NOT DESIGNATED FOR PUBLICATION

STATE OF LOUISIANA

COURT OF APPEAL

FIRST CIRCUIT

2010 CA 0847

RITA K. VESSIER

VERSUS

OFFICE OF THE SECRETARY OF THE LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS

Judgment rendered: OCT 2 9 2010

****

On Appeal from the 19th Judicial District Court
Parish of East Baton Rouge, State of Louisiana
Suit No: 555,275; Division 27
The Honorable Todd W. Hernandez, Judge Presiding

****

David Holman Williams **New Orleans, Louisiana**	**Counsel for Plaintiff/Appellant** **Rita K. Vessier**
Neal R. Elliott, Jr. **Baton Rouge, Louisiana**	**Counsel for Defendant/Appellee** **Office of the Secretary of the Department of Health & Hospitals**

BEFORE: KUHN, PETTIGREW AND KLINE, JJ.[1]

Kuhn, J. concurs

[1] Judge William F. Kline, Jr., retired, is serving as judge *pro tempore* by special appointment of the Louisiana Supreme Court.

Pettigrew, J. concurs

KLINE, J.

Plaintiff/appellant, Rita K. Vessier, appeals a district court judgment that upheld a Department of Health and Hospitals (DHH) decision regarding her Medicaid reimbursement. On judicial review, the district court upheld DHH's determination to reimburse, at the Medicaid rate, the approved expenses incurred while the eligibility application was pending. For the following reasons, we affirm the district court judgment upholding the administrative decision.

PERTINENT FACTS AND PROCEDURAL HISTORY

This case concerns DHH's retroactive reimbursement to Mrs. Vessier for certain payments made on behalf of her late husband Ellis Vessier, while waiting for approval of his Medicaid application. The expenses were reimbursed, but at the Medicaid proportional rate, and not for the full amount the Vessiers paid to their heath care providers. Mrs. Vessier appealed to DHH, and an administrative hearing was held on this issue. The Administrative Law Judge (ALJ), deciding in favor of DHH, stated that "[t]he DHH's clear and consistent Medicaid policy has and continues to hold that Medicaid reimbursements are made at the Medicaid rate." Mrs. Vessier sought review of DHH's decision in the district court. The district court, maintaining the administrative ruling, affirmed DHH's decision and found the decision was not arbitrary and capricious.[2] Judgment was signed, and Mrs. Vessier filed the instant appeal.[3]

---

[2] Louisiana Revised Statutes 49:964(G) provides as follows, that the district court may affirm the decision of the agency or remand the case for further proceedings. The district court may reverse or modify the decision if substantial rights of the appellant have been prejudiced because the administrative findings, inferences, conclusions, or decisions are:

(1) In violation of constitutional or statutory provisions;
(2) In excess of the statutory authority of the agency;
(3) Made upon unlawful procedure;
(4) Affected by other error of law;
(5) Arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion; or
(6) Not supported and sustainable by a preponderance of evidence as determined by the reviewing court.
...

[3] See La. R.S. 49:965 which states that an aggrieved party may obtain a review of any final judgment of the district court by appeal to the appropriate circuit court of appeal and that appeal shall be taken as in other civil cases.

In her sole assignment of error, Mrs. Vessier alleges that it was an error of law for the district court to affirm an agency decision limiting coverage to the amount that Medicaid would have paid directly to the provider, since this left the applicant and his widow liable for additional costs.

THE COMPARABILITY PROVISION

The federal comparability provision set forth in 42 U.S.C. Section 1396a(a)(10 (B) requires that a state ... provide.

> that the medical assistance made available to any individual described in subparagraph (A) - -
>
> (ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A). [4]

MEDICAID HISTORY

Medicaid, enacted as Title XIX of the Social Security Act (codified as 42 U.S.C. Section 1396a-u (1988)), is a joint federal-state program through which the federal government provides financial assistance to states to aid them in furnishing medical care to low-income or medically needy individuals. **Blanchard v. Forrest**, 71 F.3d 1163, 1166 (5th Cir. 1996). A State's participation in the program is voluntary; however, if a State chooses to participate, the state plan must comply with the federal Medicaid statutes and regulations promulgated by the Health Care Financing Administration, the federal agency responsible for overseeing state Medicaid plans. **Id.**

Under federal Medicaid law, a state plan must provide that "the medical assistance made available to any individual ... shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual ... ." 42 U.S.C. Section 1396a(a)(10)(B). **Blanchard**, 71 F.3d at 1166. The federal statute also mandates that a state Medicaid plan must make available

[4] 42 U.S.C. Section 1396a(a)(10)(a) provides for categories to whom a state must provide medical assistance as part of its Medicaid plan.

medical assistance for covered medical services furnished to the Medicaid recipient within the three months prior to the month in which the recipient applied for Medicaid, (the retroactive coverall period) if the recipient would have been eligible for Medicaid at the time the medical services were furnished. 42 U.S.C. Section 1396a(a)(34). **Blanchard,** 71 F.3d at 1166.

At issue in **Blanchard** was whether DHH's retroactive coverage policy was violating the federal mandate. The **Blanchard** court ruled that Louisiana was violating the retroactive coverage policy because Louisiana was "failing to make available medical assistance to all Medicaid applicants who incur covered medical expenses during the three months prior to the month of application." **Blanchard,** 71 F.3d at 1168. The court further stated that state's Medicaid plan must not only be fair and equitable, it must also comply with federal statutes and regulations. **Id.**

In response to **Blanchard**, DHH promulgated rules to implement a policy to provide reimbursement to recipients, like Mr. Vessier, while their applications were pending. The promulgated rules, however, provided that the reimbursement would be at the Medicaid rate. See Louisiana Register, Vol. 23, No.2 p. 201, February 20, 1997, which provides that "(B) Reimbursement shall be made only for medical care, services and supplies covered by the Medicaid Program at the time of service," and "(D) Reimbursement shall be made only up to the maximum allowable Medicaid rate for the particular service(s) rendered."

DISCUSSION

Mrs. Vessier, challenging her limited reimbursement, asserts that this application of the DHH Rule violates the comparability provisions of 42 U.S.C. Section 1396a(a)(10)(B) and (34). She alleges that since she did not receive a full reimbursement, she has been denied the scope of coverage that is received by other Medicaid recipients. She argues that reimbursing less than the recipient paid violates Medicaid's comparability requirements. Otherwise, she argues, the

recipient is receiving less coverage than persons contemporaneously certified for services, who get the benefit of Medicaid's payment in full protection. Thus, the question at issue is whether Louisiana's policy of reimbursement authorized by DHH violates the comparability provisions of the federal statutes.

We recognize, as stated by the court in **Blanchard**, that the medical assistance made available to any individual must be fair, equitable and shall not be less in amount, duration, or scope than the medical assistance made available to any other individual. **Blanchard** at 71 F.3d 1167-68. The resolution of this case, therefore, turns on whether Mrs. Vessier's reduced reimbursement for out-of-pocket costs violated those requirements.

The courts in this country have taken at least two different approaches on this issue. A federal court in Michigan discussed how different states are handling the out-of-pocket reimbursements that the recipient has incurred before their Medicaid eligibility has been approved. *See* **Schott v. Olszewski**, 401 F.3d 682 (6th Cir. 2005). Although ultimately deciding that Michigan law must provide full reimbursement to the applicant, the court succinctly explained the dilemma as follows:

> Allowing reimbursement at the Medicaid rate is essentially a way of splitting the baby. The state agency would be in the same position that it would have been in had it paid the provider directly, whereas the recipient, while still not fully reimbursed, would recoup at least some of the money spent for medical care.
>
> The Medicaid program, like all public benefit programs, requires careful balancing of costs and benefits. Both the financial integrity of the program and the needs of individual recipients must be considered. ... (Citations omitted.)
> **Schott**, 401 F.3d at 691-92.

In another jurisdiction, a Florida state court of appeal ordered full out-of-pocket reimbursement to a particular claimant. This decision, however, was based upon the untimely delay it took the Florida agency to determine that particular claimant's eligibility status. *See* **Kurnik v. Department of Health &**

Rehabilitative Services, 661 So.2d 914,(FlaApp. 1 Dist,1995). In its ruling, the court stated, "we hold that when the state agency's determination of Medicaid eligibility is unreasonably delayed in contravention of one's rights under federal statute and regulation to reasonably prompt assistance in making application and in timely determination of eligibility, such person is entitled to be made whole for out-of-pocket expenditures made before eligibility is determined." **Kurnik** 661 So.2d at 918. It appears to be Florida's policy to not fully reimburse out-of-pocket expenses when the eligibility status is determined in a timely fashion. Timeliness, however, is not at issue here. Although Mrs. Vessier argues that it took over a year for the application to be approved for Medicaid, no evidence was introduced from either party indicating why the approval took so long or whether under the particular circumstances that this was an unreasonable delay.

To the contrary however, a New York court of appeals ruled that plaintiffs were entitled to retroactive reimbursement, but only at the Medicaid rate or fee in effect at the time the care or services were rendered. *See* **Seittelman v. Sabol**, 91 N.Y.2d 618, 697 N.E.2d 154 (N.Y. 1998). The court stated that

> [T]he legislative scheme does clearly contain a 'parity provision' which requires that the medical assistance provided to any individual 'shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual.' We conclude that retroactive reimbursement for out-of-pocket costs, rather than reimbursement at the Medicaid rate in existence at the time the services were rendered, would violate the above-referenced Federal parity provision. **Seittelman**, 91 N.Y.2d at 628 (citation omitted).

The court further stated that:

> [T]he Medicaid system is premised upon the idea that the State and Federal governments will provide financial assistance to those in need but only within certain defined and accepted financial parameters. Reimbursement of Medicaid recipients' out-of-pocket expenses, which may be considerably higher than the Medicaid rate negotiated or exacted from enrolled medical providers, would be inconsistent with this premise, and thus, could not have been within legislative intent. **Seittelman**, 91 N.Y.2d at 629.

The federal 5th Circuit in **Blanchard** while interpreting the district court's ruling regarding the Medicaid reimbursement problem, stated that the district court suggested two ways to remedy Louisiana's then-existing conflict with the federal statute. It commented, however, that the district court judgment only ordered that DHH establish a mechanism for providing retroactive coverage of applicants who paid their medical bills during the retroactive coverage period. **Blanchard**, 71 F.3d at 1169. It further stated that the broadly-phrased judgment leaves open the possibility that DHH may implement an entirely different remedy, so long as its approach establishes a mechanism to provide repayment in some form to Medicaid applicants who paid their medical bills incurred during the retroactive coverage period. **Id.** Although the **Blanchard** ruling did not address the issue of this case, it allowed DHH some flexibility in about how it was to fashion a remedy. This ruling implies that the federal statutes provide flexibility in how the individual states set up their programs as long as the services are fair and equitable in amount, duration, and scope.

Mrs. Vessier argues that there is often no single Medicaid rate to be paid for a specific service. She argues that payments are capped by a variety of factors, with the medical provider usually allowed to charge the lesser of the customary rate and a maximum set by the state agency. Mrs. Vessier did not introduce any evidence as to how this flexible charge policy affects her. Rather she argues that the reimbursement dollar amount is never equal. Therefore, she argues, the recipients are not treated the same.

In **Conlan v. Shewry**, 131 Cal.App.4th 1354, 1385, 32 Cal.Rptr.3d 667, 692 (Cal.App. 2 Dist. 2005), the court *citing* **Seittelman**, 91 N.Y.2d at 674, discussed the ramification regarding the disparity in reimbursing different amounts to different claimants. That court explained that the comparability provision was designed to avoid the receipt by one class of Medicaid recipients of a greater

amount of reimbursement dollars than another. The **Conlan** court recognized that courts in various states had gone in opposite directions and both positions had valid rationales. It ultimately held, however, that the reasoning in **Seittelman** was more persuasive. The system, the court concluded, must balance the need to treat beneficiaries fairly and equally with the obligation of fiscal responsibility. **Conlan**, 131 Cal.App. 4th at 1385, 32 Cal.Rptr.3d at 692. The Department is obligated to provide the same level of benefits, but not to ensure that all beneficiaries are made whole. **Id.**

As discussed above, after extensive research, we recognize that many courts in various jurisdictions have taken opposing approaches to the reimbursement problem. Both approaches have been found to be reasonable under the law. In Louisiana, our laws require us to give great weight to the interpretation given an ordinance by the governing body that enacted it. *See* **Residents of Shenandoah Estates Subdivision v. Green Trails, LLC**, 05-1331, p. 8 (La. App. 1 Cir. 6/9/06), 938 So.2d 1027, 1031. A reviewing court should not overturn such a determination unless it is clearly wrong. **Id.**

DHH's interpretation is not clearly wrong as revealed by our review of the jurisprudence. We therefore owe great deference to the agency's interpretation of its own laws that effect them.

Accordingly, while reimbursement at the Medicaid rate may visit hardship upon some recipients, like Mrs. Vessier, we cannot say that the rules promulgated by DHH on out-of-pocket reimbursements violates the comparability provisions of federal law. Louisiana's policy of limiting reimbursement to the DHH approved rate does not treat applicants differently since the amount of reimbursements are the same. Therefore, under the facts before us, we cannot say that Mrs. Vessier's reimbursement violated the comparability provisions of 42 U.S.C. Section 1396a(a)(10)(B).

We are sympathetic to the Vessiers' situation; however, Mr. Vessier's medical assistance was not less in amount, duration, or scope than the medical assistance available to any other individual under DHH's reasonable interpretation of the federal comparability requirement. Consequently, we must conclude that, under the facts of this case, the DHH plan was fair, equitable, and complied with the federal statute and regulation, as the **Blanchard** court required. *See* **Blanchard**, 71 F.3d at 1167-69.

DECREE

For the above stated reasons, we affirm the district court judgment that upheld the Department of Health and Hospitals' administrative decision. The costs of this appeal in the amount of $688.50 is assessed to the plaintiff/appellant Mrs. Rita K. Vessier.

AFFIRMED