Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

February 20, 2015

SENT VIA CERTIFIED MAIL, RETURN RECEIPT REQUESTED

Bill Brooks, Associate Regional Administrator
Division of Medicaid and Children's Health
Centers for Medicare & Medicaid Services
1301 Young St., Suite 832
Dallas, TX 75202

Re: Disallowance LA/2014/001/MAP

Dear Mr. Brooks,

Pursuant to Social Security Act § 1116(e), 42 C.F.R. § 430.42(b), the Louisiana Department of Health & Hospitals (DHH) hereby requests that the Secretary of the Department of Health and Human Services (HHS) reconsider the disallowance of $311,576,411 (TC), $189,999,295 (FFP). *See* Letter from Bill Brooks, Assoc. Reg'l Admin'r, Div. of Medicaid and Children's Health, CMS, to Ms. Ruth Kennedy, Medicaid Dir., La. DHH (Dec. 23, 2014) (attached as Exhibit A) [hereinafter Disallowance Letter].

CMS links this disallowance to State Plan Amendments (SPAs) 13-23, 13-25, and 13-28, which the State submitted to CMS in June 2013. On May 2, 2014, CMS disapproved these SPAs, citing its belief that the SPAs increased Medicaid payments to certain hospitals on the condition that the hospitals participate in cooperative endeavor agreements (CEAs) with the State that provide for the making of advance lease payments to the State. Letter from Marilyn Tavenner, Admin'r, CMS, to Ruth Kennedy, Medicaid Dir., La. DHH, at 2–3 (May 2, 2014) [hereinafter May 2014 SPA Disapproval Letter].

To address CMS's concerns, the State submitted replacement SPA 14-25 which explicitly delinked the additional Medicaid payments from the CEAs and any advance lease payments. Instead, SPA 14-25 established payments to Louisiana Low-Income Academic Hospitals based on criteria related to uninsured patient utilization and intern and resident full-time equivalent positions. SPA 14-25, Attachment 4.19-A, Item 1, Page 10 k (4). The replacement SPA explicitly stated that "[n]o payment" under the SPA may be "dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity." *Id.* at 5.

On December 23, 2014, CMS approved SPA 14-25 with an effective date of May 24, 2014, and also issued the disallowance for which reconsideration is sought here. *See* Letter from

Timothy Hill, Dir., Fin. Mgmt. Grp., CMS, to Ruth Kennedy, Dir., Bureau of Health Servs. Fin., La. DHH (Dec. 23, 2014) [hereinafter SPA 14-25 Approval]; Disallowance Letter, at 1. The disallowance amount represented the entirety of $311,576,411 in advance lease payments made to the State by hospitals in SFY 2013 and 2014.

CMS cited two principal concerns as the basis for the disallowance: first, it alleged that the advance lease payments were "non-bona fide provider-related donations"; second, it alleged that the lease payments were "directly linked to higher Medicaid payments" to the hospitals, are only available to "providers that agree to participate in a CEA," and thus "established a prohibited hold harmless arrangement." Disallowance Letter at 1–2.

The disallowance is unfounded and should be reversed in its entirety. In the alternative, it is overstated and should be reduced substantially.

The advance lease payments are not donations, but instead are payments by the hospitals for the fair market value (FMV) of leased facilities. That the payments were made in advance rather than in installments, does not convert them into unlawful provider donations. Moreover, under the terms of SPA 14-25, additional Medicaid payments to hospitals are not linked to participation in the CEAs or to the payment of advance lease payments.

Even if CMS were correct that some portion of the advance lease payments exceeded the FMVs of the transactions, then only that excess could reasonably be considered a "donation" and any disallowance must be limited to that amount.

I. The Lease Payment Amounts Were Set at Fair Market Value

CMS acknowledges that "[t]he state indicated that its base lease payments are based on fair market value appraisals done by independent third-party professionals . . . and *thus appear to comport with normal business practices*." Disallowance Letter, at 2 (emphasis added); *see also* May 2014 SPA Disapproval Letter, at 2 (nearly identical language). CMS argues, however, that the State "did not provide similar independent analysis to justify the substantial *advance* lease payments." Disallowance Letter, at 2 (emphasis added). CMS's distinction between "base lease payments" and "advance lease payments" is misplaced. The base lease payments, which CMS admits "appear to comport with normal business practices," were based on fair-market value analyses conducted by independent third parties. The advance lease payments were merely a prepayment of some portion of these base rents. For example, University Medical Center Management Corporation (UMCMC) agreed to prepay $110 million of the lease payments it planned to make over the course of its lease. That prepayment was not in addition to the base lease payments, but rather was an upfront payment of a share of the total payments to be made over time. The full amount of the advance payment is to be credited annually to UMCMC against the base lease payments UMCMC owes. The advance payment is not a donation, but merely a prepayment. The hospitals agreed to make such advance lease payments precisely because these amounts were comparable to what the hospitals would have paid if they had simply paid the base payments over a period of years.

II. Advance Payment of Lease Amounts Need Not Be A "Usual and Customary" Industry Arrangement

CMS grounds the disallowance in part on its assertion that the advance lease payments are "not usual and customary industry payment arrangements." Disallowance Letter, at 1. CMS states that it is "not aware of any other examples of advance lease payments of this magnitude in the State's ordinary course of business" and "[a]s such" the payments "are more aptly characterized as non-bona fide provider-related donations." Disallowance Letter at 2.

Even if it were true that advance lease payments of this magnitude are not "usual and customary" business practice, it does not follow that they are non-bona fide provider donations. As CMS itself has noted, the relevant inquiry is not whether a practice or payment is "usual," but whether the payment exceeds the fair market value of the items or services at issue in the transaction, results in the return of a donation to a provider, and thereby is converted into an impermissible hold harmless arrangement. *See* SMDL #14-004, *Accountability #2: Financing and Donations*, at 4 (May 9, 2014) ("Any arrangement . . . that obligate[s] a private hospital to . . . sign lease agreements at an amount that is *greater than fair market value* would be considered a hold harmless arrangement." (emphasis added)). Nothing in the statute or regulations would allow CMS to base a disallowance on the mere assumption that a practice is not common.

III. The Advance Lease Payments Are Not "Linked" to Higher Medicaid Payments to Hospitals

In its December 2014 disallowance letter, CMS asserts that:

> Supplemental and Disproportionate Share Hospital (DSH) *payments made under the disapproved SPAs* [13-23, 13-25, and 13-28], *are linked* to CEAs that provide . . . for non-bona fide provider-related donations . . . that the state refers to as 'advance lease payments.' . . . [A]dvance lease payments from select hospitals are directly linked to higher Medicaid payments to the same private hospitals; this established a prohibited hold harmless arrangement. Only providers that agree to participate in a CEA are eligible to receive the additional Medicaid and DSH payments under the proposed SPAs.

Disallowance Letter, at 1–2 (emphasis added).

These statements are simply incorrect.

First, although SPAs 13-23, 13-25, and 13-28 would have provided additional Medicaid payments to hospitals that had entered into CEAs, CMS disapproved these SPAs and instead approved replacement SPA 14-25. The payments made are supported by SPA 14-25 and other approved, pre-existing SPAs. Thus, there are no "payments made under the disapproved SPAs" as CMS asserts.

Second, replacement SPA 14-25 explicitly de-linked additional Medicaid payments from any requirement that a recipient facility participate in a CEA or make advance lease payments. As noted above, SPA 14-25 established payments to hospitals based on uninsured patient utilization; it explicitly provided that increased payments could not depend on any agreement to donate money or services to the State. Attachment 4.19-A, Item 1, Page 10 k (4)–(5). CMS approved this SPA precisely because it did *not* link additional Medicaid payments to advance

lease payments or participation in the CEAs.[1] Thus, there are also no payments made under the replacement SPA which are linked to CEAs or advance lease payments.

Therefore, there is no basis for CMS's assertion that the making of advance lease payments is a condition of increased Medicaid payments.

IV. Even If The Advance Lease Payments Exceeded Fair Market Value, The Disallowance Is Overstated

CMS has disallowed the entirety of $311,576,411 in advance lease payments made to the State ($311,576,411 total computable / $189,999,295). Even if CMS were correct that the advance lease payments exceeded fair market value, any disallowance should be limited to the difference between the advance payments and the fair market value of any benefit received by the hospitals in return for their payments.

CMS may only disallow provider-related "donations." 42 C.F.R. § 433.67. Although the regulations somewhat broadly define a "donation" to mean "a donation or other voluntary payment (in cash or in kind) made directly or indirectly to a State," it cannot be that any transfer of value from a provider to the State is a prohibited donation. As CMS itself has acknowledged, the provider donation rules are not "intended to limit the ability of governments and businesses to establish . . . normal and important business relationships" such as those that involve "fair market price." *See* SMDL #14-004, Accountability #2: Financing and Donations, at 1 (May 9, 2014). In its May 2014 Accountability Guidance discussing the making of advance lease payments, CMS acknowledged that a donation is limited to the "transfer of value" that results from payments at "above fair market value," and that any resulting disallowance would be limited to the "excess lease payments." *Id.* at 4 (emphasis added). CMS should not disallow the total advance lease payments simply because it believes some portion exceeds the fair market value of the transaction. The disallowance must be limited to the portion of the advance lease payment (if any) that exceeds fair market value.

V. Election to Retain Funds

The State hereby notifies CMS of its intent to retain the disallowed funds pending reconsideration and appeal before the Departmental Appeals Board.

The disallowance letter states that, as a result of the disallowance, the State must "make a decreasing adjustment on line 10(b) of the next [CMS-64] in the amount of" the disallowance; "adjust [the] state's letter of credit in accordance with the Annual Grant Award (AGA) Pilot Project Memorandum of Understanding (MOU) for the final disallowed amount plus any interest . . ."; and "[u]nder the terms of the MOU . . . adjust [the State's] next cash draw request . . . for any disallowed expenditures appealed." Disallowance Letter, at 2. The letter also states that in

[1] Although CMS noted in its approval letter that "[t]he effect" of the SPA would be that six hospitals participating in CEAs "will qualify for DSH payments," SPA 14-25 Approval, the course of discussions made clear that CMS would not approve the SPA if it believed that the increased Medicaid payments were "directly linked" to participation in the CEAs and to the making of advance lease payments.

the absence of a notification that the State has elected to retain the funds, the Secretary "will recover $311,576,411 pending the final decision of the [DAB]." *Id.* at 4.

We believe these statements are in error. The MOU provides that "[d]isallowances will be reflected by a State on the draw down request submitted subsequent to the notification of the disallowance. *Where a State is afforded the specific option under statute to hold the funds until a final resolution of the issue, the withholding of the disallowance will be dependent on the State's decision.*" MOU, at 3 (emphasis added). Here, by statute, the State may retain the amount in controversy "pending a final determination with respect to" the disallowance. Social Security Act § 1903(d)(5); *see also* 42 C.F.R. § 430.42(b)(3). Therefore, under the terms of the MOU, the State may hold the funds until a final resolution of the issue.

Additionally, even if the State did not elect to retain the funds, the Secretary would not, as noted on page 4 of the Disallowance Letter, be entitled to recover $311,576,411 pending the final decision. As CMS acknowledges on the first page of the letter, that amount represents the total computable amount, rather than the federal share. Pursuant to SSA § 1903(w)(1), the amount subject to recovery is only the federal share.

The State reserves the right to add further issues at the hearing.

Respectfully,

J. Ruth Kennedy
Medicaid Director

cc: W. Jeff Reynolds, Undersecretary
Stephen Russo, Executive Counsel

Enclosures: Disallowance Letter

EXHIBIT A
to
Louisiana Department of Health & Hospitals
Request for Reconsideration of Disallowance LA/2014/001/MAP

Letter from Bill Brooks, Assoc. Reg'l Admin'r, Div. of Medicaid and Children's Health, CMS, to Ms. Ruth Kennedy, Medicaid Dir., La. DHH (Dec. 23, 2014) (Disallowance Letter)

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
CONSORTIUM FOR MEDICAID & CHILDREN'S HEALTH OPERATIONS

Division of Medicaid & Children's Health, Region VI

CERTIFIED MAIL – RETURN RECEIPT REQUESTED

December 23, 2014

DISALLOWANCE LA/2014/001/MAP

Ms. Ruth Kennedy, Medicaid Director
Bureau of Health Services Financing
Department of Health and Hospitals (DHH)
628 North 4th Street
Baton Rouge, LA. 70821-9030

Dear Ms. Kennedy:

This letter serves as notice of a disallowance in the amount of $311,576,411 Total Computable (TC), $189,999,295 Federal Financial Participation (FFP) due to Louisiana's collection of impermissible provider-related donations. On May 9, 2014, CMS notified your agency that it had disapproved the proposed State Plan Amendments (SPA) 13-23, 13-25, and 13-28 as a result of provisions in the related cooperative endeavor agreements (CEAs) that required substantial advance lease payments by the participating hospitals that were linked to increased Medicaid payments to the same privately-owned hospitals.

Section 1903(w) of the Social Security Act (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 C.F.R. § 433.54, FFP is not available to the extent that it would be based on the use of such financing sources when 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. A hold harmless arrangement is defined to include circumstances in which an increased Medicaid payment is conditional on the receipt of a donation.

Supplemental and Disproportionate Share Hospital (DSH) payments made under the disapproved SPAs are linked to CEAs that provide, among other things, for non-bona fide provider-related donations from privately owned hospitals that the state refers to as "advance lease payments." The CEAs provide for annual facility and equipment leases along with the advance lease payments. These advance lease payments are not usual and customary industry payment arrangements and are linked to the increased Medicaid payments. CMS has determined that these are not reasonable and necessary lease payments, but are, in fact, non-bona fide provider-related donations.

The state indicated that its 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 state did not provide similar independent analysis to justify the substantial advance lease payments. Additionally, information submitted by the state indicates that the lease payments themselves 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, the unjustified advance lease payments are more aptly characterized as non-bona fide provider-related donations.

Furthermore, the substantial advance lease payments from select hospitals are directly linked to higher Medicaid payments to the same private hospitals; this established a prohibited hold harmless arrangement. 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% of net uncompensated care cost, whereas other private hospitals are paid less for inpatient care and at lower percentages for uncompensated care. The payments were made in lump sums that assumed that the private hospitals participating in the CEAs would provide similar levels of Medicaid and uninsured care as was previously provided by the public charity care hospital system.

This letter constitutes your notice of disallowance in the amount of $311,576,411 TC, $189,999,295 FFP. Please make a decreasing adjustment on line 10(b) of the next quarterly expenditure report (CMS-64) in the amount of $311,576,411 TC, $189,999,295 FFP and reference LA/2014/001/MAP. Also, you must adjust your state's letter of credit in accordance with the Annual Grant Award (AGA) Pilot Project Memorandum of Understanding (MOU) for the final disallowed amount plus any interest computed pursuant to section 1903(d)(5). Under the terms of the MOU, you must adjust, if you have not already done so, your next cash draw request in the Payment Management System for any disallowed expenditures appealed. Your adjustment must appear as a recognizable, separate entry on your request.

This disallowance is my final decision. Under section 1116(e) of the Act, the state has the opportunity either to request reconsideration of this disallowance from the Secretary or to appeal this disallowance to the Departmental Appeals Board. This decision shall be the final decision of the Department unless, within 60 calendar days after the state receives this decision, the state delivers or mails (the state should use registered or certified mail to establish the date) a written request of reconsideration to the Secretary or a written notice of appeal to the Departmental Appeals Board.

Written requests for reconsideration should be delivered or mailed to the CMS Associate Regional Administrator at 1301 Young St. Suite 832, Dallas TX. 75202 (the state should use registered or certified mail to establish the date). Requests for reconsideration by the Secretary should include: (1) a copy of the disallowance letter; (2) a statement of the amount in dispute; (3) a brief statement of why the disallowance should be reversed or revised, including any information to support the state's position with respect to each issue; (4) additional information regarding factual matters or policy considerations; and (5) a statement of your intent to return or

retain the funds. See 42 C.F.R. § 430.42(b)(2) published at 77 Fed. Reg. 31499, 31508 (May 29, 2012). The state should include in its request for reconsideration all of the information it believes is necessary for the Secretary's review of its request. If the state requests reconsideration from the Secretary and receives an unfavorable reconsideration of the disallowance from the Secretary, it may appeal the disallowance to the Departmental Appeals Board within 60 calendar days after the date that the state receives the unfavorable reconsideration.

Written requests for appeal should be delivered or mailed to:

U.S. Dept. of Health and Human Services
Departmental Appeals Board, MS 6127
Appellate Division
330 Independence Avenue, S.W.
Cohen Building, Room G-644
Washington, D.C. 20201

The state may appeal the disallowance to the DAB within 60 calendar days of the date you received this letter or, if applicable, within 60 calendar days after the date that the state receives the unfavorable reconsideration. If the state chooses to appeal this disallowance, written appeals request must include: (1) a copy of this disallowance decision; (2) a copy of the reconsideration decision, if applicable; (3) an expression of its intention to appeal the disallowance; (4) the amount in dispute; and (5) a brief statement of why the disallowance is wrong. In addition, the state should reference Disallowance Number LA-2014-001-MAP in the appeal request. The Board will notify the state of further procedures. Please also send a copy of your appeal to my attention at the following address Mr. Bill Brooks, Associate Regional Administrator; Centers for Medicare & Medicaid Services, Region 6; 1301 Young Street, Room 833; Dallas, Texas 75202.

A notice of appeal may also be submitted to the DAB by mail, by facsimile (fax) if under 10 pages, or electronically using the DAB's electronic filing system (DAB E-File). Submissions are considered made on the date they are postmarked, sent by certified or registered mail, deposited with a commercial mail delivery service, faxed (where permitted), or successfully submitted via DAB E-File. To use DAB E-File to submit your notice of appeal, you or your representative must first become a registered user by clicking "Register" at the bottom of the DAB E-File homepage, https://dab/efile.hhs.gov/; entering the information requested on the "Register New Account" form; and clicking the "Register Account" button. Once registered, you or your representative should login to DAB E-File using the e-mail address and password provided during registration; click "File New Appeal" on the menu; click the "Appellate" button; and provide and upload the requested information and documents on the "File New Appeal-Appellate Division" form. Detailed instructions can be found on the DAB E-File homepage.

If the state appeals the disallowance under section 1116(d) of the Act, section 1903(d) of the Act provides you the option of retaining the funds were previously paid to the state, which are now being disallowed by this notice, pending a final administrative decision. If the final decision upholds the disallowance and you elect to retain the funds during the appeals process, the proper amount of the disallowance plus interest computed pursuant to section 1903(d)(5) of the Act will be offset in a subsequent grant award. You may exercise your option to retain the disputed funds by notifying me, in writing, no later than 60 days after the date this letter is received. In the

absence of notification that the state elects to retain the funds, the Secretary will recover $311,576,411 pending the final decision of the Departmental Appeals Board.

If you have any question please contact Demetria Carter at 225-342-0203 or Michael Jones at 214-767-6279 or, via email, at demetria.carter@cms.hhs.gov and michael.jones@cms.hhs.gov.

Sincerely,

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

cc via Email: Jeff Reynolds/DHH
Jen Steele/DHH
Pam Diez/ DHH