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Responding to Medicaid Service Cutbacks

An Advocate's Checklist

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Medicaid provides medical assistance to people of low income, people with disabilities, and the elderly.[1] The economic recession is exerting great pressure on the program. Enrollment has increased by nearly six million since the start of the recession in December 2008 and totals around fifty million.[2] States are being asked to do more with less, as state tax revenues have declined, and a temporary enhancement in federal Medicaid funding to the states has ended.[3] As a condition of continued federal Medicaid funding, states must maintain Medicaid eligibility at March 23, 2010, levels pending the January 2014 implementation of health care reform.[4] All of these factors are causing states to cut Medicaid spending by reducing provider payments and covered benefits.

Provider payments were the first place where states looked for savings.[5] The Kaiser Commission on Medicaid and the Uninsured's annual assessment of the fifty states found that thirty-nine states implemented provider rate cuts or freezes in the 2010 fiscal year, and thirty-seven states planned to do so in the 2011 fiscal year.[6] Now

[1]See Social Security Act, 42 U.S.C. §§ 1396–1396w-5 (2011).

[2]Kaiser Commission on Medicaid and the Uninsured, State Fiscal Conditions and Medicaid 3 (Oct. 2010), http://bit.ly/sbHnYV.

[3]See American Recovery and Reinvestment Act, Pub. L. No. 111-5, § 5001, 123 Stat. 115 (2009) (establishing significantly enhanced federal Medicaid medical assistance percentages for states between October 2008 and December 2010); Education, Jobs and Medical Assistance Act, Pub. L. No. 111-226, § 201, 124 Stat. 2389, 2393 (2010) (extending enhancements, at reduced rates, through June 2011).

[4]See 42 U.S.C. §§ 1396a(a)(74), 1396a(gg) (2011).

[5]See Kaiser Commission on Medicaid and the Uninsured, *supra* note 2, at 3.

[6]See Robin Rudowitz, Associate Director, Kaiser Commission on Medicaid and the Uninsured, Workshop Presentation at National Health Law Program Health Advocates Conference: State Budgets and Medicaid—Moving Toward Health Reform, fig.13 (Dec. 6, 2010) (available from the National Health Law Program).

states are increasingly focusing on Medicaid services, reducing or eliminating coverage, or imposing strict utilization controls or all three. The Kaiser Commission's survey found that twenty states reduced benefits in the 2010 fiscal year—the largest number of states reporting such restrictions in one year since the annual surveys began in 2001—and fourteen states planned to implement service reductions in the 2011 fiscal year.[7] States also broadened their use of Medicaid managed care for delivering services to Medicaid beneficiaries.[8]

Regardless of the type of services affected or the methods used by the state to cut services, the state's actions must be consistent with what federal and state laws require. And, not surprisingly, some of the changes that states have implemented over the course of the current recession have been illegal. Since December 2008, in state and federal courts a number of cases have been filed alleging that Medicaid agencies are improperly implementing a Medicaid cutback. While most of these cases have been filed on behalf of individuals, about two dozen lawsuits have challenged significant or across-the-board reductions in services.[9] Whether involving individuals or systemic changes, the states' missteps tend to implicate a common set of legal principles. These are identified in the following legal checklist:

1. The Branch of State Government Making the Cutback Must Have the Authority to Do So

An action by one government entity may violate constitutional separation-of-powers requirements or a statute that places the authority to make the changes with another branch of government. For example, the Florida Supreme Court recently held that Gov. Rick Scott violated state constitutional separation-of-powers requirements when he issued an executive order suspending agency rulemaking requirements in an effort to speed his executive changes into law.[10]

2. The Cutback May Be a Rule that Must Be Promulgated Pursuant to the Administrative Procedure Act Before the Cutback Is Valid

Most state Medicaid agencies are subject to the requirements of their state Administrative Procedure Acts. Such acts generally define "rules" as regulations, standards, or policy statements issued by a state agency, applied generally, and effective as law. Under the typical Administrative Procedure Act, a rule must be subjected to public notice and comment before the rule can be enforced as a law.[11]

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[7] *Id.* fig.16; see also Kaiser Commission on Medicaid and the Uninsured, *supra* note 2, at 3.

[8] See Rudowitz, *supra* note 6, at 3 (thirteen states in 2010 fiscal year and twenty states in 2011 fiscal year implemented or planned to expand managed care by expanding service areas, adding eligibility groups, requiring enrollment into managed care, or implementing longterm care initiatives).

[9] Cases were identified through a search of the National Health Law Program database of technical assistance (accessed Sept. 29, 2011) and a Westlaw search of Medicaid cases dated after December 1, 2008 (accessed Sept. 30, 2011).

[10] See *Whiley v. Scott*, No. SC11-592, 2011 Fla. LEXIS 1900, at *1 (Fla. Aug. 16, 2011) ("Absent an amendment to the Administrative Procedure Act itself or other delegation of such authority to the Governor's Office by the Florida Legislature, the Governor has overstepped his constitutional authority and violated the separation of powers."). See also *McNeil-Terry v. Roling*, 142 S.W.3d 628 (Mo. Ct. App. 2004) (executive action to eliminate adult dental Medicaid services violated state statute that required coverage); *Fisher v. Roling*, 142 S.W.3d 836 (Mo. Ct. App. 2004) (same, regarding adult eyeglasses). But see *Hunter v. State*, 865 A.2d 381 (Vt. S. Ct. 2004) (rejecting constitutional separation-of-powers argument and finding state legislature validly delegated authority to secretary of administration to prepare and implement plan to eliminate optional Medicaid services); *id.* at 392–93 (collecting cases).

[11] See, e.g., *Homestyle Direct Limited Liability Company v. Department of Human Services*, No. A145136, 2011 Or. App. LEXIS 1297 (Or. Ct. App. Sept. 21, 2011) (agency unlawfully adopted nutritional and delivery standards for home meals for Medicaid beneficiaries and could not enforce invalid rules, even though petitioner had agreed to them); *Cholvin v. Wisconsin Department of Health and Family Services*, 758 N.W.2d 118 (Wis. Ct. App. 2008) (instructions in screening instrument used to assess need for Medicaid home- and community-based services were rules that needed to be promulgated pursuant to Administrative Procedure Act); *Courts v. Agency for Health Care Administration*, 965 So. 2d 154 (Fla. Ct. App. 2007) (enjoining Medicaid agency's new method for reducing services, explaining that if agency changes policy, "it must either explain its reasons for its discretionary action based upon expert testimony, documentary opinions, or other appropriate evidence, … or it must implement its changed policy or interpretation by formal rule making"). Cf. *California Association of Medical Product Suppliers v. Maxwell-Jolly*, No. A126749, 2011 Cal. App. LEXIS 1199 (Cal. Ct. App. Sept. 16, 2011) (agency properly implemented policy).

3. Cutbacks Must Meet Medicaid "Comparability" and "Reasonableness" Requirements

Carefully pled and well-argued cases brought by Medicaid beneficiaries can obtain relief under the Medicaid Act.[12] A number of federal Medicaid provisions are implicated when a state cuts a Medicaid service. The Medicaid Act requires that medical assistance made available to an individual must be of an adequate amount, duration, and scope to achieve the purpose of covering the service.[13] States are also required to use "reasonable standards" for determining the extent of medical assistance.[14]

4. States Must Adhere to Requirements for Early and Periodic Screening, Diagnostic, and Treatment Services

The Medicaid Act contains Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) provisions that apply to children and youth under 21. Among other requirements, the Act makes a comprehensive scope of EPSDT benefits available for this population, specifically any service that a state must or can cover under 42 U.S.C. § 1396d(a). The EPSDT law also requires states to cover these benefits when they are necessary to "correct or ameliorate" a child's physical or mental condition.[15] This means that across-the-board reductions in services that might be permissible for adult enrollees may not be applied to children.

5. Medicaid Agencies Must Comply with "Due Process" when Cutting Services

Medicaid service cuts must be consistent with the due process clause of the U.S. Constitution and the Medicaid Act.[16] In general, when a claim for Medicaid services is denied, reduced, or terminated, the claimant must be given advance written

[12]Some Medicaid Act provisions can be enforced pursuant to 42 U.S.C. § 1983. Courts have also recognized beneficiaries' claims under the supremacy clause to enjoin state laws that conflict with the Medicaid Act and regulations. The U.S. Supreme Court is considering supremacy clause enforcement (see *Douglas v. Independent Living Center of Southern California*, No. 09-958 (U.S. argued Oct. 3, 2011). For a discussion of the complexities surrounding private enforcement of the Medicaid Act, see Rochelle Bobroff, *Section 1983 and Preemption: Alternative Means of Court Access for Safety Net Statutes*, 10 Loyola Journal of Public International Law 27 (2009); and my Update on Private Enforcement of the Medicaid Act Pursuant to 42 U.S.C. § 1983, National Health Law Program Issue Brief (June 2011), http://bit.ly/vLF9gA.

[13]42 U.S.C. § 1396a(a)(10)(B); see also 42 C.F.R. § 440.230(b) (2011) ("Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose."). See, e.g., *Samantha A. v. Department of Social Services and Health Services*, 256 P.3d 1138 (Wash. 2011) (comparability violation where Medicaid rule reduced assistance payable for in-home personal care services based upon disabled child's age and whether child lived with parent); *Jenkins v. Washington State Department of Social and Health Services*, 160 Wash. 2d 297 (Wash. 2007) (finding comparability violation where state "shared living rule" automatically reduced coverage of in-home care hours if Medicaid beneficiary lived with paid caregiver). But see *M.R. v. Dreyfus*, 767 F. Supp. 2d 623 (W.D. Wash. 2011) (plaintiffs unlikely to succeed on merits of comparability claim challenging across-the-board reduction in personal care services).

[14]42 U.S.C. § 1396a(a)(17). See, e.g., *Lankford v. Sherman,* 451 F.3d 496, 511 (8th Cir. 2006) (Section 1396a (a)(17) preempted state rule eliminating coverage of medical equipment for people who were disabled but not blind while maintaining service for people who were blind: "a state's failure to provide Medicaid coverage for non-experimental, medically necessary services within a covered Medicaid category is both per se unreasonable and inconsistent with the stated goals of Medicaid"); *Hiltibran v. Levy*, 793 F. Supp. 2d 1108 (E.D. Mo. 2011) (state rule eliminating medical equipment and supplies violated Section 1396a(a)(17). But see *M.R.* v. *Dreyfus,* 767 F. Supp. 2d 1149 (W.D. Wash. 2011) (refusing to enjoin across-the-board reductions in Medicaid personal care service hours). See also 42 C.F.R. § 440.230(c) (2011) (prohibiting states from denying or reducing services "solely because of diagnosis, type of illness or condition"); *Weaver v. Reagan*, 886 F.2d 194 (8th Cir. 1989) (citing Section 1396a(a)(17) and 42 C.F.R. § 440.230(c) to enjoin state rule that excluded coverage of otherwise covered prescription drug for people with AIDS (acquired immune deficiency syndrome)).

[15]See 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r). See, e.g., *A.M.T. v. Gargano*, 781 F. Supp. 2d 798 (S.D. Ind. 2011) (requiring state to consider potential for regression prior to reducing child's maintenance services); *C.F. v. Department of Children and Families*, 934 So. 2d 1 (Fla. Dist. Ct. App. 2006) (reversing agency decision to reduce child's personal care services from six to four hours, finding state had applied definitions of "medical necessity" and "personal care assistance" that were more restrictive than federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements). Cf. *Moore v. Reese*, 637 F.3d 1220 (11th Cir. 2011) (roles of treating physicians and state-employed utilization review doctors when deciding medical necessity). For additional discussion, see my EPSDT, Deference to Providers, and Moore v. Reese, National Health Law Program Q&A (June 2011), http://bit.ly/sxXX7H. See also Jane Perkins & Sarah Somers, National Health Law Program, Toward a Healthy Future: Medicaid Early and Periodic Screening, Diagnosis and Treatment for Poor Children (April 2005) (available from the National Health Law Program).

[16]See U.S. Const., amend. XIV, § 1; *Goldberg v. Kelly*, 397 U.S. 254 (1970); see 42 U.S.C. § 1396a(a)(3); 42 C.F.R. §§ 431.200–431.250 (2011). Medicaid managed care organizations must also ensure due process (see 42 U.S.C. §§ 1396u-2(a)(1)(A)(i), (b)(4); 42 C.F.R. §§ 438.400–438.424 (2011); *Shakhnes v. Eggleston*, 740 F. Supp. 2d 602 (S.D.N.Y. 2010) (requirements for managed care organizations do not deprive individuals of rights under Section 1396a(a)(3))).

notice and an opportunity for an impartial hearing before any decision.[17] An exception for automatic changes in coverage is due solely to a change in state or federal law. In these instances, the state Medicaid agency must provide adequate notice of the change but not provide a fair hearing.[18]

6. Reductions in Provider Payment Rates Must Be Consistent with Medicaid's Quality and Equal Access Requirements

States' payments to Medicaid-participating providers must meet the requirements of 42 U.S.C. § 1396a(a)(30)(A). This law requires states to set payment rates consistent with "efficiency, economy and quality of care."[19] The "equal access" provision requires states to ensure that payments are sufficient to attract enough providers so that care and service are available to the Medicaid population "at least to the extent" the services are available to the general, paying population in the geographic area.[20]

7. Cost Sharing Must Be Consistent with Specific Medicaid Requirements

Two Medicaid provisions deal with beneficiary cost sharing such as premiums and copayments.[21] The provisions give states a great deal of flexibility in setting cost sharing; however, there are limits. For example, very low-income Medicaid beneficiaries may not be charged premiums, and only nominal copayments are allowed.[22] If a state wants to impose cost sharing that differs from the rules set forth in the Medicaid Act, it must obtain permission from the secretary of health and human services.[23] A recent decision from the Ninth Circuit Court of Appeals, *Newton-Nations v. Betlach and Sebelius*, defines the secretary's authority to approve copayments as experimental programs:[24] (i) The secretary of health and human services must determine that the proposal has value as a demonstration, experimental or pilot project. (ii) Whether a copayment proposal can "demonstrate something different than the last 35-years worth of health policy research," which consistently concludes that copayments cause low-income people to forgo medically necessary care, is questionable.[25] (iii)"[A] simple benefits cut, which might save money, but has no research or experimental goal" will not do.[26] (iv) The secretary of health and human services must evaluate the cost-sharing proposal's potential impact on the individuals that the Medicaid Act is intended to help.

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[17]See 42 C.F.R. §§ 431.200–431.250. See, e.g., *Baker v. Department of Health and Social Services*, 191 P.3d 1005, 1010–11 (Alaska 2008) (citing *Goldberg* and finding written notice inadequate, that notice requirement could not be broadly construed to include other information beneficiaries previously received, and that, because plaintiffs were public benefits recipients, agency must go to "greater lengths—incurring higher costs and accepting inconveniences—to reduce the risk of error" and to "be as transparent as possible in its methodology"); *Maryland Department of Health and Mental Hygiene v. Brown*, 935 A.2d 1128, 1145 (Md. Ct. App. 2007) ("a state's obligation to comply with fair hearing requirements in federal and state law for an 'optional' service such as the Older Adults Waiver Program is no less than the state's obligation when a 'mandatory' service is involved").

[18]See 42 C.F.R. § 431.220(b) (2011). Compare *Rosen v. Goetz*, 410 F.3d 919 (6th Cir. 2005) (refusing to require pretermination hearings for all affected recipients where change in coverage was result of change in state law), with *Harriman v. Department of Children and Families*, 867 So. 2d 1264 (Fla. Ct. App. 2004) (reversing termination because claimant was challenging termination of benefit for reasons other than change in law automatically affecting her benefits).

[19]42 U.S.C. § 1396a(a)(30)(A); 42 C.F.R. §§ 447.200–447.207 (2011). Private enforcement of the Section 1396a(a)(30)(A) requirements is in question (see *Douglas*, No 09-958 (*Independent Living Center v. Shewry*, 543 F.3d 1050 (9th Cir. 2008) (plaintiffs have valid cause of action under supremacy clause to argue that state cutbacks in Medicaid payments are preempted by Section 1396a(a)(30)(A)) (same case)).

[20]42 U.S.C. § 1396a(a)(30)(A).

[21]*Id.* §§ 1396o, 1396o-1; 42 C.F.R. §§ 441.50–441.82 (2011).

[22]See 42 U.S.C. §§ 1396o(a)(3), 1396o(b)(3); 42 C.F.R. § 447.53 (2011).

[23]See 42 U.S.C. § 1396o(f) (requiring waiver to impose heightened copayments); 42 U.S.C. § 1315 (authorizing secretary of health and human services to approve experimental programs).

[24]*Newton-Nations v. Betlach and Sebelius*, 660 F.3d 370 (9th Cir. 2011).

[25]*Id.* at 381.

[26]*Id.* at 380 (quoting *Beno v. Shalala*, 30 F.3d 1057, 1071 (9th Cir. 1994)).

8. Medicaid Cuts May Not Violate Laws that Prohibit Discrimination on the Basis of Disability

The Americans with Disabilities Act provides that "[n]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity."[27] To implement this provision, states must ensure that persons with disabilities receive services in the most integrated setting appropriate to their needs.[28] Public entities (which include state Medicaid agencies) may not, directly or through other arrangements, use criteria or methods of administration that have the effect of subjecting qualified individuals with disabilities to discrimination on the basis of disability.[29] Nor may public entities use eligibility criteria that screen out or tend to screen out individuals with disabilities from equally enjoying services, programs, or activities unless the criteria are shown to be necessary for the provision of that service, program, or activity.[30] A public entity may be required to make reasonable modifications to avoid discrimination unless it demonstrates that the modifications would fundamentally alter the nature of the service or program.[31] A number of courts have applied these laws in cases with compelling facts and have enjoined states' Medicaid cutbacks.[32]

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The current economic climate has resulted in many states proposing to reduce Medicaid services or provider payments or both. However, a number of alternative measures can be adopted to reduce Medicaid costs without harming beneficiaries.[33]

States should implement cost containment strategies that do not require Medicaid services to be reduced or terminated. Medicaid coverage is the linchpin that enables people of low income, people with disabilities, and the elderly to obtain health care. Many of the states' proposed cutbacks in Medicaid coverage will be undertaken legally and cannot be challenged. However, all state proposals to reduce or terminate Medicaid coverage should be reviewed for their legality and challenged if they are not legal. It would be sad, indeed, if the fiscal problems now facing state and federal governments resulted in hasty and ill-conceived policies that illegally eliminate or significantly reduce needed Medicaid coverage.

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[27]42 U.S.C. § 12137 (Americans with Disabilities Act); 29 U.S.C. § 794 (Rehabilitation Act provision governing federal-fund recipients); see *Olmstead v. L.C.*, 527 U.S. 581 (1999).

[28]See 28 C.F.R. § 35.130(d) (2011) (Americans with Disabilities Act); *id.* § 41.51(d) (Rehabilitation Act).

[29]*Id.* § 35.130(b)(3) (2011) (Americans with Disabilities Act); *id.* § 41.51(b)(3) (Rehabilitation Act).

[30]*Id*. § 35.130(b)(8).31

[31]*Id*. § 35.130(d)(7).

[32]See, e.g., *Olmstead*, 527 U.S. at 603 n.14 ("States must adhere to the [Americans with Disabilities Act's] nondiscrimination requirement with regard to the services they in fact provide."); *Fisher v. Oklahoma Health Care Authority*, 335 F.3d 1175, 1182 (10th Cir. 2003) ("a state may not amend optional programs in such a way as to violate the integration mandate"); *id.* at 1183–84 (allowing plaintiffs to proceed with Americans with Disabilities Act or Rehabilitation Act challenges to imposition of five prescription caps in Home- and Community-Based Services Waiver Program, while allowing plaintiffs unlimited prescription coverage if they entered nursing facility and noting that "a fiscal problem, by itself, does not lead to an automatic conclusion that preservation of unlimited medically-necessary benefits for participants in the [Home- and Community-Based Services] program will result in a fundamental alteration"); *Hiltibran*, 793 F. Supp. 2d 1108 (state rule eliminating medical equipment and supplies violated Americans with Disabilities Act); *Crabtree v. Goetz*, No. Civ. 3:08-0939, 2008 U.S. Dist. LEXIS 103097 (M.D. Tenn. Dec 19, 2008) (enjoining cutbacks in Medicaid home health services because evidence showed plaintiffs were persons who had disabilities and would be institutionalized because of cuts). For additional cases finding Americans with Disabilities Act violations where lack of community services implicates institutional care, see, e.g., *Cruz v. Dudek*, Case No. 10-23048-CIV-UNGARO/SIMONTON, 2010 U.S. Dist. LEXIS 118520 (S.D. Fla. Oct 12, 2010); *V.L. v. Wagner*, 669 F. Supp. 2d 1106 (N.D. Cal. 2009) (on appeal); *Brantley v. Maxwell-Jolly,* 656 F. Supp. 2d 1161 (N.D. Cal. 2009) (*Cota v. Maxwell-Jolly*, 688 F. Supp. 2d 980 (N.D. Cal. 2010) (same case; on appeal)). See also, e.g., *Radaszewski v. Maram*, 383 F.3d 599 (7th Cir. 2004) (Americans with Disabilities Act and Rehabilitation Act integration mandates required that state reasonably accommodate medically fragile individual's private-duty nursing needs to allow individual to avoid life-threatening institutionalization when he lost coverage of services upon turning 21); *Grooms v. Maram*, 563 F. Supp. 2d 840 (N.D. Ill. 2008) (plaintiff "aging out" of home care waiver and facing institutionalization was protected by integration mandate, and state Medicaid agency must "reasonably accommodate" his request for continued home care).

[33]See Michelle Lilienfeld & Jane Perkins, Medicaid Cost Containment Without Harming Beneficiaries, National Health Law Program Fact Sheet (Sept. 2011), http://bit.ly/uBbPdy (listing actions that, when taken correctly, can save states money without negatively affecting eligibility and services or imposing harmful copayments).

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