No. _____

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

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PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

The Medicaid program, established pursuant to Title XIX of the Social Security Act, provides coverage of medical care for the poor. By design, beneficiaries of the program will have no liability for the cost of their care or nominal cost-sharing responsibility. Instead, the cost of care is paid by the state Medicaid agency, which receives reimbursement for a substantial portion of its costs from the federal government.

To protect beneficiaries' right to fair decisions about their care, the United States Code and numerous federal regulations require that a state agency participating in the Medicaid program must provide a state "fair hearing" to any individual whose claim for coverage under the state Medicaid plan is denied. In the present case, the Kentucky Supreme Court found that Ms. Sexton has no standing to enforce that right because she received the care in question and could not be held personally liable for the cost. Until this decision, no court has ever held that a Medicaid beneficiary's standing to enforce her right to a state fair hearing requires her to have personal financial liability or to go without needed care.

The question presented is:

Whether 42 U.S.C. § 1396a(a)(3) requires a state participating in the Medicaid program to provide a "fair hearing" to a beneficiary when coverage of his or her medically necessary services is denied, regardless of whether the beneficiary has any risk of personal liability.

PARTIES TO THE PROCEEDING AND RULE 29.6 STATEMENT

All parties to the proceeding are named in the caption.

Pursuant to this Court's Rule 29.6, petitioner Lettie Sexton is a natural person who resides in Knott County, Kentucky. Her authorized representative, Appalachian Regional Healthcare, Inc. is a private, non-profit Kentucky corporation that has no parent corporation and has no stock.

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PETITION FOR WRIT OF CERTIORARI

Appalachian Regional Healthcare, Inc., as authorized representative of Lettie Sexton, respectfully petitions this Court for a writ of certiorari to review the judgment of the Kentucky Supreme Court in this case.

OPINION BELOW

The opinion of the Kentucky Supreme Court is published at *Commonwealth of Kentucky, Cabinet for Health and Family Services, Department for Medicaid Services v. Sexton*, 566 S.W.3d 195 (Ky. 2018). App. 1.

JURISDICTION

The Kentucky Supreme Court filed its Opinion on September 27, 2018. Its Order Denying Petition for Rehearing was issued February 14, 2019. App. 71. This Petition for Writ of Certiorari is filed within 90 days of that date. This Court has jurisdiction under 28 U.S.C. § 1257(a).

RELEVANT CONSTITUTIONAL AND STATUTORY PROVISIONS

The Supremacy Clause, Article VI, Clause 2 of the United States Constitution, provides:

> This Constitution, and the Laws of the United States which shall be made in pursuance thereof . . . shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, anything in the Constitution or Laws of any State to the contrary notwithstanding.

The Fifth Amendment to the United States Constitution provides:

> No person shall . . . be deprived of life, liberty, or property, without due process of law….

The Fourteenth Amendment to the United States Constitution, § 1 provides:

> [N]or shall any State deprive any person of life, liberty, or property, without due process of law.

Section 902 of the Social Security Act, 42 U.S.C. § 1396a(a) (2018) provides that a "State plan for medical assistance must:"

> (3) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness.

Section 1905 of the Social Security Act, 42 U.S.C. § 1396d (2018) provides:

> (a) Medical Assistance. The term "medical assistance" means payment of part or all of the cost of the following care and services or the care and services themselves, or both….
>
> (1) inpatient hospital services (other than services in an institution for mental diseases);
>
> (2) outpatient hospital services….

Section 1932 of the Social Security Act, 42 U.S.C. § 1396u-2(a)(5)(B) (2018) provides:

> (B) Information to enrollees and potential enrollees. Each managed care entity that is a Medicaid managed care organization shall, upon request, make available to enrollees and potential enrollees in the organization's service area information concerning the following:
>
> * * *
>
> (iii) Grievance and appeal procedures. The procedures available to an enrollee and a health care provider to challenge or appeal the failure of the organization to cover a service.

In addition to the foregoing, relevant federal regulations, Kentucky statutes and Kentucky administrative regulations are included in the appendix.

STATEMENT OF THE CASE

When Congress established the Medicare program in 1965, it also established the medical assistance, or Medicaid, program under title XIX of the Social Security Act to consolidate and establish minimum benefit requirements for state programs to pay for medical care to needy citizens meeting certain eligibility criteria. Pub. L. No. 89-97, Title I, § 121(a), 79 Stat. 344. Under the Medicaid program, each state electing to participate must submit a qualifying "state plan" to the Secretary of Health and Human Services. If the plan is approved, the federal government will

fund a percentage of the state's expenditures. 42 U.S.C. § 1396a(a) (2018). "Although participation in the program is voluntary, participating States must comply with certain requirements imposed by the Act and regulations promulgated by the Secretary of Health and Human Services." *Wilder v. Va. Hosp. Assoc.*, 496 U.S. 498, 502 (1990). Because Medicaid beneficiaries are necessarily poor, it is a lynchpin of the Congressional scheme that they do not have to worry about the costs of their care. There are some classes of beneficiaries and services for which the state must provide that they will have no cost-sharing (such as co-payments and deductibles) at all. Others may be subject to "nominal" cost-sharing, but participating providers may not deny care based on the individual's inability to pay. 42 U.S.C. § 1396o(a)-(e) (2010).

Federal Law Establishes the Right to a Hearing. From the outset of the program, Congress defined the term "medical assistance" as "payment of part or all of the cost" of the services required to participate in the Medicaid program, including inpatient and outpatient hospital services. Pub. L. No. 89-97, Title I, § 121(a), 79 Stat. 351 (adding § 1905 to the Social Security Act, codified at 42 U.S.C. § 1396d(a) (2018)).[1] Also from the inception of the Medicaid

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[1] In 2010, the definition was amended by the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, § 2304 to add a phrase:

> The term "medical assistance" means payment of part of all of the cost of the following care and services **or the care and services themselves, or both**….

To explain this change, the House Energy and Commerce

program, Congress mandated that a state plan *must* "provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance is denied or is not acted upon with reasonable promptness." Pub. L. No. 89-97, 79 Stat. 344 (creating §1902(a)(3) of the Social Security Act). This requirement is codified at 42 U.S.C. § 1396a(a)(3) and remains in the law unchanged today as an essential provision of any qualifying state plan. Read together, the definition of medical assistance and the requirement to provide a state fair hearing to any individual "whose claim for medical assistance under the plan is denied" are clear: The state must provide a hearing if it denies payment for a beneficiary's medical services *under the plan*.

Numerous federal regulations in 42 C.F.R. Part 431 (App. 75-87) flesh out this requirement. *See, e.g.*, 42 C.F.R. § 431.200 (2016) ("[i]mplement[ing] section

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Committee, which has jurisdiction over Medicaid, observed that the term "medical assistance" "has generally been understood to refer to both the funds provided to pay for care and services and to the care and services themselves," but that some court decisions "have read the term to refer only to payment." So, the law was changed to make clear that the term embraces *both* payment and provision of care. H.R. Reg. No. 299, 111th Cong., 1st Sess. 2009, at 649-50 (Oct. 14, 2009). There appears to be no dispute, however, that the provision of "medical assistance" by a state has always referred to, at a minimum, *payment* for services. *See*, *e.g., Equal Access for El Paso, Inc. v. Hawkins*, 562 F.3d 724 (5th Cir. 2009) (holding that medical assistance means "payment for services" only and does not mandate that the state make services available); *Mandy R. ex rel. Mr. and Mrs. R. v. Owens*, 464 F.3d 1139, 1148 n.2 (10th Cir. 2006) (summarizing range of decisions on whether "medical assistance" means payment only or includes actual services).

1902(a)(3) of the [Social Security] Act, which requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly"); 42 C.F.R. § 431.205(a) (2013) (providing that a state Medicaid agency "must be responsible for maintaining a hearing system that meets the requirements of this subpart," including "the due process standards set forth in *Goldberg v. Kelly*, 397 U.S. 254 (1970)"); 42 C.F.R. § 431.206 (2016) (requiring the state Medicaid agency to issue and publicize its hearing procedures including the "right to a hearing," and the right to be represented by a spokesman); and 42 C.F.R. § 431.220 (2016) (declaring that the State agency *must* grant an opportunity for a hearing to "[a]ny individual who requests it because he or she believes the agency has taken an action erroneously, [or] denied his or her claim for eligibility or for covered benefits or services . . ."). *See also*, 42 C.F.R. § 431.221(b) (2016); 42 C.F.R. § 431.240 (2013); and 42 C.F.R. § 431.202 (1978). While there have been some wording changes to these regulations over the years, the substance of the foregoing provisions has appeared in 42 C.F.R. Part 431 and is essentially unchanged since it was first published in 1979. *See,* 44 Fed. Reg. 17932 (March 29, 1979).

In 1997, Congress amended the law to allow state Medicaid agencies to contract with private "managed care organizations" ("MCOs") to assume the risk and manage the care of Medicaid beneficiaries, without having to seek a waiver of the usual state plan requirements from CMS. Balanced Budget Act of 1997 Pub. L. No. 105-33, 111 Stat. 251 Subtitle H § 4701,

§ 1932(a)(1)-(3).[2] Managed care allows the state to use private insurance companies as middlemen. Under traditional Medicaid, the state agency contracted with and paid providers directly. Under managed care, the state pays the MCO a flat, or "capitated," rate per month for each member, and the MCO manages beneficiaries' care and pays providers out of the capitated payments it receives from the state. An MCO thus has a built-in conflict of interest: It keeps more of the money it receives from the state if it denies coverage for beneficiaries' medical services.

This conflict created the obvious need to reinforce the beneficiary protections that Congress built into state Medicaid programs. Among numerous requirements, Congress mandated that an MCO must provide notice to its enrollees of "the procedures available to an enrollee and a health care provider to challenge or appeal the *failure of the organization to cover a service*." 42 U.S.C. § 1396u-2(a)(5)(B)(iii) (2018) (emphasis added). And in 2002, the Centers for Medicare and Medicaid Services ("CMS"), the division of the Department of Health and Human Services that

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[2] Medicaid managed care enrollment accounts for 91% of Kentucky's 1.3 million Medicaid beneficiaries today. *See* Cabinet for Health and Family Servs., Monthly Managed Care Members Count, https://chfs.ky.gov/agencies/dms/stats/McoMonthlyMemberCounts2019040113.pdf (last accessed May 9, 2019). Nationwide, the latest figures published on Medicaid.gov show 74.8 million enrolled in Medicaid and the companion Children's Health Insurance Program (CHIP), with 68% enrolled in "comprehensive managed care" and another 13% enrolled in "non-comprehensive managed care." *Who Enrolls in Medicaid?*, Medicaid.gov, https://www.medicaid.gov/state-overviews/scorecard/national-context/enrollment/index.html (last accessed May 9, 2019).

administers the Medicaid program, added an array of new regulations in 42 C.F.R. Part 438 to spell out MCO responsibilities, including their obligation to ensure state fair hearings for dissatisfied beneficiaries. 67 Fed. Reg. 41095 (June 14, 2002).

For example, Part 438, Subpart F is titled "Grievance and Appeal System." Explicitly referring to § 1902 of the Social Security Act (42 U.S.C. § 1396a(a)(3)), the regulations define an "adverse benefit determination" to include "the denial, in whole or in part, of payment for a service." 42 C.F.R. § 438.400 (2016). App. 79.[3] Under 42 C.F.R. § 438.404 (2016), an MCO's notice of an adverse benefit determination must include notice of "the right to request a state fair hearing consistent with 42 C.F.R. § 438.402(c)." That section in turn states: "An enrollee may request a state fair hearing" whenever the MCO's internal appeal process upholds an "adverse benefit determination."[4] And, it allows a provider or other authorized representative to act on the enrollee's behalf if state law permits and with the enrollee's written consent. *Id.* at (c)(1)(ii).[5] App. 80-81.

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[3] Before July 5, 2016, the regulation used the term "action" instead of "adverse benefit determination," but it had essentially the same definition. App. 79-80.

[4] A point of terminology: the term "enrollee" is used in federal law, and elsewhere, to refer to Medicaid beneficiaries who are assigned to an MCO and thereby become enrolled.

[5] The applicable Kentucky regulation, 907 KAR 17:010 § 5(3)(a), allows an enrollee to act through an authorized representative designated in writing.

To clarify the chronology of the required internal MCO appeal and the request for a State fair hearing, 42 C.F.R. § 438.408(f) (2016) states that a request for a state fair hearing may only be made following notice "that the MCO . . . is upholding the adverse benefit determination." App. 82. In fact, one regulation specifically addresses the fact pattern at issue here, where a provider provides a service while appealing an MCO's denial of authorization. Under 42 C.F.R. § 438.424(b) (2016), if the "state fair hearing officer reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the *MCO . . . must pay for those services*." (emphasis added). App. 83.

State Law Enforces the Right to a Hearing. Kentucky's General Assembly has authorized the state to participate in the Medicaid program. KRS § 205.520 (2005). The responsible state agency in the Commonwealth is the Cabinet for Health and Family Services ("Cabinet") through its Department for Medicaid Services. The Cabinet has long had in place regulations to assure beneficiaries of their right to a state fair hearing to challenge a denial of coverage for services. Among other provisions, 907 KAR 3:130 (2014) requires it to be the final arbiter of medical necessity and to "ensure the right of a recipient to appeal a negative action." Another regulation, 907 KAR 1:563 (2019), provides a right to a cabinet level administrative hearing following an "adverse action . . . affecting covered services." App. 85. Tellingly, the Cabinet never questioned a Kentucky beneficiary's right to challenge a non-coverage decision (or the option to exercise that right through the provider as

authorized representative) under the traditional Medicaid fee-for-service system.

Effective November 1, 2011, Kentucky elected to implement Medicaid managed care statewide, initially contracting with three MCOs, all affiliated with established insurance companies.[6] One of these was Respondent Coventry Health and Life Insurance d/b/a CoventryCares ("Coventry"). Consistent with the requirements of federal law, the Cabinet promulgated new regulations to assure that these MCOs would honor the required rights of their enrollees, including the right to a state fair hearing after exhausting internal MCO grievance and appeal procedures.

Like the other Kentucky regulations cited above (which remained intact), these new regulations secured the rights to a state fair hearing for those Medicaid beneficiaries who were now enrolled with an MCO. *See, e.g.*, 907 KAR 17:005 (2018) (defining "adverse action" to include denial of services or denial of payment); and KAR 17:010 (2018) (providing for the right to a state fair hearing and allowing request by an "authorized representative"). App. 86-87. In fact, 907 KAR 17:010 specifically references 42 C.F.R. Parts 431 and 438 concerning fair hearings. App. 87.

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[6] Before 2011, Kentucky had managed care in place for the 16-county region that includes the city of Louisville, with an MCO known as Passport. This exclusive arrangement was initially left intact when the state went to statewide managed care in 2011. Later, the Cabinet opened the entire state to all contracted MCOs. There are presently five MCOs recognized by the Cabinet statewide, including Respondent Coventry, now known as Aetna Better Health of Kentucky.

The Cabinet Denies a Hearing. Lettie Sexton is a Medicaid beneficiary residing in Hindman, Kentucky who was enrolled with Coventry as her MCO. Hindman is a small town in Knott County in southeastern Kentucky, the heart of Appalachia. The region is among the most impoverished in the country, with 34.6% of Knott County's residents living in poverty. U.S. Census Bureau Quick Facts: Knott Cty., Ky., https://www.census.gov/quickfacts/fact/table/knottcountykentucky/BPS030217 (last accessed May 7, 2019). With a population of 15,126 as of July, 2018, its Medicaid enrollment for the same period was 7,950, or roughly 53 percent of all residents. *Id.*; *see* Cabinet for Health and Family Servs., Monthly Membership Counts by Cty., https://chfs.ky.gov/agencies/dms/stats/KDWMMCounts20180Jul.pdf (last accessed May 7, 2019). It is an impoverished region with many citizens dependent on the state Medicaid program.

Appalachian Regional Healthcare, Inc. ("ARH") is a nonprofit organization operating hospitals throughout southeastern Kentucky. Most of the counties it serves have economic profiles similar to Knott County with high levels of dependence on Medicaid. One of ARH's hospitals, Harlan ARH, is located in Harlan County, adjacent to Knott County. On April 7, 2014, Ms. Sexton came to the emergency room of Harlan ARH complaining of chest pain. The hospital requested and obtained preauthorization to admit Ms. Sexton for observation, but Coventry approved only a 23-hour stay. Treating physicians at the hospital considered a discharge at that point to be unsafe, as Ms. Sexton also had a history of hypertension and was still complaining of chest pain radiating to her left arm. ARH requested

that approval for observation be extended to 48 hours to allow for a cardiology consultation, which Coventry refused to approve. As a responsible provider, ARH did not put Ms. Sexton out on the street, but provided her with the care that it deemed medically necessary, notwithstanding Coventry's refusal.

Pursuant to 42 C.F.R. § 438.402(c)(1)(ii) and 907 KAR 17.010 § 5(3)(a), Ms. Sexton authorized ARH to represent her by executing a form, "Appointment of Authorized Representative for Disputed Claims, Administrative Hearings and Court Appeals" and designating Phyllis Wilson and/or Tommy Scott Huff, who are both ARH employees, as her representatives. App. 88. ARH thus began the appeal process with a letter to Coventry requesting its required internal review. App. 90-91. Coventry conducted the internal review, making no objection to Ms. Sexton's right to request it, but stuck to its original decision that Ms. Sexton's additional treatment was not medically necessary. In its notice of this decision, Coventry explained the right to request a state fair hearing, obviously recognizing that the law requires it. App. 92-98.

Again on Ms. Sexton's behalf, ARH filed a request for a state fair hearing. App. 99-100. Pursuant to 907 KAR 17:010 § 5(1), a state fair hearing is "administered by the department [the Cabinet's Department of Medicaid Services] in accordance with KRS Chapter 13B," which is Kentucky's Administrative Procedure Act. App. 85. The Cabinet assigned a hearing officer and set a hearing date. Despite its prior notice of the right to a state fair hearing, Coventry moved to dismiss

Ms. Sexton's request for a hearing, arguing that she did not have "standing" because she was not at risk of financial liability for the services she received. The Cabinet's hearing officer granted Coventry's motion, canceled the scheduled hearing and recommended dismissal of the hearing request. App. 62-70. Pursuant to KRS Chapter 13B, the Cabinet Secretary accepted the recommendation and entered a Final Order, thus denying Ms. Sexton's right to a hearing on the ground that she "lacked standing to maintain the appeal." App. 60-61.

As Ms. Sexton's representative, ARH complied with KRS Chapter 13B by filing a Petition for Review in Harlan Circuit Court. The Cabinet and Coventry moved to dismiss the petition on grounds unrelated to standing. The Circuit Court denied their motions. App. 56-59. The Cabinet then filed an interlocutory appeal to the Kentucky Court of Appeals, asserting the state's sovereign immunity. The Kentucky Court of Appeals issued an Opinion and Order Vacating and Remanding and Denying Motion to Dismiss. App. 37-55. Its decision did not address standing, but was based erroneously on KRS Chapter 45A, which applies to suits against the state arising under contract. Because no contract was involved in the appeal, KRS Chapter 45A was inapplicable.

Kentucky's Highest Court Denies the Right to a Hearing. Each of the three parties thus moved the Kentucky Supreme Court for discretionary review of the Court of Appeals' analysis under KRS Chapter 45A. The Court accepted review and, in a significant opinion, announced a new test for constitutional

standing in Kentucky courts. It adopted the test for standing that this Court established in *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560-61 (1992). App. 21-24. The Court then proceeded to hold that, under *Lujan,* Ms. Sexton had no standing and no right to a state fair hearing despite the federal statutes and regulations that establish her right over and over again. App. 24-29.

Petitioner has no quarrel with the Court's adoption of the *Lujan* test. Rather, Petitioner maintains that the Court erred in applying the *Lujan* test to deny a beneficiary's right to a state fair hearing under federal law. Ms. Sexton has a right to a hearing guaranteed by Congress, CMS and Kentucky's own regulations. The Kentucky Supreme Court erred as a matter of federal law in holding that the denial of a hearing was not sufficient to meet the *Lujan* standing test for an injury-in-fact.

The Court erroneously relied on the fact that Ms. Sexton, like many Medicaid beneficiaries, "is not financially interested in any way whatsoever in the outcome of this dispute." The Court also observed that "Sexton has not alleged that she did not receive all the proper medical care that she needed." App. 24. But none of the governing Medicaid statutes and regulations makes the right to a hearing contingent on a beneficiary's liability or failure to receive care. Those governing provisions guarantee the right to a hearing whenever payment for services under the plan is denied.

The Court thus erroneously equated the denial of Ms. Sexton's right to a hearing – which secures her

right to "medical assistance . . . under the plan" – with the type of procedural right *in vacuo* that this Court found inadequate to provide standing in *Summers v. Earth Island Institute*, 555 U.S. 488 (2009). Without even acknowledging the federal laws that guarantee her right, the Court concluded that Ms. Sexton could not show an injury sufficient to satisfy the standard articulated by this Court in *Lujan*. It reversed the Court of Appeals and vacated the decision of the Circuit Court with instructions to dismiss the complaint. With that, Kentucky's highest court became the first jurisdiction to deny Medicaid beneficiaries' standing to receive a state fair hearing in the face of multiple federal laws creating that right.

REASONS FOR GRANTING THE WRIT

The right of a Medicaid beneficiary to request a state fair hearing upon denial of coverage is as old and important as the Medicaid program itself. It has never depended on whether the beneficiary risks financial liability or fails to receive necessary medical care. To the contrary, Medicaid is fundamentally an entitlement program that ensures the state will *pay for* its poorest citizens' medical care and secures the rights of beneficiaries to fair coverage decisions without concern about potential financial liability. The right to an impartial review when MCOs deny coverage is an integral component of the Congressional scheme, particularly in the context of managed care, where private MCOs have an inherent financial motive to deny claims. Because Medicaid beneficiaries by definition are not personally liable, in denying Ms. Sexton's right to a hearing, Kentucky's highest court

rendered meaningless all the federal statutes and regulations that require a hearing.

Having elected to participate in the Medicaid program, Kentucky must follow the federal statutes and regulations governing Medicaid. It has duly promulgated regulations reflecting its commitment to provide Ms. Sexton a hearing, including her right to appoint her provider as her authorized representative. ARH, on her behalf, followed the procedure prescribed by federal and Kentucky law; it requested a hearing and, when this was denied, appealed to the state's circuit court.

Notwithstanding the right conferred by Congress and buttressed by numerous federal and state regulations, the Kentucky Supreme Court nullified Ms. Sexton's hearing right, dismissing it as a mere procedural right *in vacuo* because ARH provided care pending her appeal rather than send her home and place her life in danger. However, neither ARH's charity in providing the medically necessary care her physicians ordered, nor its financial interest in a successful appeal, are relevant at all to the concreteness of Ms. Sexton's injury when denied her right to a hearing.

The decision of Kentucky's highest court conflicts with 42 U.S.C. § 1396a(a)(3), 42 U.S.C. § 1396u-2, and a host of implementing federal regulations. First, the Kentucky Supreme Court must honor those federal provisions under the Supremacy Clause. Second, its holding stands inconsistent with this Court's decision in *Goldberg v. Kelly*, 397 U.S. 254 (1970), and previous decisions of this Court that hold a denial of rights

conferred by Congress may constitute an injury sufficient to confer standing, even if those rights are intangible.

The right to a due process "fair hearing" --- which Congress granted to the millions of Medicaid beneficiaries nationwide to prevent arbitrary denials of coverage for care --- has never depended on the beneficiary having a financial interest in the appeal or on the beneficiary foregoing necessary services. Yet, Kentucky's highest court holds otherwise in a published opinion that affects scores of cases now being held in abeyance before the Cabinet and various courts in Kentucky. This Petition raises an important federal question that this Court should review to protect Medicaid beneficiaries in Kentucky and any other state that might be tempted to take shortcuts with beneficiary rights.

THE KENTUCKY SUPREME COURT'S DECISION CONFLICTS WITH DECISIONS OF THIS COURT AND 42 U.S.C. § 1396a(a)(3).

A. DENIAL OF THE EXPLICIT STATUTORY RIGHT IS AN INJURY-IN-FACT.

When a state agency accepts federal funds appropriated under the spending clause, the Supremacy Clause requires local law to yield. *See Dalton v. Little Rock Family Planning Servs.*, 516 U.S. 474, 477-78 (1996) (holding that a provision of a state constitution is invalid if it conflicts with the Medicaid Act). *Accord, CSX Transp., Inc. v. Easterwood*, 507 U.S. 658, 663-64 (1993); *Lawrence Cty. v. Lead-*

Deadwood Sch. Dist. No. 40-1, 469 U.S. 256, 269-70 (1985). Acts passed under Congress' spending power are the supreme law of the land. As this Court observed in *Bennett v. Kentucky Department of Education*, "[u]nlike normal contractual undertakings, federal grant programs originate in and remain governed by statutory provisions expressing the judgment of Congress concerning desirable public policy." 470 U.S. 656, 669 (1985); *see also Boatman v. Hammons*, 164 F.3d 286, 288 (6th Cir. 1998) ("States . . . must follow federal law in managing the [Medicaid] program.")

The three-pronged test for standing articulated in *Lujan* requires a plaintiff to show: (1) an "injury in fact;" (2) that is fairly traceable to the defendant's conduct; and (3) that can be redressed by a decision of the court. 504 U.S. 555, 560-61 (1992). An injury in fact is the "invasion of a legally-protected interest which is (a) concrete and particularized and (b) 'actual or imminent," rather than "'conjectural' or 'hypothetical.'" *Id.* at 560 (citations omitted). These concepts were embraced by the Kentucky Supreme Court in its decision below, but in failing to recognize the injury to Ms. Sexton's concrete property rights, the Court misapplied *Lujan* to the present facts.

Lujan articulates an important concept that the Kentucky Supreme Court disregarded:

> When the suit is one challenging the legality of government action or inaction, the nature and extent of facts that must be averred . . . depends considerably upon whether the plaintiff is himself an object of the action (or forgone action)

> at issue. If he is, there is ordinarily little question that the action or inaction has caused him injury, and that a judgment preventing or requiring the action will redress it.

Id. at 561-62. The situation in *Lujan* was entirely different from the present case. It was a "citizen suit" under the Endangered Species Act of 1973, "raising only a generally available grievance about government" that would benefit the plaintiff only as a member of the public at large. *Id.* at 573 n. 7. But Ms. Sexton is challenging the denial of a fair hearing right that is particular to her as a Medicaid beneficiary.

The Kentucky Supreme Court also ignores the judgment of Congress in establishing Ms. Sexton's rights. Coventry decided that her care was medically unnecessary and that it would not pay for her care. She was thus an "individual whose claim for medical assistance under the plan," i.e., payment for her care, was denied. In equating the denial of her right to a hearing with an injury that is "abstract, conjectural and hypothetical" rather than concrete, the Court failed to acknowledge the property right that Congress conferred on Ms. Sexton and violated the State's obligations under the Medicaid program.

Even before *Lujan,* this Court recognized that "[t]he actual or threatened injury required by Art. III may exist solely by virtue of 'statutes creating legal rights, the invasion of which creates standing." *Warth v. Seldin*, 422 U.S. 490, 500 (1975) (citing *Linda R.S. v. Richard D.*, 410 U.S. 614, 617 n.3 (1973); *Sierra Club v. Morton*, 405 U.S. 727, 732 (1972)). "Essentially, the standing question in such cases is whether the

constitutional or statutory provision on which the claim rests properly can be understood as granting persons in the plaintiff's position a right to judicial relief." *Id.*

The Kentucky Supreme Court did not even cite or acknowledge 42 U.S.C. § 1396a(a)(3), or any of the other statutes and regulations that establish Ms. Sexton's right to a hearing. Instead, the Court appeared to liken her case to *Summers v. Earth Island Inst.*, 555 U.S. 488 (2009), where environmental organizations challenged regulations of the United States Forest Service. That was, however, a case of citizens seeking to "vindicate the public's nonconcrete interest in the proper administration of laws." *Id.* at 497. Equating that case with the present one ignores the dispositive distinction that Ms. Sexton is an *individual* Medicaid MCO enrollee on whom Congress has specifically conferred the right to a hearing that the state Medicaid agency denied. She is the "object of the action" by the government and there is "little question" that she was denied her right and the required hearing will redress it. *See, Lujan,* 504 U.S. at 561-562.

Similarly, the Kentucky Supreme Court cites *Spokeo, Inc. v. Robins*, 136 S. Ct. 1540 (2016), but nothing in *Spokeo* diminishes the legal recognition of a Medicaid beneficiary's right to a hearing. *Spokeo* concerned a plaintiff who alleged violations of the Fair Credit Reporting Act by a "people search engine" that generated inaccurate, but not derogatory, information about him. This Court examined the requirement for injury to be "concrete" to confer standing and emphasized that intangible injuries may nonetheless

be concrete. "In determining whether an intangible harm constitutes injury in fact, both history and the judgment of Congress play important roles." *Id.* at 1549. The Court quoted with approval Justice Kennedy's concurrence in *Lujan*, explaining that "Congress has the power to define injuries and articulate chains of causation that will give rise to a case or controversy where none existed before." *Id.* (quoting *Lujan*, 504 U.S. at 578, Kennedy, J. concurring in part and concurring in judgment).

Spokeo recognizes that "the violation of a procedural right granted by statute can be sufficient in some circumstances to constitute injury in fact. In other words, a plaintiff in such a case need not allege any additional harm beyond the one Congress has identified." *Id.* at 1549 (citing *Fed. Election Comm'n v. Akins*, 524 U.S. 11, 20-25 (1998) (denial of information under FOIA is a sufficient injury in fact to satisfy Article III); and *Pub. Citizen v. U.S. Dep't of Justice*, 491 U.S. 440, 449 (1989) (advocacy organizations' inability to obtain information under the Federal Advisory Committee Act "constitutes a sufficiently distinct injury to provide standing to sue.")). In fact, this Court in *Spokeo* remanded to the Ninth Circuit, which ultimately decided that the plaintiff met the test for injury in fact. *Robins v. Spokeo, Inc.*, 867 F.3d 1108 (9th Cir. 2017), *cert. denied*, *Spokeo, Inc. v. Robins*, 138 S. Ct. 931 (2018).

A long line of additional cases on standing from this Court recognizes that denial of intangible rights conferred by Congress can create standing, even in the absence of an expressly stated individual right like that

conferred by 42 U.S.C. § 1396a(a)(3). *See, i.e., Carey v. Piphus*, 435 U.S. 247, 262 (1978) (denial of a hearing could be grounds for nominal damages under § 1983 even if it would not have changed the outcome because "a purpose of procedural due process is to convey to the individual a feeling that the government has dealt with him fairly, as well as to minimize the risk of mistaken deprivations of protected interest"); *U.S. v. Students Challenging Regulatory Agency Procedures (SCRAP)*, 412 U.S. 669 (1973) (environmental advocacy groups alleging economic, aesthetic, and recreational harm could challenge ICC surcharge on freight rates that could affect use of recyclables and in turn harm natural resources); *Trafficante v. Metro. Life Ins. Co.*, 409 U.S. 205 (1972) (recognizing Congressional intent under the Fair Housing Act to define standing "as broadly as is permitted by Article III" to find that housing "testers" denied the benefits of living in an integrated community have standing). S*ee also Strubel v. Comenity Bank*, 842 F.3d 181, 189 (2d Cir. 2016) ("We do not understand *Spokeo* categorically to have precluded violations of statutorily mandated procedures from qualifying as concrete injuries supporting standing."); *Gardner v. F.C.C.*, 530 F.2d 1086, 1091 (D.C. Cir. 1976) ("[P]articipants in an agency action have an undeniable interest in seeing to it that the procedural rights guaranteed them by law are respected.").

Here the concrete interest recognized by Congress is the right to an objective review of Medicaid non-payment decisions, a necessary corollary to a beneficiary's right to have the Medicaid program pay for medical care. Any belief of the Kentucky Supreme

Court that the interest is too abstract to be protected must yield to the judgment of Congress under the Supremacy Clause.

Our federal courts consistently recognize the property rights of beneficiaries under the Medicaid program. Federal cases typically arise in the context of actions under 42 U.S.C. § 1983,[7] for which the standards were articulated by this Court in *Blessing v. Freestone,* 520 U.S. 329 (1997) and *Gonzaga Univ. v. Doe*, 536 U.S. 273, 282 (2002) (requiring "an unambiguously conferred right" benefiting the plaintiff, couched in mandatory terms).

Concerning Medicaid, *Wilder v. Va. Hosp. Assoc.*, 496 U.S. 498 (1990), predated both of those cases but applied essentially the same analysis. *Wilder* considered the existence of a right under the Medicaid Act that – unlike the right to a hearing – was not explicit in the law, i.e., the right of health care providers to challenge the state's method of paying providers.[8] Analyzing whether the provision in question "was intend[ed] to benefit the putative plaintiff," this Court found "little doubt" that providers were the intended beneficiaries of the Boren Amendment. *Id.* at 509. Coupled with the mandatory language – the state plan "must" provide for reasonable and adequate payments to providers – it was clear that

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[7] Few plaintiffs go to the lengths to exhaust administrative remedies through the state-provided process that the plaintiff did here.

[8] The particular provision allegedly violated by the state, 42 U.S.C. § 1396a(a)(13)(A) (the "Boren Amendment"), has since been repealed, but the Court's analysis appears otherwise intact.

Congress intended to create enforceable rights for providers. *Id.* at 512.

Two federal circuit courts have specifically recognized a beneficiary's right to request a hearing under 42 U.S.C. § 1396a(a)(3). *Banks v. Secretary, Indiana Family and Social Services Administration,* 997 F.2d 231 (7th Cir. 1993), held that the plaintiffs had standing to request a hearing. The two plaintiffs had been sued – wrongfully – by health care providers for the costs of treatment, after the Medicaid program rejected the providers' claims for payment due to billing errors. The plaintiffs in turn sued both the Secretary of Health and Human Services and the state Medicaid agency over the agency's failure to pay the providers' claims or to notify the beneficiaries of the non-payment. Addressing standing, the Court analyzed *Lujan* and concluded that the plaintiffs' injuries satisfied the concreteness test even though they should never have been held liable for the cost of their care. "[A]s the plaintiffs are seeking to enforce an alleged procedural requirement of notice guaranteed by either the Medicaid regulations or the Due Process Clause of the Fifth Amendment, the disregard of which 'could impair [their] separate concrete interest' in Medicaid benefits, they have alleged an injury cognizable under Article III." *Id.* at 239 (quoting *Lujan,* 504 U.S. at 572).[9]

[9] The decision went on to rule against the plaintiffs, however, based on the fact that any payment denials were the result of the providers' billing errors and did not affect the plaintiffs' eligibility for covered benefits. In fact, one of the providers had been able to get paid while the case was pending by resubmitting its bills. The Court's reasoning distinguishes the result from Ms. Sexton's case,

The Sixth Circuit also recognized beneficiaries' right to request a hearing in *Gean v. Hattaway*, 330 F.3d 758 (6th Cir. 2003). The Plaintiffs were young men who had been placed in juvenile facilities in Tennessee. The plaintiffs complained that the state authorities had applied their Social Security benefits toward their education and maintenance rather than taking advantage of other programs (including Medicaid) and preserving their Social Security benefits. Turning to their right to a hearing under Medicaid, the Court observed that "[t]he right to a 'fair hearing' provided to beneficiaries by § 1396a(a)(3) creates an obligation on the part of the State and is phrased in terms of benefitting Medicaid recipients." *Id.* at 772-73. But the Court ruled that the plaintiffs had no such right on the facts presented. The plaintiffs were never denied care and, the Court observed, they never even made a claim under the Medicaid program. Rather, the state had provided medical care while the plaintiffs were in custody, apparently without involving Medicaid. Here, by comparison, Ms. Sexton's right to a hearing was triggered because Coventry denied Medicaid coverage for care that her doctors ordered.

Other federal Circuits recognize that 42 U.S.C. § 1396a(a) (2014) spells out all the requirements for the state Medicaid plan and confers rights clearly and unambiguously. *See, e.g., Sabree v. Richman*, 367 F.3d 180 (3d Cir. 2004) (42 U.S.C. §§ 1396a(a)(10) and 1396d(a)(15) create enforceable rights entitling "all eligible individuals" to acquire ICF/MR services with

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where Coventry's decision to deny payment was a determination about the medical necessity of services that were proposed for her.

"reasonable promptness." "Indisputably, these provisions create law, binding on those states choosing to accept Medicaid funding." *Id.* at 189). *See also Harris v. Olszewski*, 442 F.3d 456, 461 (6th Cir.), *reh'g denied* (Apr. 28, 2006) (freedom of choice provision in 42 U.S.C. § 1396a(a)(23) creates enforceable rights for "any individual eligible for medical assistance"); *Westside Mothers v. Haveman*, 289 F.3d 852, 860, 864 (6th Cir.), *cert. denied* 537 U.S. 1045 (2002) (two professional organizations had standing to challenge sufficiency of Medicaid payments under 42 U.S.C. § 1396a(a)(30)(A), "reaffirm[ing] well-established precedent holding that laws validly passed by Congress under its spending power are supreme law of the land").

Numerous federal district courts have addressed the specific requirement in 42 U.S.C. § 1396a(a)(3) for the state Medicaid agency to provide a hearing. In *Shakhnes ex rel. Shakhnes v. Eggleston*, the Court found that "plaintiff Medicaid recipients have in 42 U.S.C. § 1396a(a)(3) a right to a fair hearing enforceable through 42 U.S.C. § 1983." 740 F.Supp. 2d 602, 620 (S.D.N.Y. 2010), *vacated and remanded in part on other grounds Shakhnes v. Berlin*, 689 F.3d 244 (2d Cir. 2012). *See also*, *N.B. ex rel. Peacock v. District of Columbia* 794 F.3d 31, 36 (D.C. Cir. 2015) (recognizing right to notice and hearing following non-coverage of prescription drugs and observing, "[i]t is well established that certain government benefits give rise to property interests protected by the Due Process Clause," citing *Goldberg v. Kelly*, 397 U.S. 254); *D.W. v. Walker*, No. 2:09–cv–00060, 2009 WL 1393818 (S.D. W. Va. May 15, 2009) (finding standing to challenge West

Virginia's failure to cover EPSDT services and to provide a fair hearing); *Easley v. Arkansas Dept. of Human Services*, 645 F.Supp. 1535, 1542 (E.D. Ark. 1986) (holding that notice to beneficiaries and opportunity to be heard were required when payments to providers were denied, and noting the potential chilling effect on poor/disabled beneficiaries seeking medical care if erroneously denied coverage).

The Kentucky Supreme Court's decision even conflicts with decisions of the federal district courts sitting in Kentucky. The Eastern District of Kentucky has held that 42 U.S.C. § 1396a(a)(3) imposes "a binding obligation on the state to provide a fair hearing and is clearly 'intended to benefit [a] putative plaintiff.'" *Kerr v. Holsinger*, 2004 WL 882203 at *5 (E.D. Ky. Mar. 25, 2004). *See also, Moffitt v. Austin*, 600 F.Supp. 295, 297 (W.D. Ky. 1984) ("Thus, it is apparent that the continued receipt of Medicaid payments is a property interest protected by the Fifth Amendment.").

B. A MEDICAID BENEFICIARY'S FINANCIAL LIABILITY IS IRRELEVANT.

Under the Kentucky Supreme Court's reasoning, because ARH provided medical care without the ability to hold Ms. Sexton liable, she lacked standing to claim an injury. But as stated in *Zivotofsky v. Secretary of State*, addressing denial of rights under the Freedom of Information Act:

> Anyone whose request for specific information has been denied has standing to bring an action; the requester's circumstances – why he wants

> the information, what he plans to do with it, what harm he suffered from the failure to disclose – are irrelevant to his standing. *See, e.g., Pub. Citizen v. U.S. Dept. of Justice*, 491 U.S. 440, 449, 109 S.Ct 2558, 105 L.Ed.2d 377 (1989). The requester is injured-in-fact for standing purposes because he did not get what the statute entitled him to receive.

444 F.3d 614, 617-18 (D.C. Cir. 2006). By the same reasoning, Ms. Sexton's or even ARH's financial interest, or lack thereof, is irrelevant. Ms. Sexton was injured in fact because she did not get what the statutes entitled her to receive, i.e., a hearing to contest Coventry's decision that her medical care was unnecessary and that it would deny payment. That is all the test for standing that the law requires.

Multiple analogous cases in the Medicare context reject the logic that one loses standing to challenge a denial of coverage when services are covered by a third party. In *Ryan v. Burwell*, No. 5:14-cv-00269, 2015 WL 4545806 (D. Vt. July 27, 2015), the Secretary of Health and Human Services argued that the plaintiff Medicare beneficiaries were not injured by the denial of Medicare benefits because the services in question were covered by Medicaid instead. Analyzing *Warth* and *Lujan*, the Court disagreed; the plaintiffs had standing because they were "seeking to protect a right to Medicare coverage which is theirs by virtue of their qualification for benefits under the statute – even if Medicaid is also willing to cover the charges in question." *Id.* at *5. *See also Martinez v. Bowen*, 655 F.Supp. 95, 99 (D. N.M. 1986) ("Mrs. Hogue's claim rests on the constitutional

guarantee of due process before deprivation of a property interest. Medicare benefits are a protected property interest."); *Longobardi v. Bowen*, No. H-87-628 (MJB), 1988 WL 235576 at *2 (D. Conn. Oct. 25, 1988) ("An injury sufficient to satisfy Article III can be established merely by virtue of the alleged denial of statutorily-created rights or entitlements . . . . Mrs. Longobardi's stake in the outcome of this action is not in receiving a Medicare payment, it is in the distribution of a benefit payment which comprises a portion of her Medicare entitlement."); *Anderson v. Sebelius*, No. 5:09-cv-16, 2010 WL 4273238 at *3 (D. Vt. Oct. 25, 2010) ("[A]lthough the ALJ waived Plaintiff's financial responsibility for the services in question, a beneficiary retains his or her 'injured' status when the Secretary refuses to pay providers for Medicare benefits the beneficiary receives.").

Under the Kentucky Supreme Court's decision, a private MCO could escape accountability for deciding that care is medically unnecessary (and that it need not pay for care) if a provider acting under a sense of professional obligation or charity provides the care.[10]

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[10] There are numerous reasons a provider might continue to provide care notwithstanding an initial denial of authorization by an MCO. Hospitals that fail to provide treatment to stabilize an emergency medical condition may be subject to sanctions by CMS or private lawsuits under the Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C. § 1395dd (2003). A provider might act out of a perceived professional or ethical responsibility. Many organizations, particularly non-profit ones like ARH, have a mission to serve their community that does not allow them to turn a patient like Ms. Sexton away. And many act in reliance upon the knowledge that was once secure, that there would be a later opportunity to challenge a non-coverage decision.

This view of the law – in which a beneficiary's right of appeal might be extinguished if she receives potentially life-saving care at the provider's expense – is anathema to the purposes of the Medicaid program. As noted in the dissent to the Kentucky Supreme Court decision by Justice Wright, "[i]t is a dangerous precedent to say that the courts will not hear a party who has been injured if the party receives charity to give them what they are already entitled to." App. 33.

The Kentucky Supreme Court acknowledged the "concern" that its decision would leave MCOs without oversight in execution of their duties, but concluded that it "begs legislative, not judicial, redress." App. 28. This comment is inexplicable in light of 42 U.S.C. §§ 1396a(a)(3), 42 U.S.C. § 1396u-2, and the many federal and state regulations that assure state oversight of MCO behavior. Congress has already provided the redress. The Medicaid regulatory scheme includes a labyrinth of interrelated provisions that provide checks and balances against improper (and potentially profit-driven) coverage decisions by MCOs.[11]

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[11] Kentucky MCOs have been among the most profitable in the nation. *See, e.g.*, J.D. Palmer & C.T. Petit, *Medicaid risk-based managed care: Analysis of financial results for 2015*, MILLIMAN p. 9 (May 2016) (Reporting that Kentucky MCOs had an 80.5 percent "Medical Loss Ratio" ("MLR") – one of the lowest in the country – meaning that for each $1 paid to the MCO by the state, 80.5 cents went to patient care and the MCO pockets the rest), available at http://www.milliman.com/uploadedFiles/insight/2016/medicaid-risk-based-managed-care-analysis-2015.pdf (last accessed May 9, 2019). A "Managed Care Weekend Update" published by Citi Research on November 29, 2014 observed specifically about Coventry (which was acquired by Aetna): "By our estimate, Aetna's Kentucky Medicaid margin was well over 25% in the third quarter,

The Kentucky Supreme Court took no note of these important safeguards. The Constitutional concern underlying the doctrine of standing – to observe limitations on exercise of the judicial power – is turned on its head by a decision that squarely disregards legislative intent. *Lujan*, 504 U.S. at 559-60. As the Sixth Circuit observed, Coventry has a financial incentive to limit services: "[T]he MCO bears the risk that the costs of care may exceed the capitation payment. But on the other side, it stands to profit if beneficiaries use fewer services." *Appalachian Reg'l Healthcare, Inc. v. Coventry Health and Life Ins. Co.,* 714 F.3d 424, 426 (6th Cir. 2013).[12] Therefore,

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and we estimate the company generated almost $100 million of Kentucky Medicaid EBITDA for the quarter." Thus, at about the same time Coventry was denying coverage for Ms. Sexton's care and fighting to prevent review of its decisions, it was enjoying extraordinary profits from Kentucky Medicaid.

[12] The quoted decision resulted from Coventry's appeal of a temporary injunction entered by Judge Karl Forester of the Eastern District of Kentucky when Coventry abruptly terminated ARH's provider agreement in 2012. As the Court summarized, Coventry had discovered that "Appalachian's Medicaid patients were sicker than other Medicaid patients [elsewhere in the region], which meant they cost more to care for," so Coventry attempted to terminate its contract with ARH, on short notice and to the detriment of its many Medicaid enrollees in ARH's service area. 714 F.3d at 428. When Ms. Sexton arrived at ARH's emergency room in 2014, there was no longer a contract in place between Coventry and ARH. In the present case, the Kentucky Supreme Court alluded to the 2012 contract dispute as another reason to negate the existence of Ms. Sexton's statutory right. App. 28 n. 57. Its comment mixes apples and oranges, as any past or present right of ARH to sue Coventry directly is separate from and independent of Ms. Sexton's statutory right to a hearing, or ARH's authority to pursue it on her behalf.

Congress established the necessary checks on MCOs' conflict of interest.

C. THE FINANCIAL INTEREST OF A BENEFICIARY'S REPRESENTATIVE IS IRRELEVANT.

Sidestepping the question of Coventry's financial interest in denying coverage to Ms. Sexton, the Kentucky Supreme Court instead noted ARH's financial interest, using it as a ground to reject Ms. Sexton's right to a hearing. It stated: "ARH is using Sexton as the front to redress its own potential loss." App. 27. Calling it "a front," however, ignores the fact that ARH and Ms. Sexton followed the law when Ms. Sexton authorized ARH employees to represent her. 42 C.F.R. § 438.402(c)(1)(ii); 907 KAR 17:010 § 5(3). "The rights of parties are habitually protected in court by those who act in a representative capacity." *O'Bannon v. Town Court Nursing Ctr.*, 447 U.S. 773 (1980) (*citing Voeller v. Neilston Warehouse Co*, 311 U.S. 531, 537 (1941)).

Ms. Sexton was denied the right to which she is entitled and the denial of her right cries for redress. *See Zivotofsky v. Secr'y of State*, 444 F.3d 614, 617-18 (D.C. Cir. 2006). This Court's decision in *Sprint Communications Co. v. APCC Services, Inc.*, 554 U.S. 269 (2008), dispels any notion that ARH's representation of Ms. Sexton affects the merits of the case. There, plaintiff "aggregators" were assignees of the rights of payphone operators and sued to collect fees from long-distance carriers like Sprint. The carriers challenged the plaintiffs' standing, arguing that they had no injury in fact because the aggregators

had agreed to remit the proceeds of any suit back to the payphone operators. This Court discussed at length the history of suits brought by assignees and found history to be conclusive: "Lawsuits by assignees, including assignees for collection only, are 'cases and controversies of the sort traditionally amenable to, and resolved by, the judicial process.'" *Id.* at 285. Just as the assignees' lack of beneficial interest did not negate standing there, ARH's financial interest in the outcome of a hearing or Ms. Sexton's lack of such interest should not defeat standing.[13]

> But federal courts routinely entertain suits which will result in relief for parties that are not themselves directly bringing suit. Trustees bring suits to benefit their trusts; guardians ad litem bring suits to benefit their wards; receivers bring suit to benefit their receiverships; assignees in bankruptcy bring suit to benefit bankrupt estates; executors bring suit to benefit testator estates; and so forth.

Id. at 287-88. Similarly, there is nothing amiss here, where ARH is acting as Ms. Sexton's representative

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[13] The Kentucky Supreme Court also noted a new Kentucky law, KRS § 205.646(2), effective April 8, 2016, that creates a separate process for providers in ARH's situation to seek administrative review of MCO non-payment decisions. App. 28 n. 56. But the numerous laws giving Ms. Sexton and other beneficiaries the right to request a hearing, directly or through a representative like ARH, remain intact. Giving providers a direct right of action does not vindicate the rights of Medicaid beneficiaries that Kentucky has eviscerated. Further, the new law is inapplicable to Ms. Sexton's case and numerous other cases still pending at various stages in Kentucky that arose before the passage of the new law.

pursuant to federal and state regulations and her written consent. The extent of its financial interest in the outcome is also legally irrelevant.

CONCLUSION

The Medicaid program assures that states will pay for medical care provided to their poorest citizens, for the very reason that they cannot pay for their own care. Congress has clearly provided that a Medicaid beneficiary has a right to a "fair hearing" provided by the state when coverage of care is denied by the Medicaid program. The Kentucky Supreme Court is the only court in the country to deny that right based on a beneficiary's lack of financial responsibility for her care. Its decision is in clear conflict with Congressional intent and should be reviewed by this Court.

Accordingly, this Petition For Writ of Certiorari should be granted.

Respectfully submitted,

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