STATE OF WISCONSIN CIRCUIT COURT BRANCH 12 WAUKESHA COUNTY

KATHLEEN PAPA, et al.,

Plaintiffs,

v. Case No. 15-CV-2403

WISCONSIN DEPARTMENT OF HEALTH SERVICES,

Defendant.

DEFENDANT'S BRIEF

STATEMENT OF THE CASE

The Plaintiffs, Kathleen Papa and Professional HomeCare Providers, Inc., (collectively "Plaintiffs") filed this action for declaratory judgment and injunctive relief regarding auditing practices by the Department of Health Services (DHS) for personal care services billed to Medicaid (MA). Plaintiffs assert that DHS has exceeded its authority in certain aspects of its audit practices, and that certain DHS policies regarding recoupment constitute unpromulgated administrative rules.

BACKGROUND

Medicaid is a joint state-federal program that provides health care for eligible persons under Title XIX of the federal Social Security Act. *See* Wis. Stat. § 49.45(1). In Wisconsin, DHS is charged with responsibilities relating to fiscal matters, eligibility for benefits, and general supervision of the program, and is mandated to cooperate with federal authorities to obtain the best financial reimbursement available to the state from federal funds. Wis. Stat. §§ 49.45(2)(a)1. and 7.

As part of its authority, DHS is authorized to set conditions of participation and reimbursement in contracts with providers (Wis. Stat. § 49.45(2)(a)9.), and is authorized to establish documentation requirements to verify provider claims for reimbursement. Wis. Stat. § 49.45(3)(f). DHS is mandated to recover, after notice and opportunity for hearing, money improperly or erroneously paid or over-payments made to a provider (Wis. Stat. § 49.45(2)(a)10.a.) DHS is authorized to recover money paid for services when a provider's documentation fails to verify the actual provision of services, the appropriateness of the claim, or the accuracy of the claim. Wis. Stat. § 49.45(3)(f)1. and 2. In addition, DHS is authorized to audit and investigate as is necessary to verify the provision of services, the appropriateness of provider claims, or the accuracy of provider claims. Wis. Stat. § 49.45(3)(g)1.

The Medicaid provisions of Title XIX (42 U.S.C. §§1396 *et seq.*) and the implementing rules adopted by the Centers for Medicare and Medicaid Services (CMS) set out broad requirements concerning coverage, payment, etc., which every state must follow in order to receive federal matching funds. For Medicaid, the federal government generally focuses on recovering from the state, which, in turn, is expected to recover from the provider.[1] A state agency is required to process 90% of claims within 30 days of the date of receipt of the claim. 42 U.S.C. § 1396a (37), and must also establish procedures for prepayment and postpayment claim review to ensure the proper and efficient payment of claims and management of the program.

[1] 42 C.F.R. §§ 433.300 – 433.322 addresses a State's obligation to collect overpayments and refund the federal share. § 433.304 is a definition section, and the definitions of the words alone demonstrate the requirement for the states to identify and recover overpayments.

Federal rules also require the states to comply with the Medicaid Integrity Program. 42 U.S.C. § 1396a(69), which is administered by CMS. In September 2011, CMS issued Publication 100-15 (Medicaid Program Integrity Manual) as a reference tool for state Medicaid agencies and providers. This Manual provides information regarding recovery of improper payments, which are defined as:

> [A]ny payment that should not have been made or that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirement. Incorrect amounts include overpayments and underpayments. An improper payment includes any payment that was made to an ineligible recipient, payment for non-covered services, duplicate payments, payments for services not received, and payments that are for the incorrect amount. *In addition, when an Agency's review is unable to discern whether a payment was proper because of insufficient or lack of documentation, this payment must also be considered an improper payment.*

(Emphasis added.) Medicaid overpayments generally arise in one of six contexts:

1. The patient was not eligible for Medicaid at the time the service was provided.
2. Medicaid mistakenly paid as primary coverage when another third-party payer was properly primary.
3. The service was not Medicaid-covered, or was subject to a statutory or regulatory exclusion.
4. The service was covered but not medically necessary.
5. Medicaid was the responsible payer for a medically-necessary, covered service but the payment amount was incorrect and excessive.
6. The provider had insufficient documentation or no documentation.

If Medicaid is the proper payer and the service is both covered and medically necessary, Medicaid will pay a timely-submitted and otherwise proper claim. If the payment is incorrect, either an overpayment or underpayment occurs, giving rise to: (1) the right of the provider to appeal the underpayment; or (2) the obligation of the provider to refund, or the right of the government to recover, the overpayment.

STANDARD OF REVIEW

Plaintiffs have moved the Court for summary judgment. In order to prevail, Plaintiffs must show that there are no disputes as to any material facts and that they are entitled to judgment as a matter of law. Wis. Stat. § 802.08(2).

PLAINTIFFS' STATEMENT OF "UNDISPUTED" FACTS

Plaintiffs' brief includes a section titled "Statement of Undisputed Facts." Aside from the fact that many of their alleged "facts" are simply subjective statements or opinions presented as facts, one important element is missing. When seeking summary judgment, a movant must show that there are undisputed *material* facts, and that the movant is entitled to judgment as a matter of law. Plaintiffs have not presented any set of specific (*i.e.*, material) facts on which the Court could base summary judgment. In fact, Plaintiffs have not even alleged that DHS obtained recoupment of any Medicaid funds in any specific instance. Plaintiffs' motion therefore lacks a key element necessary for obtaining summary judgment and their request for declaratory relief.

ARGUMENT

Plaintiffs' brief includes four requests for relief. First, Plaintiffs ask the Court to set certain limits to DHS's authority to recoup Medicaid funds under Wis. Stat. § 49.45(3)(f). Second, Plaintiffs ask the Court to declare that the Medicaid Handbook provision (which Plaintiffs refer to as the "Perfection Rule") exceeds DHS's authority, or in the alternative, is an unpromulgated administrative rule. Third,

Plaintiffs ask the Court to declare that DHS's auditing practices violate the takings clauses of the U.S. and Wisconsin Constitutions. Fourth, Plaintiffs ask the Court to enjoin DHS from applying the "Perfection Rule" to future audits of Plaintiffs.

I. Plaintiffs fail to state a claim upon which relief can be granted.

Plaintiffs seek declaratory judgment under Wis. Stat. § 227.40. The general thrust of Plaintiffs' brief is that DHS's auditing practices exceed the boundaries of its authority under the law. But Plaintiffs have not established any set of facts enabling the Court to determine whether DHS has exceeded its statutory authority, nor have Plaintiffs alleged a specific injury to any plaintiff.[2] Plaintiffs seek a general advisory opinion from the Court without a factual record to which the Court could apply the relevant law.

By only providing the Court with a general objection as to how DHS has interpreted and applied the law, Plaintiffs' request for declaratory relief fails to state a claim upon which relief can be granted. As the Wisconsin Supreme Court has held, courts act only to determine actual controversies – not to announce abstract principles of law or to render purely advisory opinions. *See State ex rel. Ellenberg v. Gagnon*, 76 Wis. 2d 532, 535, 251 N.W.2d 773 (1977). That is exactly what Plaintiffs are requesting from the Court in this matter – a purely advisory opinion involving an abstract principle of law.

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[2] In the same vein, Plaintiffs lack standing to bring such a claim. Standing requires that a party has suffered or is threatened with an injury. *Norquist v. Zeuske*, 211 Wis. 2d 241, 247-48, 564 N.W.2d 748 (1997). Here, Plaintiffs have failed to allege any direct injury. Moreover, "[a]bstract injury is not enough. The plaintiff must show that he 'has sustained or is immediately in danger of sustaining some direct injury' as the result of the challenged official conduct and the injury or threat of injury must be both 'real and immediate,' not 'conjectural' or 'hypothetical.'"; *Fox v. DHSS*, 112 Wis. 2d 514, 525, 334 N.W.2d 532 (1983) (quoting *Los Angeles v. Lyons*, 461 U.S. 95, 101-02 (1983)).

While a plaintiff seeking declaratory judgment need not actually suffer an injury before availing herself of the Act (*Milwaukee Dist. Council 48,* 244 Wis.2d 333, ¶ 41, 627 N.W.2d 866), "the facts [must] be sufficiently developed to avoid courts entangling themselves in abstract disagreements." *Miller Brands-Milwaukee v. Case*, 162 Wis. 2d 684, 694, 470 N.W.2d 290 (1991) (citing *Loy v. Bunderson,* 107 Wis. 2d 400, 412, 414, 320 N.W.2d 175). Here, Plaintiffs' pleadings do not present any set of specific facts by which this Court could render a meaningful judgment.

Plaintiffs are essentially asking for the Court to direct DHS to be (in Plaintiffs' view) more reasonable as to the level of documentation DHS deems appropriate in the audit process. Such a request, however, would be purely advisory in that no specific set of facts of a particular audit are before the Court, and would provide no resolution of the general nature of Plaintiffs' complaints. For example, Plaintiffs argue that DHS should be barred from seeking recoupment unless DHS cannot verify that services were actually provided. (Pl. Brf. at 23.) This begs the question, however, as to what constitutes verification. Clearly, a key component of verification is the creation and maintenance of complete and accurate records. Without a specific set of facts in front of the Court, the Court cannot issue a ruling as to when a deficiency in documentation crosses the threshold to becoming insufficient for verification purposes. The resolution of a complaint of a general nature as asserted by the Plaintiffs is not only contrary to the law, it is impossible.

Moreover, without specific facts, the Plaintiffs' argument is circular. Plaintiffs insist that DHS should not recoup if the services were actually provided.

However, a primary component for determining whether services were actually provided is adequate documentation. Thus, both parties' arguments rest on the question: What constitutes adequate documentation? That can only be answered on a case-by-case basis. If a plaintiff has a specific set of facts whereby she believes DHS is not entitled to recoupment, she can bring such an action via a petition for judicial review under the provisions of Wis. Stat. § 227.52, *et seq.* That is how courts give guidance and how standards are developed appropriately under the law; not by the issuance of general advisory opinions, as the *Ellenberg, supra,* decision notes.

Consider the facts regarding DHS's audit of Debra Zuhse-Green, who submitted an affidavit in support of Plaintiffs' brief. Ms. Zuhse-Green's affidavit indicates that she was audited and that DHS sought recoupment of MA funds paid to her for the care of three patients. Ms. Zuhse-Green asserts that her billing practices complied with administrative code provisions, but that DHS unreasonably found that her documentation was inadequate. However, Ms. Zuhse-Green omits some key details. Her initial submissions did not disclose the existence of third-party health insurance plans that might have covered the services, nor did she document that the employer-based health plans would not cover the private duty nursing services. (*See* Affidavit of Brenda Campbell, ¶ 7.b.) In addition, her records indicated that she billed for administering Vitamin D, but did not include a physician's prescription. *Id.* ¶ 7.e. Once she submitted the additional required documentation, DHS reversed its findings and no recovery was sought. *Id.* ¶ 7.f.[3]

[3] In fact, none of the __ Affidavits of __ members who were audited indicate that DHS actually recouped any funds from any of them.

The insufficient documentation in this example could have meant that MA funds were provided for services that should have been billed to a third-party insurer, or for drugs that were not provided pursuant to a physician's prescription. The Zuhse-Green example actually clarifies the need for DHS to require providers to create and maintain complete and accurate records. Here, the audit process clearly served its purpose.

Plaintiffs' failure to provide sufficient facts make it impossible for the Court to render a meaningful, non-advisory judgment, and because it is not the proper role of the courts to announce abstract principles of law or to render purely advisory opinions, Plaintiffs' request for declaratory relief should be denied.

II. DHS is authorized to recover payments.

Plaintiffs' brief misstates the scope of DHS's authority to seek recoupment of MA funds and ignores relevant federal and state statutory authority

A. DHS has both broad authority and an obligation to recoup MA funds under federal Medicaid law.

Federal Medicaid law requires the State to recoup MA payments for services not adequately documented. The Social Security Act (sec. 1902(a)(27)) requires that a state plan for medical assistance must:

> provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees (A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan, and (B) to furnish the State agency or the Secretary with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency or the Secretary may from time to time request;

The federal rule regarding this requirement is 42 CFR § 431.107(b), which states:

> Agreements. A State plan must provide for an agreement between the Medicaid agency and each provider or organization furnishing services under the plan in which the provider or organization agrees to:
> (1) Keep any records necessary to disclose the extent of services the provider furnishes to beneficiaries;
> (2) On request, furnish to the Medicaid agency, the Secretary, or the State Medicaid fraud control unit. . .any information maintained under paragraph (b)(1) of this section and any information regarding payments claimed by the provider for furnishing services under the plan. .

Federal Medicaid rules further specify that the State Medicaid Agency must "maintain or supervise the maintenance of the records necessary for the proper and efficient operation of the [State Medicaid] plan," including among other things "[i]ndividual records on each. . .beneficiary that contain information on. . . [p]rovision of medical assistance." 42 CFR § 431.17(b)(1)(iv).

If a State Medicaid Agency does not comply with federal requirements regarding MA service records, Federal Financial Participation (FFP) in Medicaid may be disallowed or recouped. Under federal rules, "[i]In order to determine whether the State is complying with the Federal requirements and the provisions of its plan, CMS reviews state and local administration through [among other things] examination of samples of individual case records." 42 CFR § 430.32. CMS can withhold FFP if it finds the State "fail[ed] to actually comply with a Federal requirement," such as the record-keeping requirements summarized above "regardless of whether the [State Medicaid] plan itself complies with that requirement. 42 CFR § 430.35(c).

B. DHS has broad authority to seek recoupment of MA funds under State law.

The language of Wis. Stat. §§ 49.45(3)(f)1. and 2. Provides support for DHS's authority to recoup MA payments for any service for which the provider fails to maintain records required by DHS:

> 1. Providers of services under this section shall maintain records as required by the department for verification of provider claims for reimbursement. The department may audit such records to verify actual provision of services and the appropriateness and accuracy of claims.
> 2. The department may deny any provider claim for reimbursement which cannot be verified under subd. 1. or may recover the value of any payment made to a provider which cannot be so verified. The measure of recovery will be the full value of any claim if it is determined upon audit that actual provision of the service cannot be verified from the provider's records or that the service provided was not included in s. 49.46(2) or 49.471(11). In cases of mathematical inaccuracies in computations or statements of claims, the measure of recovery will be limited to the amount of the error.

Under subd. 1, DHS may audit such records to "verify actual provision of services and the appropriateness and accuracy of claims." Under subd. 2, DHS is granted the authority to recover any payment that cannot be verified based on such records. Subd. 2 specifies that "[t]he measure of recovery will be the full value of any claim if it is determined upon audit that actual provision of the service cannot be verified from the provider's records." Plaintiffs brief mischaracterizes the type and level of authority established under these provisions.

C. Plaintiffs' brief mischaracterizes the limits on DHS's authority to recover Medicaid payments.

1. Plaintiffs' brief misconstrues statutory language regarding DHS's authority.

Plaintiffs' brief incorrectly argues that the statutory language means that DHS can only recoup payment if it is shown that no actual care was provided, and cannot recover payment based on the provider's failure to maintain adequate documentation of the services billed to Medicaid, or based on the provider's failure to comply with other program requirements.

The underlying purpose of the documentation requirements (which Plaintiffs label as nothing more than regulatory traps and pitfalls) is not merely financial oversight. In addition to verifying that services are actually being provided and the appropriateness of payment, the documentation rules help ensure the quality of the care, the continuity of the care, and the safety of the MA patients.

Plaintiffs' logic is faulty because it implies that DHS's authority to recoup payments is limited to circumstances in which DHS is unable to verify that the services were actually provided. However, the language and syntax of Wis. Stat. § 49.45(3)(f) do not support the Plaintiffs' construction of the statute. The clause at Wis. Stat. § 49.45(3)(f)2., which states that DHS "may recover the value of any payment made to a provider which cannot be so verified," refers to the verification at Wis. Stat. § 49.45(3)(f)1, which refers to DHS verifying the appropriateness of and accuracy of the claim, as well as the actual provision of the service reflected on the claim. Therefore, DHS is clearly authorized to recover the value of any payments where records do not verify the appropriateness and accuracy of a claim,

as well as payments where the records do not verify the actual provision of a service. Regardless of whether a service was actually provided, if DHS cannot verify that the service met Medicaid requirements from reviewing the provider's records, the amount claimed for reimbursement is not appropriate.

The long-standing recognition of DHS's authority in this context is found in *In the Matter of N.E.W. Transportation Services, Inc.*, 95-OAH-1486 (May 14, 1996; copy attached as Exhibit A). There, the hearing examiner rejected the argument that if the covered service was provided and the billing was correct, the agency could not seek recoupment, despite inadequate documentation. Plaintiffs make that rejected argument in this matter. The *N.E.W. Transportation* decision reasoned:

> If I were to subscribe to this premise, there would be little incentive for providers to comply with MA documentation requirements unless and until they were audited. Besides being illogical, this position is not what is contemplated by the MA statute and pertinent state code provisions.

Id. at 4. That decision held that the interaction of Wis. Stats. §§ 49.45(2)(a)10, 49.45(3)(f), 49.45(2)(b)4, and Wis. Admin. Code §§ DHS 106.02(9) and 108.02(9)(a) authorized DHS's recoupment of payments to a provider when a subsequent audit found that the submitted documentation did not comply with MA requirements.

Plaintiffs ask the Court to interpret the clause, "The measure of recovery will be the full value of any claim if it is determined upon audit that actual provision of the service cannot be verified from the provider's records" to mean that DHS cannot recover the full payment for a claim if an audit determines that, although a service was actually provided, the claim was inappropriate. Construing the clause in this way is inconsistent with the first clause in § 49.45(3)(f)2., *i.e.*, that DHS may deny a

claim for reimbursement where the appropriateness of the claims cannot be verified. If DHS can refuse to *pay* an inappropriate claim, it follows that it should be able to recoup payment for an inappropriate claim. The statute contrasts recovery of the full value of the claim when the actual provision of the service cannot be verified with recovery that is "limited to the amount of the error" in cases of *mathematical* inaccuracies or inaccurate claims. Depending on the error, the limited amount could be a partial recovery, or a full recovery. Nothing in the statute prohibits full recovery when claims for services, which were actually provided, are inappropriate.

Another major problem with Plaintiffs' argument is that it hinges on the concept that, in the absence of required documentation, there is a way for DHS to determine that the care was provided. Such an approach would create chaos in the administration of Medicaid reimbursement and raises a number of questions. For example: What is the secondary evidence (after appropriate documentation) that DHS should rely upon?[4] And should DHS be required to accept oral testimony at subsequent administrative hearings as to whether specific care or services were provided? This is a wholly inadequate approach for many reasons, not the least of which is the lack of medical documentation in a patient's file during the pendency of the adversarial process, which could result in improper medical treatment. Would Plaintiffs have us rely upon subsequently created or modified documents? Such an

[4] "The Department processes an enormous number of Medicaid provider claims, and must adopt realistic and practical audit procedures. *Illinois Physicians Union v. Miller*, 675 F.2d 151, 154 (7th Cir. 1982). In the present case, the Department gave Wrightway the opportunity to address inadequate documentation following the audit. This is more than the Department is required to do. It is not appropriate to provide an open-ended opportunity for providers to supplement documentation that should have been in their records prior to claiming reimbursement." *In the*

approach is a fraudster's dream. Any procedure that would require DHS to accept verbal statements or the second- or third-best documentation would eviscerate the documentation requirement. A procedure that requires DHS to ferret out other extraneous documents to supplement the required documentation would create a disarray of documentation methodologies among the myriad of service providers, creating inefficiency in the administration of the program.

There is no foundation for the Plaintiffs' contention that § 49.45(3)(f) has to be interpreted in the context of § 49.45(2)(a)10, and that the latter provision somehow limits the impact of the former. (Pl. Brf. at 13-14.) Section (3)(f) provides that recovery can be made for inadequate documentation, while sec. (2)(a)10 specifies how such a recovery is to be made: "[a]fter reasonable notice and opportunity for hearing," and "by offsetting or adjusting amounts owed the provider under the program, crediting against a provider's future claims for reimbursement for other services or items furnished by the provider under the program, or requiring the provider to make direct payment to the department or its fiscal intermediary." There is no basis for the argument that the language "improperly or erroneously paid" in sec. (2)(a)10 somehow limits the clear authority of DHS under sec. (3)(f) to recover payments where the provider doesn't maintain adequate records.

However, even if one assumes *arguendo* that Wis. Stat. § 49.45(3)(f) must be read in conjunction with § 49.45(2)(a)10.a., the Plaintiffs' proposed construction of § 49.45(3)(f) is inconsistent with § 49.45(2)(a)10., which authorizes DHS to "recover

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Matter of Wrightway Medical Transport LLC, DHA Case ML-07-0017, p. 5 (Dec. 1, 2009) (copy attached as Exhibit B.)

money improperly or erroneously paid or overpayments to a provider." Reading these statutory sections *in pari materia* is a two-way street. Claims that fail to comply with Medicaid documentation requirements for reimbursement are improper. Adopting the Plaintiffs' proposed interpretation of § 49.45(3)(f), however, would mean DHS could not recover such improper payments.

Finally, because Plaintiffs' proposed interpretation of the relevant statutes runs counter to DHS's interpretation and application of those statutory provisions, DHS's interpretation must prevail, as it is the agency charged with enforcing the Medicaid statutes. "[W]hen the agency is charged by the legislature with the duty of applying the statute being interpreted, *its interpretation is entitled to great weight.*" *Knight v. Labor & Indus. Review Comm'n,* 220 Wis. 2d 137, 582 N.W.2d 448 (Ct. App. 1998) (internal cite omitted) (emphasis added).

2. DHS's authority is not limited to sanctions.

Plaintiffs assert that DHS's recourse for violations of documentation requirements is limited to levying sanctions, and that it cannot seek recoupment of payments. (Pl. Brf. at 15-16.) This argument is not supported by the law and is inconsistent with DHS's statutory authority, the administrative code, the policies and procedures of DHS, and prior interpretations of the regulations.

Under the statutory scheme of Subchapter IV of Chapter 49, DHS has been delegated broad regulatory authority and responsibility for oversight and management of the Wisconsin Medicaid program. The legislature specifically empowered DHS to deny claims where the reason for denial is identified pre-payment, to conduct post-payment audits, to recover improper, inappropriate or

erroneous payments, and to impose a variety of sanctions. Nothing in that subchapter indicates a legislative intent to limit DHS to only imposing sanctions if a provider's actions justify both recovery and sanctions. The legislature has specifically empowered DHS to further determine the procedures to be used in implementing its legislatively delegated authority by authorizing the agency to develop rules to implement its authority to "recover money improperly or erroneously paid or overpayments to a provider." Wis. Stat. § 49.45 (2)(a)10.c.

3. DHS's authority is not limited by the doctrine of substantial compliance.

The *N.E.W. Transportation* decision also addressed and rejected another argument of Plaintiffs – the concept of substantial compliance. (Pl. Brf. at 15.) This concept is inapplicable to eligibility for Wisconsin MA reimbursement. The doctrine of substantial compliance is customarily applied to situations in which the provisions of the statute or rule are directory rather than mandatory. Here, the documentation requirements are mandatory.[5]

Plaintiffs' argument misstates the law and would lead to absurd results. In *HealthReach Rehabilitation Services, Inc.*, ML-02-0211 (Feb. 2, 2006; copy attached as Exhibit C), a more extensive statement explains the fallacy of this argument:

> "The DHCF [now DHS] may recover the value of any payment made to a provider where the appropriateness of the payment is not verified during such an audit."

(*HealthReach*, Decision at 5). The *HealthReach* decision analyzes the provisions of

[5] Wis. Stat. § 49.45(3)(f)1. states, in part: Providers of services under this section *shall* maintain records as required by the department for verification of provider claims for reimbursement.

Wis. Stat. § 49.45(2)(a)9. and various administrative code provisions along with the language of the provider agreement to conclude that the provider was contractually bound to follow the conditions of reimbursement. As regards public policy arguments, the decision in *HealthReach* is also informative:

> The petitioner is *not* a MA recipient, i.e., one entitled to some public assistance benefit or payment. Rather, the petitioner is an entity certified by the DHCF [now DHS] to receive MA payments for covered services under contract with that DHCF to abide by MA rules and procedures of coverage. The petitioner does not have the unfettered right to bill MA for any amount of services actually provided. Rather, such providers are compensated at mandated rates for "medically necessary" services provided at appropriate levels and supplies. This is more akin to the privileges attendant to a contract relationship, with specified performance terms, not an entitlement to be paid.

Id. at 16 (emphasis in original.) The public interest in assuring the appropriateness and accuracy of claims was reiterated in *HealthReach*: "[T]he mere assertion of a professional that billable hours claimed were actually performed is indeed a slender reed upon which to premise the payment of tax-payer funded MA dollars." *Id.*

The Plaintiffs assert that "imperfections in the provider's paperwork or other compliance issues" are, at worst, minor or technical, and should not be a basis for recoupment. (Pl. Brf. at 15.) DHS, however, has no way of knowing when a record-keeping error is a truly a mistake or when it indicates that the provider did not abide by other program requirements established to ensure the appropriate provision of health care. DHS must rely on documentation requirements.

For example, several administrative code provisions require personal care services to be performed under the written orders of a physician.[6] While a lack of a

[6] *See e.g.*, Wis. Admin. Code §§ 105.17(2); 107.02(2m); and 107.112(1)(a).

physician order in the provider's documentation could mean that a physician gave a verbal order, but failed to issue a written order, it could also mean that a physician never ordered the private duty nursing services in the first place. Therefore, such services performed without a written order are subject to recoupment. DHS must rely on accurate documentation to verify that appropriate health care is provided to Medicaid recipients. Plaintiffs' "substantial compliance" argument must be rejected.

III. Topic #66 in DHS's Medicaid Provider Handbook is not an unpromulgated administrative rule.

A. Requirements for promulgation of rules.

One of the central tenets of the Plaintiffs' argument is that Topic #66 in the Medicaid Provider Handbook is an unpromulgated rule. In support, the Plaintiffs reference the elements of a rule under Wis. Stat. § 227.01(13). (Pl. Brf. at 18.) The Plaintiffs' argument on this issue, however, is belied by the relevant law:

> A statement of policy . . . does not render it a rule or constitute specific adoption of a rule and is not required to be promulgated as a rule.

Wis. Stat. § 227.10(1). Moreover, as discussed below, the handbook's reimbursement provisions are not "rules" subject to Wis. Stat. § 227, but are "official written policy." *Meda-Care Vans of Waukesha, Inc. v. Division of Hearings and Appeals*, 2007 WI APP 140, ¶ 13, 302 Wis. 2d 499, 508, 736 N.W.2d 147, 152.

DHS is required to establish conditions for participation and reimbursement in a contract for MA providers. Wis. Stat. § 49.45(2)(a)(9). The definition of "provider agreement" is a "contract between a provider and [DHS] which sets forth conditions of participation and reimbursement." Wis. Admin. Code § DHS 101.03(138). As such, the provider handbook provisions are contractual

requirements DHS is required to implement pursuant to state law and are not subject to the rulemaking requirements in Wis. Stat. § 227 *et seq.*[7]

Chapter 49 does not require DHS to promulgate rules related to every subsection, but gives DHS discretion on when to do so: "The department is authorized to promulgate such rules as are consistent with its duties in administering medical assistance. . ." Wis. Stat. § 49.45(10). As one of its duties, DHS is required to, "[p]eriodically set forth conditions of participation and reimbursement in a contract with provider of service under this section." Wis. Stat. § 49.45(2)(a)9. "Notably, the statute does not direct [DHS] to promulgate rules regarding conditions of reimbursement, but instead to include those conditions in a contract with the provider." *Meda-Care Vans*, 2007 WI APP 140, ¶ 12.

> In addition, the administrative code specifically identifies the provider agreement as "the contract between a provider and the department which sets forth conditions of participation and reimbursement," and defines the provider handbook as "a publication developed by the department for the use of providers which outlines program policies and includes instructions on claim filing and other aspects of participation...."

Id. at ¶ 13. "The handbook contains policies and guidelines 'to assist in the implementation of administrative rules.'" *Meda-Care Vans*, 2007 WI App 140, ¶ 16, *quoting Tannler v. DHSS*, 211 Wis. 2d 179, 187, 564 N.W.2d 735 (1997).

Pursuant to Wis. Stat. § 49.45(2)(a)9., DHS created provider agreements, which are contracts that require compliance with handbooks and other publications affecting reimbursement contained within DHS 108.02(4), which states:

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[7] The definition of "provider handbook" is, "a publication developed by the department for the use of providers which outlines program policies and includes instructions on claim filing and other aspects of participation in MA." Wis. Admin. Code § DHS 101.03(143).

> PROVIDER HANDBOOKS AND BULLETINS. The department shall publish provider handbooks, bulletins and periodic updates to inform providers of changes in state or federal law, policy, reimbursement rates and formulas, departmental interpretation, and procedural directives such as billing and prior authorization procedures, specific reimbursement changes and items of general information. The department shall inform providers in a handbook, bulletin or other publication of specific services requiring collection of benefits from Medicare or other health care plans under s. DHS 106.03 (7) before benefits are claimed from the MA program.

The courts have distinguished "rules" that are subject to the administrative rulemaking requirements, and "rules" that are guidance and not subject to formal rulemaking requirements. As noted in *Meda-Care Vans* the courts have held that DHS's handbook's reimbursement provisions are not subject to rulemaking requirements, but are lawfully issued policy. *See also Tannler*, 211 Wis. 2d at 187-88:

> The Department may use policies and guidelines to assist in the implementation of administrative rules provided they are consistent with state and federal legislation governing MA. As long as the document simply recites policies and guidelines, without attempting to establish rules or regulations, use of the document is permissible. DHS[]'s *MA Handbook* is a policy manual that is consistent with controlling legislation, both state and federal. Wis. Stat. § 49.45(34).

Wisconsin's statute governing administrative rules recognizes this distinction in the very definition of a "rule," which states: "'Rule' does not include, and s. 227.10 does not apply to, any action or inaction of an agency, whether it would otherwise meet the definition under this subsection, which: . . . [r]elates to expenditures by a state agency . . . ." Wis. Stat. § 227.01(13)(k). This exemption is consistent with Wis. Stat. § 49.45(2)(a)(9), directing DHS to set forth conditions for reimbursements (expenditures) in contracts. In addition:

> Each agency shall promulgate as a rule each statement of general

> policy and each interpretation of a statute which it specifically adopts to govern its enforcement or administration of that statute. *A statement of policy . . . does not render it a rule or constitute specific adoption of a rule and is not required to be promulgated as a rule.*

Wis. Stat. § 227.10(1). DHS has never promulgated its handbook provisions as rules because they are simply statements of policy that explain its regulations. When courts consider an agency's characterization of its actions they "generally give deference to the agency's views." *Beverly Health & Rehab.*, 223 F.Supp.2d at 103. Moreover, as the Wisconsin Supreme Court noted in *Barry Laboratories v. Wisconsin State Board of Pharmacy*, 26 Wis. 2d 505, 132 N.W.2d 833 (1965), where material does "not attribute anything but obvious meaning to [the statutory] terms" and is "Explanatory material which is merely informational [it] is not within the definition of 'rule.'" *Id.* at 514 (footnote omitted).

B. Topic #66 is an amalgamation of statutory and code provisions.

The gist of Plaintiffs' argument is that Topic #66 exceeds DHS's statutory authority and is an unpromulgated rule. Topic #66 states:

> For a covered service to meet program requirements, the service must be provided by a qualified Medicaid-enrolled provider to an enrolled member. In addition, the service must meet all applicable program requirements, including, but not limited to, medical necessity, prior authorization, claims submission, prescription and documentation requirements.

Plaintiffs are simply wrong. Every phrase and portion of the above-referenced provision is grounded in Wisconsin statutory and administrative code provisions:

For a covered service to meet program requirements,	*See* DHS 106.02: Providers shall comply with the following general conditions for participation as providers... And DHS 107.02(2) and (2)(a) state that services that fail to meet program requirements or state or federal

	statutes, rules and regulations are not reimbursable by MA
the service must be provided by a qualified Medicaid-enrolled provider	*See* DHS 106.02(1): A provider shall be certified (translates to must be a qualified Medicaid-enrolled provider)
to an enrolled member.	*See* DHS 106.02(2): Reimbursement for covered services only *And see* DHS 106.02 (3): The recipient of the services was eligible to receive MA benefits (translates to "an enrolled member")
In addition, the service must meet all applicable program requirements	*See* DHS 106.02(4): Shall be reimbursed only if the provider complies with applicable state and federal procedural requirements (translates to meets program requirements)
including, but not limited to, medical necessity,	*See* DHS 106.02(5): Shall be reimbursed only for services that are appropriate and medically necessary for the condition of the recipient
prior authorization,	*See* DHS 107.03(9): Any service requiring prior authorization for which PA is denied or for which PA was not obtained prior to the provision of the service is not a covered service for MA
claims submission,	*See* DHS 106.03(2)(b): Claims shall be submitted in accordance with the claims submission requirements.... *And see* DHS 107.02(i): Services that fail to meet timely submission of claims requirements are not reimbursable by MA
prescription	*See* Wis. Stat. § 49.46(2)(b)6.g.: Nursing services require a physician's prescription to be covered by MA *And see* DHS 107.12(1)(c): Private duty nursing services shall be provided only when prescribed by a physician.
and documentation requirements.	*See* Wis. Stat. § 49.45(3)(f) *And see* DHS 107.02(2)(e) and (f): Services for which records are not kept or other documentation failure are not reimbursable by MA

There is no reason for DHS to promulgate Topic #66 as a rule because it is simply a synthesis of the above-referenced statutory and rule provisions. Moreover, as noted above herein, the courts have already held that DHS's handbook provisions are not rules subject to rulemaking requirements, but rather are lawfully issued official policy. *See Meda-Care Vans, supra*, 2007 WI App 140, ¶ 13.

C. Injunctive relief is not available to Plaintiffs.

Even if one ignores the holding in *Meda-Care Vans, supra,* and even if Plaintiffs could somehow demonstrate that Topic #66 is a rule and should have been promulgated as such, the Plaintiffs' request for injunctive relief must still be denied, because the court lacks jurisdiction to grant injunctive relief in such circumstances:

> Notwithstanding par. (a), if a court finds that an agency did not adequately comply with s. 227.114, the court may not declare the rule invalid on that basis but shall order the agency to comply with that section and to propose any amendments to the rule that are necessary within a time specified by the court. Unless the legislature acts under s. 227.26 (2) to suspend the rule, *the rule remains in effect while the agency complies with the order.*

Wis. Stat. § 227.40(4)(c). Thus, the court could only require DHS to promulgate the rule. Only the legislature can suspend the rule or order the injunctive relief sought by Plaintiffs. This would be true even if there was an ongoing administrative hearing where the rule at issue was being challenged. Wis. Stat. § 227.40(4)(b). Plaintiffs' request for injunctive relief lacks legal authority and must be denied.

IV. DHS's audit standards do not violate Plaintiffs' due process rights or the takings clause.

Plaintiffs' brief (at 21-22) takes a half-swing at the constitutionality of DHS's policies, but fails to show that: (1) the rules are unconstitutional; (2) Plaintiffs were denied due process; or (3) there has been an unconstitutional taking of property.

Administrative rules are accorded the same presumption of constitutionality as are statutes enacted by the legislature. *Quinn v. Town of Dodgeville,* 122 Wis. 2d 570, 577, 364 N.W.2d 149, 154 (1985); *State v. Menard, Inc.,* 121 Wis. 2d 199, 204, 358 N.W.2d 813, 816 (Ct.App.1984). The party challenging a rule bears a heavy

burden, for its unconstitutionality must be established beyond a reasonable doubt. *Quinn,* 122 Wis. 2d at 577, 364 N.W.2d at 154. Courts will not set aside an agency regulation unless it is "clearly unreasonable." *Liberty Homes, Inc. v. DILHR,* 136 Wis. 2d 368, 385, 401 N.W.2d 805, 812 (1987) (citation omitted). Moreover, "every presumption must be indulged to sustain the [rule] if at all possible and, wherever doubt exists as to [its] constitutionality, it must be resolved in favor of constitutionality." *Chappy v. LIRC,* 136 Wis. 2d 172, 185, 401 N.W.2d 568, 574 (1987), quoting *State ex rel. Hammermill Paper Co. v. La Plante,* 58 Wis. 2d 32, 46, 205 N.W.2d 784, 792 (1973). Plaintiffs' brief does not explain how any individual plaintiff has been denied due process or has had "property" taken by DHS. As such, Plaintiffs have not come close to overcoming their heavy burden on this issue.

Regarding due process, the law allows providers who wish to contest DHS recoupment of overpayments to request a hearing. Wis. Admin. Code § DHS 108.02(9)(e). A provider may subsequently appeal a hearing decision to Circuit Court pursuant to Wis. Stat. § 227.52, *et seq.* Plaintiffs point to no instances in which they were denied such process.

In addition, recoupment does not constitute a government taking of private property without just compensation. In order to receive and retain payment for claims, providers must not only provide services, but must comply with documentation requirements. Wis. Admin. Code § 106.02(9)(g). Because DHS cannot review every claim before paying it, it can only efficiently operate by first paying claims and then auditing selected claims. The fact that DHS initially pays a

claim does not mean that the provider is forever and unequivocally entitled to those funds. DHS has specific authority to audit provider claims[8] and to subsequently recoup money improperly paid.[9] And as noted above, the Plaintiffs have not alleged any set of facts establishing any actual taking of any property. The Court cannot rule on a speculative basis as to a theoretical "taking" that has not even occurred.

CONCLUSION

WHEREFORE, DHS respectfully asks the Court to deny the Plaintiffs' motion for summary judgment, to grant summary judgment for Defendant, and to dismiss this matter and all requests for relief.

Dated this 17th day of May 2016.

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[8] Wis. Stat. § 49.45(2)(b)4. "The Department may audit claims filed by any provider of medical assistance, and as part of that audit, request of any such provider, and review, medical records of individuals who have received benefits under the medical assistance program."

[9] Wis. Stat. § 49.45(2)(a)(10.a. "The Department must . . . recover money improperly or erroneously paid or overpayments to a provider by offsetting or adjusting amounts owed to the provider . . . ."