Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

SUBJECT: Texas Health and Human Services Commission
Docket No. A-07-93
Decision No. 2176

DATE: May 16, 2008

DECISION

On May 24, 2007, the Texas Health and Human Services Commission (Texas) appealed an April 20, 2007 decision by the Centers for Medicare & Medicaid Services (CMS) to disallow $11,325,266 in federal Medicaid reimbursement. Texas claimed this reimbursement for Medicaid payment rate adjustments benefitting "high-volume" providers of Medicaid-covered services. Those rate adjustments were for covered services furnished by five categories of high-volume providers between January 2002 and December 2004. The amount of federal reimbursement disallowed for each category of high-volume provider, and the time periods to which these disallowed amounts relate, are as follows:

> **Primary Care Physicians** (**PCPs)**: $4,539,259.27 for the period January 18, 2002 through June 30, 2003;
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> **Specialists**: $2,900,100.77 for the period September 1, 2002 through June 30, 2003;
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> **Dentists:** $1,684,214.76 for the period September 1, 2002 through June 30, 2003;
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> **Ambulatory surgical centers**: $2,192,131.39 for the period from September 1, 2002 through December 31, 2004; and
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> **Birthing centers**: $9,559.90 for the period September 1, 2002 through March 31, 2002.

On October 19, 2007, Texas voluntarily withdrew its challenge to the portion of the disallowance relating to ambulatory surgical centers and birthing centers. Consequently, the outstanding issues in this appeal relate solely to rate adjustments made for high-volume PCPs, specialists, and dentists for Medicaid-covered

services performed between January 18, 2002 and June 30, 2003. The amount disallowed for those three categories of providers totals $9,123,574.80.

Texas contends that the disputed rate adjustments were adopted to improve access to care by Medicaid recipients as provided in its approved Medicaid State plan, which defined deficiencies in access as problems with either the participation of physicians and other health care providers in the Medicaid program or the ability of the Medicaid-eligible population to obtain appropriate Medicaid-covered health care. Therefore, according to Texas, these rate adjustments constituted "access-based reimbursement fees" as described in that State plan. CMS, however, determined that the rate adjustments were inconsistent with the methodology described by the State plan because they rewarded high-volume providers rather than adjusting reimbursement rates by individual services provided.

We conclude that the rate adjustments made to high-volume PCPs, specialists, and dentists for services between January 18, 2002 and June 30, 2003 were access-based reimbursement fees specifically authorized by broad language in the approved State plan in effect during that period. Because those rate adjustments were thus made in accordance with the State plan, Texas was entitled to federal reimbursement for them. Accordingly, we reverse the contested disallowance of $9,123,574.80 in federal reimbursement for the rate adjustments for high-volume PCPs, specialists, and dentists.

Legal Background

The federal Medicaid statute, title XIX of the Social Security Act (Act),[1] authorizes a program that furnishes medical assistance to low-income individuals and families as well as to blind and disabled persons. Act § 1901. The program is jointly financed by the federal and state governments and administered by the states. Id. § 1903; 42 C.F.R. § 430.0. Each state administers its Medicaid program pursuant to broad federal requirements and the terms of its "plan for medical assistance," which must be approved by CMS on behalf of the Secretary of Health and Human Services (HHS). Act § 1902; 42 C.F.R. §§ 430.10-430.16. The state plan must specify the medical items

[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.

and services covered as "medical assistance" under the state's program. Act § 1902; 42 C.F.R. § 430.10. The state plan must also describe or specify the policies, methods, and standards used to set payment amounts or rates for covered services. 42 C.F.R. §§ 447.201(b), 447.252(b).

Once the state plan is approved, a state becomes eligible to receive federal reimbursement, or "federal financial participation" (FFP), for a specified percentage "of the total amount expended . . . as medical assistance under the State plan." Act § 1903(a) (emphasis added). The term "medical assistance" is defined in section 1905(a) of the Act and includes payments by states to hospitals, physicians, and health care entities and practitioners for their provision of certain specified care and services identified in the state plan as covered by Medicaid. Thus, only those expenditures for medical assistance made by a state in accordance with the state plan are eligible for FFP.

The Medicaid program is a federal-state partnership in which states have considerable flexibility in choosing standards, methods and payment rates for reimbursement but must comply with their selections once reflected in a state plan accepted by CMS through the plan approval process. Utah Dept. of Health, DAB No. 2131 (2007). The Board will generally defer to a state's interpretation of ambiguous language in its own state plan if that interpretation is reasonable, is consistent with the purposes of the plan, and does not conflict with program requirements. New Jersey Dept. of Human Resources, DAB No. 2107, at 5 (2007); Missouri Dept. of Social Services, DAB No. 1189, at 5 (1990). Generally, a state's interpretation is entitled to more weight when it has been officially adopted, reflects consistent practice, and/or was applied contemporaneously rather than articulated for the first time in litigation. South Dakota Dept. of Social Services, DAB No. 934 (1988).

Case Background

In 1992, CMS approved Texas state plan amendment (SPA) 92-06, entitled "Methods and Standards For Establishing Payment Rates — Other Types of Care." T. Ex. C at 1. SPA 92-06 was in effect from April 1, 1992 through June 30, 2003. T. Exs. C and J.

As its title indicated, SPA 92-06 described the methods and standards used by the Texas Medicaid program to determine its payment rates for Medicaid-covered services provided by physicians, dentists, and other medical practitioners. T. Ex. C at 1-3. These payment standards and methods were referred to

collectively in SPA 92-06 as the Texas Medicaid Reimbursement Methodology (TRRM). Id. at 1.

Paragraph 1 of SPA 92-06 stated that "the TRRM for covered services provided by physicians and certain other practitioners employs a prospective payment system which is based upon the [Texas Medicaid agency's] determination of adequacy of access to health care services . . . or the actual resources required by an economically efficient provider to provide each individual service." T. Ex. C at 1. Paragraph 1 further explained that fees for individual services would be reviewed at least every two years based on resource-based reimbursement fees (RBRFs) or access-based reimbursement fees (ABRFs). Id. at 1-2.

In paragraph 1.b(1), SPA 92-06 described ABRFs as "[f]ees for individual services based upon historical payments adjusted, where the [Texas Medicaid agency] deems necessary, to account for deficiencies relating to the adequacy of access to health care services as defined in" paragraph 1.b.(2). T. Ex. C at 1. In turn, paragraph 1.b.(2) provided:

> Adequacy of Access – Measures of adequacy of access to health care services include , but are not limited to, the following determinations:
>
> (i) Adequate participation in the Medicaid program by physicians and other practitioners, and/or
>
> (ii) The ability of eligible Medicaid population to receive adequate health care services in an appropriate setting.

Id. at 1-2.

RBRFs were defined, in paragraph 1.b.(3) of SPA 92-06, as "[f]ees for individual services based upon the [Texas Medicaid agency's] determination of the resources required by an economically efficient provider to provide individual services." T. Ex. C at 2. Texas's RBRFs are based initially on a standardized resource-based relative value scale (RBRVS) developed by the Medicare program for paying physicians and other medical practitioners. T. Ex. D at 3. Under that system, first adopted by Medicare in 1992, payment for a medical service is determined using an estimate of the resources needed to provide the service, i.e., physician work (time, skill, and training required to provide the service); practice expenses; and professional-liability insurance. T. Ex. C at 3. For each medical service, the

resource-based payment system assigns a relative value unit (RVU) to each of the three resource components. Id. The sum of the three RVUs is then multiplied by a monetary "conversion factor" to produce a RBRF for the service. Id. at 2.

Paragraph 1.b.(4) of SPA 92-06 states that the conversion factor "will be updated based on the adjustments described in [paragraph 1.b.(5)] at the beginning of each state fiscal year biennium." In turn, paragraph 1.b.(5) states that the biennium conversion factor adjustment is composed of two components: an inflation adjustment and an "access-based adjustment . . . to ensure adequacy of access" as defined in paragraph 1.b.(2).

Even before its adoption of the RBRVS methodology, Texas had determined that RVUs from the Medicare program sometimes failed to generate adequate reimbursement for some Medicaid services, especially those furnished to non-elderly segments of the Medicaid patient population, such as children, pregnant women, and young adults. T. Ex. M at 3. Consequently, Texas established ABRFs for many procedures from the inception of its Medicaid program, "particularly procedures for physician groups with practices for pregnant women and children." Id. Similarly, in its 2002 Medicaid Provider Procedures Manual (2002 Manual), Texas explains that, "[i]n addition to Medicare's RBRVS," it takes "into consideration specific problems associated with adequacy of access to health care services and the particular requirements of the Texas Medicaid population." T. Ex. D at 3. Specifically, the 2002 Manual noted that such considerations led to the development of access-based fees for services "such as obstetrical and pediatric care." Id.

In 2001, the Texas legislature enacted appropriations legislation for the 2002-2003 biennium that directed the Texas Health and Human Services Commission (THHSC), the state agency responsible for administering Medicaid in Texas, to "establish a provider reimbursement methodology that recognizes and rewards high volume Medicaid practitioners, especially those along the Texas-Mexico border and in medically underserved inner-city areas, where Medicaid funding is vital to the health care delivery system." T. Ex. A at 2 (section 54). In a related provision, the legislature appropriated funds to be used for "medical professional services rate increases in the Medicaid program." Id. at 3 (section 29). According to the legislation, these rate increases were "intended to enhance Medicaid clients' access to medically appropriate services, as well as to attract and retain medical professionals and to reward high-volume Medicaid providers, particularly providers along the Texas-Mexico border

and in rural areas." Id.[2]

Following enactment of this legislation, Texas (i.e., THHSC) established definitions of "high-volume" PCPs, specialists, and dentists in conjunction with expert advisory panels.[3] T. Ex. K at 5-6. Texas defined high-volume PCPs as those who received payment for 3,600 or more Medicaid units of service during a qualifying period and high-volume specialists as those who provided units of service in the top 50% of total services paid within their recognized speciality during the qualifying period. Id. High-volume dentists were defined as those who were paid for 900 or more Medicaid units of service during the qualifying period. Id.

Texas set the rate adjustments for each category of high-volume practitioners as follows: (1) high-volume PCPs would receive 1.9 percent more for their Medicaid-covered services than lower-volume PCPs would receive; (2) high-volume specialists would receive 6.1 percent more; and (3) high-volume dentists 3.7 percent more. T. Ex. K at 5. Texas implemented these payment rate adjustments for services performed between January 1, 2002 and June 30, 2003. T. Ex. B.

In September 2003, Texas proposed to amend paragraph 1 of SPA 92-06 effective July 1, 2003. T. Ex. J. The new amendment stated that "fees for covered services provided by physicians and certain other practitioners are based upon the determination of adequacy of access to health care services by" THHSC. Id. at 5. The new amendment went on to specifically identify the high-volume providers, the qualifying periods, and the percentage "add-on payments" to be made for "all Medicaid services performed on or after July 1, 2003." Id. CMS approved the proposed

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[2] The legislation also allocated funds for "dental rate increases." T. Ex. A at 3 (section 30). Like the increases for "medical professional services," the dental rate increases were "intended to enhance Medicaid clients' access to medically appropriate dental services, as well as to attract and retain dental professionals and to reward high-volume Medicaid providers, particularly providers along the Texas-Mexico border and in rural areas." Id.

[3] THHSC established definitions, criteria, and rate adjustments for PCPs and specialists in conjunction with the Texas Physician Payment Advisory Committee and the Oral Health Safety Advisory Committee and the Dental Best Practices Advisory Workgroup. T. Ex. K at 5-6.

amendment, designating it SPA 03-20. Id. SPA 03-20 became effective July 1, 2003. Id.

In the course of reviewing the proposed state plan amendment, CMS asked Texas if it had made any "supplemental or enhanced payments." T. Ex. K at 4. Texas stated that it made "additional payments" to high-volume PCPs, specialists, and dentists for services provided between January 2002 and June 2003 based on the legislation and methodology discussed above. Id. at 4-6.

CMS then asked Texas to refund the federal government's share of the additional payments, on the grounds that CMS would not pay (after January 1, 2001) for any FFP claimed under a proposed state plan amendment that had not yet been approved. T. Ex. L. Texas refused, asserting that rate adjustments for high-volume providers were not "supplemental or enhanced" payments and were not claimed under the proposed amendment, but rather were access-based rates properly designed under the State plan then in force to ensure adequate access to necessary medical care. T. Ex. M at 2.

The disallowance at issue followed. T. Ex. N. Texas then filed the instant appeal.

Discussion

1. Rate adjustments for certain high-providers constituted access-based reimbursement fees as defined in the State plan.

As the case background makes clear, the parties disagree about whether the disputed rate adjustments for high-volume PCPs, specialists, and dentists were made in accordance with SPA 92-06, the relevant state plan provision. Texas maintains that the rate adjustments were authorized by SPA 92-06 because they constituted access-based reimbursement fees.

SPA 92-06 defined access-based reimbursement fees as "[f]ees for individual services based upon historical payments adjusted, where the Single State Agency deems necessary, to account for deficiencies relating to the adequacy of access to health care services[.]" T. Ex. C at 1 (emphasis added). Simply put, under SPA 92-06, ABRFs are thus expansively defined as any adjusted payments or fees for medical services that were intended by Texas to account for deficiencies in "adequacy of access."

We find that Texas's rate adjustments for high-volume providers met SPA 92-06's definition of access-based reimbursement fees.

The adjustments increased the fee schedule payments made for individual Medicaid-covered services when billed by specified providers. A fee schedule payment is a payment made to a physician or other practitioner for an individual covered medical service furnished to a Medicaid recipient. Because the rate adjustments simply increased the fee schedule amounts for services furnished by high-volume providers, those adjustments constituted a portion of the "fees for individual services" paid to those providers. CMS does not, for example, contend that the high-volume adjustments were actually lump-sum incentive payments made in amounts unrelated to the specific services being reimbursed or otherwise demonstrate that the adjustments did not relate to individual services being provided.

In addition, the record shows, and CMS does not dispute, that the rate adjustments implemented a legislative mandate to increase Medicaid reimbursement in order "to enhance Medicaid clients' access" to medical and dental services and to "recognize and reward" high-volume providers, especially those along the Texas-Mexico border, in rural areas, and in "medically underserved inner-city areas." T. Ex. at 2, 3. Implicit in that legislative mandate was a finding that existing Medicaid reimbursement rates were insufficient to secure the participation of adequate numbers of medical professionals and to ensure the availability of medical care to significant populations of Medicaid recipients (e.g., those in "underserved" inner-cities and border areas). Consequently, there is a clear basis for Texas's assertion that the rate adjustments were made to made to "account for deficiencies relating to the adequacy of access to health care services."

The definition of access-based fees expressly permitted Texas to "adjust" its fees when necessary to promote "access." In approving the State plan language, CMS did not require any restrictions on how such fee adjustments might be determined or applied or place any constraints on the nature of the adjustments beyond the definition in the State plan. Since the purpose of increasing payments for high-volume providers was to ensure adequacy of access, the rate adjustments met the definition of access-based reimbursement fees in SPA 92-06.

CMS asserts, nevertheless, that the rate adjustments should not be considered as access-based reimbursement fees under the language in SPA 92-06. In support of that position, CMS argues that --

> ABRFs were fees for individual services adjusted to account for deficiencies relating to adequacy of

> access. In other words, if THHSC determined that there were not enough physicians providing a particular service, THHSC could adjust the payment rate for the particular service so as to encourage physicians to participate in the Medicaid program. Accordingly, prior to January 18, 2002, Texas paid medical professionals ABRFs based on a list of access-based fees for various procedure codes. In sharp contrast, high-volume add-on payments were not based on fees for individual services. High-volume add-on payments were paid based on the volume of services provided during a specific time period by certain providers without regard for the types of services provided. . . .

Response Br. at 7-8 (citations omitted). The thrust of this argument is that CMS would have us read SPA 92-06 as requiring Texas to establish and pay access-based reimbursement fees *only by procedure type* rather than on the basis of provider characteristics. SPA 92-06's text, however, contains no such requirement. SPA 92-06 merely states that access-based reimbursement fees are "fees for individual services adjusted" to account for inadequacy of access to health care services. As discussed, the disputed rate adjustments were made by increasing the fees for individual services furnished by a high-volume provider. Thus, the adjustments were "fees for individual services" under the plain meaning of that term. There is no evidence that Texas has ever interpreted SPA 92-06 as precluding the use of access-based fees to assure the participation of particular groups of providers based on their level or intensity of program participation. Nor does CMS offer any evidence that it sought such a restriction in its review of the State plan.

CMS also contends that because the physicians, dentists, and others who received rate adjustments "were already providing a high-volume of services in the Medicaid program, Texas cannot reasonably argue that add-on payments were adjustments that addressed deficiencies relating to adequate participation or adequacy of access to health care." Response Br. at 9. CMS notes that Texas provided no statistical proof of the existence of deficiencies in the participation of high-volume PCPs, specialists, and dental providers during the months for which the rate adjustments were made. Id.

We reject CMS's suggestion that there is no relationship between the disputed rate adjustments and assuring adequacy of access. It is widely known that Medicaid payment rates, which are substantially lower than payment rates under Medicare or private insurance, may deter participation in Medicaid by physicians and

dentists. See, e.g., T. Ex. I at 2-3, 7 (indicating that inadequate reimbursement rates is one reason why few dentists are willing to serve Medicaid children). The rate adjustments implemented by Texas were explicitly intended to help offset the greater financial disadvantage to high-volume practitioners of carrying a large Medicaid caseload and, in doing so, to encourage them to stay in the program. T. Ex. M at 2. Texas could reasonably determine that, without these adjustments, some high-volume providers might be unable or unwilling to continue their participation, and that the loss of even one or a few of these providers in a community, particularly a medically underserved one, could substantially reduce the ability of Medicaid recipients in that community to obtain timely and appropriate medical care. In addition, by paying higher rates to high-volume providers, Texas could reasonably seek to encourage providers to accept more Medicaid patients, thus improving access.

We also reject CMS's assertion that Texas was obligated to present statistical evidence of access deficiencies. As noted, the appropriation of state funds to pay for the adjustments reflects a factual finding by the Texas legislature that the level of Medicaid participation by PCPs, dentists, and other health care professionals is inadequate to ensure that Medicaid recipients are able to obtain necessary medical and dental care in appropriate settings.

In any event, Texas could reasonably interpret SPA 92-06 as authorizing rate adjustments intended to preserve or maintain the level of access for communities of Medicaid recipients that might be vulnerable to the loss of high-volume providers. In other words, Texas was authorized to pay access-based reimbursement fees to address perceived threats to access; the state was not required to wait until the actual loss of critical high-volume providers caused access to care to deteriorate. That interpretation is consistent with the text of SPA 92-06, which stated that access-based reimbursement fees would be paid to "account for deficiencies relating to the adequacy of access" without indicating that those deficiencies had to be preexisting ones or had to be statistically documented.

In addition, the interpretation advanced by Texas is the most consistent with the federal statutory requirement that states set payment rates that "are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area[.]" Act § 1902(a)(30)(A) (emphasis added). Were Texas to set fees at levels that it determined would reduce provider participation or

reduce the ability of Medicaid recipients to obtain medical care, Texas would risk noncompliance with the statutory command to make payments that "are sufficient" to ensure that medical care is "available" to Medicaid recipients.

2. Texas did not change the payment methodology set out in its State plan in implementing these rate adjustments.

CMS further argues that, because SPA 92-06 made no explicit mention of payments to "high-volume" providers, such payments reflect a different payment "methodology" than the one described in SPA 92-06. Response Br. at 7. While it is true that SPA 92-06 did not expressly reference adjusting fees based on the volume of Medicaid services, neither does the SPA articulate any other specific methodology for how Texas may calculate and distribute the adjustments authorized for addressing access deficiencies. We thus disagree that these adjustments constitute a methodology different from the access-based reimbursement methodology described in SPA 92-06 because SPA 92-06 did not prescribe the form or manner in which access-based reimbursement fees were to be paid. In fact, SPA 92-06 is silent about those matters; it merely states that such fees would be paid for "individual services." Texas had broad discretion to decide how access-based reimbursement fees would be determined and used, with the only limitation being that they be designed to assure adequacy of access. The issue of State plan compliance therefore turns on whether the disputed rate adjustments meet SPA 92-06's definition of "access-based reimbursement fees," fees that Texas was undisputably authorized to pay. We have, for reasons already discussed, concluded that the rate adjustments do indeed fall within the scope of that definition.

CMS contends that Texas's own "practices and policies" are inconsistent with its current interpretation of SPA 92-06. Response Br. at 9. CMS asserts that Texas did not make rate adjustments for high-volume PCPs, specialists, or dentists prior to 2002, and that the Texas Medicaid Provider Procedures Manual, which is republished annually and sets out Texas Medicaid program policies, made no mention of such adjustments until 2005. Id. However, these omissions are immaterial because the rate adjustments were access-based reimbursement fees authorized by SPA 92-06, and because SPA 92-06 authorized Texas to establish those fees at whatever level its Medicaid agency "deem[ed] necessary" to ensure adequacy of access. A state does not violate or act inconsistently with its state plan merely because it exercises discretion conferred by the plan. See Missouri Dept. of Social Services, DAB No. 1412 (1993). As we have noted, at no point prior to July 2003 did Texas interpret SPA 92-06 as

precluding rate adjustments by category of provider as a means of ensuring adequacy of access.

3. The claims here were not based on retroactive application of SPA 03-20 but on the State plan in effect when the rates were paid.

Finally, CMS asserts that FFP may not be claimed under a proposed state plan amendment prior to its approval. Because CMS considered the high-volume rate adjustments to constitute a "significant and substantial change" in payment methodology, CMS argued that Texas could not obtain FFP for those adjustments until it amended the State plan to authorize them. Response Br. at 9-10. Since the proposed State plan amendment expressly prescribing high-volume provider rate adjustments was not approved until after the disputed payments were made, the FFP claims based on those adjustments must, CMS argues, be denied. Id. at 9-10.

The flaw in this argument is that the FFP claimed here is based on the pre-existing State plan not on the later amendment. Because the rate adjustments were access-based fees authorized by SPA 92-06, we do not agree, as we have said, with CMS's characterization of them as a significant and substantial change in payment methodology. Texas's proposal to amend its State plan to incorporate the specific rate adjustments on an ongoing basis does not imply that those adjustments were not permissible under the State plan as it was already written and approved.

Conclusion

For the reasons discussed above, we reverse the disallowance of $9,123,574.80.

/s/
Judith A. Ballard

/s/
Constance B. Tobias

/s/
Leslie A. Sussan
Presiding Board Member