Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Office of the Secretary

January 3, 2014

Bill Brooks
Associate Regional Administrator
Division of Medicaid & Children's Health, DHHS/CMS
1301 Young Street, Room #833
Dallas, TX 75202

Dear Mr. Brooks,

A telephone conference call was held on Wednesday, December 18, 2013, between representatives of the Centers for Medicare & Medicaid Services ("CMS"), the Louisiana Department of Health and Hospitals ("DHH"), and the Board of Supervisors of Louisiana State University and Agricultural and Mechanical College ("LSU"), to discuss State Plan Amendments 13-23, 13-25, and 13-28, recently submitted by DHH to CMS (the "SPAs"). At the conclusion of the call, it was agreed that DHH and LSU would summarize in writing the information presented during the conference call.

Initially, and as set forth more fully below, DHH and LSU emphasize the following key points:

1. The SPAs are critical to sustaining access to safety net care and support for graduate medical education while Louisiana moves away from the existing two-tier delivery system to one in which the State's uninsured and high-risk Medicaid populations receive care through public-private partnerships.

2. The SPAs provide for standard Medicaid payment methodologies and are substantively similar to payment methodologies already in the state plan. The SPAs simply make payment methodologies previously available to the state-owned hospitals available to private entities that agree to provide safety net care under the public-private partnerships.

3. The transactions under which hospital operations have been transitioned to public-private partnerships are valid, enforceable agreements that are commercially reasonable and that were negotiated at arms-length by the parties.

4. The leases that are part of the overall public-private partnership agreements were negotiated at arm's length by LSU and its partners, and amounts due under the leases were determined and are supported by fair-market-value appraisals performed by third-party professionals according to industry standards.

5. Any advance lease payments serve to pay down the partners' overall rent obligation, in exchange for which the partners receive equivalent consideration.

Bienville Building • 628 N. 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"

6. The State's Medicaid payments to a private partner are not positively correlated to the partner's advance lease payment or any subsequent lease payment, and Medicaid payments to the partner under the applicable SPAs will continue unaffected during those years when the advance lease payments are applied to the rent obligation.

Background

Historically the State of Louisiana has owned and operated a public hospital system. In 1997, the Louisiana Legislature assigned to LSU the responsibility for owning and operating the State public hospital system. Until very recently, there were ten hospitals within the system: (1) Earl K. Long in Baton Rouge; (2) the Interim LSU Public Hospital in New Orleans, which is temporarily serving as an interim hospital facility until completion of the new University Medical Center; (3) University Medical Center in Lafayette; (4) W.O. Moss in Lake Charles; (5) Bogalusa Medical Center in Bogalusa; (6) Leonard J. Chabert Medical Center in Houma; (7) Lallie Kemp Medical Center in Independence; (8) Louisiana State University Medical Center (LSU-S) in Shreveport; (9) E.A. Conway in Monroe; and (10) Huey P. Long in Pineville.

For decades, this system served Louisiana well, providing health care to millions of Louisiana citizens. Over time, however, the system helped foster evolution of a two-tier system in which private hospitals and non-state public hospitals cared for insured patients, and the State public hospital system cared for the great majority of the State's uninsured and high-cost, medically fragile Medicaid populations. The State public hospital system thus became the "medical home" for the State's uninsured and high-risk Medicaid populations, as well as for LSU's graduate medical education programs, isolating both those patients and LSU's GME programs from the additional opportunities available in the private sector.

As so often happens, unforeseen circumstances created opportunities for change and improvement to the system. In 2005, the devastation wrought by Hurricane Katrina forced the closure of LSU's "Big Charity" hospital facility in New Orleans and, consequently, the movement of the "LSU patient population" and LSU's teaching programs into the private sector in New Orleans and surrounding communities, including Baton Rouge. The strong support of community hospitals in the wake of Katrina provided the impetus for LSU, the State, and private parties to begin working collaboratively to restructure the State public hospital system to better address Louisiana's health care delivery and GME needs. Additional impetus was provided by the immediate need to address the obsolete Earl K. Long inpatient facility and declining inpatient census in Baton Rouge.

In responding to these circumstances, the State and LSU recognized that simply rebuilding the existing two-tier structure was not the best solution for LSU's GME programs or patients. Accordingly, in 2009, LSU negotiated two Memorandums of Understanding ("MOUs") that dramatically shifted the State's role in providing hospital care:

1. LSU executed an MOU with Our Lady of the Lake Hospital ("OLOL") in Baton Rouge. This first MOU served as the basis for a 2010 public-private partnership in the form of a cooperative endeavor agreement ("CEA") by and among LSU, OLOL and the State of Louisiana under which, beginning in 2013: (a) the obsolete Earl K. Long facility would be closed, (b) OLOL would assure access to care for uninsured and high-risk Medicaid patients,

and (c) OLOL would serve as the principal training site for LSU's GME programs previously based at Earl K. Long. It was originally contemplated that the Earl K. Long outpatient clinics would become provider-based clinics of LSU's University Medical Center in Lafayette, Louisiana; however, the CEA was subsequently amended to provide that OLOL would lease those outpatient facilities from LSU and operate them as provider-based clinics of OLOL. On November 1, 2012, Louisiana Medicaid submitted SPAs in TN 12 – 63 and 64 that authorized UPL payments for inpatient and outpatient services to OLOL. On May 16, 2013 TNs 13 – 20 and 21 were submitted that contained SPAs to reimburse OLOL 95% of cost for inpatient and outpatient Medicaid claims. All four SPAs were approved on July 23, 2013.

2. LSU, the State of Louisiana, and Tulane University executed an MOU with the newly-created University Medical Center Management Corporation ("UMCMC"), a private entity, for UMCMC to operate the new University Medical Center in New Orleans as a replacement facility for "Big Charity" upon completion of construction. The MOU provides that UMCMC will be operated in accordance with best practices in private hospital management, but also in accordance with the State's historical commitment to care for the uninsured and high-risk Medicaid populations and in support of LSU's and Tulane's GME programs. This MOU also contemplated a subsequent CEA to further define the public-private partnership with UMCMC.

The urgency of the State's and LSU's movement away from the direct provision of health care to a public-private partnership model in order to improve access to care and GME was dramatically increased in state fiscal year 2013, when Louisiana was notified that its blended Federal medical assistance percentage (FMAP) would be reduced from 71.38% to 66.58%. This FMAP reduction resulted in a cut in excess of $329 million to the Medicaid budget of the State public hospital system. In response to the resulting funding shortage, and to alleviate the growing burden on LSU, as a university, of continuing to carry primary responsibility for operating the public safety net system, LSU and the State sought to accelerate the timeline for transitioning the State public hospital system to the public-private partnership model. LSU was supported in these efforts by consultants from Health Management Associates, as well as other advisors.

LSU subsequently entered into discussions with multiple not-for-profit health systems with historical commitments to their communities. Following these discussions, LSU selected potential not-for-profit partners for nine of the ten State public hospitals (a partnership for Lallie Kemp Medical Center in Independence is still in development). Eventually (and as discussed further below), eight separate CEAs for these nine facilities were negotiated with not-for-profit partners (LSU Medical Center in Shreveport and E.A. Conway in Monroe were negotiated together in one CEA transaction).

To maintain Medicaid funding for the facilities at the levels paid when they were previously operated by LSU, DHH submitted SPAs that made the newly-leased facilities eligible for payments previously provided to the LSU hospitals as state-operated hospitals under the state plan. These SPAs are absolutely critical to maintain the safety net in Louisiana through the public-private partnerships. Specifically, SPA 13-25 authorized DSH payments at 100% of uncompensated care for the facilities in New Orleans, Lafayette, Houma, and Lake Charles at comparable levels to what had previously been paid to the hospitals when operated by LSU, and SPA 13-28 did the same for the facilities in Shreveport, Monroe, Bogalusa, and Alexandria. In addition, DHH submitted SPA 13-23, which

authorized Upper Payment Limit (UPL) payments for inpatient services provided by the Louisiana Children's Medical Center (the partner in New Orleans) and the Lafayette General Health System (the partner in Lafayette). The UPL payments are necessary to continue access to care for Medicaid clients receiving services at the private hospitals. All of the aforementioned SPAs provide for standard Medicaid payment methodologies and are substantively similar to payment methodologies already in the state plan, including the SPAs previously submitted and approved in connection with the OLOL CEA.

CMS responded to each of the submissions with a Request for Additional Information, including additional information regarding the financial relationships between the parties. More specifically, under the heading "Transfer of Value Agreements," CMS requested that DHH "provide all agreements that would present the possibility of a transfer of value between the two entities," and CMS stated that it "has concerns that such financial arrangements meet the definition of non-bona fide provider donations as described in federal statute and regulations." DHH provided copies of the CEAs and leases, but CMS indicated that it still had concerns. The December 18, 2013, conference call and this follow-up letter are intended to address those concerns.

Overview of the CEAs

The eight CEAs negotiated by LSU with its private partners represent a complete restructuring of the public hospital system and two-tier health care delivery system in Louisiana. Although similar in concept and approach, each CEA transaction was individually negotiated with executive staff from each private partner and was tailored to conform to different legal constraints, different facts and circumstances in each hospital's community, and different approaches from each private partner. For example:

- Baton Rouge and Lake Charles: Louisiana law expressly prohibits LSU from closing any hospital facility without legislative authorization. Because there was already sufficient inpatient bed capacity in Baton Rouge and Lake Charles without the state-owned facility, the Legislature authorized the closure of (respectively) the Earl K. Long and W.O. Moss hospitals, including the emergency rooms. In Baton Rouge, the private partner needed to maintain the outpatient capacity and preferred to do so in the hospital's existing off-campus outpatient clinics, so it leased those clinics (but not the main hospital facility) from LSU. Conversely, in Lake Charles, while the private partner did not need the facility's inpatient capacity, the partner needed the facility's physical space to enhance outpatient services, so the partner leased the former inpatient facility from LSU to become provider-based outpatient clinics of the partner's main hospital campus.

- Lafayette: The Lafayette community has a continuing need for the LSU facility's inpatient capacity. Accordingly, the partner leased the hospital facility as a going concern and will continue to provide both inpatient services and outpatient services.

- Shreveport and Monroe: These two hospital facilities are so integrated into the LSU Health Science Center's Shreveport-based GME programs that LSU selected a single partner to operate both hospitals, and leased both hospital facilities (based on separate, third-party, fair market value appraisals for each facility) as going concerns to the partner.

- New Orleans: Since Hurricane Katrina in 2005, LSU has been operating out of an interim facility in New Orleans (the Interim LSU Public Hospital) with insufficient capacity to support its patient care and GME needs. LSU is looking forward, however, to completion of the new academic medical center facility as the permanent replacement for "Big Charity." The New Orleans transaction is addressed more specifically below.

Although the CEAs were individually tailored, the transactions are similar in many respects. All of the CEAs are public-private partnerships that obligate the partners to provide care for medically indigent and uninsured patients of the hospitals and to support (where applicable) LSU's graduate medical education programs. All of the transactions include provisions that LSU hospital employees would be laid off from employment and that the partner could, in its discretion, offer future employment to the former LSU employees. All of the private partners provide their own professional liability insurance for their employees.

Additionally, in all of the transactions except Chabert (Houma) and Huey P. Long (Alexandria), the partners lease existing State-owned facilities and equipment from LSU. (No lease was necessary in the Chabert transaction because the private partner's use of the assets is based on an IGT by the public hospital partner, with a corresponding right-of-use. No lease was necessary in the Huey P. Long transaction because no public facilities are to be utilized by the private partners.). The total amount of rent paid by the partners over the life of the leases was determined and is supported by fair-market-value appraisals performed by third-party professionals according to accepted industry standards. Three of the appraisals are based on the facility operations as a going concern, and three are based on the value of the hospital's fixed assets, all as determined by professional appraisals. The Baton Rouge and Lake Charles leases were appraised utilizing a fixed-assets (rather than going-concern) methodology because those facilities will no longer be operated as inpatient hospital facilities. The New Orleans lease was appraised utilizing a fixed-assets (rather than going-concern) methodology because of the temporary status of the ILH facility and the absence of any historical operations in the new facility currently under construction.

The leases of LSU's facilities and equipment with its partners were negotiated by LSU and the partner. DHH did not participate in the lease negotiations, nor did DHH participate in the appraisal process, nor did DHH participate in the determination of the rent to be paid by the partners under the lease agreements.

Advance Lease Payments

After LSU selected its potential partners, the parties began negotiating the details of the transactions. The partners engaged highly-qualified health care counsel and hospital management consultants to guide them in negotiating and structuring the transactions, and professional appraisers to determine fair market value rates for the leased assets.

As the transactions were negotiated and significant resources were expended by all parties to rapidly transition the hospitals in the face of budget shortfalls created by FMAP reductions, the State and LSU requested, and the partners agreed to make, significant up-front, at-risk payments. These up-front payments were originally negotiated as "milestone" payments to be paid upon successfully achieving or resolving various pre-closing points in the negotiations, and their purpose was to assure

the partners' continuing commitment to the transactions during the negotiations, given the consequences to the hospitals if the transactions did not quickly move forward to closing. Such commitments are not uncommon in commercial transactions where the parties are required to move rapidly and therefore invest significant financial and human resources to maintain the enterprise while the final terms of the transaction are negotiated and contingencies are addressed.

Before any up-front payments were made, however, they were re-negotiated as advance lease payments. The purpose of the re-negotiation was two-fold. First, the partners were increasingly reluctant to put up-front payment at risk without some type of executed agreement between the parties. Accordingly, the parties re-negotiated the payments as advance lease payments that were dependent upon execution of final, enforceable lease agreements between the parties. This reassured the partners that they would be able to offset the advance payments against future rent obligations. Second, by linking the advance payments to arms-length leases supported by independent, fair-market-value appraisals, the parties sought to avoid any argument that the upfront payments were not commercially reasonable.

As outlined above, nine of ten public hospitals have been or are in the process of being transitioned to a public-private partnership under eight separate CEAs. Of the eight CEAs, six of the transactions include facility leases. Of the six transactions that include facility leases, five were ultimately negotiated to include an advance lease payment. Of those five transactions, all except New Orleans and Lake Charles include an advance lease payment that is equal to one (1) year of rent and that is applied at the end of the lease term. In Baton Rouge, this equates to a twenty percent (20%) advance lease payment under its five-year term, and in Lafayette and Bogalusa, this equates to a ten percent (10%) advance lease payment under their ten-year terms. The Lake Charles advance lease payment is equal to a little less than two (2) years of rent, or a little less than twenty percent (20%) of the total rent obligation, credited at the end of its ten-year term.

In all of the transactions that include an advance lease payment, Medicaid payments to the private partner under the applicable State Plan Amendments will continue even as the advance lease payment is applied to the partner's rent obligation. In other words, payments under the SPA continue, unaffected, even though the partner may have no out-of-pocket rent expense at all during that specific lease year or (in the case of the New Orleans transaction, and as set forth below) is receiving a partial credit against annual rent during that specific lease year.

Unique Aspects of the New Orleans Transaction

The facts and circumstances of the New Orleans are particularly unique, due primarily to the not-yet-completed construction of the new University Medical Center facility as a replacement facility for "Big Charity" and to the anticipated utilization of the new facility by both LSU and Tulane for their GME training programs.

As previously noted, it had been anticipated since the MOU was signed in 2009 that upon completion of construction, the new University Medical Center would be owned by LSU but operated by UMCMC, a private entity, under a CEA. The FMAP reductions accelerated the timeline for the CEA to include a transition period until the new facility is complete. Charged with implementing a management and operational infrastructure in accordance with the best practices of private hospital operators in a shorter amount of time than anticipated, the UMCMC Board elected to partner with Louisiana Children's Medical Center (LCMC), a New Orleans based, successful

hospital holding company with a long track record of successfully partnering with LSU's GME programs and commitment to the uninsured and high-risk Medicaid populations in the region. After successfully negotiating a restructuring of UMCMC's governing documents to incorporate many of the provisions and remain consistent with the commitments made to LSU and Tulane in the MOU, UMCMC executed a Member Substitution Agreement under which LCMC became the sole member of UMCMC.

UMCMC made an advance lease payment of $110 million for its right to occupy and operate the new $1 billion academic medical center that will be part of the University Medical Center for a term of forty years. This advance payment is, percentage-wise, significantly less than the ten- to twenty-percent advance payments made by the partners in the Baton Rouge, Lafayette, Lake Charles, and Bogalusa transactions. The parties further agreed that during the first twenty years that it occupies the new building, UMCMC will receive an annual "credit" of $5.5 million, adjusted for inflation, against the amount of annual rent otherwise due to LSU. In other words, during each of the first twenty years that UMCMC occupies the new building, $5.5 million of the advance lease payment previously paid by UMCMC will be applied to UMCMC's annual rent payment to LSU for that year. In the other transactions, the advance lease payments are applied at the end of the lease term.

UMCMC also paid in advance all of the rent due for the ambulatory care building and parking garage that will be adjacent to the new facility's patient care towers. This $140 million rental payment entitles UMCMC to use and occupy the new ambulatory care building and parking garage for forty years.

The Advance Lease Payments are not Provider-Related Donations

A "provider-related donation" is defined in pertinent part as "a donation or other voluntary payment (in cash or in kind) made directly or indirectly to a State or unit of local government by or on behalf of a health care provider." 42 CFR § 433.52.

The advance lease payments are not donations or voluntary payments. To the contrary, they are payments of rent that serve to pay down the partners' overall rent obligation for facilities and equipment, the amounts of which are supported by fair-market-value appraisals that were negotiated at arms-length between the parties, and in exchange for which the partner is entitled to occupy the leased premises for a given period of time pursuant to a valid and enforceable lease. The financial arrangements between the partners and the State are commercially reasonable transactions and are not different from a transaction in which a private lessor would be involved. The fact that LSU is the lessor of the health care facilities does not make the lease payment a "provider-related donation." A partner that prepays all or a portion of the rent due under a valid and enforceable lease is receiving valuable consideration for its payment, and there will come a time during the term of the lease when, in exchange for its continued occupancy of the facility, the partner will either owe no rent at all or will receive a partial credit against its rent. All the while, Medicaid payments to that partner will continue unaffected.

Even if CMS was to consider an advance lease payment to be a provider-related donation, it would not be an impermissible non-bona fide donation under 42 CFR § 433.54.

It is the State's and LSU's position as set forth above that the advance lease payments are not provider-related donations, and thus it should be unnecessary to determine whether an advance lease

payment is a "bona fide" donation under 42 CFR § 433.54. Even if CMS were to consider a partner's advance lease payment and the partner's subsequent receipt of credit against its future rent obligation as provider donation, however, the advance payment and subsequent credit are not impermissible non-bona fide donations.

Section 433.54 provides in pertinent part that a bona fide donation is a provider-related donation made to the State or unit of local government that has no direct or indirect relationship to Medicaid payments made to the health care provider, any related entity providing health care items or services, or other providers furnishing the same class of items or services as the provider or entity. Provider-related donations have no direct or indirect relationship to Medicaid payments if those donations are not returned to the individual provider, the provider class, or related entity under a hold harmless provision or practice. A hold harmless provision or practice if any one of the following applies: (a) the State's Medicaid payment is positively correlated to the donation; (b) the State's Medicaid payment varies based only on the amount of the donation; or (c) the State provides for any direct or indirect payment, offset, or waiver such that the provision of that payment, offset or waiver directly or indirectly guarantees to return any portion of the donation to the provider.

None of the three potential criteria of a "hold harmless practice" applies in this case.

First, the State's Medicaid payments to the partner are not positively correlated to its advance lease payment or any subsequent lease payment. The amount a partner pays to lease a facility from LSU is unrelated to the amount of Medicaid reimbursement a partner will receive from DHH. Under the CEAs, DHH will only pay for actual care provided by the partner. While the partner's lease payment to LSU is fixed based on independent appraisals, its Medicaid reimbursement will vary with the cost of care provided. For example, if a partner's demonstrated cost of providing care is $60 million (and such amount is below the partner's maximum reimbursement, if applicable)[1] as negotiated under its CEA, the partner will receive $60 million. If that partner's demonstrated cost of care is $30 million, however, the partner will receive $30 million.

Second, the State's Medicaid payments to the partner do not vary based only on the amount of the partner's advance lease payment, for the same reasons cited above. The State's Medicaid payment to the partner varies with the partner's cost of care.

Finally, the State does not provide for any direct or indirect payment, offset, or waiver that directly or indirectly guarantees to return any portion of the donation to the provider. To the contrary, the leases with the partners provide that any unearned prepaid rent will not be returned to the partner if the lease is breached or otherwise terminated early by the partner. The fact that the partner will receive credit for the advance rent it paid against its future rent obligations as long as the lease remains in effect for the requisite period is a commercially reasonable provision, not a guarantee that the advance rent will be returned to the provider.

In summary, the fact that a private party pays fair market value to the State for items or services, and that the State makes Medicaid payments to the private party, does not make the arrangement a "hold harmless" plan or provision. If such an arrangement is a "hold harmless" arrangement, the State could never sell items or services to a provider of Medicaid-covered services. For a financial

[1] Some partners' reimbursement is capped as negotiated under its CEA, while other partners' reimbursement is not capped.

transaction between a health care provider and a unit of state or local government to be considered a non-bona fide donation under the provisions of 42 CFR § 433.54, it must first be a provider-related donation as defined under 42 CFR § 433.52. Neither an advance lease payment nor any subsequent lease payment constitutes a provider-related donation under this regulatory definition; instead, they are payments by the partner in exchange for access to and use of LSU's facilities under valid and enforceable leases. To the extent an advance lease payment or subsequent lease payment could be construed to be a provider-related donation, however, it would not violate 42 CFR § 433.54 because no advance lease payment or subsequent lease payment has any direct or indirect relationship to the Medicaid payments made to the partner or any related entity providing health care items or services under a hold harmless practice.

Conclusion

Louisiana has for several years been in the process of restructuring the State public hospital system by transitioning it from the old two-tier model to public-private partnerships, while at the same time sustaining access to safety net care and support for graduate medical education. The timeline for the transition was greatly accelerated in state fiscal year 2013 by the FMAP reduction and its corresponding impact on LSU's Medicaid budget for the public hospitals in excess of $329 million. Consequently, the State and LSU entered into a series of CEAs to rapidly transition the public hospital system to a public-private partnership model. In connection with the CEAs, DHH submitted SPAs to allow it to pay the private partners appropriate DSH, UPL and per-diem Medicaid reimbursement. Some of these transactions include leasing publicly-owned health care facilities to the private partner for FMV, as established by independent, professional valuation. In some transactions, the partner paid a portion of the rent payments due for the leased facilities in advance, for which the partner receives credit during the term of the lease. Such lease payments generate state general funds, but are neither provider-related donations nor non-bona fide donations under applicable regulations. For these reasons, the SPAs should be approved.

Thank you again for your time and input on the telephone conference, and for your careful consideration of this critically important issue. We trust you will forward a copy of this letter to the people within CMS who were on the conference call. If we can provide any additional information or be of any further assistance, please do not hesitate to let us know.

Sincerely,

Kathy Kliebert, Secretary
Louisiana Department of Health and Hospitals

Frank Opelka, M.D.
Vice President, Health Care Redesign
Louisiana State University and Agricultural
and Mechanical College