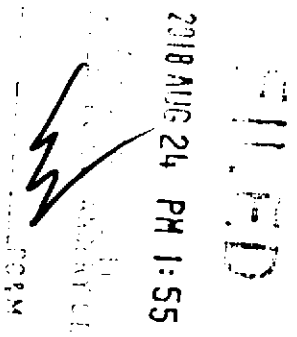
IN THE CHANCERY COURT FOR DAVIDSON COUNTY, TENNESSEE

The Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Health System,	)	
Plaintiff,	)	
v.	)	Case No. 18-926-IV
Division of TennCare, Department of Finance and Administration; Dr. Wendy Long, in her official capacity as Director of TennCare; and Larry B. Martin, in his official capacity as Commissioner of the Department of Finance and Administration.	)	
Defendants.	)	



COMPLAINT

Plaintiff, The Chattanooga-Hamilton County Hospital Authority d/b/a/ Erlanger Health System ("Erlanger"), for its complaint for declaratory judgment and injunction relief against Defendants Division of TennCare, Tennessee Department of Finance and Administration; Dr. Wendy Long, in her official capacity as Director of TennCare; and Larry B. Martin, in his official capacity as Commissioner of the Department of Finance and Administration (collectively, "TennCare" or the "Bureau") states:

Introduction

This complaint seeks declaratory and injunctive relief that certain amendments to Tennessee's state Medicaid plan violate the provisions of Tenn. Code Ann. § 71-5-108 (the "Statute") and are therefore invalid, unlawful, and unconstitutional. TennCare is purposefully siphoning money from hospitals who treat Tennessee's neediest citizens, in order to favor the insurance companies that TennCare employees routinely work for after leaving state government.

The Statute required the Bureau to amend the state plan to establish a payment methodology that would require TennCare Managed Care Organizations ("MCOs") to pay the *average in-network contract rate* to noncontract hospitals that provide emergency services to Medicaid enrollees. Bureau executives decided to ignore the Tennessee General Assembly's directive and instead acted to enrich insurance companies at the expense of Tennessee medical providers. The Bureau deliberately amended the state plan to adopt a static rate that approximated the *lowest in-network contract rate* at the time.

In a related case, *Chattanooga-Hamilton County Hospital Authority v. UnitedHealthcare Plan of the River Valley, Inc.*, 475 S.W.3d 746 (Tenn. 2015), the Tennessee Supreme Court held that Erlanger must exhaust administrative remedies before challenging TennCare rules in court, in accordance with Section 4-5-225(b) of the TUAPA. On April 19, 2017, Erlanger filed an administrative proceeding with the Bureau (the "TennCare Proceeding") seeking an order invalidating the two rules the Bureau promulgated to codify the rates it had set in the state plan amendments.

In the TennCare Proceeding, Erlanger filed an amended petition seeking also to invalidate the underlying state plan amendments, which plainly also violate the Statute. In response to the amended petition, the Bureau moved to dismiss Erlanger's petition seeking to invalidate the state plan amendments for lack of subject-matter jurisdiction, and the Bureau Commissioner's Designee (the "Designee") entered a final order dismissing the request for a declaratory order invalidating the state plan amendments for lack of jurisdiction. Thus, the Bureau has officially determined that it lacks jurisdiction to issue any declaratory order invalidating the state plan amendments.

Having officially taken the position that the state plan amendments in issue are not subject to review under the TUAPA, the Bureau has refused to issue a declaratory order invalidating those

state plan amendments. Additionally, Erlanger has exhausted its administrative remedies concerning the state plan amendments. *See* Tenn. Code Ann. § 4-5-223(a); *Pickard v. Tenn. Dep't of Env't & Conservation*, 2012 Tenn. App. LEXIS 565, at *23 (Tenn. Ct. App. Aug. 14, 2012).

Accordingly, Erlanger brings this action to invalidate the unlawful state plan amendments, a remedy that the Designee held is unavailable under Tenn. Code Ann. § 4-5-225(b). Moreover, Erlanger requests that the Court issue an order staying the TennCare Proceeding and expediting the trial of this matter. Resolving Erlanger's claims regarding the unlawful state plan amendments will greatly assist in the resolution of the TennCare Proceeding.

Jurisdiction and Venue

1. The Court has jurisdiction and venue over this matter pursuant to Tenn. Code Ann. §§ 4-5-255 and 1-3-121.

Facts

2. Erlanger is a nonprofit hospital system based in Hamilton County, Tennessee with its principal offices located at 975 East Third Street, Chattanooga, Tennessee 37043. Erlanger operates a tertiary referral hospital and Level I Trauma Center serving Southeast Tennessee, North Georgia, North Alabama, and Western North Carolina.

3. The Bureau is a government agency under the control of the Tennessee Department of Finance and Administration. The Bureau oversees Tennessee's Medicaid program, known as "TennCare." Dr. Wendy Long is the Director of TennCare, and Larry B. Martin is the Commissioner of the Tennessee Department of Finance and Administration. Erlanger adds Dr. Long and Mr. Martin as parties only in their official capacities.

The TennCare Program

4. Medicaid is a joint federal and state program that helps with medical costs for some people with limited income and resources. Tennessee operates the TennCare program as a managed care program, utilizing for-profit MCOs that assume the obligation to pay for the health care of their enrollees. The Bureau enters into risk agreements with each such MCO, under which the MCO receives a capitation payment for each enrollee and must assume the risk of paying for such enrollee's covered health care expenses. If the MCO pays less for its enrollees' health care than the amount it receives in capitation payments, the MCO stands to earn a profit. TennCare MCOs have earned billions of dollars in profits. For example, in 2017 alone UnitedHealthcare Plan of the River Valley, Inc. d/b/a AmeriChoice ("AmeriChoice") earned over $125 million in profit.

5. To control the cost of health care for their enrollees, MCOs negotiate contracts with hospitals and health care professionals to form networks of providers for enrollees to use for their health care needs. Under the TennCare program, rates paid to hospital providers are negotiated by contract and are not publicly released.

The Statute, Tenn. Code Ann. §71-5-108

6. In 2005, Congress enacted the Federal Deficit Reduction Act of 2005 (the "DRA"). The DRA established payment rates for hospitals that did not have a contract with an MCO, but provided emergency services to Medicaid beneficiaries pursuant to their obligations under the Emergency Medical Treatment and Labor Act ("EMTALA"), 42 U.S. Code § 1385dd. The DRA provided, in relevant part, as follows:

> Any provider of emergency services that does not have in effect a contract with a Medicaid managed care entity that establishes payment amounts for services furnished to a beneficiary enrolled in the entity's Medicaid managed care plan must accept as payment in full no more than the amounts (less any payments for indirect

> costs of medical education and direct costs of graduate medical education) that it could collect if the beneficiary received medical assistance under this subchapter other than through enrollment in such an entity. In a State where rates paid to hospitals under the State plan are negotiated by contract and not publicly released, the payment amount applicable under this subparagraph shall be the average contract rate that would apply under the State plan for general acute care hospitals or the average contract rate that would apply under such plan for tertiary hospitals.

42 U.S.C. § 1396u-2(b)(2)(D).

7. In response to the DRA, in 2007 the Tennessee General Assembly enacted Tenn. Code Ann. § 71-5-108 (the "Statute"), entitled "State plan amendment; payment methodology." This Statute provides as follows:

> The TennCare bureau is directed to submit a state plan amendment to the centers for Medicare and Medicaid services that sets out a payment methodology for Medicaid enrollees who are not also enrolled in Medicare, consistent with provisions in § 6085 of the federal Deficit Reduction Act of 2005 [the "DRA"], regarding emergency services furnished by noncontract providers for managed care enrollees. The payment amount shall be the average contract rate that would apply under the state plan for general acute care hospitals. A tiered grouping of hospitals by size or services may be utilized to administer these payments. The payment methodology developed pursuant to this section shall be budget neutral for the state fiscal year 2007-2008 when compared to the actual experience for emergency services furnished by non-contract providers for Medicaid managed care enrollees prior to January 1, 2007. It is the intent that this section only applies to the emergency services furnished by noncontract providers for Medicaid managed care enrollees.

Tenn. Code Ann. § 71-5-108 (emphasis added).

The Bureau Decides to Do Something Different

8. TennCare officials at the Bureau, many of whom now work for the very insurers they once regulated, disagreed with the Tennessee General Assembly's directive to pay out-of-network hospitals the average contract rate.

9. In the TennCare Proceeding, the Bureau's designee testified that the Agency understood that the General Assembly, in enacting the Statute, had directed the Bureau to amend

the state plan to include a payment methodology that would require MCOs to pay the average in-network contract rate to out-of-network hospitals that provide covered emergency services to enrollees: "Q: And you knew that the state DRA required out-of-network emergency care providers to receive the average contract rate, not the lowest rate, contract? . . . . A: I would assume so, yes." (K. Gaither Dep. 239:10-14.)

10. The Bureau's designee further testified that the Agency, nevertheless, decided to do something different: "Q: But you recognize, don't you, that the state DRA required something different, didn't it? A: It does." (K. Gaither Dep. 240:21-25.)

Bureau Secretly Opts for "Lowest-in-network Rates"

11. The Bureau's designee further testified that the Bureau decided to put in-place static rates based on a percentage of 2006 and 2008 Medicare rates for covered emergency services: "Q: And that static rate that TennCare chose to impose ensured that at most out-of-network providers of emergency care in Tennessee would receive the lowest contract rates paid to in-network providers for those same services, correct? A: Correct." (K. Gaither Dep. 242:14-19.)

12. The Bureau's intention and rationale for selecting these rates was that they approximated the lowest in-network rates paid in the State to hospital providers. Indeed, the Bureau specifically asked TennCare MCOs for their lowest in-network rates and used those rates exclusively to derive the rates that it would impose through the unlawful state plan amendments.

The 74% SPA

13. On January 18, 2008, the Bureau submitted state plan amendment 08-003 ("74% SPA") to the Centers for Medicare and Medicaid Services ("CMS") for its approval. Because Medicaid is a joint federal-state program, state plans must comply with both state and federal law. *See* 42 C.F.R. § 430.12 ("The plan must provide that it will be amended whenever necessary to

reflect . . . [m]aterial changes in State law, organization, or policy, in the State's operation of the Medicaid program.") In reviewing a proposed state plan amendment, CMS does not consider whether the amendment complies with state law. Instead, according to sworn testimony filed by the Deputy Director of CMS in another lawsuit: "In reviewing state plan amendments, [CMS] normally considers it to be the responsibility of the state to ensure that expenditures proposed in a state plan amendment will comply with state law." *See* Decl. of Timothy B. Hill, filed in *Berger v. Burwell*, No. 5:17-cv-00025-FL, Doc. 10-2 ¶¶ 4, 6 (E.D.N.C. Jan. 16, 2017) (attached hereto as **Exhibit 1**). CMS approved the 74% SPA with an effective date of February 1, 2008.

14. The Bureau did not follow the requirements of the Tennessee Uniform Administrative Procedure Act ("TUAPA"), Tenn. Code Ann. §4-5-101 *et seq.*, for agency rulemaking with respect to the 74% SPA.

15. The 74% SPA purported to establish the rate for out-of-network hospital providers of covered outpatient emergency services. It set a static rate at 74% of 2006 Medicare rates. This approximated the lowest in-network rates paid by TennCare MCOs at the time. Those static rates from 2006 are now much lower than the lowest in-network rates applicable today—over ten years later. Thus, in stark contradiction to both the letter and purpose of Statute to protect hospitals and medical providers, the Bureau's static rates have created a windfall for profit-driven MCOs on the backs of out-of-network hospitals like Erlanger that have no choice but to provide emergency care to Tennessee's neediest citizens.

16. The Bureau never brought to the attention of the Tennessee General Assembly that it had decided not to amend the state plan to require the payment of rates that approximated the average in-network contract rates for outpatient emergency services, but rather the lowest in-network contract rates.

The 57% SPA

17. In or about 2010, the Bureau set about to amend the state plan again to set an out-of-network rate for inpatient emergency services. The Bureau undertook this mission at the urging of Al King, the President of AmeriGroup, Tennessee, Inc., which was in the midst of a rate dispute with Hospital Corporation of America. Thus, yet again in defiance of the letter and purpose of the Statute to protect hospitals and medical providers, the Bureau unlawfully set lower static rates to benefit for-profit insurance companies at the expense of hospitals and medical providers across Tennessee.

18. The Bureau again solicited "lowest in-network rate" information from TennCare MCOs and used those numbers to set an out-of-network rate for inpatient emergency services: "Q: The aggregated information that [the Bureau] requested, was it average contract rates, or was it lowest contract rates? A: I believe it was lowest." (K. Gaither Dep. 42:23-43:1.)

19. On March 23, 2010, the Bureau submitted state plan amendment 10-003 (the "57% SPA") to CMS for its approval. CMS approved the 57% SPA with an effective date of March 17, 2010.

20. The Bureau did not follow the TUAPA requirements for agency rulemaking with respect to the 57% SPA.

21. The 57% SPA purports to establish the rate for out-of-network hospital providers of covered inpatient emergency services. It set a static rate at 57% of 2008 Medicare diagnostic related group rates. This approximated the lowest in-network rates paid by TennCare MCOs at the time. Those static rates from 2006 are now much lower than the lowest in-network rates applicable today—over ten years later.

22. The Bureau never brought to the attention of the Tennessee General Assembly that it had decided not to amend the state plan to require the payment of rates that approximated the average in-network contract rates for inpatient emergency services, but rather the lowest in-network contract rates.

23. The Bureau again acted contrary to the letter and purpose of the Statute in imposing the 57% SPA, which creates a windfall for-profit insurance companies and harms nonprofit hospitals like Erlanger that have no choice but to provide emergency care. The 57% SPA provides TennCare MCOs a profit incentive to delay transferring patients to in-network facilities.

The Tennessee Supreme Court Opinion

24. On June 29, 2009, Erlanger filed a lawsuit in Chancery Court against AmeriChoice, a TennCare MCO. Erlanger sought to recover "reasonable rates" for out-of-network emergency services it provided to AmeriChoice enrollees. During the pendency of that lawsuit, the Bureau promulgated two rules to codify the rates established by the 74% SPA and the 57% SPA. Those rules are Tenn. Comp. R & Regs. Ch. 1200-13-1308(2)(b) (the "74% Rule"), and Tenn. Comp. R & Regs. Ch. 1200-13-1308(2)(c) (the "57% Rule").

25. AmeriChoice invoked the 74% Rule and the 57% Rule as affirmative defenses. AmeriChoice argued that Erlanger's claim amounted to a challenge to these two rules that must first be presented to the Bureau under Tenn. Code Ann. §4-5-225(b).

26. Ultimately, the Tennessee Supreme Court held that, under Tenn. Code Ann. §4-5-225(b), Erlanger must exhaust its administrative remedies before challenging the 74% Rule and the 57% Rule in court. *See Chattanooga-Hamilton Cty. Hosp. Auth. v. UnitedHealthcare Plan of the River Valley, Inc.*, 475 SW.3d 746, 767 (Tenn. 2015).

The TennCare Proceeding

27. On April 19, 2017, Erlanger filed a petition before the Bureau seeking a declaratory order under Tenn. Code Ann. §4-5-225(b) that to the extent the 74% Rule and the 57% Rule establish the mandatory maximum payments to out-of-network hospitals that provide emergency services to TennCare enrollees, those rules violate the Statute and are invalid and unconstitutional. (Pet. for Decl. Order p. 5.)

28. During deposition discovery, it became apparent that the Bureau would take the position that the 74% SPA and the 57% SPA would still bind hospitals and MCOs even if Erlanger succeeds in invalidating the 74% Rule and the 57% Rule. Thus, Erlanger amended its petition in the TennCare Proceeding expressly to include the 74% SPA and the 57% SPA. (Am. Pet. for Decl. Order ¶ 1.)

29. In its answer to Erlanger's amended petition, the Bureau officially took the position that "[t]he validity or applicability of a TennCare State Plan Amendment is not subject to agency or court review through Tennessee's Uniform Administrative Procedure Act ("UAPA"), Tenn. Code Ann. §4-5-101 through -502." (Ans. to Am. Pet. for Decl. Order p. 4, ¶ 2.) The Bureau further answered: "No agency or court has subject matter jurisdiction to consider Petitioner's UAPA claims regarding TennCare's State Plan Amendments or to order the agency to amend its State Plan under Tenn. Code Ann. §4-5-223." (Ans. to Am. Pet. for Decl. Order p. 4, ¶ 2.)

30. The Bureau moved to dismiss Erlanger's petition seeking to invalidate the state plan amendments for lack of subject-matter jurisdiction. The Bureau argued that it lacked the authority to adjudicate Erlanger's petition because state plan amendments are not "rules" and are not subject to agency review under the TUAPA. The ALJ denied the Bureau's motion to dismiss for lack of subject-matter jurisdiction. The Bureau appealed to its Designee (who is actually just

a TennCare employee), who purported to reverse the ALJ and dismiss the claims regarding the SPAs for lack of subject-matter jurisdiction.

31. The Bureau thus either lacks subject matter to issue the requested declaration regarding the SPAs, or it has refused to do so. *See* Tenn. Code Ann. § 4-5-224(b) (authorizing a suit for declaratory judgment in chancery court where "the complainant has petitioned the agency for a declaratory order and the agency has refused to issue a declaratory order").

32. Erlanger has exhausted its administrative remedies with respect to the 74% SPA and the 57% SPA.

Count One
(Declaratory Relief – 74% SPA)

33. Erlanger incorporates the previous allegations, as if recopied herein.

34. The 74% SPA violates Tennessee law and is invalid. Specifically, the 74% SPA does not comply with the Statute, Tenn. Code Ann. § 71-5-108, which required the Bureau to amend the state plan to establish out-of-network rates for emergency hospital services that equal the average contract rates paid to in-network hospital providers, not the lowest rates paid to in-network hospital providers.

35. By failing to comply with the Statute, and instead amending the state plan with the 74% SPA, the Bureau acted outside the enabling legislation. By doing so, the Bureau acted unconstitutionally in violation of separation of powers. *See* Tenn. Const. Art. II, § 2 ("No person or persons belonging to one of these departments shall exercise any of the powers properly belonging to either of the others, except in the cases herein directed or permitted.").

WHEREFORE, Erlanger requests that the Court declare the 74% SPA is invalid, unenforceable, unlawful, and unconstitutional.

Count Two
(Declaratory Relief – 57% SPA)

36. Erlanger incorporates the previous allegations, as if recopied herein.

37. The 57% SPA violates Tennessee law and is invalid. Specifically, the 74% SPA does not comply with the Statute, Tenn. Code Ann. § 71-5-108, which required the Bureau to amend the state plan to establish out-of-network rates for emergency hospital services that equal the average contract rates paid to in-network hospital providers, not the lowest rates paid to in-network hospital providers.

38. By failing to comply with the Statute, and instead amending the state plan with the 57% SPA, the Bureau acted outside the enabling legislation. By doing so, the Bureau acted unconstitutionally in violation of separation of powers. *See* Tenn. Const. Art. II, § 2 ("No person or persons belonging to one of these departments shall exercise any of the powers properly belonging to either of the others, except in the cases herein directed or permitted.").

WHEREFORE, Erlanger requests the Court to declare that the 57% SPA is invalid, unenforceable, unlawful, and unconstitutional.

Count Three
(Injunctive Relief)

39. Erlanger incorporates the previous allegations, as if recopied herein.

40. Erlanger is an affected person who seeks injunctive relief in this action regarding the legality or constitutionality of a governmental action.

41. Erlanger seeks the following injunctive relief compelling the Bureau to comply fully and completely with the letter and spirit of the State DRA, which it willfully disobeyed in submitting the 74% SPA and the 57% SPA:

A. That the Court order the Defendants to withdraw and replace the 74% SPA with a state plan amendment that establishes a rate to be paid to out-of-network hospitals that provide out-patient emergency services to TennCare enrollees, and ordering that the rate shall be equal to the average contract rate paid by TennCare MCOs to in-network hospitals each year for such services; and

B. That the Court order the Defendants to withdraw and replace the 57% SPA with a state plan amendment that establishes a rate to be paid to out-of-network hospitals that provide in-patient emergency services to TennCare enrollees, and ordering that the rate shall be equal to the average contract rate paid by TennCare MCOs to in-network hospitals each year for such services.

Erlanger also asks that this petition be considered a related matter and consolidated with Erlanger's Petition for Review of Order of TennCare Designee Dismissing Claims in Contested Case for a Declaratory Order filed on August 24, 2018, with this Court.

Respectfully submitted,

Steven A. Riley (No. 6258)
Gregory S. Reynolds (No. 18204)
James N. Bowen (No. 24082)
Keane Barger (No. 33196)
RILEY WARNOCK & JACOBSON, PLC
1906 West End Avenue
Nashville, Tennessee 37203
(615) 320-3700
(615) 320-3737 (fax)
sriley@rwjplc.com
greynolds@rwjplc.com
jimbowen@rwjplc.com
kbarger@rwjplc.com

Attorneys for Plaintiff

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NORTH CAROLINA
WESTERN DIVISION

Civil Action No. 5:17-cv-00025-FL

PHIL BERGER and TIM MOORE,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	**DECLARATION OF TIMOTHY B. HILL**
	)	
SYLVIA MATHEWS BURWELL, in her official capacity as Secretary of Health and Human Services, *et al.*,	)	
	)	
Defendants.	)	
	)	

DECLARATION OF TIMOTHY B. HILL

I, Timothy B. Hill, declare as follows:

1. I am Timothy B. Hill, Deputy Director for the Center for Medicaid and CHIP Services (CMCS) within the Centers for Medicare and Medicaid Services (CMS) at the U.S. Department of Health and Human Services. As Deputy Director of CMCS, I lead activities related to national Medicaid policy and operations and I work with states in the implementation of their Medicaid programs, including review and approval of Medicaid state plan amendments.

2. The Affordable Care Act (ACA) allows states to provide Medicaid coverage to all adults with incomes up to 133 percent of the federal poverty level. This is commonly referred to as Medicaid expansion. The state of North Carolina has not previously submitted a state plan amendment to CMS to expand its Medicaid program under the ACA. In recent weeks, CMS has been involved in conversations with representatives of the Governor of North Carolina, and I understand from those conversations that the state is preparing to submit a state plan amendment that proposes to expand the state's Medicaid program.

3. It is my understanding that the state of North Carolina seeks to submit its state plan amendment to expand Medicaid coverage and that their planned future effective date is January 1, 2018. Our conversations with representatives of the Governor of North Carolina have not depended upon, and have not resolved, how North Carolina ultimately may authorize or finance the state share of expenditures of this proposed Medicaid expansion. Consistent with CMS's usual approach involving state plan amendments, it is not uncommon for the agency to approve a state plan amendment and for the state thereafter to seek authorization or otherwise obtain approval from the state legislature for specific budgetary authority for certain state Medicaid expenditures. Moreover, in the case of North Carolina, if CMS were to approve a state plan amendment and the state legislature did not subsequently enact legislation authorizing changes in the state Medicaid program, the state could submit an additional state plan amendment ending the authority for expansion. In the case of North Carolina, this would have the practical effect of

the state not expanding its Medicaid program under the ACA.

4. The Medicaid statute, 42 U.S.C. § 1396a(b), specifies that the Secretary of Health and Human Services "shall approve" any state plan amendment that fulfills the conditions specified in subsection (a) of that statutory provision unless a state plan amendment imposes certain restrictive age requirements, restrictive residency requirements, or restrictive citizenship requirements. There is no requirement in 42 U.S.C. § 1396a(b) that allows the Secretary to deny a state plan amendment because the state may need to enact further legislation or seek additional budgetary approvals, or otherwise seek authority from other state actors under state law. Indeed, absent explicit authority allowing her to disapprove a state plan amendment, the Medicaid statute provides the Secretary "shall approve" any state plan amendment that fulfills the requirements of 42 U.S.C. § 1396a(a). CMS, in the course of reviewing state plan amendments, does not require particular state approvals before approving federal matching payments of a state's non-federal share of Medicaid expenditures. In reviewing state plan amendments, the agency normally considers it to be the responsibility of the state to ensure that expenditures proposed in a state plan amendment will comply with state law.

5. Even if North Carolina seeks to expand Medicaid coverage under an approved state plan amendment and later rescinds such coverage through a subsequent state plan amendment, CMS would not impose a financial penalty and there would be no reduction to the federal matching dollar rates otherwise available to North Carolina for its Medicaid program. In the case of North Carolina, upon federal approval of its proposed Medicaid expansion state plan amendment, the state could receive 94 percent federal matching dollars for costs associated with medical assistance for its newly-eligible adult beneficiaries starting January 1, 2018, and at the statutorily prescribed rate after that time.

6. The Medicaid statute obligates the Secretary to pay a state the federal matching percentage for amounts that are expended in accordance with an approved state plan. But there is no federal authority to recoup or deny federal funding for medical assistance that were approved and are expended consistent with federal law, regardless of questions that arise with respect to state law, either before or after the submission of a state plan amendment. This is the case whether the state withdraws its state plan amendment before it is approved, or if the state submits a new state plan amendment in response to legislative developments or if a state court orders North Carolina to submit a new state plan amendment. With respect to Medicaid expansion, a state can choose whether and when to expand, and, if a state covers the expansion group, it may decide later to drop such coverage by state plan amendment.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: January 16, 2017
Baltimore, Maryland

Timothy B. Hill
Deputy Director, CMCS, CMS