DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Dallas Regional Office
1301 Young Street, Room 827
Dallas, Texas 75202

DIVISION OF MEDICAID AND CHILDREN'S HEALTH, REGION VI

17 July, 2015

Reference: **SPA – LA 14-0041**
(Supplemental Payments for Non-Stated Government Owned and Operated Nursing Facilities)

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:

This is to acknowledge the CMS' letter dated 16 July 2015, stating Disapproval of State Plan Transmittals No.14-0041. This action is reflected on the enclosed CMS-179. For your convenience, we are enclosing copies of the material withdrawn.

If you have any questions, please call Tammy Sampson at ext. 214-767-6431.

Sincerely,

Marsha Marks

DN: c=US, o=U.S. Government, ou=HHS, ou=CMS, ou=PIV, serialNumber=D72A10D821086D940A79ADA1685901084242645C872B90C3E8
Date: 2015.07.17 09:06:36 -05'00'

Marsha Marks, Health Insurance Specialist
Centers for Medicare & Medicaid Services
Division of Medicaid and Child Health

Enclosures:
CMS Disapproval Letter Dated 7/16/15
Copies of Disapproved Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

JUL 16 2015

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

Dear Ms. Kennedy:

I am responding to your request to approve Louisiana State Plan Amendment (SPA) 14-0041. The Centers for Medicare & Medicaid Services (CMS) received SPA 14-0041 on December 30, 2014, with a proposed effective date of November 22, 2014. The purpose of this amendment is to allow for supplemental payments to qualifying non-state government owned or operated nursing facilities. Because Louisiana did not establish that the proposal would be consistent with sections 1902(a)(2), 1902(a)(4), 1902(a)(30)(A), 1903(a), and 1903(w) of the Social Security Act (the Act), I am unable to approve this SPA.

Section 1902(a)(30)(A) of the Act requires that states have methods and procedures to assure that payments are consistent with economy, efficiency and quality of care. In addition, section 1902(a)(4) of the Act requires that states have methods of administration that the Secretary deems necessary for the proper and efficient administration of the state plan. Implementing federal regulations at 42 Code of Federal Regulations (CFR) 430.10 and 42 CFR 447.252(b) require that the state plan be a comprehensive written statement containing all information necessary for CMS to determine whether the plan can be approved as a basis for Federal financial participation (FFP) in the state program. To be comprehensive, payment methodologies should be understandable, clear and unambiguous. In addition, because the plan is the basis for FFP, it is important that the plan language provide an auditable basis for determining whether payment is appropriate.

As proposed, to qualify for the supplemental payments, a provider must execute an undefined agreement with the state. CMS requested that the state provide the required agreements and the documentation supporting the relationships, and any related financial transactions between the local unit of government and those facilities proposed to receive the supplemental payments. CMS also requested that the state identify in the plan the non-state government facilities to which the payments would be applicable. The state did not comply with our request and responded that the agreements and relationships have not yet been developed.

Because the state plan does not clearly explain the conditions under which supplemental payments will be made, CMS cannot conclude that the requirements of sections 1902(a)(4) and 1902(a)(30)(A) of the Act have been satisfied.

In addition, CMS requested information regarding the source of the required non-federal share of these proposed payments, consistent with section 1902(a)(2) of the Act. The state indicated that the state share for these payments would come from intergovernmental transfers (IGTs). CMS requested that the state provide details regarding these arrangements. The state could not provide copies of any signed IGT agreements executed by the non-state government entities. As previously mentioned, CMS cannot determine from the state plan the amount of the payments; therefore, we cannot determine the amount of the non-federal share to be provided by the non-state government entities.

Since the IGT agreements have not been executed, the source of the funds that would be transferred could not be determined. Section 1903(w)(6)(A) of the Act indicates that the non-federal share of claimed expenditures may be financed with funds "derived from state or local taxes transferred from or certified by units of government within a state as the non-federal share under this title, regardless of whether the unit of government is also a health care provider, except as provided in section 1902(a)(2), unless the transfer of funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-federal share under this section." Because CMS did not receive supporting documentation to indicate that the source of the transferred funds is permissible, we cannot conclude that the intergovernmental transfers from the non-state government entities were of the nature authorized by section 1903(w)(6)(A) to be used as the non-Federal share of claimed expenditures.

To the extent that the transferred funds are not described under section 1903(w)(6)(A) of the Act, they would be subject to the provider tax and donation limitations under section 1903(w) of the Act. With respect to those limitations, the state has not established that the proposed payments are permissible provider taxes or donations that are not part of a hold harmless arrangement under section 1903(w) of the Act. Section 1903(w) of the Act generally provides that provider taxes or donations that do not meet certain requirements cannot finance the non-federal share of claimed expenditures. Provider taxes must be broad-based and uniform across the class of providers, and neither provider taxes nor donations may be part of a hold harmless arrangement. A hold harmless arrangement is a direct or indirect relationship of a provider tax or donation to Medicaid or non-Medicaid payments that effectively results in repayment of the provider tax or donation. To the extent that the transferred funds do not fall within the IGT exception, they do not appear to be imposed broad-based and uniform across the class of nursing facilities. As a result, CMS is unable to determine that the financing arrangements are consistent with 1903(w) of the Act and 42 CFR 433.54 and 433.68.

In addition, as required by section 1902(a)(2), the state plan must assure adequate funding for the non-federal share of expenditures from state or local resources for the amount, duration, scope or quality of care and services available under the state plan. The state plan services must have adequate funding and must not be contingent upon the availability of the non-federal share in order to be provided. Without further information, CMS cannot conclude that adequate funding

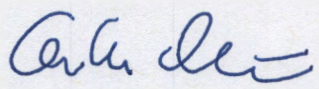
is available now or in future years for the non-federal share of expenditures for the services provided under SPA 14-0041 in accordance with section 1902(a)(2).

Because of these concerns, we cannot conclude that the proposed SPA provides a basis for FFP in the state program under section 1902(a)(2) and 1902(a)(4) of the Act and the overall federal-state financial framework established under section 1903(a) of the Act. For these reasons, after consulting with the Secretary as required by 42 CFR 430.15, I am disapproving the SPA.

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,



Andrew M. Slavitt
Acting Administrator

Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Office of the Secretary

December 30, 2014

Bill Brooks
Associate Regional Administrator
Division of Medicaid & Children's Health
DHHS/Centers for Medicare and Medicaid Services
1301 Young Street, Room #833
Dallas, Texas 75202

Dear Mr. Brooks:

RE: Louisiana Title XIX State Plan
Transmittal No. 14-0041

I have reviewed and approved the enclosed Louisiana Title XIX State Plan material.

I recommend this material for adoption and inclusion in the body of the State Plan.

Sincerely,

Kathy H. Kliebert
Secretary

Attachments (2)

Disapproved Per CMS Letter to State Dated 16 July, 2015

Bienville Building • 628 North 4th Street • P.O. Box 629 • Baton Rouge, Louisiana 70821-0629
Phone #: 225/342-9509 • Fax #: 225/342-5568 • *WWW.DHH.LA.GOV*
"An Equal Opportunity Employer"

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **14-0041**

2. STATE: **Louisiana**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **November 22, 2014**

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447, Subpart C

7. FEDERAL BUDGET IMPACT:
a. FFY **2015** **$83,380.73**
b. FFY **2016** **$100,191.78**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-D, Page 9.m
Attachment 4.19-D, Page 9.m(1)
Attachment 4.19-D, Page 1
Attachment 4.19-D, Page 1a
Attachment 4.19-D, Page 1b

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

NONE – New Page
NONE – New Page
Same (TN 95-01) – Remove
Same (TN 95-01) – Remove
Same (TN 93-08) – Remove

10. SUBJECT OF AMENDMENT: **The SPA proposes 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.**

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The Governor does not review state plan material.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Kathy H. Kliebert

14. TITLE:
Secretary

15. DATE SUBMITTED:
December 30, 2014

16. RETURN TO:

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

Disapproved Per CMS Letter to State Dated 16 July, 2015

FORM HCFA-179 (07-92)

Disapproved Per CMS Letter to State Dated 16 July, 2015

LOUISIANA TITLE XIX STATE PLAN
TRANSMITTAL #: **14-0041**
TITLE: **Nursing Facilities Reimbursement Methodology - Supplemental Payments (UPL)**
EFFECTIVE DATE: **November 22, 2014**

FISCAL IMPACT:
Increase

	year	% inc.	fed. match	*# mos	range of mos.	dollars
1st SFY	2015			7.3	November 22, 2014 - June 30,2015	$94,412,876
2nd SFY	2016	3.0%		12	July 2015 - June 2016	$159,855,226
3rd SFY	2017	3.0%		12	July 2016 - June 2017	$164,650,883

*#mos-Months remaining in fiscal year

Total Increase in Cost FFY **2015**

SFY 2015 $94,412,876 for 7.3 months November 22, 2014 - June 30,2015 $94,412,876

SFY 2016 $159,855,226 for 12 months July 2015 - June 2016
$159,855,226 / 12 X 3 July 2015- September 2015 = $39,963,807
$134,376,683

FFP (FFY 2015) = **$134,376,683** **X** **62.05%** = **$83,380,732**

Total Increase in Cost FFY **2016**

SFY 2016 $159,855,226 for 12 months July 2015 - June 2016
$159,855,226 / 12 X 9 October 2015 - June 2016 = $119,891,420

SFY 2017 $164,650,883 for 12 months July 2016 - June 2017
$164,650,883 / 12 X 3 July 2016 - September 2016 = $41,162,721
$161,054,141

FFP (FFY 2016)= **$161,054,141** **X** **62.21%** = **$100,191,781**

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905(a) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN - ARE DESCRIBED AS FOLLOWS:

Supplemental Payments

A. Effective for dates of service on or after November 22, 2014, any nursing facility that is owned or operated by a non-state governmental entity may qualify for a Medicaid supplemental payment adjustment, in addition to the uniform Medicaid rates paid to nursing facilities.

B. The supplemental Medicaid payment to a non-state, government-owned or operated nursing facility shall not exceed the facility's upper payment limit (UPL) pursuant to 42 CFR 447.272.

C. Payment Calculations. The Medicaid supplemental payment adjustment shall be calculated as follows. For each state fiscal year (SFY), the Medicaid supplemental payment shall be calculated as the difference between:

1. The amount that the department reasonably estimates would have been paid to nursing facilities that are owned or operated by a non-state governmental entity using the Medicare Resource Utilization Groups (RUGs) prospective payment system. For each Medicaid resident that is in a nursing facility on the last day of a calendar quarter, the minimum data set (MDS) assessment that is in effect on that date is classified using the Medicare RUGs system. The Medicare rate applicable to the Medicare RUG, adjusted by the Medicare geographic wage index, equals the Medicaid resident's estimated Medicare rate. A simple average Medicare rate is determined for each nursing facility by summing the estimated Medicare rate for each Medicaid resident in the facility and dividing by total Medicaid residents in the facility; and

2. The Medicaid per diem rate for nursing facilities that are owned or operated by a non-state governmental entity. The Medicaid rate shall be adjusted to include laboratory, radiology, and pharmacy services to account for program differences in services between Medicaid and Medicare. The statewide average of laboratory, radiology, and pharmacy services is calculated using Medicaid cost report data.

D. Each participating nursing facility's upper payment limit (UPL) gap shall be determined as the difference between the estimated Medicare rate calculated in §20029.C.1 and the adjusted Medicaid rate calculated in §20029.C.2.

Each facility's UPL gap is multiplied by the Medicaid days to arrive at its supplemental payment amount. Medicaid days are taken from the Medicaid cost report.

Disapproved Per CMS Letter to State Dated 16 July, 2015

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905(a) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN - ARE DESCRIBED AS FOLLOWS:

E. Frequency of Payments and Calculations

1. For each calendar quarter, an estimated interim supplemental payment will be calculated as described in this Section utilizing the latest Medicare RUGs and payment rates and Medicaid cost reports and available Medicaid payment rates. Payments will be made to each nursing facility that is owned or operated by a non-state governmental entity and that has entered into an agreement with the department to participate in the supplemental payment program.

2. Following the completion of the state's fiscal year, the final supplemental payment amount for the state fiscal year just ended will be calculated. These calculations will be based on the final Medicare RUGs and payment rates and the most recently reviewed Medicaid cost reports and Medicaid payment rates that cover the just ended state fiscal year period. The final supplemental payment calculations will be compared to the estimated interim supplemental payments and the difference if positive will be paid to the non-state governmental entity, and if negative, collected from the non-state governmental entity.

Disapproved Per CMS Letter to State Dated 16 July, 2015