U.S. District Court Grants Summary Judgment After Second Circuit Reverses and Remands - Rejecting Connecticut's Medicaid Reimbursement Methodology

On September 1, 2006, the U.S. District Court for the District of Connecticut granted a motion for summary judgment filed by the Connecticut Primary Care Association [and Connecticut FQHCs that receive grant funds under Section 330 of the Public Health Service Act] finding that CMS's approval of Connecticut's Department of Social Services ("DSS") Plan to apply a 4200 visits per physician per year screen when calculating Medicaid Prospective Payment System ("PPS") amounts owed to the plaintiffs is not entitled to deference. The court further held that DSS cannot rely on CMS approval of the Plan as grounds for its compliance with the Benefits Improvement and Protection Act of 2000 ("BIPA") for purposes of FQHC reimbursement, particularly where CMS failed to articulate an explanation for use and approval of the screen even after the Health Resources and Services Administration ("HRSA") discontinued its use of that screen.

On November 8, 2002, the Second Circuit had issued an order reversing and remanding for further proceedings a decision by the Federal District Court, after the lower court had enjoined the State of Connecticut from applying the screen. *Community Health Center, Inc. v. Wilson-Coker*, 2d Cir., No. 02-7061 (November 8, 2002).

In the initial decision, the District Court rejected the State's argument that Medicare's 4200 visits could be applied by the State under Medicaid because the measure was based on a 4200 visits screen applied by HRSA, which was subsequently abandoned in 1993. The court also concluded that the "4200 visit standard contained in Connecticut's state plan is not found in validly-promulgated [Federal] regulations," and its use "to reduce payments to CHCI is thus unlawful." Consequently, the lower court enjoined the State from applying the 4200 visits screen in computing any future payments that CHCI may be due under the Medicaid program, and from reducing any future payment by virtue of any past use of the 4200 visits requirement. *See Community Health Center, Inc. v. Wilson-Coker*, 175 F. Supp. 2d 332 (D. Conn. 2001).

The Circuit Court rejected the lower court's reasoning, stating that, regardless of whether the Federal regulation that formed the basis for the State's productivity screen was adopted through invalid procedures, the productivity screen is not necessarily unreasonable (and, therefore, invalid). The determinative factor is whether the screen allows FQHCs to receive payment for all costs that are "reasonable and related" to their costs of providing services.

The Court noted that States generally have a degree of discretion in choosing how to expend Medicaid funds. Therefore, absent any contrary Federal definition, States have flexibility to adopt their own approach to defining "reasonable and related" for purposes of Medicaid payments. The Court also recognized that the Centers for Medicare and Medicaid Services ("CMS") reviewed and approved the State's Medicaid plan amendment, which included the productivity screen, and noted that such approval should be given a measure of deference.

Accordingly, on remand, the lower court was directed to consider both the reasonableness of the screen and what role CMS's approval of the State program should play in making such assessment. Following discovery that included the depositions of CMS officials as to the

approval process for the 4200 screen, the lower court found that the screen was not reasonable and that CMS's approval did not matter. DSS was not entitled to rely on CMS approval of the 4200 screen because that approval, the court found, was nothing more than a "rubber stamp."