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October 11, 2018

Mr. David Sumner
Executive Director
Independent Regulatory Review Commission
14th Floor, Harristown 2
333 Market Street
Harrisburg, PA 17101

Re: PAR Comments on Regulation #14-540: Home and Community Based Supports and Licensing

Dear Mr. Sumner:

PAR is a statewide association dedicated to ensuring that Pennsylvanians with an Intellectual Disability or Autism (ID/A) have access to essential supports and services that can enable them to live an "Everyday" life. Our provider members employ tens of thousands of Direct Support Professionals (DSPs) throughout the Commonwealth who strengthen the abilities of over 50,000 persons with ID/A to live and to enjoy their lives in their communities.

Regulation #14-540, "Home and Community Based Supports and Licensing," is now pending before the Independent Regulatory Review Commission (IRRC) for review to determine whether the final form regulations submitted by the Department of Human Services ("DHS") satisfy the conditions for approval set forth in the Regulatory Review Act, 71 P.S.§745.56 et seq. Those conditions include whether the regulations "are in the public interest," "are clear and lack ambiguity" and are consistent with applicable statutes and regulations. It is not an understatement to say that the final form regulations represent the most significant set of changes to Pennsylvania's ID/A service delivery system in decades.

The regulations consist of five separate but related sets of regulations that establish program, operational and licensing standards that will govern the day-to-day provision of care, supports and services to persons with ID/A throughout Pennsylvania. Additionally, the regulations will control the determination of the fees paid to providers under the Medical Assistance Program which is the sole payor for ID/A services and supports. In Fiscal Year 2017-2018, expenditures for ID/A related community based residential and non-residential supports and services that these regulations govern amounted to over $3 billion. Whether the regulations fairly and reasonably assure the required alignment between providers' payment rates and the necessary costs that they routinely must incur to meet the documented needs of individuals with ID/A involves a most critical determination for the Commission.

PAR acknowledges and appreciates the efforts of DHS and the Office of Developmental Programs (ODP) to engage the public in a lengthy dialogue about the proposed rulemaking. We are pleased that ODP included many of PAR's recommendations in the Final Form Chapters. Numerous regulations reflect consensus among ODP, providers, consumers, families and other advocacy communities and the regulations will promote improved outcomes for ID/A consumers and families consistent with the federal Home and Community Based Services (HCBS) Settings Final Rule whose final compliance deadline is March 2022.

Regulatory improvements include clarifications that promote alignment across the regulations involving community integration; rights of the individual; the use of restrictive procedures; prohibited procedures; incident investigation; and individual needs. All parties share the common goal of providing Everyday Living opportunities such as housing, employment and safety to persons with ID/A.

In our review of and discussions about the Final Form regulations with our membership (and ODP), however, we have noted core regulatory provisions that remain vague, ambiguous or both and that without clarification will inevitably lead to post-adoption uncertainty and unpredictability in their application. For example, the regulations do not prevent ODP from freezing payment rates in the interim years between the required 3-year data update. Indeed, the Department expressly acknowledges how the application of an annual inflation adjustment to the rates to reflect the impact of market based inflation is solely a budgetary consideration and is not a factor that is part of the rate setting process. (See Preamble at 202, 208.) As we discuss in Attachment A, PAR urges the Commission to consider that federal law prohibits a state from basing provider payment rates solely on budgetary considerations. Rates ultimately must be sufficient to meet consumers' needs. The absence of an annual inflator based on a national recognized index equals approximately $100,000,000 in lost capacity annually that acts as a rate cut to services. PAR has raised these concerns to DHS and ODP to obtain formal pre-adoption clarity regarding post adoption interpretation and application of certain regulations. DHS and ODP have declined our request.

We identify in Attachment A to this letter those regulatory provisions that pose foundational concerns about their actual implementation. It should not be that regulated entities must await post-adoption interpretations of regulations when the requests for interpretations are raised pre-adoption and the interpretations can be plainly addressed, will directly and substantively effect access to and the delivery of quality ID/A services and that concern the expenditures of billions of dollars. Providers, people with ID/A, their families and other stakeholders need and are entitled to clarity and transparency in regulations that govern performance and payment. The Final Form regulations are most detailed in identifying and imposing prescriptive expectations on providers (and related "sanctions" for alleged non-compliance). Thus, the contrasting reluctance to provide corresponding clarity about payment for services and supports is unsettling.

PAR can support the regulations because of the various program improvements over Chapter 51 and the fact that DHS properly followed the regulatory review process which was absent in the promulgation of Chapter 51. But we urge the Commission, in its consideration and application of the standards that govern the Commission's approval of regulations, to ask DHS to provide necessary and salient clarity to the regulations as referenced in the Attachment and so eliminate the inherent vagueness and ambiguity in the regulatory text and assure compliance with applicable law prior to their adoption. The provision of such clarity will affirm the intended fairness in the application of the regulations.

Sincerely,

Shirley A. Walker

Shirley Walker
President and CEO

Attachment A: PAR Comments Detail on ODP Final Form Regulations
Attachment B: Summary of PAR Questions to the Department Presented in Attachment A.
Exhibit 1: Christ the King Manor v. Secretary of Health and Human Services
Exhibit 2: Application for 1915 (c) HCBS Waiver Appendix I Page 315

ATTACHMENT A

PAR Comments Detail on ODP Final Form Regulations

1. Final Form Regulation: 6100.571(a) Fee Schedule Rates

(a) The Department will establish fee schedule rates, based on the factors in subsection (b), using a market-based approach so that payments are consistent with efficiency, economy and quality of care and sufficient to enlist enough providers so that services are available to at least the extent that such services are available to the general population in the geographic area.

PAR Comment:
The Department, in subsection 6100.571 (d), describes subsection (a) as reflecting its "rate setting methodology." Subsection (a) does describe, albeit in general and vague terms, the general payment standard that ODP must adhere to in setting ID/A provider payment rates. As written, subsection (a) provides that ODP will employ a "market-based approach" in setting fee schedule rates "so that payments are consistent with efficiency, economy and quality of care and sufficient to enlist enough providers so that services are available at least to the extent that such services are available to the general population in the geographic area."

But neither subsection (a) nor any of the regulatory definitions within Chapter 6100 define what the "market-based approach" standard actually means and how it will guide ODP in setting fee schedule rates.

Prices in the "market" of course can be determined, for example, by changes in supply and demand. Eligibility for entry into the ID/A services system, however, is controlled by ODP, the nature and scope of ID/A services to be rendered are strictly governed by ID/A regulations and providers' fees are unilaterally set by ODP.

So, given the fact that the ID/A system is a single payer system dependent solely on government funding, and that ODP sets the rates, what does ODP mean by and how does it intend to utilize the "market-based approach" identified in subsection (a) when it uses the "factors" identified in subsection (b) of the regulation to set fee schedule rates? Does a "market- based approach" include the application of the most current wage scale data that reflects competitive salaries in the "marketplace" in establishing fee schedule rates? Does a market-based approach include application of a nationally recognized inflation index in establishing fee schedule rates every fiscal year and, if not, why not? Will the market-based approach account for the current market conditions that affect recruitment and retention of employees and the ID/A industry-wide annual staff, which, based on a conservative estimate of 50,000 Direct Support Professionals, faces annual turnover of over 13,000 positions and vacancy of 5,950 positions, which challenge the remaining workforce with double shifts and high

overtime requirements? These figures are extremely high and unacceptable and represent enormous instability for individuals and their families.

Besides the reference to the vague "market-based approach" standard, the remainder of subsection (a) tracks the provision of applicable federal law that governs the establishment of Medical Assistance funded fee-for-service payment rates. (See 42 U.S.C. § 1396a(a)(30)(A).) But again, what does it mean to say that payment rates must be "consistent with efficiency, economy and quality of care and sufficient to enlist enough providers so that services are available to at least the extent that such services are available to the general population in the geographic area"? In the Regulatory Analysis Form ("RAF") at 2-3 and in the Preamble to the Final Form Regulations ("Preamble") at 199-200, the Department acknowledges that 42 U.S.C. § 1396a(a)(30(A) is a requirement that relates to its Medical Assistance State Plan but appears to be confused regarding the similar applicability of the statutory standard to the Department's "Waiver Programs" which are the subject of the Final Form Regulations. The Department's Waivers, of course, make express reference to this applicable statutory standard. See Exhibit 1.

Actually, the text has no practical meaning in regard to payments for ID/A services as there is no comparison with the "general population" to be made. Unlike comparing access, for example, by Medical Assistance clients to physicians, dentists and hospitals with the "general population," in the case of ID/A services, there is no general "ID/A" population with which to compare access.

Since the publication of the pending ID/A rulemaking in November 2016, PAR has consistently urged DHS and ODP to recognize and adopt the plain and clear directives from the U.S. Court of Appeals for the Third Circuit (as stated on three separate occasions in cases involving the Pennsylvania Medical Assistance Program), that federal law "requires that [provider payment rates] be 'sufficient to meet recipients' needs.'" Christ the King Manor, Inc. v. Secretary of Health and Human Services, 730 F.3d 291, 308 (3d Cir. 2013), quoting Pennsylvania Pharmacists Association v. Houstoun, 283 F.3d 531, 538 (3d Cir. 2003) (emphasis added). See also Rite Aid of Pa., Inc. v. Houstoun, 171 F.3d 842, 856 (3d Cir. 1999).

The payment standard adopted by the Third Circuit is binding on DHS and ODP. Why does 6100.571(a) not incorporate the unambiguous statutory standard established by the Third Circuit?[1]

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[1] In both the RAF at 2-3 and the Preamble at 199-200, ODP acknowledges PAR's reference to Christ the King, supra, but dismisses PAR's reliance on that decision (and, similarly, Pennsylvania Pharmacists and Rite Aid) as "misplaced because under these [Chapter 6100] regulations, the [fee schedule] rates apply to waiver services and do not contain a budget adjustment factor ("BAF") that was in dispute in the litigation". Regrettably, ODP misperceives and so misunderstands the point of PAR's reliance on Christ the King in PAR's public comments regarding the federal legal standard that controls ODP's payment rate policies. The distinct point in PAR's reference to Christ the King in its public comments was to note how in discussing the contours of 42 U.S.C. § 1396a(a)(30)(A), the Third Circuit held that provider payment rates must "be sufficient to meet recipients' needs." See Exhibit 2.

The Final Form regulations do include "service needs" within the list of data "factors" set forth in 6100.571 (b) that are to be used in the rate setting process. And although it is appropriate to include "service needs" as a rate setting "factor," there is a fundamental distinction between a particular factor or factors used in a rate development process and the outcome that the process must produce. The applicable Third Circuit standard in rate setting requires the Department to focus on and to assure the outcome that payment rates are sufficient to meet consumers' needs.[2]

In sum, ODP did not include a definition of "market-based approach" in the Final Form Regulations nor does it explain in the Preamble the meaning of market-based approach and how that concept will assure that fee schedule rates are "sufficient to meet recipients' needs." The regulatory text is unfortunately both vague and ambiguous and, without clarification, will inevitably result in uncertainty, confusion and continuous debate.

2. Final Form Regulation: 6100.571(b)

(b) In establishing the fee schedule rates in subsection (a) the Department will examine and use data relating to the following factors:

(1) The service needs of the individuals.

(2) Staff wages, including education, experience, licensure requirements and certification requirements.

(3) Staff-related expenses, including benefits, training, recruitment and supervision.

(4) Productivity. Productivity is the amount of service delivered relative to the level of staffing provided.

(5) Occupancy. Occupancy is the cost related to occupying a space, including rent, taxes, insurance, depreciation and amortization expenses.

(6) Direct and indirect program and administration-related expenses.

(7) Geographic costs based on the location where the HCBS is provided.

(8) Federally-approved HCBS definitions in the waiver and determinations

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[2] The Department is clear in the Preamble that the data factors in 6100.571(b) are "considered" in developing fee schedule rates but it does not discuss how the specific factors will be accounted for. How the factors are developed and utilized, of course, will determine the legal sufficiency of the fee schedule rates, i.e., the outcome of the process.

made about cost components that reflect reasonable and

necessary costs related to the delivery of each HCBS.

(9) The cost of implementing applicable Federal and State statutes and regulations and

local ordinances.

(10) Other factors that impact costs.

PAR COMMENT:
This subsection lists the specific data factors that the Department "will examine and use" in establishing the fee schedule rates in accordance with the "market-based approach" directive established in subsection (a).

ODP does not explain the plain inconsistency between its avowed use of a "market-based approach" to setting rates and its categorical refusal during the rate setting process, both on an annual basis and whenever it chooses to "update" the data factors and to re-set fees, to include and apply as a "factor" in the rate setting process a nationally recognized and relevant inflation index. The Department's justification for not including an inflation adjustment as a factor in 6100.571 (b) is that the inclusion of such a factor is a task for the General Assembly since the General Assembly "appropriates HCBS funds through the Commonwealth's annual budgeting process." See Preamble at 202, 208. The General Assembly appropriates funds to support the provision of ID/A services; however, it does not establish ID/A payment rates in whole or in part just as it does not establish the capitation rates paid to managed care organizations under the Department's HealthChoices Program in whole or in part. Instead, the General Assembly naturally relies upon the Department, as the agency responsible for establishing rates, to determine the level of funding necessary to assure that provider rates are sufficient to meet recipients' needs using its "market-based approach" and the "factors" listed in 6100.571(b).

The Department's refusal to include an annual inflation adjustment to the fee schedule rates between the required 3-year "updates" of the data factors is equally worrisome as it imposes irrational and impermissible rate freezes on ID/A providers for any interim fiscal year the Department does not update between the 3-year required update. To allow rates to remain stagnant from year to year will not reasonably account for the impact of rising costs that providers incur each year, documented by nationally-recognized indexes. Indeed, the absence of a market-based index, applied on an annual basis, has the potential to erode services by over $100 million annually, causing harm to the individuals served and the providers that support them.[3]

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[3] As the U.S. Court of Appeals for the Third Circuit held in Rite Aid of Pennsylvania, Inc. v. Houstoun, 171 F.3d 842, 853, 856 (3rd Cir. 1999), a state's "process of decision-making" in adopting a rate setting methodology must be "reasonable and sound" and "budgetary considerations may not be the sole basis

3. Final Form REGULATION: 6100.671(c)

(c) The Department will update the data used in subsection(b) at least every three years.

PAR Comment

How does the Department interpret and intend to apply its duty "to update the data used in subsection (b) at least every three years"? There is no explanation in the RAF nor in any of the Responses to Comments nor will the Department issue a pre-adoption interpretation of this most critical regulatory provision.[4]

ODP revised fee schedule rates for the first time in a decade on July 1, 2017.[5] ODP, outside of the rulemaking process, also has stated that the July 2017 fees rely on May 2015 Bureau of Labor Statistics for compensation-related data with no known use of an inflation index to bring the data forward to be current. So, if the current fee schedule rates were established on the basis of "market-based data" from 2015, under the plain text of the regulation, and given the absence of a data "update" in FY 16/17, FY 17/18, and so far in FY 18/19, should there not be an "update" in FY 18/19? And if not in FY 18/19, under subsection (c), when might the earliest update occur and when would the latest update occur if the regulations ultimately are approved in calendar year 2018? Section 6100.571 is effective upon final publication. How will the Department calculate the third year when interpreting the required update of data "at least every three years"? And, when it conducts an update, will the Department bring the data forward through the duration of the fiscal year that the revised fees that are calculated from the data will be in effect?

4. Final Form Regulations: 6100.571(d) and (e)

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for a revision." By deliberately refusing to include as a factor an inflation adjustment when setting rates from year to year (and during an "update") together with its unabashed reference to the General Assembly and the budgeting process, the Department acknowledges its annual imposition of a per se rate freeze on ID/A provider rates in the years between a "data update." Whether current rates fairly reflect "market conditions" is the Department's unavoidable legal responsibility. The Department makes an unsupportable distinction regarding the funds that the General Assembly appropriates in response to the Department's annual ID/A budget request and the funds that would result from a budget request that reflects the application of an inflation index. The Department must distinguish between developing rates using a "market-based approach" in contrast to a "budget-based approach."

[4] It is notable that although the Final Form Regulations consist of nearly 700 pages of prescriptive text relating to demand on and expectations of ID/A providers, the provisions of 6100.571 that govern the expenditure of over $3 billion are but three pages in length.

[5] Until January 1, 2018, cost-based residential cost-based rates were revised yearly based on two-year old cost report data that was not adjusted for inflation. Effective January 1, 2018, there are no "cost-based rates."

(d) The Department will publish a description of its rate setting methodology used in subsection (a) as a notice in the *Pennsylvania Bulletin* for public review and comment. The description will include a discussion of the use of the factors in subsection (b) to establish the fee schedule rates; a discussion of the data and data sources used; and the fee schedule rates.

(e) The Department will make available to the public a summary of the public comments received in response to the notice in subsection (d) and the Department's response to the public comments.

PAR Comment:
These regulations govern the process by which the Department will inform the public about updates to the rate setting data in subsection (b) and revised fee schedule rates. As written, under subsection (d), the Department will publish for public review and comment a Notice in the Pennsylvania Bulletin that provides "a description of its rate setting methodology" along with a discussion of the use of the rate setting factors and the data sources used to establish the fee schedule rates and the rates themselves. Separately, under subsection (e), the Department "will make available to the public a summary of the public comments received in response to the notice in subsection (d) and the Department's response to the public comments."

The Department's notice provisions are flawed in several respects. First, there is no mention in (d) as to when the Notice that explains how the rate setting factors were actually utilized and that lists the revised fee schedule rates will be published in the Pennsylvania Bulletin. Second, it is unclear from the regulatory text whether the rates, as published, are proposed or final rates. The purpose of the Notice is to provide the public with the most critical opportunity to review and comment on both the rate setting methodology and the rates, which are the outcome of the methodology. Thereafter, upon consideration of public comments, the Department might amend the methodology and the rates and publish a second Notice explaining changes made or not made to the methodology and the rates in response to the public comments. That is assuredly not the process contemplated in subsections (d) and (e).

Instead, under (d), the timing of the Notice announcing the use of the factors and the rates is unknown. So, a single Notice may be published post adoption of the annual General Appropriations Act and thus too late for any changes or corrections to be made to the rate setting methodology/data updates and to the rates. Thereafter, as stated in subsection (e), the Department would "make available [how is not mentioned] to the public a summary of the public comments received in response to the notice in subsection(d) and the Department's response to the public comments." Such a scenario is unavailing in providing the public with the essential opportunity to have meaningful involvement in and impact on the rate setting process. Under these regulations, the methodology and the Fee Schedule rates appear to be established in the first Notice published in the Pennsylvania Bulletin. If so, then the public's comments about the methodology and the rates become meaningless.

Why would the Department not publish a first Notice shortly after the Governor's presentation of the annual budget proposal to the General Assembly that explains its proposed rate setting methodology, how the rate setting factors and data were updated and utilized and the rates that are the outcome of the process? The public should then be afforded the standard 30-day time period to comment on the contents of the Notice. In doing so, the Department would have the benefit of the public's comment about the rate setting methodology and would determine whether to adjust the methodology (and the rates) or not. It would then publish in the Pennsylvania Bulletin, consistent with ten years of prior practice, its final methodology and fee schedule rates along with its explanation of any changes to the factors or data and to the rates themselves due to the public comments and why it chose to make any or no changes to the methodology and the rates.

The Department's notice provisions as set forth in subsections (d) and (e) are ambiguous and have the effect of side stepping the typical public notice and comment process. PAR's suggested alternative provides the public with the robust opportunity to have an important voice in the rate setting process.

ATTACHMENT B

Summary of PAR Questions to the Department Presented in Attachment A.

6100.571(a)

Define what a "market-based approach" means.

How will a market-based approach account for current market conditions relating, e.g., to wage scales and inflation and costs of utilities and transportation?

How will a market-based approach result in fee schedule rates that assure quality of care and that align with the routine and rising costs that providers must continually incur to meet the needs of individuals?

6100.571 (b)

Why does the market-based approach to rate setting and the factors in (b) not include the application of a nationally recognized index to account for inflation?

Why are fee schedule rates not adjusted to account for inflation in the fiscal years between updates to the data?

Were the data sources used and the fee schedule rates that were effective during FY 2017-2018 adjusted to account for inflation? Will the same rates that were effective during Fiscal Year 2017-2018 apply to ID/A providers throughout Fiscal Year 2018-2019, as well as during Fiscal Year 2019-2020?

6100.571 (c)

What data factors did the Department rely on to establish the most recent fee schedule rates that became effective July 1, 2017? Did the data and the rates account for inflation?

Under this regulation, when is the earliest date that the Department can update the data factors in subsection (b)? What is the latest date, i.e., "at least every three years," by when it must update the data factors and the fee schedule rates?

6100.571 (d) and (e)

Under subsection (d), when during a fiscal year would the Department publish the referenced Notice in the Pennsylvania Bulletin?

Will the Notice reflect a proposed rate setting methodology and proposed data updates and proposed revised fee schedule rates or will the Notice reflect a final methodology, data updates and fee schedule rates?

If the Notice contains final updates and rates, how can public comments, questions and recommendations regarding the data updates and the rates be taken into account by the Department beforehand?

How does the Department intend in subsection (e) to "make available to the public a summary of the public comments received ... and the Department's responses to the public comments"?

If the Notice in (d) contains proposed updates and rates, what is the purpose of and need for (e)?

Will the Department publish a second formal Notice in the Pennsylvania Bulletin that explains the final methodology and data updates and any changes made in response to public comments along with explanations regarding why suggested changes to the updated data, factors, and/or the rates were declined?

Exhibit 1: Page 1 of 2
Christ the King Manor v. Secretary of HHS

and internal quotation marks omitted); see *also id.* ("To ignore what we perceive as persuasive statements by the Supreme Court is to place our rulings ... in peril.").

In addition to that suggestion from the Supreme Court, some of our sister circuits have held that SPA approvals are the type of agency action entitled to *Chevron* deference under *Mead*, and no circuit court precedent holds to the contrary. In *Managed Pharmacy Care*, for example, the Ninth Circuit concluded that "Congress explicitly granted the Secretary authority to determine whether a State's Medicaid plan complies with federal law," and that "[i]t is [**34] well within the Secretary's mandate to [*307] interpret the statute via case-by-case SPA adjudication." *716 F.3d at 1249*. Similarly, the D.C. Circuit has held that, through express delegation of interpretive authority, "Congress manifested its intent that the Secretary's determinations, based on interpretation of the relevant statutory provisions, should have the force of law." *Pharm. Research & Mfrs. of Am. v. Thompson, 362 F.3d 817, 822, 360 U.S. App. D.C. 375 (D.C. Cir. 2004)*. In short, the reasoning goes, the *Chevron* framework applies to SPA approvals. *Id. at 821*; *see also Managed Pharmacy Care, 716 F.3d at 1248* ("*Chevron* applies to SPA approvals ... ."); *Harris v. Olszewski, 442 F.3d 456, 467 (6th Cir. 2006)* ("[T]he agency's approval of the state plan amendment is entitled to *Chevron* deference.").

We agree. *HN9*[↑] The Medicaid Act expressly states that the Secretary must "approve any plan which fulfills the conditions specified" in the statute. *42 U.S.C. § 1396a(b)*. Through that provision, Congress delegated to the agency the responsibility to make interpretive decisions regarding which state plans satisfy the Act's requirements. Those decisions carry the force of law, as HHS is prohibited from making payments to states [**35] whose plans do not comply with the Act, *42 U.S.C. § 1396c*,[20] and the state must pay for Medicaid services "using rates determined in accordance with methods and standards specified in an approved State plan," *42 C.F.R. 447.253(f)*. *See Nat'l Cable & Telecomms. Ass'n v. Brand X Internet Servs., 545 U.S. 967, 980-81, 125 S. Ct. 2688, 162 L. Ed. 2d 820 (2005)* (applying the *Chevron* framework because a statute gave an agency "the authority to promulgate binding legal rules" (citing *Mead, 533 U.S. at 231-34*)). SPA approvals are therefore the type of agency action that warrants *Chevron* deference under *Mead*.

With that in mind, we turn to HHS's approval of SPA 08-007, given the strictures of *Section 30(A)* and *Section 13(A)*.

2. *Compliance with Section 30(A)*

HN10[↑] *Section 30(A)* requires that a state Medicaid plan:

> provide such methods [**36] and procedures relating to the utilization of, and the payment for, care and services available under the plan ... as may be necessary to safeguard against unnecessary utilization of such care and services and *to 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. § 1396a(a)(30)(A) (emphasis added). Put more simply, it mandates that a state plan include "methods and procedures" that "assure that payments to providers produce four outcomes: (1) 'efficiency,' (2) 'economy,' (3) 'quality of care,' and (4) adequate access to providers by Medicaid beneficiaries." *Pa. Pharmacists Ass'n, 283 F.3d at 537* (quoting *42 U.S.C. § 1396a(a)(30)(A)*). *Section 30(A)* is one of the statutory prerequisites a state plan must satisfy to receive federal approval, and thus federal funding. *See 42 U.S.C. § 1396a(a)* (defining the requirements that a state plan "must" satisfy); *id. § 1396a(b)* ("The Secretary shall approve any plan [*308] which fulfills the conditions [**37] specified in *subsection (a)* of this section ... .").

We have considered Section 30(A)'s requirements on two previous occasions. In *Rite Aid of Pennsylvania v. Houstoun*, we held that it mandates "substantive compliance" with the four specified factors, but it "does not impose any particular method or process for getting to that result." *171 F.3d at 851*. Rather, in contrast to an earlier and now-repealed provision of the Medicaid Act known as the "Boren Amendment," which "specifically requir[ed] that states take into account certain findings"

[20] *Section 1396c* was held unconstitutional in certain respects, not applicable here, in *National Federation of Independent Businesses v. Sebelius, 132 S. Ct. 2566, 2607, 183 L. Ed. 2d 450 (2012)* (holding that HHS "cannot apply *§ 1396c* to withdraw existing Medicaid funds for failure to comply with the requirements set out in the [Medicaid] expansion" provided for in the Patient Protection and Affordable Care Act, *124 Stat. 119*).

Exhibit 1: Page 2 of 2
CHRIST the KING MANOR v. SECRETARY OF HHS

and make particular assurances,[21] Section 30(A) leaves it "up to a state how it will 'assure' the [required] outcomes." Id. at 852. Nonetheless, we said that the state's "process of decision-making" in setting a rate methodology must be "reasonable and sound," id. at 853, and "budgetary considerations may not be the sole basis for a rate revision," id. at 856. In *Pennsylvania Pharmacists Association v. Houstoun*, we again interpreted Section 30(A), this time for the purpose of determining whether it granted Medicaid providers a cause of action under 42 U.S.C. § 1983. 283 F.3d at 534-35. In holding that it does not, we explained that "Section 30(A), [**38] unlike the Boren Amendment, does not demand that payments be set at levels that are sufficient to cover provider costs," but instead requires that they be "sufficient to meet recipients' needs."[22] Id. at 538. Therefore, under this Court's existing jurisprudence, HN11[↑] Section 30(A) allows states to set a rate methodology using any process that is reasonable, considers more than simply budgetary factors, and results in payments that are sufficient to meet recipients' needs.

But while those prior interpretations help guide our analysis, they do not necessarily control the outcome here. Under Chevron, if HHS applied a different but nonetheless permissible interpretation of Section 30(A), then we must defer to that interpretation, even if it conflicts with our precedent. As the Supreme Court has made clear, HN12[↑] a judicial precedent cannot displace a conflicting agency construction unless the [**40] statute "unambiguously forecloses the agency's interpretation." See Brand X, 545 U.S. at 982-83. The question before us is therefore whether HHS's approval of SPA 08-007 was based on a permissible construction of Section 30(A), not whether the SPA satisfies our prior interpretation of the statute. Cf. Maneged Pharmacy Care, 716 F.3d at [*309] 1246-50 (deferring to HHS's interpretation of Section 30(A) instead of applying the court's prior interpretation of that provision).

To answer that question, we must consider the basis HHS had for concluding that Section 30(A) is satisfied, which requires that we examine the record it had before it during the SPA approval process. Rite Aid, 171 F.3d at 851 ("[I]n reviewing section 30(A) issues a court must confine itself to the agency's administrative record ... ."). That record is remarkably thin, especially when compared to the administrative records developed in other Section 30(A) challenges. In *Rite Aid*, for example, the state amended reimbursement rates to pharmacies after conducting cost studies of pharmacy pricing data, considering input from interested parties, seeking additional data on the reimbursement rates of third-party payors, and comparing [**41] Pennsylvania's rates to the rates in neighboring states. Id. at 848; see also, e.g., Long Term Care Pharmacy Alliance v. Ferguson, 362 F.3d 50, 52 (1st Cir. 2004) (noting that the state agency revised rates after it "held hearings ... and sought data from Massachusetts pharmacies as to their costs of acquisition of individual drugs"). Here, on the other hand, there is no indication in the record as to how Pennsylvania settled on the particular rate-calculation methodology proposed in SPA 08-007. Although DPW explained that the 2008-09 BAF was intended to limit payments to the amount appropriated by the state legislature, that explanation is the same as the one offered for BAFs overall. It reveals nothing about how the particular BAF proposed in SPA 08-007 — which differed from the ones imposed in years past and required independent approval — was selected, other than that it was based on legislative appropriations for that fiscal year. Absent information on how the appropriated amount was determined, or a reasoned explanation for why that amount allows for rates that are "consistent with" efficiency, economy, quality of care,

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[21] The Boren Amendment required that a state pay providers using rates that "the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards ... ." 42 U.S.C. § 1396a(a)(13)(A) (1994). The Boren Amendment was interpreted to impose both procedural and substantive requirements on states in setting reimbursement rates, and to be enforceable in a private right of action under 42 U.S.C. § 1983. See Wilder v. Va. Hosp. Ass'n, 496 U.S. 498, 524, 110 S. Ct. 2510, 110 L. Ed. 2d 455 (1990) ("The Boren Amendment [**39] ... creates a right, enforceable in a private cause of action pursuant to § 1983, to have the State adopt rates that it finds are reasonable and adequate rates to meet the costs of an efficient and economical health care provider."). The Amendment was repealed in 1997, after substantial lobbying efforts by states seeking greater latitude in setting their rates. Pa. Pharmacists Ass'n, 283 F.3d at 536, 539 & n.12.

[22] Of course, the law of supply and demand does not disappear, no matter how much one might wish it would, so a focus on recipients that gives no thought to provider costs will soon leave ample demand from needy recipients and no providers to supply services. Setting payment levels to meet recipients' needs must therefore inevitably take into account provider costs.

Exhibit 2: Page 1 of 1

one):

✓ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. **Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

● **No. The State does not make supplemental or enhanced payments for waiver services.**

○ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. **Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

No. State or local government providers do not receive payment for waiver services. Do not complete item I-