STATE OF MAINE
KENNEBEC, SS.

SUPERIOR COURT
DOCKET NO. CV-18-__

MAINE EQUAL JUSTICE PARTNERS, CONSUMERS FOR AFFORDABLE HEALTH CARE, *et al.*,

Petitioners,

v.

RICKER HAMILTON, COMMISSIONER MAINE DEPARTMENT OF HEALTH & HUMAN SERVICES,

Respondent.

RULE 80C MERITS BRIEF OF PETITIONERS

INTRODUCTION

Although this case arises in the context of a complex social and political debate, this Court's task is limited. Quite simply, a single question of law is presented: When a statute unambiguously mandates that the Department of Health and Human Services ("DHHS") take a specific action, must DHHS comply? The answer, of course, is yes.

Here, "An Act To Enhance Access to Affordable Health," 2017 Me. Legis. Serv. Initiated Bill Ch. 1 (I.B. 2) (L.D. 1039) (WEST) (the "Medicaid Expansion Act"), enacted by the citizens of Maine on November 7, 2017 and codified at 22 M.R.S. § 3174-G(1)(H), unambiguously mandates that DHHS submit to the Centers for Medicare and Medicaid Services ("CMS") by April 3, 2018, a State Plan Amendment (SPA) "ensuring MaineCare eligibility" for certain adults with incomes below 138 percent of the federal poverty level. This SPA can be as simple as the two-page, check-the-box form used by the State of Connecticut for this same purposes, a copy of which is attached to the 80C Petition as Exhibit B. Despite the simplicity of both its task and its

statutory mandate, DHHS has failed or refused to comply. This Court should order it to do so pursuant to 5 M.R.S. §§ 11001 & 11007.

RELEVANT BACKGROUND

I. HISTORY OF MEDICAID

Congress created Medicaid in 1965 as a program to provide federal funds to states that pay for medical treatment for the poor. 42 U.S.C. §§ 1396 *et seq.* State participation is voluntary, but once a state chooses to participate, it must administer a plan in a manner that meets federal requirements. *Frew v. Hawkins*, 540 U.S. 431, 433 (2004). To receive federal funds, states must prepare a plan that defines the categories of individuals eligible for benefits and the specific kinds of medical services the plan will cover. 42 U.S.C. §§1396a(a)(1) and (17). A state plan must comply with federal criteria regarding covered services, eligible populations, and costs, 42 U.S.C. §1396a, and the plan must be approved by the federal Secretary of Health and Human Services. 42 U.S.C. §1396a(b). If the secretary determines that a state has changed or administered its approved plan in such a way that it no longer complies with federal requirements, the secretary may reduce or eliminate federal payments to the noncomplying state. 42 U.S.C. §1396c.

The federal Medicaid statutes require participating states to provide medical coverage for certain populations. 42 U.S.C. §1396(a)(10). As originally enacted, mandatory coverage applied to individuals who received cash assistance under one of four programs: Old Age Assistance, 42 U.S.C. §§301 *et seq.*; Aid to Families with Dependent Children, 42 U.S.C. § 601 *et seq.*; Aid to the Blind, 42 U.S.C. § 1201 et seq.; and Aid to the Permanently and Totally Disabled, 42 U.S.C. §§1351 *et seq. Id.*; *see also Schweiker v. Gray Panthers*, 453 U.S. 34, 37 (1981). Over time, Congress has amended the Medicaid program on multiple occasions to expand the scope of those

to whom mandatory coverage must apply. The term used for this concept is "mandatory eligibility." For example, between 1988 and 1990, Congress required states to include as program beneficiaries pregnant women with family incomes up to 133 percent of the federal poverty line, children up to age 6 at the same income levels, and children ages 6 to 18 with family incomes up to 100 percent of the federal poverty line. 42 U.S.C. §§1396a(a)(10)(A)(i) and 1396a(l); *accord* 22 M.R.S. § 3174-G.

States may also provide optional coverage for the "medically needy," meaning persons whose income exceeds financial eligibility criteria for those programs, and hence for Medicaid, but who otherwise satisfy the criteria for one or more of those assistance programs. 42 U.S.C. §1396a(a)(10)(C); *Pharmaceutical Research & Mfrs. of Am. v. Walsh*, 538 U.S. 644, 651 (2003). If states choose to cover an optional eligibility group, the federal government subsidizes a significant portion of the cost.

Maine has elected to participate in the federal Medicaid program. The Maine Department of Health and Human Services ("DHHS") acts as the single state agency to supervise and administer the Medicaid program, which (combined with the State Children's Health Insurance Program) is known as MaineCare. Title 22, Maine Revised Statutes, Chapter 855.

II. MEDICAID EXPANSION

In 2010, Congress enacted the Patient Protection and Affordable Care Act ("ACA"), Pub.L. No. 111–148, 124 Stat. 119 (2010). Among its many provisions, the ACA created a new category of mandatory beneficiaries, called Group VIII, consisting of all individuals under the age of 65 with incomes below 133 percent of the federal poverty line. 42 U.S.C. §1396a(a)(10)(A)(i)(VIII). Income eligibility for Group VIII must be calculated using a modified adjusted gross income that disregards the top five percentage points, so a household can have an

actual adjusted gross income of up to 138 percent of the federal poverty level and still qualify. 42 U.S.C. §1396a(e)(14)(I)(i). In addition, the ACA changed the essential health-benefits package that states must provide to all Medicaid recipients. 42 U.S.C. §§1396a(k)(1); 1396u–7(b)(5); 18022(B). The ACA guaranteed that the federal government would pay 100 percent of the costs for covering the newly eligible Group VIII individuals for three years, through 2016. 42 U.S.C. §1396d(y)(1)(A). Thereafter, the federal contribution would gradually decrease to a permanent minimum of 90 percent in 2020. 42 U.S.C. §1396d(y)(1)(B) through (E).

On June 28, 2012, the United States Supreme Court announced its decision in *Natl. Fedn. of Indep. Business v. Sebelius*, 567 U.S. 519 (2012), in which it upheld the ACA's individual mandate to obtain insurance, *id.* at 574, and similarly upheld the ability of Congress to expand the availability of health care. *Id.* at 583-84. However, the Court declared that 42 U.S.C. §1396c, the provision that authorizes the secretary to reduce or eliminate federal subsidies to participating states for noncompliance with federal mandates, was unconstitutional if used to compel states to extend Medicaid coverage to Group VIII. *Id.* at 585-86. Essentially, the Supreme Court made coverage of Group VIII optional rather than mandatory.

Since that time, 33 states (including Maine and the District of Columbia) have expanded coverage to Group VIII. https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/. Maine expanded coverage to Group VIII by citizens' initiative after the governor vetoed several legislative attempts at expansion.

III. MAINE'S ENACTMENT OF MEDICAID EXPANSION

Although Governor LePage has opposed Medicaid Expansion, Maine's elected legislators have consistently supported it. Five times in the past five years the Maine Legislature has approved an expansion of the state Medicaid program to cover more low-income Mainers, but had insufficient votes to overcome a gubernatorial veto. *See* LD 1546, "An Act To Strengthen

Maine's Hospitals, Increase Access to Health Care and Provide for a New Spirits Contract" (2013); LD 1066, "An Act To Increase Access to Health Coverage and Qualify Maine for Federal Funding" (2013); LD 1640, "An Act To Expand MaineCare for Veterans and Low-income Residents" (2014); LD 1578, "An Act To Increase Health Security by Expanding Federally Funded Health Care for Maine People" (2014); LD 633, "An Act to Improve the Health of Maine Citizens and the Economy of Maine by Providing Affordable Market-based Coverage Options to Low-income Uninsured Citizens" (2016).

Frustrated by the failure to enact Medicaid expansion because of the Governor's exercise of his veto power, Petitioner Maine Equal Justice Partners ("MEJP") and others initiated a citizen referendum to adopt Medicaid expansion that could not be subject to a gubernatorial veto under the Maine Constitution. Me. Const. Art IV, Part Third, Section 19. On November 7, 2017, Maine voters passed the citizens' initiative to implement Medicaid expansion with over 59% of the vote. The Medicaid Expansion Act became effective on January 3, 2018. 22 M.R.S. § 3174-G(1)(H). (A copy of the enacted law is attached to the Petition as Exhibit A). It provides that the department "shall provide for the delivery of federally approved Medicaid services to" Group VIII individuals "[n]o later than" July 2, 2018. *Id.* An "approved Medicaid service" is expressly defined by statute. 22 M.R.S. § 3172(1-B). The Medicaid Expansion Act further provides that the "department shall provide such a person, at a minimum, the same scope of medical assistance as is provided to a person described in paragraph E." 22 M.R.S. § 3174-G(1)(H). "The scope of medical assistance to be provided within this section shall be that authorized by the Federal Sixth Omnibus Budget Reconciliation Act, Public Law 99-509." 22 M.R.S. § 3174-G(3).

The Medicaid Expansion Act mandates that DHHS take several intermediate steps, including: (1) no later than April 3, 2018, DHHS "shall submit a state plan amendment to the …

Centers for Medicare and Medicaid Services ensuring MaineCare eligibility for" Group VIII individuals; and (2) DHHS "shall adopt rules … in a timely manner to ensure that [Group VIII individuals] are enrolled for and eligible to receive services no later than" July 2, 2018. 22 M.R.S. § 3174-G(1)(H). The required SPA, once approved by CMS, enables Maine to receive federal funds for the MaineCare services that it is required to provide under the Medicaid Expansion Act. This SPA is a simple submission that consists of a few filled-in boxes on a form that is two pages long. For example, Connecticut received approval of a very simple state plan amendment for Medicaid expansion. *See* Exhibit B to the 80C Petition. The Act imposes on the Commissioner a non-discretionary duty to submit a state plan amendment substantially similar to the state plan amendment approved for the State of Connecticut (and for many of the other 31 states that have implemented Medicaid expansion). The Commissioner lacks any lawful basis for refusing or failing to do so.

IV. DHHS' REFUSAL TO COMPLY WITH MAINE'S MEDICAID EXPANSION ACT HAS REAL AND NEGATIVE CONSEQUENCES

Due to the failure or refusal of DHHS timely to submit the required SPA, each and every individual petitioner faces a delay in obtaining medically necessary health coverage. Voters enacted the Medicaid Expansion Act based on estimates that it would extend medically-necessary and potentially life-saving health coverage to an additional estimated 70,000-80,000 Mainers. *See* http://mejp.org/sites/default/files/Medicaid-Expansion-Get-the-Facts-10-5-17.pdf (citing a study by the Maine Health Access Foundation estimating that approximately 70,000 people would gain coverage, and an estimate by the non-partisan Office of Fiscal Policy and Review that 80,000 Mainers would gain coverage). Those estimated 70,000-80,000 Mainers now face a delay in obtaining medically-necessary and potentially life-saving health coverage.

The organizational petitioners will also be adversely affected. MEJP must now divert its limited resources to education, training, and individual representation for people who are not able to timely access medically necessary health care services. It must also engage in significant efforts to keep clients, social service agencies, providers and others that assist people who otherwise would be covered through expansion with information about other options. Similarly, Consumers for Affordable Health Care ("CAHC") is also now redirecting people to other more limited options for access to health care, e.g. hospital free care, sliding fee clinics, etc. CAHC has had to do this during a time of limited resources, further diverting CAHC's resources from other parts of its mission. Finally, for both the Maine Primary Care Association ("MPCA") and Penobscot Community Health Care ("PCHC"), the Expansion Act's simplification and expansion of eligibility will not only relieve the administrative burden on staff but will also greatly increase the number of people served by the centers who will have insurance coverage. Most important, for the patients that the centers serve, they will not only have access to the center's services, but also to the full range of health care services that are necessary. Both MPCA and PCHC are now training staff and gearing up for Medicaid Expansion on July 2, 2018 and will be working with patients to apply for MaineCare on that date. If DHHS delays implementation of Medicaid Expansion, it will not only create confusion, but will also further drain their limited resources and will mean that many of the patients they serve may go without the medical care that they need to maintain their health and well-being.

ARGUMENT

This case presents an issue that is neither novel nor complicated. DHHS is statutorily required to submit a SPA by April 3, 2018. 22 M.R.S. § 3174-G(1)(H). DHHS has failed or

refused to comply with this unambiguous statutory mandate. This Court should order it to do so within 3 days pursuant to 5 M.R.S. §§ 11001 & 11007.

I. THE ACT UNAMBIGUOUSLY REQUIRES THE COMMISSIONER TO SUBMIT AN SPA

The Medicaid Expansion Act requires that: "No later than 90 days after the effective date of this paragraph, **the department shall** submit a state plan amendment" to CMS. 22 M.R.S. § 3174-G(1)(H). Use of the word "shall" imposes a mandatory duty and does not provide the Commissioner with any discretion. The Legislature has provided specific rules to "be observed in the construction of statutes, unless such construction is inconsistent with the plain meaning of the enactment." 1 M.R.S. § 71. One of those specific rules is that, when used in laws enacted after December 1, 1989, the words "'Shall' and 'must' are terms of equal weight that indicate a mandatory duty, action or requirement." *Id.* § 71(9-A). *Accord McGee v. Sec'y of State*, 2006 ME 50, ¶ 14 & n.3, 896 A.2d 933, 938–39. Reading the word "shall" to indicate a mandatory duty is not inconsistent with the plain meaning of the Medicaid Expansion Act. Indeed the legislative history of gubernatorial obstruction on this issue and the enactment by a veto-proof citizens' initiative only reinforces the plain intent that the word "shall" was used to indicate a mandatory duty, action or requirement.

"If the meaning of the language is clear, we interpret the statute to mean what it says." *N.A. Burkitt, Inc. v. Champion Rd. Mach. Ltd.*, 2000 ME 209, ¶ 6, 763 A.2d 106, 107 (*citing Kimball v. Land Use Regulation Comm'n,* 2000 ME 20, ¶ 18, 745 A.2d 387, 392). Here, the statutory mandate is clear. Moreover, that clear mandate "coheres with the more general proposition that public welfare laws are to be construed liberally to effect their remedial purposes." *Beaulieu v. City of Lewiston*, 440 A.2d 334, 344 (Me. 1982). In addition to this state statutory mandate to submit the SPA, the Medicaid Expansion Act constitutes a "material change

in State law" that triggers a concomitant federal regulatory mandate to submit a state plan amendment. 42 CFR 430.12 (c)(2)(ii).

There is no statutory basis for the Commissioner to fail or refuse to submit the SPA. Even if the statute were somehow ambiguous on this mandatory timing or duty—which it is not—DHHS would not receive any deference in its failure to timely submit the SPA. The Superior Court, in another case involving DHHS, has previously held than when statutory interpretation issues "involve the passage of time and the counting of days" those are "concepts which are not uniquely within the Department's own expertise" so DHHS "is not entitled to the deference that it might receive in interpretations of other" statutory provisions. *Portland Surgery Ctr., LLC v. Comm'r*, No. CIV.A.AP-03-71, 2004 WL 765324, at *2 (Me. Super. Feb. 23, 2004).

The effective date of the Medicaid Expansion Act is January 3, 2018. The date "90 days after the effective date" of the Medicaid Expansion Act is April 3, 2018. DHHS has failed or refused to submit the state plan amendment to CMS by April 3, 2018, as required by the Act. Accordingly, "Judicial review of agency inaction or failure to act pursuant to Rule 80C is" the appropriate mechanism to now "compel an agency to take action that the agency was legally bound to take." *Annable v. Bd. of Envtl. Prot.*, 507 A.2d 592, 593–94 (Me. 1986); *accord* 5 M.R.S. §§ 11001(2) ("The relief available in the Superior Court shall include an order requiring the agency to make a decision[1] within a time certain"); 11007(4)(B) ("The court may: … direct the agency to hold such proceedings or take such action as the court deems necessary.") The

[1] "Despite the distinctly adjudicative flavor" of the word "decision" to describe agency action, the Law Court has explained that its use in Maine's APA is intended to encompass a broader array of agency actions than decisions made in licensing or adjudicatory proceedings. *Brown v. State, Dep't of Manpower Affairs*, 426 A.2d 880, 883 (Me. 1981). Properly understood, § 11001(2) provides judicial authority "to compel an agency to take [any] action that the agency was legally bound to take." *Annable*, 507 A.2d at 593–94.

Court should compel DHHS to submit the SPA within three days to avoid delaying access to medically-necessary and potentially life-saving healthcare for 70,000 Mainers.[2]

CONCLUSION

For the reasons stated above, and in their 80C Petition and Motion to Expedite, Petitioners request that this Court:

a. Declare that the Commissioner is under an existing statutory obligation pursuant to 22 M.R.S. § 3174-G(1)(H) to submit a state plan amendment to the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services ensuring MaineCare eligibility for people under 65 years of age who qualify for medical assistance pursuant to 42 United States Code, Section 1396a(a)(10)(A)(i)(VIII);

b. Order that DHHS, within 3 days, submit the required state plan amendment to CMS;

c. Declare that DHHS is under an existing statutory obligation pursuant to 22 M.R.S. § 3174-G(1)(H) to adopt rules, including emergency rules pursuant to Title 5, section 8054 if necessary, to implement § 3174-G(1)(H) in a timely manner to ensure that people under 65 years of age who qualify for medical assistance pursuant to 42 United States Code, Section 1396a(a)(10)(A)(i)(VIII) are enrolled for and eligible to receive services no later than July 2, 2018; and

[2] The Law Court has recently held that when, as here, a public benefits program is funded by general appropriations, and a statute is amended to provide similar benefits to a new class of individuals, DHHS is "**required** to provide" those benefits to the newly eligible class of individuals "in the same way that it **must** provide" benefits to the previously eligible class of individuals. *Manirakiza v. Dep't of Health & Human Servs.*, 2018 ME 10, ¶ 15, 177 A.3d 1264, 1269 (emphasis added). To the extent that the Commissioner's failure or refusal to submit the SPA indicates a refusal to take other mandatory steps, including the requirement that "[t]he department shall adopt rules … in a timely manner to ensure that the persons described … are enrolled for and eligible to receive services no later than" July 2, 2018, the Court can and should remedy that refusal as well. *See* 5 M.R.S. § 8058(1). At a minimum, the Court should retain jurisdiction over the case to make sure that a similar failure to act in the future can be promptly remedied.

d. Order that DHHS adopt the required rules in a timely manner to ensure that eligible individuals are enrolled for and eligible to receive services no later than July 2, 2018.

Dated: April 30, 2018

/s/ James T. Kilbreth

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