IN THE 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
HON. ARTHUR E. GAMBLE, JUDGE

FINAL BRIEF OF APPELLEE ROBERT F. COLWELL, JR., D.D.S.

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes and Rules

Other Authorities

ISSUES PRESENTED

I. WHETHER THE DISTRICT COURT CORRECTLY HELD THAT IOWA CODE SECTION 249A.4(11) REQUIRES THE DEPARTMENT TO PROVIDE COLWELL A STATE FAIR HEARING.

Cases

Auen v. Alcoholic Beverages Division, 679 N.W.2d 586 (Iowa 2004)
Birchansky Real Estate, L.C. v. Iowa Department of Public Health, 737 N.W.2d 134 (Iowa 2007)
Brakke v. Iowa Department of Natural Resources, 897 N.W.2d 522 (Iowa 2017)
Citizens' Aide/Ombudsman v. Rolfes, 454 N.W.2d 815 (Iowa 1990)
City of Marion v. Department of Revenue & Finance, 643 N.W.2d 205 (Iowa 2002)
Dico, Inc. v. Iowa Employment Appeal Board, 576 N.W.2d 352 (Iowa 1998)
Eyecare v. Department of Human Services, 770 N.W.2d 832 (Iowa 2009)
Federal Express Corp. v. Mason City Human Rights Commission, 852 N.W.2d 509 (Iowa Ct. App. 2014)
Goldberg v. Kelly, 397 U.S. 254 (1970)
Greenwood Manor v. Iowa Department of Public Health, 641 N.W.2d 823 (Iowa 2002)
Iowa Dental Association v. Iowa Insurance Division, 831 N.W.2d 138 (Iowa 2013)
Kay-Decker v. Iowa State Board of Tax Review, 857 N.W.2d 216 (Iowa 2014)
Office of Consumer Advocate v. Iowa Utilities Board, 744 N.W.2d 640 (Iowa 2008)
Painters & Allied Trades Local Union v. City of Des Moines, 451 N.W.2d 825 (Iowa 1990)
Perry v. Dowling, 95 F.3d 231 (2d Cir. 1996)
Pippen v. State, 854 N.W.2d 1 (Iowa 2014)
Renda v. Iowa Civil Rights Commission, 784 N.W.2d 8 (Iowa 2010)
Soo Line R.R. v. Iowa Department of Transportation, 521 N.W.2d 685 (Iowa 1994)
State v. Snyder, 634 N.W.2d 613 (Iowa 2001)
State v. Wagner, 596 N.W.2d 83 (Iowa 1999)

State ex. rel. K.M. v. West Virginia Department of Health & Human Services, 575 S.E.2d 393 (W. Va. 2002)
Turner v. Perales, 869 F.2d 140 (2d Cir. 1989)
Wal-Mart Stores, Inc. v. Caselman, 657 N.W.2d 493 (Iowa 2003)

Statutes and Rules

Iowa Code § 17A.19
Iowa Code § 17A.19(10)
Iowa Code § 17A.19(10)(b)
Iowa Code § 17A.19(10)(c)
Iowa Code § 17A.19(10)(f)
Iowa Code § 17A.19(10)(f)(1)
Iowa Code § 17A.19(10)(i)
Iowa Code § 17A.19(10)(j)
Iowa Code § 17A.19(10)(k)
Iowa Code § 17A.19(10)(l)
Iowa Code § 17A.19(10)(m)
Iowa Code § 17A.19(10)(n)
Iowa Code § 17A.19(11)
Iowa Code ch. 249A
Iowa Code § 249A.2
Iowa Code § 249A.2(7)
Iowa Code § 249A.2(12)
Iowa Code § 249A.2(13)
Iowa Code § 249A.4(11)

Other Authorities

66 Fed. Reg. 6228-01 at 6343, 2001 WL 42230 (Jan. 19, 2001)
1 Norman J. Singer, Sutherland Statutory Construction § 2.01 (5th ed. rev. vol. 1994)

II. WHETHER THE DISTRICT COURT CORRECTLY HELD THAT THE DEPARTMENT'S RULES PROVIDE COLWELL A RIGHT TO A STATE FAIR HEARING INDEPENDENTLY AND/OR AS A REPRESENTATIVE OF HIS PATIENTS.

Cases

Des Moines Independent Community School District v. Department of Job Service, 376 N.W.2d 605 (Iowa 1985)
Dico, Inc. v. Iowa Employment Appeal Board, 576 N.W.2d 352 (Iowa 1998)
Evercom Systems, Inc. v. Iowa Utilities Board, 805 N.W.2d 758 (Iowa 2011)
Eyecare v. Department of Human Services, 770 N.W.2d 832 (Iowa 2009)
Greenwood Manor v. Iowa Department of Public Health, 641 N.W.2d 823 (Iowa 2002)
Hollinrake v. Iowa Law Enforcement Academy, 452 N.W.2d 598 (Iowa 1990)
Mosher v. Department of Inspections & Appeals, 671 N.W.2d 501 (Iowa 2003)
Office of Consumer Advocate v. Iowa Utilities Board, 744 N.W.2d 640 (Iowa 2008)
Sommers v. Iowa Civil Rights Commission, 337 N.W.2d 470 (Iowa 1983)
Soo Line R.R. v. Iowa Department of Transportation, 521 N.W.2d 685 (Iowa 1994)
Star Equipment, Ltd. v. Iowa Department of Transportation, 843 N.W.2d 446 (Iowa 2014)
State v. Public Employment Relations Board, 744 N.W.2d 357 (Iowa 2008)

Statutes and Rules

42 C.F.R. § 438.400(b)
42 C.F.R. § 438.402(c)(l)(i)
42 C.F.R. § 438.402(c)(l)(ii)
Iowa Admin. Code r. 191-76
Iowa Admin. Code r. 441-7
Iowa Admin. Code r. 441-7.1
Iowa Admin. Code r. 441-7.2(5)
Iowa Admin. Code r. 441-7.2(5)(b)
Iowa Admin. Code r. 441-7.2(6)
Iowa Admin. Code r. 441-7.6(2)(a)
Iowa Admin. Code r. 441-73.12(2)
Iowa Admin. Code r. 441-74.10(1)
Iowa Admin. Code r. 441-74.10(3)
Iowa Code § 17A.19(10)
Iowa Code § 17A.19(10)(b)
Iowa Code § 17A.19(10)(c)
Iowa Code § 17A.19(10)(f)

Iowa Code § 17A.19(10)(g)
Iowa Code § 17A.19(10)(h)
Iowa Code § 17A.19(10)(i)
Iowa Code § 17A.19(10)(j)
Iowa Code § 17A.19(10)(k)
Iowa Code § 17A.19(10)(l)
Iowa Code § 17A.19(10)(m)
Iowa Code § 17A.19(10)(n)
Iowa Code § 249A.4
Iowa Code § 249A.4(11)
Iowa Code § 514J.102(l)(a)

Other Authorities

ARC 3093C (effective July 12, 2017)
ARC 3871C (effective August 8, 2018)
66 Fed. Reg. 6228-01 at 6343, 2001 WL 42230 (Jan. 19, 2001)
Informational Letter No. 1922-MC-FFS-D, available at https://dhs.iowa.gov/sites/default/files/1922-MC-FFS-D_AuthorizedRepresentative-for-ManagedCareAppeals.pdf

III. WHETHER THE DISTRICT COURT CORRECTLY HELD THAT COLWELL CAN BILL PATIENTS FOR SERVICES THAT DELTA DENTAL DID NOT COVER OR REIMBURSE.

Cases

Banks v. Secretary of Indiana Family & Social Services Administration, 997 F.2d 231 (7th Cir. 1993)
Becker v. Central States Health and Life Co. of Omaha, 431 N.W.2d 354 (Iowa 1988)
Bernau v. Iowa Department of Transportation, 580 N.W.2d 757 (Iowa 1998)
Black v. American Bankers Insurance Co., 478 S.W.2d 434 (Tex. 1972)
Brakke v. Iowa Department of Natural Resources, 897 N.W.2d 522 (Iowa 2017)
Eyecare v. Department of Human Services, 770 N.W.2d 832 (Iowa 2009)
Iowa Dental Association v. Iowa Insurance Division, 831 N.W.2d 138 (Iowa 2013)
Johnston Equipment Corp. of Iowa v. Industrial Indemnity, 489 N.W.2d 13 (Iowa 1992)

Renda v. Iowa Civil Rights Commission, 784 N.W.2d 8 (Iowa 2010)
Republic Bankers Life Insurance Co. v. Anglin, 433 S.W.2d 795 (Tex. Civ. App. 1968)

Statutes and Rules

42 C.F.R. § 431.200
42 C.F.R. § 431.201
42 C.F.R. § 431.202
42 C.F.R. § 431.203
42 C.F.R. § 431.204
42 C.F.R. § 431.205
42 C.F.R. § 431.206
42 C.F.R. § 438.66
42 C.F.R. § 438.402
42 C.F.R. § 438.408
42 C.F.R. § 447.15
42 U.S.C. § 438.2
42 U.S.C. § 438.106(b)
42 U.S.C. § 438.106(c)
Iowa Admin. Code r. 441-7.1
Iowa Admin. Code r. 441-73.1
Iowa Admin. Code r. 441-79.1
Iowa Admin. Code r. 441-79.6(2)
Iowa Admin. Code r. 650-30.4
Iowa Code ch. 8F
Iowa Code § 17A.19(10)
Iowa Code § 17A.19(10)(b)
Iowa Code § 17A.19(10)(c)
Iowa Code § 17A.19(10)(i)
Iowa Code § 17A.19(10)(k)
Iowa Code § 17A.19(10)(l)
Iowa Code § 17A.19(10)(m)
Iowa Code § 17A.19(10)(n)
Iowa Code § 249A.4(11)
Iowa Code § 249N.6(1)
Iowa Code § 514B.1
Iowa Code ch. 514C
Iowa Code § 514C.3B

Other Authorities

IV. WHETHER THE DISTRICT COURT CORRECTLY HELD THAT COLWELL IS ENITLED TO ATTORNEY FEES UNDER IOWA CODE SECTION 625.29.

Cases

Statutes and Rules

Iowa Admin. Code r. 441-7.1
Iowa Admin. Code r. 441-7.6(2)(a)
Iowa Code § 249A.4(11)
Iowa Code § 625.29
Iowa Code § 625.29(1)(a)
Iowa Code § 625.29(1)(b)
Iowa Code § 625.29(1)(d)

Other Authorities

Restatement (Second) of Judgments, § 83, at 266
Webster's Third New International Dictionary 27 (unabr. Ed. 2002)

ROUTING STATEMENT

Pursuant to Iowa Rule of Appellate Procedure 6.1101, this matter should be retained by the Supreme Court. This appeal involves a substantial issue of first impression relating to the interpretation and application of Iowa law and the rules of the Iowa Department of Human Services (the "Department"). See Iowa R. App. P. 6.1101(c).

STATEMENT OF THE CASE[1]

This appeal arises from the denial by the Department of certain state fair hearing requests from provider Robert F. Colwell, Jr. D.D.S. ("Colwell"). Appendix ("App.") v. I pp. 472-73, 475-76. In its denials, the Department asserted that Colwell could not be granted a state fair hearing because, among other reasons, Colwell's dispute arose from the denial of a claim by Delta Dental of Iowa ("Delta Dental"), which is one of the Department's managed care contractors administering Iowa's Dental Wellness Plan. App. v. I pp. 472-73, 475-76.

[1] Under the Iowa Rules of Appellate Procedure, appellee's brief need not contain this section or the Statement of Facts section unless the appellee is dissatisfied with the appellant's statements. Iowa R. App. P. 6.903(3). Appellant's Brief failed to include a Statement of Facts, and Appellant's Statement of the Case did not contain any references to the record or appendix. See Iowa R. App. P. 6.903(2)(e), (f). Accordingly, Appellee provides a complete Statement of the Case and Statement of Facts.

On February 15, 2017, Colwell filed a Petition for Judicial Review challenging the Department's denials of his requests for state fair hearings. App. v. I pp. 5-72. The Department filed a Motion to Dismiss Colwell's Petition, which was ultimately denied on June 8, 2017. App. v. I pp. 73-77. Thereafter, the parties submitted briefs to the Court, and the Court held a hearing on Colwell's Petition for Judicial Review on December 19, 2017 . App. v. I pp. 124-51.

On February 16, 2018, the Court issued a Ruling on Petition for Judicial Review (hereinafter "Ruling"). App. v. I pp. 124-51. The Court held that the Department's denial of Colwell's requests for state fair hearings was "unreasonable, arbitrary and capricious and was affected by an error of law." App. v. I p. 150. As a result, the Court reversed and remanded the matter to the Department and directed the Department to grant Colwell's request for administrative review and provide a "state fair hearing regarding the specific claims for payment made by Dr. Colwell and denied by Delta Dental." App. v. I p. 150.

In its February 16, 2018 Ruling, the Court also held that Colwell's request for attorney fees should be granted. App. v. I pp. 145-50. In accordance with the Court's Ruling, Colwell's counsel submitted an Attorney Fee Affidavit for Award of Fees and Costs on February 26, 2018.

App. v. I pp. 155-63. On April 6, 2018, the Court entered an Order entering judgment in favor of Colwell against the Department for attorney fees in the amount of $34,528.75 plus interest accruing from February 16, 2018. App. v. I p. 176. In that same Order, the Court – upon Motion from the Department – stayed execution of the judgment of attorney fees and the Ruling without a supersedeas bond. App. v. I p. 176.

The Department appealed the Court's Ruling by filing a Notice of Appeal on March 16, 2018. App. v. I pp. 152-54. On May 1, 2018, the Department filed a second Notice of Appeal with regard to the attorney fee judgment. App. v. I pp. 178-79. On May 4, 2018, the Department filed an Unopposed Motion to Consolidate with this Court, and the Court granted such consolidation request on May 7, 2018.

STATEMENT OF THE FACTS

Colwell is a dentist licensed in the states of Iowa and Nebraska. App. v. I p. 5. He practices dentistry in Council Bluffs, Iowa and Bellevue, Nebraska. App. v. I p. 5. The Department is an agency of the state of Iowa organized and existing pursuant to Iowa Code chapter 217. App. v. I p. 5.

On May 23, 2013, the Iowa Legislature passed the Iowa Health and Wellness Plan, which was signed into law on June 20, 2013. App. v. I pp. 5-6. The Iowa Health and Wellness Plan, which included coverage for certain

dental benefits ("the Dental Wellness Plan"), expanded access to healthcare coverage for low-income, uninsured adults (ages 19-64) who are not otherwise eligible for Medicaid. App. v. I p. 6; App. v. II p. 42 (Hageman Tr. 6:6-10). The Iowa Health and Wellness Plan, including the Dental Wellness Plan, are often referred to as "Medicaid expansion." App. v. II p. 42 (Hageman Tr. 6:8-10).

On or about April 30, 2014, the Department entered a contract numbered MED-14-011 for "the Dental Wellness Plan for the Iowa Wellness and Marketplace Choice Plan" with Delta Dental. App. v. I pp. 341-95. Effective July 1, 2015, the April, 2014 Contract was amended. App. v. I pp. 396-97. This amendment changed the contract title to "The Dental Wellness Plan for the Iowa Wellness Plan" and amended the payment methodology and capitation rate payments. App. v. I pp. 396-97. In July, 2016, another contract bearing the same number and title was executed by Delta Dental and the Department. App. v. I pp. 398-457. In September, 2016, the Department and Delta Dental signed a contract amendment indicating that such amendment was effective July 1, 2016. App. v. I pp. 458-60. This "Second Amendment" added additional language to the July, 2016 Contract regarding post-stabilization services, out-of-network provider requirements, and provider-preventable conditions. App. v. I pp. 458-60.

Through its contract with the Department, Delta Dental implements the Dental Wellness Plan and serves as one of the Department's managed care organizations for the Plan. App. v. II pp. 42, 44 (Hageman Tr. 6:11-22, 8:2-7). Delta Dental manages all aspects of implementing the Plan, including building a network of dentists. App. v. II p. 42 (Hageman Tr. 6:18-22). In exchange for management of the Dental Wellness Plan, Delta Dental receives a monthly capitation payment per enrollee. App. v. I pp. 372-73, 396, 431-33 (setting forth the payment methodology in Section 1.3.4.2 of the contract). The monthly capitation payment per enrollee is considered payment in full by the Department to Delta Dental, and Delta Dental is responsible for paying providers for the services set forth in the contract and for any other costs, expenses and charges in connection with performing the contract. App. v. I pp. 372, 433 (Section 1.3.4.3). The Dental Wellness Plan, unlike traditional Medicaid, provides a tiered benefit where members earn benefits for certain healthy behaviors, like preventative dental services. App. v. II. pp. 43, 48 (Hageman Tr. 7:6-19, 14:13-19), 66; see also, e.g. App. v. I pp. 392-93, 454-55 (providing tiered benefits description).

In addition to establishing the benefits and requirements of the Dental Wellness Plan, the Department determines who is eligible for the Dental

Wellness Plan or Medicaid. App. v. I p. 349 (Section 1.3.1.2.10); App. v. II pp. 42-43 (Hageman Tr. 6:23-7:2). The Department – either directly or through its Iowa Medicaid Enterprise ("IME") division – also reviews and approves the materials and communications that Delta Dental issues to Dental Wellness Plan providers and/or members. App. v. II pp. 46-47, 52-53, 62 (Hageman Tr. 10:11-13, 12:4-10, 19:15-20:7, 31:5-13). More specifically, the Department reviews and approves the Dental Wellness Plan Dentist Office Manual (also referred to as the "provider manual") which is prepared by Delta Dental and provided to the Dental Wellness Plan providers. App. v. II pp. 45-46, 51 (Hageman Tr. 9:2-10:19, 18:22-24). The Office Manual is intended to be consistent with Delta Dental's contract with the Department as well as the rules and regulations that govern the Dental Wellness Plan. App. v. II p. 46 (Hageman Tr. 10:14-19). The Department also discusses particular provider issues with Delta Dental, including those specifically involving Colwell. App. v. I pp. 479-83; App. v. II pp. 53-62 (Hageman Tr. 20:8-25:17, 28:5-31:4), 76-106. In other words, although Delta Dental is contracted by the Department to administer and manage the Dental Wellness Plan, the Department maintains and exercises oversight of Delta Dental – as it should since Delta Dental receives public funds to operate the Plan. App. v. II pp. 52, 57 (Hageman Tr. 19:15-22, 24:3-15). As

part of this oversight, Delta Dental is required to meet with the Department on a regular basis and submit regular reports containing specific information. App. v. I pp. 347-48, 405-06.

Colwell became a participating provider in the Delta Dental administered Dental Wellness Plan on or about April 29, 2014 by entering a Participating Dentist's Dental Wellness Plan Agreement ("the Provider Agreement"). App. v. II pp. 5-11. The Provider Agreement incorporates the Office Manual and other documents. App. v. II p. 6. Delta Dental terminated its Provider Agreements with Colwell and his associates effective January 1, 2015, which resulted in litigation. See Colwell, et. al. v. Delta Dental of Iowa and Department, Polk County Case No. CVCV051063. This litigation was resolved through a Confidential Agreement and Release between Colwell and the other plaintiffs and Delta Dental, which was effective June 9, 2016. App. v. II pp. 12-23. The Confidential Agreement and Release contained provisions relating to the Provider Agreement and also set forth certain provisions regarding the processing or reconsideration of claims submitted during certain time frames. App. v. II pp. 12-23.

Colwell timely submitted claims to Delta Dental pursuant to the Confidential Agreement and Release. On October 12, 2016, Delta Dental issued two letters regarding its review of those claims. App. v. II pp. 109-

18. Both letters related to claims originally submitted prior to January 1, 2015 and thus, they provided Delta Dental's decision on the appeal of claims that were previously denied in whole or in part. App. v. II pp. 109-18. On November 10, 2016, Delta Dental issued an addendum to the October 12, 2016 letters stating that Colwell had a "right to seek a state fair hearing with respect to the claims that were re-reviewed and disallowed" and referenced the Office Manual. App. v. I p. 423; App. v. II p. 51 (Hageman Tr. 18:15-24).

Colwell then sought a state fair hearing for the claims. App. v. II pp. 24-35. The Department acknowledged receipt of the request for a state fair hearing, but denied such request on the grounds that it "is not an issue I can grant a hearing on" and asserted that it involved a contract issue between Delta Dental and Colwell. App. v. I pp. 470-73. Colwell requested reconsideration, asserting that he met certain criteria for which the Department indicated it could grant a state fair hearing. App. v. I p. 474. Despite these clear definitions that Colwell satisfied, the Department again stated that Colwell was not entitled to a state fair hearing. App. v. I p. 475-76. The Department specifically stated that because the October 2016 decision from Delta Dental was based upon the Confidential Agreement and Release, it was a contract issue with Delta Dental. App. v. I p. 475.

ARGUMENT

I. THE DISTRICT COURT CORRECTLY HELD THAT IOWA CODE SECTION 249A.4(11) REQUIRES THE DEPARTMENT TO PROVIDE COLWELL A STATE FAIR HEARING.

A. Preservation of Error and Standard of Review.

Colwell agrees with the Department's assertion that error has been preserved. Colwell does not dispute the Department's general assertions regarding the Court's review under Iowa Code chapter 17A, but he does dispute the Department's assertions with regard to the level of deference to be afforded to the Department. See Department's Brief, Argument § I.

Judicial review of agency actions is governed by Iowa Code section 17A.19. See Iowa Code § 17A.19; Brakke v. Iowa Department of Natural Resources, 897 N.W.2d 522, 530 (Iowa 2017) (citing Kay-Decker v. Iowa State Board of Tax Review, 857 N.W.2d 216, 222 (Iowa 2014)). This Court is to "'apply the standards of section 17A.19(10) to determine if [it] reaches the same results as the district court.'" Id. (quoting Renda v. Iowa Civil Rights Commission, 784 N.W.2d 8, 10 (Iowa 2010)). The District Court may grant relief if the agency's action prejudiced the rights of the petitioner and the agency's action falls within one of the criteria set forth under Iowa Code section 17A.19(10). Id. (citing Renda, 784 N.W.2d at 10).

Two of the fourteen grounds listed in Iowa Code section 17A.19(10) specifically relate to an agency's interpretation of a provision of law. An agency action may be reversed or modified if it is "[b]ased upon an erroneous interpretation of a provision of law whose interpretation has not clearly been vested by a provision of law in the discretion of the agency." Iowa Code § 17A.19(10)(c). An agency action may also be reversed or modified if it is "[b]ased upon an irrational, illogical, or wholly unjustifiable interpretation of a provision of law whose interpretation has clearly been vested by a provision of law in the discretion of the agency." Id. at § 17A.19(10)(l). This Court has held that the Court is to review "an agency's interpretation of a provision of law under either the highly deferential 'irrational, illogical or wholly unjustifiable' standard, or the nondeferential errors-at-law standard." Iowa Dental Ass'n v. Iowa Insurance Division, 831 N.W.2d 138, 142-43 (Iowa 2013).

Deference is given "only if our legislature clearly vested authority to interpret the provision with the agency." Id. at 143 (citing Iowa Code § 17A.19(10)(c)); Iowa Code § 17A.19(11). Accordingly, in order to determine the appropriate standard of review, the Court must first address whether the agency (in this case, the Department) has been clearly vested with authority to interpret the provision of law at issue. There is no

provision clearly vesting the Department with discretion to interpret Iowa Code section 249A.4(11). Eyecare v. Department of Human Services, 770 N.W.2d 832, 836 (Iowa 2009) (holding that the Department had not been given discretion to interpret rules and regulations relating to Medicaid). While the Department asserts that its construction should be given "great weight", it admitted in its submissions to the District Court that the Department does *not* have the authority to interpret its own rules and the non-deferential error of law standard should apply. App. v. I p. 111 (December 19, 2017 Tr. 47:6-13) (admitting that the Department "doesn't have the authority to interpret its own rules" and agreeing that the Court decides what the rules mean); see also App. v. I p. 82 (stating in Department's Brief that the Court's standard of review was correction of errors at law). The District Court properly held that the Department had not been provided interpretive powers over the statutory provision at issue and thus, the standard of review was for errors at law. App. v. I pp. 132-33.

To the extent that this dispute also includes interpretation of federal statutes and rules, the Department – who is not clearly vested to interpret its own Medicaid-related statutes and rules – is most certainly not vested with discretion to interpret federal statutes and rules relating to Medicaid. See Perry v. Dowling, 95 F.3d 231, 236 (2d Cir. 1996) (citing Turner v. Perales,

869 F.2d 140, 141 (2d Cir. 1989)) (holding that when state agency is involved in interpreting a federal statute, deference is not appropriate). Accordingly, the non-deferential error at law standard applies to the Court's review of the Department's actions in this matter. See Iowa Dental Ass'n, 831 N.W.2d at 143; Iowa Code § 17A.19(11).

Even if the Department's interpretation of the statutory provision is entitled to deference, it is still subject to reversal if it is in violation of any provision of law, if it is irrational, illogical or wholly unjustifiable, if it is deemed to lack any foundation in rational agency policy, and/or if it is "unreasonable, arbitrary or an abuse of discretion." Iowa Code § 17A.19(10)(b), (i), (k), (l), (m), (n). An agency action is arbitrary or capricious when it is taken without regard to the law or facts of the case, and it is unreasonable when it is clearly against reason and evidence. Dico, Inc. v. Iowa Employment Appeal Board, 576 N.W.2d 352, 355 (Iowa 1998) (citing Soo Line R.R. v. Iowa Department of Transportation, 521 N.W.2d 685, 688-89 (Iowa 1994)). "Unreasonable" is defined as the agency acting '"in the face of evidence as to which there is no room for difference of opinion among reasonable minds…or not based upon substantial evidence.'" Greenwood Manor v. Iowa Department of Public Health, 641 N.W.2d 823, 831 (Iowa 2002) (quoting Citizens' Aide/Ombudsman v. Rolfes, 454

N.W.2d 815, 819 (Iowa 1990) (further citation omitted in original)). The Iowa Supreme Court has held that even when giving weight to the agency's interpretation, "the meaning of any statute is always a matter of law to be determined by the court." Birchansky Real Estate, L.C. v. Iowa Department of Public Health, 737 N.W.2d 134, 138-39 (Iowa 2007) (citing City of Marion v. Department of Revenue & Finance, 643 N.W.2d 205, 206 (Iowa 2002)). Accordingly, even under this arguably more deferential standard, the Department's interpretation and application of the statute at issue was properly reversed by the District Court.

Agency actions are also subject to reversal for reasons other than the interpretation or application of law. See Iowa Code § 17A.19(10)(f), (j), (n). The judicial review standards specifically recognize that agency decisions must be supported by substantial evidence in the record when that record is reviewed as a whole. Iowa Code § 17A.19(10)(f). Substantial evidence is defined as "the quality and quantity of evidence that would be deemed sufficient by a neutral, detached and reasonable person, to establish the fact at issue when the consequences resulting from the establishment of that fact are understood to be of serious and great importance." Id. at § 17A.19(10)(f)(1). This substantial evidence review must involve a "fairly intensive review of the record to avoid rubber-stamping the agency's

finding." Federal Express Corp. v. Mason City Human Rights Commission, 852 N.W.2d 509, 511 (Iowa Ct. App. 2014) (citing Wal-Mart Stores, Inc. v. Caselman, 657 N.W.2d 493, 499 (Iowa 2003)).

In reviewing an agency decision, the Court may also consider whether the agency appropriately considered the information presented to it. Iowa Code § 17A.19(10)(j). The Court may reverse the decision if during the decision-making process, the Department "did not consider a relevant and important matter relating to the propriety or desirability of the action in question that a rational decision-maker in similar circumstances would have considered prior to" granting the application. Id. Here, the Department did not even assess the relevant statutory provisions or its own rules, let alone the factual information regarding Colwell's request. Accordingly, the District Court properly reversed the Department's decision, albeit on other grounds, in that it failed to consider relevant information and failed to have substantial evidence to support its denial of Colwell's request. Id. at §§ 17A.19(10)(f), (j).

Accordingly, under these provisions of Iowa Code section 17A.19(10), the Department's action in denying Colwell's request for a state fair hearing was properly reversed. The District Court's decision should be upheld.

B. The District Court Appropriately Held that Iowa Code Section 249A.4(11) Allows and Requires a Review Mechanism for Providers.

The District Court held that Iowa Code section 249A.4(11), which states as follows, "allows and requires" the Department to create a review mechanism for providers:

> [T]he director [of the Department] is hereby specifically empowered and directed to…(11) 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 [D]epartment.

Iowa Code § 249A.4(11); App. v. I p. 134. The Court held that while "reasonable minds could differ" as to the meaning of the terms "individual" and "claim for medical assistance", Colwell, as a provider, was within the scope of Iowa Code section 249A.4(11):

> Iowa Code section 249A.2 provides definitions [of] the terms used in section 249A.4(11). It defines "medical assistance" as "payment of all or part of the costs of care and services made in accordance with Tit. XIX of the federal Social Security Act and authorized pursuant to this chapter." Similarly, the term "individual" appears in the definition of "provider", denoting "providers" like Dr. Colwell to be individuals within the meaning of the Chapter. Dr. Colwell is one such individual, seeking payment for services he provided under Title XIX of the federal Social Security Act. He satisfies the requirement of being an individual with a claim for medical assistance of his own right. The mandate of Iowa Code section 249A.4(11) embraces Dr. Colwell. With this information, the meaning of

> Iowa Code section 249A.4(11) can be parsed as follows: the Director of Human Services must "provide an opportunity for a fair hearing…to an individual (e.g. provider) whose claim for medical assistance (i.e. payment) under this chapter is denied."

App. v. I pp. 135-36 (citing Iowa Code §§ 249A.2(7), 249A.2(12), 249A.4(11)).

The Department asserts that the District Court's "parsing" of Iowa Code section 249A.4(11) should be rejected and that such provision applies only to Medicaid members rather than providers. See Department's Brief, Argument § I, at pp. 13-17.[2] The Department does not, however, engage in any statutory analysis or otherwise reject the provisions the Court relied upon in Iowa Code chapter 249A to support its conclusion. Rather, the Department baldly asserts that the logic does not apply in a managed care scenario and "unnecessarily fetters the Department's ability to modernize its Medicaid program." Department's Brief, p. 14.

[2] In general support of this assertion, the Department cites to Goldberg v. Kelly, 397 U.S. 254 (1970). In that case, the United States Supreme Court addressed the issue of the termination of cash benefits, whether a pre-termination hearing was required and if so, the requirements of such hearing. Id. at 255-56. The Court did not address dental benefits nor did it address payments to providers. See id. At least one court has called into question some of the specific findings in Goldberg due to substantial legislative changes made in 1996 to the relevant provisions. See State ex. rel. K.M. v. West Virginia Department of Health & Human Services, 575 S.E.2d 393, 402 (W. Va. 2002).

As the District Court recognized, the specific words used in Iowa Code section 249A.4(11) and defined within Iowa Code section 249A.2 lead to the conclusion that providers fall within the scope of the hearing requirement. See Office of Consumer Advocate v. Iowa Utilities Board, 744 N.W.2d 640, 643 (Iowa 2008) (citing State v. Snyder, 634 N.W.2d 613, 615 (Iowa 2001)) (providing that the rules of statutory construction do not permit courts to search for meaning beyond express terms). In identifying who is entitled to a state fair hearing, the legislature chose to use the term "an individual." Iowa Code § 249A.4(11). It did not specifically define this term, but it chose to use the same term in defining the word "provider": "an *individual*, firm, corporation, association, or institution which is providing or has been approved to provide medical assistance to recipients under this chapter." Id. at § 249A.2(12) (emphasis added).

Notably, the legislature did not choose a more restrictive and specifically defined term – recipient – to identify who is entitled to a state fair hearing. See id. at §§ 249A.4(11), 249A.2(13). Iowa Code section 249A.2(13) defines "recipient" as "a person who receives medical assistance under this chapter." Id. at § 249A.2(13). By choosing the broader term "individual" instead of "recipient", the legislature signaled its intent to allow for a broader class of individuals besides Medicaid recipients to have the

ability to request a state fair hearing. See Auen v. Alcoholic Beverages Division, 679 N.W.2d 586, 590 (Iowa 2004) (citing Painters & Allied Trades Local Union v. City of Des Moines, 451 N.W.2d 825, 826 (Iowa 1990)) ("We determine legislative intent from the words chosen by the legislature, not what it should or might have said."). If the legislature wanted to limit this provision to recipients, it could have used such language. See State v. Wagner, 596 N.W.2d 83, 87-88 (Iowa 1999)) ("We assume the legislature intends different meanings when it uses different terms in different portions of a statute. If the legislature wanted to refer to annual payments in both qualifications, it could have done so.") Accordingly, the District Court's analysis of Iowa Code section 249A.4(11) is supported by the language of the statute itself as well as the legislature's choice not to use another, more limited term available to it. See id. The Department cannot escape this conclusion under the auspices of modernizing Medicaid or for other public policy reasons. See id. at 88 (citing 1 Norman J. Singer, Sutherland Statutory Construction § 2.01, at 15 (5th ed. rev. vol. 1994)) ("Once the legislature has spoken, the court's role is to give effect to the law as written, not to rewrite the law in accordance with the court's view of the preferred public policy…. Therefore, it would be inappropriate for this court to rely on

the State's notion of the best public policy to rationalize an inference that the legislature surely intended to expand the State's territorial jurisdiction.").

The Department cites to the United States' Health and Human Services Secretary's interpretation of a similar federal provision and misleadingly cites to an Iowa Supreme Court case to assert that the interpretation is entitled to great weight. See Department's Brief, pp. 15-16. This assertion does not withstand scrutiny. First, even though the federal agency asserted that its own regulation does not require independent provider rights to challenge managed care organization decisions, it specifically recognized that a state is not prohibited from granting providers an independent right. See 66 Fed. Reg. 6228-01 at 6343, 2001 WL 42230 (Jan. 19, 2001) ("However, this regulation does not prohibit a state from granting providers the right to challenge" managed care organization "decisions affecting them."). Second, contrary to the Department's assertion, the Iowa Supreme Court's decision in Pippen v. State, 854 N.W.2d 1 (Iowa 2014) does not require this Court to give such analysis "great weight." Pippen specifically referred to "decisions and interpretations of federal courts" – not federal agencies. Id. at 30. Additionally, the Department failed to include the entire quote from Pippen, thereby changing the meaning of the Court's holding:

> Although decisions and interpretations 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, *they are neither conclusive nor compulsory*, especially when it appears earlier statutes substantially similar have also been enacted in other states.

Id. (emphasis added). Accordingly, even if this was a federal court holding interpreting the federal statute, such holding would not be conclusive or compulsory on this Court. See id.

Thus, the District Court's determination that Iowa Code section 249A.4(11) requires and allows the Department to provide a review mechanism to providers is supported by the clear language in Iowa Code section 249A.4(11), the definitions provided within Iowa Code chapter 249A and general statutory construction principles. The District Court's determination should be upheld.

II. THE DISTRICT COURT CORRECTLY HELD THAT THE DEPARTMENT'S RULES PROVIDE COLWELL A RIGHT TO A STATE FAIR HEARING INDEPENDENTLY AND/OR AS A REPRESENTATIVE OF HIS PATIENTS.

A. Preservation of Error and Standard of Review.

Colwell agrees with the Department's assertion that this argument has been preserved. The Department restates the same standard of review as its argument pertaining to the statutory analysis. See Department's Brief,

Argument §§ I, III. For the same reasons stated above, Colwell does not agree with the Department's assertions regarding the level of deference. See Argument, § I.A.

The standard of review under Iowa Code section 17A.19(10) applies to provisions of law, which includes administrative rules. See Evercom Systems, Inc. v. Iowa Utilities Board, 805 N.W.2d 758, 763 (Iowa 2011) (stating that "provision of law" includes agency rules); see Argument §, I.A (describing review of claims under Iowa Code section 17A.19(10)(c) and (l)). The Department's assertion that its construction should be given weight is contrary to the Iowa Supreme Court's pronouncement in Eyecare v. Department of Human Services:

> Iowa Code section 249A.4 empowers the director of [the Department] to adopt rules regarding reimbursement for medical and health services for Medicaid patients. [The Department] argues because the legislature has given them broad or sole authority to run the Medicaid program, it has the power to interpret its own rules and regulations. However, the statute does not clearly give [the Department] the authority to interpret its rules and regulations. See State v. Public Employment Relations Board, 744 N.W.2d 357, 360 (Iowa 2008) (finding the power to enact, implement, and administer rules and regulations is not the same as the power to interpret them); Mosher v. Department of Inspections & Appeals, 671 N.W.2d 501, 509 (Iowa 2003) (finding "general regulatory authority… does not qualify as legislative delegation of discretion" to the agency). As the legislature has not clearly vested [the Department] with the authority to interpret its rules and regulations, we will not defer to [the Department]'s interpretation. Therefore, our review of [the Department]'s

> interpretation of its rules and regulations is for correction of errors at law.

Eyecare, 770 N.W.2d at 836 (citing Iowa Code § 17A.19(10)(c)). The Court has long recognized that it is not bound by an agency's interpretation of an administrative rule, and the meaning of a rule interpreting a statute is for the court to decide. Office of Consumer Advocate, 744 N.W.2d at 643; Hollinrake v. Iowa Law Enforcement Academy, 452 N.W.2d 598, 601 (Iowa 1990). As the District Court held, the Court must not to give deference to an agency's interpretation when the interpretation is plainly inconsistent with the rule. Des Moines Independent Community School District v. Department of Job Service, 376 N.W.2d 605, 609 (Iowa 1985) (citing Sommers v. Iowa Civil Rights Commission, 337 N.W.2d 470, 475 (Iowa 1983)); App. v. I p. 136.

The Department admitted to the District Court that it has not been given interpretive powers and thus, the error at law standard should apply. App. v. I pp. 82, 111 (December 19, 2017 Tr. 47:6-13). Accordingly, the District Court correctly held that the Department's interpretation is not entitled to deference and is subject to the error at law standard. App. v. I p. 136.

Even if the Department were entitled to deference, its denial is still subject to reversal if it is in violation of any law, irrational, illogical or

wholly unjustifiable, lacks foundation in rational agency policy and/or is "unreasonable, arbitrary or an abuse of discretion." Iowa Code § 17A.19(10)(b),(i), (k), (l), (m), (n). Agency action is arbitrary or capricious when it is taken without regard to the law or facts of the case, and it is unreasonable when it is clearly against reason and evidence. Dico, Inc., 576 N.W.2d at 355 (citing Soo Line R.R., 521 N.W.2d at 688-89); see also Greenwood Manor, 641 N.W.2d at 831 (defining unreasonable as acting "in the face of evidence as to which there is no room for difference of opinion…or not based upon substantial evidence").

Agency actions must also be consistent with a rule and/or prior practices and precedents of the agency and within the scope of the agency's authority. Id. at §§ 17A.19(10)(b), (g), (h). As set forth more fully below, the Department's denial of Colwell's request for a hearing is inconsistent with the Department's own rules as well as the practices and precedents set forth in contracts and manuals that it expressly approves. Furthermore, because the Department's denial is not based upon the administrative rules that apply to the Dental Wellness Plan, such denial is not within the scope of its authority.

B. The Department's Rules Provided Colwell an Independent Right to a State Fair Hearing.

Even if the Department is not *required* by Iowa Code section 249A.4(11) to give providers a state fair hearing, the Department can certainly choose to do so through its duly enacted administrative rules. Iowa Code § 249A.4(11); 66 Fed. Reg. 6228-01 at 6343, 2001 WL 42230 (Jan. 19, 2001) (providing that the federal regulation does not prohibit a state from granting providers the right to administratively challenge managed care organization decisions affecting them). The District Court correctly held that the Iowa Administrative Code sections in effect at the time provide both for Cowell independently and a representative of a patient to pursue state fair hearings. App. v. I pp. 136-44. In its Brief, the Department's only argument – without any citation to authority – is that the appeal right is only for the Medicaid member. See Department's Brief, Argument § III. This assertion does not hold up even under the most basic analysis of the rules' language. See Hollinrake, 452 N.W.2d at 601 (citations omitted) (providing that the rules of construction pertaining to statutes also apply to administrative rules); Office of Consumer Advocate, 744 N.W.2d at 43-44 (citations omitted) (providing that courts look at the express terms used and presume that they are used in their "ordinary and usual sense with the meaning commonly attributed to them").

The Department specifically chose to have its rules regarding state fair hearings apply to the Iowa Health and Wellness Plan, which includes the Dental Wellness Plan. Iowa Admin. Code r. 441-74.10(1), App. v. I p. 234 (providing that decisions regarding eligibility or services provided under the Iowa Health and Wellness Plan may be appealed pursuant to Iowa Administrative Code section 441-7). The Department's rules for state fair hearings apply to persons meeting the definition of an "aggrieved person." Id. at r. 441-7.1, *Aggrieved Person*, ¶ 7, App. v. I p. 182. Iowa Administrative Code section 441-7.1 has a specific paragraph that identifies specifically when a *provider* is an "aggrieved person", two of which are applicable here regarding Colwell's independent right to a hearing:

- His/her/its "claim for payment or request for prior authorization of payment has been denied in whole or in part and who states that the denial was not made according to department policy…."
- He/she/it "has been notified that the managed care reconsideration process has been exhausted and who remains dissatisfied with the outcome."

Id.[3] It is non-sensical for the Department to assert that these rules only apply to Medicaid providers, when there is a specific subsection devoted to

[3] In its Brief, the Department quotes to numbered paragraph 3 of Iowa Administrative Code section 441-7.1 and ignores the provisions specific to providers that were relied upon in the Department's denials and that have been the subject of these proceedings. See Department's Brief, pp. 23-24;

providers as "aggrieved persons." See id. Further, the Department recognized the applicability of these provisions to Colwell by restating the provider provisions in November 28, 2016 denial letter. App. v. I pp. 472-73. These provisions were also provided in response to Colwell's request for the applicable procedures and protocols. App. v. I pp. 477-78 (complete records request response available at AR 439-642).

Colwell satisfies both of the definitions listed above. With regard to the first definition, Colwell's claim for payment has been denied in whole or in part. Iowa Admin. Code r. 441-7.1, *Aggrieved Person*, ¶ 7, App. v. I p. 182. Delta Dental works on behalf of the Department implementing Department policy, and thus, Delta Dental's action is the action of the Department. See App. v. I pp. 346, 350-67 (providing contract sections regarding benefits). Colwell asserts that Delta Dental's claim denials were not made in compliance with this contract and thus, were not in accordance with Department policy. App. v. II pp. 24-35.

As to the second definition, Colwell has been notified that the reconsideration process has been exhausted. Iowa Admin. Code r. 441-7.1, *Aggrieved Person*, ¶ 7, App. v. I p. 182; App. v. I p. 469. Colwell has also

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App. v. I pp. 472-73; Iowa Admin. Code r. 441-7.1, *Aggrieved Person*, ¶ 7, App. v. I p. 182.

clearly indicated that he remains dissatisfied with the outcome. See id.; App. v. II pp. 24-35.

As the District Court recognized, the Department's disregard of the clear and applicable language to Colwell's request is strained and unreasonable, lacks coherency, and is "not based upon anything but the assertions of [the Department's] counsel." App. v. I pp. 137-38. Furthermore, prior statements by the Department and its subsequent amendment of the rules support Colwell's reasonable interpretation that he is entitled to a state fair hearing under these definitions. App. v. I pp. 138-40.

1. The Department's contracts and statements support the District Court's determination that Colwell has an independent right to a hearing.

Delta Dental's contract with the Department states that providers have the right to appeal and seek a state fair hearing:

> 1.3.1.4.5: "The Plan shall, upon request, make available to Enrollees and potential Enrollees in the Plan's service area information concerning the following: …(iii) *Grievance and appeal procedures.* The procedures available to an Enrollee ***and a dental care provider*** to challenge or appeal the failure of the Plan to cover a service."
>
> 1.3.1.8: "…The Plan shall provide the following grievance, appeal, and fair hearing procedures and timeframes to ***all providers*** and subcontractors at the time they enter into a contract…***any State-determined provider appeal rights to challenge the failure of the organization to cover a service."***

> 1.3.1.8.5.3: "The Enrollee ***or Provider*** may file an Appeal either orally or in writing and must follow an oral filing with a written, signed, Appeal."
>
> 1.3.1.8.7: "Access to State Fair Hearing. Fair hearing Process: Plan notification of State Procedures. If the Plan takes Action and the Enrollee requests a State fair hearing, ***the Agency (not the Plan) must grant the Enrollee a Fair hearing if such request is made within the policies established by the Agency.*** The right to a fair hearing and how to obtain a hearing must be explained to the Enrollee ***and Provider*** by the Plan. Other information for Enrollees and Providers would include:…The Provider may request a State fair hearing only if the Agency permits the Provider to act as the Enrollee's Authorized Representative….[4] The parties to the State fair hearing include the Plan as well as the Enrollee ***and his or her representative*** or the representative of a deceased Enrollee's estate."

App. v. I pp. 351, 359, 362, 364-65 (emphasis added). Similar provisions are contained in the July, 2016 contract between the Department and Delta. App. v. I pp. 409 (Section 1.3.1.4.5), 418 (Section 1.3.1.8), 422 (Section 1.3.8.5.1), 424 (Section 1.3.1.8.7). These provisions clearly indicate that the Department can and does allow providers to independently request state fair hearings.

2. The Department's actions after Colwell's hearing request further support the District Court's holding.

After Colwell filed the underlying hearing request and the Petition for Judicial Review, the Department amended the rules relied upon by Colwell.

[4] The Department's rules specifically allow a provider to act as an enrollee's authorized representative. See Argument, § II.C (citing Iowa Admin. Code 441-7.1, *Aggrieved Person*, ¶ 7, App. v. I p. 182).

See ARC 3093C (effective July 12, 2017), App. v. I pp. 303-21. Because the amendments were not effective until July 12, 2017, they do not apply to Colwell's request for a hearing here. However, "[t]his appears to be a recognition by [the Department] that the rule in effect at the time Delta denied Dr. Colwell's claims for payment provided Dr. Colwell the right to a state fair hearing to review the denial of his claims." App. v. I p. 139. The Department's amendments created a new category for state fair hearings from managed care decisions and eliminated the Aggrieved Person provider-specific definitions relied upon by Colwell to assert an independent hearing right. See ARC 3093C, pp. 7-8 (revising Iowa Admin. Code r. 441-7.2(5) and 7.2(6)), App. v. I pp. 309-10. The fact that the Department made these wholesale changes related to managed care decisions and provider appeal rights indicates that it intended to change the law to limit a provider's independent ability to request a hearing. See Iowa Admin. Code 441-7.1, *Aggrieved Person*, ¶ 7, App. v. I p. 182; see also Star Equipment, Ltd. v. Iowa Department of Transportation, 843 N.W.2d 446, 455 (Iowa 2014) (stating that when a statute or rule is amended, there is a presumption that a change in the law was intended). The Department's changes were clearly intended to limit a provider's ability to appeal managed care decisions where such limits did not previously exist.

As a result of these contractual, statutory and regulatory provisions, it is clear that Colwell is entitled to a hearing independent of the patient. The Department's denial of Colwell's request as a mere "contractual dispute" with Delta Dental was without merit, and the District Court correctly reversed such determination. App. v. I pp. 136-40; see also App. v. II pp. 12-23. In fact, the Department's counsel admitted that the Confidential Agreement and Release did not change Colwell's position as a provider. App. v. I p. 113 (December 19, 2017 Tr. 53:6-11).

The Department's position that a provider, like Colwell, cannot independently seek a state fair hearing for any matters involving a managed care decision under the Dental Wellness Plan is not supported by the administrative rules or any other evidence and thus, the Department's denial is erroneous, lacking in substantial evidence, illogical, wholly irrational, fails to consider relevant and important information and is otherwise unreasonable, arbitrary, capricious and an abuse of discretion. See Iowa Code § 17A.19(10)(c), (f), (i), (j), (l), (m), (n). The denial is also inconsistent with rules and practices and well outside the governing law related to hearing requests. See id. at § 17A.19(10)(b), (g), (h). Accordingly, the District Court properly reversed the Department's denial of Colwell's hearing request.

C. The District Court Correctly Held that Colwell is Entitled to a State Fair Hearing as a Representative of His Patients.

In addition to the provisions described above, the Department's definition of "Aggrieved Person" states that a provider is aggrieved if "'as a managed care organization (MCO) provider or Iowa plan contractor when acting on behalf of a member [he/she/it] has a dispute regarding payment of claims.'" Iowa Admin. Code 441-7.1, *Aggrieved Person*, ¶ 7, App. v. I p. 182. Colwell satisfies this definition, because he is acting on behalf of members and has a dispute regarding a claims payment. App. v. II pp. 24-35; see, e.g., App. v. II pp. 36-39 (providing patient consent to "use and disclosure of my protected health information to carry out payment activities in connection with this claim.").

The Iowa Administrative Code provision describing the Iowa Health and Wellness Plan specifically states that a provider can request a hearing on behalf of a member: "A provider requesting a hearing on behalf of a member must have the prior express written consent of the member or the member's lawfully appointed guardian." Iowa Admin. Code r. 441-74.10(1), App. v. I p. 234. In other words, if Colwell has express written consent of the member, he can appeal decisions or coverage actions once exhausting the internal appeal process. See Iowa Admin. Code r. 441-74.10(1), (3), App. v. I p. 234 (discussing requirement that coverage decisions and actions by

plans must first be appealed through internal appeal process and then can be appealed pursuant to the Department's appeal and hearing rules).[5] Colwell does, in fact, have prior express written consent of the member or the member's lawfully appointed guardian in these matters. Colwell obtained prior consent of the member with regard to each claim to use and disclose the patient's protected health information to carry out payment activities with regard to the claim. See, e.g., App. v. II pp. 36-39.[6] The patient consent specifically refers to "dental benefit plan" and thus, the "payment activities" would include attempts to obtain payment for the claims from the dental benefit plan administered by Delta Dental. See e.g., App. v. II pp. 36-39. These state administrative law provisions allowing a provider to act on behalf of a member in filing an appeal are supported by federal law, the

[5] This sub-paragraph also provides that appeals must first go through the external review process before a state fair hearing. See Iowa Admin. Code r. 441-74.10(3), App. v. I p. 234. However, the external review process does not apply to dental care services. Iowa Admin. Code r. 191-76, App. v. I pp. 211-28; Iowa Code § 514J.102(1)(a).

[6] The forms for all patients were provided in the record, which is accessible to the Court but will not be included in the Appendix. AR 771, 774, 778-80, 784, 787, 793, 795, 801-03, 811, 816, 818, 825-27, 832-33, 854-57, 868-69, 871, 874, 878, 881, 883, 887, 895, 897, 899, 904, 908, 910, 912, 917, 921, 923, 929, 932, 935, 942, 946, 953, 956, 958, 962, 964, 966, 971, 975, 981, 985, 988, 992, 994, 1001, 1006, 1012, 1015, 1019, 1024, 1026-27, 1034, 1038, 1040, 1043, 1048-49, 1053, 1055, 1063, 1066, 1068, 1072, 1077-79, 1081, 1083, 1085, 1096, 1102, 1106, 1108-09, 1120-22, 1129-30.

Department's contract with Delta Dental and the documents utilized and approved by the Department.

The federal regulations pertaining to managed care specifically state that an "enrollee" may initiate a state fair hearing after he/she has received notice that an "adverse benefit determination"[7] has been upheld. 42 C.F.R. § 438.402(c)(1)(i), App. v. I p. 333. An "enrollee" includes "providers and authorized representatives" who have written consent of the enrollee. Id. at § 438.402(c)(1)(ii), App. v. I p. 334. This provision specifically states that a provider with written consent may file an appeal, which includes appeal through the managed care organization and through a state fair hearing, if "[s]tate law permits." Id. The Department recognized the applicability of this provision by providing a copy of it in response to Colwell's public information request for the Department's applicable hearing protocols and procedures. App. v. I pp. 477-78 (complete records request response available at AR 439-642).

The Department's April, 2014 Contract with Delta Dental contains the following provisions:

> 1.3.1.8: "The Plan shall have a system in place for Enrollees ***and Providers acting upon their behalf***, which includes a

[7] "Adverse benefit determination" includes, among other things, the denial, in whole or in part, of payment for a service. 42 C.F.R. § 438.400(b), App. v. I p. 331.

> Grievance Process, an Appeal Process, ***and access to the [Department's] fair hearing system.***"
>
> 1.3.1.8.5.1: "An Enrollee may file a Plan level Appeal. ***A Provider, acting on behalf of the Enrollee and with the Enrollee's written consent***, may file an appeal.
>
> 1.3.1.8.5.3: "The Plan must:…consider the Enrollee, ***representative,*** or estate representative of a deceased Enrollee as parties to the Appeal."
>
> 1.3.1.8.7: "Fair hearing: Parties – The parties to the State fair hearing include the Plan as well ***as the Enrollee and his or her representative*** or the representative of a deceased Enrollee's estate."

App. v. I pp. 359, 362-63, 365 (emphasis added). The Department's July, 2016 Contract also contains the same Section 1.3.1.8 provision and states as follows:

> 1.3.1.8.5.1: The Contractor shall allow the member, member's authorized representative or estate representative of a deceased member, ***including a provider who has the member's written consent,*** to file a grievance or Appeal and to be parties. Contractor shall allow the enrollee, or authorized representative, to file an Appeal either orally or in writing, and unless an expedited resolution is requested, follow the oral filing with a written, signed Appeal…. The Contractor shall provide members reasonable assistance in completing forms and taking other procedural steps.
>
> 1.3.1.8.7: The Provider may request a State fair hearing only ***if the Agency permits the Provider to act as the Enrollee's authorized representative.***

App. v. I pp. 418, 422, 424 (emphasis added). The Department's rules do, in fact, allow a provider to act as an authorized representative of an enrollee. Iowa Admin. Code r. 441-7.1, *Aggrieved Person*, ¶ 7, App. v. I p. 182.

The Office Manual, which is incorporated into the Provider Agreement and which the Department explicitly approved, provides that a participating dentist acting on behalf of a covered enrollee can conduct the appeal within Delta Dental. See Iowa Admin. Code r. 441-73.12(2), App. v. I p. 233 (providing that the managed care organization's appeal policies and procedures must be approved by the Department); App. v. I pp. 466; App. v. II pp. 6, 47, 52 (Hageman Tr. 12:4-10, 19:15-22). The actions that can be appealed include the denial or limited authorization of a requested service, the reduction, suspension or termination of a previously authorized service and the denial, in whole or in part, of payment for a service. App. v. I p. 466. If unsatisfied with Delta Dental's decision on appeal of these actions, the participating dentist may then request a state fair hearing as long as the state permits the participating dentist to act as the covered enrollee's authorized representative. App. v. I p. 467; App. v. II pp. 63-65 (Hageman Tr. 36:19-38:6), 73 (providing Delta Dental representative statement that "providers, on behalf of a member, may pursue a State Fair Hearing"). As described above, state law permits the participating dentist to seek a state fair hearing,

because the Department's rules recognize a provider as an aggrieved person both independently and as a patient representative. Iowa Admin. Code r. 441-7.1, *Aggrieved Person*, ¶ 7, App. v. I p. 182; Iowa Admin. Code r. 441-74.10(1), App. v. I p. 234. Notably, the Office Manual provision regarding state fair hearings was changed to add this provision about the provider's ability to request a state fair hearing. Compare App. v. I p. 463 with App. v. I p. 467. The Office Manual is intended to be consistent not only with Delta Dental's contract with the Department, but also the rules and regulations that govern the Dental Wellness Plan. App. v. II p. 146 (Hageman Tr. 10:14-19). Presumably, the additional reference to a provider's ability to request a state fair hearing was to ensure its consistency with the contract and the Dental Wellness Plan rules and regulations. Delta Dental also explicitly recognized the ability of Colwell to request a state fair hearing with regard to these particular claims in its November 10, 2016 letter to Colwell. App. v. I p. 469.

The Department appears to agree that Colwell, as a provider, can be an authorized representative for a state fair hearing. See Department's Brief, p. 24. The Department asserts, however, that Colwell did not have the proper form of authorization, but it provides no specific authority supporting the alleged inadequacy of the provided authorizations. See Department's

Brief, pp. 24-25. Notably, the adequacy of the authorizations was not raised in the Department's initial rejection of Colwell's requests for a hearing nor was it raised by Delta Dental in its claim denials.[8] App. v. I pp. 472-73, 475-76; App. v. II pp. 109, 117.

The applicable rule with regard to the patient authorization states only that the "designation of an authorized representative must be in writing and include the signature of the person designating the authorized representative." Iowa Admin. Code r. 441-7.6(2)(a), App. v. I p. 190. The rule does not provide what this form must specifically provide, when it has to be signed or when it has to be submitted to the Department. See id. As part of the record here, Colwell provided documents he asserts satisfy this authorization requirement. See, e.g., App. v. II pp. 36-39, 107-08 (providing New Patient Agreement with "Assignment of Benefits" provision, which includes a statement expressing understanding that the dental office "will make every effort to ensure that my dental benefits are properly utilized."). As noted by the District Court, the patient specifically authorized Colwell "to submit 'dental claims for dental care' on the patient's behalf and

[8] Under its contract with the Department, Delta Dental is required to "provide members reasonable assistance in completing forms and taking other procedural steps." App. v. I p. 422 (Section 1.3.1.8.5). This would most certainly include ensuring that the member had completed any specifically required forms in order to effectuate an appeal.

acknowledged that Dr. Colwell would 'make every effort to ensure that [the patient's] dental benefits are properly utilized." App. v. I p. 141. The Court properly held that any factual disputes about these authorizations can be adjudicated at the state fair hearing, where each side has the ability to present factual information. App. v. I p. 145.

Interestingly, the Department yet again recognized the lack of support for its position and made additional amendments to the rules in order to prevent the outcome it does not like with regard to Colwell's hearing request. See Star Equipment, Ltd., 843 N.W.2d at 455 (stating that when a statute or rule is amended, there is a presumption that a change in the law was intended). The Department first added a provision that the written consent to appeal must be filed with the appeal request. ARC 3093C, p. 7, App. v. I p. 309 (providing revised Iowa Administrative Code section 441-7.2(5)(b)). Approximately a year after this change, the Department stated that it recognized there was not a "consistent way to obtain written consent from members" and proceeded to enact a rule and required form to appoint an authorized representative. See Informational Letter No. 1922-MC-FFS-D, *available at* https://dhs.iowa.gov/sites/default/files/1922-MC-FFS-D_AuthorizedRepresentative-for-ManagedCareAppeals.pdf; see also ARC 3871C (effective August 8, 2018), App. v. I pp. 322-25 (providing

amendments to Iowa Administrative Code section 441-7 regarding authorized representative form). These rules did not exist at the time Colwell filed his claims here and the Department cannot attempt to apply standards that it wish existed in order to prevent Colwell's hearing requests.

The Department's position that a provider, like Colwell, cannot seek a state fair hearing for any matters involving a claim with Delta Dental under the Dental Wellness Plan, even as a representative of a patient, is simply not supported by the administrative rules, the contracts or any other available information and thus, the denial based upon such position is erroneous, lacking in substantial evidence, illogical, wholly irrational, fails to consider relevant and important information and is otherwise unreasonable, arbitrary, capricious and an abuse of discretion. See Iowa Code § 17A.19(10)(c), (f), (i), (j), (l), (m), (n). The denial is also inconsistent with rules and practices and in violation of the law. See id. at § 17A.19(10)(b), (g), (h). Accordingly, the District Court properly reversed the Department's denial of Colwell's hearing request.

III. THE DISTRICT COURT CORRECTLY HELD THAT COLWELL CAN BILL PATIENTS FOR SERVICES NOT COVERED OR REIMBURSED.

A. Preservation of Error and Standard of Review.

Colwell agrees with the Department's assertion that this argument was presented to and decided by the District Court. See Department's Brief, § II. However, it was presented by the Department as an argument to deny Colwell a state fair hearing as an authorized representative, rather than a separate issue presented to the Court. See App. v. I pp. 92-95. Although the Department's presentation now procedurally differs, the District Court was correct in denying the Department's argument.

The issue of whether Colwell is entitled to bill a Medicaid or Dental Wellness Plan member for an uncovered service is subject to the same standards of review set forth in Argument sections I and II herein as it pertains to the interpretation of statues and rules. This Court is to "'apply the standards of section 17A.19(10) to determine if [it] reaches the same results as the district court.'" Brakke, 897 N.W.2d at 530 (quoting Renda, 784 N.W.2d at 10). The Department has not been given deference to interpret the statutes or rules at issue and thus, an error at law standard applies to the Court's review. See Eyecare, 770 N.W.2d at 836 (holding that the Department had not been given discretion to interpret rules and regulations relating to Medicaid); Iowa Dental Ass'n, 831 N.W.2d at 143 (providing that error at law standard applies when agency has not been given deference). Accordingly, the Department's action must be reversed if it is

an erroneous interpretation of the law or in violation of the law. Iowa Code § 17A.19(10)(b), (c). Even if the Department's interpretation of the statutory provision is entitled to deference, it is still subject to reversal if it is irrational, illogical or wholly unjustifiable, lacks foundation in rational agency policy and/or is "unreasonable, arbitrary or an abuse of discretion." Id. at § 17A.19(10)(i), (k), (l), (m), (n).

B. Providers Can Bill Medicaid or Wellness Members for Uncovered Services.

The Department asserts that because Medicaid providers are required to accept what Medicaid pays as payment in full, any attempt to recoup payment from Medicaid members is a violation of the law and the Provider Agreement. See Department's Brief, Argument, § II, at pp. 19-20. The Department's position, which was rejected by the District Court, misconstrues the law and regulations. App. v. I pp. 141-44.

It should first be noted that while repeatedly trying to separate itself and Medicaid from the Dental Wellness Plan and the managed care organizations,[9] the Department equates the parties and the provider

[9] The Department's repeated efforts in this regard are belied by the facts and law. Factually, as set forth above, the Department not only contracts directly with Delta Dental, it also oversees and requires regular reporting from Delta Dental. App. v. I pp. 347-48 (Section 1.2.1.3), 405-06 (Sections 1.2.1.3-1.2.1.7); App. v. II pp. 46-47, 51-62 (Hageman Tr. 10, 12, 18-25, 28-31). Legally, there is a connection between the providers, because a provider is

agreements to support its assertion that Colwell cannot bill Medicaid patients under any circumstances. See Department's Brief, Argument §§ I, II, III. The Department also relies upon Colwell's Medicaid provider agreement in attempt to limit his payment for services provided to Dental Wellness Plan members. See Department's Brief, p. 19 (citing App. v. I p. 486 at § 2.3). The Department cannot have it both ways. If a managed care organization is subject to Medicaid-related rules as to provider billing restrictions, then it is also subject to the Medicaid-related rules pertaining to state fair hearings. See Argument, § II.

It is important to clarify that the dispute here is not over Colwell billing the difference between his usual and customary charges with what he receives from Medicaid or Delta Dental on a specific claim. That scenario –

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required to be a Medicaid provider in order to contract with the managed care organization. See Iowa Code § 249N.6(1) (requiring the health and wellness plan network to include all providers enrolled in Medicaid); see also Provider Enrollment, available at https://dhs.iowa.gov/ime/providers/enrollment (accessed August 8, 2018) (stating that once enrolled with Medicaid, a provider must then go through the managed care organization credentialing). The Department is also required to exercise oversight over Medicaid managed care programs. See 42 C.F.R. § 438.66, App. v. I pp. 326-30; Iowa Code ch. 8F. These oversight responsibilities further support the policy supporting a state fair hearing process where the Department can review and determine if the managed care organization is properly implementing the contract requirements.

often referred to as "balance billing"[10] – is clearly prohibited and not what Colwell seeks to do. See Iowa Admin. Code r. 441-79.6(2), App. v. I p. 299 (providing that charges determined in accordance with Department policy shall be the full and complete charge for the service provided and no additional payment can be sought from the recipient for services "provided under the program"). What is at issue here is the ability of Colwell – or any provider – to bill a patient for services that are not covered at all by Medicaid or the managed care organization, as the case may be. Notably, the provider contract upon which the Department relies states that a provider's restriction on seeking payment from a member applies only to situations where the provider has received some payment. App. v. I p. 486 (stating in Section 2.3 that "A provider *receiving payment* shall accept payment from the Department…as payment in full…."). Contrary to the Department's broad assertion, there is no legal or factual basis for asserting that providers can never seek payment for services provided to individuals covered by Medicaid or the Dental Wellness Plan.

When addressing the issue of payment responsibility between Medicaid and a private insurance policy, the Iowa Supreme Court

[10] Balance billing is "when a provider bills you the difference between the provider's charge and the allowed amount." Centers for Medicare & Medicaid Services, https://www.healthcare.gov/glossary/balance-billing/ (accessed August 8, 2018).

recognized the difference between a provider seeking payment for services that are not covered at all by Medicaid as opposed to balance billing. See Becker v. Central States Health and Life Co. of Omaha, 431 N.W.2d 354, 357-58 (Iowa 1988)[11] (citing Iowa Admin. Code r. 441-79.1, 79.6(2)), App. v. I pp. 235-99. The Court specifically recognized that the legal obligation for payment on services not covered is like any contract:

> Both the law and facts convince us that at the time care was provided to him, [patient] was legally obligated to pay for it. Under the elementary principles of contract law, a party who seeks medical treatment impliedly agrees to pay the reasonable value of the services rendered.

Id. (citing Black v. American Bankers Insurance Co., 478 S.W.2d 434, 437 (Tex. 1972); Republic Bankers Life Insurance Co. v. Anglin, 433 S.W.2d 795, 796 (Tex. Civ. App. 1968); 17 Am. Jur. 2d, Contracts, § 4, at 337 (1964)). This, when coupled with the fact that there is no blanket prohibition against obtaining payment for services not covered by Medicaid and the Department-approved statements made by Delta Dental, makes clear that Colwell can seek payment for non-covered services from the patient. See App. v. I p. 486, at § 2.3; see also App. v. I p. 468 (providing that if a

[11] The Court's decision in Becker v. Central States Health and Life Co. of Omaha was overruled in Johnston Equipment Corp. of Iowa v. Industrial Indemnity, 489 N.W.2d 13 (Iowa 1992), but only as to the issue of whether failing to cross-appeal an issue foreclosed raising the issue on appeal. The propositions from Becker relied upon here were not overruled. See Johnston Equipment Corp., 489 N.W.2d at 15.

procedure or service is denied, "it is not a Covered Service of the Covered Enrollee's benefit plan and the Billed Charge [defined as the amount the dentist bills] is collectable from the Covered Enrollee if the appropriate informed consent has been signed prior to the delivery of the service.").

Indeed, any federal law restrictions on seeking payment from Medicaid enrollees are limited to "covered services." 42 U.S.C. § 438.106(b), (c). There is no provision prohibiting obtaining payment for services that are not covered by Medicaid or the managed care organization, and federal law does not contain blanket prohibition on a provider collecting for services provided to Medicaid enrollees. See 42 C.F.R. § 447.15, App. v. I p. 340 (allowing providers to accept deductibles, coinsurance or copayment required by the plan to be paid by the individual and providing that "an individual's inability to pay does not eliminate his or her liability for the cost sharing charge.").

The Department cites to a case from the Seventh Circuit in attempt to bolster its argument that providers can never seek payment from Medicaid enrollees. See Department's Brief, p. 20 (citing Banks v. Secretary of Indiana Family & Social Services Administration, 997 F.2d 231, 243-44 (7th Cir. 1993)). As the District Court recognized, this case does not relate to or resolve the issue at hand. App. v. I pp. 142-43. In Banks v. Secretary of

Indiana Family & Social Services Administration, the Seventh Circuit's denial of requested relief was based upon language found in 42 C.F.R. Sections 431.200 through 431.206, which provides for fair hearings for applicants and beneficiaries. Banks, 997 F.2d at 243. These provisions do not apply to managed care situations such as this, and the issue addressed by the Court in Banks was whether the member was entitled to notice of denial of a post-treatment claim. Id. at 246; see also, e.g., 42 C.F.R. §§ 438.402, 438.408, App. v. I pp. 333-39 (providing regulations pertinent to Medicaid managed care organizations). The Court in Banks specifically recognized that its litigants did not dispute that the medical services provided to the plaintiffs were "covered services." Banks, 997 F.2d at 246. In other words, the Seventh Circuit specifically limited its holding to situations where the services at issue were covered services. See id.

The term covered services is not defined in the federal statute. See 42 U.S.C. § 438.2 (providing definitions for chapter 438, but not containing a definition for covered services). However, state law provides a definition of covered services as "services reimbursed under the dental plan." Iowa Code § 514C.3B. The Iowa Supreme Court held that this means a service is only a "covered service" if it is "actually reimbursed to some extent under the dental plan." Iowa Dental Ass'n, 831 N.W.2d at 149. Thus, applying that

definition to the situation at hand, Colwell is only prohibited from seeking payment for services rendered to a Medicaid or Dental Wellness Plan patient if the Department or a managed care organization *actually reimburses* for the service to some extent. See id. This is consistent with the provider contract provision as well as Delta Dental's Office Manual. App. v. I pp. 468, 486.

The Department attempts to escape the application of Iowa Code section 514C.3B and the Supreme Court case interpreting such provision by asserting that Medicaid is a government benefit program rather than insurance. See Department's Brief, p. 21. The Department cites no authority for such proposition, and in fact, this is contrary to the authority available. First, the federal government specifically defines Medicaid as an "*insurance program* that provides free or low-cost health coverage to some low-income people, families and children, pregnant women, the elderly, and people with disabilities." Centers for Medicare & Medicaid Services, https://www.healthcare.gov/glossary/medicaid/ (accessed August 6, 2018) (emphasis added). Second, Delta Dental is *required* to have a valid Certificate of Authority issued by the Iowa Insurance Commissioner in order to be a Dental Wellness Plan contractor. App. v. I p. 348 (Section 1.3.1.1). The Department's rules also require managed care organizations to meet the

definition of a "health maintenance organization" in Iowa Code section 514B.1. Iowa Admin. Code r. 441-73.1, App. v. I p. 230. It is unreasonable to assert that managed care organizations are required to be subject to certain parts of the regulatory framework for insurance, but not others – especially when there is no provision excluding the Dental Wellness Plan from Iowa Code chapter 514C.

Even if Iowa Code chapter 514C is not directly applicable, it is entirely appropriate for the Court to look at '"prior decisions of this court and others, similar statutes, dictionary definitions, and common usage'" when a term is not defined in the statute at issue. Iowa Dental Ass'n, 831 N.W.2d at 145 (quoting Bernau v. Iowa Department of Transportation, 580 N.W.2d 757, 761 (Iowa 1998)). The Department has provided no reasonable basis for defining "covered services" as anything but a service that is "actually reimbursed to some extent." See id.; Iowa Code § 514C.3B.

The Department's own recent actions also recognize that Medicaid or Dental Wellness Plan patients can be financially responsible to a provider for services that are provided but not ultimately covered. As discussed above, the Department recently amended its rules to include additional details regarding patient authorizations. See Informational Letter No. 1922-MC-FFS-D, *available at* https://dhs.iowa.gov/sites/default/files/1922-MC-

FFS-D_AuthorizedRepresentative-for-ManagedCareAppeals.pdf; see also ARC 3871C, App. v. I pp. 322-25. The new form specifically has the patient or member attest as follows: "My signature *does not waive my financial obligation* should the appeal be decided in the Department's favor." https://dhs.iowa.gov/sites/default/files/470-5526.pdf (emphasis added); *see also* https://dhs.iowa.gov/appeals/appeal-a-dhs-decision (providing directions for appeal with reference to the form). The Department clearly recognizes – and in fact, has the patient attest that he or she recognizes – that despite being eligible for Medicaid benefits generally, the patient may still have financial responsibility for the services rendered.

In attempt to address the District Court's rejection of its argument that Colwell could never bill Medicaid or Dental Wellness Patients for services provided, the Department asserts that providers have other recourse. See Department's Brief, pp. 20-21. The options identified by the Department are to (1) complete the internal review process; (2) negotiate with the companies or simply not participate as a provider; and (3) pursue the dispute resolution procedures set forth in the contract. See Department's Brief, pp. 20-21. Colwell did, in fact, pursue the internal review process, but as expected, Delta Dental affirmed most of its initial determinations. App. v. II pp. 109-18. Furthermore, as set forth extensively above in Argument Section II, this

internal review is not intended to be the end of the process, but rather what is required before a state fair hearing can be granted. See Argument § II. With regard to pursuit of the dispute resolution procedures set forth in the contract, Delta Dental has made clear that the state fair hearing process must first be exhausted. App. v. II pp. 49-50 (Hageman Tr. 15:18-16:4), 73 (faulting Colwell in paragraph 31 for not yet following the administrative process available through Delta or the state fair hearing process). Accordingly, the Department's own contractor has belied the assertion that Colwell can simply pursue contractual remedies. Finally, the Department's apparent "answer" to this issue that Colwell could choose not be a provider is directly contrary to the Department's purpose for the Dental Wellness Plan. Such purpose is to ensure "adequate, quality access to dental providers across the state." App. v. I p. 345. Chasing providers away from Medicaid or a program under Medicaid expansion certainly cannot be the outcome intended by the Legislature when it enacted Iowa Code section 249A.4(11) nor by the Department when it enacted Iowa Administrative Code section 441-7.1. See App. v. I p. 144. The Department's attempt to ignore the law and instead assert that a provider should leave the program if he or she does not agree lacks foundation in rational agency policy. See Iowa Code § 17A.19(10)(k).

The Department also paints Colwell and other providers as "unscrupulous" in that they may provide services they know will be denied and then bill the Medicaid member. Department's Brief p. 20. Not only is this allegation unsupported by the record or any other information, it is ridiculous. First, it assumes that dentists will provide services that are not necessary, which would be contrary to the dentist's licensure obligations. See, e.g., Iowa Admin. Code r. 650-30.4, App. v. I pp. 300-02 (describing grounds for discipline). Second, with regard to Dental Wellness Plan members in particular, such members have incomes between 0 and 133 percent of the Federal Poverty Level. See Iowa Health and Wellness Plan Fact Sheet, p. 2, available at http://dhs.iowa.gov/sites/default/files/IowaHealthand%20Wellness_Dental_FactSheet.pdf (accessed August 8, 2018). A provider would certainly not risk his license and provide services he knows will not be covered in order to collect from an individual who is financially eligible for government assistance and likely has little to no resources or assets upon which to collect.

The Department's efforts to escape the finding that Colwell can bill patients for services that are not covered by the Dental Wellness Plan through its over-generalizations and unsupported statements is an error at

law and otherwise irrational, arbitrary and capricious, and the District Court's rejection of such position should be upheld. See Iowa Code § 17A.19(10)(c), (l), (m), (n); App. v. I pp. 141-44.

IV. THE DISTRICT COURT CORRECTLY HELD THAT COLWELL IS ENTITLED TO AN AWARD OF ATTORNEY FEES.

A. Preservation of Error and Standard of Review.

Colwell agrees that the issue of Colwell's entitlement to attorney fees was preserved for review. Because the award of attorney fees involves the interpretation and application of a statute, Colwell agrees with the Department's assertion that the review is for correction of errors at law. See Department's Brief, p. 26 (citing Branstad v. State ex. rel. Natural Resource Commission, 871 N.W.2d 291, 294 (Iowa 2015) (citing, in turn, Star Equipment, 843 N.W.2d at 451). The question to be addressed by this Court is whether the District Court "correctly applied the law with respect to an award of attorney fees under Iowa Code section 625.29." Id. (citing Remer v. Board of Medical Examiners, 576 N.W.2d 598, 600 (Iowa 1998)).

B. The District Court Correctly Entered Judgment Against the Department for Colwell's Attorney Fees.

Under Iowa Code section 625.29, a party bringing an action against the state in a judicial review matter is entitled to recover attorney fees and

other expenses if such party is the prevailing party.[12] Iowa Code § 625.29. Because the District Court wholly agreed with Colwell's assertions and determined that the Department's denial of the requested state fair hearings should be reversed, Colwell was the prevailing party. As the District Court found, the Department's actions in this matter do not meet any of the asserted exceptions to Colwell's right under Iowa Code section 625.29 to recover attorney fees. App. v. I pp. 145-50.

The Department first claims that Colwell cannot recover attorney fees, because its refusal to grant a hearing was adjudicatory. See Department's Brief, pp. 27-28 (citing Iowa Code §§ 625.29(1)(b)). In defining the term "primarily adjudicative", the Iowa Supreme Court has looked to the common and ordinary definition of such terms: "Webster's Dictionary defines "adjudicative" as "to settle *finally* (the rights and duties of the parties to a court case) *on the merits* of the issues raised," to "enter on the records of a court (a final judgment, order, or decree of sentence)." Branstad, 871

[12] The Department also alleges that Colwell cannot have "unduly protract[ed] the resolution of the Petition for judicial review" in order to qualify for an award of attorney fees. Department's Brief, p. 26. This language does not appear in Iowa Code section 625.29, and there is certainly no evidence that Colwell unduly delayed the proceedings. Rather, it was the Department that filed multiple motions with the District Court in attempt to prevent a hearing on the merits. See Department's Motion to Dismiss and Motion to Amend Caption and Motion for Inclusion of Material in Administrative Record.

N.W.2d at 297 (citing Webster's Third New International Dictionary 27 (unabr. ed. 2002)) (emphasis added). In holding that Branstad was not entitled to attorney fees, the Court noted that the case involved the presentation of investigative information and defenses raised by Branstad with an initial decision entered by an Administrative Law Judge in a contested case hearing followed by a final decision of the Commission that weighed evidence, considered defenses and determined the rights and duties of the parties. Id. at 293; see also Remer, 576 N.W.2d at 599-603 (providing that similar contested case proceedings were considered adjudicative). None of those facts exist here. The Department was not to the point of adjudicating the merits – Colwell and the member's right to coverage for the services provided – and there was no evidence presented, no presentation of defenses and no contested case proceeding.

Although the Supreme Court in Ghost Player, LLC v. Iowa Department of Economic Development, 906 N.W.2d 454 (Iowa 2018) addressed whether an administrative decision had a preclusive effect, its findings are instructive in terms of defining an "adjudicative proceeding" under Iowa Code section 625.29. The Court recognized that when "other agency action" is at issue – as it is here – the facts of the proceeding must be assessed to determine whether it can be considered "adjudicatory." Id. at

465. The essential elements of adjudication are "adequate notice, the right of a party 'to present evidence and legal argument' in support of the party's contentions, and 'to rebut evidence and argument by opposing parties.'" Id. at 463 (quoting Restatement (Second) of Judgments, § 83, at 266). In making its determination that an adjudicatory process had not occurred, the Court in Ghost Player relied upon a prior case where the Supreme Court held that when a complaint was investigated and dismissed, it did not amount to an adjudicatory process. Id. at 464 (citing to George v. D.W. Zinser Co., 762 N.W.2d 865, 869-70 (Iowa 2009). In that case, the Court held that an adjudicatory process had not occurred, because the process did not allow for the presentation of evidence or the weighing of legal arguments, and the agency had not employed any procedure resembling adjudication. George, 762 N.W.2d at 869-70. In holding that an adjudicatory process had also not occurred in Ghost Player, the Court stated as follows:

> The agency actions were imbued with informality. Ghost Player did not have a right to, nor was it provided, any kind of hearing where it was allowed to present evidence and the IDED [Iowa Department of Economic Development] would be required to respond to the arguments. Ghost Player was permitted, at the agency's discretion, to present documents and attempt to persuade the IDED to grant tax credits, but the IDED was not required to make formal findings of law and fact in response to Ghost Player. The lack of procedural rights and trial-type opportunities to present evidence and argument strongly weighs against applying res judicata in this case…. Further, the IDED action granting tax credits was not a

> proceeding in which the two parties contest facts and law before an agency decision-maker in an adversarial proceeding. Adjudications are ordinarily a three-cornered proposition, with contesting parties jousting before a passive third-party tribunal. Here, the parties were binary. There were no adversaries making arguments and providing their cases before a third party as is generally required for adjudication.

Ghost Player, 906 N.W.2d at 466. Similar facts exist here. There was no third party adjudicator. The Department itself was the opposing party and the decision-maker. App. v. I pp. 472-73, 475-76. While Colwell made assertions in his reconsideration request, there was no process or opportunity to present or respond to evidence and no formal requirement for fact-finding. Contrary to the Department's assertion, this was nothing like the Court's review of a motion to dismiss, which involves an independent reviewer (the Court) with a formalized opportunity for the opposing parties to present information and arguments resulting in a formal decision from the Court with supporting factual and legal reasons. Simply put, what occurred here through the Department's cursory and unsupported denial of Colwell's state fair hearing request was nothing near an adjudicatory proceeding and thus, the Department cannot escape its liability for fees on such basis.

The Department also claims that Colwell cannot recover attorney fees, because the action involves the state determining an entitlement to a monetary benefit. Department's Brief, p. 27 (citing Iowa Code §

625.29(1)(d)). The Department did not determine entitlement to a monetary benefit. Rather, the Department took action to prevent such a determination from actually occurring. App. v. I pp. 472-73, 475-76. There was nothing in the events that occurred here that "arose from a proceeding" where the state was determining "the eligibility or entitlement to a monetary benefit or its equivalent" and thus, such exception to the award of fees does not apply. See Iowa Code § 625.29(l)(d).

The Department's denial of a state fair hearing is not supported by substantial evidence, and thus, the substantial evidence exception also does not apply. Iowa Code § 625.29(1)(a). As the District Court recognized, no evidence of any kind was allowed to be presented, and the Department blatantly ignored its own rules, its decision was legally unsound, and it was unable to support its denial without misstating the record and the law and thus, was not supported by substantial evidence. App. v. I pp. 149-50; Argument §§ I-III. The Department claims that it had substantial evidence because Colwell "had not submitted evidence that he was acting on the Member's behalf." See Department's Brief, p. 26. Not only does this ignore the successful arguments related to Iowa Code section 249A.4(11) and the administrative rules allowing Colwell to seek a hearing independently, it seeks to impose a requirement on Colwell as to the patient authorization that

did not exist at the time of his request. See Argument, §§ I.B, II.B; Iowa Admin. Code r. 441-7.1, *Aggrieved Person*, ¶ 7, 441-7.6(2)(a), App. v. I pp. 182, 190. There is simply no evidence submitted to support the Department's assertions, let alone the substantial evidence necessary to avoid liability for Colwell's attorney fees. See Iowa Code § 625.29(1)(a).

As the District Court correctly held, Colwell is entitled to recover his attorney fees under Iowa Code section 625.29. The Department cannot escape this liability under any of the purported exceptions upon which it attempts to rely. App. v. I pp. 146-50.

C. Colwell Should Also Be Awarded Appellate Attorney Fees.

For the same reasons set forth above, Colwell is entitled to recover his appellate attorney fees. See Iowa Code § 625.29; GreatAmerica Financial Services Corp. v. Prestwood Funeral Home, Inc., 901 N.W.2d 838 (Table) 2017 WL 1735689, *4 (Iowa Ct. App. 2017) (citing Bankers Trust Co. v. Woltz, 326 N.W.2d 274, 278 (Iowa 1982) (finding that award of appellate attorney fees can be made on same basis as award of district court attorney fees). The Department's counsel admitted that appellate fees should be included if the Department's appeal is not successful. App. v. I p. 167 (April 4, 2018 Tr. 4:12-21) (stating that if Colwell prevails on appeal, the "ultimate tally" for the attorney fees will require recalculation).

If the Court affirms the District Court's decision and determines that Colwell is also entitled to appellate attorney fees, Colwell's counsel will submit an attorney fee affidavit pursuant to further instructions from the Court. The Court can determine whether it will make the award or remand to the District Court for the limited determination as to the amount of appellate attorney fees. See, e.g., GreatAmerica Financial Services Corp., 2017 WL 1735689 at *4 (finding an award of appellate attorney fees appropriate and remanding to the district court for limited purpose of determining amount).

CONCLUSION

WHEREFORE for all the reasons stated herein, Appellee, respectfully requests the Court affirm the District Court's Ruling on Petition for Judicial Review and the Court's Order entering judgment in favor of Colwell against the Department for attorney fees in the amount of $34,528.75 plus interest accruing from February 16, 2018. Appellee respectfully requests an award of appellate attorney fees and an order directing Appellee to submit an attorney fees affidavit or alternatively, remanding to the District Court for the limited purpose of determining the amount of appellate attorney fees. Appellee further respectfully requests any other order the Court deems necessary under the circumstances.

REQUEST FOR ORAL SUBMISSION

Pursuant to Iowa Rule of Appellate Procedure 6.908, Appellee requests oral argument in this matter.

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CERTIFICATE OF SERVICE AND FILING

I hereby certify that on September 11, 2018, I electronically filed this Final Brief in accordance with Chapter 16 of the Iowa Rules of Court, which will electronically serve the following attorneys of record:

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CERTIFICATE OF COMPLIANCE
WITH TYPE-VOLUME LIMITATION,
TYPEFACE REQUIREMENTS, AND
TYPE-STYLE REQUIREMENTS

1. The brief complies with the type-volume limitation of Iowa Rule of Appellate Procedure 6.903(1)(g)(1) or (2) because:

[X] this brief contains 13,727 words, excluding the parts of the brief exempted by Iowa Rule of Appellate Procedure 6.903(1)(g)(1) or

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2. This brief complies with the typeface requirements of Iowa Rule of Appellate Procedure 6.9039(1)(e) and the type-style requirements of Iowa Rule of Appellate Procedure 6.903(1)(f) because:

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[ ] this brief has been prepared in monospaced typeface using [state name and version of word processing program] with [state number of characters per inch and name of type style].

/s/ *Rebecca A. Brommel* *September 11, 2018*

Rebecca A. Brommel Date