OCTOBER 1995
VOL. 29 ■ NO. 6

CLEARINGHOUSE REVIEW

JOURNAL OF POVERTY LAW

INSIDE

Elder Law

Due Process Considerations for Medicare and Medicaid Beneficiaries in Managed Care Systems

By Alfred J. Chiplin, Jr. and Patricia B. Nemore

Alfred J. Chiplin, Jr., and Patricia B. Nemore are staff attorneys at the National Senior Citizens Law Center, 1815 H St. NW, Suite 700, Washington, DC 20006; (202) 887-5280.

I. Introduction

Managed care is the health insurance buzz phrase for the mid-1990s. Although Medicare beneficiaries and elderly and disabled Medicaid beneficiaries have not participated in managed care programs to the degree the rest of the population has in the last 15 years, strong evidence suggests that this situation may change dramatically in the near future. In the wake of the failure to enact health care reform in 1994, and in the name of balancing the federal budget by the year 2002, Congress is debating and acting on proposals to achieve savings of over $400 billion from Medicare and Medicaid over the next seven years. Governors seeking greater control over their Medicaid programs appear willing to trade fewer federal dollars for less prescription from Washington about how to run the program. /1/ Many also appear to think that they can reduce their Medicaid expenditures to the congressional targets partly by increasing mandatory beneficiary enrollment in managed care programs. Medicare initiatives also include greater emphasis on managed care. The issue for advocates is no longer whether beneficiaries of public programs should be in managed care; rather, it is what advocates can do to ensure that beneficiaries receive the services they need.

Advocacy on behalf of low-income clients in managed care settings can take several forms. /2/ This article focuses on one aspect of advocacy: the due process protections available to challenge denials or reduction of services as they apply in managed care settings. It discusses the specific requirements of current Medicare and Medicaid law and proposes a framework to guide advocacy as these two programs change. It does not discuss the very substantial and significant questions of whether and how managed care actually saves money in the delivery of health care, to whom any savings that are achieved accrue, and whether the "managing" of people's health care in fact results in greater access and better health. /3/ Rather, this article's premise is that managed care is a fact of life and that such delivery systems must include basic due process rights.

For purposes of this discussion, managed care is defined broadly to include any health care delivery system that requires prior approval for access to hospital care (including rehabilitation), nursing facility care, home care, hospice care, or physician specialists or specialists in allied health and medical/social service fields. /4/ Similarly, due process is defined broadly to include notice about the type(s) and scope of services provided, notice about grievance and appeal mechanisms, including pretermination review and expedited review, and specific notice to individuals when a service is denied, reduced, or terminated.

II. Managed Care for Elderly People and People with Disabilities

Although managed care options have been available to Medicare beneficiaries since 1982, fewer than 7 percent (or 2.3 million) of the 36 million beneficiaries are enrolled in health maintenance organizations (HMOs). /5/ Nearly one quarter of the 32 million Medicaid beneficiaries are in some form of managed care, but only 30 percent (or about 2.5 million) of those are from the Supplemental Security Income (SSI) -- related populations (elderly and disabled). /6/ In contrast, 19 percent of the general population is in some form of managed care. /7/

While states have moved, through the Medicaid waiver process, to make managed care mandatory for Aid to Families with Dependent Children (AFDC) -- related populations, few have done so for SSI-related beneficiaries. /8/ According to the Kaiser Commission on the Future of Medicaid, 18 states offered managed care to their SSI populations in 1993. /9/

Three major reasons for this phenomenon are: First, older people and people with disabilities have more serious and more complex health care needs than the adults and children who comprise the AFDC-related population. Managed care providers traditionally have not served these populations and are reluctant to do so. Moreover, the emphasis in managed care on primary and preventive care is less relevant to the health needs of older and chronically disabled people. Second, most of the elderly receiving Medicaid (3.7 million individuals) are also eligible for Medicare, that is, they are dually eligible. Medicare pays for most of their physician visits, hospitalizations, therapies, and durable medical equipment; thus, savings achieved from enrollment in managed care, especially in capitated HMOs, would accrue largely to Medicare rather than to Medicaid. It is also difficult to obtain waivers of Medicare requirements that would be necessary to require these individuals to participate in managed care programs. Finally, about one-third of all Medicaid dollars is spent on long-term care, and over one-fifth is spent on nursing facility care. Yet almost no nursing facility care is capitated. /10/

Because of managed care providers' relative lack of experience in meeting the needs of elderly and disabled people, adequate grievance, notice, and appeals procedures take on special importance.

III. Statutory Due Process Principles and Precedents

The Medicare and Medicaid programs have served as the primary laboratories of experience in shaping due process rights in government sponsored health care programs. /11/ Consideration of the due process protections afforded Medicare and Medicaid applicants and beneficiaries is valuable both in representing low-income persons under current law and in designing adequate protections for reconstructed versions of the programs and for other efforts at health care reform.

A. Medicare Hearing Rights

1. Generally

With respect to denials, terminations, or reductions of services, due process for Medicare beneficiaries has been approached primarily from a constitutional-protection model, as outlined originally in the 1970 Supreme Court case Goldberg v. Kelly. /12/ In Goldberg, the court identified the opportunity to be heard as the fundamental requisite of due process. /13/

Due process principles also underlie the concept of pretermination review. As the Court noted in Goldberg, "[T]ermination of aid pending resolution of a controversy over eligibility may deprive an eligible recipient of the very means by which to live while he waits." /14/ Unfortunately, with respect to the Medicare program, pretermination review as a legal concept is not uniformly developed. Pretermination review, however, has been recognized to some extent in the areas of Medicare-covered home health care, skilled nursing facility care, and hospital care. /15/ Even there, the precise nature and scope of pretermination review are not established.

The Supreme Court has noted that "due process is flexible and calls for such procedural protections as the particular situation demands." /16/ In Mathews v. Eldridge, the Court established a three-pronged balancing test for evaluating whether a hearing procedure meets due process standards for Social Security Act cases:

First, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail. /17/

Medicare beneficiaries are entitled to reasonable notice and opportunity for a hearing. /18/ These hearings are nonadversarial. /19/ While appeals procedures vary in their specifics, they all include, at a minimum (1) an initial review and/or "reconsideration" by the original decision-making entity or someone else; (2) review in the form of a hearing before an independent hearing officer; and (3) recourse to the judicial system if a threshold amount of money remains in controversy. /20/ Attorney fees are available to successful appellants. /21/

2. Specific HMO-Related Issues

Medicare beneficiaries' due process rights have been the subject of litigation involving HMOs. For example, Medicare beneficiaries enrolled in HMOs have claimed that they were denied due process because HMO appeals procedures were not clearly defined and made known to beneficiaries. Problems have included the lack of notice or a clearly defined procedure for review (including timely review by the HMO and access to external review such as administrative law judge and judicial review). /22/ Empirical studies of Medicare HMO operations by the General Accounting Office and Medicare advocacy groups have confirmed substantial problems in claims approval and payment, processing of beneficiary appeals, and quality assurance systems. /23/

Recently, the Health Care Financing Administration (HCFA) made refinements to its HMO/competitive medical plan review and appeals provisions (as well as provisions for health care prepayment plans). /24/ The new regulations require continuation of hospital coverage pending a written notice of noncoverage that explains the reasons for noncoverage. /25/ Other provisions give Medicare beneficiaries the right to Peer Review Organization review of a determination of noncoverage; /26/ require HMOs to make certain determinations with respect to emergency or urgently needed services; /27/ give beneficiaries the right to reconsideration; /28/ require that HCFA review and make final decisions on unfavorable reconsideration determinations; /29/ and require HMOs/competitive medical plans and health care prepayment plans to provide the review procedures required for Medicare beneficiaries not enrolled in such plans, including administrative law judge review, Appeals Council review, and court review. /30/

B. Medicaid Hearing Rights

Medicaid applicants and recipients are entitled to appeal any action or inaction harmful to them. /31/ Notice and hearing protections are triggered by a broad range of adverse actions, including denials of eligibility /32/ or services; /33/ claim denials for "technical reasons," such as form errors; /34/ and imposition of copayments. /35/ In addition, the agency must issue and publicize its hearing procedures; must provide applicants and recipients with notice of an adverse agency action, generally in advance of the action (with aid and services continued pending the appeal); and must give applicants and recipients access to their case files, to review documents used by the agency in making its determination. /36/ Recipients also have the right to a hearing at which they may present witnesses and cross-examine adverse witnesses, as well as a right to receive a decision on the record within a specified time. /37/

Medicaid recipients must receive notice from the Medicaid agency of provider claims that have been denied. The agency must provide recipients with written certification that they are not liable for denied claims, /38/ and recipients are entitled to limited notice and hearing rights regarding denied provider claims. /39/

Under Medicaid, recipients may sue, without jurisdictional dollar minimums, in federal court to vindicate their rights. /40/ Attorney fees and expert fees are available to recipients who prevail. /41/ Jurisdiction is also available in many state courts.

IV. Guarding Beneficiaries' Due Process Rights

Due process rights must be carefully guarded. HMO plan administrators and state Medicaid agency officials can use internal utilization devices such as direct contact with service providers and facility administrators to regulate access to services before the actual service is provided.

In one instance, for example, a Medicare beneficiary in an HMO was prescribed nursing facility services, including physical therapy services, by her treating physician upon leaving the HMO-participating hospital. /42/ However, those services were not provided, and the beneficiary was not

told that those services had been prescribed. Instead, she was released from the participating hospital to her home. It was only after counsel intervened that the beneficiary learned that nursing facility and physical therapy services were prescribed by her doctor.

In another case, a plaintiff who had been receiving physical therapy services on an ongoing basis was terminated from services by the Arizona state agency that administers Arizona's Medicaid-like health services for the indigent. /43/ Plaintiff was not given notice concerning this termination or any explanation for it.

In both cases, plaintiffs allege that, as participants in HMO programs, they are entitled to the basic due process rights available to Medicare and Medicaid beneficiaries outside HMOs and that these due process protections were circumvented.

Advocates can engage in several activities to assure that beneficiaries in managed care plans receive all of the due process rights to which they are entitled, including (1) general community education efforts; (2) advocacy to enforce and expand existing federal and state HMO notice, grievance, and appeal procedures; /44/ (3) advocacy to assure specific notice to plan participants when a plan administrator or provider of service reduces, terminates, or denies a service; (4) advocacy to include Medicare and Medicaid beneficiaries on state and federal HMO oversight and planning bodies; (5) advocacy for federal- and state-mandated HMO ombudsman/patient advocates within all HMO structures serving Medicare and Medicaid patients. /45/

V. Basic Due Process Principles

The outline below is built on an analysis of the key principles arising under federal statutes, case law, and constitutional law that have an impact on the nature and scope of due process in the delivery of health care services, as discussed above. /46/ This outline can serve as a guide for advocacy for due process protections in the context of managed care.

1. Written notice shall be given to the patient by the insurer or health plan of:

a. any decision to deny or reduce requested services;

b. all terminations of institutional care, such as hospital, nursing home, home health, and hospice care; and

c. failure to provide specified services, such as rehabilitation services and home health services for the improvement/prevention of deterioration of a patient's condition.

2. Posted notices of the right to appeal denials, reductions, and terminations of coverage are to be appropriately displayed in public areas of all health plan facilities.

3. A "plain language" explanation of appeal rights shall be provided to individuals upon enrollment in health plans and periodically during health plan participation.

4. Expedited review of the correctness of the denial, reduction, or termination of urgently needed services must be available as follows:

a. The patient attests that services are urgently needed and that the failure to provide them promptly or the failure to continue them may impair or retard improvement or cause deterioration of the patient's health status.

b. Expedited review must be performed by an independent hearing officer (as defined below), who shall issue a written decision to the patient within two days of the request for review.

c. Services or payment by the insurer or plan must continue until an expedited review decision has been issued.

5. Review by an independent hearing officer for all other services shall be governed by the following administrative process:

a. Review of a denial, reduction, or termination decision must be provided by the insurer or health plan, which shall issue a written decision within 15 days of the request for review.

b. A hearing by an independent hearing officer must be available with 30 days of a review decision. An independent hearing officer is an individual who is not an employee or designee of the insurer or health plan.

c. A written decision setting out the hearing officer's rulings on issues of fact and law must be issued within 30 days of the hearing.

d. Beneficiary coverage of services in place before the insurer's or health plan's initial adverse decision shall continue pending a hearing decision when requested by the beneficiary, unless the continuation would be harmful to the beneficiary as documented in writing by the treating physician.

e. Beneficiaries shall have the right to present favorable evidence, including out-of-plan second opinions in cases challenging plans' service denials, the right to review and present information from their medical records, and the right to compel attendance at hearings of decision makers whose actions are being challenged.

f. Hearing officers shall have a duty to assist claimants in developing the factual record, including ordering out-of-plan second opinions.

6. Judicial review shall be available in state or federal court in cases involving at least a specified threshold amount of charges, including the aggregation of claims to meet the threshold amount. Such threshold requirements can be waived for low-income persons at the discretion of the courts. Relief for prevailing consumer-claimants should include reasonable costs and fees.

7. Grievance process. A grievance procedure shall be established within each health plan for the resolution of individuals' complaints about problems other than denial, reduction, or termination of service or payment, including, but not limited to, delays in scheduling appointments, rude or undignified treatment at health plan facilities, the physical conditions of facilities, or enrollment and disenrollment disputes. The components of the grievance process are as follows:

a. The right to complain orally or in writing to a patient advocate or other independent ombudsman, who shall investigate the facts, seek to resolve the problem in a way suitable to the patient, and prepare a written report for the individual and for the plan within 15 days.

b. The right to have the complaint referred to a grievance committee of the health plan, which will recommend action in response to the complaint and report to the individual and to the plan within 30 days.

c. The right to have still-unresolved grievances reviewed by independent monitoring entities authorized to investigate and respond with a full range of sanctions, including corrective action, civil monetary penalties, and termination of health-plan status.

8. Health plan governance. Individual health plan beneficiaries shall have the right to substantial and meaningful participation as consumers of care in all levels of governance and decision making in the operation of health plans and of state and federal oversight organizations.

VI. Conclusion

Advocates can work in various arenas to ensure that public program beneficiaries enrolled in managed care systems receive the process necessary to protect their needs for health care. The Medicare and Medicaid programs offer a substantial body of statutory, regulatory, and case law interpreting due process rights and protections. This body of law, and the principles that it reflects, provide advocates with the foundations for representing their clients in managed care settings.

Footnotes

/1/ See, e.g., Hearings Before the Senate Fin. Comm., 103d Cong., 2d Sess. (June 28, 1995) (testimony of Governors Howard Dean (Vt.), Jim Edgar (Ill.), Lawton Chiles (Fla.), and Mike Leavitt (Utah)).

/2/ E.g., advocates can successfully participate in the design of Medicaid waivers to ensure adequate protections for Medicaid recipients in managed care systems. See, e.g., Sara Rosenbaum & Julie Darnell, Medicaid Section 1115 Demonstration Waivers: Approved and Proposed Activities as of February 1995 (Feb. 1995) (paper prepared for the Kaiser Commission on the Future of Medicaid); Jane Perkins & Michele Melden, The Advocacy Challenge of a Lifetime: Shaping Medicaid Waivers to Serve the Poor, 28 Clearinghouse Rev. 864 (Dec. 1994); Jane Perkins & Stan Dorn, A Beneficiary Perspective on Medicaid Managed Care, Outline of Presentation to the 1995 Health Care Financing Administration Regional Administrators Meeting (June 27, 1995); National Health Law Program, Section 1115 Medicaid Waivers: An Advocate's Primer (1994); Lourdes A. Rivera & Michele Melden, An Advocate's Guide to Medi-Cal Managed Care (1994) (for California advocates). Advocates have identified several areas of beneficiary concern that can be addressed at the federal, state, local, and individual managed care organization level. These include marketing and information activities, enrollment, accessibility, scope of services, grievance and appeals processes, and consumer involvement generally.

/3/ For the most up-to-date discussions of research addressing these questions, see Diane Rowland et al., Medicaid and Managed Care: Lessons from the Literature, A Report of the Kaiser Commission on the Future of Medicaid (Mar. 1995).

/4/ Medicaid literature generally recognizes three primary variations on the theme of managed care. Primary care case management systems use a primary care provider as a gatekeeper of services for beneficiaries. The state (in the case of Medicaid) or insurer pays the physician on a fee-for-service basis plus an additional amount for administration. Primary care physicians are not at financial risk for the provision of services for which they are the gatekeeper. Limited risk prepaid health plans (PHPs) undertake some financial risk for services but generally do not include inpatient hospital services. This is referred to as partial capitation; i.e., the PHP is paid a flat fee per enrollee and is expected to provide some package of services for that fee. Full-risk plans, generally referred to as health maintenance organizations (HMOs) or health insurance organizations receive a capitated fee and assume the risk of providing a full range of services for that fee. The distinct trend in Medicaid managed care is toward full-risk programs. Medicare uses the terminology HMO, as well as competitive medical plan and health care prepayment plan.

/5/ Health Care Fin. Admin., Medicare: A Profile 107 (Feb. 1995).

/6/ The Kaiser Comm'n on the Future of Medicaid, Medicaid and Managed Care: Discussion Brief (draft) (Feb. 1995).

/7/ Comments of Debbie Chang, Director, Office of Legislative and Intergovernmental Affairs, Health Care Fin. Admin., at a briefing on "Medicaid: Managing a Major Change," sponsored by the Alliance for Health Care Reform (Mar. 3, 1995).

/8/ A report prepared for the National Institute for Health Care Management identifies the following states as currently having approved (though not necessarily operating) waivers to include a portion of their SSI population in some form of managed care, either as mandatory enrollees (M) or as optional enrollees (O): Arizona, statewide (M); Arkansas (M); California, county (M); Colorado, statewide (M); Florida (mental health), statewide (M); Georgia (SSI, except dually

eligible) (M); Indiana (O); Iowa (mental health), statewide (M, including dually eligible); Louisiana (M); Massachusetts (primary care and mental health), statewide (M, SSI disabled); Michigan, statewide (M); Minnesota (M); New Mexico (M, except dually eligible); North Dakota (O); South Carolina (mentally ill) (O); South Dakota (?); Tennessee, statewide (M); Texas (M, except dually eligible); Utah (mental health) (M); Wisconsin (M). In addition to those listed, nine states (California, Colorado, Massachusetts, New York, Oregon, South Carolina, Texas, Virginia, and Wisconsin) have Programs of All-Inclusive Care for the Elderly (PACE programs) that provide a full range of services under a capitated arrangement to people needing the equivalent of a skilled nursing facility level of long-term care. PACE programs operate locally; none is statewide. States as Payers: Managed Care for Medicaid Populations, The States and Private Sector: Leading Health Care Reform (Feb. 1995) (prepared by Lewin-VHI for the National Institute for Health Care Management).

/9/ The Kaiser Comm'n on the Future of Medicaid, supra note 6.

/10/ Several models exist for capitating the health care payments of people needing long-term care (LTC). The single largest model is the Arizona Long-Term Care System. In that program, which operates separately from Arizona's statewide Medicaid managed care waiver program, the full range of health care needs of individuals determined to need a nursing facility's level of services is covered by a single capitated payment to a managed care organization operating at the county level. The payment includes an amount to meet both acute and long-term care needs of the individual -- the capitated rate reflects the respective proportions of program participants who receive LTC services in the community and in a nursing facility. Actual payments to nursing facilities, however, are made, as they are in other states, on a daily rate basis. Another model that operates similarly to the Arizona program, but not on a statewide basis, is the PACE program. As noted above, PACE programs operate in nine states. In contrast to Arizona, PACE programs combine both Medicare and Medicaid dollars to pay for the full range of services.

/11/ 42 U.S.C. Secs. 395 et seq. (Medicare); 42 U.S.C. Secs. 1396 et seq. (Medicaid). Medicare eligibility is not based on an applicant's financial status. See 42 U.S.C. Sec. 395c. Eligibility for Medicaid, however, is based on state income and resource requirements and status, i.e., disability. 42 U.S.C. Sec. 396a.

/12/ Goldberg v. Kelly, 397 U.S. 254 (1970).

/13/ Id. at 267. Elements of the right to be heard have been developed in case law. Thus, due process is further defined as including the right to adequate notice, to appear personally (with or without counsel) before an impartial decision maker, to present evidence, and to confront or cross-examine adverse witnesses. See, e.g., David v. Heckler, 591 F. Supp. 1033 (E.D.N.Y. 1984); Bowen v Michigan Academy of Family Physicians, 476 U.S. 667 (1986); Kramer v. Heckler, 737 F.2d 214 (2d Cir. 1984). Courts have recognized at least three public policy interests that favor due process hearings to mediate claims and disputes with respect to entitlements: "the desire for accuracy, the need for accountability, and the necessity for a decision making procedure which is perceived as 'fair' by the citizens." Gray Panthers v. Schweiker, 652 F.2d 146, 161 -- 62 (D.C. Cir. 1980) (Gray Panthers I) (Clearinghouse No. 21,452). The court reiterated this position in Gray Panthers v. Schweiker, 716 F.2d 23, 28 (D.C. Cir 1983) (Gray Panthers II).

/14/ Goldberg, 397 U.S. at 264.

/15/ See Martinez v. Sullivan, 874 F.2d 751 (10th Cir. 1989); Kramer, 737 F.2d 214 (2d Cir. 1984); Martinez v. Richardson, 472 F.2d 1121 (10th Cir. 1972); Martinez v. Bowen, 655 F. Supp. 95 (D.N.M. 1986). See also Sarrassat v. Sullivan, 1990 Medicare and Medicaid Guide (CCH) Para. 8,504 (N.D. Cal. 1989) (skilled nursing facilities must use uniform denial notices to inform residents of their right to request facilities to submit claims to the intermediary for initial decision; the notice must also state that a facility cannot bill the resident until the intermediary makes a formal determination).

/16/ Morrissey v. Brewer, 408 U.S. 471, 481 (1972) (Clearinghouse No. 7331).

/17/ Mathews v. Eldridge, 424 U.S. 319, 334 -- 35 (1976).

/18/ 42 U.S.C. Sec. 395ff. (referring to 42 U.S.C. Secs. 405(b) -- (g)). See also 42 C.F.R. Sec. 405, subpt. G (reconsiderations and appeals under Medicare Part A); 42 C.F.R. Sec. 473, subpt. B (Peer Review Organization (PRO) reconsiderations and appeals); 42 C.F.R. Sec. 405, subpt. H (review and hearing under the supplementary medical insurance program -- Part B); 42 C.F.R. Sec. 417, subpt. Q (HMO/competitive medical plan beneficiary appeals).

/19/ See, e.g., Richardson v. Perales, 402 U.S. 389, 403 (1971) (Clearinghouse No. 48,641).

/20/ Circumstances requiring expedited appeals are illustrated by the PRO hearing procedures. These procedures apply, e.g., when a Medicare beneficiary is a hospital inpatient and the doctor and hospital agree that the patient should be discharged. If the patient requests PRO review before noon of the first working day after the denial notice is delivered to the inpatient, then the hospital must provide the patient's record to the PRO by the close of that first working day. The PRO must issue a review decision within one full working day after the date the PRO received the review request and the records. In such cases, the hospital may not charge the patient for any charges incurred before noon of the day following the day on which the PRO review decision is received by the patient. If the patient is still dissatisfied with the decision, the regular process of reconsideration, hearing, and judicial review remains available.

/21/ 42 U.S.C Sec. 405(g); Equal Access to Justice Act, 42 U.S.C. Secs. 412 et seq. (federal district court review).

/22/ See, e.g., Levy v. Sullivan, 1989 -- 2 Medicare and Medicaid Guide (CCH) Para.7,809 (C.D. Cal. 1989) (settlement calling for the processing of HMO reconsideration requests pursuant to a 30-day timeliness standard and the issuance of a new HMO manual setting out a 30- to 60-day standard for the HMO stage of reconsideration decision making.); Grijalva v. Shalala, C.A. No. 93-711 TUC/ACM (D. Ariz. filed Nov. 15, 1993) (Clearinghouse No. 49,567) (Medicare HMO enrollees sue to compel the Health Care Financing Administration to enforce program requirements for HMOs, including requiring a full range of services and an appeals system that is in compliance with due process standards).

/23/ General Accounting Office, HCFA Needs to Take Stronger Actions Against HMOs Violating Federal Standards (Nov. 12, 1991) (HRD-92-11); Medicare Advocacy Project, Inc., Medicare Risk-Contract HMOs in California: A Study of Marketing, Quality, and Due Process Rights (Jan. 1993); E. Hallowell, Challenging the HMO System of Incentives, Philadelphia Inquirer (Mar. 28, 1989). See also Center for Health Care Rights, HMO Study and Survey (1993 -- 95).

/24/ See 59 Fed. Reg. 59933 et seq.(Nov. 21, 1994) (amending 42 C.F.R. Sec. 417).

/25/ 42 C.F.R. Sec. 417.440.

/26/ 24 C.F.R. Sec. 417.605.

/27/ 42 C.F.R. Sec. 417.606.

/28/ Id. Secs. 417.614, 417.616.

/29/ Id. Sec. 417.620. It should be noted that HCFA has contracted out this reconsideration review function to a group called Network Design. HMOs can provide beneficiaries with information on how to contact this entity.

/30/ 42 C.F.R. Sec. 417.840.

/31/ 42 U.S.C. Sec. 396a(a)(3); 42 C.F.R. Sec. 431, subpt. E, as mandated by Goldberg v. Kelly and its progeny.

/32/ See, e.g., Phillips v. Noot, 728 F.2d 1175 (8th Cir. 1984) (Clearinghouse No. 32,931).

/33/ See, e.g., Eder v. Beal, 609 F.2d 695 (3d Cir. 1979) (Clearinghouse No. 25,682).

/34/ See, e.g., Easley v. Arkansas Dep't of Human Servs., 645 F. Supp. 1535 (E.D. Ark. 1986) (Clearinghouse No. 41,681).

/35/ See, e.g., Claus v. Smith, 519 F. Supp. 829 (N.D. Ind. 1981) (Clearinghouse No. 31,573); Becker v. Blum, 464 F. Supp. 152, 155 -- 57 n.5 (S.D.N.Y. 1978) (Clearinghouse No. 21,677).

/36/ 42 C.F.R. Sec. 431.242.

/37/ Id.

/38/ Easley, 645 F. Supp. 1535.

/39/ Daniels v. Tennessee Dep't of Health & Env't, 1985 Medicare and Medicaid Guide (CCH) Para. 4,562 (M.D. Tenn. 1985).

/40/ 42 U.S.C. Sec. 983; see also Suter v. Artist M., 112 S. Ct. 1360 (1992), raising questions about the standing of consumers under current law. Any limitation on rights of beneficiaries to enforce

statutory rights under the Social Security Act found in Suter was "corrected" by federal legislation in the 103d Congress. Improving America's Schools Act of 1994, Pub. L. No. 103-382, 103d Cong., 2d Sess., 108 Stat. 3518 (1994); Social Security Act Amendments of 1994, Pub. L. No. 103-432, 103d Cong., 2d Sess., 108 Stat. 4398 (1994).

/41/ 42 U.S.C. Sec. 1988.

/42/ Grijalva, C.A. No. 93-711 TUC/ACM.

/43/ Perry v. Chen, C.A. No. CV 95-140 TUC ACM (D. Ariz. filed Mar. 3, 1995) (Clearinghouse No. 50,566).

/44/ Federal notice and appeal rights are described above. See also Susan Stayn, Securing Access to Care in Health Maintenance Organizations: Toward a Uniform Model of Grievance and Appeal Procedures, 94 Columbia L. Rev. 1674, 1704 nn.206 -- 7 (1994), for citation to state laws requiring a description of grievance and or appeal systems.

/45/ Advocates could argue that states and HCFA could mandate that ombudsmen/patient advocates be available to all HMO participants, not just Medicare and Medicaid recipients, as a condition of participation in the Medicare or Medicaid programs. HCFA's administrator has taken this position with respect to Medicare discharge planning services, which are available to all patients in Medicare-participating hospitals. See 59 Fed. Reg. 64143 (Dec. 13, 1994).

/46/ This outline was developed for a white paper on due process that was used in advocacy during the 1994 health care reform debate. Charles Sabatino (ABA Commission on Legal Problems of the Elderly), Sally Hart Wilson (the Center for Medicare Advocacy, Inc.), Stan Dorn (National Health Law Program), and Vicki Gottlich, Patricia Nemore, and Alfred Chiplin (National Senior Citizens Law Center) participated in the development of this white paper.