

To: Health Advocates

From: Jane Perkins, National Health Law Program

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I. Activities Reducing/Eliminating Coverage

A. Reduction or elimination of optional population groups

E.g. poverty level aged/disabled and children and pregnant women, medically needy.

B. Benefit reduction or elimination

E.g., quantitative limits on mandatory services, such as physician visits and prescriptions; monetary caps (e.g. \$4000 cap on mental health services); eliminating physical and related therapies; dentures, eyeglasses, prosthetics, orthotics, chiropractic services; hospice services; private duty nursing; capping personal care service hour

C. Increased cost sharing (including copayments and premiums)

D. Reduction in provider payments

E. Increased use of risk based managed care for people with disabilities

II. Advocacy □ monitoring the process

A. State should consult with a medical care advisory committee. E.g. 42 U.S.C. § 1396a(a)(4); 42 C.F.R. § 431.12

B. State should involve the public in development of § 1115 waivers. E.g. __ Fed. Reg. __ (Sept. 1994)

C. State must provide public notice of any significant proposed change in its methods and standards for setting payments rates. E.g. 42 U.S.C. § 1396a(a)(13); 42 C.F.R. § 447.205.

D. State must provide individual notices of change in coverage or eligibility but need not grant hearing if the sole issue is a change in law. *E.g., 42 C.F.R. §§ 431.206, .210; 435.912, .919; Mitchell v. Johnston, 701 F.2d 337 (5th Cir. 1983) (Cutbacks to EPSDT program required notification); Eder v. Beal, 609 F.2d 695 (3d*

Cir. 1979) (individual notice required when state terminated optional service);

Kimble v. Solomon

, 599 F.2d 599 (4th Cir. 1979) (notice required to implement across-the-board reduction in Medicaid benefits);

Cramer v. Chiles

, 33 F. Supp. 2d 1432 (S.D. Fla. 1999) (conversion of ICF/DD services to HCBW without hearing violated Medicaid law and due process);

King v. Fallon

, 801 F. Supp. 925 (D.R.I. 1992) (notice required to change level-of-care assessments governing eligibility for home and community based waiver services).

But see

Benton v. Rhodes

, 586 F.2d 1 (6th Cir. 1978) (no right to individual notice of termination of optional benefits).

E. If there is a change in eligibility, the Medicaid agency should engage in an automatic redetermination of eligibility under other available categories, with benefits continued pending the determination . *E.g. Mass. Ass'n of Older Americans v. Comm'r of Pub. Welf.*, 803 F.2d 35 (1st Cir. 1986);

Salazar v. District of Columbia

, 954 F. Supp. 278 (D.C. D.C. 1996).

F. If implementation involves rules of general applicability, then state Administrative Procedure Act may require formal notice and opportunity for public comment, and rules not properly promulgated are ineffective (see Table 2 for citation to state APAs). *E.g. Failor's Pharmacy v DSHS*, 886 P.2d 147 (Wash. Dec. 15, 1994) (reduced prescription drug payment schedules invalid because not promulgated under Washington APA). NOTE: The emergency rule process may not be available.

E.g. McNeil-Terry v. Roling

, 2004 Mo. App. LEXIS 970 (Ct. App. June 29, 2004).

G. Without an underlying change in law, there should be no change in coverage without a change in medical needs . *E.g. Weaver v. Colo. Dep't of Social Servs.*, 791 P.2d 1230 (Colo. Ct. App. 1990).

H. The branch of government making the change must have authority to do so. *E.g. Moreau v. Lewis*, 64

8 So.2d 124 (S.Ct. Fla. 1995) (copayments imposed through state budget act invalid under Florida single subject requirement for appropriations acts);

Clemens v. Harvey

, 1994 WL 711230 (Neb. Dec. 23, 1994) (under Nebraska separation-of-powers doctrine, Medicaid administrator lacked constitutional authority to eliminate medically needy coverage of caretaker relatives);

Chiles v. Children A-F

, 589 So.2d 260 (Fla. S. Ct. 1991) (invalidating elimination of medically needy coverage on ground that Governor and special executive branch violated state constitutional limits on

executive power in enacting change);

Jackson v. Stockdale

, 264 Cal. Rptr. 525 (Cal. App. 1 Dist. 1989) (invalidating executive branch agency's (Medicaid agency's) reductions in dental services on ground that Legislature had implemented a statute that reserved that authority to itself).

III. Advocacy – substantive challenges

A. Civil rights protections. Cutbacks that result in coverage patterns that affect some groups disproportionately may violate civil rights protections. *E.g.* Title VI of the Civil Rights Act (enforceable through an OCR Complaint); Americans with Disabilities Act, *see*

Fisher v. Oklahoma Health Care Auth.

, 335 F.3d 1175 (10th

Cir. 2003) (ADA implicated where prescriptions limited in community settings but not in nursing homes). Note: An issue involving the extent of private enforcement is currently before the U.S. Supreme Court, *see Tennessee v. Lane*

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B. Medicaid protections. Challenges to cutbacks in Medicaid-covered services focus on whether coverage remaining after the cuts meets the legally required coverage standards.

1. Early and Periodic Screening Diagnosis and Treatment (EPSDT). Requires broad screening and treatment listed in § 1396d(a) (mandatory and optional services listing) to "correct or ameliorate" conditions, whether or not the services are covered for adults.

See

42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(b), 1396d(r). For recent discussion of cases,

see

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Fact Sheet: Medicaid Early and Periodic Screening, Diagnosis and Treatment: 2001-2003 Major Case Summary

(Feb. 2004),

available at

<http://www.healthlaw.org>

2. Prescription drugs. If a state wants to receive federal matching for prescription drugs, the manufacturer must agree to pay a rebate. In exchange, states must cover all that manufacturer's brands of "covered outpatient drugs" with some exceptions. The Medicaid Act lists drugs that can be omitted (e.g. fertility, cosmetic), sets requirements for prior authorization and formularies, and requires establishment of a drug use review program.

See

42 U.S.C. § 1396r-8.

3. Four coverage rules are important: (1) Unless the state has adopted utilization controls, treatment that is medically necessary and within the federally-defined scope of the covered service must be provided. Deference should be paid to the treating provider. (2) Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose, subject to utilization limits. (3) A state may not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the diagnosis or type of illness. (4) Services must be comparable within and among groups.

E.g.

42 U.S.C. § 1396a(a)(10)(A) and (B), 1396d(a); 42 C.F.R. § 440.210 et seq. (listing mandatory and optional services); 42 C.F.R. § 440.240(b) (amount, duration and scope); 42 C.F.R. § 440.240(c)(discrimination based on medical condition); 42 C.F.R. 440.240(a) (comparability).

NOTE: These arguments are particularly important in individual cases, when the treatment is the only available and effective treatment.

4. Cost sharing is strictly limited. For example, copayments must be "nominal." *E.g.* 42 U.S.C. § 1396o. For more information see,

Q&A: Copayments

(February 24, 2004).

C. Where there is a waiver, those Medicaid Act provisions not specifically waived remain in full force and effect.

1. § 1115 waivers limited to provisions of § 1396a and where consistent with objectives of the Medicaid Act

2. Managed care and home and community based care waivers may waive only certain provisions, *see* 42 U.S.C. § 1396n.

D. A service cannot be eliminated if the redefined service is not consistent with state law. *E.g.* *Jackson v. Stockdale*

, 264 Cal. Rptr. 525 (Cal. App. 1 Dist. 1989) (state law definition that "restorative dental assistance" must be provided prohibited state Medicaid agency from providing only care meant to prevent significant illness or disability or severe pain);

Alexander L. v. Cuomo

, 588 N.Y.S.2d 85 (Misc. 1991) (state law mandate for a "comprehensive program of medical assistance for needy persons . . . to operate in a manner which will assure a uniform high standard of medical assistance throughout the state," in such a way "that the quality of medical care and services is in the best interests of recipients" means that necessary drugs must be covered).