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IN THE COURT OF APPEALS OF INDIANA

ResCare Health Services, Inc.,
Appellant-Petitioner,

v.

Indiana Family and Social Services Administration – Office of Medicaid Policy and Planning,
Appellee-Respondent.

April 14, 2021

Court of Appeals Case No. 20A-MI-1025

Appeal from the Marion Superior Court

The Honorable Gary Miller, Judge

Trial Court Cause No. 49D03-1908-MI-32821

Riley, Judge.

STATEMENT OF THE CASE

[1] Appellant-Petitioner, ResCare Health Services, Inc. (ResCare), appeals the trial court's denial of its petition for judicial review and request for declaratory judgment in favor of Appellee-Respondent, Indiana Family and Social Services Administration – Office of Medicaid Policy and Planning (FSSA), concerning ResCare's request for reimbursement of the costs for over-the-counter medicines.

[2] We affirm.

ISSUES

[3] ResCare presents this court with three issues, which we restate as follows:

1. Whether the FSSA's interpretation that Indiana's Medicaid statute does not include reimbursement for the costs of over-the-counter medicines for private facilities is contrary to law;
2. Whether the trial court's denial of ResCare's request for reimbursement of over-the-counter medicines amounts to an unconstitutional taking under the Indiana Constitution; and
3. Whether the trial court abused its discretion in denying ResCare's request for a declaratory judgment.

FACTS AND PROCEDURAL HISTORY

[4] ResCare operates private intermediate care facilities across Indiana for individuals with intellectual disabilities, known as "ICF/IIDs." (Appellant's

App. Vol. III, pp. 11-12). For its residents who are recipients of Indiana Medicaid benefits, ResCare is entitled to reimbursement for the cost of its services paid at a per diem rate. This per diem rate is subject to annual adjustments in response to ResCare's annual cost-reporting. For its 2014 annual cost report, ResCare sought to recover the cost of over-the-counter (OTC) medicines that had been prescribed by the physicians of ResCare's residents. For example, some residents were prescribed allergy relief D-24 tablets by their physician for nasal congestion or allergy symptoms. Allergy relief D-24 tablets are not included on the Office of Medicaid Policy and Planning's Over-the-Counter Drug Formulary (Formulary) for pharmacies. This Formulary is a list of pre-approved medicines and doses that pharmacies use for seeking compensation under the Medicaid program. As the pharmacy did not get reimbursed by Medicaid when dispensing the allergy relief D-24 tablets, the pharmacy billed ResCare and ResCare included this amount in its cost report to FSSA.

[5] The FSSA retained Myers & Stauffer, L.C. to serve as its agent to audit ResCare's 2014 cost report. Myers & Stauffer proposed an adjustment to remove ResCare's costs for the non-Formulary OTC medicines from its 2014 cost report. In response to this adjustment, ResCare submitted a request for an administrative reconsideration, asserting that the residents' attending physicians ordered these OTC medicines and the pharmacy could not bill these items to the Medicaid Program. Myers & Stauffer denied the reconsideration request.

[6] On January 11, 2018, ResCare petitioned for administrative review of the rate adjustment, challenging the denial of its request for reimbursement for OTC medicines administered to its residents. On April 25, 2018, ResCare moved for summary judgment before the ALJ, arguing whether (1) ResCare could receive compensation for OTC medicines through its Medicaid per diem rate if these were not included on the Formulary; and (2) if not, ResCare could charge the unreimbursed costs for such medicines to the personal funds of its residents. The parties filed cross-motions for summary judgment. The recommended order of August 7, 2018 granted summary judgment to the agency on the first issue but was silent on the alternative argument. After seeking a ruling on the alternative issue, the ALJ recognized by email that his recommended order tacitly denied ResCare's request for summary judgment on the issue of whether it could charge its residents for OTC medicines. ResCare appealed the ALJ's decision to the final agency authority. On July 12, 2019, the FSSA issued a final order, affirming the ALJ's decision and agreeing that costs for the non-Formulary OTC medicines could not be included in ResCare's per diem rate. The FSSA also concluded that it could not rule on whether ResCare could charge the personal funds accounts of its residents for the unreimbursed costs for non-Formulary OTC medicines because the issue was not ripe and a declaratory judgment was beyond the scope of an administrative proceeding.

[7] On August 12, 2019, ResCare filed for judicial review of the FSSA's decision. On January 29, 2020, the trial court affirmed the agency's final decision concluding that non-Formulary OTC medicines are not reimbursable under

Indiana's Medicaid statutes. On March 27, 2020, ResCare filed a motion to correct errors, which was not ruled upon by the trial court and consequently was deemed denied on May 11, 2020.

[8] ResCare now appeals. Additional facts will be provided if necessary.

DISCUSSION AND DECISION

I. *Standard of Review*

[9] With AOPA in mind, we note that "our review of agency action is intentionally limited, as we recognize an agency has expertise in its field and the public relies on its authority to govern in that area." *Moriary v. Ind. Dept. of Natural Resources*, 113 N.E.3d 614, 619 (Ind. 2019). We do not try the facts *de novo* but rather "defer to the agency's findings if they are supported by substantial evidence." *Id*. "On the other hand, an agency's conclusions of law are ordinarily reviewed *de novo*." *Id.* While we are not bound by an agency's conclusions of law, "an interpretation of a statute by an administrative agency charged with the duty of enforcing the statute is entitled to great weight, unless this interpretation would be inconsistent with the statute itself." *Chrysler Grp., LLC v. Review Bd. of Ind. Dep't of Workforce Dev.,* 960 N.E.2d 118, 123 (Ind. 2012). Moreover, we do not reweigh the evidence; rather we consider the record in the light most favorable to the agency's decision. *Ind. State Ethics Comm'n v. Sanchez*, 18 N.E.3d 988, 992 (Ind. 2014). We affirm the agency's judgment unless it is clearly erroneous. *Id.*

[10] Appellate courts review questions of regulatory interpretation in a similar manner to statutory interpretation. *Natural Resources Defense Council v. Poet*

Biorefining-Northern Manchester, LLC, 15 N.E.3d 555, 564 (Ind. 2014). The goal of statutory interpretation is to "determine and give effect to the intent of the legislature." *Schumaker*, 118 N.E.3d at 20. If the statutory language is clear and unambiguous, this court gives "the words and phrases . . . their plain, ordinary, and usual meanings to determine and implement the legislature's intent." *Id*. If the statute is ambiguous, this court "seeks to ascertain and give effect to the intent of the legislature," and must read the act as a whole and endeavor to give effect to all of the provisions. *Id*. But, like statutory interpretation, "when the meaning of an administrative regulation is in question, we give great weight to the interpretation put in place by the relevant agency—unless that interpretation would be inconsistent with the regulation itself." *Natural Resources Defense Council*, 15 N.E.3d at 564.

II. *Regulatory Framework*

[11] The federal government enacted the Medicaid program through Title XIX of the Social Security Act. 42 U.S.C. § 1396. The State of Indiana participates in the Medicaid program based on the approval of the state plan by the federal government through the Centers for Medicare & Medicaid Services and is bound by federal Medicaid regulations. *Collins v. Hamilton*, 349 F.3d 371, 374 (7th Cir. 2003). Under federal law, states that choose to participate in Medicaid must provide a core set of mandatory services. 42 U.S.C. §§ 1396(a)(10)(A); 1396d(a). A state may choose to cover optional categories of services. *See Thie v. Davis*, 688 N.E.2d 182, 184 (Ind. Ct. App. 1997). If a state chooses to implement the optional categories of services, those optional services then

become a part of the State's Medicaid plan, in which the optional services become subject to the requirements of federal law. *Id*.

[12] Drug coverage is an optional Medicaid service. *See* 42 U.S.C. §§ 1396a(a)(10)(A); 1396(a)(12). When a state elects to cover pharmaceutical drugs, it has broad authority to place restrictions on that coverage. 42 U.S.C. § 1396r-8(d). A state may "exclude [] from coverage or otherwise restrict [] [p]rescription vitamins and mineral products" as well as "[n]onprescription drugs." 42 U.S.C. § 1396r-8(d)(2)(E)-(F). Indiana has elected to include drug and nutrition supplement coverage in its Medicaid program. *See* 405 IAC 5-24-1. FSSA will reimburse pharmacy providers for OTC medicines provided to Medicaid recipients. 405 IAC 5-24-5(a). But reimbursement is limited to OTC medicines listed on the Indiana Medicaid's Formulary. 405 IAC 5-24-5(b).

[13] FSSA has promulgated rules providing reimbursement to privately-owned intermediate care facilities for ICF/IIDs. 405 IAC 5-13-2(b); 405 IAC 1-1-1(5). The ICF/IIDs are paid an "all-inclusive" per diem rate for "all services provided to patients by the facility." 405 IAC 1-12-21. Those services include costs like room and board, nursing and habilitation services, medical and non-medical supplies and equipment, physical and occupational therapy, durable medical equipment and transportation. 405 IAC 5-13-3. When a new ICF/IID facility opens, FSSA has a system for providing an initial "base rate" per diem payment. 405 IAC 1-12-5. FSSA subsequently uses the ICF/IIDs cost reporting to make annual adjustments to the per diem rate. 405 IAC 1-12-6.

III. *Reimbursement for OTC Medicines*

[14] ResCare, as a private facility for ICF/IID, is subject to 405 IAC 1-12-21(b), which specifies that "[t]he per diem rate for ICFs/IID is an all-inclusive rate. The per diem rate includes all services provided to patients by the facility." The per diem rate is clarified in 405 IAC 5-13-3, which provides, in pertinent part, that:

> The per diem rate for large private and small ICFs/IID shall include the following services:
>
> * * * *
>
> (4) All medical and nonmedical supplies and equipment furnished by the facility for the usual care and treatment of residents are covered in the per diem rate and may not be billed separately to Medicaid by the facility or by a pharmacy or other provider.

[15] 405 IAC 1-12-2(cc) further indicates that "[r]outine medical and nonmedical supplies and equipment" includes those items generally required to assure adequate medical care and personal hygiene of patients or residents by providers of like levels of care. Relying on the specification of 405 IAC 1-12-2(cc), ResCare contends that "[r]outine medical and nonmedical supplies and equipment" is further defined as including those items "generally required to assure adequate medical care and personal hygiene of patients or residents by providers of like levels of care." 405 IAC 1-12-2(cc). Arguing that the OTC medicines are prescribed by the residents' physicians, ResCare observes that

these OTC medicines are "obviously required to assure adequate medical care." (Appellant's Br. p. 14). ResCare distinguishes the OTC medicines from the "nonroutine medical supplies and equipment" because these medicines can be expected in the normal course of patient care. It maintains that an ICF/IID facility providing OTC medicines as needed is a routine practice and not out of the ordinary regardless of whether the OTC medicines are needed by only a limited number of its residents.

[16] In contrast, the per diem rate for state-run facilities is specified in 405 IAC 5-13-4, which states:

> **(a)** The per diem rate for a large state ICF/MR shall include the following services:
>
> **(1)** Room and board (room accommodations, dietary services, and laundry services).
> **(2)** Medical services.
> **(3)** Mental health services.
> **(4)** Dental services.
> **(5)** Therapy and habilitation services.
> **(6)** Durable medical equipment (DME).
> **(7)** Medical and nonmedical supplies.
> **(8)** Pharmaceutical products.
> **(9)** Transportation.
> **(10)** Optometric services.

[17] Accordingly, unlike its counterpart in the private sector, state-run facilities are explicitly authorized to be reimbursed for pharmaceutical products. Private facilities, like ResCare, instead have the broad-sweeping encompassing language of "all medical and nonmedical supplies and equipment" without further differentiation.

[18] As pointed out by the trial court in its judgment, "[i]n construing a statute, the primary goal is to determine and implement the intent of the Legislature in enacting the statute." (Appellant's App. Vol. II, p. 10). As every word in the statutes "was used intentionally[,] every word should be given effect and meaning … [a]nd statutes concerning the same subject matter must be read together to harmonize and give effect to each other," we must conclude that the FSSA correctly interpreted its own rules in excluding pharmaceutical products and OTC medicines from the per diem reimbursement for private facilities. *Clippinger v. State*, 54 N.E.3d 986, 989 (Ind. 2016). Both sections are sequentially listed in the same section addressing the reimbursement rate for services provided to individuals with intellectual disabilities depending only on the nature of the facility in which they reside. Because these statutes address the same subject matter within the context of the Medicaid per diem reimbursement rate, their use of the term 'medical supplies' must be harmonized. If the FSSA had intended to include these pharmaceutical products in the per diem rate for privately-run facilities, it would have specifically included those products in the calculation, as it did for state-run facilities. Likewise, if the term "medical and nonmedical supplies and equipment" had intended to include pharmaceutical products, like OTC medicines, there would be no need to separately include these as a permissible per diem component for state-owned facilities.

[19] Our analysis is supported by 405 IAC 5-19, which applies to Medicaid Services – Medical Supplies, and which, besides defining "medical supplies" also

explicitly provides in section 1(c), that "[c]overed medical supplies do not include the following: **(1)** Drug products, either legend or nonlegend."

[20] Indiana Medicaid provides for reimbursement of OTC medicines to pharmacy providers—which ResCare is not—but this reimbursement is limited to OTC medicines on the Formulary. Pharmacies will not be compensated for dispensing non-Formulary OTC medicines, stating specifically that the FSSA "shall reimburse pharmacy providers for the cost and dispensation of nonlegend (or OTC) drugs." 405 IAC 5-24-5. Subsection (b) of the same statute, which must be read in harmony with the subsection preceding it, reads: "[o]nly those nonlegend drugs that are included on the OTC drug formulary are covered by Indiana health coverage programs." 405 IAC 5-24-5. Accordingly, when ResCare fills its residents' prescriptions for OTC medicines, no cost will be involved for Formulary OTC drugs as the pharmacy will be reimbursed by Medicaid. However, if the prescription involves non-Formulary OTC medicines, no such reimbursement exists and the pharmacy will invoice the cost to ResCare.

[21] In summary, the ordinary rules of regulatory interpretation exclude pharmaceutical and OTC medicines from the per diem rate for privately-run ICF/IID facilities, like ResCare. Instead, OTC medication has to be covered through Pharmacy Services (405 IAC 5-24-5(a) & (b))—which only provides for coverage of OTC medicines that are on the Formulary; Non-Formulary OTC medicines will then be paid for 'out-of-pocket' by ResCare. Because FSSA's conclusion that pharmaceutical and OTC medicines are not included in the

definition of medical supplies is not contrary to law, we affirm the trial court's denial of ResCare's petition for judicial review.

IV. *Constitutional Taking*

[22] Continuing its argument, ResCare contends that Medicaid's requirement that it provide non-Formulary OTC medicines prescribed by its residents' physicians without reimbursement amounts to a taking under the Indiana Constitution. In response, FSSA replies that no taking occurred as the obligations imposed upon a Medicaid provider are voluntarily assumed when the provider accepted the Medicaid contract.

[23] Section 21 of the Indiana Constitution provides that "no person's particular services shall be demanded, without just compensation. No person's property shall be taken by law, without just compensation." IN Const., art. 1, § 21. To establish a taking under Article 1, a plaintiff must show that "(1) they performed particular services, (2) on the State's demand, (3) without just compensation." *Bayh v. Sonnenburg*, 573 N.E.2d 398, 411 (Ind. 1991).

[24] In support of their respective argument, both parties rely on the same two cases: *Sonnenburg* and *Gorka v. Sullivan*, 671 N.E.2d 122 (Ind Ct. App. 1996). The *Sonnenburg* framework was developed in light of a class action suit brought by 7400 patients to recover compensation for work performed while confined in Indiana's mental hospitals. *Sonnenburg*, 573 N.E.2d at 400. The patients performed a variety of work activities while hospitalized, ranging from yard work and fixing meals to administrative tasks. *Id.* at 412. These jobs "were

full-time . . .[f]ive days a week." *Id*. The State initiated the process of putting the patients to work and "[w]ith respect to involuntarily-committed patients, the State's requests were backed up with the use or threatened use of legal process." *Id*. Relying on the "Social Compact" existing between the government and the people, our supreme court first noted that "as part of this Compact, citizens are required to yield property and general services to the State in exchange for the State's protections," but this request becomes a "demand when it is backed up with the use or threatened use of physical force or legal process which creates in the citizen a reasonable belief that he is not free to refuse the request." *Id*. at 416-17, 418.

[25] In *Gorka*, a group of Medicaid transportation service providers and patients filed suit after Indiana Medicaid announced a reduction in the reimbursement rates offered to Medicaid transportation service providers. *Gorka*, 671 N.E.2d at 123-24. Referring to *Sonnenburg*, the Providers claimed that based on the terms of their Medicaid contract, they had no choice but to transport Medicaid patients. *Id*. at 131. The Providers contended "that the Medicaid agency threatened them with legal process under the non-discrimination provisions, and that the threat constituted a demand for services according to the *Sonnenburg* test." *Id*. This court, however, distinguished *Sonnenburg* from the Providers' circumstances. *Id*. We concluded that "[i]n *Sonnenburg*, the State controlled nearly every aspect of the plaintiffs' lives, because the plaintiffs resided in state hospitals," and "the plaintiffs' mental impairments may have rendered them particularly susceptible to perceived coercion." *Id*. Turning to the case at hand,

we observed that "the Providers are business owners who manage transportation schedules, vehicles and personnel, and who provide transportation services to the general public." *Id*. Based on the facts, we found that "[g]iven the Providers' business stature and the readily available option to cancel their Medicaid contracts, the Providers' argument that the State demanded their services fails." *Id*.

[26] We find the circumstances at hand more aligned with *Gorka* than *Sonnenburg*. By voluntarily agreeing to become a Medicaid provider and entering into a Provider Agreement in 2015, ResCare agreed to comply with all "enrollment requirements" as well as "all federal and state statutes and regulations pertaining to" Indiana's Medicaid program. (Appellant's App. Vol. II, p. 116). As such, ResCare agreed to "provide covered services and/or supplies for which federal financial participation is available," and to "abide by the Indiana Health Coverage Programs Providers Manual" as well as be informed of all "[P]rovider [B]ulletins and notices." (Appellant's App. Vol. II, p. 116). These Provider Bulletins issued by Indiana Medicaid provide official notice of new and revised policies, program changes, and information about special initiatives. In December 1993, a bulletin was issued alerting Providers, like ResCare, to updates on the OTC medicine coverage. The Bulletin noted that "claims for non-[F]ormulary drugs will be denied." (Appellant's App. Vol. II, p. 150). The Bulletin clarified that "[t]he OTC drug [F]ormulary was structured to allow for the use of medically necessary OTC drugs, while not incentivizing the prescribing or dispensing of more expensive legend drugs." (Appellant's

App. Vol. II, p. 151). Accordingly, the denial of non-Formulary OTC drugs is not something new and was fully operative in 2015 when ResCare entered into the Provider Agreement with Indiana's Medicaid– the parties did not submit any evidence (nor did we find any) that non-Formulary OTC drugs were ever covered or reimbursed since the development of the Formulary.

[27] Therefore, we conclude that ResCare voluntarily undertook the obligations and costs of participating in Indiana's Medicaid program when it signed the Provider Agreement, and it cannot establish a takings claim because it is now dissatisfied with the outcome of the reimbursement rate determinations.

V. *Request for Declaratory Judgment*

[28] As its alternative argument, ResCare requests us to issue a "declaratory judgment holding that OTC drugs could be charged against client accounts if those drugs fall outside Medicaid." (Appellant's Br. p. 27). The trial court denied the request for declaratory judgment, concluding that: (1) ResCare's Complaint only sought judicial review and (2) the residents should be parties to this action.

[29] The Uniform Declaratory Judgment Act allows parties to present disputes in an orderly, efficient manner. I.C. § 34-14-1-12. Declaratory judgments are remedial in nature and are intended to afford relief from uncertainty and insecurity with respect to rights, status and other legal relations. I.C. § 34-14-1-12. "The test for determining when a declaratory judgment is appropriate is to decide whether the issuance of a declaratory judgment will effectively solve the

problem, whether it will serve a useful purpose, and whether or not another remedy is more effective or efficient." *Old Utica Sch. Pres., Inc. v. Utica Twp.*, 46 N.E.3d 1252, 1258 (Ind. Ct. App. 2015). "The determinative factor is whether the declaratory action will result in a just and more expeditious and economical determination of the entire controversy." *Id.*

[30] In its Verified Petition for Judicial Review, ResCare invoked the fact that the parties had litigated the issue before the agency and stated that even if the agency could not issue a declaratory judgment, the issue was now before the trial court for it to resolve:

> To the extent the Order rested on the concern that the [FSSA] could not issue a declaratory judgment regarding the reimbursement from personal funds accounts, this [c]ourt does have the authority to do so. *See* Ind. Code § 34-14-1-1; Ind. Tr. R. 57.

(Appellant's App. Vol. II, p. 43). ResCare reiterated the declaratory judgment request in both of its briefs to the trial court, expressly requesting the trial court to enter a declaratory judgment resolving the issue. Relying on the notice pleading requirements—pleading the operative facts so as to place defendant on notice as to the evidence to be presented at trial—ResCare asserts that FSSA was sufficiently notified that it was seeking a declaratory judgment. In response, FSSA focuses on the brief insertion of the declaratory judgment's reference in ResCare's Complaint, claiming that this passing reference to the existence of a declaratory judgment is not a "request" to the trial court to issue a declaratory judgment in its favor. (Appellee's Br. pp. 31-32). Because

ResCare failed to provide adequate notice of its intent to seek a declaratory judgment, FSSA posits that the parties did not develop an evidentiary record, nor did they fully brief the propriety of ResCare's request.

[31] Without deciding whether ResCare's request for declaratory judgment was sufficiently pleaded before the trial court, we conclude that the trial court properly declined ResCare's petition. Indiana Code section 34-14-1-1 provides that "[w]hen declaratory relief is sought, all persons shall be made parties who had or claim an interest that would be affected by the declaration, and no declaration shall prejudice the rights of persons not parties to the proceedings." Pursuant to this statutory language, ResCare invites further litigation by failing to join the residents. The residents—who are recipients of Medicaid benefits—have an interest in the outcome of the issue and will want to be heard before their limited resources are charged for the provision of non-Formulary OTC medicines especially when Formulary OTC medicines are eligible for reimbursement under Medicaid if they are provided by pharmacy providers pursuant to the OTC Formulary. Because ResCare did not join the residents as parties to the current litigation, no declaratory relief can be awarded. *See American Family Mutual Ins. Co. v. Ginther*, 803 N.E.2d 224, 231 (Ind. Ct. App. 2004) (the person seeking the declaratory relief should have joined the necessary parties), *trans. denied*.

CONCLUSION

[32] Based on the foregoing, we hold that the FSSA's interpretation that OTC medicines are not included in the per diem rate for privately-run facilities for

ICF/IID is not contrary to law; the denial of reimbursement for non-Formulary OTC medicines is not an unconstitutional taking under the Indiana Constitution; and the trial court did not abuse its discretion in denying ResCare's request for a declaratory judgment.

[33] Affirmed.

[34] Najam, J. and May, J. concur