No. 16-1083

In the Supreme Court of the United States

GABRIELLE GOODWIN, BY DONNA ANSLEY,
Petitioner,

v.

FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES,
Respondent.

On Petition for a Writ of Certiorari to the District Court of Appeals of Florida, First District

BRIEF OF AARP, AARP FOUNDATION, NATIONAL ACADEMY OF ELDER LAW ATTORNEYS, NATIONAL CONSUMER VOICE FOR QUALITY LONG-TERM CARE, NATIONAL GUARDIANSHIP ASSOCIATION, AND NATIONAL HEALTH LAW PROGRAM AS AMICI CURIAE IN SUPPORT OF PETITIONER

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STATEMENT OF INTEREST OF AMICI CURIAE[1]

Amici are organizations committed to serving the needs of low-income persons, including older Americans, individuals with disabilities, children, and women of child-bearing age. *Amici*'s work involves promoting public awareness of the disproportionate need for health care and barriers to care experienced by these populations and advocating for their interests and legal rights. It is in this capacity that *amici* submit this Brief, asking the Court to accept certiorari from the decision below.

AARP is a nonprofit, nonpartisan organization dedicated to fulfilling the needs and representing the interests of people age fifty and older. AARP fights

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[1] Amici state that no party's counsel authored this brief either in whole or in part and, further, that no party or party's counsel, or any person or entity other than AARP, AARP Foundation, National Academy of Elder Law Attorneys, National Consumer Voice for Quality Long-Term Care, National Guardianship Association, National Health Law Program, their members, and their counsel, contributed money intended to fund preparing or submitting this brief. Pursuant to Supreme Court Rule 37.2, counsel of record for all parties received timely notice of Amici's intent to file this brief and counsel for Petitioner and Respondent granted their consent in writing.

to protect older people's financial security, health, and well-being. **AARP Foundation** – AARP's charitable affiliate – creates and advances effective solutions that help low-income individuals fifty and older to secure the essentials. Among other things, AARP and AARP Foundation support access to and expansion of quality health care through publicly administered health insurance programs, including Medicaid, an essential safety net program that provides coverage to people who would otherwise be denied health care.

The National Academy of Elder Law Attorneys, Inc. (NAELA), is a professional organization of attorneys concerned with legal issues affecting the elderly and disabled. NAELA provides a professional center, including public interest advocacy, for attorneys whose work enhances the lives of people with special needs and of all people as they age. NAELA is interested in the consistent, reliable, and proper interpretation of federal Medicaid law.

The **National Consumer Voice for Quality Long-Term Care** was formed as NCCNHR (the National Citizens' Coalition for Nursing Home Reform) in 1975 due to public concern for substandard care in nursing facilities. Since that time, the Consumer Voice has become the leading national voice representing consumers in issues relating to long-term care and has become the primary source of information and tools for consumers, families, caregivers, ombudsmen, and other advocates to help ensure quality care for all

residents. Consumer Voice is dedicated to advocating for quality care, quality of life, and protection of rights for all individuals receiving long-term services and supports.

The **National Guardianship Association** is a membership organization whose more than 1100 members serve as guardians, fiduciaries, conservators, advocates and friends of individuals under guardianship. The National Guardianship Association's mission is to advance the nationally recognized standards of excellence in guardianship.

The **National Health Law Program** is a 49-year-old public interest law organization that engages in education, litigation, and policy analysis to advance access to quality health care and protect the legal rights of low-income and underserved people.

SUMMARY OF ARGUMENT

Congress intended for nursing facility residents who become eligible for Medicaid to use their own funds to pay off medical expenses they incurred prior to becoming eligible for Medicaid. The Centers for Medicare and Medicaid Services (CMS) allows states some latitude in establishing reasonable limits on how nursing facility residents and states determine how much money the resident may use to pay off these debts and how much the resident must use to defray the costs of the nursing facility care.

At issue for Petitioner and similarly situated people are the dire financial implications that ensue from an unfair calculation of a Medicaid beneficiary's cost-sharing responsibilities and the cascading consequences that this miscalculation could have on health and independence. By failing to adhere to federal requirements for how the State will calculate one's ability to pay for services that Medicaid would otherwise cover, Florida placed Ms. Goodwin at risk of indefinite financial peril.

The methodology through which beneficiaries will be allowed to spend down their assets to become eligible for Medicaid, as well as the means through which cost-sharing responsibilities will be calculated, are required by federal law to be included in a state's Medicaid State Plan. If states are permitted to simply circumvent the state plan approval process by promulgating cost-sharing into regulations exclusively, there is a great risk that illegal methodologies will be put into place. Until 2015, Florida's methodology for making cost-sharing calculations was identified only in regulation and not in an effective a State Plan Amendment that was compliant with federal law.

Amici urge the Court to accept certiorari of this matter to ensure that beneficiaries in Florida and around the country are protected from unfair determinations regarding cost-sharing responsibilities when they have pre-eligibility medical debt.

ARGUMENT

I. The Medicaid Program's Goal of Enabling Impoverished People to Have Health Care Coverage Is Thwarted If Medicaid Beneficiaries Are Unable to Use Their Income To Pay Down Pre-Eligibility Medical Debts After Becoming Eligible for Medicaid.

A. The objective of the Medicaid program is to ensure that impoverished people are not deprived of necessary medical care.[2]

Medicaid provides an important safety net for people who are poor or become poor. Many Medicaid recipients become impoverished as a consequence of paying out-of-pocket for the high costs of health care and long-term care services prior to being eligible for Medicaid. Joshua M. Wiener et al., *Medicaid Spend Down: Implications for Long-Term Care Servs. and Supports and Aging Policy*, Scan Foundation (Mar. 2013) at 1, http://www.rti.org/sites/default/files/resources/tsf_ltc-financing_medicaid-spend-down-implications_wiener-tumlinson_3-20-13_0.pdf. The Medicaid program is a key funding source for people who, like Ms. Goodwin, have exhausted their savings

[2] Amici fully concur with the arguments set forth in Ms. Goodwin's Petition for Certiorari related to the federal requirements for determining cost-sharing. We will not revisit those arguments in this brief, but instead will focus on why the implications of this case strongly favor a decision by the Court to grant the Petition.

but continue to need long-term care services and support (LTSS). It is estimated that 52 percent of older Americans will, at some point in their lives, need high levels of LTSS to help them with everyday activities. Melissa Favreault & Judith Dey, *Long-Term Services and Supports for Older Americans: Risks and Financing*, Issue Br., HHS Office of the Assist. Sec. for Planning and Evaluation (revised Feb. 2016), https://aspe.hhs.gov/system/files/pdf/106211/ElderLTCrb-rev.pdf. LTSS, for the purposes of this brief, includes care provided in a nursing facility, an assisted living facility, home health aide services, home maker services, and environmental adaptations to enable individuals to remain in a home that would otherwise be inaccessible for them.

Medicaid is a means-tested program that offers federal funding to states to provide health coverage to low-income families, including children, parents, pregnant women, seniors, and people with disabilities. See 42 U.S.C. § 1396a(a)(10). In 2015, Medicaid provided health coverage to 33 million children, 27 million adults (mostly low-income working parents), 6 million seniors, and 10 million people with disabilities. Center on Budget and Policy Priorities (CBPP), *Policy Basics: Introduction to Medicaid* at 1 (updated Aug. 16, 2016), http://www.cbpp.org/research/health/policy-basics-introduction-to-medicaid.

Medicaid does not provide services directly but, instead, pays hospitals, nursing facilities, managed health care plans, home health care providers, and other providers for covered services

that they deliver to eligible people. *Id.* at 3. About three-quarters of all Medicaid spending pays for acute services like hospitals, physician services, and prescription drugs. *Id.* The other one-quarter pays for nursing facility and other LTSS. *Id.*

The high costs of providing LTSS result in catastrophic out-of-pocket costs for many people needing services. Wiener, *supra* at 1. Prior to and even after becoming eligible for the Medicaid program, many low-income people depend upon unpaid family caregivers or go without needed care to avoid exhausting all of their savings. *Id.*

The cost of securing needed LTSS far exceeds the median savings of many households of people who are over 65 years of age. Because of the high costs of securing long term care, it is projected that roughly 18 percent of older adults will receive Medicaid at some point in their lives. Wendy Fox-Grage, AARP Public Policy Inst. *Medicaid: A Last Resort for People Needing Long-Term Services and Supports* (Mar. 2017), http://www.aarp.org/ppi/info-2017/medicaid-a-last-resort-for-people-needing-long-term-services-and-supports.html. The median annual cost of a private room in a nursing facility is about $92,000, and the base price for assisted living is about $44,000. *Id.* The average annual cost of providing homemaker services to an eligible individual for thirty hours per week is about $31,000. *Id.* However, according to the U.S. Census Bureau, the median income of older households was $40,971 in 2015, and median savings for people who are over 65 years old are quite limited and are easily

exhausted. *Id.* (finding that the median savings for this population were only $40,500 in 2013).

Medicaid provides a lifeline for 17.4 million adults age 65 and over and people with disabilities of all ages. *Id.* Medicaid is the largest payer for LTSS. *Id.* In 2014, the combined federal and state Medicaid spending for LTSS was roughly $152 billion. Medicaid beneficiaries must contribute a significant amount of their incomes towards the cost of LTSS. *Id.* To become eligible for Medicaid, some already lower-income people "spend down" their resources to meet the financial eligibility requirements for the program by paying out-of-pocket for necessary services. Paying these out-of-pocket expenses often results in incurring medical debt once assets are exhausted. People who spend down are disproportionately lower income and have significantly fewer assets than people who do not spend down. Weiner, *supra* at 4. However, after they become eligible for Medicaid, it is essential that these beneficiaries be able to pay down the medical debt they amassed.

B. Medical debt compromises most aspects of a person's well-being.

Roughly a quarter of U.S. adults ages 18-64 say they or someone in their household had problems paying medical bills in 2015. Liz Hamel et al., Kaiser Fam. Found., *The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bill Survey* at 1 (Jan. 5, 2016), http://kff.org/health-costs/report/the-burden-of-medic

al-debt-results-from-the-kaiser-family-foundationnew-york-times-medical-bills-survey/. Not surprisingly, over half of the people who are burdened with medical bills that they are unable to pay are uninsured when they accrue those debts. However, insurance is not a guarantee against accruing medical debt since 18 percent of Medicaid beneficiaries report that they have problems paying their medical bills for services that are not covered by Medicaid. People with the highest amounts of medical debt, like Ms. Goodwin, suffer the worst consequences because of the impact on their credit, and therefore their housing opportunities and access to needed services. *Id.* at 14.

Because medical debt can have ruinous consequences for people, CMS requires that states comply with federal law mandating a reasonable deduction of pre-eligibility medical debt when calculating how much an institutionalized Medicaid beneficiary must pay for her nursing facility care. 42 U.S.C. § 1396a(r)(1)(A)(ii); 42 C.F.R. § 435.831(e)(3) and (f); *see also Md. Dep't of Health & Mental Hygiene v. Ctrs. for Medicare & Medicaid Services,* 542 F.3d 424 (4th Cir. 2008) (upholding CMS' administrative decision to disapprove Maryland's proposed State Plan Amendment that would have allowed beneficiaries to deduct only the medical expenses incurred during the period of Medicaid eligibility).

Because Florida circumvented the federal requirements for calculating her share of nursing facility costs, Ms. Goodwin could not pay down the

$70,000 in medical debt she accrued prior to becoming eligible for Medicaid, as all of her income was taken up with paying for her nursing facility care. This cost-sharing calculation jeopardized her credit, her access to community-based health care, and even her ability secure housing when she became able to move from the nursing facility to the community.

People become eligible for Medicaid because they are impoverished and have exhausted their available resources. Fox-Grage, *supra* at 3. This is a time of great stress and anxiety in which the beneficiary needs their income to be used to pay off pre-eligibility debts in order to avoid falling deeper into poverty.

Although the circumstances that lead to problems with paying medical bills may vary, 63 percent of those who report having problems paying medical bills say they suffered a serious one-time accident that landed them in a hospital. Hamel, *supra* at 3. Consumers needing emergency medical care rarely know the cost of a treatment or procedure beforehand. Consumer Financial Protection Bureau (CFPB), *Consumer credit reports: A study of medical and non-medical collections* at 39 (Dec. 2014), http://files.consumerfinance.gov/f/201412_cfpb_reports_consumer-credit-medical-and-non-medical-collections.pdf. The lack of transparency that results from emergent treatment is exacerbated by the fact that a consumer can receive multiple bills from the same or related providers – the identity and role of whom the patient may not even be aware. *Id.* at 41.

The consequences of medical debt are very real and have long-standing implications for the individual related to collections actions, the destruction of credit scores, and even bankruptcy. *Id.* at 4.

Among those who report difficulty in paying their medical bills, there are some categories of families that are most predictably going to be harmed—those who have debts over $5000 (66 percnt), those who say the family member who generated the debt has a disability (57 percent), and those who describe their financial situation as being insufficient to meet their basic needs (56 percent). Hamel, *supra* at 14. The Petitioner Ms. Goodwin fell into at least two of these groups at the point at which her cost-sharing responsibilities were being determined by the Florida Medicaid agency as her debt totaled $70,000 and her medical condition was the result of a disabling spinal cord injury.

The havoc wreaked by medical debt can mean that a nursing facility resident like Ms. Goodwin may be unable to secure housing in the community when her time to leave the facility and return to the community is at hand. Robert W. Seifert, *Home Sick: How Medical Debt Undermines Housing Security,* 51 ST. LOUIS L.J. 325 (2007). Medical debt impacts the ability to secure a mortgage or even lease a property. *Id.* at 342. Medical debt does not have to be particularly large to harm a person's housing prospects and credit standing. *Id.* at 338 (38 percent of people surveyed who had medical debts on their

credit report which could impact their credit scores showed debts under $1000). The corrosive impact that medical debt can have on accessing housing increases the longer that a person carries the debt, as demonstrated by the fact that 78 percent of those with medical debt older than one year have that debt documented on their credit report. *Id.*

As a consequence of Florida's unfair calculation of Ms. Goodwin's cost-sharing responsibilities, she could not use her monthly income to pay down her pre-eligibility medical debt. The harmful consequences of continuing to carry medical debt worsen the health outcomes for people who are already vulnerable. For example, people with medical debt which they cannot pay down may be placed in even greater turmoil as they: are unable to get basic needs met if they ration necessary care and drugs; are denied needed care from medical providers to whom they money; ration non-medical expenses; suffer stress from aggressive collection agencies; suffer aggravation of medical conditions as a consequence of the psychological and emotional stress; and/or feel pressured to convert the existing debt to third-party creditors that could substantially increase the size those bills. Melissa B. Jacoby & Mirya Holman, *Managing Medical Bills on the Brink of Bankruptcy*, 10 YALE J. HEALTH & ETHICS 239, 246 (2010). For some people who are trying to move from hospitals or nursing facilities back to their communities and their homes, these adverse consequences can be so overwhelming that they cannot make the transition from institutional settings.

II. It is Essential that States Adhere to Medicaid Program Requirements Related to Securing CMS Approval For The Administration of their Medicaid Programs.

A. States have wide latitude in how they structure their medicaid program but changes impacting beneficiaries must be made transparently.

Participation in the Medicaid program by states is voluntary, but if states elect to participate, they must comply with requirements imposed by the Medicaid Act and federal regulations governing matters such as who receives care and what services are provided at what cost. *Nat'l Fed'n of Indep. Bus. v. Sebellius*, 132 S. Ct. 2566, 2581 (2012). A participating state must submit a Medicaid plan, or a "comprehensive written statement . . . describing the . . . program." 42 C.F.R. § 430.10. The Medicaid State Plan must identify, among other things, the means through which a state will implement spend down requirements to establish eligibility, as well as the methodology to calculate the amount a beneficiary must contribute to the cost of her care is she resides in a nursing facility. 42 C.F.R. § 435.725.

Once a state's plan is approved, a state must operate its program consistent with its plan and the Medicaid Act and regulations. *See generally* 42 U.S.C. § 1396a(b). While the federal payments have always come with strings attached, "participation in the Medicaid program is entirely optional," *Harris v.*

McRae, 448 U.S. 297, 301 (1980), and an unwilling state can opt out by withdrawing its Medicaid plan, *see* 42 C.F.R. § 430.48(b)(2). Moreover, the state plan must be amended to reflect changes in federal law or policy or material changes in state law, organization, policy, or operation of the state Medicaid program. § 430.12(c).

Changes to the manner in which a state calculates the Medicaid beneficiaries' cost-sharing obligations are the kind of changes that must be approved by CMS prior to being implemented for three important reasons: 1) to ensure that the changes that the state is making conform with federal requirements; 2) to allow for the state and CMS to negotiate necessary changes; and 3) to provide an opportunity for affected parties to have notice of the changes. *See* 42 U.S.C. § 1316(a)(1) (establishing that when a state submits a state plan amendment, CMS has 90 days to approve the amendment, disapprove the amendment, or request additional information). If CMS does not act within the required time frame, the state plan amendment is considered approved. 42 C.F.R. § 430.16(a). If CMS requests additional information, CMS has a second 90-day period in which to approve or disapprove the amendment. *Id.*

If states could simply circumvent the state plan approval process by promulgating cost-sharing in regulations without federal consideration, the vital notice provisions outlined above will be frustrated.

B. The burden of submitting State Plan Amendments to secure approval for cost-sharing is minimal, but beneficiaries are deprived notice if a state circumvents the State Plan Amendment process.

It is vital that states operate their Medicaid Programs transparently and in accordance with federal requirements. States' interests and autonomy are well protected by the availability of a detailed appeals process to challenge any CMS disapproval of any component of a state plan amendment. Moreover, the detailed process for communication between states and CMS protects Medicaid beneficiaries by ensuring that states' implement their Medicaid programs in accordance with federal requirements.

If a State Plan Amendment is disapproved or the state is otherwise dissatisfied with the CMS action, the State may obtain an administrative hearing to reconsider the decision. 42 U.S.C. § 1316(a)(2). The request for reconsideration must be made within 60 days of receipt of the notice of final determination. Within 30 days after receiving the request for reconsideration, the CMS Administrator notifies the state of the time and place for the hearing. The hearing is to occur within 60 days of the notice of final determination unless the State and CMS Administrator agree in writing to an earlier or later date. *Id.* at § 1316(a)(3); 42 C.F.R. § 430.18. The hearing procedures are set forth at 42 C.F.R. §§ 320.60-430.104 and include requirements

for all pleadings, correspondence, and exhibits to be publicly available for review and copying and publication of information about the reconsideration in the *Federal Register*. The State and CMS are parties to the hearing. To ensure that the community has access to the proposed changes and CMS's disapproval of the state plan amendment, other individuals and groups may be recognized as parties if they have been injured by the contested issues, and their "interest is within the zone of interests to be protected by the governing Federal statute." 42 C.F.R. § 430.76(b). The presiding officer will act on the petition. In lieu of participating as a party, interested individuals or groups can request permission to file an *amicus curiae* petition in the case. *Id.* at § 430.76(c).

A state that loses its administrative hearing on reconsideration can file an appeal directly to the appropriate United States circuit court of appeals. 42 U.S.C. § 1316(a)(3). This is precisely what the state of Maryland did in *Md. Dep't of Health & Mental Hygiene,* 542 F.3d 424, after CMS disapproved its State Plan Amendment that would have prohibited nursing facility residents from deducting pre-eligibility medical expenses in the same manner that Florida prohibited these deductions by regulation.

CONCLUSION

For the reasons set forth above, Amici respectfully urge this Court to grant the Petition for Writ of Certiorari.

Respectfully Submitted,

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