STATE OF MINNESOTA
IN COURT OF APPEALS
A13-1717

Sekou Bamba,
Appellant,

vs.

Minnesota Department of Human Services, et al.,
Respondents.

Filed May 5, 2014
Affirmed
Schellhas, Judge

Ramsey County District Court
File No. 62-CV-13-1340

Jennifer Linder Wright, Alexander Saumer (certified student attorney), University of St. Thomas Legal Services Clinic, Minneapolis, Minnesota (for appellant)

Lori Swanson, Attorney General, Patricia A. Sonnenberg, Assistant Attorney General, St. Paul, Minnesota (for respondents)

Considered and decided by Schellhas, Presiding Judge; Cleary, Chief Judge; and Klaphake, Judge.*

U N P U B L I S H E D O P I N I O N

SCHELLHAS, Judge

Appellant challenges the district court's denial of his appeal from respondent's order denying payment for appellant's long-term care. We affirm.

* Retired judge of the Minnesota Court of Appeals, serving by appointment pursuant to Minn. Const. art. VI, § 10.

FACTS

Appellant Sekou Bamba is a 74-year-old man who came to the United States from Liberia in 2010 and suffered a stroke in December 2010. North Memorial Hospital treated Bamba and facilitated his admission, on January 12, 2011, to Benedictine Health Center at Innsbruck (Benedictine) for long-term care. Minnesota's Medicaid Emergency Medical Assistance (EMA) program paid for Bamba's care at Benedictine from January 2011 until January 8, 2012. But, in January 2012, respondent Minnesota Department of Human Services (DHS) notified Bamba and Benedictine that payment for his care at Benedictine would be terminated due to legislative amendments to the EMA statute in 2011, and DHS thereafter denied Benedictine's "Limited Exception Request" for EMA coverage.[1] Bamba appealed, and a human-services judge (HSJ) conducted a "fair

[1] The 2011 legislative amendments precipitated threats of a lawsuit by advocates for EMA recipients, and DHS therefore entered into a settlement that allowed EMA recipients to submit to DHS an "Emergency Medical Assistance−Care Plan Certification Request" form (CPC request), completed by their physicians. The CPC request required an EMA recipient's physician to

> [e]xplain how the treatment, services provided in the nursing home . . . and/or medications prescribed address the recipient's diagnoses, medical condition, symptoms or other circumstances and how they are directly responsible for preventing a medical emergency from immediately arising. Specifically, describe how the treatment, services, and/or medications are of such a nature that if discontinued, the recipient's condition would deteriorate so rapidly that the absence of immediate medical attention would reasonably be expected to result in quickly placing the recipient's health (typically within 48 hours), in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

hearing" under Minn. Stat. § 256.045, subd. 3 (2012); found that Bamba is not a United States citizen; concluded that the long-term-care services provided to Bamba are not covered by EMA; and recommended affirmance of DHS's decision to deny EMA. The Minnesota Commissioner of Human Services adopted the HSJ's recommendation, and Bamba appealed to the district court. The district court affirmed the commissioner's decision.

This appeal follows.

D E C I S I O N

Bamba argues that the commissioner's denial of EMA (1) is an error of law because DHS did not obtain approval from the federal government for a Medicaid state plan amendment before terminating his EMA coverage and (2) is not supported by substantial evidence in the record. This court may reverse or modify the agency's decision if the agency's findings, inferences, conclusions, or decisions are affected by an error of law or unsupported by substantial evidence in view of the entire record as submitted. Minn. Stat. § 14.69(d)−(e) (2012). "On appeal from the district court's appellate review of an administrative agency's decision, this court does not defer to the district court's review, but instead independently examines the agency's record and determines the propriety of the agency's decision." *Johnson v. Minn. Dep't of Human Servs.*, 565 N.W.2d 453, 457 (Minn. App. 1997). The party challenging an agency decision bears the burden of proving that one of the grounds listed in section 14.69 entitles him to relief on appeal. *Estate of Atkinson v. Minn. Dep't of Human Servs.*, 564 N.W.2d 209, 213 (Minn. 1997).

Commissioner's Application of 2011 Legislative Amendments

Bamba argues that DHS erred at law by implementing 2011 legislative amendments to Minn. Stat. §§ 256B.01–.84 (2010) without first submitting a state Medicaid plan amendment (SPA) to the federal Centers for Medicare & Medicaid Services (CMS). CMS is the federal agency that administers the Medicaid program. *Shagalow v. State, Dep't of Human Servs.*, 725 N.W.2d 380, 385 (Minn. App. 2006), *review denied* (Minn. Feb. 28, 2007). Federal law requires states to submit an SPA to CMS when "[m]aterial changes in State law, organization, or policy, or in the State's operation of the Medicaid program" occur. 42 C.F.R. § 430.12(c)(1)(ii) (2014).[2]

"'[D]ecisions of administrative agencies enjoy a presumption of correctness, and deference should be shown by courts to the agencies' expertise and their special knowledge in the field of their technical training, education, and experience.'" *In re Request for Issuance of SDS General Permit MNG300000*, 769 N.W.2d 312, 317 (Minn. App. 2009) (quoting *Reserve Mining Co. v. Herbst*, 256 N.W.2d 808, 824 (Minn. 1977)). "The rationale for deference to administrative agency decisions is rooted in the separation-of-powers doctrine and the agency's training and expertise in the subject matter." *Id.* "But an appellate court need not defer to an agency's interpretation of its own regulation when the regulation's language is clear and understandable." *Id.* (citing *Resident v. Noot*, 305 N.W.2d 311, 312 (Minn. 1981)).

[2] We cite the most recent version of the statutes and regulations in this opinion because they have not been amended in relevant part. *See Interstate Power Co. v. Nobles Cnty. Bd. of Comm'rs*, 617 N.W.2d 566, 575 (Minn. 2000) (stating that, generally, "appellate courts apply the law as it exists at the time they rule on a case").

> The supreme court has summarized the approach to judicial review of agency decisions concerning regulations as follows: (1) "when a decision turns on the meaning of . . . an agency's own regulation, it is a question of law that [appellate courts] review de novo"; (2) "when the language of the regulation is clear and capable of understanding, [an appellate court] give[s] no deference to the agency's interpretation and . . . may substitute [its] . . . judgment for that of the agency"; and (3) "when the relevant language of the regulation is unclear or susceptible to different reasonable interpretations, . . . [an appellate court] will give deference to the agency's interpretation and will generally uphold that interpretation if it is reasonable."

Id. (quoting *In re Annandale NPDES/SDS Permit Issuance*, 731 N.W.2d 502, 515 (Minn. 2007)). "[W]hen determining whether to defer to an agency, we will consider that agency's expertise and special knowledge." *Id.* (quotation omitted). "When an agency's decision relies on application of the agency's technical knowledge and expertise to the facts presented, deference should be afforded to the agency's decision." *Id.* (citing *In re Review of 2005 Annual Automatic Adjustment of Charges for All Elec. & Gas Utils.*, 768 N.W.2d 112, 119 (Minn. 2009)).

> [D]eference to an agency's interpretation of a statute is appropriate particularly when the administrative practice at stake involves a contemporaneous construction of a statute by the people charged with the responsibility of setting its machinery in motion; of making the parts work efficiently and smoothly while they are yet untried and new.

Annandale, 731 N.W.2d at 512 (quotations omitted).

Medicaid Program

"Medicaid is a cooperative federal-state program through which the Federal Government provides financial assistance to States so that they may furnish medical care

to needy individuals." *Developmental Servs. Network v. Douglas*, 666 F.3d 540, 544 (9th Cir. 2011) (quoting *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 502, 110 S. Ct. 2510, 2513 (1990)). "To qualify for federal assistance, a State must submit to the Secretary of the Department of Health and Human Services and have approved a plan for medical assistance that complies with statutory requirements." *Id.* (quotations omitted). "If CMS determines that a state plan or plan amendment does not comply with those requirements, it may deny the state federal funds." *Id.* (citing 42 C.F.R. §§ 430.15, .18).

Minnesota's EMA Program

"Generally, Minnesota provides medical assistance 'for needy persons whose resources are not adequate to meet the cost' of a variety of medical services." *A.A.A. v. Minn. Dep't of Human Servs.*, 832 N.W.2d 816, 819 (Minn. 2013) (quoting Minn. Stat. § 256B.01 (2012)). The Minnesota EMA program, which is part of the state medical-assistance program, is complex and is authorized by the federal Medicaid statute that governs payment for emergency medical care provided to certain citizens and noncitizens to treat their emergency medical conditions.[3] 42 U.S.C. § 1396b(v) (2012); *see* Minn. Stat. § 256B.06, subd. 4(f) (Supp. 2013) (requiring payment for care and services furnished to noncitizens, who otherwise meet the eligibility requirements of chapter 256B, "if such care and services are necessary for the treatment of an emergency medical condition").

[3] The Supreme Court has described the federal Medicaid statute as "almost unintelligible to the uninitiated." *Schweiker v. Gray Panthers*, 453 U.S. 34, 43, 101 S. Ct. 2633, 2640 (1981) (quotation omitted).

In 1996, Congress enacted the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), providing, in relevant part, that an alien who is not a qualified alien is ineligible for any federal benefit, subject to certain exceptions, including for treatment of an emergency medical condition. Pub. L. No. 104-193, 110 Stat. 2105, 2261–62, 2268–69 (codified in relevant part at 8 U.S.C. §§ 1611, 1621 (2012)). Under 42 U.S.C. § 1396b(v)(1) (2012), "no payment may be made to a State . . . for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law." Payment to a state for medical assistance furnished to an unqualified noncitizen is permitted only if

> (A) such care and services are necessary for the treatment of an *emergency medical condition* of the alien, (B) such alien otherwise meets the eligibility requirements for medical assistance under the State plan approved under this subchapter . . . , and (C) such care and services are not related to an organ transplant procedure.

Id. § 1396b(v)(2) (emphasis added). An "emergency medical condition" is

> a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—
>
> (A) placing the patient's health in serious jeopardy,
> (B) serious impairment to bodily functions, or
> (C) serious dysfunction of any bodily organ or part.

Id. § 1396b(v)(3). The "emergency medical condition" also must have a "sudden onset." 42 C.F.R. § 440.255(c)(1) (2014).

A state Medicaid plan that is submitted to CMS for approval "consists of preprinted material that covers the basic requirements, and individualized content that reflects the characteristics of the particular State's program." 42 C.F.R. § 430.12(a) (2014). The federal regulations do not require states to list the services provided to "aliens." *See* 42 C.F.R. § 440.255(c). But the federal regulations do require states to specify in their state Medicaid plans that "aliens" will be provided only the limited services specified in 42 C.F.R. § 440.255. *See* 42 C.F.R. §§ 440.210(c), .220(c) (2014). And section 440.255 limits coverage to treatment for an acute and severe medical condition. 42 C.F.R. § 440.255(c)(1). Minnesota's Medicaid plan, which includes EMA, contains the following provision:

> The Medicaid agency meets the requirements of section 1903(v) of the Act with respect to payment for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Payment is made only for care and services that are necessary for the treatment of an emergency medical condition, as defined in section 1903(v) of the Act.

Following passage of the PRWORA in 1996, Minnesota amended Minnesota Statutes section 256B.06, subdivision 4 (1996), which governed eligibility for medical assistance including eligibility for treatment of emergency medical conditions. 1997 Minn. Laws ch. 85, art. 3, § 19, at 608–10. As amended in 1997, section 256B.06, subdivision 4(a) (Supp. 1997), limited eligibility for medical assistance to "citizens of the United States, *qualified noncitizens* as defined in this subdivision, and other persons

residing lawfully in the United States." (Emphasis added.) But section 256B.06, subdivision 4(g)−(h) (Supp. 1997), provided

> (g) Payment shall also be made for care and services that are furnished to noncitizens, regardless of immigration status, who otherwise meet the eligibility requirements of chapter 256B, *if such care and services are necessary for the treatment of an emergency medical condition*, except for organ transplants and related care and services and routine prenatal care.
>
> (h) For the purposes of this subdivision, the term "emergency medical condition" means a medical condition that meets the requirements of United States Code, title 42, section 1396b(v).

(Emphasis added.)

In 2011, the Minnesota legislature again amended chapter 256B, further limiting payment for medical care furnished to unqualified noncitizens for emergency-medical-condition services. 2011 Minn. Laws 1st Spec. Sess. ch. 9, art. 6, § 27, at 1237–40. Former subdivision 4(g) was modified and recodified to 4(f), former subdivision 4(h) was recodified to 4(g), and new language was added to subdivision 4(h). *Id.* at 1239. Minnesota Statutes section 256B.06, subdivision 4(h)(1) (Supp. 2013),[4] now provides that

> [n]otwithstanding paragraph (g), services that are necessary for the treatment of an emergency medical condition *are limited* to the following:
>
> (i) services delivered in an emergency room or by an ambulance service licensed under chapter 144E that are directly related to the treatment of an emergency medical condition;

[4] Subdivision 4(h) was not modified by the 2013 amendments to subdivision 4. 2013 Minn. Laws ch. 108, art. 1, § 25, at 870–73.

> (ii) services delivered in an inpatient hospital setting following admission from an emergency room or clinic for an acute emergency condition; and
> (iii) follow-up services that are directly related to the original service provided to treat the emergency medical condition and are covered by the global payment made to the provider.

(Emphasis added.) Minnesota Statutes section 256B.06, subdivision 4(h)(2) (Supp. 2013), lists numerous services that are *not* "[s]ervices for the treatment of emergency medical conditions." Services for treatment of emergency medical conditions *do not include* "continuing care, including long-term care, nursing facility services, home health care, adult day care, day training, or supportive living services." Minn. Stat. § 256B.06, subd. 4(h)(2)(iv).

Bamba argues that the 2011 legislative amendments violate federal law because DHS did not submit an SPA to CMS for approval before implementing the legislative amendments. *See* 42 C.F.R. § 430.12(c)(1)(ii) (2014) (requiring states to submit an SPA to CMS when "[m]aterial changes in State law, organization, or policy, or in the State's operation of the Medicaid program" occur). DHS argues that the legislative amendments did not require an SPA. We agree with DHS.

The 2011 amendments to chapter 256B clarified, in relevant part, the scope of the state EMA program. *See* 2011 Minn. Laws 1st Sp. Sess. ch. 9, art. 6, § 27, at 1237−40. The amended law retains the previous statutory definition of "emergency medical condition," delineating coverage for emergency medical services provided to noncitizens under Minnesota's EMA program. Minn. Stat. § 256B.06, subd. 4(g) (2013). CSM publishes the *State Medicaid Manual* that sets forth guidelines for participating states to

follow in their Medicaid programs. *Moore v. Reese*, 637 F.3d 1220, 1235 (11th Cir. 2011). The manual does not instruct states to include a detailed description of their EMA programs in their state Medicaid plan. *See State Medicaid Manual* §§ 3210–3213.2. The *State Medicaid Manual* instructs states to submit an SPA only if the state opted to provide Medicaid to specific groups of noncitizens. *Id.*, § 3210.1. The manual states as follows: "Submit an amendment to your approved State plan if you make any changes in the eligibility of aliens whose coverage is optional, as described in §§ 3211.5−3211.7." *Id.*

Bamba cites cases from the Ninth Circuit in support of his argument that states are strictly required to obtain federal approval before making a material change to their Medicaid programs. *See Cal. Ass'n of Rural Health Clinics v. Douglas*, 738 F.3d 1007, 1010−11, 1016–17 (9th Cir. 2013) (noting earlier rule that state agency must obtain federal approval of SPA before implementing it but holding that state statute at issue violated federal law); *Developmental Servs. Network*, 666 F.3d at 546 (ruling that agency violated federal law by implementing SPA before receiving approval); *Or. Ass'n of Homes for the Aging, Inc. v. Oregon*, 5 F.3d 1239, 1241, 1244 (9th Cir. 1993) (affirming district court ruling that Oregon's temporary rule reclassifying nursing services was invalid because state agency did not submit SPA to federal government for approval). None of these cases involves healthcare services provided to unqualified noncitizens, and Bamba's reliance on the cases is therefore misplaced. *See Rural Health Clinics*, 738 F.3d at 1007–18; *Developmental Servs. Network*, 666 F.3d at 540–49; *Homes for the Aging*, 5 F.3d at 1239–44. The cases involve attempts by state

agencies to enforce state law that made material changes to the approved Medicaid plans before the states obtained approval of the SPA. *See Rural Health Clinics*, 738 F.3d at 1010–11; *Developmental Servs. Network*, 666 F.3d at 543; *Homes for the Aging*, 5 F.3d at 1240–41. In this case, the 2011 legislative amendments that DHS implemented *comported* with federal law and Minnesota's Medicaid plan. *See* Minn. Stat. § 256B.06, subd. 4(h)(2)(iv).

DHS cites persuasive extra-jurisdictional cases in support of its contention that federal Medicaid law does not include nursing-home care in its definition of emergency medical care. *See Greenery Rehabilitation Grp., Inc. v. Hammon*, 150 F.3d 226, 227−28, 231–33 (2d Cir. 1998) (reversing district court decision that two noncitizen, nursing-home residents with severe head injuries met the requirement for emergency medical care because they were receiving care for chronic conditions, not conditions that were sudden, severe, and short-lived physical injuries or illnesses that required immediate treatment to prevent further harm); *see also Scottsdale Healthcare, Inc. v. Ariz. Health Care Cost Containment Sys. Admin.*, 75 P.3d 91, 97–98 (Ariz. 2003) (distinguishing between acute and chronic conditions and holding that if individual's condition is manifested by chronic symptoms, it is not an emergency medical condition); *Diaz v. Div. of Soc. Servs.*, 628 S.E.2d 1, 5 (N.C. 2006) (holding that emergency medical condition is manifested by acute symptoms at time of treatment and requires immediate treatment to stabilize condition); *Spring Creek Mgmt. v. Dep't of Pub. Welfare*, 45 A.3d 474, 482–83 (Pa. Commw. Ct. 2012) (holding that stroke victim was not suffering from emergency medical condition under federal law). Although not binding authority on this

court, the circumstances in *Greenery Rehabilitation* are strikingly similar to Bamba's circumstances, and the reasoning in the case supports DHS's argument.

Bamba essentially argues for an expansion of Minnesota's EMA program to cover the long-term-care services, i.e., nursing-home costs, of uninsured, unqualified noncitizens. Under present federal law, let alone state law, this expansion would be tantamount to mandating that nursing homes provide free long-term care without any hope for reimbursement from the patient or government under Medicaid. Moreover, such an expansion of EMA coverage would directly run afoul of the PRWORA, 8 U.S.C. §§ 1611, 1621, which generally makes unqualified "aliens" ineligible for any federal-aid programs except, in relevant part, for treatment of emergency medical conditions. And such an expansion would result in unqualified "aliens" receiving greater public benefits than citizens and qualified "aliens" who have no funds or insurance coverage for nursing-home care. Under the PRWORA, qualified "aliens" are generally denied public benefits, such as nonemergency medical care, until they have been in the United States for five years or otherwise qualify. 8 U.S.C. § 1613(a) (2012).

Bamba argues that, because DHS unlawfully implemented the 2011 legislative amendments, "the sole reason for Mr. Bamba losing benefits, he is entitled to have his EMA benefits restored." And, in his reply brief, he states that "[t]here is no dispute that, prior to the 2011 amendments, Mr. Bamba qualified for EMA benefits for his nursing home care under the Minnesota EMA program." The question of whether Bamba was qualified for EMA benefits prior to the 2011 amendments is not before us. But we note that Bamba has offered no legal authority to support a proposition that his mere receipt

of benefits prior to the 2011 amendments is tantamount to a conclusion that he was actually qualified under federal or state law to receive them.

No party disputes that payments for Bamba's benefits have materially changed, but in this appeal we must examine whether Minnesota's Medicaid plan materially changed. Because we conclude that the 2011 Minnesota legislative amendments were not "[m]aterial changes in State law, organization, or policy, or in the State's operation of the Medicaid program" within the meaning of 42 C.F.R. § 430.12(c)(1)(ii), we also conclude that DHS did not violate federal law by not submitting an SPA to CMS for approval before implementing the legislative amendments. Therefore, neither the HSJ nor the commissioner erred as a matter of law in applying the statutory criteria in the 2011 amendments to Bamba's request for EMA coverage.

Fair Hearing

Burden of Persuasion at Fair Hearing

The HSJ announced at the fair hearing that the "burden of proof [was] on [DHS]." DHS did not object to the judge's statement. On appeal, each party argues that the other bore the burden of persuasion at the fair hearing based on Minnesota statutes section 256.0451, subdivision 17 (2012), which provides that

> [t]he burden of persuasion is governed by specific state or federal law and regulations that apply to the subject of the hearing. If there is no specific law, then the participant in the hearing who *asserts the truth of a claim* is under the burden to persuade the human services judge that the claim is true.

(Emphasis added.) The party bearing the burden of persuasion must prove facts under the preponderance-of-the-evidence standard. Minn. Stat. § 256.0451, subd. 22(b) (2012).

DHS argues that, because Bamba claimed that he met the criteria for EMA payment of his nursing-home care, he had the burden of persuading the HSJ that he had an emergency medical condition. Bamba argues that DHS bore the burden of producing evidence to persuade the HSJ that Bamba was not eligible for EMA.

We can find no published Minnesota case construing section 256.0451, subdivision 17, but we conclude that we need not resolve this question to decide this case. On appeal, Bamba bears the burden to show that one of the grounds listed in section 14.69 entitles him to relief on appeal. *See Estate of Atkinson*, 564 N.W.2d at 213.

Substantial Evidence

Bamba contends that the commissioner's decision is not supported by substantial evidence on the record and that the decision is based on evidence outside the record at the fair hearing. Substantial evidence is "(1) such relevant evidence as a reasonable mind might accept as adequate to support a conclusion; (2) more than a scintilla of evidence; (3) more than some evidence; (4) more than any evidence; or (5) the evidence considered in its entirety." *Cannon v. Minneapolis Police Dep't*, 783 N.W.2d 182, 189 (Minn. App. 2010) (quotation omitted).

Bamba argues that the HSJ erred by admitting DHS's appeal summary, and he argues that its contents about the review of Bamba's appeal by Telligen and DHS's medical review agent are outside the record. DHS disagrees and argues that Bamba waived his right to challenge admission of the appeal summary by failing to object at the hearing.

State law generally requires an agency to prepare an agency appeal summary that informs the person involved of the evidence on which the agency relies and the legal basis for its determination. Minn. Stat. § 256.0451, subd. 3(a), (c) (2012). The appeal summary must be mailed or otherwise provided to the person involved at least three working days before the fair hearing. *Id.*, subd. 3(a). DHS mailed its appeal summary to Bamba in advance of the fair hearing and noted in it that DHS was submitting the appeal summary in lieu of appearing at Bamba's hearing. At the hearing, the HSJ reviewed all exhibits that had been submitted, noted that DHS's appeal summary was listed as exhibit 27, and asked Bamba's counsel if he had any objections to the exhibits. Bamba raised no objection, and the HSJ judge received all of the exhibits as evidence.

A party failing to object to the admission of evidence generally waives later challenges to that evidence. *Town of Forest Lake v. Minn. Mun. Bd.*, 497 N.W.2d 289, 290 (Minn. App. 1993), *review denied* (Minn. Apr. 29, 1993). Bamba waived any objection to the admission of DHS's appeal summary by failing to object to its admission at the hearing. We therefore consider the appeal summary in our review of the evidence.

The HSJ concluded that "[t]reatment for [Bamba]'s ischemia, pneumonitis and end stage renal disease do not currently meet the federal definition of an emergency medical condition and are specifically excluded by State law." Based on our careful review of the record, that conclusion is supported by substantial evidence. We do not include a detailed summary of that evidence because we wish to protect Bamba's privacy. But we note that the testimony of Dr. Newton and Nurse Practitioner Bikkie

reveals that Bamba's care needs relate to chronic conditions, not emergency medical conditions, and the care that Benedictine has provided Bamba relates to his chronic conditions and the tasks of daily living. When asked at the hearing what the most likely outcome would be if Bamba were not receiving any assistance with his care, Dr. Newton replied, "He'd be at very high risk of falling, if he's trying to transfer on his own. He would not be able to probably be eating well or taking in enough fluids and he would have trouble managing his medications." Nurse Practitioner Bikkie testified that Bamba suffers from multiple chronic medical conditions, including hypertension, dysphagia, chronic kidney disease, aspiration pneumonia, and dementia; and that Bamba had two episodes of aspiration that year. In its appeal summary, DHS stated that it denied Bamba's EMA request because the record did not support Dr. Newton's claim that Bamba "is at great risk of aspiration while eating and may contract pneumonia as a result," stating,

> There is no evidence that Mr. Bamba is at high risk of aspiration or that he regularly aspirates his food. There is no information that care providers are able to prevent Mr. Bamba from aspirating food. There is no information that in the event he aspirates his food that the aspiration necessarily results in pneumonia, or that in the event Mr. Bamba contracts pneumonia the pneumonia necessarily results in hospitalizations.

DHS also observed that Bamba's most common treatment at Benedictine relates to his behavioral issues, not treatment or prevention of aspiration.

Substantial evidence, including the testimony of Dr. Newton and Nurse Practitioner Bikkie, reveals that Bamba's care needs relate to chronic conditions, not to

emergency medical conditions, and that the care that Benedictine has provided to Bamba has related to his chronic conditions and tasks of daily living. Care for these conditions is not included in the federal definition of "emergency medical condition" and is expressly excluded by the 2011 amendment to Minnesota's EMA statute. Although Bamba *may* require hospitalization if his care at Benedictine is discontinued, he may not. If he does, no one disputes that such hospitalization could be covered under EMA as an emergency medical condition.

Raising the issue for the first time in his reply brief, Bamba also argues that we should take note of a distinction between a denial of EMA benefits and a termination of benefits, maintaining that Bamba's EMA benefits were terminated, not denied. Indeed, at oral argument, Bamba suggested that he had an "entitlement" to EMA benefits. We decline to address this argument raised for the first time in Bamba's reply brief. *See In re Perez*, 843 N.W.2d 562, 567 n.10 (Minn. 2014) (stating that argument made for first time in reply brief was waived).

We conclude that the record contains substantial evidence to support the commissioner's decision that the long-term-care services provided to Bamba at Benedictine were not services necessary for the treatment of an emergency medical condition within the meaning of federal or state law. Assuming without deciding that DHS bore the burden of persuasion at the fair hearing, we conclude that DHS proved by a preponderance of the evidence that Bamba's long-term-care treatment at Benedictine was not covered by the EMA program and that substantial evidence supports the commissioner's decision. The commissioner therefore did not err by concluding that

Bamba was not entitled to EMA payments to cover the cost of his long-term care at Benedictine.

Affirmed.