

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

Pee Dee Health Care, P.A.,

Docket No. 10-ALJ-08-0387-AP

Appellant,

vs.

South Carolina Department of Health and
Human Services

Respondent.

ORDER

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AUG 15 2018

SC Court of Appeals

STATEMENT OF THE CASE

This matter is before the Administrative Law Court (ALC or court) pursuant to a Notice of Appeal filed by Pee Dee Health Care, P.A. (Appellant). The Appellant seeks review of a final agency decision by a hearing officer for the South Carolina Department of Health and Human Services (Department or Respondent). The fundamental issue presented in this appeal is whether the Department has properly reimbursed the Appellant for its services as a Medicaid provider.

BACKGROUND¹

The Appellant is a Rural Health Clinic (RHC). *See* 42 U.S.C. § 1395x(aa) (defining RHCs under Subchapter XVIII of the Social Security Act²); *see also* 42 U.S.C. § 1396d(l) (adopting the 1395x meaning, with certain qualifications, for purposes of Subchapter XIX, the Subchapter at issue in this case). As an RHC, the Appellant provides healthcare services, for which it is reimbursed by the Department under the Medicaid program. RHCs have been recognized as

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¹ The following terms and initialisms will be defined and used throughout the order and any amendments for convenience.

APM Alternate Payment Method

CMS Centers for Medicare and Medicaid Services

MEI Medicare Economic Index

RHC Rural Health Clinic

BIPA Benefits Improvement and Protection Act of 2000

FQHC Federally Qualified Health Center

PPS Prospective Payment System

SPA State Plan Amendment

² The "Social Security Act" encompasses Title 42, Chapter 7, Subchapters I through XXI of the United States Code.

SC ADMIN. LAW COURT

essential community providers for medically underserved patients, like Medicaid recipients. See S.C. Code Ann. § 44-6-910 (2018).

Medicaid is a program that was enacted pursuant to Title XIX of the Social Security Act of 1965. It authorizes federal grants to states for medical assistance to low-income persons. It is an optional program jointly financed by the federal and state governments, and administered by the states. Once a state chooses to participate in the program, "it must comply with all federal Medicaid laws and regulations." *Doe v. Kidd*, 501 F.3d 348, 351 (4th Cir. 2007) (citation omitted). The Department is the state agency charged with administering the Medicaid program in South Carolina. See S.C. Code Ann. § 44-6-30(1) (Supp. 2011) and § 44-6-132 (Supp. 2011). In that capacity, the Department entered into an agreement (the State Plan) with the federal Centers for Medicare and Medicaid Services³ (CMS) as to how the Medicaid program will be administered in 1980. See SCDHHS, *State Plan Under Title XIX of the Social Security Act Medical Assistance Program*, available at <https://www.scdhhs.gov/site-page/state-plan-under-title-xix-social-security-act-medical-assistance-program>. Subsequent changes to that plan are known as State Plan Amendments (SPAs). The State Plan is the primary method by which the Medicaid program is implemented and administered in South Carolina.

In addition to administering the State Plan as approved by CMS, the Department enters into contracts with service providers like the Appellant. The contracts⁴ entered into by the parties provide, "The Rural Health Clinic (RHC) Medicaid rate for services rendered under this contract shall be determined based upon applicable Medicare/Medicaid laws, rules or regulations and

³ CMS is a federal agency which falls under the United States Department of Health and Human Services (HHS).

⁴ The record reflects one contract entered into in 2001, effective until 2004; one entered into in 2004 and effective until 2007; and one entered into in 2009, effective until 2010.

SCDHHS policies and procedures in accordance with Attachment 4.19-B of the State Plan for Medical Assistance.”

The method by which the laws governing Medicaid dictates reimbursement changed in 2001 with the passage of the federal Benefits Improvement and Protection Act of 2000 (BIPA). Historically, RHCs were reimbursed “on a reasonable cost basis, based on Medicare cost reimbursement principles” CMS, *State Medicaid Manual*, § 6301, last updated June 28, 2000, available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>. The central reimbursement dispute in this case begins with the federal enactment of BIPA⁵ and the subsequent change in the payment method by which the Department reimbursed the Appellant for its services. BIPA provides for two types of reimbursement: the prospective payment system (PPS) and the alternative payment method (APM). See 42 U.S.C. § 1396a(bb).⁶ Simply stated, the PPS is calculated using the prior year’s billing as a predictor. That base amount is increased by a percentage dictated by the Medicare Economic Index (MEI) to account for inflation and adjusted to account for any change in the provider’s scope of services. See *id.* at § 1396a(bb)(3)(A) & (B). The APM is not defined, other than to require that the chosen alternative method is agreed to by the State and the RHC and results in payment equal to or greater than the PPS. *Id.* at § 1396a(bb)(6)(A) & (B). In 2001, CMS approved the Department plan amendment (the State Plan Amendment or SPA) for use of an APM for reimbursing RHCs. This SPA is known as Attachment 4.19-B.⁷ The SPA does not detail how

⁵ Specifically, the Benefits Improvement and Protection Act of 2000 (BIPA), Pub. L. 106-554, Appendix F, Section 702, entitled “New prospective payment system for Federally-qualified health centers and rural health clinics” (available at <https://www.gpo.gov/fdsys/pkg/PLAW-106publ554/pdf/PLAW-106publ554.pdf>, pages 574–76).

⁶ The text of this subsection has not changed since 2001. For purposes of this order, the court refers to the 2015 US Code available on the United States Government Publishing Office website. Section 1396a(bb) is available at <https://www.gpo.gov/fdsys/pkg/USCODE-2015-title42/pdf/USCODE-2015-title42-chap7-subchapXIX-sec1396a.pdf>, code pages 3449–50.

⁷ Attachment 4.19-B may be found on pages 1991 through 1995 of the Volume 8 of the Record on Appeal.

the Department calculates the PPS; it only explains the approved APM system. However, in order to know if an APM is legally valid, an accurate calculation of the PPS rate must be available for comparison.

In 2002, after implementing changes to account for the BIPA, the Department director explained its method of reimbursing the Appellant as follows:

The BIPA 2000 legislation allows for an alternate method of reimbursement for [RHCs] if the alternative method provides an amount that is at least equal to the amount that would be received under the new PPS reimbursement methodology. Tests of reasonableness such as productivity and rate caps may also be used. As you know, [SCDHHS] has decided to continue our current cost based reimbursement methodology as an alternate method of reimbursement. Our current methodology reimburses at the same RHC rate as Medicare, and is determined by the Medicare Intermediary. As required by the legislation, an analysis shows that our cost based alternative method will reimburse providers an amount that is at least equal to the amount they would receive using the PPS reimbursement methodology.

Our [SPA] which continues the current cost based methodology (including a productivity factor and a cap on the RHC rate) has been approved by the [CMS] effective January 1, 2001.

An analysis of [the Appellant's] RHC rate shows that using the PPS methodology, the maximum reimbursement rate for FY 2001 would be \$59.94 per encounter. Using our cost based alternate methodology, the maximum rate that [the Appellant] could receive would be the RHC cap for CY 2001 which is \$63.14.

The parties in this case disagree as to which tests of reasonableness may be used in calculating the PPS. The above excerpt was contained in a letter sent in response to a December 21, 2001 memorandum the Appellant sent to the Department, in which it expressed objection the new payment method and sought guidance on pursuing an appeal. The Appellant maintains that the memorandum constituted its first action in the ongoing dispute over reimbursement methodology. The Department's letter gave instructions for filing an appeal, but the Appellant denies ever receiving the response and never filed directly with the Department's appeal division.

The Appellant took no further action until 2005, when the Appellant filed suit against, *inter alia*, the Department in the South Carolina Court of Common Pleas. The matter was removed to

federal district court, where the Appellant was allowed to amend its complaint to include a Section 1983 claim on the issue of reimbursement. The Department moved to dismiss the claim, citing the contract between the parties, which contained a forum selection clause. The federal district judge dismissed the claim. The dismissal was appealed to the Fourth Circuit Court of Appeals in Richmond, Virginia. The Fourth Circuit found that the contract between the Department and the Appellant contained a facially valid forum selection clause, designating the state administrative process as the forum in which the parties would settle disputes, and this prevented, until proven otherwise, the Appellants from exercising their right to a Section 1983 claim in federal court. *See Pee Dee Health Care, P.A. v. Sanford*, 509 F.3d 204, 213–14 (4th Cir. 2007).

Eventually, the matter returned to state court. The Circuit Court stayed the case after being informed of the pending administrative cases now before this court for review. *See* Docket No. 2005CP4004612A. The instant appeal arose out of two administrative appeals⁸ with the Department. Appeal #09-MISC-003 was filed after the Department sent the Appellant a letter on December 30, 2008 stating that reimbursement rates were being adjusted for the period of January 1, 2006 through December 31, 2006. Appeal #09-MISC-058 was filed after the Department notified the Appellant of a reimbursement rate change, effective February 13, 2009. Therefore, this order concerns only the payments affected by the contested Department determinations.

JURISDICTION

While the parties have contractually agreed to resolve disputes under the Administrative Procedures Act (APA), that does not in itself confer jurisdiction upon the court. *See Badeaux v.*

⁸ While these cases are referred to as “appeals,” they are, for the purposes of administrative procedure, *de novo* contested cases, which are reviewed under an appeals standard for the first time at the ALC. *See* S.C. Code Ann. § 1-23-600(D)–(E) (Supp. 2017) (providing for ALC appellate review of agency contested case final decisions); S.C. Code Ann. Reg. 126-150, *et seq.* (2012) (providing procedures for hearings before the Department). *See also* S.C. Code Ann. § 44-6-190 (2002).

Davis, 337 S.C. 195, 205, 522 S.E.2d 835, 840 (Ct. App. 1999) (citation omitted) (“The jurisdiction of a court over the subject matter of a proceeding is determined by the Constitution, the laws of the state, and is fundamental. Lack of subject matter jurisdiction may not be waived, even by consent of the parties, and should be taken notice of by this Court.”). However, in this case, the Appellant contested specific Department actions and appealed them via the Department’s appeal procedure.⁹ Therefore, this matter is properly before the ALC as an appeal of a final agency decision. See S.C. Code Ann. § 1-23-600(D)–(E) (Supp. 2017) & § 44-6-190 (2018); see also *Estate of Nicholson ex rel. Nicholson v. S.C. Dep’t of Health & Human Servs.*, 377 S.C. 590, 594, 660 S.E.2d 303, 304–05 (Ct. App. 2008).

STANDARD OF REVIEW

This case is before the Court on an appeal from a Final Order of DHHS pursuant to S.C. Code Ann. § 1-23-600(E) of the Administrative Procedures Act (APA). Section 1-23-380(A)(6) of the Administrative Procedures Act (APA) govern the circumstances in which an appellate body may reverse or modify an agency decision. That section provides:

The Court may reverse or modify the decision if substantial rights of the appellant have been prejudiced because the administrative findings, inferences, conclusions or decisions are:

- (a) in violation of constitutional or statutory provisions;
- (b) in excess of the statutory authority of the agency;
- (c) made upon unlawful procedure;
- (d) affected by other error of law;
- (e) clearly erroneous in view of the reliable, probative and substantial evidence on the whole record; or
- (f) arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

S.C. Code Ann. § 1-23-380(A)(6) (2005).

⁹ This is a broad subject-matter jurisdiction statement and does not address the procedural jurisdiction issue of the 2001 appeal.

An agency decision is supported by “substantial evidence” when the record as a whole allows reasonable minds to reach the same conclusion reached by the agency. *Bilton v. Best Western Royal Motor Lodge*, 282 S.C. 634, 321 S.E.2d 63 (Ct. App. 1984). A decision will not be set aside simply because reasonable minds may differ on the judgment. *Lark v. Bi-Lo*, 276 S.C. 130, 276 S.E.2d 304 (1981). In applying the substantial evidence rule, the factual findings of an administrative agency are presumed to be correct. *Rodney v. Michelin Tire Co.*, 320 S.C. 515, 466 S.E.2d 357 (1996), citing *Kearse v. State Health and Human Services Finance Comm’n.*, 318 S.C. 198, 456 S.E.2d 892 (1995). Furthermore, the reviewing court is prohibited from substituting its judgment for that of the agency as to the weight of the evidence on questions of fact. *Grant v. South Carolina Coastal Council*, 319 S.C. 348, 461 S.E.2d 388 (1995), citing *Gibson v. Florence Country Club*, 282 S.C. 384, 318 S.E.2d 365 (1984). Finally, the party challenging an agency action has the burden of proving that the agency's decision is unsupported by substantial evidence. *Waters v. South Carolina Land Resources Conservation Comm’n.*, 321 S.C. 219, 467 S.E.2d 913 (1996), citing *Hamm v. AT&T*, 302 S.C. 210, 394 S.E.2d 842 (1994); *Tennis v. S.C. Dep’t of Soc. Servs.*, 355 S.C. 551, 558, 585 S.E.2d 312, 316 (Ct. App. 2003) (citation omitted).

The ALC may reverse or remand a decision which is affected by an error of law. *Gilliam v. Woodside Mills, et al.*, 312 S.C. 523, 435 S.E.2d 872 (Ct. App. 1993). However, in reviewing the errors of law, the ALC does give deference to the Department's interpretation of its own rules and the relevant federal rules and manual provisions applied. *Hampton Nursing Center v. State Health and Human Services Finance Commission*, 303 S.C. 143, 399 S.E. 2d 434 (Ct. App. 1990) and *Ruocco v. S.C. Board of Registration for Professional Engineers and Land Surveyors*, 314 S.C. 111, 441 S.E. 829 (Ct. App. 1994). However, an agency's interpretation of federal laws, state statutes, or its own regulations and rules is not entitled to any deference if the agency's

interpretation contravenes the plain language of the relevant law or regulation. *Brown v. Bi-Lo.*, 354 S.C. 436 (2003).

ISSUES ON APPEAL¹⁰

1. Whether the hearing officer erred in finding that Appellant did not file an administrative appeal with the Department in 2001.
2. Whether the Department failed to reimburse Appellant in accordance with the law.
 - a. Whether the contract between the Department and the Appellant allows payment outside the terms of the governing statutes.
 - b. Whether the Appellant has consented to an APM.
 - c. Whether the Department is collaterally estopped from arguing its position in this case by a federal district court order where it was a party.
 - d. Whether the Department's interpretation of reimbursement procedure is entitled to deference.
 - e. Whether the hearing officer erred in determining that the Appellant failed to allege a change in scope of services.
3. Whether the hearing officer erred in concluding that the State Plan need not be promulgated at regulations.

DISCUSSION

2001 Appeal¹¹

The Appellant argues that the hearing officer erred in concluding that the Appellant did not successfully file an administrative appeal in 2001 by virtue of a memorandum to the Department's director. Subsequent to this argument, the Appellant asserts that the hearing officer originally found

¹⁰ The court distills these issues from the Appellant's somewhat disorganized thirty-one (31) "exceptions" to the hearing officer's order. No formal issues on appeal were stated in the Appellant's original 55-page brief. Inasmuch as any issue raised in that brief or subsequent briefs of the Appellant is not addressed in this Order, that issue is either not preserved for appellate review or abandoned as conclusory.

¹¹ In order to simplify the issues before the court in this case and allow the parties to brief recent developments in case law, the court issued an interlocutory scheduling order ruling on the issue of the 2001 appeal. That ruling is reiterated here.

that an appeal was filed and that this un-appealed finding is the law of the case. On September 21, 2009, the hearing officer found:

Via memorandum dated December 21, 2001 to William Prince, the Director of SCDHHS, Petitioner specifically objected to Respondent's use of an APJM and requested that Respondent reimburse Petitioner for actual costs of operation. In addition, Petitioner wrote, "If the decision of your agency to use the alternate payment methodology is final, this letter is an appeal of that decision," and I so find.^[12]

This finding does not find or conclude that the Appellant filed an appeal. It merely finds that the memorandum existed and was sent to William Prince. The fact that the memorandum existed is not disputed. Moreover, this finding does not conflict with the hearing officer's later conclusion that the memorandum was not a properly filed appeal in his final order. Therefore, the issue of the 2001 appeal does not concern law of the case, but merely whether the hearing officer erred in concluding that the appeal was not properly filed.

South Carolina Regulation 126-152 has long provided that an appeal of a Department decision must be filed in writing and directed to the Appeals and Hearings division of the Department. See S.C. Code Ann. Regs. 126-152 (2012). Mr. Prince responded to the Appellant's memorandum in a letter dated February 4, 2002, where he stated that an appeal would have to be filed with the appeals division. The Appellant asserts that it never received the letter. However, that is immaterial to the issue of whether the Appellant filed an appeal. There is no evidence in the record that the Appellant filed an appeal of any type with the appeals division. Therefore, the hearing officer did not err in concluding that the Appellant did not file a valid appeal in 2001.

¹² The memorandum continued, "Please advise, in writing, of the steps need to address this matter and to pursue the appeal through your department."

Contractual Relationship

Before reaching the substance of this case, it is necessary to address any arguments that would foreclose a ruling on the merits. The Department argues that the Appellant cannot challenge its payment methods because it is bound by contract and because it has essentially ratified the method of payment or waived the right to challenge the method by entering into the 2004 contract with knowledge of the Department's practices. Two separate questions are implicated by the contracts. The first is whether the contracts can constitute acceptance of the use of an APM instead of the PPS, a choice provided for by federal statute. The second is whether the incorporation of Attachment 4.19(B) into the terms of the contract overrides any other statutory or regulatory requirements. As to this second question, the court concludes that any contract provision requiring payment contrary to federal law is void and unenforceable. *See Grant v. Butt*, 198 S.C. 298, 17 S.E.2d 689, 693 (1941) (citations omitted) ("It seems to be well established in this State that contracts having for their object anything that is . . . contrary to statutory enactments or constitutional provisions . . . are void; and that the Courts of this State will not lend aid to the enforcement of contracts that are in violation of law or opposed to sound public policy."); *see also Mason v. Mason*, 412 S.C. 28, 56–57, 770 S.E.2d 405, 420 (Ct. App. 2015), reh'g denied (Apr. 24, 2015), cert. dismissed (July 31, 2015). Therefore, this court will not construe the contracts between the parties as permitting payment inconsistent with federal policy and enacted statutes.

As to whether the Appellant consented to the method of payment by entering into the 2004 contract, the court finds the Department's argument unpersuasive, as did the hearing officer. He ruled this administrative appeal did not arise under the terms of the contract. The issues in this case arise out of the final agency decisions issued by the Department, not the contracts. In support

of its position that the contract prevents adjudication of the merits, the Department cites a lease case that provides:

A waiver is an intentional relinquishment of a known right. It may be either express or implied. An implied waiver results from acts and conduct of the party against whom the doctrine is invoked from which an intentional relinquishment of a right is reasonably inferable. Summary judgment should be denied where the facts, although not in dispute, are nonetheless subject to conflicting inferences.

Lyles v. BMI, Inc., 292 S.C. 153, 158–59, 355 S.E.2d 282, 285 (Ct. App. 1987) (citations omitted).

The Appellant's behavior in this case does not give rise to a clear inference of waiver, even assuming the contract governed the appeal: the Appellant did not complete the Agreement on Reimbursement Methodology put forward by the Department and the Appellant continued to express objection to the methodology in the 2001 memorandum and the civil suit. Moreover, the contract in question does not directly state the APM in its payment provisions. The contract provides that payment will be made "based upon applicable Medicare/Medicaid laws, rules or regulations and SCDHHS policies and procedures in accordance with Attachment 4.19-B¹³ of the State Plan for Medical Assistance." Appellant is attempting to enforce this provision inasmuch as it requires compliance with federal Medicaid law. Therefore, the court finds no reason to reverse the ruling of the hearing officer.

Collateral Estoppel

The Appellant argues that a recent District of South Carolina federal court decision related to some of the issues in this case should be applied under the doctrine of collateral estoppel to prevent the Department from continuing to assert its position. *See Genesis Health Care, Inc. v. Soura*, 165 F. Supp. 3d 443 (D.S.C. 2015). The doctrine of collateral estoppel—also known as issue preclusion—bars the relitigation of issues that were "actually litigated and decided" in a prior

¹³ The Court notes that Attachment 4.19-B itself provides for the possibility of choosing the PPS over the APM on Page 1e, Section 2b, item 1.

suit. *Catawba Indian Nation v. State*, 407 S.C. 526, 537, 756 S.E.2d 900, 906 (2014) (citations omitted). “The party asserting collateral estoppel must demonstrate that the issue in the present lawsuit was: (1) actually litigated in the prior action; (2) directly determined in the prior action; and (3) necessary to support the prior judgment.” *Carolina Renewal, Inc. v. S.C. Dep’t of Transp.*, 385 S.C. 550, 554, 684 S.E.2d 779, 782 (Ct. App. 2009) (citation omitted). The *Genesis* declaratory judgment order, decided on summary judgment, concerned questions of law, not questions of fact, and was presumably decided without the benefit of the type of evidentiary hearing that happened in this case.

This court rejects applying the doctrine of collateral estoppel at this juncture of the case. To begin with, this issue was not raised and ruled upon by the lower tribunal. *Lapp v. S.C. Dep’t of Motor Vehicles*, 387 S.C. 500, 507, 692 S.E.2d 565, 569 (Ct. App. 2010) (citation omitted) (“To be preserved for appellate review, an issue must have been: (1) raised to and ruled upon by the trial court, (2) raised by the appellant, (3) raised in a timely manner, and (4) raised to the trial court with sufficient specificity.”). The reason for this is that the *Genesis* decision cited by the Appellant had not yet been issued when the facts of this case transpired. Indeed, the plan amendment at issue in *Genesis* had not yet been added when this case was decided. Applying collateral estoppel at this juncture would upend traditional procedure and would reverse the purpose of the doctrine, which is to prevent *relitigation* where there has already been an opportunity for full and fair litigation. *Roberts v. Recovery Bureau, Inc.*, 316 S.C. 492, 497, 450 S.E.2d 616, 619 (Ct. App. 1994) (citation omitted) (“Under the doctrine of offensive nonmutual collateral estoppel, a party may be prevented from relitigating an issue which was actually litigated and directly determined in a prior action if the party had a full and fair opportunity to litigate the issue in the first action and there are no circumstances which justify affording him a second opportunity to retry the

issue.”). Indeed, full and fair litigation happened in this case to a further extent than it did in *Genesis*. In that case, which was decided on summary judgment which by definition truncates litigation, the judge specifically noted that the Department did not fully argue the question of Section 1396a(bb). *See Genesis*, 165 F. Supp. 3d at 452 (“SCDHHS has not addressed the actual language of Section 1396a(bb) . . .”). If anything, the hearing decision in this case might have estopped the litigation of this issue in federal court.

In addition to not finding the full and fair litigation element of the collateral estoppel doctrine present in this case, the court does not find the issues in the two cases to be similar enough to invoke issue preclusion. While the reasoning in the *Genesis* case is persuasive, the “common claim” in that case turned on a different state plan provision. Further, the federal court did not reach the full depth of this issue that has been raised in this case. While the case persuasively dealt with the issue of the applicability of Section 1396a(bb), it did not go so far as to apply the section to circumstances and facts like those at issue in this case. Such is the nature of summary judgment in a declaratory judgment case. Therefore, while the court finds the reasoning in *Genesis* to be useful in parsing this case, it nonetheless moves forward to addressing the hearing officer’s rulings on the merits of the issues presented by the parties.

Reimbursement Methodology

The central issue in this case is the method by which the Department reimburses the Appellant for Medicaid services. As explained, the controversy arose over the Department’s implementation of the BIPA. The statutory language at issue is as follows:

(bb) Payment for services provided by Federally-qualified health centers and rural health clinics

(1) In general

Beginning with fiscal year 2001 with respect to services furnished on or after January 1, 2001, and each succeeding fiscal year, the State plan shall provide for payment for services described in section 1396d(a)(2)(C) of this title furnished

by a Federally-qualified health center and services described in section 1396d(a)(2)(B) of this title furnished by a rural health clinic in accordance with the provisions of this subsection.

(2) Fiscal year 2001

Subject to paragraph (4), for services furnished on and after January 1, 2001, during fiscal year 2001, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the center or clinic of furnishing such services during fiscal years 1999 and 2000 which are reasonable and related to the cost of furnishing such services, or based on such other tests of reasonableness as the Secretary prescribes in regulations under section 1395l(a)(3) of this title, or, in the case of services to which such regulations do not apply, the same methodology used under section 1395l(a)(3) of this title, adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during fiscal year 2001.

(3) Fiscal year 2002 and succeeding fiscal years

Subject to paragraph (4), for services furnished during fiscal year 2002 or a succeeding fiscal year, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to the amount calculated for such services under this subsection for the preceding fiscal year— (A) increased by the percentage increase in the MEI (as defined in section 1395u(i)(3) of this title) applicable to primary care services (as defined in section 1395u(i)(4) of this title) for that fiscal year; and (B) adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during that fiscal year.

(6) Alternative payment methodologies

Notwithstanding any other provision of this section, the State plan may provide for payment in any fiscal year to a Federally-qualified health center for services described in section 1396d(a)(2)(C) of this title or to a rural health clinic for services described in section 1396d(a)(2)(B) of this title in an amount which is determined under an alternative payment methodology that—(A) is agreed to by the State and the center or clinic; and (B) results in payment to the center or clinic of an amount which is at least equal to the amount otherwise required to be paid to the center or clinic under this section.

42 U.S.C. § 1396a. This 2001 statute establishes the new PPS on the average of two years' costs.

An agency may use an APM instead of the new PSS if it is equal to or higher than the new PPS and the RHC agrees. To determine if the Department's APM meets or exceeds payments calculated with the PPS, it must first be determined if the Department calculates the PPS rate correctly. The hearing officer upheld the Department's payment methodology in all but one aspect: he concluded that the Department had incorrectly calculated the original PPS rate (or

baseline rate) using a 95% reasonable costs limit. The hearing officer concluded that the Department should have used a 100% reasonable costs average instead. The hearing officer based his decision on the following authorities: the BIPA, 42 U.S.C. § 1395l (also referred to as “Section 1833”), 42 U.S.C. § 1395x (v)(1)(A), and 42 C.F.R. 405.2468.

In this case, the Appellant has rejected the use of an APM. The Department argues that it is not in the Appellant’s best interests to be paid in accordance with PPS instead of APM, because according to their calculations, the APM results in a higher payment. This is irrelevant to the issues at hand. The statute clearly provides that the APM must be agreed to by the RHC. 42 U.S.C. § 1396a(bb)(6). The RHC in this case did not agree; ergo, they must be reimbursed either by the PPS or by an APM to which they do agree.

The Department also argues that the court should defer to the CMS’ approval of its APM in Attachment 4.19-B. There is some debate over the deference due to an approved SPA. There appears to be a split on this issue at the federal level. *Compare, e.g., California Ass’n of Rural Health Clinics v. Douglas*, 738 F.3d 1007, 1013–14 (9th Cir. 2013) (holding that deference to CMS would not be applied where Congress has clearly spoken), *with Cmty. Health Care Ass’n of New York v. Shah*, 770 F.3d 129, 144–48 (2d Cir. 2014) (adopting deference to those who “must labor daily in the minefield of often arcane policy”); *see also Legacy Cmty. Health Servs., Inc. v. Jaznek*, 184 F. Supp. 3d 407, 417–18 (S.D. Tex. 2016) (providing overview of federal court precedent on deference to CMS and noting that the 9th Circuit has ruled both ways on different provisions). South Carolina has applied the agency deference rule to the interpretations of the state Medicaid agency in the past, although there does not appear to be any precedent on the specific issue of CMS approval. *See Hampton Nursing Ctr. v. State Health & Human Servs. Fin. Comm’n*, 303 S.C. 143, 147, 399 S.E.2d 434, 436 (Ct. App. 1990). However, the Court does not find it

necessary to reach the issue of deference. Attachment 4.19-B does not provide any clarification on calculating the PPS, only the state's adopted APM. Since the Appellant has opted not to be reimbursed via the APM, this order is only concerned with the calculation of the PPS. The plain language of the federal statute guides that analysis, and it is not necessary to parse the issue of deference due to an SPA. Where Congress has clearly spoken, it is not necessary to weigh permissible interpretations. *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 842-43, 104 S. Ct. 2778, 2781 (1984) ("If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress."); see also *Brown v. S.C. Dep't of Health & Envtl. Control*, 348 S.C. 507, 515, 560 S.E.2d 410, 415 (2002) (citation omitted) (where agency interpretation is contrary to plain language of the statute, court will reject that interpretation).

It is indisputable that Section 1396a(bb) governs the reimbursement of RHCs. Indeed, it is obvious that the primary issue in this case is the formula for the PPS in §1396a(bb)(2). This formula provides the foundation from which all other calculations must be made. The PPS reimbursement formula is as follows: a per visit amount equal to the average of 100% of the reasonable costs of furnishing services for fiscal years 1999 and 2000 adjusted for any change in scope of services in 2001. 42 U.S.C. § 1396a(bb)(2). The difficulty in this case is determining what costs are allowable. No precise definition is given, but Congress provided the following options: "costs (1) "which are reasonable and related to the cost of furnishing such services," (2) "or based on such other tests of reasonableness as the Secretary prescribes in regulations under section 1395l(a)(3) of this title," (3) "or, in the case of services to which such regulations do not apply, the same methodology used under section 1395l(a)(3) of this title" The Department

has apparently been utilizing a Medicare rate cap found in Section 1395I(f), tangentially related to the methodology in Section 1395(a)(3).

The Department argues that its use of the rate cap in Section 1395I(f) is consistent with its pre-BIPA calculation methods. The Department argues that the BIPA PPS rate was intended to be based on the methods that states were using prior to its enactment because similar language is used. Essentially, the intent of the BIPA was to expediate the process of calculating reimbursement by averaging two documented years and adjusting each year for inflation. However, the Department's argument assumes that its pre-BIPA method of calculation was consistent with the prior reasonable costs language. Simply because the Department has calculated reimbursement by using the Medicare rate cap in the past, does not mean that its use of the cap was ever consistent with the language of the RHC reimbursement statute.

In 2005, the 4th Circuit summarized the history of the reimbursement method at issue as follows:

The methods for reimbursement provided by federal law have changed over the years. Between 1989 and 1997, the federal Medicaid law required States to reimburse qualified healthcare providers for "100 percent of costs which are reasonable and related to the cost of furnishing such services or based on such other tests of reasonableness as the Secretary prescribes in regulations." From 1997 until 2000, the federal Medicaid law required States to reimburse qualified healthcare providers for "100 percent (or 95 percent for services furnished during fiscal year 2000 . . .) of costs which are reasonable and related to the cost of furnishing such services or based on such other tests of reasonableness as the Secretary prescribes in regulations." Finally, at the end of 2000, Congress amended federal law to require States to implement prospective payment systems for funding qualified healthcare providers. The prospective payments prescribed, however, are based on a "reasonable cost" reimbursement requirement similar to the requirements previously applied. The reasonable cost requirement instructs States to start with a base amount equal to "an amount (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the center or clinic of furnishing such services during fiscal years 1999 and 2000 which are reasonable and related to the cost of furnishing such services, or based on such other tests of reasonableness as the Secretary prescribes in regulations." For every year after 2001, the

reimbursement level increases from that base amount by a predetermined percentage.

Chase Brexton Health Servs., Inc. v. Maryland, 411 F.3d 457, 460 (4th Cir. 2005) (internal citations omitted).¹⁴

All of the excerpts listed above have one commonality: each requires the payment of 100 percent of reasonable and related costs. This same standard is currently codified in Section 1396a(bb)(2). All of the options for reimbursement calculation mention tests of reasonableness. The Department claims that its method is compliant with *all* of the options listed in the statute. Not only does this defy logic and the statutory construction principle that Congress would not have included three options if they all carried the same meaning,¹⁵ it ignores the fact that the plain language of the statute never mentions any limits or caps—it only mentions 100 percent of reasonable costs. This court agrees with Judge Currie—the plain language of the statute clearly forecloses the use of a rate cap that would reduce reimbursement below the RHC's reasonable costs. *Genesis Health Care, Inc. v. Soura*, 165 F. Supp. 3d 443, 454 (D.S.C. 2015).¹⁶

Because the Department has not been using a PPS calculation method consistent with any of the options listed in Section 1396a(bb)(2), it is not possible to determine what a correct calculation would be and whether the Department's APM would be equal to or higher than that number. Because the Department is the sole agency responsible for enunciating policy and

¹⁴ The Department cited this opinion, which discussed Medicaid as background to a jurisdictional issue in the case, to support its interpretation of Section 1396a(bb). Interestingly, the Department did not mention that on remand the District Court granted the Plaintiffs' Motion for Summary Judgment, ruling Maryland's use of a rate cap and ceiling system arbitrary and capricious, despite the application of a deference standard. See *Chase Brexton Health Servs., Inc. v. Maryland Dep't of Health & Mental Hygiene*, No. CIV.A. MJG-03-1548, 2006 WL 6593814 (D. Md. Dec. 15, 2006).

¹⁵ "It is 'a cardinal principle of statutory construction' that 'a statute ought, upon the whole, to be so construed that, if it can be prevented, no clause, sentence, or word shall be superfluous, void, or insignificant.'" *TRW Inc. v. Andrews*, 534 U.S. 19, 31, 122 S. Ct. 441, 449 (2001) (citations omitted).

¹⁶ Although Judge Currie was ruling on payment of FQHCs, the same principle is applicable. Based on the plain language of section 1396a(bb), the PPS calculation for RHCs and FQHCs should be the same. Arguably, the Department could offer separate APM rates.

exercising discretion in administering Medicaid law, it is not within the court's purview to dictate the correct result. However, based upon the Department's actions as described, the present determination by the Department is incorrect. Because the Department's current method of calculation falls outside the plain language of the statute, this matter is remanded to the Department to calculate a PPS consistent with the option for tests of reasonableness listed.

Scope of Services

In addition to arguing that the Department has not calculated the correct PPS rate, the Appellant argues that the Department has failed to account for a change in scope of services. See 42 U.S.C. § 1396a(bb)(3) ("adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during that fiscal year"). The hearing officer ruled that the Appellant failed to allege a change in scope. The Appellant has pointed to no authority that warrants reversing the hearing officer's reasoning that some impetus to provide the Department with evidence of a change in scope lies with the Appellant. Certainly, however, the law makes it clear that such evidence must be considered if provided.

Promulgation of State Plan as Regulation under the APA

The Appellant also takes the position that the Department has failed to promulgate as regulations its State Plan, as required by the APA.¹⁷ The hearing officer ruled that "Federal and State Law do not require [the Department] to have its State Plan be submitted to the South Carolina General Assembly for approval, [the Department's] State Plan must only be submitted to CMS for approval" (emphasis in original). However, this was a preliminary ruling and the hearing officer did not rely on the State Plan in reaching a ruling on the merits of this case. Rather, the hearing

¹⁷ The Appellant also argues that various unspecified and unwritten "reimbursement policies" should be promulgated. It does not appear that the hearing officer ruled on this issue; therefore, neither does this court.

officer applied controlling federal provisions in concluding that the State Plan contained errors of law. The State Plan was clearly not applied as binding or carrying the force and effect of law.¹⁸ Because the State Plan was to some extent adverse to the Appellant's position in this matter and because the hearing officer overruled the State Plan in partially ruling for the Appellant, it is simply not necessary to reach the issue. Ruling on this case under the controlling federal statutes is dispositive. See *Futch v. McAllister Towing of Georgetown, Inc.*, 335 S.C. 598, 613, 518 S.E.2d 591, 598 (1999). Moreover, the Appellant has not demonstrated any prejudice as a result of the hearing officer's ruling. Because the State Plan was not applied, the Appellant can suffer no detrimental effect as to the merits of his case. See *Snyder's Auto World, Inc. v. George Coleman Motor Co.*, 315 S.C. 183, 186, 434 S.E.2d 310, 312 (Ct. App. 1993) (citation omitted); see also *Devereux v. Champion Cotton Press Co.*, 17 S.C. 66, 72 (1882) (internal punctuation and citation omitted) ("The rule governing the correction of errors at law requires that two things be made clear by the party alleging error: first, that some erroneous ruling has been made; and, second, that he has been prejudiced thereby as to the merits of his case.").

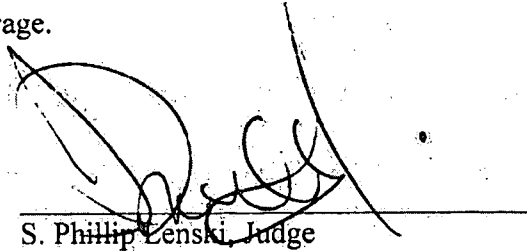
ORDER

IT IS HEREBY ORDERED that the order of the Department is **AFFIRMED** in part and **REVERSED** in part. This matter is **REMANDED** to the Department for a ruling by the Division of Appeals and Hearings. The exclusive issue before the Department is whether to apply option one or option two for the calculation of reasonable costs and the enunciation of test compliant therewith. The Department shall then calculate the reimbursement due to the Appellant for the

¹⁸ The hearing officer specifically held that 'CMS incorrectly approved [the Department's] State Plan Attachment 4. 19-B that directs [the Department's] reimbursement rates to RHC's even though this Attachment violates 42 USC Section 1396a(bb) (BIPA)' (emphasis in original). In so ruling, the hearing officer stated, "If the policies of SCDHHS do not fall within the broad Federal guidelines, then I certainly am not bound by those policies."

period at issue in this case. The Department may then remit any additional money due to the Appellant or request repayment of any overage.

AND IT IS SO ORDERED.

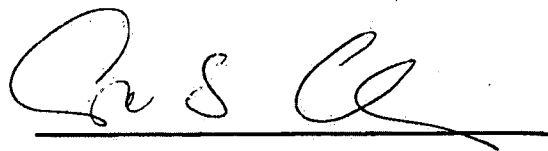


S. Phillip Lenski, Judge
S.C. Administrative Law Court

June 7, 2018
Columbia, South Carolina

CERTIFICATE OF SERVICE

I, Erika S. Easler, hereby certify that I have this date served this Order upon all parties to this cause by depositing a copy hereof, in the United States mail, postage paid, in the Interagency Mail Service, or by electronic mail to the address provided by the party(ies) and/or their attorney(s).

A handwritten signature in black ink, appearing to read 'Erika S. Easler', written over a horizontal line.

Erika S. Easler
Judicial Law Clerk

June 7, 2018
Columbia, South Carolina