IN THE COURT OF APPEALS OF NORTH CAROLINA

2022-NCCOA-10

No. COA20-282

Filed 4 January 2022

Macon County, No. 19 CVS 61

JOHN A. HENDRIXSON, Petitioner,

v.

The DIVISION OF SOCIAL SERVICES and the DIVISION OF HEALTH BENEFITS of the NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES, Respondents.

Appeal by Respondents from order entered 9 January 2020 by Judge J. Thomas Davis in Macon County Superior Court. Heard in the Court of Appeals 23 February 2021.

Ott, Cone & Redpath, P.A., by Matthew Jordan Cochran, for petitioner-appellee.

Attorney General Joshua H. Stein, by Special Deputy Attorney General Katherine M. McCraw, for respondents-appellants.

MURPHY, Judge.

¶ 1 When a state agency implements an unpromulgated rule not permitted by statutory or regulatory authority, the rule implemented may not be enforced. Here, because the rule implemented by the North Carolina Department of Health and Human Services regarding Medicaid coverage was unsupported by any statutory or

regulatory authority and implemented as an unpromulgated rule, we affirm the Superior Court's conclusion that the rule was unenforceable.

BACKGROUND

¶ 2 In June 2018, Plaintiff John Hendrixson filed an application for Medicaid coverage with the Macon County Department of Social Services ("Macon County DSS") for his medical expenses, requesting retroactive coverage for outpatient hospital expenses incurred on 6 March 2018 in the amount of $8,208.43; on 3 April 2018 in the amount of $1,470.00; and on 26 April 2018 in the amount of $10,633.94. At the time of his application, Hendrixson was 65 or older. Although his application for Medicaid was approved, it was determined that he should have a deductible of $1,670.00[1] and was only approved for full Medicaid benefits for his medical expenses incurred from 26-30 April 2018 because Macon County DSS determined his deductible was not met until 3 April 2018.[2]

¶ 3 A Medicaid deductible is deemed to be met, and Medicaid coverage begins, once applicable medical bills add up to an amount that is greater than the amount of the

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[1] This amount was initially $2,505.00 but was later reduced to $1,670.00. Hendrixson had a Medicaid deductible because his total monthly income exceeded the limit to receive full Medicaid benefits without a deductible.

[2] Medicaid coverage begins during the month the application was submitted and has retroactive coverage for up to three months. *See* 42 C.F.R. § 435.915 (2020). In this case, Hendrixson was a Medicaid beneficiary as of June 2018, the month in which he applied for Medicaid coverage, with retroactive coverage beginning in March 2018.

Medicaid deductible. *See* 10A N.C. Admin. Code 23E.0209 (2020). However, in this case, only 20% of Hendrixson's earlier two medical bills—$1,641.69 from 6 March 2018 and $294.00 from 3 April 2018—were applied towards his deductible because Hendrixson was not enrolled in Medicare Part B, despite being qualified in terms of his age, which would have otherwise provided coverage for the 80% excluded. The basis for this decision was the North Carolina Department of Health and Human Services' ("Department") Aged, Blind, and Disabled Medicaid Manual ("the Manual"), which states, in relevant part:

> If a Medicare applicant is eligible for [Medicare] Part B benefits, he must apply for and except [sic] the coverage. If he refuses, the applicant is responsible for payment of claims that would have been paid by Medicare Part B if he had applied. If the applicant fails to enroll in Medicare Part B, charges which would have been paid by Medicare Part B cannot be applied to the deductible.
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> . . .
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> Medicaid applicant [sic] who are age 65 or older must apply for and be enrolled in Medicare Part B. If the applicant fails to enroll, Medicaid pays no portion of the costs for medical services that would have been covered by Medicare Part B. The provider may bill the recipient for the total cost of the services provided.

¶ 4 Using this 20% method, Macon County DSS determined that Hendrixson had $1,641.69 from his 6 March 2018 medical bill and $294.00 from his 3 April 2018 medical bill that were applicable to his Medicaid deductible of $1,670.00, satisfying his Medicaid deductible on 3 April 2018, and he had coverage for charges after 3 April

until 30 April. The effect of this decision was that Hendrixson's $1,670.00 deductible was determined to be met on 3 April 2018, despite his 6 March 2018 medical bill in the amount of $8,208.43. As an extension of this, Hendrixson did not receive Medicaid coverage for his medical expenses incurred on 6 March 2018 and 3 April 2018, and he was financially responsible for these charges.

¶ 5 Hendrixson appealed the decision of Macon County DSS, contending that it improperly denied coverage or penalized Hendrixson for not enrolling in Medicare Part B, in contravention of *Duke Univ. Med. Ctr. v. Bruton*, 134 N.C. App. 39, 516 S.E.2d 633 (1999), by only applying 20% of his medical bills towards his deductible. Macon County DSS responded that the application was instead approved with a deductible that Hendrixson was required to meet prior to attaining full Medicaid coverage and that applying 20% of the medical bills to the deductible here was consistent with Medicaid policy due to Hendrixson's eligibility for, and failure to enroll in, Medicare Part B. Ultimately, an assistant chief hearing officer issued the Department's final decision for the purpose of N.C.G.S. § 108A-79(k), which affirmed the methodology used by Macon County DSS and concluded that Hendrixson was entitled to coverage for 3 April 2018 through 30 April 2018.[3]

¶ 6 Hendrixson subsequently petitioned the Macon County Superior Court for

[3] It appears the charges covered were exclusive of 80% of the charges from 3 April 2018 that Medicare would have covered.

judicial review of the Department's final decision. On 9 January 2020, the Superior Court entered an order reversing the final agency decision, concluding the Department erred and prejudiced Hendrixson's substantial rights because its decision was affected by errors of law, was made upon unlawful procedure, was in excess of the statutory authority of the agency, and violated the Supremacy Clause. In coming to this ultimate conclusion, the Superior Court reached the following conclusions: (1) "Under the plain language of applicable federal statutes, federal regulations, the State Plan, and the North Carolina Administrative Code, [Hendrixson] satisfied his . . . deductible of [$1,670.00] on [6 March 2018] when he incurred [$8,208.43] in unpaid medical expenses"; (2) federal laws, federal regulations, and the State Plan do not condition or limit Medicaid eligibility based on Medicare Part B enrollment; (3) applicable laws and regulations do not permit differential determination of Medicaid eligibility based on Medicare Part B enrollment; (4) federal reimbursement is available for retroactive Medicaid coverage like the coverage Hendrixson was requesting; (5) no law authorizes the Department to disregard 80% of incurred medical expenses in determining when a Medicaid deductible is met; (6) even if N.C.G.S. § 108A-55.1 did limit individuals' Medicaid eligibility, it would be in conflict with federal statutes and regulations and violate the Supremacy Clause; and (7) the Manual's provisions utilized in this case are unpromulgated rules and are unenforceable against Hendrixson. The Division of

Health Benefits and the Division of Social Services of the Department (collectively, "NCDHHS") timely appeal.

ANALYSIS

¶ 7 NCDHHS contends the Superior Court erred in reversing NCDHHS's actions because: (A) NCDHHS did not condition Medicaid coverage on Medicare coverage and instead approved Hendrixson's Medicaid application while requiring him to pay a deductible calculated according to N.C.G.S. § 108A-55.1, which prohibited NCDHHS from paying the medical expenses that Medicare would have covered; (B) NCDHHS properly applied N.C.G.S. § 108A-55.1, which NCDHHS contends constrains how retroactive coverage may be provided; and (C) N.C.G.S. § 108A-55.1 does not violate the Supremacy Clause because it is not in conflict with federal law. Hendrixson responds, respectively: (A) NCDHHS indirectly conditioned his March 2018 Medicaid benefits on his enrollment in Medicare by refusing to apply his incurred medical expenses to his deductible due to failure to enroll in Medicare Part B; (B) N.C.G.S. § 108A-55.1 does not impact retroactive Medicaid benefits and NCDHHS improperly interprets and applies N.C.G.S. § 108A-55.1 in light of its plain language and applicable federal law; and (C) N.C.G.S. § 108A-55.1, as interpreted by NCDHHS, is in conflict with federal law. The ultimate issue presented by this case is whether the applicable statutory and regulatory law supports NCDHHS's determination of when Hendrixson's Medicaid deductible was met as, if it does not, the Manual's 20% method

was unenforceable as an unpromulgated rule.

¶ 8 In *Bruton,* we held:

> Appellate review of a judgment of the [S]uperior [C]ourt entered upon review of an administrative agency decision requires that the appellate court determine whether the [S]uperior [C]ourt utilized the appropriate scope of review and, if so, whether the [S]uperior [C]ourt did so correctly. The nature of the error asserted by the party seeking review dictates the appropriate manner of review: if the appellant contends the agency's decision was affected by a legal error, [N.C.G.S. § 150B-51(1), (2), (3) & (4)], *de novo* review is required; if the appellant contends the agency decision was not supported by the evidence, [N.C.G.S.] § 150B-51(5), or was arbitrary or capricious, [N.C.G.S.] § 150B-51(6), the whole record test is utilized. [N.C.G.S.] § 150B-4(a) permits review of an agency's declaratory ruling in the same manner as that of an order in a contested case. Therefore, the standard of review for the agency's declaratory ruling is determined by [N.C.G.S.] § 150B-51. Under [N.C.G.S. §] 150B-51, a reviewing court is permitted to reverse or modify the agency's decision if the rights of the petitioners may have been prejudiced because the agency's findings, inferences, conclusions, or decisions are affected by error of law. Because [the] appellees alleged in their petition for judicial review that [the] appellants erroneously construed state and federal law regarding the relation between Medicare and Medicaid, our standard of review is *de novo*. In *de novo* review, an appellate court may substitute its judgment for that of the agency.

Id. at 41-42, 516 S.E.2d at 635 (citations and marks omitted). Here, like the appellee in *Bruton*, Hendrixson's petition for judicial review contended that the agency decision was made upon unlawful procedure and errors of law, entitling him to de

novo review of these issues by the Superior Court.[4] The Superior Court properly employed de novo review, and we now review whether the Superior Court did so correctly. *Id.* at 41, 516 S.E.2d at 635 ("Appellate review of a judgment of the [S]uperior [C]ourt entered upon review of an administrative agency decision requires that the appellate court determine whether the [S]uperior [C]ourt utilized the appropriate scope of review and, if so, whether the [S]uperior [C]ourt did so correctly.").

¶ 9 At the outset, it is helpful to briefly describe how Medicare and Medicaid function in circumstances like those presented by this case. Relevant to this case, Medicare provides insurance coverage for individuals at least 65 years old. *See* 42 U.S.C. § 1395c (2019). Medicare Part A provides coverage for inpatient hospital expenses and "[e]nrollment is essentially automatic . . . ." *Bruton*, 134 N.C. App. at 42, 516 S.E.2d at 635; *see* 42 U.S.C. §§ 1395c-1395i–5 (2019); 42 C.F.R. § 406.6 (2020). Meanwhile, Medicare Part B provides coverage for certain hospital outpatient services, physician services, and services not covered by Part A. *See Bruton*, 134 N.C. App. at 42, 516 S.E.2d at 635; 42 U.S.C. § 1395k (2019); 42 C.F.R. § 407.2 (2020). Enrollment in Medicare Part B is generally not automatic, *see* 42 C.F.R. §§ 407.4-

[4] Although Hendrixson's petition for judicial review included reference to "erroneous findings of fact," the Superior Court found Hendrixson's argument was focused on issues that fall under N.C.G.S. § 150B-51(b)(1)-(4) and receive de novo review, resolved the dispute based on these issues, and did not address any findings of fact being erroneous.

407.40 (2020), and requires the patient to pay insurance premiums to enroll, after which the federal government pays most of the reasonable costs, with patients paying the remaining cost and an annual deductible. *See Bruton*, 134 N.C. App. at 42, 516 S.E.2d at 635; 42 U.S.C. §§ 1395l, 1395r-1395s (2019); 42 C.F.R. § 407.2 (2020). "Together, the part B premiums, deductibles and coinsurance are generally referred to as 'Part B cost-sharing.'" *Bruton*, 134 N.C. App. at 42, 516 S.E.2d at 635.

¶ 10 In *Bruton*, we described Medicaid as follows:

> Congress established the Medicaid program as Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 et seq., in 1965 to provide federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons. States participating in the optional program are entitled to federal financial participation [("FFP")] and are thereby reimbursed for a portion of their costs. Although participation in the Medicaid program is entirely optional, once a State elects to participate, it must comply with the requirements of Title XIX and the requirements of the Secretary of Health and Human Services. Participating states must serve (1) the "categorically needy," defined as families with dependent children eligible for public assistance under the Aid to Families with Dependent Children ("AFDC") program,[5] 42 U.S.C. § 601 *et seq*., and (2) the aged, blind, and disabled persons eligible for benefits under the Supplemental Security Income ("SSI") program, 42 U.S.C. § 1381 *et seq*.

Id. at 43, 516 S.E.2d at 636 (citations and marks omitted); *see generally* 42 U.S.C. §§

[5] North Carolina's Temporary Assistance for Needy Families program is called the Work First Program. *See* N.C.G.S. §§ 108A-27 to -39 (2019).

1396-1396w-5 (2019).

¶ 11 People eligible for both Medicare and Medicaid are

> commonly called "dual eligibles." 42 U.S.C. §§ 1395v & 1395i–2(g). While dual eligibles are, by definition, eligible for Medicare part A enrollment and part B insurance coverage, because they are impoverished there exists the risk that they will be unable to afford cost sharing requirements.
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> Medicare and Medicaid statutes have addressed this problem by creating a "buy-in" program, under which participating states with Medicaid plans use Medicaid funds (i.e., state funds for which federal matching funds under Medicaid are available) to pay for the cost-sharing requirements under Medicare. For dual eligibles, the state gets a real deal, because, given that Medicaid is treated as a payor of last resort, by enrolling dual eligibles for part B coverage, the primary financial payment for services received comes from the federal government for any services that are covered under both Medicare and Medicaid. In other words, states use their Medicaid dollars, some of which are themselves federal in origin, to buy their dual eligibles into the federal program, thus shifting the primary payment for costs from the state Medicaid program to the federal Medicare program.
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> Although the "buy in" agreements are considered voluntary, the state Medicaid program is required, under the statutory revisions of 1990, to pay the cost-sharing portions of Medicare as these expenditures fall within the definition of "medical assistance" in the Medicaid statute. 42 U.S.C. § 1396a(a)(10)(E)(i) and 42 U.S.C. § 1396d(p)(3).

Bruton, 134 N.C. App. at 43-44, 516 S.E.2d at 636 (citations and marks omitted).

A. Conditioning of Medicaid Coverage on Medicare Coverage

¶ 12 In light of this statutory context, we must first address whether NCDHHS

improperly conditioned Medicaid coverage on Medicare coverage. The primary issue here is whether there is a meaningful distinction between approving Medicaid coverage after a delay due to the application of only 20% of the medical bills to a Medicaid deductible, on the grounds that Medicaid would cover only that amount if the eligible party had applied for Medicare coverage, and denying Medicaid coverage for a failure to enroll in Medicare, as prohibited by *Bruton*. *See id*. at 46, 516 S.E.2d at 638. NCDHHS contends it was not requiring Hendrixson to enroll in Medicare or making his enrollment a condition of qualifying for Medicaid, but was instead complying with state law by not spending money from Medicaid on services that Medicare would have covered. However, *Bruton* reveals this is a distinction without meaning.

¶ 13 At the outset, we note that, since the time *Bruton* was decided, federal law regarding Medicaid and Medicare has not meaningfully changed in relation to the issue before us. In *Bruton*, "the policy at issue [denied] Medicaid payments to recipients who [were] potentially eligible for Medicare, but who [had] failed to apply." *Id*. at 44, 516 S.E.2d at 637. The policy was described as follows: "Medicaid will deny claims for recipients age 65 and over who are entitled to Medicare benefits but fail to apply. You may bill the recipient for Medicare-covered services if he fails to apply for Medicare benefits." *Id*. at 40, 516 S.E.2d at 634. This policy was challenged by the petitioners and upheld by the Department's Division of Medical Assistance ("DMA").

Id. The petitioners sought judicial review of DMA's decision, and the Guilford County Superior Court reversed DMA's decision after determining that the policy was contrary to federal regulations and statutes and constituted an improperly promulgated rule under the North Carolina Administrative Procedure Act ("NCAPA"). *Id.* at 40-41, 516 S.E.2d at 634-35. DMA appealed this decision, and we concluded:

> [F]ederal law requires the state to bear [the burden of a Medicaid recipient's failure to take advantage of federal Medicare assistance]. A review of the pertinent statutes and regulations reveals that the DMA policy is contrary to federal law. In addition, we conclude that this policy constitutes an unpromulgated legislative rule such that enforcement amounts to an "unlawful procedure" under the NCAPA.

Id. at 46, 516 S.E.2d at 637. We also noted:

> Medicare is not a condition of eligibility for Medicaid under federal law:
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> > As a condition of eligibility, the agency must require applicants and recipients to take all necessary steps to obtain any annuities, pensions, retirement, and disability benefits to which they are entitled, unless they can show good cause for not doing so.
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> 42 C.F.R. § 435.608. Medicare is neither an annuity, pension, retirement, or disability benefit. No federal statute or regulation makes Medicare application a condition of Medicaid eligibility. As discussed below, [the] respondents admit that Medicare is not a condition of Medicaid eligibility, but maintain that federal and state law supports the DMA policy of denying payments under these circumstances.

Id. at 46, 516 S.E.2d at 638.

¶ 14 Additionally, we expressly rejected the contention that 42 U.S.C. § 1396b(b)(1), which denies federal funds to states for Medicaid expenditures when the recipient was not enrolled in Medicare Part B and Medicare Part B funds could have paid for the expenditures if the recipient was enrolled, "provides the state agency a basis to deny state Medicaid payments when otherwise eligible recipients have failed to previously enroll in Medicare." *Id.* at 47, 516 S.E.2d at 638 (relying on 42 C.F.R. § 431.526(d)'s interpretation of 42 U.S.C. § 1396b(b)(1) to come to this conclusion); *see* 42 U.S.C. § 1396b(b)(1) (2019) (stating Medicaid reimbursement "shall not take into account any amounts expended as medical assistance with respect to individuals aged 65 or over and disabled individuals entitled to hospital insurance benefits under subchapter XVIII of this chapter [Medicare Part A] which would not have been so expended if the individuals involved had been enrolled in the insurance program established by part B of subchapter XVIII of this chapter"). Specifically, we stated:

> Far from providing state agencies a ground to *deny* Medicaid payments, this statute was intended to effectively *require* states to enroll dual eligibles in Medicare part B in order to receive matching funds for part A. . . .
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> . . . .
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> Finally, no other statute or regulation specifically directs or authorizes the state agency to deny Medicaid coverage on the grounds that the recipient is potentially eligible for

Medicare.

Bruton, 134 N.C. App. at 47-48, 516 S.E.2d at 638-39.

¶ 15 Here, NCDHHS delayed, and effectively denied, full Medicaid coverage on the basis of Hendrixson's failure to enroll in Medicare Part B and instead applied 20% of Hendrixson's medical fees, representing the amount that Medicaid would cover if Hendrixson would have been enrolled in Medicare Part B, to his Medicaid deductible. By delaying the moment that Medicaid coverage would activate on the basis of Hendrixson's failure to enroll in Medicare Part B, NCDHHS has avoided payment of medical fees it would otherwise be obligated to pay under Medicaid.

¶ 16 Considering the binding principles from *Bruton*, we reject NCDHHS's contention that this case is distinguishable from *Bruton*. The situation in *Bruton* was essentially the same as Hendrixson's situation—both concern the refusal to provide Medicaid payments for costs that would be covered by Medicare Part B to individuals who could have filed for Medicare Part B coverage but failed to do so. Although in *Bruton* the denial of coverage was complete, the partial denial of coverage here still falls under the same analysis as *Bruton*. The Superior Court correctly concluded the policy of NCDHHS was in violation of federal law under *Bruton*; and, like in *Bruton*, we conclude NCDHHS's "policy of denying Medicaid coverage for hospital inpatient services because recipients have not applied for Medicare is contrary to federal law." *Id.* at 51, 516 S.E.2d at 640.

B. Retroactive Coverage and N.C.G.S. § 108A-55.1

¶ 17 One potential basis for NCDHHS's actions that was not addressed in *Bruton* is N.C.G.S. § 108A-55.1, which was enacted in 2003, after *Bruton* was decided. *See* 2003 S.L. 284 § 10.27. NCDHHS contends N.C.G.S. § 108A-55.1 permits it to refuse to provide coverage for Medicare Part B expenditures. Hendrixson, meanwhile, contends the actual issue is whether federal law requires extension of full Medicaid coverage despite the provisions of N.C.G.S. § 108A-55.1, which he contends are inapplicable here.

¶ 18 We "review matters of statutory interpretation de novo." *JVC Enters., LLC v. City of Concord*, 376 N.C. 782, 2021-NCSC-14, ¶ 8.

> Legislative intent controls the meaning of a statute. The intent of the General Assembly may be found first from the plain language of the statute, then from the legislative history, the spirit of the act and what the act seeks to accomplish. If the language of a statute is clear, the court must implement the statute according to the plain meaning of its terms so long as it is reasonable to do so.

Midrex Techs., Inc. v. N.C. Dep't of Revenue, 369 N.C. 250, 258, 794 S.E.2d 785, 792 (2016) (citations and marks omitted).

¶ 19 N.C.G.S. § 108A-55.1 reads:

> The Department shall require State Medical Assistance Program recipients who qualify for Medicare to enroll in Medicare, in accordance with Title XIX of the Social Security Act, in order to pay medical expenditures that qualify for payment under Medicare Parts B and D, except

> that enrollment in Part D is not required if the recipient has creditable prescription drug coverage as defined by federal law.
>
> *Failure to enroll in Medicare shall result in nonpayment of these expenditures under the State Medical Assistance Program.* A provider may seek payment for services from Medicaid enrollees who are eligible for but not enrolled in Medicare Parts B and D.

N.C.G.S. § 108A-55.1 (2019) (emphasis added).

¶ 20 A plain reading of this statute reflects that N.C.G.S. § 108A-55.1 only permits NCDHHS to deny Medicaid payments for medical expenditures that would qualify for Medicare Part B coverage but for the beneficiary's failure to enroll in Medicare Part B.[6] *Id.* The statute makes no reference to the determination of when Medicaid deductibles are met as it relates to this situation, and a plain reading of the statute does not permit us to apply N.C.G.S. § 108A-55.1 to the calculation of when Medicaid deductibles are met. This interpretation is buttressed by federal Medicaid provisions that require the State to make Medicaid payments for medical expenses directly to the healthcare provider, which, in conjunction with N.C.G.S. § 108A-55.1's use of "payment[s]," suggests the statute is focused on who healthcare providers can seek payments from. *See* 42 C.F.R. § 430.0 (2020) ("Payments for services are made

[6] We note that while it is possible N.C.G.S. § 108A-55.1 is unconstitutional under the federal statutes and regulations, especially in light of *Bruton's* interpretation of federal law, the issue is not before us as NCDHHS did not actually limit Medicaid coverage after Hendrixson's deductible was met.

directly by the State to the individuals or entities that furnish the services."); N.C.G.S. § 108A-55.1 (2019). We conclude that N.C.G.S. § 108A-55.1 is not intended to apply to the determination of when a Medicaid deductible has been met.[7]

¶ 21 Additionally, N.C.G.S. § 108A-55.1 states the Department "shall" require Medicaid recipients to enroll in Medicare. N.C.G.S. § 108A-55.1 (2019). It is well established that "[o]rdinarily, the word 'must' and the word 'shall,' in a statute, are deemed to indicate a legislative intent to make the provision of the statute mandatory." *State v. Watson*, 258 N.C. App. 347, 354, 812 S.E.2d 392, 397, *appeal dismissed*, 371 N.C. 340, 813 S.E.2d 852 (2018). In light of this principle, the plain language of N.C.G.S. § 108A-55.1 mandates that the Department has an obligation

[7] Even if N.C.G.S. § 108A-55.1 were ambiguous, requiring statutory construction, we would come to the same conclusion. *See Wayne Cty. Citizens Ass'n v. Wayne Cty. Bd. Of Comm'rs*, 328 N.C. 24, 29, 399 S.E.2d 311, 315 (1991) ("Where a statute is susceptible of two interpretations, one of which is constitutional and the other not, the courts will adopt the former and reject the latter."). If N.C.G.S. § 108A-55.1 were ambiguous and could potentially permit NCDHHS to delay when a Medicaid deductible was met based on the failure to enroll in Medicare, it would be unconstitutional because it would conflict with federal law, as interpreted by *Bruton*, by conditioning Medicaid coverage on Medicare enrollment. *See Bruton*, 134 N.C. App at 46-48, 516 S.E.2d at 637-39 ("[F]ederal law requires the state to bear [the burden of a Medicaid recipient's failure to take advantage of federal Medicare assistance]. . . . Medicare is not a condition of eligibility for Medicaid under federal law[.] . . . Finally, no other statute or regulation specifically directs or authorizes the state agency to deny Medicaid coverage on the grounds that the recipient is potentially eligible for Medicare."). As a result, even assuming N.C.G.S. § 108A-55.1 were ambiguous, we would not construe N.C.G.S. § 108A-55.1 to permit NCDHHS's actions here.

to require any Medicaid "recipients" to enroll in Medicare.[8] *See* N.C.G.S. § 108A-55.1 (2019); *Bruton*, 134 N.C. App. at 45-46, 47, 516 S.E.2d at 637, 638 ("The underlying issue is whether the state or the health care provider should bear the burden of a Medicaid recipient's failure to take advantage of federal Medicare assistance. We conclude that federal law requires the state to bear this burden. . . . Far from providing state agencies a ground to *deny* Medicaid payments, [42 U.S.C. § 1396b(b)(1)] was intended to effectively *require* states to enroll dual eligibles in Medicare part B in order to receive matching funds for part A.").[9] Such an enrollment cannot occur for retroactive charges, as a Medicaid applicant would become a Medicaid "recipient" only upon being approved for Medicaid coverage. Additionally,

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[8] We note that the Record here does not reflect any indication that the Department attempted to enroll Hendrixson or requested he enroll in Medicare Part B, and instead reflects only that Hendrixson had previously declined to enroll in Medicare Part B.

[9] We also note that federal statutes and regulations seem to contemplate states enrolling those eligible for Medicaid in Medicare Part B. *See* 42 U.S.C. § 1395v(a) (2019) ("The Secretary shall, at the request of a State . . . enter into an agreement with such State pursuant to which all eligible individuals in either of the coverage groups described in subsection (b) of this section (as specified in the agreement) will be enrolled under the program established by this part[, Medicare Part B]."); 42 C.F.R. § 431.625(a)(1) (2020) ("[42 U.S.C. § 1395v] of the Act requires the Secretary to have entered into an agreement with any State that requested that agreement before [1 January 1970], or during calendar year 1981, under which the State could enroll certain Medicare-eligible beneficiaries under Medicare Part B and agree to pay their premiums."). We further note that the coverage groups in 42 U.S.C. § 1395v(b) have been expanded to include "individuals who are eligible to receive medical assistance under the plan of such State approved under subchapter XIX[, Medicaid] . . . ." 42 U.S.C. § 1395v(h)(1) (2019). In conjunction, the federal laws seem to permit states to enroll individuals eligible for Medicaid in Medicare Part B if states include it in their state plan for medical assistance.

enrollment in Medicare Part B, at least for late enrollment, is ordinarily only prospective and limited to specific timeframes. *See* 42 U.S.C. § 1395p-1395q (2019) (requiring enrollment that provides prospective coverage during: (1) the initial enrollment period spanning the 3 months prior to the month someone turns 65 years old to the 3 months after the month someone turns 65 years old, (2) the general enrollment period spanning 1 January to 31 March of each year, or (3) the special enrollment periods for those who are working aged, working disabled, or international volunteers; and allowing special enrollment and potentially retroactive Medicare Part B coverage where there is an unintended nonenrollment due to misinformation from a federal source). As a result, it will typically be impossible for the Department to require Medicaid recipients to enroll in Medicare Part B for past medical expenditures. On this basis, we conclude the General Assembly did not intend for N.C.G.S. § 108A-55.1 to apply to retroactive Medicaid coverage.

¶ 22 The availability of federal reimbursement for retroactive Medicaid coverage bolsters this conclusion. NCDHHS contends N.C.G.S. § 108A-55.1 was enacted in 2003 to "prevent a situation where a dual eligible Medicaid beneficiary would insist that [NCDHHS] pay medical expenses that would not be reimbursed [by the federal government] . . . ." However, even assuming this legislative intent is correct, the applicable federal statutes and regulations permit federal reimbursement for retroactive payments made under Medicaid. *See* 42 U.S.C. § 1396b(b)(1) (2019); 42

C.F.R. § 431.625(d)(3) (2020). 42 U.S.C. § 1396b(b)(1) states:

> [T]he amount [of FFP] determined under subsection (a)(1) of this section for any State for any quarter beginning after [31 December 1969], shall not take into account any amounts expended as medical assistance with respect to individuals aged 65 or over and disabled individuals entitled to hospital insurance benefits under [Medicare] which would not have been so expended if the individuals involved had been enrolled in the insurance program established by part B of [Medicare], other than amounts expended under provisions of the plan of such State required by section 1396a(a)(34) of this title.

42 U.S.C. § 1396b(b)(1) (2019). In turn, 42 U.S.C. § 1396a(a)(34) states:

> [I]n the case of any individual who has been determined to be eligible for medical assistance under the plan, such assistance will be made available to him for care and services included under the plan and furnished in or after the third month before the month in which he made application (or application was made on his behalf in the case of a deceased individual) for such assistance if such individual was (or upon application would have been) eligible for such assistance at the time such care and services were furnished[.]

42 U.S.C. § 1396a(a)(34) (2019). Read together, these statutes permit federal reimbursement for Medicaid payments expended to provide retroactive coverage. *See* 42 U.S.C. § 1396b(b)(1) (2019); 42 U.S.C. § 1396a(a)(34) (2019). Federal regulations reaffirm this approach. *See* 42 C.F.R. § 431.625(d)(3) (2020) ("No FFP is available in State Medicaid expenditures that could have been paid for under Medicare Part B but were not because the person was not enrolled in Part B. . . . However, FFP is

available in expenditures required by [42 C.F.R. §§ 435.914, redesignated as 435.915], and 436.901 [] for retroactive coverage of beneficiaries.");[10] 42 C.F.R. § 435.915 (2020) ("The agency must make eligibility for Medicaid effective no later than the third month before the month of application if the individual—(1) Received Medicaid services, at any time during that period, of a type covered under the plan; and (2) Would have been eligible for Medicaid at the time he received the services if he had applied (or someone had applied for him), regardless of whether the individual is alive when application for Medicaid is made."). As a result, even assuming NCDHHS has accurately stated the legislative intent behind N.C.G.S. § 108A-55.1, the availability of federal reimbursement for retroactive coverage of Medicaid expenditures supports our conclusion that the General Assembly did not intend for N.C.G.S. § 108A-55.1 to apply to retroactive Medicaid coverage.

¶ 23 In light of the foregoing analysis, we conclude that N.C.G.S. § 108A-55.1 does not apply to the determination of when a Medicaid deductible has been met and does not apply to retroactive Medicaid coverage. For this reason, the Superior Court

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[10] Although 42 C.F.R. § 431.625(d)(3) refers to 42 C.F.R. § 435.914, the regulation in 42 C.F.R. § 435.914 at the time of 42 C.F.R. § 431.625's passage was relocated to 42 C.F.R. § 435.915, and it appears 42 C.F.R. § 431.625 was mistakenly not updated. *See* Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010, 77 Fed. Reg. 17,182 (23 March 2012). This being an unintentional error is solidified by the content of 42 C.F.R. § 435.914, as of 23 March 2012, being entirely unrelated to retroactive coverage despite 42 C.F.R. § 431.625's reference to retroactive coverage. *See* 42 C.F.R. § 431.625(d)(3) (2020) (emphasis added) ("However, FFP is available in expenditures required by [42 C.F.R. §§ 435.914, redesignated as 435.915], and 436.901 [] *for retroactive coverage of beneficiaries*.").

properly concluded that N.C.G.S. § 108A-55.1 is inapplicable here. N.C.G.S. § 108A-55.1 does not provide a basis for NCDHHS to have considered only 20% of Hendrixson's medical expenses when determining when his Medicaid deductible was met.

C. Constitutionality of N.C.G.S. § 108A-55.1

¶ 24 Although the parties also discuss the constitutionality of N.C.G.S. § 108A-55.1, our conclusion that N.C.G.S. § 108A-55.1 does not apply to deductibles or retroactive Medicaid coverage or permit NCDHHS to have limited the amount of medical expenses applied to Hendrixson's deductible prohibits us from reaching the constitutionality of N.C.G.S. § 108A-55.1. *See Anderson v. Assimos*, 356 N.C. 415, 416, 572 S.E.2d 101, 102 (2002) ("[T]he courts of this State will avoid constitutional questions, even if properly presented, where a case may be resolved on other grounds.").

¶ 25 However, to resolve the misconceptions contained within the argument, we address NCDHHS's argument that 42 C.F.R. § 431.625(b) "frees a state from its usual obligation to pay all of a Medicaid beneficiary's medical expenses [where dual eligibles are concerned]" and that N.C.G.S. § 108A-55.1 is appropriate under this federal regulation. The title of 42 C.F.R. § 431.625 is "Coordination of Medicaid with Medicare part B." 42 C.F.R. § 431.625 (2020). This regulation's stated purpose is to "(i) Specif[y] the exception, relating to Part B coverage, from the requirement to

provide comparable services to all beneficiaries; and (ii) Prescribe[] FFP rules concerning State payment for Medicare premiums and for services that could have been covered under Medicare." 42 C.F.R. § 431.625(a)(4) (2020). Additionally, 42 C.F.R. § 431.625(b), which is titled "Exception from obligation to provide comparable services; State plan requirement," states "[t]he State's payment of premiums, deductibles, cost sharing, or similar charges under Part B does not obligate it to provide the full range of Part B services to beneficiaries not covered by Medicare." 42 C.F.R. § 431.625(b)(1) (2020). NCDHHS interprets 42 C.F.R. § 431.625(b) to permit states to refuse Medicaid payments for medical expenses that would have been covered by Medicare Part B if an eligible Medicaid beneficiary failed to enroll. However, the text and history of the regulation suggests otherwise.

¶ 26 NCDHHS reads 42 C.F.R. § 431.625(b) to permit providing less Medicaid coverage to those eligible for, but not enrolled in, Medicare Part B than those enrolled in Medicaid coverage but ineligible for Medicare Part B. Contrary to this interpretation, based on the language and title of the provision, we read 42 C.F.R. § 431.625(b) to permit states to provide differential Medicaid coverage to equally needy individuals if the coverage diverges by providing more coverage to those who are also enrolled in Medicare Part B and less coverage to those who are not enrolled in Medicare Part B. This interpretation is informed by Medicaid's requirement that states provide comparable services to those who are similarly needy. *See* 42 U.S.C. §

1396a(a)(10)(B) (2019) ("[M]edical assistance made available to any individual described in subparagraph (A) [i.e., the categorically needy]—(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual [i.e., any other categorically needy individual], and (ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A) [i.e., the medically needy.]"); 42 C.F.R. § 440.240(b) (2020) ("The plan must provide that the services available to any individual in the following groups are equal in amount, duration, and scope for all beneficiaries within the group: (1) The categorically needy. (2) A covered medically needy group.").

¶ 27 Additionally, 42 C.F.R. § 431.625 was formerly designated as 45 C.F.R. § 249.41, which was titled "Coordination of title XIX [Medicaid] with part B of title XVIII [Medicare], Social Security Act" and stated:

> *Comparability*. Payment made by a State of premiums under [Medicare part B], whether through a "buy-in" agreement or otherwise, or provision for meeting part or all of the cost of the deductibles, cost sharing, or similar charges under part B, does not impose an obligation on the State to make comparable services available to other [Medicaid] recipients (below age 65). This provision permits the States to enter into agreements to pay the premium charges under part B or to pay the deductibles and other charges under that program without obligating themselves to provide the range of part B benefits to other individuals who are under [Medicaid].

45 C.F.R. § 249.41(b) (1970); 34 Fed. Reg. 1324 (28 Jan. 1969). Although this language has changed as Medicaid and Medicare have changed, the earlier iteration of the rule helps inform the legislative intent behind the regulation because of its inclusion of "below age 65."[11] *Id.* This additional context makes clear that the regulation is intended to create an exception from the requirement to provide equal coverage by allowing differential coverage where additional Medicare Part B coverage is available, through Medicaid's payment of the cost-sharing requirements of Medicare Part B, to dual eligibles, but not available to those who are ineligible for Medicare Part B. In this case, it confirms that the regulation is intended to ensure that states are not obligated by the comparability requirement to provide the services it provides to those enrolled in Medicare Part B to those who are not eligible for such service due to their lack of access to Medicare Part B. *See* 42 U.S.C. § 1396a(a)(10)(B)

[11] We note that at the time this was implemented, Medicare was available only to those 65 years old or older. *See* Social Security Amendments of 1965, Pub. L. No. 89-97, § 102(a), 79 Stat. 286, 291 (noting that the program "provides basic protection against the costs of hospital and related post-hospital services in accordance with this part for individuals who are age 65 or over and are entitled to retirement benefits under title II of this Act or under the railroad retirement system"). The language specifying "below age 65" was removed when Medicare was changed to apply to other groups as well. *See* Social Security Amendments of 1972, Pub. L. No. 92-603, § 201(a)(2), 86 Stat. 1329, 1371 (noting that the program "provides basic protection against the costs of hospital and related posthospital services in accordance with this part for (1) individuals who are age 65 or over and are entitled to retirement benefits under title II of this Act or under the railroad retirement system and (2) individuals under age 65 who have been entitled for not less than 24 consecutive months to benefits under title II of this Act or under the railroad retirement system on the basis of a disability"); 39 Fed. Reg. 16,972 (10 May 1974).

(2019); 42 C.F.R. § 440.240(b) (2020).

¶ 28 We conclude that 42 C.F.R. § 431.625(b) does not permit states to limit Medicaid coverage for those who are eligible for, but not enrolled in, Medicare Part B as compared to those who are only eligible for, and enrolled in, Medicaid. As a result, 42 C.F.R. § 431.625(b) would not permit N.C.G.S. § 108A-55.1 to function in the manner suggested by NCDHHS. Further, like in *Bruton*, "no other statute or regulation specifically directs or authorizes the state agency to deny Medicaid coverage on the grounds that the recipient is potentially eligible for Medicare." *Bruton*, 134 N.C. App. at 48, 516 S.E.2d at 639. Similarly, there are no statutes or regulations that permit discounting medical expenses that could have been covered under Medicare Part B if the Medicaid beneficiary was enrolled when determining that a Medicaid deductible has been met.

D. The Manual Directives

¶ 29 The only remaining basis for NCDHHS's actions is the Manual directives. The Superior Court concluded the provisions that purported to authorize NCDHHS's actions here were unpromulgated NCAPA rules, and that "[b]ecause the [] Manual provisions relied upon by the Department are unpromulgated and are contrary to applicable law and regulations, they cannot be enforced against [Hendrixson] so as to withhold any coverage for which he is eligible under the State Plan." NCDHHS has not challenged this conclusion directly, and instead has only argued that applicable

statutes and regulations permitted the actions taken by NCDHHS.

¶ 30 If we had agreed with NCDHHS's arguments, it would render moot the unpromulgated rules issue since there would be a statutory or regulatory basis for its actions. However, in light of our holding that there is no federal or state law that permitted NCDHHS to consider only 20% of Hendrixson's medical expenses in determining when his deductible was met, the unpromulgated rules issue is not moot. Nonetheless, we need not analyze whether the Manual directives at issue here are unpromulgated rules, as NCDHHS has not challenged this conclusion on appeal, and has therefore abandoned the issue. *See* N.C. R. App. P. 28(a) (2021) ("The scope of review on appeal is limited to issues so presented in the several briefs. Issues not presented and discussed in a party's brief are deemed abandoned."). As a result, "there is neither statutory nor regulatory authority for" NCDHHS's policy of limiting the medical expenses considered in reaching a Medicaid deductible and the policy "is an application of unpromulgated legislative rule[s] and amounts to an unlawful procedure, requiring that we affirm the judgment of the [S]uperior [C]ourt." *See Bruton*, 134 N.C. App. at 52, 516 S.E.2d at 641.

CONCLUSION

¶ 31 Considering the federal statutes and regulations, as well as *Bruton's* interpretation of federal law, there is no basis to conclude any federal law contemplated the approach that NCDHHS employed in determining whether

Hendrixson's Medicaid deductible was met and when his coverage began. The only potential state law basis for NCDHHS's actions here was N.C.G.S. § 108A-55.1, which does not permit NCDHHS's actions. As a result, NCDHHS's treatment of Hendrixson's Medicaid deductible was solely based on the Manual directives, which we treat as unpromulgated rules. Like in *Bruton*, we conclude that NCDHHS's actions in following the unpromulgated rules constitute an unlawful procedure, and we affirm the Superior Court's decision.

AFFIRMED.

Chief Judge STROUD and Judge GRIFFIN concur.

Report per Rule 30(e).