

Congressional proposal. In the Congressional majority's interpretation of the resolution, the umbrella fund did not truly respond to changes in enrollment, and the base-fixed allocation was virtually identical to their earlier approach. In contrast, the bi-partisan interpretation put less of the funding in the fixed allocation, did not allow changes in the state contribution, and had an umbrella that did adjust for unexpected enrollment increases. Regardless of their differences, these proposals produced similar federal savings of \$72 billion and \$64 billion respectively.

### **Proposals for Entitlement to Coverage**

One of Medicaid's most fundamental characteristics is the federal entitlement it confers on its beneficiaries. That entitlement, roughly analogous to an insurance contract in the private sector, has three components: (1) a legal right, enforceable in federal court, to (2) a defined set of benefits for (3) people who satisfy specified eligibility criteria. All aspects of this Medicaid entitlement were challenged in the 1995-96 debate.

Currently, federal law requires states to cover nursing home care for people judged to need such care whose income and assets are low enough to qualify them for Supplemental Security Income (SSI)--\$5,640 for individuals and \$8,640 for couples in 199x. In addition, federal law give states the option (which all states take) to cover people whose incomes (though not assets) exceed SSI levels, either by setting a special income standard (up to 300% of the SSI level) or by providing coverage once a person's spending on nursing home care reduces income to eligibility levels. Federal law allows but does not require states to cover long-term care at home or in the community. Although states can (and some do) cover that care on an unlimited basis (footnote: Federal law requires states to cover home health care for people eligible for nursing home care. However, home health care may focus more on skilled care than on the personal care services that constitute long-term care. Federal law gives states the option to cover personal care, but few states take advantage of it. Most spending in x states--from data book], most states cover home and community-based care under "waivers" of standard Medicaid requirements that enable them to serve a limited number of people, provide limited benefits, or target a limited geographic area.

Access to Medicaid coverage for long-term care, even more than for other services, has always been limited, explicitly in the case of home and community-based services and, for nursing home care, by the availability of providers willing to deliver service at Medicaid's

relatively low rates. However, Medicaid's entitlement means that for nursing home care and, up to limits for home and community-based care, eligible people who obtain service from a provider willing to participate can count on Medicaid to pay for their care.

The earliest Congressional proposal eliminated all aspects of the Medicaid entitlement. In its commitment to state flexibility, that proposal included neither specific federal eligibility requirements nor federal benefit specifications (except vaccinations for children) and withdrew individuals' right to sue for coverage in federal court. Instead, the proposal required only that states "set aside" a share of each year's total spending — to use on any services they might choose — for three groups the law currently requires states to cover: low-income mothers and children, people with disabilities, and low income elderly. Set-asides were to reflect states' historical shares of spending on federally required coverage for these groups — along with nursing home residents whom states currently have the option to cover. In total, these set-asides obligated less than 50 percent of the block grant funding.

Criticism of such limited population protections led to modifications as this proposal went through the legislative process. Although lacking any further specification of eligibility or benefits, the Balanced Budget Act of 1995 required states to "guarantee" coverage for poor pregnant women and children under the age of 13 and for people with disabilities, as defined by states. No "guarantees" were included for low income elderly or elderly in need of long-term care. No group or individual had the right to sue for coverage.

The Administration proposal left Medicaid's current entitlement and coverage provisions intact.

The Governors' resolution restored some protections but fell short of Medicaid's current entitlement. The resolution recommended extension of the "guarantees" in the Balanced Budget Act of 1995 to include almost all population groups that federal law now requires states to cover [Fn: Most important, the resolution did not recommend coverage guarantees for children 13 through 18, a group that would be covered under current law by 2002. In addition, the recommendation to apply state rather than federal definitions of disability would exclude people in these categories who are covered under current law.] and further required that states offer almost all benefits, including nursing home care, that federal law requires them to offer. However, the resolution gave states "complete flexibility" to establish the

amount, duration and scope of these benefits, and to vary their provision across population groups and geographic areas. Jeanne will clean

Both the Governors' resolution and its legislative successors also addressed the right of individuals to seek legal enforcement of coverage "guarantees". Like earlier Congressional proposals, these proposals eliminated an individual's right to sue for enforcement of state requirements in federal court. (Fn on other stuff) However, these proposals replaced this right with a right to sue in state court.

Although the legislative process moved congressional proposals ever closer to current Medicaid law, even the 1996 proposals departed significantly from Medicaid's current federal entitlement and coverage provisions. First, despite the language of "guarantees", elimination of the Medicaid statute and, by extension, associated federal regulations and legal interpretations?, creates an opportunity for states to exercise considerable discretion in specifying who qualifies for what kinds of services. Second, access to state courts is not a perfect substitute for access to federal courts in terms of enforcement of "guarantees." Federal courts provide a broader and more forceful set of remedies for action found to be unlawful than are typically available under state law, including injunctions that stop that action or force alternative action. ??? In addition, federal courts establish precedent that applies consistently across cases, over time, and across the fifty states. Reliance on state rather than federal court would instead produce considerable variation in interpretation and enforcement across states. In addition, federal judges, being federally appointed and appointed for life, are removed from state political processes. ~~State judges, who are elected or appointed by governors, are more subject to influence by the same pressures and interests that produce the state actions these legislative proposals would have them evaluate.~~ Finally, when considered in conjunction with the financing changes described above, these legislative proposals provide insufficient federal dollars to support the entitlement to coverage specified in current law. Whether that fact abrogates the entitlement or leaves states on the fiscal hook would undoubtedly be litigated (and differentially resolved) in any number of state courts.

### **Proposals for Family Protections and Obligations**

Although Medicaid's long-term care protections are contingent upon beneficiaries' exhaustion of their own incomes and resources, family members are currently protected against

## PRIVATE RIGHT OF ACTION

**A Federal Private Right of Action is Important to Maintaining the Guarantee.** The Governors (and the Congressional conference report) have eliminated any federal cause of action by Medicaid beneficiaries. Claims brought by individuals to enforce their rights under Medicaid would be limited to state courts and state law. Only the Secretary of Health and Human Services could bring an action in federal court on behalf of Medicaid beneficiaries.

The Governors want to reduce the number of Medicaid cases filed. In addition, they do not want court decisions from federal courts in other states to have any effect on how they run their Medicaid programs. While, under their proposal, cases heard in other states' courts would no longer have precedential value, it is not likely that fewer cases would be filed; they would simply be filed in state court.

You have taken the position that you support maintaining the guarantee under Medicaid. Since the inception of the Medicaid program, a person eligible for Medicaid has had both a guarantee of access to certain services and the right to enforce this commitment. A "guarantee" without a right to enforce it and a remedy for its deprivation is a hollow promise. We believe that preservation of the *federal cause of action* for individuals to enforce Medicaid eligibility assures this guarantee.

- **Consistent Interpretation.** Those aspects of the Medicaid program that are common to all states -- like eligibility -- should be consistently interpreted and administered. The basic guarantee of who is covered should be uniform across the country; without a federal cause of action, it will not be. For example, under current interpretations, a woman who has a miscarriage is considered "pregnant" and therefore eligible for services for complications arising from the miscarriage. Under the Governors' plan, if a state improperly denied those services, she could no longer go to federal court to enforce her right. The issue would instead be litigated in fifty states; in some states, she would receive care while in others she might not.
- **Significant Limitation of Remedies.** The remedies available under state law are generally more limited than under federal law. Very few state laws allow beneficiaries to obtain injunctions against the continuation of policies found to be unlawful or to recover attorneys fees.

The Governors (and the conference report) claim to maintain a right to sue in federal court through the Secretary of Health and Human Services. However, this poses three problems: (1) the Secretary can sue only if a state is in "substantial noncompliance" -- a much higher standard than exists today; (2) the Health Care Financing Administration will become involved in greater numbers of lawsuits and face significant new administrative burdens; and (3) it is unclear what remedies are available. If the only remedy that the Secretary can seek is the withdrawal of federal funds, this would cause significant harm to the beneficiaries that the Secretary is supposed to represent (and might even make this remedy unusable).

- **Departure from Other Federal Statutes.** Eliminating the federal cause of action would single out Medicaid as the one federal statute that confers individual rights that could not be enforced in federal court by its intended beneficiaries. Such an unprecedented step would be seen as a signal of second-class status and would set off a massive reaction from beneficiary groups and their allies.

**Suggested Revisions to Medicaid Cause of A.001 (April 2, 7:23 p.m.)  
(4/10/96 a.m.)**

*What about OLC's rec.?*

“(z)(1) Except as provided in this subsection, no beneficiary\* or provider may bring an action in Federal court arising from this title unless the beneficiary or provider has exhausted an administrative process established by the State consistent with paragraph (4).

*Still disagree*

“(2) Paragraph (1) shall not apply to an action brought —

“(A) for the enforcement of the [provisions/requirements] under subsection (a)(10)(D) (relating to qualified medicare beneficiaries) and section 1905(p) (relating to medicare cost-sharing);

“(B) for the enforcement of section 1919 (relating to nursing home standards);

“(C) for the enforcement of section 1927 (relating to prevention of spousal impoverishment);

“(D) for the enforcement of ~~section (a)(10)~~ . . . .

“(3) Paragraph (1) shall not apply to an action brought in a case in which—

“(A) a delay in provision of services during the administrative process may result in serious impairment to the health, or in irreparable injury to, the individual;

*Why both?*

“(B) the responsible officer in the administrative process lacks authority to provide for the relief requested or there is otherwise no adequate remedy [at law]; **OK**

“(C) compliance with the exhaustion requirement of such paragraph would be futile.

“(4) In the case of an action brought by a beneficiary,\* an administrative process

is consistent with this section only if —

“(A) it provides for timely fair hearings consistent with the requirements of subsection (a)(3) and Subpart E of Chapter IV of 42 Code of Federal Regulations (as in effect as of January 1, 1996), and

“(B) it does not restrict the rights of beneficiaries\* to such a hearing because they are enrolled in an entity contracting on a risk basis under section 1903(m) or in an entity contracting with a State under a waiver under section 1915(b) or section 1115.

Subparagraph (B) shall not be construed as preventing a State from providing for a fair hearing through such an entity so long as such hearing meets the requirements of subparagraph (A).

(b) EFFECTIVE DATE. — The amendments made by this section shall apply to actions initiated on or after October 1, 1996.

\*Issue: does use of the term “beneficiary” foreclose an action by an applicant for benefits? Should we say “individual?”

Good question



**facsimile**  
TRANSMITTAL

to: Jenn Klein

fax #: 456-2878

re: cc: memo

date: 4/9/96

pages: 2 , including this cover sheet.

From the desk of...

**Sara Rosenbaum**

**Director and Professor of Health  
Care Sciences**

**The George Washington University  
Center for Health Policy Research  
2021 K St, NW, STE 800  
Washington, DC 20006**

**202-296-6922**

**Fax: 202-296-0025**



CENTER FOR HEALTH POLICY RESEARCH

# MEMO

**To:** Catherine Hayes  
**From:** Sara Rosenbaum  
**Subject:** Right to bypass administrative remedies  
**Date:** April 9, 1996

Sorry that it took me a few days to get back to you. I think that it is impossible to describe the precise situations in which exhaustion of administrative remedies is not required. Therefore I urge that you use the three principles that are used by courts to determine whether exhaustion is required:

- **Exhaustion of remedies might irreparably injure the plaintiff** (this could be harm to a patient that is either life or health threatening and it could also describe harms to a provider to the extent that you want to give providers the right to bypass. Personally I would not give providers permission to sidestep the exhaustion rules, since they will claim large economic injury and will go directly to court)
- **There is no adequate remedy at law.** This covers situations in which plaintiff's claims are the type that a hearing officer has no authority to hear or whose remedies the officer has no power to grant. Common examples are claims that involve no factual dispute (very rare) and that are purely questions of federal law
- **Exhaustion would be futile.** Again, this covers situations in which the administrative system has no power to grant the relief sought.

The three bases for bypass should be drafted in the alternative ("or"). Again, I would confine these exemptions to injured beneficiaries and would not include providers. We already have one case in which an HMO that had ceased to function was able to get a federal injunction against contract termination on the grounds that it was being deprived of "property" (i.e., the patients) without due process and that it would suffer irreparable injury if the hearing were held after the termination had gone into effect. The state therefore was enjoined from notifying the plan's members that they were free to leave the HMO.

Call if you have questions. How about lunch? I haven't seen you in forever.

ONE HUNDRED FOURTH CONGRESS

THOMAS J. BALEY, JR., VIRGINIA, CHAIRMAN

CARLOS J. MOOREHEAD, CALIFORNIA

VICKI GARDNER

JACK PHELPS, TEXAS

MICHAEL G. OXLEY, OHIO

MICHAEL BLUMKIN, FLORIDA

DAN SCHASPER, COLORADO

JOE BARTON, TEXAS

J. DENNIS RASHTERT, ILLINOIS

FRED UPTON, MICHIGAN

CLIFF STEARNS, FLORIDA

BILL PAXON, NEW YORK

PAUL E. GILLMOR, OHIO

SCOTT L. KLUG, WISCONSIN

GARY A. FRANKS, CONNECTICUT

JAMES C. GREENWOOD, PENNSYLVANIA

MICHAEL D. CRAPO, IDAHO

CHRISTOPHER COX, CALIFORNIA

NATHAN DEAL, GEORGIA

RICHARD BURR, NORTH CAROLINA

BRIAN P. BILBRAY, CALIFORNIA

ED WHITFIELD, KENTUCKY

GREG GANSKE, IOWA

DAN FRISA, NEW YORK

CHARLIE NORMOOD, GEORGIA

RICK WHITE, WASHINGTON

TOM COBURN, OKLAHOMA

JOHN D. BINGELL, MICHIGAN

HENRY A. WAXMAN, CALIFORNIA

EDWARD J. MARKEY, MASSACHUSETTS

W.J. "BILLY" TAUBER, LOUISIANA

RON WYDEN, OREGON

RALPH M. HALL, TEXAS

JOHN BRYANT, TEXAS

RICK BOUCHER, VIRGINIA

THOMAS J. MANTON, NEW YORK

EDOUARD TOWNS, NEW YORK

GERRY E. STUDDS, MASSACHUSETTS

FRANK PALLONE, JR., NEW JERSEY

SHERROD BROWN, OHIO

BLANCHE LAMBERT LINCOLN, ARKANSAS

BART GORDON, TENNESSEE

ELIZABETH FURSE, OREGON

PETER DEUTSCH, FLORIDA

BOBBY L. RUSH, ILLINOIS

ANNA G. ESHOO, CALIFORNIA

RON KLING, PENNSYLVANIA

BART STUPAK, MICHIGAN

JAMES E. DERDERIAN, CHIEF OF STAFF

# U.S. House of Representatives Committee on Commerce

Washington, DC 20515-6115

## DEMOCRATIC STAFF

## FAX COVER SHEET

DATE:

12 APRIL 96

TO:

JENNIFER KLEIN

FROM:

BRIDGETT TAYLOR

FAX NUMBER:

456-2878

 NUMBER OF PAGES:  
(Including Cover)

3

COMMENTS:

 Please review & send comments to  
me.

Fax # 225-5288

 (If there are problems with this transmission,  
please phone 226-3400, Democratic Staff, 564 FHOB.)

1 SEC. \_\_\_\_ REQUIREMENT OF EXHAUSTION OF ADMINISTRA-  
2 TIVE REMEDIES BEFORE BRINGING ACTION  
3 IN FEDERAL COURT.

4 (a) IN GENERAL.—Section 1902 of the Social Secu-  
5 rity Act, as amended by ..., is further amended by adding  
6 at the end the following new subsection:

7 “(z)(1) Except as provided in this subsection, no ben-  
8 eficiary or provider may bring an action ~~against a State~~  
9 in Federal court arising from this title unless the bene-  
10 ficiary or provider has exhausted an administrative proc-  
11 ess established by the State consistent with paragraph (4).

12 【By accepting funding under this title, a State is consid-  
13 ered to have consented to be sued in Federal court consist-  
14 ent with this subsection and to have permitted actions  
15 against State officials to compel compliance with the re-  
16 quirements of this title.】

Wilder  
not  
determined

17 “(2) Paragraph (1) shall not apply to an action  
18 brought—

19 “(A) for the enforcement of rights of individ-  
20 uals under subsection (a)(10)(D) (relating to quali-  
21 fied medicare beneficiaries) and section 1905(p) (re-  
22 lating to medicare cost-sharing);

23 “(B) for the enforcement of section 1919 (relat-  
24 ing to nursing home standards);

25 “(C) for the enforcement of section 1927 (relat-  
26 ing to prevention of spousal impoverishment);

→ Sara & I  
don't think  
this should  
be in.  
Qd be construed  
against others  
not listed.

2

1 "(D) [additional items may be added]

2 "(3) Paragraph (1) shall not apply to an action  
3 brought in a case in which—

4 "(A) a delay in provision of services <sup>that may cause irreparable harm,</sup> ~~during the~~ <sup>injury</sup>  
5 ~~period of the administrative process [may]/[is likely~~ <sup>no adequate</sup>  
6 ~~to] result in severe and long-lasting impairment to~~  
7 ~~the health of an individual;~~

8 "(B) ~~the responsible officer in the administra-~~  
9 ~~tive process lacks authority to provide for the relief~~  
10 ~~requested; and~~ <sup>or there is no adequate remedy</sup>  
11 <sup>at law</sup>

12 "(C) compliance with the exhaustion require-  
13 ment of such paragraph would be futile.

14 "(4) An administrative process is consistent with this  
15 section only if—

16 "(A) it provides for fair hearings consistent  
17 with the requirements of section 1902(a)(4), and

18 "(B) it does not restrict the rights of bene-  
19 ficiaries to such a hearing because they are enrolled  
20 with capitated organizations under section 1903(m).

21 Subparagraph (B) shall not be construed as preventing  
22 a State from providing for a fair hearing through such  
23 a capitated organization so long as <sup>the proced. used by the</sup> such hearing meets <sup>org. meet</sup>  
24 the otherwise applicable requirements of this title."

(b) EFFECTIVE DATE.—[to be provided]

April 2, 1996 (7:23 p.m.)

Are these fair hearing requirements enough?

1. Decision w/in 24 hrs in emergencies?

2. State agency hearing after adverse decision?

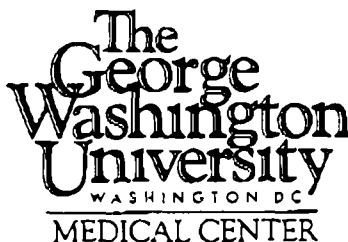
3. Hearing must be held w/in days

Should we allow 2 layers here?

There doesn't seem to be a specific time period. Do we need one? I found it. 90 days.

Any man. care organization that offers a grievance process.

all reqs applicable to state process + external review of final decision.



CENTER FOR HEALTH POLICY RESEARCH

# MEMO

**To:** Jen  
**From:** Sara Rosenbaum  
**Subject:** Right of action draft language  
**Date:** April 9, 1996

Attached is my marked up copy of the draft language, with the following changes:

Page 1, line 8: strike "against a State". People cannot sue states under *Ex Parte Young* and *Seminole*. People sue state officials. Any reference to a "State" will sink the whole thing.

Page 1, lines 12-16: strike in its entirety. Wilder is still good law, and we don't need states to consent to suit. Lawyers sue state *officials*.

Page 1 lines 17-26: I know what Andy is trying to do, but I don't think it works. Rather than making a political point the provision will simply set off a stampede among every left out group for an exemption. Also, having to go through a hearing is not so bad so long as the bypass procedures on the next page remain. Many of the claims listed in this exemption clause in fact may involve factual disputes over whether states' actions violate their own policies.

Page 2, lines 4-10: I have altered the language to bring the exemptions into conformity with equitable theories. We should not get fancy and try to describe the situations that might arise. We should just use the terms of art that are invoked in various situations to support a bypass of administrative remedies.

Page 2 line 16: Citation is corrected

Page 2 line 19: provision broadened to include all managed care organizations offering grievance procedures, since plans that are not federally qualified or state licensed HMOs are in use.

Page 2 lines 21-22: Cleanup of language in the draft to clarify that the state may substitute a fair hearing that meets all of the requirements of paragraph (A).

Call if you have any other questions.

APR-03-96 18:25 FROM:

ID.

1 SEC. REQUIREMENT OF EXHAUSTION OF ADMINISTRA-  
2 TIVE REMEDIES BEFORE BRINGING ACTION  
3 IN FEDERAL COURT.

4 (a) GENERAL.—Section 1902 of the Social Secu-  
5 rity Act, as amended by ..., is further amended by adding  
6 at the end the following new subsection:

7 "(2)(1) Except as provided in this subsection, no ben-  
8 eficiary or provider may bring an action ~~against the State~~  
9 in Federal court arising ~~under~~ this title unless the bene-  
10 ficiary or provider has exhausted an administrative proc-  
11 ess established by the State consistent with paragraph (4).  
12 ~~[By accepting funding under this title, a State is consid-~~  
13 ~~ered to have consented to be sued in Federal court consist-~~  
14 ~~ent with this subsection and to have permitted actions~~  
15 ~~against State officials to compel compliance with the re-~~  
16 ~~quirements of this title.]~~

17 "(2) Paragraph (1) shall not apply to an action  
18 brought—

19 "(A) for the enforcement of rights of individ-  
20 uals under subsection (a)(10)(D) (relating to quali-  
21 fied medicare beneficiaries) and section 1905(p) (re-  
22 lating to medicare cost-sharing);

23 "(B) for the enforcement of section 1919 (relat-  
24 ing to nursing home standards);

25 "(C) for the enforcement of section 1927 (relat-  
26 ing to prevention of spousal impoverishment);

April 2, 1996 (7:23 p.m.)

*[Handwritten signatures and initials]*

TOO  
many  
problems

2

1 "(D) [additional items may be added]

2 "(3) Paragraph (1) shall not apply to an action  
3 brought in a case in which—

4 "(A) a delay in provision of services during the  
5 period of the administrative process ~~may~~ <sup>may</sup> ~~is likely~~  
6 ~~to result in severe and long lasting impairment to~~  
7 ~~the health of an individual.~~ <sup>irreparable injury or</sup>  
8 ~~(B) the responsible officer in the administra-~~ <sup>would at law or</sup>

9 ~~tive process lacks authority to provide for the relief~~  
10 ~~requested, and~~ <sup>there is no adequate remedy</sup>  
11 ~~(C) compliance with the exhaustion require-~~ <sup>at law</sup>

12 ~~ment of such paragraph would be futile.~~

13 "(4) An administrative process is consistent with this  
14 section only if—

15 (A) it provides for fair hearings consistent  
16 with the requirements of section 1902(a)(4), and

17 (B) it does not restrict the rights of bene-  
18 ficiaries to such a hearing because they are enrolled  
19 with ~~capitated~~ <sup>a managed care</sup> organizations ~~under section 1903(m).~~ <sup>that offers a</sup>

20 Subparagraph (B) shall not be construed as preventing  
21 a State from providing for a fair hearing through such  
22 a ~~capitated~~ <sup>managed care</sup> organization so long as such hearing meets  
23 the other applicable requirements of this title."

24 (b) EFFECTIVE DATE.—[to be provided]

deny pending of admin  
plaint  
Habit out of  
my way  
MD  
OR  
- while  
- no adequate  
remedy  
at law

Are these fair hearing requirements enough?

1. Decision w/in 20/30 days? in emergencies

2. State agency hearing after adverse decision?

3. Hearing must be held w/in days

Should we allow 2 layers here?

complaint + grievance procedure

decided that meets the requirements of paragraph (A)

There doesn't seem to be a specific time period. Do we need one? Oops! I found it. 90 days.

April 2, 1996 (7:23 p.m.)

satisfy the requirements of §§ 431.153 through 431.154.

(59 FR 56232, Nov. 10, 1994)

#### § 431.153 Evidentiary hearing.

(a) For actions specified in § 431.151, the State must give a provider the opportunity for a full evidentiary hearing.

(b) When a NF requests a hearing. Except when a civil money penalty is imposed, when a NF requests a hearing, the hearing need not be completed before the proposed effective date of the denial or termination of participation, or imposition of any remedy.

(c) When an ICF/MR requests a hearing. When an ICF/MR requests a hearing, it must be completed—

(1) Before the effective date of the denial, termination or nonrenewal of participation; or

(2) Within 120 days after that date.

(d) Time period for request of hearing. The affected NF or ICF/MR, or its legal representative or other authorized official, must file the request for hearing in writing within 60 days from receipt of the notice of the proposed denial, termination, or nonrenewal of participation, or imposition of a civil money penalty or other remedies.

(e) When remedies are imposed. (1) Notwithstanding any provision of State law, the State must impose all remedies timely on any provider of services participating in the Medicaid program—

(1) After notifying the facility timely of the deficiencies and impending remedies; and

(1) Except as specified in paragraph (e)(2) of this section, during any pending hearing that may be requested by the provider of services, as provided in paragraph (b) of this section.

(2) The State must not collect a civil money penalty until a final administrative decision is made that supports the imposition of the penalty.

(f) Non-State operated NF. In the case of a non-State operated NF upon which remedies have been imposed, the State must give the facility—

(1) Notice, as specified in paragraph (h) of this section; and

(2) An opportunity for a full evidentiary hearing on the issue of the noncompliance that led to the imposi-

tion of enforcement actions, except for State monitoring and loss of nurse aide training, as provided in § 488.406 of this chapter.

(g) Remedies imposed during pending hearing. Except for the collection of civil money penalties, the State must impose all such remedies during any pending hearing.

(h) Contents of notice. The notice to the facility must include—

(1) The basis for the decision; and

(2) A statement of deficiencies on which the decision is based.

(i) Required elements of hearing. The hearing must, at a minimum, include—

(1) An opportunity for the facility to appear before an impartial decision maker to refute the certification of noncompliance upon which the denial, termination, nonrenewal of participation for ICFs/MR, or upon which the denial, termination, or imposition of other remedies for NFs are based;

(2) An opportunity for the facility to be represented by counsel or another representative;

(3) An opportunity for the facility or its representatives to be heard in person, to call witnesses, and to present documentary evidence; and

(4) A written decision by the impartial decision maker, setting forth the reasons for the decision and the evidence upon which the decision is based.

(j) In civil money penalty cases, a State's conclusion about a NF's level of noncompliance must be upheld unless clearly erroneous.

(k) Dually participating facilities. If a NF is also participating or seeking to participate in Medicare as a SNF, and the basis for the State's denial or termination of participation in Medicaid is also a basis for denial or termination of participation in Medicare, the State must advise the facility that—

(1) The appeal procedures specified for Medicare facilities in part 498 of this chapter apply; and

(2) A final decision entered under the Medicare review procedures is binding for the purposes of Medicaid participation and Medicare participation in a dually participating facility or a facility seeking to participate in Medicare and Medicaid.

(l) If HCFA determines that a NF is not in substantial compliance with par-

ticipation requirements, thereby resulting in HCFA's imposition of alternative remedies, or if HCFA denies, or terminates the provider agreement(s) of such a facility, and the findings and proposed remedies of HCFA prevail in accordance with § 488.452 of this chapter, the facility is entitled only to the review procedures specified in part 498 of this chapter, in lieu of the procedures specified in this subpart.

(59 FR 56232, Nov. 10, 1994; 60 FR 50117, Sept. 28, 1995)

#### § 431.154 Informal reconsideration for ICFs/MR.

(a) If the State decides to provide the opportunity for an evidentiary hearing required by § 431.153(a) only after the effective date of a denial, or nonrenewal of participation, the State must offer the facility an informal reconsideration, to be completed before the effective date.

(b) The informal reconsideration must, at a minimum, include—

(1) Written notice to the facility of the denial, termination or nonrenewal and the findings upon which it was based;

(2) A reasonable opportunity for the facility to refute those findings in writing, and

(3) A written affirmation or reversal of the denial, termination, or nonrenewal.

(44 FR 9753, Feb. 15, 1979, as amended at 59 FR 56233, Nov. 10, 1994)

### Subpart E—Fair Hearings for Applicants and Recipients

SOURCE: 44 FR 17932, Mar. 29, 1979, unless otherwise noted.

#### GENERAL PROVISIONS

#### § 431.200 Basis and purpose.

This subpart implements section 1902(a)(3) of the Act, which requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly. This subpart also prescribes procedures for an opportunity for hearing if the Medicaid agency takes action to suspend, terminate, or reduce services. This subpart also implements sections 1819(f)(3),

## § 431.201

1919(f)(3), and 1919(e)(7)(F) of the Act by providing an appeals process for individuals proposed to be transferred or discharged from skilled nursing facilities and nursing facilities and those adversely affected by the preadmission screening and annual resident review requirements of section 1919(e)(7) of the Act.

[57 FR 56505, Nov. 30, 1992]

### § 431.201 Definitions.

For purposes of this subpart:

**Action** means a termination, suspension, or reduction of Medicaid eligibility or covered services. It also means determinations by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by a State with regard to the preadmission screening and annual resident review requirements of section 1919(e)(7) of the Act.

**Adverse determination** means a determination made in accordance with sections 1919(b)(3)(F) or 1919(e)(7)(B) of the Act that the individual does not require the level of services provided by a nursing facility or that the individual does or does not require specialized services.

**Date of action** means the intended date on which a termination, suspension, reduction, transfer or discharge becomes effective. It also means the date of the determination made by a State with regard to the preadmission screening and annual resident review requirements of section 1919(e)(7) of the Act.

**De novo hearing** means a hearing that starts over from the beginning.

**Evidentiary hearing** means a hearing conducted so that evidence may be presented.

**Notice** means a written statement that meets the requirements of § 431.210.

**Request for a hearing** means a clear expression by the applicant or recipient, or his authorized representative, that he wants the opportunity to present his case to a reviewing authority.

[44 FR 17932, Mar. 29, 1979, as amended at 57 FR 56505, Nov. 30, 1992]

## 42 CFR Ch. IV (10-1-95 Edition)

### § 431.202 State plan requirements.

A State plan must provide that the requirements of §§ 431.205 through 431.246 of this subpart are met.

### § 431.205 Provision of hearing system.

(a) The Medicaid agency must be responsible for maintaining a hearing system that meets the requirements of this subpart.

(b) The State's hearing system must provide for—

(1) A hearing before the agency; or

(2) An evidentiary hearing at the local level, with a right of appeal to a State agency hearing.

(c) The agency may offer local hearings in some political subdivisions and not in others.

(d) The hearing system must meet the due process standards set forth in *Goldberg v. Kelly*, 397 U.S. 254 (1970), and any additional standards specified in this subpart.

### § 431.206 Informing applicants and recipients.

(a) The agency must issue and publicize its hearing procedures.

(b) The agency must, at the time specified in paragraph (c) of this section, inform every applicant or recipient in writing—

(1) Of his right to a hearing;

(2) Of the method by which he may obtain a hearing; and

(3) That he may represent himself or use legal counsel, a relative, a friend, or other spokesman.

(c) The agency must provide the information required in paragraph (b) of this section—(1) At the time that the individual applies for Medicaid;

(2) At the time of any action affecting his or her claim;

(3) At the time a skilled nursing facility or a nursing facility notifies a resident in accordance with § 483.12 of this chapter that he or she is to be transferred or discharged; and

(4) At the time an individual receives an adverse determination by the State with regard to the preadmission screening and annual resident review requirements of section 1919(e)(7) of the Act.

[44 FR 17932, Mar. 29, 1979, as amended at 57 FR 56505, Nov. 30, 1992; 58 FR 25784, Apr. 28, 1993]

## Health Care Financing Administration,

### NOTICE

### § 431.210 Content of notice.

A notice required under § 431.206 (c)(2), (c)(3), or (c)(4) of this subpart must contain—

(a) A statement of what action the State, skilled nursing facility, or nursing facility intends to take;

(b) The reasons for the intended action;

(c) The specific regulations that support, or the change in Federal or State law that requires, the action;

(d) An explanation of—

(1) The individual's right to request an evidentiary hearing if one is available, or a State agency hearing; or

(2) In cases of an action based on a change in law, the circumstances under which a hearing will be granted; and

(e) An explanation of the circumstances under which Medicaid is continued if a hearing is requested.

[44 FR 17932, Mar. 29, 1979, as amended at 57 FR 56505, Nov. 30, 1992]

### § 431.211 Advance notice.

The State or local agency must mail a notice at least 10 days before the date of action, except as permitted under §§ 431.213 and 431.214 of this subpart.

### § 431.213 Exceptions from advance notice.

The agency may mail a notice not later than the date of action if—

(a) The agency has factual information confirming the death of a recipient;

(b) The agency receives a clear written statement signed by a recipient that—

(1) He no longer wishes services; or

(2) Gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information;

(c) The recipient has been admitted to an institution where he is ineligible under the plan for further services;

(d) The recipient's whereabouts are unknown and the post office returns agency mail directed to him indicating no forwarding address (See § 431.231 (d) of this subpart for procedure if the recipient's whereabouts become known);

## NOTICE

## § 431.210 Content of notice.

A notice required under § 431.206 (a)(2), (c)(3), or (c)(4) of this subpart must contain—

(a) A statement of what action the State, skilled nursing facility, or nursing facility intends to take;

(b) The reasons for the intended action;

(c) The specific regulations that support or the change in Federal or State law that requires the action;

(d) An explanation of—

(1) The individual's right to request an evidentiary hearing if one is available, or a State agency hearing; or

(2) In cases of an action based on a change in law, the circumstances under which a hearing will be granted; and

(e) An explanation of the circumstances under which Medicaid is continued if a hearing is requested.

[44 FR 17932, Mar. 29, 1979, as amended at 57 FR 56505, Nov. 30, 1992]

## § 431.211 Advance notice.

The State or local agency must mail a notice at least 10 days before the date of action, except as permitted under §§ 431.213 and 431.214 of this subpart.

## § 431.213 Exceptions from advance notice.

The agency may mail a notice not later than the date of action if—

(a) The agency has factual information confirming the death of a recipient;

(b) The agency receives a clear written statement signed by a recipient that—

(1) He no longer wishes services; or

(2) Gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information;

(c) The recipient has been admitted to an institution where he is ineligible under the plan for further services;

(d) The recipient's whereabouts are unknown and the post office returns agency mail directed to him indicating no forwarding address (See § 431.231 (d) of this subpart for procedure if the recipient's whereabouts become known);

## § 431.202 State plan requirements.

A State plan must provide that the requirements of §§ 431.205 through 431.246 of this subpart are met.

## § 431.205 Provision of hearing system.

(a) The Medicaid agency must be responsible for maintaining a hearing system that meets the requirements of this subpart.

(b) The State's hearing system must provide for—

(1) A hearing before the agency; or

(2) An evidentiary hearing at the local level, with a right of appeal to a State agency hearing.

(c) The agency may offer local hearings in some political subdivisions and not in others.

(d) The hearing system must meet the due process standards set forth in *Goldberg v. Kelly*, 397 U.S. 254 (1970), and any additional standards specified in this subpart.

## § 431.206 Informing applicants and recipients.

(a) The agency must issue and publicize its hearing procedures.

(b) The agency must, at the time specified in paragraph (c) of this section, inform every applicant or recipient in writing—

(1) Of his right to a hearing;

(2) Of the method by which he may obtain a hearing; and

(3) That he may represent himself or use legal counsel, a relative, a friend, or other spokesman.

(c) The agency must provide the information required in paragraph (b) of this section—(1) At the time that the individual applies for Medicaid;

(2) At the time of any action affecting his or her claim;

(3) At the time a skilled nursing facility or a nursing facility notifies a resident in accordance with § 483.12 of this chapter that he or she is to be transferred or discharged; and

(4) At the time an individual receives an adverse determination by the State with regard to the preadmission screening and annual resident review requirements of section 1919(e)(7) of the Act.

[44 FR 17932, Mar. 29, 1979, as amended at 57 FR 56505, Nov. 30, 1992; 58 FR 25784, Apr. 28, 1993]

(e) The agency establishes the fact that the recipient has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;

(f) A change in the level of medical care is prescribed by the recipient's physician;

(g) The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act; or

(h) The date of action will occur in less than 10 days, in accordance with § 483.12(a)(5)(ii), which provides exceptions to the 30 days notice requirements of § 483.12(a)(5)(i).

[44 FR 17932, Mar. 29, 1979, as amended at 57 FR 56505, Nov. 30, 1992; 58 FR 25784, Apr. 28, 1993]

## § 431.214 Notice in cases of probable fraud.

The agency may shorten the period of advance notice to 5 days before the date of action if—

(a) The agency has facts indicating that action should be taken because of probable fraud by the recipient; and

(b) The facts have been verified, if possible, through secondary sources.

## RIGHT TO HEARING

## § 431.220 When a hearing is required.

(a) The agency must grant an opportunity for a hearing to:

(1) Any applicant who requests it because his claim for services is denied or is not acted upon with reasonable promptness;

(2) Any recipient who requests it because he or she believes the agency has taken an action erroneously;

(3) Any resident who requests it because he or she believes a skilled nursing facility or nursing facility has erroneously determined that he or she must be transferred or discharged; and

(4) Any individual who requests it because he or she believes the State has made an erroneous determination with regard to the preadmission and annual resident review requirements of section 1919(e)(7) of the Act.

(b) The agency need not grant a hearing if the sole issue is a Federal or State law requiring an automatic

#### §431.221

change adversely affecting some or all recipients.

[44 FR 17932, Mar. 29, 1979, as amended at 57 FR 56505, Nov. 30, 1992]

#### §431.221 Request for hearing.

(a) The agency may require that a request for a hearing be in writing.

(b) The agency may not limit or interfere with the applicant's or recipient's freedom to make a request for a hearing.

(c) The agency may assist the applicant or recipient in submitting and processing his request.

(d) The agency must allow the applicant or recipient a reasonable time, not to exceed 90 days from the date that notice of action is mailed, to request a hearing.

#### §431.222 Group hearings.

The agency—

(a) May respond to a series of individual requests for hearing by conducting a single group hearing;

(b) May consolidate hearings only in cases in which the sole issue involved is one of Federal or State law or policy;

(c) Must follow the policies of this subpart and its own policies governing hearings in all group hearings; and

(d) Must permit each person to present his own case or be represented by his authorized representative.

#### §431.223 Denial or dismissal of request for a hearing.

The agency may deny or dismiss a request for a hearing if—

(a) The applicant or recipient withdraws the request in writing; or

(b) The applicant or recipient fails to appear at a scheduled hearing without good cause.

#### PROCEDURES

#### §431.230 Maintaining services.

(a) If the agency mails the 10-day or 5-day notice as required under §431.211 or §431.214 of this subpart, and the recipient requests a hearing before the date of action, the agency may not terminate or reduce services until a decision is rendered after the hearing unless—

#### 42 CFR Ch. IV (10-1-95 Edition)

(1) It is determined at the hearing that the sole issue is one of Federal or State law or policy; and

(2) The agency promptly informs the recipient in writing that services are to be terminated or reduced pending the hearing decision.

(b) If the agency's action is sustained by the hearing decision, the agency may institute recovery procedures against the applicant or recipient to recoup the cost of any services furnished the recipient, to the extent they were furnished solely by reason of this section.

[44 FR 17932, Mar. 29, 1979, as amended at 45 FR 24882, Apr. 11, 1980]

#### §431.231 Reinstatement of services.

(a) The agency may reinstate services if a recipient requests a hearing not more than 10 days after the date of action.

(b) The reinstated services must continue until a hearing decision unless, at the hearing, it is determined that the sole issue is one of Federal or State law or policy.

(c) The agency must reinstate and continue services until a decision is rendered after a hearing if—

(1) Action is taken without the advance notice required under §431.211 or §431.214 of this subpart;

(2) The recipient requests a hearing within 10 days of the mailing of the notice of action; and

(3) The agency determines that the action resulted from other than the application of Federal or State law or policy.

(d) If a recipient's whereabouts are unknown, as indicated by the return of unforwardable agency mail directed to him, any discontinued services must be reinstated if his whereabouts become known during the time he is eligible for services.

#### §431.232 Adverse decision of local evidentiary hearing.

If the decision of a local evidentiary hearing is adverse to the applicant or recipient, the agency must—

(a) Inform the applicant or recipient of the decision;

(b) Inform the applicant or recipient that he has the right to appeal the decision to the State agency, in writing.

#### Health Care Financing Administration

within 15 days of the mailing of the notice of the adverse decision;

(c) Inform the applicant or recipient of his right to request that his appeal be a *de novo* hearing; and

(d) Discontinue services after the adverse decision.

#### §431.233 State agency hearing after adverse decision of local evidentiary hearing.

(a) Unless the applicant or recipient specifically requests a *de novo* hearing, the State agency hearing may consist of a review by the agency hearing officer of the record of the local evidentiary hearing to determine whether the decision of the local hearing officer was supported by substantial evidence in the record.

(b) A person who participates in the local decision being appealed may not participate in the State agency hearing decision.

#### §431.240 Conducting the hearing.

(a) All hearings must be conducted—

(1) At a reasonable time, date, and place;

(2) Only after adequate written notice of the hearing; and

(3) By one or more impartial officials or other individuals who have not been directly involved in the initial determination of the action in question.

(b) If the hearing involves medical issues such as those concerning a diagnosis, an examining physician's report, or a medical review team's decision; and if the hearing officer considers necessary to have a medical assessment other than that of the individual involved in making the original decision, such a medical assessment must be obtained at agency expense and made part of the record.

#### §431.241 Matters to be considered at the hearing.

The hearing must cover—

(a) Agency action or failure to act with reasonable promptness on a claim for services, including both initial and subsequent decisions regarding eligibility;

(b) Agency decisions regarding changes in the type or amount of services;

(1) It is determined at the hearing that the sole issue is one of Federal or State law or policy; and

(2) The agency promptly informs the recipient in writing that services are to be terminated or reduced pending the hearing decision.

(b) If the agency's action is sustained by the hearing decision, the agency may institute recovery procedures against the applicant or recipient to recoup the cost of any services furnished the recipient, to the extent they were furnished solely by reason of this section.

[44 FR 17932, Mar. 29, 1979, as amended at 45 FR 24882, Apr. 11, 1980]

#### § 431.231 Reinstatement of services.

(a) The agency may reinstate services if a recipient requests a hearing not more than 10 days after the date of action.

(b) The reinstated services must continue until a hearing decision unless, at the hearing, it is determined that the sole issue is one of Federal or State law or policy.

(c) The agency must reinstate and continue services until a decision is rendered after a hearing if—

(1) Action is taken without the advance notice required under § 431.211 or § 431.214 of this subpart;

(2) The recipient requests a hearing within 10 days of the mailing of the notice of action; and

(3) The agency determines that the action resulted from other than the application of Federal or State law or policy.

(d) If a recipient's whereabouts are unknown, as indicated by the return of unforwardable agency mail directed to him, any discontinued services must be reinstated if his whereabouts become known during the time he is eligible for services.

#### § 431.232 Adverse decision of local evidentiary hearing.

If the decision of a local evidentiary hearing is adverse to the applicant or recipient, the agency must—

(a) Inform the applicant or recipient of the decision;

(b) Inform the applicant or recipient that he has the right to appeal the decision to the State agency, in writing,

within 15 days of the mailing of the notice of the adverse decision;

(c) Inform the applicant or recipient of his right to request that his appeal be a *de novo* hearing; and

(d) Discontinue services after the adverse decision.

#### § 431.233 State agency hearing after adverse decision of local evidentiary hearing.

(a) Unless the applicant or recipient specifically requests a *de novo* hearing, the State agency hearing may consist of a review by the agency hearing officer of the record of the local evidentiary hearing to determine whether the decision of the local hearing officer was supported by substantial evidence in the record.

(b) A person who participates in the local decision being appealed may not participate in the State agency hearing decision.

#### § 431.240 Conducting the hearing.

(a) All hearings must be conducted—

(1) At a reasonable time, date, and place;

(2) Only after adequate written notice of the hearing; and

(3) By one or more impartial officials or other individuals who have not been directly involved in the initial determination of the action in question.

(b) If the hearing involves medical issues such as those concerning a diagnosis, an examining physician's report, or a medical review team's decision, and if the hearing officer considers it necessary to have a medical assessment other than that of the individual involved in making the original decision, such a medical assessment must be obtained at agency expense and made part of the record.

#### § 431.241 Matters to be considered at the hearing.

The hearing must cover—

(a) Agency action or failure to act with reasonable promptness on a claim for services, including both initial and subsequent decisions regarding eligibility;

(b) Agency decisions regarding changes in the type or amount of services;

(c) A decision by a skilled nursing facility or nursing facility to transfer or discharge a resident; and

(d) A State determination with regard to the preadmission screening and annual resident review requirements of section 1919(e)(7) of the Act.

[57 FR 56505, Nov. 30, 1992]

#### § 431.242 Procedural rights of the applicant or recipient.

The applicant or recipient, or his representative, must be given an opportunity to—

(a) Examine at a reasonable time before the date of the hearing and during the hearing:

(1) The content of the applicant's or recipient's case file; and

(2) All documents and records to be used by the State or local agency or the skilled nursing facility or nursing facility at the hearing;

(b) Bring witnesses;

(c) Establish all pertinent facts and circumstances;

(d) Present an argument without undue interference; and

(e) Question or refute any testimony or evidence, including opportunity to confront and cross-examine adverse witnesses.

[44 FR 17932, Mar. 29, 1979, as amended at 57 FR 56506, Nov. 30, 1992]

#### § 431.243 Parties in cases involving an eligibility determination.

If the hearing involves an issue of eligibility and the Medicaid agency is not responsible for eligibility determinations, the agency that is responsible for determining eligibility must participate in the hearing.

#### § 431.244 Hearing decisions.

(a) Hearing recommendations or decisions must be based exclusively on evidence introduced at the hearing.

(b) The record must consist only of—

(1) The transcript or recording of testimony and exhibits, or an official report containing the substance of what happened at the hearing;

(2) All papers and requests filed in the proceeding; and

(3) The recommendation or decision of the hearing officer.

## **§431.245**

(c) The applicant or recipient must have access to the record at a convenient place and time.

(d) In any evidentiary hearing, the decision must be a written one that—

(1) Summarizes the facts; and  
(2) Identifies the regulations supporting the decision.

(e) In a *de novo* hearing, the decision must—

(1) Specify the reasons for the decision; and

(2) Identify the supporting evidence and regulations.

(f) The agency must take final administrative action within 90 days from the date of the request for a hearing.

(g) The public must have access to all agency hearing decisions, subject to the requirements of subpart F of this part for safeguarding of information.

## **§431.245 Notifying the applicant or recipient of a State agency decision.**

The agency must notify the applicant or recipient in writing of—

(a) The decision; and

(b) His right to request a State agency hearing or seek judicial review, to the extent that either is available to him.

## **§431.246 Corrective action.**

The agency must promptly make corrective payments, retroactive to the date an incorrect action was taken, and, if appropriate, provide for admission or readmission of an individual to a facility if—

(a) The hearing decision is favorable to the applicant or recipient; or

(b) The agency decides in the applicant's or recipient's favor before the hearing.

[57 FR 56506, Nov. 30, 1992]

## **FEDERAL FINANCIAL PARTICIPATION**

## **§431.250 Federal financial participation.**

FFP is available in expenditures for—

(a) Payments for services continued pending a hearing decision;

(b) Payments made—

(1) To carry out hearing decisions; and

## **42 CFR Ch. IV (10-1-95 Edition)**

(2) For services provided within the scope of the Federal Medicaid program and made under a court order.

(c) Payments made to take corrective action prior to a hearing;

(d) Payments made to extend the benefit of a hearing decision or court order to individuals in the same situation as those directly affected by the decision or order;

(e) Retroactive payments under paragraphs (b), (c), and (d) of this section in accordance with applicable Federal policies on corrective payments; and

(f) Administrative costs incurred by the agency for—

(1) Transportation for the applicant or recipient, his representative, and witnesses to and from the hearing;

(2) Meeting other expenses of the applicant or recipient in connection with the hearing;

(3) Carrying out the hearing procedures, including expenses of obtaining the additional medical assessment specified in §431.240 of this subpart; and

(4) Hearing procedures for Medicaid and non-Medicaid individuals appealing transfers, discharges and determinations of preadmission screening and annual resident reviews under part 483, subparts C and E of this chapter.

[44 FR 17932, Mar. 29, 1979, as amended at 45 FR 24882, Apr. 11, 1980; 57 FR 56506, Nov. 30, 1992]

## **Subpart F—Safeguarding Information on Applicants and Recipients**

SOURCE: 44 FR 17934, Mar. 29, 1979, unless otherwise noted.

## **§431.300 Basis and purpose.**

(a) Section 1902(a)(7) of the Act requires that a State plan must provide safeguards that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan. This subpart specifies State plan requirements, the types of information to be safeguarded, the conditions for release of safeguarded information, and restrictions on the distribution of other information.

(b) Section 1137 of the Act, which requires agencies to exchange information in order to verify the income and

## **Health Care Financing Administration**

eligibility of applicants and recipients (see §435.940ff), requires State agencies to have adequate safeguards to assure that—

(1) Information exchanged by the State agencies is made available only to the extent necessary to assist in the valid administrative needs of the program receiving the information, a information received under section 6103(l) of the Internal Revenue Code of 1954 is exchanged only with agencies authorized to receive that information under that section of the Code; and

(2) The information is adequately stored and processed so that it is protected against unauthorized disclosure for other purposes.

[51 FR 7210, Feb. 28, 1986]

## **§431.301 State plan requirements.**

A State plan must provide, under State statute that imposes legal sanctions, safeguards meeting the requirements of this subpart that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan.

## **§431.302 Purposes directly related to State plan administration.**

Purposes directly related to plan administration include—

(a) Establishing eligibility;

(b) Determining the amount of medical assistance;

(c) Providing services for recipients and

(d) Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the plan.

## **§431.303 State authority for safeguarding information.**

The Medicaid agency must have authority to implement and enforce the provisions specified in this subpart for safeguarding information about applicants and recipients.

## **§431.304 Publicizing safeguarding requirements.**

(a) The agency must publicize provisions governing the confidential nature of information about applicants and recipients, including the legal sanctions

To : Robert Jaye@OGC.HCF@OS.DC  
Cc :  
Bcc :  
From : Nan Hunter@OGC.IO@OS.DC  
Subject : medicaid & private right of action  
Date : Tuesday, April 2, 1996 at 9:55:34 am EST  
Attach :  
Certify : Y  
Encrypt : N

-----  
white house counsel's office is analyzing the impact of the new seminole  
indians case. you should take a look at it also. meanwhile, two questions  
from them:

1. is there a private right to sue stated in the statutory text of medicaid, or  
did it result from judicial interpretation? if the latter, do you know the  
case?
2. which is the statutory provision that establishes state participation as  
voluntary, with conditions attached if a state elects to opt in?

thanks.

To : Nan Hunter@OGC.IO@OS.DC

Cc :  
Bcc :  
From : Robert Jaye@OGC.HCF@OS.DC  
Subject : re: medicaid & private right of action  
Date : Tuesday, April 2, 1996 at 10:09:37 am EST  
Attach :  
Certify : N  
Encrypt : N

-----  
I've given this assignment to Dan Aibel. My preliminary responses to your specific questions are that there is no specific right of private action mentioned in the medicaid statute, but it just grew up in the AFDC context and was largely unquestioned. You can get some of the flavor of that in the Medicaid context from the section 1983 memo I sent you during one of the furloughs.

Similarly, there is nothing specific that states that participation in medicaid by a State is voluntary. That also grew up in the AFDC context. it was definitely mentioned in *rosado v. Wyman* and may have also been mentioned in *King v. Smith*. Most Medicaid cases involving alleged states noncompliance with some aspect of medicaid mention it. Legally, it may be based on the notion that Medicaid and AFDC are grant programs and no one is required to accept a grant, but if they do so, they are obligated to adhere to the terms of the grant. Further (and perhaps more accurate) details to follow from Dan in about a week.



**STATE OF FLORIDA  
AGENCY FOR HEALTH CARE ADMINISTRATION**

**MEMORANDUM**

**Date:** March 7, 1996  
**To:** Dyke Snipes, Chief, Medicaid Program Analysis  
**From:** Frank D. Hughes, Regulatory Analyst Supervisor, Medicaid Cost Reimbursement  
**Subject:** State/Federal Litigation Issues

The following represents recent to current provider challenges of Florida Medicaid payments administered by Medicaid Program Analysis:

1. **Federal Court Jurisdiction -**

A. **Hospitals -**

- (1) **Tallahassee Memorial Regional Medical Center, Inc. - Civil Action No.: 93-40463**

**Boren challenge of payments for psychiatric services provided to patients under 21 years of age.**

B. **Intermediate Care Facilities for the Mentally Retarded/Developmentally Disabled**

- (1) **Florida Association of Rehabilitation Facilities, Inc., et. al. - Case No.: 89-0984 - Civ - Nesbitt**

**Boren challenge by association membership of reimbursement to all privately owned/operated and vendor operated Florida ICF/MR-DD facilities.**

2. **State Court Jurisdiction**

A. **Hospitals -**

- (1) **Florida Hospital - Orlando, et al. - Case No. 95-1573**

**Boren challenge of payments for psychiatric services provided to patients under 21 years of age.**

**B. Nursing Homes -**

- (1) Hillhaven Corp. et.al. - Case No. 95-4538
- (2) Health Care & Retirement Corp. - Case No. 95-5131

Boren challenge by both providers resulting from change in reimbursement methodology for nursing homes.

- (3) Numerous, on-going actions initiated by the nursing home provider group to challenge allowable cost determinations made during the state field audit process. Approximately 90-95 new cases are initiated annually.
- (4) Frequent litigation initiated by the nursing home provider group as individuals or groups to challenge reimbursement rules and methodologies. Annual volume is approximately 20 new cases each year.

**C. ICF/MR-DD Facilities**

Litigation in process at present involves one provider group with 18 facilities. Litigation involving 17 facilities concerns allowable cost. Litigation in the remaining case concerns reimbursement methodology.

## Medicaid Benefits/Eligibility Litigation

| YEAR INITIATED | CASE                         | ISSUE                                                                                  | PLAINTIFF                       | STATE OR FEDERAL | CURRENT STATUS                              |
|----------------|------------------------------|----------------------------------------------------------------------------------------|---------------------------------|------------------|---------------------------------------------|
| Benefits       |                              |                                                                                        |                                 |                  |                                             |
| 1991           | Cooley v. HRS                | Liver bowel transplant under 21                                                        | Cooley                          | Federal          | Judgment for the state                      |
| 1993           | McLaughlin v. Williams       | Liver bowel transplant under 21                                                        | McLaughlin                      | Federal          | Judgment for the plaintiff                  |
| 1993           | Alderman v. Williams         | Heart transplant for persons over 21                                                   | Alderman                        | Federal          | Judgment for the state                      |
| 1995           | Pittman v. Secretary of DHRS | Liver bowel transplant under 21                                                        | Pittman                         | Federal          | Judgment for the plaintiff                  |
| 1995           | Canteen v. Cook              | Lung transplant over 21                                                                | Canteen                         | Federal          | No decision - recipient died                |
| 1996           | Watson v. Cook               | Lung transplant over 21                                                                | Watson                          | Federal          | Judgment for the state                      |
| 1996           | Kelly v. Cook                | Private duty nursing services for over 21 - OBRA '89 authorizes care for children only | Kelly                           | Federal          | No decision                                 |
| 1989           | ME v. Chiles                 | Challenges mental health coverage for kids in state custody                            | Class action for the recipients | Federal          | No decision                                 |
| 1995           | Renee B. v. HRS and AHCA     | Unrestricted abortion coverage                                                         | Class action for the recipients | State            | No decision                                 |
| 1991           | Solis v. HRS                 | Illegal alien applying for asylum requesting AFDC and Medicaid coverage                | Solis                           | State            | AFDC for plaintiff, Medicaid denied         |
| 1995           | Moreau v. Gerald Lewis       | Challenges pharmacy co-pay                                                             | Pharmacy Providers              | State            | Judgment for the state                      |
| 1995           | 10 hospitals v. AHCA         | Authorize Medicaid payment for private psychiatric hospitals                           | Providers                       | State            | Judgment for the plaintiff, appealed to DCA |
| 1995           | Guttman v. AHCA & PCA        | Wrongful termination of an HMO                                                         | St. John's HMO                  | State            | No decision                                 |
| 1995           | Hunter v. Chiles             | Coverage for Augmentative Communication Devices (ACDs)                                 | Eric Hunter<br>Corey Powell     | Federal          | Pending                                     |

| YEAR INITIATED       | CASE                                                        | ISSUE                                                                                                     | PLAINTIFF                                              | STATE OR FEDERAL    | CURRENT STATUS |
|----------------------|-------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------|---------------------|----------------|
| Benefits (continued) |                                                             |                                                                                                           |                                                        |                     |                |
| 1996                 | Orlando Transportation/<br>United Transportation v.<br>AHCA | Sole source contracting for<br>Medicaid transport services in<br>Orange, Seminole and<br>Osceola counties | Orlando<br>Transportation/<br>United<br>Transportation | State/Circuit Court | Pending        |
| Eligibility          |                                                             |                                                                                                           |                                                        |                     |                |
| 1993                 | Plaintiff v. HRS                                            | SSI                                                                                                       | Hartman                                                | State               | Dismissed      |
| 1993                 | Plaintiff v. HRS                                            | SSI Disability                                                                                            | Edlin                                                  | State               | Reversed       |
| 1993                 | Plaintiff v. HRS                                            | SSI Assets                                                                                                | Dunlap                                                 | State               | Affirmed       |
| 1993                 | Plaintiff v. HRS                                            | AFDC ADM Procedure                                                                                        | Ball                                                   | State               | Dismissed      |
| 1993                 | Plaintiff v. HRS                                            | SSI Disability                                                                                            | Campbell                                               | State               | Dismissed      |
| 1993                 | Plaintiff v. HRS                                            | SSI Income                                                                                                | Zimmerman                                              | State               | Dismissed      |
| 1993                 | Plaintiff v. HRS                                            | SSI Disability                                                                                            | Rodriguez                                              | State               | Dismissed      |
| 1993                 | Plaintiff v. HRS                                            | SSI Assets                                                                                                | Klein                                                  | State               | Affirmed       |
| 1993                 | Plaintiff v. HRS                                            | SSI Disability                                                                                            | Roth                                                   | State               | Pending        |
| 1993                 | Plaintiff v. HRS                                            | SSI Disability                                                                                            | Rukab                                                  | State               | Dismissed      |
| 1993                 | Plaintiff v. HRS                                            | SSI Income                                                                                                | Taylor                                                 | State               | Affirmed       |
| 1993                 | Plaintiff v. HRS                                            | SSI Disability                                                                                            | Scordas                                                | State               | Pending        |
| 1993                 | Plaintiff v. HRS                                            | SSI Assets                                                                                                | Wile                                                   | State               | Affirmed       |
| 1993                 | Plaintiff v. HRS                                            | SSI Disability                                                                                            | Merchant                                               | State               | Dismissed      |
| 1993                 | Plaintiff v. HRS                                            | SSI Disability                                                                                            | Chapman                                                | State               | Dismissed      |
| 1993                 | Plaintiff v. HRS                                            | Benefits                                                                                                  | Kurnik                                                 | State               | Reversed       |
| 1993                 | Plaintiff v. HRS                                            | SSI                                                                                                       | Kenny                                                  | State               | Affirmed       |
| 1994                 | Plaintiff v. HRS                                            | SSI Assets                                                                                                | Stewart                                                | State               | Pending        |
| 1994                 | Plaintiff v. HRS                                            | SSI Assets                                                                                                | Livermore                                              | State               | Dismissed      |
| 1994                 | Plaintiff v. HRS                                            | SSI Disability                                                                                            | Captain                                                | State               | Pending        |
| 1994                 | Plaintiff v. HRS                                            | SSI Income                                                                                                | Ginsburg                                               | State               | Pending        |
| 1994                 | Plaintiff v. HRS                                            | SSI Assets                                                                                                | Lowison                                                | State               | Pending        |
| 1994                 | Plaintiff v. HRS                                            | SSI Level of Care                                                                                         | Kaye                                                   | State               | Reversed       |
| 1994                 | Plaintiff v. HRS                                            | SSI Disability                                                                                            | Reno                                                   | State               | Pending        |

TO:

FROM: OMNIFAX

| YEAR INITIATED          | CASE             | ISSUE             | PLAINTIFF    | STATE OR FEDERAL | CURRENT STATUS |
|-------------------------|------------------|-------------------|--------------|------------------|----------------|
| Eligibility (continued) |                  |                   |              |                  |                |
| 1994                    | Plaintiff v. HRS | SSI Assets        | Brozen       | State            | Dismissed      |
| 1994                    | Plaintiff v. HRS | SSI Disability    | Sapp         | State            | Dismissed      |
| 1994                    | Plaintiff v. HRS | AFDC              | Reaney       | State            | Dismissed      |
| 1994                    | Plaintiff v. HRS | SSI Disability    | Jackson      | State            | Dismissed      |
| 1994                    | Plaintiff v. HRS | AFDC Income       | Bembry-Hicks | State            | Affirmed       |
| 1994                    | Plaintiff v. HRS | SSI Disability    | Glaser       | State            | Dismissed      |
| 1994                    | Plaintiff v. HRS | SSI Overpayment   | Shonfeld     | State            | Dismissed      |
| 1994                    | Plaintiff v. HRS | SSI ADM Procedure | Seccia       | State            | Dismissed      |
| 1994                    | Plaintiff v. HRS | SSI Disability    | Denegar      | State            | Dismissed      |
| 1994                    | Plaintiff v. HRS | SSI Disability    | Davis        | State            | Reversed       |
| 1994                    | Plaintiff v. HRS | Benefits          | Trigo        | State            | Dismissed      |
| 1994                    | Plaintiff v. HRS | SSI Disability    | Ayden        | State            | Dismissed      |
| 1994                    | Plaintiff v. HRS | SSI Disability    | Mahoney, F   | State            | Dismissed      |
| 1994                    | Plaintiff v. HRS | SSI Income        | Mahoney, M   | State            | Dismissed      |
| 1994                    | Plaintiff v. HRS | SSI Disability    | Sines        | State            | Dismissed      |
| 1994                    | Plaintiff v. HRS | AFDC              | McKnight, J  | State            | Dismissed      |
| 1994                    | Plaintiff v. HRS | SSI Disability    | Ferita       | State            | Pending        |
| 1994                    | Plaintiff v. HRS | SSI Assets        | Schenk       | State            | Dismissed      |
| 1994                    | Plaintiff v. HRS | SSI Disability    | Moricato     | State            | Pending        |
| 1994                    | Plaintiff v. HRS | SSI Level of Care | Cabanas      | State            | Dismissed      |
| 1994                    | Plaintiff v. HRS | SSI Disability    | Carfile      | State            | Dismissed      |
| 1995                    | Plaintiff v. HRS | SSI ADM Procedure | Salomon      | State            | Pending        |
| 1995                    | Plaintiff v. HRS | SSI Assets        | Were         | State            | Dismissed      |
| 1995                    | Plaintiff v. HRS | SSI Disability    | Curran       | State            | Dismissed      |
| 1995                    | Plaintiff v. HRS | SSI Income        | Sheldon      | State            | Dismissed      |
| 1995                    | Plaintiff v. HRS | SSI Income        | East         | State            | Dismissed      |

TO:

FROM: OMNIFAX

| YEAR INITIATED       | CASE             | ISSUE             | PLAINTIFF  | STATE OR FEDERAL | CURRENT STATUS |
|----------------------|------------------|-------------------|------------|------------------|----------------|
| Eligible (continued) |                  |                   |            |                  |                |
| 1995                 | Plaintiff v. HRS | SSI Disability    | James      | State            | Dismissed      |
| 1995                 | Plaintiff v. HRS | SSI Income        | Thiebodeau | State            | Dismissed      |
| 1995                 | Plaintiff v. HRS | SSI ADM Procedure | Marino     | State            | Dismissed      |
| 1995                 | Plaintiff v. HRS | SSI               | Roccio     | State            | Dismissed      |
| 1995                 | Plaintiff v. HRS | SSI ADM Procedure | Carson     | State            | Dismissed      |
| 1995                 | Plaintiff v. HRS | SSI Income        | Vaughn     | State            | Pending        |
| 1995                 | Plaintiff v. HRS | SSI Disability    | Powell     | State            | Dismissed      |
| 1995                 | Plaintiff v. HRS | SSI Income        | Geiger     | State            | Dismissed      |
| 1995                 | Plaintiff v. HRS | SSI Disability    | Peters     | State            | Pending        |
| 1995                 | Plaintiff v. HRS | SSI Disability    | Fox        | State            | Dismissed      |
| 1995                 | Plaintiff v. HRS | SSI Disability    | Mateo      | State            | Pending        |
| 1995                 | Plaintiff v. HRS | SSI ADM Procedure | Gies, I    | State            | Dismissed      |
| 1995                 | Plaintiff v. HRS | SSI ADM Procedure | Gies, W    | State            | Dismissed      |
| 1995                 | Plaintiff v. HRS | AFDC Age          | Pelaez, C  | State            | Dismissed      |
| 1995                 | Plaintiff v. HRS | SSI Disability    | Beebe      | State            | Dismissed      |
| 1995                 | Plaintiff v. HRS | SSI Disability    | Hall       | State            | Pending        |
| 1995                 | Plaintiff v. HRS | SSI Disability    | Shaffer    | State            | Pending        |
| 1995                 | Plaintiff v. HRS | SSI Disability    | Niles      | State            | Dismissed      |
| 1995                 | Plaintiff v. HRS | SSI Disability    | Carter     | State            | Pending        |
| 1995                 | Plaintiff v. HRS | SSI ADM Procedure | Taylor     | State            | Dismissed      |
| 1995                 | Plaintiff v. HRS | SSI Assets        | Conklin    | State            | Dismissed      |
| 1995                 | Plaintiff v. HRS | SSI Disability    | Walker     | State            | Pending        |
| 1995                 | Plaintiff v. HRS | SSI Disability    | Boissy     | State            | Pending        |
| 1995                 | Plaintiff v. HRS | SSI Overpayment   | Walsh      | State            | Dismissed      |
| 1995                 | Plaintiff v. HRS | SSI Disability    | Moser      | State            | Dismissed      |
| 1995                 | Plaintiff v. HRS | SSI Citizenship   | Ramirez    | State            | Dismissed      |

MAR 11, 1996 10:16AM P.08

TO:

FROM: OMNIFAX

| YEAR INITIATED                | CASE             | ISSUE          | PLAINTIFF | STATE OR FEDERAL | CURRENT STATUS |
|-------------------------------|------------------|----------------|-----------|------------------|----------------|
| Eligibility to obtain medical |                  |                |           |                  |                |
| 1995                          | Plaintiff v. HRS | SSI Disability | Horton    | State            | Dismissed      |
| 1995                          | Plaintiff v. HRS | SSI Disability | Mazzoni   | State            | Pending        |
| 1995                          | Plaintiff v. HRS | SSI Disability | Rodriguez | State            | Dismissed      |
| 1996                          | Plaintiff v. HRS | AFDC Income    | Poley     | State            | Pending        |
| 1996                          | Plaintiff v. HRS | SSI Disability | Bryant, G | State            | Pending        |
| 1996                          | Plaintiff v. HRS | SSI Disability | Bryant, L | State            | Pending        |
| 1996                          | Plaintiff v. HRS | SSI Income     | Thomas    | State            | Pending        |



### Possible Compromise Proposal

In other conversations, the following compromise approach has been discussed:

The right of action under federal law would be preserved, but in one category of cases, federal court review would be precluded. For individualized benefit claims, exhaustion of a health plan or HMO process and a state administrative process would be required, and an appeal could go only to state courts of appropriate jurisdiction, unless the claim exceeds a specified threshold amount. In other cases (all eligibility claims and benefit claims in which the validity of the state plan or a state policy were challenged), exhaustion of a state administrative process would be required, but the beneficiary could seek review in federal court.

**5. Should the ability of states to impose copayments be expanded?**

- a. Limit copayments to "nominal amounts" and prohibit any copayments for pregnant women, children, individuals in managed care plans. (Current law)
- b. Allow states to set copayments scaled to family size and income, but retain prohibitions against copayments for pregnant women, children, etc. (Coalition budget)
- c. Allow states to set copayments scaled to family size and income for all Medicaid recipients.

**6. Should there be a federal cause of action under the Medicaid statute?**

- a. Retain federal cause of action for individuals and providers. (Current law)
- b. Retain federal cause of action for individuals and providers, but eliminate most lawsuits by repealing Boren.
- c. Mandate a state administrative process before allowing suits to be brought in state court. No federal cause of action. *(STATES COULD LEGISLATE COULD VARY REMEDIES FROM STATE TO STATE.)*
- d. Require an individuals and providers to go through state administrative process prior to filing suit in federal court, unless the individual or provider alleges that the state plan violates the federal statute or if the administrative process does not take timely action.

or state  
law

↓  
If hearing officer  
doesn't have the  
ability to grant the  
relief

and  
penalties

on, because prisoner § 1983 administrative remedies in

ons of the Act make sense, f exhaustion could not be and if Congress intended to this no-exhaustion rule. demonstrates that Congress g out specific exceptions to s cannot require exhaustion vance to alter the balance g the procedural framework

appeals argue that exhaus- could be required because it They argue that an exhaus- the perceived burden that courts;<sup>13</sup> would further the al-state relations by post- l after the state adminis- issue;<sup>14</sup> and would enable s expertise in the area at rt's ultimate decision.

fficient to justify a judicial deci- sion. See *Thermtron Prod-* 336, 344 (1976); *Steelworkers v.* 965). In any event, it is by no use an exhaustion requirement in the federal courts, at least in the 18. principles to actions brought pursu- veral commentators. See, *e. g.*, o for the Federalism Seesaw, 25 U. L. Rev. 838 (1964).

As we noted earlier, policy considerations alone cannot justify judicially imposed exhaustion unless exhaustion is consistent with congressional intent. See *supra*, at 501-502, and n. 4. Furthermore, as the debates over incorporating the exhaustion requirement in § 1997e demonstrate, the relevant policy considerations do not invariably point in one direction, and there is vehement disagreement over the validity of the assumptions underlying many of them.<sup>15</sup> The very difficulty of these policy considerations, and Congress' superior institutional competence to pursue this debate, suggest that legislative not judicial solutions are preferable. Cf. *Diamond v. Chakrabarty*, 447 U. S. 303, 317 (1980); *Steelworkers v. Bouligny, Inc.*, 382 U. S. 145, 150, 153 (1965).

Beyond the policy issues that must be resolved in deciding whether to require exhaustion, there are equally difficult questions concerning the design and scope of an exhaustion requirement. These questions include how to define those categories of § 1983 claims in which exhaustion might be de-

<sup>13</sup> For example, there is serious disagreement over whether judicial or administrative procedures offer § 1983 plaintiffs the swiftest, least costly, and most reliable remedy. See, *e. g.*, 1977 Hearings 263-264; *id.*, at 232-233; Note, 68 Colum. L. Rev. 1201, 1207 (1968). Similarly, there is debate over whether the specialization of federal courts in constitutional law is more important than the specialization of administrative agencies in their areas of expertise, and over whether the symbolic and institutional function of federal courts in defining, legitimizing, and enforcing constitutional claims outweighs the educational function that state and local agencies can serve. See, *e. g.*, Whitman, *Constitutional Torts*, 79 Mich. L. Rev. 5, 23 (1980); Note, 68 Colum. L. Rev., *supra*, at 1208. Finally, it is uncertain whether the present "free market" system, under which litigants are free to pursue administrative remedies if they truly appear to be cheaper, more efficient, and more effective, is more likely to induce the creation of adequate remedies than a *McKart*-type standard under which plaintiffs have no initial choice. See, *e. g.*, Note, 8 Ind. L. Rev. 565 (1975). Cf. 1977 Hearings 21, 34, 51; Hearings on S. 1393 before the Subcommittee on the Constitution of the Senate Committee on the Judiciary, 95th Cong., 1st Sess., 442 (1977).

sirable; how to unify and centralize the standards for judging the kinds of administrative procedures that should be exhausted;<sup>16</sup> what tolling requirements and time limitations should be adopted;<sup>17</sup> what is the res judicata and collateral estoppel effect of particular administrative determinations; what consequences should attach to the failure to comply with procedural requirements of administrative proceedings; and whether federal courts could grant necessary interim injunctive relief and hold the action pending exhaustion, or proceed to judgment without requiring exhaustion even though exhaustion might otherwise be required, where the relevant administrative agency is either powerless or not inclined to grant such interim relief. These and similar questions might be answered swiftly and surely by legislation, but would create costly, remedy-delaying, and court-burdening litigation if answered incrementally by the judiciary in the context of diverse constitutional claims relating to thousands of different state agencies.<sup>18</sup>

<sup>16</sup>Section 1997e resolved this problem by directing the Attorney General to promulgate minimum standards and to establish a procedure by which prison administrative remedies could be reviewed and certified. §§ 1997e(b) and (c). If a procedure has not been certified, the court is directed to compare the procedure with the Attorney General's standards and to continue the case pending exhaustion only if the procedure is in substantial compliance with the standards of the Attorney General. § 1997e(a)(2).

<sup>17</sup>Unless the doctrine that statutes of limitations are not tolled pending exhaustion were overruled, see *Board of Regents v. Tomanio*, 446 U.S. 478 (1980), a judicially imposed exhaustion requirement might result in the effective repeal of § 1983. Congress avoided this problem in § 1997e by directing the court to merely continue the case for a period not to exceed 90 days.

<sup>18</sup>The initial bill proposing to include an exhaustion requirement in § 1997e provided:

"Relief shall not be granted by a district court in an action brought pursuant to [§ 1983] by an individual involuntarily confined in any State institution . . . , unless it appears that the individual has exhausted such plain,

The ve  
involved  
ation of t  
why Con.  
certain §  
such a na  
After full  
ments, C  
§ 1983 ac  
that diff  
urged by  
See n. 18  
will or sh  
§ 1983 cla  
together  
§ 1983 cla

speedy, ar.  
5791, 95th  
Congress c  
tified that  
litigation t  
federal co  
much time  
dures with  
165, 169-1

"The qu  
Eleventh  
Regents is  
Tr. of Ora  
pare *Hopk*  
*Florida D.*  
(1981). T  
Eleventh A  
raised this  
argue it in  
the en bar  
possible E.

The Agricultural Marketing Agreement Act authorizes formal rulemaking after hearing before an ALJ, to be reviewed by a Judicial Officer on behalf of the Secretary, and subject to review by a district court. After an order by the Judicial Officer, one aspect of which he decided to "leave . . . to the Secretary," the Dairy sought review by the district court. The court of appeals held (1) that administrative remedies had been exhausted, because the Judicial Officer had made a ruling, and (2) that the order was "sufficiently final for purposes of judicial review" because rights had been determined and review "would not disrupt the orderly process of adjudication." *American Dairy of Evansville, Inc. v. Bergland*, 627 F.2d 1252, 1260 (D.C. Cir. 1980). A dissenter demonstrated that the statute, 7 U.S.C. § 608c(15)(A), required an administrative determination after hearing, before a court could review, as held in *United States v. Ruzicka*, 329 U.S. 287, 295 (1946), but the majority responded that "Appellants have sought review by the Judicial Officer, and a ruling has been made on their petition. That is all that the Act requires for them to seek review by the district court." *Id.* at 1259. The dissenter's assertion that "a final decision by the Secretary has consistently been deemed an absolute prerequisite to district court review," *id.* at 1270, is supported only by cases that use the term "Secretary" as synonymous with "Department" and not by cases that distinguish between "Judicial Officer" and "Secretary." Most decisions "by the Secretary" are probably never called to the attention of the individual who is the Secretary.

#### § 26:11. Inadequacy of Administrative Remedies

One need not exhaust administrative remedies that are inadequate. Whenever exhaustion will be futile it is not required. The problems are to determine what constitutes inadequacy or futility.

Early cases made clear that administrative delay is enough reason for dispensing with the exhaustion requirement. When an agency delayed for two years, the Supreme Court held exhaustion not required: "Property may be as effectively taken by long-continued and unreasonable delay in putting an end to confiscatory rates as by an express affirmance of them." *Smith v. Illinois Bell Tell. Co.*, 270 U.S. 587, 591 (1926). Similar cases are *Prendergast v.*

New York Tel. Co., 262 U.S. 43 (1923); *Banton v. Belt Line Ry.*, 268 U.S. 413 (1925). When the National Railroad Adjustment Board had a "jurisdictional frustration" because of disagreement between two of its divisions, the Court held a declaratory judgment appropriate. *Order of Railway Conductors of America v. Swan*, 329 U.S. 520, 524 (1948). The Court later held that delays of as long as 10 years in the NRAB made exhaustion unnecessary. *Walker v. Southern R. Co.*, 385 U.S. 196 (1966).

Exhaustion was held excused by fraudulent control of one company by another, preventing access to the agency. *Montana-Dakota Utilities Co. v. Northwestern Public Service Co.*, 341 U.S. 246 (1951). Exhaustion before the Federal Trade Commission was held not required on a problem on which it could do no more than investigate, recommend, and report. *United States Alkali Export Ass'n v. United States*, 325 U.S. 196, 210 (1945).

In challenging a provision of the Social Security Act that discriminated in favor of women and against men, the challengers failed to exhaust administrative remedies, but the Court reached the merits because "the Government stipulated that any administrative appeal would have been futile, since § 402(g) on its face precludes granting benefits to men." *Weinberger v. Wiesenfeld*, 420 U.S. 636, 641, n. 8 (1975).

Exhaustion was not required when relief depended upon doubtful interpretation of a state statute, *Union Pac. R. Co. v. Board of Commissioners*, 247 U.S. 282 (1918); and when the Supreme Court's analysis showed "uncertainty surrounding the adequacy" of the remedy. *Hillsborough Tp., Somerset County, N.J. v. Cromwell*, 326 U.S. 620, 625 (1946).

Futility on account of probability of an adverse administrative decision may or may not relieve from the requirement of exhaustion. In *City Bank Farmers' Trust Co. v. Schnader*, 291 U.S. 24 (1934), the Court found intent of state officers "to perform what they consider their duty" enough to justify intervention of a court of equity. But an earlier case dispensed with exhaustion because the agency definitely expressed the view that it lacked jurisdiction. *Gilchrist v. Interborough Rapid Transit Co.*, 279 U.S. 159 (1929). And in the later prominent case of *Myers v. Bethlehem Shipbuilding Corp.*, 303 U.S. 41 (1938), exhaustion of the NLRB remedy on the question whether the Board had jurisdiction under the commerce clause was obviously futile, but the Supreme Court required it,

citing in note 9, 303 U.S. at 51, eighteen previous Supreme Court cases requiring exhaustion. In the Myers opinion, the Court said nothing about possible futility of exhausting the Board's remedies on the question of the Board's power under the commerce clause or on other questions.

A statutory right to "request" the Illinois Attorney General to bring suit was deemed an inadequate remedy in *McNeese v. Board of Education*, 373 U.S. 668 (1963), but that facet of the opinion was submerged in other questions.

A prisoner did not have to exhaust remedies before a parole board because: "Whether to require exhaustion is discretionary. If pursuing an administrative remedy would be futile, the requirement may be waived. . . . We are especially reluctant to require exhaustion when, as here, both parties agree administrative proceedings would be futile." *United States ex rel. Marrero v. Warden*, 483 F.2d 656, 659 (3d Cir.), reversed on other grounds 417 U.S. 653 (1974).

A discharged teacher who raised disputed issues of fact was not required to exhaust remedies that did not include trial procedure. *Plano v. Baker*, 504 F.2d 595, 598 (2d Cir. 1974).

Case law is on both sides of the question whether assertedly faulty administrative procedure must be exhausted. The court required exhaustion in *Wallace v. Lynn*, 507 F.2d 1186 (D.C. Cir. 1974), explaining that if the plaintiffs were unjustly treated they could then seek review. But in *Finnerty v. Cowen*, 508 F.2d 979, 982-83 (2d Cir. 1974), the court said "we agree with other recent opinions dispensing with the exhaustion requirement in situations where the very administrative procedure under attack is the one which the agency says must be exhausted." A remedy through a hearing excluding press and public need not be exhausted. *Fitzgerald v. Hampton*, 467 F.2d 755 (D.C. Cir. 1972), mandate stayed 409 U.S. 1055 (1973), then vacated 409 U.S. 1100 (1973).

Women discharged from the Navy were required to exhaust remedies before the Secretary even though the Secretary's Instruction showed that he would decide against the women. *Champagne v. Schlesinger*, 506 F.2d 979 (7th Cir. 1974). The court did not specifically respond to the argument that "since the Secretary of the Navy's own Instruction clearly defines his view, further intraservice appeal is useless."

A deaf student brought an action against a university for relief under the Rehabilitation Act forbidding discrimination against a

handic  
provid  
distric  
plaint  
order.  
Unive  
groun  
refusi  
adequ  
Unive  
with r  
was ar  
provid  
opinio  
v. Bak  
Daley  
(1967).  
render  
therefo  
F.2d a  
196, 19  
Railro  
as 10  
765-67  
to ext  
agency  
Civil R  
134.

W  
two Al  
depart  
not req  
of the  
648 F.2  
U:  
an obje  
neglect  
dinary  
positio  
circums

handicapped individual; on the ground that the university failed to provide sign language interpreter services. In granting relief, the district court required the student to file an administrative complaint with HEW. The court of appeals reversed that part of the order, and held that exhaustion was not required. *Camenisch v. University of Texas*, 616 F.2d 127 (5th Cir. 1980), vacated on other grounds, 451 U.S. 390 (1981). Each of the three grounds for refusing to require exhaustion is important. (1) The court found no adequate administrative procedure available, relying on *Cannon v. University of Chicago*, 441 U.S. 677 (1979), in which the Court held with respect to a similar provision that a cut-off of federal funds was an inappropriate remedy for an individual complainant, since it provides no personal redress. The court cited the concurring opinion of Justice Stevens in *Regents of the University of California v. Bakke*, 438 U.S. 265, 419, n. 26 (1978), and *Green Street Ass'n v. Daley*, 373 F.2d 1, 8, 9 (7th Cir. 1967), cert. denied 387 U.S. 932 (1967). (2) The court said that "excessive administrative delays render HEW's administrative remedies inadequate to help him and therefore a waiver of the exhaustion requirement is justified." 616 F.2d at 134. The court cited *Walker v. Southern R. Co.*, 385 U.S. 196, 198 (1966), holding exhaustion of a remedy before the National Railroad Adjustment Board not required because of delays as long as 10 years. (3) The court cited *Weinberger v. Salfi*, 422 U.S. 749, 765-67 (1975), for its unexplained statement that "there is no need to exhaust an administrative remedy where the administrative agency has waived the exhaustion requirement, which the Office of Civil Rights of HEW has done in these sorts of cases." 616 F.2d at 134.

When the Secretary of the Interior had made clear his position, two Alaskan boards within the Department had no authority to depart from the Secretary's position, and therefore exhaustion was not required because "resort to either Board would be futile in light of the Secretary's position." *Aleknagik Natives Limited v. Andrus*, 648 F.2d 496, 501 (9th Cir. 1981).

Under a statute barring consideration by a reviewing court of an objection not urged before the agency "unless the failure or neglect to urge such objection shall be excused because of extraordinary circumstances," futility of asking the agency to reverse a position it recently adopted was held not to be an extraordinary circumstance. *Power Plant Division, Brown & Root, Inc. v. Occu-*

pational Safety and Health Review Commission, 659 F.2d 1291 (5th Cir. 1981), on rehearing 673 F.2d 115 (1982).

Exhaustion by going to an Appeals and Review Board which had taken an adverse position "would be futile" and therefore was not required. *Cafferello v. United States Civil Service Commission*, 625 F.2d 285 (9th Cir. 1980).

Exhaustion would be futile and is not required when the Administrator has ruled definitively on the sole issue on which review is sought. *Porter County Chapter of the Izaak Walton League v. Costle*, 571 F.2d 359, 364 (7th Cir.), cert. denied 439 U.S. 834 (1978).

An agency's adverse decision with respect to some of a company's plants makes exhaustion futile with respect to similar plants of the company. *Continental Can Co. v. Marshall*, 603 F.2d 590, 597 (7th Cir. 1979).

Even though the court said that the Administrator's failure to provide by regulation an opportunity to file exceptions to the ALJ's decision was unlawful, the court refused to reverse, because the petitioner "never sought to file exceptions . . . and thus provide the Administrator with an opportunity to permit exceptions to be filed. Petitioner has failed to demonstrate that requesting the opportunity to file exceptions would be so futile as to relieve petitioner of the obligation to apply to the Administrator in the first instance." *Klinestiver v. Drug Enforcement Administration*, 606 F.2d 1128, 1130 (D.C. Cir. 1979).

When plaintiffs took no administrative appeal because the Chief Personnel Officer told them they had no appeal rights, the court held that for that reason they were not required to exhaust their appeal rights. *Athas v. United States*, 597 F.2d 722, 725 (Ct. Cl. 1979).

# § 26:12. Rehearings and Administrative Appeals — § 704 of the APA

The 1958 Treatise said that § 10(c) of the Administrative Procedure Act (which is now 5 U.S.C. § 704) has been almost completely ignored in judicial opinions. That observation may be repeated as of 1982, for only a handful of opinions have considered the provision in the 36 years since the APA was enacted. The

provision looked.

The

§ 26:10. T

Exce

action

sectic

mine

form

requi

inope

Althc

appendix :

of what is

law," Sen

statement

§ 704 but :

stantially

appeals. F

the Court

mere form

swept awa

appeal to

judicial re

Chicago. N

law was cl

In tw

take into a

McKart v.

elaborate o

a selective :

a criminal

problem by

"final" des

for violatin

402 U.S. 18

failing to m

failing to s

have held t

The S

---

Theresa Roschborough

514-0539

---

# DISCUSSION DRAFT ONLY

## INDIVIDUAL RIGHT OF ACTION

### Scope

a) The following adjudication process applies to <sup>individual factual</sup> disputes regarding benefits, deductibles and co-payments. The status quo would remain for disputes regarding eligibility and premiums, and enrollment and disenrollment-related issues, except that the requirement to exhaust the state administrative process prior to filing in court would be made explicit for that category of claims as well. For persons enrolled in HMOs, the "HMO level" process applies only to disputes regarding benefits included in the contract between the State and the HMO.

b) For purposes of this document, "individual" means a person aggrieved by a decision to deny, delay, reduce or terminate coverage of a benefit or by a decision as to the required amount of a co-payment or deductible. Such a person may be a beneficiary, a provider, or a provider acting on behalf of a beneficiary.

c) The process outlined below shall not be required as a precondition to an individual seeking to disenroll from a plan.

### HMO level

a) HMO must have an internal grievance process that satisfies 42 CFR 434.32. HMO must provide for furnishing individual with dated proof of filing a claim.

b) In determining disputes regarding emergency services or urgently needed services, HMO must apply definitions of those terms in 417 CFR 401.

c) If a claim for pre-service authorization is not granted or no final action is taken within 24 hours, the individual may file immediately with the state administrative process.

d) If there is no final action on a claim, other than one for pre-service authorization, within 30 days after filing, or if the individual is aggrieved by the action taken on a claim, the individual may file immediately with the state administrative process.

e) Individuals in HMOs must exhaust the HMO internal grievance process. Failure by the HMO to meet the time limits stated in (c) or (d) shall constitute exhaustion of the internal grievance process.

### State administrative process

a) State must provide fair hearing process that satisfies 42 CFR, Part 431 to all aggrieved individuals whether claim originates in a managed care or fee-for-service plan.

b) If a claim for pre-service authorization is not granted or no final action is taken

## DISCUSSION DRAFT ONLY

within 48 hours after filing, the individual may seek immediate judicial review.

c) If there is no final action on a claim, other than for pre-service authorization, within 60 days after filing, or if the individual is aggrieved by the final action taken on a claim, the individual may seek judicial review.

d) Individuals must exhaust the state administrative process. Failure by the state agency to meet the time limits stated in (b) or (c) shall constitute exhaustion of the administrative process.

### Judicial review

a) Individuals may seek review of a final order of the state administrative process in a state court of competent jurisdiction or, if the amount in controversy exceeds \$50,000, in a federal district court. Amount in controversy would be determined by the same rules that are used to determine the amount in controversy in cases brought in federal court under diversity jurisdiction.

b) This process shall be the exclusive remedy for claims by individuals raising factual disputes as to particular cases of benefit coverage, deductibles, and co-payments, in which the statutory or constitutional validity of a coverage policy is not in dispute.

c) Nothing herein shall be construed to deny, impair or otherwise adversely affect a right or remedy available under law to any person, except as stated in (b).

d) A state may not contract with a plan or provider to waive or abrogate any third-party claims that a beneficiary might otherwise assert against the plan or provider, except as stated in (b).

any

## FAX TRANSMITTAL

|                                                                                            |                                                             |                                                                         |
|--------------------------------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------|
| TO:                                                                                        | Jennifer Klein                                              |                                                                         |
| ORGANIZATION:                                                                              | The White House                                             |                                                                         |
| Telephone Number:<br>456-2599                                                              | Fax Number:<br>456-2878                                     | # of Pages<br>(including cover sheet)<br><br>3                          |
| FROM:                                                                                      | Gregg Haifley<br>CHILDREN'S DEFENSE FUND<br>HEALTH DIVISION |                                                                         |
| Telephone Number:<br>(202) 662-3541<br>FAX Number:<br>(202) 662-3560                       |                                                             | Date: 3/28/96<br><br>Time: <span style="float: right;">AM<br/>PM</span> |
| Comments: Following is a piece on exhaustion of administrative remedies in Medicaid cases. |                                                             |                                                                         |

Please call 662-3541 if you did not receive all of this fax transmission.

## Requiring Exhaustion of Administrative Remedies in Medicaid Cases Would be a Terrible Mistake for Beneficiaries, States and the Courts

A number of governors have proposed that, before a Medicaid beneficiary could file a federal court lawsuit to enforce his or her federal rights, the beneficiary should first have to exhaust administrative remedies.\* This is a bad idea for beneficiaries, states, the federal government, and our courts.

1) Medicaid beneficiaries and the paralegals or lawyers who represent them already take to administrative hearings those fact-based cases which are appropriate to be heard there, and take to federal court only those cases which are appropriate to be heard there. Well over 99% of all claims are made to the administrative agency, not to federal courts, and seek to resolve factual disputes.

2) Those cases that are brought in federal court use federal laws to challenge the policies of the state, or its widespread practices. These policies or practices cannot be remedied in an administrative hearing. In fact, many states bar hearing officers from even considering such issues, and in virtually all states they are not trained to interpret federal law. The cases brought in federal court do not involve those types of questions of individual fact that need to be dealt with administratively. When such factual issues are present and there are not important legal issues, lawyers and beneficiaries typically do go through administrative processes.

3) An exhaustion requirement would lead to protracted and mostly pointless litigation over the preliminary collateral issue of whether or not exhaustion in the particular case is needed. Before 1982, when the Supreme Court definitively put an end to the practice, a couple of federal courts of appeals required exhaustion of administrative remedies in welfare and Medicaid cases, when such remedies were adequate. The result was that huge amounts of agency, lawyer and judge time went into litigation over this collateral issue in courts across the nation, and significant delays occurred while courts worked through this issue. But it was rare that a judge ever wound up dismissing a Medicaid case for failure to exhaust administrative remedies because beneficiaries and lawyers were not bringing to court those cases in which exhaustion was appropriate. Nevertheless, the collateral preliminary litigation entailed probing such matters as the finality of administrative decisions, the length or formality of the state's administrative process, the impartiality of the decision-maker, etc., much of which was itself intrusive and aggravated federal-state relations. The effect was to create an additional unnecessary obstacle to resolution of important underlying federal legal issues. This extra obstacle is particularly harmful in cases involving rights to health care where the applicant's or recipient's health can be harmed during the delay.

4) Very few Medicaid cases are brought in federal court each year. The number of beneficiary lawsuits filed in federal court generally averages fewer than one per year per state. (In addition, there are provider reimbursement claims, that would no longer be brought because the underlying substantive basis for them in the federal Medicaid statute would disappear under pending Medicaid proposals.)

---

\*A separate proposal to send all Medicaid claims to state courts is also a bad idea, and is addressed in a separate analysis.

5) Beneficiaries do not lightly go to federal court. Federal courts are often more expensive places in which to litigate. And they cannot award compensatory damages or back benefits to beneficiaries, because the Eleventh Amendment, as construed in Edelman v. Jordan, 415 U.S. 651 (1974), prohibits such relief against a state. Therefore, if state administrative or judicial remedies are effective, people will use them (state courts have concurrent jurisdiction with federal courts over 42 U.S.C. § 1983 claims). People use the simpler, speedier, less expensive remedy so long as they perceive it to be fair. Indeed, it has been suggested that this "free market" system in which there is a choice is an incentive to agencies to keep administrative remedies cheaper and more effective. Patsy v. Florida International University, 457 U.S. 496, 513 n. 15, and sources cited there.

6) Since 42 U.S.C. § 1983 was passed immediately after the Civil War, there has been a 125 year history of not requiring exhaustion in cases brought pursuant to section 1983 to enforce federal laws. Only one limited exception has been carved out by Congress, after extensive debate, in 1980. That exception limits federal court suits by prisoners and was passed to reduce the huge number of prisoner cases (nearly 10,000 in 1978 -- 5% of the federal courts' entire civil caseload), many of which were frivolous, filed pro se without counsel, handwritten, or otherwise a major and inappropriate burden on the federal courts. See, e.g., 125 Cong. Rec. H 3639. In other words, the only previous administrative exhaustion requirement was passed to protect federal courts from thousands of frivolous suits. Here, the states seek protection from meritorious suits numbering in the teens or the dozens rather than the thousands. Congressional imposition of an exhaustion requirement at the behest of defendants seeking relief from valid claims would be a major inroad on the right to sue to enforce federal rights, and a terrible precedent for Congressional action against other types of meritorious claims.

7) Even when exhaustion of administrative remedies is normally required, there is an exception if it would be futile. Before exhaustion is required, relief must be available within a reasonable time; procedures must be fair; interim relief must be available in appropriate cases to prevent irreparable injury (an especially urgent concern in cases involving medical benefits); the agency must be able to grant relief commensurate with the claim; the decision cannot be based on a secret policy; and other standards. See, for example, Patsy v. Florida International University, 634 F.2d 900, 912-913 (5th Cir. 1981), rev'd, 457 U.S. 496 (1982), and Bowen v. City of New York, 476 U.S. 467 (1986). Even in the prisoner exhaustion situation discussed earlier, Congress set out minimum standards. Such standards, if designed carefully and appropriately, would mean that federal courts would rarely toss out a Medicaid claim for failure to exhaust, but would face all these criteria as unnecessary threshold matters, and would involve every federal court in deciding not just whether a state violated substantive Medicaid rules, but also and unnecessarily whether large portions of a state's administrative process are fair.

For Medicaid applicants and recipients, an exhaustion requirement would present a major inappropriate obstacle to securing relief from state policies and practices challenged as contrary to federal law. The effect of an exhaustion requirement would be to delay resolution of meritorious federal challenges at great expense - both in time and money for litigants and the courts, and in injury to the health of children and other applicants and recipients.

**DEPARTMENT OF HEALTH & HUMAN SERVICES**

Office of the Secretary

Office of the General Counsel  
Washington, D.C. 20201  
(202) 690-7780  
Fax: 690-7998

**MEMORANDUM**

To: Jack Ebeler  
Jerry Klepner  
Bruce Vladeck

From: Nan D. Hunter *ndh*

Date: 18 March 1996

Re: Medicaid lawsuits against states

-----

The attached memorandum from the HCFA division of OGC outlines the final results of a legal database search for federal court lawsuits filed against states in which a violation of Medicaid law was alleged. There are inherent limitations in a search of this kind, as the memorandum explains. From what was found, however, we have learned the following:

\* From 1991 to 1996, there were 127 reported cases. This is a much lower number than we originally believed. The difference is because of the number of duplicated references to the same cases which were included in the preliminary search.

\* Of the 127, 63 were brought by beneficiaries. The others were brought by providers, including 27 Boren Amendment cases, and by states.

\* The federal courts ruled for defendants in slightly more than half the cases.



## DEPARTMENT OF HEALTH &amp; HUMAN SERVICES

Office of the General Counsel  
Health Care Financing Division

MAR 15 1996

MEMORANDUMTO : Nan Hunter  
Deputy General CounselFROM : David R. Smith  
Attorney

A handwritten signature in dark ink, appearing to be "DRS", is written over the name "David R. Smith" in the "FROM" field.

SUBJECT: Medicaid cases reported during the period from Feb. 1, 1991 to the present

This responds to your request that we refine the data which we produced on February 16, 1996 in response to an inquiry regarding the number of Medicaid beneficiary cases and Medicaid cases brought by providers under the Boren amendment<sup>1</sup> during the previous five years.

We conducted this original search based on a request for an expedited reply. The search involved four separate WestLaw searches, two in the ALLCASES database and two in the ALLFEDS database. Each search involved the period from February 1, 1991 through the February 16, 1996. The ALLCASES searches attempted to elicit the total number of federal and state court cases involving the two issues. The ALLFEDS searches restricted these searches to Federal cases.

For Boren Amendment cases, we searched for all cases which include the West key number for Medicaid cases and "Boren" after January 31, 1991. For Medicaid cases we searched for all cases which included the words "Medicaid applicant" or "Medicaid recipient" also within the same date range. We recognized at the time we conducted these searches that they would necessarily include cases which may not have been responsive to the request, or which could have been duplicated in the

---

<sup>1</sup>The Boren amendment provides standards for state payment for Medicaid hospital and nursing facility services. See § 1902(a)(13)(A) of the Social Security Act.

Page 2 - Nan Hunter

results list.<sup>2</sup> We also recognized that our count would exclude cases which are not reported (unless furnished to West Publishing) and cases which did not include our search terms. For example, we did not search for cases including the term "Medicaid beneficiary." We then produced a cite list and provided you with our totals for all four searches

On March 6, 1996 we received your message requesting our analysis of the 226 Federal court cases which we had originally reported. We then once again performed the research and this time analyzed the data to eliminate duplicate cases<sup>3</sup> and cases which were not properly identified as Medicaid cases. Our revised general Medicaid search produced 223 cases<sup>4</sup> which we then reviewed individually. We used the case summaries generated by WestLaw to review the contents of the cases, to determine whether they were class action suits, to ascertain whether they were beneficiary or provider cases, and to attempt find out which party prevailed.

This review produced the following results:

1. The "Medicaid applicant" and "Medicaid recipient" search found 127 unduplicated cases which were actually Medicaid cases.<sup>5</sup>

---

<sup>2</sup>Westlaw often will report a case at different court levels and even at different stages of the proceedings at the same court level if the court issues separate opinions.

<sup>3</sup>As we discussed with you, we considered a case to be a duplicate if it had already been reported in our WestLaw search at any level of proceeding, even if the earlier decision involved an issue not involved in the later proceeding. Thus, a appellate decisions, district court decisions on the merits, district court decisions on attorneys fees, and district court decisions on preliminary relief would only count as one decision if they involved the same parties and arose out of the original complaint.

<sup>4</sup>We assume that the original number was a counting error.

<sup>5</sup>We account for the difference between the 223 cases and this number by virtue of eliminating the duplicate cases and the non-Medicaid cases. Several of the cases found in the search were Medicare cases rather than Medicaid. Others were ERISA cases, criminal fraud cases involving Medicaid providers but not related to charges under the Medicaid program, and others were HUD cases.

Page 3 - Nan Hunter

2. We found 27 unduplicated Boren amendment cases. (Of this amount only 14 were included in the "Medicaid applicant" and "Medicaid recipient" search.<sup>6</sup> The remaining 13 cases were unduplicated Boren amendment cases found after reexamining the more specific "Boren amendment" search.)
3. Our search found 42 class action cases<sup>7</sup> which were brought by beneficiaries.
4. There were 21 cases brought by beneficiaries which were not styled as class actions.
5. Our results showed 50 other cases. These would include actions by states suing HHS, and provider suits against states or HHS on grounds other than the Boren amendment.
6. Our data contained the following win/loss distribution: Plaintiffs won 59, defendants won 65, and 3 cases were difficult to determine the prevailing party. (These figures, too, are subject to some caveats. By eliminating duplicate cases (cases which arose out of the initial litigation, whether on appeal or in different phases of the litigation) one party may have prevailed in a part of the action which was eliminated from the count. Also, a party may have prevailed on its claim during a period prior to February 1, 1991, but lost in a decision reported during our search period.)

You also asked us to review the separate analyses prepared by the National Health Law Program of federal court Medicaid cases concerning eligibility and benefits. We found there was very little correlation between our figures and theirs. This appears to be due to differences in the respective search criteria. Their search looked for "eligibility" cases (based on a statutory citation) and "amount, duration, or scope" cases. Ours did neither. Moreover, it is possible that they did not use the same criteria for eliminating duplicate cases since they have not explained their rules for identifying those cases. While they may have eliminated some duplicate cases for each year, several of these cases appear in different year print outs. Neither our nor

---

<sup>6</sup>These 14 cases were included in the original 223 figure. The other 13 were included in the separate figure we had provided for Boren amendment cases.

<sup>7</sup>Here, too, we provide a word of caution. We counted as a class action any case which was brought as such (rather than only those certified by the court as a class action). Our cross section of cases made it very difficult to establish whether a class was actually certified in each case. A class may have been certified at a different portion of the proceedings than that captured by our search.

Page 4 - Nan Hunter

their search strategies are perfect or attempted to obtain the same count. The results will depend upon the information sought.



# National Health Law Program, Inc.

**MAIN OFFICE**

2639 South La Cienega Boulevard  
Los Angeles, California 90034  
(310) 204-6010  
Fax #: (310) 204-0891

**BRANCH OFFICES**

1815 H. Street, N.W. Suite 705  
Washington, D.C. 20006  
(202) 887-5310  
Fax #: (202) 785-6792

211 N. Columbia St. 2nd Floor  
Chapel Hill, NC 27514  
(919) 968-6308  
Fax #: (919) 968-8855

**MEMO**

**To:** Jennifer Klein  
**From:** Mark Regan  
**Date:** 3/7/96  
**About:** The federal litigation story in today's  
Washington Post

Back in May 1987 our program published a Clearinghouse article titled "Medicaid Transplant Litigation Proliferates," citing a grand total of eight cases, so the story in Thursday's Post punched a certain button. There in the lead was William A. Kimble, transplant litigator, and there, listed by implication although not by name, were Montoya v. Johnston, 654 F.Supp. 511 (W.D. Tex. 1987) (liver transplant), Periera v. Kozlowski, 805 F.Supp. 361 (E.D. Va. 1993) (heart transplant), and Pittman v. Secretary, 998 F.2d 887 (11th Cir. 1993) (liver/bowel transplant), and there was the Post, implying that this is what federal Medicaid litigation is all about. The question is, are transplant cases typical?

No.

Transplant cases do epitomize a certain kind of dispute between patients and health insurers. The Time Magazine cover story in January on HMOs, which involved HealthNet's refusal to cover a bone marrow transplant, is the most famous example. Medicaid providing health insurance for so many poor people, there are always going to be Medicaid transplant cases. But they're not typical.

Of the reported federal-court eligibility and benefits cases since 1988 which I've been able to identify, only 10 (less than 10%) are transplant cases.

Transplant cases are atypical because ...

a) They're individual cases, while most federal court cases filed by recipients involve systemic class-wide violations of the Medicaid Act;

b) Their special life-or-death nature means that more is at stake, both for the recipient and for the state, than in the ordinary individual case, which makes it somewhat more likely that a recipient will feel a special need to seek out a decisionmaker who is not subject to state fiscal pressures; and

c) Medicaid transplant law has been more than usually unclear during the past few years -- at least until a HCFA policy statement

in the fall of 1993, the area really did invite litigation.

Traditionally, a Medicaid transplant case was an amount, duration and scope case, involving claims that state coverage of transplants was insufficient [42 C.F.R. § 440.230(b)] or discriminatory [ §§ 440.230(c) and .240]. Of special concern was the lack of ascertainable standards for the life-or-death decisions states were making. See, e.g., Allen v. Mansour, 681 F.Supp. 1232, 1238 (E.D. Mich. 1986) ("a constantly shifting pattern of requirements").

In COBRA (Pub. L. No. 99-272, April 1986), Congress tried to require states to have written standards for transplants under which similarly situated individuals were treated alike and State restrictions would be consistent with the accessibility of high-quality care. See 42 U.S.C. § 1396b(i)(1), added by § 9507(a) of COBRA. But this requirement was weirdly phrased: states would not get paid for any transplants unless they had these standards. An obvious question which invited (and got) litigation was whether a state could choose not to cover any transplants at all. See Ellis v. Patterson, 859 F.2d 52 (8th Cir. 1988) (Answer: yes, it could make this choice). Another question was whether if a state covered transplants and if it had standards, the standards were judicially reviewable. See Meusberger v. Palmer, 900 F.2d 1280 (8th Cir. 1990) (Answer: yes, the standards were reviewable). Then there was the question of what the requirement that similarly situated individuals be treated alike actually meant. See Dexter v. Kirschner, 972 F.2d 1113 (9th Cir. 1992) (Answer, per the Ninth Circuit: basically nothing beyond equal protection).

Add to the mix the question of transplants for children, raised in its most direct form by the EPSDT treatment requirement in OBRA '89, 42 U.S.C. § 1396d(r)(5). Under this statute necessary health care and treatment for children must be covered even though it is not otherwise covered under a state Medicaid plan. Most of the relatively recent federal transplant litigation has involved transplants for children -- and turned on the relationship between the direct federal treatment requirement and the general discretion over transplants which some courts think they have seen in the transplant statute. Mr. Kimble's more recent cases are part of this pattern.

Now, through proposed regulations, HCFA may have somewhat reduced the legal uncertainty surrounding transplants for children. The policy announced in the preamble is that

organ transplants, which are generally considered safe and effective, and any related services must be furnished to individuals who are eligible for EPSDT services and who would benefit from these services, as long as the particular transplant procedure is considered safe and not experimental.

58 Fed. Reg. 51288, 51293 (October 1, 1993). Maybe this has made states' responsibilities clearer and helped reduce the volume of federal litigation over transplants for children.

Or maybe states just realized on their own what they were supposed to do.

In any event, it'd be a shame if people lost their right to enforce federal law in federal court because some states resented being sued in their role as health insurers for the desperately sick. States actually have limited exposure in those cases. Unlike HealthNet in the Time Magazine story, states can't be sued for damages when they wrongfully deny treatment to Medicaid patients. Prospective relief is all that's available. Given that limited exposure, and the fact that transplant cases are so atypical of federal litigation, something else must be accounting for some of the Governors' vehemence on this issue.

In fact, the Post story actually spells out the real problem. States don't want to be sued in federal court because they don't want to be subject to federal guarantees. As Gerald Whitburn put it, "If we are going to have state governors driving the train, then legal questions about their decisions should be addressed by the state judiciary."

What Mr. Whitburn forgets is that the Governors have agreed, or say they have agreed, to be subject to federal law, particularly in the world of eligibility. They are not the sole drivers of the train, and the courts which Mr. Whitburn so obviously thinks belong to them should not be the only courts available to the people that federal law will continue to protect.

## PRIVATE RIGHT OF ACTION

**A Federal Private Right of Action is Important to Maintaining the Guarantee.** The Governors (and the Congressional conference report) have eliminated any federal cause of action by Medicaid beneficiaries. Claims brought by individuals to enforce their rights under Medicaid would be limited to state courts and state law. Only the Secretary of Health and Human Services could bring an action in federal court on behalf of Medicaid beneficiaries.

The Governors want to reduce the number of Medicaid cases filed. In addition, they do not want court decisions from federal courts in other states to have any effect on how they run their Medicaid programs. While, under their proposal, cases heard in other states' courts would no longer have precedential value, it is not likely that fewer cases would be filed; they would simply be filed in state court.

You have taken the position that you support maintaining the guarantee under Medicaid. Since the inception of the Medicaid program, a person eligible for Medicaid has had both a guarantee of access to certain services and the right to enforce this commitment. A "guarantee" without a right to enforce it and a remedy for its deprivation is a hollow promise. We believe that preservation of the *federal cause of action* for individuals to enforce Medicaid eligibility assures this guarantee.

- **Consistent Interpretation.** Those aspects of the Medicaid program that are common to all states -- like eligibility -- should be consistently interpreted and administered. The basic guarantee of who is covered should be uniform across the country; without a federal cause of action, it will not be. For example, under current interpretations, a woman who has a miscarriage is considered "pregnant" and therefore eligible for services for complications arising from the miscarriage. Under the Governors' plan, if a state improperly denied those services, she could no longer go to federal court to enforce her right. The issue would instead be litigated in fifty states; in some states, she would receive care while in others she might not.
- **Significant Limitation of Remedies.** The remedies available under state law are generally more limited than under federal law. Very few state laws allow beneficiaries to obtain injunctions against the continuation of policies found to be unlawful or to recover attorneys fees.

The Governors (and the conference report) claim to maintain a right to sue in federal court through the Secretary of Health and Human Services. However, this poses three problems: (1) the Secretary can sue only if a state is in "substantial noncompliance" -- a much higher standard than exists today; (2) the Health Care Financing Administration will become involved in greater numbers of lawsuits and face significant new administrative burdens; and (3) it is unclear what remedies are available. If the only remedy that the Secretary can seek is the withdrawal of federal funds, this would cause significant harm to the beneficiaries that the Secretary is supposed to represent (and might even make this remedy unusable).

- **Departure from Other Federal Statutes.** Eliminating the federal cause of action would single out Medicaid as the one federal statute that confers individual rights that could not be enforced in federal court by its intended beneficiaries. Such an unprecedented step would be seen as a signal of second-class status and would set off a massive reaction from beneficiary groups and their allies.

**Your Proposal Increases Flexibility While Maintaining the Guarantee.** Under your plan, you eliminate causes of action by providers over payment rates by repealing the Boren Amendment. This removes state officials' greatest source of concern over litigation. You could also eliminate health care providers and plans right to sue in federal court for any reason.

Your proposal maintains current law on private enforcement of beneficiary rights under Medicaid. You could take steps to address the Governors' concerns by separating eligibility claims from some benefits claims. On eligibility issues, which are most closely linked to the concept of a guarantee, individuals would retain their current right to bring suits in federal court. However, individuals would be required to exhaust a state administrative process before filing in court. Most claims involving benefits would be heard only in state courts. A benefits claim could be heard in federal court only if there were an allegation that the state plan or a contract between the state and a provider violated a provision of federal law.

Under this approach:

- There would be no suits by health care providers or health plans over reimbursement rates or any other issue.
- Everyone filing a claim would be required to exhaust administrative remedies. A recent survey of state Medicaid agencies found that in the 40 states that responded, less than 5% of fair hearing decisions were appealed to a court. In California, for example, 4,600 fair hearings were held and less than 1% were appealed. In Wisconsin, 376 fair hearings were held, and 8 (2%) were appealed. (Texas Legal Services Center, 1994)
- Most disputes over benefits would be heard in state court.
- Claims brought by individuals over eligibility would be heard in federal court. **Across the country, there were 6 reported cases over eligibility in 1994, 8 in 1993, 6 in 1992 and 8 in 1991.** (National Health Law Program, Inc., 1995)

## Seeking Medicaid, in Court

ONE OF the most important issues in the budget battle over Medicaid is also one of the most obscure. Congressional Republicans seek not just to limit the program's future cost but to change its structure by transferring greater control to the states. They would largely be the ones to decide what kinds of care to give to whom, subject to only the most general federal requirements. But who would then determine, in a program to which the federal government would still be contributing more than \$100 billion a year, whether even those requirements were being met? Unsurprisingly, there is a conflict here.

Advocacy groups say that, to keep the program operating as it should, they need to retain the right to take offending states to federal court. They believe it will be even more important to have such a protection if other federal supervision of the program through regulation and the executive branch is relaxed, as the Republicans and many governors propose. But the governors who don't want the Department of Health and Human Services as overseer don't want the federal courts as overseers either. They say there's already too much of that, and that judges ought not be running health care, welfare and other programs and commanding state and local governments to spend money even to the extent that they already do.

As a compromise, the governors in their recent proposals with regard to Medicaid suggested that aggrieved groups be allowed to sue under-performing state agencies initially only in state courts. But because state courts tend to operate under different rules, that would likely leave such groups with a lot less leverage than

they have now. You're balancing risks in a situation such as this: too much litigation vs. not enough attention to the health care needs of the poor.

The right to file these lawsuits is of enormous importance. It affects the balance of power in the society in all kinds of fundamental ways—the relationship of citizens to government, the judiciary to the political branches, the federal government to the states. The Supreme Court broadened the right in 1980, construing a Reconstruction-era statute to permit private citizens to sue state and local officials in federal courts for violations not just of civil rights laws but other federal statutes.

It's absolutely the case that sometimes such lawsuits end up binding state and local officials. You need only look to the District government. Half its agencies are tied up in court for failure to deliver the services they are obliged to deliver by law. But surely the lawsuits aren't the problem in this. If the law requires that a benefit be conferred, then it ought to be conferred. If there isn't the money, then raise the money or change the law, but don't leave the false promise in place and ask the courts to look the other way.

The fight with regard to Medicaid has been to preserve the entitlement of certain groups to certain levels of care even while giving greater flexibility to the states. The president, who has fought for the entitlement, has been careful to say not merely that it should exist but that it should be enforceable. He's right, and that's why the private right of action, as the power to go to court is called, is so important and needs to be preserved.

## *Top-of-the-Line in Prince George's*



YALE LAW SCHOOL  
P.O. Box 208215  
New Haven, Connecticut 06520-8215

February 28, 1996

The Honorable William J. Clinton  
President of the United States  
The White House  
1600 Pennsylvania Avenue  
Washington, DC 20500-2000

Dear Mr. President:

The nation's Governors have made a thoughtful proposal concerning the restructuring of Medicaid. Nevertheless, there are aspects of their plan that should be rejected. In particular, we believe that opportunities for beneficiary enforcement of federal requirements in federal court must be maintained.

The Governors propose a bifurcated system of enforcement. Beneficiaries would pursue remedies through state administrative and judicial processes with the remote possibility of a unifying appeal to the United States Supreme Court. Enforcement of federal standards through federal court action would be available only to federal administrators.

The problem with limiting beneficiaries to state remedies is straightforward: those remedies will be highly heterogeneous and of differential effectiveness. On the other hand, were the federal government to attempt to ensure the effectiveness of state remedies, it would have to specify their structure and character as conditions on the receipt of federal Medicaid funds. This quite rightly would be perceived as a highly intrusive new set of federal requirements. In short, neither leaving beneficiaries to the vagaries of state law, nor seeking to unify or specify that law, is an attractive alternative to the current system.

The Governor's further suggestion for federal enforcement of conditions against states in federal court is unlikely to supply either remedial certainty or doctrinal uniformity. The federal government has a remarkably poor record in enforcing conditions in federal grants to the states. Only the most egregious cases can be pursued, and, even then, a host of political considerations sharply constrain federal action.

In short, we believe that the elimination of beneficiary enforcement actions in federal court is not a "legal detail" in the Governors' proposal. The maintenance of an effective enforcement scheme is, indeed, a useful test of whether there are serious and legitimate federal interests that should be defended in the restructuring of Medicaid. If so, as the Governors' proposals clearly presume, those federal interests should not be compromised by potentially lax and highly variable enforcement.

Letter to the Honorable William J. Clinton  
February 28, 1996

Page two

Finally, it is hard to overemphasize the degree to which the legal regime for the enforcement of beneficiary rights structures the political relationships in Medicaid policy-making. "I'll see you in federal court" is often the only effective way for beneficiary representatives to get invited to the legislative assembly or to the relevant executive departments of state government. Beneficiaries bearing federal rights thus have the possibility of providing a counterweight to the power of providers in state political processes, not to mention the opportunity to stabilize Medicaid policy in the face of state fiscal pressures. In the final analysis the ability of federal legal entitlements to give beneficiaries a voice in state Medicaid processes may be the crucial ingredient in maintaining a fair and effective Medicaid system in the years ahead.

Thank you very much for considering our unsolicited views on these matters. We wish you well in the difficult and delicate work of the current legislative session.

Yours sincerely,

A handwritten signature in dark ink, appearing to be "Jerry Mashaw", written in a cursive style.

Jerry Mashaw  
Sterling Professor of Law

A handwritten signature in dark ink, appearing to be "Burke Marshall", written in a cursive style.

Burke Marshall  
Nicholas deB. Katzenbach Professor  
Emeritus



## Democratic Policy Committee

Richard A. Gephardt, Chairman

H-301 The U.S. Capitol  
Washington, D.C. 20515

Phone: 202/225-6760

Fax: 202/226-0938

### FACSIMILE COVER SHEET

To: ROBINER KLEIN

From: ANDY SCHWIDEN 6-4162

Fax #: 456-2878

Date: \_\_\_\_\_ Pages: (not including cover) 8

Message:

FYI.

NOTICE: This telecopy transmission and any accompanying documents may contain confidential or privileged information. They are intended only for use by the individual or entity named on this transmission sheet. If you are not the intended recipient, you are not authorized to disclose, copy, distribute or use in any manner the contents of this information. If you have received this transmission in error, please notify us by telephone immediately so that we can arrange retrieval of the fixed documents.

TO: Karen, Bridgett

FROM: Andy

RE: Background on Private Right of Action for Medicaid beneficiaries

DATE: 1/26/96

### **Current Law**

In civil matters, such as Medicaid disputes, the Federal courts will hear and rule on cases only under certain circumstances. There is a complex set of procedural hoops that a beneficiary must jump through in order to persuade a Federal court just to hear his or her claim against a State Medicaid agency (or Medicaid managed care plan) -- in legal jargon, to establish a private right of action. What follows is a brief overview of those hoops:

The Medicaid statute does not expressly establish a private right of action in Federal court for either providers or beneficiaries. Private rights for both beneficiaries and providers are the result of court decisions.

Note that the Social Security Act does, however, expressly give States a right to Federal court review of a decision by HCFA to disapprove a State plan amendment or to find the State in substantial noncompliance with State plan requirements (section 1116(a)).

The Medicaid statute (section 1902(a)(3)) expressly gives an individual the right to a "fair hearing before the State agency" if the individual has had a claim for medical assistance denied or not acted upon with "reasonable promptness." There is only one State (Texas) that does not provide State court review of such "fair hearing" determinations.

In order to enforce a right in Federal court, a Medicaid beneficiary must demonstrate that (1) the court has jurisdiction, and (2) he or she has a private cause of action to enforce the substantive right created by statute or regulation.

The first factor, Federal court jurisdiction, is routinely satisfied in Medicaid cases (often by invoking 42 U.S.C. section 1983, a civil rights statute which gives Federal courts jurisdiction to hear cases brought against individuals who violate Federally-created rights while acting under color of State law.)

The second factor, whether there exists a private cause of action, is must be established by Medicaid beneficiaries based on case law, because the Medicaid statute does not expressly confer a right of action. The Supreme Court has set forth

some elaborate tests as to whether a private right of action is implied by a Federal statute like Title XIX; lower Federal courts apply these tests in each case brought to them to determine whether the plaintiff has a private right of action.

In Wilder v. Virginia Hospital Association, 496 U.S. 498 (1990), the Supreme Court held that hospitals seeking to enforce the "Boren" amendment against State Medicaid agencies had met its test for establishing a private right of action. This case opened the door for the subsequent "Boren" litigation by hospital and nursing home associations.

However, in 1992, the Supreme Court reversed field, and issued a ruling that appeared to undercut previous case law on the ability of beneficiaries (but not providers) to get access to the Federal courts to enforce State plan requirements under the Social Security Act, Suter v. Artist M., 503 U.S. 347 (1992). The Court's rationale in that case was overturned by the Congress in 1994 (P.L. 103-382) in the so-called "Suter" provision, section 1130A of the Social Security Act.

## Cases

I have not found any definitive listing of all Federal court cases brought against State officials to enforce compliance with Federal Medicaid requirements. Neither the Republican Governors nor the Committee reports on the Republican proposal give any indication of what particular Federal cases -- other than actions to enforce the "Boren" amendment -- have been problematic for the Governors.

Jane Perkins of the National Health Law Program and Gordon Bonnyman of Legal Services of Middle Tennessee supplied the following examples of recent Federal court enforcement of Medicaid rights by beneficiaries. Note that these are reported cases; there is also Federal court litigation that is not reported because it is settled prior to a ruling or because the plaintiffs have withdrawn the action after the defendants, faced with the prospect of litigation, have corrected their behavior to the plaintiffs' satisfaction.

## Timely and Fair Hearings

- Virginia Medicaid agency required to decide fair hearing requests without lengthy delays, Shifflett v. Kozlowski, 843 F. Supp. 133 (W.D. Va. 1994).
- West Virginia Medicaid Agency required to adhere to Federal Medicaid fair hearing requirements and cease ex parte communications between hearing v. officers (who should be impartial) and State agency personnel, Sears Lewis, No. 2:94-0093 (S.D. W.V. 1995) (consent order).

### **Delays in Processing Eligibility Applications**

- Tennessee Medicaid agency required to comply with Federal requirements for timely processing (within 90 days) of applications for eligibility by disabled individuals who were unable to obtain needed medical care while their applications were pending, Brown v. Luna, 735 F. Supp. 762 (M.D. Tenn., 1990).
- New York Medicaid agency required to adhere to Federal "corrective action regulation" where applicants incurred out-of-pocket expenses for Medicaid-covered services due to agency delays or errors, Greenstein v. Bane, 833 F. Supp. 1054 (S.D.N.Y. 1993).

### **Coverage of Services (EPSDT)**

- California Medicaid agency required to implement Federal EPSDT provision calling for a lead blood assessment appropriate for age and risk factors, Matthews v. Coye, No. C-90-3620 (N.D. Ca.) (stipulation and dismissal, Oct. 17, 1992).
- West Virginia Medicaid agency required to adhere to Federal EPSDT requirements for outreach and education and preventive screening for eligible children in foster care system, Sanders v. Lewis, No. 2:92-0353 (S.D.W.Va.) (consent order, Aug. 16, 1993).

### **State Fair Hearing Experience**

Last year, the Texas Legal Services Center conducted a survey of State Medicaid Agencies to determine how burdensome the Agencies felt judicial review of fair hearings to be (the Center was trying -- unsuccessfully as it turned out -- to make the case to the Texas legislature to allow State court review of fair hearing decisions).

40 States responded. In most cases, less than 5 percent of the fair hearing decisions were appealed to a court. Only 3 of the States (Minnesota, New Jersey, Tennessee) answered "YES" to the question, "Does the ability of applicants to appeal fair hearings to court impose an unreasonable burden on your agency?" ←

California reported holding about 4,600 fair hearings each year, of which less than 1% were appealed. The State responded that availability of judicial review of fair hearings was "a burden, but not an unreasonable burden," and that the impact on the agency of judicial review is "beneficial because it helps to update policy."

Michigan did not respond.

Missouri reported holding 4,435 fair hearings per year, of which 8 to 10 percent were appealed. The State responded that the availability of judicial review did not impose an unreasonable burden because "minimal preparation is required to defend the appeal." It also stated that the availability of judicial review has a "positive impact [on the State agency] in that it requires the agency to be objective."

Utah reported holding 75 to 100 fair hearings per year, of which 1 was appealed to court. It responded that the availability of judicial review did not impose an unreasonable burden on the agency and did not have an adverse impact on the agency.

Wisconsin reported holding 376 fair hearings per year, 8 (2 percent) of which were appealed to court. The State responded that the availability of judicial review did not impose an unreasonable burden on the State agency and does not have an adverse impact on the agency: "helps to interpret or clarify policy."

It is my understanding that in almost all, if not all of these States, the judicial review is usually taken to State court, not Federal court. Nonetheless, many of the benefits of judicial review cited by the State agencies themselves would apply whether the reviewing court was State or Federal.

## **Republican Proposals**

**Conference report.** In the vetoed conference report, Title XIX, and all the judicial interpretation of that Title, are repealed. In proposed section 2154(d), the following provision appears:

"Only the Secretary, in accordance with this title, may compel a State under Federal law to comply with the provisions of this title or a MediGrant plan, or otherwise enforce a provision of this title against a State, and

no action may be filed under Federal law against a State in relation to the State's compliance, or failure to comply, with the provisions of this title or of a MediGrant plan except by the Secretary as provided under this section."

**Governors' Meetings.** In "Staff Summary of Medicaid Discussions Held on December 22, 1995," the following two-part "option" appeared:

"(a) States must offer individuals (or classes) a private right of action in state court as a condition of participation in the program. This would follow some State administrative appeal process. Once all State judicial remedies are exhausted, individuals may appeal to the U.S. Supreme Court.

(b) Independent of any State judicial remedy, the Secretary of HHS may bring action in Federal court on behalf of individuals (or classes)."

**Leaked Proposal Attributed to Covington & Burling.** On page 2 of "A Proposal for Resolving the Medicaid Reform Issue While Retaining the Current Title XIX Program," the following is suggested:

"Existing rights of program beneficiaries to seek legal redress for claimed violations of their rights would be maintained, but beneficiaries would have to utilize State processes where States offer adequate administrative and judicial remedies."

Stated another way, at p. 9, "The provision would preclude access to Federal courts for any person who has access to a State remedy as spelled out in the State plan."

### **Possible Administration Compromise Proposal**

In conversations with White House staff, the following approach has been discussed:

Preclude Federal court review of cases in which individuals believe they have been improperly denied a covered service or erroneously charged a copayment or deductible, but only if the State has established adequate procedures for reviewing these individual benefits claims, including State court review.

There would be no change in current law with respect to Federal court review of all other disputes, including those relating to eligibility.

### **Another Wrinkle: Managed Care**

The following case summary, provided by Gordon Bonnyman of Legal Services of Middle Tennessee, illustrates the additional issues in individual benefits cases posed by managed care:

"A beneficiary assigned to a managed care organization (MCO) was referred for a neurological test to evaluate a possible blocked carotid artery. For over a year, the MCO refused to cover the exam, which, because of the inadequacy of its provider network, would have required it to pay a neurosurgeon for out-of-plan care. The State had failed to comply with Federal requirements that it create a grievance process for reviewing such denials of care, and the woman's appeals to the MCO were ignored. She sought to enforce an existing court order against the State, requiring the Medicaid program to provide beneficiaries with a hearing in conformity with Federal regulations. She switched MCO's at the next open enrollment period. The new MCO immediately provided the neurological evaluation and scheduled surgery to clear the blocked artery. However, she suffered a disabling stroke before the surgery could be performed. Daniels v. Department of Health, No. 79-3107 (M.D.Tenn., 1995)."

### **Examples of cases affected by foreclosure of private enforcement of federal Medicaid law**

The following examples are drawn from the large body of caselaw that has developed under Title XIX, under existing law defining beneficiaries' ability to enforce federal law and regulations.

**\* Managed care - Inadequate provider networks** - In a state whose Medicaid program had been converted to capitated managed care, a major managed care organization (MCO) had a seriously inadequate provider network. The network was lacking in major specialties, and did not include even a single hospital to serve its 50,000 enrollees living in one of the state's major metropolitan areas. The state was aware of the MCO's inadequate network, but kept on making capitation payments, and allowed the MCO to continue marketing to new beneficiaries.

A beneficiary assigned to the MCO was referred for a neurological test to evaluate a possible blocked carotid artery. For over a year, the managed care organization (MCO) refused to cover the exam, which, because of the inadequacy of its provider network, would have required it to pay a neurosurgeon for out-of-plan care. The state had failed to comply with federal requirements that it create a grievance process for reviewing such denials of care, and the woman's appeals to the MCO were ignored. She sought to enforce an existing court order against the state, requiring the Medicaid program to provide beneficiaries with a hearing in conformity with federal regulations. She switched MCOs at the next open enrollment period. The new MCO immediately provided the neurological evaluation and scheduled surgery to clear the blocked artery. However, she suffered a disabling stroke before the surgery could be performed. *Daniels v. Department of Health*, No. 79-3107 (M.D. Tenn., 1995).

**\* Delays in processing applications** - A state took six months or more to process Medicaid applications for individuals who were disabled, including applicants with terminal illness. Applicants were unable to obtain medical care while the applications were pending, and brought suit to enforce federal regulations requiring disposition of applications within 90 days of filing. One of the plaintiffs died, untreated, of the heart disease that was the basis of her disability-related Medicaid application. The court ultimately required the state to comply with the federal regulation re. timeliness of processing. *Brown v. Luna*, 735 F.Supp. 762 (M.D. Tenn., 1990) rem. in unreported appellate decision (6th Cir. 1991).

**\* Fair procedures for determining eligibility for nursing home care** - A state established a pre-admission utilization review process to medically screen applicants for Medicaid coverage of nursing home care. The procedure did not conform with federal due process regulations. If reviewers doubted that a person

met the medical criteria for approval, they would either take no action at all on an application, or would simply return it without explanation. Patients, their families and nursing facilities were told nothing about the standards being applied, what evidence the agency had considered, or even what decision had been made. Patients would wait for months in debilitated condition in hospitals, or in their own homes, without any way of knowing if or when they would ever be able to obtain nursing home care. The federal court ordered the agency to notify applicants of its decisions, explain the reasons, establish an appeals procedure and process appeals within 90 days. *Doe v. Word*, Civil Action No. 3-84-1260 (M.D. Tenn. 1987), reported in CCH Medicare and Medicaid Guide ¶36,076)

**\* Managed care - medically fragile children** - A medically fragile infant was denied home nursing care prescribed by hospital physicians at the time of his discharge from the NICU. The family could have placed the child in a state-run Intermediate Care Facility for the Mentally Retarded (ICF/MR), in which case financial responsibility for his care would have been transferred from the MCO to the state. However, the mother dropped out of college, and the grandmother gave up her job, in order to care for Julian at home. He required round-the-clock nursing care, and life-threatening crises occurred frequently. Still, the MCO refused to provide the prescribed nursing services. Although Julian's counsel repeatedly requested review of the denial by the state Medicaid agency, the agency ignored the requests for 9 months, during which period Julian underwent three emergency hospitalizations. Only when an affidavit was filed in a pending federal court due process action did the state provide a hearing as required by federal law and the state's own Administrative Procedures Act. The hearing resulted in a finding that the MCO denial of care was without justification, and nursing care is now being provided. See *Daniels v. Department of Health*, No. 79-3107 (M.D. Tenn., 1995).

**\* Managed care - dumping into long term care to avoid acute care responsibilities** - A 19 year old sustained a serious closed head injury in an automobile accident. After a period of acute care and rehabilitation, he was transferred to a geriatric nursing facility. He was the only child of older parents who lived in a rural community 40 miles from the nursing facility. The parents wanted to care for him at home. Their church and his former high school classmates had put together a plan, approved by his physician, to help the family care for him at home.

The young man's Medicaid MCO refused, however, to provide the 2-3 weeks of home nursing care needed to transition to the new arrangement, while the family and friends were learning how to care for him. Although the services were medically necessary and covered by their Medicaid contract, the MCO had a strong incentive to deny coverage. So long as he remained in the geriatric facility, the state Medicaid program would cover his care (at \$2,500/month) on a fee-for-service basis, while also paying the MCO a monthly capitation fee for providing the small amount of acute care not included in the nursing facility's payments. Once he left the nursing facility,

the MCO would be at risk for the cost of his care. By refusing to cover the transitional care, the MCO could keep the patient in the nursing home.

The state, despite its financial interest in moving the patient from the nursing home, ignored the family's attempts to appeal the denial of transitional home nursing care. A hearing was afforded only after the filing of a federal court action challenging the failure to provide due process. See *Daniels v. Department of Health*, No. 79-3107 (M.D. Tenn., 1995).

\* **Nursing home evictions** - States failed to establish a hearing process, as required by 42 U.S.C.1396r(c), for residents facing involuntary discharge from a Medicaid-subsidized nursing facility. Residents had no means of demonstrating that their threatened evictions were illegal because they were in retaliation for having complained about poor care. In each case, the residents sued the state and a hearing process was created as prescribed by federal law. *Miller v. Mass. Dept. of Public Health*, Mass. Super. Ct., Suffolk County (7/92); *Murphy/Brown v. Flaherty*, No. 91-CV-10863 (N. C. Gen. Court of Justice, Sup. Ct. Div., Wake County, NC, 10/1/91)

**National Health Law Program  
Four Page Memorandum**

**To: Nan Hunter**

**Fr: Jane Perkins and Mark Regan, Staff Attorneys**

**Da: Feb. 16, 1996**

**Re: 15 Reasons Why Prompt Federal Court Access is Needed by Medicaid Consumers**

---

**Problems with exclusive state court jurisdiction:**

1. Federal courts interpret complex federal laws on a daily basis. They oversee complex, ongoing compliance issues. State courts often lack the resources that are needed to thoroughly hear and monitor these cases. Many state court judges do not have law clerks. Some mid-level court judges do not even have secretaries. Dealing with all Medicaid cases will add more burdens on these already strained state resources. Example: Local judges in central North Carolina already have sent domestic cases to the legal aid office for first review. Their dockets are so crowded that they rely on legal aid to do a sort of "first screening" of these cases before they will be moved by the court. Adding Medicaid cases will further overcrowd these dockets.

2. As the NGA proposal is written, the state court will rely on a record created during an administrative hearing that has been presided over by a hearing officer who is probably not a lawyer and whose expertise is sifting facts -- not interpreting complex federal statutes. This hearing officer will probably allow in inadmissible evidence during the hearing. (The fact that the evidence was inadmissible will "go to the weight" the hearing officer will give it -- whatever that means. If relied on in the decision, the evidence will probably not be acknowledged as inadmissible.) Claimants may (and often do) go through this administrative hearing without an attorney or representative. The thought that these hearing officers will be trained to be judges is ludicrous. (Our office and Appalachian Research and Defense Fund finally sued the West Virginia Medicaid agency in federal court after hearing officers continued to engage in ex parte communications with state officials while deciding claims. The Alaska practice has been for hearing officers routinely to consult with "program officers" if any legal issue looks difficult.) At any rate, state judges, conditioned to approve evidentiary decisions made by state hearing officers, would be trying to resolve federal legal issues on the basis of a systematically bad record.

3. Federal district court judges are just as "home grown" as local state court judges, and they, too, issue decisions that interpret the federal law mindful of local circumstances. However, state judges are subject to state pressures against which (some) federal judges are immune. This was true when (some) federal judges protected civil rights while (some) state judges did not, and it is true today.

4. The cases which get filed in federal court are typically cases whose issues are entirely federal. If you have good state issues or a significant question about back benefits, Pennhurst II and Eleventh Amendment considerations put you in state court. So the central question in a case you would want to file in federal court is going to be federal.

5. Federal judges generally understand Medicaid issues more readily than do state judges, if only because federal judges deal with Social Security cases and, at least on disability-linked Medicaid issues, there is a lot of conceptual overlap.

6. In cases with both federal and state issues, federal judges start with the federal issues, state judges start with the state issues. Our subjective impression in reading recent state cases on technical Medicaid issues, such as transfers of assets and trusts, is that state judges are very deferential to state agency readings of state statutes. By the time they turn to the federal statutes, their impression of what is going on is fixed and they do not give detailed attention to, for example, federal legislative history.

7. Enforcement procedures are much better in federal court. In complex Medicaid cases dealing with systemic state-compliance issues (which the vast majority of federal cases are), the court is typically ordering the agency to come into compliance and will need to engage in ongoing monitoring. State courts do not have the staff, resources, or time to oversee and enforce cases ordering systemic change. State courts are used to dealing with damages cases, not ongoing prospective injunctive relief. State agencies understand this and are scared of federal court. Threat of a federal suit is sure to get state officials to talk with us.

8. The Governors may not have realized just how complicated the process they would like to create could become. To permit but confine Medicaid lawsuits in the way the Governors want, Congress would first have to establish a federal right. A crucial part of this process, Supreme Court review of state-court Medicaid decisions, would depend on the presence of a federal right, because as relevant here the Supreme Court would not have jurisdiction under Article III unless there were a federal question. Congress cannot override the Constitution in this regard.

Yet, Congress would have to prohibit the federal right from being litigated in any federal court other than the Supreme Court. A federal right would have to be strong enough (under the Golden State standard) so state courts would have to deal with it, but somehow be unenforceable in the lower federal courts. The only logical way we can think to do this would be explicitly to deny jurisdiction over Medicaid cases to federal courts other than the Supreme Court.

Explicitly denying federal courts jurisdiction over a class of cases while insisting that state courts consider those cases would be a tricky business. There is not much precedent for it, perhaps no precedent at all. The closest that current Medicaid law approaches to creating a situation in which state courts handle cases that federal courts do not is in the requirement that to get federal Medicaid money, states have state laws on the subject of medical child support and third-party coverage. Yet it is very doubtful that cases arising under those state laws could be reviewable as federal questions in the U.S. Supreme Court -- a crucial part of the Governors' compromise.

The way to avoid creating these jurisdictional tangles is to stay out of the business of limiting federal jurisdiction over federal causes of action. Ensuring that federal courts remain available to vindicate federal law thus turns out to be the simplest as well as the most sensible thing to do.

9. This country has long held the principle that the person alleging the wrong gets to select his or her forum.

#### Problems with requiring administrative exhaustion

10. The whole idea of exhaustion creates an opportunity for states to avoid compliance with federal law. Suppose you have an end-of-the-session state legislative decision to play fast and loose with a federal requirement -- for example, to use a resources test for poverty-level children which is much more restrictive than federal law expects. An immediate lawsuit to rectify the situation apparently would be forbidden under the Governors' proposal absent exhaustion of remedies. We are concerned that a statute explicitly requiring exhaustion would mean that exhaustion exceptions (futility, etc.) would not apply or would be limited. In health care settings, these exceptions are sometimes crucial.

11. Going through the state hearing process is an excellent idea for an individual client with a fact-intensive problem -- the client can get an overworked Legal Aid lawyer or paralegal for a fair hearing which resolves the problem but certainly can't get that Legal Aid lawyer to file a federal case. But the larger problem here is systematic state noncompliance with the requirements of federal law, where prompt correction of state errors is necessary. Exhaustion requirements cause delays -- in fact, are meant to cause delays.

12. Exhaustion requirements mean that many people who have been wronged will never get their problems addressed. In any systematic non-compliance situation, the typical state procedure to cure would be to promulgate policy and issue mass change notices. Many people wouldn't understand the notices or would accept notices at face value -- with the notices implying that requesting a hearing would be useless. This creates serious problems for those people who miss appeal deadlines. Only a few people will appeal and obtain good representation.

13. Hearing officers typically are not trained to interpret federal laws (or state laws, for that matter). In some states, hearing officers can't deal with constitutional issues. In other states, hearing officers can't contradict anything in the state Medicaid manual or regulations -- even if federal and state statutes are both to the contrary.

14. Administrative exhaustion places yet another burden on already strapped state agencies. If immediate access to court is not possible, the only sane advice for clients is for clients to request a hearing. In a mass change/noncompliance situation affecting thousands of people, that means that thousands of people ought to be requesting fair hearings.

One final note

15. To target Medicaid clients for denial of federal court access when there is such access for other health programs -- Medicare, ERISA, MCH, etc. evidences a hidden agenda. We should talk about whatever the real issue is here -- it cannot be federal court cases because there just aren't that many filed. Rather, the focus must be that the proponents of this system want to avoid systemic relief cases that will cure broad based injustices and protect the maximum number of people against harm. If as a group state fair hearing officers and state judges would vindicate federal law just as conscientiously as federal judges, the National Governors' Association on behalf of states would not be insisting so vehemently that Medicaid lawsuits systematically be forced through state administrative procedures and then confined to state court and excluded from federal court.

*January 19, 1996*

## **CHECKS, BALANCES, AND BUREAUCRATS -- CONTINUING THE RIGHT OF MEDICAID BENEFICIARIES TO GO TO COURT WHEN THEY ARE HARMED**

Prepared by: Jane Perkins and Mark Regan

When Congress enacted Medicaid as a third party insurance program in 1965, it was well aware that there would be disputes over how the program worked in particular states. Rather than leave matters to the arbitrary discretion of front-line local officials, Congress required states participating in Medicaid to offer Medicaid applicants and recipients basic due process of law: notice of what was happening and an opportunity to be heard by an impartial decision-maker. Since that time, checks and balances have operated through 'fair hearings,' at which poor people and agency officials attempt to resolve their differences, and through litigation, in which judges defend federal law by occasionally deciding that state agency officials have misinterpreted what Congress wanted them to do.

Now, however, the fight is on to ensure that consumers have the right to go to court when they are harmed by the actions or inactions of their third party insurers -- the states or organizations contracting with the states. This memo:

- (1) summarizes the provisions in current law, the Congressional proposal, and the Administration proposal that affect beneficiaries' ability to go to court when a Medicaid Act provision is violated;
- (2) annotates cases which illustrate the benefits of court review; and
- (3) summarizes a 1995 survey of state administrative agencies which assesses their attitudes towards judicial review and their track records on judicial appeals.

### **The Current Law and Proposals to Change It**

Under current law, Medicaid beneficiaries and applicants have basic "due process" rights. They have the right to notice of decisions by the state Medicaid agency to deny or terminate services and the right to have an impartial decision-maker review the state agency's initial decision. If the claimant is dissatisfied with the administrative decision, the case can be appealed to state court -- in every state but Texas, discussed below. The right to appeal

Checks, Balances, and Bureaucrats  
National Health Law Program (Jan. 19, 1996)  
page 2

denials or delays in eligibility and services through an administrative fair hearing process is found at 42 U.S.C. § 1396a(a)(3) and 42 C.F.R. § 431.200 *et seq.* The right to appeal an adverse decision to state court is typically established in a state's Medicaid statutes, or in its Administrative Procedure Act, or both. In addition, 42 U.S.C. § 1983, part of the Civil Rights Act, allows individuals to go before a state or federal court if their rights under the U.S. Constitution or Medicaid Act are deprived as a result of state action. To bring this type of court case to enforce a provision of the Medicaid Act, a person must have rights under a provision which are sufficiently definite that the state knows what is expected of it. See *Wilder v. Virginia Hospital Ass'n*, 496 U.S. 498 (1990); *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1 (1981).<sup>1</sup>

The Administration's Medicaid proposal, which was issued in December following the President's veto of the Congressional budget reconciliation bill, does not change existing law regarding fair hearings or judicial review.

By contrast, the Congressional "MediGrant" proposal, as set out in a late-November Conference Agreement, would have deleted all federal fair hearing requirements and would have made significant changes in Medicaid beneficiaries' rights to go to court when they are harmed. At the very least, the Agreement would have replaced Medicaid with MediGrant and specifically precluded a federal cause of action based on the MediGrant statute in either federal or state court. Theoretically, an individual could have petitioned the U.S. Department of Health and Human Services to take action against a state which was violating MediGrant law, but the Secretary of Health and Human Services' allowable response to such a petition -- even to a "pattern of complaints" or an "egregious" problem -- appears to have been limited to notifying the state that a problem existed. It was not at all clear that this process could produce either retrospective or individual relief. Presumably, state legislatures would have been free to create state-based statutory or Administrative Procedure Act rights to enforce federal MediGrant provisions in state courts -- yet, states might also have attempted specifically to exclude MediGrant decisions from judicial review.

The MediGrant proposal's anti-lawsuit provision was written so broadly that it might even have caused problems with federal civil rights actions in cases involving MediGrant programs. For example, actions under Title VI of the Civil Rights Act, the Americans with Disabilities Act, and the Federal False Claims (*qui tam*) Act could have been affected.

What this means is that many of the promises in the MediGrant proposal would have been hollow and unenforceable by consumers. Medicaid consumers would not have been able to count on any of the protections promised in the statute. Federal taxpayers would not have

---

<sup>1</sup> The Medicaid Act continues to be enforceable despite arguments that *Suter v. Artist M.*, 112 S.Ct. 1360 (1992), fundamentally changed the law. In any event, Congress partially overruled the *Artist M.* decision in 1994. See Pub. L. No. 103-382.

Checks, Balances, and Bureaucrats  
National Health Law Program (Jan. 19, 1996)  
page 3

been sure that states would be accountable for the billions of dollars distributed to them.

Examples:

- The MediGrant proposal purported to require that nursing homes be surveyed for substandard care, unnecessary use of drug and physical restraints, and other quality of care problems. Yet, residents of a substandard nursing home which a state failed to survey could not have sued the state to show that the MediGrant Act's detailed survey specifications had been violated;
- The MediGrant proposal purported to protect at-home spouses from impoverishment when their spouses were institutionalized. Yet, the at-home spouse or an adult child whose savings were wiped out by the payment of nursing home bills could not have sued the state to enforce the spousal impoverishment protection;
- The MediGrant proposal indirectly suggested that beneficiaries should not be gouged when too much money was charged for MediGrant-covered services. Yet, beneficiaries could not have taken a state to court for its failure to defend them against federally-forbidden "balance billing";
- The MediGrant proposal purported to require states to provide some sort of coverage to pregnant women whose family incomes were below the poverty line. Yet, a poor, pregnant woman improperly denied prenatal care would have had no effective way to enforce this requirement against a state;
- The MediGrant proposal asserted that immunizations for children would have to be covered. Yet, a child improperly denied the cost-effective and life-saving immunizations recommended for young children could not have gone to court to get them.

Obviously, it's possible to think of intermediate possibilities between the Administration's insistence that Medicaid protections be enforceable and the Conference Agreement's determination to make federal requirements effectively illusory. Discussions about intermediate possibilities -- review of some determinations but not others, review in some forums but not others -- are continuing alongside larger budget negotiations. Moreover, even if the Medicaid Act's enforceability is not directly eliminated, there could be significant amendment -- perhaps weakening -- of the Medicaid Act's provisions on eligibility and services which currently place clear, enforceable directives on the states. Ambiguous or fuzzy provisions are hard to enforce.

At this point, in the midst of doubt about the future of Medicaid, it remains all too clear that beneficiaries' rights to go to court face serious threats. Advocacy is needed

Checks, Balances, and Bureaucrats  
National Health Law Program (Jan. 19, 1996)  
page 4

to maintain clear federal Medicaid directives on eligibility, services, and due process and, perhaps, to obtain state-based protections in the future.

As shown below, the case law and the states' own reporting illustrate the vital and positive role of court review, and importantly, how infrequently courts are really called upon to obtain relief.

### Examples of cases

Most of the time, Medicaid programs operate as Congress intended. However, there are some exceptions, and sometimes the only realistic way those exceptions can be corrected is through litigation. Here are some examples:

#### Timely and fair hearings:

Sears v. Lewis, No. 2:94-0093 (S.D. W.Va. 1995) (consent order)(required West Virginia Medicaid agency to adhere to federal Medicaid fair hearing provisions and cease ex-parte, sometimes post-hearing, communications between hearing officers and state agency personnel)

Shifflett v. Kozlowski, 843 F. Supp. 133 (W.D. Va. 1994) (required Virginia Medicaid agency to adhere to Medicaid provisions and decide fair hearing requests without lengthy delays; the Virginia procedure had required applicants to wait for a year before the agency would consider all of the issues)

Featherston v. Stanton, 626 F.2d 591 (7th Cir. 1980) (required Indiana Medicaid agency to bring its fair hearing procedures into compliance with Act and allow claimants to confront adverse witnesses)

#### Delay in processing applications:

Brown v. Word, No 3-88-0326 (M.D. Tenn. 1988) (consent order) (required Tennessee Medicaid agency to process disability applications according to federal Medicaid timeframes; in some cases, clients had been waiting six months for a decision)

Greenstein v. Bane, 833 F. Supp. 1054 (S.D. N.Y. 1993) (required New York Medicaid agency to adhere to federal "corrective action regulation" where claimants incurred out-of-pocket expenses for Medicaid-covered services due to agency errors or delays; agency required to reimburse in full rather than only to the Medicaid rate); see also Blanchard v. Forrest, No. 95-30168 (5th Cir., January 8, 1996) (requiring agency to make claimants whole in this situation, but giving agency choice among options)

Checks, Balances, and Bureaucrats  
National Health Law Program (Jan. 19, 1996)  
page 5

Alexander v. Hill, 549 F. Supp. 1355 (W.D. N.C. 1983), same case, 533 F. Supp. 126 (W.D.N.C.), aff'd, 707 F.2d 780 (4th Cir. 1983) (required North Carolina Medicaid agency to process Medicaid applications in a timely manner)

Mikel v. Reser, 440 F. Supp. 1226 (E.D. Mo. 1977) (required Missouri Medicaid agency to process Medicaid applications in a timely manner rather than allowing them to pend for months)

Services for children:

Sanders v. Lewis, No. 2:92-0353 (S.D. W.Va.) (consent order, Aug. 16, 1993), reprinted in Medicare and Medicaid Guide (CCH) 34,120 (required West Virginia Medicaid agency to adhere to federal EPSDT requirements for outreach and education and preventive care screening for children in the foster care system)

Matthews v. Coye, No. C-90-3620 (N.D. Cal.) (stipulation and dismissal, Oct. 17, 1992) (required California Medicaid agency to implement federal EPSDT provision calling for a lead blood assessment appropriate for age and risk factor)

Bond v. Stanton, 630 F.2d 1231 (7th Cir. 1980), same case, 372 F. Supp. 984 (N.D. Ind. 1974) (requiring state to implement the federal EPSDT screening and education provisions)

Morland v. Gilligan, No C74-53 (N.D. Ohio 1974) (settlement)

Domingues v. Milliken, No. G1988-72CA5 (W.D. Mich. 1973) (order)  
(both cases ordered the state to implement an EPSDT program)

Complaints involving private contractors/managed care plans:

Catanzano v. Dowling, 60 F.3d 113 (2d Cir. 1995), aff'g, 847 F. Supp. 1070 (W.D.N.Y. 1994) (required New York Medicaid agency to allow claimants for home health services a fair hearing pursuant to the Medicaid Act because decisions by participating home health agencies to deny/reduce services amounted to state action -- an important notion, given conversion of state programs to private managed care companies)

J.K. v. Dillenberg, 836 F. Supp. 694, 699 (D. Ariz. 1993) (required Arizona Medicaid program to allow managed care enrollees fair hearings pursuant to the Medicaid Act because it is "patently unreasonable to presume that Congress would permit a state to disclaim federal responsibilities by contracting away its obligations to a private entity.")

Checks, Balances, and Bureaucrats  
National Health Law Program (Jan. 19, 1996)  
page 6

### Texas Medicaid Hearing Survey

Texas is the only state in the United States which does not allow its own state courts to review decisions by hearing officers denying, terminating, or suspending Medicaid (and AFDC and Food Stamps) benefits. The 1995 legislature considered but failed to bring judicial review to the state. During the legislative session, a survey of state Medicaid agencies was conducted by the Texas Legal Services Center. The survey was directed to administrators of the Medicaid program and state agency personnel with in-depth knowledge of the fair hearing process. There was follow up for non-responses and to confirm and clarify information that was reported.

Here are some highlights from this survey:

**(a) Question: Does the availability of judicial review for recipients have an adverse impact on your agency?**

1. Of the 41 states and jurisdictions that responded, only four claimed that the availability of judicial review for recipients had an adverse or somewhat adverse impact on the agency.
2. Reasons given by these four states: Hawaii -- court's jurisdiction encompasses "equity," which is not part of the administrative process but can ultimately affect the decision; New Mexico -- adverse, if the decision contradicts the agency; Montana -- mixed, because court considers "equity"; Tennessee -- "somewhat" adverse.
3. States reporting "no adverse impact" often articulated strong testimonials for the benefit of judicial review. Quoting from some state responses:
  - California -- "it's beneficial because it helps to update policy"
  - Illinois -- "beneficial impact because it initiates needed policy change or vindicates policy"
  - Missouri -- "has positive impact in that it requires the agency to be objective"
  - N.J. -- "acts as a quality control of our policy and regulations"
  - Wis. -- "helps to interpret or clarify policy"
  - Wyo. -- "forces agency to scrutinize policy and procedures"

Checks, Balances, and Bureaucrats  
National Health Law Program (Jan. 19, 1996)  
page 7

(b) Question: How many fair hearings do you hold in a year? How many of these hearings are appealed to a court of law?

| <u>State</u>   | <u>Hearings</u>     | <u>Appeals</u> |
|----------------|---------------------|----------------|
| Alabama        | 50-60               | 4              |
| Alaska         | 32                  | 3              |
| Arizona        | 900                 | 1%             |
| Arkansas       | 534                 | 9              |
| California     | 4600                | less than 1%   |
| Colorado       | 87                  | 5              |
| D.C.           | 400                 | 3              |
| Delaware       | 135                 | 3-5            |
| Florida        | 1438                | 43             |
| Guam           | "few"               | "few"          |
| Hawaii         | 42                  | 1              |
| Illinois       | 615                 | 42             |
| Indiana        | 3493                | 97             |
| Iowa           | 551                 | 17             |
| Kansas         | 300                 | 5%             |
| Maryland       | 500-600             | 2-3%           |
| Massachusetts  | 5000                | 12-20          |
| Minnesota      | less than 528       | 15             |
| Missouri       | 4435                | 8-10%          |
| Montana        | 401                 | 1-5%           |
| Nebraska       | 309                 | 1 or 2%        |
| Nevada         | 60                  | 2              |
| New Hampshire  | 177                 | 1%             |
| New Jersey     | 800-1000            | no answer      |
| New Mexico     | 100-120             | 1%             |
| New York       | 16,766 <sup>2</sup> | 1%             |
| North Carolina | 400                 | less than 1%   |
| North Dakota   | 23                  | 4              |
| Ohio           | 8714                | 29             |
| Oregon         | 70                  | 1-2            |
| Penn           | 9981                | n/a            |
| Puerto Rico    | 15-20               | 0              |
| South Carolina | 50                  | less than 1%   |
| South Dakota   | 40                  | 15%            |

<sup>2</sup> Since January 1994, a number of these fair hearings involved reductions in home health/personal care hours. State of New York Memorandum (April 11, 1995).

Checks, Balances, and Bureaucrats  
National Health Law Program (Jan. 19, 1996)  
page 8

|               |        |     |
|---------------|--------|-----|
| Tennessee     | 1200   | 20% |
| Utah          | 75-100 | 0-1 |
| Vermont       | 225    | 5   |
| Washington    | 75     | 3%  |
| West Virginia | 242    | 1   |
| Wisconsin     | 376    | 8   |
| Wyoming       | 10     | 5%  |

### Conclusion

Medicaid consumers' rights to go to court are part of the tremendous struggle currently underway in Washington, D.C. Over the years, the basic due process rights attached to the Medicaid program have become one of its major consumer protections. These due process protections are quite simple, and they make common sense when something as serious as health care coverage is on the line. They ensure notice of a proposed denial or termination of coverage that was requested and a fair hearing before an impartial decision-maker when the problem cannot be relieved through discussions with the local, front-line personnel.

This infrequently used, yet all-important due process formula is now at risk. Instead, consumers are faced with a potentially hollow program that offers some of them eligibility and some services but does not contain meaningful avenues for redress if problems arise. Notably, we do not assume that states will seek actively to "do the wrong things" with their Medicaid/Medicaid programs. Unfortunately, past experience has shown that without judicial review -- or the threat of judicial review -- states' unexamined actions and cutbacks will sometimes take the wrong turn.

Please contact Jane Perkins, (919) 968-6308, or Mark Regan, (310) 204-6010, with questions or comments.