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

# ACTION REFERRAL

| TO | DATE |
|---|---|
| Singleton | 10-11-11 |

| DIRECTOR'S USE ONLY | ACTION REQUESTED |
|---|---|
| 1. LOG NUMBER 10-158 | [ ] Prepare reply for the Director's signature<br>DATE DUE _____ |
| 2. DATE SIGNED BY DIRECTOR<br>CC: Hess, Waldrep<br>Cleared 12/7/11, letter attached. | [X] Prepare reply for appropriate signature<br>DATE DUE 10/20/11<br>[ ] FOIA<br>DATE DUE _____<br>[ ] 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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| 2. | | | |
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FELDESMAN
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FIDELL LLP

EDWARD T. WATERS
ewaters@ftlf.com



October 7, 2011

Anthony E. Keck, Director
South Carolina Department of Health and Human Services
1801 Main Street
Columbia, SC 29202

Re: FQHC Payments for Dual Eligibles

Dear Director Keck:

We represent Sandhills Medical Foundation, Inc. and Carolina Health Centers, Inc. (collectively, "the health centers") and are writing to you on their behalf. As you may be aware, these health centers are recipients of funding under § 330 of the Public Health Service Act and, as such, are designated in the Social Security Act ("the Act") as a federally qualified health center ("FQHC") for purposes of Medicaid and Medicare. We are concerned that a recently published change to South Carolina's Medicaid program and specifically to payments for individuals who are enrolled in both the Medicaid and Medicare programs ("dual eligibles") will be used, inappropriately, to reduce South Carolina's payment obligations under § 1902(bb) of the Act.

In a recent notice, the State announced a new Medicaid payment methodology applicable to claims received on or after August 1, 2011. The notice states that for payment of "professional claims with third party coverage including Medicare":

> The Medicaid payment will be the Medicaid allowed amount less the amount paid by the third party. If the provider has contracted to accept an amount less than the Medicaid allowed or the provider files an assigned claim for a dual eligible recipient, the Medicaid payment may not exceed the sum of the third party coinsurance and deductible.

The reason that we write to you is to inquire whether or not your office intends to apply this policy to FQHC payments for Medicaid covered services. If it does, the two health centers' collective revenue will fall by an estimated $27,000 per month ($15,000 per month for Sandhills Medical Foundation, and $12,000 per month for Carolina Health Centers) due to the fact that the Medicare coinsurance is significantly lower than the difference between the health centers' Medicaid and Medicare rates. Such a steep drop in revenues will force the health centers to consider and implement a variety of cost saving measures such as staff layoffs, cuts to fringe benefits and other actions to make up for this loss of revenue.

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Moreover, we do not believe that a reduction of payments for Medicaid enrollees, regardless of whether they are also enrolled in Medicare program or have coverage under another third-party payor, is lawful. As you may be aware, there are unique Medicaid payment provisions for FQHCs under the so-called prospective payment system ("PPS") provisions of § 1902(bb) of the Act. FQHCs receive cost-related payment under Medicaid for providing "federally-qualified health center services," as defined in § 1905(l)(2)(A) of the Act, as well as any other ambulatory services offered by the FQHC and otherwise defined in the State plan, *see id.* § 1905(a)(2)(C). Federal law requires States to pay for these services on a fixed per-visit or PPS rate. That rate, which varies from FQHC to FQHC, is based on 100 percent of the FQHC's average reasonable costs incurred during 1999 and 2000, adjusted for inflation and any changes in the scope of services furnished by the FQHC during the years since 2001. *Id.* § 1902(bb)(2), (3). States may, as South Carolina has done, develop an alternative to the PPS payment called an alternative payment methodology ("APM"), provided that the methodology is agreed to by the State and the FQHC, and that it results in payment to the FQHC that is at least equal to the PPS rate. *Id.* § 1902(bb)(6).

These unique payment requirements are a direct result of the important role that FQHCs serve as safety net providers. All FQHCs receive grants authorized under § 330 of the Public Health Service Act ("PHS Act") to provide primary and preventive care to medically underserved populations, without regard to a patient's ability to pay. FQHCs may use grant funds only to pay for the cost of services to uninsured and underinsured patients; the funds may not be used to subsidize the costs of providing care under other public or private programs. In addition, under § 330 requirements, FQHCs must participate in Medicare and Medicaid and must "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).

Congress instituted cost-based payment requirements for FQHCs over two decades ago to strike an appropriate balance between the requirement that FQHCs participate in Medicare and Medicaid, and the discretion that these programs generally have to set payment rates. Accordingly, Congress made clear that Medicaid must "cover[] the cost of treating its own beneficiaries," so that the FQHC's § 330 grant can be used for its intended purpose. *See* H.R. Rep. No. 101-247, at 192 (1989); *see also Three Lower Counties Community Health Servs. v. State of Maryland Dep't of Health and Mental Hygiene,* 498 F.3d 294, 297-8 (4th Cir. 2007) (citing this legislative history in support of a holding that the State of Maryland had failed to make adequate supplemental payments to FQHCs under Medicaid managed care).

Simply put, there is no provision of federal law or of the South Carolina State plan that would support a payment methodology that pays an FQHC less for services merely because the patient served has additional coverage from a third-party payor such as Medicare. Indeed, to reduce Medicaid payments to FQHCs based on factors other than

a reduction in services (which is certainly not the case with the dual eligible population) not only is contrary to the plain language of § 1902(bb) but also is contrary to the underlying policy articulated by Congress, *i.e.* that each program must pay its fair share of the costs incurred to implement that program.

There are a number of other legal and policy considerations that are either violated or not well served by the State's apparent action. However, we do not think, given the clear direction set by Congress for payments to health centers under the Medicaid program, that further discussion is necessary. We would ask, instead, that your office make clear that the new billing and payment provisions cited above do not apply to FQHCs such as Sandhills Medical Foundation and Carolina Health Centers and, thereby, put an end to this matter.

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

Sincerely,

Feldesman Tucker Leifer Fidell, LLP

By: Edward T Waters SV
Edward T. Waters

From: (202) 466-8960
Edward T. Waters

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**Anthony E. Keck, Director**
**South Carolina Department of Health**
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South Carolina Department of Health & Human Services

Anthony E. Keck, Director
Nikki R. Haley, Governor

December 7, 2011

Edward T. Waters, Esquire
Feldesman Tucker Leifer Fidell, LLP
1129 20th Street, NW
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Washington, DC 20036

RE: FQHC Payments for Dual Eligibles
Your Letter of October 7, 2011
Your Clients: Sandhills Medical Foundation, Inc. and
Carolina Health Centers

Dear Mr. Waters:

Thank you for your letter of October 7, 2011. We have reviewed the information that you provided along with our state plan.

The Public Notice issued on July 8, 2011, included information about the implementation date for changes to the reporting of third party liability claims and Medicaid payment for such claims. This information had been the subject of 2 previous bulletins in October and December 2010, and was based on a State Plan Amendment (SPA) submitted to the Centers for Medicare and Medicaid Services (CMS) for approval in August 2011.

Under § 1902(a)(25) of the Social Security Act [42 U.S.C. 1396a(a)(25)], the State is required to identify and pursue recovery of liable third parties. The Medicaid regulations at 42 C.F.R. § 433, Subpart D, require the State to have in place a method for avoiding cost to the program when there is information that a third party is liable for payment of the claim. This implements the oft stated Congressional purpose that Medicaid is to be the payor of last resort. Within these regulations, the Secretary created an exception to the cost avoidance of claims where the services involved are prenatal care and preventive pediatrics, including EPSDT. There is no mention of special treatment or exemption from the third party liability requirements for an FQHC.

In your letter you quoted § 330(k)(3)(G)(ii)(II) of the Public Health Service Act, 42 U.S.C. § 254b(k)(3)(G)(ii)(II), which states:

> (G) the center--:
> ii) has made and will continue to make every reasonable effort—

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- (II) to collect reimbursement for health services to persons described in subparagraph (F) on the basis of the full amount of fees and payments for such services *without application of any discount*. (emphasis in letter)

We would call your attention to § 330(k)(3)(F) of the Act, 42 U.S. C. § 254(b)(k)(3)(F), which states:

> F) the center has made or will make and will continue to make *every reasonable effort to collect appropriate reimbursement for its costs in providing health services to persons who are entitled to insurance benefits under* title XVIII of the Social Security Act [42 USCS §§ 1395 et seq.], to medical assistance under a State plan approved under title XIX of such Act [42 USCS §§ 1396 et seq.], or to assistance for medical expenses under any other public assistance program or *private health insurance program (emphasis added).*

This section of the Public Health Services Act requires the FQHC to pursue recovery from a liable third party. This is in keeping with there being no exemption of FQHCs from the application of the third party liability regulations.

In the course of its request for approval of the SPA, we contacted CMS regarding the applicability of the TPL requirements to FQHCs and the appropriate methods for coordinating payments for dually eligible beneficiaries. Nancy Dieter of CMS Central Office staff responded regarding treatment of dually eligible beneficiaries as follows:

> State Medicaid programs have several options for payment of Medicare cost-sharing amounts (deductibles, coinsurance, copays).
>
> For Medicare-covered services that are also covered in the Medicaid State plan, the States may pay (1) the cost-sharing amount established by Medicare, (2) an amount that, when added to the amount paid by Medicare, doesn't exceed the Medicaid State plan payment rate for the service, or (3) an amount, approved by CMS, that is at least equal to the Medicaid State plan rate for the service but less than the Medicare cost-sharing amount.
> For Medicare-covered services that are not covered in the Medicaid State plan, the States must establish a rate of payment for the service that is sufficient to maintain access to care for dual eligible beneficiaries. This may be the Medicare cost-sharing amount or a State-determined amount.
>
> States may vary payment methods by service and/or by type of dual eligible. Each State's approved payment methods are set out in the Medicaid State plan.

In response to the applicability of TPL rules to FQHCs, Sheri Gaskins of CMS Central Office wrote:

> In regards to your specific concern, I asked the following question: Is there a requirement that TPL rules are different for FQHCs i.e. does a state have to make sure the FQHC is paid at PPS regardless of what they are required to pay if there is another third party payer?
>
> The answer is no. All existing TPL rules would apply in the case of the FQHC being paid by another entity.

The SPA which was submitted in August 2011 was approved by CMS on October 17, 2011. A copy of that SPA is enclosed. Effective for claims processed on or after August 9, 2011, the Medicaid payment for Medicare Part B claims for dually eligible beneficiaries is "the Medicaid claim payment less the amount paid by Medicare not to exceed the sum of the Medicare coinsurance and deductible." For claims processed prior to August 9, 2011, the Medicaid payment would be the Medicaid claim payment less the amount paid by Medicare. This methodology applies to all providers.

We believe that our methodology and interpretation of the TPL requirements is consistent with the instructions and guidance received from CMS. We will continue to apply the Medicaid TPL requirements and the reimbursement set out in our State Plan to FQHCs.

If you have any questions, please contact me at (803) 898-2793.

Sincerely,

Bruce D. Carter
Assistant General Counsel

BDC/b