Tackling Medicaid Waiver Cuts & Waiting Lists: Part 4

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Overview

- Constitutional Due Process
- Medicaid Fair Hearings
- Medicaid Managed Care Notice & Appeal
- Common Waiver Problems
- Case Examples
- Discussion

Constitutional Due Process

- 14th amend., U.S. Const.
  - *Goldberg v. Kelly,* 397 U.S. 254 (1970)
  - *Mathews v. Eldridge*, 424 U.S. 319 1976)
- Three steps:
  1. Protected property interest?
  2. State action?
  3. What process is due?

Medicaid Fair Hearings

42 U.S.C. § 1396a(a)(3)

opportunity for fair hearing before state agency

when claim for assistance is denied or not acted on with reasonable promptness

42 C.F.R. pt. 431

Opportunity for fair hearing:

Applicant – “claim for services is denied or is not acted upon with reasonable promptness”

Beneficiary – “because he or she believes the agency has taken an action erroneously”

42 C.F.R. § 431.220(a)(1)-(2)

Written Notice @:

- Application
- Denial of benefits/failure to act with reasonable promptness
- Reduction, suspension, termination of service or eligibility
- NF transfer or discharge
- Adverse decision re: PASRR
- Any other decision or action affecting Medicaid applicant or enrollee “where a hearing is required by law”

- NOT: *sole* issue is law requiring automatic change

42 C.F.R. § 431.220

Requirements for Written Notice

- Basis for action, factual & legal
- Continued benefits and how to get them
- Fair hearing process & time frames
- Right to representation
- When expedited hearing is available

- Must be translated for certain LEP beneficiaries
- Accessibility requirements

42 C.F.R. §§ 431.210, 438.404

Continued Benefits

- Must continue pending final hearing decision
  - If hearing is requested w/in 10 days of action
  - Beneficiary can be required to pay for benefits if he loses

42 C.F.R. § 431.230

Fair Hearing Rights:

- *De novo* hearing
- Review case file prior to hearing, including reasonable assistance
- Present witnesses and submit evidence
- Question/cross examine witnesses
- Make arguments without interference
- Impartial hearing officer
- Examine documents to be used at the hearing, contents of case file

- Decisions
  - based exclusively on evidence introduced at hearing
  - explain right to request a state agency hearing or seek judicial review, to the extent that either is available.

42 C.F.R. §§ 431.242, 438.406(b)

Medicaid Managed Care

- Enrollees still have all Medicaid fair hearing rights

- Appeal = "Adverse benefit determination"
- Continued benefits
- Exhaustion … generally required for state fair hearing
- Effectuation

42 U.S.C. § 1396u-2(b)(4); 42 C.F.R. part 438 (2016)

Adverse Benefit Determination

- Denial or limited authorization of services, including medical necessity, setting;
- Reduction, suspension, termination of previously authorized service;
- Denial, in whole or in part, of payment;
- Failure to provide services in a timely manner;
- Failure to act within the timeframes for resolution of grievances and appeals;
- In rural area with only one plan, denial of right to obtain out-of-plan services;
- Denial of request to dispute financial liability, e.g. premiums & cost sharing

42 CFR §§ 438.400; .406

Continued Benefits

- The plan must continue benefits if:
  - Enrollee timely appeals
  - Appeal involves termination, suspension, or reduction of previously authorized service;
  - Service was ordered by an authorized provider;
  - The period covered by the original authorization has not expired; and
  - Enrollee files for continued benefits within 10 calendar days of the notice

Effectuation of Appeal Decision

- ABD Affirmed
  - Enrollee can obtain state fair hearing
  - If final, MCO can recoup *if*
    - Furnished solely because of the con’t benefit requirement *and*
    - To the extent consistent with *state* policy
- ABD Reversed:
  - “Authorize or provide” services as expeditiously as enrollee’s health requires, w/i 72 hours from receiving notice of reversal

Problems we see in HCBS Waivers:

- Notices:
  - Difficult to understand
  - Do not comply with legal requirements re: content
  - Are not provided in writing
  - Given to provider, not enrollee
- Continued benefits in managed care
- Secret coverage standards
- Denial of eligibility, services, assessment results, placement on wait list, modification of services
- Refusal or failure to offer listed waiver services
- Discouragement

Problems in Practice: Cases

Forums for Enforcement

- Administrative complaint/appeal
  - Medicaid – Administrative Fair Hearing
  - Managed Care – Internal grievance or appeal
- State Courts
- Federal Courts

Cyrus v. Walker, 233 F.R.D. 467 (S.D.W.V. 2005), same case, 407 F. Supp. 2d 319 (2005)

- Agency eliminated the role of treating physicians in the annual eligibility determination for HCBS waiver.
- Reviews conducted by nurses employed by a for-profit entity.
- Assessment standards were not announced.
- Assessment tools were not shared.
- Persons were not notified of reasons for denial.
- Persons could not confront adverse witnesses (i.e., nurses).

Cyrus v. Walker (con't)

- Prelim. Inj. (2003) & Agreed Final Order (2005):
  - Restoration of benefits pending final order (prelim. Inj.)
  - New notices of denial (e.g., reasons, assessment & policy attached)
  - Accommodations re: assessment, notice, fair hearing
  - Nurses could not make medical decisions, diagnoses
  - Assessment forms available for review

McCartney v. Cansler, 608 F.Supp.2d 694 (E.D.N.C 2009), aff'd, 382 Fed. App'x 334 (4th Cir. 2010)

- State through its contractor instructed providers to request more limited services and would approve that amount
- Verbal denials of services without notice and appeal rights
- Failure to provide continued benefits
- Failure to offer de novo hearing
- Discouragement of services & appeals

McCartney v. Cansler (con't)

- Reviewer must consider all information provided, make individualized determinations based on medical necessity
- Misinformation and intimidation of providers, enrollees prohibited
- When speaking with providers use of a script required (script specifically addressed discouragement)
- New notices
- State Medicaid agency – statewide training events

L.S. v. Delia, 2012 WL 12911052 (E.D.N.C. 2012)

- Existing HCBS services were cut based on plans' use of Supports Intensities Scale (SIS) assessment tool.
- Plaintiffs put within a Supports Needs Matrix (SNM) & assigned a certain level of/budget for services.
- Complaint:
  - Failure to provide due process on reductions in services
  - Inadequate and improper notices
  - Assessment tools failed to make medical necessity decisions on individual facts of the case and controlling law, but instead based decisions on arbitrary guidelines and procedures that were not readily ascertainable.

L.S. v. Delia (con’t)

- Settlement (2014):
  - Set requirements for notices that cut services
  - Prohibited plans from using assessment tools as anything beyond a guideline
  - Reaffirmed that services that are **medically necessary** must be authorized
- 2017: Biggs v. Cohen to enforce settlement
  - Plaintiffs’ waiver services had been reduced based on undue reliance on assessment tools
  - State agreed to publish bulletin for MCOs

July 2018 Bulletin to MCOs

- Services to be provided based on medical necessity
- SIS is “only one piece of evidence” & “may be considered as a guideline only”
- Discouraging recipient from requesting services violates the settlement and MCO contracts with State
- Denials cannot use generalized language (e.g., “The assigned budget would typically meet the needs of someone with similar support needs.”)
- Instead: “The information provided does not indicate that the individual would benefit from the combination of service hours requested.”
- New notices, corrected forms, and training

https://files.nc.gov/ncdhhs/Joint-Communication-Bulletin--J297--LME-MCO-LS-V-Wos-Instruction--002-.pdf

Murphy by Murphy v. Harpstead, 421 F.Supp.3d 695 (D. Minn. 2019)

- Denial not limited to rejection of an application for services, but also occurs when:
  - Agency does not authorize services requested
  - Agency authorizes services but does not provide the type or amount

  - ➢ Waiver recipients cannot be expected to know what services are available and to specifically apply for them before due process is triggered

- Notices failed to outline reasons for denial and the general information unrelated to the specific request was insufficient
- Legitimate claim of entitlement to services they actually seek

Other Cases

- K.W. v. Armstrong
- C.S. v. Saiki
- Pashby v. Delia
- Salazar v. District of Columbia
- Brandy C. v. Palmer
- Rogers v. Cohen

NY Cases:

- Hanley v. Zucker, 2016 WL 3963126
- Taylor v. Zucker, 2105 WL 4560739
- Scofero v. Zucker, 2016 WL 3964589, Scofero v. VNA Homecare, 2017 WL 3097612
- Samele v. Zucker, 324 F..Supp.3d 313 (2018)
- Bellin v. Zucker, 2020 WL 2086009 (appealed)

To Watch:

- Alexander v. Mayhew (FL)
- Harrison v. Phillips (TX, appealed to 5th)
- Waskul v. Washtenaw County Community Mental Health (MI, appealed to 6th)

Other Due Process Advocacy Opportunities

- Challenge the process and the cuts v. the tool
- Managed care contracts
- Administrative challenges to policies and procedures
  - E.g., Ledgerwood v. DHS; McCrann v. NC DHHS
- 1915(c) waiver language
  - Use of public comment opportunities
- Due process rights training to waiver participants
- Person centered planning standards

Resources:

- Perkins, Demanding Ascertainable Standards, 2016 Clearinghouse Rev. 1 (2016), https://heinonline.org/HOL/LandingPage?handle=hein.journals/clear50&div=8&id=&page=
- Advocates' Guide to Accessibility in Medicaid Managed Care Grievances and Appeals (NHeLP, DREDF, JIA)
  - https://healthlaw.org/resource/advocates-guide-to-accessibility-in-medicaid-managed-care-grievances-and-appeal/
- Medicaid Managed Care Final Regulations: Grievance & Appeals Systems
  - https://healthlaw.org/resource/issue-brief-2-medicaid-managed-care-final-regulations-grievance-appeals-systems/#.V0iZ8fkrKM8

Questions?

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