IN THE SUPREME COURT OF IOWA

SUPREME COURT NO. 18-0464

ROBERT F. COLWELL, JR., D.D.S.,

Petitioner/Appellee

v.

IOWA DEPARTMENT OF HUMAN SERVICES,

Respondent/Appellant

APPEAL FROM THE IOWA DISTRICT COURT
FOR POLK COUNTY
THE HONORABLE ARTHUR E. GAMBLE, DISTRICT JUDGE

APPELLANT'S REPLY BRIEF

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CERTIFICATE OF SERVICE

On the 29th day of August, 2018, the State served the Appellant's Reply Brief on all other parties to this appeal via EDMS:

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ARGUMENT

I. WHETHER DHS MUST PROVIDE ADMINISTRATIVE HEARINGS TO MANAGED CARE PROVIDERS IN THE MEDICAID PROGRAM CONCERNING PAYMENT OF CLAIMS.

The case before the Court is a simple, straight-forward contract payment dispute between Delta Dental and Dr. Colwell. The Department of Human Services did not make a substantive determination on the claims presented. That decision was made by Delta Dental based on its contractual agreement with Dr. Colwell. Indeed, most of the documents relied upon by Dr. Colwell are Delta Dental documents.[1] This is not properly a dispute between DHS and Dr. Colwell, but is rather a dispute between Delta Dental and Dr. Colwell. Dr. Colwell asks DHS to adjudicate disputes between providers and managed care organizations under the Medicaid benefit program. Under Iowa Code section 17A.23(3), "[a]n agency shall have only that authority or discretion delegated to or conferred upon the agency by law and shall not expand or enlarge its authority or discretion beyond the powers delegated to or conferred upon the agency." *Brakke v. Iowa Dep't of Nat. Res.*, 897 N.W.2d 522, 531 (Iowa 2017). Resolutions of private contractual

[1] The Administrative Record includes an expanded set of documents assembled by agreement between DHS and Dr. Colwell.

disputes is a judicial function. Iowa Code § 611.1-2 (describing civil actions before the court).

Standard of Review

Weight is not the same concept as deference. DHS should be entitled to weight in its determination of how to administer the Iowa Medicaid program. *Strand v. Rasmussen*, 648 N.W.2d 95, 100 (Iowa 2002). DHS is the single state agency vested with the authority to administer this cooperative state-federal program. *See, e.g.*, 42 C.F.R. 431.10. Where interpretation of the law has not been vested in the discretion of an agency, legal issues are subject to de novo review. *Bearinger v. Iowa Dep't of Transp.*, 844 N.W.2d 104, 106 (Iowa 2014). Whether or not DHS must provide all providers a state fair hearing is a question of law.

Interpretation of Iowa Code § 249A.4(11)

Statutory interpretation begins with the plain language of the statute. *McGill v. Fish*, 790 N.W.2d 113, 118 (Iowa 2010); *Matter of Estate of Ganter*, 893 N.W.2d 896, 902 (Iowa 2017) (citing *Auen v. Alcoholic Beverages Div.*, 679 N.W.2d 586, 590 (Iowa 2004)) (recognizing that we may not "extend, enlarge or otherwise change the meaning of a statute" "[u]nder the guise of construction"). "[W]e read statutes as a whole rather than looking at words and phrases in isolation." *Id.* (quoting *McGill v. Fish*,

790 N.W.2d 113, 118 (Iowa 2010)*; Matter of Estate of Ganter*, 893 N.W.2d 896, 902 (Iowa 2017) (citing *Auen v. Alcoholic Beverages Div.*, 679 N.W.2d 586, 590 (Iowa 2004)).

Iowa Code § 249A.4(11) reads:

> [The Director of DHS] Shall provide an opportunity for a fair hearing before the department of inspections and appeals to an individual whose claim for medical assistance under this chapter is denied or is not acted upon with reasonable promptness. Upon completion of a hearing, the department of inspections and appeals shall issue a decision which is subject to review by the department of human services.

Iowa Code Ann. § 249A.4 (West) (*see also* 249A.2(2) defining Director as the Director of DHS). The term individual is used in Iowa Code section 249A.3 describing those class of persons who are eligible for Medicaid as individuals or families. The intended beneficiary of the state fair hearing is the Medicaid member, the individual entitled to the Medicaid benefit.

The U.S. Secretary for the Department of Health and Human Services has made clear that this same language in the federal statute does not mandate an independent right of appeals for providers.

> We believe that if the Congress had intended that providers have specific appeal rights under Federal law, these would have been provided for in section 1903(m) or section 1932 of the Act. We believe that this is best left for providers and MCOs or PHPs to negotiate. However, this regulation does not prohibit a State from granting providers the right to challenge MCO and PHP decisions affecting them.

66 Fed. Reg. 6228-01 at 6343, 2001 WL 42230 (Jan 19, 2001); *see also* 81 Fed. Reg. 27498-01 at 27510-11, 2016 WL 2591856 (May 6, 2016) (Medicaid Act only provides for enrollee appeal rights). As this Court has noted "decisions and interpretation of federal courts may be illustrative and instructive to state courts in construing statutes patterned after those enacted by Congress and *entitled to great weight in determining construction to be given the same phrase in subsequently enacted state statutes*." *Pippen v. State*, 854 N.W.2d 1, 30 (Iowa 2014) (emphasis added). Although the Department believes its decision was proper under the Administrative Rules in effect at the time, the Department has amended and clarified those rules to make clear that providers do not have a right to a fair hearing under managed care. The district court's statutory construction would nullify the current Department rules.

II. WHETHER DHS MUST PROVIDE ADMINISTRATIVE HEARINGS TO DR. COLWELL.

The question of whether DHS can provide a hearing to Dr. Colwell is different from the question of whether it must provide a hearing to Dr. Colwell. Iowa Admin. Code r. 441-7.1(3) describes who is entitled to a hearing. The descriptions, the full text of the rule is set out in the initial brief, describe the Member as the person to whom the benefit of a fair hearing enures.

Petitioner is correct that the Department has amended its rules, and those rules clarify the Department's position that managed care providers do not have a right to an administrative hearing. ARC 3093C. This does not signify a change in policy, but a *clarification* intended to implement the Department's policy determination. The Notice in the second paragraph states: "These adopted amendments to Chapter 7 *clarify* that appeals related to health care decisions made by an MCO must follow a different process than the one used for other Department appeals." (Emphasis supplied).

The Department agrees that a provider can represent a Member as an authorized representative. Iowa Admin. Code r. 441-74.10(1). Although Dr. Colwell argues he did have member consent, the documents presented in the supplemental appendix were not presented to the Department at the time the Department made its decision. Judicial review is appellate in nature, and should be a review of the decision based on the documents provided to the agency at the time of the decision. *Christiansen v. Iowa Bd. of Educ. Examiners*, 831 N.W.2d 179, 186 (Iowa 2013) (citing *Anderson v. W. Hodgeman & Sons, Inc.*, 524 N.W.2d 418, 420 (Iowa 1994)) ("District courts exercise appellate jurisdiction over agency actions on petitions for judicial review."). Even reviewing the documents provided in accordance with the district court's order in the supplemental appendix, the

"authorization" in question appears to be part of initial documents signed upon intake, rather than an express authorization to undertake the appeals in question. The "authorization" does not even mention Medicaid.

III. WHETHER ANY PROVIDER CAN BILL A MEDICAID MEMBER FOR A SERVICE THAT IS NOT PAID.

Medicaid is not insurance. In *Becker v. Central States Health and Life Co. of Omaha*, 431 N.W.2d 354 (Iowa 1988):

> Suffice it to say that Medicaid is not insurance as that term is used in the exclusion. Insurance is a contract whereby, for a stipulated consideration, one party undertakes to compensate the other for loss on a specified subject by specified perils. *Black's Law Dictionary* 721 (5th ed. 1979). In contrast, Medicaid provides government medical assistance to a limited category of persons who are unable to meet the full cost of their care. No contractual arrangement for a stipulated consideration is involved.

Id. at 358-59. It is a public benefits program for the indigent. *See Clark by Clark v. Iowa Dept. of Human Services*, 513 N.W.2d 710, 710-11 (Iowa 1994). Petitioner claims this is not "balance billing," which he concedes is prohibited. Iowa Admin. Code r. 441-79.6(2). Federal Medicaid law compels states to limit participation in the Medicaid program to only those "providers who accept, as payment in full, the amounts paid by the agency plus any deductible, coinsurance or copayment required by the [state Medicaid] plan to be paid by the individual. . . . An individual's inability to pay does not eliminate his or her liability for the cost sharing charge." 42

C.F.R. § 447.15. This basic concept, which prohibits patient billing for costs of care other than minimal cost sharing charges, is carried over into the federal government's Medicaid managed care regulations, which under the "Enrollee Rights and Protections" section provides:

> Each MCO, PIHP, and PAHP must provide that its Medicaid enrollees are not held liable for any of the following:
>
> (a) The MCO's, PIHP's, or PAHP's debts, in the event of the entity's insolvency.
>
> (b) Covered services provided to the enrollee, for which—
>
> (1) The State does not pay the MCO, PIHP, or PAHP; or
>
> (2) The State, or the MCO, PIHP, or PAHP does not pay the individual or health care provider that furnished the services under a contractual, referral, or other arrangement.
>
> (c) Payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the enrollee would owe if the MCO, PIHP, or PAHP covered the services directly.

42 C.F.R. § 438.106.

The services at issue are all "covered" services in accordance with his own arguments presented to DHS in the initial request for hearing. *See* Confidential Appendix, pp. 507-518. According to Dr. Colwell's pleading, he was not paid due to Delta Dental's contention that there were irregularities in his claims.

At page 57, Petitioner misconstrues DHS's argument. The Department is entitled to rely on the Medicaid manual and the Medicaid agreement. Those set outside parameters on any provider who works within the Medicaid program. The dispute on individual claims, however, is a dispute between Delta Dental and Dr. Colwell.

The other arguments of Petitioner skirt the central issue. DHS requires its managed care organizations to comply with certain typical regulatory tools of the insurance industry as a proxy for viability – to ensure the MCO will be able to manage the risk and provide Medicaid benefits to the members. Satisfying criteria as a "health maintenance organization" in Iowa Code section 514B.1 under Iowa Admin. Code 441-73.1, and having a certificate of authority by the Iowa Insurance Commissioner do not change the fact that the State and Federal Medicaid regulations provide the parameters of the Medicaid benefit program, not the regulation of the insurance division.

Petitioner's argument at p. 63 is wide of the mark. There are specific provisions for apportioning the risk of loss pending appeal under both state and federal Medicaid law. If a Member is denied a benefit and appeals that denial, *and wants that benefit to continue during appeal*, the Member expressly assumes responsibility for the services provided between the

notice of disallowance and the resolution of the appeal. 42 C.F.R. § 438.420(d); IAC 441-73.14(2). A Medicaid member can appeal without assuming this risk of loss by accepting the denial pending appeal. This is one of the reasons it is important to assure that it is the Member who is driving the appeal, not just the provider.

IV. WHETHER DHS OWES ATTORNEY'S FEES.

Without restating the Department's initial position set forth in it's brief, DHS asserts that attorney's fees are not appropriate because this entire proceeding is predicated on a request for an adjudication of claims. Dr. Colwell's request for hearing was denied. This is an adjudication of his request. It determines the relative rights of the parties and disposes of the request for relief. "Where an administrative agency is engaged in deciding specific legal claims or issues through a procedure substantially similar to those employed by courts, the agency is in substance engaged in adjudication." Restatement (Second) of Judgments, Section 83, comment, as cited in *Ghost Player, L.L.C. v. Iowa Dep't of Econ. Dev.*, 906 N.W.2d 454, 463 (Iowa 2018).

Regarding the request for appellate fees, DHS similarly objects to the request for the same reasons it advanced in the initial brief. If a claim is dismissed on a motion to dismiss by the district court, and reinstated by the

court of appeals, the decision-making process at issue is still adjudicative in function. The action Petitioner is seeking from the Department is adjudicative. And the adjudication in question, if one credit's Dr. Colwell's assertion he is appealing on behalf of his patients, is the determination of eligibility or entitlement to a monetary benefit. Iowa Code § 625.29(1)(d).

CONCLUSION

DHS contends its decision to deny state fair hearings to a dentist who had his claims for payment reviewed by the managed care organization Delta Dental was correctly reached. The Department appeals, however, not simply to avoid the administrative hearings ordered by the district court, but to set aside the sweeping language of the district court's order on two primary issues. First, neither state nor federal law ***require*** the Medicaid program to offer a state fair hearing to providers. The right to be protected is that of the beneficiary – the Medicaid member. The district court's ruling reads the statute to require that state fair hearings be provided to providers. This is incorrect as a matter of law and unduly fetters the Department's efforts to modernize the Medicaid delivery system by creating contemporary contractual relationships between the payor and the provider.

Second, the district court's finding that a provider can obtain payment from a Medicaid member grants the court's imprimatur to an unpermitted

practice. It is illegal and in violation of Dr. Colwell's provider agreement to obtain payment from the Member. Providers who accept Medicaid must agree to accept what Medicaid pays upon adjudication of their claims. Claims that are denied do not give rise to a right to collect from the impoverished Medicaid member.

Finally, the Department asserts its decision was correctly reached based on the information provided to it and based on the rules in place. Attorney's fees should be denied on the basis of any of the three statutory exceptions: because the Department's determination was based on substantial evidence presented to it, because the process in question involves determination of entitlement to a monetary benefit, and because the Department's role is adjudicative, even in pre-merits dismissals of a claim for relief.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limitation of Iowa R. App. P. 6.903(1)(g)(1) or (2) because:

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DATED: August 29, 2018

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