

# Demanding Ascertainable Standards

## Medicaid as a Case Study

BY JANE PERKINS

State governments are increasingly entering into contracts with private entities for operation of traditional state functions. This dynamic is intense in state Medicaid programs. States are contracting with outside entities to make decisions about eligibility and the nature and extent of the Medicaid benefits that individuals can receive. These entities may be public: for instance, the state division of developmental disabilities. Or they may be private: for instance, a third-party claims administrator or a managed care organization.

whether a child has a handicapping malocclusion that requires orthodontic services.<sup>1</sup>

Problems arise when these contractual arrangements result in program enrollees and beneficiary advocates being refused access to the standards and procedures that govern operation of the program. The following examples are illustrative:

- After L.S. was enrolled in a managed care plan, a care coordinator employed by the plan visited her to review her receiving in-home services. The case co-

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### Problems arise when these contractual arrangements result in program enrollees and beneficiary advocates being refused access to the standards and procedures that govern operation of the program.

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State Medicaid agencies and their contractors are also increasingly relying on preset guidelines or assessment tools or both to make coverage decisions. Typically these products are marketed by private companies that contract with, and in some instances issue licenses to, state agencies or their contractors for use of the product. While currently most strongly associated with Medicaid home-and-community-based services, use of assessment tools and coverage guidelines is becoming pervasive— affecting everything from admission to a hospital and the length of a hospital stay to

ordinator asked L.S. questions and filled out an assessment form. Thereafter L.S. received a letter from the plan stating that her score did not qualify her for Medicaid services. L.S. was given no explanation of where the score came from or why it meant that she did not qualify.

- A.C.'s Medicaid private-duty nursing and personal care services were reduced by her managed care organization. The notice said that the reduction was based on "clinical decision support

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<sup>1</sup> For additional information about federal assessment requirements and selected state assessment tools, see [David Machledt, National Health Law Program, Medicaid Assessments for Long-Term Supports and Services \(LTSS\)](#) (May 5, 2015).



criteria." A.C. requested an administrative hearing and asked for a copy of the criteria used to make the decision. The health plan and state Medicaid agency, citing the state trade secrets act and the federal copyright statutory scheme, refused disclosure.

- Advocates noticed that their clients were having difficulty locating a health care provider willing to accept Medicaid. They surveyed health care providers in the area and were repeatedly told that Medicaid participation was not financially feasible because payments offered by managed care organizations did not cover the cost

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of the care. The advocates asked the state for the payment rates but were refused on the grounds that the rates were confidential and trade secrets.

These practices prevent the use of “ascertainable standards” and are inconsistent with the transparent use of public funds.<sup>2</sup> Such practices also create serious Medicaid and due process problems. Without access to coverage standards, an enrollee cannot determine whether the agency's decision making complied with federal and state Medicaid requirements. Enrollees cannot know whether application of a particular coverage guideline is even appropriate for use in their case. For example, the assessment tool used to determine coverage may have been tested and validated for use in connection with adults with disabilities but not for use in connection with children. Or the assessment tool may be validated for deciding an individual's limitations in activities of daily living but not for calculating the amount of services that the individual needs as a result of those limitations.

Here I describe legal protections that should prevent the application of secret standards in the Medicaid context. But, while focusing on Medicaid, these arguments can be used in other public benefits contexts, too.

### Background Legal Principles

When a state Medicaid agency contracts with another entity, the first question

<sup>2</sup> See *Holmes v. New York City Housing Authority*, 398 F.2d 262, 265 (2d Cir. 1968) (finding “ascertainable standards” are needed to avoid ad hoc decision making).

that often arises is: who is ultimately responsible to Medicaid beneficiaries if the provisions of the contract are not fulfilled as federal law requires? The answer: the state Medicaid agency.

### The Single State Agency Requirement.

Regardless of the contractual arrangement being used by the state, federal law requires each state that participates in Medicaid (all do) to designate a “single State agency” that is responsible for assuring the proper implementation of Medicaid law, regulations, and guidelines.<sup>3</sup> Thus, while a contractor may agree to undertake responsibilities that have previously rested with the state, the single state agency requirement means that the state Medicaid agency still retains the ultimate responsibility for ensuring that the Medicaid program operates as the law requires. That duty cannot be delegated or impaired.<sup>4</sup> Pursuant to this requirement, if guidelines are being kept secret by a

<sup>3</sup> See *State Plans for Medical Assistance*, 42 U.S.C. § 1396a(a)(5) (2014); *Single State Agency*, 42 C.F.R. § 431.10(e) (2016).

<sup>4</sup> See, e.g., *K.C. v. Shipman*, 716 F.3d 107, 119 (4th Cir. 2013) (noting federal law requires single state agency, not managed care plans, to be responsible and concluding, “One head chef in the Medicaid kitchen is enough”); *Shakhnes v. Berlin*, 689 F.3d 244, 248 (2d Cir. 2012) (affirming single state agency requirement where state had delegated responsibilities to local entities); *Hillburn v. Maher*, 795 F.2d 252, 261 (2d Cir. 1986) (noting that single state agency requirement derives from desire to focus accountability for program operation); *J.K. v. Dillenberg*, 836 F. Supp. 694 (D. Ariz. 1993) (finding state action and due process rights being implicated when managed care organizations decided requests for behavioral health services); see also *San Lázaro Association Incorporated v. Connell*, 286 F.3d 1088, 1101 (9th Cir. 2002) (noting that single state agency requirement ensures “systemwide efficiency” and “systemwide performance”); *Cota v. Maxwell-Jolly*, 688 F. Supp. 2d 980, 997 (N.D. Cal. 2010) (refusing to allow agency to “pass the buck” to private contractors and finding plaintiffs likely to succeed on due process claim where agency planned no notice of reduction of Medicaid-covered adult day services).

contractor in violation of the law, the state Medicaid agency has the legal responsibility for the violation and the duty to correct it. As a federal district court judge in the District of Columbia recently concluded, “it is patently irresponsible to presume that Congress would permit a state to disclaim federal responsibility by contracting away its obligation to a private entity.”<sup>5</sup>

Importantly the single state agency must ensure compliance with a number of beneficiary protections that are established by statute and the U.S. Constitution.

**Medicaid Notice, Hearing, and Information Requirements.** The Medicaid Act requires the state to “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.”<sup>6</sup> Regulations implement this statute. The regulations require, among other essentials, that the applicant or beneficiary be informed in writing of the right to a hearing “[a]t the time of any action affecting his or her claim.”<sup>7</sup> The notice must contain, among other information, “the rea-

<sup>5</sup> *Salazar v. District of Columbia*, 596 F. Supp. 2d 67, 69–70 (2009) (quoting *John B. v. Menke*, 176 F. Supp. 2d 786, 800–801 (M.D. Tenn. 2001)). See *Catanzano v. Dowling*, 60 F.3d 113, 118 (2d Cir. 1995) (noting that “to presume that Congress would permit a state to disclaim federal responsibilities by contracting away its obligations to a private entity” would be “patently unreasonable”) (citation and internal quotations omitted).

<sup>6</sup> 42 U.S.C. § 1396a(a)(3). See 42 C.F.R. §§ 431.200–431.246 (fair hearings for applicants and beneficiaries), 438.400–438.424 (grievance system for Medicaid managed care); *Medicaid and Children's Health Insurance Program (CHIP) Programs: Medicaid Managed Care*, 80 Fed. Reg. 31098, 31283–85 (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); *CENTERS FOR MEDICARE AND MEDICAID SERVICES, THE STATE MEDICAID MANUAL* § 2900.

<sup>7</sup> *Informing Applicants and Beneficiaries*, 42 C.F.R. § 431.206(c)(2). See *id.* § 431.201 (defining “action” as “termination, suspension, or reduction of Medicaid eligibility or covered services”).

## If guidelines are being kept secret by a contractor in violation of the law, the state Medicaid agency has the legal responsibility for the violation and the duty to correct it.

sons for the intended action.”<sup>8</sup> Numerous courts have applied these rules to require states and contracting entities to correct deficient notices.<sup>9</sup> For example, in *L.S. v. Delia* a federal court found that the North Carolina Medicaid agency and a managed care company likely violated Medicaid protections when they used assessment tools to reduce home-and-community-based services without explaining “the significance of the score or how to challenge it.”<sup>10</sup>

The Medicaid regulations also spell out fair hearing requirements. The agency must “make available to an applicant or beneficiary, or his representative, a copy of the specific policy materials necessary—(1) [t]o determine whether to request a fair hearing, or (2) [t]o prepare for a fair hearing.”<sup>11</sup> Upon requesting a hearing and prior to the hearing, a claimant must have an opportunity to examine the claimant’s case file, as well as the documents and records that will be relied upon at the hearing by the agency.<sup>12</sup> At the hearing, the claimant must be allowed to present witnesses and cross-examine adverse witnesses who are

responsible for the decision.<sup>13</sup> The fair hearing decision must be based exclusively on the evidence introduced at the hearing.<sup>14</sup>

Enrollees in managed care settings have added rights to receive information about covered benefits. The state or its contractor must ensure that potential enrollees receive summary information about the benefits that will be covered by the managed care plan, “but the State must provide more detailed information upon request.”<sup>15</sup> The enrollee or potential enrollee should get this information within a time frame to be able to use it to make an informed choice among available health-plan alternatives.<sup>16</sup> Moreover, when a managed care entity is using practice guidelines, the managed care entity should disseminate them “to all affected providers and, upon request, to enrollees and potential enrollees.”<sup>17</sup>

Taken together, these provisions should require managed care entities and the state to supply specific information about the assessment tools and coverage criteria that are used to decide which benefits are covered.

### Procedural and Substantive Constitutional Due Process Requirements.

Medicaid beneficiaries have constitutional rights to procedural and substantive due process.<sup>18</sup> The U.S. Supreme Court has long recog-

nized procedural due process rights to prior notice and a meaningful opportunity to be heard when an individual is in jeopardy of losing benefits, such as medical care.<sup>19</sup> Specifically “a recipient [must] have timely and adequate notice detailing the reasons for a proposed termination, and an effective opportunity to defend...”<sup>20</sup> At a minimum the agency must “explain, in terms comprehensible to the claimant, exactly what the agency proposes to do and why the agency is taking this action.”<sup>21</sup>

As explained by *Goldberg*, Medicaid enrollees have five irreducible constitutional protections 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 pretermination notice informing the claimant of the right to continue benefits pending a final

<sup>19</sup> See *Mathews v. Eldridge*, 424 U.S. 319, 348 (1976) (holding that due process rights vary among property interests and that specific dictates require consideration of (1) private interest affected by action; (2) risk of erroneous deprivation of that interest through procedures being used and probable value of additional procedures; and (3) government’s interest, including fiscal and administrative burdens that additional procedural requirement would entail); *Goldberg v. Kelly*, 397 U.S. 254 (1970) (holding that when welfare benefits are terminated, recipient has due process rights to meaningful notice and pretermination hearing); *Mullane v. Central Hanover Bank and Trust Company*, 339 U.S. 306, 314–15 (1950) (holding that, when threatened with loss of property interest, due process under Fourteenth Amendment requires that state must give “notice reasonably calculated, under all the circumstances, to apprise interested parties of the pendency of the action and afford them an opportunity to present their objections”). See generally *Board of Regents of State Colleges v. Roth*, 408 U.S. 564, 577 (1972) (noting that property interests subject to due process are created by “existing rules or understandings that stem from an independent source such as state law—rules or understandings that secure certain benefits and that support claims of entitlement to those benefits”).

<sup>20</sup> *Goldberg*, 397 U.S. at 267–68.

<sup>21</sup> *Ortiz v. Eichler*, 616 F. Supp. 1046, 1061 (D. Del. 1985), aff’d, 794 F.2d 889 (3d Cir. 1986); *id.* at 1062 (“If calculations of a claimant’s income or resources are involved, [the agency] must set forth the calculations it used to arrive at its decision, i.e., explain what funds it considers the claimant to have and what the relevant eligibility limits are. This detailed information is needed to enable claimants to understand what the agency has decided, so that they may assess the correctness of the agency’s decision, make an informed decision as to whether to appeal, and be prepared for the issues to be addressed at the hearing.”) (citations omitted). See Hager & Jones, *supra* note 8.

<sup>8</sup> *Content of Notice*, *id.* § 431.210(b). See *Sovereign Hager & Ty Jones, What Does Due Process Mean for State Notices on Receiving Public Benefits?*, CLEARINGHOUSE ARTICLE (Feb. 2016).

<sup>9</sup> See, e.g., NATIONAL HEALTH LAW PROGRAM, THE ADVOCATE’S GUIDE TO THE MEDICAID PROGRAM 2.23 & nn.380–82 (May 2011 & Supp. Oct. 2012) (citing cases).

<sup>10</sup> *L.S. v. Delia*, No. 5:11-cv-354, 2012 U.S. Dist. LEXIS 43822, at \*46 (E.D.N.C. March 29, 2012).

<sup>11</sup> *Availability of Agency Program Manuals*, 42 C.F.R. § 431.18(e). See *id.* § 431.18(g) (stating agency “must make copies of its program policy materials available without charge or at a charge related to the cost of reproduction”).

<sup>12</sup> *Procedural Rights of the Applicant or Beneficiary*, *id.* § 431.242(a)(1).

<sup>13</sup> *Id.* § 431.242(b)–(e). See, e.g., *Ortiz v. Eichler*, 794 F.2d 889, 895–96 (3d Cir. 1986) (finding hearing officer could not admit into evidence or consider statements by witnesses not present for cross-examination by claimants).

<sup>14</sup> *Hearing Decisions*, 42 C.F.R. § 431.244(a).

<sup>15</sup> *Information Requirements*, *id.* § 438.10(e)(2)(ii).

<sup>16</sup> *Id.* § 438.10(e)(1)(ii).

<sup>17</sup> *Practice Guidelines*, *id.* § 438.236(c).

<sup>18</sup> *U.S. Const. amend. XIV*, § 1.

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.<sup>22</sup> In sum, when government action may injure an individual and the reasonableness of the action depends on a finding of fact, “the evidence used to prove the Government’s case must be disclosed to the individual so that he has an opportunity to show that it is untrue.”<sup>23</sup>

A number of court cases have assessed the constitutional requirements for due process when Medicaid services are denied, reduced, or terminated.<sup>24</sup> In particular, these constitutional minimums have protected Medicaid beneficiaries against service reductions made pursuant to state-sponsored assessment tools. In *Mocznianski v. Ohio Department of Job and Family Services*, for example, the Medicaid agency used the Ohio Developmental Disability Profile to reduce Mocznianski’s in-home services from 112 to 72 hours per week, notwithstanding that her condition and circumstances were unchanged from when the state deemed the 112 hours per week of care medically necessary. Because of the static nature of her condition, Mocznianski questioned the validity of the Ohio Developmental Disability Profile and asked to see it. The state refused to permit examination. Citing *Goldberg*, the Ohio Court of Appeals ordered disclosure:

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[T]he instrument is a decisive measure. It is simply unimaginable that the operation of such a device should not be disclosed to an individual whose benefits are in jeopardy by its application. In our view, maintaining the operation of the [Ohio Developmental Disability Profile] as a secret is not in conformity with the *Goldberg* dictate that evidence be disclosed and that all decisions regarding a recipient’s eligibility must be based solely on evidence adduced at a hearing.<sup>25</sup>

The constitutional concepts were also applied in *Baker v. Department of Health and Social Services*.<sup>26</sup> *Baker* arose after the Alaska Medicaid agency implemented a 13-page “personal care assessment tool” for state-contracted nurses to use to determine eligibility for personal care attendant services. In the months following introduction of the assessment tool, over 900 individuals experienced reductions of services. Affected individuals complained that the written notices they received did not convey the data needed to allow them to appeal the determination. Citing *Goldberg*, the court ruled for the plaintiffs. The court rejected the agency’s argument that “notice” should be broadly construed to include not only the written notice but also other information enrollees received about the assessment process. Because the plaintiffs were welfare recipients, the court found that the agency 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.”<sup>27</sup>

Constitutional due process includes a substantive component under the Fourteenth Amendment that prohibits the government and its agents from acting in an irrational, arbitrary, or capricious manner that deprives an individual of a property interest (such as Medicaid).<sup>28</sup> A number of courts have relied upon this due process protection to require states to use ascertainable standards in gauging

<sup>22</sup> *Goldberg*, 397 U.S. at 269–71. See also *Provision of Hearing System*, 42 C.F.R. § 431.205(d) (requiring Medicaid hearing system to comply with *Goldberg*).

<sup>23</sup> *Goldberg*, 397 U.S. at 270 (quoting *Greene v. McElroy*, 360 U.S. 474, 496–97 (1959)).

<sup>24</sup> See, e.g., NATIONAL HEALTH LAW PROGRAM, *supra* note 9, at 2.23 & n.379 (citing cases).

<sup>25</sup> *Mocznianski v. Ohio Department of Job and Family Services*, 195 Ohio App. 3d 422, 431 (Ohio Ct. App. 2011).

<sup>26</sup> *Baker v. Department of Health and Social Services*, 191 P.3d 1005 (Alaska 2008). See generally *Allen v. Department of Health and Social Services*, 203 P.3d 1155, 1167 (Alaska 2009) (regarding food stamps).

<sup>27</sup> *Baker*, 191 P.3d at 1010–11. Compare L.S., 2012 U.S. Dist. LEXIS 43822, at \*49–50 (finding constitutional violation likely where recipient was notified that annual budget was being reduced because of “Support Intensity Scale” score but “did not understand the score, how the score was reached, and did not have opportunity for a hearing in front of an impartial decision maker”), *Oster v. Lightbourne*, No. C 09-4668, 2012 WL 691833, at \*16–18 (N.D. Cal. March 2, 2012) (finding notice inadequate when it failed to inform Medi-Cal recipients of role that functional rankings process played in their disqualification), and *Perdue v. Gargano*, 964 N.E.2d 825, 835 (Ind. 2012) (finding Medicaid notice defective and stating, “Providing affected individuals with notice explaining in detail the reasons underlying the state’s adverse decision empowers individuals to protect their own interests and complements the state’s efforts to achieve accuracy”), with *Kuehl v. Washington Department of Social and Health Services*, No. 41076-1-II, 2011 (Wash. Ct. App. Oct. 12, 2011) (finding no violation where notice outlined assessment tool’s formula for reducing hours of home care services and included “Assessment Details” about state’s determination).

<sup>28</sup> See, e.g., *Daniels v. Williams*, 474 U.S. 327, 337 (1986) (Stevens, J., concurring).

eligibility for a program or benefit.<sup>29</sup> Relatedly, state public records laws also require disclosure of the standards that states use to make coverage decisions.<sup>30</sup>

### Recent Medicaid Case Examples

In recent years advocates have begun to enforce Medicaid beneficiaries' rights to information by using the statutory, disclosure, and due process requirements summarized above. The following examples from Idaho, Pennsylvania, and the District of Columbia are illustrative.

#### Understanding Reductions in Home Care Services in Idaho.

*K.W. v. Armstrong* arose after Idaho began using an assessment tool to terminate and reduce services for enrollees in a Medicaid home-and-community-based services program for individuals with intellectual disabilities.<sup>31</sup> The Idaho Department of Health and Welfare calculated an annual budget for each participant,

and payments for the participant's services had to fall within that budget. To arrive at the budget, assessors employed by the department visited participants to evaluate the participants' disability and needs (e.g., medications and activities of daily living); they used a form called an "Inventory of Individual Needs." The assessor entered the information into a computerized form called an "Individualized Budget Calculation." Budget software automatically produced a spreadsheet listing the participant's need categories and the corresponding assigned dollar amounts, with a total annual budget amount included. The software generated a notice informing the participant of the annual budget amount only. Service plans would then be developed. Thereafter the participant received a "service plan notice" stating what services were approved or denied and the participant's right to appeal.

The *K.W.* class challenged this process as violating its Medicaid and constitutional entitlements to adequate notice, and the court entered a preliminary injunction. 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 explaining that the budget could have changed because "laws, rules, or tools may have affected your budget" and stating 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.<sup>32</sup> Not surprisingly the court rejected the notice as inadequate and stated, "Read as a whole, this notice gives participants nothing more than the general explanation that several factors may have

affected their individual budgets."<sup>33</sup> The agency had argued that the revised notice gave 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 ... 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 [the agency]."<sup>34</sup>

Interestingly the agency appealed this case to the Ninth Circuit; the agency challenged the district court's ruling that the calculation of new budgets is an "action" under Medicaid regulation 42 C.F.R. § 431.201. The agency 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 of an "action." The Ninth Circuit rejected the argument.<sup>35</sup> The Ninth Circuit noted that the amount of home-and-community-based services is capped by the individual's budget 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."<sup>36</sup> The Ninth Circuit also affirmed the preliminary injunction under the due process claim; the Ninth Circuit held that enrollees had a property interest in their current budget and rejected the agency's argument that participants could have no expectation that their budgets would continue beyond

29 *Holmes*, 398 F.2d at 265 (finding "ascertainable standards" are needed to avoid ad hoc decision making). See, e.g., *Carey v. Quern*, 588 F.2d 230, 232 (7th Cir. 1978) ("[D]ue process requires at least that the assistance program be administered in such a way as to insure fairness and to avoid the risk of arbitrary decision making. Typically this requirement is met through the adoption and implementation of ascertainable standards of eligibility.") (citations omitted); *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 Schools Incorporated v. Stottlemeyer*, 947 F. Supp. 929, 940–41 (S.D.W.V. 1997) (citing *Holmes* and finding plaintiffs likely to succeed on due process claim because authorization of Medicaid behavioral health services lacked ascertainable standards); *Mayer v. Wing*, 922 F. Supp. 902, 911 (S.D.N.Y. 1996) (same, regarding personal care services). See also *Hallmark Cards Incorporated v. Kansas Department of Commerce and Housing*, 88 P.3d 250, 257 (Kan. Ct. App. 2004) (citing *Holmes* and noting that "[i]n the absence of rules, however, due process requires the agency to demonstrate that its internal and written standards of eligibility for statutory benefits 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 extend *Holmes*).

30 All states have public records laws to allow access to public documents. For citations of states' laws, see [FOIAdvocates, State Public Record Laws](#) (n.d.).

31 *K.W. v. Armstrong*, Nos. 1:12-cv-22, 3:12-cv-58, 298 F.R.D. 479 (D. Idaho March 24, 2014), order clarified by [Nos. 1:12-cv-22, 3:12-cv-58](#) (D. Idaho Feb. 13, 2015), affirmed, [789 F.3d 962](#) (9th Cir. 2015).

32 *K.W.*, 298 F.R.D. 479.

33 *Id.* at 490.

34 *Id.* at 491.

35 *K.W.*, 789 F.3d 962.

36 *Id.* at 971. See also *L.S.*, 2012 U.S. Dist. LEXIS 43822, at \*38, 43 (rejecting defendants' arguments that assessment and notification of budget reductions did not trigger notice and hearing rights because services had not been terminated).

a year because, under Idaho law, the budgets were recalculated annually.<sup>37</sup>

**Obtaining Managed Care Payment Rates in Pennsylvania.** As in most other states, Pennsylvania's Medicaid agency contracts with various managed care organizations to render essential services to enrollees. Litigation arose after individuals complained that they could not obtain timely dental services, even though these services were included and prepaid through the managed care contracts.

Advocates tendered requests to the Department of Public Welfare, the single state agency; the advocates sought the capitation rates that the department paid to the managed care organizations for dental services and the amounts paid by the managed care organizations to provide dental services. The requests were submitted under Pennsylvania's public records law, called the Right-to-Know Law.<sup>38</sup> The department rejected the requests on the grounds that each managed care organization had informed it that the rates were "trade secrets and/or confidential proprietary information" exempted from disclosure.<sup>39</sup> An appeals officer ordered disclosure of the capitation rates and concluded that the trade-secrets-and-confidential-proprietary-information exemption does not extend to a statutorily defined subset of public records—"financial records"—and that the capitation rates were financial records because, among other reasons, they "dealt with the disbursement of billions of dollars in taxpayer funds for the acquisition of health insurance for



Medicaid participants.”<sup>40</sup> The managed care rates remained secret, however. The advocates appealed, and the Pennsylvania Supreme Court ultimately found that managed care rates neither were exempted from the Right-to-Know Law nor were they trade secrets. The court concluded that the arguments for nondisclosure greatly understated the relationship between the government and managed care organizations, as the “subcontracts containing [managed care r]ates plainly ‘deal with’ [the department]’s disbursement of billions of dollars of public monies to provide access to essential healthcare to vulnerable populations, as well as the Department’s acquisition of services to meet its own obligation under federal and state law (albeit through middlemen).”<sup>41</sup> By contrast, the court refused to order disclosure of

the rates of payments made by managed care subcontractors to the actual providers of dental services to Medicaid enrollees because the court found that these rates were confidentially negotiated between the subcontractors and the providers and were not part of the standard contract between the department and the managed care organization.<sup>42</sup> Given the importance of health services and the associated significant expenses, the court called on the state legislature to tackle the secrecy of third-party records downstream from the actual Department of Public Welfare contracts.<sup>43</sup>

**Revealing Clinical Coverage Guidelines in the District of Columbia.** In *Salazar v. District of Columbia* the plaintiffs in this certified class action case moved to compel discovery after Health Services for Children with Special Needs, a managed care organization based in Washington, D.C., denied a class member’s request for in-home services. According to the organization, it based the denial on the InterQual clinical coverage guidelines for

37 *K.W.*, 789 F.3d at 973–74.

38 Right-to-Know Law, 65 PA. CONS. STAT. ANN. §§ 67.101–67.3104 (2015).

39 *Department of Public Welfare v. Eiseman*, 125 A.3d 19, 22 (Pa. 2015), affirming in part and reversing in part [85 A.3d 1117](#) (Pa. Commw. Ct. 2014) (discussing Right-to-Know Law).

40 *Eiseman*, 125 A.3d at 22 (quoting Final Determination in *Eiseman v. Department of Public Welfare*, No. AP 2011–1098, slip op. at 15 (Office of Open Records Sept. 17, 2012)).

41 *Id.* at 30. See generally, e.g., [Wilmington Star-News Incorporated v. New Hanover Regional Medical Center Incorporated](#), 480 S.E.2d 53, 57 (N.C. Ct. App. 1997) (holding price lists contained in contract between public hospital and private health maintenance organization could be trade secrets but were not exempt from disclosure under trade secrets exception to public records act because lists belonged to public agency, not private person); [Tulsa Tribune Company v. Fulton](#), 696 P.2d 497, 500 (Okla. 1984) (rejecting nursing homes’ claim that Medicaid cost reports and audits were trade secrets protected from public disclosure).

42 *Dental Benefit Providers Incorporated v. Eiseman*, Nos. 48 EAP 2014, 49 EAP 2014, 50 EAP 2014, 124 A.3d 1214 (Pa. 2015), affirming [86 A.2d 932](#) (Pa. Commw. Ct. 2014).

43 *Dental Benefit Providers Incorporated*, 124 A.3d at 1223.

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## Advocates working with affected clients can take a number of commonsense approaches to ensuring that government contracting does not result in confusion and secret operations.

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in-home services.<sup>44</sup> The “InterQual Criteria” are evidence-based treatment standards developed and copyrighted by McKesson, a health care services company, which, in turn, has licensed their use to Health Services for Children with Special Needs.<sup>45</sup> Health Services for Children with Special Needs uses the InterQual Criteria to authorize, reauthorize, and terminate home health, private-duty nursing, and personal care services being prescribed for children enrolled in Medicaid.<sup>46</sup>

Health Services for Children with Special Needs and McKesson refused to supply the InterQual Criteria and claimed that they were protected by the D.C. Uniform Trade Secrets Act and the federal copyright statutory scheme.<sup>47</sup> 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.<sup>48</sup> The court reasoned that to presume that Congress would permit Washington, D.C., to disclaim its responsibility to ensure enforcement of these laws by contracting away its obligations to managed care organizations, such as Health Services for Children with Special

Needs, or their licensors, such as McKesson, would be “patently irresponsible.”<sup>49</sup>

After the defendants asked for reconsideration of the disclosure order, the court assessed the interests of the parties. On the one hand, the court acknowledged McKesson’s financial interest and noted that the InterQual Criteria were copyrighted and (at the time of the discovery motion) licensed to more than 4,000 health plans, hospitals, government agencies, and managed care organizations.<sup>50</sup> On the other hand, the court recognized that the plaintiffs had an obligation to monitor compliance with the settlement and needed to know what criteria Health Services for Children with Special Needs relied upon to make treatment decisions. The court was also persuaded by the particular challenges faced by parents and caretakers of children with special needs:

[I]t is essential for them to know what criteria [Health Services for Children with Special Needs] 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 those 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 care for their children even if they are not entitled to Medicaid benefits.<sup>51</sup>

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49 *Id.* (citations omitted).

50 *Salazar*, 750 F. Supp. 2d at 68.

51 *Id.* at 70.

Disclosure was ordered, subject to a protective order. Notably the court’s opinion rejected a number of limitations suggested by the defendants that the court found to be “far too restrictive,” including items that would have limited disclosure to cases where authorization for specific services had already been denied; required plaintiffs to use the InterQual Criteria only in instances of denial or termination of benefits for specific members of the plaintiff class; required the plaintiffs to use “anticopy” paper; and required plaintiffs to obtain written permission from McKesson before any release at any time.<sup>52</sup>

### Recommendations

States are increasingly contracting with outside entities to operate government functions. As I have discussed, these contracts cannot deprive Medicaid beneficiaries of their rights to information about how the Medicaid program works and how the program’s rules have been specifically applied to the beneficiaries’ cases. Advocates working with affected clients can take a number of commonsense approaches to ensuring that government contracting does not result in confusion and secret operations.

First, 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 that 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 whether or not it has delegated decision-making responsibilities to another entity.

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52 *Id.* at 69.

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44 *Salazar v. District of Columbia*, 596 F. Supp. 2d 67 (D.D.C. 2009), motion to reconsider granted in part and denied in part, 750 F. Supp. 2d 65 (D.D.C. 2010).

45 *McKesson, InterQual Criteria* (n.d.).

46 *Salazar*, 596 F. Supp. 2d at 68.

47 17 U.S.C. §§ 101–1332 (2014) (copyright law); *Uniform Trade Secrets Act*, D.C. Code §§ 36-402 to 36-410 (2014).

48 *Salazar*, 596 F. Supp. 2d at 69. See *id.* (quoting Information Requirements, 42 C.F.R. §§ 438.10(f)(6)(v)–(vi), which entitle individuals to information about amount of benefits and “procedures for obtaining benefits, including authorization requirements,” to be given “in sufficient detail to ensure that enrollees understand the benefits to which they are entitled”).

Second, 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 enrollee 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 the enrollee's services and how these tools and guidelines were applied in the enrollee's specific case—with enough specificity and in a way that allows the enrollee to understand the basis for the action and whether and how to challenge it.

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.

Third, keep in mind that an agreement for purposes of a single fair hearing will not fix the systemic use of secret standards. Additional advocacy may be needed to get Medicaid officials to revoke or restrict the secret policies. The laws and cases establishing enforcement requirements for procedural due process, ascertainable standards, and Medicaid notices and hearings will be at the foundation of this advocacy effort.

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