Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

SUBJECT: Texas Health and Human Services Commission
Docket Nos. A-07-37
A-07-94
A-07-100
A-07-126
Control Nos. TX-06-005-MAP
TX-07-002-MAP
TX-07-005-MAP
TX-07-009-MAP
Decision No. 2114

DATE: September 17, 2007

DECISION

The Texas Health and Human Services Commission (Texas or HHSC) appealed determinations by the Centers for Medicare & Medicaid Services (CMS) disallowing Medicaid claims submitted by Texas for non-emergency medical transportation at the Federal Medical Assistance Percentage (FMAP) rate applicable to Medicaid services. CMS found that HHSC provided reimbursement to the Texas Department of Transportation (TX-DOT) to administer the non-emergency transportation program and that TX-DOT entered into subcontracts for the transportation services. CMS determined that the expenditures by TX-DOT were not allowable at the FMAP rate because the transportation was not furnished "by a provider to whom a direct vendor payment can appropriately be made" by the state Medicaid agency and because the recipients' freedom of choice is limited under the TX-DOT transportation program. Nov. 29, 2006 Disallowance Ltr. at 1. CMS found that the transportation was provided through "arrangement" with TX-DOT as a Medicaid administrative expense. CMS disallowed the difference between the 50 percent administrative rate and the applicable FMAP rates for federal fiscal year (FFY) 2004 through the second quarter of FFY 2007. The total amount at issue is $21,783,877.

On appeal, Texas argues that it complied with federal law and, further, that the disallowance is premature as to periods of time after the proposed effective date of a pending Medicaid state plan amendment related to non-emergency medical transportation

services. Texas moved for a stay to permit the parties to engage in discussions about the proposed plan amendment that might resolve part, if not all, of the dispute. The Board granted the motion, but later set a briefing schedule at CMS's request after determining that a further stay was not warranted.

For the reasons explained below, we conclude that, prior to June 1, 2006, the services were furnished by "providers to whom a direct vendor payment [could] appropriately be made by the [State] agency" but that, after that date, some of the services were furnished under brokerage contracts, with no direct vendor payment appropriately made from any state agency to the entity that actually provided the service. We further conclude, moreover, that Texas established that, under the medical transportation program (even as administered by TX-DOT), recipients had the freedom of choice of providers that was required for Texas to receive FFP in payments for the services at the FMAP rate. Thus, we conclude that part of the claims at issue are allowable at the FMAP rate, under the existing approved plan. Accordingly, we uphold the disallowance determination in part and reverse it in part, in an amount to be determined pursuant to our instructions below. Texas may be entitled to an additional lump sum payment of FFP for the services provided under brokerage contracts if CMS approves the Texas plan amendment with an effective date during the disallowance period, but Texas is not entitled to that payment pending CMS's approval of the plan amendment.

Legal background

Medicaid, established under title XIX of the Social Security Act (Act), is a program in which the federal government and states share the cost of providing necessary medical care to financially needy and disabled persons. Sections 1901, 1903 of the Act.[1] Each state establishes and administers its own Medicaid program subject to various federal requirements and the terms of its "plan for medical assistance" (state plan), which must be approved by the Secretary of Health and Human Services (Secretary). Section 1902 of the Act. Once the state plan is approved, a state becomes entitled to receive federal

[1] The current version of the Social Security Act can be found at www.ssa.gov/OP_Home/ssact/comp-ssa.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. Also, a cross reference table for the Act and the United States Code can be found at 42 U.S.C.A. Ch. 7, Disp Table.

reimbursement, or "federal financial participation" (FFP), for a percentage of its program-related expenditures. Section 1903(a) of the Act.

FFP is available at the FMAP rate for expenditures for "medical assistance under the State plan." Section 1903(a)(1) of the Act. Section 1905(a) of the Act defines "medical assistance," in general, as payment of part or all of the cost of the listed services (which a state either must or may cover in its state plan) when provided to the specified eligible individuals (recipients). Section 1905(a)(28) of the Act (formerly section (a)(27)) provides that "medical assistance" includes "any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary." Medicaid regulations specify that transportation may be either medical assistance or an administrative cost. Specifically, 42 C.F.R. § 440.170(a) provides:

> *Transportation.* (1) "Transportation" includes expenses for transportation and other related travel expenses determined to be necessary by the agency to secure medical examinations and treatment for a recipient. (2) Transportation, as defined in this section, is **furnished only by a provider to whom a direct vendor payment can appropriately be made by the agency**. If **other arrangements** are made to assure transportation under § 431.53 of this subchapter, FFP is available as a **administrative cost**.

(Emphasis added.) For purposes of the Medicaid fee-for-service program, the term "provider" means "an individual or entity furnishing Medicaid services under an agreement with the Medicaid agency" unless the context indicates otherwise. 42 C.F.R. § 400.203. The term "Medicaid agency" or "agency" means the "single State agency administering or supervising the administration of a State Medicaid plan" unless the context indicates otherwise. Id. Requirements for a "single State agency" are in section 1902(a)(5) of the Act and subpart A of 42 C.F.R. Part 431. We discuss those requirements in more detail below.

Section 431.53 of 42 C.F.R., titled "**Assurance of transportation,**" requires that a Medicaid state plan must:

> (a) Specify that the Medicaid agency will ensure necessary transportation for recipients to and from providers; and

> (b) Describe the methods that the agency will use to meet this requirement.

Section 431.51(b) of 42 C.F.R. provides that a state plan must provide that--

> (1) Except as otherwise provided under paragraph (c) of this section and part 438 of this chapter, a recipient may obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is–
> (i) Qualified to furnish the services; and
> (ii) Willing to furnish them to that particular recipient.

This section is based on section 1902(a)(23) of the Act, on free choice of providers. The regulatory exceptions are from section 1932(a) of the Act, which permits a state to restrict the freedom of choice of providers under specified circumstances, and from section 1915 of the Act. Section 1915 provides that a state shall not be found out of compliance solely because it imposes certain specified allowable restrictions on freedom of choice. Section 1915 also permits a state to request a waiver of the freedom of choice requirement for some services, including transportation.

CMS's State Medicaid Manual addresses the freedom of choice requirement in the context of medical transportation, indicating that freedom of choice does not apply to transportation claimed as an administrative expense, but does apply to transportation claimed as a medical expense. TX Ex. L. The manual goes on to say:

> You **may enter into contractual arrangements for medical transportation** and inform recipients of the availability of this service. Also, you may establish allowable payments for private medical transportation not to exceed the costs which would have been incurred under the contract, for comparable services. However, you **must not limit medical transportation to its [sic] contractual arrangements.**

Id. (emphasis added). The manual also states: "Freedom of choice does not require you to provide transportation at unusual or exceptional cost to meet a recipient's personal choice of provider." Id.

Section 6083 of the Deficit Reduction Act of 2005 (DRA), effective February 8, 2006 gives states the option to establish a non-emergency medical transportation program. Specifically, DRA amended section 1902(a) of the Act by adding a new section, which permits a state plan to--

> (70) at the option of the State and notwithstanding paragraphs (1), (10)(B), and (23), provide for the establishment of a non-emergency medical transportation brokerage program in order to more cost-effectively provide transportation for individuals eligible for medical assistance under the State plan who need access to medical care or services and have no other means of transportation which--
> (A) may include a wheelchair van, taxi, stretcher car, bus passes and tickets, secured transportation, and such other transportation as the Secretary determines appropriate; and
> (B) may be conducted under contract with a broker who--
> (i) is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, resources, qualifications, and costs;
> (ii) has oversight procedures to monitor beneficiary access and complaints and ensure that transport personnel are licensed, qualified, competent, and courteous;
> (iii) is subject to regular auditing and oversight by the State in order to ensure the quality of the transportation services provided and the adequacy of beneficiary access to medical care and services; and
> (iv) complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on the prohibitions on physician referrals under section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate).

Factual background

Since 1975, item 12 of Attachment 4.19-B of the Texas Medicaid State Plan has provided:

> Payment for authorized medical transportation furnished to eligible recipients as a Title XIX benefit by approved transportation providers both private and public will be based on a negotiated reasonable charge per trip adjusted to reflect a round trip in cases where assurance contracts are the best method to reduce costs.

> In payment-per-trip contracts, payment will be based on reasonable charges not to exceed the rates established by the Single State Agency. Transportation and reimbursement, therefore, under this plan are assistance expenditures and will not exceed the upper limits contained in 45 C.F.R. 250.30.

CMS Ex. A.[2] Texas used the term "assurance contracts" because this plan provision was a response to a court decision holding that Texas was not meeting the requirement to assure necessary transportation services to Medicaid recipients. TX Br. at 2. In 1975, Texas expressed its understanding that transportation services directly identified with particular eligible individuals and provided pursuant to such contracts should be matched at the FMAP rate. TX Ex. B. Texas asserts, and CMS does not deny, that HCFA (CMS's predecessor organization) accepted this position. TX Br. at 3; CMS Br. at 9. Indeed, this understanding is reflected in state plan review materials provided by CMS. A commenter expressed concern that the amendment should specify that "under assurance contracts individual recipients must be identified together with service rendered in order to qualify at assistance expenditures – otherwise 50% matching." CMS Ex. 11, at unnumbered page 8.

Attachment 3.1 - D of the State plan, first approved in 1977, sets out the methods of assuring transportation and provides at section 2.d.:

> When not otherwise available, State agency funded reimbursements will supplement other available sources as necessary through:
> (1) Individual provider contracts with other persons for use of the other person's private means of transportation.
> (2) Contracts with a variety of public and private transportation providers to include both profit and non-profit organizations.

TX Ex. C. An Appendix to Attachment 3.1A of the State plan, approved in 1989 and amended in 2003, included limitations on medical transportation. TX Ex. D. Amendments to pages of the State plan that referenced these attachments and identified transportation as a service under the State plan, as well as

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[2] We note that the regulatory reference to Medicaid upper payment limits in the plan provision is outdated. Those requirements are now in Part 447 of 42 C.F.R.

providing the required assurances, were approved most recently in 2003.

The 2003 amendments reflected changes from a reorganization in Texas. In 1991, the Texas legislature created the HHSC and in 1993 designated it as the single State agency (State Medicaid agency). TX Ex. E. Attachment 1.2-A of the State plan, approved in 1993, describes HHSC as the State agency with "primary responsibility for overseeing the delivery of state health and human services" by 12 Health and Human Services (HHS) agencies. TX Ex. K, at K-1. This attachment describes the responsibility of the HHSC as the single State agency as follows:

> As the single state agency, HHSC has the authority to exercise administrative discretion in the administration and supervision of the Medicaid State Plan. This includes administration and supervision of the Medicaid program policies, rules, and operations which may be carried out by the HHS agencies. The HHS agencies do not have authority to change or disapprove any administrative decision of HHSC or otherwise substitute their judgment for that of the agency as to the application of policies and rules issued by HHSC. HHSC is authorized to oversee, monitor and evaluate the Medicaid programs and to require corrective actions of the agencies which implement the programs pursuant to the agreement with HHSC.

Id. The attachment includes an organization chart (which does not mention TX-DOT) as page 2. Id. at K-2. Pages 3 and 4, approved in 1994 and 1995, list the "Medicaid Programs" operated by the different HHS agencies and include "Medical Transportation" under the Texas Department of Health. Id. at K-3 to K-4.

In 2004, the Texas legislature revised provisions governing health and human services to give HHSC even greater authority and control, reorganizing the HHS agencies into four new departments. TX Ex. J (HB 2292, 78th Legislature, Regular Session, 2003). While this legislation retained HHSC's status as the single State agency for Medicaid, it also required HHSC to enter into an interagency contract with TX-DOT to "assume all responsibilities of the Texas Department of Health and the [HHSC] relating to the provision of transportation services for clients of eligible programs." Id. at J-1 to J-2. TX-DOT was authorized to "contract with any regional transportation provider or with any regional transportation broker for the provision of public transportation services." Id. at J-2.

Texas did not at the time submit a plan amendment to reflect this reorganization. Pursuant to the new law, however, TX-DOT and HHSC entered into an interagency contract setting out TX-DOT's responsibility for funding and delivery of transportation services, including services under the Medical Transportation Program (MTP). The parties agreed, among other things, to "make any amendments that may be necessary for this contract to be consistent with HHSC's status as the single state agency for Medicaid." CMS Ex. 3, at 1. This interagency contract contemplates that TX-DOT would "operate" the MTP (except for ambulance services). Id. at 3. Pursuant to the interagency contract, TX-DOT entered into contracts, awarded through a competitive bidding process, for medical transportation in each of the State's regions.

On January 18, 2006, the Dallas Regional Office of CMS notified Texas that CMS was deferring the FFP claimed for transportation services on the expenditure report for the quarter ended September 30, 2005. The letter indicated that, through discussions with Texas officials, the Regional Office had discovered that "the State significantly changed their transportation program." TX Ex. F, at F-2. The letter stated:

> Currently, HHSC transfers (pass-through) the Title XIX funds to TX-DOT. TX-DOT has eleven service call centers that receive client requests for transportation services. The call center arranges for the transportation on a per-trip basis, and assigns a unique identification number. None of the transportation claims are processed through the MMIS [Medicaid Management Information System]. TX-DOT has its own unit that processes the claims. The claim record is created for the contractor from the unique confirmation number assigned at the service call center.

Id. The letter referred to federal requirements and concluded that the "current arrangement in Texas should be reimbursed as an administrative expense, not at the FMAP rate." Id.

Shortly after this, Congress passed the DRA. In a letter to State Medicaid Directors dated March 31, 2006 (SMDL #06-009), CMS described the amendment in the DRA permitting states to establish non-emergency medical transportation (NEMT) brokerage programs, and attaching a form for a plan amendment to implement such a program. TX Ex. G. The same day, Texas submitted a plan amendment to establish such a program, with a proposed effective date of February 8, 2006. TX Ex. H. CMS sought more information

from Texas about this amendment and asked for some revisions to it, but has neither approved nor disapproved the amendment yet.

On November 29, 2006, CMS disallowed $14,849,602 in FFP for medical transportation claimed by Texas for FFYs 2004, 2005, and 2006, including the deferred claim and some claims previously paid. CMS subsequently disallowed $1,966,536 for the fourth quarter of FFY 2006, $2,655,823 for the first quarter of FFY 2007, and $2,311,916 for the second quarter of FFY 2007.

Issues

It is undisputed here that the claims at issue were for transportation provided to eligible Medicaid recipients who needed it. Moreover, CMS does not allege that the amounts paid for that transportation exceeded the amounts permitted under the Medicaid State Plan. The main issue is whether the expenditures for transportation services met the requirements to be reimbursable at the FMAP rate, or were provided under another "arrangement" and therefore are reimbursable only as administrative expenses at the 50 percent rate.[3]

CMS based its conclusion that FFP at the FMAP rate is not available on 1) its findings about the respective roles of HHSC and TX-DOT; and 2) on its finding that the recipients did not have freedom of choice about transportation providers.

Texas disputes these findings and also argues alternatively that, since Texas has submitted a plan amendment under DRA that could be effective as of February 6, 2006, the disallowance for the period after that date should be reversed. CMS argues that we should uphold the disallowance for the entire period and that Texas is mistaken about when its plan amendment might be effective.

We address each of these issues below.

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[3] In responding to Board questions about this case, CMS seems to imply for the first time that the claims made by Texas include payments made to TX-DOT for administering the MTP. This is inconsistent with the previous descriptions of the claims as being for the transportation services furnished to Medicaid recipients. If the claims do include administrative costs incurred by TX-DOT, however, we would agree with CMS that those costs are reimbursable only at the 50 percent rate. Our decision does not preclude CMS from further examining the nature of the costs.

Analysis

1. *Some, but not all, of the transportation services at issue were furnished by a provider to whom a "direct vendor payment" could appropriately be made by the State agency.*

Texas argues that CMS's "description of the relationship between HHSC and TX-DOT is incorrect and inaccurate, and, consequently, the perception of the relationship between HHSC and the transportation providers is also inaccurate." TX Br. at 7. Texas acknowledges that it did not amend its State plan to reflect the most recent organizational changes. According to Texas, however, the HHSC clearly retained its designation as the single State agency, with authority to supervise the administration and operation of the Medicaid program. Texas quotes state laws clearly reflecting that authority. TX Br. at 8. Texas points out that the previous structure was also described as one in which HHSC "was the oversight agency over twelve other agencies with various operational responsibilities." Id. Since (under that structure) the then Department of Health provided the medical transportation, HHSC's current use of TX-DOT to operate the transportation program, under HHSC's supervision, is not a significant change, Texas asserts. TX Br. at 8. Texas says that item 12 of Attachment 4.19B refers to contracts but does not specifically identify what State operating unit or organizational unit will maintain and implement those contracts, so its interpretation of its plan is a reasonable one to which we should defer.[4]

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[4] Texas also argues that, in New Jersey Dept. of Human Services, DAB No. 1090 (1989), the Board held that the fact that New Jersey changed the actual agency that operated its medical transportation program (without amending its state plan) was not a sufficient basis for disallowing New Jersey's claims for transportation services in light of New Jersey's consistent practice in operating its program. That case is distinguishable, however. It involved transportation provided by DCYF, a division of the New Jersey Department of Human Services (the single state agency for Medicaid), and claimed as an administrative cost under a state assurance that included transportation "under arrangement with DPW," a different division of the Department. CMS said this meant that DPW had to actually provide the transportation; the Board held that New Jersey had reasonably and consistently over many years interpreted the plan language (which was not a necessary part of the State plan) to include transportation

CMS replies that it is not claiming the plan is ambiguous. CMS acknowledges that item 12 of Attachment 4.19-B of the Texas Medicaid State Plan, as approved by CMS in 1975, references payments through contracts with approved transportation providers. CMS further states that the "scheme" in the current State plan, as drafted in 1975, "would qualify for an enhanced rate if it was actually being implemented." CMS Br. at 9.[5] CMS states, however, that "in reality Medicaid funds are passed through to TX-DOT which is neither a brokerage . . . or approved transportation vendor operating under a Medicaid provider agreement." Id.[6]

The key issue is not whether TX-DOT is a "brokerage" or a vendor, however. Texas does not claim that TX-DOT is a vendor to whom a direct payment for services may be made, nor does it claim that TX-DOT is a broker (and, as we discuss below, that would not help Texas here). Instead, Texas claims that TX-DOT was simply operating the MTP under the supervision of HHSC so that the payments made under transportation contracts with TX-DOT qualify for the FMAP rate as payments for services, pursuant to its approved State plan, just like the payments made when the Department of Health was operating the MTP. When asked what is the significance under the regulations of the fact that TX-DOT is neither a brokerage nor a vendor, moreover, CMS acknowledged there "is no relevance . . . if TX-DOT was simply operating the MTP under the supervision of HHSC and making direct payments to vendors." CMS Response to Order at unnumbered page 2. CMS went

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provided by DCYF under an interagency agreement with DPW.

[5] We note that CMS refers to the FMAP rate as an "enhanced rate," citing Board decisions about the higher burden on a state when it is claiming FFP at an enhanced rate. CMS Br. at 5. Those decisions, however, were referring to special, higher than usual rates Congress has provided for specific types of administrative costs or specific categories of covered medical services, not to the FMAP rate, which applies to all "medical assistance" expenditures. CMS is nonetheless correct, however, that Texas has the burden of showing that it is entitled to FFP at the FMAP rate, rather than at the 50 percent rate.

[6] After the word "brokerage," CMS's brief has the parenthetical statement "(as set out in the criteria listed at 45 C.F.R. § 92(b) - (f))." Apparently, CMS intended to refer to the criteria for competitive bidding under grants to states, as set out in 45 C.F.R. § 92.36(b) - (f), and cited in SMDL #06-009 with reference to brokerage contracts.

on, however, to conclude that under this circumstance the only rate available is the 50% rate because the FMAP rate is available only "if the payments are being made to transportation providers qualifying as vendors." Id. CMS's response indicates CMS thinks that the payments at issue here were made to "another state agency or subdivision." Id. Texas says, however, that the payments claimed (except for payments made to a transportation broker under the proposed plan amendment) were payments made to the transportation providers by the state comptroller's office after authorization for payment through the state TEJAS information system, just as payments were made to transportation providers when the Department of Health operated the MTP. CMS Ex. 5, at 5; TX Reply at 3; TX Response to Order at 6.[7] CMS made no specific finding to the contrary.

CMS asserts that its view of the relationship between HHSC and TX-DOT is not inaccurate, but is based on the *Interagency Cooperation Contract*, which CMS says "reflects an agreement between these two distinct State agencies." CMS Br. at 8. Specifically, CMS relies on Attachment A of the interagency contract, and mentions the following aspects of the relationship (in addition to the transfer of funds between the two agencies):

- utilizing 11 call centers, TX-DOT arranged for the transportation on a per-trip basis, creating a claim record from the unique confirmation number assigned by the service call center;
- no Medicaid provider numbers were issued to the entities that contracted with TX-DOT;
- TX-DOT independently processed these claims, so they were not part of the MMIS system; and
- after review of the current operations, CMS found no measurable involvement by the HHSC in the expenditure of funds.

CMS Br. at 8. CMS also points out that the current organizational chart for HHSC shows that TX-DOT is not included on the HHSC organizational chart in the same way as other

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[7] TEJAS stands for Transportation's Electronic Journal for Authorized Services. CMS Ex. 5, at 5. The TEJAS system was developed when the transportation program was being operated by the Department of Health and is used to verify Medicaid eligibility (based on the eligibility file transmitted to TX-DOT), to schedule trips, and for claims payment; payment vouchers are processed by TX-DOT's Financial Information Management System. Id.; TX Reply at 3.

"agency-divisions" are and that the website for TX-DOT classifies the MTP under its Division for Public Transportation. Id. at 8-9. Since CMS neither explained why any of its findings make a difference nor cited any statutory or regulatory authority under which these findings would be relevant, the Board's Order To Develop the Record asked CMS about these findings.

The Board asked whether there is a requirement that provider numbers be assigned. CMS responded:

> Generally, a state assigns a unique Medicaid provider number to a provider to simplify the claims payment process. This Medicaid provider number is tied to all payment claims submitted by the state. According to the [HHSC], every Medicaid provider must be assigned a Medicaid provider number to be reimbursed for Medicaid services. HHSC does not assign transportation providers a provider number, therefore HHSC must not consider transportation a medical service.

CMS Response to Order at unnumbered page 3. This response to the Board's direct question indicates that there is no federal requirement for assignment of provider numbers.[8] Moreover, even

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[8] CMS does, in response to another question, cite to 42 C.F.R. § 431.107 as requiring provider agreements, thus obliquely suggesting that its finding that Texas did not have provider agreements with the service providers is significant (even though CMS's brief did not rely on this finding). CMS does not, however, explain why a contractual arrangement between a transportation provider and a state agency administering the MTP would not meet the requirements of the cited section if it contains the requisite provisions regarding recordkeeping and disclosure, and Texas asserts that the contracts did contain such provisions. TX Response to Order at 6. The CMS response also refers the Board to a document on effective dates of provider agreements, but this document refers to an interpretation of 42 C.F.R. § 489.13(d). CMS Ex. 11, at unnumbered pages 1-3. That regulation, however, applies to Medicare provider agreements, not to Medicaid provider agreements, and does not apply to transportation providers. We note that the term "provider agreement" is sometimes used in the Medicaid program to refer only to the agreements with certain institutional providers that are subject to survey and certification. See, e.g., SMM § 4602. With respect to transportation services, CMS approved the Texas State plan provision for use of "contracts with providers" and "payment-per-trip contracts" for services to be claimed at the

if HHSC generally requires assignment of such numbers, we would not draw the inference from lack of such numbers that CMS wants us to draw here. HHSC considered the transportation at issue here to be a medical service and claimed it as such. Moreover, the TEJAS system functioned to identify the provider of each service claimed under a contractual arrangement with a provider since it formed the basis for payment to the provider. (The TEJAS system also clearly identified each particular service to an individual Medicaid recipient - the condition mentioned in approval of the 1975 state plan provision as key to claiming at the FMAP rate.)

CMS also failed, in response to a specific Board question, to cite any requirement that transportation claims be processed through a state's MMIS system in order to be reimbursed at the FMAP rate.[9] CMS instead merely reiterates its finding that the TX-DOT's call centers arranged for the transportation on a per-trip basis, creating a claim record from the unique confirmation number assigned by the call center, and asserts that this "is strictly an administrative function at the 50/50 match rate." Id. That the processing of the requests for transportation is an administrative function is relevant only if the claims at issue included the costs incurred by TX-DOT in processing the transportation requests. But CMS made no finding that the claims at issue are for any costs other than the payments made by the State Comptroller's office to the providers or (for some claims, as discussed below) to service brokers, for transportation services documented in the TEJAS system as services provided to individual Medicaid recipients.

CMS also does not cite to any federal requirement relevant to its finding about the TX-DOT call centers assigning a unique confirmation number for any approved transportation request although the Board asked CMS to explain the significance of this finding. Instead, CMS acknowledges that the confirmation number "may be sound for purpose[s] of tracking each service transaction." Id. CMS notes that a confirmation number is not a

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FMAP rate. TX Ex. A. Moreover, the State Medicaid Manual specifically says, in the context of transportation as a service, that a state may "enter into contractual arrangements for medical transportation . . . ." TX Ex. L.

[9] While an MMIS system has controls to prevent duplicate payments and services, Texas asserts it has such controls in place in TEJAS, and there was no finding that any of the claims at issue here were for duplicate payments.

Medicaid provider number, but, again, does not cite any regulation requiring such a number.

After discussing the relationship of the two State agencies, CMS's brief goes on to assert:

> However, the issue before the Board is not the allowability of the transportation costs, but rather at what rate should such claims be reimbursed. As illustrated by the Board, the key distinction in identifying the appropriate rate for transportation in the Medicaid context is the nature of the entity. New Jersey Department of Human Services, DAB No. 1090 (1989). When a vendor receives **direct payments from the State**, this cost qualifies as a medical service and reimbursement is at the FMAP rate. However, in Texas the transportation was arranged by TX-DOT, who received its funds from the State, who then reimbursed or made payments to the various contractors.

Id. at 10 (emphasis added). CMS does not dispute that TX-DOT is a State agency, and at least some transportation vendors had contracts with TX-DOT and received direct payments from the State. The 1975 state plan provision does not specify that the "assurance contracts" with providers of transportation for payment at a "negotiated reasonable charge per trip" will be contracts directly with the single State agency (although it does specifically refer to the "Single State Agency" as responsible for setting a maximum rate). TX Ex. A. Moreover, CMS in 1994 approved plan provisions indicating that the Department of Health was the operating agency for the MTP. TX Ex. K, at K-3.

CMS clarified, in response to a Board question, that its brief used the term "State" to mean the single State agency (HHSC). CMS does not support its position that the direct payment must come from the single State agency with any cite to a regulation or policy issuance, however. The regulation specifying when the FMAP rate is available for transportation refers to services being furnished by a provider to whom a "direct vendor payment can appropriately be made by the agency." 42 C.F.R. § 440.170. In context, that regulation could be read as meaning the single State agency. But CMS does not adequately explain why the FMAP rate would be available for payments made under contracts with vendors during the period when the Department of Health operated the MTP, but not available while TX-DOT is operating the program. The Department of Health was a Health and Human Services Agency, but there is no evidence in the record showing that it was merely a division of the HHSC, as CMS suggests, rather than a separate

state agency. The mere fact that some state agencies might be considered health and human services agencies and have a closer relationship to HHSC than TX-DOT would seem to be irrelevant if HHSC can legitimately delegate operation of the MTP program to another State agency, so long as it continues to provide the requisite degree of supervision, and if the HHSC was providing that supervision over TX-DOT's operation of the MTP.

Under 42 C.F.R. § 431.10(e)(3), "Authority of the single State agency," in order to qualify as the Medicaid agency--

> (1) The agency must not delegate to other than its own officials, authority to–
> (i) Exercise administrative discretion in the administration or supervision of the plan; or
> (ii) Issue policies, rules, and regulations on program matters.
> (2) The authority of the agency must not be impaired if any of its rules, regulations, or decisions are subject to review, clearance, or similar action by other offices or agencies of the State.
> (2) If other State or local agencies or offices perform services for the Medicaid agency, they must not have the authority to change or disapprove any administrative decision of that agency, or otherwise substitute their judgment for that of the Medicaid agency with respect to the application of policies, rules, and regulations issued by the Medicaid agency.

The clear implication of this is that other State agencies may "perform services for the Medicaid agency" so long as these requirements are met.

CMS does not specifically allege that the requirements in section 431.10(e)(3) of the regulations were not met, but says generally that CMS found "no measurable involvement by HHSC in the expenditure of funds" for the MTP program. CMS Br. at 9. As mentioned above, CMS relies in part on Attachment A from the *Interagency Cooperation Contract* to support this finding. CMS, however, ignores contract provisions that directly address the concerns in section 431.10(e)(3). For example, the *Interagency Cooperation Contract*, Attachment A, Article 1 (titled "Scope and Intent) begins with the statement that "HHSC is the single state agency for Medicaid" and ends with the parties' agreement to "make any amendments that may be necessary for this contract to be consistent with HHSC's status as the single state agency for Medicaid." CMS Ex. 3, at 1. Under the contract, HHSC was responsible for providing all Medicaid medical reviews required

by state or federal law, including reviews related to exceptions to policies related to a specific mode of transport or to a requirement for an attendant, and for processing all appeals from decisions to deny or modify MTP service. TX-DOT had to respond to the HHSC Office of Inspector General (OIG) on provider and claims investigations, and promptly notify HHSC of any notice of recovery relating to the MTP from the OIG. The parties were required to share information with each other about the program and to cooperate fully in making any major changes to the MTP. The Attachment also includes provisions for TX-DOT access to and training on HHSC computer systems, for furnishing eligibility files, and for verifying files against the MTP TEJAS System Database. CMS Ex. 3.

Texas provided additional information, in response to questions from CMS and in its brief, regarding the oversight of HHSC over the MTP operated by TX-DOT and how HHSC retains its administrative discretion and policy role over Medicaid transportation services. CMS Ex. 5; TX Reply at 2-3 (citing TEX GOV CODE §§ 531.0055(b) and 531.021). That information, together with the terms of the *Interagency Cooperation Contract*, indicates to us that the requisite oversight exists.

Finally, we again note that the regulation on transportation for which the FMAP rate is available refers to transportation "furnished only by a provider to whom a direct vendor payment can appropriately be made by the agency." 42 C.F.R. § 440.170(a). This wording does not require that the payment in fact be made directly by the single State agency. Indeed, both before and after TX-DOT took over the MTP, the actual payments to providers were made by the statewide financial system administered by the State Comptroller's Office, based on the information in the TEJAS system, except for those payments that were made to brokers, who then paid the providers. CMS Ex. 5, at 5-6; TX Response to Order at 6.

Thus, we are convinced that, to the extent that TX-DOT entered into contracts with the <u>providers</u> of transportation services who could appropriately receive <u>direct</u> vendor payments from the State, the payments to the providers qualify for the FMAP rate under the State plan and federal requirements, so long as freedom of choice was preserved (which we discuss below).

On the other hand, however, Texas effectively concedes that, after it implemented its proposed plan amendment (which it says it did on June 1, 2006), some of the services were <u>not</u> services under a contract with a provider to whom a direct vendor payment could appropriately be made by a state agency, as required by

federal regulations and the state plan. Instead, some of the payments were made to transportation brokers, under contracts with them, rather than directly to services vendors.

Texas acknowledged in response to questions from CMS that "[i]f the transportation services vendor is a broker, the broker pays the transportation providers." CMS Ex. 5, at 4. This response goes on to say that "[f]ifteen Transportation Area Vendors were selected to cover twenty-four transportation services areas." Id. In response to the Board's Order to Develop the Record, Texas clarified that, prior to implementing its proposed plan amendment, TX-DOT had contracts directly with transportation providers on a county-by-county basis. After June 1, 2006, however, at least some of the contracts were with brokers.

Clearly, Congress, in enacting section 6083 of the DRA, considered payments to brokers not to qualify as payments to providers to whom a direct vendor payment can appropriately be made. The legislative history of the provision that became section 6083 describes the "current law" as providing that a "state may only receive matching payments at its FMAP rate if the provider actually supplying the service receives payment directly from the state" and that "[o]ther arrangements (e.g., payment to a broker who manages and pays transportation providers) must be claimed as an administrative expense." H.R. REP. No. 276, 109th Cong. 2d Sess. (2005). Moreover, the existing approved State plan provision for transportation as a Medicaid benefit refers only to contracts with providers. TX Ex. A. Texas itself distinguishes the brokers from the service providers in its response to CMS's questions about the TX-DOT contracts, yet cites no authority from pre-DRA law for claiming payments to brokers at the FMAP rate.

Thus, we conclude that some of the claims at issue here were paid under "other arrangement" (that is, arrangements with brokers) and are allowable only at the 50 percent administrative rate. Even those claims that were for direct vendor payments to providers, however, are eligible for FFP at the higher rate only if Texas was meeting the freedom of choice requirements. As we discuss next, we conclude that Texas met those requirements.

2. The mere fact that the TX-DOT transportation program contracted with particular providers to serve specified areas does not mean that recipients' freedom was limited.

As mentioned above, CMS also denied FFP at the FMAP rate because it determined that "the recipients' freedom of choice of

providers is limited under the TX-DOT transportation program." November 29, 2006 Disallowance Ltr. at 1. Citing 42 C.F.R. § 431.5l, CMS said that "Texas may not restrict transportation providers to those subcontracted with TX-DOT without an approved freedom of choice waiver." Id.

Texas does not claim to have a freedom of choice waiver for transportation services, nor does it assert that any of the other exceptions in section 431.51 apply. Texas points out in its brief that the availability of medical transportation is often greatly limited by factual circumstances outside the control of either the Medicaid agency or the recipient. According to Texas, the State Medicaid Manual "acknowledges these kinds of limitations and indicates that freedom of choice does not require transportation to be provided at unusual or exceptional cost to meet a recipient's personal choice of provider." TX Br. at 11. This is true, but the State Medicaid Manual also goes on to say that a state "must not limit medical transportation to its contractual arrangements." TX Ex. L.

Texas asserts, however, that while its Medicaid program had contractual arrangements for a variety of types of medical transportation and informed recipients of the availability, "recipients were not limited to these contractual arrangements because they could also arrange for private transportation at rates that would not exceed the rates paid for comparable services." TX Br. at 12.

Texas states generally in its brief that "the recipients' freedom of choice is not so limited as to be violative of the statutory and regulatory requirement." TX Br. at 11. In its response, CMS characterizes this statement as an admission that Texas did in fact limit recipients' freedom of choice. CMS Br. at 11. This is not a fair characterization of what Texas says in its brief, however. Clearly it was saying instead that the only limits were ones consistent with federal requirements, and that recipients were not limited to the transportation services provided through the TX-DOT contractual arrangements. Limiting the private transportation to rates paid for comparable services is not only consistent with federal requirements, but also is a limit contemplated by the approved plan, as are other limits, such as a limit to services that are appropriate for the recipient's physical limitations. TX Exs. A, D. CMS does not specifically deny the assertion by Texas that recipients could receive transportation by means other than the TX-DOT contracts, nor did CMS cite to any state rule, policy, or other document limiting recipients' choice of providers to those under the TX-DOT competitively-bid contracts. In response to the Board's

questions, moreover, Texas provided a copy of its administrative rules, which offer recipients the option to choose any individual to provide transportation services; so long as that individual signs a participation agreement and meets requirements such as having a current driver's license and vehicle insurance, the individual (called an "individual volunteer contractor" or "individual driver registrant") will receive the mileage rate set by HHSC for providing needed transportation. TX Ex. M.

CMS does not provide any evidence that recipients were in fact limited to the transportation that was made available to Medicaid recipients through the TX-DOT competitively-bid contracts and apparently would have us infer such a limit merely because those contracts existed. We see no reason, however, to infer that Texas was not following its own administrative rules regarding choices available to recipients, absent some affirmative evidence showing such conduct by Texas.

In response to a Board question about its basis for concluding that Texas limited freedom of choice, CMS also asserts: "Texas contracted with select providers without an approved waiver and CMS policy strictly prohibits this from occurring." CMS Response to Order at unnumbered page 3. CMS cites no policy to support this assertion, however, and the assertion is directly contradicted by CMS's official policy in the State Medicaid Manual, which specifically says that a state "may enter into contractual arrangements for medical transportation and inform recipients of the availability of this service." SMM § 2113; TX Ex. L. While the State Medicaid Manual provision goes on to say that a state "must not limit medical transportation to its contractual arrangements," nothing in the provision implies that entering into such arrangements will automatically be considered an impermissible limit on freedom of choice.

CMS's response also implies that the interagency agreement somehow acted as a limit on freedom of choice because it contemplates transportation being offered by TX-DOT only through contractual arrangements. The interagency agreement, however, contemplates that TX-DOT will operate the MTP, and nothing in that agreement makes competitively bid contracts the only means of transportation to be made available to recipients under that program. CMS Ex. 3. Finally, Texas has represented to CMS that the mileage rate established by HHSC continues to be paid to "individual driver registrants," even though the rates

established through the competitive bid process are paid to other transportation providers/brokers. CMS Ex. 5, at 3.

In sum, CMS appears to have no valid basis for its conclusion that recipients were limited to the transportation provided under the competitively bid contracts, and Texas has provided evidence that its program recipients did have freedom of choice, subject only to permissible limits such as payment at the mileage rate set by the HHSC.

> *3. The mere fact that Texas has a plan amendment pending approval does not require us to recalculate the disallowance, but, if the amendment is approved, Texas may be entitled to a lump sum payment for the difference between the 50 percent and FMAP rates for services provided consistent with the plan amendment.*

Texas argues that, if SPA 06-022 (its amendment to implement the new DRA provision for brokerage arrangements) is approved, expenditures made after February 8, 2006, that were made in accordance with the approved amendment will be matchable at the FMAP rate.[10] Texas says this means that "even if the Board upholds the disallowance, the amount of the disallowance must be recalculated to exclude amounts for time periods after February 8, 2006." TX Br. at 12. "Until a decision is made on the pending SPA 06-22," Texas contends, the amount for Quarter II, 2006 and subsequent quarters "should be excluded from the disallowance." Id.

CMS responds that, according to 42 C.F.R. § 430.20, "under no circumstances will February 8, 2006 be the effective date of the SPA 06-022" because the SPA submitted "was not approvable and in fact required a number of revisions." CMS Br. at 11. The provisions of section 430.20 that CMS cites for this proposition, however, are from paragraph (a) of section 430.20. That paragraph addresses the effective date of a "new plan." The provisions governing effective date of a plan amendment are in paragraph (b), which provides:

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[10] Texas also says that it submitted this amendment notwithstanding its disagreement with CMS that FFP in its current transportation program was available only as an administrative cost. Thus, we do not read this statement in the brief as meaning that Texas concedes that its costs are matchable at the FMAP rate only after February 8, 2006.

> (1) For a plan amendment that provides additional services to individuals eligible under the approved plan, increases the payment amounts for services already included in the plan, or makes additional groups eligible for services provided under the approved plan, the effective date is determined in accordance with paragraph (a) of this section.
> (2) For a plan amendment that changes the State's payment method and standards, the rules of § 447.256 of this chapter apply.
> (3) For other plan amendments, the effective date may be a date requested by the State if CMS approves it.

We do not need to decide, however, the earliest possible effective date of the plan amendment. Under the Medicaid regulations, there is no specific provision permitting FFP in a proposed plan amendment for which approval is pending. CMS says that SPA 06-022 has not been approved and is still "off the clock" because there is a pending request for additional information. CMS Response to Order at unnumbered page 3.

The regulations do provide that, if a disapproval of a state plan amendment is overturned, a state is paid a lump sum equal to any funds incorrectly denied. 42 C.F.R. § 430.18(e)(2). Similarly, if CMS does approve SPA 06-022 (or disapproves it and that disapproval is overturned on appeal), we would expect that Texas would be paid any funds due under the amendment from whatever the effective date is that is either approved by CMS or later set on appeal. Whether such a payment should be made, however, may depend on any revisions made to the proposed wording of the plan amendment and on whether what Texas was doing during the relevant period was consistent with the plan amendment as approved.

Thus, while we saw some merit to staying this proceeding for a short period of time to see whether CMS would approve SPA 06-022 and whether the approval would affect the disallowance for the period after the effective date of the amendment, we do not agree with Texas that amounts for periods starting with Quarter II of 2006 should be "excluded" from any disallowance resulting from our decision.

Conclusion

For the reasons explained above, we conclude that, prior to June 1, 2006, the services were furnished by "providers to whom a direct vendor payment can appropriately be made by the [State] agency" but that, after that date, some of the services were furnished under brokerage contracts, with no direct vendor

payment appropriately made from any state agency to the entity that actually provided the service. We further conclude, moreover, that Texas established that, under the medical transportation program (even as administered by TX-DOT), recipients had the freedom of choice of providers that was required for Texas to receive FFP in payments for the services at the FMAP rate. Thus, we conclude that part of the claims at issue are allowable at the FMAP rate, under the existing approved plan. Accordingly, we uphold the disallowance determination in part and reverse it in part, in an amount to be determined pursuant to our instructions below.

In response to the Order to Develop the Record, Texas identified one of the entities (American Medical Response) having a contract with TX-DOT (as of June 1, 2006), as a "broker" meeting the requirements of the DRA, based on preliminary discussions with CMS. TX Response at 3. Texas says that the difference between the FMAP rate and the 50 percent rate for payments associated with this broker is $1,522,876.30, but notes that this amount includes amounts claimed after the period at issue here that have not yet been disallowed and appealed. Texas also says that the preliminary determination "while not yet final, appears to be based on an assessment that the other transportation services area providers are direct service providers of transportation being provided in their areas." Id. Merely because other entities do not qualify as brokers under the DRA, however, does not automatically mean that they qualify as providers to whom a direct vendor payment can appropriately be made. Since the parties are engaged in ongoing discussions of this issue, we expect that they can cooperate to identify what part of the disallowances for the period after June 1, 2006, relates to payments not made directly by the state to a provider of transportation services. If they cannot agree, CMS should issue a new determination with its findings on this issue, and Texas may appeal that determination to the Board.

Finally, while Texas may be entitled to an additional lump sum payment of FFP for the services provided under brokerage contracts if CMS approves the Texas plan amendment with an effective date during the disallowance period, we conclude that

Texas is not entitled to that payment pending CMS's approval of the plan amendment.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Judith A. Ballard
Presiding Board Member