

UNITED STATES DISTRICT COURT  
DISTRICT OF MASSACHUSETTS

COMMONWEALTH OF MASSACHUSETTS )  
 )  
 v. ) C.A. No. 07-11930-MLW  
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 )  
 KATHLEEN SEBELIUS in her )  
 official capacity as Secretary )  
 of Health and Human Services, )  
 ET AL, )  
 Defendants. )

MEMORANDUM AND ORDER

WOLF, D.J.

September 23, 2009

This case arises out of plaintiff's attempts to obtain direct reimbursement from Medicare for certain medical services paid for by Massachusetts Medicaid. Plaintiff filed suit for declaratory and injunctive relief to require Medicare to pay Massachusetts Medicaid directly, and for Medicare to process four test claims for reimbursement filed by Massachusetts Medicare. Defendants moved to dismiss on the basis that the Complaint fails to state a claim upon which relief may be granted. Plaintiff filed a cross-motion for summary judgment. For the reasons summarized below and described in greater detail in court on September 21, 2009, defendants' Motion to Dismiss is being allowed.

Medicare provides federal health insurance for elderly and certain disabled individuals. See 42 U.S.C. 1395 et seq. Medicaid, funded both by the federal and state governments, is administered by the states and provides health insurance for

America's poor. See 42 U.S.C. §1396 et seq.

Some individuals, known as "dual eligibles," are covered by both Medicare and Medicaid. In the case of dual eligibles, federal law generally requires that Medicare bear the cost of medical services, because Medicaid is the payer of last resort. See 42 U.S.C. §1396a(a)(25); Arkansas Dept. of Health and Human Services v. Ahlborn, 547 U.S. 268, 291 (2006). However, Medicare and Medicaid eligibility determinations may occur at different times. Relevant to this case are instances where Medicaid pays for medical services for an individual, but a later determination establishes that the individual is retroactively eligible for Medicare coverage.

Plaintiff argues that in cases of retroactive dual eligibility, it should be able to collect reimbursement directly from Medicare because 42 U.S.C. §1396a(a)(25)(B) provides that Medicaid must seek reimbursement from liable third parties. Defendants argue that direct payment is precluded by 42 U.S.C. §1395f(a), which states that, with exceptions not relevant here, payments may be made only to providers. See also 42 C.F.R. §424.33. The Department of Health and Human Services ("HHS"), the agency that administers the Medicare statute, see 42 U.S.C. §§1302, 1395f(a)(1), 1395hh, interprets the statutes and regulations to prevent Medicare from paying Medicaid directly because, as the parties agree, Medicaid is not a provider.

HHS's interpretation is entitled to deference under Chevron

U.S.A. v. Natural Resources Defense Counsel, 467 U.S. 837 (1984), and its progeny.<sup>1</sup> Under Chevron, the court must determine "(1) whether the statute unambiguously forbids the Agency's interpretation, and, if not, (2) whether the interpretation, for other reasons, exceeds the bounds of the permissible." Barnhart v. Walton, 535 U.S. 212, 217-18 (2002) (citing Chevron, 467 U.S. at 843). An agency's interpretation is impermissible if it is "arbitrary, capricious, or manifestly contrary to the statute." Chevron, 467 U.S. at 844. Where an agency interprets its own regulations, its interpretation is controlling "unless 'plainly erroneous or inconsistent with the regulation.'" Auer v. Robbins, 519 U.S. 452, 460 (1997); see also Thomas Jefferson Univ. v. Shalala, 512 U.S. 504, 512 (1994).

Here, the statute and regulations are clear and support HHS's interpretation. Section 1395f(a) provides that Medicare payments for medical services may only be made to providers, and HHS interprets this section to mean that Medicare may not make payments

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<sup>1</sup>Chevron deference is appropriate where (1) Congress expressly left a legislative gap for the agency to fill (express authority) or (2) where it is apparent from

the agency's generally conferred authority and other statutory circumstances that Congress would expect the agency to be able to speak with the force of law when it addresses ambiguity in the statute or fills a space in the enacted law, even one about which Congress did not actually have an intent as to a particular result.

(implied authority). United States v. Mead Corp., 533 U.S. 218, 229 (2001). This case involves express authority.

to Medicaid. Moreover, even if §1395f(a) were ambiguous, the court must defer to HHS's reasonable interpretation of the statute.

Although §1396a(a)(25)(B) requires Medicaid to seek reimbursement from "liable third parties," it does not create liability where none otherwise exists. Section 1396a(a)(25)(B) creates a duty to seek reimbursement, not a right to receive it.

No case cited by the parties directly addresses the issue here. However the court finds persuasive the reasoning in two analogous cases, Connecticut Dept. of Social Services v. Leavitt, 428 F.3d 138, 142 (2d Cir. 2005), and New York v. Sebelius, 2009 WL 1834599 (N.D.N.Y. June 22, 2009). In Connecticut Department of Social Servies, the Second Circuit, according Chevron deference to HHS, held that 42 U.S.C. §1395f(a) and 42 C.F.R. §424.33 require that Medicare pay only providers of services. See 428 F.3d at 146. The district judge in New York v. Sebelius held that 42 U.S.C. § 1396a(a)(25)(B) imposes a duty on Medicaid to seek reimbursement, but does not entitle Medicaid to wholesale reimbursement from Medicare. See 2009 WL 1834599, at \*8.

In support of its position, plaintiff cites New York State Dept. of Social Services v. Bowen, 846 F.2d 129 (2d Cir. 1988), and Atlanticare Med. Ctr. v. Commissioner, Div. of Med. Assistance, 439 Mass. 1 (2003). However, New York State Dept. of Social Services held only that Medicaid may represent Medicare beneficiaries for the purposes of certain administrative appeals. It did not discuss whether direct payments from Medicare to Medicaid are authorized.

Atlanticare held that Massachusetts Medicaid may not sue providers to recover Medicaid payments that should have been made by Medicare. 439 Mass. at 14. The United States was not a party to Atlanticare, which was decided by the Supreme Judicial Court of the Commonwealth of Massachusetts without the benefit of briefing by the United States. The court respectfully disagrees with the Supreme Judicial Court's suggestion in Atlanticare that Medicaid may obtain direct reimbursement from Medicare. See id. at 11.

Finally, plaintiff attempts to draw a distinction in §1395f between "payments for services," which pursuant to §1395f may be made only to providers, and "reimbursement," which may sometimes be made to non-providers. In support of its position, plaintiff points to §1395f(d)(2), which allows reimbursement directly to Medicare beneficiaries for certain emergency services. However, §1395(d)(2) is an express exception to the rule stated in §1395f(a) that payment must be made to providers. No comparable exception authorizes Medicare to pay Medicaid directly.

Accordingly, it is hereby ORDERED that:

1. Defendants' Motion to Dismiss (Docket No. 10) is ALLOWED.
  
2. Plaintiff's Cross-Motion for Summary Judgment (Docket No. 12) is MOOT.

/S/ MARK L. WOLF  
UNITED STATES DISTRICT JUDGE