# 2018 MEDICAID CASE LAW UPDATE

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## *2017 – 2018 Medicaid Litigation Highlights*

- Rates and other Medicaid Reimbursement Challenges
  - Post-*Armstrong* suits against States
    - Suits to enforce Medicaid requirements other than 42 U.S. 1396a(a)(30)(A) affecting payment
    - Civil rights theories
    - State law claims
  - Post-*Armstrong* Suits against HHS under the Administrative Procedure Act
    - Challenges to CMS Approval of State Plan Amendments under 42 U.S.C. 1396a(a)(30)(A)
    - Disproportionate Share Hospital cases: hospital-specific limit
    - Affordable Care Act payments for primary care

## *2017 – 2018 Medicaid Litigation Highlights*

- Medicaid Waiver Cases
  - Sufficiency of services, provision of services in most integrated setting, delays in waiting lists: ADA and Rehabilitation Act claims
  - Approval of work requirements
- Planned Parenthood Litigation
- Provider Assessment Cases
- Managed Care Litigation
- Fraud

# PROVIDER RATE CHALLENGES

*Armstrong* and After

## *Current State of Litigation on Medicaid Reimbursement Challenges Against States*

- 1997 – Payment Requirements for hospitals and nursing homes ("costs of efficiently and economically operated facilities") replaced by "public process" requirement for rate-setting; 42 U.S.C. 1396a(a)(13)(A)
- General payment standard: 42 U.S.C. 1396a(a)(30)(A) ("Section 30(A)"). State plan must assure that payments are:
  1. "Consistent with efficiency, economy, quality of care"
  2. "Sufficient to enlist enough providers so that care and services are available [to beneficiaries] at least to the extent that such care and services are available to the general population in the geographic area" -- "equal access" requirement

## *Current State of Litigation on Medicaid Reimbursement Challenges Against States*

- Supreme Court's decision in *Gonzaga University* (2002): Statute must have individually focused, "rights- creating" language to support private action under 42 U.S.C. 1983
- After *Gonzaga*, most federal courts have held that Section 30(A) does not create rights that can be privately enforced under Section 1983

## *Current State of Litigation on Medicaid Reimbursement Challenges Against States*

Supreme Court's decision in *Armstrong*:

- No private right of action to challenge enforcement of pre-empted State law under Supremacy Clause
- 5 Justices -- No "action in equity" to challenge payment rates under Section 30(A): express provision of remedy of withholding of federal funds coupled with "judicially unadminstrable" nature of Section 30(A)
- 4 Justices -- Medicaid statute itself does not provide action: sets forth conditions for federal approval and not individual rights, withholding of federal funds exclusive remedy
- Justice Breyer: relied on specific "complex and non-judicial nature" of Section 30(A) as precluding suit

## *Medicaid Rate Challenges After Armstrong*

- No majority view in *Armstrong* precluding private suits to enforce other Medicaid statutory provisions (under 42 U.S.C. 1983 or as "action in equity")
- Federal courts after *Armstrong* have found enforceable rights under Medicaid provisions other than Section 30(A):
  1. 42 U.S.C. 1396a(a)(10): required provision of "medical assistance" as defined to eligible beneficiaries (e.g., EPSDT)
  2. 42 U.S.C. 1396a(a)(8): reasonable promptness
  3. ACA redefinition of "medical assistance": States must ensure provision of required services, not just pay
- ADA and Rehabilitation Act still provide private rights of action to challenge State Medicaid determinations, e.g., reductions, caps, limits, and exclusion of services

## *Medicaid Reimbursement Challenges Against States*

Theories Under Other Medicaid Statutory Provisions

- *BT Bourbannais Care v. Norwood* (7th Cir.)
  1. New operators of nursing facilities claim that State failed to recalculate rates based on costs incurred under new ownership as required under State plan.
  2. Court finds private right of action pursuant to 1396a(a)(13)(A) [required public process for proposed rates and underlying methodologies for hospitals, nursing facilities, and ICFs/DD]
- *Heritage Operations Group, LLC v. Norwood* (N.D. Ill) – Claim that adjustments to individual facility payments (based on State MDS audits) require preliminary public process under Section 1396a(a)(13)(A)

## *Medicaid Reimbursement Challenges Against States*

Arguments Under 42 U.S.C. 1396a(a)(8) and 1396a(a)(10): Required Availability of Services

*Chisolm v. Gee* (E.D. La.)

- Court denies motion to vacate consent decree directing State to cover Applied Behavioral Analysis for autism
- Court finds continued violation of "reasonable promptness," links reduced rates to increased waiting times for providers of ABA services

*A.H.R. v. Wash.* (W.D. Wash.); *O.B. v. Norwood* (N.D. Ill.)

- Suits under Section 1396a(a)(8) and 1396a(a)(10) allege that medically fragile children are not receiving approved hours of in-home nursing; difficulties in obtaining qualified nurses at available rates cited

## *Medicaid Reimbursement Challenges Against States*

Suits Under Provider-Specific Payment Provisions

*Legacy Community Health Services v. Smith* (5th Cir.)

- Plaintiff alleges that Texas policy requiring MCOs to fully reimburse FQHCs at per-visit PPS rates violates requirements that (1) MCOs pay FQHC not less than payments made to other providers, and (2) State make "wrap around" payments of difference from PPS amount
- Court finds plaintiff has standing to challenge policy (due to impact on its bargaining position with MCO) and enforceable rights under Medicaid requirements
- ***Merits***: Statute imposes a floor but not a ceiling on MCO payments to FQHC, and requires State "wrap around" payments only to extent of any shortfall from PPS amount

## *Medicaid Reimbursement Challenges Against States*

- State Law Theories
  - *Commonwealth of Ky. v. St. Joseph Health System, Inc.* (Ct. App. Ky. May 19, 2017)
    - State law requires critical access hospital reimbursement at 101% of reasonable costs
    - State followed CMS informal letter and state plan amendment to pay critical access hospitals at Medicare technical component rate for outpatient laboratory services
    - Court of appeal determines that the reduced payment for outpatient laboratory services by critical access hospitals violated state law

## Medicaid Reimbursement Challenges Against States

- State Law Theories
  - *Northern Kentucky Mental Health-Mental Retardation Regional Board, Inc. v. Commonwealth of Ky.* (Ct. App. Ky.)
    - State applied a 19.5% parity adjustment factor for a psychiatric children's hospital, in part by grouping the psychiatric children's hospital services with non-psychiatric hospital services
    - Court of appeal determined that hospital provided services in an innovative manner, compared to non-psychiatric hospitals
    - Court of appeal finds that the application of the 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

## Medicaid Reimbursement Challenges Against States

- State Law Theories: Late Pursuit of Unpaid Claims
  - *John P. Murphy Homes, Inc.* (Me.)
    - Provider sought ten years' of underpayments from the State of Maine
    - Action barred due to failure to invoke the administrative review process
    - Court determined that equitable estoppel did not apply because the provider's reliance on statements by two state employees was unreasonable
  - *Cf Excelth, Inc. v. State of Louisiana* (Ct. App. La.)
    - FQHC submitted claims in regular course of business to state's billing agent
    - State's billing agent placed claims into a file; claims were never processed
    - State's billing agent committed to process the claims, but never did
    - State later sought to recoup interim payments made to provider, which would have been payable if the claims had been processed
    - Court affirms overturning of recoupment
      - Provider established proof by a preponderance of the evidence that fiscal agent had proper information to process the claims, but improperly failed to process them

## *Medicaid Reimbursement Challenges Against States*

- State Law Discrimination Violations
  - *Perea v. Dooley* (N.D. Cal., remanded to Alameda Sup. Ct. (CA))
    - Lawsuit filed by the Mexican American Legal Defense and Educational Fund and the Civil Rights Education and Enforcement Center on behalf of individuals, including a man who has cerebral palsy and is semi-paraplegic, the Service Employees International Union-United Healthcare Workers West, a community health center and National Day Laborer Organizing Network
    - Alleged that low Medi-Cal reimbursement rates have a disparate impact on Latinos; alleges that CA has in effect a separate and unequal system of health care, Medi-Cal for the largest proportion of Latinos and private insurance plans, whose recipients are disproportionately white
    - Alleges violations of state anti-discrimination laws, the State Constitutional equal protection and substantive due process clauses and a taxpayer action for injunctive relief
    - State removed to federal court; federal court remanded back to state court for lack of federal question
      - Rejected that a federal issue was necessarily raised based on the requirement that HHS approve higher reimbursement rates

## *Medicaid APA Reimbursement Challenges*

*Hoag Memorial Hospital v. Price* (9th Cir.)

- Challenge to CMS approval of 10% reduction in rates for outpatient hospital services over 8 mo. period in 2008-09
- State submitted access study showing constant levels of Medicaid beneficiary utilization of outpatient services and proportion of hospitals furnishing services to beneficiaries over 3 year period, including period reduced rates in effect (*Managed Pharmacy Care*: reflects MACPAC factors)
- Court holds that even though Section 1396a(a)(30)(A) requires only a substantive result and no particular methodology or type of evidence (*Managed Pharmacy Care*), statute requires separate consideration and direct evidence of comparative access of beneficiaries and general population, not just level of beneficiary access

## *Medicaid APA Reimbursement Challenges Disproportionate Share Hospital (DSH) Specific Limits*

- Medicaid Act establishes hospital-specific DSH limit of:

  > the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this subchapter, other than under this section, and by uninsured patients) by the hospital to [Medicaid or uninsured patients].

- In 2003, Congress enacted requirement that each state provide to the Secretary an annual audit and report of DSH program.
- In 2008, CMS adopted final rule implementing reporting and auditing requirements.
- In 2010, CMS issued two FAQs (33 and 34), directing states to subtract payments received from private insurance and Medicare from costs for hospital-specific limit.

## *Medicaid APA Reimbursement Challenges DSH Hospital Specific Limits (FAQs 33 and 34)*

- *New Hampshire Hospital Association v. Burwell*, 2017 U.S. Dist. LEXIS 29549 (D.N.H. March 2, 2017): grants partial summary judgment for plaintiffs and enjoins CMS from enforcing FAQs 33 and 34
  - Count I: Even to the extent the term "as determined by the Secretary" granted CMS the authority to consider Medicare and commercial payments as offsets to costs, "[a]t most, the statute might have delegated to the Secretary the ability to determine by regulation that additional payments should be considered."
  - Count II: The court determined that the FAQs violated the APA by being substantive rules that were not promulgated using notice-and-comment rulemaking under the APA.
  - Count III: The court determined that while federal law may impose public notice obligations on a state prior to amending their state plans, such failure does not give rise to liability by CMS or the other defendants.
- *Children's Hospital of the King's Daughters, Inc. v. Price*, 258 F. Supp. 3d 672 (E.D. Va. June 20, 2017): holds FAQ 33 invalid
- *Tennessee Hospital Association v. Price*, 2017 U.S. Dist. LEXIS 96601, 2017 WL 2703540 (M.D. Tenn. June 21, 2017): holds FAQs 33 and 34 invalid

## *Medicaid APA Reimbursement Challenges DSH Hospital Specific Limits (Regulatory Action)*

- Remember last year?
- April 3, 2017, CMS published a final rule, effective June 2, 2017, requiring states to subtract payments received from Medicare or private health insurance on behalf of Medicaid-eligible individuals. 82 Fed. Reg. 16114, 16122.




## *Medicaid APA Reimbursement Challenges DSH Hospital Specific Limits (Regulatory Action)*

- *Missouri Hospital Association v. Hargan*, 2018 U.S. Dist. LEXIS 22024, 2018 WL 814589 (W.D. Mo. Feb. 9, 2018):
  - FAQs were legislative rules subject to APA notice and comment requirements
  - FAQs exceeded CMS' statutory authority
  - 2017 Final Rule invalid as contrary to statute
- *Children's Hospital Assn. of Texas v. Azar*, 2018 U.S. Dist. LEXIS 35962 (D. D.C. March 6, 2018): vacating final rule

## Medicaid APA Reimbursement Challenges

- *Alameda Health System v. CMS* (N.D. Cal.)
  - Statewide limit for disproportionate share hospital (DSH) payments are based on uncompensated costs associated with inpatient and outpatient hospital services
  - CMS interpreted the definition of outpatient hospital services in 2008 to exclude hospital based costs incurred by rural health clinics and federally qualified health centers in a letter to the State of California, citing regulatory and sub-regulatory guidance
  - County hospitals and health systems brought challenge under the APA against CMS, as well as a claim for declaratory relief
  - Court holds that CMS' "rule" was not promulgated in accordance with the APA's requirements of notice-and-comment rulemaking
    - Rejects CMS' argument that policy was an exempt interpretive rule
  - Court holds that hospital-based FQHC services met the regulatory definition of outpatient hospital services
  - Court rejects CMS' reliance on a rescinded final rule defining outpatient services as excluding services covered under another aid category and other Federal Register statements

## Medicaid APA Reimbursement Challenges

*Averett v. HHS* (M.D. Tenn.)

- Medicare (42 U.S.C. 1395l(x)) provided 10% payment "bump" in 2011-2015 for primary care services furnished by "primary care practitioner," defined as physician with specified "primary specialty designations" (family, internal, geriatric, pediatric), and whose provision of primary care services accounted for 60% of allowed charges in a prior period
- For 2013-2014, 42 U.S.C. 1396a(a)(13)(C) required payment at Medicare rate for primary care services furnished by a "physician with a primary specialty designation of family, internal, or pediatric medicine"
- Medicaid regulation provides that physician has one of the "primary specialty designations" if he attests that he is (1) Board certified in one of the specialties, or (2) has billed under E&M or vaccine administration codes as 60% of total Medicaid codes billed (42 C.F.R. 447.400)

## *Medicaid APA Reimbursement Challenges*

- Plaintiffs are not Board-certified and do not meet 60% billing metric; State seeking to recoup enhanced payments after audit
- Plaintiffs claim alternative 60% billing requirement is inconsistent with Section 1396a(a)(13)(C); claim Congress intended that Medicaid enhanced payments would apply to payments for primary care services furnished by any physician
- Court: 60% billing threshold is not permissible construction
    1. Court -- Congress' did not intend "primary specialty designation" to be linked to a billing metric, since billing threshold was independent element of "primary specialty designation" under Medicare but was omitted from Medicaid provisions
    2. Court rejects argument that Medicaid provisions did not specify how to determine whether a physician had a specified primary specialty designation, and billing metric was a reasonable standard; Congress had expressed its "clear intent" that enhanced Medicaid payments could not be linked to billing history
- Court: Invalidates entire regulation, rather than billing threshold alone -- "substantial doubt" that CMS would choose Board certification as sole criterion for enhanced payments

# COVERAGE / WAIVER CASES

## *Medicaid and ADA Restrictions on State Flexibility*

- Medicaid Provisions (enforceable under 42 USC 1983)
  1. Required provision of "medical assistance" as defined to eligible beneficiaries (e.g., EPSDT)
  2. Reasonable promptness in furnishing services
  3. ACA redefinition of "medical assistance": States must ensure provision of required services, not just pay
  4. "Reasonable standards" in extent of coverage
  5. Services in sufficient amount, duration, and scope
  6. May not reduce/limit covered services by diagnosis/condition
  7. Comparable coverage among beneficiaries
- ADA, Rehabilitation Act apply to limits, caps, exclusions of services if court finds risk of institutionalization

## *Medicaid and ADA Restrictions on State Flexibility*

- Courts have invalidated under these provisions:
  1. Limitation of coverage of optional services to certain medical conditions (e.g., limitation of prescription footwear to certain conditions)
  2. Exclusion of coverage for certain services (e.g., Direct-Acting Viral Drugs for Hepatitis C patients with low fibrosis scores, cosmetic procedures for gender dysphoria)
  3. Across the board reductions in assessed medically necessary hours of covered services (e.g., personal care services, in-home nursing services)
- Courts consider risk of institutionalization under ADA and Rehabilitation Act

## *Medicaid and ADA Restrictions on State Flexibility / Waivers*

- *Mikkelson v. Piper* (D. Minn.); *Ball v. Kasich* (S.D. Ohio) – Allegations of lengthy placement on waiting lists state claims for violations of reasonable promptness, ADA even in absence of risk of institutionalization (isolation in home, disconnectedness from greater community)
- *Murphy v. Minnesota* (D. Minn.) – Alleged failure to inform beneficiaries in community group residential facilities of availability of support services in individualized housing states claims for violations of reasonable promptness, freedom of choice of alternatives under waivers, ADA (right to be in most integrated setting even if no imminent risk of institutionalization)
- *Michael T. v. Bowling* (S.D. W. Va.); *K.W. v. Arm*strong (9th Cir.) – Reductions in individual budgets (and waiver services) based on needs inventory deprive beneficiaries of property interest in continued level of services; require meaningful explanation of basis for budget reduction and opportunity to challenge.
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## *Medicaid and ADA Restrictions on State Flexibility / Waivers*

- *Donnegan v. Norwood* (N.D. Ill.) – Disabled persons allege that transition from uncapped in-home nursing services based on medical necessity under EPSDT to more limited services under a waiver for those over 21 (capped by the cost of nursing home care) violates ADA
  - Also allege that State is violating ADA by discriminating among classes of disabled persons in providing uncapped in-home services to medically fragile, technology-dependent persons under a separate waiver
- *Steimel v. Wernert* (7th Cir.) – Transition of waiver beneficiaries to new waivers that cap individual budgets and reduce time in activities outside home under supervision violates ADA requirement of "most integrated setting" even in absence of risk of institutionalization

## *Stewart v. Azar* (D.C.D.C.)

- On January 11, 2018, CMS issues a State Medicaid Director Letter announcing that it would allow states to condition Medicaid on participation in a work or "community engagement" program.
- On January 12, 2018, CMS approves Kentucky's new Medicaid waiver, Kentucky HEALTH
  - Resembles a high-deductible commercial plan
    - $1,000 added to deductible account at beginning of every 12-month eligibility period. Individuals may transfer 50% of remaining balance to an account to pay for non-covered services, e.g., vision, dental, OTC medications, fitness-related services
  - Imposes a work requirement of 80 hours per month of specified employment or community engagement activities. Exempts pregnant women, former foster care youth or medically frail individuals. Failure to meet can lead to suspension of eligibility
  - Lockouts for up to 6 months for failure to pay monthly premiums (up to 4% of income), timely renew eligibility or timely report a change in circumstances
  - Cost sharing for non-emergency use of emergency department ($20)
  - No retroactive eligibility
  - Elimination of non-emergency medical transportation

## *Stewart v. Azar* (D.C.D.C.)

- On January 24, 2018, 15 Kentucky Medicaid enrollees filed a class action lawsuit in the U.S. District Court for the District of Columbia challenging CMS' authority to impose the work requirement policy and approve the Kentucky waiver (filed as *Stewarrt v. Hargan*)
- Theories:
  - State Medicaid Director Letter violates the Administrative Procedure Act as –
    - Outside the 1115 waiver authority
    - Underground rulemaking
    - Based on factors not intended by Congress to be considered; fails to consider important aspects of the problem, and offered an explanation for their decision that runs contrary to the evidence

## *Stewart v.* Azar (D.C.D.C.)

- Theories (contd.)
  - Challenges work requirement, premium requirements and penalties, cost-sharing for non-emergency use of emergency room, and bar on retroactive coverage based on:
    - Categorically outside the scope of 1115 waiver authority
    - Not an experimental, pilot or demonstration project, nor likely to promote objectives of the Medicaid Act
    - Based on factors not intended by Congress to be considered; fails to consider important aspects of the problem, and offered an explanation for their decision that runs contrary to the evidence
  - Challenges lockout penalties and non-coverage of non-emergency medical transportation based on second and third bullets above
  - APA claim against Kentucky HEALTH program as a whole
  - Claim under US Constitution, Article II, section 3, clause 5 against ultra vires administrative action

# PLANNED PARENTHOOD CASES

Termination of Provider Agreements

## Planned Parenthood Cases

*Planned Parenthood of Kansas* (10th Cir.); *Planned Parenthood of Gulf Coast* (5th Cir.)

- Courts reject arguments that under *Armstrong*, plaintiffs cannot privately enforce 42 U.S.C. 1396a(a)(23) (beneficiary "freedom of choice" of any "qualified" provider): join 6th, 7th, 9th Circuits
  1. Although Section (a)(23), like Section (a)(30)(A), is also part of larger section setting forth State plan requirements, only plurality in *Armstrong* suggested that there is no private right of action to enforce any of those requirements
  2. Section (a)(23), unlike Section (a)(30)(A), contains individually focused, "rights-creating" language beyond a State plan requirement
- "Qualified" relates solely to fitness and competency of provider to furnish services; State cannot eviscerate beneficiary's right to select from any qualified provider by terminating provider on basis unrelated to provider's competence or quality of care

## Planned Parenthood Cases

*Jane Does 1-3 v. Gillespie* (8th Cir.) – Court holds that Section 1396a(a)(23) does not confer enforceable rights

- Supreme Court's decisions in *Gonzaga* and *Armstrong* effectively repudiated *Wilder*
- 1396a(a)(23) part of a broader provision with aggregate focus of conditions for federal funding and not conferral of individual rights
- Other remedies for State non-compliance with Section 1396a(a)(23) preclude beneficiary enforcement: withholding of federal funds, rights of excluded providers to appeal (risk of inconsistent results if patients can separately litigate in federal court)

See also concurrence in *Gillespie*, dissent in *Planned Parenthood Gulf Coast*: Enforceable right for beneficiaries under Section 1396a(a)(23) inconsistent with Supreme Court's decision in *O'Bannon v. Town Court* (beneficiaries lack right under 1396a(a)(23) to continue to receive care in a facility that the State has determined is not qualified

# PROVIDER ASSESSMENT CASES

Impact of Bankruptcy on Collections and Classification as "Taxes"

## *In re Gardens Regional Hospital and Medical Center, Inc*. (Bankr. C.D. Cal.)

- Non-profit hospital filed for bankruptcy in the Bankruptcy Court of the Central District of California
  - May 15, 2017: Court determines that the debtor could sell its defunct acute care facility without Attorney General approval because the closed hospital no longer qualified as a "health care facility" for the purposes of the California statute requiring approval of sales of health care facilities
  - June 21, 2017: Debtor hospital ceased making hospital provider fee payments (used to fund supplemental payments to hospitals). State thereafter withheld both regular Medicaid payments and supplemental payments to recover the unpaid hospital provider fee payments.
    - Debtor hospital challenged the withholds as a setoff violating the automatic stay in bankruptcy
    - Court determines that fees due and supplemental Medicaid payments are logically related, and therefore arose out of the same transaction or occurrence
  - September 25, 2017: Provider fees not taxes imposed primarily for a public purpose entitled to payment as an administrative priority claim under 11 U.S.C. 503(b)(1)(B)(i)

## Priority of Provider Assessments in Bankruptcy

- *In re Ridgecrest Healthcare, Inc.* Bankr. C.D. Cal. Aug. 24, 2017): SNF provider fees not entitled to priority under 11 U.S.C. 507(a)(8) as an excise tax on transaction.
  - Court holds that the outstanding provider fees were an excise tax, but not imposed on any single, discrete transaction.
- *In re Gardens Regional Hospital and Medical Center, Inc.* (Bankr. C.D. Cal. Sept. 25, 2017): Hospital provider fees not taxes imposed primarily for a public purpose entitled to payment as an administrative priority claim under 11 U.S.C. 503(b)(1)(B)(i)

## *Biggs v. Betlach* (Nov. 17, 2017)

- Legislature enacted exaction on hospitals to fund Medicaid expansion
- Legislators file suit alleging the exaction is unlawful for failing to garner the 2/3 supermajority required for taxes under AZ Constitution
- Arizona Supreme Court upholds trial court finding that the assessment meets an exception from being defined as a "tax" as being authorized by statute, not prescribed by formula, amount, or limit and set by a state officer or agency

# MANAGED CARE CASES

- Growth in Medicaid managed care has impact on Medicaid litigation – coverage and payment decisions delegated to MCO; no State actor (in absence of evidence of State coercion, significant encouragement, or joint action); plans have arbitration agreements
- *Memisovski v. Maram* (N.D. Ill.) – Court orders State to end delays in payments to MCOs as the result of 2 year budget impasse; evidence that unpaid providers leaving MCOs or no longer accepting new Medicaid patients
- *Eastpointe Human Services v. N.C.* (E.D. N.C.) – MCO cannot challenge State approval of disengagement of a county from its plan and alignment with another MCO (MCO had no enforceable right under 1396a(a)(23))
- *Lake Cumberland Hospital v. Coventry* (E.D. Ken) – Challenge by hospital network member to MCO payment of $50 "triage fee" for services later determined to be non-emergency was "related to contract" and exclusively subject to arbitration

# FRAUD

## *Larisa's Home Care, LLC v. Nichols-Shields* (Or. Oct. 26, 2017)

- Beneficiary obtained Medicaid benefits through fraud by attorney-in-fact
- Adult foster care provider sued for full private pay rates
- Oregon Supreme Court reasons that patient would not have qualified for Medicaid due to undisclosed transfers, thus Medicaid law does not bar equitable action by Medicaid service provider
  - Remanded to the court of appeal to consider whether Medicaid's hold harmless restrictions barred provider from recovery

# QUESTIONS?

With respect to Alan Dorn, who contributed to this paper and is a presenter at this session, this paper, along with the remarks of Mr. Dorn, are intended to be purely informational and informal in nature. Nothing in this paper or in Mr. Dorn's statements is 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 the other relevant facts or legal arguments of the parties.

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