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STATE OF WISCONSIN
IN SUPREME COURT

KATHLEEN PAPA and
PROFESSIONAL HOMECARE PROVIDERS, INC.,

Plaintiffs-Respondents-Petitioners,

v.

WISCONSIN DEPARTMENT OF HEALTH SERVICES,

Defendant-Appellant.

APPEAL NOS. 2016-AP-2082, 2017-AP-634
Waukesha County Case No. 15-CV-2403
The Honorable Kathryn W. Foster, Presiding

NON-PARTY BRIEF OF AMICI CURIAE WISCONSIN HOSPITAL ASSOCIATION, INC., WISCONSIN MEDICAL SOCIETY, INC., WISCONSIN DENTAL ASSOCIATION, INC., PHARMACY SOCIETY OF WISCONSIN, INC., WISCONSIN HEALTH CARE ASSOCIATION, INC., WISCONSIN PERSONAL SERVICES ASSOCIATION, INC., AND LEADINGAGE WISCONSIN, INC.

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ARGUMENT

Wisconsin Hospital Association, Inc., Wisconsin Medical Society, Inc., Wisconsin Dental Association, Inc., Pharmacy Society of Wisconsin, Inc., Wisconsin Health Care Association, Inc., Wisconsin Personal Services 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, dentists, dental hygienists, pharmacists, pharmacy technicians, skilled nursing and therapy centers, personal care agencies, community-based providers, and facilities that provide long-term care, assisted living, and senior housing.

The Associations each have members that provide services to Medicaid recipients. All these members are potentially subject to—and some have actually been subjected 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).

The Associations' members need clarity 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 broadly affect Association members' relationships with the Medical Assistance program and Medicaid beneficiaries; Medicaid providers' ability to challenge recoupment orders issued by DHS; and individual providers' decisions whether to participate in the Medical Assistance program.

Clarity is needed because DHS recoupment actions against providers have introduced confusion. And this confusion comes as providers already face significant barriers to serving Medicaid recipients, as documented by providers, academics, and journalists. Studies show that in addition to low Medicaid reimbursement rates, providers' concerns about overly burdensome documentation requirements factor into many providers' decision whether to accept Medicaid patients. For providers across Wisconsin, including small businesses and individuals, an overzealous DHS recoupment approach costs time and money, threatening health care access for Medicaid beneficiaries.

Although the statutes governing Wisconsin's Medicaid program are complex, the statutes relevant to this case are relatively straightforward. Under Wis. Stat. § 49.45(3)(f), DHS may recoup the full amount of a paid claim only if provider records cannot verify that *services were actually provided*, or if the provider was paid for a *non-covered service*.

However, DHS has argued it has expansive authority to recoup the full amount of payments made for *any compliance or documentation error* identified in an audit, even when it is undisputed that a *covered service* was *actually provided*.

Although the evidence in this case relates to recoupment actions against nurses, DHS has not limited application of this perfection standard to the nursing profession. 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 they undeniably provided.

In 2016, the circuit court correctly determined this interpretation is inconsistent with the Wisconsin statutes governing DHS's authority to recoup Medicaid payments. The circuit court's decision provided essential clarity regarding the limits of DHS's recoupment authority under the statutes. This Court should restore that clarity.

A policy of recouping the full provider payment for any compliance or documentation error is inconsistent with any remedy the State 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 to prevent and deter fraud, waste, and abuse in the Medicaid program. Eliminating fraud helps guarantee these services are available for those who really need them. But recouping payments for *covered services* that were *actually provided* does nothing to prevent such fraud. It only deters qualified health care providers from providing services to patients.

Wisconsin statutes strike the appropriate balance between DHS's oversight role and its responsibility to ensure access to health care for Medicaid recipients. This case simply asks the Court to direct that the statutes be followed as written.

I. Health care providers face significant barriers to serving Medicaid recipients and need clarity regarding when DHS is allowed to recoup payments.

Academics and journalists have documented the significant barriers health care providers face when providing health care services to Medicaid recipients.

In addition to poor reimbursement rates, studies cite burdensome paperwork requirements as a primary reason providers opt out of Medicaid programs:

"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."[1]

"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."[2]

"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

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[1] 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.

[2] Peter Cunningham & Ann O'Malley, *Do Reimbursement Delays Discourage Medicaid Participation By Physicians?*, HEALTH AFFAIRS 28, no. 1 (2009), at 18; *see also* Steve Berman *et al.*, *Factors that Influence the Willingness of Private Primary Care Pediatricians to Accept More Medicaid Patients*, PEDIATRICS, 110 no. 2 (2002).

administrative requirements of accepting public insurance, doctors sometimes just don't want the hassle."[3]

An expansive recoupment practice only adds to these disincentives to provide health care access to Medicaid beneficiaries in Wisconsin. Petitioners allege—correctly—that DHS has utilized an enforcement approach of recouping Medicaid payments for *covered services* that were *actually provided*, based solely on alleged non-compliance with documentation requirements. DHS concedes OIG has "characterized all the compensation a nurse received for services she provided to Medicaid patients for days, weeks, month[s], or even years as 'overpayments' due to non-compliance." (DHS Br. at 8).

The simple question is whether Wis. Stat. § 49.45(3)(f) permits this or not.

DHS claims answering this question "would provide no benefit to the parties or the public" (DHS Br. at 25), yet the Associations' members would greatly benefit from a clear statement of when DHS *cannot* recoup the full value of a previously paid claim. We know *Newcap v. Dept. of Health Services*, 2018 WI App 40, 383 Wis. 2d 515, 916 N.W.2d 173, concluded DHS may recoup the full value of a claim if "actual provision of the service" "cannot be verified using the records DHS required the provider to maintain." *Id.* ¶¶ 17-18. What is missing is a clear statement that DHS cannot cite non-compliance with record-keeping requirements as a basis to recoup the full value of a claim *unless* the error leaves DHS **unable to confirm from the provider's required records that covered services were actually provided**. Wis. Stat. § 49.45(3)(f).

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[3] Elizabeth Renter, *You've Got Medicaid—Why Can't You See the Doctor?*, U.S. NEWS, May 26, 2015.

DHS's response to the circuit court's order only enhances the need for clarity. DHS summarizes that order as providing three remedies. (DHS Br. at 9–10). First, the court declared DHS's recoupment authority under Wis. Stat. § 49.45(3)(f) "is limited to claims for which either DHS is unable to verify from a provider's records that a service was actually provided or for which an amount claimed was inaccurate or inappropriate for the service that was provided." (*Id.*) That is what Wis. Stat. § 49.45(3)(f) says, but does DHS disagree? And on what basis? DHS does not say.

Second, the court declared recovering payments "other than as legislatively authorized by Wis. Stat. § 49.45(3)(f) […] exceeds DHS's authority." (DHS Br. at 10). Does DHS disagree with this? Again, it does not say—though it is difficult to imagine a serious argument against this limitation on DHS's authority.

Third, the court enjoined DHS from applying or enforcing a "Perfection Rule," ordering that "DHS may not recover payments made to Medicaid-certified providers for *medically-necessary*, *statutorily-covered benefits* based solely on the providers' noncompliance with Medicaid policies where the documentation verifies that the services were provided." (DHS Br. at 10, emphasis added). Yet again, it is unclear which *substantive* element of this prohibition DHS disagrees with. DHS rather adds to the confusion by arguing throughout its brief that no such "Perfection Rule" exists.

Let's be clear: if the circuit court had merely enjoined a policy DHS was not practicing anyway, it would not have pursued its appeal. It may not say so, but DHS must *want* to recoup payments for covered services that were actually provided, based on mere paperwork errors. DHS took that approach against the nurses and Association members. Now DHS seeks to prevail because (it says) it never issued any

rule codifying its approach. But if that is the case, DHS is acting *ultra vires* and should be ordered to stop. With or without a rule, Wis. Stat. § 49.45(3)(f) bars its approach.

If DHS cannot articulate to this Court a clear position on the limits of its recoupment authority, how are Medicaid providers to know those limits? When a healthcare provider voluntarily participates in the Medicaid program, it is already taking on substantial under-cost payment and compliance requirements. When millions of dollars in payment are at risk based on how DHS interprets its recoupment authority, it is critical that providers know whether DHS may fully take back payments "*for medically-necessary statutorily-covered benefits* based solely on the providers' noncompliance with Medicaid policies where the documentation verifies that the services were provided."

II. The challenged recoupment policy exceeds DHS's statutory authority and any remedy to which the State would be entitled under principles of contract law and equity.

The record demonstrates that until the circuit court's 2016 order, DHS had an expansive policy and practice of recouping payments it made to nurses for covered services they provided going back five years. DHS frequently sought to recoup the full value of these services—even when the nurses maintained documentation of the services they provided and all agreed the services were authorized, the nurses provided the services, and the payments were appropriate for the services provided.

DHS justified these recoupments based on providers' failure to perfectly comply with complex program and documentation requirements. Based on its review of the record, the circuit court concluded DHS's recoupment policy

amounted to a "Perfection Rule" not authorized by law. (R.63 at 26:21–25).

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

DHS cannot recoup provider payments outside 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. Wis. Stat. § 227.10(2m).

Under Wis. Stat. § 49.45(3)(f), DHS may audit records only for limited purposes: "to verify actual provision of services and the appropriateness and accuracy of claims." And DHS may recover the "full value of any claim" in just two cases: (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., is not a covered service. Wis. Stat. § 49.45(3)(f)2.[4]

Nothing in Wis. Stat. § 49.45(3)(f) 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 from the provider's records. 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).

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[4] 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.* This type of partial recoupment is not at issue here.

B. Recouping the full value of claims for any compliance imperfection exceeds any contract remedy DHS could receive.

DHS argues its relationship with Medicaid providers is tantamount to a contract. (DHS Br. at 8). Yet any claim by DHS to recover the full amount of payment for covered services 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] 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," that 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 (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, 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 unique to the Medicaid program. Yet DHS has argued it may recoup the full value of covered services 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 prevent fraud, and it further exacerbates barriers to program participation.

Wisconsin statutes already strike the appropriate balance between ensuring compliance with Medicaid program requirements and preventing Medicaid fraud, while also reducing administrative burdens on legitimate providers and protecting beneficiary access to care.

The legislature granted DHS authority to recoup a Medicaid payment in full *if* actual provision of the service cannot be verified from the provider's records or the provider was paid for a non-covered service. Wis. Stat. § 49.45(3)(f). It also granted DHS authority, in appropriate cases, to de-certify or restrict a provider's participation in the program and sanction a provider's non-compliance with program requirements. *See*, *e.g.*, Wis. Stat. §§ 49.45(2)(a)12.a and 13.; *see also* Wis. Admin. Code §§ DHS 106.065(2) and 106.07(4).

However, fully recouping payments for covered services rendered to a Medicaid beneficiary due to non-material compliance lapses does nothing 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). Nor can that be what the legislature intended in enacting Wis. Stat. § 49.45(3)(f).

To the extent DHS implies it must pursue perfection to comply with *federal* requirements (DHS Br. at 4-5), that's simply untrue. DHS can point to no federal statute or rule (and there is none) requiring its aggressive approach. To the contrary, at least one state has codified a *prohibition* on recouping Medicaid payments for documentation errors. Georgia recently enacted a statutory amendment (2017 H.B. 206) providing:

> Any clerical or record-keeping error, including but not limited to a typographical error, scrivener's error, or computer error; any unintentional error or omission in billing, coding, or required documentation; or any isolated instances of incomplete documentation by a provider of medical assistance regarding reimbursement for medical assistance may not in and of itself constitute fraud *or constitute a basis to recoup payment for medical assistance provided*, so long as any such errors or instances do not result in an improper payment.

Ga. Code Ann. § 49-4-151.1(a) (emphasis added). "Improper payment" is defined as "any payment that was made to an ineligible recipient, payment for noncovered services, duplicate payments, payments for services not received, payments that are for the incorrect amount, and instances when the department is unable to discern whether a payment was proper because of insufficient or lack of documentation." *Id.*

If federal law somehow compelled DHS's current approach, Georgia could not have adopted this statute without placing all of its Medicaid funding at risk. Of course,

the truth is exactly the opposite: federal law permits Georgia's statute, just as it permits Wis. Stat. § 49.45(3)(f)2 and the circuit court's orders. The problem is that DHS is violating both.

Failing to address DHS's unclear, expansive recoupment interpretation will discourage qualified providers from participating in the Medicaid program. In addition to the significant disincentives that already exist, DHS's approach forces providers to risk having to return—based on *any* compliance deviation from complex rules and policies that are often unique to the Medicaid program—up to five years of payments for *covered* services their records can verify they *actually provided*. Inevitably, this risk will dissuade providers from serving Medicaid patients. Rather than protecting taxpayers from fraud, waste, and abuse, an overly expansive recoupment policy will only create additional challenges for Medicaid beneficiaries seeking access to care in communities across Wisconsin.

CONCLUSION

The Associations respectfully submit that this Court should reverse the decision of the court of appeals and reinstate the decision and orders of the circuit court.

Respectfully submitted this
4th day of March, 2020.

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FORM AND LENGTH CERTIFICATION

I hereby certify that this brief conforms to the rules contained in Wis. Stat. (Rule) §§ 809.19(8)(b) and (d) for a brief using a proportional serif font. The length of this brief, including footnotes, is 2,987 words.

James E. Goldschmidt

CERTIFICATION REGARDING ELECTRONIC BRIEF

I hereby certify that I have submitted an electronic copy of this brief that 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.

James E. Goldschmidt

CERTIFICATE OF SERVICE

I hereby certify that I caused this Brief of Amici Curiae to be hand-delivered to the Supreme Court of Wisconsin on March 4, 2020.

I further certify that on March 4, 2020, I caused three copies of this Brief of Amici Curiae to be served upon all parties of record via U.S. Mail to their respective counsel:

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