



ISSUE BRIEF

Medicare/Medicaid Technical Assistance #92:

RECENT COURT DECISIONS INVOLVING FQHC PAYMENTS AND METHODOLOGY

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This paper summarizes five recent federal court decisions that should be of interest to Federally Qualified Health Centers (“FQHCs”). In four cases, FQHCs successfully challenged limits used by states in making Medicaid payments to FQHCs and challenged the manner in which states made supplemental payments. In another case, the court dismissed the FQHC’s challenge to two Medicare regulations because the FQHC sued in federal court before it had utilized its right to appeal an adverse decision on a specific reimbursement claim first to the Provider Reimbursement Review Board and then to the Secretary of Health and Human Services.

I. Recent Cases Invalidating Medicaid Reimbursement Formulas for FQHCs

Federal District Courts have recently struck down Connecticut’s and Maryland’s use of Medicaid payment limits applicable to FQHCs. These limits had been used by the State Medicaid programs even though they were not based on any study or analysis by the States to justify such limits.

A. Connecticut’s Physician Productivity Screen

In December 2000, Congress, as part of the Benefits Improvement and Protection Act of 2000 (“BIPA”), changed the Medicaid payment methodology applicable to FQHCs. Connecticut then submitted to the Centers for Medicare and Medicaid Services (“CMS”) a revised Medicaid plan which provided, in pertinent part, that its Medicaid payments to a FQHC would be reduced to the extent that the FQHC’s physicians had fewer than 4,200 patient visits per year. This productivity standard had been part of Connecticut’s Medicaid reimbursement formula since 1996 and was based on a federal **Medicare** regulation issued in 1992. 57 Fed. Reg. 24961 (June 12, 1992). CMS approved the new Connecticut Medicaid plan in June 2001.

A Connecticut FQHC then sued the Commissioner of Connecticut’s Department of Social Services (Patricia Wilson-Coker), and in November 2001 the federal District Court held that the 1992 federal Medicare regulation had been improperly promulgated and that, accordingly, Connecticut’s Medicaid FQHC reimbursement formula -- which had, in turn, incorporated the productivity standard contained in that regulation -- was invalid. *Community Health Center, Inc. v. Wilson-Coker*, 175 F. Supp. 2d 332 (D. Conn. 2001). In 2002, the U.S. Court of Appeals reversed the District Court. The Court of Appeals said that the Medicaid program had the authority to impose a cost limit borrowed from the Medicare program, but it returned the case to the District Court for a determination of whether Connecticut’s reliance on this productivity screen was resulting in payment based on 100 percent of the FQHCs’ reasonable and related costs in providing Medicaid services. *Community Health Center v. Wilson-Coker*, 311 F.3d 132 (2nd Cir. 2002).

The Connecticut Primary Care Association then joined the legal dispute, and in 2006 the District Court decided that Connecticut’s use of the productivity standard violated the requirement in the Medicaid statute, section 1902(bb) of the Social Security Act, 42 USC 1396a(bb), that a FQHC be reimbursed “in an amount...equal to 100

percent of the average of the costs of the center or clinic in furnishing such services...which are reasonable and related to the cost of furnishing such services...” *Connecticut Primary Care Association v. Patricia Wilson-Coker*, 2006 WL 2583083 (D. Conn. 2006). The District Court concluded that Connecticut could not rely on CMS’s approval of its Medicaid plan when CMS failed to articulate an explanation for its approval of the 4,200 screen after the Health Resources and Services Administration (“HRSA”) had discontinued its use of that screen.¹

FQHCs or Primary Care Associations in states that also use the 4,200 screen in their Medicaid reimbursement plan can, therefore, cite this case if they wish to challenge such use.

B. Maryland’s Use of An Administrative Cost Cap and Per Visit Ceiling

In 1991, Maryland adopted a Medicaid reimbursement formula for FQHCs which contained two cost limits that did not reimburse a FQHC for: (a) administrative costs that are more than one-third of total costs and (b) primary care per visit costs that exceed 115 percent of the median per visit cost of either all urban FQHCs or all rural FQHCs in Maryland (depending, of course, on whether the center in question is an urban or rural center). CMS originally approved the Maryland formula in 1991 and approved it again in 2001 in connection with Maryland’s Medicaid State Plan Amendment that was submitted in order to comply with BIPA requirements.

Even though these two cost limits were not based on any sort of study or analysis by the State, Maryland attempted to justify its formula on the grounds that it was adopted after notice and comment rulemaking. The U.S. Court of Appeals directed the District Court to consider a FQHC’s challenge of these limits. *Chase Brexton Health Services, Inc. v. State of Maryland*, 411 F. 3d 457 (CA 4 2005). The District Court then rejected Maryland’s arguments on the ground that the Maryland formula had no rational basis and did not address “the circumstances of the FQHC under consideration.” *Chase Brexton Health Services v. State of Maryland Dept. of Health & Mental Hygiene*, (D. MD. December 15, 2006). The Court said that the cost limits had to have some sort of basis if they were going to be applied to limit a health center’s payments under the Medicaid program.

II. Cases Addressing Supplemental and Out-of-Network Payment Obligations

A. Maryland’s Managed Care Supplemental Medicaid Payments and “Out-of-Network” Emergency Care Payments

¹ HRSA had used the 4,200 visit standard based on productivity data it had collected in 1978 on Rural Health Clinics (“RHCs”). The Health Care Financing Administration (“HCFA”) then used this productivity standard when it set a Medicare reimbursement rate for RHCs in 1982 and extended it to Medicare reimbursement for FQHCs in 1996 even though HCFA knew in 1996 that HRSA had abandoned the use of this standard and even though HCFA had never collected its own productivity data for FQHCs. The District Court, therefore, concluded that CMS had never “actually evaluate[d] whether the 4,200 screen as applied to FQHCs complies with the Medicaid statute (or the Medicare statute, for that matter).”

A Maryland FQHC challenged Maryland's method of making supplemental payments to it for providing services to Medicaid managed care patients. In reversing the District Court, the Court of Appeals found that the way in which the State made payments to the FQHC violated federal law in two significant ways. First, the State failed to make full supplemental payments to the health center in accordance with the schedule required by federal law. The Court of Appeals stated that the four month payment requirement found in federal law was clear and unambiguous and that the State's excuses as to why making full payment took longer than four months were unavailing. *Three Lower Counties Community Health Services, Inc. v. State of Maryland*, 498 F.3d 294 (4th Cir., 2007).

Second, the Court of Appeals found that the State failed to make or arrange for payments for services provided by the health center to Medicaid managed care patients on an "out-of-network" basis when those patients presented to the health center and "immediately required [services] due to an unforeseen illness, injury, or condition." 42 U.S.C. §1396b(m)(2)(A)(vii). The Court decided that the Medicaid Act requires either the State or the managed care organization to compensate a health center for emergency services provided to Medicaid patients even if the health center is out-of-network. This situation arose because, even though the health center did not have a contract with a particular managed care organization, patients who were enrolled with that managed care organization still came to the health center and received services on an out-of-network basis because of the emergency situation.

The Court of Appeals rejected the health center's arguments that the State had illegally delegated certain supplemental payment administration obligations to the managed care organizations, and the Court also found that the State's use of a "market rate" for the managed care organizations was legal. However, as to the two findings made in the health center's favor, the Court of Appeals returned the case to the District Court for implementation of the Court of Appeals' decision.

B. Court of Appeals Upholds FQHC's Right to Receive Supplemental Medicaid Payments

In 2005 and again in October 2006, a federal Court of Appeals found in favor of a Puerto Rico FQHC that had brought suit against the Commonwealth of Puerto Rico to receive supplemental payment for services provided under the federal Medicaid statute.² Meanwhile, the FQHC also had a contract dispute with the Municipality of San Juan. The Commonwealth asserted that, under Puerto Rico law, the FQHC was required to have a written contract in order to have an enforceable lease with the Municipality of San Juan and that without such a contract the health center was operating "illegally." As a result, in December 2006 the federal District Court that initially heard the matter denied

² See *Dr. Jose S. Belaval, Inc. v. Perez-Perdomo*, 465 F. 3d 33 (1st Cir. 2006) and *Rio Grande Cmty. Health Ctr., Inc. v. Rullan*, 397 F. 3d 56 (1st Cir. 2005) for applicable background on prior litigation, including an important discussion underscoring a health center's ability to seek enforcement of FQHC payment provisions pursuant to 42 U.S.C. § 1983. *Rullan*, 397 F. 3d at 73-75.

the health center the right to receive federal Medicaid payments from the Commonwealth.

The FQHC appealed, and Court of Appeals held that the health center's entitlement to payment from the Commonwealth turned only on whether or not the health center meets the definition of an FQHC and whether or not it provided covered medical services. *Dr. Jose S. Belaval, Inc. v. Perez-Perdomo*, 488 F.3 11 (1st Cir. 2007). The Court of Appeals said that "there is no reason to think that these federally required [Medicaid] payments can be displaced by landlord-tenant law." Accordingly, the Court of Appeals reversed the opinion of the District Court and sent the case back to the District Court, with instructions to order the Commonwealth to pay the FQHC the \$6.8 million (plus interest) that it had been ordered to pay in October 2006.

III. When to sue in court to challenge a Medicare regulation

In October 2007, a federal District Court dismissed a FQHC's challenge to two federal Medicare reimbursement ceilings -- a per visit payment "cap" and a physician productivity "screen" -- because the FQHC had not exhausted its Medicare administrative remedies, *i.e.*, it had not first filed an appeal as to a specific Medicare cost report with the fiscal intermediary and then the Provider Reimbursement Review Board ("PRRB") of the U.S. Department of Health and Human Services. *Three Lower Counties Community Health Services, Inc. v. Department of Health and Human Services*, 2007 WL 2932767 (D.D.C. October 9, 2007). Before filing the case in federal court, the FQHC wrote to the PRRB asking it to decide whether it could invalidate these two CMS regulations. Rather than decide the legality of these federal regulations, the PRRB instead dismissed the FQHC's case in April 2007 because the health center was not challenging before the PRRB the failure of the fiscal intermediary to completely reimburse the FQHC **in connection with a particular cost report**.

The FQHC then turned to the federal court. The District Court said that the Medicare statute and CMS's implementing regulations require that before suing in federal court the FQHC should have taken two steps: asking the PRRB to review a particular denial of full reimbursement by the fiscal intermediary; and if the PRRB were to affirm the intermediary's denial, seeking review by the Secretary of Health and Human Services. The District Court, citing the Supreme Court's decision in *Shalala v. Illinois Council on Long Term Care, Inc.*, 529 U.S. 1, 20, 22-23 (2000), said that this administrative process "must be followed, even if it is time-consuming and even if the agency cannot grant the relief sought." (citations omitted). The case is currently on appeal to the United States Court of Appeals for the District of Columbia Circuit.

Another federal District Court gave a similar rationale when in 2007 it dismissed a complaint by the Puerto Rican Association of Physical Medicine and Rehabilitation, three physicians, and several patients challenging a CMS regulation governing when Medicare will reimburse for physical therapy incident to a physician's services. In March 2006 plaintiffs wrote to CMS to challenge a new regulation, effective June 2005, that defines what qualifications a physical therapist must have in order to obtain Medicare

reimbursement. CMS wrote back rejecting the challenge. Plaintiffs then immediately sued in federal court. The District Court said that either the physicians or the patients should have first utilized a multi-step administrative process (filing a Medicare claim and then appealing its denial to an Administrative Law Judge and then to the Medicare Appeals Council) before going to a federal court for help. *Puerto Rican Association of Physical Medicine and Rehabilitation, Inc. v. United States*, 2007 WL 1799634 (D. Puerto Rico 2007). The District Court relied on a Court of Appeals decision rejecting an association's challenge to the same regulation, saying that while the association could not file a Medicare claim, injured physicians or patients could have used the administrative process. *National Athletic Trainers' Association, Inc. v. United States Department of Health and Human Services*, 455 F.3d 500 (5th Cir. 2006).

IV. Conclusion

Taken together, these cases show the willingness of federal courts to consider issues relating to Medicaid payment to FQHCs and to apply well-established principles found in administrative law that prohibit State and federal governments from engaging in conduct that is arbitrary and capricious or otherwise unlawful. More specifically, these cases constitute important precedent for other health centers that may be considering challenging state Medicaid payment caps.