The Home- and Community-Based Waiver Program Under Medicaid: An Update

By Michele Melden

Michele Melden is a staff attorney at the National Health Law Program, 2639 S. La Cienega Blvd., Los Angeles, CA 90034; (310) 204-6010.

While states cover home health services for Medicaid recipients in a variety of ways, one of the most common is for states to elect to operate "home- and community-based waiver" (HCBW) programs. HCBW programs are typically targeted to specific population groups and often are capped, financially or through enrollment limits or limits on geographic areas served. All 50 states currently operate some type of HCBW program under Medicaid.

This article updates an earlier article on home health resources under Medicaid. /1/ This article focuses on case law that has evolved as a result of Medicaid recipients challenging denials or limitations of services under HCBW programs and provides strategies for addressing such denials. /2/

I. Statutory Authority for Waivers

States may obtain "waivers" to provide home- and community-based services to individuals who, but for the home services, would be institutionalized in a hospital or nursing facility. /3/ The waivers enable states to avoid requirements that otherwise would apply under Medicaid law. In particular, under the HCBW program, states may waive statewideness, comparability, and certain income and resource rules. /4/ These waivers often are used to offer an expanded scope of services to a limited population, either through numerical or geographic limits that otherwise would be illegal under federal law.

States can operate three different kinds of HCBW programs. First, states may obtain waivers for any individuals who would be eligible for Medicaid if institutionalized in a hospital or nursing facility or intermediate care facility for the mentally retarded and who, but for the waiver, would be institutionalized. /5/ Such states may not set a limit of less than 200 on the number of slots available to recipients. /6/ Second, home- and community-based waivers are available to provide home care to elderly individuals over age 65 for whom nursing home care is unavailable due to a supply shortage. /7/ Under both types of waivers, the home- and community-based services may be provided only if they are "cost-effective." /8/ In addition, eligible individuals may receive an expanded set of benefits not otherwise available to Medicaid recipients. /9/

The third type of waiver is a "model" waiver under which deeming rules are waived so that certain individuals become eligible for Medicaid, but such individuals do not obtain access to an expanded

scope of services. /10/ Recently promulgated rules limit the number of recipients in a model waiver to 200. /11/

II. Addressing Denials and Terminations

Typical problems with HCBW services are that recipients are denied approval either for a request for such services or for the full amount requested or that they are sent a notice of termination upon a redetermination of need. The typical bases for denial are that the person does not meet the required level of need or that the care at home would not be "cost effective." The result of such denials, reductions, or terminations often is institutionalization and permanent removal from one's home and community.

The first steps an advocate should take are to (1) obtain a copy of the waiver and all other accompanying documentation between the state and the Health Care Financing Administration regarding the waiver; (2) obtain information regarding the assessment tools used to determine level of need, including the survey instrument and any applicable state regulations or subregulatory policies; and (3) obtain information regarding the cost-effectiveness test, including any applicable state regulations or subregulatory policies.

Next, the following questions must be analyzed:

- Is the exclusion contrary to a federal statute?
- Is the federal statute enforceable?
- Were the client's substantive due process rights violated?
- Were the client's procedural due process rights violated?
- Does the client have a right to an HCBW program tailored to the client's individual needs?
- Are other resources under Medicaid available to cover home care?

A. Is the Exclusion Contrary to a Federal Statute?

1. Level of Need

Under the first type of waiver, HCBW services may be provided to individuals for whom there has been a determination that "but for the provision of such services" the individual otherwise would require institutional care. /12/ An important federal case in Colorado, Martinez v. Ibarra, held that the state could not use criteria for the HCBW program that were stricter than those that actually would be used to determine whether individuals required the specific institutional level of care. /13/ Thus, in that case, the court struck down a screening instrument that required individuals applying for the HCBW program to show a greater need than that required to be placed in a nursing facility.

While states may limit eligibility for HCBW programs based on what level of institutional care the individuals otherwise would need, /14/ they must cover all individuals who otherwise need that level of care unless there are other applicable waivers or limits, such as numerical caps or limits based on geography.

At the same time, the Ninth Circuit upheld the use of HCBW criteria for determining whether individuals were at the "hospital" level of care that required an actual hospitalization, rather than an expected hospitalization. In Beckwith v. Kizer, the court reviewed an HCBW waiver in California targeting individuals requiring more than 90 days of hospital care. /15/ Under the waiver, only individuals who actually were discharged from a hospital stay of at least three days could qualify. The court found that the criteria were "rationally related" to the statutory requirements that the individuals otherwise require hospital care. /16/

2. Category of Medicaid Eligibility

In a separate context, the Second Circuit has interpreted the Medicaid statute as authorizing states to limit eligibility for HCBW programs to individuals based on their category of Medicaid eligibility. In Skandalis v. Rowe, the court reviewed an HCBW waiver in Connecticut that excluded individuals with incomes exceeding 300 percent of the Supplemental Security Income level, even though such individuals could qualify for Connecticut's medically needy Medicaid program. /17/ The court found that the statute authorized this exclusion based on two provisions. First, the statute states that HCBW services may be provided at state option "to any group or groups of individuals described in section 1396d(a) [which lists the various groups that states may cover]." /18/ Second, the statute authorizes states to obtain "comparability" waivers that enable them to limit eligibility for the HCBW programs. /19/

Several states limit the waivers to individuals with particular kinds of conditions, such as ventilator-dependence or conditions related to Acquired Immune Deficiency Syndrome. /20/ These limits appear legal under Skandalis. Nonetheless, any individual within a specified category should be eligible as long as the individual met the level-of-need determination, as well as the cost-effectiveness determination.

3. Cost-effectiveness

HCBW services may be approved only if they are "cost effective." No reported cases have addressed cost-effectiveness tests. It is important to note, however, that the tests the states use are circumscribed by the statute. Under the first type of waiver, the estimated annual average per capita expenditure for persons requiring home- and community-based care must not exceed 100 percent of the estimated annual average per-capita expenditure for individuals in the comparable institution. /21/ States also have the option, in making estimates for waivers that apply only to individuals with particular illnesses or conditions, to base the comparison only on the average per-capita expenditures for such illnesses or conditions. /22/ However, because Martinez v. Ibarra limits states' flexibility to exclude individuals whose coverage is anticipated under the statutory

requirements, a state's use of restrictions based on formulas more restrictive than those specified by the statute is questionable. /23/

In addition, under this type of waiver, states have the option of denying HCBW care to particular individuals if it is determined that the amount spent on home care would exceed the amount that would be spent on institutional care. /24/ States must, however, expressly provide for this in the waiver itself. /25/

Under the second type of waiver targeted to the elderly in states with a shortage of nursing home beds, cost effectiveness is determined in relation to an amount representing aggregate expenditures for these services prior to the waiver, updated annually for inflation and changes in the size of the state's population of individuals over age 65. /26/

4. Nonwaived Portions of the Medicaid Act

Any nonwaived portions of the Medicaid statute apply. For example, in McMillan v. McCrimon, a federal court in Illinois struck down waiting lists for the HCBW program as violating the right to make prompt application for Medicaid services. /27/ Other states sometimes limit the number of slots per county, although no such limit is approved explicitly in the waiver. The McMillan decision puts the legality of such policies into question. In addition, a state court in Colorado mandated operation in all counties of its HCBW program based on the statewideness requirement that had not been waived in the statute. /28/

B. Is the Federal Statute Enforceable?

In some cases, state defendants have challenged recipients' ability to enforce the HCBW provisions pursuant to 42 U.S.C Sec. 1983. /29/ In these cases, the analysis requires answering three questions:

1. Was the provision in question intended to benefit the plaintiff?

2. Does the statutory provision in question create binding obligations on the defendant governmental unit or merely express a congressional preference? And

3. Is the interest the plaintiff asserts specific enough, rather than "vague and amorphous, to be enforced judicially?" /30/

The Sixth Circuit recently upheld the right to sue a state based on its administration of its HCBW program; it found some of the statutory provisions in question enforceable under Section 1983 and others not enforceable. In Wood v. Tompkins, the court upheld a Section 1983 action to enforce various assurances made by the state in its home- and community-based waiver, as long as the assurances were found to be based on statutory and regulatory provisions intended specifically to benefit recipients. /31/ In that case, plaintiff recipients brought an action challenging the state's methodology in determining cost effectiveness. While the court held that requirements relating to eligibility determinations and to providing "necessary safeguards (including adequate standards for

provider participation) . . . to protect the health and welfare of [recipients]" were intended to benefit recipients, other provisions were ruled unenforceable, including the requirements regarding states' determinations of cost effectiveness. /32/

More important, the court held that Medicaid Act requirements being phrased as "assurances" states must provide to the federal government did not preclude recipients from enforcing these assurances against the states. /33/ Rather, the court found that, as long as the "onus of compliance" rested with the state, recipients could enforce such requirements. /34/

While the Wood v. Tompkins decision is important in holding that some of the assurances made in the waiver are enforceable as a matter of federal law, recipients also should consider trying to enforce waiver provisions in state court as third-party beneficiary contract actions. /35/

C. Were the Client's Substantive Due Process Rights Violated?

The constitutional right to due process protects against arbitrary interference with property rights. Goldberg v. Kelly held that government-established entitlements are constitutionally protected property rights. /36/ In an important decision affecting HCBW services, a federal court in Colorado found that the HCBW program's failure to establish clear, written procedures regarding determinations of need violated recipients' due process rights. /37/ This case also would be relevant to situations in which states made up rules for their waiver programs that were not specified in the waivers themselves.

In another context, many advocates have complained about redeterminations of the need for HCBW services that were used to achieve budget cutbacks without any underlying changes in medical conditions or program rules. Two state courts reviewing denials for HCBW services following "redeterminations of need" found that the due process protection against arbitrary administration of a program prevented terminations from home care unless there were a change in medical condition or underlying regulations or statute. /38/

D. Were the Client's Procedural Due Process Rights Violated?

As with all Medicaid services, state agencies must follow the federal Medicaid regulations on notice and hearing rights. /39/ Several courts have clarified that these rights apply to home health services. Specifically, these rights apply to level-of-need assessments, require that notices be in writing to recipients, and require that notices be specific enough to provide a basis for a challenge. /40/ These rights extend to terminations of home health providers from the program if the effect is to terminate a recipient's benefits. /41/

Decisions in New York State have reached opposing decisions regarding whether a person returning home from a temporary hospitalization can be cut off from home health services without a notice and hearing. In the first decision, Granato v. Bane, the court found that no notice was required for a termination from home health services following a hospitalization because, according to the court, there was a clear change in medical condition, and thus no "change" in services. /42/ In

the second decision, a separate court, claiming to make its decision consistent with Granato, rejected the state's argument that individuals who were hospitalized could be "reassessed" automatically, without notice and hearing rights. /43/ Instead, notice and hearing rights would apply to any changes in home care, regardless of an intervening hospitalization. /44/

Another issue in the context of home- and community-based services has been many states' use of other entities, such as home health agencies, to conduct assessments of need. Some states have argued that these assessments, which actually result in the denials or terminations, are not covered by the due process protections because there has been no "state action." This argument recently was rejected when a county social services agency in New York responsible for these assessments claimed that it could not be sued for violating due process rights because its actions were not "state action." /45/

Recipients who are or may be institutionalized also have a related right to be informed of the right to HCBW alternatives. /46/ However, recipients must be given the choice of where to receive services and thus cannot be forced to stay at home. /47/

E. Does the Client Have a Right to an HCBW Program Tailored to the Client's Individual Needs?

A number of cases have raised challenges under Section 504 of the Rehabilitation Act and the Americans with Disabilities Act (ADA) either because clients did not fit the criteria for certain HCBW programs or because no programs were available and they wanted new programs created. /48/

Debate continues as to whether Section 504 or the ADA can be used to challenge discrimination between different groups of persons with disabilities, as opposed to being limited to challenges based on discrimination between persons with disabilities and persons without disabilities. Two important recent decisions from the Third Circuit suggest conflicting approaches. First, in the more recent decision, Helen L. v. Didario, the court found discrimination in a refusal to provide attendant care in the home of a woman with a traumatic brain injury. /49/ The refusal was based on the program's targeting of individuals "to the most mentally alert." Because the woman would have received such services in a nursing facility unless she received them in her home, the court found that Pennsylvania's Medicaid program violated the ADA by failing to provide her with services "in the most integrated setting." A few decisions by other federal district courts held similarly that violations occurred when programs serving persons with disabilities excluded individuals with more severe disabilities. /50/

In contrast, another decision by the Third Circuit, Easley v. Snider, /51/ took the position that discrimination can exist only between persons with disabilities and persons without disabilities. In this case, the court rejected an argument that the attendant care program could not discriminate against individuals who were not mentally alert. The decision turned, however, on the court's conclusion that including individuals who were not mentally alert would "fundamentally alter" the nature of the program.

No courts have held that either Section 504 or the ADA give rise to an affirmative duty on the part of state agencies to create home- and community-based alternatives. /52/

F. Are Other Resources under Medicaid Available to Cover Home Care?

Although this article does not focus on other mechanisms for providing home care under Medicaid, it is the important final question. Keep in mind that while many such services are "optional" and therefore may not be covered in one state (such as private-duty nursing or respirator services for the ventilator-dependent), two mechanisms are not optional but mandatory and thus always should be considered.

First, for children under age 21, the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program is mandatory. /53/ Under EPSDT, all services that are necessary "to correct or ameliorate defects and physical and mental illnesses and conditions" are mandatory for children, as long as they are coverable under the federal Medicaid program under 42 U.S.C. Sec. 1396d(a), regardless of whether the services otherwise are covered under a state's Medicaid plan for adults. /54/ Thus, services such as private-duty nursing and respiratory care for ventilator-dependent individuals that otherwise are optional are mandatory for children when medically necessary.

Second, a provision in the Medicaid Act has been almost completely untested with respect to its scope. That section requires that home health be included under every state Medicaid plan "for any individual who, under the State plan, is entitled to nursing facility services." /55/ Under the regulations, home health services must include nursing services, home health aide services, and medical supplies, equipment, and appliances. /56/

Some states do not provide any services under this section at all. Other states provide services in only a very limited amount. For example, some states provide home health services under this provision only to individuals who depend on ventilators, or for a maximum of 20 hours per week, limited to a three-month period. Both of these practices can be challenged. First, a failure to provide the service at all is a direct violation of the statutory requirement. Second, while states may set utilization limits on services based on such criteria as medical necessity and utilization control procedures, states may not set limits that "conflict with the overall purpose" of the Act, or which result in a failure to meet the needs of most people requiring the service. /57/ In addition, states may not discriminate against individuals on the basis of medical condition. /58/

Third, neither the mandatory nor optional home health services explicitly require a cost-effectiveness test, which is required under the HCBW program. /59/ Thus, in a recent decision from a federal court in New York reviewing personal care services, the court found that such care could not be denied just because institutional care was cheaper if, in fact, institutional care was not actually available. /60/

III. Conclusion

As states use HCBW programs to deliver home care as an alternative to institutional care under Medicaid, existing case law provides a useful basis for protecting and expanding recipients' access to such alternatives. The National Health Law Program will assist advocates on these and other home care issues, and advocates should share developments with and contact it for assistance.

Footnotes

/1/ See Michele Melden, Expanding Medicaid Access to Home Health Care Services, 24 Clearinghouse Rev. 673 (Nov. 1990). While this update focuses on "home- and community-based waiver" (HCBW) services, the previous article covered the spectrum of home health services coverable by Medicaid. The previous article still is current with respect to the full spectrum of home health options except for two options added since 1990: (1) a state option to cover "respirator services" in the home only for individuals dependent on ventilators (42 U.S.C. Secs. 1396a(e)(9), d(a)(20); 42 C.F.R. Sec. 440.185); and (2) a state option to cover "community-supported living arrangements" for functionally disabled elderly individuals (42 U.S.C. Secs. 1396d(a)(23), 1396t). In addition, legislation that would have required that personal care be included as a component of mandatory home health, beginning in 1990, was repealed; instead, personal care services remain an optional service. 42 U.S.C. Sec. 1396d(a)(24).

/2/ This article does not address other "waivers" that are available to provide home care, such as "Katie Beckett waivers" (a waiver on deeming requirements for children who would be eligible for Medicaid if in an institution, but not otherwise eligible for Medicaid while living at home, under 42 U.S.C. Sec. 1396a(e)(3)); or waivers for children receiving federal adoption or foster care assistance who are infected with Acquired Immune Deficiency Syndrome (AIDS) or are drug dependent at birth (under 42 U.S.C. Sec. 1396n(e)).

/3/ 42 U.S.C. Secs. 1396n(c)(1), (d)(1); 42 C.F.R. Secs. 440.180 -- 81, 441.301 -- 10, 441.350 -- 65. Relevant Health Care Financing Administration (HCFA) transmittals include HCFA, State Medicaid Manual, Sec. 2700.6 (transmittal No. 79) (Apr. 1992); id. Sec. 4440-46 (transmittal No. 54) (Aug. 1991) (available from the National Health Law Program (NHeLP)).

/4/ 42 U.S.C. Sec. 1396n(c)(3), (d)(3).

/5/ Id. Sec. 1396n(c)(1).

/6/ Id. Sec. 1396n(c)(10).

/7/ Id. Sec. 1396n(d). Oregon is the only state with this type of waiver; however, as of June 1994, it has applied to terminate the waiver. CCH, Medicare & Medicaid Guide Para. 14,625.35.

/8/ 42 U.S.C. Sec. 1396n(c)(2)(D), 1396n(d)(5)(A).

/9/ Under the first type of waiver, services may include case management, homemaker/home health aide services, personal care services, adult day health services, habilitation services, respite care, day treatment or other partial hospitalization services, psychosocial rehabilitation services, and

clinic services for individuals with chronic mental illness. Id. Sec. 1396n(c)(4)(B). Under the waiver targeted just to the elderly living in states with a shortage of nursing home beds, services may include case management, homemaker/home health aide services, personal care services, adult day health services, respite care, and "other medical and social services that can contribute to the health and well-being of individuals and their ability to reside in a community-based care setting." Id. Sec. 1396n(d)(4).

/10/ Id. Sec. 1396n(c)(3); 42 C.F.R. Sec. 441.305(b) While these authorities do not mention explicitly "model" waivers, the HCFA's State Medicaid Manual gives them this name. See HCFA, State Medicaid Manual Sec. 4443.

/11/ 42 C.F.R. Sec. 441.305(b). Notably, the preamble to these regulations states that this policy has been an "administrative" policy, not one that is explicitly derived from the statute. See 59 Fed. Reg. 37,702, 37,711 -- 12 (July 25, 1994).

/12/ In the first type of waiver, the level of care would be care in a hospital, nursing facility, and/or intermediate care facility for the mentally retarded. 42 U.S.C. Sec. 1396n(c)(1). In the second type, the level of care would be care in a nursing facility. 42 U.S.C. Sec. 1396n(d)(1).

/13/ Martinez v. Ibarra, 759 F. Supp. 664 (D. Colo. 1991).

/14/ E.g., waivers may be obtained only for individuals who otherwise would require hospital care. See, e.g., Beckwith v. Kizer, 912 F. 2d 1139 (9th Cir. 1990).

/15/ Beckwith, 912 F.2d at 1139.

/16/ Id. at 1144.

/17/ Skandalis v. Rowe, 14 F.3d 173 (2d Cir. 1994), rev'g 811 F. Supp. 782 (D. Conn. 1993).

/18/ See 42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(VI).

/19/ See id. Sec. 1396n(c)(3).

/20/ See CCH, Medicare & Medicaid Guide Para. 14,625.35. E.g., states with waivers for individuals with AIDS-related conditions include Illinois, Iowa, Missouri, Pennsylvania, South Carolina, and Washington.

/21/ 42 U.S.C. Sec. 1396n(c)(2)(D).

/22/ Id. Sec. 1396n(c)(7)(A).

/23/ In fact, in Wood v. Tompkins, 33 F.3d 600 (6th Cir. 1994), the court upheld the use of 42 U.S.C. Sec. 1983 to challenge a state's financial cap on home care. However, as will be discussed below, the court found that the provision regarding the cost-effectiveness determination was not intended to benefit recipients.

/24/ 42 U.S.C. Sec. 1396n(c)(4)(A).

/25/ 42 C.F.R. Sec. 441.301(a)(3).

/26/ 42 U.S.C. Sec. 1396n(d)(5)(A).

/27/ McMillan v. McCrimon, 807 F. Supp. 475 (C.D. Ill. 1992), interpreting 42 U.S.C. Sec. 1396a(a)(8) ("such assistance shall be furnished with reasonable promptness to all eligible individuals"). While this decision did not review explicitly the provision for its enforceability under 42 U.S.C. Sec. 1983, two other cases have found that this particular provision is enforceable under 42 U.S.C. Sec. 1983: See Sobky v. Smoley, 855 F. Supp. 1123 (E.D. Cal. 1994); Wellington v. District of Columbia, 851 F. Supp. 1 (D.D.C. 1994).

/28/ See Christy v. Ibarra, 826 P.2d 361 (Colo. Ct. App. 1991), cert. denied (Mar. 10, 1992).

/29/ The principal Supreme Court cases setting forth the requisite analysis under Section 1983 generally are: Suter v. Artist M., 112 S. Ct. 1360 (1992) (Clearinghouse No. 48,036); Wilder v. Virginia Hosp. Ass'n, 496 U.S. 498 (1990); Golden State Transit Corp. v. City of Los Angeles, 493 U.S. 103 (1989); Wright v. Roanoke Redevelopment & Hous. Auth., 479 U.S. 418 (1987); and Maine v. Thiboutot, 448 U.S. 1 (1980).

/30/ Wilder, 496 U.S. at 509.

/31/ Wood, 33 F.3d at 600.

/32/ Specifically, the court found the following provisions enforceable: 42 U.S.C. Sec. 1396n(c)(2)(A), (B), (C), (E); and 42 C.F.R. Sec. 441.302(a), (b), (c), (d), (f)(2). Specifically, the court found unenforceable 42 U.S.C. Sec. 1396n(c)(2)(D) and 42 C.F.R. Sec. 441.302(b), (e). However, in an unreported decision that was vacated on jurisdictional grounds, a federal court in Illinois, relying on Suter v. Artist M., found that none of the statutory provisions under the HCBW program were enforceable under Section 1983 because the statute required the state agency to provide only a "plan" for covering certain individuals. See Frances J. v. Bradley, No. 92-C-5190 (N.D. Ill. Dec. 14, 1992), reprinted in CCH, Medicare & Medicaid Guide Para. 40,972, vacated on jurisdictional grounds, 19 F. 3d 337 (7th Cir. 1994). Congress has "fixed" this problem by enacting legislation that permits use of Section 1983 even where the statute requires only a "plan" as long as the other parts of the three-prong analysis can be met. Act of Oct. 20, 1994, Pub. L. No. 103-382 Sec. 555(a), 1994 U.S.C.C.A.N. (108 Stat.) 4057 -- 58, inserting Sec. 1123a into the Social Security Act.

/33/ 33 F.3d at 610 -- 11.

/34/ Id.

/35/ See Jane Perkins & Michele Melden, The Advocacy Challenge of a Lifetime: Shaping Medicaid Waivers to Serve the Poor, 28 Clearinghouse Rev. 864 (Dec. 1994) (a discussion -- also

applicable to HCBW waivers -- on third-party beneficiary contract actions in the context of "Section 1115" Medicaid waivers).

/36/ Goldberg v. Kelly, 397 U.S. 245 (1970).

/37/ Martinez v. Ibarra, 759 F. Supp. 664 (D. Colo. 1991).

/38/ See Weaver v. Colorado Dep't of Soc. Servs., 791 P.2d 1230 (Colo. Ct. App. 1990); Collins v. Eichler, No. 90A-JL2 (Del. Super. Ct. Mar. 25, 1991), reprinted in 1991 WL 53,447.

/39/ See 42 C.F.R. Secs. 431.200-246.

/40/ See King v. Fallon, 801 F. Supp. 925 (D.R.I. 1992); Catanzano v. Dowling, 847 F. Supp. 1070 (W.D.N.Y. 1994); Steele v. Magnant, S90-00485 (N.D. Ind. Sept. 3, 1992), reprinted in CCH, Medicare & Medicaid Guide Para. 40,372.

/41/ Haymons v. Williams, 795 F. Supp. 1511 (M.D. Fla. 1992).

/42/ Granato v. Bane, 841 F. Supp. 64 (N.D.N.Y. 1994), recon. denied (N.D.N.Y. Dec. 13, 1994), reprinted in 1994 WL 705,256.

/43/ See Burland v. Dowling, No. 407324/93 (N.Y. Sup. Ct. Nov. 15, 1994). This case distinguished Granato by stating that Granato authorized only reassessments for "increases" in care but did not address Granato's holding on notice and hearing rights. Id. at 7.

/44/ Id. at 9 -- 10.

/45/ Catanzano v. Richardson, No. 6:89-CV-01127, decision and order at 9 (July 28, 1994) (available from NHeLP -- Los Angeles). See generally J.K. v. Dillenberg, 836 F. Supp. 694 (D. Ariz. 1993) (due process applies to denials by managed care plan because it is implementing state Medicaid procedures).

/46/ 42 U.S.C. Sec. 1396n(d)(2)(C) (applies only to the waiver for the elderly for whom there is a nursing home bed shortage); 42 C.F.R. Sec. 441.302(d). See also Steele v. Magnant, S90-00485, Order (N.D. Ind. Sept. 3, 1992), reprinted in CCH, Medicare & Medicaid Guide, Para. 40,372 (required state Medicaid agency to come up with plan for informing individuals in need of institutional care of their alternatives to receive home- and community-based services).

/47/ 42 C.F.R. Sec. 441.302(d)(2).

/48/ Section 504 of the Rehabilitation Act, 29 U.S.C. Sec. 794; Americans with Disabilities Act, 42 U.S.C. Secs. 12101 et seq.

/49/ Helen L. v. Didario, 1995 WL 34,200 (3d Cir. 1995).

/50/ See Jackson v. Fort Stanton Hosp. & Training Sch., 757 F. Supp. 1243 (D.N.M. 1990), rev'd on other grounds, 964 F.2d 980 (10th Cir. 1992) (community service program for the mentally disabled was discriminatory because it excluded individuals with severe handicaps); Garrity v. Gallen, 522 F. Supp. 171 (D.N.H. 1981) (Section 504 violated when community placements for mentally retarded excluded residents of intermediary care facilities on an assumption that they could not benefit because of the severity of their disability); Lynch v. Maher, 507 F. Supp. 1268 (D. Conn. 1981) (preliminary injunction against Medicaid program that would not approve applications for home care by individuals who required more than 20 hours per week). In addition, in Martin v. Voinovich, 840 F. Supp. 1175 (S.D. Ohio 1993), the court did not reach the merits but only the jurisdictional issue and held that claims under Section 504 and the Americans with Disabilities Act were permissible to challenge exclusion from an HCBW program if individuals were treated differently just on the basis of their disability.

/51/ Easley v. Snider, 36 F.3d 297 (3d Cir. 1994).

/52/ See Kentucky Ass'n for Retarded Citizens, Inc. v. Conn, 674 F.2d 582 (6th Cir.), cert. denied, 459 U.S. 1041 (1982); Martin v. Voinovich, 840 F. Supp. 1175 (S.D. Ohio 1993); Sabo v. O'Bannon, 586 F. Supp. 1132 (E.D. Pa. 1984); Williams v. Secretary of the Exec. Office of Human Servs., 609 N.E.2d 44 (Mass. 1993).

/53/ 42 U.S.C. Secs. 1396a(a)(10)(A), 1396d(a)(4)(B).

/54/ Id. Sec. 1396d(r)(5).

/55/ Id. Sec. 1396a(a)(10)(D).

/56/ 42 C.F.R. Sec. 441.15.

/57/ Id. Sec. 440.230(d). See Meyers v. Reagan, 776 F.2d 241 (8th Cir. 1985) (finding that underlying purpose of coverage of rehabilitative care was to help recipients attain or retain capability for independence or self-care, court required treatment of electronic speech device for hearing-impaired individual); Mitchell v. Johnston, 701 F.2d 337 (5th Cir. 1983) (Texas's limits on dental care invalidated because of failure to constitute a minimally acceptable dental health program); Ledet v. Fischer, 658 F. Supp. 775 (M.D. La. 1982) (Louisiana's limit on eyeglasses for patients recovering from postcataract surgery failed to meet needs of most individuals requiring eye care); see also Alexander v. Choate, 469 U.S. 287 (1985) (in dicta, Court stated that 14-day- per-year limit on hospitalization would not conflict with Medicaid Act because most people needing hospital service would not be deprived of necessary service).

/58/ See Weaver v. Reagan, 886 F.2d 194 (8th Cir. 1989) (found exclusion of AZT discrimination against individuals with AIDS-related illnesses); Montoya v. Johnston, 654 F. Supp. 511 (W.D. Tex. 1987) (court invalidated $50,000 limit on transplants as discrimination against children needing liver transplants where minimum deposit required was $100,000); Allen v. Mansour, 928 F.2d 404 (E.D. Mich. 1986) (unpublished disposition) (court invalidated as discriminatory state's requirement that patients requiring liver transplants due to alcoholic cirrhosis must document two years of abstention).

/59/ Proposed federal regulations specify that states may apply cost-effectiveness tests under the Early and Periodic Screening, Diagnosis, and Treatment Program and specifically may apply such tests in determining whether to authorize home health services. 58 Fed. Reg. 51,288, 291 -- 92 (Oct. 1, 1993). However, these cost-effective services must be appropriate and available. Id.

/60/ Burland v. Dowling, No. 407324/93 (N.Y. Sup. Ct. Nov. 15, 1994) (available from NHeLP -- Los Angeles).