STATE OF WISCONSIN
COURT OF APPEALS
DISTRICT II

KATHLEEN PAPA and
PROFESSIONAL HOMECARE
PROVIDERS INC.,

Plaintiffs-Respondents,

v.

Case No. 2016AP2082 and
2017AP634

WISCONSIN DEPARTMENT OF
HEALTH SERVICES,

Defendant-Appellant.

**APPEAL FROM FINAL ORDERS OF THE
WAUKESHA COUNTY CIRCUIT COURT,
THE HONORABLE KATHRYN W. FOSTER PRESIDING**

NONPARTY BRIEF OF AMICI WISCONSIN HOSPITAL ASSOCIATION, INC., WISCONSIN MEDICAL SOCIETY, INC., WISCONSIN DENTAL ASSOCIATION, INC., PHARMACY SOCIETY OF WISCONSIN, INC., WISCONSIN HEALTH CARE ASSOCIATION, INC., AND LEADINGAGE WISCONSIN, INC.

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Wisconsin Hospital Association, Inc., Wisconsin Medical Society, Inc., Wisconsin Dental Association, Inc., Pharmacy Society of Wisconsin, Inc., Wisconsin Health Care Association, Inc., and LeadingAge Wisconsin, Inc. (collectively, the "Associations"), are non-profit organizations that represent the interests of health care providers across Wisconsin. Together, the Associations represent hospitals, health systems, physicians, residents, medical students, dentists, dental hygienists, pharmacists, pharmacy technicians, pharmacy students, skilled nursing and therapy centers, community-based providers, and facilities that provide long-term care, assisted living, and senior housing.

Each of the Associations has members who accept Medicaid recipients as patients, all of whom are potentially subject to recoupment actions by the Department of Health Services ("DHS") and the Office of the Inspector General ("OIG") under Wis. Stat. § 49.45(3)(f). For this reason, the Associations have a significant interest in the interpretation and application of Wis. Stat. § 49.45(3)(f) and the scope of DHS's authority to recoup payments under this statute. This Court's decision will affect the terms of the Associations'

members' relationships with the Medical Assistance program and Medicaid beneficiaries, will affect provider participation in the Medical Assistance program, and ultimately will impact the quality and accessibility of health care for Medicaid beneficiaries in Wisconsin.

Providers face significant barriers to serving Medicaid recipients, and these barriers have been documented by providers, academics, and journalists for years. Study after study finds that in addition to low Medicaid reimbursement rates, providers' concerns about burdensome documentation requirements factor into many providers' decisions to accept Medicaid recipients as patients. For individuals and organizations alike, administrative burdens unique to the Medicaid program add monetary and time costs and ultimately can negatively impact health care access for Medicaid beneficiaries.

Although the statutes governing the Medicaid program in Wisconsin are complex, the statutes relevant to this case are relatively straightforward. Under Wis. Stat. § 49.45(3)(f), DHS may audit provider records to verify actual provision of services and the appropriateness and accuracy of claims. DHS may recoup the full amount of payments when actual provision

of the service cannot be verified from the provider's records or when the provider was paid for a non-covered service, and DHS may recoup the amount of the error in the case of an overpayment.

However, DHS is asking the Court to interpret its statutory mandate expansively, allowing it to recoup for any compliance or documentation error, even when it is undisputed that a covered service was actually provided. The circuit court correctly determined that this interpretation is inconsistent with the Wisconsin statutes governing DHS's authority to recoup Medicaid payments. Additionally, DHS's policy of recouping the full amount of provider payment for any compliance or documentation error is inconsistent with any remedy it would be entitled to under principles of contract law or equity, and further exacerbates the barriers Wisconsin health care providers face in providing quality health care services to Medicaid recipients.

The Associations strongly support efforts by the Governor and DHS to prevent and deter fraud, waste, and abuse in the Medicaid program because "[e]liminating fraud helps guarantee these services are available for those who really need them." Press Release, Governor Scott Walker

Announces Wisconsin Office of the Inspector General (OIG) Fights Fraud, Saves Taxpayer Dollars (March 7, 2016). However, the authority DHS claims to recoup payments for services actually provided does little to prevent such fraud, and only serves to deter qualified health care providers from providing services to patients. As written, Wisconsin statutes strike the appropriate balance between DHS's oversight role and its responsibility to ensure access to health care for Medicaid recipients, and these statutes should be enforced, as written, by this Court.

I. Health Care Providers Face Significant Barriers To Serving Medicaid Recipients.

For years, academics and journalists have documented the significant barriers that health care providers face when providing health care services to Medicaid recipients. *See*, *e.g.*, Peter Cunningham & Ann O'Malley, *Do Reimbursement Delays Discourage Medicaid Participation By Physicians?*, Health Affairs 28, no. 1 (2009); Peter Ubel, *Why Many Physicians Are Reluctant To See Medicaid Patients*, Forbes, Nov. 7, 2013; Elizabeth Renter, *You've Got Medicaid – Why Can't You See the Doctor?*, US News, May 26, 2015; Guy Boulton, S*tate's Low Medicaid Payments Pinch Doctor*

Practices in Low-Income Areas, Milwaukee Journal Sentinel, July 19, 2014; *Barriers to Private Pediatricians Accepting Medicaid Patients Identified*, Reuters Health Medical News, Nov. 13, 2009. One study notes that in 2013, just prior to the implementation of the Affordable Care Act, a national average of 30 percent of office-based physicians refused to accept new Medicaid patients, and that refusal rates were even higher among specialists. Lawrence P. Casalino, *Professionalism and Caring for Medicaid Patients – the 5% Commitment?*, 369 New Eng. J. Med. 1775, 1775 (2013).

Chief among these barriers is that providers are paid less for serving Medicaid recipients than they are paid for serving patients with private insurance, and often less than the cost of providing the care. This concern is especially acute in Wisconsin. *See*, *e.g.*, Boulton, *supra* (noting that in 2014, Wisconsin's reimbursement rate was among the worst in the country); Eljay, LLC & Hansen Hunter & Co., P.C., *A Report on Shortfalls in Medicaid Funding for Nursing Center Care* (2016) (Wisconsin reimburses nursing homes $168 each day for Medicaid patient stays even though the projected cost was $221 per patient per day); Niodita Gupta et al, *Research Brief: Medicaid Fee-For-Service Reimbursement Rates for Child and*

Adult Dental Care Services for all States, *2016*, 2017 Health Pol'y Inst. 1 (noting that Wisconsin is one of three states with the lowest reimbursement rates for dental care services among states that provide dental services via fee-for-service); Jill Murphy, *Legislators Limit Choices for Medicaid Patients; Low Reimbursements Result in Fewer Providers*, The Post-Crescent, June 25, 2017 ("While requiring 25-50 percent more administrative time for providers to gain authorization for treatment, Medicaid pays on average 43-50 percent less than commercial insurers for the same services.").

Yet, a low reimbursement rate is not the only disincentive that providers face to serving Medicaid recipients. Study after study cites burdensome paperwork requirements as a significant reason that some providers opt out of Medicaid programs. Sharon K. Long, *Physicians May Need More Than Higher Reimbursements to Expand Medicaid Participation: Findings from Washington State*, Health Affairs 32, no. 9 (2013), at 1563 ("Focus-group participants reported that delays in reimbursements and difficulties with claims processing took up physician and staff time and thus added substantially to the costs of serving Medicaid enrollees. . . . Those findings were echoed in the survey results. Paperwork was reported to be a

major problem by 23.6 percent of the physicians who were seeing Medicaid patients."); Cunningham & O'Malley, *supra* ("Administrative burden includes payment delays, rejection of claims because either the billing form was completed incorrectly or the physician was not able to verify the patient's Medicaid eligibility, preauthorization requirements for certain services, and complex rules and regulations on how claims are to be filed. Indeed, although inadequate reimbursement is the reason most frequently cited by physicians for limiting Medicaid patients (cited by 84 percent of physicians), the majority of physicians also cite concerns about paperwork (70 percent) and billing delays (65 percent) as important reasons.") Steve Berman et al, *Factors that Influence the Willingness of Private Primary Care Pediatricians to Accept More Medicaid Patients*, Pediatrics, 110 n. 2 (2002); *see also* Ubel, *supra* ("To make matters worse, these low reimbursements came on top of increasingly complex paperwork that their office staff are forced to fill out."); Renter, *supra* ("When comparing reimbursement rates among health insurance plans, Medicaid is the lowest payer, meaning it's not a moneymaker for doctors' offices. Paired with the administrative requirements

of accepting public insurance, doctors sometimes just don't want the hassle.").

The Associations are concerned that an expansive, unreasonable, and unique DHS policy that would allow recoupment of Medicaid payments for covered services actually provided will only add to the disincentives for health care providers to participate in the Medicaid program, and could ultimately undermine health care access for Medicaid beneficiaries in Wisconsin.

II. The Policy That DHS Advocates For Exceeds Its Statutory Authority And Any Remedy It Would Be Entitled To Under Principles Of Contract Law And Equity.

The record demonstrates that DHS has an expansive policy and practice of recouping payments it made to nurses for covered services they provided going back five years. DHS frequently seeks to recoup the full value of these services—even when the nurses maintained documentation of the services they provided and everybody agrees that the services were authorized, that the nurses provided the services, and that the payments were appropriate for the services provided.

DHS justifies these recoupments based on providers' failure to perfectly comply with complex program and

documentation requirements. The circuit court concluded that DHS's recoupment policy amounted to a "perfection rule" that is not authorized by the statutes. (R.63 at 26:21-25.)

Although the evidence in this case relates to recoupment actions against nurses, DHS has not limited its application of a perfection standard to the nursing profession. Some members of the Associations have faced similar recoupment actions, and have been asked to pay back the full value of Medicaid payments they received for covered services that they undeniably provided as well.

A. A policy of recouping the full value of claims for any compliance imperfection exceeds DHS's statutory authority.

DHS is advocating for an expansive recoupment policy that exceeds its statutory authority. Administrative agencies must have an "*explicit* grant of authority" from the legislature before they can implement or enforce any standard or requirement. *See* State of Wisconsin, Office of the Governor, Executive Order No. 50 Relating to Guidelines for the Promulgation of Administrative Rules (citing Wis. Stat. § 227.10(2m)). A statutory provision containing a specific standard or requirement does not confer on the agency the authority to enforce or administer a rule containing a standard

or requirement that is more restrictive than the standard or requirement contained in the statutory provision. *Id.* (citing Wis. Stat. § 227.11(2)(a)2).

Under Wis. Stat. § 49.45(3)(f)1, DHS may audit records "to verify actual provision of services and the appropriateness and accuracy of claims." DHS may recover the "full value of any claim" under two circumstances: (1) when "actual provision of the service cannot be verified from the provider's records"; and (2) when "the service provided was not included in s. 49.46(2) or 49.471(11)"—*i.e.*, it is not a covered service. Wis. Stat. § 49.45(3)(f)2. DHS may also recover something less than the full value of the service "[i]n cases of mathematical inaccuracies in computations or statements of claims." *Id.* In such cases, "the measure of recovery will be limited to the amount of the error." *Id.*

There is nothing in Wis. Stat. § 49.45(3)(f)1 that grants DHS the authority to recoup the full value of services for a compliance or documentation error when the actual provision

of covered services can be verified.[1] By recouping payments made to service providers when the services are covered and their provision can be verified, DHS is exceeding the authority granted to it by Wis. Stat. § 49.45(3)(f)1.

B. A policy of recouping the full value of claims for any compliance imperfection is inconsistent with any contract remedy DHS would be entitled to receive.

At page 5 of its Brief, DHS argues that its relationship with providers is tantamount to a contract. *See also* Wis. Stat. § 49.45(2)(a)9. Yet, any claim by DHS to recover the full amount of payment for covered services that were actually provided goes far beyond any contract remedy it could receive for a provider's failure to perfectly comply with all program and documentation requirements.

The purpose of contract damages "is to compensate the injured party for losses necessarily and foreseeably flowing from the breach, but the damaged party is not entitled to be placed *in a better position* because of a damage award than [it]

[1] Wisconsin statutes provide other means for DHS to address compliance errors and omissions. Under Wis. Stat. § 49.45(2)(a)12.a, DHS may "[d]ecertify a provider from or restrict a provider's participation in the medical assistance program" under certain circumstances, and under Wis. Stat. § 49.45(2)(a)13, DHS may "[i]mpose additional sanctions for noncompliance with the terms of provider agreements . . . or certification criteria[.]" Examples of such sanctions have been defined by DHS in rule at Wis. Admin. Code §§ DHS 106.065(2) and 106.07(4).

would have been had the contract been performed." *Pleasure Time, Inc. v. Kuss*, 78 Wis. 2d 373, 385, 254 N.W.2d 463 (1977) (emphasis added). Normally, the measure of contract damages is the difference between the contract price and the value of what the non-breaching party actually received. To fully excuse the non-breaching party's own obligations under the contract, a breach must be "material," meaning that it is "so serious a breach . . . as to destroy the essential objects of the contract." *Mgmt. Computer Servs., Inc. v. Hawkins, Ash, Baptie & Co.*, 206 Wis. 2d 158, 183, 557 N.W.2d 67, 77 (1996). "If the breach is relatively minor and not of the essence, the [non-breaching party] is [] still bound by the contract; [it] can not abandon performance and get damages for a total breach . . . ." *Id.* (quoting Arthur Linton Corbin, Corbin on Contracts § 700, at 310 (1960)).

Here, the health care providers undeniably provided covered services to Medicaid recipients, and both the recipient and DHS undeniably accepted the benefits of the services they provided. It is fundamentally unfair to expect providers to provide services to Medicaid recipients for free if they fail to follow every technical requirement in a complex series of statutes, rules, and policies that are often unique to the

Medicaid program. Yet, DHS seeks to recoup the full value of covered services that were actually provided. If a private insurer sought the same recoupment remedy for non-material errors or omissions, such a remedy would be rejected under both contract law and principles of equity. DHS's broad claim of recoupment authority should be rejected as well.

III. A Perfection Rule Is Unnecessary To Ensure Compliance With Medicaid Requirements Or To Prevent Fraud, And It Further Exacerbates Barriers To Participation In The Medical Assistance Program.

The State of Wisconsin has a responsibility to taxpayers to prevent Medicaid fraud, including false claims for reimbursement for services that were not actually provided. The State of Wisconsin also has an interest in ensuring compliance with Medicaid program requirements—even when there is no suspicion of fraud. But a balance must be struck between on the one hand, ensuring that providers comply with program requirements, and on the other hand, reducing the administrative burden on legitimate providers and protecting beneficiary access to care.

As shown above, Wisconsin statutes already strike the appropriate balance. When a health care provider has been paid for providing services to a Medicaid beneficiary, the

Legislature granted DHS authority to recoup the full amount of payments if actual provision of the service cannot be verified from the provider's records or if the provider was paid for a non-covered service, and it may recoup the amount of the error in the case of an overpayment. The Legislature also granted DHS authority to de-certify or restrict a provider's participation in the program and impose sanctions for a provider's non-compliance in appropriate cases. However, fully recouping payments for covered services already rendered to a Medicaid beneficiary due to non-material compliance lapses does little to prevent waste, abuse, or fraud, (*see* R.63 at 4:24-5:9; 14:9-15, 16:19-17:10; R.65 at 25:24-26:5, 27:1-7, 28:5-11) and cannot be what the Legislature intended when it enacted Wis. Stat. § 49.45(3)(f).

Instead, the real world implication of a perfection policy for recoupments will be to discourage qualified health care providers from providing needed services to Medicare recipients. As shown above, there are already significant barriers to accepting Medicaid recipients as patients. When, in addition to these disincentives, providers are also faced with a very complex set of statutes, rules, and policies that are often unique to the Medicaid program, coupled with the possibility

having to return payments for legitimate services going back as far as five years for *any* compliance deviation, it is reasonable to expect that health care providers will be dissuaded from serving Medicaid patients. Rather than protecting taxpayers from fraud, waste, and abuse, such a policy only creates barriers to access to health care for Medicaid beneficiaries in communities across Wisconsin.

CONCLUSION

For the reasons stated above, the Associations contend that the decisions of the circuit court should be affirmed.

Dated this 4th day of December, 2017.

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FORM AND LENGTH CERTIFICATION

I hereby certify that this brief conforms to the rules contained in Wis. Stat. §§ 809.19(8)(b) and (d) for a brief where proportional serif font is used. The enclosed nonparty brief contains 2740 words.

Dated this 4th day of December, 2017.

s/Rachel A. Graham
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CERTIFICATION REGARDING ELECTRONIC BRIEF

I hereby certify that I have submitted an electronic copy of this brief, which complies with the requirements of Wis. Stat. § 809.19(12). I further certify that the electronic brief is identical in content and format to the printed form of the brief filed as of this date.

Dated this 4th day of December, 2017.

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CERTIFICATE OF SERVICE

I hereby certify that three true and correct copies of this nonparty brief were sent via U.S. Mail this 4th day of December, 2017, to the following:

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