**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
*OFFICE OF DIRECTOR*

# ACTION REFERRAL

| TO | DATE |
|---|---|
| Roberts | 6-17-14 |

| DIRECTOR'S USE ONLY | ACTION REQUESTED |
|---|---|
| 1. LOG NUMBER 000411 | [ ] Prepare reply for the Director's signature<br>DATE DUE _____ |
| 2. DATE SIGNED BY DIRECTOR<br>cc: Mr. Keck, Singleton, Day | [ ] Prepare reply for appropriate signature<br>DATE DUE _____<br>[ ] FOIA<br>DATE DUE _____<br>[X] Necessary Action |

| APPROVALS (Only when prepared for director's signature) | APPROVE | * DISAPPROVE (Note reason for disapproval and return to preparer.) | COMMENT |
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| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

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Director_Day

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June 12, 2014

**VIA FIRST CLASS AND ELECTRONIC MAIL**

Cindy Mann
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Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
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Dear Director Mann,

We represent CareSouth Carolina ("CareSouth"), a South Carolina recipient of funding under Section 330 of the Public Health Service Act and a federally-qualified health center ("FQHC"), and are writing to you on its behalf. As discussed below, our client has been informed by the South Carolina Department of Health and Human Services ("SCDHHS") that the Centers for Medicare and Medicaid Services ("CMS") has endorsed the position that SCDHHS is obligated to pay only the Medicare coinsurance amount for visits between a CareSouth provider and patients who are enrolled in both Medicare and Medicaid, the so-called "full-benefit dual eligible" population.[1] Currently, CareSouth's Medicaid FQHC payment rate is in excess of $180 per visit and if SCDHHS persists in implementing this policy, CareSouth will be underpaid by as much as $80 per dual eligible visit. This discrepancy means that CareSouth is effectively subsidizing almost 50% of the cost of covered services provided to dual eligible patients, which translates into a loss on these services in excess of $500,000 per year.

It is well settled that South Carolina is required under federal law to pay FQHCs on a "per visit" basis for Medicaid covered services based on the cost of providing those services. *See* Social Security Act ("SSA") § 1902(bb). With respect to the particular question of paying for services provided to dual eligible beneficiaries, Section 1902(bb) makes no distinction between these beneficiaries and other individuals enrolled in the Medicaid program. The statute simply requires full payment for all Medicaid covered services provided to individuals enrolled in the State's Medicaid program. Thus, as an initial matter, SCDHHS's position is not supported by the plain language of the statute. It is also not supported by the legislative history of Section 1902(bb) and its predecessor provisions. Specifically, that history shows that Congress designed the FQHC payment provisions to prevent subsidy of a health center's deficient Medicaid payments by an operating grant under Section 330 of the Public Health Service Act ("PHS Act") – the

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[1] SCDHHS claims that a recent State Plan Amendment (SPA 11-012) gives it the authority to cut payment for dual eligibile beneficiaries. We have enclosed it for your convenience.

very type of subsidy that is taking place in South Carolina. Medicaid's role as payor of last resort provides further confirmation that any Medicare payments serve as an offset to the State's obligation to make fully compensable payments, not an obviation of those obligations. In short, SCDHHS's actions are contrary to federal law.

Consequently, before we leap to conclusions about CMS's views on these issues, we are writing to you to seek a statement of CMS's position so that we know how best to advise our client. Due to the significant and daily loss of funds, we ask that your office respond to this request *by July 11, 2014* so that we can fully advise our client. If we do not receive a response within that time, we will be forced to assume that SCDHHS has correctly stated CMS's position and will act accordingly.

**Factual Background**

In State Plan Amendment ("SPA") 11-012, which took effect on August 9, 2011, SCDHHS announced its intention to cap Medicaid payments to dual-eligible beneficiaries at the amount of Medicare cost-sharing. As noted in the SPA, for QMB, QMB Plus, and "Other Medicaid Recipients," the State's cost-sharing payment for Part B-covered services (including FQHC services) "will amount to the Medicaid claim payment less the amount paid by Medicare *not to exceed the sum of the Medicare coinsurance and deductible.*"[2] *See* Enclosure (SC State Plan, Supp. 1 to Att. 4.19-B, p. 3 (emphasis added)).

CareSouth believes SCDHHS is incorrectly relying on this SPA to cap Medicaid payments to FQHCs for services provided to full-benefit dual eligible beneficiaries (*i.e.*, QMB Plus and Other Medicaid Recipients) at the health center's Medicare all-inclusive payment rate, rather than the full (and significantly higher) Medicaid payment the health center would otherwise receive under the PPS reimbursement provisions of SSA § 1902(bb). FQHCs are reimbursed under Medicaid for providing "federally-qualified health center services," as well as any other ambulatory services offered by the FQHC and otherwise defined in the State plan. *See* SSA §§ 1905(l)(2)(A), 1905(a)(2)(C).[3] (We refer to these services here collectively as "FQHC services.").

**Legal Analysis**

We do not believe that SPA 11-012 has the effect that SCDHHS asserts it does. As an initial matter, the impact of SCDHHS's payment scheme, which requires CareSouth to subsidize care to dual eligible patients due to the State's failure to pay up to the FQHC PPS rate, is directly contrary to the basic principles underpinning Medicaid FQHC reimbursement. Most FQHCs receive grants authorized under Section 330 of the PHS Act to provide primary and preventive care to medically underserved populations,

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[2] For federally-qualified health centers, the Medicare Part B deductible is waived. Therefore, "medicare cost-sharing" under the SPA would be limited to the Medicare coinsurance amount for FQHCs.

[3] For many South Carolina health centers, including our client, the health center-specific rate under Medicaid is an "alternative payment methodology," as provided for in SSA § 1902(bb)(6)) and set forth in the State plan, which exceeds the health center's present Medicare cost-based all-inclusive rate. Until the implementation of SPA 11-012, health centers received payment from Medicaid for the difference between the provider's Medicaid FQHC rate and the amount paid by Medicare.

without regard to a patient's ability to pay. Grant funds are intended to cover the cost of services to uninsured and underinsured patients; the funds are not intended to be used to subsidize the costs of providing care under other public or private programs. Under Section 330, FQHCs must participate in Medicare and Medicaid and "make every reasonable effort . . . to collect reimbursement for health services to persons [covered by Medicare, Medicaid, any other public assistance program, or private health insurance] on the basis of the full amount of fees and payments for such services *without application of any discount.*" PHS Act § 330(k)(3)(G)(ii)(II), 42 U.S.C. § 254b(k)(3)(G)(ii)(II) (emphasis added).

When it instituted a cost-based reimbursement methodology for FQHCs in 1989, Congress made clear that Medicaid must "cover[] the cost of treating its own beneficiaries," so that the FQHC's Section 330 grant can be used for its intended purpose. *See* H.R. Rep. No. 101-247, at 192 (1989). Thus, to reduce Medicaid payments to FQHCs based on the scope of the "medicare cost-sharing" benefit is contrary to the underlying policy articulated by Congress when it enacted the FQHC reimbursement scheme that ensures each program pays its fair share of the costs incurred. As noted above, because of SCDHHS's reimbursement policy, CareSouth is forced to subsidize as much as $80 per visit of the cost of providing services to dual eligible patients; this outcome is plainly contrary to the Congressional intent behind establishing a cost-based FQHC reimbursement methodology.

Conversely, due to the application of the Medicare FQHC upper payment limitations ("UPL"), CareSouth's allowable costs of providing services to dual eligible patients far exceed its actual reimbursement under Medicare. In fact, as the preamble to the recent CMS final rulemaking establishing a Medicare PPS reimbursement methodology for FQHCs noted, "about 72 percent of FQHCs had average costs per visit that exceeded the UPL" and "application of the limits and adjustments currently in place reduced FQHCs' submitted costs of services by . . . about 14 percent." 79 Fed. Reg. 25436, 25439 (May 2, 2014). Thus, adherence to the Medicaid PPS rate for full-benefit dual eligible beneficiaries is crucial to ensure that FQHCs receive true cost-based reimbursement for services to dual eligible patients as intended by Congress.

Further, the Medicaid third-party liability regulation supports the argument that the State is required to fully reimburse an FQHC up to the full Medicaid state plan rate for Medicaid-covered services irrespective of any "medicare cost-sharing" element. That regulation obligates the State, after the amount of a third party's liability is determined, to pay the provider's claim "*to the extent that payment allowed under the agency's payment schedule exceeds the amount of the third party's payment.*" 42 C.F.R. § 433.139(b)(1) (emphasis added). Medicaid is "payor of last resort" for services that are covered under both Medicare and Medicaid, when provided to full-benefit dual eligible beneficiaries.

We believe that SCDHHS is improperly relying on SPA 11-012, which relates to the "medicare cost-sharing" benefit defined at SSA § 1905(p)(3), to counter the specific statutory FQHC payment provisions and the "payor of last resort" rule.

"Medicare cost-sharing" is a discrete category of "medical assistance" available to certain low-income Medicare beneficiaries. It was initially created by Congress to

allow certain low-income Medicare beneficiaries ("qualified medicare beneficiaries," or "QMB") who did not qualify for Medicaid to afford Medicare coverage. For this group, Medicaid covers premiums and coinsurance and deductible amounts for Medicare services, regardless of whether those services are also covered by Medicaid.

"Medicare cost-sharing" originally comprised the sole form of Medicaid available to QMBs ("QMB Only"). Although a statutory amendment later entitled beneficiaries who both meet the QMB income and resource thresholds and are otherwise entitled to full Medicaid services ("QMB Plus") to payment of "medicare cost sharing," statutory language makes clear that the parameters of the "medicare cost-sharing" benefit do not alter Medicaid's obligation to provide and pay for Medicaid-covered services *other than* "medicare cost-sharing" to full-benefit dual eligible beneficiaries (including QMB Plus) up to the full Medicaid state plan rate. SSA § 1902(a)(10)(G)(VIII).

In addition, although SSA § 1902(n) describes the "options for payment of Medicare cost-sharing amounts" and gives states some discretion to limit payment for "medicare cost-sharing," that discretion does not exempt states from paying for Medicaid-covered services provided to full-benefit dual eligibles at an amount equal to the full Medicaid state plan rate. Instead, Section 1902(n) allows States to set a cap on "medicare cost-sharing" for a service so as not to *exceed* the "payment amount that otherwise would be made under the State plan. . ." SSA § 1902(n)(2). The provision was enacted in the Balanced Budget Act of 1997, to accommodate the fact that State Medicaid programs frequently had *lower* payment rates than the rates used under Medicare. The provision was intended to give states the flexibility to cap "medicare cost-sharing" at those lower Medicaid rates. H.R. Conf. Rep. 105-217, 1997 U.S.C.C.A.N. 176, 491-92.

Indeed, a State's decision to limit provider payments for services to a full-benefit dual eligible to the Medicare allowed amount, while paying the higher rate (*i.e.,* the State Plan rate) for the same service for other categorically needy beneficiaries, as South Carolina has been doing, violates the comparability requirement at SSA § 1902(a)(10)(A) and 42 C.F.R. § 440.240(b)(1).

In sum, where the Medicaid rate for a service is higher than the Medicare allowed amount, Medicaid's obligation as payor of last resort is more expansive than the Medicare cost-sharing obligation and effectively subsumes it. This conclusion is in fact supported by the description in the approved South Carolina State Plan of the scope of services provided to QMB Plus:

> The Medicaid Agency pays Medicare Part A and Part B deductible and co-insurance amounts for all services available under Medicare *and pays for all Medicaid services furnished to individuals eligible both as QMBs and categorically or medically needy (subject to any nominal Medicaid co-payment).*

State Plan § 3.2(b)(1)(iii) (emphasis added).

Due to the high number of full-benefit dual eligible beneficiaries that CareSouth serves, South Carolina's erroneous policy has a dramatic impact on CareSouth's

Medicaid reimbursement. Each month in 2012, the health center lost more than $50,000 in Medicaid payments as a result of the policy. Each month in 2013, the health center lost approximately $43,000. Further, CareSouth has been forced to eliminate a number of training programs intended to assist other South Carolina FQHCs in improving the delivery of health care services.

We appreciate your attention to this matter, as South Carolina's decision to proceed with what we perceive as an unlawful payment policy hinders CareSouth's ability to serve aged and disabled low-income patients. We request that CMS indicate: 1) whether, in CMS's view, SPA 11-012 sufficiently authorizes the State to proceed with capping reimbursement for FQHC services provided to full-benefit dual eligible beneficiaries at the Medicare rate rather than the higher Medicaid PPS rate; and 2) whether CMS agrees or disagrees with our interpretation of the relationship between "medicare cost-sharing" and the role of Medicaid as "payor of last resort." Because of the urgency of this problem to our client, we request that CMS respond *by July 11, 2014.*

If you have any questions, please do not hesitate to contact the undersigned.

Sincerely,

Feldesman Tucker Leifer Fidell, LLP

By: Edward T Waters Isrq
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Enclosure

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment of Medicare Part A, Part B and Part C Deductible/Coinsurance

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Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters SP.

   For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 in item D of this attachment (see 3. below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters MR.

3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 in items A, B and C of this attachment, for those groups and payments listed below and designated with the letters NR.

4. Any exceptions to the general methods used for a particular group or payment are specified on Page 3 in item A of this attachment (see 3. above).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment of Medicare Part A, Part B and Part C Deductible/Coinsurance

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| QMBs: | Part A | NR | Deductibles | NR | Coinsurance |
| | Part B | NR | Deductibles | NR | Coinsurance |
| | Part C | NR | Deductibles | NR | Coinsurance |
| Other Medicaid Recipients | Part A | NR | Deductibles | NR | Coinsurance |
| | Part B | NR | Deductibles | NR | Coinsurance |
| | Part C | NR | Deductibles | NR | Coinsurance |
| Dual Eligible (QMB Plus) | Part A | NR | Deductibles | NR | Coinsurance |
| | Part B | NR | Deductibles | NR | Coinsurance |
| | Part C | NR | Deductibles | NR | Coinsurance |

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment of Medicare Part A, Part B and Part C Deductible/Coinsurance

A. Effective with claims processed on or after August 9, 2011, payment for Medicare Part A coinsurance and deductibles (other than nursing facilities) will be reimbursed as follows:

The Medicaid payment will amount to the Medicaid claim payment less the amount paid by Medicare not to exceed the sum of the Medicare coinsurance and deductible. The Medicaid claim payment amount will be calculated in accordance with Attachment 4.19-A of the South Carolina State Plan.

B. Effective with claims processed on or after August 9, 2011, payment for Medicare Part B coinsurance and deductibles will be reimbursed as follows:

The Medicaid payment will amount to the Medicaid claim payment less the amount paid by Medicare not to exceed the sum of the Medicare coinsurance and deductible.

C. Effective with claims processed on or after August 9, 2011, payment for Medicare Part C coinsurance and deductibles will be reimbursed as follows:

The Medicaid payment will amount to the Medicaid claim payment less the amount paid by Medicare not to exceed the sum of the Medicare coinsurance and deductible (and/or co-payments and deductibles).

D. For services which are covered by Medicare but are not covered by the SC State Plan, the Medicaid claim payment referenced in paragraphs A, B and C above, will be 75% of the Medicare rate for QMB recipients. There will be no payment for non-covered SC State Plan services for non-QMBs. See section 4.19-D of the Medicaid State Plan for the limitation on nursing home coinsurance payments.




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