

Q&A Using Assessment Tools to Decide Medicaid Coverage: Case Developments¹

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Q: My state is using an assessment tool to make Medicaid coverage decisions for home and community based services (HCBS). Clients are reporting reductions, often drastic, in their level of approved services. They do not understand the reasons for the reductions. Our efforts to obtain detailed explanation from the state Medicaid agency have been unsuccessful. Are there examples of successful cases challenging the use of these tools?

A: Yes. Although there has not been a great deal of litigation in this area, Medicaid beneficiaries have successfully argued a variety of legal claims in their efforts to ensure fairness in the application of assessment tools.

Discussion

Background on assessments

Assessment of the individual's health condition and service needs is at the heart of the Medicaid program. In the vast majority of cases, the assessment is a seamless part of the individual's visit to the health care provider and payment to the provider for services rendered. That said, the state Medicaid agency does have a role to play in determining the extent to which it will pay for services. See *Moore ex rel. Moore v. Reese*, 637 F.3d 1220 (11th Cir. 2011). Over the years, states have made their coverage decisions using various assessment tools. The tool may be administered by the Medicaid participating

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provider, a state-employed eligibility worker or case manager, or a private entity that has contracted with the state to make the determinations.

Assessment tools are an increasing part of the process for deciding the amount, duration and scope of services, including where HCBS waivers are in place. There are a number of reasons for this. Once an HCBS waiver is granted, the state must assure the federal government that it will evaluate a recipient's need for institutional services. See 42 U.S.C. § 1396n(c)(2)(B) (regarding waivers for persons with intellectual disabilities); *id.* § 1396n(d)(2)(B) (regarding waivers for the elderly). An assessment tool can accomplish this requirement. The policy climate also favors use of assessment tools because they are often developed and/or applied by private contractors. Also, the objective decision making that is produced through proper administration of an appropriate assessment tool ensures fairness when Medicaid beneficiaries are vying for enrollment in an HCBS waiver with a limited number of slots. *Cf. Ark. Dep't of Human Serv. Div. of Econ. & Med. Servs. v. Kistler*, 898 S.W.2d 32 (Ark. 1995) (reversing termination of HCBS where state had failed to establish a discernable standard for determining whether the recipient had a qualifying disability).

The needs assessment can be a single or a multi-step process. Eligibility for some services, such as orthodontia for handicapping malocclusions, may be determined with a single assessment. However, decisions regarding HCBS typically require at least two steps: The threshold assessment determines "functional eligibility" – whether the individual's support needs meet or surpass the state's level of care criteria for a given institutional setting or HCBS program. The second assessment identifies the type and intensity of services an individual needs and informs care planning. Some states use distinct screening tools for each step while others embed the functional eligibility screen in a longer, comprehensive assessment. Each approach has different benefits and raises different concerns.²

Regardless of the nature of the assessment tool being used, the mandatory requirements of the Medicaid Act and other laws must be met. Not surprisingly, problems have occurred. This Q&A describes the claims for relief that are most commonly raised by improper use of assessment tool.

² For in-depth discussion of the features and uses of assessment tools and examples from the states, see David Machledt, National Health Law Program, *Medicaid Assessments for Long-Term Supports and Services* (Apr. 3, 2015) (available from TASC or NHeLP).

Legal Requirements

Rulemaking. In most states, the Medicaid agency must promulgate rules pursuant to a state Administrative Procedure Act (APA) that requires public notice and comment before the rule is implemented. While defined differently from state to state, in general, a rule is an agency statement of general applicability that implements, applies, or interprets law or policy. Depending on the state's definition, the assessment tool and supporting documents will constitute rules that are subject to the notice and comment requirements. And, rules that are not properly promulgated will be invalid and cannot be used.

Cholvin v. Wis. Department of Health & Family Services reviewed a process whereby eligibility for an HCBS waiver was determined by certified screeners using a screening instrument to conduct a face-to-face assessment of each applicant's functional level. The assessment was then scored by a computer program to decide service needs. The court found that the screening instrument included rules that should have been promulgated pursuant to Wisconsin law and remanded the case for a determination of eligibility without application of those rules. See 758 N.W. 2d 118, 126 (Wis. Ct. App. 2008); see also, e.g., *Courts v. Agency for Health Care Admin.*, 965 So.2d 154 (Fla. Dist. Ct. App. 2007) (striking state Medicaid agency's new method for reducing claimant's HCBS waiver services, finding that the reduction was due to budget problems and explaining that if an agency changes a policy, "it must either explain its reasons for its discretionary action based upon expert testimony, documentary opinions, or other appropriate evidence, ... or it must implement its changed policy or interpretation by formal rule making."); see generally *Chappell ex rel. Chappell v. Bradley*, 834 F. Supp. 1030, 1032 n. 2, as clarified, No. 91 C 4572, 1993 WL 496700 (N.D. Ill. Nov. 24, 1993) ("It is very arguable that the requirement of a [score of] 42 on the Salzmann Index in order to receive prior approval for orthodontic treatment is a rule...."). But see *Remnish v. N.D. Dep't of Human Servs.*, 756 N.W.2d 182, 188 (N.D. 2008) (affirming denial based on computerized Progress Assessment Review tools that Department's witnesses could not explain at fair hearing and that had not been promulgated as a rule, finding these were "explanatory guidelines used to aid Departmental personnel in exercising their professional judgment when applying the federally-mandated eligibility criteria.... [W]hen the eligibility criteria are set out in federal statutes and regulations, it is unnecessary to adopt a state's implementing guidelines and manual provisions as formal rules.").

Medicaid comparability. The Medicaid Act mandates that the medical assistance a state provides for any categorically needy individual "shall not be less in amount, duration, or scope" than the assistance provided to other categorically needy

individuals. 42 U.S.C. § 1396a(a)(10)(B)(i).³ Courts have consistently applied this comparability requirement, enjoining assessment programs that treat some recipients differently from others even though each has the same level of need.

Two cases from Washington illustrate. *Jenkins v. Washington State Department of Social and Health Services*, invalidated a shared living rule that automatically reduced recipients' in-home benefits by 15 percent when they lived with their paid caregivers. The shared living rule operated to reduce the base number of hours determined to be appropriate after the initial determination of benefits was made using the "Comprehensive Assessment Reporting Evaluation," or CARE, assessment tool. While the court acknowledged that the Department

may use the CARE assessment program to initially classify, rate, and determine a recipient's level of need ...[,] DHHS violates the comparability requirement when it reduces a recipient's benefits based on a consideration other than the recipient's actual need. A 15 percent reduction across the board for all recipients who live with their caregivers does not address, and in fact ignores, the realities of the recipients' individual situations.

160 Wash.2d 287, 299 (Wash. 2007); see also *Id.* at 300 ("Once a person is assessed to require and receive a certain number of care hours, the assessment cannot be reduced absent a specific showing that fewer hours are required. To 'presume' some recipients need fewer hours of care, without individualized determination violates the comparability requirement."). The holding in *Jenkins* controlled a subsequent case, *Samantha A v. Department of Social and Health Services*, 171 Wash.2d 623 (Wash. 2011). In that case, the State automatically reduced a child's personal care services, as determined by application of the CARE tool, based on the child's age and whether the child was living with their legally responsible parent. This automatic reduction was also held to violate the Medicaid comparability requirements.

EPSDT. The Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) provisions apply to children and youth under age 21. Among other things, EPSDT provides a comprehensive coverage of any service that a state must or can cover under 42 U.S.C. § 1396d(a) and requires all states to cover these benefits when they are necessary to "correct or ameliorate" a child's physical or mental conditions. *Id.* §§ 1396a(a)(43), 1396d(r)(5). The state's implementation of an assessment tool

³ Categorically needy individuals also shall not be provided with medical assistance that is less in amount, duration and scope than the assistance available to non-categorically needy individuals. 42 U.S.C. § 1396a(a)(10)(B)(ii).

program will likely violate EPSDT if it produces across-the-board service limits or reductions that do not account for the child's individual needs.

While not involving HCBS, the court's reasoning from *Chappell ex rel. Savage v. Bradley* is helpful. In that case, the Illinois Medicaid agency contracted with Delta Dental to make decisions on whether children had handicapping malocclusions requiring orthodontic treatment. The contract required Delta Dental to use the Salzman Handicapping Malocclusion Assessment Record Index ("Salzman Index") to determine whether the severity of the malocclusion warranted treatment. At first, the required score was set at 30. In subsequent years, the qualifying score was raised to 35, 40, and 42, thus resulting in fewer and fewer children qualifying for orthodontic services. These changes were mainly for monetary reasons. The court ruled that a bright-line test for orthodontic treatment utilizing the Salzman Index without regard for the child's medical necessity for the service violated the EPSDT law. 834 F. Supp. 1030, 1035 (N.D. Ill. 1993). The court also found that the Medicaid agency needed to inform children of the orthodontic services available by revising the enrollee manual, which stated that orthodontics "requires a score of 42 or above" on the Salzman Index for approval. The manual needed to inform children that, if they have a severely handicapping malocclusion needing treatment, they will be allowed orthodontic treatment no matter what their Salzman Index score. *Id.* at 1035 (citing 42 U.S.C. § 1396a(a)(43)(A)).

Medicaid and constitutional due process: Medicaid enrollees have also attacked state Medicaid agencies and their agents for making coverage decisions using assessment protocols that are not readily available to the claimant, *i.e.*, using standards that are not ascertainable. A number of cases have also been filed to require the state to adhere to the Medicaid and constitutional requirements for adequate notice and opportunity for a hearing when assessment tools cause services to be denied, reduced or terminated. A few of these cases are summarized here.⁴

In *L.S. v. Delia*, the North Carolina Medicaid agency and its contracting managed care plan implemented a functional assessment and budgeting system that resulted in dramatic reductions in approved levels of HCBS, even though enrollees' underlying behavioral health conditions had not changed. The scoring instruments were not explained to enrollees. Rather, the managed care plan was telling enrollees to meet with their case workers to develop plans of care to bring their level of services within the newly derived budget. Enrollees filed suit arguing that Medicaid law required that they be provided adequate notice of the budget decision, and constitutional due process required the defendants to disclose the assessment tools and how their scoring and

⁴ For additional discussion, see Jane Perkins, *Q&A: Ensuring that Assessment Tools are Available to Enrollees* (July 17, 2015) (available from TASC or NHeLP).

categorizations worked. The state and managed care plan argued that computation of the budget was not an “action” that denied, reduced or terminated any services and, thus, no notice was required. *L.S. v. Delia*, No. 5:11-CV-354-FL, 2012 U.S. Dist. LEXIS 43822 (E.D. N.C. Mar. 29, 2012).

The court sided with the plaintiffs, finding that the defendants were using a layered process to make decisions—assessing functional needs, placing enrollees into supports needs categories with an attendant budget, and then telling enrollees to sign new plans of care to come within the budget or lose their services altogether. According to the court, while each of these efforts might not have been an agency action itself, when viewed together, agency action was being taken. 2012 U.S. Dist. LEXIS 43822, at *43. A preliminary injunction ordered the state and managed care plan to stop reducing home and community based services and to restore lost services until the defendants complied with legal requirements for adequate due process. *Id.* at *57.⁵

K.W. ex rel. D.W. v. Armstrong addresses a similar situation in an Idaho HCBS 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 collected information is fed into a computerized form called an “Individualized Budget Calculation,” and software automatically produces a list of the participant’s need categories and an annual assigned budget amount. The software also 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.

⁵ New Medicaid regulations, effective July 2017, require managed care plans to provide enrollees with adequate notice of a decision to deny, reduce or terminate services. 42 C.F.R. § 438.404. The notice must address “the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee’s adverse benefit determination ... includ[ing] medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.” *Id.* § 438.404(b). Prior to the appeal hearing, the managed care plan must also provide the enrollee and his authorized representative, free of charge, with the case file, including medical records and any new or additional evidence considered or generated by or at the direction of the managed care plan in connection with the appeal. *Id.* § 438.402(b)(5).

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 plaintiffs and the Medicaid agency continued to dispute the adequacy of notices that the State developed in an effort to get the case dismissed. For example, one notice stated the budget amount, attached a copy of the spreadsheet, and included a section stating that the budget could have changed because “laws, rules, or tools may have affected your budget” and/or because of “a combination” of changes in the Medicaid budget tools and 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.

The Department appealed the case to the Ninth Circuit, arguing (as did the defendants in North Carolina) that the budget itself did not result in termination, suspension or reduction of any Medicaid services; thus, no “action” had occurred, and no notice was required by Medicaid regulation, 42 C.F.R. § 431.201. Rejecting the argument, the Ninth Circuit reasoned that the amount of waiver services is capped by the individual’s budget under Idaho law and that services must be reduced or denied to bring the cost of the service plan within the budget: “It was therefore reasonable for the district court to conclude that, as a practical matter, calculating a lower budget decreases a participant’s Medicaid services, thereby triggering the notice requirements of the Medicaid regulations.” 789 F.3d 962, 971 (9th Cir. 2015). The Ninth Circuit also concluded that waiver participants have a property interest in their current budget, and rejected the Department’s argument that participants had no expectation that their budgets would continue beyond a year because, under Idaho law, the budgets are recalculated annually. *Id.* at 972.

The case continues. On March 28, 2016, the district court concluded that the process for developing the budget tool—and, thus, the automated process that applies the budget tool—“arbitrarily deprives participants of their property rights and hence violates due process.” No. 1:12-cv-00022, 2016 WL 1254225, at *5, 11 (D. Idaho Mar. 28, 2016) (on file with author). The Idaho Medicaid agency built its budget tool using data from past waiver participants’ records; however, the Department was forced to discard 66% of the original sample size because of unmatched Medicaid ID numbers, missing assessment data, and missing paid claims data. The budget tool would produce an

inadequate budget for 10%-15% of participants. The district court saw the need for placing a “premium on testing the tool for accuracy and establishing a robust appeal process where the inevitable errors can be corrected.” *Id.* at *8. The court noted that the plaintiffs are “entitled to ‘such procedural protections as the particular situation demands,’” and, as a result, the Defendant must: (1) produce additional ascertainable standards to define standards being applied during the review process; (2) develop notices clearly explaining what factors the review relied upon to arrive at the budget; (3) reach out to a suitable representative—e.g., a family member, advocate, or guardian—before conducting a hearing and receive a commitment to assist the participant in the appeal; and (4) include as evidence in an appeal, the booklet completed by case workers to determine eligibility for benefits. *Id.* at *8-13; *id.* at *11 (noting concerns of copyright holder but suggesting alternatives, such as a protective order).

Finally, in *M.A. v. Norwood*, a case involving children’s in-home shift nursing services, a district court recently entered a preliminary injunction where the introduction of a new assessment tool caused 66% of the children to be found no longer eligible; 32%, eligible for a reduced level of services; and only 2%, eligible for their previously approved level of services. See No. 1:15-cv-03116, slip op. at 3 (N.D. Ill. May 4, 2016) (on file with author). The court found a likely due process violation because families knew their children had to reach a score of 30 to qualify for nursing services but were not informed as to how points are allocated on the assessment tool checklist. The lack of articulated standards left the plaintiffs unable to meaningfully appeal an eligibility determination. Slip op. at 14-15.

Americans with Disabilities Act (ADA) and/or the Rehabilitation Act (RA). The Americans with Disabilities Act provides that: “No qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.” 42 U.S.C. § 12137 (ADA); see also 29 U.S.C. § 794 (RA requirement for federal fund recipients). To implement this provision, states must assure that persons with disabilities receive services in the most integrated setting appropriate to their needs. See 28 C.F.R. § 35.130(d) (ADA); 28 C.F.R. § 41.51(d) (RA); see also *Olmstead v. L.C. v. Zimring*, 527 U.S. 581 (1999).⁶

⁶ In addition, public entities may not, directly or through other arrangements, use criteria or methods of administration that have the effect of subjecting qualified individuals with disabilities to discrimination on the basis of disability. See 28 C.F.R. § 35.130(b)(3)(ADA). Thus, public entities cannot use eligibility criteria that screen out or tend to screen out an individual with a disability or class of individuals with disabilities from equally enjoying services, programs, or activities unless the criteria are shown to be necessary for the provision of that service, program, or activity. *Id.* § 35.130(b)(8). A public entity must also make reasonable

V.L. v. Wagner illustrates how courts have applied these laws when assessment tools create inequities among populations and place individuals with disabilities at risk of institutionalization. 669 F. Supp. 2d 1106 (N.D. Cal. 2009). Evidence in *V.L.* showed that recipients' in-home support services were being terminated or reduced based on numerical rankings and a complicated formula that was not designed, and had never been used, to measure an individual's need for these services. The rankings and formula were particularly inaccurate measures of the needs of individuals with mental impairments, including Alzheimer's disease, who required verbal rather than physical assistance. *Id.* at 1112. Evidence from recipients, caregivers, experts, and county officials established that class members faced a severe risk of institutionalization as a result of losing in-home support services. *Id.* at 1119-20.

Recommendations

Assessment tools must be used carefully. If the application of an assessment instrument results in large scale reductions in services for Medicaid enrollees whose conditions have not improved and whose needs have not changed, this is a cause for concern and investigation.

Initially, the advocate should obtain a copy of the assessment tool, conduct web-based research to learn about its ownership and design features, and seek to locate an expert who can help determine whether the assessment tool has been properly designed to meet the needs to the affected populations and whether, based on initial reports from clients, the tool is being correctly and consistently administered. Then, there are factual questions to assess. Among them:

- In addition to the assessment tool itself, what documents support the administration of the tool (e.g., a handbook, a manual)? Are the assessment tool and supporting materials publicly available?
- Was the assessment tool designed to be used with the affected populations? For example, was it designed to determine the needs of an individual living in a home or community-based setting, or was it designed for application in a nursing facility? Was it designed for adults, or was it also tested to be applied to children? If individuals with both physical and cognitive impairments are included in the affected population, does the assessment tool accurately determine the service needs for both conditions?

modifications to avoid discrimination unless it can demonstrate that the modifications would fundamentally alter the nature of the service, program. *Id.* § 35.130(d)(7).

- How is the assessment administered? Are on-site assessments arranged with enough advance notice? Is the assessment a one-step or multi-step process, and if a multi-step process, how does it work?
- What are the qualifications of the individuals administering the assessment? How have these individuals been trained (e.g., do assessors have appropriate training/expertise in identifying functional needs or has the assessor simply been trained to administer the assessment tool)? Does the training include testing or quality assurance mechanisms to ensure proper administration of the tool?
- When actually administering the assessment tool on site, do assessors refer only to summary information on the tool itself or are they also incorporating explanations from the manuals/explanatory materials?
- Does the look-back period used to assess functioning include a sufficient span of time for the assessor to get accurate information about the individual?
- What is the evidence-based justification for the time and task guidelines or other algorithms used to translate assessed needs into an amount, duration and scope of services?
- Has the assessment tool been normed for the population and services of your state?
- Does the tool assess the willingness and actual ability of the natural supports to provide care? Does it assess the well-being of the natural supports to help determine whether their ability to provide care is compromised by the lack of paid supports/respite or other resources that could help these supports?
- If the tool is used for both HCBS and institutional care, is it administered the same way with the same questions and policies, including look back period?
- Do the scoring support documents indicate which questions are factored into the calculation of eligibility vs. supports?
- Does application of the assessment seem equitable across populations, for example as between individuals with intellectual disabilities, traumatic brain injury, individuals with HIV/AIDS?
- Is the completed assessment tool, including the scoring support documents, provided to the individual at the time services are denied, reduced or terminated?
- Is this assessment tool used by other states, and if so, what has the beneficiary experience been like?
- Was a new assessment tool piloted before implementation such that the results from application of the new tool were compared to the results from the previous assessment tool?
- Are there published studies or reports that assess or refer to the use of this assessment tool?
- Are beneficiaries churning in and out of services and, if so, is there correlation with who is performing the assessments?

- Since the assessment tool was introduced, what percentage of enrollees are no longer eligible, eligible for reduced services, and eligible at the previous levels?
- When an action occurs, is the individual given an individualized written notice?
- What is the timing of this notice?
- Does the notice inform the individual of the legal and factual reasons for the action *in an individualized way*?
- At what point, if any, is the completed assessment tool, including the scoring support documents, provided to the individual?
- How to enrollees challenge a denial, reduction, or termination of services?
- Are case files and supporting documents available to individuals and their authorized representative?

When there are systemic problems, advocates may be able to make a number of legal arguments. These include claims regarding rule making; Medicaid Act requirements such as comparability, notice and fair hearing, and EPSDT; constitutional due process; and the ADA/Rehabilitation Act. NHeLP is working with advocates to monitor the use of assessment tools and is available to work with you.