NATIONAL HEALTH LAW PROGRAM

Fact Sheet
Medicaid Managed Care Litigation[1]

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This fact sheet describes recent trends in litigation related to Medicaid managed care, highlighting selected cases. It also includes a docket listing Medicaid managed care cases from the past 25 years.

Medicaid Managed Care

The Medicaid Act authorizes states to provide services through managed care entities, including HMO-like managed care organizations (MCOs), prepaid health plans (PHPs), and Primary Care Case Management systems (PCCMs). Statutes and regulations impose detailed requirements on these entities, governing outreach and enrollment, services, network adequacy, and notice and hearing.[3]

Beneficiaries and providers have sued state Medicaid agencies and, on occasion, the managed care entities themselves, alleging that these requirements have been violated. Certain issues recur regularly, particularly problems with notice and hearing systems, enrollment, and services.

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[2] Yale Law 2L.
[3] For additional discussion of Medicaid managed care, *see* Sarah Somers, *Q&A: Managed Care Informing and Disclosure Requirements* (Aug. 2012); Sarah Somers, *Q&A: Medicaid Managed Care and Disability Discrimination Protections* (May 2012); Jane Perkins, *Q&A: Assuring Accountability and Stewardship in Medicaid Managed Care: Public Reporting Requirements for States and MCOs* (June 2007), available from TASC or NHeLP.

This fact sheet discusses some notable case trends from the past several years. It contains a comprehensive summary all of the Medicaid managed care cases that we were able to find, organized by state. It also lists cases under the topic that they address (e.g., notice and hearing, provider reimbursement.)

Case Trends

The Fourth Circuit has recently reaffirmed that state Medicaid agencies are ultimately responsible for Medicaid program compliance and are the deciders.

Earlier this year, the Fourth Circuit made a ruling that could have implications beyond the procedural issue in the case. In *K.C. ex rel. Africa v. Shipman,* the court held that a Medicaid MCO could not appeal an adverse district court ruling when the co-defendant state Medicaid director did not appeal.[4] The plaintiffs had filed suit against the state Medicaid director and a MCO responsible for managing delivery of behavioral health services, alleging that the MCO improperly terminated services without complying with notice and hearing requirements. The district court awarded a preliminary injunction in plaintiffs' favor, ordering defendants to reinstate plaintiffs' services to their prior levels and enjoining them from reducing those services without a hearing. The MCO appealed the preliminary injunction order, but the Medicaid agency did not.

The court held that Medicaid's single state agency requirement precluded the MCO from bringing an appeal when the state agency did not.[5] The court further cited a regulation prohibiting other agencies or offices from changing or disapproving an agency's administrative decision or substituting its judgment for the agency's.[6] And, the court reasoned, the Medicaid agency made such an administrative decision by deciding not to appeal.

In language that may prove helpful in other cases, the court held:

> In sum, the single state agency requirement represents Congress's recognition that in managing Medicaid, states should enjoy both an administrative benefit (the ability to designate a single agency to make final decisions in the interest of efficiency) but also a corresponding burden (an *accountability regime* in which that agency *cannot evade federal requirements by deferring to the actions of other entities*).[7]

[4] 716 F.3d 107 (4th Cir. 2013). Plaintiffs' counsel are Disability Rights North Carolina, the National Health Law Program, and Legal Services of Southern Piedmont.
[5] The single state agency requirement is 42 U.S.C. § 1396a(a)(5).
[6] 716 F.3d at 112.
[7] *Id.* at 112-13

Further,

> the vesting of responsibility over a state's Medicaid program in a single agency *safeguards against the possibility that a state might seek to evade federal Medicaid requirements by passing the buck* to other agencies that take a less generous view of a particular obligation.[8]

Advocates who are attempting to hold states accountable for failing to ensure that MCOs comply with Medicaid requirements may find this reasoning useful. This case is an important companion to cases recognizing that health plans contracting with the state may also be state actors and subject to requirements governing the state such as *J.K. v. Dillenberg* (stating, "[i]t is patently irresponsible to presume that Congress would permit a state to disclaim federal responsibility by contracting away its obligation to a private entity.")[9] Moreover, it is also consistent with the decision in *Salazar v. D.C.* to require managed care plans to disclose copyright-protected medical necessity criteria.[10]

Together, these cases help to ensure that both the state and the managed care plans must comply with Medicaid requirements, and the state is ultimately responsible for compliance.

Private enforcement managed care provisions has had a mixed track record in recent years.

Providers and beneficiaries have attempted to hold managed care entities accountable through suits to enforce various statutory provisions. Some statutory provisions apply equally to FFS systems, such as the fair hearing and reasonable promptness requirements. In a number of recent cases, with mixed success, provider plaintiffs have attempted to enforce provisions specific to managed care systems.[11]

For example, the First Circuit found that a provision requiring states to supplement the managed care rate of payments to Federally Qualified Health Centers (FQHCs) when necessary to match a certain level (required by 42 U.S.C. § 1396a(bb)) is privately enforceable under § 1983. See *Rio Grande Cmmty. Health Ctr., Inc. v. Rullan*.[12] In another case, *St. Francis Hosp. v. Foundation Health*, the plaintiff hospital sought reimbursement for out-of-network emergency services provided to the defendant HMO's enrollees. The HMO argued that two of plaintiffs' claims were not enforceable

[8] *Id.* at 112. (emphasis added).
[9] 836 F. Supp. 694, 699 (D. Ariz. 1993).
[10] 596 F.Supp.2d 67, 69-70 (D.D.C. 2009), modified in part on reconsid., 750 F.Supp.2d 65 (2010).
[11] For more, see Jane Perkins, *Update on Private Enforcement of the Medicaid Act Pursuant to 42 U.S.C. § 1983* (Sept. 2012), available from TASC and NHeLP.
[12] 397 F.3d 56 (1st Cir. 2005).

under § 1983. The court disagreed, finding that plaintiffs could enforce provisions involving payment for emergency services and prohibition of restrictions that discriminated against classes of providers (42 U.S.C. §§ 1396b(m)(2)(A)(vii) and 1396n(b)(4)).[13]

Other challenges have not passed the initial enforceability hurdle. For example, in *AlohaCare v. Haw. Dep't of Human Servs.,* the court held that FQHCs did *not* have enforceable rights under several Medicaid provisions: §§ 1396b(m)(1)(A) and (1)(A)(describing the obligations of MCOs to make services available); § 1396u-2(b)(5) (describing MCOs' obligations to ensure adequate access to providers); § 1396u-2(a)(1)(A)(ii) (allowing states to limit the number of agreements with managed care entities); § 1396b(i)(17) (restricting the use to which managed care entities may put Medicaid funds); and § 1396u–2 (a)(2)(A) (exempting children with special needs from enrollment in managed care entities). The court held that these provisions were not intended to benefit providers. It explicitly left open the possibility that beneficiaries could enforce some of these provisions.[14] Indeed, in another Hawaii case, *G. v. Haw. Dept. of Human Servs*., the court held beneficiaries could enforce several managed care provisions imposing beneficiary protections and requiring demonstration of solvency (42 U.S.C. §§ 1396b(m)(1)(C)(i), 1396u-2(a)(1)(A), 1396u-2(b)(5)).

Most recent cases involving Medicaid managed care requirements have been filed by providers over rate issues.

In the past five years, there have been more than 20 decisions in cases filed by managed care plans or providers. Most of these cases involve reimbursement or rates. *See* Chart of Cases by Subject, p. 7. Only a few cases involve attempts to enforce beneficiary protections, like *G. v. Haw. Dep't of Human Servs,* discussed above. While the *G.* plaintiffs survived motions to discuss, the court ultimately granted summary judgment for Defendants.[15] Similarly, in *Ariz. Ass'n of Providers for Persons with Disabs., v. Ariz.*, the court held that plaintiff beneficiaries and providers stated claim for violation of Network adequacy requirements, based on service suspension and rate cuts, but failed to present evidence sufficient to show a violation and vacated a preliminary injunction halting the cuts.

[13] No. 98-cv-648-K(E), 2000 U.S. Dist. LEXIS 4466 (N.D. Okla. Feb. 22, 2000).
[14] 567 F. Supp. 2d 1238 (D. Haw. 2008), aff'd, 572 F.3d 740 (9th Cir. 2009).

[15] See summary at p. 16, *infra.*

Plaintiffs have had some success with *qui tam* actions making federal False Claims Act claims

Under the federal False Claims Act (FCA), private individuals (called "relators") may file civil actions on behalf of the federal government. These are known as "*qui tam"* actions and are intended to recover money that the government paid as a result of conduct forbidden under the FCA. The FCA imposes liability for knowingly making or using a false record or material statement to obtain payment from the government.[16] An FCA claim can be based on a false certification of compliance with a statutory or regulatory requirement, if that certification is a condition of payment from the government.[17]

In recent years, a number of *qui tam* actions filed against Medicaid MCOs have resulted in published decisions, with mixed results. In *United States ex rel. Tyson v. Amerigroup Ill., Inc*., plaintiffs claimed that the MCOs obtained Medicaid contracts by falsely promising that they would not discriminate based on need for health services and that they submitted false claims for payment in the form of enrollment applications containing false certifications. The court found that the false assurances were actionable under the FCA, that the nondiscrimination provisions were material, and that the jury's award of $48 million in damages was not so excessive as to warrant remittitur.[18]

In *United States ex rel. Upton*, the court held that the relators (current and former employees) adequately pled intentional discrimination against enrollees, by alleging that the Medicaid MCO intentionally violated their contract by refusing to enroll pregnant women and individuals in need of specialists ("cherry picking") and that they knowingly and falsely certified that they were not doing so. But, the court also held that relators failed to adequately plead that the MCO's certifications of non-discrimination were conditions for receiving payment from the government. The relators filed another amended complaint. The court found that this new complaint contained the necessary allegations, because it asserted that the managed care plan never intended to comply with the contractual provisions prohibiting discrimination when it agreed to the contracts and knew discrimination was occurring when it submitted certification to the contrary.[19] This case is continuing.

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[16] 31 U.S.C. § 3729(a)(1).
[17] *U.S. ex rel. Upton,* 900 F. Supp. 2d 821, 828 (N.D. Ill. 2012), citing *U.S. ex. Rel. Crews v. NCS Healthcare of Ill., Inc.,* 460 F.3d 853 (7th Cir. 2006).
[18] 488 F. Supp. 2d 719, (N.D. Ill. 2007).
[19] *United States ex rel. Upton v. Family Health Network, Inc.*, 2013 U.S. Dist. LEXIS 29620, 2013 WL 791441 (N.D. Ill. Mar. 4, 2013).

In *U.S. v. APS Healthcare, Inc.,* the relator filed a False Claims Act action against managed care entity APS, which contracted to provide care management and coordination services to aged, blind, and disabled Medicaid recipients within the Nevada's fee-for-service system. The relator claimed that, among other things, APS was understaffed such that many cases sat "dormant for months," during which patients did not receive services; patients received inadequate care plans; and, to manage its backlog, APS dis-enrolled patients from disease management and care coordination services. While allegations did show that APS had not fulfilled its contractual obligations, they did not "plead a nexus between this failure and the submission of false claims." Without such a nexus, the allegations of sub-par medical services did not state a viable FCA claim.[20]

Qui tam False Claims Act cases can be a powerful tool, because managed care entities found to have violated the Act are subject to heavy fines. In order to be a relator, however, individuals must provide information that would not otherwise be public. For this reason, relators are usually current or former employees of managed care plans or providers. Thus, advocates may be able to obtain necessary information from these sources, including current and former employees of home based service provider agencies.

Selected Medicaid Managed Care Cases by Subject (see full docket for citation)

Enrollment

Rodriguez v. Belshe (CA)

Clark v. Belshe (CA)

Lackner v. Dep't of Health Servs. (CA)

Humana Med. Plan, Inc. v. State (FL)

Dayton Area Health Plan v. Ohio Dep't of Ins. (OH)

Okla. Chap. Of Am. Acad. Of Pediatrics v. Fogarty (OK)

Network Issues

Ariz. Ass'n of Providers for Pers. With Disabs. v. Ariz. (AZ)

Hyden v. N.M. Human Servs. Dep't (NM)

[20] No. 2:11-cv-01454-MMD-GWF, 2013 WL 420402 (D. Nev. Jan. 30, 2013).

Yuchnitz v. PCA Health Plan of Tex., Inc. (TX)

Notice and Hearing

Medina v. Kelly (AZ)

Perry v. Chen (AZ)

Rodriguez v. Chen (AZ)

J.K. v. Dillenberg (AZ)

Eric H. v. Belshe (CA)

Jackson v. N.C. Dep't of Human Servs. (NC)

Nichols v. Office of Med. Assist. Progs. (OR)

Metts v. Houstoun (PA)

Grier v. Goetz (and related cases) (TN)

Hamby v. Neel (TN)

Qui Tam/False Claims Act

U.S. ex rel. Upton v. Family Health Network (IL)

U.S. ex rel. Tyson v. Amerigroup Ill. (IL)

U.S. v. APS HealthCare (NV)

Reimbursement and Payment issues

Arkansas Med. Soc'y v. Knickrehm (AR)

Watts Health Fnd. v. Belshe (CA)

Urban Health Care Coal. v. Sebelius (D.C.)

Midwest Emergency Assoc.-Elgin, Ltd. v. Harmony Health Plan of Ill. (IL)

Ill. HMO Guar. Ass'n v. Dep't of Ins. (IL)

NevadaCare, Inc. v. Dep't of Soc. Servs. (IA)

Tran v. Concannon (ME)

Three Lower Counties Comm. Health Servs. (MD)

Cedar-Riverside People's Ctr. v. Minn. Dep't of Human Servs. (MN)

Community Healthcare Assoc. v. N.Y. State Dep't of Health (NY)

Okla. Chap. Of Am. Acad. Of Pediatrics v. Fogarty (OK)

St. Francis Hosp. v. Fnd. Health (OK)

Medevac Midatlantic, LLC v. Keystone Mercy Health Plan (PA)

Trs. of the Univ. of Pa. v. Americhoice Pa. (PA)

Rio Grande Commty. Health Ctr. v. Rullan (PR)

River Park Hosp., Inc. v. BlueCross BlueShield of Tenn., Inc. (TN)

El Paso Healthcare Sys. v. Molina Healthcare of N.M., Inc. (TX)

Healthkeepers, Inc. v. Richmond Ambulance Auth. (VA)

Amundson v. Wis. Dep't of Health Services

Services

Emily Q. v. Bonta (CA)

Karen L. v. HealthNet of the Ne. (CT)

Agency for Health Care Admin. v. Baker Co. Med. Servs. (FL)

G. v. Haw. (HI)

Memosovski v. Maram (IL)

Westside Mothers (MI)

U.S. v. APS HealthCare, Inc. (NV)

Hyden v. N.M. Human Servs. Dep't (NM)

Kirk T. v. Houstoun (PA)

Scott v. Snyder (PA)

John B. (TN)

Crabtree v. Goetz (TN)

Frew (TX)

Sanders v. Lewis (WV)

Enforcement of Medicaid Provisions

AlohaCare v. Haw. Dep't of Human Servs. (HI)

Haw. Coal. For Health v. Haw. (HI)

Starko, Inc. v. First Presbyterian Health Plan, Inc. (NM)

St. Francis Hosp. v. Foundation Health (OK)

Medevac Midatlantic v. Keystone Mercy Health Plan (PA)

Pa. Pharmacists Ass'n v. Houstoun (PA)

Rio Grande Cmmty. Health Ctr. v. Rullan (PR)

John B. (TN)

Frew (TX)

Transparency

HealthNet of Conn. v. Freedom of Info. Comm'n (CT)

Salazar v. D.C.(DC)

Medicaid Managed Care Cases by State

Arizona

Wood v. Betlach, No. CV-12-08098-PCT-DGC, 2013 U.S. Dist. LEXIS 16601 (D. Ariz. Feb. 7, 2013).

> Plaintiffs challenged the state Medicaid agency's authority to impose heightened co-payments and the federal government's authority to approve them. The court held that HHS' failure to consider (1) the efficacy of heightened, mandatory co-payments as a cost-saving measure and (2) the impact co-payments would have on Medicaid beneficiaries in 1115 demonstration project before approving the waiver was arbitrary and capricious. Plaintiffs presented evidence that copayments were inconsistent with managed care, which is already designed to save costs. Judge remanded the decision to HHS, without vacating, for HHS to remedy the reasoning. The court also held that notices to plaintiffs regarding new co-payments did not violate due process.

Planned Parenthood Ariz., Inc. v. Betlach, 899 F. Supp. 2d 868, (D. Ariz. 2012).

> Plaintiffs challenged enforcement of act prohibiting health care providers who perform elective abortions from receiving Medicaid funding. The court held that the federal government's waiver of the freedom of choice requirement to operate Arizona's managed care 1115 demonstration did not permit state to enforce the act. CMS did not waive the additional guarantee of an individual's free choice of providers of family planning services.

Ariz. Ass'n of Providers for Pers. with Disabilities v. Arizona, 219 P.3d 216 (Ariz. Ct. App. 2009).

> Plaintiffs beneficiaries and providers alleged that the state violated MCO network adequacy requirements, based on service suspensions and rate reductions. The court held that they stated claim, but failed to present evidence sufficient to show a violation of provision.

Medina v. Kelly, No. CIV 98-0494PHXRGS (D. Ariz., March 18, 1998) (pleadings available from NHeLP).

> The court held that, to ensure due process and compliance with federal regulations, final administrative decisions must occur within 90 days of the first request for a hearing; settlement includes uniform grievance notices.

Perry v. Chen, 985 F. Supp. 1197 (D. Ariz. 1996).

> Beneficiaries sued state Medicaid agency for due process violations. The court held that actions taken by health plans contracting with a state Medicaid agency to deny, terminate, or reduce covered services constituted state actions which triggered federal mandated notice and hearing due process procedures under Medicaid fair hearing provision, 42 U.S.C. §1396a(a)(3), and implementing regulations. Key factors were the fact that the health plans were paid and regulated by the state.

Rodriquez v. Chen, 985 F. Supp. 1189 (D. Ariz. 1996).

> Beneficiaries sued state Medicaid agency for due process violations. The court held that notices violate the U.S. Constitution, federal Medicaid statute and regulations, and state statute and regulations. The state Medicaid agency was ordered to use notices that include a statement of the intended action, detailed reasons for the action, and specific financial information and legal authority for the action.

J.K. v. Dillenberg, 836 F. Supp. 694 (D. Ariz. 1993).

> Medicaid beneficiaries challenged adequacy of behavioral health services for children. The court held that there was state was action when a private Regional Behavioral Health Authorities (REBHA) reduced, suspended, or terminated medically-necessary mental health services to a child--officials could not contract away their duties to a private entity. The court rejected the state's argument that REBHAs were independent contractors who did not have to abide by the due process notice provisions in Medicaid law. The court denied summary judgment on the claim that REBHAs violated due process requirements in 42 U.S.C. § 1396(a)(3) and 42 C.F.R. §§ 431.200- 431.250, its decisions did not reflect a policy effecting entitlements, but were merely discretionary as to how to execute contractual obligations.

Arkansas

Arkansas Medical Society v. Knickrehm, No. 4:92-CV-00429SWW (E.D. Ark. Apr. 11, 2000).

> In a challenge by Medicaid providers, the court granted contempt and a preliminary injunction barring implementation of mental health managed care program that would have reduced reimbursement rates to psychiatric physicians who treat Medicaid patients under age 21 below those agreed to in a consent

order, and questioning whether the program complied with statutory provisions governing Medicaid managed care programs.

National Park Medical Center, Inc. v. Arkansas Dept. of Human Serv., 322 Ark. 595 (1995).

An unsuccessful bidder for a Medicaid service contract challenged the validity of administrative rules adopted to implement a Medicaid waiver program, alleging violations of Administrative Procedures Act's (APA's) public comment requirement and Freedom of Information Act's (FOIA's) open meetings requirement. The Court found for the department.

California

Emily Q. v. Bonta, 208 F. Supp. 2d 1078 (C.D. Cal. March 30, 2001).

Medicaid-eligible children alleged that they were denied mental health benefits – specifically Therapeutic Behavioral Services – to which they were entitled. The court granted the plaintiff's motion for permanent injunction holding that federal law required the state Medicaid agency to provide notice regarding all EPSDT services including notice of TBS and EPSDT services. Court also imposed liability on DHS to provide compensatory TBS to those wrongfully denied, rejecting defendant's 11th Amendment objection. County managed care plans were also included in the relief order.

Rodriquez v. Belshe, No. BS035856 (Cal. App. Dep't Super. Ct. Los Angeles, Sept. 25, 1995) (complaint available from NHeLP).

This case sought to require the Department of Health Services to monitor and enforce plaintiffs' rights under state laws to disenroll from managed care plans and promptly resume receiving services from their choice of fee-for-service provider.

Watts Health Foundation v. Belshe, No. 95-1251ABC (C.D. Cal. Feb. 27, 1995) (complaint available from NHeLP).

The health plan challenged the prepaid rates paid to it, arguing that the rates were inadequate and set in an arbitrary and capricious manner. The complaint cites various Medicaid provisions, including: 42 U.S.C. § 1396b(m) (requiring rates to be set on an actuarially sound basis); 42 U.S.C. §1396a(a)(13)(A) (the Boren Amendment); and 42 U.S.C. § 1396a(a)(30) (the equal access provision).

Clark v. Belshe, 66 F.3d 332 (9th Cir. 1995), No. CIV-87-1700 JFM (E.D. Cal. Dec. 12, 1994) (Order).

> Suit filed by Medi-Cal beneficiaries who needed dental services but had difficulty locating providers who participate in Medi-Cal. Following a series of decisions against the state agency, the state began unilaterally to remove a portion of the class members from the operation of the court's judgment by requiring them to enroll in managed care – "without any review from the court of the merits of the substituted program and whether it complied with the requirements of either Medicaid statute or the court's judgment." The district court ordered the Medicaid agency to cease implementation of a mandatory managed dental care program in Sacramento County. However, the appellate court vacated the opinion of the district court and held that California must obtain the federal waiver required to implement the program in order for the dispute to become ripe for judicial resolution.

Lackner v. Dept. of Health Servs., 35 Cal. Rptr. 2d 482 (Cal. Ct. App. 1994).

> Plaintiffs alleged that the state of California infringed upon their constitutional right of privacy by implementing Cal. Welf. & Inst. § 14016.5, which transferred Medi-Cal beneficiaries into managed care plans from fee-for-service plans within 30 days. The court held that the default enrollment provision does not infringe on the beneficiaries' right to choose their own health care provider because it does not rise to the level of an egregious breach of the asserted privacy interest.

Gutierrez v. Coye, No. 949269 (Cal. App. Dep't Super. Ct. May 25, 1993 and May 10, 1994).

> Stipulations and settlements set forth notice procedures for disenrollment and access standards for MCO enrollees. The parties also agreed to negotiate due process procedures.

Gonzalez v. Cohen Medical Corporation, d/b/a Tower Health Services, No. 48330-4 (Cal. App. Dep't Super. Ct. July 6, 1993); No. 486330-4 (Cal. App. Dep't Super. Ct. Fresno, July 2, 1993).

> The court ordered representatives of defendant primary care case management (PCCM) plan to stop engaging in fraudulent PCCM plan membership enrollment and retention practices. The court required defendant to provide potential enrollees with certain information, including the fact that plan salespersons do not represent the state, Medi-Cal or the local welfare agency, that enrollment is voluntary and after enrolling, individuals must use the PCCM's network for

routine care. Defendant was also ordered to follow all laws regarding marketing and disenrollment and to make no misrepresentations about the nature and scope of its health plan.

Wickline v. California, 239 Cal. Rptr. 810 (Cal. Dist. Ct. App. 1986).

Under the specific facts of the case, the court found the Medi-Cal program was not liable for malpractice resulting from the state's cost containment/utilization review program. The Court, however, noted that it is conceivable that a state-sanctioned UR program could be the "cause" of injury.

Colorado

RX Pharmacies Plus, Inc., v. Weil, 883 F. Supp. 549 (D. Colo. 1995).

Plaintiffs sued, alleging that limitations on choice of pharmaceutical providers violated Medicaid's freedom of choice provision. They were enrolled in waiver program in which beneficiaries must enroll in an HMO or choose a primary care provider (PCP). The court found no violation. Beneficiaries choosing the PCP could continue to obtain drugs from the pharmacy of their choice. HMO enrollees must obtain their drugs through the HMO. The court found no additional waiver was necessary to limit pharmacy services for HMO enrollees.

Connecticut

Rathbun v. Health Net of the Northeast, Inc., UWYX01CV085012640S, 2009 Conn. Super. LEXIS 2337 (Conn. Super. Ct. Aug. 21, 2009).

The court held that when a state has assigned its statutory right to recover from a third-party to an MCO, the Medicaid MCO has a right to seek recovery from the proceeds of personal injury settlements or awards obtained by Medicaid managed care enrollees for the medical costs incurred on behalf of the enrollee. The reimbursement is limited to the amount of Medicaid funds paid and identified as part of any settlement.

Aff'd Rathbun v. Health Net of the Northeast, Inc., 133 Conn. App. 202 (2012); *cert granted Rathbun v. Health Net of the Northeast, Inc.*, 304 Conn. 905 (2012).

Goldstar Medical Servs., Inc. v. Dept. of Social Servs., 288 Conn. 790 (2008).

Plaintiffs, a Medicaid provider distributing oxygen devices and its owner, were audited by the Department of Social Services (DSS) to evaluate compliance with record-keeping requirements and were found to be non-compliant. DSS terminated the provider agreement with both the organization and with the owner

personally. Owner argued that DSS lacked jurisdiction to sanction him personally, because he was not a provider. The court held that a provider under the managed care program can be either an individual or an entity.

Health Net of Conn. v. Freedom of Info. Comm'n, No. CV064010428S, 2006 WL 3691796 (Conn. Super. Ct. Nov. 29, 2006).

Plaintiffs submitted state FOIA requests to obtain records from Medicaid managed care contractors. MCOs argued that the records were not subject to disclosure because they did not perform a governmental function. Court held that MCOs are "programs" of the state Medicaid agency. The contractors engaged in high-level decision-making including the establishment of provider fees, preferred drug lists, and prior approval lists. Therefore, those matters are subject to disclosure under Connecticut's Freedom of Information Laws.

Karen L. v. Health Net of the Northeast, 78 Fed. App'x 772 (2d Cir. 2003)..

Plaintiffs, a class of Medicaid recipients enrolled in Health Net of Northeast MCO, challenged the MCO's decision to remove 105 drugs from its formulary and therefore terminating payments for these drugs without proper notice. The court affirmed the district court's decision to deny the plaintiff's motion for preliminary injunction because plaintiffs presented no evidence of imminent harm due to a denial of needed drugs.

Prior history: *Karen L. ex rel. Jane L. v. Health Net of the Ne*., 267 F. Supp. 2d 184 (D. Conn. 2003) (denying preliminary injunction); *Karen L. v. Physicians Health Servs*., 202 F.R.D. 94 (D. Conn. 2001) (certifying class).

District of Columbia

Prince George's Hosp. Ctr. v. Advantage Healthplan Inc., 865 F. Supp. 2d 47 (D.D.C. 2012).

The court found no implied private cause of action, under the Medicaid statute, to allow a hospital to recover from an MCO for emergency services provided to MCO enrollees. The statute was not created for the sole benefit of healthcare providers and there was no evidence of legislative intent to create a remedy that would be inconsistent with the legislative purpose of state administration of the Medicaid program.

Salazar v. D.C.

Medicaid recipients brought suit against the District of Columbia alleging violations of Medicaid requirements. The parties negotiated a settlement agreement and the judge entered it as an order.

- Settlement Order entered: The court found the District in violation of Medicaid laws governing application processing, redeterminations, and EPSDT outreach and screening services. The remedial order contains specific steps the District must take to come into compliance with these laws even as it implements Medicaid managed care, including oral and written notice regarding EPSDT, Spanish-language outreach, family contact prior to the due date of an EPSDT exam, implementation of plan-level tracking systems, and compliance measures. *Salazar v. D.C.*, 954 F. Supp. 278 (D.D.C. 1996).
- After repeated attempts to have DC comply with the settlement order, court granted plaintiff's motion for a prospective, per diem penalty schedule of fines. Plaintiffs were required to file a quarterly praecipe. *Salazar v. D.C.*, No. 93-452, 2006 U.S. Dist. LEXIS 46130 (D.D.C. Jul. 7, 2006).
- After filing five praecipes with the court the District Court ordered the District of Columbia to pay $931,050 in penalties. *Salazar v. D.C.*, 570 F. Supp. 2d 105 (D.D.C. 2008).
- The state Medicaid agency and managed care plans refused to provide copyrighted medical necessity criteria without imposing very restrictive limitations, to which plaintiffs objected. The court ordered that the criteria be produced and be accessible to class members who may quality for services affected by the criteria. *Salazar v. D.C.,* 596 F.Supp.2d 67 (D.D.C. 2009), *modified in part on reconsid.,* 750 F.Supp.2d 65 (2010).
- District of Columbia appealed the 2008 order imposing fines. The appellate court found both the 2008 and 2006 orders reviewable and affirmed all but one of the District Court's impositions of fines. *Salazar v. D.C.*, 602 F.3d 431 (D.C. Cir. 2010).
- District of Columbia argued that under *Gonzaga University v. Doe*, 536 U.S. 273 (2002), consent decree was unenforceable because there was no underlying private right of action. Court held that §1386a(a)(43) did create a private right of action that could be enforced under § 1983. *Salazar v. District of Columbia*, 729 F. Supp. 2d 257 (D.D.C. 2010); *appeal dismissed, Salazar v. D.C.*, 671 F.3d 1258 (D.C. Cir. 2012) (appeal dismissed for lack of jurisdiction).

D.C. Hosp. Ass'n v. D.C., 224 F.3d 776 (D.C. Cir. 2000).

Plaintiffs sued to challenge District of Columbia's exclusion of Medicaid Managed Care payments from the calculation of hospitals' DSH entitlements. The court held that the exclusion violates the Medicaid statute (42 U.S.C. § 1396r-4(c)(1))

Urban Health Care Coalition v. Sebelius, 853 F. Supp. 2d 101 (D.D.C. 2012).

> Hospitals challenged constitutionality of 42 U.S.C. § 1396u-2(b)(2)(D), which requires MCOs to reimburse out-of-network hospitals for emergency services provided to MCO enrollees at the rate established by the Medicaid agency for those services. Application of this provision caused the hospitals to accept lower reimbursements. The court dismissed the case for lack of subject-matter jurisdiction because the hospitals could not show that a favorable ruling would redress their injury.

Florida

Humana Med. Plan, Inc. v. State, 898 So. 2d 1040 (Fla. Dist. Ct. App. 2005).

> Florida law required state Medicaid agency to adjust the way Medicaid beneficiaries were assigned to managed care plans in one county. An MCO that lost many assignments under the new law challenged the law as a violation of Florida's constitution because it was a local, rather than statewide, law that was enacted without the requisite notice requirements. Court ruled that the law had a material statewide impact on the Medicaid program and was not a "local law" subject to notice requirements

Agency for Health Care Admin. v. Baker County Med. Servs., 832 So. 2d 841 (Fla. Dist. Ct. App. 1st Dist. 2002).

> Hospital sued state Medicaid agency seeking reimbursement for emergency outpatient services provided to Medicaid HMO enrollees. Court held that the state's determination that the hospital was not a Medicaid provider for HMO enrollees was reasonable and therefore was not obligated to pay hospital directly for services. States utilizing HMOs to provide medical care must cover emergency services, but are given the option of paying for such services directly or requiring the HMO to cover them. 42 U.S.C. § 1396b(m)(2)(A)(vii). When a state requires an HMO to provide emergency care as a covered service, federal law prohibits the state from paying another provider for services that are supposed to be provided by a Medicaid HMO. 42 C.F.R. § 434.57.

Hawaii

AlohaCare v. Ito, 126 Haw. 326 (2012).

> HMO submitted proposal to state Medicaid agency to provide Medicaid services through existing managed care plan contract, but was rejected. Contracts were awarded to accident and health insurance companies. HMO challenged the award of contracts to these companies. The court held that both accident and

health insurers and HMOs are authorized to offer the closed panel or limited physician group model of care required by the Medicaid managed care contracts. The court concluded that this holding does not nullify Hawaii's Health Maintenance Organization Act.

G. v. Hawaii

Plaintiffs--aged, blind, disabled adults—challenged the method by which Hawaii is providing services to the ABD population. Hawaii transitioned the population from fee-for-service to managed care, with two HMOs providing services. In a series of decisions, the district court grants summary judgment for defendants' claims

- Plaintiffs' Administrative Procedure Act claims survive motion to dismiss; the "freedom of choice" provision and requirements for Medicaid HMOs in 1396b(m)(1) are enforceable through § 1983. However, plaintiffs cannot enforce § 1386u-2(a)(1)(A)(ii) via § 1983. *G. v. Haw. Dep't of Human Servs.*, Nos. 08-00551 and 09-0004, 2009 WL 1322354 (D. Haw. May 11, 2009).
- CMS' decision to waive freedom of choice provision to allow Hawaii to mandate MCO enrollment was not "arbitrary and capricious" *G. v. Haw. Dep't of Human Servs*., 676 F. Supp. 2d 1046 (D. Haw. 2009).
- The court grants summary judgment in favor of the defendants on plaintiff's adequate assurance claim. The court found that the State's decision to restrict the number of MCO's to two, did not impede access to care in contravention of 42 U.S.C. § 1396u-2(b)(5). The court held (1) the adequate assurance provision of the Medicaid Act only requires that an MCO make assurances of future performance, for example through letters of intent. The MCO is not required to have signed contracts with providers, at the time the MCO signs a contract with the state Medicaid agency; (2) A court need only look at the language of the contract to determine if the MCO's assurances were adequate. 42 U.S.C. § 1396u-2(b)(5) does not impose a continuing obligation on states (or courts) to evaluate whether the MCO's provider network is, in fact, adequate. *G. v. Haw. Dep't of Human Servs*. 703 F. Supp. 2d 1078 (D. Haw. 2010).
- The court granted defendant's motion for summary judgment on plaintiff's ADA and Rehabilitation Act equal access claims because plaintiffs failed to present evidence indicating that they had suffered a harm based upon a denial of meaningful access to any Medicaid benefits by reason of their disability. *G. v. Hawaii*, Nos. 08-00551 ACK-BMK; and 09-00044 ACK-BMK, 2010 U.S. Dist. LEXIS 92377 (D. Haw. Sept. 3, 2010).
- The court did not find a violation of 42 U.S.C. § 1396b(m)(1)(A)(i) because the plaintiffs failed to show they had less access to services than other Medicaid beneficiaries. *G. v. Hawaii*, 794 F. Supp. 2d 1119 (D. Haw. 2011).

Haw. Coalition for Health v. Hawaii, 365 Fed. Appx. 874 (9th Cir. Haw. 2010).

> Plaintiff brought action seeking to enjoin implementation of managed care program for aged, blind, and disabled adults. Because plaintiffs brought case before managed care program was implemented, the court held that plaintiffs did not state a claim upon which relief could be granted. 42 U.S.C.S. § 1396u-2(b)(5) only requires assurances of future performance, and does not require adequate provider networks already be in place.

AlohaCare v. Haw. Dep't of Human Servs., 567 F. Supp. 2d 1238 (D. Haw. 2008), *aff'd*, 572 F.3d 740 (9th Cir. 2009).

> The state Medicaid agency rejected a proposal from AlohaCare, a non-profit group of FQHC's, to provide managed health care to the ABD population. AlohaCare alleged violations of the Medicaid Act. The court ruled that the FQHCs could not bring claims for violations of the Medicaid Act under § 1983. In part, the court concludes that a statute-not a regulation-must confer a right. Additionally, Congress did not intend §1396b(m) to confer a specific, individually enforceable right to contract eligibility for FQHC's.

Illinois

United States ex rel. Upton v. Family Health Network, 900 F. Supp. 2d 821 (N.D. Ill. 2012).

> Relators successfully pled specific instances of Medicaid MCO's "cherry picking" scheme to discriminate against patients with higher health needs (e.g. pregnant women and patients in need of specialists). But, relators did not successfully plead that MCO's certifications of non-discrimination were conditions for receiving payment from the government, as required for claim under the False Claims Act.
>
> *Subsequent History*: Relators remedied the deficiencies in their Third Amended Complaint, successfully alleging that fraudulent inducement by asserting that Family Health intended not to comply with the contractual provisions prohibiting discrimination when it agreed to put them in their contracts and knew it was and would continue to discriminate when it submitted certification to the contrary. *United States ex rel. Barbara v. Family Health Network, Inc*., 2013 U.S. Dist. LEXIS 29620, 2013 WL 791441 (N.D. Ill. Mar. 4, 2013)

Midwest Emergency Assoc.-Elgin Ltd. v. Harmony Health Plan of Illinois, 888 N.E.2d 694 (Ill. Ct. App. 2008).

> Provider filed suit against administrator of Medicaid managed care plans, seeking full reimbursement for services. The court rejected the claim, holding that, in the absence of a contract between an MCO and a provider, the appropriate reimbursement rate for out-of-network emergency services provided to a Medicaid managed care enrollee is the fee-for-service rate paid by the state Medicaid agency for such services.

United States ex rel. Tyson v. Amerigroup Ill., Inc., 488 F. Supp. 2d 719, (N.D. Ill. 2007).

> Plaintiffs claimed that the MCOs obtained Medicaid contracts by falsely promising that they would not discriminate based on need for health services and that they submitted false claims for payment in the form of enrollment applications containing false certifications. The court found that the false assurances were actionable under the FCA and that the nondiscrimination provisions were material and that the jury's award of $ 48 million in damages was not so excessive as to warrant remittitur.

Ill. HMO Guar. Ass'n v. Dep't of Ins., 864 N.E.2d 798 (Ill. App. Ct. 2007).

> After HMO, serving Medicaid patients, became insolvent, hospitals submitted unpaid claims for services rendered to enrollees to the Illinois HMO Guarantee Association, an association intended to insure providers and enrollees against HMO insolvency. The Association refused to pay these claims asserting a "Medicaid defense" that since Medicaid beneficiaries could not be held liable to providers, the Association did not have to pay. The court rejected this defense on the basis of collateral estoppel and required the Association to pay the Medicaid claims.
>
> *Related Litigation*: *Ill. HMO Guar. Ass'n v. Shapo*, 357 Ill. App. 3d 122 (2005).

Memisovski v. Maram, No. 92 C 1982, 2004 U.S. Dist. LEXIS 16772 (N.D. Ill. Aug. 23, 2004).

> The court held that Illinois' Medicaid program, including MCOs serving 20% of plaintiff class, violated EPSDT provisions requiring equal access to providers, notification of the availability of EPSDT services, and data collection. The court specifically found that "no MCO that has ever contracted with IDPA to provide services to the Medicaid population in Cook County has met the EPSDT requirements in the MCO Contracts."

Jones v. Chicago HMO Ltd. of Illinois, 730 N.E.2d 1119 (Ill. 2000).

> Medicaid patient brought medical malpractice case against doctor and HMO. HMO argued it could not be held liable for malpractice. The Supreme Court of Illinois ruled that an HMO can be held responsible for medical malpractice under a theory of institutional negligence, and specifically for assigning excess patients to a physician.

Medcare HMO v. Bradley, 788 F. Supp. 1460 (N.D. Ill. 1992).

> The court determined that the HMO was entitled to a permanent injunction to prohibit the state Medicaid agency from cancelling its contract without cause, and without communicating to the HMO's enrollees or providers that the HMO's contract had been or would be cancelled, or communicating to the HMO's enrollees or providers to change their affiliation with the HMO, and failing to pay the HMO all monies owed it under the contract.

Indiana

Molina Healthcare of Ind., Inc. v. Henderson, No. 1:06-cv-1483-JDT-WTL, 2006 WL 3518269 (S.D. Ind. Dec. 4, 2006).

> Plaintiffs, MCOs whose contracts were not renewed by the state, failed to show that states selection of new MCO companies was a violation of the freedom of choice provisions. Plaintiffs could not show that state's selection of MCOs would provide insufficient access to providers. Providers due process claims were not privately enforceable under § 1983.

Iowa

NevadaCare, Inc. v. Dept. of Social Servs., 783 N.W.2d 459 (Iowa 2010).

> Managed care provider brought suit against the state DHS claiming a contract violation for setting capitation rates the MCO would receive, the court granted judgment to DHS finding no violation because rates had been calculated on an actuarially sound basis.

Medco Behavioral Care Corp. of Iowa v. Iowa Dept. of Human Servs., 553 N.W.2d 556 (Iowa 1996).

> Court affirmed district court's holding that as a matter of law, a mental health care vendor was properly disqualified from participating in the bidding process to provide managed mental health care to Iowa's Medicaid program because of an organizational conflict of interest with the entity conducting policy analysis of the project.

Kentucky

Kentucky Spirit Health Plan, Inc. v. Commonwealth of Ky. Finance and Admin. Cabinet, Civ. Action No. 12-CI-1373 (May 31, 2013) (order granting summary judgment) (available from NHeLP).

A Medicaid MCO sued for the right to early termination of its contract with the Medicaid agency without incurring a fine. The MCO claimed that inaccurate and incomplete data lead to actuarially unsound rates. The court granted summary judgment for the agency.

Maine

Tran v. Concannon, No. 99-227-B-H, 2000 WL 761975 (D. Me. Jan. 6, 2000).

> After settlement, the plaintiff Medicaid beneficiary amended the complaint and alleged four different counts. The magistrate judge held that the only injury to the plaintiff was the denial of payment to the MCO provider of speech therapy services leading to a three-month cessation of those services. The judge granted the defendant the dismissal of two counts and denied the defendant the dismissal of two counts only to the extent that those claims arose from the three-month break.

Bach‑Tuyet Tran v. Concannon, No. 99‑227‑B‑H (D. Me. Nov. 5, 1999) (settlement agreement).

> Parties agreed that when EPSDT preventive and diagnostic services are provided, the Department will pay the full amount allowed for the claim and seek reimbursement from any liable third party to the limit of legal liability, that the Department must clarify "extenuating circumstances" when Medicaid recipients need not utilize third‑party HMO coverage, and that the Department would develop easily understood written information on the rights and responsibilities of Medicaid recipients regarding third‑party insurance.

Maryland

Three Lower Counties Cmty. Health Servs., Inc. v. Maryland, 498 F.3d 294 (4th Cir. 2007).

> Three Lower Counties (TLC), an FQHC, sued the state seeking declaratory judgment that State violated Medicaid Act by not making required supplementary payments to FQHCs. The court held that states are required to include in their contracts with MCOs a provision that requires either the MCO or the State to reimburse out-of-network FQHCs for services provided to the MCO's Medicaid

enrollees when such services are "immediately required due to an unforeseen illness, injury or condition." Section 1396b(m)(2)(A)(ix) sets a floor for the amount of the payment to the FQHC. The payment must be "not less than" the amount paid to a non-FQHC provider, but it does not need to be exactly what a non-FQHC provider would be paid.

Subsequent litigation:

- TLC sought full payment for past and future services rendered. Court granted summary judgment for TLC's out-of-network emergency services claim, but denied its motion on the supplemental payment claim because retroactive monetary relief was barred by § 1983. 2011 U.S. Dist. LEXIS 709, 2011 WL 31444 (D. Md. Jan. 5, 2011).
- Both parties moved to amend the judgment. The court denied both motions. *Three Lower Cntys. Cmty. Health Servs., Inc. v. Md. Dep't of Health & Mental Hygiene*, No. WMN-10-2488, 2011 U.S. Dist. LEXIS 120726 (D. Md. Oct. 19, 2011); 2011 U.S. Dist. LEXIS 94254 (D. Md. Aug. 23, 2011), *aff'd Three Lower Counties Cmty. Health Servs. v. Md. Dep't of Health & Mental Hygiene*, 490 Fed. Appx. 601 (4th Cir. Md. 2012).

Massachusetts

Rosie D. v. Romney, 410 F. Supp. 2d 18 (D. Mass. 2006).

Plaintiffs, a class of Medicaid-eligible children suffering emotional disturbances, proved that defendants, violated the reasonable promptness and equal access provisions of the Medicaid, EPSDT statutes. Parties submitted a joint motion to dismiss the claim based on 1396u-2, the managed care provision.

Subsequent History: *Rosie D. ex rel. John D. Romney*, 474 F. Supp. 2d 238 (D. Mass. 2007): The court approved a plan submitted by the State, over the plan submitted by the plaintiffs, to remedy the defects identified by the court. Discussed MCO capacity for expected enrolment.

Michigan

Westside Mothers

Plaintiffs challenged the failure of managed care Medicaid program to assure EPSDT services, to inform children of the availability of these services, and to assure adequate network capacity to deliver EPSDT services.

- Plaintiffs appealed the district court's decision to preclude them from showing that the state of Michigan was not providing adequate EPDST services mandated by the Medicaid Act. The appellate court reversed the decision of the district court and held that the Medicaid program was not merely a contract between

state and federal government, the plaintiffs' action was not barred by sovereign immunity, and Medicaid Act's medical screening and treatment provisions created a private right of action. *Westside Mothers v. Haveman*, 289 F.3d 852 (6th Cir. 2002), *cert. denied*, 537 U.S. 1045 (2002).

- On remand, the court denied the defendants', state officials, motion for summary judgment that they cannot be sued for the failure of medical providers to provide EPSDT services. The court stated that entering into contracts with private providers does not relieve a state of its statutory duty to provide these services in a state plan as set forth in 42 U.S.C. § 1396a(a)(43)(B). *Westside Mothers v. Olszewski,* 368 F. Supp. 2d 740 (E.D. Mich. 2005), *aff'd*, 454 F.3d 532 (6th Cir. 2006).

Office of the Attorney Gen., Michigan, Op. No. 7036, 1999 WL 958531 (Oct. 18, 1999).

Michigan Attorney General concluded that under the State's Public Health Code and its Medicaid managed care program, an HMO is obligated to reimburse physicians for emergency care rendered to Medicaid recipients.

Nevada

U.S. v. APS Healthcare, Inc., No. 2:11-cv-01454-MMD-GWF, 2013 WL 420402 (D. Nev. Jan. 30, 2013).

Relator filed False Claims Act action against managed care entity, APS, which contracted to provide care management and coordination services to aged, blind, and disabled Medicaid recipients within the Medicaid fee-for-service system. The relator claimed that, among other things, APS was understaffed such that many cases sat "dormant for months," during which patients did not receive services; patients received inadequate care plans; and, to manage its backlog, APS dis-enrolled patients from disease management and care coordination services. While allegations did show that APS had not fulfilled its contractual obligations, they did not "plead a nexus between this failure and the submission of false claims." Without such a nexus, the allegations of sub-par medical services "cannot state a viable FCA claim"

New Mexico

Starko, Inc. v. Presbyterian Health Plan, Inc., 276 P.3d 252 (N.M. Ct. App. 2011).

Plaintiffs, a class of pharmacists, sued the state arguing they were not properly reimbursed for their services to Medicaid patients. The court held that the pharmacists had an implied cause of action because the statutes at issue were enacted for the benefit of the pharmacists. Furthermore, entering into contracts with MCOs did not result in pharmacists waiving claims to be paid according to Medicaid rates instead of lower MCO rates.

Subsequent History: Petition for writ of certiorari granted in New Mexico Supreme Court.

Previous decision: Starko, Inc. v. Gallego, 140 P.3d 1085 (N.M. App. 2006) (rejecting due process claim under 42 U.S.C. § 1983 against Medicaid officials who approved MCO contracts).

Families and Youth Inc. v. Maruca, 156 F. Supp. 2d 1245 (D.N.M. 2001).

Managed care providers and consumers challenged the state and federal agencies' proposed change from delivering and paying for behavioral health services under Medicaid managed care program to fee-for-services system. The court dismissed the plaintiffs' claim based on the doctrine of mootness, "prudential" or "remedial" mootness, and ripeness. The court held that the complaint was moot because HCFA extended the managed care system in New Mexico, prudentially moot because the government was in the process of changing its policies such that any actions in question is unlikely, and not ripe because there was no controversy without the waiver.

Hyden v. N.M. Human Servs. Dept., 16 P.3d 444 (N.M. Ct. App. 2000).

Plaintiff' filed suit because request for treatment by out-of-network physicians employing non-conventional allergy therapy after MCO had offered in-network conventional therapy was denied without a hearing. The court held that plaintiff was entitled to a fair hearing because her Medicaid MCO's offer of medical services that were ineffective or even harmful on a "take-it-or-leave-it" basis was equivalent to denying services.

Ward v. Presbyterian Healthcare Servs., 79 F. Supp. 2d 1276 (D.N.M. 1999).

Plaintiff brought negligence action against Medicaid MCO for failure to provide behavioral health services to plaintiff's daughter. Plaintiff argued that MCO was negligent per se because it did not follow Medicaid statutory requirements governing MCOs. But court granted defendant's motion to dismiss stating that the requirements in 42 U.S.C. § 1396u-2 did not establish a standard of conduct for MCOs.

New York

Cmty. Healthcare Assoc v. New York State Dep't of Health, No. 10-cv-08258, 2013 U.S. Dist. LEXIS 14429 (S.D.N.Y. Feb. 1, 2013).

Out-of-network FQHCs who provided services to Medicaid managed care enrollees challenged state's policy of refusing to reimburse FQHCs for these

services. Court granted summary judgment for FQHCs on this claim as the state's practice violated the plain terms of 42 U.S.C. § 1396a(bb)(2). The cost of these services must fall on either the state or the MCO. Even if the state chooses to delegate responsibility for payments, as New York did, and MCOs are not compliant, the State must provide payment to the FQHC and then enforce its contract with the MCO.

Cmty. Health Care Ass'n of N.Y. v. DeParle, 69 F. Supp. 2d 463 (S.D.N.Y. 1999).

The plaintiff providers sued state, federal, and county health officials, alleging that the officials failed to provide them reasonable cost reimbursement under the county's Medicaid managed care contract in violation of 42 U.S.C. § 1396b(m)(2). The state and federal defendants were dismissed on Eleventh Amendment and mootness grounds, respectively. The court granted plaintiff's motion for summary judgment against the county because the county's contracts with the FQHC clearly violated reasonable cost reimbursement provisions of the Medicaid Act.

North Carolina

K.C. ex rel. Africa v. Shipman, __ F.3d __, No. 12-1575, 2013 WL 1926605 (4th Cir. N.C. May 10, 2013).

MCO contracting with the state Medicaid agency appealed adverse district court decision, but state Medicaid agency did not. The court held that the MCO may not pursue an appeal absent the state Medicaid agency's participation, because the single state Medicaid agency requirement precludes a subdivision of that agency from changing or disapproving of an administrative decision of that agency.

Jackson v. N.C. Dep't of Human Res. Div. of Mental Health, Developmental Disabilities, and Substance Abuse Servs., 505 S.E.2d 899 (N.C. Ct. App. 1998).

Plaintiffs challenged the lack of due process, notice and opportunity to be heard before an impartial decision maker regarding services rendered by Carolina Alternatives, the state Medicaid managed behavioral health care program. The case was dismissed for failure to exhaust administrative remedies and has been appealed. The court of appeals affirmed the district court's decision and held that failure to publish administrative remedies for review of denial of medical care did not alleviate the necessity of exhausting administrative remedies under North Carolina Administrative Procedure Act (NCAPA) and the remedies provided by NCAPA were adequate.

Ohio

Aetna Better Health, Inc. v. Colbert, 2012 Ohio 6206 (Ohio Ct. App. Dec. 28, 2012).

> Plaintiff MCOs, rejected for state Medicaid contracts, challenged the state's bidding process as unfair, arbitrary, and unreasonable. The Court held that the state Medicaid agency must deal in good faith with bidders for Medicaid managed care contracts. Plaintiffs did not show any evidence of that state agency acted in an unreasonable, improper or arbitrary and capricious manner.

Value Behavioral Health v. Ohio Department of Mental Health, 966 F. Supp. 557 (S.D. Ohio 1997), *vacated*, 966 F. Supp. 557 (S.D. Ohio Jul. 17, 1998).

> Plaintiff, an MCO that lost a bid for a contract to provide Medicaid services, filed suit against the state alleging violations of procurement laws. The court held that the state violated federal procurement laws, 42 U.S.C. § 1396a(a)(4) and 45 C.F.R. Part 74, by unlawfully holding unilateral discussions and disclosures with one bidder. Court rescinded the contract award to that bidder. This case also found that procurement laws are enforceable under 42 U.S.C. § 1983 by unsuccessful bidders. The judgment, however, was vacated and the appeal was dismissed on July 17, 1998.

Dayton Area Health Plan v. Ohio Dept. of Insurance, 668 N.E.2d 999 (Ohio Ct. App. 1995).

> The court held that state regulations requiring all HMOs to hold an open enrollment period once a year, during which the HMO was required to accept all commercial, non-group applicants, was not pre-empted by a federal waiver of 75/25 enrollment requirements.

Oglesby v. Barry, No. C-3-89-125 (S.D. Ohio 1989).

> Consent judgment required the Dayton Area Health Plan and the Health Plan Network to meet the 75/25 enrollment mix requirement, 42 U.S.C. § 1396b(m), and to adhere to the Medicaid due process statute, 42 U.S.C. § 1396a(a)(3), for certain denials of prior authorization.

Oklahoma

Okla. Chapter of Am. Acad. of Pediatrics v. Fogarty, 205 F. Supp. 2d 1265 (N.D. Okla. 2002), *rev'd on other grounds*, 472 F.3d 1208 (10th Cir. 2007).

> Defendant's auto-enrollment system did not violate 42 U.S.C. § 1396u-2(a)(4)(D), which requires that states assign a recipient to a provider if the recipient fails to

choose a managed care program. Court found violations of other federal Medicaid requirements including that defendants violated the “equal access” provision, 42 U.S.C. § 1396a(30)(A), by failing to set physician reimbursement rates at a rate that would attract providers to the extent they were available in the insured population. Defendants also were not promptly furnishing medical assistance in accordance with U.S.C. § 1396a(a)(8).

St. Francis Hosp. v. Foundation Health, No. 98-CV-648-K (E), 2000 U.S. Dist. LEXIS 4466 (N.D. Okla. Feb. 22, 2000).

Plaintiff hospital sought reimbursement for out-of-network emergency room services provided to the defendant HMO's Medicaid enrollees. The court denied the HMO's motion to dismiss, holding: (1) the HMO was not an arm of the state entitled to sovereign immunity from suit; (2) plaintiffs did not fail to exhaust administrative procedures; (3) abstention was inappropriate; and (4) the plaintiff had stated federal claims under 42 U.S.C. § 1396b(m)(2)(A)(vii) and 1996n(b)(4) for which relief could be granted under section 1983.

Oregon

DCIPA, LLC v. Lucille Slater Packard Children's Hospital at Stanford, 868 F. Supp. 2d 1042 (D. Or. 2011).

Court granted Medicaid managed care plans summary judgment on the issue of whether the plan fulfilled its financial obligation to a children's hospital by paying 80% of the Medicaid rate instead of the "reasonable value" of billed charges.

Nichols v. Office of Med. Assistance Programs, 15 P.3d 578 (Or. Ct. App. 2000).

Plaintiff, Medicaid HMO enrollee, sought an administrative hearing to challenge two changes to the bed she used. Agency ruled that bed changes were not actions that entitled plaintiff to a hearing. The court reversed and determined that equipment changes were "actions" by the HMO to change plaintiff’s home health services and plaintiff was therefore entitled to notice and hearing.

Pennsylvania

Medevac Midatlantic, LLC v. Keystone Mercy Health Plan, 817 F. Supp. 2d 515 (E.D. Pa. 2011).

An emergency service provider failed to state a claim under 42 U.S.C. § 1983 claim against an MCO plan for denying payment for emergency air services. The emergency service provider was not a third party beneficiary to the contract between Pennsylvania agency and the MCO.

Trs. of the Univ. of Pa. v. Americhoice of Pa., Inc., No. 4392, 2007 Phila. Ct. Com. Pl. LEXIS 16 (Phila. Ct. Com. Pl. Jan 23, 2007).

> Providers sued Medicaid MCO over reimbursement rates for emergency services provided by out-of-network providers. Pennsylvania Act 68 requires that the reimbursement rate for non-contract emergency services equal to "reasonably necessary costs." Act 68 does not mandate the use of the Medicaid rate. Calculating "reasonably necessary costs" is a factual determination and cannot be prescribed as a matter of law.

Pa. Pharmacists Ass'n v. Houstoun, 283 F.3d 531 (3rd Cir. 2002), *cert. denied*, 547 U.S. 821 (2002).

> The court held that pharmacists, Medicaid providers contracting with HMOs, could not assert a claim under § 1983 that state's Medicaid reimbursement plan violated § 1396a(a)(30)(A). Medicaid recipients, however, can bring a claim against the state Medicaid program provided that low reimbursement rates affect the "quality of care" and threaten access requirements.

Kirk T. v. Houstoun, No. 99-3253, 2000 WL 830731 (E.D. Pa. June 27, 2000*), Kirk T. ex rel. Deborah T. v. Houstoun*, NO. 99-3253,1999 WL 820201 (Sept. 28, 1999).

> Plaintiffs challenged the lack of reasonably prompt services for children with severe behavioral, emotional and/or psychiatric disabilities and the failure of defendant to assure an adequate network of mental health providers. Plaintiff successfully demonstrated that services are not being provided and the court granted summary judgment on the issue of whether MCOs are providing prompt behavioral health and TSS services, in accordance with 42 C.F.R. § 434.52.

Anderson v. Houstoun, No. 97-CV-3808 (E.D. Pa. Apr. 1, 1998), reprinted in Medicare & Medicaid Guide (CCH) ¶ 46,311.

> Individuals with disabilities filed Americans with Disabilities Act claim against Medicaid agency, alleging lack of access to services. The court found that the Medicaid agency had failed to assure that Medicaid-contracting HMOs have facilities that are accessible to individuals with mobility impairments or to provide information to managed care enrollees in alternative formats.

Metts v. Houstoun, No. 97-CV-4123, 1997 WL 688804 (E.D. Pa. Oct. 24, 1997), *settlement*, No. 97-CV-4123 (E.D. Pa. Mar. 27, 1998).

> Settlement agreement strengthened numerous due process protections when managed care plans deny, reduce, or terminate outpatient services, including equipment and supplies, and prescription medications.

Woolfolk v. Duncan, 872 F. Supp. 1381 (E.D. Pa. 1995).

> Plaintiff sued his managed care plan, HealthPass, for refusing to provide medical care after he tested HIV-positive. The court denied defendant's motion for summary judgment. The case suggests that a managed care plan may be liable for the discrimination by the provider network.

Scott v. Snyder, No. 91-CV-7080 (E.D. Pa. Nov. 27, 1995) (stipulation) (available from NHeLP).

> Stipulation and settlement contains outreach initiatives and performance standards and measures that the Medicaid agency will undertake to assure that persons under age 21 obtain EPSDT services, including specifically children enrolled in capitated managed care plans.

Brinson v. Department of Public Welfare, 641 A.2d 1246 (Pa. Commw. Ct. 1994).

> The court held that the state's implementation of a Medicaid managed care program without publishing rules pursuant to the state's Administrative Procedure Act did not violate the APA. The Court found the state did not interpret any section of law but merely exercised the authority it already possessed to enter into managed care plans on behalf of beneficiaries.

Puerto Rico

Rio Grande Cmty. Health Ctr., Inc. v. Rullan, 397 F.3d 56 (1st Cir. 2005).

> FQHC brought action under 42 U.S.C. § 1983 to enforce 42 U.S.C. § 1396a(bb), which requires that states supplement MCO payments to FQHCs when the MCO payment is below the Prospective Payment System rates. These payments are called "wraparound payments." The Court held that the statutory provision is enforceable, and affirmed a preliminary injunction requiring Puerto Rico to provide wraparound payments to FQHCs as they become due.

Tennessee

John B.

Plaintiffs challenged failure of Medicaid managed care program to provide EPSDT services. Parties reached a settlement.

- Settlement order included: improving outreach and informing (including targeted informing of at risk groups), updating and implementing statewide periodic screening requirements to identify both physical and mental health problems; clear definition of medical necessity, and enhanced measurements of performance. *John B. v. Menke*, No. 3-98-0168 (M.D. Tenn. Aug. 28, 1998).
- In litigation to enforce the consent decree, the court held that the State's managed care system failed to adequately meet EPSDT requirements mandated by federal law and the consent decree because TennCare did not acquire essential providers and tertiary pediatric care centers and failed to adopt outreach strategies and screening guidelines. *John B. v. Menke*, 176 F. Supp. 2d 786 (M.D. Tenn. 2001).
- Defendants moved to vacate the consent decree based on intervening cases in the 6th Circuit where the 6th Circuit held that the court must examine each provision of a consent decree in order to determine whether that provision is privately enforceable. (citing *Westside Mothers II* and *Brown v. Tenn. Dep't of Finance and Administration*). The court vacated the consent decree's requirement that the availability of services is geographically comparable based on *Westside*'s holding that 1396a(a)(30) is not privately enforceable. The court left open the following questions for district court on remand: (1) does the prior holding that under §§1396a(a)(8) and (10) the state only has obligation to pay for services, rather than provide them, apply to §1396a(a)(43)? (2) Does the *Westside Mothers II* holding that the requirement against waitlists is not privately enforceable extend to the waitlist provision in § 1396a(a)(43)(C)? (3) 1396a(a)(43)(A) is privately enforceable. Is the remainder of 1396a(a)(43) privately enforceable? *John B. v. Goetz*, No. 09-6145 (6th Cir. Dec. 16, 2010).
- On remand, the district court held that 1396a(a)(43)(B) and (C) are privately enforceable, and that their application is unaffected by the Sixth Circuit's holding in *Westside Mothers II* so that Tennessee is required to provide and pay for services. Paragraphs of the consent decree based on those provisions are also enforceable. The Court finds that several paragraphs of the Consent Decree should be vacated as a result of the 6th Circuit's decision, but that the majority of the Consent Decree should remain in effect. *John B. v. Emkes*, 852 F. Supp. 2d 944 (M.D. Tenn. 2012).
- Court finds that Tennessee has met the terms of the consent decree and grants the motion to vacate. *John B. v. Emkes*, 852 F. Supp. 2d 957 (M.D. Tenn. 2012).
- 6th Circuit affirms the district court's decision to vacate the consent decree. *John B. v. Emkes*, 710 F.3d 394 (6th Cir. Tenn. 2013).

Crabtree v. Goetz, No. 3:08-0939, 2008 U.S. Dist. LEXIS 103097, 21 Am. Disabilities Cas. (BNA) 1103 (M.D. Tenn. Dec. 18, 2008).

Medicaid beneficiaries receiving home health care services through Medicaid MCOs challenged cuts to these services under the Americans with Disabilities Act and Section 504 of the Rehabilitation Act, alleging cuts would result in institutionalization and state had failed to make individualized determinations of medical necessity. Court granted preliminary injunction to prevent cuts and rejects the state's cost-defense citing the fact that MCOs are generating administrative costs that represent half of the Plaintiffs' health care costs.

Grier

Class-action litigation began in 1979 on behalf of present and future Medicaid patients who asserted that the Medicaid program failed to provide them with adequate notice and procedural protection upon denial of their claims. The parties entered into several consent decrees, beginning in 1986 and another in 1992. In 1994 Tennessee converted its Medicaid program to a managed care program called TennCare.

- In 1995 plaintiffs filed motions to modify the consent decree because TennCare was being administered in a manner inconsistent with the decree. The court held that actions taken by MCOs to deny or terminate eligible Medicaid recipients' covered health plan services constituted state actions that triggered federal due process notice and hearing requirements, 42 U.S.C. § 1396a(a)(3) and 42 C.F.R. § 431.200 *et seq. Daniels v. Wadley*, 926 F. Supp. 1305 (M.D. Tenn., May 15, 1996).
- Sixth Circuit vacated this holding, stating that the district court should never have reached the question of whether an MCO is a state actor. *Daniels v. Mencke*, 145 F.3d 1330 (6th Cir. Tenn. 1998).
- The court held that new HMOs that contract with the State of Tennessee are bound by the revised consent decree. Although HMOs did not participate in the litigation when the revised consent decree was entered, they are obligated to adhere to the revised consent decree due to contractual principles. *Tenn. Ass'n of Health Maint. Orgs., Inc. v. Grier*, 262 F.3d 559 (6th Cir. 2001).
- Parties again revised the consent decree, in response to budget crisis in TennCare program. Although the court allowed some cost-saving mechanisms such as preferred drug list and prior authorization, the court included numerous provisions to improve and protect due process rights of individuals enrolled in the TennCare managed care program. *Grier v. Goetz*, 402 F. Supp. 2d 871 (M.D. Tenn. 2005).

Hamby v. Neel, 368 F.3d 549 (6th Cir. 2004).

> Beneficiaries filed suit alleging notices did not comply with statutory requirements and constitutional due process. The court held that, though notices adequately informed Plaintiffs of TennCare's denial of their applications, the notices violated due process rights because they failed to inform Plaintiffs that (1) their applications were denied because they were not considered uninsurable persons; (2) their applications were rejected because the applications were incomplete due to a lack of proof of a previous insurance denial; (3) if an appeal of a denied application was not pursued, applicants would be barred from a claim of benefits originating from the date of their original applications; and (4) if applicants did submit new applications with insurance denial letters, the second claim would cut off eligibility based on the first applications.

River Park Hosp., Inc. v. Bluecross Blueshield of Tenn., Inc., 173 S.W.3d 43 (Tenn. Ct. App. 2002).

> After hospital and Medicaid MCO failed to renew a contract, hospital sought reimbursement from the MCO for services provided to MCO enrollees. MCO reimbursed the hospital at the rate previously established in the lapsed contract. Court held that under Tennessee law, hospital was entitled to a higher reimbursement rate and remanded to the trial court to determine a "reasonable rate" for services provided.

Brandie Hinds v. Blue Cross and Blue Shield of Tennessee, No. 3:95‑0508 (Dec. 28, 1995).

> The court held that a bowel or bowel and liver transplant service (including all pre‑ and post‑transplant care and services and transportation for the plaintiff and her legal guardian to the University of Pittsburgh) to be medically necessary and ordered the BC/BS Managed Care Organization to provide the service. The Court relied upon the federal EPSDT requirements, 42 U.S.C. § 1396d(r)(5), and also found plaintiff had standing as a third party beneficiary to enforce specific contract provisions between BC/BS and TennCare regarding covered services.

Tennessee Medical Association (TMA) v. Manning, No. 01-A-01-9410, 1995 WL 228681 (Tenn. App. Apr. 19, 1995).

> TMA alleged violations of federal laws regarding payment methodology, 42 U.S.C. § 1396b(m), and state Administrative Procedure Act violations regarding the adoption of MCO payment rates. The court dismissed the suit, alleging that TMA lacked standing to bring a private cause of action because the case involved payments from the state to MCOs, not to providers.

Linton v. Comm'r of Health & Env't, 65 F.3d 508 (6th Cir. 1995), *aff'g*, *Linton v. Carney*, 779 F.Supp. 925 (M.D. Tenn. 1990).

> Tennessee policy restricting the number of beds in nursing home available to Medicaid patients was found to violate Medicaid statutes as well as to have a disparate impact on minorities and in violation of Title VI of the Civil Rights Act of 1964.

Daniels v. White, No. 79-3107-NA-CV (M.D. Tenn. June 16, 1994).

> The court refused to apply traditional Medicaid rules to newly eligible uninsured individuals under the state's waiver program. Specifically, the court held that the state did not have to undertake automatic redetermination of eligibility for plaintiffs eligible for coverage under the expansion program. In so doing, the court noted its "skepticism" that the TennCare waiver project was subject to the statutes relied on by plaintiffs, 42 U.S.C. §§ 1396a(a)(8) and 1396a(a)(19).

Texas

El Paso Healthcare Sys. v. Molina Healthcare of N.M., Inc., 683 F. Supp. 2d 454 (W.D. Tex. 2010).

> Provider challenged Medicaid MCO's underpayment for emergency outpatient services. The court denied motion for summary judgment because there were material issues of fact about whether a contract existed. The court determines that the payment amounts are determined by New Mexico regulations and are based on Medicare allowable costs

Hawkins v. El Paso First Health Plans, Inc., 214 S.W.3d 709 (Tex. App. 2007).

> MCOs filed suit, alleging that underweight birth infants eligible for SSI and therefore ineligible for managed care must be disenrolled. The court held that the state has an obligation to retroactively disenroll the child from the MCO to the date that the child became eligible for SSI.

Methodist Hosps. of Dallas v. Amerigroup Tex., Inc., 231 S.W.3d 483 (Tex. Ct. App. 2007), *aff'g*, No. 04-032450G, 2005 WL 4927522 (Tex. D.Ct. Sept. 15, 2005).

> The court held that when a patient became eligible for SSI and was disqualified for mandatory participation in the HMO, the HMO did not have an obligation to pay for care delivered after patient's Medicaid eligibility was terminated.

Frew

Class action litigation initiated in 1993 on behalf of all Medicaid-eligible children under age 21 in Texas. Plaintiffs alleged failure to provide EPSDT services. A consent decree was entered in 1996. Plaintiffs brought subsequent litigation to enforce the terms of the consent decree.

- *In 1998 plaintiffs moved to enforce the decree and the state countered that the decree was unenforceable. The district court found that Texas had violated various parts of the consent decree.* Specifically, the court concluded that Medicaid managed care plaintiffs receive poor and incomplete checkups, many providers do not receive sufficient training to assist EPSDT patients, and Texas inflates data on managed care patients' checkups. *Frew v. Gilbert*, 109 F. Supp. 2d 579 (E.D. Tex. 2000).
- *Defendants appealed the district court's decision. In 2003, on appeal to the Supreme Court, the court held that the decree was enforceable because it addressed federal interests, even if elements of the decree were not specifically mandated by the Medicaid Act. The case was remanded to the district court for continued enforcement. Frew v. Hawkins, 540 U.S. 431 (2003).*
- *Defendants moved to dissolve consent decree in its entirety or in the alternative for areas of the state under managed care plans. Court denied the motion because defendants failed to present evidence of changed circumstances. Frew v. Hawkins*, 401 F. Supp. 2d 619, 676-81 (E.D. Tex. 2005).

Yuchnitz v. PCA Health Plan of Tex., Inc., No. 3-99-00130, 2000 WL 12960 (Ct. App. Tex. Jan. 6, 2000).

> Plaintiff, an optician and "significant traditional provider" of Medicaid services, was excluded from Medicaid MCO's provider network. The court finds that the contract between the MCO and the Texas Department of Health did not intend the plaintiff to be a third party beneficiary, rejecting his argument that the MCO was obligated to include plaintiff in network by the terms in the contracts with the state.

Virginia

Healthkeepers, Inc. v. Richmond Ambulance Auth., 642 F.3d 466 (4th Cir. Va. 2011).

> MCO sought declaratory judgment about the rate owed for ambulance services provided to Medicaid MCO enrollee, absent a contract between the MCO and ambulance provider. The court interpreted § 1396u-2(b)(2)(B) to include ambulance services as part of "outpatient" emergency services. Therefore, under

§ 1396u-2(b)(2)(B) the MCO must only pay the rate outlined by the state Medicaid agency for the services.

Washington

Columbia United Providers, Inc. v. Washington, No. C12-5174BHS, 2012 U.S. Dist. LEXIS 58105 (W.D. Wash. Apr. 25, 2012).

MCOs, rejected in the State's Medicaid bidding process, alleged that the bidding process was unfair and violated state and federal laws. Court denied preliminary injunction finding that (1) the state received assurances from selected MCOs at time of contracting that provided "adequate assurances" of network capacity and (2) the MCOs had certified that their bids were "actuarially sound."

West Virginia

Sanders v. Lewis, No. 2:92-0353, reprinted at Medicare & Medicaid Guide (CCH) ¶ 43,590 (S.D.W. Va. Mar. 1, 1995).

The court granted summary judgment for plaintiffs and ordered the Medicaid agency to implement a compliance plan to assure that children in out-of-home placement obtain EPSDT services. Part of the relief in this case included a provision requiring the state to meet and confer with plaintiffs' counsel if it was considering implementing managed care through § 1915(b) or § 1115 waivers in a manner that would affect the plaintiff class.

Wisconsin

Amundson et al., v. Wis. Dep't of Health Servs., No. 12-cv-609-bbc (W.D. Wis. Jan. 23, 2013)

Plaintiffs, a class of individuals with developmental disabilities who live in group homes operated by Medicaid MCOs, brought a § 1983 suit challenging budget cuts to the group home program. Plaintiffs alleged several violations of the Rehabilitation Act, ADA and the due process requirements under Medicaid. The court granted defendants motions to dismiss because plaintiffs had failed to state a claim upon which relief could be granted. Disparate treatment of individuals with different types of disabilities is not a violation of the Rehabilitation Act or the ADA. Furthermore the Medicaid agency is immune from suit on the due process claims under the Medicaid Act.

Nelson v. Milwaukee County, No. 04C0193, 2006 WL 290510 (E.D. Wis. Feb. 7 2006).

Plaintiffs, a class of adults with disabilities brought a class action alleging that the state Medicaid agency was discriminating against them by inadequately compensating service providers and managed care organizations. Plaintiffs' claims survived motion to dismiss because the plaintiffs' claims that the state discriminated based on severity of disability sufficiently allege differential treatment by reason of disability. Plaintiffs also successfully alleged that funding cuts could force plaintiffs into more restrictive settings, that state has an obligation to provide reasonable accommodations and that capitated payments are insufficient to attract providers, thereby violating Medicaid's equal access requirements.

Later decision: Bzdawka v. Milwaukee County, 238 F.R.D. 469 (E.D. Wis. 2006) (certifying class)