DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Becky Pasternik-Ikard
Chief Executive Officer
4345 N. Lincoln Blvd.
Oklahoma City, Oklahoma 73105

JAN 4 2019

Dear Ms. Pasternik-Ikard:

I am responding to your request regarding Oklahoma's state plan amendment (SPA) 18-22. The Centers for Medicare & Medicaid Services (CMS) received SPA 18-22 on April 23, 2018, with a proposed effective date of May 1, 2018. The purpose of the proposed amendment is to provide supplemental payments to 18 facilities the state identified as non-state government owned (NSGO) nursing facilities.

Under proposed SPA 18-22, supplemental payments would be made to 18 (of the approximately 40) nursing facilities now nominally controlled by The City of Hugo and The City of Pauls Valley. The cities received the nursing homes' operating licenses and provider agreements through contracts with various private providers and contemporaneously contracted with the private providers to operate the facilities.

As explained below, CMS is unable to approve proposed SPA 18-22 because the SPA does not comport with sections 1903(w), 1902(a)(4), 1902(a)(19), 1903(a)(1) and 1902(a)(30)(A) of the Social Security Act (the Act), the implementing regulations, and the applicable federal cost principles.

The Proposed State Plan Amendment does not comport with the Medicaid Statute and the Implementing Regulations

CMS reviewed the proposed state plan language, the state's responses to CMS's Request for Additional Information, and other documents related to SPA 18-22. The public-private partnerships created by the cities' contracts with the private nursing home operators appear designed to allow the participants to qualify for Intergovernmental Transfers (IGTs), and split the resulting federal supplement payments without any significant net expenditures by the state or cities. The cities' ownership and control of the nursing facilities is somewhat illusory and was not obtained at fair market value. As a result, the proposed amendment is inconsistent with a number of statutory mandates related to the financing and administration of state Medicaid plans.

The state must demonstrate that there is non-federal funding to support expenditures claimed under the state plan as the basis for federal matching funding. The state indicated that the non-federal share for the supplement payments would come from IGTs from the two cities. IGTs are a permissible funding mechanism for supplemental payments, but only if they meet the statutory

and regulatory requirements. Section 1903(w)(6)(A) of the Act explains 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 . . . unless the transferred 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."

CMS reviewed the materials Oklahoma provided regarding the source of the IGTs and determined that the private entities were ultimately the sources of the non-federal share. The cities do have sufficient tax funds or other revenue streams to fund the IGTs; these funds are allocated in the cities' budgets to general government costs. The cities paid only $10 to obtain the nursing facility licenses that confer "ownership" status, which then entitles the public-private partnership to qualify for the Medicaid supplemental payment. The cities have minimal operational responsibility or financial risk in the operations of the nursing facilities. The cities are not entitled to the ordinary revenue or profits generated by the operations of the facilities and do not have a revenue stream from the facilities except from the proposed supplemental payments. The supplemental payments are comprised primarily of federal funds, which cannot be the source of an IGT. CMS has determined that the IGTs are not derived from local taxes, but rather donations from the private healthcare providers. When viewed in their totality, the transactions between the partners are not at fair market value. The donations are impermissible because they are part of a hold harmless arrangement, in which some or all of the contributions are returned to the private parties in the form of supplemental payments. As a result, CMS has determined that the cities' IGTs are not a permissible source of the non-federal share of supplemental payments because the funding mechanism created by public-private partnerships is inconsistent with 1903(w) of the Act, as promulgated in 42 C.F.R. §§ 433.51(c), 433.52, 433.57, 433.54(c)(3).

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. See also, 45 C.F.R. 75.400 (a-c). The regulations further 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. 42 C.F.R. § 430.10. Because the state plan is the basis for FFP, the plain language must provide for an auditable basis for determining whether payment is appropriate. As a result of these requirements, the state must "maintain or supervise the maintenance of the records necessary for the proper and efficient operation of" their state plans, including "[s]tatistical, fiscal, and other records necessary for reporting and accountability as required by the Secretary." 42 C.F.R. §§ 431.17(b)(2), 433.32 (a); 45 C.F.R. § 75.302(b), 403(g). Although the state submitted thousands of pages of documents, the state has not demonstrated that the public-private partnerships form legal and financial relationships that are appropriately characterized as non-state government owned (NSGO) or operated facilities, under either the state's requirements or, more importantly, for the purpose of funding a permissible IGT under section 1903(w)(6). Even if an NSGO characterization of the facilities were appropriate, the public-private partnerships result in IGTs that are derived from impermissible provider-related donations.

CMS believes that if a state encourages public-private partnerships that create a high risk for funding violations and must utilize significant resources to conduct case-by-case document reviews and monitoring, it will be administering its plan in an inefficient manner. The costs of administrating the program are significant; the state charges a participation fee to the facilities to cover its portion of the expenses and the federal governmental pays the other half of the approximately $4.1 million in administrative costs. The public-private partnerships deduct the participation fees from the supplemental payments, effectively shifting the entire administrative costs of the SPA to the federal government. The state has not demonstrated these costs are reasonable. Based on these considerations, the state has not established that the SPA is consistent with section 1902(a)(4) and the implementing regulations.

Section 1902(a)(30)(A) of the Act requires that state plans provide payment methods for care and services available under the plan that are consistent with efficiency, economy, and quality of care. The state has not explained how the cities' involvement in the operations of multiple nursing homes is efficient or economical. See also, 45 C.F.R. 75.404. A majority of the supplemental payments will be transferred to the cities, in the form of returned IGTs and the cities' portion of the supplemental payments. In many instances, the federal government's share of the supplement payments is approximately double the amount of the net supplement payments ultimately received by the nursing facilities (it should be approximately 60%). These figures demonstrate the degree to which the proposed SPA would shift costs to the federal government, but also highlights the SPA's inefficient mechanism for making supplemental payments available to nursing facilities. The result is that payments under this section of the plan would not be used for the purposes intended and in compliance with the requirement under section 1902(a)(30)(A) of the Act that payment rates must be consistent with "efficiency, economy, and quality of care."

Section 1903(a)(1) provides that federal matching funds are only available for expenditures made by states for services under the approved state plan. Thus, the return and diversion of a majority of the supplemental payment from the nursing facilities to the cities is not in compliance with section 1903(a)(1) and 31 U.S.C. § 1301 (a)("Purpose Statute") because the supplemental payments would not go towards medical assistance in the nursing facilities (i.e. the providers).

Based on the above consideration, CMS has also determined that the public-private partnerships would violate section 1902(a)(19) of the Act, which requires that care and services be provided consistent with "simplicity of administration and the best interests of the recipients." As noted above, the public-private partnerships are formed and maintained by a complex series of legal and financial transactions, which the state is not a party to, but must review and monitor to ensure compliance. Although the complex, mutualistic relationship between the parties financially benefits the participants, the best interests of recipients are not served by a payment structure that would divert a majority of the supplemental payments from the healthcare providers to the city governments, in the form of returned IGTs and overseer fees. The participants' pecuniary interests in the proposed SPA are outweighed by the administrative and fiscal burdens on the Medicaid program. Fundamentally, the best interest of Medicaid

beneficences requires that the supplemental payments should be available to the nursing facilities to support access to quality care and services.

Conclusion

For these reasons, after consulting with the Secretary as required by 42 C.F.R. § 430.15, CMS is disapproving this 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 C.F.R. § 430.18. Your request for reconsideration should be sent to Ms. Maritza Bodon, Centers for Medicare & Medicaid Services, Center for Medicaid & CHIP Services, 7500 Security Boulevard, Mail Stop 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 714, Dallas, Texas 75202.

Sincerely,

Mary C. Mayhew
Deputy Administrator and Director