

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF CONNECTICUT**

ANDREA BARTON REEVES, Commissioner,
Connecticut Department of Social Services,

Plaintiff,

v.

XAVIER BECERRA, Secretary of Health and
Human Services,

Defendant.

Civil Action No. _____

COMPLAINT

I. PRELIMINARY STATEMENT

1. This is an appeal of a fundamentally erroneous, final decision of the Defendant, Secretary of the U.S. Department of Health and Human Services, that denied a claim for Medicare Part A coverage of skilled nursing facility (“SNF”) services.

2. Plaintiff, Commissioner of Connecticut’s Department of Social Services, is the subrogee of A.D. (“Mr. D”), a Medicare beneficiary who was also eligible for benefits from Connecticut’s Medicaid program during the dates of service at issue. Plaintiff sought to recover from Medicare the payments made by the Connecticut Medicaid program for SNF services rendered to Mr. D.

3. Plaintiff contests Defendant’s decision that Medicare Part A does not cover Mr. D’s SNF services provided from March 15 through April 10, 2022, because such coverage depends on the receipt of *daily skilled nursing care*, which he did not receive. This is mistaken. An Administrative Law Judge found that Mr. D required and received *daily skilled rehabilitation services* (occupational therapy) during the period at issue. Medicare law and the Defendant’s

own regulations unequivocally establish that Medicare Part A covers SNF services when the beneficiary requires “skilled nursing *or skilled rehabilitation services*, or both, on a daily basis.” 42 C.F.R. § 409.31(b) (emphasis added).

4. The Defendant’s decision is based on a clear error of law. It should be reversed.

II. THE PARTIES

5. Plaintiff, Andrea Barton Reeves, serves as Commissioner of the Connecticut Department of Social Services and as such is responsible for the administration of the Medicaid program in Connecticut. She brings this action in her official capacity.

6. Defendant, Xavier Becerra, is the Secretary of the U.S. Department of Health and Human Services (“the Secretary”) and as such is responsible for the administration of the Social Security Act and the Medicare program through the Centers for Medicare & Medicaid Services (“CMS”). The Secretary is the proper defendant in this appeal of a final decision of the Medicare Appeals Council (“the Council”). 42 C.F.R. § 405.1136(d). He is sued in his official capacity.

III. JURISDICTION AND VENUE

7. Jurisdiction is conferred on this Court by 42 U.S.C. § 405(g) as made applicable to and incorporated in the Medicare statute by 42 U.S.C. § 1395ff(b)(1)(A). Plaintiff appeals a final decision of the Secretary that denied coverage for SNF services. Plaintiff has exhausted administrative remedies. Jurisdiction is also conferred by 28 U.S.C. §§ 1331 and 1361. Plaintiff seeks a declaration of rights pursuant to the Declaratory Judgment Act, 28 U.S.C. §§ 2201 and 2202.

8. The Administrative Law Judge (“ALJ”) Appeal Number is 3-12955684905. *See* Exhibit 1. The Council Docket Number is M-24-1633. *See* Exhibit 2. This Complaint is timely filed within 60 days of the Plaintiff’s receipt of the Council’s decision. 42 C.F.R. §§ 405.1130,

405.1136(c)(1)-(2). The amount in controversy exceeds \$1,840. *Id.* §§ 405.1006(c), 405.1136(a)(1).

9. Venue is proper in this District pursuant to 42 U.S.C. § 405(g) and 28 U.S.C. § 1391(e). *See also* 42 C.F.R. § 405.1136(b)(1).

IV. LEGAL FRAMEWORK

A. Medicare and Skilled Nursing Facility Services

10. Enacted in 1965 as Title XVIII of the Social Security Act, Medicare is the federal health insurance program for people who are at least age 65, or who are under 65 and have significant disabilities. 42 U.S.C. §§ 1395 *et seq.*

11. Medicare Part A (also called “hospital insurance”) covers, *inter alia*, inpatient hospital services, SNF care, and home health services. Medicare Part B (also called “medical insurance”) generally covers outpatient items and services such as physician office visits, durable medical equipment, ambulance services, and *outpatient* rehabilitation services (including physical and occupational therapy).¹

12. This case concerns Medicare Part A coverage of SNF care. Beneficiaries can generally qualify for such coverage for up to 100 days after certain hospital stays. 42 U.S.C. §§ 1395d(a)(2), 1395x(a), 1395x(h)-(j); 42 C.F.R. §§ 409.20-409.36, 409.60.

13. To qualify for Medicare Part A coverage of SNF care, a Medicare beneficiary must meet certain requirements. 42 C.F.R. §§ 409.30-409.36 (Subpart D of regulations titled “Requirements for Coverage of Posthospital SNF Care”). Relevant for this case, the beneficiary must “require skilled nursing or skilled rehabilitation services, or both, on a daily basis.” 42

¹ Parts C and D of Medicare, which are not at issue in this case, cover medical services and prescription drugs through private insurance companies.

C.F.R. § 409.31(b)(1); *see also* CMS, Medicare Benefit Policy Manual, Pub. 100-02 (“MBPM”), Ch. 8 § 30² (care in a SNF is covered if, *inter alia*, the patient “requires skilled nursing services or skilled rehabilitation services,” and the patient “requires these skilled services on a daily basis....”).

14. “Daily basis” is defined as at least five days per week for skilled rehabilitation (therapy) services, or as seven days per week for skilled nursing services, or a combination of skilled therapy and nursing services. 42 C.F.R. § 409.34; MBPM Ch. 8 § 30.6.

15. The statute and regulations also define the types of SNF services that are *included* in Part A coverage when a beneficiary meets the requirements for such coverage. 42 C.F.R. §§ 409.20-409.27 (Subpart C of regulations titled “Posthospital SNF Care”); 42 U.S.C. § 1395x(h) (“Definitions” portion of the statute, describing “extended care services...furnished to an inpatient of a skilled nursing facility”).

16. The provision of the regulation titled “Included services” specifies in relevant part that “subject to the conditions and limitations set forth” elsewhere in the regulations (including the above-cited provisions regarding the “daily skilled care” requirement):

“posthospital SNF care” means the following services furnished to an inpatient of a participating SNF...:

- (1) Nursing care provided by or under the supervision of a registered professional nurse.
- (2) Bed and board in connection with the furnishing of that nursing care.
- (3) Physical therapy, occupational therapy, and speech-language pathology services.
- (4) Medical social services.

² Available at: <https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/bp102c08.pdf>.

(5) Drugs, biologicals, supplies, appliances, and equipment.

(6) Services furnished by a hospital with which the SNF has a transfer agreement in effect under § 483.70(j) of this chapter.

(7) Other services that are generally provided by (or under arrangements made by) SNFs.

42 C.F.R. § 409.20(a)(1)-(7); *see also* 42 U.S.C. § 1395x(h); MBPM Ch. 8 § 10.

17. The provisions cited above define “bed and board” services in relation to the receipt of nursing care in the general sense. *E.g.* 42 U.S.C. §§ 1395x(h)(1)-(2) (“nursing care provided by or under the supervision of a registered professional nurse,” and “bed and board in connection with the furnishing of such nursing care,”); 42 C.F.R. §§ 409.20(a)(1)-(2). This is unsurprising, as in Medicare-participating skilled *nursing* facilities, registered professional nurses are responsible for the overall delivery of care to residents, which is provided by nurses of varying qualifications and at different levels of skill and care, depending on a resident’s need. *See, e.g.*, 42 U.S.C. §§ 1395i-3(b)(2)(B) (each SNF resident’s “plan of care” must be initially prepared “by a team which includes...a registered professional nurse with responsibility for the resident”); 1395i-3(b)(3)(B)(i) (each SNF resident’s mandatory comprehensive assessment must be conducted or coordinated, and signed and certified by a registered professional nurse); 1395i-3(b)(4)(B)-(C) (SNF services must be provided by “qualified persons in accordance with each resident’s written plan of care” and SNFs must generally provide 24-hour licensed nursing service that is “sufficient to meet nursing needs of its residents and must use the services of a registered professional nurse at least 8 consecutive hours a day, 7 days a week.”); 1395i-3(b)(8)(A) (requirement of daily posting of “current number of licensed and unlicensed nursing staff directly responsible for resident care in the facility.”).

18. But the provisions defining “posthospital SNF care” in no way hinge coverage of “bed and board” services exclusively on the receipt of “*daily skilled nursing*” services. The legal

requirements for Medicare Part A *coverage* of included services are independent from these definitions, and clearly establish that daily skilled nursing *or* rehabilitation services make a beneficiary eligible for Part A coverage of all “posthospital SNF care,” which includes bed and board. 42 C.F.R. §409.31(b)(1). CMS’s Policy Manual also clearly construes the requirements in this manner. *See, e.g.*, MBPM Ch. 8 § 30.6 (“Skilled nursing or skilled rehabilitation services (or a combination of these services) must be needed and provided ‘on a daily basis,’....A patient whose inpatient stay is based solely on the need for skilled rehabilitation services would meet the ‘daily basis’ requirement when they need and receive those services on at least 5 days a week.”).

B. Medicare Appeals Brought by a State Medicaid Agency

19. Medicaid, codified as Title XIX of the Social Security Act, is a joint federal-state program that provides health coverage for, among others, people 65 and older and people with disabilities who meet certain income and asset requirements.

20. A “dually eligible” beneficiary is one who is eligible for both Medicare and Medicaid benefits. For dually eligible beneficiaries, Medicare is the primary payor and Medicaid is the secondary payor.

21. Medicaid is generally the payor of last resort. The Social Security Act requires states to take all reasonable measures to ascertain the legal liability of third parties for health care items and services provided to Medicaid beneficiaries. 42 U.S.C. § 1396a(a)(25)(A).

22. A Medicaid state agency that has paid a provider for items or services furnished to a dually eligible beneficiary can require the provider to submit a claim to Medicare for those items or services. In this way, the Medicaid program may recover its earlier payment for items and services that should have been paid by Medicare. If Medicare denies the claim, the Medicaid

state agency may appeal that denial through Medicare's administrative appeal system. 42 C.F.R. § 405.908.

23. A Medicaid state agency becomes party to a Medicare appeal by filing a request at the first level of administrative review, known as "redetermination." 42 C.F.R. §§ 405.906(b)(2), 405.908. The Medicaid state agency participates as a statutory subrogee of the beneficiary and retains its party status through all levels of administrative and judicial review. 42 U.S.C. § 1396k(a)(1); 42 C.F.R. §§ 405.908, 433.145(a)(1).

V. FACTUAL STATEMENT AND ADMINISTRATIVE PROCEEDINGS

24. During the claim period, Mr. D was eligible for and enrolled in Medicaid as well as Medicare Parts A and B.

25. Mr. D was a resident of Geer Nursing and Rehabilitation Center (a SNF) at Robert C. Geer Memorial Hospital in Canaan, Connecticut during the dates of service at issue. He was 77 years old at the time, and the SNF documentation showed over 35 diagnoses. His principal diagnosis was stage 5 chronic kidney disease. His conditions also included diabetes mellitus, muscle weakness, dysphagia,³ hand pain, trigger finger,⁴ contracture of his left hand, left shoulder pain, a history of urinary tract infections, history of testicular cancer, and history of a stroke in 2021.

26. After a diagnosis of COVID-19, the SNF billed Medicare Part A for covered services from March 7 through March 11, 2022.⁵ Thereafter, the SNF billed *Medicaid* for Mr.

³ Difficulty swallowing.

⁴ Condition affecting the tendons that flex the fingers and thumb, typically resulting in one or more finger becoming stuck in a bent position.

⁵ A prior hospital stay is generally required before Medicare Part A covers SNF care. 42 C.F.R. § 409.30(a). CMS waived this requirement during the COVID-19 Public Health

D's care through April 10, 2022, and Plaintiff paid the provider for those dates of service. Separately, however, the provider billed Medicare Part B solely for the daily occupational therapy ("OT") services that Mr. D needed and received during that same period. Medicare pays for skilled therapy services on an "outpatient" basis under Part B when the services cannot be billed as part of the all-inclusive, Part A inpatient benefit (for instance, if the therapy services are not provided on a "daily" basis). 42 C.F.R. § 410.59(b); MBPM Ch. 15, § 220.A (defining Part B "[t]herapy (or outpatient rehabilitation services)" to include skilled OT).⁶

27. Subsequently, at Plaintiff's request, the SNF submitted a claim to Medicare for Part A inpatient coverage for dates after March 11, 2022, *i.e.*, for *all* services and care Mr. D received, not just the OT services. Medicare denied the claim and Plaintiff timely requested redetermination, and then reconsideration (the subsequent level of appeal). Plaintiff disagreed with Medicare's denials, which stated that Mr. D did not require or receive daily skilled nursing or therapy services, and thus did not qualify for Part A inpatient coverage of his SNF care.

28. Plaintiff then requested an ALJ hearing, which was held on October 19, 2023. Plaintiff's counsel argued that the record demonstrated that Medicare's requirements for Part A SNF coverage were met from March 15 to April 10, 2022.⁷ Mr. D required and received medically reasonable and necessary skilled rehabilitation (OT) services on a daily basis during

Emergency, allowing patients such as Mr. D to be eligible for coverage *without* a prior hospital stay provided they met all other requirements for SNF care.

⁶ Available at:
<https://www.cms.gov/medicare/prevention/prevntiongeninfo/downloads/bp102c15.pdf>.

⁷ Originally the claim encompassed March 12 to April 10, 2022. At the ALJ level of appeal, the Plaintiff narrowed the claim to March 15 to April 10, 2022, based on the resumption of qualifying daily skilled care on March 15. Under Medicare policy, a period of Part A-covered SNF services may be interrupted briefly and then resumed. MBPM Ch. 8 § 20.2.3.

that time. Thus, the beneficiary was entitled to Medicare Part A payment of his SNF stay for those dates.

29. Plaintiff's counsel argued that the SNF should have resumed billing Mr. D's SNF stay to Medicare Part A during those dates, rather than *improperly* billing Medicaid for his SNF stay (including for room and board) and separately billing Medicare Part B for the daily skilled OT services. In other words, the SNF was wrong to bill the OT as Part B outpatient services when, under Medicare law, those daily skilled OT services qualified Mr. D for full, Part A inpatient SNF benefits (which include bed and board).

30. The ALJ issued a decision on November 30, 2023. Exhibit 1. He applied the requirements for SNF coverage found at 42 C.F.R. § 409.30-409.35 to the factual record. *Id.* at 4. The decision was fully favorable, finding that the evidence established that the requirements for Part A SNF coverage were met, and holding that Mr. D's SNF stay during the dates of service was entitled to Medicare payment. The ALJ found that after Mr. D was evaluated, orders were placed for skilled OT five times per week (meeting Medicare's definition of "daily" rehabilitation services). The OT orders were to address his left-hand contracture (neither he nor his caregivers could straighten his fingers for hygiene purposes, resulting in a fungal rash), increased hand pain, and generalized weakness. The ALJ also found that Mr. D received the ordered services. Treatment included diathermy,⁸ underwater ultrasound, range of motion work, pain reduction techniques, stretching, introducing and increasing tolerance to orthotics, multiple modifications of his prosthesis, and hygiene education and assistance. He was later discharged from OT having met all goals. *Id.* at 3.

31. The ALJ also noted Plaintiff's arguments that Mr. D received "skilled therapy on

⁸ Deep heat treatment.

a daily basis.” *Id.* Based on the “medically reasonable and necessary” OT services Mr. D received, the ALJ concluded that the SNF care at issue met the requirements for Part A coverage under 42 C.F.R. §§ 409.30-409.35. *Id.* at 4. The ALJ decision was consistent with the preponderance of the evidence in the record, and with Medicare’s statute, regulations, and policy. It contained no error of law.

32. On January 29, 2024, a CMS contractor referred the ALJ’s decision to the Medicare Appeals Council for possible review on the Council’s own motion. 42 C.F.R. § 405.1110(a). The basis for the referral was the CMS contractor’s view that the decision contained “an error of law material to the outcome of the claim.” *Id.* § 405.1110(b)(1).

33. The Council issued a decision on April 26, 2024, received by Plaintiff’s counsel on May 1, 2024, agreeing with the CMS contractor and reversing the ALJ’s decision. Exhibit 2.

34. The Council characterized the claim as an appeal for “coverage of SNF services – specifically, bed and board—provided to the beneficiary.” Exhibit 2 at 3. The Council noted that “[t]he ALJ concluded the SNF care met Medicare coverage requirements because the beneficiary received daily occupational therapy (OT), which the ALJ determined was medically reasonable and necessary.” *Id.* at 4. It stated that “CMS argues that under 42 C.F.R. § 409.20(a), Medicare only covers bed and board SNF services if they are furnished in connection with daily skilled nursing services, but the ALJ did not identify any skilled nursing services and instead based coverage on the beneficiary’s receipt of OT services.” *Id.*

35. The Council went on to state:

After reviewing the record, we agree with CMS that the ALJ’s decision contains a material error of law. Again the claim at issue here involves Part A coverage for SNF bed and board....Pursuant to 42 C.F.R. § 409.20, bed and board is a covered service in connection with the furnishing of posthospital SNF nursing care, meaning nursing care that qualifies for the posthospital SNF benefit, which is daily skilled nursing care. The ALJ erred by not applying 42 C.F.R. § 409.20 and

anchoring coverage for the bed and board SNF services on OT services rather than nursing services. . . . This error was material because the beneficiary did not receive and require daily skilled nursing services and, as a result, Part A does not cover the bed and board at issue.

Id. at 5.

36. The Council then proceeded to analyze whether the nursing services furnished to Mr. D rose to the level of daily skilled nursing care and found that they did not. *Id.* at 5-6 (listing non-skilled nursing services). Yet Plaintiff never claimed that the beneficiary required and received daily skilled nursing care during the dates in question.

37. The Council reversed the ALJ decision, concluding that “Medicare does not cover the SNF services, consisting of bed and board. . . .” *Id.* at 7.

38. The Council is the highest level of administrative review and its decision is the final decision of the Secretary. Plaintiff has exhausted administrative remedies for denial of her claim for Medicare Part A coverage and payment of all SNF services that Mr. D received from March 15 through April 10, 2022.

39. Plaintiff submitted a timely request to the Council to “reopen” its decision. 42 C.F.R. § 405.980(a)(1)(4); *see also id.* § 405.986(a)-(c) (a party must establish “good cause” for reopening based on certain grounds). Upon information and belief, the Council is experiencing severe delays – regularly lasting years – in issuing decisions in response to party requests. To date Plaintiff has received no response or acknowledgement of the request to reopen the decision in this case. To ensure swift resolution of this dispute over a fundamental error of law, Plaintiff filed this request for judicial review and declaratory relief.

40. Plaintiff routinely appeals for Medicare Part A coverage of SNF services in the course of her duty to pursue third-party liability for Medicaid payments. She has often won Part A coverage based on beneficiaries’ receipt of daily skilled rehabilitation services, such as

physical or occupational therapy, without claiming daily skilled nursing services for the same dates of service. The Secretary's novel and erroneous construction of 42 C.F.R. § 409.20(a) in the underlying case threatens the coverage of critically-needed, medically necessary services for Medicare beneficiaries (whether or not they are dually eligible for Medicaid) and conflicts with the plain meaning and intent of the statute and the Secretary's own regulations. *E.g.*, 42 C.F.R. § 409.31(b)(1). It is also inconsistent with CMS's published literature for beneficiaries regarding coverage of SNF care. *E.g.*, Medicare.gov, Skilled nursing facility (SNF) care ("Skilled care is...health care given when you need skilled nursing or skilled therapy.... Medicare-covered services in a skilled nursing facility include, but aren't limited to: A semi-private room...Meals").⁹

41. Nothing in the record reflects that Plaintiff sought Part A coverage and payment solely for Mr. D's "bed and board" at the SNF, as the Council claimed. The administrative record demonstrates that the claim before the agency is for full Part A coverage and payment for the entirety of the post-hospital SNF care services provided to Mr. D during the dates of service, pursuant to the criteria set forth at 42 C.F.R. § 409.30-409.35. If those criteria are met, an individual is eligible not just for covered bed and board, but also a panoply of other services delineated at 42 C.F.R. § 409.20(a), including but not limited to nursing, therapy, medical social services, drugs, supplies, and equipment.

42. The Council erred in predicating its conclusion on the idea that Plaintiff's appeal was limited to a claim for reimbursement of "bed and board." There is no evidence for that notion. Proceeding from that erroneous premise, the Council then erred by conflating the

⁹ Available at: <https://www.medicare.gov/coverage/skilled-nursing-facility-snf-care>.

definition of what is *included* in posthospital SNF services (42 C.F.R. § 409.20) with the actual *requirements for coverage* of SNF services (42 C.F.R. §§ 409.30-409.35).

43. The plain language of 42 C.F.R. § 409.20(a) defines Medicare-covered SNF care to include “[n]ursing care” and “[b]ed and board in connection with the furnishing of that nursing care.” *See also* 42 U.S.C. §§ 1395x(h)(1)-(2). This provision does not say “*skilled* nursing care,” much less the “*daily skilled* nursing care” that the Council has read into it. The Council’s decision overlooks the fact that SNF patients require and receive care from various types of nurses and at different levels of care. *See supra* ¶ 17. Such nursing is covered when the patient meets the requirements for coverage at 42 C.F.R. §§ 409.30 *et seq.* By the same token, bed and board are also covered when those criteria are met.

VI. PROPRIETY OF ISSUANCE OF A WRIT OF MANDAMUS

44. As the administrator of Connecticut’s Medicaid program, Plaintiff is suffering and will continue to suffer injury by reason of the Secretary’s actions complained of herein. The Secretary’s misconstruction of the requirements for Medicare Part A coverage of SNF services means that the costs of furnishing those services are being and will continue to be borne by the Medicaid program. The Secretary’s actions also interfere with the Plaintiff’s duty, as payor of last resort, to pursue third-party liability.

45. Plaintiff has a clear right to the relief sought. To the extent there is no other adequate remedy available to correct an otherwise unreviewable defect in the Secretary’s administration of the Medicare benefit, only the mandamus relief which this Court can provide will fully redress the wrongs done to her. The Secretary has a plainly defined and nondiscretionary duty to provide the relief Plaintiff seeks.

VII. CAUSE OF ACTION: VIOLATION OF MEDICARE STATUTE AND REGULATIONS

46. Plaintiff realleges and incorporates the foregoing paragraphs as if fully set forth herein.

47. The Secretary's final decision denying Plaintiff's claim for Medicare Part A coverage and payment of SNF services during the period at issue is not supported by substantial evidence, incorrect as a matter of law, and should be reversed. The Secretary's denial of Part A SNF coverage on the grounds that a beneficiary must receive daily skilled nursing rather than daily skilled rehabilitation in order to qualify for such coverage violates the Medicare statute, regulations, and policy manual.

VIII. PRAYER FOR RELIEF

WHEREFORE, the Plaintiff respectfully requests that this Court:

1. Declare that the Secretary's construction of 42 C.F.R. § 409.20 to require the receipt of daily skilled nursing services, and to exclude the receipt of daily skilled rehabilitation services, as basis for Medicare Part A coverage of SNF services, including bed and board, violates the Medicare statute, regulations, and policy manual.

2. Reverse the underlying decision of the Secretary and award the Part A coverage and payment for SNF services to which the Plaintiff is entitled;

3. In the alternative, remand the case to the Secretary with instructions to cover and pay for the SNF services at issue under Part A;

4. Award Plaintiff reasonable attorneys' fees and costs; and

5. Grant the Plaintiff such additional and alternative relief as may be just and proper under the circumstances of the case.

DATED: June 25, 2024

Respectfully submitted,

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