used, novel or relatively unknown." *Id.* at 1156 n. 11.

Under the *Rush* definition, the prescription of AZT beyond its labeled indications is not experimental. The record here establishes that physicians commonly prescribe AZT for patients who have neither a history of PCP nor a CD4 count below 200. Plaintiffs' experts stated that based on their own practice, professional literature, conferences, and contacts with other physicians, AZT is generally accepted by the medical community as an effective and proven treatment for AIDS patients who do not meet the criteria in the FDA indications. Dr. J. William Campbell, a specialist in infectious diseases at Washington University School of Medicine in St. Louis, stated in his affidavit that,

> AZT is the only treatment approved for persons with AIDS or ARC. * * * AZT is generally accepted by the professional medical community, and specifically by specialists in infectious diseases as an effective and proven treatment for HIV infection, including HIV infection where there is absent a history of PCP or a T4 helper/inducer lymphocyte count below 200, but where other of the AIDS-indicator diseases recognized by the Centers for Disease Control are present. * * * In the exercise of their professional medical judgment, doctors commonly prescribe AZT for patients not meeting [the FDA] criteria.

Defendants' expert, Dr. John Mills, a professor of medicine at the University of California at San Francisco, does not controvert the affidavits of plaintiffs' experts in which they conclude that AZT may be medically necessary for AIDS patients who do not meet the restrictive diagnostic criteria in Missouri's regulation. Although Dr. Mills stated that the use of AZT beyond labeled indications was experimental in the sense that scientific studies had not conclusively determined its effectiveness, Dr. Mills agreed that "doctors commonly exercise professional medical judgment and prescribe drugs for uses not within the indications articulated by the FDA." Specifically with regard to AZT, Dr. Mills stated that "doctors commonly prescribe AZT for patients not meeting those two criteria" (history of PCP or CD4 count below 200) and in fact, Dr. Mills himself testified that he has prescribed AZT outside the FDA indications.

Our decision in *Pinneke v. Preisser*, 623 F.2d 546 (8th Cir.1980), is controlling on the issue presently before us. In *Pinneke*, the Iowa Medicaid agency had a policy which stated "an irrebuttable presumption that the procedure of sex reassignment surgery can never be medically necessary when the surgery is a treatment for transsexualism," and accordingly denied Medicaid benefits for such surgery. *Id.* at 549. However, because sex reassignment surgery was the only available treatment for transsexualism, the Eighth Circuit held that Iowa's policy denying Medicaid coverage for sex reassignment surgery, where it was deemed medically necessary by the applicant's own physician, conflicted with the objectives of the Medicaid program. The court held, "a state plan absolutely excluding the only available treatment ... for a particular condition must be considered an arbitrary denial of benefits based solely on the 'diagnosis, type of illness, or condition.'" *Id.* Relying on *Beal v. Doe*, *supra*, 432 U.S. at 445 n. 9, 97 S.Ct. at 2371 n. 9, this court emphasized the importance of professional medical judgment in the determination of medical necessity. "The decision of whether or not certain treatment or a particular type of surgery is 'medically necessary' rests with the individual recipient's physician and not with clerical personnel or government officials." *Pinneke v. Preisser*, *supra*, 623 F.2d at 550. *See also* S.Rep. No. 404, 89th Cong., 1st Sess., *reprinted in* 1965 U.S.Code Cong. & Admin. News 1943, 1986, ("the physician is to be the key figure in determining utilization of health services").

As in *Pinneke*, Missouri's Medicaid rule constitutes an irrebuttable presumption that AZT can never be medically necessary treatment for AIDS patients who have neither a history of PCP nor a CD4 count below 200. The record here establishes that such a presumption is unreasonable in light of the widespread recognition by the

medical community and scientific literature that AZT is the only known antiviral treatment for individuals with AIDS.

The Medicaid statute and regulatory scheme create a presumption in favor of the medical judgment of the attending physician in determining the medical necessity of treatment. In denying coverage of AZT to the plaintiff class, the defendants have done nothing to overcome that presumption except to rely on the FDA approval process in a manner expressly rejected by the FDA. In the face of widespread recognition by the medical community and the scientific and medical literature that AZT is the only available treatment for most persons with AIDS, we find that Missouri Medicaid's approach to its coverage of the drug AZT is unreasonable and inconsistent with the objectives of the Medicaid Act. As in *Pinneke*, this approach "reflects inadequate solicitude for the applicant's diagnosed condition, the treatment prescribed by the applicant's physicians, and the accumulated knowledge of the medical community." *Pinneke* v. *Preisser*, *supra*, 623 F.2d at 549.

In sum, we hold that pursuant to the objectives of the Act, Missouri Medicaid may not deny coverage of AZT to AIDS patients who are eligible for Medicaid and whose physicians have certified that AZT is medically necessary treatment.

The district court's order enjoining defendants from denying the coverage of AZT is overly broad in that it did not require certification by the patient's doctor of the medical necessity of the treatment. Accordingly, the district court is instructed to modify its order consistent with this opinion.

As modified, the judgment of the district court is affirmed.

Mark Lewis WARREN, Appellant,

v.

DRAKE UNIVERSITY, an Iowa Corporation; Richard Calkins; and Robert Blink, Appellees.

No. 88-2851.

United States Court of Appeals, Eighth Circuit.

Submitted June 12, 1989.

Decided Sept. 25, 1989.

Law student brought action against university after he was expelled from law school. The United States District Court for the Southern District of Iowa, Donald E. O'Brien, Chief Judge, entered judgment in favor of university, and law student appealed. The Court of Appeals, Larson, Senior District Judge, sitting by designation, held that under Iowa law, former law student's election to have jury determine whether university had breached its contract with student by failing to follow procedures outlined in student handbook and honor code when it refused to reinstate him following disciplinary suspension precluded appellate review of issue of whether evidence supported jury's finding that contract had not been breached.

Affirmed.

Federal Courts ⇐629

Under Iowa law, former law student's election to have jury determine whether university had breached its contract with student by failing to follow procedures outlined in student handbook and honor code when it refused to reinstate him following disciplinary suspension precluded appellate review of issue of whether evidence supported jury's finding that contract had not been breached. F.R.A.P.Rule 10(b)(2), 28 U.S.C.A.

Anthony F. Renzo, San Francisco, Cal., for appellant.

TO: Bruce Lindsay
FROM: Jennifer Klein
DATE: 2/16/96
RE: Private Right of Action Under Medicaid

The National Governors' Association Medicaid Resolution eliminates a federal cause of action for Medicaid beneficiaries. We are preparing for a meeting with the President on Wednesday to review our position on the NGA Resolution and this is one of the issues I am most concerned about.

I am wondering if you could suggest a law professor or prominent lawyer who the President knows and respects and who might be willing to write a letter about the importance of maintaining the federal cause of action. I have attached a brief document describing our concerns as well as the NGA Resolution (see page 3).

Please feel free to call me at 6-2599 or at home at 265-8398.

GEORGETOWN UNIVERSITY LAW CENTER

Federal Legislation Clinic

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Timothy M. Westmoreland
Senior Policy Fellow
Ralph G. Neas
Visiting Professor

~~Confidential:~~ Attorney-Client Privilege

MEMORANDUM

TO: Chai Feldblum
David Rapallo

DETERMINED TO BE AN ADMINISTRATIVE MARKING
INITIALS: MA DATE: 2-28-14

FROM: Matt Haltom

DATE: February 9, 1996

RE: **Constitutionality of Requiring a State Cause of Action for Medicaid**

Issue Presented: May Congress require a state to create a state cause of action to be heard in state court as a condition of receiving federal funds?

Short Answer: Yes, so long as the state ultimately retains a choice of whether to adopt the cause of action. If Congress requires states to create a state cause of action to be handled in state courts without conditioning this requirement on federal funds, this would likely be seen as a violation of state sovereignty.

1. **South Dakota v. Dole**, 483 U.S. 203 (1987). This case, which is the main precedent on conditional federal funds, involved a federal law that denied a percentage of federal highway funds to states which refused to set the drinking age at 21. **The Court held Congress may, under its spending power, attach conditions on the receipt of federal funds, so long as such conditions meet four requirements:**

a. The exercise of the spending power must be for the "**general welfare**,"
b. The condition on receiving funds must be **unambiguous**, "enabling the states to exercise their choice knowingly, cognizant of the consequences of their participation,"
c. Conditions on federal grants must be related to a **national concern**, and
d. Conditional grant of federal funds must **not be independently barred by other constitutional provisions** (opponents of a potential compromise may argue that the 10th Amendment constitutes such a bar, but the cases following strongly suggest that a federal interest, the Spending Power and the Supremacy Clause would over-ride the 10th amendment).

2. South Carolina v. Baker, 485 U.S. 505 (1988). In this tax case, the Court held that **Congress did not violate the 10th Amendment by "effectively compelling" states to issue bonds in a registered form by denying unregistered bonds a federal income tax exemption for earned interest**. The Court found that Congressional reservation of tax-exempt status for registered bonds left the states with a choice as to whether or not to register their bonds. State retention of this choice prevented the federal statute from being unconstitutional.

3. New York v. United States, 505 U.S. 144 (1992). This case involved a federal statute which attempted both to encourage and compel the States to dispose of radioactive waste. The Court held that the statute's provisions compelling States either to accept ownership of the waste or regulate according to Congress' instructions were unconstitutional. Put simply, **"requiring the States to regulate pursuant to Congress' direction would present a simple unconstitutional command to implement legislation enacted by Congress." However, Congress may encourage States to adopt a legislative program under its spending power, so long as conditions on federal funds meet the four requirements of the Dole case.**

4. Frank v. U.S., 860 F.Supp. 1030 (1994). The federal district court found provisions of the Brady Bill which required local law enforcement officials to administer the federal program to be unconstitutional. The court held the "Federal Government may not compel states to enact or administer a federal statutory program" and found that the provisions usurped the power of the State Legislature. The court noted, however, that Congress may use other means (such as its Spending Power) to encourage the adoption of such a program.

5. See also 42 U.S.C.A. §666. In this statute Congress required States to adopt laws mandating the use of specific procedures to improve the effectiveness of child support enforcement as a condition on receiving federal funds designed to aid families with children. This statute's constitutionality has not been challenged in court.

DISCUSSION DRAFT ONLY

OTHER OPTIONS

1. Define criteria for federal court jurisdiction rather than for state court jurisdiction. Federal court jurisdiction could be limited to a claim that involves an allegation that--

a) the State plan, on its face or as interpreted and applied by the State, or
b) a [managed care contract] [contract with a provider] entered into by the State to provide services to Medicaid beneficiaries

violates a provision of Federal law.

2. Require submission of a claim challenging the validity of a State policy, rule or contract provision to the Secretary for a compliance review prior to filing in federal court. Secretary would have 90 days in which to examine the claim. If secretarial review upheld the State, claimant would have right to sue in federal court.

- Serious admin. burden
- If don't act, claimant can go to fed. ct.
- If Sec. doesn't take - Sec. wld have to take action
- not much additional time

3. Distinguish between:

a) claims filed by optional eligibles

- Chevron - this determination wld get judicial deference

b) claims filed concerning optional benefits

- Remedy if Sec. doesn't agree w/ state
  - → Sec. can order compliance & w/hold funds
  - → Benef. gets no injunctive relief

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Timothy M. Westmoreland
Senior Policy Fellow
Ralph G. Neas
Visiting Professor

~~Confidential~~: Attorney-Client Privilege

MEMORANDUM

TO: Jennifer ~~Klaine~~ Elain

FROM: Matt Haltom

DATE: February 8, 1996

RE: **Attached Memo**

Jennifer - Chai and David wanted me to stress that this is preliminary research. I will be sending you a more complete memo on Section III, the implications of federal funding on requiring states to create a cause of action, by the close of business tomorrow.

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~~**Confidential:**~~ **Attorney-Client Privilege**
MEMORANDUM

DETERMINED TO BE AN ADMINISTRATIVE MARKING
INITIALS: MA DATE: 2-29-14

TO: Chai Feldblum
David Rapallo

FROM: Matt Haltom

DATE: February 8, 1996

RE: **Causes of Action in State Courts:**
Preliminary Research

I. May Congress require state courts to hear a federal private cause of action?

A. Short Answer: Yes. Congressional authority for such a statute would derive from the Supremacy Clause (Article VI §2) of the U.S. Constitution. The cases below support this proposition:

1. Testa v. Katt, 330 U.S. 386 (1947). This case involved a state court enforcement of a federal penal statute imposing wartime price controls. The Court rejected the state court's claim that it had no more responsibility to enforce a federal statute than it did a statute of a foreign country and held that **state courts were not free under the Supremacy Clause to refuse enforcement of a federal claim.** The cause of action does not have to be denied in federal court, since under Article III, Congress may assign jurisdiction.

2. FERC v. Mississippi, 456 U.S. 742 (1982). This case involved a utility law designed to combat the energy crisis. **The Court upheld the statute's requirement that state public utility commissions settle disputes arising under the statute.**

3. South Carolina v. Baker, 485 U.S. 505 (1988). In this tax case the Court held that **Congress did not violate the 10th Amendment by "effectively compelling" states to issue bonds in a registered form by denying unregistered bonds a federal income tax exemption for earned interest**. The Court asserted that states "must find their protection from Congressional regulation through the national political process, not through judicially defined spheres of unregulable state activity."

Note: In many of the cases I researched, the Court expressed doubt as to whether a state agency may be ordered to actually promulgate **regulations** as a matter of state law, as this would violate the sovereignty of state governments. County of Allegheny, New York v. United States, 505 U.S. 144 (1992). However, it is my understanding that the potential compromises in question would not prescribe specific state regulations.

II. May Congress require a state court to hear a federal cause of action as a condition of receiving federal funding under a federal grant-in-aid program?

B. Short Answer: Yes. The law appears to be even more accommodating to this option.

1. South Dakota v. Dole, 483 U.S. 203 (1987). This case involved a federal law which denied a percentage of federal highway funds to states which refused to set the drinking age at 21. **The Court held that Congress may, under its spending power, attach conditions on the receipt of federal funds, so long as such conditions meet four requirements:**

a. The exercise of the spending power must be in the "**general welfare.**"

b. The condition on receiving funds must be **unambiguous**, "enabling the states to exercise their choice knowingly, cognizant of the consequences of their participation."

c. Conditions on federal grants must be related to a **national concern**.

d. Conditional grant of federal funds must not be independently barred by other constitutional provisions (opponents of a potential compromise will argue that the 10th Amendment constitutes such a bar, but the cases listed above strongly suggest that a federal interest plus the Supremacy Clause might override the 10th amendment).

III. May Congress require a state to create a state cause of action to be heard in state court?

A. Short Answer: Probably yes, if done as a condition of receiving federal funds.

1. If Congress requires states to create a state cause of action to be handled in state courts without conditioning this requirement on federal funds, this would likely be seen as a violation of state sovereignty. See County of Allegheny, New York v. United States, 505 U.S. 144 (1992). However, if the requirement is made as a condition of receiving federal funds (as in the Dole federal highway funds case cited above) it would probably be upheld. I am continuing research on this subject and will complete a memo shortly.

I. Private Right of Action in Federal Court

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 action in federal courts on behalf of Medicaid beneficiaries. The Governors want to eliminate a federal cause of action because they do not want court decisions from federal courts in other states to have any effect on how they run their Medicaid programs.

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.

- **Departure from Other Federal Statutes.** Eliminating the federal cause of action would single out Medicaid as the one federal statute 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.

- **Consistent Interpretation.** Those aspects of the Medicaid program that are common to all states -- like eligibility -- should be subject to consistent interpretation and administration. The basic guarantee of who is covered should be uniform across the country; without a federal cause of action, it will not be. If, for example, Medicaid guarantees services to pregnant women and a state improperly denies those services to a woman who has complications arising from a miscarriage, that woman could no longer go to federal court to enforce her right to care. The issue would instead be litigated in fifty states; in some states, she would receive the 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).

- **Elimination of Remedies under Civil Rights Law.** While it is not clear that the Governors intend to go this far, the conference agreement precludes the right to enforce civil rights laws. Protection against discrimination in state programs has been established under the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975 and the Americans with Disabilities Act of 1990. If this is what the Governors intended, the civil rights community is likely to be very concerned.

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 and the most frequent basis for cases filed in federal court.

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.

We have been working with White House Counsel, the Office of Legal Counsel and the Department of Health and Human Services General Counsel to analyze the pros and cons of the Governors' proposal and to develop alternatives. We are prepared to brief you if you would like to discuss both sides of this issue in more detail.

DISCUSSION DRAFT ONLY

INDIVIDUALIZED BENEFIT CLAIMS

Scope

a) The following adjudication process applies to 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.

DISCUSSION DRAFT ONLY

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 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 individualized benefit claims. An "individualized benefit claim" would be defined as a claim by a recipient under this Title solely that an error of fact has been made, under a contract, policy or practice that is not in dispute, in deciding:

(1) whether to provide or cover a service for the individual, including a determination of medical necessity or a decision as to amount, duration and scope of services; or
(2) whether or in what amount to charge a co-payment or deductible to the individual.

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).

INTEROFFICE MEMORANDUM

TO: JENNIFER

FROM: SARA

SUBJECT: ADDITIONAL THOUGHTS ON THE GOVERNORS MEMO

DATE: JANUARY 2, 1996

In looking over the Governors' memo once more I have concluded that the first option under "Right of Action" is seriously flawed and should not remain as an option as currently presented. Specifically the option states that :

> **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(sic) (emphasis added).**

This option can be read in one of two ways (or both ways): (1) states would have to create an individual right of action under state law, thereby waiving sovereign immunity and/or (2) state administrative procedure acts would constitute a state right of action within the meaning of the federal conditions of participation.

1. If one reads the Option as compelling a state to create a right of action against itself and thereby waive its sovereign immunity as a condition of participation in Medicaid, then serious constitutional problems might be present. Can Congress insist that as a condition of participation in a federal grant program a state give individuals a right to sue the state and thereby waive state sovereignty? I would think not. I think that this question should be put immediately to the Office of the Legal Counsel. My guess is that such a requirement is either unconstitutional outright or else is on such shaky ground that within weeks of passage states would be lining up to sue to overturn the provision, thereby leaving beneficiaries with **no** right of action (I assume that Section 1983 would be superseded by legislation in the federal statute foreclosing a federal right of action).

2. If the states are suggesting that a state administrative procedure act would fulfill the federal requirement of a right of action, then two major consequences could follow. First is the issue of remedies. The model APA includes injunctive relief as a remedy; however, a state could alter the range of remedies available under the Medicaid right of action and limit plaintiffs to declaratory relief only (nothing in the option as written commits the Governors to any particular range of remedies). In such a situation no prospective injunctive relief would be available. Prospective injunctive relief is of course the reason why Section 1983 actions are brought. Second, state APAs provide no attorneys fees. Thus, real relief might not be available, and poor people would have no means for pursuing their right in court.

3. If a state's APA is not meant to suffice as a right of action (as the memorandum appears to suggest) then we are back to problem 1.

4. Were the Administration to insist on a full right of action with injunctive relief and attorneys' fees, you would be right back at problem #1.

Give me a call and let's discuss.

Children's Defense Fund

FAX COVER SHEET

TO: Jennifer Klein

ORGANIZATION: _____

FAX #: 456-2878

FROM: Stan Dorn, Director
Health Division

DATE: 1/5/96 TIME: 4:30

NUMBER OF PAGES (INCLUDING COVER SHEET): 5

NOTES: _____

If you have any problems receiving this fax, please contact me at (202) 662 - 3595.

25 E Street, NW
Washington, DC 20001
Telephone 202 628 8787
Fax 202 662 3510

DRAFT

Section 1. Limitations on Federal Cause of Action for Certain Claims

(a) Notwithstanding any other provision of law, no federal cause of action under this Title for an individualized benefit claim shall exist, except as described in Section 2.

(b) For purposes of this section and section 2, an individualized benefit claim is a claim, by a recipient under this Title, solely that an error of fact has been made, under a contract, policy or practice that is not in dispute, in deciding whether:

(1) to provide or cover a service for the individual (including a decision as to amount, duration and scope of services); or

(2) to charge a co-payment or deductible to the individual.

(c) This section shall not be construed to foreclose, preempt or otherwise adversely affect any other claim under federal or state law, except as described herein.

Section 2. State Plan Requirement for Review of Individualized Benefit Claims

(a) A state plan for medical assistance shall include the procedures set forth in subsections (b) and (c) of this section for review of individualized benefit claims.

(b) Individualized benefit claims involving determinations by managed care organizations related to services covered by a contract with the single state agency.

1. MCO level review of non-urgent[1] coverage and cost sharing disputes

[1]Urgent care services that, in the opinion of a qualified provider (including the patient's treating provider), are needed within 48 hours of the request for services.

- process within the MCO for furnishing an individual with dated proof of the filing of a claim, by an individual or provider, for coverage or payment of a service (including a claim regarding cost-sharing)
- initial determination of a request for services, within a reasonable time period, appropriate to the requested service [**maximum time??**]; written notice of the determination with reasons for the denial
- initial determination by an individual with medical expertise relevant to the individual's case
- the right to an internal review of an adverse initial determination, with review within 10 days of the request
- the right to be represented at the internal review by a person of the individual's choosing
- an internal review by an individual who was not involved in the initial determination, and who has neither a personal nor a financial stake in the outcome of the review
- the right to inspect medical records, manuals, written policies and other relevant documents maintained by the MCO and related to the initial coverage determination
- a face-to-face hearing, if requested by the individual, including the right to present evidence (including the oral or written statements of other experts) and to question decision-makers in the individual's case
- a timely written decision, not to exceed 10 days following the date of the internal review, which sets forth the final decision, the reasons for the decision, and the medical evidence (including the opinion and recommendation of the individual's physician) on which the decision is based

- If MCO fails to act within a time frame, in either this paragraph or paragraph two relating to urgent care, no further exhaustion of MCO remedies is required, and immediate access is available to state administrative review.

2. MCO-level review in urgent cases.

- An initial determination and a final written determination by an impartial reviewer (as described above) within 24 hours of the time of the initial request for coverage, which sets forth the final decision, the reasons for the decision, and the medical evidence (including the opinion and recommendation of the individual's physician or other provider) on which the decision is based
- The right to present to the impartial decision maker additional evidence and information from other experts

3. State agency review of non-expedited MCO benefit and cost sharing determinations

- right to agency review of a final HMO benefit or cost sharing determination
- fair hearing procedures that follow the existing Medicaid fair hearing regulations pertaining to reviews of initial determinations, with a timely final decision.

4. State agency review of expedited MCO decision

- fair hearing procedures that follow the existing Medicaid fair hearing regulations pertaining to reviews of initial determinations
- an expedited review (within 72 hours) of the initial coverage request to the MCO
- the right to present additional evidence from other experts

- a final state agency decision within 48 hours of the initial coverage request to the MCO, supported by medical evidence

5. Right to judicial review

- right to judicial review following a final state agency determination
- power vested in court to grant "make whole" relief including injunctive or mandamus relief, damages, and other relief as appropriate
- if state agency review is not timely, as described above, no further exhaustion is required before judicial review
- traditional exceptions to exhaustion requirements if futile or if there is risk of irreparable injury

(c) Individualized benefit claims involving determinations made by the state agency (without MCO involvement)

- If state administrative process fails to take timely action, as described above, no further exhaustion required
- state fair hearing requirements as under current law
- a right to judicial review of the final state agency determination, with same scope of powers as under subsection (b).

MEMO

To: Jen
From: Sara Rosenbaum
Subject: Comments on Governors and Nan
Date: December 30, 1995

Here are my comments on the Governors and Nan.

I. Governors

A. Eligibility

1. States that were covering up to 185% and are now required to do so would be permitted to reduce coverage. Also, see standards and methodologies comments below

2. No comment; see standards and methodologies

3. This speeds up coverage by about one year but then ends the obligation at 13 rather than at 19, as under current law

4. Alters the existing disability standards to include an additional "functional" test to be defined by state. To get SSI a child needs to be severely functionally disabled (welfare reform) and an adult needs to be so disabled that he or she cannot work. An added test for eligibility (a) does not seem justifiable given the already serious tests used for SSI and (b) since an added test cannot really be dreamed up, seems to be proposed only to delay further the Medicaid coverage. SSI should be enough to trigger Medicaid eligibility.

5. Adds a functional test to elderly SSI recipients. Currently age 65 and over along with SSI receipt is enough. This added criterion would have the same delaying effect as under #4 and would allow states to limit coverage to all by the most severely disabled elderly.

Under both 4 and 5, it should also be pointed out that stringent tests of medical necessity (which are permissible for adults) can achieve the same results as denial of eligibility. E.g., no NF coverage unless 3 or more ADLs; no home health unless 2 or more ADLs; restrictive drug formularies, etc. To deny eligibility altogether, as 4 and 5 would do, is unacceptable, particularly if you give discretion on what constitutes medical necessity.

6. No comment. Note that non-functionally disabled elderly and disabled persons would lose all supplemental Medicaid coverage and would get only Medicare cost sharing.

7. The option would permit rollback in coverage to only the "new" welfare groups.
Income standards and methodologies: The question is what happens to the non-cash children and pregnant women (1,2,3) whose eligibility is now determined in accordance with AFDC standards and

Don't eliminate deeming. Don't retain disregards. Demos? Oregon?

methodologies? If the second option is taken, a state also would reduce coverage of groups 1-3. States that elect the more restrictive standards (i.e., "new" welfare standards applied to Medicaid) should be required to cover children and pregnant women with gross incomes of 150% of poverty. This will help offset the loss of earned income disregards, child care deductions and the effects of household deeming changes.

Note that the transitional work program for welfare recipients has disappeared.

B. Depending on how A is resolved, you should not permit B as it now stands. The option should be available only **after** all SSI disabled and elderly are covered, all, low income children under 19 are covered, and coverage has been extended to adults in poor (<100% FPL) working families.

C.

1. If the federal government establishes an asset limit why should states be able to go below this? Existing asset tests should be retained with the "most closely related" standard preserved.
2. No comment
3. No comment
4. I am not sure (other than the time frame) how this provision differs from the existing transfer of asset rules or what the Governors seek.

C (second).

Note that right of action is exclusively listed under "eligibility". As my previous memo indicated there are many state actions other than denial or termination of eligibility that give rise to a federal right of action. Do they mean to suggest no ROA for other state conduct that is alleged to violate the law?

Option 1(a) I cannot tell if they mean only a state created right of action with foreclosure of Section 1983, or exclusive jurisdiction to hear Section 1983 cases involving Medicaid in state courts. Whatever it is, it is not acceptable.
(B) is meaningless

Option 2 seems to be current law. Fine.

Benefits

Once again I say, why should the federal government pay more than half the cost of worthless benefits? Note also that states will make out like bandits if the per capita cap is based on the current benefit package but they do not have to provide it. Some flexibility and some increased cost sharing is OK, but beyond that it is highway robbery. With that, here are my comments.

A.

1. Ridiculous. But of particular concern is preventing discrimination based on a condition. That is, if they want to do horrid benefits for one diagnosis, it applies to all. We will end up with McGann in Medicaid, which is supposed to function as a last resort program for very sick poor people. The disability and HIV community and others will come down on your head. Benefits will also shrink badly for persons with mental disabilities. We will have Oregon everywhere and plans will be able to use whatever medical necessity evaluation criteria they choose (which is the real goal here) and will come down hard against certain conditions. Oppose at all costs. I would require the use of reasonable criteria and prohibit discrimination on the basis of condition or diagnosis.

With respect to children it is vital to hang onto the concept that a benefit is necessary if it ameliorates the effects of an illness or **condition** and is necessary to promote a child's growth an development. This standard is unique to Medicaid and is more controversial than the EPSDT benefit package itself.

2. The equal access provision must be retained
3. Who can tell what they mean? Does "modified" mean repealed? If they don't care about removing all benefits, then which ones do they want to knock out?

B.
1. Same as A (1)
2. Same as a(2).

Also, children covered as an optional group should at least get ambulatory care covered under the plan for mandatory children. Adults should get at least physician, hospital, diagnostic , rehab, and prescribed drugs. Why should the federal government pay better than half the cost for worthless benefits or have I already said that?

They do not discuss cost sharing. OK to income-related premiums for persons over 100%FPL (except children and pregnant women). No deductibles. Copayments **not** ok for preventive care for children and pregnant care for women. Many studies show that children's preventive services very sensitive to copayments.

Nan

Big improvement. A few comments.

Scope

a) Nan seems to have extended exhaustion to any factual dispute regarding eligibility, premiums, enrollment and disenrollment. She also says that the exhaustion requirement would be made "explicit". There is no "explicit" or "implicit" requirement to exhaust now. As a practical matter I will tell you that people commonly do not run to federal court over individual factual disputes. They go to fair hearings. Courts are where the big Medicaid coverage and eligibility policy cases go. Therefore, I do not see this "individual factual disputes" concession as making a huge difference for beneficiaries.

Exhaustion applied to any factual dispute over eligibility, benefits or enrollment is well beyond what we discussed.

B) OK

c) ok

HMO
OK

State

a) OK
b)why does the state have 48 hours? Drug rebate amendments use a 24 hour coverage standard, which is required for HMOs, supra.

Judicial

There should be an explicit right of action immediately in state court (a bypass of the administrative process) if exhaustion would lead to irreparable injury. This right should extend to both HMO enrollees and non-enrollees.

A and b) The amount in controversy has little meaning here. The federal right of action should be preserved in federal court if the state court is unable to grant the necessary relief. What if the state court can only grant declaratory relief and cannot issue prospective injunctive relief? This is what gets lost if the 1983 right of action in federal court is done away with entirely for this class of claims, as Nan is suggesting. Also lost would be attorneys' fees and other forms of relief that are part of Section 1983.

C) OK
d) I am glad this is here. I asked her to put this in.

The George Washington University
WASHINGTON DC

CENTER FOR HEALTH POLICY RESEARCH

MEMO

To: Interested persons
From: Sara Rosenbaum, Director
Subject: Congressionally mandated state right of action under Medicaid
Date: January 3, 1996

A December 22, 1995, Staff Summary of Medicaid Discussions between Republican and Democratic Governors presents the following options on the issue of whether Medicaid beneficiaries should have an individual right of action:[1]

"Option 1: The state is accountable to the federal government through the state plan. This agreement is enforced through state administrative action and the state courts. The state is also accountable to individual classes(sic). This relationship is outlined as follows:

> 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 (sic). 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 courts on behalf of individuals or classes.

Option 2: The state is accountable to the federal government through the state plan, enforced through administrative action by the Secretary of HHS and the federal courts. The state is also accountable to individuals (or class). This may be enforced through a right of action in federal courts."

While the options are presented in a somewhat cryptic fashion, the first appears to be designed to replace the existing federal right of action under §1983 of the Civil Rights Act with a state right of action (presumably to enforce guarantees under the state's Medicaid plan).

---

[1]The memorandum also presents as an option that certain classes of individuals (children, pregnant women, certain elderly and disabled individuals and certain other persons) would retain an entitlement to coverage for a defined (although altered) set of benefits. Since the discussions appear to contemplate retaining a specific guarantee of Medicaid benefits in federal law for certain classes of persons, this gives rise to the separate question of whether these individuals whould have the right to enforce theri entitlement in a judicial forum.

Enforcement would be through administrative and judicial review, with an appeal to the United States Supreme Court. The second option appears simply to restate current law.

In considering Option 1 several of us (whose area of expertise is health and welfare law and not constitutional law) have been identified several possible areas of concern. Because of the urgency of this matter and the speed with which negotiations are taking place, we are seeking assistance from individuals with expertise in Constitutional law. Our questions are as follows:

1. Can Congress *require* a state to create a right of action under state law as a condition of receiving federal funding under a federal grant-in-aid program? As we read Option 1, it does not require state courts to entertain a *federal* right of action; we assume that such a requirement already exists under the Supremacy clause. Instead the option appears to require states to create a *state* right of action (which could conceivably be under their administrative procedures act or under a new statute) as a condition of participation in Medicaid.

We know of no similar situation (although they may exist) in which states have been required as a condition of receiving federal funds to extend to individuals the right to bring an action against them in state court. To the extent that there is no precedent for such a federal requirement, our concern is that a law of this nature would immediately be subject to challenge by a state that is unwilling to waive its sovereign immunity in this fashion.

2. If Congress can require states to create a state right of action, can it dictate the terms and requirements of a new right of action, and if so, what terms and conditions should be included if the state-created right of action is to be as effective as §1983? We have the following specific concerns about the details of a state right of action requirement:

- Under Section 1983 a claimant can obtain injunctive relief. While injunctive relief is a feature of the uniform Administrative Procedures Act, a state might elect not to waive its sovereign immunity to this extent in the case of a Medicaid claim. Should injunctive relief be a prescribed component of a state right of action?

- A successful litigant in a Section 1983 case can recover attorneys fees. We presume that recovery of fees is not common in state laws pertaining to litigation by welfare beneficiaries. Should an attorneys fees provision be added?

- Where a state right of action is tied to the state's administrative procedure act an additional set of issues relates to procedural fairness matters. No exhaustion of administrative remedies is required under §1983 actions challenging the legality of state policies and laws; given the lack of factual issues in these types of cases, claims before an administrative agency would appear to be without any purpose. Moreover, in a state fair hearing, a claimant often is arguing before an administrative officer employed by the very agency that allegedly abrogated his or her rights. Therefore, should federal law set forth

minimum due process standards for the state's administrative fair hearing process offered as part of a state right of action?

Staff Summary of Medicaid Discussions
Thursday, December 22, 1995
11:00 A.M.

ELIGIBILITY

A. GUARANTEED COVERAGE GROUPS

1. Pregnant women to 133% of poverty
2. Children under age 6 to 133% of poverty
3. Children under age 13 to 100% of poverty
4. Persons with Disabilities — income to 100% of SSI (≈ 80% of poverty); functional impairment defined by state [unresolved]
5. Elderly (65+) — income to 100% of SSI (≈ 80% of poverty); functional impairment = need for institutional care
6. Qualified Medicare Beneficiaries and related groups
7. Adults from AFDC Program-Related Groups - States must choose from among the following options.
   - Continue serving individuals who would qualify under current AFDC rules; or
   - states are encouraged to develop work programs to develop AFDC when they do so they may establish a single eligibility system for both medical assistance and the new AFDC program.

Under current law a mandatory coverage for children is being phased in annually. That phase-in is not complete. It remains unresolved whether the phase-in should be included in the reformed program.

B. OPTIONAL COVERAGE GROUPS

In additions to the above categories, states would be free to provide health care to any other group of individuals or families. States would have complete freedom to define the eligibility standards for this population.

C. ASSETS STANDARDS

Persons with disabilities and the elderly would also be required to meet both an income and assets standard. The following are some principles to guide that standard.

1. The federal government should establish the asset limit. States could establish more restrictive limits, if they so choose.
2. Federal spousal impoverishment standards would apply.
3. Federal estate recovery standards would apply.
4. For eligibility purposes, the state may consider the maximum amount assets for the three years prior to application. If assets were divested during that period, the burden of proof is on the applicant and not the state to show that those assets were not divested to obtain nursing home coverage.

C. RIGHT OF ACTION

The states must be held accountable for the operation of the program. There are however, at least two strategies by which the accountability can be enforced.

Option 1: The state is accountable to the federal government through the state plan. This agreement is enforced through state administrative action and the state courts. The state is also accountable to individuals classes. This relationship is outlined as follows.

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 courts on behalf of individuals (or classes).

Option 2: The state is accountable to the federal government though the state plan, enforced through administrative action by the Secretary of HHS and the federal courts. The state is also accountable to individuals (or class). This may be enforced through a right of action in federal courts.

BENEFITS

The current Medicaid program includes ten mandatory benefits which must be offered to all beneficiaries and 34 benefits that may be offered to beneficiaries at state option. This proposal maintains this listing of benefits but makes them available as follows.

A. GUARANTEED COVERAGE GROUPS

States must offer to each beneficiary in the guaranteed coverage groups all of the benefits that are mandatory in the current program with the following conditions. States may offer any of the optional benefits to this population.

1. States have complete authority to define amount, duration and scope of services
2. States have complete authority to establish payment rates for providers.
3. The OBRA '89 provisions that expand mandatory benefits for children should be modified.

B. OPTIONAL COVERAGE GROUPS

For these coverage groups, there are no mandatory benefits and all benefits are at state option.

1. States define amount, duration and scope of services.
2. States establish payment rates for providers.

FINANCING

Discussion of financing should take into account the following principles.

1. Base expenditures should reflect a state's recent spending patterns.
2. A relationship between the state and federal government should be maintained.
3. Increases in the base, over the next seven years, should reflect changes in eligible populations (e.g. children, mothers, disabled and the elderly)

4. The financing system should address economic fluctuations among states to protect them against disproportionate variations in the economic cycle.
5. States should not be penalized financially if changes are made in mandatory populations as a result of program restructuring under welfare reform.

States are willing to engage in a process to develop a specific mechanism to address these principles.

FEDERAL FUNDS AND SAVINGS FROM BASELINE

It is acknowledged that the final savings from baseline in this proposal will be somewhere between 51 billion and 133 billion.

PROGRAM FLEXIBILITY

While there is considerable agreement among participants concerning program flexibility. The details of such changes are still under discussion.

EFFECTIVE DATE AND TRANSITION

Under discussion.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Office of the General Counsel
Washington, D.C. 20201

FACSIMILE TRANSMISSION

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Total number of pages 2

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MEMORANDUM

To: Jennifer Klein

From: Nan D. Hunter

Date: 3 January 1996

Re: Right of action

Sara called me last night re: her discussions re: whether the Governors' memo anticipates forcing states to enact waivers of sovereign immunity. Even after speaking with Alan and Charlie, I remain unclear about what the governors want and frankly, I think they do too. I do not read them as volunteering to endorse new legislation that would create state law versions of sec. 1983. But I do not know whether what they do want is to move all litigation, including sec. 1983 cases with full remedial relief available, into state courts; or whether they are really seeking what the Republican conference bill included, which was immunity from challenges brought under federal law in any forum. So I don't know whether we are even playing in the same ballpark of options that they are.

I spoke to Alan about my proposal and he was unsure about what Romer's response would be. He thought the Boren piece quite good, but felt that the claims process changes might be considerably more narrow than what the governors have in mind. (not a surprise) He did think, however, that even if it didn't work, just offering it demonstrated good faith. He said he would discuss the issue in general terms with Romer, et al and get back to us; he hasn't yet. We also haven't heard from Charlie.

I am concerned that the principals/leaders will reach and wrestle with this issue soon. Who is briefing them on this issue? What is the process?

I am in all day, but will be leaving town tomorrow for a conference in San Antonio.

DISCUSSION DRAFT ONLY

INDIVIDUAL RIGHT OF ACTION

Scope

a) The following adjudication process applies to 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).

Confidential

DISCUSSION DRAFT ONLY

BOREN-STYLE CLAIMS

Issue

Notwithstanding the repeal of the Boren amendment in the Administration's proposed amendments to Title 19, would Sec. 1902(a)(30)(A) provide an alternative cause of action for providers seeking essentially the same relief?

Existing law

In Wilder v. Virginia Hospital Ass'n, 496 U.S. 498 (1990), the Supreme Court ruled that providers of health care in the Medicaid program could sue states pursuant to Sec. 1983 to compel compensation for services rendered in accord with the "reasonable rate" standard established in 42 U.S.C. Sec. 1902(a)(13)(A) (popularly known as the Boren amendment). The Court ruled that the language of that provision was sufficient in its clarity and in its mandatory nature to establish an enforceable right. Two years later, in Suter v. Artist M., 112 S.Ct. 1360 (1992), the Court, without reversing Wilder, held that one of the 16 listed state plan requirements under the Adoption Assistance and Child Welfare Act of 1980 was not sufficiently precise to support a private right of action. The Court stressed the importance of "examining exactly what is required of States" under the statute, and found that the only unambiguous requirement of that Act was that "a State have a plan approved by the Secretary which contains the 16 listed features." The features themselves, however, were deemed to be too general to create a privately enforceable right. Such "generalized dut[ies are]...to be enforced not by private individuals, but by the Secretary." There is substantial confusion in the courts about how to harmonize the two decisions, which have been widely criticized as inconsistent.

The Administration's Medicaid proposal would explicitly repeal the Boren amendment, but would leave in place another, long-standing subsection of Sec. 1902(a) that states as follows:

> A State plan for medical assistance must...(30)(A) provide such methods and procedures relating to the...payment for care and services available under the plan...as may be necessary to...assure that payments are...sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

Governors have questioned whether providers might be able to rely on this provision to secure essentially the same kind of relief as was sought by the provider plaintiffs in Wilder.

DISCUSSION DRAFT ONLY

Possible resolution

Immediately following the provision repealing the Boren amendment, new statutory language could be drafted for inclusion in the Administration's proposal that would state that Congress intends that there be no privately enforceable right of action by providers against a State for the establishment of compensation rates that comply with the standards set forth in this section, i.e. Sec. 1902(a).

MEMO

To: Files
From: Sara Rosenbaum
Subject: Beneficiary rights of action under Medicaid; options for reform
Date: December 24, 1995

This memorandum reviews the various types of beneficiary-related claims that have been raised under Medicaid over the past 30 years and considers alternative remedies for managed care enrollees. There is no single answer regarding how a revised Medicaid statute will alter existing rights of action. As the entitlement is diminished courts increasingly can be expected to rule that the provisions of the statute are too ambiguous to create judicially enforceable rights. Therefore, it is virtually impossible (short of cutting off the existence of a right of action altogether) to prospectively identify which rights of action will survive and which will not. Only as courts begin to construe the revised statute will the answer become clear. Moreover, certain state conduct that gives rise to rights of action under Section 1983 to enforce Medicaid statutory provision also may constitute violations of other federal statutes, including federal civil rights laws or other federal civil rights laws such as the qui tam statute. Prohibitions of rights of action arising from the Medicaid statute itself presumably would not affect these other rights of action.

Despite the difficulties in eliminating rights of action across the board, it may be possible to alter existing legal processes in order to reduce the possibility of certain types of claims. The first part one of this memorandum identifies the principal classes of federal legal claims under the statute. Depending on the depth of amendment, some or most of these claims could survive the reform process. The second portion of the memo explores the use of an ADR system for benefit claims by managed enrollees. Since as much as 70 percent of beneficiaries can be expected to be enrolled in plans once managed care is fully implemented, these alterations could be expected to significantly affect the use of courts (state or federal) to resolve grievances.

It also is important to note that probably only a relative handful of beneficiary grievances against state Medicaid programs ever result in the filing of federal claims. In part this is because of the difficulties of pursuing a legal claim through an extensive federal action. Moreover, many types of state actions giving rise to a beneficiary grievance represent a violation of *both state Medicaid laws and rules and federal law*. As a result, I would assume that the great majority of aggrieved individuals (including both beneficiaries and providers) pursue eligibility, benefit or other grievances through the state fair hearing process (which I assume will be retained as a state plan requirement). Despite this fact, requiring a state fair hearing before filing *all* federal claims would be highly inappropriate in my opinion, because state fair hearing systems only have jurisdiction to hear claims of **state law** (i.e., that a state action violates state laws and regulations). While state courts can of course hear federal claims (and commonly do so) a state fair hearing process is not an adequate remedy at law for an individual with a federal claim, because the administrative process cannot resolve the claim.

1. State Action that Gives Rise to a Federal Cause of Action Under the Existing Medicaid Statute

a. Eligibility-related claims

- Wrongful denial of eligibility based on eligibility conditions that constitute either an erroneous interpretation of federal law or a condition of eligibility that does not apply to Medicaid (e.g., denial of Medicaid to children based on application of AFDC grandparent and sibling income deeming rules that do not apply to Medicaid; denial of coverage to migrant workers eligible for Medicaid because they are working in a state because they do not permanently reside in the state; denial of coverage to pregnant women who have not reached the third trimester of pregnancy).

- Wrongful termination of eligibility (e.g., termination of coverage for reasons not applicable to Medicaid, such as welfare time limits; termination on the grounds that a patient has entered an IMD, when in fact the institution is not an IMD).

- Termination of coverage without redetermination under alternative eligibility category (e.g., termination of welfare without determining eligibility for transitional benefits, termination of coverage for functionally disabled child losing SSI without determining potential eligibility as poverty child).

- Failure to determine eligibility promptly (federal time limits apply to eligibility determination procedures).

b. Benefit related claims

- Denial of a claim for covered benefits on the ground that the benefit was not necessary or its provision was excluded.

- Prior authorization systems that result in unreasonable delays for beneficiaries seeking services (e.g., authorization for a non-formulary drug; authorization for additional physician services beyond a certain number permitted each month in the case of a seriously disabled adult or child).

- Benefit coverage criteria that are impermissible under federal law[1] (denial of one or more types of benefits for individuals with certain conditions such as HIV or dementia, denial of coverage for special EPSDT benefits for children, coverage criteria that reduce coverage below reasonable levels needed to achieve the purpose of the benefit).

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[1] Note that many types of benefit denials are permissible under federal law, so long as the denial does not impermissibly discriminate against certain types of medical conditions or uses criteria not related to the medical necessity of the service.

- Failure to cover certain benefits required by federal law.

- Use of impermissibly high cost sharing requirements.

c. Access-related claims

- Failure to assure sufficient numbers of participating providers (including providers in health plans) so that services are reasonably available to beneficiaries.

d. Long term care claims

- Termination of nursing facility benefits without a level of care hearing.

- Denial or termination of home health benefits without a fair hearing.

- Termination of eligibility for home and community based waiver benefits.

- Refusal to provide benefits to a disabled child because they are identified in an individual treatment plan developed by a special education or child welfare program.

- Refusal to authorize covered personal attendant services for disabled children attending school.

e. Claims related to managed care

- Failure to comply with federal requirements pertaining to administration of managed care programs. Examples of issues giving rise to federal claims under one or more provisions of the statute are as follows:

  • Failure by the state to maintain a sufficient number of contracts with managed care providers so that patients mandated to enroll in managed care in order to receive benefits can enroll in a plan promptly in order to receive covered benefits.

  • Failure by a state to maintain a disenrollment process that permits timely disenrollment for cause.

  • Failure by the state to honor benefit requests by enrollees for Medicaid services not covered under their HMO contract (e.g. special benefits for disabled children not offered by HMOs but covered by Medicaid).

  • Failure by the state to maintain a fair hearing process for enrollees aggrieved by an action of their HMO (such as a denial of benefits, failure to make an assignment of a

patient to a gatekeeper provider, and so forth).

• Failure by the state to carry out federal duties pertaining to monitoring plan performance for access and quality.

• Permitting an HMO to maintain service restrictions and exclusions not permitted under federal law.

2. The effect of health plan enrollment on pre-existing claims

Enrollment in a managed care plan relegates to a private entity many of the duties previously under the direct control of the state. Therefore, *in the case of grievances related to actions for which the plan is primarily responsible*, an alternative dispute resolution system might be required. The types of claims that would be subject to this ADR would be benefit and cost sharing claims that relate to services covered under the plan's contract. For such an ADR system to work effectively, the following limitations and procedural requirements should be in place:

- The ADR system should apply only in the case of plans that maintain an internal grievance system that meets minimum requirements (e.g., existing grievance requirements under 42 CFR Part 417 that apply to HMOs or a state law that contains similar requirements).[2]

- The ADR system should be used only if the state maintains a process of administrative and state judicial review of claims by individuals aggrieved by final plan action. At a minimum the state's administrative review system should include an expedited external administrative and judicial review procedure for individuals (or their providers acting on their behalf) whose claim involves an urgent need for care (within 48 hours) and whose request is either denied or not acted upon within the prescribed time limit.

- The ADR system should apply only to claims for services and benefits **covered in the managed care plan's service contract** with the state. If an individual grievance involves a service for which the plan is not responsible then exhaustion of this process should not be required. The scope of the coverage should be drafted to permit a beneficiary to raise any benefit-related claim, including failure of a plan to assign a provider to the individual in a timely fashion, as well as failure by the plan to approve specific services or referrals to specialists.

- The ADR system should not apply to individuals seeking to disenroll from the plan for cause, unless such a request is treated as a request for urgent care and therefore subject to an

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[2] For example the state of Minnesota maintains an administrative and judicial review system for all residents enrolled in non-ERISA plans, regardless of plan sponsor. A system of general applicability to all HMO enrollees in a state should suffice so long as it includes an expedited review requirements for urgent claims and recognizes the full scope of claims.

expedited process. (Many plans are being cited at the present time for making it impossible for enrollees to get out even for cause so that they can keep getting paid).

- The ADR system should not apply when the dispute involves a claim against the state (failure to oversee the plans, failure to provide non-contract benefits). In these cases, existing processes should apply.

- The ADR system should cover both plan actions and plans' failure to act.