DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Dallas Regional Office
1301 Young Street, Suite 833
Dallas, Texas 75202

DIVISION OF MEDICAID & CHILDREN'S HEALTH - REGION VI

December 1, 2016

Ms. Jen Steele
Interim Medicaid Director
Bureau of Health Services Financing
Louisiana Department of Health and Hospitals
Post Office Box 91030
Baton Rouge, Louisiana 70821-9030

RE: Louisiana 16-0022

Dear Ms. Steele:

We have reviewed the proposed State plan amendment (SPA) to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 16-0022. The purpose of the SPA is to establish new supplemental payments to private intermediate care facilities entering into a cooperative endeavor agreement with the Department to provide a privately operated living setting to residents discharging from Pinecrest Supports and Services Center.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act (the Act) and the regulations at 42 Code of Federal Regulations (CFR) 447 Subpart C. Before we can continue processing this amendment, we need additional or clarifying information.

The regulation at 42 CFR 447.252(b) requires that the State plan include a comprehensive description of the methods and standards used to set payment rates. Section 6002 of the State Medicaid Manual explains further that the State plan must be comprehensive enough to determine the required level of Federal Financial Participation (FFP) and to allow interested parties to understand the rate setting process and the items and services that are paid through these rates. Further, since the plan is the basis for FFP, it is important that the plan's language be clear and unambiguous. Therefore, we have the following questions/concerns regarding TN 16-0022:

FORM-179

1. Form 179, Block 7 – Please provide a detailed analysis of how the FFP determination was made and provide supporting documentation of the calculation for Federal Fiscal

Year (FFY) 2016 and 2017. Also, please include the number of providers that are expected to participate in the new supplemental payments for private ICF/IIDs.

EFFICIENCY, ECONOMY, AND QUALITY OF CARE

2. SPA amendment LA16-0022 proposes to establish a new supplemental payment methodology for private ICF/IID facilities that have a lease arrangement for state-owned ICF/IID beds. Section 1902(a) (30) (A) of the Act requires that payment rates must be consistent with "efficiency, economy and quality of care." Please justify how the establishment of these new supplemental payments is consistent with the principles of "efficiency, economy, and quality of care."

SIMPLICITY OF ADMINISTRATION

3. Section 1902(a) (19) of the Act requires that care and services will be provided with "simplicity of administration and the best interest of the recipients." Please explain why this amendment is consistent with simplicity of administration and in the best interest of the nursing home recipients.

LEGISLATION

4. Please clarify if the State, Parish, or a Hospital Service District has issued any proposals or enacted any legislation to support the new supplemental payments methodology for supplemental payments to private intermediate care facilities entering into a cooperative endeavor agreement with the Department to provide a privately operated living setting to residents discharging from Pinecrest Supports and Services Center. Please submit that documentation for our review.

STATE PLAN LANGUAGE – 4.19-D

5. Please note that this methodology is not comprehensive. To comply with regulations at 42 CFR 447.252(b), the State plan methodology must be comprehensive enough to determine the required level of payment and the FFP to allow interested parties to understand the rate setting process and the items and services that are paid through these rates. Claims for federal matching funds cannot be based upon estimates or projections.

   Currently, the methodology is too broad based. CMS suggests the following changes:

   a. Please send us a list of providers and their address on who is eligible for the new supplemental payments.

   b. Please clarify how a private ICF/IID qualifies for the supplemental payments. Please include specific language on Attachment 4.19-D page 20.

   c. Please clarify why the State is seeking to move patients from the Pinecrest Supports and Services Center to private ICF/IID facilities.

   d. Please provide CMS with the base rates for Pinecrest Supports and Services Center and the private ICF/IID facilities.

e. As you are aware, CMS must have copies of all signed standard Cooperative Endeavor Agreements or agreements under active consideration. In addition, for future submission that State will need to provide copies of all signed Intergovernmental Transfers (IGTs), leases, management agreements, MOUs, management contracts, loan agreements, and any other agreements that would present the possibility of a transfer of value between the two entities. Please send us signed copies for our review.

f. CMS has concerns over the establishment of supplemental payments to private intermediate care facilities entering into a cooperative endeavor agreement with the Department to provide a privately operated living setting to residents discharging from Pinecrest Supports and Services Center. CMS has concerns that such financial arrangements meet the definition of non-bona fide provider donations as described in federal statute and regulations. Please clarify the arrangements under the cooperative endeavor agreements.

g. Detailed information needs to be provided to determine whether the dollar value of the contracts between private and public entities had any fair market valuation. There can be no transfer of value or a return or reduction of payments reflected in these agreements.

h. Additionally, 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.

i. Please clarify how the monthly supplemental payment will be calculated and how the transitional rate of $329.26 factors into the payment methodology. Will the State perform a reconciliation? Please include specific language on Attachment 4.19-D page 25.

6. CMS wants the State's assurance regarding financial transactions. The following sentence should be included in the reimbursement methodology:

   "No payment under this section is dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity."

7. Did the State receive any feedback or complaints from the public regarding the current proposal or about the changes to future ICF/IID arrangements? If so, what were the concerns and how were they addressed and resolved?

   <u>Please clarify the additional questions related to the new supplemental payments:</u>

8. Please justify why Louisiana needs to pay supplemental payments to private intermediate care facilities entering into a cooperative endeavor agreement with the Department to provide a privately operated living setting to residents discharging from Pinecrest Supports and Services Center.

9. Why do these payments need to be made to these specific providers?

10. Why has Louisiana decided to target these particular providers to the exclusion of other providers of the same services?

11. Does the state expect that these payments will positively impact access to care or quality of care?

12. If it is to improve access, please provide data that shows there is an access issue.

13. What outcome does the state hope to achieve by targeting payments to private intermediate care facilities entering into a cooperative endeavor agreement with the Department to provide a privately operated living setting to residents discharging from Pinecrest Supports and Services Center?

14. How will the state monitor the impact of the supplemental payments with respect to the expected outcomes?

15. How will the state measure if targeting payments resulted in the desired outcome?

16. How do the supplemental payments compare to the base payments?

17. Does the individual receive the same level of care at Pinecrest Supports and Services Center versus the private ICF/IID facilities? If the level of care is different, then please provide a chart to indicate the various services provided at the governmental and private facilities.

18. §1902(a)(10)(B) of the Act provides that Medicaid services must be available to all categorically eligible individuals on a comparable basis (e.g., services available to adult beneficiaries with disabilities cannot be different in their amount, scope and duration from the services that are available to other adult beneficiaries). What impact (if any) will the supplemental payments have regarding services available to those individuals transferred to the private ICF/IID facility?

PRIVATE ICF/IID PROVIDERS

19. How many private ICF/IID providers have any lease or management arrangements with state-owned ICF/IID?

20. Will there be any arrangements, agreements and/or MOUs with the Hospital Service District?

21. Please describe the arrangement(s) how the private ICF/IID currently operates.

22. Do any of the private ICF/IID facilities have any management arrangements with State, Parish, or any other local government?

23. Please disclose all entities with which the State is in discussions concerning the actions proposed under this SPA and the intended outcome of such discussions.

24. What powers are authorized to the private ICF/IID and the state-owned ICF/IID? Please provide documentation from the state or parish legislation to support their authorities.

25. What are the private ICF/IID and the state-owned ICF/IID main functions and responsibilities?

FUNDING QUESTION

The following questions are being asked and should be answered in relation to all payments made to all providers under Attachment 4.19-A of your State plan, including payments made outside of those being amended with this SPA.
Please be aware that some of the questions have been modified. If you have already provided this information in response to other requests for additional information, you may refer us to that response. Please indicate the SPA and date of the response.

26. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

27. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment.

If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

(i) a complete list of the names of entities transferring or certifying funds;
(ii) the operational nature of the entity (state, county, city, other);
(iii) the total amounts transferred or certified by each entity;
(iv) clarify whether the certifying or transferring entity has general taxing authority; and,
(v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

28. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan.

    If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

29. Please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e. applicable to the current rate year) UPL demonstration.

30. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

In accordance with our guidelines to State Medicaid Directors dated January 2, 2001, if we have not received the State's response to our request for additional information within 90 days from the date of this letter, we will initiate disapproval action on the amendment.

We are requesting this additional/clarifying information under provisions of section 1915(f) of the Social Security Act (added by PL 97-35). This has the effect of stopping the 90-day clock for CMS to take action on the material. A new 90-day clock will not begin until we receive your response to this request.

Please submit your response to the following address:

Centers for Medicare and Medicaid Services
Division of Medicaid and Children's Health Operations
Dallas Regional Office

Attention: Bill Brooks
1301 Young Street, Suite 833
Dallas, Texas 75202

If you have any questions, please contact Tamara Sampson, of my staff, at (214) 767-6431 or by e-mail at Tamara.Sampson@cms.hhs.gov

Sincerely,

Bill Brooks
Associate Regional Administrator
Division of Medicaid and Children's Health Operations