No. 15-4066

IN THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

KATHRYN A. PRICE, as next friend and Attorney-in-Fact on behalf of GERALDINE SAUNDERS: MARILYN WENMAN, Executor of the Estate of Better Hilleger, Deceased, on behalf of BETTY HILLEGER,

Plaintiffs-Appellees,

v.

MEDICAID DIRECTOR, OFFICE OF MEDICAL ASSISTANCE, OHIO DEPARTMENT OF JOB AND FAMILY SERVICES, DIRECTOR; OHIO DEPARTMENT OF AGING.,

Defendants-Appellants.

On Appeal from the United States District Court
For The Southern District of Ohio

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING APPELLANT AND REVERSAL

BENJAMIN C. MIZER
Principal Deputy Assistant Attorney General
CARTER M. STEWART
United States Attorney
ALISA B. KLEIN
JEFFREY CLAIR
(202) 514-4028
jeffrey.clair@usdoj.gov
Attorneys, Civil Division
Room 7243, Department of Justice
950 Pennsylvania Ave., N.W.
Washington, D.C. 20530

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases: **Page**

Statutes:

Regulations:

Legislative Materials:

Miscellaneous:

IN THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

No. 15-4066

KATHRYN A. PRICE, ET AL.,

Plaintiffs-Appellees,

v.

MEDICAID DIRECTOR, ET AL.,

Defendants-Appellants.

On Appeal from the United States District Court
For The Southern District of Ohio

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING APPELLANT AND REVERSAL

STATEMENT OF INTEREST

The United States, through the Department of Health and Human Service's Centers for Medicare & Medicaid Services, administers the Medicaid statute and provides federal financial participation in state expenditures for medical assistance authorized under a state Medicaid plan. It has a direct financial interest in the scope of Medicaid assistance provided by the States as well as a substantial programmatic interest in ensuring that Medicaid-funded

services meet statutory standards for quality, appropriateness, freedom of individual choice, and patient safety.

QUESTION PRESENTED

Whether a Medicaid beneficiary who establishes eligibility for home and community-based services authorized under a state waiver program is entitled to retroactive coverage for services rendered before admission to the waiver program and development of a statutorily-mandated plan of care.

INTRODUCTION AND SUMMARY

The Medicaid statute authorizes States to provide "home and community-based" support services that enable a beneficiary who requires a level of care typically provided in a hospital, nursing home, or intermediate care facility to remain at home or in a community-based residential setting, such as an assisted living residence. Covered services include assistance with activities of daily living, personal care services, and other supportive services that help beneficiaries keep their preferred living arrangements and avoid institutionalization.

Congress has imposed several important limitations on eligibility for these home and community-based services. One key requirement is that the services be rendered "pursuant to" a plan of care that is based on a comprehensive assessment of clinical and functional need, that ensures the

beneficiary can be safely treated outside an institutional setting, and that maximizes individual beneficiary choice.

The central question in this appeal is whether services rendered *before* this plan of care is in place qualify for Medicaid coverage. The district court concluded that so long as the prior services are consistent with a plan of care developed after the fact, they can be covered retroactively, for up to three months before the beneficiary applies for Medicaid benefits.

The court's holding is contrary to the plain language of the statute and the Secretary's consistent administrative interpretation. The statute provides that home and community-based services must be provided "pursuant to" a plan of care, not they need only be consistent with a plan of care developed after services are rendered. Moreover, the district court's interpretation defeats the core purpose of the plan of care requirement. Congress intended to ensure that home and community-based services are based on a comprehensive assessment of need, an advance determination that home and community-based services are appropriate for the beneficiary, and patient participation in the choice of services. The district court's holding frustrates all these advance planning requirements.

The court's holding is also inconsistent with the terms and conditions of the Secretary's approval of the Ohio waiver program and the State's underlying assurances that the addition of waiver services will not increase Medicaid

costs. States are not obligated to provide home and community-based services under a waiver program. Rather, these services are available only if the State elects to provide them, decides on the appropriate scope of waiver services, and obtains the approval of the Secretary of Health and Human Services. Among other requirements, a State must provide the Secretary with reasonable assurances that the addition of waiver services will not increase the average annual per capita costs for individuals who need a level care like that typically provided in a skilled nursing home or intermediate care facility.

Here, in compliance with long-standing HHS policy, Ohio only sought prospective coverage of waiver services. Its cost estimates were based on the assumption that coverage would be prospective only and limited to services provided after a beneficiary is admitted into the waiver program and after a plan of care is in place. The Secretary's approval of the waiver program was based on that assumption as well. The district court's holding would nonetheless compel Ohio to provide up to three months of additional, retroactive coverage for every beneficiary enrolled in the waiver program—a result at odds with the State's costs assurances and the terms of the Secretary's waiver approval.

For all these reasons, the district court's judgment should be reversed.

STATEMENT

A. Statutory Background

Medicaid is a cooperative federal-state program established in 1965. It provides federal financial assistance to States for the purpose of reimbursing medical care provided to needy individuals. *Wilder* v. *Virginia Hosp. Ass'n,* 496 U.S. 498, 502 (1990); *Atkins* v. *Rivera*, 477 U.S.154, 156 (1986). State participation in Medicaid is voluntary, but those States that elect to participate must comply with requirements imposed by the Medicaid statute and implementing regulations promulgated by the Secretary of Health and Human Services. *Armstrong* v. *Exceptional Child, Inc.*, 135 S. Ct. 1378, 1382 (2015); *Wilder*, 496 U.S. at 502.

The Medicaid statute authorizes States to provide, with the Secretary's approval, "home and community-based services" that help a beneficiary receive care at home or in a community setting rather than in a nursing home or other long-term care institution. In 1981, Congress concluded that a disproportionate percentage of Medicaid resources were being used for long-term institutional care, and that many persons residing in Medicaid-funded nursing homes or intermediate care facilities would be capable of living at home or in the community if additional support services were available. *See Sanchez* v. *Johnson*, 416 F.3d 1051, 1054 (9th Cir. 2005). It accordingly enacted provisions authorizing States to provide case management services, homemaker

services, home health aide services, personal care services, and other support services (except room and board) that would enable a beneficiary to remain at home or in a community residential setting rather than entering a nursing home or similar institution. Pub. L. No. 97-35, § 2176, 95 Stat. 357, 813 (1981), adding 42 U.S.C. 1396n(c)(4)(B); *see generally Olmstead* v *LC*, 527 U.S. 581, 601 (1999); *see also* 42 C.F.R. 440.167-181 (defining home and community-based services).

States participating in Medicaid are not obligated to provide home and community-based services. *See* 42 U.S.C. 1396a(a)(10)(A) (listing services that must be provided as part of the State Medicaid plan). They may, however, provide these services to a limited number of beneficiaries under a state waiver program authorized by 42 U.S.C. 1396n(c). Medicaid generally requires that services offered under the state Medicaid plan be available state-wide, see 42 U.S.C. 1396a(a)(1), and that all beneficiaries have access to services of a comparable amount, duration, and scope. 42 U.S.C. 1396a(a)(10)(B). The Secretary, however, may waive these two statutory requirements with respect to the provision of home and community-based waiver services, thereby permitting a State Medicaid program to limit the number of beneficiaries eligible for these services, and to treat state payment for services provided under the waiver as reimbursable "medical assistance" authorized under the state Medicaid plan. 42 U.S.C. 1396n(c)(1), (3).

Home and community-based services under a waiver are available for three target populations: individuals who would otherwise require the level of care provided in a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities, 42 U.S.C. 1396n(c)(1); individuals 65 years of age or older who require the level of care provided in a skilled nursing facility or intermediate care facility, 42 U.S.C. 1396n(d); and children under five years of age who, at the time of birth, were drug dependent or infected with AIDS, 42 U.S.C. 1396n(e). The Ohio home and community-based waiver at issue here was approved under 42 U.S.C. 1396n(c) and is open to Medicaid-eligible individuals age 21 or older who require skilled or intermediate level care.

The Medicaid statute imposes three conditions on these waiver services that are of particular relevance here. First, to obtain approval of the waiver, the State must provide reasonable assurances that the waiver program will be expenditure-neutral with respect to individuals who would need the level of care provided in an institutional setting; that is, the state must reasonably estimate that its average annual per capita expenditures for such individuals with the waiver program in place will not exceed per capita expenditures without the waiver program. 42 U.S.C. 1396n(c)(2)(D); *see Bryson* v. *Shumway*, 308 F.3d 79, 82-83 (1st Cir. 2002).

Second, the State must make a determination that an individual seeking services under the waiver program meets Medicaid's income, resource, and other eligibility requirements, and that but for the provision of home and community based services, he or she would require the level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded. 42 U.S.C. 1396n(c)(1).

Finally, services under the waiver must be provided "pursuant to a written plan of care." 42 U.S.C. 1396n(c)(1). Among other requirements, the plan of care must be based on an individualized assessment of clinical, support, and functional needs, identify the services that will meet these needs, identify risks to the individual and measures taken to minimize them, involve the individual in the planning process to the maximum extent feasible, and prevent the provision of unnecessary or inappropriate services. 42 C.F.R. 441.301(c).

B. Factual Background and District Court Proceedings

1. This case involves Ohio's assisted living waiver program. The Ohio program provides services that enable an individual who might otherwise require care in a nursing facility or intermediate care institution to remain in assisted care or similar residential care facilities. Covered services include nursing services, personal care services (such as assistance with bathing, mobility, and dressing), on-duty response services, coordination of meals, social

and recreational planning, and non-medical transportation. District Court Order, CR. 121, Page ID # 2017-18. To be eligible for the program, an individual must have a need for intermediate or skilled level care, reside in a residential care facility certified by the Ohio Department of Aging, be eligible for Medicaid, and have an appropriate plan of care specifying the types of services he will receive under the waiver program. *Ibid.*

Ohio regulations permit only prospective coverage of these services. They thus provide that coverage may not begin until the individual meets the criteria for receiving Medicaid services under the state Medicaid plan, and until the individual meets the requirements for receiving services under the waiver program—including the requirement that the individual be admitted into the waiver program and have an approved plan of care in place. *Id.* at 6-7.

2. Plaintiffs are a class of Medicaid beneficiaries who live in residential care facilities and who have applied for participation in the Ohio assisted care waiver program. They allege that Ohio regulations limiting coverage to services rendered after a care of plan is approved violate Medicaid provisions assertedly requiring the State to cover assisted living services provided up to three months prior to an application for benefits if the individual was eligible for Medicaid during that time. They principally rely on 42 U.S.C. 1396a(a)(34), which provides that a state Medicaid plan must:

> provide that in the case of any individual who has been determined to be eligible for medical assistance under the plan, such assistance will be made available to him for care and services included under the plan and furnished in or after the third month before the month in which he made application (or application was made on his behalf in the case of a deceased individual) for such assistance if such individual was (or upon application would have been) eligible for such assistance at the time such care and services were furnished.

Plaintiffs argue that this statutory provision requires retroactive coverage of waiver services, and that Ohio's waiver regulations render them unable to pay all the facility's charges and vulnerable to discharge for non-payment of a debt.

3. The district court granted summary judgment for the plaintiffs and ordered Ohio to cover waiver services for up to three months prior to a waiver application if the individual was eligible for Medicaid services during that period, and if the pre-application services are consistent with the subsequently approved plan of care.[1]

First, the court construed section 1396n(c)(1)'s requirement that waiver services be provided "pursuant to" an appropriate plan of care as meaning only that the services in question be consistent with the plan rather than under the

[1] The parties consented to have a magistrate judge issue a final judgment rather than a recommended decision subject to further review in the district court. See District Court Clerk's Notation of Record ("CR.") No. 11.

authority of an existing plan. District Court Order, CR. 121, Page ID # 2043-44.

Second, the court declined to defer to an HHS interpretation construing the statute to limit coverage to waiver services rendered after a plan of care is in place. HHS's Centers for Medicare & Medicaid Services has issued guidance for state waiver applications stating that waiver services must generally be furnished pursuant to a plan of care, and that an individual is not eligible for waiver services until a plan of care is in place. *Id.*, Page ID # 2051. The court, however, concluded that the agency's interpretation is not entitled to deference because it is assertedly inconsistent with section 1396a(a)(34)'s unambiguous directive to provide retroactive coverage, inconsistent with Congress's intent to provide liberal coverage for waiver services needed to avoid institutionalization, and unsupported by a fully-developed, reasoned explanation for the agency's position. *Id.*, Page ID # 2052-55.

Third, the court reasoned that although services in a nursing facility must also be provided in accordance with a plan of care, Medicaid typically covers nursing facility services before a written plan of care is in place. *Id.*, Page ID # 2044, 2049, citing 42 U.S.C. 1396r(b)(2) and 42 C.F.R. 483.20(k)(2)(i). It found no basis for treating home and community-based waiver services differently. *Ibid.*

Finally, the court concluded that denying retroactive services would frustrate Congress's goal of avoiding institutionalization and lowering Medicaid expenditures for individuals who would otherwise require nursing home care but who could, with adequate support services, live safely in the community. *Id.*, Page ID # 2056.

ARGUMENT

I. Home And Community-Based Services May Not Be Covered Before A Beneficiary Is Admitted To the Waiver Program And A Plan of Care Is In Place.

The home and community-based waiver provision states that:

> The Secretary may by waiver provide that a State plan approved under this subchapter may include as "medical assistance" under such plan payment for part or all of the cost of home or community-based services (other than room and board) approved by the Secretary *which are provided pursuant to a written plan of care to individuals* with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan.

42 U.S.C. 1396n(c)(1) (emphasis added).

The Secretary, acting through CMS, interprets these provisions as requiring that a beneficiary be admitted to the waiver program and have a plan of care in place before waiver services may be covered. That interpretation is consistent with the plain meaning of the statute and furthers core objectives of

the waiver program. The agency's interpretation is accordingly entitled to substantial deference on judicial review.

As an initial matter, the Medicaid statute states that home and community-based services must be rendered "pursuant to" a plan of care. In a legal context, the phrase "pursuant to" ordinarily means under the authority of or as provided by the document in question. *See Black's Law Dictionary* 1431 (Garner ed. 10th ed. 2014) (defining "pursuant to" to mean "in compliance with," "under," or "as authorized by").

That interpretation advances Congress's clear intent to ensure that there is a determination, *in advance*, that the individual needs services at a level of care typically provided in a hospital, skilled nursing facility, or intermediate care facility, that the individual can nonetheless be cared for safely in a home or community setting with adequate alternative services, and that services are provided in a manner that maximizes individual patient choice. *See* H. Conf. Rep. No. 97-208, 97th Cong., 1st Sess. 966 (1981), *reprinted in* 1981 U.S.C.C.A.N. 1010, 1328. Congress stressed that "[t]he determination of which long-term care options are feasible in a particular instance should be based on the individual's needs, as determined by an evaluation" and that "the integrity of patient choice should be preserved." *Ibid.* The waiver program is thus intended to ensure that services are provided only after careful evaluation of

the beneficiary's clinical and functional needs, and that they are structured in a manner that facilitates individual patient choice in decision-making.

The Secretary's interpretation is entitled to substantial deference under *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-45 (1984). *Chevron* holds that the reviewing court must defer to any permissible interpretation of an ambiguous statute where it appears that Congress has expressly or impliedly delegated to the agency authority to make rules or other determinations carrying the force and effect of law. *Gonzales* v. *Oregon*. 546 U.S. 243, 255-56 (2006); *United States* v. *Mead Corp.*, 533 U.S. 218, 299 (2001); *Varsity Brands, Inc.* v. *Star Athletica, LLC*, 799 F.3d 468, 477-78 (6th Cir. 2015). Here, the pertinent statute requires that waiver proposals be submitted to the Secretary for review and approval, and that waiver services may be treated as reimbursable "medical assistance" under the state Medicaid plan only to the extent the waiver is approved by the Secretary. 42 U.S.C. 1396n(c)(1).

In *Douglas* v. *Independent Living Center of Southern California, Inc.*, 132 S. Ct. 1204 (2014), the Court stressed that the Secretary's determinations regarding the scope of medical assistance provided under a state Medicaid plan are entitled to substantial deference. Addressing the Secretary's authority to approve a state plan amendment proposing reductions in provider reimbursement rates, the Court explained:

> The Medicaid Act commits to the federal agency the power to administer a federal program. And here the agency has acted under this grant of authority. That decision carries weight. After all, the agency is comparatively expert in the statute's subject matter. And the language of the particular provision at issue here is broad and general, suggesting that the agency's expertise is relevant in determining its application.

Id. at 1310.

This Court and other courts of appeals have accordingly recognized that where, as here, Congress grants the Secretary, acting through CMS, authority to review and approve state provisions governing the scope medical assistance, the Secretary's determinations are an exercise of delegated legislative power entitled to deference under *Chevron* unless contrary to an unambiguous statutory requirement.

In *Pharm. Research & Mfrs. Am.* v. *Thompson*, 362 F.3d 817 (D.C. Cir. 2004), for example, the D.C. Circuit held:

> In the case of the Medicaid payment statute, the Congress expressly conferred on the Secretary authority to review and approve state Medicaid plans as a condition to disbursing federal Medicaid payments. . . . In carrying out this duty, the Secretary is charged with ensuring that each state plan complies with a vast network of specific statutory requirements, see generally 42 U.S.C. 1396a[.] Through this 'express delegation of specific interpretive authority,' *Mead*, 533 U.S. at 229, 121 S. Ct. at 2172, the Congress manifested its intent that the Secretary's determinations, based on interpretation of the relevant statutory provisions, should have the force of law. The Secretary's interpretations of the Medicaid Act are therefore entitled to *Chevron* deference.

Id. at 822.

The Ninth Circuit has similarly held that the Secretary's decisions on whether to approve or disapprove a state plan amendment are entitled to deference. The court reasoned it must "abide by an agency's interpretation or implementation of a statute it administers if Congress has not directly spoken 'to the precise question at issue' and if the agency's answer is 'permissible' under the statute." *Managed Pharmacy Care* v. *Sebelius*, 716 F.3d 1235, 1246 (9th Cir. 2013), quoting *Chevron*, 467 U.S. at 842-43. It held that it must defer to the Secretary's approval of a state Medicaid plan amendment.

This Court, consistent with other appellate precedent, has held that the Secretary's construction of ambiguous terms in the course of making determinations regarding the scope of medical assistance under a State Medicaid plan is entitled to *Chevron* deference. *See Harris v. Olzewski*, 442 F.3d 456, 468-69 (6th Cir. 2006) (CMS determinations regarding whether to grant exemption from Medicaid freedom of choice provisions entitled to *Chevron* deference); *Rosen* v. *Goetz*, 410 F.3d 919, 927 (6th Cir. 2005) (substantial deference must be accorded to CMS's approval of a State's proposed process for disenrolling from Medicaid).

Here, CMS has issued to States instructions and policy guidance making clear that waiver services may not be covered until the individual: (1) meets Medicaid's basic eligibility requirements, (2) is determined to require the level of care provided by a hospital, skilled nursing facility, or intermediate care

facility, (3) meets the requirements for obtaining home and community-based services under the waiver program and is actually admitted to the waiver program, and (4) has a written plan of care conforming to the policies and procedures established in the approved waiver program.[2] Hobbs Affidavit, CR. No. 113-1, Page ID # 1829-30.

Moreover, CMS applied this guidance in the course of a making a specific administrative determination as to whether and how Ohio could implement a home and community-based waiver program. CMS thus approved the waiver based on assurances provided the State. CMS Waiver Approval, CR. 89-2, Page ID # 732. These assurances included Ohio's representation that Federal Financial Participation "is not claimed for waiver services furnished prior to the development of the service plan or for services not included in the service plan." Ohio Waiver Application, CR, 89-3, Page ID

[2] CMS's instructions set forth an exception permitting retroactive coverage, before establishment of a plan of care, of case management services used to formulate the plan of care for individuals transitioning from a nursing home or similar institution to the community. *See* Hobbs Affidavit, CR. 113-1, Page ID # 1832-33. This exception furthers Congress's intent to require an adequate plan of care by enabling States to engage in the initial evaluation and outreach necessary to formulate the plan of care in the first instance. *Id.* Page ID # 1830. It is a common sense rule recognizing that special procedures are needed to accommodate the initial planning that must precede development of the beneficiary's plan of care when he or she is leaving a highly-structured institutional setting and transitioning to home or community-based care. The exception has no application to the waiver services at issue here, which are limited to individuals who are already living in a community residential living facility and wish to remain there.

#740. They also included the State's "agreement to provide HCBS [home and community-based services] to no more individuals than those indicated as unduplicated recipients" in its estimates of per capita expenditures. *Ibid.* The terms of the Secretary's approval, consistent with prior statement of policy, thus made clear that coverage would be limited to beneficiaries who are enrolled in the waiver program and have a plan of care in place. Under *Chevron*, the Court must defer to this consistent and reasonable interpretation of the statute.

The district court's reasons for rejecting the Secretary's interpretation are unpersuasive. First, the court's construction of the statute is not consistent with the most natural interpretation of the statutory text. In particular, the court concluded that the plain language of the statute unambiguously includes home or community-based waiver services that are "consistent with" a plan of care developed after the fact. But the statute does not say services must merely be "consistent with" a plan of care developed after the fact. It instead states that the services must be "pursuant to" a plan of care—a phrase that in a legal context usually means under the authority of the document in question. *See* p. 12-13, *supra.* The district court's construction is, at best, one plausible reading of the term. But it is neither the only construction nor the most natural reading of the plain language in this context.

Second, the court erred in failing to accord substantial deference to CMS's reasoned construction of the statute. The court principally reasoned that the statute unambiguously requires retroactive coverage before a plan of care is in place and thus leaves no room for administrative interpretation. But CMS's interpretation is, at a minimum, at least one permissible interpretation of the statutory requirement that services be provided "pursuant to" the plan of care. And as explained above, it is far better suited to vindicating Congress's intent to ensure that waiver services be based on an adequate assessment of need, an advance determination that the individual can be safely cared for in a home or community setting, and patient choice.

The court further reasoned that CMS's interpretation is not entitled to deference because it does not squarely address retroactive coverage and does not set forth a detailed explanation of the agency's reasoning. District Court Order, CR. 121, Page ID # 2052-53. CMS's guidance, however, is expressly addressed to the earliest date coverage may be provided and expressly states that a plan of care must be in place *before* Medicaid may reimburse waiver services. Hobbs Affidavit, CR. 113-1, Page ID # 1829-30. Moreover, the agency's specific waiver approval is expressly limited to the terms proposed by Ohio, which plainly limit coverage to individuals who are enrolled in the waiver program and have a plan of care in place. The district court therefore erred in

failing to accord *Chevron* deference to CMS's eminently reasonable interpretation of the statute.

Third, the district court erred in concluding that denial of retroactive coverage before a plan of care is in place would frustrate Congress's intent to make home and community-based waiver services readily available. Congress intended to ensure, not only that services be available, but that they be tailored to an individualized assessment of need, offer a safe alternative to institutionalization, and reflect individual patient choice. Merely requiring that services be "consistent with" a later developed plan of care is inconsistent with all these objectives. Indeed, it creates an incentive to draft the plan of care to conform to the services rendered rather than to ensure that services conform to a plan of care thought out in advance.

Fourth, the district court overstated the extent to which the plan of care requirement imposes an impediment to timely waiver services. CMS facilitates timely provision of waiver services by permitting them to be delivered pursuant to a provisional plan of care for the first 60 days of eligibility while a more comprehensive plan of care is being developed and implemented. *See* Hobbs Affidavit, CR. 113-1, Page ID # 1829. Ohio indicates that in calendar year 2014, an appropriate needs assessment and initial plan of care were developed in an average of 8.4 days from the date of an individual's application to

participate in the waiver program—hardly an insurmountable barrier to access. *See* Hobbs Affidavit, CR. 89-4, Page ID # 864, ¶ 8.

Moreover, Ohio represents that an individual may apply for a needs assessment and plan of care *before* he or she meets Medicaid's financial and other eligibility criteria. Appellants Br. at 42-43. That option is particularly significant for members of the plaintiff class who, by definition, are already in an assisted living facility when they apply for services. Many class members have previously paid the facility's fees with private funds and seek Medicaid coverage, not because they now need a different level of care, but because they have exhausted their income and resources and have no means of continuing to pay the facility's charges without Medicaid assistance under the waiver program. *See, e.g.,* Appellees Br. at 3-4. Ohio's offer to develop a plan of care before the individual "spends down" his income and resources to Medicaid eligibility levels offers a further means of ensuring that waiver services meeting all the statutory and regulatory requirements can be delivered promptly. As the State notes, with a modicum of advance planning, these individuals can have a plan of care in place by the time they meet Medicaid's financial eligibility requirements. Reply Br. at 5-6.

Finally, although the district court correctly observed that services provided in a nursing facility may be covered prior to the development of a plan of care, there is a reasonable basis for treating them differently. The

Medicaid statute provides that services in a nursing facility must be provided "in accordance with" a plan of care. 42 U.S.C. 1396r(b)(2). Implementing regulations further require that a plan of care be developed within 21 days of the patient's admission. See 42 C.F.R. 483.20(b)(2) (comprehensive assessment of need must be completed within 14 days of admission) and 42 C.F.R. 483.20(k)(2) (comprehensive plan of care must be developed within seven days of comprehensive patient assessment). The district court is correct that nursing home services may be covered before the nursing home comprehensive plan of care is completed. But a patient will often enter a nursing home in exigent circumstances, such as after a hospital discharge, thus making advance development of a comprehensive plan of care impractical. Accordingly, and unlike services under a waiver program, a preexisting plan of care is *not* a condition of Medicaid coverage of nursing facility services. Moreover, there must be a physician order for the patient's immediate care in the facility before he or she may be admitted. 42 C.F.R. 483.20(a). There is thus an initial determination, made *before* services are rendered, that admission to the nursing home is medically appropriate in light of the patient's clinical and functional needs. That is not the case with respect to waiver services rendered outside an institutional setting, before the development of a plan of care and attendant determination of need.

II. The District Court's Holding Contravenes Statutory Limitations On Retroactive Coverage of Waiver Services, The Terms Of Secretary's Approval Of Ohio's Optional Waiver Program, And The State's Assurances That Addition Of Waiver Services Will Not Increase Medicaid Costs.

There is no dispute that Ohio intended its waiver program to include only prospective coverage for services rendered *after* a beneficiary is admitted into the waiver program and *after* a plan of care is in place. Ohio waiver regulations provide that "the medicaid funded component of the assisted living program shall not pay for any service provided to an individual before ODA's [Ohio Department of Aging's] designee enrolls the individual into the program and before the case manager authorizes the service in the consumer's service plan." Ohio Administrative Code 173-38-03(c)(1)(B), reprinted at CR. 89-1, Page ID # 730. The State's waiver application to the Secretary, consistent with CMS requirements, accordingly made clear that "all waiver services are furnished pursuant to the service plan," and that "Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan." CR. 89-3, Page ID # 740. Ohio thus made plain that its waiver program would not afford retroactive coverage before these requirements are met. The Secretary approved the waiver on that basis.

The district court, in nonetheless ordering retroactive coverage, imposed a requirement that violates the terms of the waiver program proposed by Ohio

and approved by Secretary. Plaintiffs may argue that once a State opts to provide home and community-based services through a waiver program, it must comply with all statutory requirements, including the retroactivity provisions of 42 U.S.C. 1396a(a)(34). There is a three-fold problem with that argument, however.

First, the statute does not permit retroactive coverage of home and community-services rendered before an individual is admitted into the waiver program. To qualify for benefits in the three-month period prior to an application for benefits, the individual must show that he "was (or upon application would have been) eligible for such assistance at the time such care and services were furnished." 42 U.S.C. 1396a(a)(34). An individual, however, cannot be eligible for services under the waiver program until one of the limited number of waiver slots becomes available and he or she is enrolled into the waiver program.[3] Services rendered before that time are not services authorized by the waiver program. And if they are not provided under the

[3] Ohio projected that it could serve a maximum of 4,867 participants in the waiver program. Ohio Waiver Application. CR. 89-3, Page ID # 855. It anticipated that the number of available waiver slots might not be sufficient to meet demand, that individuals seeking to participate in the waiver program might have to be placed on a waiting list, and that Medicaid assistance will not commence until a slot become available and the individual is enrolled in the waiver program. *Id.*, Page ID #730. It is our understanding that none of the named plaintiffs needed to be placed on a waiting list before enrolling in Ohio's waiver program. CMS advises, however, that in 2014, more than 582,000 people were on waiting lists for enrollment in waiver programs operating in 38 states, including Washington, D.C.

authority of a waiver, they are not "medical assistance" covered by the state Medicaid plan. In that circumstance, the individual does not meet the central requirement of the 42 U.S.C. 1396a(a)(34) retroactivity provision: that he was or would have been eligible for Medicaid coverage at the time the services were rendered.

Contrary to plaintiffs' contentions, this interpretation does not eviscerate the retroactivity provisions of 42 U.S.C. 1396a(a)(34) or somehow render them inoperative with respect to other Medicaid services. For example, an individual who receives in-patient hospital services three months' prior to applying for Medicaid can readily show whether he or she met Medicaid's financial and qualitative eligibility requirements during that time. And as in-patient hospital services are a mandatory service that cannot be limited to a set number of beneficiaries or a specific geographic area, services rendered an individual who is otherwise eligible for Medicaid will be covered during the retroactive period if medically necessary.

Unlike in-patient hospital services, and indeed unlike most other Medicaid services, there are several additional conditions on eligibility for services under a home and community-based waiver program.[4] One of the

[4] The cases on which plaintiffs rely (*see* Appellee Br. at 30-31) are distinguishable for precisely this reason. *Schott* v. *Olszewski*, 401 F.3d 682 (6th Cir. 2005), involved coverage of medical services incident to an emergency hospitalization. *See id.* at 684. And *Carroll* v. *DeBuono*, 998 F. Supp. 190 (1997)

limited number of waiver slots must be available. The individual must both qualify for enrollment in the waiver program and be entitled to preference ahead of other individual's on the State's waiting list. And, as explained above, a suitable plan of care must be in place. Limiting coverage to periods in which these requirements are met does not vitiate Medicaid's retroactive coverage provisions. It is, instead, a straightforward application of section 1396a(a)(34)'s express requirement that the individual "was (or upon application would have been) eligible for such assistance at the time such care and services were furnished."

Second, even assuming, for purposes of argument, that retroactive coverage for services predating enrollment in the waiver is statutorily required for those States that elect to participate in a waiver program, that would not authorize the district court to simply direct such additional coverage, without regard to the limitations in the waiver program proposed by Ohio and approved by the Secretary. As noted above, home and community-based services are not a mandatory part of a state Medicaid program. They are optional with the States. *See* 42 U.S.C. 1396a(a)(10)(A) (listing services that must be provided as part of the State Medicaid plan); *see also* 42 U.S.C.

(N.D. N.Y. 1998) involved whether retroactive coverage extended to services rendered by a provider not enrolled in the Medicaid program. Neither case involved waiver services or services where the beneficiary failed to meet all the conditions on eligibility for the service during the pre-application period.

1396n(c)(i) (providing that States may provide home and community-based services as an *optional* part of the state Medicaid plan).

A reviewing court has the authority to invalidate a program that does not meet a putative retroactive coverage requirement for optional waiver services. But it would then be up to the State to decide whether it wishes to provide an enlarged home and community-based waiver program affording retroactive coverage, and up to the Secretary to decide whether to approve the modified waiver program. The State, for example, might elect to reduce the number of waiver slots to accommodate the added expense of retroactive coverage. Or it might elect to abandon a waiver program with such requirements entirely—a course of action that, because waiver services are optional, is entirely within the State's discretion. In any event, the court's remedial power stops with its authority to determine whether the Ohio waiver program now in effect meets statutory requirements. It cannot compel Ohio to enlarge the optional waiver program beyond that proposed by the State and approved by the Secretary. *Cf. FPC* v. *Idaho Power Co.*, 344 U.S. 17, 20 (1952) (court's reviewing power ends when agency's error is laid bare).

Finally, the district court's order, by enlarging the waiver to include retroactive coverage, undermines the State's assurances that the waiver program will not increase Medicaid costs. The statute requires a State, as a condition of waiver approval, to provide reasonable assurances that the addition of waiver

services will not increase the average annual per capita cost of serving individuals who need care at a level provided by a hospital, skilled nursing facility, or intermediate care facility. *See* 42 U.S.C. 1396n(c)(2)(D). Here, Ohio represented to the Secretary that coverage under the waiver would not commence until a waiver slot is available, the individual is enrolled in the program, and a plan of care is in place. CR. 89-3, Ohio Waiver Application, Page ID # 730. It further represented that this waiver program would not increase the total cost or average per capita cost of serving individuals who need a level of care provided by nursing homes or intermediate care facilities. *Id.*, Page ID # 740, 855-59.

The district court's retroactive coverage order requires Ohio to pay for up to three months of additional waiver services for each of the several thousand beneficiaries in the program—a substantial increase in costs, and one not reflected in the cost assurances the State previously provided CMS in seeking approval of its prospective-only waiver program. Plaintiffs might respond that absent retroactive coverage, individuals would enter nursing facilities sooner, that such care is invariably more expensive than care under a waiver program, and that the addition of retroactive coverage therefore has no effect on the cost assurances underlying the Secretary's approval of the waiver program. But if Congress believed that waiver services would never increase costs, it would not have required the States to show, as a condition of obtaining

waiver approval, that the addition of home and community-based services will not increase per capita costs for individuals who need a nursing facility level of care. Not every individual denied waiver services will enter institutional care, especially if they already reside in assisted living facility. And the statute, on its face, makes clear that Congress was not prepared to presume that the addition of a home and community-based waiver program will be cost free.

The district court nonetheless ordered Ohio to provide retroactive coverage of waiver services carrying costs well beyond those reviewed and approved by the Secretary. That is inconsistent with statutory provisions making Medicaid coverage of waiver services contingent on assurances that the waiver will not increase per capita costs the Secretary's approval.

CONCLUSION

The district court's judgment should be reversed.

Respectfully submitted,

BENJAMIN C. MIZER
Principal Deputy Assistant Attorney General
CARTER M. STEWART
United States Attorney
ALISA B. KLEIN
(202) 514-1497
/s/ JEFFREY CLAIR
(202) 514-4028
jeffrey.clair@usdoj.gov

Attorneys, Civil Division
Room 7243, Department of Justice
950 Pennsylvania Ave., N.W.
Washington, D.C. 20530

FRAP 32(a)(7) CERTIFICATE OF COMPLIANCE

I certify that this brief has been prepared in Microsoft Word using a 14-point, proportionally spaced font, and that based on word processing software, the brief contains 6,677 words.

/s/ Jeffrey Clair

jeffrey.clair@usdoj.gov
(202) 514-4028

CERTIFICATE OF SERVICE

I certify that on March 22, 2016, I electronically filed the foregoing Brief for the Federal Respondents using the Court's CM/ECF system, which constitutes service under the Court's rules.

/s/ Jeffrey Clair

jeffrey.clair@usdoj.gov
(202) 514-4028