



Ensuring that Assessment Tools are Available to Enrollees

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The amount of Medicaid services for enrollees, particularly home and community based services, is increasingly being determined through prior authorization processes that use assessment tools and clinical coverage criteria. These assessment documents may not be made available to the enrollee. However, Medicaid law and due process call for disclosure—whether the decision is made by the Medicaid agency or an entity with which the agency has contracted (e.g., a managed care company or third party administrator).

Discussion

State Medicaid agencies are increasingly entering into contracts that provide for an entity other than the agency to make decisions about the amount of services that enrollees can receive. These entities may be public, for instance the state division of developmental disabilities, or private, for instance a managed care organization.

State Medicaid agencies and their contractors are also increasingly relying on assessment tools to make coverage decisions. Typically, these tools and criteria are “products” sold to the entity by private companies that contract with, and in some instances issue use licenses to, State agencies and their contractors. And while associated with Medicaid home and community based services, use of assessment tools is becoming pervasive—affecting everything from the length of a hospital stay to whether a child has a handicapping malocclusion that requires orthodontia.¹

Problems arise when enrollees and beneficiary advocates are refused access to the assessment tools and/or the procedures that are used to apply the tool in a particular case. Sometimes the enrollee will be told their score but receive no explanation of where the score comes from or what it means. In other cases, the notice of denial is silent as to the existence of the scoring system, which may or may not come to light if the enrollee decides to appeal the decision. In some states, the managed care company may have a licensing agreement that contains a non-disclosure clause that is then cited to refuse a request for disclosure. In some cases, the state or its contractors claim that their assessment tools and the criteria for applying them are trade secrets.

¹ For information about federal assessment requirements and selected state assessment tools, see David Machledt, National Health Law Program, *Fact Sheet: Medicaid Assessments for Long-Term Supports and Services* (May 5, 2015), http://www.healthlaw.org/publications/browse-all-publications/medicaid-assessments-for-LTSS#.VbEpQ_IWKts.

These practices are inconsistent with policies that should govern the transparent use of public funds. And, as described in this Q&A, they create serious Medicaid and due process problems. Without access to the decisional criteria, an enrollee cannot determine whether the decision making process complied with federal or state Medicaid coverage requirements. Enrollees cannot know whether the assessment tool is even appropriate for use in their case (*e.g.*, a parent does not know whether the tool has been tested and validated for coverage decisions regarding children, or the assessment tool may be validated for deciding an individual's limitations in activities of daily living but not the amount of services that the individual needs as a result). Absent disclosure, an individual who has been denied coverage cannot adequately prepare evidence and witnesses to refute the decision.

Background legal principles

Regardless of the contracting arrangements being used by the state, under federal law the state Medicaid agency is the "single state agency" responsible for assuring the proper implementation of Medicaid law, regulations, and guidelines. That authority cannot be delegated or impaired. See 42 U.S.C. § 1396a(a)(5); 42 C.F.R. § 431.10(e). See, *e.g.*, *K.C. ex rel. Africa H. v. Shipman*, 716 F.3d 107, 119 (4th Cir. 2013) (noting federal law requires the single state agency, not managed care plans, to be responsible and concluding, "One head chef in the Medicaid kitchen is enough."); *Hillburn v. Maher*, 795 F.2d 252, 261 (2d Cir. 1986) (noting that the single state agency requirement derives from the desire to focus accountability for program operation); *J.K. v. Dillenberg*, 836 F. Supp. 694 (D. Ariz. 1993) (finding state action and that due process rights were implicated when managed care organizations decided requests for behavioral health services). The single state agency requirement means that, if guidelines are being kept secret by the state or its contractors in violation of the law, the state Medicaid agency has the legal responsibility to correct the problem.

Importantly, the single state agency must ensure compliance with the due process requirements established in Medicaid law, see 42 U.S.C. § 1396a(a)(3) (requiring "opportunity for a fair hearing before the State agency to an individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness"); 42 C.F.R. § 431.200 *et seq.*; 42 C.F.R. § 438.400 *et seq.* (regarding Medicaid managed care); CMS, *State Medicaid Manual* § 2900 *et seq.* See also Medicaid and CHIP Programs; Medicaid Managed Care, 80 Fed. Reg. 31,098, 31,283-85 (June 1, 2015) (proposed rules concerning grievances and appeals in Medicaid managed care, to be codified at 42 C.F.R. §§ 438.400-438.424).

Medicaid regulations provide that the agency must inform the applicant or beneficiary in writing of his right to a hearing "at the time of any action affecting his or her claim." 42 C.F.R. § 431.206(c)(2). The notice must contain, among other information, "the reasons for the intended action." *Id.* at § 421.210(b). Regulations define an "action" as a "termination suspension, or reduction of Medicaid eligibility or covered services," *Id.* at § 431.201. Numerous courts have applied these rules to

require states and contracting entities to correct deficient notice procedures. See, e.g., NATIONAL HEALTH LAW PROGRAM, THE ADVOCATE'S GUIDE TO THE MEDICAID PROGRAM 2.23 & n. 380-82 (May 2011 and Oct.2012 Supp.) (citing cases).

The Medicaid regulations also include fair hearing requirements. Among other things, a claimant must have an opportunity to examine his or her case file, as well as the documents and records that will be relied upon at the hearing by the agency. 42 C.F.R. § 431.242(a)(1) At the hearing, the claimant must be allowed to present witnesses, establish facts, present argument, and cross-examine adverse witnesses. *Id.* at § 431.242(b)-(e). The fair hearing decision can be based exclusively on the evidence introduced at the hearing. *Id.* at § 431.244(a).

As noted above, these protections apply even if the state has delegated a decision-making role to a private entity. There are also express regulatory protections that arise in managed care settings. Among other things, the state or its contractor must ensure that potential enrollees receive summary information about benefits covered “but the State must provide more detailed information upon request.” 42 C.F.R. § 438.10(e)(2)(ii). The enrollee or potential enrollee should get this information within a timeframe to use it in choosing among available health plan alternatives. *Id.* at § 438.10(e)(1)(ii). Importantly, when a managed care entity is using practice guidelines, they are supposed to disseminate them “to all affected providers and, upon request, to enrollees and potential enrollees.” 42 C.F.R. § 438.236(c). Taken together, these provisions should require managed care entities and the state to provide specific information about the assessment tools and coverage criteria that are used to decide which benefits are covered.

In addition to statutory and regulatory protections, Medicaid beneficiaries have constitutional due process rights. The Supreme Court has long held there is a right to prior notice and a meaningful opportunity to be heard when an individual is in jeopardy of a serious loss of benefits, such as medical care. See *Mathews v. Eldridge*, 424 U.S. 319, 348 (1976); *Goldberg v. Kelly*, 397 U.S. 254 (1970). These rights are grounded in the due process clause of the U.S. Constitution, U.S. Const. amend. XIV, § 1. As explained by *Goldberg*, there are five irreducible constitutional protections for Medicaid enrollees when state action is being taken to deny, reduce or terminate Medicaid: (1) a meaningful notice stating the basis for the action and, when coverage is to be reduced or terminated, a pre-termination notice informing the claimant of their right to continue benefits pending a final administrative decision, (2) the opportunity for a fair hearing during which the claimant can confront and cross-examine the witnesses and evidence relied on by the agency, (3) the right of the claimant to be represented by counsel, (4) an impartial decision maker, and (5) a reasoned decision, based solely on evidence adduced at the hearing. 397 U.S. at 269-71. See 42 C.F.R. § 431.205(d) (requiring Medicaid hearing system to comply with *Goldberg*). A number of court cases decide the constitutional requirements for due process when Medicaid services are denied, reduced or terminated. For example, the Third Circuit decided “the extent of a pre-hearing notice required to be given ... under the due process clause” and required notices that, at a minimum,

Provide a detailed individualized explanation of the reason(s) for the action being taken which includes, in terms comprehensible to the claimant, an explanation of why the action is being taken ...and ... if calculations of income or resources are involved, set forth the calculations used by the agency....

Ortiz v. Eichler, 794 F.2d 889, 892, 896 (3d Cir. 1986). See, e.g., NATIONAL HEALTH LAW PROGRAM, THE ADVOCATE’S GUIDE TO THE MEDICAID PROGRAM at 2.23 & n. 379 (May 2011 and Oct.2012 Supp.) (citing cases).

Due process also requires state agencies to use “ascertainable standards” in gauging eligibility for a program or benefit. *Holmes v. New York City Hous. Auth.*, 398 F.2d 262, 265 (2d Cir. 1968). A number of courts have cited *Holmes* to support requirements that public benefit agencies avoid ad hoc decision making by adopting and administering ascertainable standards. See, e.g. *Casey v. Quern*, 588 F.2d 230, 232 (7th Cir. 1978); *Strouchler v. Shah*, 891 F. Supp. 2d 504, 515-16 (S.D. N.Y. 2012) (“[D]ecisions regarding entitlements to government benefits [must] be made according to ascertainable standards that are applied in a rational and consistent manner.”)(citation omitted); *Pressley Ridge Sch., Inc. v. Stottlemeyer*, 947 F. Supp. 929, 940 (S.D. W.V. 1996) (same). *Accord Hallmark Cards, Inc. v. Kansas Dep’t of Commerce & Hous.*, 88 P.3d 250, 257 (Kan. App. 2004) (noting that due process requires the agency distributing statutory benefits demonstrate that its standards of eligibility are “objective and ascertainable” and that they are applied “consistently and uniformly”). But see *Lightfoot v. District of Columbia*, 448 F.3d 392, 401 (D.C. Cir. 2006) (refusing to follow *Holmes*).

Recent Medicaid case examples

Assessment tools in Idaho

K.W. ex rel D.W. v. Armstrong was filed by enrollees in a home and community based waiver for individuals with intellectual disabilities. The Idaho Department of Health and Welfare calculates an annual budget for each waiver participant, and payments for the participant’s services must come within that budget. Assessment providers hired by the Department visit with the participant to evaluate their disability and needs (e.g., medications, activities of daily living) using a form called an “Inventory of Individual Needs.” The assessment provider fills the form out by hand and then enters the information into a computerized form called an “Individualized Budget Calculation.” Budget software automatically runs a spreadsheet that lists all of the participant’s need categories and their corresponding dollar amounts and produces the annual assigned budget amount. The software generates a notice that is sent to the participant informing them of the annual budget. The participant and their caseworker then develop a service plan that must come within the budget. Thereafter, the participant receives a Service Plan Notice informing him of what services were approved or denied and of his right to appeal.

The *K.W.* class challenged this process as violating their Medicaid and constitutional entitlements to adequate notice, and a preliminary injunction was entered. Following entry of the injunction, the Medicaid agency developed several notices in an effort to get the case dismissed. The agency ultimately filed a notice with the court and asked that it be approved. This notice stated the budget amount, attached a copy of the spreadsheet, and included a section that explained that the budget could have changed because “laws, rules, or tools may have affected your budget” and also stated that the budget had changed because of “a combination” of changes in the Inventory of Individual Needs, changes in the Medicaid budget tool, and changes in Idaho law. 298 F.R.D. 479 (D. Idaho 2014). Not surprisingly, the court rejected the notice as inadequate, stating: “Read as a whole, this notice gives participants nothing more than the general explanation that several factors may have affected their individual budgets.” *Id.* at 490. The Department had argued that it provided the particulars to individuals because it attached the completed spreadsheet, which the individual could review to figure out what changed. However, the court found this “burden shifting is impermissible” because “[i]n the end, the participant is left to do the math and hope his post hoc analysis matches the analysis actually employed by IDHW.” *Id.* at 491.

Interestingly, the Department recently appealed this case to the Ninth Circuit, challenging the district court’s ruling that the calculation of new budgets is an “action” under the Medicaid regulations 42 C.F.R. § 431.201. The Department argued that the budget itself did not result in the “termination, suspension, or reduction” of any Medicaid services and, thus, did not meet the regulatory definition. The Ninth Circuit rejected the argument. It noted that the amount of waiver services is capped by the individual’s budget under Idaho law, Idaho Code § 56-253(3), and that services must be reduced or denied to bring the cost of the service plan within the budget: “[A]s a practical matter, calculating a lower budget decreases a participant’s Medicaid services, thereby triggering the notice requirements of the Medicaid regulations.” _ F.3d _, 2015 WL 3529727, at *7 (9th Cir. June 5, 2015). The Ninth Circuit also affirmed the preliminary injunction under the due process claim, holding that waiver participants have a property interest in their current budget and rejecting the Department’s argument that participants could have no expectation that their budgets would continue beyond a year because, under Idaho law, the budgets are recalculated annually. *Id.* at *12.

Clinical coverage guidelines in the District of Columbia

In *Salazar v. District of Columbia*, the plaintiffs sought discovery of the Interqual clinical coverage guidelines for in-home services as part of their duty as class counsel to monitor compliance with a settlement order. The Interqual Criteria are evidence-based treatment standards developed and copyrighted by McKesson, which, in turn, has licensed their use to HSCSN, a DC-based managed care organization. HSCSN uses the Interqual Criteria to authorize, re-authorize, and terminate home health, private duty nursing, and personal care services being prescribed for children enrolled in Medicaid.

HSCSN and McKesson refused to provide the criteria, claiming that they were

protected by the D.C. Uniform Trade Secrets Act and the federal Copyright Statutory Scheme, 17 U.S.C. § 101 et seq. However, finding “no authority for the proposition ... that the federal copyright laws and local trade secret laws trump the federal Medicaid statute and regulations,” the Court ordered disclosure. 596 F. Supp. 2d 67, 69 (D.D.C. 2009), *reconsid. granted in part & denied in part*, 750 F. Supp. 2d 65 (D.D.C. 2010) (quoting 42 C.F.R. § 438.10(f)(6)(v), which entitles individuals to information about the amount of benefits and the “procedures for obtaining benefits, including authorization requirements,” to be provided “in sufficient detail to ensure that enrollees understand the benefits to which they are entitled”). The Court reasoned that it would be “patently irresponsible” to presume that Congress would permit D.C. to disclaim its responsibility to ensure enforcement of these laws by contracting away its obligations to MCOs, such as HSCSN, or their licensors, such as McKesson. 596 F. Supp. 2d at 69-70 (citations omitted).

While rejecting the defendant’s arguments for nondisclosure, the Court was sensitive to McKesson’s business interests. The Interqual review methodology and criteria sets are peer-reviewed and copyrighted, and at the time of the discovery motion, McKesson licensed use of the criteria to more than 4000 health plans, hospitals, government agencies and MCOs. 750 F. Supp. 2d at 67-68.

On the other hand, the Court recognized that the plaintiffs have an obligation to monitor compliance with the settlement and need to know what criteria HSCSN relies upon to make treatment decisions. The Court also clearly persuaded by the particular challenges that parents and caretakers of children with special needs face:

[I]t is essential for them to know what criteria HSCSN relies upon in making its decisions about authorization, as well as termination, of services for children with special needs. Without knowing these criteria, beleaguered caretakers of these children cannot effectively advocate for the services to which they are entitled. Nor can they, in the absence of knowledge about the Criteria, make alternative plans to provide for their children even if they are not entitled to Medicaid benefits.

750 F. Supp. 2d at 70 (quoting 596 F. Supp. 2d at 69). The Court ordered disclosure of the Criteria subject to a protective order. In doing so, the Court specifically refused to include provisions in the order that the court found to be “far too restrictive,” including provisions that would have limited the use of the Criteria to instances of denial, limitation or termination of health care benefits for specific members of the plaintiff class, required written permission from McKesson before any release at any time, and prohibited plaintiffs from copying or duplicating the Criteria at any time. *Id.* at 69. *See generally Dep’t of Public Welf. v. Eiseman*, 85 A.2d 117 (Pa. Commw. Ct. 2014) (State Right to Know Law case finding that capitation rates paid by the Medicaid agency to managed care organizations (MCO) are financial records and not protected from disclosure as trade secrets but that MCO rates paid to dental subcontractors were confidential records protected from disclosure); *Dental Benefit Providers v. Eiseman*, 86 A.2d 932 (Pa. Commw. Ct. 2014) (State Right to Know Law case refusing to order disclosure of documents showing provider rates paid by Medicaid dental subcontractors) (on appeal).

Conclusion and recommendations

A number of action steps flow from the discussion, above:

1. If the state Medicaid agency or its contractors refuse to make vital information available in a contested case, immediately send a letter to the agency reminding it of the well-established constitutional, statutory and regulatory due process guarantees that protect Medicaid beneficiaries and give them the right to review the evidence that was used to decide their case. Remind the agency that these protections are binding on the single state agency regardless of whether it has delegated decision-making responsibilities to another entity.
2. If services are denied, reduced or terminated, the agency must ensure that the enrollee receives a written notice that complies with Medicaid and due process requirements. This means that the individual should be given detailed information at the time of the action about the use of any assessment tools or clinical guidelines that have been used to decide their services and how these tools/guidelines were applied in their specific case—with enough specificity and in a way that allows the individual to understand the basis for the action and whether/how to challenge it.
3. Be aware that, when deciding whether to require disclosure of evidence-based criteria and assessment tools, some courts may balance the commercial interests of the licensing company against the due process interests of the Medicaid beneficiary. This balancing may result in restricted disclosure, but it should not result in nondisclosure. *See Salazar*, 750 F. Supp. 2d 65.
4. Keep in mind that an agreement for purposes of a single fair hearing will not address the systemic use of secret standards. Additional advocacy may be needed to get Medicaid officials to revoke or restrict the secret policies.

