No. 18-1446

In the
Supreme Court of the United States

LETTIE SEXTON,
ex rel. Appalachian Regional Healthcare, Inc.,
Petitioner,

v.

COMMONWEALTH OF KENTUCKY,
CABINET FOR HEALTH AND FAMILY SERVICES and
COVENTRY HEALTH AND LIFE INSURANCE COMPANY
d/b/a COVENTRYCARES OF KENTUCKY,
Respondents.

On Petition for Writ of Certiorari to the Supreme Court of Kentucky

REPLY BRIEF FOR PETITIONER

CAROLE D. CHRISTIAN
Counsel of Record
WYATT, TARRANT & COMBS, LLP
500 West Jefferson Street
Suite 2800
Louisville, Kentucky 40202
(502) 562-7588
cchristian@wyattfirm.com

Counsel for Petitioner

September 25, 2019

Becker Gallagher · Cincinnati, OH · Washington, D.C. · 800.890.5001

TABLE OF CONTENTS

TABLE OF AUTHORITIES ii

INTRODUCTION. 1

I. KENTUCKY'S REFUSAL TO RECOGNIZE MS. SEXTON'S RIGHT TO A HEARING RAISES A FEDERAL QUESTION. 1

II. THE NEW KENTUCKY LAW DOES NOT SOLVE THE PROBLEM. 6

III. THE CABINET HAS NOT PROVIDED "AN OPPORTUNITY FOR A FAIR HEARING". . . 9

IV. THE PUBLIC POLICY ESTABLISHED BY CONGRESS INCLUDES FAIR HEARINGS TO OVERSEE MCO DECISIONS. 10

CONCLUSION. 12

APPENDIX

Appendix 1 Findings of Fact; Conclusions of Law; and Recommended Order in the Commonwealth of Kentucky, Cabinet for Health and Family Services, Division of Administrative Hearings (August 29, 2019) . . . . . App. 1

TABLE OF AUTHORITIES

CASES

Appalachian Reg. Healthcare, Inc. v. Coventry Life Ins. Co.,
714 F.3d 424 (6th Cir. 2013). 11

King v. Smith,
392 U.S. 309 (1968). 6

Wilder v. Va. Hosp. Ass'n,
496 U.S. 498 (1990). 4

Younger v. Harris,
401 U.S. 37 (1971). 5, 6

CONSTITUTION, STATUTES, REGULATIONS

42 U.S.C. §1396a 1, 2, 5, 9

42 U.S.C. §1396a(a)(3) 4

42 U.S.C. §1396a(a)(19) 6

42 U.S.C. §1396u-2(a)(5)(B) 10

42 U.S.C. §1983 5

STATE STATUTES AND REGULATIONS

907 KAR 17:010 §1(3) 7

KRS 13B.140 . . . . . 2, 3, 5

KRS 13B.150(2) 2

OTHER AUTHORITIES

CMS's 2019-2020 Medicaid Managed Care Rate Development Guide, https://www.medicaid.gov/medicaid/managed-care/downloads/guidance/2019-2020-medicaid-rate-guide.pdf 10, 11

HHS Office of Inspector General Active Work Plan, https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000387.asp 10

INTRODUCTION

Coventry Health and Life Insurance Company ("Coventry") and the Commonwealth of Kentucky Cabinet for Health and Family Services (the "Cabinet") argue incorrectly that the Kentucky Supreme Court decision did not decide a question of federal law. In truth, the Court disregarded the federal laws that require states participating in the Medicaid program to provide fair hearings to Medicaid beneficiaries, and thereby secured the Commonwealth's denial of a right conferred on Ms. Sexton by Congress. Pursuant to 42 U.S.C. §1396a, Ms. Sexton's right to a hearing to review Coventry's denial of coverage for her medical services is concrete and particularized, and the Commonwealth must honor it.

The law establishing this right is fully set forth in the Petition. This Reply focuses on the Respondents' attempt to evade review by mischaracterizing the Kentucky Supreme Court's decision as one involving purely state law, and their inaccurate suggestion that the systematic denial of Medicaid beneficiaries' fair hearing rights is otherwise inconsequential.

I. KENTUCKY'S REFUSAL TO RECOGNIZE MS. SEXTON'S RIGHT TO A HEARING RAISES A FEDERAL QUESTION.

Coventry argues that there is no federal question because "the decision below never mentions [42 U.S.C.] Section 1396a." Coventry Response 12. Both Coventry and the Cabinet argue that the Supreme Court found Ms. Sexton had no standing to file a judicial appeal from the denial of her right to a hearing based only on

state law. Regardless of any self-serving characterization of the matter, the decision violates Ms. Sexton's federally-assured rights.

Respondents offer a false distinction that, if anything, provides an additional reason for this Court's review. In asserting the right to a hearing required by federal law on Ms. Sexton's behalf, ARH followed all of the prescribed steps. Yet the final word of the Commonwealth is that a hearing will not be provided despite federal law that mandates otherwise. Whether or not the Kentucky Supreme Court cited to 42 U.S.C. §1396a is irrelevant: The Commonwealth has violated Ms. Sexton's federally-assured right to a hearing.

The Petition for Writ of Certiorari lays out in detail the federal regulations relating to Ms. Sexton's right to a hearing, as well as the parallel state regulations. Pet. 4-10, App. 75-87. On Ms. Sexton's behalf, ARH complied with the law and requested a hearing with the Cabinet that was wrongly denied. KRS 13B.140 provides that "all final orders of an agency shall be subject to judicial review in accordance with the provisions of this chapter." The circuit court's scope of review includes whether the agency acted "in violation of constitutional or statutory provisions" or its action was "deficient as otherwise provided by law." KRS 13B.150(2). The Final Order of the Cabinet advised Ms. Sexton that the decision to deny her a

hearing could be appealed to a state circuit court.[1] Thus, ARH, on Ms. Sexton's behalf, filed a judicial appeal.

After ARH followed the prescribed procedures on Ms. Sexton's behalf, the Kentucky Supreme Court slammed the door on her hearing rights. It erected a bar to relief based on "standing," without regard to Congressional intent. Under the Supremacy Clause and the state's commitment to follow federal law as a condition of federal financial participation in Medicaid, however, the state's law on "standing" in original cases is irrelevant. Kentucky undertook to provide a fair hearing to Ms. Sexton, but its Supreme Court sustained the Cabinet's refusal to do so.

In arguing that the Kentucky Supreme Court's decision is strictly about state law, Respondents rely on the Court's language purporting to limit its decision to the question of standing to seek review in the courts, while avoiding the question whether Ms. Sexton had standing to request a hearing before the agency. This attempted distinction is illusory and meaningless. A "right" that the state's highest court refuses to vindicate — or for that matter, even to acknowledge — is in reality no right at all. The decision here brings full circle the denial of Ms. Sexton's federal right by the Commonwealth of Kentucky, which voluntarily chose to participate in the Medicaid program and is therefore

---

[1] The statutory citation provided in Petition Appendix D, the Final Order of the Secretary of the Cabinet for Health and Family Services, contains a reference to KRS 138.140. This is a typographical error; the correct reference is KRS 13B.140. *See* App. 60.

required to "comply with certain requirements imposed by the Act and regulations promulgated by the Secretary of Health and Human Services." *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 502 (1990). When the agency refuses to provide a hearing, the courts' refusal to hear her appeal is no less a violation of federal law than the agency's original refusal.

Further, even if there is a potential distinction between the illegal action (or inaction) of the Cabinet on the one hand, and the refusal of Kentucky courts to exercise jurisdiction over the agency's inaction on the other, it is a distinction worthy of this Court's scrutiny. This Court should not allow a state to insulate itself from review of an agency decision that violates federal law based on the premise that "our standards for judicial standing in state courts are not subject to review under the Supremacy Clause." The Commonwealth of Kentucky committed to provide a state fair hearing to Medicaid beneficiaries, which includes its judiciary's mandate to enforce the law if agency personnel get it wrong in the first instance.

A state may have authority to fix its own rules for judicial standing in original cases, but it may not abdicate the critical watchdog obligation to oversee agency decisions involving federal rights. Even assuming room exists for argument or interpretation, this case merits the Court's attention to determine the scope of a state's commitment under 42 U.S.C. §1396a(a)(3), and whether that commitment requires the state's judiciary to honor federal law in all respects, including its decisions concerning "standing."

The Cabinet adds a straw-man argument in suggesting that the Petition argues "that 42 U.S.C. §1396a requires a state's judiciary to provide Medicaid beneficiaries with a forum in which to appeal adverse administrative decisions in all instances." Cabinet Response 13. But any such argument is unnecessary. Kentucky law provides for judicial appeal of agency decisions, including decisions relating to Medicaid, in KRS 13B.140. The Commonwealth's refusal to provide one in this case because its highest court does not value the underlying federal right is a bait-and-switch evasion of its promises to the federal government and to Medicaid beneficiaries.

Both Respondents argue that Ms. Sexton might vindicate her right to a hearing through a direct action pursuant to 42 U.S.C. §1983 in federal court. While that is a possibility, it is neither an exclusive remedy nor a preferable one. Nothing in the Medicaid statutory scheme suggests Congressional intent to burden federal courts with direct actions in every case of an unsatisfactory agency decision where the state judicial procedure is adequate.

More importantly, the availability of a federal proceeding does not excuse state courts from complying with federal law. Kentucky has provided for appeals to state courts of agency decisions concerning Medicaid. The Cabinet even instructed Ms. Sexton that such an appeal was her next available step. Pursuit of a judicial appeal is an integral part of the state fair hearing process provided by Kentucky. Suing directly in federal court might have resulted in challenges relating to abstention pursuant to the *Younger*

doctrine[2] or objections that she has failed to exhaust administrative remedies. Certainly an indigent Medicaid beneficiary is ill-equipped to sort out the vagaries of federal-state jurisdiction, and federal law does not require her to do so when the Cabinet's Final Order (and state law) clearly advise her to seek review in state court.[3] When the state has committed to follow federal law and put the resources of its judiciary behind it, its courts should not then get to decide case-by-case which beneficiaries are worthy of the rights conferred by Congress. *See, King v. Smith*, 392 U.S. 309 (1968).

II. THE NEW KENTUCKY LAW DOES NOT SOLVE THE PROBLEM.

Coventry attempts to minimize the significance of this case by pointing to a 2016 Kentucky law, KRS 205.646, establishing an administrative process specifically for providers to challenge MCO non-payment decisions. Notably, the Cabinet's response does not discuss this new procedure; the Cabinet knows

---

[2] *See*, *Younger v. Harris*, 401 U.S. 37 (1971).

[3] In this vein, another federal requirement for state Medicaid plans should be noted; 42 U.S.C. 1396a(a)(19) requires a state plan to: "provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients." If Kentucky's convoluted rationale for denying Ms. Sexton a hearing requires a beneficiary to resort to federal court notwithstanding clear instructions and state law providing for state-court review, the result is not consistent with either simplicity or the best interest of recipients.

it is not a panacea. The new law provides a Band-Aid for the problem of providers who are unable to get paid by MCOs, but does nothing to acknowledge or secure the federal right of the Medicaid *beneficiary* to request a hearing. The laws relied on by Ms. Sexton and ARH, discussed at length in the Petition, remain fully intact. The new procedure is additional; nothing in it diminishes the *beneficiary's* right to request a hearing under any of the laws – state or federal – discussed in the Petition.

Importantly, the new law does not remedy the problem of Kentucky's disdain for the right of Medicaid beneficiaries to fair adjudications of medical necessity. Fair hearings do more than assure that providers will be paid. They help assure beneficiaries of availability and accessibility of medical care in the future, and remove the potential chilling effect on seeking treatment that might occur for one who has been told that his emergency room visit was "medically unnecessary." The federal law protects *beneficiaries*, while the new state law serves a related, but different purpose.

The potential problem created by the Kentucky Supreme Court is illustrated by one recent hearing officer decision involving a Medicaid beneficiary who is not enrolled with an MCO,[4] so the 2016 law does not apply. Following the reasoning of the Court in this

---

[4] In Kentucky, certain categories of beneficiaries are not required to enroll with an MCO and remain covered by traditional Medicaid. These include nursing home residents, among others. *See* 907 KAR 17:010 §1(3).

case, the Cabinet's Hearing Officer recommended that a beneficiary's request for a hearing be dismissed for lack of standing, as he had received the treatment at issue and would not be held financially responsible. Reply App. 1-8. Although this decision is not final until adopted by the Secretary of the Cabinet, it demonstrates the ongoing effect of the Kentucky Supreme Court's decision, in that case to disenfranchise Medicaid beneficiaries who are not enrolled with MCOs.[5]

The significance of a state Supreme Court decision refusing to enforce Medicaid beneficiaries' rights is not limited to Kentucky. As noted in the Petition (Pet. 7, n. 2), there are approximately 74.8 million Medicaid beneficiaries nationwide, under both managed care schemes and traditional Medicaid. Coventry does not indicate whether any other states have implemented additional provider protections like the new Kentucky law, or whether any such laws apply to beneficiaries in traditional Medicaid as opposed to managed care. Regardless, if other states follow the lead of the Kentucky Supreme Court, the rights of potentially millions more Medicaid beneficiaries could be at stake.

Finally, Coventry's own Response to the Petition betrays the falsity of its effort to cast this dispute as an isolated matter involving only a few hours of care of a single patient. Coventry notes the unremarkable result

---

[5] Before managed care was brought to Kentucky and before the Kentucky Supreme Court's decision in the present case, there was never a question about a beneficiary's right to appeal an adverse coverage decision, and no inquiry into his or her potential financial liability was ever necessary.

that the Kentucky Court of Appeals has, within the past month, followed the Kentucky Supreme Court's decision in several cases involving the same issue. Coventry Response 16, n. 2. These cases are the tip of an iceberg. ARH alone is involved in at least fourteen other cases still pending in the Kentucky Court of Appeals, a handful of cases in various state circuit courts (approximately 45 others have been dismissed pursuant to the decision in this case, over ARH's objections), and approximately 120 more cases before the administrative agency. All of these cases arose before the passage of the new law, which therefore does not apply and does not render them moot.

III. THE CABINET HAS NOT PROVIDED "AN OPPORTUNITY FOR A FAIR HEARING".

The Cabinet argues that it has complied with the requirement in 42 U.S.C. §1396a, asserting that "Sexton was granted the opportunity for a hearing through the process set forth in the regulation," notwithstanding its refusal to actually conduct a hearing. Cabinet Response 3, 12-13. We pass through the proverbial looking glass with this illusion. The Cabinet never explains how refusing to conduct a hearing that was timely requested by Ms. Sexton is the same as providing an "opportunity for a hearing." Its logic calls to mind the perennial *Peanuts* comic strip gag in which Lucy tees up the football, then snatches it away just as Charlie Brown prepares to kick it. Ms. Sexton's "opportunity" for a hearing is as meaningless as Charlie Brown's opportunity to kick the ball. Trickery and word games aside, the Cabinet violated the law without justification.

IV. THE PUBLIC POLICY ESTABLISHED BY CONGRESS INCLUDES FAIR HEARINGS TO OVERSEE MCO DECISIONS.

Coventry attempts to dismiss as imaginary any public policy concerns about its financial incentive to deny care. Congress's disagreement with Coventry's premise is evident in, among other provisions, the requirement of 42 U.S.C. §1396u-2(a)(5)(B) for MCOs to have procedures for enrollees "to challenge or appeal the failure of the organization to cover a service," and for state fair hearings when those results are unsatisfactory. In fact, in June 2019 the Office of Inspector General of the Department of Health and Human Services added to its Active Work Plan a study of the rate at which Medicaid MCO decisions denying care are overturned on appeal because "capitated payment models in managed care may create an incentive for MCOs to inappropriately limit or deny access to covered services to increase profits." *See* https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000387.asp (last accessed September 24, 2019).

Congress and the OIG have recognized that the "link between utilization and [an MCO's] capitation rates" is not a "direct feedback loop," as Coventry contends. Coventry Response 3-4, 24-25. While capitation rates set by the state are required to be "actuarially sound," these calculations are highly complex, leave ample room for subjectivity, and are determined for future contract periods based on aggregated historical information for all MCOs. *See* CMS's 2019-2020 Medicaid Managed Care Rate

Development Guide, https://www.medicaid.gov/medicaid/managed-care/downloads/guidance/2019-2020-medicaid-rate-guide.pdf (last accessed September 23, 2019). Nothing in the law prevents, for example, profit-based decisions by one MCO in the hope that the aggregate experience of other MCOs will wash out the effects of its own underpayment decisions when future rates are set. Nothing in the law adequately prevents "adverse selection," i.e., strategic decisions by MCOs to alter where they participate or who they contract with based on past profit or loss, like Coventry's 2012 decision not to contract with ARH in eastern Kentucky. *See Appalachian Reg. Healthcare, Inc. v. Coventry Life Ins. Co.*, 714 F.3d 424 (6th Cir. 2013). Coventry's suggestion that MCOs have no incentive to maximize profits in Medicaid managed care decisions whitewashes history and experience. *See also* Pet. 30-31, n. 11.

Finally, the attenuated possibility that profit-driven payment decisions will affect MCO contract rates in the future fails entirely to protect the rights of a Medicaid beneficiary whose medically necessary care is not covered today, next week, or even next year. State fair hearings are the lynchpin of the Medicaid program because they provide Medicaid beneficiaries with disinterested reviews of medical coverage decisions. This is the "direct feedback loop" designed by Congress. Beneficiaries should never be required to rely on Coventry's own assurances that it is trustworthy, which is why Congress has assured them that they will receive fair hearings. Neither Kentucky nor any other state that participates in Medicaid is free to disregard this guarantee.

CONCLUSION

For the foregoing reasons, the Petition for Writ of Certiorari should be granted.

Respectfully submitted,

Carole D. Christian
Counsel of Record
WYATT, TARRANT & COMBS, LLP
500 West Jefferson Street, Suite 2800
Louisville, Kentucky 40202
(502) 562-7588
cchristian@wyattfirm.com

Counsel for Petitioner
Lettie Sexton ex rel. Appalachian Regional Healthcare, Inc.

APPENDIX

APPENDIX

TABLE OF CONTENTS

Appendix 1 Findings of Fact; Conclusions of Law; and Recommended Order in the Commonwealth of Kentucky, Cabinet for Health and Family Services, Division of Administrative Hearings (August 29, 2019) . . . . . App. 1

APPENDIX 1

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
Division of Administrative Hearings
Health Services Administrative Hearing Branch
Case No. HSAHB DMS 19-0455

[Filed August 29, 2019]

IN RE: [redacted]
Appeal of Denial of Inpatient Hospital Services

FINDINGS OF FACT; CONCLUSIONS OF LAW; AND RECOMMENDED ORDER

* * * * * * *

Introduction

The above-referenced matter came before the undersigned *sua sponte* following the filing of an appeal designated by the Department for Medicaid Services ("DMS"), Disease and Case Management Branch ("DCMB") as a Medicaid recipient appeal and which was forwarded to the Division of Administrative Hearings ("DAH") via a memorandum stating "the hearing concerns denial of Inpatient Hospital Services for [redacted]".[1] The appeal was filed by [redacted] Appeals Specialist with

[1] The appeal was received by the DAH on June 5, 2019 and assigned to the undersigned on August 27, 2019.

Owensboro Health Regional Hospital ("OHRH"), ostensibly of behalf of Medicaid recipient, [redacted] ("Appellant"). The appeal letter filed by [redacted] Appeals Specialist, and documents attached with it, did not include any document showing that [redacted] had authorized her to file the appeal on his behalf.[2] Because the request for an administrative hearing by the Appellant was not filed by an individual authorized to file it and because the Appellant does not have standing to dispute a matter such as fee payment when the medical services have already been provided to him by the Medicaid services provider, the tribunal recommends that the Medicaid recipient appeal filed herein be dismissed. Based upon the foregoing, the tribunal makes the following:

FINDINGS OF FACT

1. An adverse action determination dated May 10, 2019 was issued by the DMS to Owensboro Health Regional Hospital ("OHRH") which denied reimbursement for inpatient hospital services (dates of service: 09/28/2017 thru 10/05/2017) provided by OHRH to [redacted], an inmate incarcerated with the Kentucky Department of Corrections. *Appeal letter dated May 20, 2019 and documents attached thereto as filed by* [redacted] *Appeals Specialist with Owensboro Health Regional Hospital.*

---

[2] The matter that [redacted] disputes stems from a denial of reimbursement to OHRH by the DMS for inpatient hospital services it provided to the Appellant in 2017.

2. A letter postmarked May 24, 2019 and signed by [redacted] Appeals Specialist was received by the DMS and designated as a Medicaid recipient appeal. Nothing was mentioned nor filed by [redacted] Appeals Specialist that showed that she had the written consent of [redacted] or his legal guardian to request an administrative hearing on his behalf. *Appeal letter dated May 20, 2019 and documents attached thereto as filed by* [redacted] *Appeals Specialist with Owensboro Health Regional Hospital.*

3. At the time the appeal was mailed on May 24, 2019 by [redacted] Appeals Specialist, there is no evidence that she had the written consent of [redacted] or his legal guardian authorizing her to file an appeal on the Appellant's behalf.

Based upon the foregoing Findings of Fact the tribunal reaches the following:

CONCLUSIONS OF LAW

1. There is no question but that only a Medicaid recipient, who in the case under review is [redacted], or his legal guardian, or his authorized representative has the legal right to initiate the administrative action herein. Kentucky Administrative Regulation (KAR), 907 KAR 1:563§4(1) provides as follows:

> Section 4. Request for an Administrative Hearing. (1) An applicant, recipient, or an authorized representative may request an administrative hearing by filing a written request with the department.

907 KAR 1:563§4(1). In addition, KAR very clearly defines who may be deemed to be "an authorized representative" and therefore entitled to file a request for an administrative hearing and provides as follows:

> (5) "Authorized representative" means:
> (a) For a recipient or applicant who is authorized by Kentucky law to provide written consent, an individual or entity acting on behalf of, and with written consent from, the recipient or the applicant; or
> (b) A legal guardian.

907 KAR l:563§1(5). The tribunal concludes that the appeal filed herein should be dismissed, as a matter of law due to a failure to comply with Kentucky regulatory law based upon the provisions 907 KAR 1:563§4(1) which provides that only a recipient or authorized representative may request an administrative hearing by filing a written request with the department. There is no evidence that the individual who filed the appeal herein, [redacted] Appeals Specialist, was the authorized representative of the Medicaid recipient at the time the request for an administrative hearing was filed.

2. The tribunal further concludes that it is well settled that under federal law Medicaid recipients are not legally responsible for amounts not reimbursed to providers by state Medicaid agencies. [See, 42 C.F.R. § 447.15 which provides that "[a] state plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers *who accept, as payment in full, the amounts paid by the*

agency...." (emphasis added). *See also, Florence Nightingale Nursing Home v. Perales*, 782 F.2d 26, 29 (2d Cir. 1986) [42 C.F.R. § 447.15 prevents health care providers from seeking contributions from patients beyond the limits set by the Medicaid regulatory scheme), *cert. denied,* 479 US. 815, 107 S. Ct. 68, 93 L.Ed.2d 26 (1986)]. See also *Banks v. Secretary of Indiana Family and Social Services Admin.*, 997 F.2d 231 (7th Cir. 1993). The Secretary of the Cabinet for Health and Family Services has ruled in *In Re: Donald Gore*, CHFS Administrative Action No. AHB DMS 13-1019 (Final Order dated June 9, 2014) that "... Appellant has no standing because Appellant has not suffered an injury in fact that can be redressed by a favorable decision. Appellant has received the services requested and cannot be required to pay for those services. Pursuant to 42 C.F.R. § 447.15, a Medicaid provider cannot seek payments from a Medicaid recipient of amounts not reimbursed by the state [citations omitted]." The *In Re: Donald Gore* ruling was reaffirmed by the Secretary in the CHFS administrative case of *In Re: Lettie Sexton*, CHFS Administrative Action No. DAH DMS 14-2692 (Final Order dated October 28, 2014). Following an appeal of the Secretary's ruling in *In Re: Lettie Sexton* and a review by the Supreme Court of Kentucky of the issue of a Medicaid enrollee's standing in *Sexton v. Cabinet for Health and Family Services*, the Secretary's ruling was not overturned and therefore must be honored as precedent by this tribunal pursuant to *In Re: Sandra Adams*, CHFS Administrative Action No. DAH DPP 16-2105 (Final Order dated March 24, 2017). Therefore, the tribunal concludes that even if [redacted] Appeals Specialist were to be deemed the authorized

representative of the Appellant in this matter, the Appellant lacks legal standing to pursue a claim for reimbursement for services which have been provided to him by his Medicaid services provider, OHRH. In conclusion, and in accordance with the legal precedents and the directives of the Secretary of the Cabinet for Health and Family Services as set forth in the case law and the CHFS Final Orders cited *supra*, the tribunal issues the following:

RECOMMENDED ORDER

IT IS RECOMMENDED that the appeal filed herein ostensibly on behalf of Medicaid recipient [redacted] concerning the denial by the DMS of reimbursement to Owensboro Health Regional Hospital for inpatient hospital services provided to [redacted] be **DISMISSED AS AN UNAUTHORIZED APPEAL** pursuant to 907 KAR 1:563§4(1); and further that the appeal filed herein be **DISMISSED DUE TO APPELLANT'S LACK OF STANDING** to pursue an administrative hearing for the benefit of his Medicaid services provider, Owensboro Health Regional Hospital.

NOTICE TO PARTIES OF EXCEPTION AND APPEAL RIGHTS

Pursuant to KRS 13B.110(4): A copy of the hearing officer's recommended order shall also be sent to each party in the hearing and each party shall have fifteen (15) days from the date the recommended order is mailed within which to file exceptions to the recommendations with the CHFS Secretary. Exceptions shall be filed at the following address:

CHFS Secretary; C/O Division of Administrative Hearings; 105 Sea Hero Road, Ste. 2; Frankfort, KY 40601.

Pursuant to Kentucky case law *(see Rapier v. Philpot*, 130 S.W.3d 560 (Ky. 2004) and subsequent cases), when a party fails to file exceptions, the issues the party can raise on judicial review under KRS 13B.140 are limited to those findings and conclusions contained in the CHFS Secretary's final order that differ from those contained in the hearing officer's recommended order.

Pursuant to KRS 13B.120(4): The CHFS Secretary shall render a final order in an administrative hearing within ninety days after the hearing officer submits a recommended order to the CHFS Secretary, unless the matter is remanded to the hearing officer for further proceedings.

Pursuant to KRS 13B.140: All final orders of the CHFS Secretary shall be subject to judicial review in accordance with the provisions of KRS Chapter 13B. A party shall institute an appeal by filing a petition in the Circuit Court of venue, as provided in the agency's enabling statutes, within thirty days after the final order of the agency is mailed or delivered by personal service. If venue for appeal is not stated in the enabling statutes, a party may appeal to Franklin Circuit Court or the Circuit Court of the county in which the appealing party resides or operates a place of business.

Finally, pursuant to KRS 23A.010(4): Such review [by the Circuit Court] shall not constitute an appeal but an original action." Some courts have interpreted

this language to mean that summons must be served when filing an appeal petition in the Circuit Court.

SO RECOMMENDED the 29th day of August 2019.

/s/
RICHARD G. SLOAN
Hearing Officer

[Certificate of Service Omitted for this Appendix]