MEMORANDUM IN SUPPORT

I. STATEMENT OF THE CASE

On April 5, 2004, Defendant, Ohio Department of Job and Family Services ("ODJFS"), promulgated an emergency rule establishing rates for certain Medicaid services that are unreasonably high and which violate Ohio law (“April 5 Emerging Rule”). For example, services for autistic children, which cost $45,000 in Delaware County under the old rule, must now be compensated under the April 5 Emerging Rule at a rate of over $328,000 with no change in the type or amount of service. Nursing services must be paid at more than two times the average rates currently billed by private providers. Rates for other services in the rule are similarly arbitrary, unreasonably high and contrary to applicable Ohio law.

The April 5 Emergency Rule creates a windfall for private providers. When private providers receive compensation in excess of the legal limits, the rule does not allow any reconciliation of payments or payback to the state if payments are in excess of a provider's usual and customary rates. Further, the rule removes a major tool for confirming that proposed services are medically necessary.

Plaintiffs, including an individual receiving services as a consumer, taxpayers[1], and the Delaware County MR/DD Board[2], seek a declaration that the April 5 Emergency Rule violates Ohio law and an injunction against any payments to providers which are:

- above the provider's usual and customary rates; and
- for services that have not been reviewed by a team and incorporated in a plan adopted by the team in accordance with applicable Ohio law.

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[1] Affidavits from each plaintiff taxpayer are attached as Exhibits A through G.

[2] A copy of the resolution of the Delaware County MR/DD Board is attached as Exhibit H.

II. OVERVIEW OF MEDICAID

A. The Medicaid Program

The Medical Assistance Program ("Medicaid") is a health insurance program for low income and disabled persons created under Title XIX of the Social Security Act, 42 U.S.C. §1396a et. seq. States are not required to participate in Medicaid, but if they do, they must comply with all federal requirements of the program. Ohio has elected to participate in Medicaid. O.R.C. § 5111.01 et. seq.

Once a state agrees to participate in Medicaid, federal law requires that certain services be available to all eligible recipients. 42 U.S.C. 1396a(a)(10)(A). Other services that a state may choose to offer are listed in 42 U.S.C. 1396d. The State Medicaid Plan ("State Plan") includes a list of all services offered by a state and the conditions adopted by the state for delivery of Medicaid services. Once a state has elected to include a service in the State Plan, the state is obligated to provide that service to all eligible Medicaid recipients. 42 U.S.C. 1396a.

The cost of Medicaid is shared between the federal government and the state. 42 U.S.C. § 1396d(b). In Ohio, the federal share of the program ("federal financial participation" or "FFP") covers approximately 58% of the total cost of Medicaid services. The state's contribution, called the "match," must be from public funds. MR/DD Boards are required to pay the match when the MR/DD Boards are acting as administrators of the Medicaid program. The conditions under which MR/DD Boards are required to pay match are set forth in O.R.C. § 5126.055 and § 5111.041. MR/DD Boards pay the match from local levies or from funds appropriated by the state legislature to the MR/DD Boards.

B. Role of Boards of Mental Retardation and Developmental Disabilities in Medicaid

ODJFS is the single state agency responsible for adiministering the Medicaid program in Ohio. ODJFS has elected to administer certain parts of Medicaid, including CAFS, by delegating authority to other Ohio departments. ODJFS has delegated limited authority to administer CAFS to the Ohio Department of Mental Retardation and Developmental Disabilities ("ODMR/DD"). The ODMR/DD, with concurrence of ODJFS, has, in turn, delegated certain Medicaid administrative functions to local MR/DD Boards.[3] The scope of this delegation and the role of the MR/DD Boards as Medicaid Local Administrative Authorities (MLAA) is defined in O.R.C. § 5126.055. The MR/DD Board's functions and duties change when the MR/DD Board is acting as a Medicaid service provider.

C. Community Alternative Funding System (CAFS) program

One of the programs that Ohio elected to provide under its Medicaid State Plan is the "Community Alternative Funding System" or "CAFS."[4] O.R.C. § 5111.041 and § 5126.12. CAFS offers eligible recipients a variety of skill development, active treatment, nursing, therapy, psychological, counseling, transportation and nutrition services. O.A.C. § 5101:3-37-02. CAFS services are currently provided through four entities: MR/DD Boards, school boards that have elected to participate in the CAFS system, children services boards and private providers. Approximate amounts paid for CAFS services through each entity for calendar year 2003 are as

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[3] MR/DD Boards have been in existence since 1967 for the purpose of developing and providing services to persons with mental retardation and developmental disabilities from birth until old age. MR/DD Boards operate under authority set forth in O.R.C. Chapter 5126. Many services are funded solely through non-Medicaid sources such as local levies and state subsidies. Local levies raised by MR/DD Boards account for approximately 55% of all funding for community based services to persons with mental retardation or developmental disabilities.

[4] CAFS is part of the benefit option described as "other diagnostic, screening, preventive and rehabilitative services" in 42 U.S.C. 1396d(a)(13). Federal rules for this category are at 42 C.F.R. 440.130.

follows:[5]

Entity	Total CAFS	FFP
County MR/DD Boards	$261,539,400	$149,693,964
School Districts	$89,969,054	$51,675,946
Children Services Boards	$419,803	$247,805
Private Providers	$12,951,700	$8,913,311
Total	$364,879,957	$210,531,026

The MR/DD Boards have traditionally paid match for CAFS services provided by the MR/DD Boards and are required to pay match for private providers of CAFS services when the MR/DD Board is acting as the local medicaid administrator under O.R.C. § 5126.055(B).

III. COMPENSATION FOR CAFS SERVICES

A. Compensation prior to January 1, 2004

Prior to the first of this year, compensation for CAFS was based on a cost reimbursement system. Each year a CAFS provider must prepare and submit a cost report showing "those costs recognized as reasonable and allowable" pursuant to relevant federal and Ohio standards. OAC § 5123:2-15-10(D). ODJFS paid CAFS providers actual allowable costs, subject to interim and final audits.

B. Rule in effect January 1, 2004

On January 1, 2004, ODJFS promulgated a rule[6] that changed the CAFS payment system from a cost-based to a fixed rate system for each type of CAFS service. The basis for the rates in the January rule is not entirely clear, but each county was assigned a specific rate for each service for all providers in that county, whether private or public. The MR/DD Boards and their representatives immediately challenged the rates administratively because the new rates were well in excess of prevailing rates. For example, the rule required some counties to pay a private

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[5] Affidavit of Charles Arndt, attached as Exhibit I.

provider over $1 million for 260 days of psychology services to one individual, including services delegated to unlicensed (non-professional) personnel, as in ABA services to autistic children (e.g. Greene County $1.7 million, Fairfield County $1.1 million, Cuyahoga County $1.1 million). Rates for other professional services were equally beyond prevailing charges for comparable services under comparable circumstances (e.g. Pickaway County is required to pay $1.7 million for 260 days of nursing services to one individual).

In addition to the rate disparity, the rule is arbitrary because it requires that County MR/DD Boards reconcile payments with actual costs and return any overpayment. Conversely, private providers have no such duty to compare receipts with actual cost and, amazingly, private providers have no duty to refund any overpayment and may keep the windfall.

The State Plan amendment, which incorporated the proposed rule, was challenged for a variety of reasons by the Center for Medicare and Medicaid Services (CMS), the federal agency responsible for managing Medicaid and monitoring state implementation. On March 19, 2004, CMS notified ODJFS that the federal share of CAFS would be suspended until Ohio gave a satisfactory explanation for the issues raised by CMS. (copy attached as Exhibit L).

C. Emergency Rule effective April 5, 2004.

On April 5, 2004, ODJFS issued an emergency rule, which rescinded the January 1, 2004 rule and promulgated a new fixed rate structure. A copy of the April 5 Emergency Rule is attached as Exhibit M. The second set of fixed rates created three rate categories: one for all MR/DD Boards, one for all school districts that provide CAFS services to children, and one for all other providers. All providers billing CAFS prior to December 31, 2003 will continue to be paid at the rate that was in effect on December 31, 2003. New CAFS Providers, however, are to

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[6] Ohio Admin. Code § 5101:3-38-10 (copy attached as Exhibit K).

be paid at rates set forth in the appendix to the April 5 Emergency Rule. The distinction is material because many private providers of CAFS services began billing for CAFS on or after January 1, 2004.

The April 5 Emergency Rule states that private providers are not subject to reconciliation and are not required to refund any difference between the payment received for CAFS services and their usual and customary rates. Public providers, by contrast, must reconcile their payments with actual cost and reimburse the difference to the state if the payment exceeds actual costs. If the payment is less than actual cost, there is no adjustment to the payment to public entities (i.e. public schools and county MR/DD Boards).

The April 5 Emergency Rule also temporarily suspends provisions in Ohio law which require that all Medicaid CAFS services be included in an Individual Service Plan ("ISP") which is developed by a team. This process for team review is an essential tool in ascertaining whether the proposed services are medically necessary. As a result there is no mechanism that allows review of medical necessity of a proposed service until after the service has been provided and paid for.

Plaintiffs filed this lawsuit to enjoin the implementation of the April 5 Rule on the grounds that the arbitrary and capricious rates violate Ohio law, which requires that providers be compensated at a rate which will not exceed their "usual and customary" rate. The April 5 Rule also violates Ohio law because it removes the ISP requirement mandated by law.

IV. LEGAL ARGUMENT

A. Standard of Review For Injunctive Relief

It is well established in Ohio that this Court may enter a temporary restraining order and preliminary injunction upon considering four criteria: (1) a likelihood of success on the merits; (2) irreparable harm in the absence of the injunction; (3) whether the injunction will harm others;

and (4) whether the public interest will be served by an injunction. *Vanguard Transportation Systems v. Edwards Transfer* (Franklin Cty. 1996), 109 Ohio App. 3d 786, 790; Ohio Rev. Code § 2727.02. These four factors are not prerequisites to relief. Rather, they are merely elements to be balanced in relation to one another in order to determine whether injunctive relief is justified. *Metropolitan Detroit Plumbing & Mechanical Contractors Ass'n v. HEW*, 418 F. Supp. 585, 586 (E.D. Mich. 1976).

As shown below, balancing these four factors demonstrates that Plaintiffs are entitled to temporary and preliminary injunctive relief.

B. Analysis

1. <u>Plaintiffs Will Likely Succeed On The Merits</u>

a. The Rate Structure in the April 5 Emergency Rule is Unlawful.

The rates set by the April 5 Emergency Rule are unlawful because Ohio (and federal) law prohibits payment beyond a provider's "usual and customary" charges. The Ohio rule for reimbursement of Medicaid services limits the payment as follows:

> …[ODJFS] will not pay for services that are charged at a rate greater than the provider's ***usual and customary*** charge to other patients.

O.A.C. § 5101:3-1-02(B)(7)[7] (emphasis added). This limitation is consistent with the federal rule governing Medicaid payments:

> The agency may pay the customary charges of the provider but must ***not pay more than the prevailing charges*** in the locality for comparable services under comparable circumstances.

42 C.F.R. 447.325[8] (emphasis added).

[7] This rule was adopted to implement the general authority of ODJFS in O.R.C. § 5111.02(A)(1) and § 5111.02(B) to set rates for Medicaid services. The general authority to set rates for CAFS services is at O.R.C. § 5111.041(C)(3)(c).

[8] The rule implements the general requirement that a state participating in Medicaid must:

The rates set by the April 5 Emergency Rule violate the requirement that providers be compensated at a rate that will not exceed their "usual and customary" rate. This is best illustrated by the relationship between the Step by Step Academy and the Delaware County MR/DD Board.

- Step by Step Rates

Step by Step has provided services to the Delaware County MR/DD Board for almost three years. Each year prior to January 1, 2004, the Delaware County MR/DD Board entered into contracts with Step by Step Academy for services to children with autism. ***Step by Step never billed the Delaware County MR/DD Board more than $45,000 per year per child for these services***.[9]

Step by Step became a certified Medicaid CAFS provider and can now bill for the same services through CAFS. Under the April 5 Emergency Rule, identical services ***will now be paid at a rate in excess of $328,000 - an increase of over 600%.*** This rate is not based on any costs proposed by the Step by Step Academy and will not be subject to any reconciliation based on actual costs. Step by Step, at least for the duration of the April 5 Emergency Rule, will not have to include the service in an ISP after the individual's ISP team has reviewed the need.

> … provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4) [42 USCS § 1396b(i)(4)]) *as may be necessary to safeguard against unnecessary utilization of such care and services* and to assure that payments are ***consistent with efficiency, economy, and quality of care*** and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

42 USC 1396a(a)(30)(A) (emphasis added).

[9] Affidavit of Robert Morgan, Exhibit J.

- **State-Wide Average Charges for Comparable Services**

The experience with Step by Step is not unique. During the months of February and March 2004, ODMRDD Director, Kenneth Ritchey, and his staff, at the direction of ODJFS Director, Tom Hayes, studied all the rules, including the reimbursement rule, for corrections in rates and other issues for the effective implementation of these rules. The ODMRDD studied what ODJFS and other Medicaid providing departments paid for similar professional services and developed a revised reimbursement rule, attached as Exhibit N.[10] Appendix A to Exhibit N shows rates that are based on a usual and customary rate for professional services for all providers. Rather than incorporating the rates researched and proposed by ODMR/DD, ODJFS adopted the rates in the April 5 Emergency Rule.

The following chart[11] illustrates the difference between current rates paid by ODJFS for comparable services (reflected in Appendix A to Exhibit N) to other Medicaid providers and the rates under the April 5 Emergency Rule for professional services paid through CAFS:

Child	**Current Ave. Rates**	**Em. Rule Hourly**	**% Difference**
Nursing	$55.00	$140.60	155.6%
OT	$70.00	$116.44	66.3%
Phys. Ther	$70.00	$138.36	97.7%
Speech	$70.00	$172.64	146.6%
Psych	$108.00	$205.68	90.4%
Soc. Work	$108.00	$121.64	12.6%
Adult			
Nursing	$55.00	$156.80	185.1%
OT	$70.00	$72.24	3.2%
Phys. Ther.	$70.00	$144.60	106.6%
Speech	$70.00	$242.60	246.57%
Psych	$108.00	$143.40	32.8%
Soc. Work	$108.00	$114.40	5.9%

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[10] Affidavit of Charles Arndt, Exhibit I.

[11] These figure are set forth in graph form in Exhibit O attached.

It is apparent that only charges for adult OT and Social Work services are close to being comparable in cost. All other rates violate the clear prohibition of Ohio (and federal) law against compensating providers at a rate that exceeds the provider's "usual and customary" charges.

In addition to these glaring inequities, the rates set by the April 5 Emergency Rule are arbitrary and capricious because they are not rationally related to actual charges. The arbitrary character of the rates set forth in the April 5 Emergency Rules is demonstrated by a review of rates for active treatment for children and adults. Rates for different types of providers are as follows:

	County Boards	**Schools**	**Private**
Children	$47.74	$83.20	$70.53
Adults	$47.74	NA	$87.14

The April 5 Emergency Rule compensates private providers at 87% above the average Active Treatment County Board rate for adults and 48% above the average Active Treatment County Board rate for children. The rule establishes this disparity despite the higher costs generally incurred by MR/DD Boards and other public providers and the absence of significant experience in providing such services by private providers.

b. Suspension of Individual Plans is Contrary to Ohio Law.

The April 5 Emergency Rule also violates Ohio law because it removes the ISP requirement. Removing the requirement for an ISP violates express Ohio statutes that require an ISP and eliminates the primary tool for ascertaining what services are medically necessary for the individual as required by Ohio law.

O.R.C. § 5126.15(B)(3) explicitly states that each individual receiving CAFS services must have an ISP. This requirement is explained further by the ISP rule at O.A.C. § 5123:2-15-18(C), which explicitly requires an ISP. The April 5 Rule violates Ohio law because is suspends

these requirements for an ISP.

Suspension of the ISP requirement also violates Ohio statutes and rules on medical necessity. No individual may receive services through Medicaid unless those services are medically necessary.[12] O.A.C. § 5101:3-1-02(B)(1); O.A.C. § 5101:3-1-60(C). The rules confirm that medical necessity is "a fundamental concept underlying the Medicaid program." O.A.C. § 5101:3-1-01(A). Medical necessity in the CAFS program is determined in part by assessments and evaluations conducted by MR/DD Boards (O.R.C. §§ 5126.055(B)(1), 5126.15(B)(2); O.A.C. § 5123:2-15-18(B)), which are then reviewed in a team meeting. The team recommends the services that are necessary for the individual. O.A.C. § 5101:3-38-01(A)(15)(b); O.A.C. § 5123:2-15-18(A). Suspending the ISP requirement will remove the only effective means of ascertaining the medical necessity of CAFS services.

Under these circumstances, Plaintiffs will make a strong showing of success on the merits of their claims against Defendants.

2. Plaintiffs Will Be Irreparably Harmed If the Requested Relief Is Not Granted

Irreparable harm is an injury for which a court cannot compensate the movant should he prevail in the final decree. *See generally State ex rel. Great Lakes College v. Medical Board* (Franklin Cty. 1972), 29 Ohio St. 2d 198. The purpose of the remedy is to prevent a future wrong (irreparable injury) that the law is unable to do, not to redress past wrongs. *Id.* In this case, Plaintiffs have no adequate remedy at law.

The April 5 Emergency Rule is currently in effect and was put into effect as an emergency measure without the usual review process through O.R.C. § 101.35, which establishes the joint committee on agency rule review. There is no mechanism to challenge the

[12] "Medical necessity" is defined at O.A.C. § 5101:3-1-01.

implementation of this emergency rule and no mechanism for taxpayers or MR/DD Boards to recover funds paid to private providers that are in excess of amounts permitted under federal law. Absent the relief requested, taxpayers and MR/DD Boards have no remedy and will be adversely affected in the following ways (none of which can be remedied at law): a) reduce the amount of state and local finances available for non-Medicaid MR/DD services; b) eliminate ability to assess medical necessity; and c) jeopardize the availability of non-Medicaid services to persons with MR/DD.

a. Adverse impact on state and local finances.

The April 5 Emergency Rule will have a clear and immediate impact on the state budget. A program for autistic children, which formerly cost the taxpayers $45,000 per year, will now cost the taxpayers over $328,000 with no change in services. Nursing services will now cost over twice the usual and customary rates. The state (or MR/DD Boards) will be required to pay more than double the prevailing rates for speech/language services for children, for adult physical therapy and for adult psychology services. Every type of professional care will cost significantly more than prevailing rates.

Money damages are inadequate because the taxpayers and MR/DD Boards will never be able to recoup these unlawful overpayments because private providers are not subject to reconciliation and are not required to repay amounts that are beyond their usual and customary fees.

The impact will have severe consequences at the local level beyond the waste of state resources. CMS has already made it clear that the CAFS program is so far out of compliance with federal law that CMS is suspending the federal share (58%) of CAFS payments. This means that the taxpayers must not only pay exorbitant and illegal rates, but must also pay the full

cost without any contribution from the federal government. A CAFS service will now be paid with 100% state funds rather than at the 42% rate before the April 5 Emergency Rule came into effect. With total current CAFS payments totaling approximately $365 million, the loss of FFP amounts to approximately $210 million.

b. Adverse impact on ability to assess medical necessity.

By removing the requirement for an ISP, the April 5 Emergency Rule has removed the requirement that services be incorporated in a plan that is developed by a team reviewing, among other issues, medical necessity. Removing the requirement for an ISP removes thus removes the most important method for assessing medical necessity. MR/DD Boards will be faced with the prospect of paying for unnecessary services because there will be no review of the need for those services before the services are initiated. There is no adequate remedy at law available to correct this unlawful result.

c. Adverse impact on services to other persons with MR/DD.

The Delaware County MR/DD Board is required to pay excessive costs for CAFS services to providers and is prevented from receiving any FFP for services. As a direct result, the MR/DD Board is unable to provide services to individuals with mental retardation or developmental disabilities who do not qualify for Medicaid. The Delaware County MR/DD Board, which has been forced to reduce non-Medicaid services already, will have to reduce those non-Medicaid services even further.[13]

The suspension of FFP for CAFS by CMS creates three possible alternatives:

- Delaware County can be required to pay the full cost of services without any FFP contribution and no additional contribution from the state;

[13] Resolution of the Delaware County MR/DD Board, Exhibit H; Affidavit of Robert Morgan, Exhibit J.

- Delaware County can be required to pay the match for services and the state will pay the balance of the amount -- formerly covered by FFP -- from state General Revenue Funds. The cost for the additional amounts will be deducted from subsidies given to MR/DD Boards; or

- The state will pay the full cost of CAFS services and deduct the cost from subsidies to the Delaware County MR/DD Board and other MR/DD Boards around the state.[14]

Under any of these scenarios, the Delaware County MR/DD Board will have even greater difficulty in paying for non-Medicaid services to individuals served by the MR/DD Board. The effect, which cannot be remedied at law, is that an unnecessary and disproportionate amount of state and/or local dollars that could otherwise be used for non-Medicaid services and programs must be used to make up for the loss of federal Medicaid funds.

Accordingly, Plaintiffs will suffer irreparable harm unless an injunction issues in its favor. Taken in conjunction with the conclusive showing of a likelihood of success on the merits, there is ample support for the granting of injunctive relief.

3. <u>Injunctive Relief Will Serve the Public Interest Without Causing Harm to Defendants</u>

In granting an injunction, courts must give due consideration to the rights of all parties in interest, not just the party seeking the injunction. *Matula v. Cornersburg Pizza, Inc.* (Mahoning Cty.), 1975 Ohio App. LEXIS 6118. Thus, this Court must consider the harm, if any that would befall Defendants and the general public if injunctive relief were granted.

There is a strong policy favoring prudent management and expenditure of public funds. In addition, public policy favors access by persons with MR/DD to services. Granting the subject injunction will benefit the public interest and the interests of Plaintiffs. Providers will be

[14] Affidavit of Charles Arndt, Exhibit I.

reimbursed at “usual and customary” rates, reconciliation will apply to all providers and medical necessity will be determined prior to the rendering of services.

Injunctive relief will also benefit (not harm) the interests of Defendants. Because Plaintiffs seek an order that will serve to implement (lawful) lower rates, the source of federal funding will not be at risk so that more funds will be available for non-Medicaid services. Accordingly, Defendants will not have to make up for the loss of these federal funds.

Under these circumstances, issuance of the injunction will inflict no harm on Defendant and will serve vital public interests.

V. Conclusion

For the reasons stated above, Plaintiffs respectfully request that the Court declare that the April 5 Emergency Rule violates Ohio law and issue a temporary restraining order and preliminary injunction enjoining Defendants, and all officers, agents, servants, employees, attorneys, and those acting in active concert or participation with them, from and against making any payments to providers that are above the provider's usual and customary rates and which are for services that have not been reviewed by a team and incorporated into an ISP adopted by the team in accordance with applicable Ohio law.

Respectfully submitted,

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CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true copy of the foregoing was served this 26th day of April 2004, by hand-delivery and U.S. Mail postage prepaid to counsel for Defendants, Alan Schwepe, Assistant Attorney General, 30 East Broad Street, 26th Floor, Columbus, Ohio 43215.

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James J. Hughes, III