oregon	$21	$22	$72	$4,000	$256	$265
West Virginia	$16	$16	$50	$3,465	$254	$265
Wisconsin	$21	$22	$60	$3,850	$239	$267
Washington	$23	$23	$67	$4,250	$253	$280
California	$22	$23	$76	$3,750	$238	$285
Maryland	$19	$20	$76	$3,400	$270	$287
Maine	$21	$22	$100	$4,950	$275	$295
Pennsylvania	$20	$20	$58	$3,280	$272	$295
Rhode Island	$22	$24	$66	$4,895	$250	$300
District of Columbia	$20	$20	$110	$6,890	$294	$303
Vermont	$23	$24	$135	$4,072	$277	$303
Delaware	$22	$23	$50	$5,500	$294	$310
New Hampshire	$23	$25	$69	$4,373	$291	$325
New Jersey	$20	$21	$86	$5,430	$300	$325
New York	$21	$22	$75	$3,684	$340	$358
Massachusetts	$23	$25	$65	$5,247	$346	$368
Hawaii	$23	$25	$74	$4,750	$333	$370
Connecticut	$20	$22	$80	$5,289	$390	$425
Alaska	$25	$25	$103	$5,500	$650	$660

Source:
https://www.genworth.com/corporate/about-genworth/industry-expertise/cost-of-care.html
Accessed: 6/17/14

Exhibit B