Fact Sheet:
The Burden of Proof in Medicaid Cases

For the National Association of Protection and Advocacy Systems, Inc.
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Introduction

In this fact sheet, we discuss the burden of proof that Medicaid applicants and beneficiaries bear when seeking eligibility and coverage for necessary services. We will focus on this issue as it arises in connection with administrative hearings.[1]

Individuals seeking Medicaid benefits must apply for eligibility. Once eligibility is determined, medical services may be covered for beneficiaries. If an individual is denied eligibility, or if coverage for services are denied, individuals may request an administrative hearing to contest these determinations. In other circumstances, individuals who are already receiving benefits may have their eligibility terminated or benefits are terminated . Because the Medicaid statute and regulations do not address the issue, questions may arise regarding the

[1]For more about administrative hearings, s*ee also* Perkins and Somers, *Representing Clients who Need Medicaid Early and Periodic Screening, Diagnosis and Treatment*, National Association of Protection and Advocacy Systems (Sept. 2001); Perkins, Q & A, Medicaid Fair Hearings (December 23, 2002).

burden of proof in these circumstances.

A. **Sources to Consult**

The Medicaid program is a cooperative federal-state partnership and its basic requirements are governed by federal law. [2] The statute discusses administrative hearings in a single sentence, requiring that state Medicaid plans "provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness."[3] Regulations flesh out this requirement. Among other things, if a state Medicaid agency intends to take action that is adverse to an individual, he or she must receive written notice of the intended action that is both adequate and timely.[4] An adverse action is a termination, suspension or reduction of Medicaid eligibility or covered services.[5] If requested, an administrative hearing must be conducted at a reasonable time, date and place by an impartial hearing official.[6] At the hearing, the applicant or recipient must be allowed to present witnesses, establish facts, present argument and cross-examine adverse witnesses.[7] The burden of proof at the hearing is not addressed.[8]

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[2]42 U.S.C. §§ 1396 - 1396v; 42 C.F.R.§§ 430.0 - 456.725. All statutory references hereinafter are to Title 42 of the United States Code and all regulatory references are to Title 42 of the Code of Federal Regulations unless otherwise indicated.

[3]§ 1396a(a)(3).

[4]§§ 431.206(b), 431.201, 431.210, 435.912, 435.919.

[5]§ 431.210.

[6]§ 431.240(a).

[7]§ 431.242(b)-(e).

[8]At least one court has noted specifically that "neither federal statutes nor regulations establish the standard of proof required . . ." *Dillingham v. N.C. Dep't of Human Resources*, 132 N.C. App. 704, 711 (N.C. Ct. App. 1999). *See also Bonnie L. by and through Hadsock v. Bush*,

Because the statute and regulations are silent on the point, claimants and their advocates must look elsewhere to determine who bears the burden of proof. First, a number of federal and state decisions address the issue. Moreover, every state and the District of Columbia have Administrative Procedure Acts (APAs) that govern the conduct of administrative hearings. With only a few exceptions, such as Virginia, state laws require the Medicaid agency to comply with APA requirements.[9] Thus, advocates should first review their state's APA to determine whether it addresses the burden of proof. Several that do are discussed below. Legal authority for the administrative burden of proof might also be found in state common law. In addition, Medicaid fair hearing decisions are required by law to be available to the public.[10] Accordingly, advocates should be able to obtain them and review the Medicaid decisions that administrative law judges in their states have issued to see whether they discuss the burden of proof. These sources are discussed more fully below.

B. Burden when Eligibility for Benefits is at Issue

To be eligible for Medicaid, individuals must apply and meet financial, citizenship and residency requirements. When an individual appeals action of a state Medicaid agency, the burden of proof depends on whether the issue is the initial eligibility of an applicant or whether the eligibility of a current beneficiary will be terminated.

Generally speaking, the burden is placed upon the party who is attempting to change the status quo. Accordingly, those applying for eligibility usually bear the burden of proof, while

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180 F. Supp. 2d 1321, 1329, *rev'd on other grounds* (noting that the Medicaid statute does not impose a particular burden of proof).

[9]Va. Code Anno. § 2.2-4018.3.

[10]42 C.F.R. §§ 431.244(g).

the state Medicaid agency generally bears this burden when attempting to terminate eligibility. Some courts characterize this issue in terms of "presumptions." For example, there may be a presumption that a person who quit a job did so to qualify for Medicaid benefits. In that case, that person would have the burden of proof to show that he did not quit for that reason.[11] Illustrations of these principles follow.

1. Initial Eligibility and Service Determinations

The Supreme Court, in *Lavine v. Milne*, stated that applicants for most government benefits "bear the burden of showing their eligibility *in all respects*."[12] At issue in *Lavine* was the constitutionality of a New York statute that established a rebuttable presumption that any person who had voluntarily terminated employment or reduced earning capacity within 75 days had done so with the intent of qualifying for benefits.[13] Thus, the burden of proof was on the applicant to show that he had no such intent in order to qualify for benefits. The plaintiffs argued that this presumption violated their constitutional due process rights. The Court disagreed and upheld the presumption, noting that "the provision carries no procedural consequence; it shifts to the applicant neither the burden of going forward nor the burden of proof, for he appears to carry that burden from the outset."[14] Courts have frequently applied *Lavine's* reasoning to cases involving initial Medicaid eligibility determination. "

[11]Courts have stricken down irrebuttable presumptions in eligibility requirements as unconstitutional. *See, e.g.*, *Buckner v. Maher,* 424 F. Supp. 366 (D. Conn. 1976); *Owens v. Roberts,* 377 F. Supp. 45 (M.D. Fla. 1974); *Udina v. Walsh,* 440 F. Supp. 1151(E.D.Mo. 1977). The laws that were fatally flawed because they utilized presumptions which foreclosed any avenues of proof under which an applicant might achieve eligibility**.**

[12] *Lavine v. Milne,* 424 U.S. 577, 582-583 (1976) (emphasis added).

[13] *Id.* at 578.

[14]*Id.* at 584.

State rules classifying beneficiary resources as exempt or countable have been challenged on the grounds that the burden of proof has been misplaced. For example, in *Fischer v. State Dep't Social and Rehab. Servs.*, Kansas state law provided that "countable," or non-exempt, resources of an applicant that exceeded $2000 would disqualify the applicant from eligibility. [15] Under the state law, certain items of real property were exempt, including income-producing property. The plaintiff claimed that some of his property was exempt, but the state Medicaid agency reached the opposite conclusion. At the hearing, the outcome hinged on who had the burden of proving how the property should be characterized. The court held that the burden of proof rested upon the plaintiffs "to show their eligibility in all respects."[16] Income determination rules have faced scrutiny, with similar results. For example, in *Greely v. Comm'r*, the plaintiff complained that he should not bear the burden of proof to show that his income did not disqualify him from coverage as a "categorically needy" person under Medicaid.[17] The court disagreed, holding that "the party seeking review of agency action has the burden of showing that the decision of the agency is not supported by competent evidence."[18]

Numerous decisions has involved rules governing transfers of assets. The Medicaid statute currently provides that transfers of assets for less than fair market value may result in a penalty period in which an otherwise eligible person becomes ineligible for certain limited

[15]271 Kan. 167 (2001).

[16]*Id.* at 176.

[17]2000 ME 56, 748 A.2d 472 (2000).

[18]*Id.* at 476. *See also Okale v. N.C. Dep't Health and Human Servs.*, 153 N.C. App. 475 (2002) (holding that plaintiff failed to establish that she was a state resident and thus eligible for Medicaid).

categories of Medicaid services.[19] When Medicaid agencies consider whether transfers of assets should disqualify applicants from eligibility, the statute requires that the burden of proof be placed upon the applicant. Applicants must make "a satisfactory showing" that: (1) the applicant intended to dispose of the assets wither at fair market value or for other valuable consideration; (2) the assets were transferred exclusively for a purpose other than to qualify for medical assistance; or (3) all assets transferred for less than fair market value have been returned to the individual.[20] The statute also provides that, even if the above factors are not satisfied, the disqualification may be waived if "the State determines . . . that the denial of eligibility would work an undue hardship."[21] In *Drogolowicz v. Quern*,[22] the plaintiff had been denied eligibility for Medicaid coverage because he gave $6,000 to his sons while hospitalized and expecting to die. When he recovered, he applied for Medicaid to cover the portion of the hospital bill that he could not pay. An Illinois state statute in effect at that time provided that a person who transferred a property interest to obtain Medicaid would be disqualified for a period of time. The statute also provided that certain transfers were presumed to be for the purpose of obtaining Medicaid and could be rebutted only by evidence "sufficient to prove the contrary."[23] The court rejected the plaintiff's claims that this provision was unconstitutional and violated the Medicaid Act, holding that it simply "places the burden of proof on the applicant from the outset to demonstrate what resources and income are available for his personal and medical need," which

[19] § 1396p.

[20] § 1396p(c)(2)(C).

[21] § 1396p(c)(2)(D).

[22] 74 Ill. App. 3d 862 (Ill. App. Ct. 1979).

[23] *Id.* at 863.

is permissible.[24] The Court of Appeal for the Fourth Circuit upheld a Virginia provision establishing a rebuttable presumption of ineligibility for individuals who transferred financial assets before applying for Medicaid benefits.[25]

2. Termination or Reduction of Eligibility or Services

The burden of proof should rest with the state Medicaid agency when the appeal involves a decision to terminate eligibility or services. When Medicaid services or eligibility are terminated or reduced, the burden of proof question implicates constitutional concerns. In *Goldberg v. Kelly,* the Supreme Court held that a pre-termination hearing was required before public benefits could be terminated.[26] In that decision, the Court set forth requirements for a constitutionally adequate hearing. These include the right of the claimant to confront witnesses and rebut adverse evidence "in a meaningful manner."[27] This requirement has implications for assigning the burden of proof. The party with the burden of proof typically presents its evidence first. Therefore, if the claimant whose eligibility or benefits have been terminated bears the burden of proof, then that individual will be forced to present evidence anticipating the state agency's justification, evidence and testimony for the termination before the state's evidence has

[24] *Id.* at 866.

[25] *Randall v. Lukhard*, 729 F.2d 966, 967 (4th Cir. 1984). *Randall* also includes a discussion of the necessary standard of proof. For more cases discussing the standard of proof, *see Harrison v. Dep't Income Maintenance,* 202 Conn. 672 (1998) (holding that decision of hearing officer that intent to qualify for Medicaid benefits "must be inferred" by transfer of assets was stricter than the federal and state standard and was thus an abuse of discretion); *Gardner v. Dep't of Soc. Welf.*, 135 Vt. 504 (1977) (holding that a presumption that a transfer of assets was made to qualify for Medicaid is not in and of itself to be given evidentiary weight, rather, the trier of fact should simply weigh evidence presented by applicant to determine whether the presumption is overcome).

[26] 397 U.S. 254 (1970).

[27] *Id.* at 267.

been placed in the record. Practical speaking, such a hearing does not allow an individual claimant to confront adverse witnesses and testimony in a meaningful way.

State court decisions, while not necessarily acknowledging these constitutional issues, generally recognize that the burden of proof rests with the state Medicaid agency when edibility and services are being terminated. For example in *Kegel v. New Mexico,* the state Medicaid agency had terminated the plaintiff's eligibility.[28] The agency claimed that plaintiff had access to a trust valued at an amount that exceeded the eligibility limitations of the program. The court reversed the decision, holding that the burden of proof was on the state to show that the trust was available for the purpose of eligibility determination.[29] The court observed that nothing in the record supported a finding that the trust was available to the plaintiff, thus, the agency's burden was not met.[30] Similarly, in *Simmons v. Van Alstyne*, the Medicaid agency terminated the plaintiffs' eligibility after discovering that they had additional resources.[31] The plaintiffs had a communal living arrangement in which all income was pooled to meet basic needs. The agency determined that the entire pool of resources was available to the plaintiffs equally and thus the plaintiffs' resources exceeded Medicaid eligibility levels.[32] The agency argued that the plaintiffs had not met their burden of proof to reverse the agency decision because they gave only oral statements as to the manner in which income was disbursed, but presented no books, records or

[28] 113 N.M. 563 (N.M. Ct. App. 1992).

[29] *Id.* at 565.

[30] *Id.* at 13.

[31] 410 N.Y.S. 2d 400, 1978 N.Y. App. Div. LEXIS 13722 (Sup. Ct. N.Y. 1978)

[32] *Id.* at **4.

other documentary evidence.[33] The court reversed the decision, holding that "the burden of proof when discontinuing aid is upon the local agency in the first instance and not upon the petitioner."[34] Further, "the hearsay and conjectural evidence introduced by the [agency] on the fair hearing does not meet this burden . . ."[35]

C. Coverage of Services

In order for services to be covered under Medicaid they must be medically necessary. Questions arise as to how necessity for services is determined. Service decisions inherently have a different dynamic than eligibility determinations. This is because Medicaid is an insurance program through which services are provided by private health care providers. In traditional fee-for-services systems, the providers are reimbursed by the state Medicaid agency. In managed care systems, Medicaid beneficiaries receive services through a health plan that has received capitated payments. In these systems, benefits nearly always must be authorized by the plan before a beneficiary receives them. In either case, in order for a service to be at issue in the first place, a health care provider must have prescribed or recommended it in some way. Thus, the Medicaid beneficiary has already put forth "evidence" that he needs a certain service.

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[33] *Id.* at **6.

[34] *Id.* at **8.

[35] *Id.*

When a state Medicaid agency is attempting to terminate services, the burden generally falls upon the agency to show that services are no longer necessary. For example, in *Jones v. Bureau of TennCare*, the plaintiff's home health services were terminated.[36] A determination had been made, and was affirmed by an administrative law judge, that services were no longer medically necessary. The state court reversed, citing the regulations implementing Tennessee's Administrative Procedures Act and held that the party seeking "to change the present state of affairs" had the burden of proof. In this case, as the state was attempting to terminate services, it bore the burden.[37] Similarly, in *Collins v. Eichler*, the state terminated the plaintiff's home and community based services, claiming that her medical condition had improved to the point that she no longer needed services.[38] The Delaware Supreme court reversed this decision. It held that the burden of proof was on the state to show that benefits should be terminated and must also show that a change of circumstances had occurred.[39]

D. State Administrative Procedures Acts

As mentioned above, a number of states address the burden of proof at administrative hearings in their APAs. For example, Delaware's APA provides that "the burden of proof will always be on the applicant or proponent."[40] APAs with similar provisions include Colorado and

[36]94 S.W.3d 495 (Tenn. Ct. App. 2002).

[37]*Id.* at 500.

[38]No. 90A-JL2, 1991 Del. Super. LEXIS 105, *3 (1991)

[39]*Id.* at *10. *See also, e.g. Kerr v. Holsinger*, No. 03-68-JMH, 2004 U.S. Dist. LEXIS 7804 (E.D. Ky. Mar. 25, 2004) (without discussion, placing the burden of proof on the state to show that termination of home and community based or nursing facility services was proper).

[40]Del. Code Ann. tit. 29-10125(c). *Cf. In re: Colleen Rivers* No. 00061422M (undated) (holding that the burden rests upon a managed care plan to show that services are "medically unnecessary" once they have been recommended by physician.) Copies available from NHeLP.

the District of Columbia.[41] Tennessee and Kentucky provide more detail. The Tennessee regulation provides that the party who initiated contested case proceedings has the ultimate burden of proof but notes that "[i]n some cases the party who initiated the proceedings will not be the party with the burden of proof on all issues.[42] Kentucky has a more detailed provision:

> In all administrative hearings, unless otherwise provided by statute or federal law, the party proposing the agency take action or grant a benefit has the burden to show the propriety of the agency action or entitlement to the benefit sought. The agency has the burden to show the propriety of a penalty imposed or the removal of a benefit previously granted. The party asserting an affirmative defense has the burden to establish that defense. The party with the burden of proof on any issue has the burden of going forward and the ultimate burden of persuasion as to that issue.[43]

Conclusion

Despite the fact that the federal Medicaid statute and regulations do not address the burden of proof, advocates can obtain guidance from federal and state decisions, state APAs and state common law. If the state in which you practice does not have a clear answer, sources from other states will help you to construct the argument.

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[41]Colo. Rev. Stat. § 24-4-105(7) (providing that "[e]xcept as otherwise provided by statute, the proponent of an order shall have the burden of proof . . . "); D.C. Code § 2-509 (same);

[42]*Id.*

[43]Ky. Rev. Stat. Ann. § 13B.090(7).