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The State of South Carolina
OFFICE OF THE ATTORNEY GENERAL

HENRY MCMASTER
ATTORNEY GENERAL

May 28, 2003

The Honorable George H. Bailey
Member, House of Representatives
333-A Blatt Building
Columbia, South Carolina 29211

Re: Medicaid Fees for Durable Medical Equipment

Dear Representative Bailey:

You have requested an opinion from this Office concerning payment for Durable Medical Equipment (DME) by South Carolina's Medicaid program. By way of background, you indicate that

> Some of my constituents are in the business of providing Durable Medical Equipment (DME) to citizens of South Carolina for use in their homes, primarily through the Medicare and Medicaid programs. These DME providers believe that officials in the Medicaid program in South Carolina are administering portions of the Medicaid program unfairly and perhaps illegally.

Given this background, you specifically ask for an opinion on the following issues:

> 1. Is it within Medicaid's mandated guidelines to change DME fee schedules for payment of DME items and/or policy for payments and then make the change retroactive to a past date? How much notice is Medicaid required to give DME providers of changes in fees and/or policy regarding payment and items covered under the Medicaid program? For example, Medicaid issued a bulletin dated 12/19/02 regarding probable change in fees and said the effective date was 1/1/03. To this date, we have received no notice of any specific changes. In many cases DME suppliers provide the item or service under existing guidelines only to find out at a later date that coverage rules for payment as well as the payment amount have been changed retroactively without sufficient notice.

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> 2. For patients who are eligible for coverage under both the Medicare and Medicaid programs, is Medicaid required by laws to pay the Medicare annual deductible fee? For example, Medicare pays for a particular item and applies the Medicare payment to the patients' annual deductible, while the same item is not covered by Medicaid policy so no payment is made. In these cases the DME provider has supplied the item to the patient and is prohibited by Medicaid from billing the patient, therefore no one pays the provider. Is this legal under Medicaid guidelines?

Each of your issues will be addressed in turn. Initially, however, it must be noted that Medicaid and Medicare are governed by a complex web of statutes and regulations. Conflicting interpretations of these laws are often seen in the opinions of various courts addressing similar issues. The difficulty in interpreting the laws related to Medicaid and Medicare was expressed rather directly by the United States Court of Appeals for the Fourth Circuit in Rehabilitation Ass'n of Virginia v. Kozlowski, 42 F.3d 1444 (4th Cir.1994), where it was said that

> There can be no doubt but that the statutes and provisions in question, involving the financing of Medicare and Medicaid, are among the most completely impenetrable texts within human experience. Indeed, one approaches them at the level of specificity herein demanded with dread, for not only are they dense reading of the most tortuous kind, but Congress also revisits the area frequently, generously cutting and pruning in the process and making any solid grasp of the matters addressed merely a passing phase.

42 F.3d at 1450. Further, Medicaid and Medicare provisions are subject to regulation and interpretation by both federal and state agencies. In South Carolina, our Medicaid program is directed and regulated by the State's Department of Health and Human Services (SCDHHS). The construction of statutes "... by the agency charged with executing [them] is entitled to the most respectful consideration [by the court] and should not be overruled without cogent reasons." Faile v. South Carolina Employment Security Commission, 267 S.C. 536, 230 S.E.2d 219 (1976). As a matter of policy this Office typically defers to the administrative agency charged with enforcement of the statutes in question. See Op. S.C. Atty. Gen., dated February 5, 2001. Therefore, as a general matter, questions related to the implementation of South Carolina's Medicaid program should be addressed to SCDHHS.

LAW/ANALYSIS

Question 1

Medicaid is a financial assistance program for the poor, jointly administered by the federal government and the states. The states set fee schedules, and health care providers who participate in Medicaid must accept the scheduled fee as payment in full. See New York Health and Hospitals

Corporation v. Perales, 833 F.Supp. 353 (S.D.N.Y. 1993). Each state develops a schedule or methodology that establishes the fee that the state will pay a service provider for every item or service covered under the state's Medicaid plan. See McCreary v. Offner, 1 F.Supp.2d 32 (D.C.1998). States are generally granted wide discretion in determining fee structures under Medicaid. See Briarcliff Haven, Inc. v. Department of Human Resources of the State of Georgia, 403 F.Supp. 1355 (N.D.Ga. 1975). Further, the District Court in Briarcliff Haven held that prospective decreases in the Medicaid reimbursement levels for providers do not offend the Federal Medicaid Act. Id. at 1363.

It is apparent that the State through SCDHHS has adopted a State Plan for the administration of our Medicaid program. It is further apparent that SCDHHS has established fee guidelines for the reimbursement of providers of goods and services who have properly enrolled in the program. Other than setting a maximum rate which may be paid to providers for some services and items, the Medicaid Act requires only that the State's Medicaid plan "... assure that payments are consistent with efficiency, economy, and quality of care and 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." 42 U.S.C.A. § 1396a(a)(30)(A). Additionally, the corresponding federal regulations require only that the State's payments to health care providers be "sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population." 42 C.F.R. § 447.204.

Accordingly, it is clear that SCDHHS is given wide latitude in the setting of fee schedules for health care providers who are enrolled in the State's Medicaid program. SCDHHS has the authority to change the fees it pays providers, including the authority to reduce those fees, as long as the overall standards of the Medicaid Act referenced above are maintained. Further, it is my understanding from discussions with SCDHHS that providers are notified of reduction in fees in advance of implementation. Federal regulations only require public notice of any significant proposed change in a state's methods and standards for setting payment rates for services. See 42 C.F.R. § 447.205.

Question 2

Your second question relates to services or items provided to individuals who are eligible for both Medicaid and Medicare. Specifically, your question relates to a situation in which an individual's Medicare deductible has not been met at the time the individual is provided with an item of medical equipment and the item itself is not covered by the State's Medicaid program.

42 U.S.C.A. § 1396a(n)(2) provides in part that "... a State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for medicare cost-sharing to the extent that payment under subchapter XVIII of this chapter for the

service would exceed the payment amount that otherwise would be made under the State plan under this subchapter for such service if provided to an eligible recipient other than a medicare beneficiary." Moreover, the corresponding federal regulation states that the "State payment of ... premiums on behalf of a Medicaid recipient does not obligate it to pay on the recipient's behalf the ... deductible and coinsurance amounts for those Medicare ... services not covered in the Medicaid State plan." 42 C.F.R. § 431.625(c)(1). Therefore, the Medicaid Act does not require the State to provide reimbursement or pay any fee in the situation presented in your second question. The fact that the State is not required to pay any fee in this situation, however, does not necessarily mean that the provider is to provide the item free of charge. So long as Medicaid is not billed for the service or item or the service or item is not a Medicaid covered service or item, providers are free to bill the Medicaid eligible individual.

CONCLUSION

SCDHHS has the authority to reduce the fees it pays DME providers enrolled in the State's Medicaid program for Medicaid covered items which have been provided to Medicaid eligible individuals. SCDHHS provides advance notice for any reduction in fees or charges. Additionally, federal regulations do require public notice of any significant proposed change in a state's methods and standards for setting payment rates for services.

The State Medicaid program is not obligated to pay any deductible, coinsurance or co-payment fee for an item of DME not covered by the Medicaid program. A Medicaid enrolled DME provider is not prohibited from billing a Medicaid eligible individual for an item that is not covered by the Medicaid program.

Sincerely,

David K. Avant
Assistant Attorney General

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