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Q & A
Responding to Medicaid Cutbacks
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Q. The State Medicaid agency is citing fiscal constraints and considering ways to cut Medicaid services. We are engaging in education and policy advocacy so that state officials will have a full understanding of how their decisions will affect low income people and people with disabilities. Are there laws we should be aware of as states are making changes?

A. States have a great deal of flexibility in their administration of the Medicaid program. However, the actions the state takes to eliminate or reduce services must be legal, whether the services are mandatory or optional under the Medicaid Act.

Discussion

Since the beginning of the economic recession in December 2008, a number of cases have been filed in state and federal courts alleging that Medicaid agencies are improperly implementing a Medicaid cutback. While most of these cases have been filed on behalf of individuals, about two dozen lawsuits have challenged across-the-board reductions that have resulted in confusion regarding continued coverage and/or due process rights.[2] Some of these cases involve significant reductions in services after the state introduced special assessment tools and computer software to determine recipients' needs and services, while others involve utilization review technicians who are feeding their assessments into a software program.

Regardless of the type of services affected or the methods used by the state to cut services, the state's plans and actions must be consistent with what federal and state laws require, such as:

1. <u>The branch of state government making the cutback must have authority to do so.</u>

Otherwise, the action by one government entity may violate constitutional separation of powers requirements or a statute that places the authority to make the changes with another branch of government. *See Whiley v. Scott*, No. SC11-592, _ So.3d _, 2011 WL 3568804, at *1 (Fla. Aug. 16, 2011) ("Absent an amendment to the Administrative Procedure Act itself or other delegation of such authority to the Governor's Office by the Florida Legislature, the Governor has overstepped his constitutional authority and violated the separation of powers."). *Compare McNeil-Terry v. Roling*, 142 S.W.3d 628 (Mo. Ct. App. 2004) (holding that executive action to eliminate adult dental services violated a state statute that required the coverage) *and Fisher v. Roling*, 142 S.W.3d 836 (Mo. Ct. App.

[1] This Q&A updates an October 2010 Q&A from the National Health Law Program.

[2] Cases were identified through a search of the National Health Law Program data base of technical assistance (accessed Sept. 29, 2011) and a Westlaw search of Medicaid cases dated after December 1, 2008 (accessed Sept. 30, 2011).

2004) (same, regarding adult eyeglasses) *with Hunter v. State*, 865 A.2d 381 (Vt. S. Ct. 2004) (rejecting constitutional separation of powers argument and finding state legislature validly delegated authority to the Secretary of Administration to prepare and implement a plan to eliminate optional Medicaid services); *id.* at 392-93 (collecting cases).

2. A planned Medicaid cutback may need to be promulgated through the public notice and comment processes of the state Administrative Procedure Act (APA).

Most state Medicaid agencies are subject to the requirements of the state APA. State APAs generally define "rules" to be regulations, standards or statements of policy issued by a state agency that are applied generally and that have the effect of law. In recent years and with mixed results, a number of cases have challenged policies cutting Medicaid services as violations of the state APA.

Cholvin v. Wis. Dep't of Health & Family Servs. reviewed a process whereby eligibility for the 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 instructions being used by the screeners were rules that needed to be promulgated pursuant to Wisconsin statute. *See* 758 N.W. 2d 118 (Wis. Ct. App. 2008); *see also, e.g., Homestyle Direct, LLC v. Dep't of Human Servs.*, No. 20091957, _ P.3d _, 2011 WL 4376186 (Or. App. Sept. 21, 2011) (holding agency unlawfully adopted nutritional and delivery standards for home meals for Medicaid beneficiaries and agency could not enforce the invalid rules, even though petitioner had agreed to them); *Courts v. Agency for Health Care Admin*., 965 So.2d 154 (Fla. Ct. App. 2007) (reversing state Medicaid agency's new method for reducing claimant's HCBS waiver services, finding that the reduction was in response to budget problems and explaining that if an agency changes a non-rule-based 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"); *Radaszewski v. Garner*, 805 N.E.2d 620 (Ill. Ct. App. 2003) (recognizing claim of "sham" rulemaking, finding that Department's elimination of private duty nursing from the state Medicaid plan in order to terminate litigation between the parties evinced an intent to enact the change regardless of what transpired during the rulemaking process). *Compare Cal. Ass'n of Med. Prod. Suppliers v. Maxwell-Jolly*, No. A126749, _ Cal. Rptr. 3d _, 2011 WL 4130078 (Cal. Ct. App. Sept. 16, 2011) (finding agency properly implemented policy); *Rennich v. N.D. Dep't of Human Servs.*, 756 N.W.2d 182, 188 (N.D. S. Ct. 2008) (holding that Department's computerized Progress Assessment Review tool was an "explanatory guideline" used "to aid the Department 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").

3. Federal Medicaid requirements for "reasonable standards" and "comparability" may also be enforced in appropriate cases.

In *Lankford v. Sherman*, the Eighth Circuit Court of Appeals held that a state regulation that eliminated coverage of home-based medical equipment services for people with disabilities who were not blind was preempted by federal law, 42 U.S.C. § 1396a(a)(17), which requires states to operate their Medicaid programs using "reasonable standards." 451 F.3d 496 (8th Cir. 2006). In reaching its decision, the Court noted that "a state's failure to provide Medicaid coverage or non-experimental, medically necessary services within a covered Medicaid category is *both per se unreasonable and inconsistent* with the stated goals of Medicaid. *Id.* at 511 (emphasis in original), *on remand*, No. 050-4285-CV-C-DW, 2007 WL 689749 (W.D. Mo. Mar. 2, 2007) (granting plaintiffs' motion for summary judgment and enjoining the state regulation).

For other case examples, *see, e.g., Jensen v. Mo. Dep't of Health & Senior Servs.*, 186 S.W.3d 857 (Mo. Ct. App. 2006) (holding federal Medicaid "deeming" restrictions, 42 U.S.C. § 1396a(a)(17)(D), preempted state "unmet need" and "undue hardship" regulations that required consideration of potential contributions and services from an adult claimant's parents and reversing state decision to reduce claimant's personal assistance services). *See generally Independent Living Ctr. v. Shewry*, 543 F.3d 1050 (9th Cir. 2008) (finding plaintiffs have a valid cause of action under the Supremacy Clause to argue that state cutbacks in Medicaid payments are preempted by the federal Medicaid payment statute, 42 U.S.C. § 1396a(a)(30)(A)). *See also Md. Dep't of Health & Mental Hygiene v. Brown*, 935 A.2d 1128, 1143 (Md. Ct. App. 2007) (finding that state Medicaid agency could not "set a higher bar" for eligibility under an HCBS waiver than is prescribed by the federal government and refusing to sustain a state standard that required all care to be provided under the supervision of a licensed medical professional); *C.F. v. Dep't of Children & Families*, 934 So.2d 1 (Fla. Dist. Ct. App. 2006) (reversing Department decision to reduce young boy's personal care services from six to four hours daily, finding that the state had applied definitions of "medical necessity" and "personal care assistance" that were more restrictive than federal EPSDT requirements). *See also* Sarah Somers, National Health Law Program, *Q&A: Preemption and the Medicaid Act* (Dec. 2006) (available from TASC or NHeLP).

Indeed, carefully pled and well-argued cases can obtain relief under the Medicaid Act. In California, for example, Medicaid recipients have obtained a preliminary injunction against cutbacks in in-home support services. *See V.L. v. Wagner*, 669 F. Supp. 2d 1106 (N.D. Cal. 2009) (on appeal). The California Medicaid agency acted to reduce in-home supports using an assessment tool that was not designed to determine individuals' needs for in-home services and that, when used, resulted in people with cognitive disabilities being disparately terminated from services. The district court found the policy to violate Medicaid's "comparability" requirement, 42 U.S.C. § 1396a(a)(10)(B), which prohibits one group of Medicaid recipients from being treated differently from others where there is the same need for the service. Moreover, because the services that were being cut had already been determined by social workers to be necessary to permit elderly and disabled individuals to remain safely in their homes, the court found a violation of the Medicaid regulation, 42 C.F.R. § 440.230(b), that requires coverage of a service "sufficient in amount, duration and scope to achieve its purpose." *See also Cota v. Maxwell-Jolly*, 688 F. Supp. 2d 980 (N.D. Cal. 2010) (on appeal) (reaching similar conclusions regarding announced cuts in adult day health services).

State court cases from Washington also illustrate application of these claims. State regulations implementing the Washington personal care and in-home waiver programs included a process for assessing recipients' limitations in activities of daily living and their personal care assistance needs. Called Comprehensive Assessment and Reporting Evaluation (CARE), the process included a provision (now repealed) that automatically reduced coverage of in-home care hours by 15 percent if the beneficiary lived with the paid care-giver. This was known as the "Shared Living Rule." The Shared Living Rule was challenged in two state court cases filed by individuals whose providers lived with them. Among other things, the individuals challenged the Shared Living Rule as a violation of the amount, duration and scope comparability requirements of 42 U.S.C. § 1396a(a)(10)(B). The State responded that the federal government had waived the comparability requirement when it approved the HCBS waiver. In *Jenkins v. Wash. State Dep't of Soc. & Health Servs.*, the Washington Supreme Court sided with the plaintiffs, however. It noted that a waiver of comparability did not give the State carte blanche to ignore the federal Medicaid requirements. According to the court, in determining the extent to which comparability had been waived, it was important to assess the basis of the federal government's action. The Court pointed out that the waiver application discussed neither the CARE nor the Shared Living Rule. *See* 160 Wash. 2d 297, 300 (Wash. S. Ct. 2007). The 6-3 decision held that the Shared Living Rule was invalid because it violated the Medicaid Act comparability

requirement. Moreover, reductions in services could occur only after an individualized determination of a beneficiary's needs. *Id. Compare Gasper v. Dep't of Soc. & Health Servs.*, 129 P.3d 849 (Wash. Ct. App. 2006) (consolidated on appeal with *Jenkins)* (holding Shared Living Rule violated comparability but did not violate Medicaid free choice of provider requirements). *See also Samantha A. v. Dep't of Soc. Servs. & Health Servs.*, 256 P.3d 1138 (Wash. 2011) (finding comparability violation where Medicaid rule reduced assistance payable for in-home personal care services based upon disabled child's age and whether child lived with parent).

Unfortunately, these decisions were undermined somewhat by a subsequent federal court case, *Pfaff v. State of Wash.*, No. C07-5280, 2008 WL 5142805 (W.D. Wash. Dec. 8, 2008), which was filed by providers and recipients after the Shared Living Rule had been repealed. The court refused to apply collateral effect to *Jenkins* and award damages. The court also refused to grant relief under a host of other claims, including under the ADA and RA, holding discrimination occurs "solely by reason of the person's disability," and here, the Shared Living Rule was applied to plaintiff recipients not by reason of their disability but because of the living arrangement of their chosen provider. 2008 WL 5142805, at *11-12.

In another Medicaid case, *Watson v. Goldberg*, recipients challenged cutbacks in nursing-level services. *See* No. 03-227, 2008 WL 2944998 (D. Ore. July 23, 2008). The Oregon Medicaid agency was using a Client Assessment and Planning System to determine individuals' needs for assistance with activities of daily living and to classify them into one of 18 service priority levels. Due to budget concerns, the agency amended its program to eliminate care to individuals placed in or above the 13th priority level. The *Watson* plaintiffs argued that the State could not re-define eligibility for nursing level HCBS waiver services because the Medicaid Act established federal eligibility standards which require states to uniformly provide long-term care to needy Medicaid recipients. Id. at *3, 7 (citing 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(4)(A)). The federal court disagreed. The court relied on two other Medicaid provisions: (1) the opening provision of the Medicaid Act, which says the purpose of the program is to provide medical assistance "as far as practicable under the conditions in the state." Id. at *3, 9 (quoting 42 U.S.C. § 1396); and (2) the "reasonable standards" provision, which allows states flexibility in determining coverage rules. *Id. at *10* (quoting 42 U.S.C. § 1396a(a)(17)). The court held that these federal statutes "do not require states to provide nursing home or HCBS waiver services to every Medicaid beneficiary who needs such services … [and] … do not preclude states from modifying eligibility standards in ways that affect the number of beneficiaries receiving nursing care or HCBS waiver services." *Id.* at *5. The court was also persuaded that the State could make the changes because the federal government had approved them. Id. *at *4, 10. See also M.R. v. Dreyfus*, 767 F. Supp. 2d 623 (W.D. Wash. 2011) (finding plaintiffs unlikely to succeed on merits of comparability claim challenging across-the-board reduction in personal care services).

Finally, advocates must take care when considering private enforcement of a Medicaid Act provision. Only those provisions that clearly create individual rights are enforceable under 42 U.S.C. § 1983. And while advocates have long obtained injunctive relief under the Supremacy Clause when state laws are in conflict with federal statutes or regulations, the Supreme Court is currently considering Supremacy Cause enforcement. *See Douglas v. Indep. Living Ctr. of So. Cal.*, No 09-958 (U.S.S.Ct. argued Oct. 3, 2011). For discussion of the complexities surrounding private enforcement of the Medicaid Act, *see, e.g.*, Rochelle Bobroff, *Section 1983 and Preemption: Alternative Means of Court Access for Safety Net Statutes*, 10 LOY. J. OF PUB. INT. L. 27 (2009). For discussion of enforcement of the Medicaid Act pursuant to § 1983, see Jane Perkins, *Update on Private Enforcement of the Medicaid Act Pursuant to 42 U.S.C. § 1983* (June 2011), *at http://www.healthlaw.org/images/stories/issues/courtaccess/2011_6_28_Update_on_Private_Enforcement_of_Medicaid_Act.pdf.*

4. States must adhere to the requirements for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, and individuals aging out of EPSDT may also be protected.

The EPSDT provisions apply to children and youth under age 21. Among other things, the Act makes a comprehensive scope of benefits available, specifically any service that a state must or can cover under 42 U.S.C. § 1396d(a). The law requires states to cover these benefits when they are necessary to "correct or ameliorate" a child's physical or mental conditions. *See* 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r). This means that across-the-board reductions in services that might be permissible for adult recipients cannot be applied to children. *See, e.g., C.F. v. Dep't of Children & Families*, 934 So.2d 1 (Fla. Dist. Ct. App. 2006) (reversing agency decision to reduce child's personal care services from six to four hours, finding State had applied definitions of "medical necessity" and "personal care assistance" that were more restrictive than federal EPSDT requirements). *Cf. Moore ex rel. Moore v. Reese*, 637 F.3d 1220 (11th Cir. 2011) (discussing roles of treating physicians and state-employed utilization review doctors when deciding medical necessity). For additional discussion, *see* Jane Perkins, National Health Law Program, *EPSDT, Deference to Providers and Moore v. Reese* (June 2011), *at http://www.healthlaw.org/images/stories/epsdt/2011_06_28_QA_Moore_vs_Reese.pdf.; A.M.T. v. Gargano*, 781 F. Supp. 2d 798 (S.D. Ind. 2011) (requiring state to consider potential for regression prior to reducing child's maintenance services).

Young adults aging out of EPSDT may also be protected against cutbacks in services. In *Radaszewski v. Maram*, Eric Radaszewski was receiving 16 hours of private-duty nursing daily through a Medicaid waiver for medically fragile children under age 21. When Eric turned 21, the state Medicaid agency reduced his coverage to only five hours of private-duty nursing each day. Eric faced a dilemma: He could not remain safely at home with the reduced coverage; yet, he would be at great risk for infections and other life-threatening problems in an institutional setting. Eric filed a lawsuit to enforce the integration mandate of the federal disability law, which requires states to administer their programs in the most integrated setting appropriate to the needs of qualified individuals with disabilities. *See* 28 C.F.R. § 35.130(d) (ADA); 28 C.F.R. § 41.51(d) (RA). The Seventh Circuit Court of Appeals eventually heard Eric's case. It held that if the level of care Eric would need to survive in an institution was equally or less costly than the care Eric requested at home, then he had a viable claim to receive the care at home. Under the ADA/RA integration mandates, that care would present a reasonable accommodation that would not work a fundamental alteration of the State's programs and services. *See* 383 F.3d 599 (7th Cir. 2004).

On remand, Eric offered extensive testimony about his medical conditions and expert testimony to sustain both his own contentions regarding costs and to rebut the evidence presented by the state Medicaid agency. The district court found that Eric would require a *hospital* level of care that would likely cost more than the private duty nursing that allowed Eric to remain at home. The State could reasonably accommodate Eric's condition by taking the steps needed to cover the necessary private-duty nursing. *See* No. 01-C-9551, 2008 WL 2097382 (N.D. Ill. Mar. 26, 2008). *See also Grooms v. Maram*, 563 F. Supp. 2d 840 (N.D. Ill. 2008) (finding plaintiff "aging out" of home care waiver and facing institutionalization was protected by the integration mandate and state Medicaid agency must "reasonably accommodate" his request for continued home care); *Jones v. Dep't of Pub. Aid,* 867 N.E.2d 563 (Ill. App. Ct. 2007) (finding that ADA required the Department to continue necessary home care for plaintiff "aging out" of under-21 home care program); *Sidell v. Maram*, No. 05-1001, 2007 WL 5396285 (C.D. Ill. May 14, 2007) (same, relying on *Radaszewski*); *Fisher v. Maram*, No. 06-C-4405, 2006 WL 2505833 (N.D. Ill. Aug. 28, 2006) (same).

5. Cost sharing must adhere to statutory limits.

Two Medicaid provisions address beneficiary cost sharing (e.g. premiums and copayments. *See* 42 U.S.C. §§ 1396o, 1396o-1; 42 C.F.R. §§ 441.50-441.82. The provisions give states flexibility when imposing cost sharing; however, there are limits. For example, very low-income Medicaid beneficiaries cannot be charged premiums, and only nominal copayments are allowed. 42 U.S.C. §§ 1396o(a)(3), 1396o(b)(3); 42 C.F.R. § 447.53. If a state wants to impose cost sharing that differs from that allowed in the Medicaid Act, it must obtain permission from the Secretary of the U.S. Department of Health and Human Services (Secretary). *See* 42 U.S.C. § 1396o(f) (requiring waiver to impose heightened copayments); 42 U.S.C. § 1315 (authorizing Secretary to approve experimental programs). A recent decision from the Ninth Circuit Court of Appeals defines the Secretary's authority to approve copayments as experimental programs:

1. The Secretary must determine that the proposal has value as a demonstration, experimental or pilot project.

2. "[A] simple benefits cut, which might save money, but has no research or experimental goal" will not do.

3. The Secretary must evaluate the cost sharing proposal's potential impact on the individuals that the Medicaid Act is intended to help.

4. It is questionable whether a state's proposal can "demonstrate something different than the last 35-years worth of health policy research," which consistently concludes that copayments cause low-income people to forego medically necessary care.

Newton-Nations et al. v. Betlach & Sebelius, No. 10-16193, _ F.3d _, 2011 WL 3689241, at *8 (9th Cir. Aug. 24, 2011).

6. State Medicaid agencies must comply with due process when they implement service cutbacks.

Medicaid cutbacks must be implemented consistent with the Due Process Clause of the U.S. Constitution and the Medicaid Act and implementing regulations. See U.S. Const., amend. XIV, § 1; 42 U.S.C. § 1396a(a)(3); 42 C.F.R. §§ 431.200-431.250; *Goldberg v. Kelly*, 397 U.S. 254 (1970). Federal Medicaid regulations generally require advance written notice and an opportunity for a hearing when a claim for medical assistance is denied, reduced, terminated or not acted on with reasonable promptness. *Id.* There is an exception for automatic changes in coverage due solely to a change in state or federal law. In these instances, the state Medicaid agency must provide adequate notice of the change but not a fair hearing. 42 C.F.R. § 431.220(b). *Compare Rosen v. Goetz*, 410 F.3d 919 (6th Cir. 2005) (refusing to require pre-termination hearings for all affected recipients where change in Medicaid coverage was the result of a change in state law) *and Garrett v. Puett*, 707 F.2d 930 (6th Cir. 1983) (same) *with Harriman v. Dep't of Children & Families*, 867 So.2d 1264 (Fla. Ct. App. 2004) (reversing termination of coverage because claimant was challenging termination of benefit for reasons other than the change in law automatically affecting her benefits).

In *Baker v. Dep't of Health & Soc. Servs*., the Alaska Medicaid agency implemented a Personal Care Assessment Tool (PCAT) for determining eligibility for its Personal Care Attendant program. The PACT is a 13-page worksheet filled out by a state-contracted nurse assessor on the basis of information gathered during a personal interview with the recipient. In the nine months following introduction of the PCAT, over 900 individuals experienced reductions of their in-home

services. Affected individuals filed a class action case in state court, complaining that the written notices they received did not convey critical data that would allow the recipient to appeal the Department's determination. Citing *Goldberg*, the court ruled for the plaintiffs. The court rejected the Department's argument that "notice" should be broadly construed to include not only the written notice but also other information recipients already received about the assessment process. Rather, a complete written notice was needed. Because plaintiffs were welfare recipients, the court found that the Department needed to go to "greater lengths—incurring higher costs and accepting inconveniences—to reduce the risk of error" and to "be as transparent as possible in its methodology." 191 P.3d 1005, 1010-11 (Alaska S. Ct. 2008). The court also found that the Department should include of copy of each recipient's PACT in the notice of action.

West Virginia Medicaid recipients raised a similar challenge after the state agency contracted with a private company to re-determine eligibility for a Medicaid waiver program. Utilization reviewers from the company would visit recipients' homes, often with little advance notice, and re-assess their needs for assistance with activities of daily living. Thereafter, a number of recipients received termination notices. They filed a lawsuit and argued that their due process rights were being violated in two ways. First, they claimed they had not received adequate prior notice or opportunity to challenge the cutbacks. Second, they argued that the screening criteria were impermissible secret standards. They pointed out that the new standards were obviously more restrictive than the prior standards because their underlying health care needs were unchanged or deteriorating. The parties settled the case after the court denied the State's motion to dismiss. *See Cyrus v. Walker*, 409 F. Supp. 2d 748 (S.D. W.Va. 2005) (order denying motion to dismiss). *See also* Jane Perkins, National Health Law Program, *Q&A: Due Process Issues with Private Contractors* (Oct. 2008) (available from NHeLP).

See also, e.g., Md. Dep't of Health & Mental Hygiene v. Brown, 935 A.2d 1128, 1145 (Md. Ct. App. 2007) (noting that "a state's obligation to comply with fair hearing requirements in federal and state law for an 'optional' service such as the Older Adults Waiver Program is no less than the state's obligation when a 'mandatory' service is involved"); *Reese v. Dep't of Health & Mental Hygiene*, 934 A.2d 1009 (Md. Ct. App. 2007) (holding claimant had a property right and, thus, a right to a fair hearing to challenge Medicaid's denial of her request for placement in an ICF). *Compare Summer H. v. Fukino*, No. 09-00047, 2009 WL 455340 (D. Haw. Feb. 23, 2009) (denying as moot plaintiffs' request for a temporary restraining order to enjoin a 15 percent cutback in their HCBS waiver and EPSDT services after state Medicaid agency filed a letter with the court confirming that plaintiffs' benefits were restored after they filed administrative appeals. Due to budget problems, the Hawaii Medicaid agency informed Medicaid beneficiaries they needed to identify 15 percent of their services that could be cut or the agency would make the cuts for them).

7. Medicaid enrollees may be able to rely on the ADA/RA to avoid reductions in medically necessary services.

Adult Medicaid enrollees may also be able to seek relief under the Americans with Disabilities Act (ADA) and/or the Rehabilitation Act (RA). This is particularly the case where the state is reducing the amount or duration of a covered service as opposed to eliminating the coverage altogether. *See, e.g., Olmstead v. L.C. v. Zimring*, 527 U.S. 581, 603 n. 14 (1999) ("States must adhere to the ADA's nondiscrimination requirement with regard to the service they in fact provide."); *Fisher v. Okla. Health Care Auth.*, 335 F.3d 1175, 1182 (10th Cir. 2003) ("[A] state may not amend optional programs in such a way as to violate the integration mandate").

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." *See* 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). 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); 28 C.F.R. § 41.51(b)(3) (RA). 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*. at § 35.130(b)(8). A public entity must also make reasonable modifications to avoid discrimination unless it can demonstrate that the modifications would fundamentally alter the nature of the service, program. *Id*. at § 35.130(d)(7).

A number of courts have applied these laws to compelling factual cases to enjoin State's Medicaid cutbacks. In *Fisher*, the Tenth Circuit Court of Appeals allowed the plaintiffs to proceed with an ADA/RA challenge to the imposition of a five prescription cap in the HCBS waiver, while allowing individuals in institutional settings unlimited prescription drug coverage. In its decision, the circuit court pointed out that the plaintiffs were not demanding a new service and also found that "a fiscal problem, by itself, does not lead to an automatic conclusion that preservation of unlimited medically-necessary benefits for participants in the [HCBS] program will result in a fundamental alternation." *Id.* at 1183-84. Similarly, in *Crabtree v. Goetz*, 22 individual plaintiffs recently obtained a preliminary injunction barring cutbacks of their Medicaid home health services. The State implemented the service cuts, without any individualized re-assessment of the recipients' personal circumstances and even though the State had previously found the level of care that each plaintiff was receiving to be medical necessary. All of the *Crabtree* plaintiffs lacked family supports to enable them to stay at home and, because of the changed policy, faced almost certain institutionalization. The court's preliminary injunction decision focused heavily upon the individual plaintiffs' needs. It found the plaintiffs were persons with disabilities who would be institutionalized because of the State's home health cuts. The court also noted that the State Medicaid agency implemented the cutbacks without waiting to coordinate its actions with the Tennessee Long Term Community Care Act, a comprehensive reorganization of long term care that the state legislature had just enacted. *See* No. Civ. 3:08-0939, 2008 WL 5330506 (M.D. Tenn. Dec. 19, 2008). For additional cases finding ADA violations when Medicaid services were reduced or terminated, *see, e.g., Hiltibran v. Levy*, No. 10-4185-cv-NKL, _ F. Supp. 2d _, 2011 WL 2534332 (E.D. Mo. June 24, 2011) (holding state rule eliminating medical equipment and supplies violated ADA); *Cruz v. Dudek*, 2010 WL 4284955 (S.D. Fla. Oct. 12, 2010); *V.L. v. Wagner*, 669 F. Supp. 2d 1106 (N.D. Cal. 2009) (on appeal); *Brantley v. Maxwell-Jolly*, 656 F. Supp. 2d 1161 (N.D. Cal. 2009), *same case, Cota v. Maxwell-Jolly*, 688 F.Supp.2d 980 (N.D. Cal. 2010) (on appeal)).

8. Reductions in provider payment rates must be consistent with Medicaid's quality and equal access requirements.

State's payments to Medicaid-participating providers must meet the requirements of 42 U.S.C. § 1396a(a)(30)(A). *See also* 42 C.F.R. § 447.200-447.207. This law requires states to set payment rates consistent with "efficiency, economy and quality of care." 42 U.S.C. § 1396a(a)(30)(A). The so-called "equal access" provision also requires states to assure that payments are sufficient to attract enough providers so that care and service are available to the Medicaid population "at least to the extent" the services are available to the general, paying population in the geographic area. *Id.* These requirements have a history of successful private enforcement. *See* National Health Law Program, *The Advocate's Guide to the Medicaid Program* at 4.14-4.15 (May 2011) (collecting cases).

However, private enforcement of the (30)(A) requirements is currently before the U.S. Supreme Court. *See Douglas v. Indep. Living Ctr. of So. Cal.*, No 09-958 (U.S.S.Ct. argued Oct. 3, 2011), *same case*, *Independent Living Center v. Shewry*, 543 F.3d 1050 (9th Cir. 2008) (finding plaintiffs have valid cause of action under Supremacy Clause to argue that state cutbacks in Medicaid payments are preempted by (30)(A)).

9. Individuals can appeal a reduction of services in an administrative hearing.

It is critical for claimants to understand the state rules that govern their fair hearing processes, particularly burdens of proof and the scope of review. Moreover, claimants need to present the most compelling facts possible, supported by testimony from treating providers who are personally familiar with the claimant's health care history and needs.

For cases illustrating the role played by such elements as assignment of the burden of proof and the standard of review, *compare In re Ryan*, 958 A.2d 678 (Vt. S. Ct. 2008) (finding that Department had not met its burden of proof to reduce claimant's home-based services and that decision of assessor hired by the Department was entitled to no special deference) *with Suzman v. Comm'r*, 876 A.2d 29 (Me. S. Ct. 2005) (finding that reduction of HCBS waiver recipient's personal care hours based on a reassessment conducted by a Department-hired assessor was not "clearly erroneous"); *see also, e.g., Reiff v. Colo. Dep't of Health Care Policy & Fin.*, 148 P.3d 355 (Colo. Ct. App. 2006) (concluding ALJ could properly consider testimony introduced at the hearing concerning claimant's need for Medicaid HCBS and that the ALJ decision should be based exclusively on the evidence produced at the hearing; rejecting the argument that the scope of the ALJ's review was limited to the Department's functional assessment tool); *see* 42 C.F.R. § 431.244(a). *Compare Shockley v. Ohio Dep't of Job & Family Servs.*, No. 04AP-1199, 2005 WL 2160783 (Ohio. Ct. App. Sept. 8, 2005) (noting the limited standard of review *on appeal* and finding that "reliable, probative and substantive evidence" supported the trial court decision upholding Department's decision to transfer individual from Home Care [skilled level of care] Waiver to Transition [ICF level of care] Waiver). *See also* Sarah Somers and Jane Perkins, National Health Law Program, *Fact Sheet: Burden of Proof in Medicaid Hearings* (Oct. 2004) (available from TASC or NHeLP).

Conclusion

Medicaid coverage is the lynchpin that enables low income people and people with disabilities to obtain health care. States' actions to reduce or eliminate covered services must be monitored to make sure that they are legal. It would be sad, indeed, if the fiscal problems now facing state and federal governments resulted in hasty and ill-conceived policies that illegally eliminate or significantly reduce needed Medicaid coverage.