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QQ. Medicaid Litigation Update

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2018 MEDICAID LITIGATION UPDATE[1]

(Major Decisions: Cases Reported March 1, 2017 through March 8, 2018)

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I. REIMBURSEMENT

A. Federal Cases

Court of Appeals Finds That CMS Failed to Compare Beneficiary and General Population Access to Care in Approving Rate Reduction -- **Hoag Memorial Hospital Presbyterian v. Price**, 866 F.3d 1072 (9th Cir. August 7, 2017) – California hospitals challenged HHS's approval of a Medicaid state plan amendment submitted in September 2008 implementing a 10% rate reduction for outpatient services from July 2008 through February 2009. Following an initial disapproval based on the State's failure to provide information concerning the impact on beneficiary access, HHS ultimately approved the amendment in 2011 after the State submitted data showing a relatively constant level of beneficiary utilization of outpatient services over a three year period. Based on the Ninth Circuit's decision in Managed Pharmacy Care v. Sebelius, 716 F.3d 1235 (2013), the district court deferred to the Secretary's approval, finding that the absence of any information comparing beneficiary access to services to that of the general public was permissible, as 42 U.S.C. 1396a(30)(A) required only a substantive result and not any particular procedure for achieving or assessing compliance with that mandated result. The Ninth Circuit reversed, holding that while Managed Pharmacy Care held that Section 30(A) did not require the Secretary employ any particular methodology (in that case, consideration of provider

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[1] Both this paper and the remarks of Alan Dorn of the Office of General Counsel, U.S. Department of Health and Human Services, are intended to be purely informational and informal in nature. Nothing in this paper or in Mr. Dorn's statements are intended to represent or in any way reflect the official interpretation or position of the Department of Health and Human Services, the Centers for Medicare & Medicaid Services, or the Office of General Counsel. The case summaries in this paper solely reflect the facts and legal reasoning as set forth by the deciding tribunal, and do not necessarily reflect other potentially relevant facts or legal arguments.

costs) to achieve the statute's required substantive outcome, its decision did not relieve the Secretary of his duty to employ some metric reasonably targeted to achieve that result. The Court further held that the requirement that payments are sufficient to enlist enough providers so that care and services are available "at least to the extent" that such care and services are available to the general population on its face mandated that the required level of beneficiary access to care be equal to or greater than that of the general population, and further mandated the comparison of data showing the levels of access available to both Medicaid beneficiaries and the general population. The Court therefore held that HHS's approval of the plan amendment violated Section 30(A) as it failed to include any consideration regarding the mandated result of beneficiaries' access to care relative to that of the general public, but considered only the level of access for beneficiaries alone without any comparative access data.

Court of Appeals Holds That "Public Process" Requirement of 42 U.S.C. 1396a(a)(13)(A) Is Privately Enforceable -- **BT Bourbonnais Care v. Norwood**, 866 F.3d 815 (7th Cir. Aug. 8, 2017) – Operators of newly purchased Illinois nursing facilities contended that the State's failure to recalculate rates based on the costs incurred under the new ownership, as required by the State plan, violated the provisions of 42 U.S.C. 1396a(a)(13)(A) mandating a "public process" for the determination of nursing facility payment rates. The district court denied the State's motion to dismiss, finding that Section 1396a(a)(13)(A) created enforceable rights and that Eleventh Amendment concerns over retroactive payments of increased rates were not ripe because it was not certain at this stage that the requested public process, if ordered, would result in increased rates. The court certified for appeal the question of whether Section 1396a(a)(13)(A) created enforceable rights.. The Seventh Circuit found that neither Gonzaga nor Armstrong flatly barred the use of 42 U.S.C. 1983 to enforce Spending Clause statutes, and noted that it had previously concluded that other Medicaid provisions – e.g., 42 U.S.C. 1396a(a)(8), 1396a(a)(10), and 1396a(a)(23) – created rights enforceable under 42 U.S.C. 1983. Applying the Blessing factors, the Court determined that Section 1396a(a)(13)(A) was intended to benefit nursing home providers, was not vague and amorphous but spelled out specific requirements for rate setting, and was unambiguously couched in terms of a binding obligation. The Court further found that the public process requirement of Section 1396a(a)(13)(A) was meaningful, as information from that process would be relevant to CMS's oversight of the State Medicaid plan and possible compliance action as well as to provider challenges to rates in State court. The Court of Appeals also determined that there was no evidence that Congress had foreclosed enforcement of Section 1396a(a)(13)(A) either expressly or impliedly through a comprehensive enforcement scheme, and distinguished Armstrong on the basis that the Supreme Court there concluded that the combination of the judicially unadministrable provisions of 42 U.S.C. 1396a(a)(30)(A) and CMS's ability to enforce the Medicaid Act by withholding funds precluded enforcement of that particular section. Finally, the Court held that the Eleventh Amendment did not bar the suit to the extent that the plaintiffs at this stage requested an injunction ordering the State to prospectively provide the required public process in setting rates. The Court pointed out that the Eleventh Amendment might bar retrospective relief if the requested public process determined that the providers had been underpaid.

District Court Denies Hospitals' Motion to Remand Removed State Court Challenge to Medicaid Rate Reductions -- **Tulare v. Local Health District v. California Department of Health Care Services**, 2017 U.S. Dist. LEXIS 72407 (N.D. Cal. May 11, 2017) – California "non-contract" hospitals filed a state court mandamus action challenging Medicaid rate reductions for such

providers (which were approved by CMS and later rescinded on a prospective basis), alleging violations of 42 U.S.C. 1396a(a)(30)(A) and equal protection. Following removal to federal court, the plaintiffs moved to remand, contending that they had no private right of action under the Supreme Court's decision in Armstrong and therefore lacked standing in federal court. The district court denied the motion to remand, finding that plaintiffs' right to mandamus relief under state law required resolution of substantial questions of federal law including the adequacy of payments under Section 1396a(a)(30)(A) and the equal protection clause, which was sufficient to create federal question jurisdiction, and that regardless of plaintiffs' standing under Section 1396a(a)(30)(A), they still asserted a federal claim under the equal protection clause. Plaintiffs moved to reconsider the order denying remand, arguing that they had a viable cause of action under Section 1396a(a)(30)(A) and citing a 2006 remand to state court in another removed state mandamus action challenging Medicaid reimbursement based on the Ninth Circuit's decision in Sanchez v. Johnson that Section 1396a(a)(30)(A) does not confer a private right of action. Plaintiffs also alleged that the case should be remanded so that it could be coordinated with a separate pending challenge in state court to the rate reductions. The district court denied the motion for reconsideration, finding that the 2006 remand decision did not represent a material change in law of which plaintiffs had been reasonably unaware, and that mandamus had been denied in the separate state court case on the basis of Managed Pharmacy Care v. Sebelius (9th Cir. 2013). The court also noted that in the 2006 case, although the California Court of Appeals on remand had issued a writ of mandamus against rate cuts, the legal landscape had subsequently been altered by Managed Pharmacy Care. The court therefore concluded that although plaintiffs were unable to proceed with a Section 1396a(a)(30)(A) claim in federal court, they would not be able to succeed on such a claim in state court. However, the court concluded that Sanchez did not bar their equal protection claim.

CMS' Reduction of Medicare and Commercial Payments from Uncompensated Care Costs for Purposes of Determining Medicaid Hospital-Specific DSH Limit Permanently Enjoined -- **New Hampshire Hospital Association v. Burwell**, 2017 U.S. Dist. LEXIS 29549 (D.N.H. Mar. 2, 2017) – Several New Hampshire hospitals and the New Hampshire Hospital Association brought suit against the Secretary of Health and Human Services, CMS, and the Administrator of CMS seeking an injunction against a policy clarification, issued in the form of 2008 answers to frequently asked questions ("FAQs 33 and 34"), that Medicare and commercial insurance payments for services furnished to Medicaid patients should be offset from a hospital's costs for furnishing Medicaid services in calculating the hospital-specific limit for supplemental Medicaid payments to hospitals serving a disproportionate share of low income patients (DSH payments). After having issued a preliminary injunction on March 11, 2016, the district court issued a permanent injunction prohibiting CMS from enforcing the informal policy clarifications on March 2, 2017. The district court granted summary judgment for plaintiffs on Counts 1 and 2, finding that CMS had not issued the policies through formal rulemaking. The district court determined that the inclusion of commercial insurance payments or Medicare payments, as sums to be subtracted from the costs of Medicaid services in arriving at the hospital specific limit, was not reflected in either the statute (42 U.S.C. 1396r-4(g)(1)(A)) or the regulation (42 C.F.R. 447.299(c)(16)). The district court further determined that CMS's policy effected a substantive change in existing law requiring notice and comment, since it modified the formula for calculating the hospital specific limit in a manner not reflected in the statute or regulation and was binding on State Medicaid agencies. The court granted summary judgment for the Secretary

on Count 3, as the State's alleged failure to provide notice of amendments to the State plan did not give rise to any liability on the part of CMS under the Administrative Procedure Act.

- See also: **Children's Hospital of the King's Daughters, Inc. v. Price**, 258 F. Supp. 3d 672 (E.D. Va. June 20, 2017) (holding invalid, on similar grounds, FAQ 33 which provides that, in calculating the hospital-specific limit, the State subtract payments received from private health insurance on behalf of Medicaid-eligible individuals), and **Tennessee Hospital Association v. Price**, 2017 U.S. Dist. LEXIS 96601, 2017 WL 2703540 (M.D. Tenn. June 21, 2017) (holding invalid, on similar grounds, FAQs 33 and 34 which provide that, in calculating the hospital-specific limit, the State subtract payments received from Medicare or private health insurance on behalf of Medicaid-eligible individuals). **NOTE**: On April 3, 2017, CMS published a final rule, effective June 2, 2017, requiring that, in calculating the hospital-specific limit, the State subtract payments received from Medicare or private health insurance on behalf of Medicaid-eligible individuals. 82 Fed. Reg. 16114, 16122.

CMS' Reduction of Medicare and Commercial Payments from Uncompensated Care Costs for Purposes of Determining Medicaid Hospital-Specific DSH Limit Enjoined -- **Missouri Hospital Association v. Hargan**, 2018 U.S. Dist. LEXIS 22024, 2018 WL 814589 (W.D. Mo. Feb. 9, 2018) -- Missouri hospitals challenged 2010 CMS policy statements ("FAQs 33 and 34") and a subsequent 2017 Final Rule (42 C.F.R. 447.299(c)(10)(i)) providing that a hospital's uncompensated costs of furnishing care to Medicaid and uninsured patients, for purposes of determining the hospital-specific limit for Medicaid disproportionate share hospital payments under 42 U.S.C. 1396r-4(g)(1)(A), are defined as costs net of payments by Medicare and private insurance for Medicaid patients dually eligible for Medicare or private insurance. The district court held that the FAQs were legislative rules subject to APA notice and comment requirements because inclusion of private insurance and Medicare payments in calculating a hospital's uncompensated care costs was not contemplated by either the statutory provisions (42 U.S.C. 1396r-4(g)(1)(A)) or the existing regulation (42 C.F.R. 447.299(c)) for determining the hospital specific limit, and therefore substantively impacted the HSL calculation as opposed to simply interpreting the statute and the regulation. The court further held that the FAQs exceeded CMS's statutory authority because inclusion of private insurance and Medicare payments in the calculation of uncompensated care costs expanded the Congressionally-mandated calculation set forth in the statute. The court also concluded that the 2017 Final Rule was invalid as contrary to the statute. The court rejected HHS's arguments that the statute provided that DSH payments were subject to uncompensated care costs, that the amount of such costs was to be determined by the Secretary, and that the legislative history demonstrated congressional intent that DSH payments be limited by all payments received from or on behalf of Medicaid and uninsured patients. The court stated that the language of the statute unambiguously limited offsetting payments to non-DSH Medicaid payments and that the interpretation in the final rule including other third party payments as offsetting rendered the statutory language "net of payments under this subchapter" superfluous. The court also noted that the statute specifically provided that State or local government payments for care to indigent patients shall not be considered a source of third party payment.

- See also, **Children's Hospital Assn. of Texas v. Azar**, 2018 U.S. Dist. LEXIS 35962 (D. D.C. March 6, 2018) (vacating the Final Rule)

Challenge to Exclusion From Determination of DSH Hospital-Based Limit of Costs of Provider-Based Services Covered Under Non-Hospital Services Benefit Category -- **Alameda Health System v. Centers for Medicare and Medicaid Services**, 2017 U.S. Dist. LEXIS 207728, 2017 WL 6450506 (N.D. Cal. Dec. 18, 2017) – Hospitals operating outpatient, provider-based federally qualified health centers challenged CMS policy that excluded the costs of provider-based services that are recognized and paid for under a non-hospital services Medicaid benefit category (such as hospital-based FQHCs) from being included in the determination of hospital-specific limits for DSH payment purposes. The district court held that CMS's stated policy was a "legislative rule" that was not promulgated in accordance with the APA requirements of notice-and-comment rulemaking. The court rejected CMS's argument that its policy was an exempt interpretive rule that implemented the plain language of the Medicaid statute which included only the costs of "hospital services" in the calculation of hospital-specific limits and distinguished FQHC services from inpatient and outpatient hospital services. The court determined that hospital-based FQHC services met the regulatory definition of outpatient hospital services and that nothing in the statue or regulations prevented consideration of outpatient hospital services for DSH purposes because a hospital seeks FQHC certification for the outpatient department furnishing those services. The court further determined that previous CMS statements requiring States to use consistent definitions of hospital services and use consistent treatment of physician and other provider-based clinics did preclude states consistently defining outpatient hospital services to encompass services that are reimbursed under different payment mechanisms including hospital-based FQHC payment. Finally, the court concluded that CMS had previously rescinded a final rule defining outpatient services as excluding services covered under another Medicaid benefit category, and a statement in the preamble to a 2014 final rule defining "uninsured" for DSH purposes that reiterated that services furnished in a hospital-based FQHC could not be considered outpatient services was not a valid logical outgrowth of the proposed rule.

Challenge to Billing Percentage Requirement for Enhanced Medicaid Payments for Primary Care Services -- **Arnett v. United States Department of Health and Human Services**, 2018 U.S. Dist. LEXIS 13480, 2018 WL 558825 (M.D. Tenn. Jan. 24, 2018) – Following audit determinations that they did not qualify for enhanced Medicaid payments for primary care services in 2013 and 2014, plaintiff physicians challenged the requirement of 42 C.F.R. 447.400(a) that to have one of the specified primary specialty designations (family, internal, or pediatric medicine), a physician either must be Board certified with such a specialty or have furnished evaluation and management services and vaccine administration services under specified codes that equaled at least 60 percent of the Medicaid codes billed during the most recent calendar year. Plaintiff asserted that while the Medicare provisions authorizing enhanced payments for primary care services (42 U.S.C. 1395l(x)) required that a primary care practitioner receiving such payments must be a physician who has a specified primary specialty designation and whose primary care services accounted for at least 60 percent of allowed charges, the Medicaid provisions for enhanced primary care payments (42 U.S.C. 1396a(a)(13)(C)) did not include any billing metric and instead provided for enhanced payments for physicians with the specified primary specialty designation. The district court held that the Medicaid billing requirement was invalid and that Tennessee was not entitled to recoup enhanced primary care payments on that basis. The court concluded that Congress' use of the term "primary specialty designation" in the Medicaid provisions could not itself be linked to a billing metric, as evidenced by the fact that the Medicare provisions enacted at the same time listed the physician's

primary specialty designation and billing history as separate and independent elements of the "primary care practitioner" designation. The court further found that the reference to Medicare in Section 1396a(a)(13)(C)) (requiring Medicaid payment for primary care services at least at the level of payment for such services under Medicare) was persuasive evidence that Congress intended that the term "primary specialty designation" in the Medicaid statute have the same meaning as that term in the Medicare statute (which set forth the billing metric as a separate requirement). The court additionally reasoned that the omission from the Medicaid provisions of a billing metric set forth in the Medicare provisions was further evidence that Congress did not intend to link a physician's entitlement to enhanced Medicaid payment to billing history. The court also rejected HHS's argument that the Medicaid provisions did not specify how to determine whether a physician had one of the specified primary specialty designations and that the 60% billing code threshold was a reasonable standard for doing so; the court found that Congress had expressed its clear intent that enhanced Medicaid payments for primary care services could not be linked to a physician's billing history and further noted that CMS had not formulated any standard in the Medicare primary care payment rule for assessing whether a physician had a "primary specialty designation. Finally, the court invalidated the enhanced payment regulation in its entirety, rather than preserving the provision tying "primary specialty designation" to board certification, finding that there was "substantial doubt" that CMS would have chosen board certification as the sole criterion for a qualifying "primary specialty designation" in the absence of the billing requirement.

Court Rejects FQHC's Claim That State Requirement That MCOs Fully Reimburse FQHCs At Their PPS Rate Violates Medicaid Act -- **Legacy Community Health Services v. Smith**, 881 F.3d 358 (5th Cir. Jan. 31, 2018) – A federally qualified health center (FQHC) challenged a Texas Medicaid policy requiring managed care organizations to fully reimburse FQHCs at their PPS rates. Plaintiff asserted that this policy violated the provisions of 42 U.S.C. 1396b(m)(2)(A)(ix), which requires MCOs to provide an FQHC with payments that are not less than what it would make for the services if furnished by a non-FQHC provider, and 42 U.S.C. 1396a(bb)(5)(A), which requires the State to make supplemental "wraparound" payments of the difference between an MCO's payment and the PPS amount. Plaintiff also alleged that the State had failed to assure payment for non-emergency, out-of-network services furnished to its former MCO's enrollees after the MCO terminated its contract following significant increases in Medicaid encounters and costs.

- Standing: The Fifth Circuit held that Legacy had standing to challenge the State's requirement that MCOs fully reimburse FQHCs, based on the loss of its contract with the MCO resulting from the State's requirement. The Court rejected Texas's contention that plaintiff had suffered no injury because it had been paid its full PPS rate and had no right to a contract with the MCO, since the State's policy nevertheless limited its bargaining position with MCOs. The Court also concluded that even though plaintiff had not shown that the loss of its MCO contract would be redressed by a favorable decision, a decision invalidating Texas's policy would restore its statutorily conferred "bargaining chip" with that and other MCOs. The Court further concluded that plaintiff had standing to assert its claims with respect to non-payment for non-emergency, out-of-network services. However, the Court held that the FQHC lacked standing to challenge the State's policy – subsequently submitted and approved in a State plan amendment by CMS as an "alternative payment methodology" under 42 U.S.C. 1396a(bb)(6) – refusing to reimburse FQHCs with supplemental wraparound payments if an MCO fails to reimburse

the FQHC fully. The Court reasoned that although plaintiff had standing to challenge the policy requiring MCOs to reimburse FQHCs fully because it had lost the ability to negotiate freely with MCOs for below PPS but above-market rates, Texas's policy of not making supplemental payments did not affect plaintiff's bargaining positions and did not result in the loss of its MCO contract; plaintiff had received full payment from its MCO, and any speculative risk of not receiving full reimbursement was insufficient to confer standing.

- Private Right of Action: The Court next held that 42 U.S.C. 1396a(bb) provided plaintiff with rights to full payment at the PPS rate enforceable under 42 U.S.C. 1983; the Court stated that the plurality's statement in *Armstrong* that the Medicaid Act was intended to benefit the infirm rather than providers was distinguishable from the specific command in the Section 1396a(bb) to benefit FQHCs by assuring full payment and if taken to the conclusion urged by the State would likely overrule decisions such as *Wilder*.
- Merits: The Court determined that the State's policy requiring MCOs to fully reimburse FQHCs was not barred by 42 U.S.C. 1396a(bb)(5), which the Court determined required supplemental payments by the State only in the event of a shortfall between the PPS amount and MCO payments and did not prohibit States from requiring MCOs to pay the full PPS rate in the first place. The court further determined that Section 1396b(m)(2)(A)(ix) established a floor for FQHC/MCO contact payment rates – the amount the MCO would pay for the services if furnished by a non-FQHC provider – but did not set an implied ceiling for what a State may require in such contracts. (The Court declined to give deference to a 1998 CMS SMDL providing that States could not impose requirements on FQHC/MCO contracts beyond those stated in 1396b(m)(2)(A)(ix)). The Court further noted that although prior to 1997 the Medicaid statute itself required MCOs to reimburse FQHCs fully, the change in that requirement did not mean that States were barred from imposing such a requirement. Finally, the Court rejected plaintiff's claims that Texas was required to reimburse it for non-emergency out-of-network services it provided to the MCO's enrollees after the MCO terminated its contract. The court reasoned that 42 U.S.C. 1396b(m)(2)(A)(vii), which required State/MCO contracts to specify whether the state will reimburse providers for emergency out-of-network services, delineated the out-of-network services the State is responsible for. The Court observed that if the distinction between in-network and out-of-network care were eliminated and the State had to reimburse FQHCs for all out-of-network care to Medicaid enrollees, FQHCs would have little incentives to contract with MCOs. The Court further rejected plaintiff's reliance on its obligation to treat patients despite inability to pay, finding that that requirement was part of the FQHC's Section 330 grant responsibilities and Medicaid funds could not be used to fulfill a Section 330 obligation.

Federal Court Action Challenging FQHC Payment Barred by Terms of Provider Agreement -- **Genesis Health Care, Inc. v. Soura**, 2017 U.S. Dist. LEXIS 24322, 2017 WL 698610 (D. S.C. Feb. 22, 2017) – Plaintiff, a federally qualified health center, challenged the State's Medicaid payment practices as violating the reimbursement requirements of 42 U.S.C. 1396a(bb) and other Medicaid statutory provisions. Plaintiff alleged, *inter alia*, that the exclusion of payment for certain specialty drugs under its provider agreement violated Medicaid statutory provisions regarding exemption of drugs subject to 340B discounts from national rebate agreements, by preventing plaintiff from obtaining 340B pricing for the specialty drugs it dispenses. The district

court dismissed the action on the ground that the terms of the provider agreement provided that the administrative and judicial review provisions of South Carolina law constituted the sole and exclusive remedy for any dispute arising under the agreement, and that any actions for the enforcement of the agreement or for the review of any agency decision with respect to the contract brought pursuant to the judicial review provisions of State law shall be instituted in State court. The court determined that although a provider may enforce the FQHC payment requirements of 42 U.S.C. 1396a(bb) through an action under 42 U.S.C. 1983, a provider may voluntarily waive the right to pursue that claim in federal court. The court also rejected the plaintiff's arguments that the provider agreement provisions were inapplicable because its claims relied on 42 U.S.C. 1983 and Medicaid statutory requirements rather than the provider agreement itself. The court found that this result did not contravene a strong public policy of the federal courts to hear federal claims, since Medicaid disputes were commonly heard in state administrative and judicial tribunals and no federal policy barred state courts from hearing federal claims.

Court Remands Removed State Court Action Alleging that Low Reimbursement Rates Affect Access to Care By Latino Beneficiaries -- **Perea v. Dooley**, 2017 WL 4676682 (N.D. Cal. Oct. 18, 2017) – Plaintiffs initially filed a State court action alleging that low reimbursement rates to physicians and clinics denied meaningful access to health care to California Medicaid beneficiaries, the majority of them Latinos, in violation of equal protection and due process provisions of the California constitution as well as California law prohibiting the state from impairing the accomplishment of the objectives of a state program with respect to persons of a particular ethnic group identification, and providing that the State's Medicaid program was intended to allow eligible persons to obtain health care in the same manner employed by the public generally and without discrimination based on economic disability. The State removed the action to federal court, alleging that the district court had original jurisdiction because it arose under the "reasonable promptness" and "equal access to care" provisions of the federal Medicaid Act (42 U.S.C. 1396a(a)(8) and 1396a(a)(30)(A)). The court granted plaintiffs' motion to remand the action to State court, finding that federal issues were not necessarily raised. The court observed that plaintiffs pled only State law claims, and the State had not shown that plaintiffs' right to relief necessarily depended on resolution of substantial questions of federal law. The court rejected the State's contention that plaintiffs' complaint cited federal Medicaid Act requirements, noting that the complaint relied on California laws setting forth similar objectives to those in the Medicaid Act and that plaintiff's entitlement to relief therefore could be proved based on independent State law grounds without resort to federal law. The court also rejected the State's argument that a federal issue was necessarily raised because the higher reimbursement rates the plaintiffs sought would have to be approved by HHS; the court found that proper exercise of federal jurisdiction depended on the claims raised, not on the remedies sought. The court concluded that no federal question was required to be resolved to determine whether plaintiffs were entitled to relief under State law.

Court of Appeals Upholds Medicare Offset of Reimbursable Hospital Taxes by Medicaid Supplemental Payments -- **Dana-Farber Cancer Institute v. Burwell**, 878 F.3d 336 (D.C. Cir. Dec. 22, 2017) – Plaintiff challenged the Medicare program's offset of reimbursable Massachusetts hospital taxes paid into a Trust Fund (also funded by general State appropriations and surcharges on non-governmental purchasers of hospital and ASC services) by Medicaid payments made by the Trust Fund to the hospital for services to low income uninsured and

underinsured individuals. Under the State scheme, a hospital would deposit the net amount due the Trust Fund (i.e., the hospital tax less the expected Trust Fund payment) and the State, after depositing the Trust Fund payment into the same account, would then withdraw from that account the full amount of the hospital tax (the hospital's deposit plus the Fund payment). The district court rejected the Secretary's contention that the amount of the Trust Fund payment to the hospital was an offsetting "refund" of the tax payment made by the hospital under Medicare regulations, holding that the Trust Fund payments were not sufficiently related to or associated with the hospital tax beyond the existence of a common account from which the hospitals deposited and the State disbursed funds. The district court found that the record established that the Trust Fund payments were intended not to reduce or refund the expense of the hospital tax but to reimburse hospitals for the costs of providing care to underinsured or uninsured patients, and were determined using a formula based on estimates of actual costs of providing uncompensated care. The district court also noted that the State withdrew the full amount of the Hospital Tax from a hospital's bank account (so that the hospital actually incurred the "full amount" of the tax), and that many hospitals received more in Trust Fund payments than they paid in hospital taxes (and therefore such payments could not be characterized as a "refund" of a previous expense). The Court of Appeals reversed. The Court determined that the tax was imposed to generate revenue for the Fund payments, thereby linking the two, and the State accordingly sought only a net payment from the provider (tax liability less expected Fund payment); therefore, the provider's "cost actually incurred" was only the net payment due the Fund regardless of its nominal tax liability. The Court also concluded that even if the Fund payments had the separate purpose of compensating hospitals for the cost of care to low income individuals rather than to reduce tax liability, under the State's scheme the payments nevertheless operated as "refunds" of the tax payments. The Court also rejected plaintiff's argument that considering the Fund payments as refunds of the Hospital Tax effectively treated the Tax as having a "hold harmless" feature for hospitals receiving Fund payments, contrary to the Medicaid statute's conditions for permissible provider taxes (42 U.S.C. 1396b(w)(1)(A)(iii)). The Court concluded that the reduction of the allowable Medicare costs did not change the treatment of the Tax itself as a permissible Medicaid provider tax, and that Medicaid determinations did not control the analysis under Medicare.

District Court Upholds Medicare Offset of Reimbursable Hospital Taxes by Medicaid Supplemental Payments **Breckenridge Health, Inc. v. Price**, 2017 Fed. App. 0194P (6th Cir. Aug. 23, 2017) – Kentucky hospitals challenged a final decision disallowing Medicare reimbursement for provider taxes paid by the hospitals on their gross revenues that were deposited into a trust fund that funded Medicaid Disproportionate Share Hospital payments. CMS determined that Medicaid DSH payments derived from the trust fund effectively refunded the taxes paid, and offset the taxes by the DSH payments received. The Sixth Circuit affirmed, finding that under the Kentucky provider tax scheme, the net economic effect of the DSH payment was to reimburse the hospitals for the amount they paid in taxes. The Court concluded that the DSH payments reduced the hospitals' tax costs and therefore constituted a refund of those costs under the Medicare regulations. The Court also rejected the plaintiffs' argument that the DSH payments had to be paid specifically to make a provider whole for the tax expenses in order for offset to be appropriate. The Court found that the regulation required only that payments be associated with the tax.

See also: **Sierra Medical Services Alliance v. Kent**, 2018 U.S. App. LEXIS 5670 (9th Cir. March 6, 2018) (Rejecting argument of providers of ambulance services that, in light of low Medicaid payment rates allegedly reimbursing only 20 percent of the costs of transporting Medicaid patients, California law requiring ambulance companies to provide emergency medical transportation regardless of ability to pay effectuated an unconstitutional government "taking" of private property; plaintiffs failed to produce sufficient evidence of overall economic impact of Medicaid payments on their bottom line.)

B. State Cases

State Medicaid Agency Required to Reimburse Critical Access Hospitals for Outpatient Laboratory Services at Full Medicare Reimbursement Rate – **Commonwealth of Kentucky v. St. Joseph Health System, Inc.**, 521 S.W.3d 576 (Ct. App. Ky. May 19, 2017) -- The Kentucky Medicaid program reimbursed critical access hospitals at the Medicare technical component rate for outpatient laboratory services, rather than the full Medicare reimbursement rate of 101% of reasonable costs. The court of appeal determined that the state's reduced payment for outpatient laboratory services violated state law, which required payment to the critical access hospitals at the full Medicare rate, and that a CMS informal letter and state plan amendment to the contrary could not supercede the state statute with respect the proper reimbursement rate.

State Medicaid agency's Rate Setting for Psychiatric Children's Hospital by Application of 19.5% Parity Adjustment Factor was Arbitrary and Capricious by Being Contrary to State Law – **Northern Kentucky Mental Health-Mental Retardation Regional Bd., Inc. v. Commonwealth of Ky.**, 2017 WL 1035125 (Ct. App. Ky. Mar. 17, 2017) Kentucky law requires that payments for hospital care "shall be on bases which relate the amount of the payment to the cost of providing the services or supplies." In establishing rates to a psychiatric children's hospital, the State established rates substantially below their costs due to the application of a 195% parity adjustment. (The rates resulted in payments between 84-88% of costs.) The court analyzed the state agency's grouping of "similar" services, here services by non-psychiatric acute care hospitals with the services provided by psychiatric hospitals, to determine the parity adjustment factor. The court noted that the plaintiff efficiently provided services in an innovative manner, by comparison to similar services provided by acute care hospitals. Accordingly, the court found that establishing equivalency through the application of a parity adjustment factor was arbitrary and capricious due to the state's inability to show that the new methodology relates to the psychiatric hospital's actual and allowable costs.

Dismissal of Administrative Challenges to Hospital Outpatient Rate Reductions overturned – **Sarasota County Public Hospital Dist. v. Fla. Agency for Health Care Admin.**, 2017 WL 5895126 (Dist. Ct. App. Fla. Nov. 30, 2017) The Florida state Medicaid agency issued letters to hospitals announcing a significant reduction of funding to hospitals for Medicaid outpatient services, despite the passage of zero rate reductions and sufficient funds from the Florida Legislature. Sixty-seven hospitals sought administrative hearings, which were dismissed as premature. The Court of Appeal reversed and remanded the dismissals on the basis that the letters affecting unaudited rates constituted final agency action.

State Properly Granted Summary Judgment in Claim for Payments – **John F. Murphy Homes, Inc. v. State of Maine**, 158 A.3d 921 (Me. Apr. 11, 2017) -- Provider of special purpose

medical services sued State of Maine for failure to pay for ten years, based on breach of contract, quantum meruit, and an equitable claim for unjust enrichment or equitable estoppel. The Supreme Court held that the provider could not pursue a breach of contract claim or a quantum meruit due to its failure to invoke the administrative payment review process, as the State had not otherwise waived sovereign immunity. The court further held that the provider could prevail on an equitable estoppel claim because its reliance on statements of two State employees was unreasonable and thus, could not support an equitable estoppel claim.

State Improperly Denied Payment to FQHC – **Excelth, Inc. v. State of Louisiana**, 2017 WL 6505231 (Ct. App. La. Dec. 19, 2017) The court overturned a recoupment by the state Medicaid agency related to claims that had been transmitted by FQHC to billing agent, but that were erroneously placed by billing agent into a file that resulted in claims never being processed. The court held that the state Medicaid agency was solely responsible for the intermediary's failure to process the claims, and that the recoupment did not result from wrongdoing by the provider. The court thus held that the provider established proof by a preponderance of the evidence that the fiscal agent had the proper information to process the claims, but improperly failed to process them. The court further affirmed the grant of interest to the provider.

Request for Claims for Reimbursement Subject to Disclosure Under the Texas Public Information Act – **Paxton v. Texas Health and Human Servs. Comm'n**, 2017 WL 6504084 (Ct. App. Tex. Dec. 14, 2017) Texas' state Medicaid agency refused a public information request for certain information (date of service, procedure code, claim status, billed amount, paid amount, provider name, provider National Provider Identifier, provider masked Texas Provider Identifier, provider type code, provider specialty code, provider county code, provider zip code, and billing entity) derived from Medicaid reimbursement claims by healthcare providers and requested a letter ruling from the Attorney General regarding the agency's disclosure obligations. The Texas Attorney General determined that the Medicaid claim numbers are confidential, but other information must be disclosed. The state Medicaid agency filed suit against the Attorney General, seeking relief from the Attorney General's decision. The court determined that only the information in a Medicaid record that concerns a Medicaid recipient or applicant was shielded from disclosure. The court remanded to the trial court for further proceedings.

Mississippi Supreme Court Affirms Lower Court's Judgment that Prescription Drug Manufacturer Committed Common-Law Fraud and Violated the Mississippi Consumer Protection Act by Inflating Average Wholesale Prices – **Watson Laboratories, Inc. v. State of Miss.**, 2018 WL 372297 (Miss. Jan. 11, 2018) The State of Mississippi filed suit against more than 80 prescription drug manufacturers alleging that the prescription drug manufacturers inflated reported prices, which caused the Medicaid agency to reimburse pharmacies at inflated rates. Following a bench trial, the chancery court determined that the drug manufacturer had committed common law fraud and violated the Mississippi Consumer Protection Act, awarding the state $30 million in civil penalties and damages. The Supreme Court affirmed the lower court's ruling.

Supreme Court of Oregon Determines that Provider May Recover from Fraudfeasor Who Obtained Medicaid Benefits Through Fraud to Demand Higher Rate Charged to Private Pay Patients – **Larisa's Home Care, LLC v. Nichols-Shields**, 362 Or. 115 (Or. Oct. 26, 2017) -- An adult foster care provider sued a defendant, who, through fraud by patient's attorney-in-fact, qualified for Medicaid and thus, obtained a lower rate from the provider for services. The

provider claimed unjust enrichment against the defendant, seeking the reasonable value of the services. The court first held that as of the date when the patient applied for Medicaid, if the undisclosed transfers had been disclosed, the patient would not have qualified for Medicaid. Second, the court held that the patient was legally responsible for the patient's attorney-in-facts false representations. The court went on to determine that the defendant had been unjustly enriched by the false representations. The court further determined that Medicaid law does not bar equitable actions by Medicaid service providers, particularly where the patient used fraud to obtain benefits. The court remanded to the court of appeal the issue of whether the Medicaid program's prohibition of accepting payment for services (hold harmless) barred the plaintiff from recovery for consideration in the first instance.

See also: **SCO Family of Servs. V. N.Y. State Dept. of Health**, 149 A.D.3d 753 (Sup. Ct. N.Y. Apr. 5, 2017) (affirming State's denial of payment of Medicaid funds based on agency's determination that residential treatment facility exceeded maximum vacancy rate).

II. COVERAGE

Court of Appeals Upholds Disapproval of State Plan Amendment Adding Coverage for Pretrial Juvenile Detainees -- **Ohio Department of Medicaid v. Price,** 864 F.3d 469 (6th Cir. July 24, 2017) – HHS disapproved Ohio's proposed State plan amendment providing Medicaid coverage for care furnished to pretrial juvenile detainees on the ground that such coverage violated the statutory bar on Medicaid coverage for an individual who is "an inmate of a public institution." 42 U.S.C. 1396d(a)(29)(A). The Sixth Circuit affirmed the disapproval, finding that the Secretary's determinations regarding state plan amendments, based on interpretations of relevant statutory provisions, was entitled to Chevron deference. The Court concluded that the Secretary's construction of the inmate exclusion as not distinguishing between adults or juveniles, or between convicted detainees and those awaiting trial, was permissible (especially because Congress had expressly enacted other age-based distinctions in the Medicaid statute), and consistent with Congress' intent that Medicaid not fund items and services that are the traditional responsibility of a state or local government entity. The Court further rejected the State's contention that juvenile pretrial detainees fit a regulatory exception (42 C.F.R. 435.1010) for individuals living in a public institution for temporary periods pending other arrangements appropriate to their needs. The Court found that the regulation could not be more expansive than the statute, and accorded Auer deference to the Secretary's conclusion that the regulation could not elevate the temporary nature of a pretrial detainee's stay above the pivotal factor of the involuntary nature of the detention that is central to the statutory exclusion (which the Court found supported by other regulatory exceptions for individuals in a public educational or vocational training institution, or individuals in a publicly operated community residence [the latter exception itself excluding correctional or holding facilities for prisoners or detainees]). Finally, the Court concluded that CMS's denial of the plan amendment was consistent with a longstanding expressed policy regarding involuntarily detained individuals, including juveniles awaiting trial in detention centers.

Court Rejects ADA and Rehabilitation Act Challenges to Reduction in Beneficiary's Private Duty Nursing Services -- **Carpenter-Baker v. Ohio Department of Medicaid**, 2017 WL 5572836 (S.D. Ohio Nov. 20 2017) – A Medicaid beneficiary with severe mental and physical disabilities, including seizures requiring medication administered directly after a seizure, alleged

that repeated actions by the State reducing her weekly hours of covered private duty nursing services below 128 hours per week violated Medicaid fair hearing requirements (42 U.S.C. 1396a(a)(3)) as well as the integration mandates of the ADA and Rehabilitation Act. The court held that the Medicaid claim was moot because a hearing examiner had reversed the State's latest reduction in PDN services. The court further rejected plaintiff's ADA and Rehabilitation Act claims, finding that the reductions in plaintiff's PDN hours had been based on an individualized assessment of her condition and a determination that her seizures could be managed by trained homemaker/personal care aides (available under a State waiver program in which plaintiff participated). The court distinguished other decisions holding that reductions, caps, or other restrictions on services violated the ADA and Rehabilitation Act, on the ground that those cases involved State actions of general applicability reducing or limiting benefits to classes of individuals based on categorical distinctions (as would be the case if the State had implemented a blanket reduction or cap on PDN services for all persons with seizures or who suffered from similar disabilities). The court further stated that even if the State's determination had been incorrect, it did not follow that the decision had been based on discrimination due to a disability. The court further rejected plaintiff's challenge to the methodology and validity of the State's determination in her case, finding that the antidiscrimination provisions of the ADA and Rehabilitation Act were not appropriate vehicles for challenging a State's assessment of an individual beneficiary's medical needs, as those individual determinations could be disputed through the State hearing process. The court subsequently granted plaintiff a stay pending appeal of any further State action reducing her PDN hours. 2018 U.S. Dist. LEXIS 24686 (S.D. Ohio Feb. 15, 2018). The court concluded that plaintiff had shown sufficient evidence of irreparable harm due to the loss of medical benefits, and that it was conceivable the Sixth Circuit would find that a decision reducing Medicaid benefits, based solely on a plainly incorrect individual assessment, could be presumed sufficiently discriminatory to survive a motion for summary judgment.

Court Determines That Delays in Required Services Under Consent Decree Violate "Reasonable Promptness" Requirement -- **Chisholm v. Gee**, 2017 U.S. Dist. LEXIS 139669, 2017 WL 3730514 (E.D. La. Aug. 30, 2017) – Louisiana moved to vacate a 2001 consent decree and subsequent orders directing the State to provide behavioral and psychological services available to Medicaid beneficiaries with Autism Spectrum Disorder; among other requirements, the State was directed to enroll as providers Board Certified Behavioral Analysts who provided Applied Behavioral Analysis (ABA) services. The district court denied the State's motion, finding that the State had failed to comply with requirements to provide services with reasonable promptness under 42 U.S.C. 1396a(a)(8). The court noted that Congress in the ACA had amended the definition of "medical assistance" so that the reasonable promptness requirement now required the timely provision of care and services and not just timely payment whenever services are provided. The court further cited to the EPSDT regulations that require the initiation of treatment no later that 6 months after the request for screening services, and determined that the evidence in the present case showed that some class members were waiting more than 6 months and in some cases over one year to receive ABA services notwithstanding the fact that children with autism require early intervention. The court rejected the State's assertions that delays in treatment were due not to its administrative procedures but to insufficient numbers of behavioral analysts and psychologists in Louisiana providing ABA services. The court determined that because there was enough evidence that a reduction in reimbursement rates for ABA services

had played a role in increasing waiting times for services, that terminating the consent decree would be premature.

Challenge to Restrictions on Coverage of FDA-Approved Therapies for Hepatitis C Patient – **Ryan v. Birch**, 2017 U.S. Dist. LEXIS 143568, 2017 WL 3896440 (D. Colo. Sept. 5, 2017) – Plaintiffs challenged Colorado's policy restricting Medicaid coverage of Direct-Acting Antivirals to Hepatitis C patients with fibrosis scores of F2 (intermediate liver scarring) or higher on a scale of F0 to F4. Plaintiffs alleged violations of 42 U.S.C. 1396a(a)(10)(A) (requirement that State provide "medical assistance" to all eligible individuals) and 1396a(a)(10)(B) (comparability of services between the categorically and medically needy, and among medically needy individuals). The court denied the State's motion to dismiss, rejecting its argument that plaintiffs' claims challenged the State's methodology for determining coverage and therefore could only be asserted under the "reasonable standards" requirement of 42 U.S.C. 1396a(a)(17) (which the Tenth Circuit has held does not create enforceable rights). The court held that plaintiffs sufficiently stated a claim under 42 U.S.C. 1396a(a)(10)(A), which prohibits States from denying coverage of medically necessary services in a category that the State is required or has elected to provide. The court also held that plaintiffs sufficiently stated a claim under 42 U.S.C. 1396a(10)(B) because they alleged that DAA was treatment is medically necessary for every Medicaid enrollee infected with Hepatitis C.

Due Process Challenges to Denials of Individual Prescription Drug Coverage At Point of Sale -- **N.B. v. District of Columbia**, 244 F. Supp. 3d 176 (D. D.C. March 26, 2017) – Medicaid beneficiaries alleged that denials of individual prescription drug coverage generated at the point of sale by an automated claims management system violated due process, where beneficiaries were not given notice of the reasons for denial or afforded coverage pending a hearing. The district court held that due process required written notice at the point of sale of the reasons for denial of coverage and their procedural rights, and rejected the district's arguments that beneficiaries did not need to know the reasons to exercise their appeal rights and in any event could proactively ask the pharmacist or call District officials to obtain more information. However, the court held that due process did not require the District to cover denied prescriptions until a decision following an evidentiary hearing. The court found that denial of coverage for an individual drug did not rise to the level of the total denial or termination of benefits, plaintiffs had not shown a significant risk of erroneous deprivation under an automated claims management system, and the District would face significant burdens if it was required to pay for prescriptions until it held an evidentiary hearing.

Challenge to Reductions in Coverage Status for Eligible Immigrants -- **Darjee v. Betlach**, 2016 U.S. Dist. LEXIS 148306 (D. Ariz. Oct. 25, 2016), 2017 U.S. Dist. LEXIS 49276, 2017 WL 1191100 (D. Ariz. March 31, 2017) – The magistrate judge recommended dismissal of an action alleging that the State improperly reduced eligible immigrants Medicaid coverage from full-scope to emergency-only benefits upon annual re-certifications of eligibility. The magistrate judge determined that the plaintiffs lacked standing as their full benefits had been restored and the State had claimed correction of computer problems that had improperly applied the 5 year residency requirement for qualified aliens to exempt individuals (e.g., refugees, battered immigrants, individuals who had entered the country prior to 1996). The magistrate judge concluded that plaintiffs had not established a reasonable expectation that they would be subject

to the same action again and had failed to sufficiently allege facts establishing that the reduction in benefits was the result of a State policy or practice. The magistrate judge also held that the Medicaid statute's "reasonable promptness" requirement (42 U.S.C. 1396a(a)(8)) did not support a cause of action for erroneous re-determinations of eligibility, and in any event was inapplicable where there had not been a delay in receiving any benefits and instead plaintiffs continued to receive some benefits. In the second decision, the district court determined that the plaintiff's claims were not moot as the plaintiffs had alleged that errors continued and therefore they remained at risk for future reductions. The district court further held that the "reasonable promptness" requirement extended beyond delays in the initial processing of initial Medicaid applications to erroneous re-determinations of eligibility, and mandated the prompt provision of all benefits for which an individual is eligible (here, full-scope benefits for the exempt resident aliens). The district court also held that plaintiffs stated cognizable claims under 42 U.S.C. 1396a(a)(8) as they had alleged that the computer problems continued. Finally, the district court held that plaintiffs had adequately stated due process claims of lack of adequate notice in alleging that the statement in benefit notices "your immigration status does not let you get full medical services" was not a sufficiently clear statement of the specific reason for reducing full benefits.

- In the most recent decision, 2018 U.S. Dist. LEXIS 22658 (D. Ariz. Feb. 9, 2018), the Magistrate Judge recommended denial of plaintiff's motion for class certification. The magistrate judge determined that the plaintiffs did not meet the commonality requirement of suffering the same injury. The magistrate concluded that plaintiff's allegation that the class was "at risk" of being erroneously identified by the State's computer system as possibly eligible for reduced benefits did not itself equate to a common violation of the reasonable promptness requirements of Section 1396a(a)(8), and in any event the mere existence of a shared legal issue in the absence of a showing that class members actually suffered the same injury was insufficient to establish commonality. The magistrate found that actual determinations to reduce benefits could only be made by a trained worker, the evidence showed that there were different reasons for an eligibility worker's decision to reduce benefits and that proposed erroneous reductions were corrected in sufficient time to allow full benefits to be provided with reasonable promptness, and plaintiffs' allegations of "sweeping problems" with the computer system that automatically rendered incorrect benefit reductions were unsupported where the State implemented a detailed manual review process for all proposed benefit reductions. The magistrate concluded that the Court could not determine that there was a class of immigrant Medicaid recipients that have not had medical assistance furnished with reasonable promptness. The magistrate similarly concluded that the plaintiffs had not demonstrated typicality where the computer system only identified cases where benefits might be reduced, actual decisions to reduce benefits were only made by eligibility workers, and benefit reductions could result from a variety of errors or omissions rather than through the same source of conduct. Finally, the court determined that the numerosity requirement was not met, as the evidence showed that only five beneficiaries did not receive notices of reinstated of full benefits prior to the effective dates of proposed reductions and there was no basis for the court to conclude that these individuals had waited long enough to warrant a conclusion that services had not been furnished with reasonable promptness.

Challenge to Erroneous Determinations of Emergency Services-Only Coverage Status for Eligible Immigrants -- **Unan v. Lyon**, 853 F.3d 279 (6th Cir. March 31, 2017) – After Michigan, in the course of implementing ACA-required system changes, caused non-citizen Medicaid applicants to be assigned to emergency services-only coverage instead of comprehensive Medicaid coverage due to computer problems, two named plaintiffs filed a class action complaint alleging that the State failed to promptly provide comprehensive Medicaid pursuant to 42 U.S.C. 1396a(a)(8), failed to provide comprehensive Medicaid to applicants pending a reasonable opportunity to verify their immigration status following attestation to such status pursuant to 42 U.S.C. 1320b-7(d)(4)(A), and failed to provide the plaintiffs with an opportunity to be heard regarding the denial of comprehensive Medicaid pursuant to 42 U.S.C. 1396a(a)(3). The State moved to correct the computer problems and began approving for full Medicaid coverage individual applicants (including, two days after the complaint was filed, the named plaintiffs) who attested to eligible immigration status, and the district court subsequently granted the State's motion for summary judgment and dismissed plaintiffs' motion for class certification as moot. On appeal, the Sixth Circuit held that the named plaintiffs' claims were not moot, finding that the timing of the State's actions providing the named plaintiffs with full coverage (two days after the lawsuit and contemporaneous motion for class certification were filed), notwithstanding the fact that the State had been aware of the computer problems five months prior to the lawsuit, established that the State had attempted to "pick off" the named plaintiffs by granting them requested relief through an ad hoc process rather than as an incidental outcome of a standard procedure. The Court also found that the named plaintiffs' claims were not moot under the "inherently transitory" exception, because of the uncertainty as to how long their claims would survive before the district court could rule on class certification and the evidence of continued erroneous assignments of other class members to emergency services-only coverage even after the State claimed to have implemented a permanent fix after the suit was filed. The Court further held that the putative class's claims of inadequate notices were not moot because plaintiffs claimed the notices did not inform applicants of the specific time periods they may have been erroneously assigned such coverage and were therefore insufficient to alert individuals as to the precise issues relating to their eligibility. The Court also found that the putative class's claims of erroneous assignments of emergency services-only coverage were not moot because the State had failed to put forward sufficient evidence that the wrongful assignment of coverage could not reasonably be expected to recur (as the plaintiffs had submitted evidence that numerous erroneous assignments of coverage had continued to occur even after the State had claimed to fix the problems). However, the Court affirmed the district court's denial of summary judgment on the different grounds that there was a genuine dispute of fact over whether continued erroneous assignments of Medicaid coverage were the result of ongoing systemic patterns and practices or were the results of worker errors in individual cases. The Court also held that the State was entitled to summary judgment on plaintiff's notice claims, as the notices alerted non-citizen Medicaid applicants of their rights to a hearing and plaintiffs had not shown that knowledge of the specific time period when an individual was erroneously assigned to emergency services-only coverage was necessary to the appeals process.

Challenge to Denial of Coverage Based on Erroneous Determination of Non-Resident Status -- **Odi v. Alexander**, 2017 U.S. Dist. LEXIS 32824, 2017 WL 914818 (E.D. Penn. March 7, 2017) – A beneficiary's estate brought claims against State Medicaid officials under Title VI of the

Civil Rights Act, 42 U.S.C. 1983, and the Medicaid Act's reasonable promptness requirements (42 U.S.C. 1396a(a)(8)), after the beneficiary had died from untreated breast cancer. Prior to her death, the State on several occasions denied or terminated her Medicaid benefits on the erroneous grounds that the beneficiary was not a citizen or alien lawfully admitted for permanent residence, despite her actual permanent resident status. The district court rejected the State's argument that the Section 1983 claims were barred by Pennsylvania's two year statute of limitations for personal injury action, finding that the State's ongoing conduct constituted continuing violations and that even if the Section 1983 claims were untimely, equitable tolling should apply where the beneficiary was in severe need of aid, had been given erroneous reasons for the denial or termination of her benefits, and her appeals had been unreasonably delayed. The court further held that the complaint adequately stated due process violations based on the alleged failure of the State to provide an appeals process. The court dismissed the Title VI claims on the ground that the individual state officials could not be held liable under Title VI. Finally, the court held that 42 U.S.C. 1396a(a)(8) created enforceable rights but dismissed the claims under that provision because the State officials had been sued solely in their official capacity.

Beneficiary's Challenge to Denial of Prior Authorization for Services -- **D.U. v. Seemeyer**, 2018 U.S. Dist. LEXIS 26669, 2018 WL 1010486 (E.D. Wis. Feb. 20, 2018) – Plaintiff, a severely disabled minor child, field suit under 42 U.S.C. 1983 challenging the State's denial of prior authorization for private duty nursing care on the ground that she had not shown a need for at least eight hours per day of skilled nursing intervention. Plaintiff contended that the State's action violated Medicaid provisions requiring the provision of medically necessary EPSDT services to beneficiaries under 21 and requiring that all covered services be sufficient in amount, duration, and scope to reasonably achieve its purpose. The district court held that a former State employee responsible for reviewing requests for prior authorization of private duty nursing services and who had denied plaintiff's request was entitled to qualified immunity from liability because even though case law at the time clearly established that plaintiff was entitled to all medically necessary services, case law also established that the State had a legitimate role in reviewing treating physicians' assertions of medical necessity and the employee's determination had been reasonably based on review of all the medical information. The court further held that sovereign immunity did not bar plaintiff's claim for injunctive relief against the Secretary of the Wisconsin Department of Health Services, and that there was a genuine issue of material fact precluding the State's motion for summary judgment concerning whether plaintiff required at least eight hours per day of skilled nursing care.

Beneficiary's Challenge to Denial of Prior Authorization for Services -- **Moore v. Secretary, Indiana Family and Social Services Administration**, 2017 U.S. Dist. LEXIS 36827, 2017 WL 993077 (N.D. Ind. March 15, 2017) – Plaintiff brought ADA, Rehabilitation Act, Medicaid Act, and due process and equal protection claims against Indiana and its Medicaid contractor after she was denied prior approval to cover removal of her ovaries following a diagnosis of breast cancer. The district court dismissed plaintiff's ADA and Rehabilitation Act claims because plaintiff failed to allege facts that plausibly stated that she had been discriminated against because of a disability, the claims were filed past Indiana's two year statute of limitations for personal injury actions, and Title II of the ADA was not applicable to State contractors. However, the Court held that plaintiff had plausibly stated that the State had violated the Medicaid Act by failing to treat her oncologist's request that the State reconsider the denial of prior approval as an appeal,

and by failing to provide administrative review. The court also held that plaintiff had a property interest in Medicaid benefits and therefore stated due process and equal protection claims. Finally, the court denied class certification because the proposed class (disabled Medicaid beneficiaries who were recommended for certain services but were harmed as a result of inaccurate evaluations during the approval process) was vague and plaintiff had not alleged how her claims presented questions common to the class.

See also: **Ratcliff v. Logisticare Solutions, LLC**, 2018 U.S. Dist. LEXIS 11719 (C.D. Cal. Jan. 24, 2018) – Medicaid beneficiaries brought a state court action against a manager of Medicaid non-emergency medical transportation services alleging negligence and other state law claims arising out of the failure to provide them with adequate NEMT. The defendant removed the action to federal court, but the district court remanded, rejecting the defendant's argument that the Medicare Act's exclusive provisions for federal administrative and judicial review preempted state law claims relating to the provision of Medicaid benefits.

III. WAIVER / MANAGED CARE / OLMSTEAD / ADA ISSUES

A. Waivers / Olmstead / ADA Issues

Claims That Waiver Beneficiaries Residing In Community Residential Facilities Are Deprived of Choice of Individualized Housing Services -- **Murphy v. Minnesota Department of Human Services**, 260 F. Supp. 3d 1084 (D. Minn. May 18, 2017) – Medicaid beneficiaries residing in Community Residential Setting facilities under the State's Disability Wavier alleged that Minnesota had failed to ensure that they were informed of the availability of individualized housing services (under which individuals would exercise choice as to support services such as person-centered planning, roommates, daily schedules, and interaction with the outside community), failed to ensure that their needs for such services were adequately assessed, failed to ensure the provision of transition planning and support for such services, and failed to ensure the provision of notices of denial or information regarding appeal rights with respect to requests for such services. Plaintiffs claimed that these failures deprived them of the services in the most integrated setting, in violation of 42 U.S.C. 1396a(a)(3) (Medicaid fair hearing requirements), 42 U.S.C. 1396a(a)(8) (reasonable promptness in the provision of Medicaid services), the ADA, the Rehabilitation Act, and due process. The district court first held that plaintiffs' claims of segregation from the community in their current residential settings established concrete injury sufficient to confer standing. The district court further held that plaintiffs' claims were ripe since, even if plaintiffs' current residential settings were determined to be proper community settings under new federal regulations after the five- year transition period under those regulations, plaintiffs stated viable claims that those facilities were nor the most integrated settings for them. The court also determined that although individuals do not have an absolute entitlement to waiver services for purposes of the reasonable promptness requirement, plaintiffs in this case had stated a viable reasonable promptness claim because they were not on waiting lists but were actually enrolled in the Disability Waiver, the State was therefore obligated to provide all enrolled individuals with the opportunity for access to all needed services, and individualized housing services (including the costs of person-centered planners) were available under the waiver. The court also held that the reasonable promptness provision applied to both the payment for services and the provision of the services themselves. The court next determined

that State law created a legitimate claim of entitlement, for eligible individuals for whom funding was available, to services, including individualized housing services, enabling them to be integrated into their communities. The court concluded that plaintiffs had plausibly alleged inadequate procedural protections violating both due process and the Medicaid Act's fair hearing requirement. The court also held that plaintiffs stated valid ADA and Rehabilitation Act claims. The court determined that allegations of unjustified isolation in the community and allegations of living in settings that were not the most integrated settings appropriate to plaintiffs' needs stated violations of the integration mandate regardless of whether plaintiffs also alleged that they were at risk of institutionalization. Finally, the court held that at the pleading stage, plaintiffs had requested only reasonable modifications that would not fundamentally alter the State's existing Disability Waiver program. The court concluded that plaintiffs were not requesting new benefits but merely alleging discrimination with respect to existing waiver services and that the State in its Olmstead plan had already identified individualized housing services as an available means to move waiver beneficiaries into more integrated settings.

- In a later ruling, 2017 U.S. Dist. LEXIS 160455 (D. Minn. Sept. 29, 2017), the district court granted plaintiffs' motion for class certification. The court found that regardless of possible differences in county-level decisions made with respect to individual class members, plaintiffs' claims raised the common question of the alleged failure of the State's Department of Human Services to exercise oversight and establish statewide criteria and procedures to ensure that individualized housing services were furnished to all eligible individuals, that adequate notice and opportunity for hearing was being afforded to waiver recipients throughout the State who are denied individualized housing, and that services were furnished in the most integrated setting. The court determined that the possibilities that some class members would not move out of community residential facilities, or that such facilities were the most integrated setting for those individuals, did not defeat commonality.

Challenge to Continued Placement on Waiting Lists for Waiver Services – **<u>Mikkelson v. Piper</u>**, 2017 U.S. Dist. LEXIS 104497, 2017 WL 2881125 (D. Minn. July 6, 2017) -- Plaintiffs, representing a putative class, alleged that their lengthy continued placement on waiting lists for county-operated Developmental Disability waiver programs, despite the availability of allocated funds withheld by the State to address unexpected needs or withheld by local county agencies as reserves and returned to the State where unspent in a given year, violated the "reasonable promptness" provisions of the Medicaid Act (42 U.S.C. 1396a(a)(8)) as well as the ADA and Rehabilitation Acts. Plaintiffs also alleged that they were not given advance notice of their placement on a waiting list, not informed of the basis for continued placement on a waiting list, or given an opportunity to challenge their placement, all of which also deprived them of the opportunity to make informed choices about seeking other potentially available services in violation of the freedom of choice provisions of 42 U.S.C. 1396n(c)(2)(C). In a July 2016 decision (<u>Guggenberger v. Minnesota</u>, 198 F.Supp.3d 973), the court: (1) rejected the State's sovereign immunity claims, (2) held that recent legislative enactments (e.g., imposition of caps on reserves) and adoption of the State's Olmstead plan did not moot plaintiffs' claims because plaintiffs remained on the waiting lists and the State had not established that it had ended the challenged improper management of the waiver program, (3) determined that plaintiffs had stated plausible claims under Sections 1396a(a)(8) and 1396n(2)(C) because they had been

determined to be eligible for waiver services under unused slots, (4) held that plaintiffs had a legitimate claim of entitlement to waiver services where there was sufficient funding available and therefore stated cognizable claims under the due process clause and the Medicaid statute's fair hearing requirement (42 U.S.C. 1396a(a)(3)) that they were entitled to notice and an opportunity to be heard concerning the reasons for their initial and continued placement on the waiting lists, and (5) ruled that plaintiffs sufficiently alleged violations of the ADA and the Rehabilitation Act, even though they failed to plead that they were either currently institutionalized or at risk of institutionalization, based on allegations of lack of independence, isolation in their homes, and disconnectedness from the greater community as a result of the denial of waiver services. In its latest decision, the court rejected Minnesota's Eleventh Amendment argument that rather than primarily seeking prospective injunctive relief to end an ongoing violation of federal law with an ancillary effect on the State treasury, plaintiffs primarily sought to compel the expenditure of state funds by requiring that those funds remain available and mandating the counties to spend greater amounts of their allocated funds. The court determined that plaintiffs' latest amended complaint was primarily tied to allegations of ongoing violations of federal law, even if relief enjoining such violations going forward would increase expenditures of State funds. The court also rejected the State's argument that the relief sought by plaintiffs violated federalism and separation-of-powers principles by removing from its executive and legislative branches decisions as to how the State spends its funds and directing that all funds appropriated for developmentally disabled waiver services remain available. The court concluded that plaintiffs' amended complaint sought to enjoin ongoing mismanagement of existing waiver funds and did not seek a supplemental appropriation; however, the court noted that the permissible scope of any relief to be granted would have to take into account federalism concerns.

Challenge to Denial of Requests for Funding of Waiver Services That Exceed Individual Budgets -- **Michael T. v. Bowling**, 2017 U.S. Dist. LEXIS 152962, Sept. 20, 2017, prior ruling at 2016 U.S. Dist. LEXIS 123749 (S.D. W.Va. Sept. 13, 2016) – A putative class of Medicaid recipients of community waiver services for intellectually and developmentally disabled individuals challenged State Medicaid agency decisions denying their requests for funding of services that exceeded their individual budgets as determined by a third party contractor using a proprietary algorithm applied to the annual functional assessment. Plaintiffs alleged that these denials resulted in substantial reductions in services previously approved in excess of their calculated budgets, and alleged violations of due process, Medicaid notice and fair hearing requirements, the ADA, and the Rehabilitation Act. The district court held that although some of the named plaintiffs had not exhausted state administrative review (and therefore continued to receive services at prior levels), their claims were ripe since they faced the imminent risk of reductions in services. The court found that plaintiffs had a property interest in continued receipt of services at prior funding levels, and that the State's procedures presented a serious risk of erroneous deprivations of plaintiffs' interests in their benefits since there was no notice of the factors or methodology used by the contractor in determining individual budgets or individualized explanations of the reasons for individual budget allocations, and plaintiffs therefore had no meaningful opportunity to challenge such determinations. The court further found that the evidence failed to establish that the State regularly granted exceptions and increased recipients' budgets where necessary to keep individuals in the community. The court determined that providing ascertainable standards in making the budget determinations would not impose undue

administrative or fiscal burdens on the State. The court also concluded that there was sufficient evidence of irreparable harm, citing testimony of caregivers and relatives as well as the prior determinations authorizing services for plaintiffs in excess of their budgets.

- In its later ruling, the district court denied plaintiffs' motion to extend the preliminary injunction to all 4,600 members of the class, which would return all class members to their previous service authorization levels. The court determined that it would be inequitable to order the State to restore previous service authorization levels for all class members while the State simultaneously prepared to implement a new service authorization system which potentially addressed the due process and other concerns expressed by the court in previously issuing the preliminary injunction.

Challenge to State Postponement of Hearings on Denials of Requests for Funding of Waiver Services That Exceed Individual Budgets -- **Disability Rights of West Virginia v. Crouch**, 2017 WL 6045448 (S.D. W.Va. Dec. 6, 2017) – A disability rights advocacy organization challenged the State's decision to hold in abeyance Medicaid fair hearings on appeals from decisions denying beneficiaries' requests for funding of waiver services that exceeded their individual budgets as determined by a third party contractor using a proprietary algorithm applied to the annual functional assessment, pending the outcome of the litigation in Michael T. v. Crouch contesting these reductions on due process, Medicaid, ADA, and Rehabilitation Act grounds. The court granted the State's motion to dismiss, holding that the action had been mooted by the State's decision to schedule hearings (although plaintiff contended that the crux of its action, the failure of the State to take final action in accordance with the "reasonable promptness" requirement, had not been mooted out) and that the plaintiff lacked representational standing on behalf of waiver beneficiaries because the relief requested (payment for requested services that exceeded their allotted budgets) required participation in the suit by individual members.

Claims of Discrimination By Disabled Children Aging Out of Uncapped EPSDT Services -- **Donegan v. Norwood**, 2017 U.S. Dist. LEXIS 210361 (N.D. Ill. Dec. 21, 2017) – Plaintiffs, disabled persons under 21 receiving in-home shift nursing services as a mandatory EPSDT benefit under Illinois' non-waiver Nursing and Personal Care Services (NPCS) program, brought a class action under the ADA, Rehabilitation Act, and 42 U.S.C. 1983, alleging that they were at risk of institutionalization or serious harm as a result of aging out of NPCS and becoming eligible only for more limited services under the State's Home Services Program (HSP) waiver (which required a determination of the need for a nursing facility level of care, based the amount of in-home shift nursing services on such determinations, and capped funding based on the cost of nursing home care for physically disabled adults). Plaintiffs contended that they would not be eligible for the same amount of in home shift nursing services through HSP that they received through NPCS. With respect to this first claim, the district court denied class certification, finding that plaintiffs did not satisfy the commonality and typicality requirements of Rule 23, as the court found that there was no way to determine that the named plaintiffs and the putative class were at a systemic risk of institutionalization as a result of the challenged State actions. Plaintiffs also contended that the State was discriminating between disabled persons aging out of NPCS and other disabled persons aging out of Illinois' EPSDT-related Medically Fragile, Technology Dependent Program who (as the result of a consent decree in a prior class action, Hampe v. Hamos) remained eligible for uncapped in-home shift nursing services based on

determinations of medical necessity. With respect to this second claim, the district court preliminarily rejected (for purposes of the motion for class certification) the State's argument that plaintiffs did not state a disability claim by alleging that they did not receive the same benefits as a different group of disabled persons with greater medical needs. The court determined that plaintiffs' theory was that the level of care to which they were entitled should be determined by the same process – uncapped funding based on medical necessity – as applied to other disabled populations even if the needs of the latter populations were at a higher level of care. With respect to the plaintiffs' claims of discrimination between groups of disabled persons, the court certified a class, finding that factual differences relating to the type of care and necessity of institutionalization for each plaintiff and putative class member were not relevant to plaintiffs' contention that the amount and level of care they received should be determined through the same medical necessity analysis used to determine approved care for other groups of disabled persons.

Allegations That Long Waiting Lists for Waiver Services Result From State's Budget Policies Favoring ICF Services State Viable Claims of Violations of ADA, Rehabilitation Act, and Freedom of Choice Requirements for Waivers -- **Ball v. Kasich**, 244 F. Supp. 3d 662 (S.D. Ohio March 23, 2017) – Adults with intellectual and developmental disabilities alleged that limited access to home and community-based care under Ohio's waiver programs resulted from State budget policies that matched federal Medicaid funds for ICF services but required county boards to supplement federal funding for waiver programs. Plaintiffs alleged that this policy discouraged county boards of developmental disabilities from providing waiver services over ICF services, resulting in significant waiting lists and long wait times for waiver services for those living in large ICFs as well as those still residing in the community. Plaintiffs claimed that Ohio's actions violated the ADA, the Rehabilitation Act, and the freedom of choice requirements for Medicaid waivers (42 U.S.C. 1396n(c)(2)(B)). The district court denied the Governor's motion to dismiss the Rehabilitation Act claims on Eleventh Amendment grounds (because the Rehabilitation Act expressly abrogated state immunity), but granted the Governor's motion to dismiss the ADA and Social Security Act claims on Eleventh Amendment grounds because the Governor did not have the requisite connection to the challenged actions. The court also rejected the State's argument that plaintiffs' action was barred by a consent decree in earlier litigation brought by a class of developmentally disabled individuals seeking community housing and services under which the State agreed to seek additional waiver slots and Medicaid funding for community-based housing and plaintiffs released the State from future claims. The court found that the consent decree had terminated by its own terms and that res judicata did not apply since plaintiffs in the current action alleged continuing violations of federal law. The court also determined that plaintiffs' ADA and Rehabilitation Act claims were sufficiently ripe even though they did not allege that institutionalization was imminent. Finally, the court held that 42 U.S.C. 1396n(c)(2)(B) and its implementing regulations created enforceable rights for individuals who need institutional care to be informed of feasible alternatives under a waiver and given the choice of either institutional care or community services. The court rejected the State's argument that the statute did not require the provision of information or the offer of alternatives prior to actual placement of a beneficiary in an ICF.

District Court Denies Class-Wide Relief to Nursing Facility Residents Alleging Lack of Effective Transition Services -- **Brown v. District of Columbia**, 322 F.R.D. 51 (D. D.C. Sept. 13, 2017) --

A class of disabled individuals residing in nursing facilities for more than 90 days and who were eligible for home and community-based services alleged that the District's failure to provide effective transition services –including discharge planning and informing nursing facility residents of community-based alternatives – caused the class to remain in such facilities in violation of the integration mandate of the ADA and Rehabilitation Act. Following a trial, the district court denied injunctive relief and dismissed the complaint, finding that plaintiffs had failed to show a concrete, systematic policy or practice that uniformly denied class members an effective transition assistance program and caused class members' continued institutionalization, and also failed to prove that their segregation could be remedied by a single injunction. The Court found that the District provided information and other outreach on community-based long term care options, identified individuals in facilities who would like to receive services in the community and provided outreach to those individuals, provided assistance with enrollment in home and community-based services and other benefits (such as the Money Follows the Person program), assisted individuals in seeking housing through other agencies, and tracked individual and overall programmatic progress. The court concluded that although plaintiffs had identified shortcomings in individual cases, they had not shown systematic deficiencies that would support class relief. The court further held that plaintiffs had failed to show that their injuries could be redressed by a single, class-wide injunction. The court found that a pervasive lack of affordable and accessible housing, as well as diverse individualized issues preventing class members from accessing housing (e.g., available private housing is not wheelchair accessible, or an individual has a criminal record that would prevent a landlord from renting), made effective class-wide relief inappropriate.

Challenge to State Action Denying Placement in Most Integrated Setting -- **Schine v. New York State Office for People with Developmental Disabilities**, 2017 U.S. Dist. LEXIS 2362 (E.D.N.Y. Jan. 5, 2017), and 2017 U.S. Dist. LEXIS 51962 (E.D.N.Y. March 31, 2017) -- Plaintiff, a 51 year old intellectually disabled Medicaid beneficiary receiving community services under a Medicaid waiver, challenged the State's denial of his request to reallocate funding within his approved budget to allow him to relocate from a studio apartment to a more interactive residential setting that would provide more interaction and reduce the risk of institutionalization. The State allegedly denied his request because the new housing costs would exceed the housing component of his approved budget (although the new housing costs also covered food and services included under other budget components and his total costs remained within his approved budget). In the initial decision, the magistrate judge concluded that plaintiff stated cognizable claims under the ADA and Rehabilitation Act by alleging that the State had denied him a reasonable accommodation and meaningful access to the most integrated setting appropriate to his needs. The court rejected the State's arguments that the ADA and Rehabilitation Act required a showing of differential treatment between disabled and nondisabled persons and that the integration mandate was limited only to presently institutionalized individuals. The Court further stated that the State's fundamental alteration defense was not appropriate for resolution at the pleadings stage. The court rejected the State's argument that plaintiff was seeking a new type of benefit, finding that the State already had established a program funding living and treatment in the community and that plaintiff was not requesting additional services but simply to have the same services administered in a manner that reasonably accommodated his particularized challenges. Finally, the court concluded that plaintiff's reasonable accommodation claim did not require a showing of discriminatory animus

or disparate impact, but only that his disability made it difficult to meaningfully access services available to both the disabled and the non-disabled without a reasonable accommodation; plaintiff had sufficiently alleged that the State's arbitrary categorization of costs associated with the new living arrangement impeded him from effective access to the support services provided by the State. In the second decision, the district court adopted the Magistrate's recommendations. The court held that plaintiff's allegations that he was not in the most integrated setting that enabled interaction with non-disabled persons to the fullest extent possible, and that the stress of his current living situation would continue to worsen to the extent that he would require institutionalization, stated violations of the ADA. The district court further rejected the State's argument that the requested relief would constitute a fundamental alteration of services by requiring a new benefit of payment for room and board contrary to the Medicaid statute. The district court determined that since plaintiff's allotted budget included State-only as well as Medicaid funds, and plaintiff alleged that relocation to the interactive residential setting would reduce funds currently required for separate support services in his studio setting, it was not clear as a matter of law that the requested relief would require the improper use of Medicaid funds.

Court Holds That Challenge to Reductions in Waiver Services States Valid ADA, Rehabilitation Act, and Due Process Claims -- **Mitchell v. Community Mental Health of Central Michigan**, 243 F. Supp. 3d 822 (E.D. Mich. March 22, 2017) – Two developmentally disabled beneficiaries receiving in-home community living support services administered through a local contract provider challenged the provider's elimination of payment for supervisory care while they slept. After plaintiffs filed suit, a State Administrative Law Judge reversed the State's determination in the case of one of the plaintiffs and ordered coverage for the nighttime care going forward, though he denied a request for retroactive reimbursement. The district court held that plaintiffs were not required to exhaust their state administrative remedies in order to bring claims under the ADA, the Rehabilitation Act, and 42 U.S.C. 1983 (alleging due process violations). The district court further held that plaintiff's claims were not barred under the *Rooker-Feldman* doctrine barring federal court review of prior state court judgments (because the plaintiffs alleged that their injuries were caused by the contractor's reduction of services, not state administrative decisions), or by *res judicata* (since the State ALJ decision could not adjudicate plaintiffs' ADA, Rehabilitation Act, or due process claims). The court next ruled that the Eleventh Amendment did not bar plaintiffs' claims for declaratory and prospective injunctive relief or their Rehabilitation Act claims, but did bar their ADA claims for damages because they alleged that their services had been reduced because of the contractor's erroneous interpretation of the Medicaid Manual and not due to their disabilities. The court also concluded that plaintiffs had stated viable due process claims based on inadequate notices that failed to convey the intent to reduce Medicaid benefits or reasons for such actions. The court held that plaintiffs stated viable ADA and Rehabilitation Act claims though their allegations that the State's erroneous interpretation of the Medicaid manual to deny coverage for nighttime supervision put them at serious risk of institutionalization. However, the court denied a preliminary injunction, finding that one of the plaintiffs had already received prospective relief through the administrative process and the other plaintiff had failed to demonstrate irreparable harm since he had failed to pursue the same administrative remedy that could restore the denied care.

Allegations That State Fails to Establish Adequate System of Providers Resulting in Delays in Access to Waiver Services -- **C.F. v. Lashway**, 2017 U.S. Dist. LEXIS 91607, 2017 WL

2574010 (W.D. Wash. June 14, 2017) (denying class certification) and 2017 U.S. Dist. LEXIS 101317, 2017 WL 2806835 (June 29, 2017) (denying plaintiffs' motion for summary judgment) – Developmentally disabled beneficiaries who qualified for community-based habilitative services under existing waivers alleged that the State had failed to establish an adequate system of providers to ensure that they promptly received services and had a choice of providers, resulting in violations of the ADA and Rehabilitation Act as well as Medicaid requirements of reasonably prompt access to services, meaningful choice of providers, and written notice and a right to appeal determinations or delays in the provision of services. In its initial decision, the court denied class certification, finding that the proposed class was not sufficiently definite because it included individuals who "desired" community-based services and contained no temporal component for failing to "promptly" receive services. The court also determined that the proposed class failed to meet commonality requirements because plaintiffs had merely asserted that the class was suffering violations of the same requirements and had merely raised questions claimed to be common to the class (e.g., whether the State's practices facilitated provision of community-based services with reasonable promptness, whether the State's referral and payment system effectively provided services with reasonable promptness, whether the State's quality assurance system ensured that contracted providers were delivering sufficient supports to client needs), but had failed to identify specific policies or practices that affected all members of the class. In its later decision, the court denied plaintiffs' motion for summary judgment, finding that the "reasonable promptness" requirement was governed by a test of reasonableness, that plaintiffs had failed to address how services had not been provided with reasonable promptness, and the State had presented sufficient evidence to raise genuine disputes of fact (plaintiffs had failed to consider other supported living options, delays in arranging services had occurred because of plaintiffs' unique needs and State had offered enhanced reimbursement to supported living providers). The court also held that because the fair hearing requirements of 42 U.S.C. 1396a(a)(3) only provided beneficiaries with a right to a hearing where their Medicaid claims were denied or not acted upon with reasonable promptness, the same disputes of material fact precluding summary judgment on plaintiffs' reasonable promptness claims also precluded summary judgment on their fair hearings claim.

Inadequate Notices and Appeal Rights for Reductions in Individual Waiver Budgets -- **K.W. v. Armstrong**, 2017 U.S. Dist. LEXIS 155756 (D. Idaho Sept. 22, 2017) – In previous decisions, the district court and Court of Appeals had held that reductions in the individual budgets of disabled waiver participants based on automatic calculations made by a Budget Tool from individual needs inventories were "actions" reducing services for which notices explaining which assessed factors actually affected the calculated budget and an opportunity for a fair hearing were required by due process and the Medicaid statute. The parties reached a settlement under which the State agreed to develop a new budget tool and maintain plaintiffs' services until the new budgets could be implemented and, where appropriate, appealed and reviewed. In its latest ruling, the court denied the State's motion to dismiss individual claims of 16 class members that reductions in their budgets put them at risk of being institutionalized. The court rejected the State's contention that the new budget tool, revised notices, and new hearing procedures mooted these claims. The court determined that the new procedures still required State funding and CMS approval before it could be implemented and that even in that case the new procedures could reduce budgets putting the individual plaintiffs at risk of institutionalization.

Challenge to State Policy Categorically Excluding Individuals From Supportive Living Facilities Based on Diagnosis of Mental Illness **H.O.P.E. Inc. v. Eden Management LLC**, 2017 U.S. Dist. LEXIS 160614 (N.D. Ill. Sept. 29, 2017) – Plaintiffs, individual Medicaid beneficiaries and an organization promoting elimination of discriminatory housing practices, sued Illinois officials and operators of Supportive Living Facilities (SLFs) under a Medicaid Supportive Living Program waiver, alleging that the State promulgated and enforced a policy under which the SLFs categorically and unlawfully excluded individuals based on the presence of any mental illness. (Illinois' approved waiver provided eligibility for SLF services for individuals who were aged or physically disabled but did not have a primary or secondary diagnosis of developmental disability or "serious and persistent mental illness.") Plaintiffs asserted claims under the Fair Housing Act, the ADA, and the Rehabilitation Act, and sought modifications to Illinois' waiver, including elimination of discrimination based on mental illness and assurance that SLF housing would not be denied based on mental health conditions where a prospective resident was otherwise qualified. The court rejected the State's argument that the compliant failed to state claims of discrimination under the ADA and Rehabilitation Act because the State had discretion under the Medicaid Act and regulations to target the aged and physically disabled in designing their waiver programs and not include individuals with intellectual or developmental disabilities or the mentally ill. The court concluded that plaintiffs did not assert that all persons wit mental diagnoses or disabilities must be placed in SLFs, bur alleged only that the State could not exclude elderly or physically disabled individuals from living in SLFs on the categorical basis of mental health diagnoses that had not been screened as rendering them unsuitable to live in SLFs. Finally, the court held that plaintiffs stated viable Fair Housing Act claims against the State, finding that the SLF program provided apartment-style housing in addition to services and participants paid consideration in the form of room and board under the program to occupy a SLF.

Court Rejects Beneficiary's ADA Challenge to State Closure of Facility and Transfer to Community-Based Residential Setting -- **D.T. v. Armstrong**, 2017 U.S. Dist. LEXIS 91725, 2017 WL 2590137 (D. Idaho June 14, 2017) – Parents of a nineteen year old individual with profound intellectual and developmental disabilities challenged sought to enjoin the State's closure of the Intermediate Care Facility for the Intellectually Disabled in which he resided and transfer to a community-based residential setting with 24 hour residential habilitation supported living services provided through an agency. The district court rejected plaintiffs' argument that closure of the facility would violate the integration mandate of the ADA and Rehabilitation Act because the community setting would be unable to meet their son's needs resulting in his likely transfer to a geographically distant and more restrictive ICF/ID than his current ICF setting near his family. The court found that the threatened injury was speculative and held that in any event premature discharge into the community could not be an ADA violation. The court concluded that because the son would be receiving the same level of support, community placement promoted the ADA's integration mandate and that the public interest supported State flexibility in determining whether to close facilities.

Court Rejects Beneficiaries' ADA Challenge to State Closure of Facility -- **United States v. Virginia**, 2018 U.S. Dist. LEXIS 17829 (E.D. Va. Feb. 2, 2018) – The district court rejected motions by residents of a large State-operated residential training center to enjoin their discharge from the training center and transfers to another training center. The State had decided to close

four of its five training centers following its agreement to a consent decree, in an ADA case brought by the United States, that expanded living opportunities in the broader community through increases in the number of Medicaid waivers. The movants, who resided in one of the centers to be closed and would be transferred to the remaining center if they did not select alternative placements within the time allotted, alleged that care in the remaining center was inferior to that in their current center and that their forced transfer would violate Virginia law. However, the district court held that the state law claims were not sufficiently related to the present case so as to permit the court to exercise supplemental jurisdiction. The court stated that the residents' motion did not pertain to the ADA violations that were the basis for the consent decree and did not seek to enforce the consent decree itself, and in any event was barred by the Eleventh Amendment's prescription against federal courts enjoining states based on state law. On the merits, the court determined that the movants had not shown that the State's lawful acts in closing training centers and transferring residents itself resulted in irreparable harm, and that granting injunctive relief would require the State to leave the residents in understaffed facilities that would soon close.

District Court Dismisses As Moot Challenge To Denial of Coverage For Prescribed Private Duty Nursing Services Hours After State Repeals Underlying Policies -- **C.V. v. Senior**, 2017 U.S. Dist. LEXIS 42398 (S.D. Fla. March 22, 2017) – Three medically fragile children challenged Florida's denial of coverage for prescribed hours of private duty nursing services at home based on specific policies barring coverage where private duty services are provided solely for the convenience of caregivers or where a beneficiary is able to attend medical day care, and providing that covered services will be decreased over time as caregivers are taught to provide skilled care. Plaintiffs stated ADA and Rehabilitation Act claims as well as claims under 42 U.S.C. 1983 for violations of the Medicaid Act's EPSDT and reasonable promptness provisions. The district court held that the plaintiff's claims were moot because the State had repealed the challenged policies. The court rejected plaintiffs' contention that the case was not moot because general medical necessity criteria still allowed for application of a "convenience" standard; the court found that plaintiffs' claims depended on the denial of services as a specific result of the repealed policies and plaintiffs' concerns had been fully addressed by the repeal of those policies. The court also determined that although Florida had made the changes after the plaintiffs had filed suit, the changes had been formally put in place as a result of an extensive public rulemaking process and could not be undone without going through that same process. Finally, the court found that the changes had been consistently applied, since the State's contract providers were bound by the changes and plaintiffs had not been denied any requested services since those changes.

See also: **Fortier v. New Mexico Human Services Department**, 2017 U.S. Dist. LEXIS 108418 (D. N.M. July 13, 2017) – Plaintiff challenged the State's denial of eligibility for a waiver program for individuals with intellectual disabilities or related conditions. Plaintiff, who asserted that her functional capacity was similar to an individual with an intellectual disability, contended that the State's definition of "related condition" based on an individual's diagnosis rather than his functional capacity (as under the federal definition) violated the provisions of 42 U.S.C. 1396n(c)(2)(C) requiring that eligible individuals be informed of the feasible alternatives available under the waiver. However, the Court held that Section 1396n(c)(2)(C) did not compel a State to alter its definition of who is eligible for a waiver program or adopt the broader definition in the federal regulation.

See also: **Shing v. Maryland Developmental Disabilities Administration**, 2017 U.S. Dist. LEXIS 62411 (D. Md. April 25, 2017), affirmed by 2017 WL 4329724 (4th Cir. Sept. 29, 2017) – After plaintiff was initially denied request for an increase in home and community-based services, an Administrative Law Judge ordered the State to provide the additional services requested. Subsequently, the State declined to act on new, separate requests for more services while the recently approved services were implemented, and dismissed plaintiff's request for hearing on the ground that the State had not taken an appealable action. Simultaneously with her administrative appeal, plaintiff filed a federal court action alleging that the State had improperly handled her request for increased services and seeking punitive damages. The district court dismissed, finding that plaintiff had not alleged discriminatory acts for purposes of stating ADA claims but had raised only common law tort claims over which the court lacked jurisdiction. Similarly, the court concluded that plaintiff's mere reference to Medicaid regulation did not convert her common law claims into a federal cause of action.

B. Managed Care

Court Orders Enforcement of EPSDT Class Action Consent Decree In Light of State Budget Impasse Delaying Payments to MCOs and Their Providers -- **Memisovski v. Maram**, 2017 U.S. Dist. LEXIS 124793 (N.D. Ill. June 7, 2017), and 2017 U.S. Dist. LEXIS 124843 (N.D. Ill. June 30, 2017) – Medicaid beneficiaries sought to enforce 1993 and 2005 consent decrees in class actions that, respectively, required Illinois to continue to promptly furnish Medicaid to all eligible beneficiaries notwithstanding state budget impasses and required Illinois to provide EPSDT services to all eligible children in Cook County. At the beginning of the most recent State budget impasse in July 2015, plaintiffs in both cases successfully moved for emergency orders enforcing both consent decrees and requiring the State to continue to make timely Medicaid payments in compliance with federal law, including capitated payments to Medicaid managed care entities (which managed and paid for the care furnished to over 60 percent of the State's Medicaid beneficiaries), until the budget impasse was resolved. When by June 2017 the budget impasse had continued for two years, due to insufficient revenues the State comptroller elected to fund the obligations of the two Medicaid consent decrees at significantly reduced levels in comparison to other obligations imposed by state statute (e.g., payroll, debt service, pension obligations, mandated payments to local governments, education funding) or state court orders some of which continued to be fully funded. The district court held that the comptroller had not demonstrated a lawful basis for not complying with the prior orders and that compliance with state statutes did not excuse a failure to comply with a federal consent decree. The Court ordered the parties to negotiate so that payments to the MCOs would at least be sufficient to sustain services to class members. Negotiations did not produce an agreement, and in its second order the court identified a backlog of $4 billion in Medicaid bills, $3 billion of which was owed to MCOs. The court found that this backlog had substantially affected beneficiaries' access to care in violation of the consent decrees, as the MCOs had not been paid and therefore had not paid their providers resulting in providers (including large hospital systems) withdrawing from MCO networks, physicians no longer accepting Medicaid patients, and one or more of the MCOs themselves threatening to terminate their contracts with the State. The court concluded that other than its debt service obligations, the State had not demonstrated a valid basis for its choices in funding its obligations under the Medicaid decrees. The court ordered the State to pay $586 million per month (prior to federal participation) for new claims submitted after July 1 for

services involved in the two cases and pay an additional $2 billion during fiscal year 2018 in order to reduce the backlog to FY 2015 levels.

Court Holds That Medicaid Freedom of Choice Provisions Do Not Confer Enforceable Right on Medicaid MCO to Challenge State Approval of Disengagement of A County From Its Plan-- **Eastpointe Human Services v. North Carolina Department of Health and Human Services**, 2017 U.S. Dist. LEXIS 100686, 2017 WL 2831270 (E.D. N.C. June 29, 2017) – Plaintiff, a Managed Care Organization operating capitated Prepaid Inpatient Health Plans for the provision of mental health, developmental disability, and substance abuse benefits in 12 North Carolina counties, sued State officials and another mental health MCO to prevent the State's approval of the proposed disengagement of one of its service counties from its plans and alignment with the other MCO. Plaintiff claimed that a State statute authorizing county disengagement from an MCO and realignment with another MCO following State approval violated 42 C.F.R. 438.62 (requiring the State to provide for continued services during an enrollee's transition from one MCO to another) and the Contracts Clause. The court held that 42 C.F.R. 438.62 could not create enforceable rights not already implicit in the underlying statute and that the statute implemented by the regulation, 42 U.S.C. 1396a(a)(23), did not create a private right of action for non-beneficiaries such as plaintiff. The court further held that there was no impairment of a contract for purposes of the Contract Clause where a party retained the right to recover damages for breach of contract (which the State statute did not prevent), and that in any event an attempted action under 42 U.S.C. 1983 alleging State impairment of a private contract will not lie.

Hospital Challenge to Medicaid MCO Payment for Emergency Services – **Lake Cumberland Regional Hospital v. Coventry Health & Life insurance Co.**, 2017 U.S. Dist. LEXIS 148858, 2017 WL 4071111 (E.D. Ken. Sept. 14, 2017) – A hospital member of an MCO network filed suit seeking declaratory and injunctive relief regarding the MCO's policy of paying a $50 "triage fee" for emergency services for which it later determined using diagnostic codes and other information were not of an emergency nature. The hospital contended that this policy violated provisions of its MCO contract and federal law requiring use of the prudent layperson standard. The court dismissed the complaint, finding that the dispute was "related to the contract" and thus exclusively subject to arbitration under the contract.

Court Denies Injunction Ordering MLTC Plan to Authorize Twenty Four Hour Care in the Community -- **Scofero v. VNA Homecare Options, LLC**, 2017 U.S. Dist. LEXIS 114155 (W.D.N.Y. July 21, 2017) – Plaintiff, a 70 year old resident of a skilled nursing facility in need of 24 hour medical care, brought an action against a Medicaid Managed Long Term Care (MLTC) Plan and State Medicaid officials seeking an injunction to compel compliance with a Medicaid fair hearing decision ordering the MLTC Plan to enroll plaintiff and authorize 24 hour care in the community. The MLTC Plan had been unable to secure providers, either in-network or out-of-network, willing and able to provide 24 hour care. The district court held that plaintiff had not made the clear showing of entitlement to relief required for a mandatory injunction. The court rejected plaintiff's due process claim, finding that the MLTC plan had complied with its obligations under the fair hearing decision to enroll plaintiff and authorize 24 hour care as well as its obligations under 42 C.F.R. 438.206(b)(4) and (c)(1)(ii) to either make such services available or to seek to cover such services out of network, but had been unsuccessful in securing out of network coverage. The court also rejected plaintiff's claims under the Medicaid statute's "reasonable promptness" requirement (42 U.S.C. 1396a(a)(8)), finding that even if the provision

was privately enforceable, it did not define a specific time limit for furnishing services but was governed by a test of reasonableness and factors outside the MLTC Plan's control had contributed to the delay in the provision of services. The court further held that plaintiff had failed to demonstrate the extreme or very serious damage alternatively required for a mandatory injunction, since plaintiff was currently seeking appropriate medical care and, unlike other cases in which plaintiffs who successfully lived in the community with in-home assistance demonstrated a serious risk of institutionalization because of challenged action and were seeking to maintain the status quo, plaintiff here was seeking to alter the status quo even though it was uncertain he could safely live at home. Finally, the court found that the evidence failed to show irreparable harm to plaintiff's mental status based on his continued stay at the nursing home.

Sole Shareholder Challenges Sale of Medicaid MCO In State Rehabilitation Proceeding -- **D.C. Healthcare System v. District of Columbia**, 270 F. Supp. 3d 72 (D. D.C. Sept. 7, 2017) – After beneficiaries of a locally funded health care program became Medicaid eligible under the ACA and were transferred to a Medicaid MCO, resulting in an increase in the MCO's costs over previously established capitation rates that threatened its financial viability, the District of Columbia filed a consent petition in D.C. court seeking to place the MCO into rehabilitation. The D.C. court approved a rehabilitation plan that included an asset purchase agreement with another managed care entity and a settlement of the MCO's claims against the District for the payment of unsound capitation rates. The MCO's sole shareholder, which was not a party to but participated in the rehabilitation proceeding, appealed the rehabilitation plan and the settlement but withdrew the appeal. However, the shareholder filed an action in federal court under 42 U.S.C. 1983 seeking compensatory and punitive damages and alleging that District officials had conspired to deprive the shareholder of its property rights in violation of due process and Medicaid law. The shareholder also alleged common law claims, including breach of contract through payment of actuarially unsound rates and use of the fraudulent means to induce the shareholder's consent to the rehabilitation order and settlement. The district court dismissed the action under the *Rooker-Feldman* doctrine which bars lower federal court review of decisions of state court of last resort. The district court determined that the shareholder had been effectively treated as a party in the rehabilitation proceedings (and in fact was able to appeal the orders in that proceeding), the shareholder's allegations of injury as the result of the actions of District officials were so intertwined with the outcome of the D.C. court proceedings as to amount to a challenge to that outcome (instead of a challenge to statutes or rules governing those proceedings), and the orders in the rehabilitation proceedings were issued before the federal court proceedings commenced.

State properly excluded certain populations from enrollment in coordinated care organizations – **Adamson v. Oregon Health Authority**, 289 Or.App. 501 (Ct. App. Or. Dec. 28, 2017) Petitioner challenged adoption of regulation excluding certain classes of individuals from enrollment in coordinated care organizations. The court rejected this challenge due to the petitioner's failure to identify any statute contravened by the challenged exclusions.

See also: **WellCare Healht Insurance Co. of Ky., Inc. v. Trigg County Hosp., Inc.**, 532 S.W.3d 163 (Ct. App. Ky. Sept. 29, 2017) (case challenging $50.00 triage/emergency department denial fees should have been dismissed as MCO did not waive its right to arbitration).

IV. ELGIBILITY

A. Federal Cases

Challenge to Eligibility Determination Dismissed After Plaintiff's Death Moots Claims for Prospective Injunctive Relief -- **Pecha v. Lake**, 700 Fed. Appx. 840 (10th Cir. July 25, 2017) (unpublished) – An applicant for Medicaid benefits filed an action under 42 U.S.C. 1983 challenging first Oklahoma's failure to make a timely determination as to eligibility and subsequently the State's denial of eligibility on the grounds that plaintiff had transferred assets and could not claim an exemption for remaining property for which he was unable to actively participate in farming. After the district court initially ordered payment of three months' retrospective payment under 42 U.S.C. 1396a(a)(34) and permitted plaintiff's claim for prospective injunctive relief to go forward, upon plaintiff's death the court dismissed the action finding that the death rendered prospective injunctive relief impossible and that the incidental retrospective benefits could not be tied to any prospective relief. The Tenth Circuit affirmed, holding that plaintiff's claims for prospective relief were moot as he could no longer show a continuing or future injury. The Court rejected plaintiff's claims of an ongoing violation of federal law by the State, noting that plaintiff himself had no valid claim for injunctive relief. The Court further affirmed that plaintiff's claim for retrospective benefits as ancillary relief failed because there was no claim for injunctive relief to which the claim for retrospective benefits could be ancillary.

Court Holds That Open-Ended Remands of Erroneous Benefit Denials Violate Medicaid Act -- **Lisnitzer v. Zucker**, 2018 U.S. Dist. LEXIS 15022 (E.D.N.Y. Jan. 26, 2018) – A Medicaid applicant brought a class action challenging the State's alleged practice on appeals of benefit determinations of reversing erroneous denials, remanding those matters back to the Medicaid agency, and terminating the appeal, rather than determining eligibility by a final administrative decision within 90 days of the fair hearing request. The district court rejected the State's argument that the action became moot when the Medicaid agency determined after the action was filed that the named plaintiff was eligible for Medicaid, because once standing was established for the named plaintiff it was established for the entire class. The court found that the named plaintiff's individual claims were not moot because he (and other class members) would be subject to periodic redeterminations of eligibility and could suffer repeated deprivations under the challenged State practice with such deprivations evading timely review where the State made a final eligibility determination. The court further noted that in any event class certification would relate back to the filing of the complaint, thereby preserving the named plaintiff's otherwise moot claims for class certification purposes. On the merits, the court determined that 42 U.S.C. 1396a(a)(3), as implemented by 42 C.F.R. 431.244(f)(1), created a right to receive a final hearing decision within 90 days of a fair hearing request, and that the open-ended remand of the named plaintiff's appeal resulted in a violation of his right to "final administrative action" determining his eligibility within 90 days of his fair hearing request.

District Court Enjoins Immediate Dismissals of Fair Hearing Appeals Without Providing Beneficiaries An Opportunity to Reschedule -- **Fishman v. Danes**, 247 F. Supp. 3d 238 (E.D. N.Y. March 29, 2017) – In prior decisions, the Second Circuit Court of Appeals (682 Fed. Appx. 797) and the district court (164 F.Supp.3d 409) held that New York's practice of immediately dismissing beneficiary appeals of terminations of Medicaid eligibility – thereby ending the continuation of benefits pending such appeals -- whenever beneficiaries failed to appear for their

scheduled hearings violated the Medicaid statute's fair hearings requirement (42 U.S.C. 1396a(a)(3)), as implemented by 42 C.F.R. 431.223 (State may dismiss a request for hearing if a beneficiary fails to appear "without good cause") and the State Medicaid Manual (allowing dismissal only where the beneficiary fails to respond to a post-default notice providing an opportunity to reschedule). The Second Circuit had also held that the regulation was relevant in determining the scope of the enforceable right conferred by 42 U.S.C. 1396a(a)(3). In its latest decision, the district court issued a permanent injunction and rejected the State's argument that the plaintiff class lacked standing because the named plaintiffs had not submitted proof that they had been liable for medical expenses following the dismissal of their administrative appeals. The district court held that the violation of the named plaintiffs' substantive legal rights under 42 U.S.C. 1396a(a)(3) and its implementing regulations and manual provisions was sufficient to confer standing without regard to specific economic harm. The court further determined that both named plaintiffs had incurred liabilities for medical care, due to the terminations of their coverage, at the time suit was filed in 2009. The court also held that the case had not become moot because New York law still did not require the provision of post-default notices to beneficiaries and the certified class in any event retained a live legal interest in the outcome of the litigation. Finally, the court rejected the State's argument that plaintiffs had not established causation between the lack of post-default notices and the alleged injury of failure to reopen abandoned appeals, since it was the failure to provide the post-default notices and not the failure to reopen the hearings that was the injury plaintiffs sought to remedy.

Exception to Transfer of Assets Rules For Unlimited Transfer to A Spouse Does Not Apply To Nursing Facility Resident's Reapplication for Medicaid After Initial Benefits Terminated Following Receipt of Personal Injury Settlement -- **Fagan v. Brembly**, 244 F. Supp. 3d 280 (D. Conn. March 21, 2017) -- Three years after initially being determined eligible for Medicaid, a nursing home resident had his benefits discontinued when he received a $1 million personal injury settlement. After he transferred this amount to his community spouse and reapplied for Medicaid, Connecticut imposed a transfer of assets penalty precluding Medicaid coverage of his long-term care for 7 years. The district court held that once the beneficiary had initially been determined eligible, the limits on spousal transfers set forth in the spousal impoverishment provisions of 42 U.S.C. 1396r-5(f)(1) (exempting spousal transfers up to the community spouse resource allowance) continued to apply to his transfers to the community spouse after his initial benefits had been discontinued but before he reapplied for Medicaid. The court rejected plaintiff's argument that the unlimited exception in 42 U.S.C. 1396p(c)(2)(B) for transfers to spouses made prior to the initial determination of eligibility should control. The court determined that, where there had been a single continuous period of institutionalization, the "initial determination" referred only to the first determination of eligibility and did not extend to the second application of an individual who, after having previously been determined to be eligible and receiving Medicaid, loses eligibility and reapplies during that same continuous period of institutionalization. The district court noted that neither Morris v. Oklahoma Department of Human Services, 685 F.3d 925 (10th Cir. 2012) or Hughes v. McCarthy, 734 F.3d 473 (6th Cir. 29013), which both held that the limitations on spousal transfers in Section 1396r-5(f)(1) did not apply to transfers prior to a determination of eligibility, did not apply to the current case. The court reasoned that because plaintiff could not have made the unlimited transfer prior to his eligibility being discontinued, allowing him to make the same unlimited transfers after his benefits were discontinued would allow him to bypass the transfer limits essential to the intended functioning of the spousal impoverishment provisions. The court

therefore concluded that for purposes of Section 1396r-5(f)(1) the "initial determination" of eligibility was applied to an entire continuous period of institutionalization and did not correspond to each new application for Medicaid during that period.

Denial of Eligibility Based on Distributions from Testamentary Trust – **Kadingo v. Johnson**, 2017 U.S. Dist. LEXIS 11024 (D. Colo. Jan. 26, 2017), and 2017 U.S. Dist. LEXIS 128778, 2017 WL 3478494 (D. Col. Aug. 14, 2017) – Colorado initially notified plaintiff, a 92 year old Medicaid nursing home resident, of an overpayment of $92,000 in benefits based on her placement of the proceeds of the sale of her residence into a testamentary trust established by her spouse (with the trustee having absolute discretion over distributions), which the State considered a transfer of assets for less than fair consideration. An Administrative Law Judge concluded that this notice was defective, but separately established a future period of disqualification for benefits running from the date of a final agency decision (rather than the date of transfer), based on a finding that expenditures from the trust had constituted an impermissible transfer. Plaintiff did not appeal, and the State issued a final decision activating the transfer penalty. Subsequently, the State issued a new notice (apparently to cure the deficiencies of its first notice) that imposed the same period of disqualification (though running from the new notice) on yet a different basis that plaintiff's failures to elect her spousal share and obtain family and exempt property allowances against her spouse's estate under Colorado law, with the result that the assets plaintiffs would have obtained through such an election were diverted to the testamentary trust, was a transfer of assets without fair consideration. The ALJ dismissed plaintiff's appeal of this latest notice, finding that he had already heard the case and the State had already issued a final decision. In its initial decision (January 26, 2017), the district court held that plaintiff's suit was not subject to claim preclusion or issue preclusion based on the state administrative proceedings and her failure to appeal the ALJ's decision, since plaintiff had lacked the opportunity in those proceedings to contend that State regulations and policies treating plaintiff's failures to elect the spousal share or obtain family and exempt property allowances against her husband's estate as a transfer without fair consideration violated the Medicaid statute and due process. The court further concluded that 42 U.S.C. 1396p(d)(2)(A), which provides that assets of trusts "other than [those established] by will" shall be considered in determining eligibility, created an enforceable right that assets contained in a testamentary trust are exempt, and that plaintiff stated a plausible claim that Colorado regulations treating her failure to elect her spousal share as a transfer without fair consideration violated the statute by requiring her to forego her right to be a beneficiary of an exempt trust. The Court also held that plaintiff stated a cognizable claim that Colorado's fair hearing regulations violated due process and the fair hearing requirements of 42 U.S.C. 1396a(a)(3) by precluding her from raising constitutional and statutory challenges to the transfer of assets determination during the administrative hearing. In its later decision (August 14, 2017), the court held that the provisions of Section 1396p(d)(2)(A) did not shield plaintiff's entitlement to a share of the proceeds from the sale of her late husband's residence under Colorado's elective share and allowances statutes from treatment as assets, and did not shield plaintiff's failures to elect such share and obtain such allowances – with those proceeds instead funding the testamentary trust – from treatment as a prohibited transfer. The court also rejected plaintiff's claims of violations of due process and the fair hearing requirements of 42 U.S.C. 1396a(a)(3).

District Court Holds That Nursing Homes and Their Residents Properly Allege Violations of Medicaid Statute, the ADA, the Rehabilitation Act, and Due Process Relating to State Failure to Timely Process Medicaid Applications -- **Doctors Nursing & Rehabilitation Center, LLC v. Norwood**, 2017 U.S. Dist. LEXIS 87015, 2017 WL 2461544 (N.D. Ill. June 7, 2017) – Nursing home providers and individual residents alleged that Illinois failed to process Medicaid applications within required time frames and failed to provide benefits to residents whose applications had been approved. Plaintiffs alleged violations of 42 U.S.C. 1396a(a)(10)(A) and 1396d(a)(4)(A) (requirement to provide Medicaid benefits, including nursing facility services, to eligible individuals), 1396a(a)(8) ("reasonable promptness" in determining eligibility and providing benefits), the ADA, the Rehabilitation Act, and the Equal Protection Clause. The district court rejected the State's argument that it lacked jurisdiction on Eleventh Amendment grounds, finding that plaintiffs sought injunctive relief requiring the processing of benefits and provision of benefits but did not seek money damages for past violations. The court also determined that the healthcare providers had authority to bring suit on their patients' behalf, based on 42 C.F.R. 435.923(b) (authorized representative may act on behalf of the beneficiary "in all other matters with the [State] agency.") Finally, the district court held that plaintiffs had properly alleged violations of 42 U.S.C. 1396a(a)(8) and 1396a(a)(10), both of which created enforceable rights.

- In a subsequent decision, 2017 U.S. Dist. LEXIS 141703 (Sept. 1, 2017), the court issued a preliminary injunction ordering the State to determine eligibility for individual plaintiffs' whose applications for long-term care benefits had been pending for more than 90 days and to bring the State's claims processing procedures into compliance with the reasonable promptness requirement and the payment time frames of 42 C.F.R. 447.45. The court again rejected the State's claims that plaintiffs were impermissibly seeking retroactive payments in contravention of the Eleventh Amendment.

Estate's Challenge to Denial of Coverage Dismissed on Eleventh Amendment Grounds -- **Deal v. Velez**, 244 F. Supp. 3d 435 (D. N.J. March 20, 2017) – A deceased beneficiary's estate sued State and county Medicaid officials alleging that the beneficiary had been wrongfully denied coverage of assisted living services for a closed period. The district court dismissed the claims under 42 U.S.C. 1983 against the State officials, finding that plaintiff had not alleged an ongoing violation of federal law that injunctive relief would abate but instead sought retrospective relief directing the State officials not to treat a modified support order as a transfer of assets so that Medicaid would cover benefits for the period in question. However, the court held that the county officials were "persons" amendable to suit in their official capacity, provided that payment of any judgment would not come from the State Treasury.

Court Dismisses Suit By Nursing Facility Residents Seeking Retroactive Corrective Payments Where State Failed to Make Timely Eligibility Determinations -- **Evangelical Lutheran Good Samaritan Society v. Randol**, 2017 U.S. Dist. LEXIS 113031, 2017 WL 3085778 (D. Kan. July 20, 2017) – Residents of skilled nursing facilities who had applied for Medicaid alleged that the State had failed to make eligibility determinations within 45 days as required by 42 C.F.R. 435.912(c)(3)(ii) in non-disability cases (although all plaintiffs had eventually been approved or denied for eligibility), and sought an order requiring the State to approve Medicaid benefits and make retroactive corrective payments for all plaintiffs. The court dismissed plaintiffs' claims under the Americans with Disabilities Act, finding the plaintiffs had failed to allege that they had

not been provided benefits by reason of their disabilities. The court also dismissed plaintiffs' due process and equal protection claims, finding that plaintiffs had not identified any fundamental rights that had been denied, had no protected property interest in Medicaid benefits, and had not asserted that they were treated differently than anyone else. The court further held that 42 C.F.R. 435.912(c)(3)(ii) did not create enforceable rights, and that plaintiffs' request for retroactive corrective payments was barred by the Eleventh Amendment.

Court Dismisses Suit By Nursing Facility Residents Seeking Retroactive Corrective Payments Where State Failed to Make Timely Eligibility Determinations -- **Wicomico Nursing Home v. Padilla**, 2017 U.S. Dist. LEXIS 124158, 2017 WL 3383105 (D. Md. Aug. 7, 2017) – Several nursing homes, as assignees and/or authorized representatives of current or former residents, alleged that Maryland violated 42 U.S.C. 1396a(a)(8) (reasonable promptness), the ADA, the Rehabilitation Act, and the Due Process Clause though its failures to timely process Medicaid applications and issue eligibility determinations. The district court dismissed the action, finding that because all of the residents on whose behalf the suit had been brought either had been granted benefits or were deceased, plaintiffs could obtain only retrospective relief in the form of retroactive benefit payments. The court also determined that plaintiffs did not state due process claims because Maryland law provided appeal rights to individuals claiming their applications had not been timely acted upon.

Nursing Facility Challenges State's Determination Regarding Post-Eligibility Treatment of Resident's Income -- **Evangelical Lutheran Good Samaritan Society v. Betlach**, 2017 U.S. Dist. LEXIS 123060, 2017 WL 3334870 (D. Ariz. Aug. 4, 2017) – A nursing facility alleged that Arizona was required to pay for a mentally disabled resident's care both prior to and following the effective date of her Medicaid eligibility, because annuity payments that would be used to pay non-covered medical expenses (including her personal liability following eligibility) had been misappropriated by her child. The court held that the nursing facility was not able to bring an action on the resident's behalf under FRCP 17(a) since the agreement between the resident and the facility did not authorize the facility to bring legal claims on her behalf, but gave the facility an opportunity to resolve this defect. The court also held that the facility's ADA and Rehabilitation Act claims (including claims for compensatory and punitive damages) were not barred by the Eleventh Amendment, but that the facility's requests under 42 U.S.C. 1983 for an order directing the retroactive approval of Medicaid as well as compensatory and punitive damages were barred by the Eleventh Amendment. The court also determined that if the facility was the real party in interest, it had plausibly stated a claim under the ADA and Rehabilitation Act that the State had failed to account for her disability, including her inability to manage her finances and collect her annuity payments, in including those payments in its calculation of her personal liability. Finally, the court dismissed the facility's claims under 42 U.S.C. 1983, concluding that 42 U.S.C. 1396a(r)(1)(A) (requiring that post-eligibility treatment of income take into account incurred medical expenses not paid by a third party) did not create enforceable rights.

Court Dismisses Nursing Facility's Challenge to State Decision Denying Eligibility for Deceased Resident -- **Hillspring Health Care Ctr. V. Dungey**, 2018 WL 287954 (S.D. Ohio Jan. 4, 2018) – A nursing facility, asserting that it was a third party beneficiary of a resident's Medicaid benefits, challenged a final State administrative determination, affirmed on State judicial review, denying Medicaid eligibility for the resident on the ground that the patient held a

life insurance policy with a cash surrender value exceeding the Medicaid resource limit; the facility contended that the patient (subsequently deceased) had lacked the mental capacity to immediately convert the policy to cash. The court dismissed the compliant, holding that because the beneficiary was deceased she could not benefit from the requested declaratory and injunctive relief and there was no threat of continuing injury. The court rejected the facility's argument that it had a legally cognizable interest in the outcome of the litigation as the resident' authorized representative. The court determined that 42 C.F.R. 400.203, which includes as an "applicant" an individual whose application is submitted through another person after the individual's death, did not provide that such other person was legally entitled to serve as the representative of the individual in any other matter, including federal court proceedings in contravention of standing requirements. The court similarly held that 42 C.F.R. 435.923, providing that "authorized representatives" may act on behalf of the applicant "in all other matters with the agency," did not apply since the deceased resident could no longer be considered to be an "applicant" following the State's final administrative action on her application. The court distinguished other cases (e.g., Doctors Nursing & Rehabilitation Center v. Norwood (N.D. Ill.)) holding that providers could pursue federal court litigation to secure Medicaid benefits for individuals still awaiting Medicaid eligibility determinations. The court alternatively held that the facility's action was barred by the *Rooker-Feldman* doctrine barring federal court review of final state court adjudications; the court concluded that the plaintiffs Medicaid, ADA, and Rehabilitation Act claims were not "independent " claims that did not seek to overturn the state court judgment. The court further concluded that plaintiff's claims were barred by *res judicata*, as plaintiff had a full opportunity to raise its Medicaid, ADA, and Rehabilitation Act claims in the state administrative and court proceedings. The court next held that the facility could not bring claims under 42 U.S.C. 1983 since any purported violations of the resident's rights occurred after her death when her eligibility for Medicaid was initially denied, and the facility was not her estate's representative and therefore had no legal authority to assert claims on her behalf under Section 1983. Finally, the court held that plaintiff's ADA, Rehabilitation Act, and Section 1983 claims were barred by the two year statute of limitations, and that continuing "ill effects" from the allegedly unlawful State action did not constitute a "continuing violation."

Court Holds That Nursing Facility Is Not Authorized to Challenge Denial of Resident's Eligibility -- **Communicare LLC v. Dungey**, 2018 U.S. Dist. LEXIS 20094, 2018 WL 741136 (S.D. Ohio Feb. 7, 2018) – After the State denied the Medicaid application of a nursing facility resident on the ground that her daughter (who was her power of attorney) had failed to respond to requests for necessary information, the nursing facility, alleging that it was the resident's appointed representative, challenged the State's denial as violating the Medicaid Act, the due process clause, the ADA, and the Rehabilitation Act. The district court held that although the resident was unable to manage her own affairs due to her mental and physical impairments, she had not been found to be incompetent and therefore did not lack the capacity to appoint the nursing facility as her authorized representative. However, the court also determined that an undated "Designation of Authorized Representative" Form was insufficient evidence that the resident had appointed the facility as her authorized representative at the time the suit was filed.

Court Holds That Nursing Facility May Challenge State Determinations of Residents' Liability Towards Cost of Care -- **Westminster Nursing Center v. Cohen**, 2017 WL 5632661 (E.D. N.C. Nov. 22, 2017) – A nursing home, acting as the authorized representative for several of its residents, challenged State determinations regarding those residents' monthly liability towards

the cost of their care. The court ruled that the nursing had organizational standing to sue for claims pertaining to its residents who had signed agreements authorizing the facility to pursue in its own name any legal proceedings relating to their Medicaid eligibility. The court dismissed plaintiff's ADA and Rehabilitation Act claims, finding that plaintiff had not alleged any instance under which the State had made different determinations on the basis of disability. The court further held that plaintiff's request for reversal of the State's determinations regarding the monthly liability of its residents, and recovery of costs of the care that the State should have paid, was not barred by the Eleventh Amendment, because a suit seeking recovery for expenses that a State should have paid in the first instance may properly be characterized as seeking prospective relief. The court also held that State administrative remedies were not required to be exhausted in an action under 42 U.S.C. 1983, and that plaintiff did not stand as a defendant in a State coercive administrative proceeding to which Younger abstention applied. The court held that the mere allegations that residents' requests for adjustments to their monthly liability were denied did not state due process violations where plaintiff failed to plead that the additional procedural protections were unavailable. The court concluded that plaintiff had not stated a claim for violations of the reasonable promptness requirement (42 U.S.C. 1396a(a)(8)), where plaintiff had not alleged the dates on which requests for adjustment had been denied (and therefore the court could not assess whether the State had processed the residents' claims with reasonable promptness), and with respect to other residents alleged only that requests for adjustments had not been approved. However, the court held that plaintiff stated a cognizable claim of violations of the enforceable provisions of 42 U.S.C. 1396a(a)(10) and 1396d(a)(4)(A) (provision of "medical assistance," including payment for nursing home care, to eligible individuals). The court determined that the State had improperly applied to the residents a State regulation governing the determination of patient monthly liability without first submitting the regulation to CMS for approval as a State plan amendment.

Court Holds That Nursing Facility Lacks Standing to Challenge Denial of Eligibility for Deceased Resident -- **Diversicare v. Glisson**, 2017 U.S. Dist. LEXIS 178392 (E.D. Ky. Oct. 27, 2017) – Plaintiff, a nursing facility, applied for Medicaid benefits on behalf of a legally incompetent resident. Following the resident's death, the facility was appointed by the probate court as the resident's authorized representative in an attempt to obtain retroactive benefits, but a State fair hearing decision denied eligibility on the basis of inadequate documentation of assets. The facility asserted State violations of the Medicaid Act, ADA, Rehabilitation Act, and due process. The district court held that the facility lacked standing to assert these claims in federal court, as it did not have a valid appointment or power of attorney or assignment of a right to act on the resident's behalf executed by her legal guardian. The court further noted that after the resident's death, only a representative of her estate could bring suit under 42 U.S.C. 1983, the ADA, or the Rehabilitation Act, and that the facility, as a creditor rather than a representative of the estate (which had not been opened by the probate court), had no right to assert claims under those statutes. The district court further held that the facility lacked associational standing, because it was not a voluntary trade organization or association formed to advocate for its residents, who instead were its customers and not members. Finally, the court determined the fact that a facility may apply for benefits on behalf of its residents when authorized to do so did not confer standing to assert vicarious personal injury claims.

Health Insurer Lacks Standing to Challenge State's Determination of Post-Eligibility Income -- **Seniors Benefit Resources v. New Jersey Department of Human Services**, 2018 WL 555244 (D. N.J. Jan. 25, 2018) – A corporation that facilitated access to insurance for nursing home residents with periodontal disease alleged that the State failed to promptly process residents' applications for redetermination of Medicaid eligibility required to ensure that a resident's intended purchase of supplemental insurance did not affect his eligibility or the amount of his obligation toward the cost of his care (because the Medicaid regulations provide that "health insurance" premiums are deducted from a resident's income). Plaintiff contended that as a result of the State's inaction, it had suffered financial losses and Medicaid beneficiaries had not received necessary periodontal treatment. The district court determined that plaintiff had Article III standing to bring its claims, because it alleged financial losses as a result of the State's failure to process redetermination applications (which prevented nursing home residents from purchasing supplemental insurance), and a favorable decision requiring the State to process the redetermination applications would redress its injury. However, the district court held that plaintiff did not fall within the zone of interests protected by the Medicaid regulations allowing nursing home residents to deduct supplemental insurance costs from their income. The court found that plaintiff's desired profit from residents' purchase of supplemental insurance, after the State processed their redetermination applications, was incidental to the Medicaid scheme.

Challenge to State Fair Hearing Decision Barred by Eleventh Amendment -- **Williams v. Connolly**, 2017 WL 5479508 (D. N.J. Nov. 15, 2017) – Plaintiff, a resident of a nursing home, challenged a final state fair hearing decision denying her claim to a "caregiver" exemption under 42 U.S.C. 1396p(c)(2) to the transfer of assets rules for her prior transfer of her home to her son, with whom she had been living prior to her institutionalization. (Previously, plaintiff had liquidated her investment assets to purchase this home from her son, before she transferred it back to him.) Plaintiff contended that an alleged State policy requiring proof that the care furnished by a caregiver child exceeded normal personal support activities violated several Medicaid provisions. The district court rejected the State's contentions that Younger abstention applied because plaintiff had not sought State judicial review of the final State administrative action and that plaintiff's failure to exhaust state remedies precluded an action under 42 U.S.C. 1983. The district court also rejected the State's argument that the State administrative decision had preclusive effect, finding that plaintiff's federal court action did not challenge the final decision but instead contested the validity under federal Medicaid law of the State policy that resulted in that decision. However, the district court held that plaintiff's request that the court order the state to redetermine her Medicaid application in accordance with the Medicaid statute and grant an exemption for the transfer of home amounted to retroactive relief barred by the Eleventh Amendment. The court further concluded that in the absence of a permissible claim for coercive relief, plaintiff could not maintain an action solely for declaratory relief.

See also: **Edwards v. New Jersey Department of Human Services**, 2018 U.S. App. LEXIS 3525 (3rd Cir. Feb. 15, 2018) – Assuming that 42 U.S.C. 1396a(q)(1)(A) created an enforceable right to deduction of a personal needs allowance from monthly income which otherwise is applied to the cost of care, a beneficiary residing in a state-run psychiatric facility did not state any deprivation of that right where his personal needs allowance was paid out of income earned as a "patient care worker" and he contended that he should be permitted to keep that money and be paid an additional amount reflecting the personal needs allowance.

See also: **Miller v. Rosado**, 2017 U.S. Dist. LEXIS 123182 (N.D. Ind. Aug. 4, 2017) – The district court dismissed a Medicaid applicant's action alleging that a State ALJ's dismissal of his appeal violated due process. The court held that because plaintiff alleged only a past and not an ongoing violation, the Eleventh Amendment barred his action.

B. State Cases

Supreme Court of Arizona Determines That Hospital Assessment to Fund Expansion of Medicaid Constitutional – **Biggs v. Betlach**, 243 Ariz. 256 (Az. Nov. 17, 2017) Arizona's Legislature acted to expand Medicaid eligibility to all individuals with incomes not exceeding 133 percent of the federal poverty level. To pay for the expanded coverage, the Legislature required the state Medicaid director to levy an "assessment" on Arizona hospitals. Thirty-six legislators and three citizens sought to enjoin implementation of the hospital assessment on the grounds that it violated a state constitutional provision requiring a two-thirds vote. That state constitutional provision provided that "[a]n act that provides for a net increase in state revenues … is effective on the affirmative vote of two-thirds of the members of each house of the legislature." The Arizona Supreme Court held that the assessment fell into an exception from the two-thirds vote requirement for any "[f]ees and assessments that are authorized by statute, but are not prescribed by formula, amount or limit, and are set by a state officer or agency."

A Trust May Be Considered a Countable Asset When Determining Medicaid Eligibility If the Beneficiary Has Access to the Principal or Corpus of the Trust; Use of a Residence Held by Trust Does Not Automatically Mean Beneficiary Has Access to the Corpus -- **Daley v. Secretary of Executive Office of Health and Human Services**, 74 N.E.3d 1269, 477 Mass. 188 (Mass. 2017) --The Massachusetts Supreme Judicial Court considered two cases with similar circumstances, where appellants were determined to be ineligible for Medicaid long-term care benefits because the value of their residence was a countable asset despite its transfer to a trust. Medicaid long-term care benefits are paid to eligible beneficiaries who have less than $2,000 in countable assets; for this reason, many people begin to spend down their assets or place them in trusts in anticipation of long-term care needs. In this case, both the Nadeau and Daley trusts consolidated all assets, but reserved use of a residence for the lifetime of the grantors. Under Federal law 42 U.S.C. § 1396p(d)(3), if a beneficiary may receive payment from the principal of a trust under any circumstance, the value of that trust shall be considered an asset. If a beneficiary receives payment only from the income of a trust, however, the trust itself is not considered a countable asset. The Federal Health Care Finance administration (HCFA) has interpreted payments from principal to include "noncash property disbursements, such as the right to use and occupy real property." The Court agreed with this interpretation, but held that the state Medicaid program, MassHealth, had misconstrued its meaning and application in these cases. When a home is transferred to a trust, like any other asset it adds to the corpus of the trust. However, in neither of the present cases did the use of the residence constitute payment from the corpus, or principal, of the trust – rather, they were payment from *income* of the trust. The Nadeau trust held ownership of the residence in fee simple, and through continued use of the house the couple received the equivalent of a rental value, or income that would be received from an asset of the trust, but not a payment from the trust itself. The Daley trust did not own the residence in fee simple, but instead the Daley family retained a life estate deed in the home. While such an interest conferred more control to the Daleys than simple use or rental, the life

estate they possessed was an interest not owned by the trust and thus was not considered payment from the corpus. The Court vacated both judgments on the grounds that the residences should not have been counted as assets, but remanded for the lower court to consider additional potential assets.

Purchase of a Life Insurance Policy Using All of Beneficiary's Remaining Assets Was a Non-allowable Transfer Made At Below Market Value -- **Moore v. State Department of Human Services,** 74 N.E.3d 1173, 2017 Ill. App (4th) 160414 (2017) --Decedent, Elda Buckley, resided in a long-term care facility prior to her death. In late 2011, she applied through a personal representative to receive Illinois state Medicaid benefits. On the same day, she purchased a life insurance policy that included a rider payable to the executrix of her estate, Christine Moore. State Medicaid law, section 5-2.1 of the Code (305 ILCS 5/5-2.1 (West 2010)) prohibits a person seeking Medicaid from making "a voluntary or involuntary assignment or transfer of any legal or equitable interests in real property or in personal property, whether vested, contingent or inchoate, for less than fair market value." Prior to purchasing the insurance policy, Buckley had $15,000 in cash assets available to use toward her long-term care, but used those funds to buy an insurance policy that benefited executrix. Social Security Act § 1917, 42 U.S.C.A. § 1396p; 305 Ill. Comp. Stat. Ann. § 5/5-2.1; Ill. Admin. Code tit. 89, §§ 120.388(f)(1), 120.388(f)(2). The Circuit Court held that the purchase of the life insurance policy occurred at below fair market value and constituted a nonallowable transfer. The Appellate Court agreed. Because Buckley did not receive the benefit of this policy, the Departments properly deemed this transaction as one procured for less than fair market value.

Life Estate Was Improperly Valued and Its Sale Thus Constituted a Non-allowable Transfer -- **Stutz v. Ohio Department of Job and Family Services**, --- N.E.3d ----, 2017 -Ohio- 7287 (Ohio Ct. App. 3d. 2017) --Medicaid recipient used incorrect calculation method to determine the fair market value of a life estate transferred to her sons and failed to rebut the presumption of an improper transfer. The life estate was therefore properly valued as an asset for Medicaid calculations. The Appellant owned a life estate that she claimed was appraised at $2000, and sold the interest to her sons for $1800. The Ohio Department of Job and Family Services (Agency) determined that the actual value of the interest was nearly $25,000, based upon a specific statutory process established in the Ohio Administrative Code for determining the value of a life estate, Ohio Adm. Code 5160:1–3–05.17. Appellant instead used a general definition of fair market value (Ohio Adm. Code 5160:1–3–05.1(B)(4)) – in direct contravention of the well-settled principle of statutory construction that a specific statute prevails over a general statute, when applicable.

State Improperly Refused Eligibility for Medicaid Benefits After Approving Benefit Extension and Then Changing Eligibility Window Without Notice to Beneficiary -- **Godaire v. Department of Social Services, 165 A.3d 1257, 174 Conn. App. 385** (Conn. App. Ct. 2017) -- Recipient of medical assistance for dental work challenged Department of Social Services' (DSS) determination of ineligibility; the Court held that the substantial rights of the plaintiff had been violated, and the DSS decision was based on unlawful procedure. Plaintiff was eligible for dental benefits by an extension of prior coverage through February 2015, and for a subsequent period from March through August 2015, subject to a spend-down requirement. His claim for services received in February was later denied, after the eligibility period was changed to begin in April 2015. DSS acknowledged, and the record showed, that the Plaintiff had been given notice of

eligibility for the time period in which he sought care. DSS claimed this was an "incorrect" extension and should have been "corrected," but the Plaintiff was never notified. (Plaintiff also alleged that this case transfer from one judicial district to another denied him access to the courts, but the Court held this was permissible under statue and did not deprive Plaintiff of access.)

Under Federal Law a Person Over 65 May Participate in a Pooled Special Needs Trust, and Such a Trust Is Not Countable as an Asset for Determining Medicaid Eligibility -- **Hutson v. Mosier**, 54 Kan. App. 2d 679, 401 P.3d 673 (Kan. Ct. App. 2017) -- Appellant challenged a transfer penalty that delayed her Medicaid application and thereby her access to long-term care. She transferred assets to a pooled supplemental needs trust while residing in a nursing home, and over the age of 65; Kansas Department for Children and Families (DCF) determined that the transfer was subject to penalty. The Court held that it was not, as under Federal Medicaid law a person over 65 may participate in a pooled special needs trust, and such a trust is not countable as an asset for determining Medicaid eligibility. The transaction would only be subject to a transfer penalty if the applicant did not receive fair market value; here, there was insufficient evidence to show whether or not Appellant received fair market value for a trust that was pooled with other small funds and would provide for her own care and the care of others if funds remained after her death. The Court remanded to an Administrative hearing for factual determination on that question.

See also: **Hegadorn v. Department of Human Services Director,** --- N.W.2d ----, 320 Mich.App. 549 (Mich. Ct. App. 2017) --In three consolidated cases, assets placed in "solely for the benefit of" (SBO) trusts were countable when determining eligibility for Medicaid long term care benefits. Each of the three recipients had a spouse who established an SBO trust within months of the beginning of care. Because such a trust "requires that the assets be distributed back to the beneficiary community spouse during his/her lifetime . . . , there is a condition under which the principal could be paid to or on behalf of the person, which makes the assets countable."

V. FEDERAL FINANCIAL PARTICIPATION

Court Holds That DAB's Dismissal of State's Appeal From A Disallowance As Untimely Is "Final Decision" Subject To Judicial Review -- **Delaware State Department of Health and Social Services v. United States Department of Health and Human Services**, 272 F. Supp. 3d 103 (D. D.C. Aug. 8, 2017) – CMS notified Delaware of a Medicaid disallowance of $10,082,769 representing the federal share of recoveries from legally obligated third parties that CMS had determined (based on OIG audits) had not been separately credited to CMS on the State's quarterly expenditure reports. (OIG had determined that Delaware had not furnished support for its assertion that, due to computer problems that made the State unable to track third party payments separately from other collections, it had manually netted such third party payments against expenditures and reported only the net expenditures). Delaware filed a request for reconsideration shortly after the 60 day deadline for doing so under 42 U.S.C. 1316(e), and CMS rejected this request as untimely approximately one year later. Within 60 days of CMS's rejection, Delaware filed an appeal with the Departmental Appeals Board, but the Board Chair dismissed the appeal on the ground that it had been filed well past the 60 day time frame for direct appeals to the Board required by Section 1316, and denied the State's simultaneous request for an extension. The district court held that the Chair's dismissal represented a "final

decision" for purposes of judicial review under Section 1316(e), and rejected HHS's argument that the Chair's action was not a decision of "the Board." The district court also found that the availability of subject matter jurisdiction under Section 1316(e) did not depend upon whether Delaware had timely filed its request for reconsideration or appeal to the Board. The court next held that Delaware had plausibly claimed that the Char's rejection of its appeal as untimely was arbitrary and capricious because CMS had erroneously determined that the 60 day time frame for seeking reconsideration was jurisdictional and that it lacked authority to grant an extension, the Chair had failed to recognize that once the State had elected to seek reconsideration it was required to complete or withdraw from the process before seeking Board review, and the Chair had therefore erroneously determined that Delaware had filed its appeal to the Board over one year late. The court also rejected HHS's argument that Delaware did not have a cognizable claim because it had not exhausted administrative remedies. The court relied on D.C. Circuit decisions finding jurisdiction to review final decisions of the Medicare Provider Reimbursement Review Board dismissing provider appeals for untimeliness. Finally, the court dismissed Delaware's common law claims for unjust enrichment and for money had and received.

Disallowance of State Claims for Administrative Costs of County Agencies Based on Lack of Cost Allocation Plan -- **Pennsylvania Department of Human Services**, DAB Decision No. 2835 (Nov. 30, 2017) – CMS disallowed $26.1 million in federal financial participation for claimed Medicaid-allocable expenditures in 2012-2013 by county mental health agencies operating waiver programs that provided home and community-based services to severely intellectually disabled recipients. During the period at issue, the State's approved Public Assistance Cost Allocation Plan (PACAP) did not address the role of the county agencies in administering waiver programs or set forth the method by which their costs would be allocated to Medicaid. Affirming the disallowance, the Departmental Appeals Board rejected the State's argument that the PACAP was not required to address allocation of county-level costs because its Medicaid program was state-administered. The DAB also determined that apart from the PACAP, Pennsylvania had not demonstrated that any methodology (such as county allocation plans) was in place to allocate county administrative costs. The DAB rejected the State's argument that the general statement in its PACAP that costs of another governmental agency will be supported by a written agreement that specifies the services being purchased, the basis for billing, and a stipulation that billing will be based upon costs incurred, together with its preprinted agreements with the county agencies , sufficed. The DAB noted that in addition to having conforming agreements with outside agencies, the regulations (45 C.F.R. 95.507(b)) required that the State PACAP itself describe the activities performed by the county agencies and the procedures used to identify, measure, and allocate costs to benefitting programs, and include the county cost allocation plans. The DAB also found that the State's form agreements with the county in any event were merely open-ended arrangements delegating operation of the waiver to the counties with quarterly advance payments from the State and a State option to review such advance payments against actual expenditures, and did not reflect discrete purchase agreements for predefined quantities of services that set forth a specified basis for determining billing that would ensure only services benefitting Medicaid were billed. The DAB also rejected the State's argument that CMS's prior knowledge of the counties' participation in the waiver precluded the disallowance. The DAB further determined that having claimed the costs at issue as State administrative costs, Pennsylvania could not assert that some of those costs were for direct case management services to justify omitting them from its PACAP. Finally, the DAB rejected the State's request for a hearing to determine whether CMS previously had interpreted the cost

allocation requirements so as to not mandate provision of information regarding allocation of local government costs to Medicaid, and rejected the State's request for a remand to CMS to amend its PACAP retroactively.

Disallowance of Allocated State School-Based Administration Costs Based on OIG Audit of Random Moment Sampling Determinations -- **Arizona Health Care Cost Containment System**, DAB Decision No. 2824 (Oct. 2, 2017) – The Departmental Appeals Board affirmed a disallowance of $11.7 million in claimed federal financial participation under Medicaid for school-based administration costs in 2004-2008 associated with furnishing health services to Medicaid-eligible children under the Individual with Disabilities Education Act. OIG determined that Arizona's use of a random moment time study to allocate school-based administrative costs to Medicaid (under which a selected sample of school employees are surveyed at randomly selected workday moments to report time spent on Medicaid and non-Medicaid activities) did not support $11.7 million of its claims. Based on the OIG audit, CMS disallowed $5.4 million in FFP because for two of the quarters involved, the State did not submit data files to support the universes of total available moments and participants or the sample of random moments for selected participants, and therefore OIG could not verify whether the actual observation forms were for the sample items selected. The DAB rejected the State's argument that it was not required to have retained these documents at the time of the OIG audit. The DAB determined that based on the FFP claiming period of two years from when expenditures are made (and the State's failure to assert that it had filed claims earlier than that timeframe) and the requirement to retain documentation for three years from a final expenditure report, the State's obligation to retain documents extended past the start of the OIG audit. The DAB disagreed that disallowance of the total FFP claimed for these two quarters (as opposed to an amount proportional to the percentage of FFP disallowed for other quarters for which the State did have documentation but FFP was disallowed for other reasons) was a disproportionate punitive sanction. Based on the OIG audit, CMS disallowed $6.3 million for the other quarters in the audit period. OIG determined that in calculating the statewide Medicaid percentages, the State had discarded sample items that either reflected non-responses by the selected employees or responses that were incomplete or had inaccurate information (e.g., no activity codes or description, no signature or date, completed by someone other than the selected participant), and therefore should have been but were not coded as non-Medicaid activities in the absence of a valid, approved alternate methodology to address non-responses. The DAB affirmed, finding that CMS's 2003 Guide, reasonably read, provided that absent a valid alternate methodology non-responses should not be discarded, and that the evidence suggested that Arizona and its contactor had acknowledged this interpretation. The DAB also noted that CMS had never approved the alternate methodology set forth in the State's 2004 plan (which essentially sought approval to deviate from the general rule of including all responses) and that the State had not demonstrated that it had excluded non-responses during the audit period in accordance with a later 2010 CMS-approved plan that set forth a different alternative methodology allowing non-responses to be excluded if the return rate was at least 85%.

Disallowance of Allocated State Administration Costs Based on OIG Audit of Random Moment Sampling Determinations -- **Florida Agency for Health Care Administration**, DAB Decision No. 2808 (July 27, 2017) – Florida appealed a disallowance of $1.8 million in federal financial participation in claimed administration costs incurred by its State disability agency in operating home and community-based waiver services programs. The disallowance was based on an OIG

audit of "random moment sampling" (RMS) forms completed by agency employees and used to estimate the percentage of total employee time devoted to Medicaid activities (and then multiplying that percentage by total pooled administrative costs), in accordance with the State's Cost Allocation Plan. Based on a review of a sample of RMS forms that identified areas of noncompliance with CAP instructions (e.g., undated activity coding changes, completion of form by employee other than that selected to be part of the sample, failure to enter time or date of signature, random moment outside of core hours, date or time of entry did not match randomly selected sample moment), OIG concluded that the Medicaid observation percentages used by Florida to calculate claimed administration costs were overstated. The DAB reviewed the individual OIG error determinations challenged by Florida, and determined that 35 of the 37 disputed error determinations were correct and remanded to CMS to recalculate the disallowance. The DAB rejected Florida's argument that errors identified by OIG were minor or technical. The DAB observed that CAP instructions existed to ensure that activities documented on the RMS form were adequately reported, related to the selected random moments and not to other moments that might skew the sample results, and correctly coded as Medicaid-reimbursable or not: for example, initialing a correction to an activity code on the RMS form ensured that the corrected activity was entered by the employee selected for the sample and not someone lacking personal knowledge, dating the correction would assure that the employee made the correction at a point where he could accurately recall what had happened in the selected moment, and entering the date and time of the observation verified that it occurred at the pre-designated randomly selected moment. Noting that even slight variations in Medicaid observation percentages in the RMS sample could shift substantial amounts among federal and state programs, the Board concluded that CMS could insist on strict compliance with CAP requirements for the RMS process to ensure that the federal government bears only its allocable share of State agency administration costs.

Disallowance of State Claim For 100% Federal Financial Participation in Post-January 1, 2014 Payments for Services for Pre-ACA Childless Low Income Adults Under Demonstration Project -- **New Jersey Department of Human Services**, DAB Decision No. 2780 (March 31, 2017) – New Jersey claimed 100% federal financial participation for those Medicaid services furnished prior to January 1, 2014 under a demonstration project for childless low income adults under 65, but for which the State made expenditures after January 1, 2014 (the effective date of the ACA's expansion of Medicaid to include this group at a 100% FFP rate). The DAB upheld CMS's disallowance of this claim in excess of the State's regular, pre-ACA FFP rate. The Board determined that CMS had reasonably interpreted the Act and regulations as providing the increased FFP rate of 100% for calendar quarters beginning in 2014 only for the costs of services furnished on or after January 1, 2014 to newly eligible childless adults under 65. The Board observed that when a statute or regulation does not address the precise question at issue, it will defer to the agency's interpretation so long as it is reasonable, the nonfederal party had actual and timely notice of that interpretation (taking into account, among other things, whether the agency's interpretation predates a disallowance or represents a position first articulated in litigation that the agency seeks to apply retroactively), and the nonfederal party had not relied to its detriment on another reasonable interpretation. The DAB rejected New Jersey's reliance on the phrase "amounts expended by such State" in the statutory and regulatory provisions establishing the 100% federal match (42 U.S.C. 1396d(y) and 42 C.F.R. 433.10(c)(6)(i) as conditioning the enhanced match solely on when the expenditures were made and not when the services are provided. The Board determined that under those provisions the enhanced FFP

applied "with respect to" the "newly eligible individuals" described in 42 U.S.C. 1396a(a)(10)(A)(i)(VIII) (and 42 C.F.R. 435.119) as individuals "beginning January 1, 2014" who are childless adults under 65 not otherwise eligible under the State plan. The Board therefore concluded that CMS reasonably interpreted the statute to conclude that because this group did not exist until January 1, 2014, only expenditures for services furnished on or after that date to those individuals are eligible for the enhanced FFP. The Board further determined that although 42 U.S.C. 1396a(k)(2) gave States the option prior to January 2014 to extend coverage to individuals who would be described in Section 1396a(a)(10)(A)(i)(VIII) "if that subclause were effective before January 1, 2014," those individuals were therefore not covered as newly eligible individuals under Section 1396a(a)(10)(A)(i)(VIII) for whom services were matched at the 100% FFP rate. The DAB further concluded that CMS's interpretation was consistent with an April 2010 State Medicaid Director Letter which similarly stated that the enhanced FFP was available "only for individuals enrolled in the new adult group." The DAB found that the terms and conditions of the pre-2014 demonstration project reflected that the low income adults enrolled in the demonstration were not considered as within the ACA Medicaid expansion and that federal funding for the demonstration would be provided at the regular matching rate. The Board also rejected New Jersey's argument that the general FFP provisions of 42 U.S.C. 1396b(a)(1) as well as prior DAB decisions tied federal payment to the FFP rate in effect when expenditures were made; the DAB concluded that the ACA tied increased FFP to different periods of services furnished to the expansion population.

Disallowance of FFP in Payments to Contractor for Training Nursing Facility Staff -- **Pennsylvania v. United States Department of Health and Human Services**, 2017 U.S. Dist. LEXIS 35255, 2017 WL 959172 (M.D. Penn. March 13, 2017) -- Pennsylvania claimed, as Medicaid administrative costs, payments it made over a 15 year period to a contractor that provided training to nursing facilities on reducing the use of restraints (as part of a CMS-approved restraint reduction initiative). CMS disallowed $3,001,056 in FFP on the ground that the costs were not necessary for the proper and efficient administration of the Medicaid program, as required of Medicaid administrative costs by applicable law and cost principles. CMS cited a 1994 letter to State Medicaid Directors providing that claims for Medicaid administrative costs may not include the overhead costs of operating a provider facility (such as the supervision and training of provider staff), cannot be an integral part or extension of direct medical services, and may not include the costs of medical assistance services that providers furnish to Medicaid recipients. CMS determined that the contract costs were not an activity of the State in administering its Medicaid plan, but constituted costs related to facility responsibilities in providing services (a component of direct medical assistance), since the training was intended to support and augment the in-service training for nursing facilities and to enhance the quality of service delivery at nursing facilities. The DAB, in upholding the disallowance in 2015 (Decision 2361), noted that even prior to the 1994 SMDL, its decisions had rejected claims that the costs of State training of provider staff were allowable administrative costs. The DAB also held the fact that the contract costs could not be reimbursed through the rate-setting process (since the facilities themselves did not incur such costs and instead the State funded the training) did not convert the costs into costs of administering the State plan. In affirming the DAB's decision, the district court accorded Skidmore deference to the 1994 SMDL, finding that the Medicaid statute (at 42 U.S.C. 1396b(a)(7) did not define what constitutes "necessary" costs expended in the "administration" of the State plan and instead delegated this determination to the Secretary. The

district court further determined that the SMDL's distinction between claimable costs that enhanced administration (e.g., outreach, intake, eligibility determinations, information systems development) and non-claimable costs which enhanced the quality of care (such as provider training) was reasonable. The court rejected the State's argument that the disallowance arbitrarily denied FFP in costs that would have been reimbursable if incurred by providers and paid through the rate-setting mechanism. Instead, the court determined that the DAB had properly explained that reimbursing provider training costs through rate-setting alone was necessary to assure that the State met its responsibility to determine whether rates are reasonable and adequate as well as to prevent duplicate program payments for the same activities. Finally, the court rejected the State's arguments that the DAB had improperly denied its discovery request for documents relating to FFP in the training initiative (because the request was non-specific and speculative, and would not have changed the fact that the State structured the program in a manner that precluded reimbursement) and that the Grants Administration Manual limited the disallowance to the three year record retention period (because the Manual did not have the force of law and the disallowance was based on the State's own records).

VI. THIRD PARTY LIABILITY AND RECOVERY

A. Federal Cases

Challenge to State Allocation of Fixed Percentage of Beneficiary's Tort Recovery to Medical Expenses -- **Gallardo v. Dudek**, 263 F. Supp. 3d 1247 (N.D. Fla. April 18, 2017), and 2017 U.S. Dist. LEXIS 112448, 2017 WL 3081816 (N.D. Fla. July 18, 2017) – Parents of an injured Medicaid beneficiary challenged Florida's assertion of a Medicaid lien for $323,508 (out of total Medicaid payments of $862,000) against the settlement of a personal injury action for $800,000, representing a 4% recovery of damages (for past and future medical expenses, lost earnings, parents' loss of consortium, and other damages) valued at $20 million. The parents claimed that State law violated the Medicaid statute by (1) allowing satisfaction of the Medicaid lien from third party payments for both past and future medical costs), (2) establishing a formula for State recovery of the lesser of the amount actually paid by Medicaid or 50% of the judgment or recovery remaining after a 25% reduction for attorneys' fees (i.e., up to 37.5% of the beneficiary's recovery from a third party), and (3) allowing rebuttal of this allocation only through a showing by clear and convincing evidence in an administrative proceeding that the allocation exceeds the portion of the recovery that represents compensation for medical expenses. The district court first held that the third party liability provisions of 42 U.S.C. 1396a(a)(25)(H) – stating that "to the extent payment has been made … for medical assistance," the State may assert a lien on "payment by any other party for such health care items or services" – prohibited the State from seeking reimbursement of past medical expenses from portions of a beneficiary's recovery representing future medical expenses. The district court also held that Florida's flat allocation of up to half a beneficiary's recovery (after 25% for attorneys' fees) to medical expenses, subject to rebuttal only by clear and convincing evidence, created a "quasi-irrebuttable" presumption that violated the Medicaid statute, as interpreted by the Supreme Court in Ahlborn and Wos. The court concluded that Florida had presented no evidence, as required by Wos, that its administrative criteria for allocating medical and nonmedical expenses yielded reasonable results in the mine run of cases. **Note:** Pub. L. 113-6, Section 202(b), amended Section 1912(a)(1)(A)of the Medicaid statute by replacing assignments of rights to "payment for medical care from any third party" with assignments of rights to "any payment from a third party

that has a legal liability to pay for care and services under the plan"; the original effective date of October 1, 2014 was moved to October 1, 2017 (Pub. L. 113-93, Section 211 (2014); Pub. L. 114-10, Section 220 (2015)).

State Claim for Payment of Medical Insurance Benefits in Interpleader Action -- **United States Life Insurance Company v. Holtzman**, 2018 WL 566324 (3rd Cir. Jan. 26, 2018) – An insurance company filed an interpleader action against the New Jersey Medicaid agency and the insured of a policy providing indemnification for the cost of care in a nursing facility that had been paid by Medicaid. The Court of Appeals held that the Medicaid agency was entitled to the disputed insurance proceeds under the third party liability provisions of 42 U.S.C. 1396a(a)(25) as well as implementing New Jersey law, which required the insured, as a condition of Medicaid eligibility, to assign to the State any rights to payment from a liable third party. The court determined that any provisions in the policy making Medicaid the primary payer or establishing a contractual obligation to pay the insured for nursing facility expenses yielded to the subrogation rights accorded to the State under federal and state law, thereby protecting the public fisc and preventing the beneficiary from reaping an unintended windfall.

Challenge to Medicaid Plan's Assertion of Subrogation Rights -- **Vestal v. First Recovery Group, LLC**, 2018 U.S. Dist. LEXIS 22169 (M.D. Fla. Feb. 12, 2018) -- Plaintiff, a Medicaid beneficiary, brought a State court action against First Recovery Group, an entity retained by a Medicaid plan to represent the plan in connection with its subrogation rights. Plaintiff contested the amount of the lien asserted by FRG in connection with plaintiff's settlement of a medical malpractice suit. FRG removed the action to federal court on the basis of diversity, and moved to dismiss based on plaintiff's failure to exhaust state administrative remedies in contesting the lien. The district court determined that Florida's administrative procedure for contesting the State's formula-based allocation of personal injury recoveries, enacted following the Supreme Court's decision in *Wos v. E.M.A.*, applied to plaintiff because her medical malpractice settlement was approved (thereby vesting the Medicaid plan's recovery rights) subsequent to enactment of the administrative procedure. The court held that plaintiff was not required to exhaust administrative remedies because she was not contesting the calculation of the lien but was collaterally attacking the lien on the ground that she had relied on FRG's earlier assertion of a smaller lien amount in settling her malpractice suit. However, the court dismissed plaintiff's action on the ground that FRG was an improper defendant since the right of repayment belonged to the Medicaid plan and FRG had no legal claim to the funds subject to the plan's lien.

Court Finds Medicaid Payments Are Not A Collateral Source in Civil Rights Action Notwithstanding County Contributions Supporting Supplemental Medicaid Payments -- **Felts v. Board of County Commissioners**, 2017 U.S. Dist. LEXIS 119616, 2017 WL 3267742 (D. N.M. July 31, 2017) – In a suit by an individual under 42 U.S.C. 1983 against the county for damages resulting from the use of excessive force during an arrest, the district court held that Medicaid payments represented a "collateral source" that could not be used to reduce the county's liability. The court rejected the county's argument that Medicaid payments were not distinct from the county's funds (and hence could not be treated as a "collateral source") because the county contributed 1/16 of 1% of its taxes on gross receipts to a county Medicaid fund that supported supplemental payments for primary care services. The court concluded that since the State contributed the full non-federal share of 30% for regular Medicaid payments, it could not be said that the Medicaid payments made on behalf of plaintiff were attributable to the county. The court

also rejected the county's argument that plaintiff's damages could not include portions of billed charges not paid by Medicaid.

Collateral Source Rule Not Applicable To Seaman's Recovery Against Vessel In Jones Act Suit -- **Terrebone v. B& J Martin**, 2017 U.S. Dist. LEXIS 40058, 2017 WL 1073801 (E.D. La. March 20, 2017) – In a seaman's Jones Act suit against his vessel for the reasonable cost of medical care, the district court held that the vessel could avoid liability to the extent that medical bills had been paid by Medicaid. The court noted that historically, a vessel's "cure" obligation had been satisfied by the free medical care previously provided to seamen through Public Health Service hospitals and that courts had held that Medicaid was the functional equivalent of that free treatment.

B. State Cases: State Liens on Tort Recoveries

Medicaid Lien Properly Imposed on Bad Faith Damages From Settlement, but State Cannot Recover Reimbursement From Funds Allocated for Future Medical Expenses -- **Willoughby v. Agency for Health Care Administration**, 212 So.3d 516 (Fla. 2d DCA 2017) -- Florida Medicaid beneficiary challenged the amount available to satisfy a lien imposed by the Agency for Health Care Administration (AHCA), the state Medicaid agency. The beneficiary was involved in an automobile accident, and the AHCA paid approximately $148,000 in medical expenses resulting from the accident. When the beneficiary received a settlement of approximately $4.2 million dollars from the insurance companies involved, the AHCA filed a lien to recover the amount paid, pursuant to state and federal law. The beneficiary petitioned to have this amount reduced, but the ALJ denied the request and the beneficiary appealed. First, he argued that the majority of the settlement constituted bad faith damages, which should not be subject to the lien; the Court disagreed. While the amount paid exceeded the automobile insurance policy cap, the court held that the entire settlement was provided to the beneficiary as a result of injuries sustained in the automobile accident, and thus under Florida law was an allowable source from which AHCA could seek reimbursement. Second, the beneficiary argued that the AHCA could only recover from settlement funds specifically allocable to *past* medical expenses. The Court agreed. Under federal law, a Medicaid program may not impose a lien on settlement amounts beyond those provided as payments for medical care. The AHCA argued that this amount should include funds allocated for both past and future medical care – in this case, an estimated amount of over $5 million. However, the parties stipulated that, among other things, the $4.2 million settlement did not make the beneficiary whole and would not cover future medical expenses or other losses; and that the settlement recovery included less than $148,000 for past medical expenses. Under the United States Supreme Court's reasoning in *Arkansas Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268, 126 S.Ct. 1752, 164 L.Ed.2d 459 (2006) and *Wos v. EMA*, 568 U.S. 627, 133 S.Ct. 1391, 185 L.Ed.2d 471 (2013), the Court concluded that the AHCA could not, in fact, recover reimbursement from funds allocated for future medical expenses. Medicaid anti-lien provisions prohibit recovery from any funds not specified for medical *payments*, and anticipated future medical expenses cannot be considered payments. This decision directly contradicts an opinion out of Florida's First District Court, and the Court here certified conflict with *Giraldo v. Agency for Health Care Administration*, 208 So.3d 244 (Fla. 1st DCA 2016).

Michigan Law Allowing Medicaid Recovery of the Full Cost of Services Provided Without Exception Was Preempted by Federal Law -- **Neal v. Detroit Receiving Hospital**, 319

Mich.App. 557 (Mich. Ct. App. 2017) -- The Court found that a Michigan state Medicaid law was partially preempted by federal law, based on the precedent set by the United States Supreme Court in *Arkansas Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268, 126 S.Ct. 1752, 164 L.Ed.2d 459 (2006). Plaintiff, a Michigan Medicaid beneficiary, filed a medical malpractice action that resulted in a confidential settlement agreement. The settlement agreement included $26,775 allocated to medical expenses. Meridian Health Plan, a Michigan Medicaid plan, sought to recover from this settlement the full amount of $110, 283.19 for medical expenses paid. The trial court entered an order requiring plaintiff to pay the full amount, based on state law MCL 400.106(5) allowing the state to impose a Medicaid lien to "recover the full cost of expenses paid" unless the state explicitly agreed to accept a lesser amount. The Court held this was inconsistent with federal anti-lien provision 42 U.S.C. 1396p(a)(1) restricting recovery to only the parts of a settlement designated as payments for medical expenses. The state is not permitted to recover medical expenses from the property of a beneficiary, and a settlement amount not designated for medical expenses is the property of such a beneficiary. The Michigan law was preempted to the extent that it allowed for broad recovery of all amounts paid by a Medicaid plan, without restrictions. However, the plaintiff improperly negotiated her settlement to include such a low proportion of funds designated for medical expenses, without judicial oversight of the agreement and without the state's involvement. The case was remanded to trial court for evaluation of the settlement agreement and final determination of the amount owed to Meridian Health Plan.

Supreme Court of New York Appellate Division Holds that Ahlborn Proportional Calculation Method was Suggested But Not Required Method for Determining Medicaid Lien Recovery -- **D.J. v. 636 Holding Corp.**, 154 A.D.3d 453 (N. Y. App. Div. 2017) --Minor plaintiff and his mother sued the owners of an apartment complex for negligently failing to keep the premises safe, where the minor was shot and sustained serious injuries. The suit resulted in a settlement of $4.35 million, and the City of New York Social Services (DSS) imposed a Medicaid lien to recover $250,070 in medical expenses paid on plaintiff's behalf. The Court here found that the Supreme Court had properly denied plaintiff's motions to vacate or reduce the lien and upheld the order that DSS be reimbursed for the full amount. Plaintiff argued that the entire settlement was paid for pain and suffering, and that no amount was allocated for medical expenses. The Court found this argument unpersuasive, as the settling party had disregarded DSS' requests for involvement in the settlement process, and their significant advance notice of the lien. Alternatively, plaintiff argued that the lien should be reduced to an amount proportional to the settlement amount, which was approximately 17% of the total claimed damages of $25 million. This formula was applied by the United States Supreme Court in *Arkansas Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268, 126 S.Ct. 1752, 164 L.Ed.2d 459 (2006), but the Court here found that this calculation method did not apply in the present case. While the U.S. Supreme Court found the allocation method used in *Ahlborn* to be acceptable, they did not prescribe this as the only allocation method available. Furthermore, in *Ahlborn* the parties agreed to this calculation method and specified that the lien could be reduced proportionally; here, the parties made no such stipulation. On this Court's reading, "in *Ahlborn* and later in *Wos,* the Court merely made clear that where the amount of a lump sum settlement attributable to medical expenses was not established by a verdict or by a stipulation binding on all parties, a judicial resolution of the issue was required (*Wos* at 638, 133 S.Ct. 1391; *Ahlborn* at 288, 126 S.Ct. 1752)." *D.J.*, 154 A.D.3d 453, 456.

- *But see* **Martinez v. Department of Health Care Services**, Not Reported in Cal.Rptr.3d (Cal. Ct. App. 2017) -- A medical malpractice case settled for $150,000, approximately 45% of the actual value of the case, with no funds designated for medical expenses. The Court applied the *Ahlborn* proportional calculation to conclude that the appropriate amount DHCS could recover was 45% of the Medi-Cal lien.

C. State Cases: Estate Recovery

Supreme Court of Michigan Held That Michigan Medicaid Estate Recovery Program Was Properly Noticed and Used a Permissible Retroactive Effective Date -- **In re Estate of Rasmer**, 903 N.W.2d 800, 501 Mich. 18 (Mich. 2017) -- Appeals filed on behalf of four estates claimed that the Michigan Medicaid estate recovery program (MMERP) could not recover benefits paid to deceased beneficiaries during their lifetimes, based upon allegations of insufficient notice and improper retroactivity of new policy. Appellants argued that since the MMERP was approved by CMS and implemented by the state years after the dates decedents began receiving Medicaid benefits, proper notice was not given because the beneficiaries should have been given written notice at the time of enrollment. The Supreme Court of Michigan held that the Department of Health and Human Services (DHHS) was not required to give individualized notice of the program, and that notice was properly given in writing as part of a periodic redetermination process. Indeed, DHHS could not have been expected to give notice in 2008 of a final program that was not approved by CMS until 2011, as required by federal Medicaid law. Allegations of due process violation were similarly rejected, based on the sufficiency of notice and the parties' ability to appeal the determinations through the courts. The estates alternatively argued that the MMERP was barred from recovery because of an impermissible effective date, retroactive one year from the date of program approval. The Court rejected this argument as well, holding that the state violated no statutory provision in implementing the MMERP program after approval from CMS, including imposition of a retroactive effective date. Thus, DHHS was not statutorily barred from recovering from these estates.

State May Recover for "Medical Assistance" Paid, Including "Nonmedical" Expenses Such As Room and Board -- **In re Estate of Vollmann**, 896 N.W.2d 576, 296 Neb. 659 (Neb. 2017) – The Nebraska Department of Health and Human Services (DHHS) sought to recover from an estate funds for "medical assistance" paid. Neb. Rev. St. § 68-919 allows that DHHS may recover from an estate the full amount paid for medical assistance services on behalf of the deceased; estate argued that room and board and other "nonmedical" services provided at a nursing facility were not recoverable as medical assistance. Turning to state and federal statute and regulation for interpretation, the Court held that Nebraska statute is unambiguous in its intent that reimbursable medical assistance include various nonmedical expenses that must be provided by a nursing home coincident with care. While the recovery in this case was almost the entirety of the estate, no undue hardship resulted.

VII. PROVIDER PARTICIPATION

A. Termination of Planned Parenthood Providers

Challenge to Termination of Planned Parenthood Provider -- **Planned Parenthood of Kansas and Mid-Missouri v. Andersen**, 2018 U.S. App. LEXIS 4102, 2018 WL 991502 (10th Cir. Feb. 21, 2018) -- Kansas terminated the Medicaid provider agreements of two Planned Parenthood affiliate clinics, citing alleged video evidence of purported practices of Planned Parenthood of America and other Planned Parenthood affiliates relating to unlawful agreements to sell fetal tissues and the alleged failure of one of the plaintiffs to cooperate in solid waste disposal inspections. Kansas also cited claims submissions concerns about other Planned Parenthood affiliates identified by neighboring States. The providers, along with three "Jane Doe" patients, sought injunctive relief, raising claims under the Medicaid "freedom of choice" provisions (42 U.S.C. 1396a(a)(23)) and the Equal Protection Clause.

- Standing: The Court of Appeals rejected the State's argument that because of the availability of State administrative and judicial review, plaintiffs lacked standing and the case was not ripe for review. The Court also rejected the State's contention that it should abstain under Younger, finding that administrative proceedings available to the providers were not coercive civil enforcement proceedings and that the individual plaintiffs were not subject to an exhaustion requirement.
- Private Right of Action: The court further held that the "freedom of choice" provisions provided the individual plaintiff with a private right of action under 42 U.S.C. 1983 (joining the 5th, 6th, 7th, and 9th Circuits, and splitting with the 8th Circuit). The Court distinguished the Supreme Court's decision in Armstrong as involving the separate payment provisions of 42 U.S.C. 1396a(a)(30)(A), and noted that only a plurality in Armstrong held that the Medicaid Act itself did not provide a cause of action. The Court also concluded that unlike the payment provisions that the Supreme Court in Armstrong found to contain broad "judgment-laden" standards that are difficult to judicially administer, the criterion in Section 1396a(a)(23) that a provider be "qualified to perform the service or services required" was fully capable of judicial assessment. The Court further rejected the State's argument (and the Eighth Circuit's holding in Gillespie) that Armstrong established Congress had foreclosed private enforcement by providing a remedy of federal withholding of Medicaid funds in the event of State noncompliance. The Court concluded that Armstrong had not repudiated the Supreme Court's holding in Wilder that the administrative power to withhold federal funding foreclosed private party reliance on 42 U.S.C. 1983 to vindicate federal rights, and further noted that the withholding of federal funding would not redress the individual plaintiffs' claims of violations of their rights to receive care form their chosen providers.
- Merits: The Court held that the term "qualified" related solely to the fitness and competency of a provider to furnish services, and that a State could not defeat a beneficiary's right to select a "qualified" provider by terminating its agreement with that provider on a basis unrelated to the provider's competence or the quality of care it furnishes. The Court reasoned that if a State could wrongfully terminate a qualified provider without any challenge by affected patients, the patients' freedom of choice rights would be eviscerated. The Court held that the State's authority under 42 U.S.C. 1396a(p)(1) to terminate providers for any reason upon which the Secretary could take

similar action was cabined by the right conferred on patients by 42 U.S.C. 1396a(a)(23) to challenge erroneous termination decisions that wrongfully deprive them of their rights of access to qualified and willing providers. The Court distinguished the Supreme Court's decision in O'Bannon v. Town Court Nursing Center as involving the different issue of the procedural due process rights of patients to a hearing to remain in a facility that they did not contest failed to provide quality care, as opposed to the substantive rights of the individual plaintiffs in this case to receive care from a provider that was wrongfully terminated on grounds unrelated to competence or quality of care. The Court rejected the State's reliance on 42 U.S.C. 1320a-7(b)(5)(B) and (b)(12)(B) as bases for termination (reasons bearing on professional competence or financial integrity; failure to grant access to the State survey agency for review of the quality of services), concluding that the evidence failed to support a finding that the clinic failed to provide access to State employees investigating its waste disposal practices and that the inspection was unrelated to a review of the clinic's quality of care, professional competence, or financial integrity. The Court also rejected the State's argument that it properly terminated the Planned Parenthood clinics under 42 U.S.C. 1320a-7(a)(1), (3), or (b)(1)(A)(ii) (exclusions based on criminal convictions related to health care programs), finding that no Planned Parenthood affiliate had been convicted for the illegal sale of body parts, the clinics in any event were not the same "entities" for purposes of those statutory provisions as the affiliates depicted in the videos, and the clinics were not sufficiently affiliated with those affiliates through ownership or control interests. or the specific subjects of any Medicaid billing fraud investigations initiated against other Planned Parenthood affiliates. Finally, the Court rejected the State's reliance on allegations of Medicaid billing fraud against other Planned Parenthood affiliates, finding that the clinics in this case were not the specific subjects of any Medicaid billing fraud investigations.

- Dissent: The dissent stated that the freedom of choice provisions of 42 U.S.C. 1396a(a)(23) did not unambiguously confer an enforceable right on Medicaid beneficiaries to challenge a State's exercise of its authority under 42 U.S.C. 1396a(p)(1) to terminate Medicaid providers on separate State law grounds.

Eighth Circuit Holds That Medicaid Freedom of Choice Provisions Do Not Create Enforceable Rights in Suit Alleging Wrongful Termination of Planned Parenthood Provider -- **Jane Does 1-3 v. Gillespie**, 867 F.3d 1034 (8th Cir. Aug. 16, 2017), rehearing en banc denied, 2017 U.S. App. LEXIS 22734 (Nov. 13, 2017) – Following Arkansas' termination of its Medicaid provider agreements with Planned Parenthood of Arkansas and Eastern Oklahoma based on alleged wrongful conduct by other Planned Parenthood affiliates, three of its Medicaid patients brought an action for injunctive relief under 42 U.S.C. 1983 claiming that by excluding Planned Parenthood from its Medicaid program for reasons unrelated to its fitness to provide medical services, Arkansas had violated the "freedom of choice" provisions of 42 U.S.C. 1396a(a)(23). The Eighth Circuit vacated the district court's injunction, holding (with a single judge dissenting) that Section 1396a(a)(23) did not unambiguously create a federal right for individual patients that can be enforced under 42 U.S.C. 1983. The Court found that the Supreme Court's post-Wilder decisions, including Gonzaga and Armstrong, had effectively overruled Wilder's recognition that the Medicaid Act created enforceable rights whenever the provisions in question were intended to benefit a plaintiff. The Court stated that Section 1396a(a)(23), like the provision at issue in Armstrong, was phrased as a directive to States as to what they must do to receive federal funding and to the federal agency charged with approving State plans, and not as

a conferral of an entitlement or enforceable right on the beneficiaries of the State's decision to participate in Medicaid. The Court also reasoned that the Congress had conferred other means of enforcing State compliance with 42 U.S.C. 1396a(a)(23), including the withholding of federal funds and the authority of the Secretary to promulgate regulations, under which the Secretary had required States to provide appeal rights to excluded providers, posing the potential for parallel litigation and inconsistent results if individual patents could separately litigate in federal court whether a provider was "qualified" under Section 1396a(a)(23). The Court discounted the reliance of other circuits on the fact that Section 1396a(a)(23) refers to "any individual eligible for medical assistance," concluding that the State plan requirements of Section 1396a(a) as a whole, together with the provisions of 42 U.S.C. 1396c authorizing the Secretary to discontinue federal payments if the State fails to substantially comply with those requirements, established an aggregate focus inconsistent with the conferral of individual rights. The Court also stated that the decisions of other courts finding that Section 1396a(a)(23) and other Medicaid provisions conferred enforceable rights had been based on the Supreme Court's "now-repudiated" Wilder decision. Finally, the Court rejected *amici*'s reliance on 42 U.S.C. 1320a-2, which states that a Social Security Act provision is not to be deemed unenforceable because of its inclusion among State plan requirements. The Court noted that the 1994 enactment of Section 1320a-2 pre-dated Gonzaga and Armstrong and that it was deciding the different question not of when a provision is deemed unenforceable but whether Section 1396a(a)(23) unambiguously conferred an enforceable right. The Court stated that while Section 1320a-2 meant that a Social Security Act provision was not unenforceable because of its inclusion in a larger regime of State plan requirements, other elements of the statute – including its focus on federal regulators rather than individual patients, the availability of alternative means to enforce compliance with Section 1396a(a)(23), and the aggregate focus of the statute on substantial compliance as a condition of continued funding – remained relevant. The Court observed that notwithstanding Section 1320a-2, the Supreme Court in Armstrong had similarly concluded that the payment provisions of Section 1396a(a)(30)(A) was phrased as a directive to the federal agency and not as a conferral of the right to sue upon beneficiaries.

- NOTE: The concurring opinion presented, as an "alternative ground" for dismissing plaintiffs' claims, that even if Section 1396a(a)(23) conferred an enforceable right on beneficiaries, that right extended only to entitlement to choose among a range of qualified providers and not a right to a particular provider the State has terminated or a right to challenge the merits of a State's determination that a particular provider is no longer qualified. The concurrence relied on the Supreme Court's decision in O'Bannon v. Town Court Nursing Center, in which the Court held that Section 1396a(a)(23) did not confer on the residents of a decertified nursing facility the right to continue to receive benefits for care by a particular provider that had been decertified.

Challenge to Termination of Planned Parenthood Provider -- **Planned Parenthood of Gulf Coast, Inc. v. Gee**, 862 F.3d 445 (5th Cir. June 29, 2017), prior decision at 837 F.3d 477 (5th Cir. Sept. 14, 2016) -- Planned Parenthood Gulf Coast, which operates two family planning centers and clinics in Louisiana, together with three individual Medicaid beneficiaries, challenged Louisiana's termination of the Medicaid provider agreements for its Louisiana facilities. After the initial termination notice had stated no reasons for the action, a second notice invoking authority under State law to terminate "for cause" cited federal false claims cases brought against Planned Parenthood Gulf Coast or Planned Parenthood affiliates as well as alleged

misrepresentations by Planned Parenthood Gulf Coast in previous correspondence with the State concerning whether it or any Planned Parenthood affiliates had fetal tissue donation programs in Texas. After the district court entered a preliminary injunction, the Fifth Circuit affirmed in a unanimous opinion in September 2016 (837 F.3d 477). The Court: (1) held that the freedom of choice provisions of 42 U.S.C. 1396a(a)(23) conferred enforceable rights (at least for the individual plaintiffs), (2) concluded that the Supreme Court's decision in Armstrong v. Exceptional Child Center did not apply to the freedom of choice provisions of 1396a(a)(23) (noting that only four Justices in Armstrong had found that there could be no private right of action under the Medicaid Act itself), (3) rejected the State's argument that it had discretion to determine for purposes of Section 1396a(a)(23) whether a provider is "qualified" for reasons unrelated to its fitness to furnish and properly bill for services, and (4) rejected Louisiana's stated grounds for termination of the provider agreement. Subsequently, one of the panel judges changed her opinion to dissent, and the Court reissued its initial opinion as a majority opinion along with the dissent (862 F.3d 445). The dissenting judge, citing O'Bannon v. Town Court Nursing Center, 447 U.S. 773 (1980), asserted that although Section 1396a(a)(23) provided a cause of action for a beneficiary denied access to a provider that the State has determined meets all federal and state requirements, it did not give a beneficiary a right to challenge the merits of a State's determination that a particular provider is not qualified to furnish services or the merits of a State's termination of a particular provider's Medicaid agreement on the basis of noncompliance with federal and state requirements. The dissent stated that the Supreme Court in O'Bannon, in rejecting beneficiary claims of a due process right to contest the merits of a State's termination of a nursing facility's Medicaid provider agreement, had concluded that the substantive right provided by Section 1396a(a)(23) included the right to choose among a range of qualified providers and remain in a facility that continues to be qualified without government interference, but did not confer a right to enter an unqualified facility or to continue to receive benefits for care in a facility that the State had determined was qualified. The dissent further stated that regardless of their ultimate merits, the asserted bases for termination of the provider agreements were at least facially related to grounds of provider fraud or misconduct that would be adequate for termination under 42 U.S.C. 1396a(p)(1) (authorizing a State to exclude from Medicaid any entity for any reason for which the Secretary could exclude the entity under Medicare).

- Subsequently, a Petition for Rehearing *En Banc* was denied by equally divided court. 876 F.3d 699 (5th Cir. Nov. 28, 2017). The dissenting opinion stated that the panel's majority opinion disregarded the Supreme Court's holding in O'Bannon v. Town Court Nursing Center, 447 U.S. 773 (1980) that 42 U.S.C. 1396a(a)(23) does not confer on an individual patient a constitutionally protected substantive property interest in receiving care from a disqualified Medicaid provider.

B. Other Provider Participation Cases

Court of Appeals Finds that State Agency Officials Are Entitled to Prosecutorial Immunity In Suit Alleging Racially Biased Termination of Provider -- **Bon-Ing, Inc. v. Hodges**, 2016 U.S. Dist. LEXIS 157258 (S.D. Ohio Nov. 14, 2016), and 2017 Fed. Appx. 461 (6th Cir. Jun 30, 2017) – Owners of an Ohio skilled nursing facility brought an action under 42 U.S.C. 1983 against Directors of the Ohio Department of Health (ODH), claiming that multiple survey findings of immediate jeopardy (based on unabated resident-to-resident abuse) that resulted in termination of

Medicare/Medicaid participation by CMS and revocation of its license by ODH contained misrepresentations of facts and stemmed from racial animus. The district court and the Sixth Circuit dismissed plaintiffs' claims, finding that the ODH officials were entitled to absolute immunity because their actions were prosecutorial or adjudicatory in nature, had the potential in the absence of immunity to subject the officials to damage suits because of their financial impact on the facility, and were subject to due process protections of hearings or opportunities to be heard.

Challenge to Termination of Medicaid Provider Agreements Based on Suspension of License of Commonly Owned Entities -- **Miracles House, Inc. v. Senior**, 2017 U.S. Dist. LEXIS 186336 (S.D. Fla. Nov. 9, 2017) – An owner of Medicaid-certified group homes providing healthcare to the permanently disabled, and several residents of those homes, challenged the State's termination of the Medicaid provider agreements of those facilities based on the State's suspension of the license of a separate assisted living facility operated by the same owner, following discovery of significant patient care deficiencies. Plaintiffs contended that the termination of the group homes was unrelated to their specific fitness to provide care and therefore violated the freedom of choice requirements of 42 U.S.C. 1396a(a)(23). The district court dismissed the claims of the owner, finding that Section 1396a(a)(23) granted only the residents enforceable rights. However, the district court denied the residents' claims for a preliminary injunction, finding that 42 U.S.C. 1320a-7 permitted HHS and the State to exclude from participation in Medicaid any entity whose license to provide health care has been suspended by a State licensing authority for reasons bearing on the entity's professional competence or performance.

VIII. BANKRUPTCY

Court Holds That State May Recoup Unpaid Hospital Quality Assurance Fees From Both Supplemental Quality Assurance Payments and Regular Medicaid Payments, But Unrecovered Fees Are Not Taxes Entitled to Payment As Administrative Priority Claim -- **In re Gardens Regional Hospital & Medical Center**, 569 B.R. 788 (Bankr. C.D. Cal. June 21, 2017) – By statute, California imposed on all hospitals (regardless of its participation in Medicaid) a Hospital Quality Assurance (HQA) fee, calculated based on annual fee-for-service, managed care, and Medicaid patient days. Aggregate fees, as augmented by federal financial participation, were redistributed by the State to hospitals through supplemental quality assurance (QA) payments under a separate formula. After the debtor hospital stopped paying its quarterly HQA fees and then filed for bankruptcy, the State began withholding both regular Medicaid payments and supplemental QA payments to recover the HQA fees. The bankruptcy court held that under the doctrine of recoupment, California was entitled to withhold supplemental QA payments owed to the debtor for purposes of recovering the unpaid HQA fees. The court determined that the HQA fees and supplemental QA payments were logically related, and therefore arose from the same transaction or occurrence, since HQA fees were imposed to secure additional federal funds in order to make the supplemental QA payments. The court further found that this logical relationship existed even though the debtor's HQA fee obligation and supplemental QA payment obligation were calculated under different formulas, and even though some hospitals were exempt from the HQ fees even though they received supplemental QA payments. The court also held that the doctrine of recoupment entitled the State to withhold regular Medicaid payments in

order to recover the unpaid HQA fees. The court determined that the mandatory terms of the Debtor's Medicaid provider agreement, in authorizing the State to deduct unpaid HQA fees from any Medicaid payments owed to the hospital, created a sufficient logical relationship between the debtor's HQA fee liability and its Medicaid payment entitlements to invoke the doctrine of recoupment. The court distinguished the Seventh Circuit's decision in Saint Catherine Hospital of Indiana v. Indiana Family and Social Services Administration, 800 F.3d 312 (7th Cir. 2015), which rejected Indiana's argument that the withholding of Medicaid payments to recover similar unpaid hospital fees was a permissible recoupment, on the ground that the hospital's provider agreement in that case did not contain any provision authorizing such a recovery.

- In a subsequent decision, 573 B.R. 811 (Sept. 25, 2017), the bankruptcy court held that unrecovered HQA fees were fees rather than taxes that were entitled to payment as an administrative priority claim under 11 U.S.C. 503(b)(1)(B)(i). The bankruptcy court determined that the HQA amounts were not imposed primarily for a public purpose (as required to be considered a tax) but were exacted to specifically benefit hospitals by increasing the amount of federal matching funds and therefore State funds available to be paid to the hospitals. The court noted that the State could waive interest and penalties from late payments based on a hospital's showing of hardship, excess HQA fees collected were required to be refunded to hospitals, a prescribed portion of HQA funds distributed were required to be used to minimize uncompensated care furnished by hospitals, and hospitals were not required to use the funds saved for treatment of additional Medicaid patients. Alternatively, the bankruptcy court held that even if the HQA fees did qualify as a tax, the State was still not entitled to an administrative priority claim, since the State's claim for unpaid HQA fees arose pre-petition. The court determined that even though the unpaid HQA fee debt pertained to two post-petition billing periods, the determination and calculation of those fees were made pre-petition.

Court Determines That Quality Assurance Fees Against a Nursing Home Are Not Entitled to Priority In Bankruptcy As Excise Taxes -- **In re Ridgecrest Healthcare, Inc.**, 571 B.R. 838 (Bankr. C.D. Cal. Aug. 24, 2017) – California filed a proof of claim asserting a priority claim of $432,000 in Quality Assurance (QA) fees against a skilled nursing facility. California imposed a uniform QA fee per resident day based on the aggregate net revenues of all skilled nursing facilities subject to the fee. The State argued that its claim was entitled to priority under 11 U.S.C. 507(a)(8) as an excise tax on a transaction. The bankruptcy court determined that the QA fees were an excise tax because they represented an involuntary pecuniary burden (since they were imposed on all facilities regardless of whether they engaged in certain activities), were imposed by the legislature, were imposed for pubic purposes (securing additional federal financial participation and supporting facility quality improvement efforts through higher reimbursements), were imposed under the State's taxing authority not simply to provide funding to facilities but also to enhance Medicaid funding and support facility quality improvement efforts in skilled nursing facilities, and had no analog to a private creditor (since there was no private creditor who could charge the facility a flat fee based on revenue for all residents). However, the court concluded that the QA fees were not imposed on the basis of any single, discrete "transaction" for purposes of Section 507(a)(8), but instead constituted a recurring charge based on a facility's overall operations. The court therefore held that the claim was not entitled to priority but would be allowed as a general unsecured claim.

Bankruptcy Court Remands State Court Action to Foreclose On Property Subject to Medicaid Lien -- **In re Payne**, 2017 Bankr. LEXIS 3221 (Bankr. E.D. Wis. Sept. 22, 2017) – A Chapter 13 debtor removed to the bankruptcy court a prior State court foreclosure action brought by the Wisconsin Medicaid agency against real property against which a stipulated Medicaid lien (related to Medicaid services furnished to the debtor's father) had attached and which, following the father's death, had been transferred to the debtor. The State had already obtained a default judgment in the foreclosure action before the debtor filed his Chapter 13 petition. The bankruptcy court determined that the State foreclosure action was a proceeding "related to" a bankruptcy case since the outcome of the foreclosure action could have an impact on the bankruptcy case, and therefore the bankruptcy court had original but not exclusive jurisdiction over that action under 28 U.S.C. 1334. However, the court remanded the foreclosure action under the provisions of 28 U.S.C. 1334(c)(2) requiring abstention in a related proceeding based on a State law claim if the action could not have been commenced in a federal court, and the action is commenced and can be timely adjudicated in a State forum having jurisdiction.

See also: **In re Assist-Med, Inc.**, 2017 Bankr. LEXIS 4062 (Bankr. S.D. Tex. Nov. 27, 2017) – Debtor, a home health agency whose sole source of income was Medicaid payments, objected to proofs of claim filed by factors that had entered into contracts with the debtor to purchase its accounts receivable. The bankruptcy court allowed the claims. The court held that the contracts at issue were sales of accounts receivable rather than loans. The court further held that because the exceptions to the bar on reassignment of Medicaid payments in 42 U.S.C. 1396a(a)(32) did not include factoring agreements, the debtor's Medicaid payments could not be assigned to third parties such as the factors, and as a result neither of the factors could be secured in the debtor's future receivables.