

CHAPTER 10

MEDICAID

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About The Author

David H. Williams is the Litigation Director for Southeast Louisiana Legal Services. For the twenty years before assuming that position his primary focus was on public benefits litigation and advocacy, with Legal Services, in a private practice, and in collaboration with the state's Protection and Advocacy system. His litigation practice has included successful injunctive class actions, defense of the constitutionality of the Fair Housing Act in the U.S. Fifth Circuit Court of Appeals, and successful constitutional challenges and defenses to Louisiana unemployment statutes in the Louisiana Supreme Court. He is a 1986 *magna cum laude* graduate of Harvard Law School and 1979 *summa cum laude* graduate of Duke University with a degree in Public Policy Studies and Economics.

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1. INTRODUCTION

The underlying structure of the federal Medicaid program is complex. But it often provides rights and protections for clients with dire needs for services that have been denied.

Central state staff making Medicaid program decisions are often unaware of, forget, or misunderstand the applicability of the federal requirements. Other program staff are usually never privy to federal statutes, regulations, or other guidance, especially the staff who interact with the claimants. This creates an important role for lawyers and other trained advocates in reviewing and challenging state actions for not conforming to federal rights. Challenges can be appropriate regarding both denials of eligibility, and also denials of services for those who have Medicaid cards.

Importantly, as set out below, often other routes are more likely to obtain relief for the client than requesting a fair hearing.

This chapter describes eligibility, the limitations periods and best forums for seeking relief, how to find the standards governing Medicaid issues, and sets out Medicaid rights most frequently at issue for impoverished clients.

The chapter deals with Medicaid, not Medicare. (Clients can have either, or both.) Medicaid eligibility is currently shown either by a plastic card that says "Health Network of Louisiana" or for some recipients, a paper printout that is good for no more than three months. The Medicare eligibility and coverage that elderly and some individuals with disabilities get from the Social Security Administration is very different. Medicare recipients get a red, white, and blue card.

2. ELIGIBILITY FOR MEDICAID

To be eligible for Medicaid, one has to be in one of the categories of persons eligible for assistance, meet the income and resource limits for that category, and not be disqualified by some other eligibility conditions. This Chapter will look at these issues from a problem-solving perspective: first for a person denied as over-income, than as over-resource. After that disqualifications will be discussed.

If you are determining whether a client is eligible who has not yet been denied, look through the categories listed in § 2.1.4 and then consider the resource limit for the categories that might apply (§ 2.2.1) and skim the headings concerning disqualifications (§ 2.4) to spot any other issues that might need to be developed

2.1. CLIENT HAS BEEN DENIED AS OVER-INCOME.

Persons with disabilities or who are elderly often can qualify for Medicaid with income over the SSI amounts. Children can sometimes qualify with income over the CHIP limit (200% of poverty). And many parents can qualify even if not pregnant and ineligible for FITAP (the state's TANF program for families).

A frequent situation where recipients run into income problems occurs for SSI recipients at age 62. If the recipients were SSI-only, then at age 62, Social Security will require that they take early retirement in order to access Title II benefits, which reduces or ends their SSI payments. If the retirement benefits exceed the maximum SSI benefit amount by more than \$20, the recipient will lose their SSI, and potentially the Medicaid that comes with it. A similar problem

occurs for people initially certified for disability. They will often initially be certified for SSI, but if their Title II disability exceeds the SSI amount, lose their SSI and potentially their Medicaid. For clients in this particular situation, there is no universal way to extend Medicaid. There may or may not be a way to extend their Medicaid eligibility, from following the process described below.

2.1.1. Interview questions

If income eligibility is at issue, always find out:

- * What is all the income of household members, including which income is for which members?
- * Are income figures client is giving you gross or net (including whether any Medicare premiums have been deducted)?
- * Did the client receive SSI in the past? If so, when was the last time and why did it end?
- * Do they receive Social Security?
- * If they do not think they received SSI in the past, how did they first receive Social Security? Was it for disability? Did they get a lump sum? About when? Did they have a lot of assets then, that would have made them ineligible for SSI? (People who received a disability backpayment usually are paid SSI initially and are often treated legally and by the computer systems as having been on SSI even if they do not know it, and this can be a gateway to eligibility for Medicaid categories that would not otherwise be open to them.)
- * Is the recipient's SS check (if any) on their Social Security number (top right corner of notices), or is it based on the earnings of a parent (deceased, disabled, or retired) or former spouse?
- * Is the person needing medical coverage living with minor children, and if so, how is he or she related to those children?
- * What is the person's age?
- * Does the person have medical bills nearing the amount of their income over three months, for services within the three calendar months before they applied for Medicaid (or if they have not applied, in the three most recent calendar months)?

The answers to these questions may determine whether clients qualify under some eligibility categories that the agency may have overlooked.

As to all Medicaid intakes that cannot be resolved on the spot, always get a HIPAA compliant release addressed to the Department of Health and Hospitals. If information from the Social Security Administration may be needed get one directed to SSA as well.

2.1.2. Overview of reviewing income eligibility

In reviewing the cases of those who appear to be income-ineligible, the following sequence can simplify the problem:

- * Check if the client can qualify under one of the highest income limit eligibility categories providing full or nearly full Medicaid coverage.
- * Check if the client can qualify under any other eligibility categories.
- * Check the appropriate income exclusions and deductions were applied.

- * Check the special Medicaid rules on treatment of income and resources.
- * Usually it is inappropriate to get distracted by “medically needy” eligibility.

The sections below elaborate on these steps.

2.1.3. Check if the client can qualify under one of the highest income limit eligibility categories providing full or nearly full Medicaid coverage

The following categories are among the most likely refuges for persons who are elderly or have disabilities but are over income for the most commonly considered Medicaid categories. They are more fully described, with all the other categories, in § 2.1.4 below.

If a category’s higher income limit seems to solve the client’s income problem, be sure the client meets the other specific requirements for the category, like its resource limit (if any).

Medicaid Purchase Plan (up to 500% of the federal poverty line): Eligibility for persons meeting the SSI disability criteria, aged 16 – 64, and working at least part time for wages

“Pickle” eligibility: For former recipients of SSI who transitioned to solely Title II benefits. All Social Security cost of living adjustments since the loss of SSI are excluded from income. If the person lost SSI long enough ago, income can be several times the current SSI maximum.

Early Widows/Widowers or “SGA” Disabled Widows: For former recipients of SSI who lost it because of eligibility for Widow(er)’s benefits, and are not yet eligible for Medicare because they are not yet age 65. If eligible for SSI but for the receipt of the Widow(er)’s benefits, they are eligible for Medicaid.

Home and Community Based Services “Waivers”: These provide eligibility for those with incomes up to *at least* three times the SSI maximum (and sometimes higher), for those who qualify as needing a “facility level of care.” (Those in facilities can qualify with this much income or more.) Most of the waivers have multi-year waiting lists. Sometimes there are emergency slots for persons for whom the waiver will preclude institutionalization.

PACE -Program of All-inclusive Care for the Elderly: For persons aged 55 or above who would otherwise qualify for a nursing facility level of care. On enrolling, all of the recipient’s medical services will be through PACE, rather than through other medical providers. Services are centered at a particular location, so the program is only available living near a PACE center. Income can be up to three times the maximum SSI benefit.

2.1.4. Check if client can qualify under any of the other eligibility categories

Tables listing the income eligibility lines for most Medicaid programs are found at §§ Z-200 (poverty-based lines), Z-300 (Medically Needy), and Z-700 (three times the maximum SSI benefit, used for facility care and many waiver recipients) of the Medicaid Eligibility Manual. (These are the lines governing countable income. Since not all income is countable, recipients’ income can actually be over those lines.) Categories giving less than “full” Medicaid coverage are identified in § 8.1, *infra*, if not below.

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Those charts do not encompass other categories that are not based on the poverty lines or medically needy lines. The categories not covered include LIFC, for Low Income Families with Children, the various LIFC extensions (based on earnings or having child-support income), or the categories that make certain people who have lost SSI still eligible for Medicaid.

The following is a list of all the Medicaid categories Louisiana covers as of late 2012.

2.1.4.1. SSI recipients and former SSI recipients

SSI	SSI recipients qualify for Medicaid coverage, except to the extent that they are subject to a Medicaid disqualification. Disqualifications are usually related to trusts or transfers of resources, and usually affect only eligibility for Long Term Care services. <i>If a recipient has put assets into an annuity, Louisiana often judges the annuity under the trust and transfer rules.</i> ¹ Persons over age 65 need not be disabled to qualify for SSI, and over half their earned income is not counted against income limits. ²
SSI (no check)	Persons not receiving SSI because of recoupment or because the SSI payment would be less than \$10 remain eligible for Medicaid.
SSI (appeal)	Persons appealing termination of SSI. Medicaid can make its own determination of eligibility until all timely SSI administrative appeals are exhausted, even if the SSI has stopped. ³
SSI (PASS)	Persons with disabilities but income or resources over SSI standards. Under a Plan for Achieving Self Support (PASS) approved by SSA, some income and/or assets are disregarded, to allow recipient to accumulate enough for a purchase that will facilitate economic independence. (These recipients get certified for SSI by SSA.)
Disability Medicaid	Person who meets all eligibility requirements for SSI, but not receiving SSI. Usually these are people who apply directly for Medicaid while their SSI application is still being processed or is on administrative appeal.
§1619	Former SSI recipient, who still has the impairment that made him or her eligible for SSI disability and is working but not earning enough to compensate for the loss of Medicaid coverage. Eligibility must be determined by SSA. In 2012, eligibility extends to \$ 30,157 per year, and can be higher if the individual can prove it is not enough to make up for his or her loss of SSI and Medicaid. ⁴

¹ Louisiana Medicaid Eligibility Manual, hereafter "MEM", § I-1674.5.

² As noted in § 8.3.1, *infra*, the Social Security Administration does not certify for the potential retroactive Medicaid period, three and a fraction months before the SSI application. Sometimes Medicaid staff must be prompted to do the certification. See also MEM § H-700.

³ See § 2.3, *infra*.

⁴ <https://s044a90.ssa.gov/apps10/poms.nsf/lnx/0502302200>.

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Pickle eligibility	Former recipients of SSI who receive Title II (non-SSI Social Security) benefits. All Social Security cost of living adjustments since the loss of SSI are excluded from income. The person is eligible for Medicaid if the amount of their Title II benefit the month after they lost SSI is within current SSI eligibility limits. They must have lost SSI since April, 1977. ⁵
Early or Disabled or SGA Disabled Widows/ Widowers and Disabled Surviving Divorced Spouses	Former SSI recipients who are widows, widowers, or surviving divorced spouses age 50 or over, receiving Social Security under their deceased spouse's Social Security number, not yet eligible for Medicare. Any income other than from Social Security must be under the SSI income limits. ⁶
Extended Disabled Adult Child	Former SSI recipients who receive Social Security checks under a parent's Social Security number and became disabled before age 22. Any income other than from Social Security must be under the current maximum SSI amount.
Section 4913 Child	Child under age 18 who was on SSI 8/22/96 and later terminated because of revised children's disability standards. These children are entitled to Medicaid as long as they would have received SSI under the pre-1996 ("Zeb-ley") disability standard. The child's disability is irrebutably presumed to be continuing, without reviewing medical records. ⁷
PSP	Prohibited SSI Provisions-person ineligible for SSI because of a provision that does not apply under the Medicaid statute, e.g., deeming of step-parent income or resources, or treatment of proceeds from homophilia blood products litigation, <i>Walker v. Bayer</i> . ⁸ See §§ 2.1.6 & 2.2.5, <i>infra</i> , for other provisions that do not apply in Medicaid, such as requirements that resources be available and reasonably evaluated, etc.

⁵ The person must have been entitled to both Title II (non-SSI Social Security) and SSI benefits in the month before losing SSI. But the two programs count which months the payments are for differently. This requirement is usually met, as long as Title II checks began the month after the last SSI check. See MEM, SH-610.

Persons who received a Social Security lump-sum payment that was at any time designated as being at least partly for SSI, and those who never got an SSI check because it would have been less than \$10 are treated as having been SSI recipients. It may be necessary to check Social Security computer coding to know if the client is deemed to be a former SSI recipient.

SSI need not have been lost because of a cost-of-living adjustment. Many people eventually qualify for Pickle who lost SSI because their Social Security amount was always above SSI levels. An annual update with the figures needed to calculate Pickle eligibility is posted on the internet. The 2013 update is currently posted at <http://www.nslc.org/index.php/table-helps-calculate-medicaid-eligibility-under-pickle-amendment>. Calculations may be more complicated if more than one Social Security recipient is in the household. 42 C.F.R. § 435.135(b).

Persons receiving Aid to the Aged, Blind, or Permanently and Totally Disabled (the predecessors to SSI) in 1972 can have still another cost-of-living increase disregarded. 42 C.F.R. § 435.134.

⁶ As set out in 42 C.F.R. § 435.138(a)(3), the Social Security benefits can be early retirement benefits, not just disability benefits, as long as the widow(er) is disabled. **The regulation's description of these categories is incomplete.** For example, the statute does not include a requirement that the widows be age 60, and based on SSI program changes made in 1991, they can be any age over 50. 42 U.S.C. §§ 1383c(d), 1396v(a)(2)(B).

⁷ MEM §§ I-1415, I-1416.

⁸ MEM § I-1415.1; this may be based on the federal regulations concerning situations where the original SSI records cannot be accessed. 20 C.F.R. 416.994a(e).

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State retirees	State government retirees who lost SSI because of cost of living adjustments to state retirement benefits. This coverage, described in §X of the state's Medicaid Eligibility Manual, is state-funded, and not really federal Medicaid.
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2.1.4.2. Other categories related to SSI eligibility

Medicaid Purchase Plan (MPP)	For persons meeting SSI disability criteria, aged 16 – 64, and working, with countable income under 250% of poverty. (Because the SSI income disregards are applied, this can allow income over 500% of the poverty line.) Work must be at least part-time (undefined), and must be paid. Work can be sheltered work, provided through the generosity of an organization or friend. Those with countable incomes over 150% of poverty pay a monthly premium well below market rates. The recipient must take advantage of any no cost health insurance available to him or her. ^{9,10} The MEM policy states that the impairment must meet a Listing. ¹¹ The author has not seen this policy applied, and there is no basis for it in the federal statute. ¹²
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Breast or cervical cancer (B/CC)	Individuals with breast or cervical cancer as determined by the Centers for Disease Control's early detection program, under age 65 and without health insurance that will currently cover treatment for their breast or cervical cancer. ¹³ Income must be under 250% of poverty.
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TB	TB-infected, and income and resources low enough to qualify for SSI. This eligibility only covers certain TB services.
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2.1.4.3. Partial coverages for those eligible for Medicare

Qualified Medicare Beneficiary (QMB)	Medicare eligibles with countable income under poverty lines. The annual Social Security cost of living adjustment (added to check in January) does not count against eligibility until the new year's poverty lines are in effect (usually in April). ¹⁴ QMB covers almost everything that full Medicaid covers except non-emergency medical transportation, dentures, ¹⁵ personal care services, and some home health services/supplies/equipment. Not limited by Medicaid's 12 physician visits per year limit, etc. Unlike other Medicaid, there is no three month retroactive coverage period for QMBs. ¹⁶
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⁹ 29 La.Reg. 2399 (Nov. 20, 2003); 29 La. Reg. 1963 (Aug. 20, 2003).

¹⁰ It is possible the category should not apply if the individual has unearned income exceeding the SSI limits, but state policy has no such limitation. See 42 U.S.C. § 1396a(a)(10)(A)(ii)(XV).

¹¹ MEM § H-2120.2.

¹² Compare 42 U.S.C. § 1396a(a)(10)(A)(ii)(XV).

¹³ 27 La. Reg. 2072 (Dec. 20, 2001).

¹⁴ 42 U.S.C. 1396d(p)(2)(D), 1396a(a)(10)(E).

¹⁵ But see *Law v. DHH*, 43, 417 (La.App. 2 Cir. 8/13/08), 989 So.2d 871) (holding that state statute requires DHH cover dentures for QMB recipient).

¹⁶ 42 U.S.C. 1396d(a).

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Specified Low-Income Medicare Beneficiary (SLMB)	Medicare eligibles with countable income under 120% of poverty. The annual Social Security cost of living adjustment (added to check in January) does not count against eligibility until the new year's poverty lines are in effect (usually in April). ¹⁷ The coverage only pays the cost of Medicare Part B premiums and entitles one to the Medicare "Extra Help" for prescription coverage. No services are covered through Medicaid for SLMBs.
Qualified Individual ("QI-1")	Medicare eligibles with countable income under 135% of poverty and no other Medicaid coverage. Coverage (and exclusion of the annual cost of living adjustment) is the same as for SLMBs. The statutory authorization for the program periodically expires, but so far has been renewed each time the date is reached. ¹⁸
Qualified Disabled & Working Individuals (QDWI)	Working Medicare eligibles with incomes up to 200% of poverty, and not otherwise eligible for Medicaid . Medicaid will cover their Medicare Part A premiums.
"Extra Help"	Assistance through Social Security, with Medicare Part D prescription plan premiums and cost sharing, for Medicare recipients with incomes under 150% of poverty and resources under \$11,570 (\$23,120 for couples) in 2012. ¹⁹ (This is not Medicaid.)

2.1.4.4. Women who are pregnant or of child-bearing age

CHAMP-PW	Woman who while pregnant had an income under 200% of poverty. The woman remains eligible to the end of the month in which the sixtieth day after the end of the pregnancy falls. Income increases during this period do not end the eligibility. ²⁰ The unborn is counted as a person in determining household size.
LaCHIP Phase IV	Pregnant low income uninsured woman not eligible for most Medicaid because of citizenship restrictions, with countable income under 200% of poverty. Application must be made while still pregnant.
Take Charge	Woman ages 19 to 44 (inclusive) who can bear children, not insured or otherwise eligible for Medicaid, with countable income at or under 200% ²¹ of poverty. Benefit package is limited to family planning services only, including physical examinations and lab tests, family planning education and counseling, medications and supplies, and voluntary sterilization procedures. ²² Certification is for 12 months regardless of income changes.

¹⁷ 42 U.S.C. §§ 1396d(p)(2)(D), 1396a(a)(10)(E).

¹⁸ See 42 U.S.C. § 1396a(a)(10)(E)(iv), currently listing a December 2012 end date. Even before a statutory extension is enacted, the provision could be extended in an appropriations bill. So if an extension is not apparent in the statute, check back-up center Websites for information, such as www.healthlaw.org, www.nslc.org, and www.medicareadvocacy.org.

¹⁹ The resource limit increases with inflation. For current limit see <https://secure.ssa.gov/apps10/poms.nsf/lnx/0603030025>.

²⁰ 42 U.S.C. § 1396a(e)(5,6).

²¹ DHH announced in July 2012 that it would reduce the eligibility standard to 133% of poverty. <http://www.dhh.louisiana.gov/index.cfm/newsroom/detail/2550>. Through mid-October 2012 no policies, regulations, or web pages have been

²² changed to implement such a change.

MEM § H-2200.

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2.1.4.5. Children under age 21

Continuous Eligibility	Child under age 19 who was determined eligible for Medicaid within the last 12 months in any category but Medically Needy remain eligible for the full 12 months regardless of changes in circumstances, with only very limited exceptions. ²³ As an example of the effect of this, children in families certified for six months of FITAP, who did not go in for a FITAP redetermination at the end of the six months, remain eligible for the full 12 months of Medicaid. If a client needing this 12 months of coverage was certified as Medically Needy, check whether they <i>should</i> have been certified in another Medicaid category within the last 12 months. ²⁴
Deemed Eligible Child	Child under the age of 1, whose mother is certified for Medicaid for the child's date of birth. The child is deemed eligible until age 1, regardless of changes in income or the mother's Medicaid eligibility, unless the mother surrenders or unequivocally abandoned the child. (Usually no application has to be filed; a form gets filed by the hospital or Bayou Health plan reporting the birth, which results in certification.)
LaCHIP	Uninsured children under age 19, not in a public institution or institution for mental disease, with family income at or below 200% of Federal poverty lines.
CHAMP-QC	Child under age 6, under 133% of poverty. Child age 6 – 18 (inclusive), with family income at or below 100% of Federal poverty lines
Family Opportunity Act	Child with a disability in a family with gross income under 300% of Federal poverty lines (plus an \$85 income disregard). Child is required to accept (& pay for) health insurance if employer pays at least 50% of the cost. For families with incomes over 200% of poverty, premiums must be paid to Medicaid.
LaCHIP Affordable Plan ²⁵	Uninsured child under age 19 (who has not dropped employment based health insurance in last 12 months without good cause), with family income between 200 and 250% of Federal poverty lines.

²³MEM § H-1910. A change published in the Louisiana Register purported to rescind this eligibility for children with disabilities. 34 La. Reg. 253 (February 2008). But there is no authority in federal law for excluding children with disabilities, and the MEM was later revised to withdraw the exclusion. See 42 U.S.C. § 1396a(e)(12).

²⁴If so, the other category trumps the Medically Needy eligibility, since Medically Needy is only for persons ineligible under other categories. 42 C.F.R. § 435.4.

²⁵MEM § H-580.

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F, I, O, or V	Foster children and children with special needs receiving adoption assistance. Children for whom federal foster care maintenance payments or adoption assistance payments are being made under the Social Security Act are automatically eligible for Medicaid. So too are foster children placed in child care institutions by or through OCS/OYD or for whom OCS/OYD has financial responsibility, children of foster children, and children receiving state adoption subsidies. ²⁶ <i>Some children in foster care are solely state-funded. They, too, are given Medicaid cards, but it may not be true Medicaid, but a state-funded surrogate.</i> ²⁷
Youth Aging Out of Foster Care	Individual under age 21 who was in foster care on his or her 18th birthday. There is no income or asset test, and no application is required if the youth was in foster care in Louisiana. Children whose foster care was in other states are eligible by applying if they become Louisiana residents.
Louisiana Behavioral Health Partnership	Children found to need community behavioral health services to reduce psychiatric hospitalizations, with income up to three times maximum SSI amount (not counting their family's income). The child's countable resources must be under \$2000. ²⁸

2.1.4.6. Families with children under age 19, including caretaker relatives and other children living with them.

For these categories, the family must meet most of the requirements of the now-repealed AFDC program, except as noted in the category description or elsewhere in this Chapter. The most significant requirement is that the family must include at least one child (under age 18, or 18 years old and expected to complete secondary or vo-tech school before age 19) who is living with a caretaker relative within the "fifth degree of relationship" or must include a woman in her third trimester of pregnancy. (A second-cousin is at the fifth degree of relationship.) The old AFDC "deprivation" requirement is considered met if the family meets other program requirements.²⁹

Once a child meets the modified AFDC criteria, their parent(s) and full -and half-siblings living with them must be included in the assistance unit (unless on SSI or a child with excess income or resources), and all other children living with them can be included on the card (as "essential persons" under the state's old AFDC standards). If the child is not living with a parent, their caretaker relative can optionally be included. Including more people gets Medicaid for more ***unless they have income or resources that make the assistance unit ineligible***. (References below to the "family" are actually to the assistance unit.)

²⁶OCS has been delegated responsibility to certify many of these children. That does not relieve DHH, the Medicaid "single state agency" of responsibility when there is a problem. See 42 C.F.R. § 431.10.

²⁷This is category "O." MEM, §E-340.

²⁸MEM, §§ H-900 (eligibility for children not already on Medicaid), H-2700 (description of the Louisiana Behavioral Health Partnership more generally).

²⁹MEM § I-510.

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LIFC The family meets the AFDC rules and income standards in effect on July 16, 1996, plus some liberalizations (like no resource limit).³⁰

LIFC-Transitional Medicaid The family stopped meeting requirements based on the July 16, 1996 AFDC requirements (but slightly liberalized) due to an increase in earned income in the past twelve months. The family must have received LIFC coverage for 3 of the 6 months before the increase in income. Because Louisiana staff do not offer clients their “choice of category” as required by a federal regulation,³¹ a family that could have qualified for LIFC that received any kind of Medicaid should be deemed to meet the requirement of having received LIFC. To be eligible the seventh through 12th month, the family must meet certain reporting requirements (or have good cause not to), and have income under 185% of the poverty line. There is a divergence of opinion as to whether three months of retroactive Medicaid, preceding the application date, fulfill the 3 of 6 months requirement.³² Because FITAP has higher eligibility standards and different earned income disregard than Medicaid, some families on FITAP may not be eligible for Transitional Medicaid for the full 12 months. The provision is currently set to expire December 2012 (reverting to a four month extension of Medicaid)³³ but has been repeatedly extended at past sunset dates. Because an extension can occur through an appropriations act or continuing resolution that would not be reflected in the U.S. Code, check organizational websites, such as www.healthlaw.com, if the provision seems to have expired.

LIFC-Child Support Continuance³⁴ The family stopped meeting the slightly liberalized July 16, 1996 AFDC requirements in the past four months due to an increase in child support income. Must have received LIFC for 3 of the 6 months before the month in which the family became ineligible due to child support income. The divergence of opinion as to whether the three months of retroactive Medicaid fulfill the “three months” requirement.³⁵ As explained in MEM § H-1520, this extension should rarely be needed, because of the PAP rules set out in the category just below.³⁶

³⁰The state's AFDC replacement program, FITAP, has income thresholds \$50 above the LIFC threshold for each household size. All FITAP recipients are certified for Medicaid. For all but a one person assistance unit, persons with incomes between the FITAP and LIFC lines should be Medically Needy. Some of the one-person assistance units certified for FITAP should not even be Medically Needy. Because FITAP adults receive this liberalized treatment, those applying directly through the Medicaid agency should be entitled, as well. 42 U.S.C. § 1396a(a)(10)(C)(i)(III).

³¹42 C.F.R. § 435.404; *see also* 42 C.F.R. § 435.905.

³²*See* 42 U.S.C. § 1396u-1(b)(1) (defining “receiving” assistance under the old AFDC plan as being eligible for it). Louisiana, however, does not usually certify recipients for the three months of retroactive Medicaid unless there were medical expenses in the period at issue. *See* 42 C.F.R. § 435.914(a)(1).

³³*See* 42 U.S.C. 1396a(e)(1)(B) and 1396r-6(f).

³⁴MEM § H-1510; 42 U.S.C. §§ 1396a(a)(10)(A)(i)(I), 1396u-1(c)(1); 42 C.F.R. § 435.115(f)-(h).

³⁵*See* 42 U.S.C. 1396u-1(b)(1) (defining “receiving” assistance under the old AFDC plan as being eligible for it).

³⁶MEM § H-1520 points out that since child support income only counts against the child, the intended recipient should usually be placed in a higher income eligibility (CHAMP or CHIP) and the custodial parent would continue to be eligible for LIFC, rather than the time-limited child support extension.

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Prohibited AFDC Provisions	Person is ineligible under the July 1996 AFDC standards (plus liberalizations adopted by Louisiana Medicaid) because of income or resources that are not their own, their spouse's, or their natural parent's. Medicaid law allows "deeming" of income and resources only parent-to-minor-child and spouse-to-spouse. Usually at issue are child support or Survivor's Benefits of a minor child, or income of a step-parent, Minor Unmarried Mother's parent, or alien sponsor. ³⁷ Other extended family members with problematic income or resources should already be excluded as not being part of the "AFDC" assistance unit. If non-parental or non-spousal income or resources exist and the applicant is not eligible in this "PAP" category, all other Medicaid categories should be considered as well, disregarding non-parental, non-spousal income in assessing <i>every</i> Medicaid eligibility.
Regular Medically Needy	For persons not eligible for Medicaid on another basis and with countable monthly income under the Medically Needy Income Level (a little higher than the old AFDC income standards) in families with a child under age 19 within required degree of relationship.

2.1.4.7. Coverage for persons needing a facility level of care

To qualify under these categories the individual must still be aged, blind, disabled, a child, pregnant, or in families with children meeting the "fifth degree" relationship requirement.

Long Term Care facilities usually are nursing facilities or an Intermediate Care Facility for the Developmentally Disabled ("ICF/DD"). The latter includes group homes as well as larger facilities. But a hospital stay exceeding 30 days is also Long Term Care. Medicaid does not cover care in "Institutions for Mental Diseases" (certain psychiatric facilities) unless the recipient is under age 21 or age 65 or older.

For all eligibilities below, as part of the application process the agency must certify that a facility-level of care is required. An agency notice denying such a level of care is needed is, of course, appealable.

DHH is using various assessment tools and algorithms to give the level of care eligibility determination the appearance of rigor and incontestability. But often judgment calls are buried in the codings assigned to a client. The advocate should do his or her own assessment of how the client should score on the pertinent part of the instrument that determines eligibility. If it seems to the advocate that the client should have qualified, obtain DHH's instruction manuals and determine if the interviewer developed all the facts in the manner suggested by the guides. Also, if the client has been certified for a facility level of care in the past, obtain the prior results, and use them to question the inconsistency. Some condi-

³⁷ A consent decree prohibited the Department from denying or terminating Medicaid to persons who would be eligible for AFDC but for that program's step-parent, sibling, and half-sibling deeming rules. The decree should still apply with respect to Medically Needy assistance. *Thomas v. Robinson*, M.D.La. CA No. 85-0717, Consent Decree (12/12/85), ¶¶ 4, 5.

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tions do not improve. As to others, if the client scored as eligible before, a differing result on a current administration should at least create a duty of inquiry to explore what seems to have changed and whether it is realistic and appropriate to consider the client's condition to have improved.³⁸

LTC/SSI-related	Disabled adult or child, or person age 65 or above, in or expected to be in an LTC over 30 days with <i>gross income</i> under 3 times the maximum SSI payment amount.
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LTC/MNP	Disabled adult or child, or person age 65 or above, in or expected to be in an LTC over 30 days whose income, after medical expenses (including premiums and facility costs), \$20 disregard, and any other applicable disregards, is under the Medically Needy Income Level (\$92 rural, \$100 urban). In essence this extends LTC eligibility to persons whose incomes are near the cost of facility care.
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C-LTC	Child or caretaker relative of a minor child in or expected to be in Long Term Care facility 30 to 90 days with countable income under the LIFC levels. ³⁹
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Home and Community based "Waiver" services ⁴⁰	Qualifies for a level of care equivalent to nursing facility or ICF/DD level of care for at least 30 days. Gross income can reach to at least 3 times the maximum SSI payment amount. ⁴¹ The normal deductions from income are not allowed. The applicant is treated as if in an institution, so parents' income and resources are not counted against a child; spousal impoverishment rules are applied as to spouses.
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The state is permitted to limit how many people receive these services, so there are usually multi-year waiting lists for service. But sometimes emergency slots can be accessed if necessary to avoid institutionalization.⁴²

³⁸ See e.g. *Weaver v. Colorado Department of Social Services*, 791 P.2d 1230 (Colo. App. 1990), where the court found instrument scoring results were inconsistent from administration to administration, even though the claimant's physician had stated there had been no changes in his condition. The court found that such arbitrary action violated due process standards.

³⁹ MEM, § H-820.1. As to the higher income coverage for facility residents with incomes up to 3 times the SSI rate, the implementing federal regulation describes this coverage as being for only aged, blind, or disabled individuals, 42 C.F.R. § 435.236, as does the state plan. The statute does not. Compare 42 U.S.C. § 1396a(a)(10)(ii)(V).

⁴⁰ See MEM, § H-900. But it may not be immediately updated if DHH adds new waivers.

⁴¹ The State has amended the Community Choices and ADHC waivers to allow income over 3 times the SSI maximum, though recipients may have to contribute some or all income over that level to their cost of care. It is in the process of amending the other waivers to allow this same eligibility for persons with higher incomes.

⁴² The Medicaid statute requires that those likely to soon need a facility level of care be advised of their options to receive waiver services. 42 U.S.C. § 1396n(c)(2)(C); but see *Grant v. Gilbert*, 324 F.3d 383, 388 (5th Cir. 2003) (holding the provision only protects persons already applying for Waiver services; the court leaves open the possibility that a separate statutory provision may offer relief, only to nursing facility residents). Louisiana usually only tries to do the advising by requiring that those applying for LTC Medicaid (for nursing home care) sign a Freedom of Choice form, stating that they have been advised of the option to receive HCBS. Those applying for Medicaid through other channels usually do not even get informed about the HCBS Waiver services, much less get put on the waiting list. (Even those who do get put on the waiver waiting lists may not get on the *correct* list. The decision as to which waiting list someone is put on is either made by the agency during a phone call, with no notice of the state's other waivers, or by checking off an option on a form that omits many pertinent considerations.)

Someone in serious need of waiver services and too low on the waiting list, may have a claim for an earlier application/waiting-list date: for example, the date a regular Medicaid application was denied or ruled on (without putting the person on the waiting list) or the date of any request to be put on any other waiver waiting list.

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Home and Community based “Waiver” services <i>(continued from previous page)</i>	Most of the waivers include services not ordinarily covered by Medicaid, like home modifications to allow the recipient to remain in the home or additional in-home attendance. Waiver recipients also get full Medicaid coverage, including EPSDT services for those under age 21.
Program of All-inclusive Care for the Elderly (PACE)	For persons aged 55 or above who would otherwise qualify for a nursing facility level of care, and income up to three times the maximum SSI benefit. Like a Health Maintenance Organization, PACE takes over responsibility for all medical care for the individual, with the goal of keeping participants out of nursing facilities. ⁴³ Services are centered at a particular location, so the program is only available for those living near a PACE center.
Coverage for Medicare Skilled Nursing Coinsurance	The state’s Medicaid Eligibility Manual describes two rubrics to get coverage for the very high Medicare Part A Long Term Care co-insurance costs that can be charged recipients who go into a nursing facility after a hospitalization. ⁴⁴ Clients need to actively seek certification for this coverage (which costs Medicaid nothing, since it essentially zeroes out the patient portion of the bill). But it is not described under separate categories in this Chapter since the income guidelines are the one used for LTC/SSI related (three times the monthly SSI maximum) or for medically needy eligibility (medical costs, including facility costs, nearly consume all income). Nursing facilities have a financial interest in not having recipients certified for this coverage, and the Medicaid coverage for persons with incomes over three times the SSI maximum is comparatively new and a complex certification, which could be missed by agency staff.

2.1.4.8. Coverage for other persons who are aged, blind, disabled, or in families with children

Spend-down Medically Needy	For persons not eligible for Medicaid on another basis who are aged, blind, disabled, or in a family with minor children whose recently incurred medical expenses nearly consume all of their countable quarterly income. This “spend-down” is like an insurance deductible—the expenses used to satisfy it do not get paid by Medicaid, only other, additional expenses in a three month period.
Emergency Medical Services ⁴⁵	Coverage for medical care after sudden onset and acute symptoms that could be expected to jeopardize health or organs (including labor and delivery) for persons ineligible for Medicaid because of citizenship requirements. (The recipient would be eligible under one of the other Medicaid categories if he or she were a citizen.) Certification is retrospective, only for the past services; no card is issued.

⁴³ 42 U.S.C. § 1396u-4; see § 8.7.9, *infra*.

⁴⁴ MEM §§ H-840, H-1030.

⁴⁵ MEM § I-315; § 2.4.6, *infra*.

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LBHP MNP The Louisiana Behavioral Health Partnership makes persons eligible for Medicaid if community care is likely to prevent psychiatric hospitalizations. Adults must meet the financial rules of the medically needy program, requiring that their recently incurred medical expenses must consume nearly all of their quarterly income.⁴⁶ This “spend-down” is like an insurance deductible—the expenses used to satisfy it do not get paid by Medicaid, only other, additional expenses in a three month period. For mental health services the benefit will work most readily for those with incomes under \$112 a month (rural) or \$120 a month (urban).⁴⁷

2.1.4.9. Affordable Care Act and other coverage for those not otherwise eligible for Medicaid

Greater New Orleans Community Health Connection (GNOCHC) Not actually under the Affordable Care Act, but a precursor, this Medicaid (§ 1115) waiver provides primary care (clinic) coverage only for persons with incomes under 200% of poverty, who have been uninsured at least 6 months, and are not eligible under the traditional Medicaid categories. Recipients must reside in Orleans, St. Bernard, Jefferson, or Plaquemines Parishes.⁴⁸ The waiver originally promised to cover prescription drugs, but this was phased out, supposedly after opportunity for public input, but it was not well publicized.

Refugee Medical Assistance Refugee, asylee, Cuban Haitian entrant, Iraqi or Afghan Special Immigrant, or severe trafficking victim not otherwise eligible for Medicaid, within 8 months of arrival or of grant of asylum. Covers full range of Medicaid services. Newborns borne to mother are eligible through the end of the mother’s 8 months. Income must be under the Medically Needy Income Level, with or without deducting recent medical expenses (“spend-down”).

Pre-Existing Condition Insurance Plan (PCIP) Not Medicaid, but under the Affordable Care Act, persons who have been without health coverage for at least six months who have a pre-existing conditions can purchase deeply subsidized coverage.⁴⁹ The monthly premium varies by age and which of three plans are selected. The low cost plan is currently \$296 a month for persons age 45-54 and \$411 for those over age 55.

⁴⁶ MEM, § H-1060.

⁴⁷ See MEM § Z-300.

⁴⁸ MEM § H-2600.

⁴⁹ <https://www.pcip.gov/#StateInformation>; https://www.pcip.gov/Who's_Eligible.html

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Affordable Care Act Medicaid expansion	Under the health care reform act (“Affordable Care Act”), if not repealed, as of January 1, 2014 states can cover non-disabled, non-pregnant adults under age 65 who are not eligible for Medicare or otherwise eligible for Medicaid, with incomes up to 138% of the federal poverty line. This coverage was to be mandatory, and was to be 100% federal funded for 2014 through 2016 and at least 90% federally funded thereafter. Under the Supreme Court’s decision in <i>National Federation of Independent Business v. Sebelius</i> , ⁵⁰ the federal Medicaid agency cannot cut off funding for states that do not offer this coverage. Louisiana’s Governor has announced he intends to decline the option. Income counting rules for the new eligibility will be based on modified adjusted gross income (IRS rules) rather than traditional Medicaid rules. The state can make a set of services available to the group that is less than under traditional Medicaid.
Subsidized coverage through insurance “exchanges”	Unaffected by the Supreme Court’s decision in <i>National Federation of Independent Business v. Sebelius</i> , beginning in 2014 (unless repealed) the 2009 Patient Protection and Affordable Care Act also provides subsidies in the form of refundable tax credits for private insurance purchased for persons with incomes from 100-400% of poverty. These credits are also available for legal immigrants with incomes below 100% of poverty and not eligible for Medicaid.
Prescription assistance programs	Pharmaceutical companies may offer assistance with drug costs based on individual showing of need or sometimes more generally to Medicare recipients. ⁵¹

2.1.5. Check if the appropriate income exclusions and deductions were applied.

Especially if a client is close to an income limit or if there is earned income (for which there are large disregards), deductions and disregards can be as important as the income limits. The deductions and disregards that apply depend on whether an applicant is considered part of a family with minor children (“C-related”) or instead as an aged, blind, or disabled individual (“SSI-related”).⁵² If an applicant fits both characterizations, then he or she gets to take advantage of whichever rules are more favorable.⁵³

As an example, until 2014 for someone being evaluated under the C-related categories, the first \$50 a month of child support the family receives gets excluded

⁵⁰ 132 S.Ct. 2566 (2012).

⁵¹ See § 8.7.1.8, *infra*.

⁵² 42 U.S.C. § 1396a(r)(2); 42 C.F.R. §§ 435.401(c), 435.601(a, b). The Medicaid regulations repeatedly refer to some states as using more restrictive Medicaid standards than are used in the SSI program. Such states are often called “209(b) states.” They do not give Medicaid to all SSI recipients, but only persons who would have qualified under their

⁵³ program for the aged, blind, and disabled that preceded the SSI program. Louisiana is not a 209(b) state.

⁴² C.F.R. § 435.404.

from consideration, and the first \$90 in earned income is excluded. (After 2014, income tax rules will be used for determining C-related income.) But a child who is also disabled can, as an alternative, qualify under an SSI-related category. SSI rules would exclude: one third of its child support income, the first \$85 and one half of the family's remaining earned income; and additional income is based on the number of family members the parents' income supports. Different income limits are available in the SSI-related and C-related categories.

Also, because of the differing rules, for someone certified as Medically Needy, who is both C-related and SSI-related, the amount of their spend-down may differ depending on whether he or she is certified as C-related or SSI-related.

2.1.5.1. Income rules for those who qualify as aged, blind, or disabled

Louisiana, like most states, has agreed to follow Social Security Administration rules for determining eligibility of applicants or recipients who are aged (aged 65 or older) or blind or disabled.

Those who are aged, blind, or disabled are termed "SSI-related." They are SSI-related even if their income or resources make them ineligible for the SSI program. For these individuals, the most important income deductions and exclusions are:

- the first \$20 a month of income (of any type) and
- the first \$65 a month in earned income plus *half of their remaining earned income*. The rules also allow subtraction of many medical expenses of people who returned to work while still disabled.⁵⁴

But any other income exclusions and disregards from the SSI program also apply. So the SSI regulations on income should be checked, as the best list of exclusions and disregards.⁵⁵

For married individuals living with their spouse, the rules require both that the individual's countable income be below the individual SSI amount, and that the income when combined with the spouse's be below the couple's SSI amount.

State Medicaid programs have the option to liberalize most income and resource rules.⁵⁶ Louisiana has chosen not to count "in-kind support and income" against SSI-related applicants.⁵⁷

As to their Medicaid eligibility, SSI-related couples who are in the same medical or long-term care facility can be treated as a couple or as individuals, whichever is to their advantage.⁵⁸ (If only one spouse of a couple is in or expected to be in a facility for at least 30 days, income eligibility is judged under the normal rules. But in determining how much income they must contribute to their "patient liability" or "cost of care," spousal impoverishment rules allow certain amounts of income to pass out to the "community spouse.")

2.1.5.2. Income rules for those who qualify as being child-related or in a family

The rules that apply at least until 2014 to eligibility categories designed for families with children (who may or may not have disabilities) come from the federal Aid to Families with Dependent Children program (AFDC), which was

⁵⁴"Impairment-related Work Expenses," see 20 C.F.R. §§ 416.979 and 416.1112(e)(6).

⁵⁵20 C.F.R. Part 416, Subpart K.

⁵⁶42 U.S.C. § 1396a(f)(2).

⁵⁷30 La. Reg. 2489 (November 2004).

⁵⁸MEM § H-831.4(B); 42 U.S.C. § 1382(e)(3).

repealed in 1996.⁵⁹ Absent change, beginning in 2014 (with different dates for different individuals⁶⁰) this will change, to use IRS concepts in determining the income of these individuals (except children in foster care or receiving IV-E adoption assistance and for Medically Needy assistance).⁶¹

The AFDC rules exclude or deduct:

- The first \$90 a month of earned income per working individual. For the first 12 months of earnings, an additional \$30 of earned income is disregarded. For the first four months of employment disregard still another 1/3 of the remaining earned income. (Do not use FITAP's \$900 earned income disregard; this disregard did not exist under the AFDC program.)
- Dependent care costs needed for employment or employment-related education or training (up to \$200 a month for child care for children under 2; \$175 a month for those who are older, this can include for care for elderly dependents in the household).
- The first \$50 a month in child support the family receives.
- Child support paid outside the home.
- Educational grants and loans.
- SSI recipients and their income and resources from the household.

A notable exception to application of the AFDC rules is that under the old AFDC rules, an unborn child was not counted as a member of the household until the third trimester. Louisiana now counts the unborn as a household member from conception, at least when there are other children in the household.⁶² This increases the maximum income level the household can have.

Under the IRS rules that may apply in 2014 and thereafter, countable income is based on "Modified Adjusted Gross Income" (MAGI), taking Adjusted Gross Income (the bottom line of the first page of the IRS 1040 tax form), and adding back in foreign income, tax exempt interest, and Social Security income that was excluded.⁶³ There will continue to be no resource test for eligibility, as is already the case for these categories in Louisiana. The biggest changes are loss of the AFDC disregards set out in the paragraph above and that the following types of income will no longer count against eligibility, since not included in IRS Adjusted Gross Income: child support received, alimony received, pre-tax contributions to retirement and health insurance cafeteria plans and flexible spending accounts. In addition, the IRS rules create a standard filing unit of persons whose income is determined together, using a single MAGI figure. This will also presumably trump Medicaid protections that have prevented deeming income against eligibility in the past except spouse to spouse and from parent to minor child.⁶⁴ In addition, by adopting the tax household, sometimes income of additional people will be counted against eligibility, like that of students over age 19.

⁵⁹ See 42 U.S.C. § 1396u-1. Those AFDC rules can be found in the 1996 editions of 42 U.S.C. § 601 et seq., and 45 C.F.R. Parts 201 - 237.

⁶⁰ 42 CFR § 435.603(a).

⁶¹ 42 CFR § 435.603(j). Language in the regulation also suggests the new rules may not apply as to persons seeking or receiving Personal Care Services or Home Health Services (which includes medical equipment and supplies for use in the home, misnomered "Durable Medical Equipment" in Louisiana.) § 435.603(j)(4). Since these services can be received by persons in almost any eligibility category, the implication is unclear.

⁶² 29 La. Reg. 910 (June 20, 2003).

⁶³ See 42 C.F.R. § 435.603(e).

⁶⁴ See 42 C.F.R. § 435.603(f).

States are to come up with income thresholds that use the new rules that continue the eligibility of about the same number of individuals who were eligible under the old standards.⁶⁵ But this does not require that every individual eligible under the old rules also qualify under the new thresholds.

2.1.6. Other Medicaid provisions that trump the AFDC and SSI methodologies

2.1.6.1. Deeming prohibitions

The Medicaid statute prohibits counting income or resources available to only some household members against other people not entitled to it, except from spouse to spouse, and parent to minor child.⁶⁶ Therefore, income of step-parents, most minors, and grandparents cannot be counted against other household members' Medicaid eligibility, unless actually made available to them in cash. The qualification about income being made available "in cash" is important. Often the benefit that other household members receive from another's income is in-kind: food, bills paid, etc. And spending can often be re-arranged in this manner if this is not already occurring. Under the AFDC-linked rules, in-kind income usually is not counted against eligibility.⁶⁷ Louisiana has also opted to not count "in-kind support and maintenance" as to categories for which it can exempt the income.⁶⁸

Louisiana's Medicaid agency has created separate categories partially recognizing the eligibility created by the deeming prohibitions ("PAP" and "PSP"), but the deeming prohibitions apply program-wide and are not limited to the categories with the lowest income limits, as might be implied by those particular two categories.

As mentioned in the immediately preceding section, these protections may end for most recipients and applicants in 2014, when IRS rules will govern most eligibility for persons under age 65.

2.1.6.2. Children are entitled to 12 months of Medicaid at a time, even if the circumstances causing them to qualify end.

As referenced in § 6.4, Louisiana has opted to provide "Continuous Eligibility" for a full twelve month period any time a child is determined eligible for any kind of Medicaid other than Medically Needy coverage. Once a child is determined eligible for Medicaid, by any agency (DHH, DCFS, or SSA) they are entitled to a full 12 months of coverage, regardless of changes in circumstances. So if a family fails to attend their six-month FITAP redetermination appointment, the children remain entitled to Medicaid without any break until 12 months after when they were last recertified. Disabled children certified for a short period of SSI (such as while in a hospital, when their parents' income is not counted against their eligibility), are entitled to the full 12 months of Medicaid. This provision might also effectively extend a four month eligibility certification (for children losing LIFC eligibility due to child support) or six month certification (for LIFC Transitional Medical Assistance based on earnings) to 12 months of eligibility.

⁶⁵ 76 Fed.Reg. 51148-01 (8/17/11) (Notice of Proposed Rulemaking). The proposed rules were adopted at 77 FR 18310-01 (3/27/2012).

⁶⁶ 42 U.S.C. § 1396a(a)(17)(D); 42 C.F.R. § 435.602(a).

⁶⁷ MEM § I-1524 ("In-Kind Income").

⁶⁸ MEM § I-1534 ("In-Kind Income" and "In-Kind Support and Maintenance (ISM)"); 30 La. Reg. 2489 (November 20, 2004).

2.1.6.3. Only the spouse's income and resources count against the eligibility of a family member living in a facility or seeking waiver services

The income of family members (and resources, other than those of the spouse) do not count against the Medicaid eligibility of family members in or expected to be in a facility (including hospitals, nursing facilities and ICF/DDs) for 30 days. The same rule is applied to those receiving or applying for Home and Community Based "Waiver" Services.⁶⁹ Eligibility rules posted on the internet show that at least some states apply the rule to hospice services, too.

But for non-disabled children, the agency counts their family's income and assets against their eligibility for the first 90 days they are in a facility. This is based on the state's 1996 AFDC policy, and may be challengeable.

2.1.6.4. Blood products litigation settlements

The Medicaid statute exempts the settlement received by hemophiliacs as part of litigation against blood products manufacturers from being counted against any Medicaid eligibility.⁷⁰ This applies to all Medicaid eligibilities. It applies to the original settlement; income the assets earn is not protected, unless otherwise shielded under Medicaid law. The settlement proceeds also do count against SSI eligibility; most people affected will be former SSI recipients.

2.1.6.5. Only counting income and resources that are available and reasonably evaluated

The Medicaid statute also requires that only income and resources that are actually available and reasonably evaluated be taken into account.⁷¹ Surprisingly, though, courts have held that Medicaid agencies can nonetheless count income as "available" even though the applicant is required to pay it out to others as child support.⁷²

As to income, this protection may be superseded for most applicants and recipients in 2014, when IRS rules will govern. See § 2.1.5.2, *supra*.

2.1.6.6. Other exceptions that the state may develop over time

States are permitted to make liberalizations from the rules of the SSI and AFDC programs, as long as no individuals are disadvantaged.⁷³ Louisiana's Medicaid agency has done this many times. As a result, rules may change still further after publication of this Manual. Most or all liberalizations would be promulgated using in the Louisiana Register.

2.1.6.7. Other possible protections

The statutory section setting out these last requirements and the deeming prohibition is 42 U.S.C. § 1396a(a)(17). In dealing with special income or resource situations with sound equities but not favored under the rules set out by the agency or this Chapter, review this statute again to consider whether it may protect the client. It has language that might have implications for a client's particular situation. For example, it requires that standards be "reasonable," "comparable," and "consistent with the objectives of" the Medicaid Act.

⁶⁹ 42 U.S.C. § 1396a(a)(10)(ii)(VI); MEM § H-921.4(A).

⁷⁰ Balanced Budget Act of 1997, Pub.L. 105-33, § 4735; MEM § I-1416.1.

⁷¹ 42 U.S.C. § 1396a(a)(17)(B,C).

⁷² *Peura By and Through Herman v. Mala*, 977 F.2d 484 (9th Cir. 1992); *Emerson v. Steffen*, 959 F.2d 119 (8th Cir. 1992); *Tarin v. Commissioner of the Div. of Medical Assistance*, 424 Mass. 743, 678 N.E.2d 146 (Mass. 1997).

⁷³ 42 U.S.C. § 1396a(r)(2).

2.1.6.8. In extreme situations, where the individual is under age 65, consider use of an “income trust”

Individuals who meet the Social Security disability standards and are under age 65 are allowed to transfer their own resources or income into a “pooled trust” run by a non-profit on behalf of persons with disabilities.⁷⁴ If they have forms of income that are transferable,⁷⁵ it may be possible to assign excess income to a pooled trust in order to qualify for Medicaid. The recipient can then receive the benefit of the income in forms that do not count against Medicaid eligibility, notably in-kind. Most pooled trusts will not handle such frequent transactions, and the costs of administration are not inconsiderable. But if a person needs health coverage to access life-saving medications, this avenue can be considered.

2.1.7. Usually it is inappropriate to get distracted by Louisiana’s very limited “medically needy” eligibility.

Looking to Medically Needy eligibility last benefits claimants, since Medically Needy coverage is not as broad as standard Medicaid coverage. First, there is usually a deductible (discussed immediately below). Secondly, Louisiana never covers some services for the Medically Needy (though some of its restrictions are illegal).⁷⁶

There are two kinds of Medically Needy eligibility: “Regular Medically Needy” and “Spend-Down Medically Needy.” The Regular Medically Needy are those whose incomes are under the income eligibility limits (called the MNIES, for Medically Needy Income Eligibility Standard). The MNIES in urban parishes is \$100 monthly for a single person, and goes up by less than \$100 per additional person.⁷⁷ The lines are slightly lower for rural parishes. Those who are Regular Medically Needy get certified for six months of Medicaid.

Few in Louisiana qualify as Regular Medically Needy. Because of the configuration of Louisiana’s categories, it is nearly impossible for people in SSI-related categories to be Medically Needy without a spend-down.⁷⁸ Adults in families with income slightly over the “LIFC” limits can qualify as Regular Medically Needy.

“Spend-down” eligibility is for those whose income is above the MNIES, but have recent medical bills that, when deducted from their income, bring their income under the MNIES. The federal Medicaid statute requires that states deduct from the income of persons seeking medically needy assistance costs they have incurred for medical care.⁷⁹ This is called the “spend-down.” It will be explained more fully below. Medicaid certifications for spend-down recipients are for up to three months at a time.

Both Medically Needy groups (Regular and Spend-down) must also meet all other Medicaid eligibility requirements (like any resource limit for the SSI-related) and requirements to be either aged, blind, disabled (under the SSI standards) or

⁷⁴ 42 U.S.C. § 1396p(d)(4)(C).

⁷⁵ Compare 42 U.S.C. § 407, preventing assignment of Social Security Title II income.

⁷⁶ For Louisiana’s Medically Needy service limitations, see 24 La.Reg. 955 (May 1998). The list is no longer entirely accurate and of course, particular limitations may be illegal, such as its not covering all EPSDT services for recipients under age 21, as noted in the EPSDT discussion, *infra*.

⁷⁷ The limits are set out at DHH’s MEM. SZ-300. They are based on the income limits of the state’s old AFDC program. 42 C.F.R. §§ 435.811(c), 435.1007(b). The precise methodology for determining them was changed somewhat by the enactment of 42 U.S.C. § 1396u-1(b).

⁷⁸ Someone with nearly no income, but ineligible for SSI because of assets that Medicaid or the state does not count could qualify. An example would be someone with over \$2000 in assets because of the cash surrender value of a life or burial insurance policy. As stated above, Louisiana does not count such policies, with a face value of \$10,000 or less, against the Medically Needy resource limit.

⁷⁹ 42 U.S.C. § 1396a(a)(17).

child-related (children, pregnant women, and certain caretakers living with children or pregnant women). Persons who do not fit within those groups will not qualify as medically needy, regardless of the degree of their medical need.⁸⁰

2.1.7.1. The “spend-down”

The spend-down amount is like a flexible insurance deductible. The size of the deductible depends on the applicants’ income. *Importantly, like an insurance deductible, the bills that make the spend-down amount do not get paid by Medicaid.*⁸¹

The “Spend-Down Medically Needy” have their eligibility reviewed in three month increments. To “spend-down” for three months of eligibility, the applicant needs bills equal to the amount of their countable income in the three month period, after subtracting three times the monthly MNIES from that income.⁸² (In determining countable income, disregard all income that would be disregarded under SSI or AFDC rules, depending on whether the person is C-related or Aged, Blind, or Disabled.⁸³)

As an example of how the spend-down works, a single elderly or disabled person’s countable income may be \$820 a month. If they are in an urban parish their MNIES is \$100 a month, and SSI rules disregard the first \$20 a month in income. The remaining income is \$700 a month, \$2,100 for three months. If the person has at least \$2100 in useable medical bills, he or she can qualify for a three month Medically Needy Medicaid card. But the \$2100 in bills will not be covered by Medicaid.⁸⁴ If he or she had a recent hospitalization that generated a \$9,000 bill, all of that bill but the \$2,100 deductible can be covered by Medicaid.

2.1.7.2. Special Medically Needy rules for persons in long-term care facilities

Louisiana has adopted a federal option to use a shorter spend-down period for persons in long term care. This enables them to qualify for Medicaid based on a smaller spend-down: they need spend-down only one month’s income (minus the MNIES) instead of three months’ income (minus the MNIES).

Louisiana’s other Long Term Care category covers persons with monthly incomes under three times the SSI rate (around \$2,100 in 2012). But the cost of nursing facility care is far higher—even Medicaid pays facilities approximately \$2,500 a month per person. This had the potential to create a tremendous inequity. Those with an income of \$2,000 a month can commit all but \$38 a month of their income and receive full Medicaid coverage. But those with an income of \$2,500 are over the income line and could commit their whole income to the facility cost, and still be at least \$400 short. The medically needy coverage with a one month spend-down bridges this gulf.

⁸⁰ See e.g., 42 C.F.R. § 435.4, defining medically needy as “families, children, aged, blind, or disabled individuals, and pregnant women” meeting certain additional requirements. See also 42 U.S.C. § 1396d(a)(i-xi) (listing groups who can qualify as Medically Needy).

⁸¹ 42 C.F.R. § 435.831(i)(5).

⁸² For an example of how to perform the spend-down calculations, see *Brandenburg v. Office of the Secretary, DHH*, 98-163 (La. App. 3 Cir. 6/3/98), 716 So.2d 100.

⁸³ 42 C.F.R. § 435.831(b)(1&2). As examples: families with children can deduct child care expenses they pay to enable an individual to work or get training, since this was an aspect of the AFDC program; elderly individuals can deduct the first \$65 in earnings, and half of any remaining earned income, since this is part of how the SSI program treats income.

⁸⁴ If the bills that make the spend-down occur on the same day as other services, the agency worker must submit a form to Baton Rouge clearing which bills make up the spend-down and which others are eligible for payment before any of the bills for that first coverage date will be paid by Medicaid.

However, there still is a gap or problem for people whose incomes (minus the MNIES) are over the rate Medicaid pays facilities, but less than the private pay cost of a facility. The federal regulations permit states to *project* long term care expenses for applicants, but in such projections must use the Medicaid facility rate.⁸⁵ For expenses that are not projected, but have already been incurred, there is no such limitation (and such a limitation would be an illegal limitation on what incurred expenses are taken into account).

The result is that those with incomes under the rate Medicaid pays nursing facilities (after deductions and subtracting the MNIES) get a Medicaid card all month and can be certified for six months at a time. Those with higher incomes are eligible only after they have *incurred* enough bills to be eligible. The Medicaid Eligibility Manual instructs staff to hold these applications until the person is eligible.⁸⁶ There are a host of legal claims if the application is instead denied.

2.1.7.3. What bills count towards the spend-down

Medical bills (and insurance premiums, including for Medicare) can be applied towards the spend-down if they are for services received within, or were paid during, the three months for which coverage is sought or the three months before applying.⁸⁷

This means any procedural denial of an application may need to be strenuously challenged or negotiated out. If the applicant instead reapplies, bills that previously were countable may no longer be within the three months before the new application date, and so would no longer count toward the spend-down.

Bills cannot be counted if they were applied towards a previous spend-down that was approved.⁸⁸ Nor can they be included if a third party, such as Medicaid or an insurance company, is required to pay them.⁸⁹

Medical bills voluntarily paid by third parties who are not legally obligated to pay them (like relatives) can be applied to the spend-down.⁹⁰

Bills can be counted once they are “incurred” even if they *have* not been paid. This allows Medically Needy applicants to have income that is more than the MNIES amount to live on. Conversely, older bills can be counted if paid within the three month period for which coverage is sought.⁹¹ This provides a way to increase one’s countable expenses.⁹²

Possibly illegally, Louisiana no longer allows bills within the three months before applying to be used for additional sequential periods determined off the application. Formerly, applicants could elect not to get coverage for the three months before applying (meaning if they came in with a large hospital bill, they could forego coverage of the hospital bill), and that bill would be enough to qualify the applicant for a year of Medicaid (because one year is the maximum period that can be determined off a single application).

⁸⁵ 42 C.F.R. § 435.831(g)(1).

⁸⁶ MEM § H-1041.

⁸⁷ 50 LAC Part III, § 939; 42 C.F.R. § 435.831(f).

⁸⁸ See 42 C.F.R. § 435.831(f).

⁸⁹ 42 C.F.R. § 435.831(d). “Financially responsible relatives” are not treated as a third party. 42 C.F.R. § 435.831(e) (2 & 3).

⁹⁰ *Cohen by Cohen v. Quern*, 608 F.Supp. 1324, 1330 (N.D.Ill. 1984).

⁹¹ 42 C.F.R. § 435.831(f)(5).

⁹² Clients who are nearly eligible may become eligible, by paying on a medical debt just before applying. But because the “spend-down” amount does not get covered by Medicaid, paying on a bill in order to qualify makes sense only if one is seeking a card for a different service, to be received in the time the card will cover.

That procedure seemed correct, since federal law provides that once the applicant is certified, any amounts incurred in the original three month period, that Medicaid does not pay, can be applied to subsequent three month periods covered by the same application.⁹³ Louisiana Medicaid staff now may not give the option to extend one's eligibility additional months this way. They may instead automatically pay all bills subsequent to those needed to meet the spend-down amount.

Regardless of whether the new limitation is legal, the agency cannot certify applicants for only a single-spend down period and then force them to reapply. (On reapplying, the bills preceding the first application would no longer be recent enough to be counted.) Because the federal regulations require that the state agency "Continue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible," the agency must review for additional periods of eligibility without reapplication.⁹⁴

2.1.7.4. What bills can be covered once spend-down eligibility is established

To get Medicaid to pay a bill, it must be within the coverage period, which cannot extend further back than three calendar months before the month in which the client applied.⁹⁵ (For someone who applies May 15th, bills back to February 1 can be counted towards the spend-down and can be paid to the extent that they exceed the spend-down.) And as noted above, bills used in meeting the "spend-down" do not get covered by Medicaid.

The state plan specifies that in meeting the spend-down the agency first applies charges for health insurance, then medical expenses not covered under the Medicaid plan, then expenses that Medicaid would cover.⁹⁶ If the client has bills Medicaid cannot cover, and if done correctly, this maximizes using those bills in the spend-down, and maximizes Medicaid payment towards bills the program can cover.

2.2. CLIENT HAS BEEN DENIED MEDICAID BASED ON EXCESS RESOURCES.

The most frequent avenues for relief for persons who have been denied Medicaid for having too many resources follow, sequenced from easiest to more time consuming.

2.2.1 Check the correct resource limit was applied.

There is no single income and resource limit that determines eligibility for Medicaid. Instead, a person must be pigeon-holed into one of more than forty Medicaid discrete eligibility categories in order to qualify for the program. The forty-plus categories have been created through efforts over time to make it easier for some within the groups to qualify. Different categories have different resource limits. (The categories for non-disabled children and their parents currently have no resource limit.)

As a result, the first step is to confirm that the correct resource limit was applied to a client denied for excess resources.

⁹³ 42 C.F.R. § 435.831(f)(6).

⁹⁴ 42 C.F.R. § 435.930(b); *see also* 42 C.F.R. § 435.916(f)(1) (effective Jan. 1, 2014). A Medically Needy application covers up to a year of eligibility, as long as there is no break in eligibility. MEM, SSG-1700, H-1011.3.

⁹⁵ 42 U.S.C § 1396a(a)(34).

⁹⁶ Louisiana's Medicaid state plan, Attachment 2.6-A, p. 14; *see also* 42 C.F.R. § 435.831(h).

The agency's resource limits for various eligibility categories are listed in charts at §§ Z-900 and Z-2200 of the Medical Eligibility Manual. The limits set out in Z-2200, for the Medicare Savings Categories (QMB, SLMB, and QI) should escalate annually if there have been cost of living increases. The eligibility categories not listed (including all those based on pregnancy or having children in the household) have no resource limit.

Use the SSI rules in determining what counts against the limits

In determining what counts against the resource limit, the SSI rules are followed. (Medicaid relies on either SSI or the old Aid to Families with Dependent Children Program ("AFDC") rules in determining financial eligibility.⁹⁷ The AFDC rules would apply to non-disabled children, pregnant women, and families with children. Because Louisiana does not currently apply a resource test to these groups, only SSI rules are followed in determining what counts against the limits, except to the extent that Medicaid law specifically trumps the SSI rules. If the Patient Protection and Affordable Care Act is implemented in 2014, this will continue, because an implementing regulation provides that resource limits can apply only for SSI-related groups and the Medically Needy.⁹⁸)

For example, a property the client lives on is exempt as their home or residence.⁹⁹ Even if the client is not living on the property but intends to return to it when able, it is exempted as their home.¹⁰⁰ Per SSI rules, the home exemption can also reach any property adjacent to the property the client lives in (even if across the street). Finally, if a spouse or child is living in the home, it is exempt, even if the Medicaid applicant or recipient is not intending to return to it.¹⁰¹ And SSI rules hold that where it would take litigation to access the value of a property, the value is not countable.¹⁰²

But there is a special Medicaid rule that if the client is in a facility over 30 days or on a waiver, only up to \$525,000 of the home's value can be exempted. This is the 2012 figure; the amount may increase annually.¹⁰³ The amount over the excluded amount counts as a resource.

2.2.2. Check if the client can qualify for all services needed under a different category, with a higher or no resource limit.

If the client was in fact over-resource for the category originally considered, then the first and easiest solution is to consider whether the client can qualify for Medicaid under another category, which has a high enough resource limit to make them eligible and which will cover the type of services the client needs.

⁹⁷ 42 C.F.R. §435.601(b).

⁹⁸ 42 C.F.R. §435.603(g).

⁹⁹ MEM § I-1634 Property: Home property. See also *Ouzts v. Secretary, Louisiana Dept. of Health and Hospitals*, 38,634 (La.App. 2 Cir. 7/29/04), 880 So.2d 918(holding value of home property excluded, despite mineral rights).

¹⁰⁰ The Medicaid Eligibility Manual states that the home's exemption is lost if a nursing facility resident places what had been their home up for sale. *Id.* This across the board rule seems incorrect, in that there may be some situations in which one "tests the waters" even though intending to return to the home.

¹⁰¹ *Id.*

¹⁰² POMS SI 01120.010 B.2, C.2; see also 42 U.S.C. § 1382b(b)(2)(B)(exempting property where sale is barred by legal impediment). *Accord Smith v. State Dept. of Health and Hospitals*, 39,368 p. 10 (La.App. 2 Cir. 3/2/05) 895 So.2d 735, 742 (Incompetence of applicant resulted in trust being irrevocable under Illinois law, and thus, trust assets could not be considered when determining applicant's eligibility for Medicaid. Court states in dicta that if Louisiana law applied, "we do not believe that the outcome would change.")

¹⁰³ See MEM § Z-2300.

As set out above in the §§ 5.1 and 6.1, *infra*, any Medicaid application is a gateway to any Medicaid for which the applicant is eligible. And before terminating Medicaid, the agency is required to consider whether the client is eligible under any other category. As a result, if the client was eligible under any category, it was the agency's duty to certify the client.

The Z-900 and Z-2200 of the Medical Eligibility Manual charts should be consulted for additional and up-to-date limits. But the usual resource limits one can consider are:

- No resource limits if one can qualify under the rubrics for children that do not require establishing disability (CHAMP, LaCHIP, etc). This also applies for pregnant women and parents qualifying as the caretakers of dependent children.
- \$6,940, (\$10,410 for a married couple) in 2012 and escalating annually, for Medicare recipients receiving coverage that covers only their Medicare premiums, deductibles, or coinsurance, rather than the usual range of Medicaid services.¹⁰⁴ These Medicaid categories are called "Medicare Savings Programs" (MSP), Qualified Medicare Beneficiary (QMB), Specified Low Income Beneficiary (SLMB), or Qualified Individual (QI). These categories do not cover most nursing facility care and cover no waiver services.
- \$25,000 in countable resources for working persons with disabilities (Medicaid Purchase Plan).
- Over \$113,640 (for 2012 and escalating with inflation), when one member of a married couple is in a nursing, ICF/DD or other medical facility (for over 30 days) or receiving "waiver" services, and the other is not. ("Spousal impoverishment" rules), discussed in § 2.2.3, *infra*.
- \$2000 for one, \$3000 for two, and \$25 per additional person, for Medically Needy eligibility of those who are subject to resource limits.¹⁰⁵
- \$2000 (\$3000 for a couple) for most other categories based on age or disability. For children qualifying based on disability, before measuring resources against the limit, \$3,000 worth of parents' countable resources are excluded in two-parent households (and \$2,000 in a single parent household). This makes the resource limit for most disabled children in two parent households \$5,000.

The advocate's analysis should not stop with the consideration of other categories, if the category covers less than "full Medicaid", and the client needs omitted services. As set out below, other options may be able to retain Medicaid within a category offering full services. The categories that cover less than all services are the Medicare Savings Programs (QMB, SLMB, QI), Medically Needy, QDWI, Taking Charge, TB, Greater New Orleans Community Health Care Connections, Long Term Care (in facilities), and those eligible for only the Louisiana Behavioral Health Partnership.

Ironically, even if the state picks up the expansion of Medicaid that Congress had required occur in 2014, as part of the Affordable Care Act (which the Supreme court's decision in National Federation of Independent Business v. Sebelius,¹⁰⁶ made optional), it will not eliminate the problem of persons who have too many resources to qualify for

¹⁰⁴ MEM § Z-2200.

¹⁰⁵ MEM § Z-900.

¹⁰⁶ 132 S.Ct. 2566 (2012).

Medicaid. It creates a new eligibility group, but requires that the persons in the group be, among other things, under age 65, not on Medicare, not in any of Medicaid's mandatory groups, and have income under 138% of the poverty level.¹⁰⁷ Not all persons with resource problems will fall into the new eligibility group.

2.2.3. Quick options to consider in dealing with excess resources.

2.2.3.1. Caution: first moment of the month rule applies

As to all resource issues, since Louisiana currently only applies resource limits to eligibility categories that are built on the SSI program rules, SSI's "first moment of the month" rule always applies. Whether one is resource-eligible for the whole month is based on the client's situation at the first moment of the month (midnight on the first of the month). So a client who makes a change to his or her resources does not become eligible until the next month. And if a client fails to fully implement a change by the first of the month, it will be another whole month before he or she client is eligible.

2.2.3.2. Convert resources to an exempt form: like a car, home, or a burial account.

Even if over the resource limit, few legal services clients are going to have resources of great value. If the assets are liquid or can easily be liquidated, the client may be able to put them in a form that is exempt. If the client needs a car and could afford ongoing maintenance and insurance, purchasing (or even repairing) a car may advance their situation for a long time, while ending their Medicaid resource problem. If the resource is larger and they can afford ongoing payments and insurance, purchasing a residence would put the funds in an exempt form. If they already own a residence, repairs to it or reducing any mortgage should be considered. Investing up to \$10,000 in a burial account is a universally available option and often recommended by DHH staff.¹⁰⁸ (Clients must be sure not to tap such accounts for other uses.) Amounts under \$2,000 can be spent on "personal goods": furniture, appliances, etc.¹⁰⁹

Clients taking any of these paths should be sure to keep receipts, to be able to prove to the agency that none of the funds were transferred away for less than fair market value. Such transfers cause a severe penalty, discussed at § 2.4.1, *infra*. The Medicaid recipient who had excess assets must be an owner of the car, home, or burial account, to avoid these transfer of asset penalties.

2.2.3.3. Pooled trust

For recipients under age 65 and who meet SSI's disability standards, another option is to place funds in a "pooled trust" managed by a non-profit corporation. These recipients are permitted to transfer even their own funds to such trusts without penalty.¹¹⁰ The recipient loses control over the funds, but the trustee will spend them for the recipient's benefit, on items or services they would not otherwise be able to obtain, in order to improve their lifestyle or health care. This can legally shelter thousands of dollars in assets. There are at least three such trusts willing to serve Louisiana residents, with differing cost structures.

¹⁰⁷ 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).

¹⁰⁸ MEM § 1-1634 "Burial Contracts."

¹⁰⁹ MEM § 1-1634 "Property: Household Goods and Personal Effects."

¹¹⁰ 42 U.S.C. §139p(d)(4)(C).

Third parties can place other funds, that are not the recipient's, into other forms of Special Needs Trusts. But where the funds are already the recipient's, only the pooled trust avoids transfer of asset penalties.

2.2.3.4. One spouse in a facility (or on a waiver), the other not: "spousal impoverishment"

Special Medicaid resource limits and rules apply when a member of a married couple receives Waiver services (including PACE) or is expected to be in a medical facility (hospital, nursing facility and ICF/DD) for over 30 days.¹¹¹ Congress does not intend that the other ("community") spouse's assets be completely depleted in order to qualify for Medicaid.¹¹² Louisiana's implementation of the provision exempts more than \$113,640 of a couple's resources from counting against eligibility.¹¹³ The figure is for 2012 and escalates with inflation. The rule applies during all of a facility stay; there is no requirement that the first 30 days be judged under normal rules.

The spouse not in the facility will be required to take some assets out of the name of the spouse in a facility, within a year of certification for Medicaid, in order to retain eligibility.¹¹⁴ The assets can be transferred into the name of the community spouse without creating a transfer of assets problem.

Particularly with regard to a long hospitalization, agency staff may forget to apply the spousal impoverishment protection.

2.2.3.5. Occupied by a co-owner?

Among the more frustrating situations is that of a client who owns a share of "heir" property, which cannot be exempted as his or her home, because he or she is not living in it, and cannot exempt it as intending to return to it because they live in another property they own. SSI rules though do exempt property occupied by a co-owner who does not own other property they could move into.¹¹⁵ The provision is not echoed in Louisiana's Medicaid Eligibility Manual. But the state office has been convinced to recognize and apply the exemption.

2.2.3.6. Leasing (even to a friend) or gardening can cover \$6,000 in property value.

Another technique to help a client who owns a small share of heir property can be a lease. Up to \$6,000 in value of a property can be excluded if it produces a 6% annual return or profit.¹¹⁶ So if a client has a vacant property worth \$8,000 or less, \$6,000 of the equity value can be excluded by a friend renting it for \$40 a month; the remaining \$2,000 is under most Medicaid resource limits. If the property is worth less than \$6,000, the rent needed is less. Note that the owner has to obtain the 6% return on their whole share of the property, not just the \$6,000 in value that you are seeking to exempt. Also, if the owner has any costs, like taxes, the amount needed to get the 6% return is higher, since recovery of their taxes is not a profit.

¹¹¹ MEM §§ I-1537, I-1661.

¹¹² 42 U.S.C. § 1396r-5.

¹¹³ MEM § Z-800. This figure should be updated annually; if not, the Manual section may be out of date.

¹¹⁴ MEM § I-1665.

¹¹⁵ 42 U.S.C. § 1382b(b)(2)(A); 20 C.F.R. § 416.1245(a).

¹¹⁶ MEM § I-1634 "Property: \$6,000/6% rule."

If someone's medical needs are great enough, a friend or relative is sometimes willing to chip in the \$40 a month to make the person Medicaid eligible. Note that the income will count against eligibility if the client is on SSI or in a facility to which they must pay a share of the cost of care.

The SSI regulations similarly exempt up to \$6,000 in property used for "self-support", like gardening to help feed oneself.¹¹⁷

2.2.3.7. Sell under Bond for Deed

The Medicaid Eligibility Manual provides that if property is sold under a Bond for Deed, it no longer counts as a resource.¹¹⁸ Any net income from a Bond for Deed may count against eligibility if the client is on SSI or in a facility to which they must pay a share of the cost of care. The Bond for Deed should preferably comply with statutory requirements and should be registered in the mortgage or conveyance records.¹¹⁹

The advantage of selling through a bond for deed is that it does not immediately create another resource to have to deal with, unlike a sale for cash.

All sales must be for at least the proper value of the property or the agency will charge a penalty for transferring assets without fair compensation, as discussed in § 2.4.1, *infra*.

2.2.3.8. Allocate shared account to the true owner, if not the client.

If the client's name is on a shared bank account or other financial instrument, but only to help with access, or most of the resource really belongs to someone else, the SSI rules provide relief. The SSI POMS provide that while co-ownership of the funds is presumed, it can be rebutted, through proof of how the money got into the account.¹²⁰ As explained above, Louisiana Medicaid must follow SSI financial methodologies. So even though this rebuttal procedure is not set out in Louisiana's Medicaid Eligibility Manual, state office has been willing to abide by it.

2.2.3.9. Be sure to not transfer resources for less than fair market value if the client may need "long term care" (including waiver or PACE services) within the next 5 years.

The penalty for transferring resources for less than fair market value is discussed in § 2.4.1 of this Chapter. Recipients usually make themselves ineligible for critical services for up to five years by transferring away their resources without receiving fair value in return. Legislation enacted in 2006 tightened the rules considerably. Common ways around the penalty were eliminated.

One nuance is that the agency often uses property tax assessments for property value if that makes someone *ineligible* for Medicaid. But if a recipient sells property for the tax assessed value, the agency can still decide that was less than the "fair market value" for the property, and impose a disqualification.¹²¹

¹¹⁷ 20 C.F.R. § 416.1224. This exemption is not set out in the MEM.

¹¹⁸ MEM § I-1634 "Bond for Deed."

¹¹⁹ La. R.S. 9:2941, et. seq. *But see Scott v. Appar*, 238 La. 29, 37-38, 113 So. 2d 457, 460 (1959) (noncompliance with statutory requirements did not prevent contract from being treated as bond for deed).

¹²⁰ <https://secure.ssa.gov/poms.nsf/lnx/0501140205>.

¹²¹ MEM § I-1634 Property: Verification of Value of Real Property.

2.2.4. Delve into the rules of the SSI program.

The richest source for finding favorable guidance is the POMS. As has been mentioned in some of the examples above, the state Medicaid agency has repeatedly been convinced to respect rules set out in the SSI POMS, even when not in any Medicaid guidance.

2.2.5. Specific Medicaid liberalizations of the cash assistance rules.

2.2.5.1. Cash surrender value of life and burial insurance policies.

For the persons who are elderly or disabled (the SSI-related categories), in addition to the resources excluded under the federal SSI rules, state Medicaid regulations and plan amendments exclude the cash surrender value of life insurance and burial policies with a combined face value up to \$10,000 from counting against the SSI-related resource limit.¹²²

Because of the way the federal Medicaid statute is written, this state-enacted disregard does not apply to the following categories (the common factor being that the Medicaid statute deems these individuals to be SSI recipients): Pickle recipients, Disabled Widows and Widowers, Affected Children, Disabled Adult Children, Qualified Severely Impaired Individuals, and Prohibited SSI Provisions. Each of these categories are of individuals who would qualify for SSI “but for” a particular” circumstance.

As noted below, for the Medicaid Purchase Plan category, none of the value of life insurance policies counts against eligibility.

2.2.5.2. Numerous exclusions for the Medicaid Purchase Plan (MPP) eligibility.

For MPP eligibility all value of life insurance policies, medical savings accounts, and the spouse’s share of community property and separate property are not counted against the \$25,000 resource limit that applies to this category.¹²³

2.2.5.3. See § 2.1.6 regarding Medicaid rules that trump AFDC and SSI methodologies.

That separate section of this Chapter details some Medicaid rules that override the AFDC or SSI methodologies that would ordinarily apply. While set out in the income section of the Chapter, some of the rules also apply with regard to resources.

2.2.6. Advocacy-DHH can liberalize resource rules.

The Medicaid statute allows states to adopt more liberal eligibility rules, by creating additional “disregards.”¹²⁴ There are some complicated and difficult to understand limitations on this authority based on the “comparability” requirement of 42 U.S.C. § 1396a(a)(17). The federal Medicaid agency will not approve some disregards if it finds them particularly unusual, or arguably inconsistent with the design of the Medicaid categories. There are though no fixed interpretations of the comparability requirement, so the agency may relent with enough effective advocacy.

¹²² 29 La.Reg. 1486 (Aug. 20, 2003); MEM §§ I-1634 “Life Insurance.”

¹²³ MEM § H-2120.4(B).

¹²⁴ 42 U.S.C. § 1396a(r)(1).

A change in the disregards would presumably be generated by a change to DHH regulations. Legal Services programs are restricted in requesting that agencies engage in rule-making. They can though litigate or negotiate to try to change a rule that would lead to litigation, and they can use non-LSC funds to comment in a *public* rule-making proceeding.¹²⁵ Programs can, however, point out and challenge situations where current regulations violate laws, such as the Americans with Disabilities Act, etc. And clients can be referred to other organizations that can request changes to regulations. Two statewide non-profits that can be the Advocacy Center and the Health Law Advocates of Louisiana.

2.3. WHEN MUST LOUISIANA MEDICAID REJECT AN APPLICATION BECAUSE THE APPLICANT WAS DENIED SSI FOR BEING “NOT DISABLED”?

Federal regulations authorize, with limited exceptions, denial of Medicaid based on disability if SSI has been denied for not being disabled within twelve months prior to applying for Medicaid.¹²⁶ (This regulation might not preclude Medicaid eligibility if the applicant is also in a family with minor children, since there are other categories through which a person may qualify for Medicaid if residing with children, without regard to disability.)

But the regulation predates an amendment to the Medicaid statute that allows states to not follow an SSI decision that is still being administratively appealed.¹²⁷ Louisiana’s state plan adopts the option to make these independent determinations.¹²⁸ Because statutes trump regulations, states have the discretion to not follow SSI decisions that are being administratively appealed, even though the federal regulation does not provide for this.¹²⁹

The state cannot however, make an independent disability determination when an applicant has only applied with the Social Security Administration, even though the notice of the application will be forwarded to the State for consideration of Medicaid eligibility.¹³⁰ Applicants should file a separate application directly with Medicaid if they want to pursue Medicaid before their SSI application is favorably decided.

Louisiana policy divides applicants into two categories: those who appeal the denial and those who do not.¹³¹ For those who can show they timely appealed the SSI denial, the agency will make its own decision as to whether they qualify as “disabled.”¹³² Applicants who do not appeal the SSI denial will be rejected unless they meet one of the exceptions set out in MEM § G 1610.2.¹³³ Those exceptions allow an independent disability determination by Medicaid if the applicant is claiming a deterioration in a medical condition following the adverse SSI decision, a new medical condition, or the applicant is both employed *and* applying for Medicaid Purchase Plan (MPP) coverage.¹³⁴

¹²⁵ 45 C.F.R. § 1612.3(b), (e), § 1612.2(d)(1).

¹²⁶ 42 C.F.R. § 435.541; MEM § G-1610.2(exceptions), G 1610.10-12.

¹²⁷ 42 U.S.C. § 1396a(v), adopted in P.L. 101-508 § 4724(a).

¹²⁸ State plan, §2.5. <http://bhsfwweb.dhh.la.gov/onlineannualspublc/stateplan/coverage/section%202.5.pdf>. See also MEM § G 1610.10-12

¹²⁹ The federal regulation and MEM at § G-1610.12 appear to say that the exception for appeals applies only if the applicant is over-income for SSI. But the later enacted statute does not have this limitation, and governs.

¹³⁰ MEM § H-1720, p. 3.

¹³¹ MEM §§ G-1610.11-12.

¹³² MEM § G-1610.12.

¹³³ MEM §§ G-1610.11 & G-1610.13.

¹³⁴ MEM § G-1610.13.

2.4. DISQUALIFICATIONS.

Certain problems result in a disqualification from Medicaid eligibility, unrelated to the applicant's degree of current need, but as a sanction Congress has imposed against certain behaviors. Notable disqualifications are for non-cooperation with child support, not being a state resident, for not having a Social Security number, for alienage, and for transfers of resources made to qualify for Medicaid.

2.4.1. Transfer of assets for less than fair market value

If the agency discovers any, there will be penalties for transferring resources before or while on Medicaid.¹³⁵ There are exemptions to the rule, including for transfers not made with the intent of qualifying for Medicaid.¹³⁶ But it is difficult to get the agency to honor the exemptions. Whether a penalty should be imposed is very fact-dependent and only applies to eligibility for certain long term care, home health, personal care (attendant), and Waiver services. Transfers up to 60 months before the Medicaid application may be considered. (For transfers before February 8, 2006, the period was three years, unless the transfer was to a trust.) The disqualification period is set based on the amount of the transfer that was not fairly compensated.

Transfers to preserve assets or hasten Medicaid eligibility remain possible, but they require careful advance planning. Purchasing an exempt asset (house, car, repairs to either, etc.) should usually be considered first. Where the assets are already owned by the Medicaid recipient, the clearest option is available for recipients who have been found disabled and are under age 65. They can self-settle assets into a pooled trust run by a non-profit on behalf of disabled individuals.¹³⁷ Persons dealing with other types of trusts must be extremely careful about which party puts the assets in trust and other concerns; some of the statutory language is extremely subtle. Multiple interpretive materials outside the statute should definitely be consulted.¹³⁸

Good cause exceptions to the penalty can be available. States are required to allow hardship exceptions.¹³⁹ Louisiana's Medicaid Eligibility Manual does not currently set out these exceptions.¹⁴⁰ It is unknown whether this is in advertent. But

¹³⁵ 42 U.S.C. § 1396p(c). See also *Cox v. Secretary, Louisiana Dept. of Health and Hospitals*, 41,391 (La.App. 2 Cir. 8/25/06), 939 So.2d 550 (holding purported loan was a transfer because the promissory note was not an accessible asset and court found timing and terms support ALJ's credibility decision that it was not a good faith loan).

¹³⁶ MEM, § I-1674; *Bueche v. Dep't of Health & Hospitals*, 2000-1473 (La.App. 1 Cir. 6/21/02), 822 So. 2d 25 (finding transfer not to be disqualifying, because intention was not to qualify for Medicaid but to avoid legal action against the assets and because of recipient's age); *Burckett v. State Department of Health and Hospitals*, 30082 (La. App. 2d Cir. 12/10/97), 704 So.2d 1266 (transfer to compensate for relative's prior services not disqualifying, even though services had not been documented); *Brewton v. State Dept. of Health and Hospitals*, 06-804 (La.App. 5 Cir. 3/13/07), 956 So.2d 15 (contract to pay relative for future services was not a transfer since it covered services a nursing facility would not provide, like managing finances, maintenance and sale of home, attending facility conferences, visiting resident, making purchases, attending medical appointments, and dealing with Medicaid); *Carpenter v. State, Dept. of Health and Hospitals*, 2005-1904 (La.App. 1 Cir. 9/20/06), 944 So.2d 604 (rejecting DHH's unevicenced conclusion that personal care contract did not predate services, and finding it acceptable that facility resident did not pay under contract until on the verge of institutionalization; no uncompensated transfer); *Wild v. State Department fo Health and Hospitals*, 2008-1056 (La.App. 1 Cir 12/23/2008), 7 So.3d 1 (evidence was sufficient to support finding that transfer of property to trust was for estate planning purposes (avoiding future interdiction) rather than with any intent to qualify for benefits); *Pacente v. Jindal*, 99-0601 (La.App. 4 Cir. 12/29/99), 751 So.2d 343 (finding transfer to annuity to benefit wife fell within statutory exceptions to transfer penalties).

¹³⁷ 43 U.S.C. § 1396p(d)(4)(c). A partial list of pooled trusts can be found at <http://www.specialneedsanswers.com/resources/directory_of_pooled_trusts.asp>. Costs will often be beyond the reach of most legal services clients.

¹³⁸ See e.g. POMS SI 01120.203 <http://policy.ssa.gov/poms.nsf/lnx/0501120203>. As noted in the POMS, not all of the provisions it sets out apply with regard to Medicaid eligibility.

¹³⁹ 42 U.S.C. § 1396p(c)(2)(D).

¹⁴⁰ See § I-1674.

the hardship provisions can still be found in the Louisiana Administrative Code.¹⁴¹ The agency has always been very restrictive in allowing exceptions. For example, the regulations allow no exceptions if a resource is transferred within the family, unless done under one of the explicit statutory authorizations.¹⁴² Yet family members frequently will not return assets, even though Medicaid is jeopardized.

A more exhaustive treatment of transfer of asset issues is posted on Probononet.¹⁴³

2.4.2. Parent-only sanctions for not cooperating with child support

A non-pregnant parent who has failed to cooperate with Child Support Enforcement requirements may be cut off Medicaid until they again cooperate (if they were given the requisite warnings, conciliation procedures, etc.).¹⁴⁴ Case-workers can forget that the sanctions can apply only against non-pregnant parents, and not the rest of the household, causing improper termination or denial of the whole household.

2.4.3. Other TANF/FITAP sanctions

Other TANF/FITAP disqualifications do not carry over to Medicaid eligibility unless they were part of the federal AFDC statute or regulations in 1996, *and* the client has no basis for Medicaid eligibility other than through LIFC, PAP, or C-related Medically Needy eligibility.¹⁴⁵ Examples of TANF sanctions that do not apply to Medicaid include the work participation (“STEP”) sanctions, the two and five year time limits, and the requirements regarding drug testing, immunizations, school attendance.¹⁴⁶

2.4.4. Residence

To get coverage from the state’s Medicaid program, the individual must be a “resident” of the state.¹⁴⁷ There are limited provisions for persons receiving care out of state to be able to get coverage from their own state’s Medicaid program.¹⁴⁸ Special rules apply to determine the residence of persons in institutions, like nursing facilities, children, and other special situations.¹⁴⁹ “Intent to return” to the state is the touchstone of residence determinations. After Hurricane Katrina the state wanted to cut off recipients who had been out of state for six months, but refrained on being advised that this would be an improper way to judge residence.

2.4.5. Not having a Social Security number

Applicants are required to have, or apply for, a Social Security number.¹⁵⁰ However, if eligibility is sought only for a child, their parent’s Social Security number cannot be required.¹⁵¹

¹⁴¹ 50 LAC Part III, § 10905.

¹⁴² The explicit authorizations are at 42 U.S.C. § 1396p(c)(2).

¹⁴³ <http://www.probono.net/la/civillaw/search/download.157719>

¹⁴⁴ 42 U.S.C. § 1396k(a)(1) and 42 C.F.R. § 433.148 require that a parent’s Medicaid be terminated for not cooperating with child support enforcement. CMS’s State Medicaid Manual §3905 excludes pregnant women from this requirement.

At least one court has limited the child support pregnancy exception to women whose *only* basis for Medicaid eligibility is under the CHAMP-PW category. *Douglas v. Babcock*, 990 F.2d 875 (8th Cir. 1993), *cert. denied* 510 U.S. 825.

¹⁴⁵ See 42 U.S.C. § 1396u-1(a), (b)(1).

¹⁴⁶ See 29 La. Reg. 1833 (Sept. 20, 2003)(ending Medicaid sanction for non-compliance with FITAP work participation requirements).

¹⁴⁷ 42 C.F.R. § 435.403.

¹⁴⁸ 42 C.F.R. § 431.52. CMS has liberally interpreted this regulation, stating that it allows states to cover a student out of state to attend college. *Olmted Update No. 3*, July 25, 2000, Attachment 3-e. <<http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd072500b.pdf>>.

¹⁴⁹ 42 C.F.R. § 435.403.

¹⁵⁰ 42 C.F.R. § 435.910.

¹⁵¹ 42 C.F.R. § 435.910(a); *Dear State Health Official letter of September 10, 1998*, <http://www.cms.gov/smdl/downloads/sho091098.pdf>.

2.4.6. Non-citizens

Louisiana has exercised the federal option to cover all of the following persons, if they otherwise qualify under a Medicaid category: (1) SSI recipients; (2) Legal Permanent Residents who were in the country before August 22, 1996, or have been here five years since, or are veterans, or have 40 quarters of creditable earnings (which they or certain relatives earned); (3) refugees, asylees, and persons whose deportation is formally withheld by the INS (each eligible for Medicaid for the first five years); and (4) certain battered immigrants.¹⁵²

Other non-citizens are eligible for “emergency services” (including for labor and delivery, and excluding organ transplants) if they, apart from citizenship and not having a Social Security number, would qualify for Medicaid.¹⁵³ (Note that there can be a separate issue of whether persons with no intent to reside in the United States or Louisiana meet Medicaid’s state-residence requirement.¹⁵⁴) Louisiana DHH’s interpretation has been that aliens qualify for emergency hospital services, which requires an after-the-fact Medicaid application and review for “emergency.” This limitation to hospital services (as opposed to kidney dialysis, chemotherapy, and other needs which could present *chronic* emergencies) has no discernible basis in the statute.

3. PROCEDURE- DEALING WITH LIMITATIONS PERIODS AND CHOOSING THE CORRECT FORUM FOR SECURING RELIEF FOR THE CLIENT

3.1. LIMITATION PERIODS

You are looking at an unfamiliar Medicaid issue. The first question is how soon do I have to take action? Here are the most common situations.

3.1.1 Denial notice (applicant not previously certified)

The period to appeal for a fair hearing is treated as 30 days from the date stated on the notice, unless the notice specifies that the 30 days run from receipt.

The period should be tolled if the agency has not notified the claimant of the need to appeal within 30 days.¹⁵⁵

The current fair hearing process and subsequent state court judicial review (limited to the hearing record) provide less than optimal results in many cases. Most ALJs who decide the cases are former Department of Health and Hospital employees, who are extremely deferential to the agency and fail to analyze and accept legal arguments presented to them. Judicial review, in turn, is deferential to the ALJs. So most issues that involve legal or policy disputes, and not simply a failure of the client to establish some required facts are better dealt with outside the fair hearing process.

Therefore, except possibly as to factual disputes, one should determine within the 30 days whether the matter can be resolved outside the fair hearing process, by: completing negotiations; or determining that you will not need to pur-

¹⁵² 8 U.S.C. §§ 1611, 1612(b)(1)(A), 1613(b), 1641; 24 La.Reg. 1119 (6/20/98); CMS’s State Medicaid Manual § 3211, et seq. DHH’s list of who is covered by its rule is set out at 24 La.Reg. 601 (4/20/98). This list includes one category not mentioned in the preamble to the original Notice of Intent. Compare 24 La.Reg. 389 (2/20/98).

¹⁵³ 8 U.S.C. § 1611(b)(1)(A).

¹⁵⁴ CMS’s State Medicaid Manual, § 3211.10.

¹⁵⁵ Accord 42 C.F.R. § 231.206(b)(2).

sue a fair hearing, because the client has a right to go to federal court if negotiations are unsuccessful; or determining that the case will not go to court, either for lack of a federally enforceable right, weak equities, uncertain facts, etc.

If a federal issue is presented (such as violation of Medicaid Act provision that is privately enforceable or a state policy is in direct conflict with federal law), suit can be pursued in federal court within a year of the denial if a case or controversy continues, but no retroactive benefits are likely to be available. If another federal statute is violated, such as the Americans with Disabilities Act, federal rights may survive for even longer than a year.

Clients can, of course, file a new application, to start periods running again. Applications for the Medicaid card (as opposed to requests for approval of specific services) can usually cover services received in the three calendar months before the application was filed. This is not true as to applications for QMB Medicaid, and does not work for months in which the client did not meet the Medicaid eligibility requirements (for example if the client had too much in resources to be eligible).

3.1.2. Denial of “prior approval” for a particular service (applicant not previously certified for it)

If the denial is of a service that Medicaid must “prior authorize” coverage for, the above considerations as to obtaining higher review all apply. But there is one additional alternative that can often extend the periods for review and improve the record that is subject to review. The Medicaid provider can submit for “reconsideration” of the request, by submitting additional documentation, even after the 30 day fair hearing appeal period. This option is not stated on the notices, and will result in a new written, appealable agency decision.

Reconsideration requests are submitted through the prior approval provider and get reviewed by the same decision makers as initial requests. Reconsideration allows one to address procedural reasons (usually problems with documentation) for a denial, or get a quick review of additional information. This can ensure an adequate administrative record if subsequent review will be sought directly in court. But do not assume that if the procedural reasons given in a first denial are addressed, a decision on the merits will be obtained. The prior approval unit often denies a claim with new procedural denial codes on reconsideration. The reconsideration decision will usually be issued within about ten days from resubmission.

Note though, that procedures may differ for recipients placed under Bayou Health. If the recipient is under one of the Bayou Health plans, one should confirm with the particular plan whether a reconsideration like this is an option.

3.1.3. Denial of “prior approval” for a particular service by one of the Bayou Health “Prepaid” plans

Currently, three of the Bayou Health plans Louisiana assigns Medicaid recipients to are “Prepaid” plans, where the plan gets a flat payment in exchange for providing any covered services a recipient needs. These three are Amerigroup Louisiana, Inc., LaCare, and Louisiana Healthcare Connections, Inc.

When these plans deny services, recipients must exhaust the plan’s internal appeal procedure before they are able to access the state fair hearing system. (Under Bayou Health, the term “grievance” includes appealable actions like denials, but also general complaints about how one is treated by a plan, etc. Advo-

cates seeking to reverse a denial are cautioned to avoid all use of the word “grievance” and not to have clients phone in appeals, since they may get confused and agree that they wish to file a “grievance,” which might not get the access to a reversal of the denial of services.

The recipient has a right to proper notice of the reason for action, to an in-person hearing on the internal appeal, to review the record before the hearing, and to a decision by a medical professional with “appropriate clinical expertise” and not previously involved with the denial as to medical issues.¹⁵⁶

If requested, an appeal can be expedited, to usually be decided within three days. (There are contradictory statements about whether an expedited appeal can be requested orally, or must be in writing. So a written request should be used.) The advocate should try to include all evidence that should be considered regarding such appeals with the original appeal paperwork. If the plan decides that the 30 day delay of a normal appeal would not jeopardize the recipient’s health, it can convert the expedited appeal to non-expedited.

Under these prepaid plans, continued benefits pending appeal are less than we have had under Medicaid. They are only available if “the original period...has not expired” and end when the period previously authorized ends.¹⁵⁷

The regulations refer to the Prepaid plans collecting from recipients for the continued benefits from service appeals that the clients lose.¹⁵⁸ So collections could get more aggressive and could involve, in some instances, civil suits. For those in the plans, Medicaid pays a monthly fee, regardless of what services the client uses. The recipient may be liable for the fee, not just the particular services he or she received.

3.1.4. Termination notice (eligibility or services received until the notice)

For most services, if a fair hearing request is filed before the services are actually cut off, services should continue at least until the hearing. ***Exceptions to the right to continued benefits are discussed in § 6.5.1, infra.*** Perhaps the most notable exception regards services prior approved through a Coordinated Care Network (Bayou Health).¹⁵⁹ If the appeal is filed more than 10 days after the notice date, yet before services are cut off, the advocate may have to point out that 42 C.F.R. § 431.230(a) requires the continued benefits pending appeal.¹⁶⁰

The period to appeal for a fair hearing is nonetheless limited by the 30 day period discussed above.

If the recipient was not issued a notice giving at least ten days to appeal with continued benefits, he or she should be able to get continued benefits pending appeal through any timely appeal based on the agency’s failure to give notice of the separate deadline for continued benefits.¹⁶¹

¹⁵⁶ 42 C.F.R. §§ 438.404, 438.406(b)(2),(3), § 438.406(a)(3); 50 LAC Part I, §3727(A)(3)(b).

¹⁵⁷ 42 C.F.R. § 438.420(b)(4),(c).

¹⁵⁸ 42 C.F.R. § 438.420(d); 50 LAC Part I, §§ 3711(B), 3735(D).

¹⁵⁹ 42 C.F.R. § 438.420(b)(4), providing that services continue only until the end of the period that had already been approved.

¹⁶⁰ A DHH memorandum accessible to agency staff clarifies this. Medicaid Administrative Memorandum Number 2011-5.

¹⁶¹ The regulations *permit* such reinstatements. 42 C.F.R. 431.231(a). But they also **require** reinstatement if an appeal is filed within the first ten days, 431.231(c), and require notice of this right, 431.210(e); 431.211. A prudent step to take where there is no notice of the right to continued benefits might be to contact the agency before filing the appeal to obtain an assurance that continued benefits will be granted, or obtain agreement that a new notice will be issued, giving the ten day right. If neither assurance can be obtained, a federal suit and TRO (or state court stay) could enjoin the termination of assistance for failure to give proper notice.

As noted throughout this chapter, most issues are better dealt with outside the fair hearing process. But where a client has a right to continued benefits pending appeal, if not resolved before the deadline for maintaining continued benefits, it is almost always to the client's benefit to request the fair hearing. The client's medical care is protected during the usually 90 day period while the fair hearing request is under consideration. And the claim that there will be "irreparable injury", a required element in obtaining a federal temporary restraining order or preliminary injunction, is undermined if the client has this access to continued benefits.

Nonetheless, because many central agency staff are not intimidated by the fact that a fair hearing is pending, one's hand in negotiating relief may be stronger before you request a fair hearing, if it is unclear you will commit to a fair hearing rather than go straight to court.

Two situations in which it is reasonable to forego the continued benefits are when benefits would not continue the whole time the appeal pends (discussed in § 6.5.1.1, *infra*; usually these are appeals where there is no factual dispute), and some cases where it can be determined that the recipient will probably lose the appeal and would need to pursue relief in federal court thereafter, in which case they will face a period without assured benefits anyway.

In either case, taking advantage of the continued benefits may give the attorney more time to prepare TRO pleadings before a cutoff occurs.

If the client has missed the period for continued benefits pending appeal, filing a federal suit and for a TRO/preliminary injunction (and advising the agency credibly of the intention to do so) can sometimes be a faster way to restore services than waiting through the 90 day fair hearing process.

3.1.5. Relief if the client missed the appeal period by a day or two

The "state plan" filed with and approved by the federal government currently states that Louisiana runs the 30 days for appeal from receipt of the notice.¹⁶² Most DHH notices state otherwise, that the period runs from issuance of the notice. But the state plan should govern rather than the language on the notice, extending the client's period to appeal.

3.1.6. Appellant missed the hearing

Federal law requires that if an appellant misses their Medicaid fair hearing, the appeal not be closed until the agency has given a chance for the appellant to claim good cause for having missed the hearing.¹⁶³ The Division of Administrative Law recently implemented procedures to respect this right. Currently, if the hearing is missed the ALJ will issue a "Conditional Order of Dismissal of Hearing Request," allowing the claimant ten days to provide good cause. The Division of Administrative Law is requiring the responses be in writing, and the ALJ will rule on whether good cause is stated. So it is prudent to assist clients with these requests rather than leave them unassisted.

¹⁶² <http://bhsfweb.dhh.la.gov/onlineannualpublic/stateplan/gpa/attachment%204.2-a.pdf> at 1.A.

¹⁶³ Compare 42 C.F.R. 431.223(b); CMS State Medicaid Manual §2902.3(B).

3.1.7. Adverse fair hearing decision

It may not be stated on the notices, but petition for rehearing or reconsideration can be filed with the Division of Administrative Law within ten days of the date the Division of Administrative Law mailed out the decision.

The petition should specify the grounds on which the decision should be reconsidered, and should be styled a “petition for rehearing or reconsideration.”¹⁶⁴ The petition for “rehearing” explicitly extends the period for judicial review.¹⁶⁵ “Reconsideration” is more likely to be granted, since it does not require conducting an additional hearing. In cases of clear error this route is much faster and less expensive than judicial review for the client, and involves less work by the attorney, since it does not require making a general docket judge who is unfamiliar with Medicaid law comfortable enough with the issues so that he or she feels comfortable reversing the agency. But all reasons for reversal should be set out in the petition within the ten days. Do not usually count on getting an opportunity to supplement. *If you feel you need to hear the audio track from the hearing in order to draft this*, with a client release and Division of Administrative Law form, the audio track can be obtained by email and listened to on a PC.

The same decision maker reviews the petition as issued the decision you are seeking reconsideration of.

A petition for judicial review of the fair hearing decision can be filed in District Court within 30 days of its issuance. Venue is in Baton Rouge or the claimant’s domicile. (Baton Rouge court costs are extremely high.) Unlike unemployment compensation decisions, the suits are not free, so it should be accompanied by an *in forma pauperis* application, if appropriate.

Demand letters, to the Secretary of DHH, Director of the Bureau of Health Services Financing (the Medicaid program), or the DHH Legal Unit do not suspend the period for judicial review. But they may get attention from the agency, by persons more familiar with the program, who are free to delve into policy issues, and can review more than the evidence in the administrative record.

If there is a federal claim that meets the tests for federal jurisdiction, a federal suit can obtain review of the hearing decision. There is a year to seek federal review.¹⁶⁶ This period though may run from the initial adverse action, rather than the date of the hearing decision. Res judicata does not bind the federal court to defer to the ALJ’s factual or legal findings.¹⁶⁷ In addition, in federal court there will be an open record, not limited to what was established at a brief fair hearing.

As noted below, it is often complicated and hotly contested in litigation whether particular Medicaid provisions are enforceable in federal court using the civil rights statute, 42 U.S.C. § 1983. The federal Administrative Procedure Act does not apply to actions by state agencies. (And state Administrative Procedure Act claims cannot be raised against the state in federal court.¹⁶⁸) If a state policy is in conflict with federal law, there is currently clear jurisdiction over a

¹⁶⁴ La.R.S. 49:959(A).

¹⁶⁵ La.R.S. 49:964(B); La.R.S. 46:107(C).

¹⁶⁶ *Elzy v. Robinson*, 868 F.2d 793 (5th Cir. 1989); *Burnett v. Grattan*, 468 U.S. 42 (1984) (general tort period applies to § 1983 action, not a shorter period for filing administrative actions).

¹⁶⁷ *Woolley v. State Farm Fire and Cas. Ins. Co.*, 2004-CA-882 *36 (La. 1/19/05) 893 So.2d 746, 771 (ALJ decisions not entitled to res judicata in Louisiana).

¹⁶⁸ See *Pennhurst State School and Hospital v. Halderman*, 465 U.S. 89 (1984).

“Supremacy Clause” claim in federal court.¹⁶⁹ This may change.¹⁷⁰ Other federal statutes such as the Americans with Disabilities Act, or the due process clause, may provide a claim based on specific violations.

No retroactive benefits are likely to be available from the federal action. As to Medicaid issues, clients are often without care when not certified, so retroactive coverage may be of limited value anyway.

3.1.8. If the recipient did not get notice, it might not be the agency’s fault.

Louisiana’s agency now issues permanent, plastic eligibility cards for all but a few categories.¹⁷¹ Further, Louisiana’s Medicaid agency often does annual renewals of eligibility through review of information in other agencies’ databases. As a result, recipients can easily forget to notify the agency when they move, which in turn can result in their not receiving the notice that is mailed when adverse action is taken on their case. Until they need to use their Medicaid card, they may not know it is no longer active. And by the time they do know, their right to take an administrative appeal within 30 days of the adverse action may have expired.

3.2. FIRST STEPS

3.2.1. Obtain HIPAA releases

Be sure to obtain from the client a “HIPAA” compliant release before any contacts with the agency in which you want the agency to discuss or assess the client’s specific facts and information, or if information will be needed from medical providers.¹⁷² One that DHH will accept is posted on its website.¹⁷³

3.2.2. Choose the forum relief will be pursued in carefully.

The fact that a fair hearing (administrative appeal) is available to the claimant does not mean that this is the avenue for relief that should always be pursued. Obtaining a fair hearing decision usually takes about 90 days; often there are faster ways to obtain relief. Some in the agency who could grant relief will let a fair hearing play out rather than get involved once a hearing has been requested. And yet Administrative Law Judges will not touch some issues that others in the agency could address. They often will not seriously entertain or analyze legal challenges to agency policies. They also will not reverse a legal exercise of agency discretion, whether this involves a worker choice among possible options, or an agency policy choice.

And as set out below, starting on the administrative route can limit a client’s access to federal court, which is sometimes the fastest, most powerful, or otherwise most appropriate forum.

¹⁶⁹ *Planned Parenthood of Houston and Southeast Tex. v. Sanchez*, 403 F.3d 324, 331-35 (5th Cir. 2005) (Medicaid case finding jurisdiction, because the claim was for preemption under the Supremacy clause rather than under § 1983).

¹⁷⁰ A five vote majority remanded for reconsideration on other grounds a case raising this issue. *Douglas v. Independent Living Center of Southern California, Inc.*, 132 S.Ct.1204 (2012). The four dissenters strongly argued that the Supremacy claim should not be allowed. The remand suggested that once the federal Medicaid agency approves a state plan, recourse may have to be against the federal Medicaid agency through the federal Administrative Procedure Act.

¹⁷¹ “Spend-down” Medically Needy recipients usually will have received a paper proof of eligibility within the last three months. SLMB and QI and recipients do not get an eligibility card; for them, Medicaid only pays their monthly Medicare premiums.

¹⁷² See 45 C.F.R. 164.500 et. seq.

¹⁷³ <<http://new.dhh.louisiana.gov/assets/docs/HIPAA/Policy/402P.pdf>>.

The client should be advised of the options and implications before a choice is made about how to pursue a claim, even if the law office the client has consulted would not or could not pursue other avenues for relief.¹⁷⁴

Usually the source of law will constrain the choice of forum, or determine which is most hospitable. For example, rights that are not sourced in the federal statutes can usually be enforced only through a fair hearing request, followed possibly by judicial review in state court. (An exception discussed below is that if a state policy is inconsistent with, and therefore pre-empted by a federal regulation, that currently gives rise to a federal Supremacy Clause claim.)

At other times, the type of relief needed (fast, retroactive, individual, equitable, etc.) determines which forum is best.

3.3. WORK DIRECTLY WITH THE AGENCY, RATHER THAN WAITING FOR RESOLUTION BY A COURT OR ALJ.

Overwhelmingly, most of the favorable dispositions of Louisiana Medicaid fair hearing requests occur through the agency staff, rather than the ALJ, rescinding the adverse agency action. About 30% of Medicaid actions under appeal are “reversed” by agency staff after an appeal request is filed. (In contrast, the ALJs reverse on only about 7% of the appeals.)

This positive outcome through a review by agency staff can be sought through calls, demand letters, or both, without a hearing request and without subjecting the client to a 90 day delay (though one should not let a ten or 30 day time limit for appealing pass while awaiting informal resolution).

Also, even though there is a 30 day limit for requesting an appeal, the agency staff can at nearly any time go back and correct an improper decision by “reopening” it.¹⁷⁵ (While not stated in state policy, reopenings might have to occur within one year after an action.)

But as already noted, agency staff are often unaware of the governing law. So the advocate should distill the claim and present it to the agency, rather than just ask for another review. Central agency staff in Baton Rouge can access the Louisiana Register notices, state plan, Code of Federal Regulations, and statutes. Few others in the agency can or have the authority to take action based on these. So any claim involving these should be conveyed to staff in Baton Rouge.¹⁷⁶ If legal analysis by the agency will be needed, DHH’s Legal Unit will necessarily be involved and so usually should be called, written, or copied on correspondence from the outset.

3.4. REAPPLYING

Particularly where there are documentation problems or other factual issues that may resolve with a new application, the client may be advised to reapply, even while other relief is being pursued. This will often give the agency additional reason to moot an appeal in the client’s favor (and the appeal gives the agency reason to

¹⁷⁴ Louisiana Rules of Professional Conduct, Rules 1.2(a, c), 1.7(b)(2). This is true whether or not the attorney knows of other attorneys who would pursue the matter, who do not have the same limitations.

¹⁷⁵ MEM §G-1700.

¹⁷⁶ The top Medicaid staff in Baton Rouge are currently listed at <http://new.dhh.louisiana.gov/index.cfm/page/226>. Advocacy is often more effective when directed to the lowest level decision maker who has authority to resolve a problem, unless that person is wedded to current practice. A good place to begin is often the program specialist for the region, listed at http://new.dhh.louisiana.gov/assets/docs/Making_Medicaid_Better/Resources/Med_CustService.pdf.

try to resolve the new application in the client's favor). But if there are system issues the client does not want mooted, or gray issues not developed regarding the prior application, which would complicate the appeal, reapplying may be against the client's interests. And if agency policy precludes the client's eligibility, there is no reason to put the client through the unnecessary work of a new application.

Some clients should reapply while pursuing relief through an appeal or court, because the application under review only covers a specific period of time. A request for prior approval services or Medically Needy eligibility is only for specific months; most other applications for Medicaid are effective for a one year period. Especially if the recipient wants reimbursement or corrective payment from the agency for services not covered while the matter is being adjudicated, the recipient may need to reapply for each successive period of services that could have been covered, and possibly even appeal each denial (depending on the forum in which relief is pursued), in order to preserve a claim for all periods that pass by the time a judicial decision occurs.

3.5. OFTEN FASTER AND MORE EFFECTIVE THAN FAIR HEARING REQUESTS: ESCALATING POLICY ISSUES TO STATE LEVEL DECISION MAKERS

Especially where relief depends on changing a policy, the agency is best approached through means other than a fair hearing request. The approach to the agency should not usually be one of questioning, but assertive, with one's case already thought through and presented in a way that will prevent the agency from getting distracted by either minor or adverse issues.

Requesting a fair hearing puts the claimant on a 90-day slow track to resolution of his or her issue. But in cases where local or regional level agency staff are not eager to participate in fair hearings, some will resolve the underlying issue in the client's favor to avoid the hearing, if this can occur without a violation of agency policy. But where relief requires a re-examination of agency policy, higher level staff would need to authorize action in the client's favor. These staff persons are not intimidated by the agency's need to defend a fair hearing. (As discussed within § 3.7.3, below, they have the ability to, in essence, veto adverse hearing decisions.)

State level staff persons are often more willing to reconsider policy when the issue has not already been put into the fair hearing context: by being approached either with a goal of problem-solving, or to avoid becoming involved in federal litigation over the issue.

Accessing the discretion that the policy-makers may have can be an even more important consideration when one is dealing with an unusual or unanticipated effect of agency policy. For the Appeals Bureau, policy is policy; rarely will an ALJ go against it, even if the policy is legally infirm or equitably problematic.

The other possible decision makers who can authorize relief from agency policies are state court judges, who will occasionally, in a compelling case, be willing to exercise their equitable powers to preclude untoward policies or harsh applications of policy.¹⁷⁷

¹⁷⁷ See, e.g., *Labbie v. Robinson*, 544 So.2d 734 (La. App. 3 Cir. 1989) (the opinion's author is now Justice Knoll of the state Supreme Court); see also *Jurisch v. Jenkins*, 99-0076, (La. 10/19/99), 749 So.2d 597.

In situations where there *are* state law claims, one must not let the period for appealing prescribe while the matter is being considered by agency staff. *After* approaching state office staff, if one needs to preserve access to state judicial review (or continued benefits pending appeal), one can explain that a fair hearing request will be filed, but that is just to preserve later state court remedies, and that you are counting on state agency staff to resolve the issue, if willing, before a fair hearing is held.

3.6. AS TO “BAYOU HEALTH” ISSUES, CAN THE RECIPIENT WITHDRAW FROM BAYOU HEALTH, SWITCH PLANS, OR SWITCH PRIMARY CARE PHYSICIAN TO SOLVE THE PROBLEM.

There are additional layers of complication where issues stem from a Bayou Health plan’s denial of access to services. As explained in § 8.4, Louisiana has contracted to have services delivered to about two-thirds of the state’s Medicaid recipients through private plans, which are like private insurance companies responsible for providing the recipients’ care, within certain Medicaid parameters.

As recommended above, problems often can be solved by escalating the issue to higher decision makers. If a Bayou Health recipient faces a service denial, the question before one can do so is who has jurisdiction over the service. Some services are “carved out,” meaning they are not under the control of the new plans, but access continues to be determined by traditional Medicaid mechanisms. If it is not obvious from the client’s fact situation, a chart setting out which entity is responsible for which services is posted on *probononet*.¹⁷⁸ If the plan has jurisdiction, member handbooks with contact information are posted on the *MakingMedicaidBetter.com* website.

A second route is not always available but has a large payoff when it is. Some recipients either should have been excluded from Bayou Health or are voluntary or optional participants in Bayou Health. If you can get your client into one of the excluded categories they should immediately be let out of Bayou Health. If your client is in one of the optional categories or can be moved into one, then experience so far has been that DHH has been willing to let the optional recipients out of Bayou Health when faced with problems. The excluded and optional groups are not listed here, because which groups are in or out may change after publication of the Desk Manual. They are listed at 50 LAC Part I, § 3103(B,D); Louisiana Registers should be checked for any changes since the LAC was last codified.

A third option may be to switch plans or switch primary care physician (PCP) within the plan if the PCP is not being a strong enough advocate for the recipient’s needs. One can switch plans and PCPs at will during the first 90 days of each annual enrollment period. After that one is “locked in” under the DHH regulations. But the plans may be willing to allow PCP changes even after the lock-in.

A fourth option is to appeal, discussed in § 3.1.3. *supra*.

3.7. PARTICULAR RIGHTS AND PROCEDURES WITH FAIR HEARING REQUESTS.

The availability of continued benefits pending appeal, and exceptions, is discussed in § 6.5. *infra*.

¹⁷⁸<http://www.probono.net/la/civillaw/library/attachment.224105>

3.7.1. Right to an additional medical assessment

One possible advantage of a fair hearing over quick court action in cases involving disputes about medical conditions or needs is that the Medicaid state plan provides that the Department will pay for a second medical assessment “if the Hearing Officer *or the claimant* considers this necessary.”¹⁷⁹ (The Department has procedures under which it can pay for medical assessments to establish eligibility directly, through providers it contracts with, instead of as a visit on one’s Medicaid card.) It should not be assumed that ALJs are familiar with this requirement, which is more favorable than federal regulations require.¹⁸⁰

3.7.2. Few ALJ decisions are favorable

Since requesting a fair hearing can both delay and prejudice the right to seek other forms of relief, fair hearing requests should not be routinely filed or recommended without having considered the client’s alternatives. As noted above, only about 7% of appeals result in ALJs reversing the action under appeal.

3.7.3. Limitations on ALJs’ ability to issue decisions adverse to the Department.

DHH has the ability to veto ALJ decisions that would be adverse to it. If an ALJ’s decision would be adverse to the Department, the ALJ’s Recommended Decision is forwarded to a representative of the Department, who has 35 days to repudiate the decision.¹⁸¹ If the decision is repudiated, DAL currently simultaneously sends both the original recommended decision and the final DHH decision to the appellant.

Since this is an *ex parte* and totally one-sided procedure, it is subject to a due process challenge.¹⁸² In addition, since the ultimate decision maker did not hear the live testimony this may reduce the deference due the agency’s decision under the APA.¹⁸³

Especially since their decisions are subject to veto, ALJs may question whether they have the authority to invalidate agency policies. Under the state’s APA, the ALJs do have authority to rule on the legality of agency policies.¹⁸⁴ But an ALJ questioning such authority may look hard for reasons not to exercise it, and incline them to find other reasons to rule against appellants who are challenging agency policies.

3.7.4. Theoretical availability of discovery

All discovery tools are theoretically available within the fair hearing proceeding.¹⁸⁵ But because fair hearing proceedings must usually be concluded within 90 days, if the opposing party does not promptly cooperate, the tools may have limited usefulness unless the ALJ agrees to expedited time frames and takes an active role on enforcement motions.

¹⁷⁹ Attachment 4.2-A p. 2.

¹⁸⁰ Compare 42 C.F.R. § 431.240(b).

¹⁸¹ Memorandum of Understanding between La. DHH and La. DAL, Oct. 1, 2010, §§ 3.3(C),(E); 4.1.

¹⁸² The federal regulations do allow for agency review of decisions before their issuance. See 42 C.F.R. § 431.244 (referring repeatedly to hearing officers’ decisions *or recommendations*). But they do not endorse DHH’s procedure of conducting the reviews with input from only one party.

¹⁸³ La. R.S. 49:964(G)(6); accord *Universal Camera Corp. v. N.L.R.B.*, 340 U.S. 474, 493 (1951). As to problems with DHH’s previous procedures for repudiating or adopting ALJ decisions see *Doc’s Clinic, APMC v. State ex rel. Dept. of Health and Hospitals*, 2007-0480 (La.App. 1 Cir. 11/2/07), 984 So.2d 711, writ denied, 2007-2302 (La. 2/15/08) 974 So.2d 665.

¹⁸⁴ Accord La.R.S. 49:963(D), 49:958. The ALJs’ civil service job descriptions probably continue to describe them as responsible for ruling on questions of law.

¹⁸⁵ La.R.S. 49:956(5, 6); costs are not to be charged if the client is indigent. La.R.S. 46:107(B).

3.7.5. The hearing record should not be limited to facts that were before the agency at the time of the adverse decision

DHH ALJs and agency staff sometimes contend that the issue at the fair hearing concerns whether the agency made the correct decision based on the facts it had when it originally acted.

The state Administrative Procedure Act specifies that appellants are permitted to add evidence to the administrative record and argue all issues of law.¹⁸⁶ And the state Administrative Procedure Act allows reopening of a fair hearing decision even *after* a hearing if “The party has discovered since the hearing evidence important to the issues which he could not have with due diligence obtained before or during the hearing; [or]...There is a showing that issues not previously considered ought to be examined in order properly to dispose of the matter.”¹⁸⁷ A DHH ALJ has been reversed for denying a “fair hearing” for limiting the record to what was before the Medicaid agency at the time of its original decision.¹⁸⁸ In a federal consent agreement dealing with prior approval issues, DHH agreed to include on adverse prior approval decisions a statement that at the fair hearing “the claimant or his or her medical provider(s) may submit additional evidence.”¹⁸⁹ Courts in other jurisdictions have made similar rulings. And CMS’s State Medicaid Manual allows reopening of a fair hearing decision even *after* a hearing “because *new evidence* concerning the determination has been submitted which may alter that determination.”¹⁹⁰ So certainly additional evidence should be accepted at the hearing, too.

3.7.6. Date of appeal is determined by earliest action, including postmark

An appeal is treated as filed the day it is postmarked¹⁹¹, orally requested, or phoned in.¹⁹² The date the agency receives a written copy of an appeal request should not replace these dates.

Though notices specify the appeals need to be mailed (or phoned in) to the Division of Administrative Law, any request made to DHH staff must be honored, as well.¹⁹³

¹⁸⁶ La.R.S. 49: 955(C) (“Opportunity shall be afforded all parties to respond and present evidence on all issues of fact involved and argument on all issues of law and policy involved and to conduct such cross-examination as may be required for a full and true disclosure of the facts.”) At worst, this provision should authorize the appellant to evidence facts other than those initially before the agency as part of an *argument* that review should not be limited to what was originally before the agency.

¹⁸⁷ La.R.S. 49:959(A)(2 & 3).

¹⁸⁸ *Bell Oaks v. DHH*, 96-1256 (La. App. 1 Cir. 1997) 697 So.2d 739, 749. *Bell Oaks* deals with agency scoring of Requests for Proposal-essentially private bids to do business with DHH. An argument that agency review should be limited to the prior record is particularly strong in that context, but the agency attempt to do this was not upheld. *See also* State plan, Attachment 4.2, p. 2 (discussing submission of additional evidence at claimants’ fair hearings).

¹⁸⁹ *McField v. Forrest*, Stipulation and Order of Dismissal, E.D.La. No. 93-4094 (Oct. 22, 1996), ¶2. *McField* was filed as a class action, but the class was never certified. The Stipulation has language intending to convey its benefits to non-parties.

¹⁹⁰ CMS State Medicaid Manual §2904.1 (emphasis added).

¹⁹¹ Medicaid Administrative Memorandum Number 2011-5.

¹⁹² Memorandum of Understanding between La. DHH and La. DAL, Oct. 1, 2010, §§ 3.3. The federal regulations define a “Request for a hearing” as “a clear expression by the applicant or recipient, or his authorized representative, that he wants the opportunity to present his case to a reviewing authority.” There is no requirement it be in writing. CMS guidance elaborates further: “Oral Inquiries about the opportunity to appeal should be treated as requests for appeal for purposes of establishing the earliest possible date for an appeal.” CMS State Medicaid Manual § 2902.1.

¹⁹³ 42 C.F.R. § 431.220(a)(1-2)(hearing required for any claimant that requests it); 42 C.F.R. § 431.221 (b) (“The agency may not limit or interfere with the applicant’s or recipient’s freedom to make a request for a hearing.”); Memorandum of Understanding between La. DHH and La. DAL, Oct. 1, 2010, §§ 3.1, 3.2.

3.7.7. 90 day time limit for decision

Federal regulations require that the agency's final action on administrative fair hearing requests usually occur within 90 days of their filing.¹⁹⁴ For almost ten years, beginning in 1997 there was a court order in place providing that claimants were to receive the benefit at issue in their hearing if a final decision was not implemented within the 90 days.¹⁹⁵ The Order has been sunsetted, and the relief it obtained was available only as a result of the Department's being in contempt of an earlier order requiring timely adjudications (which has also been sunsetted). As a result, there is no penalty for the Department's not meeting the 90 day time line.

Nonetheless, the ALJs may require consent to extend the 90 days in conjunction with any requests for a continuance. Counsel should willingly consent to these extensions. (As noted above, DHH gets 35 days to review any Recommended Decisions that would overturn its action. Without the extension, if a hearing pends over 55 days, the ALJ may think he or she has authority to find in favor of the Department, but not against it (because the 35 day for DHH to review adverse decisions has not been reserved).

3.7.8. Appeals improperly dismissed

Louisiana's agency illegally dismisses appeals:

- as moot or resolved, based on documents transmitted to the ALJ or DAL by DHH staff, without confirming with the claimant or counsel that the matter is in fact fully resolved;
- as "withdrawn" without ensuring that the appellant's right to appeal was not interfered with by agency staff,¹⁹⁶
- in the past, as untimely filed without any hearing to determine whether the facts as to timeliness assumed by the Appeals Bureau are true.¹⁹⁷

In such cases, the agency currently also fails to notify the appellant of their right to judicial review.¹⁹⁸

If the DAL attempts to disallow an appeal because there is no adverse action notice to appeal, that would improperly give staff who take action adverse to the appellant control over access to appeals. The federal fair hearing statute does not even require that there have been a "decision" in order to appeal.¹⁹⁹

3.7.9. Agency duty to comply with appeal decisions and issue corrective payments

State agencies are required to adhere to and implement favorable fair hearing decisions.²⁰⁰ (Otherwise, the client's statutory opportunity for a fair hearing is meaningless.)

¹⁹⁴ 42 C.F.R. § 431.244(f); see also *Richard M. Dickson v. George Fischer, et al.*, E.D.La. CA No. 81-563, June 3, 1981, ¶14.

¹⁹⁵ *Blanchard v. Forrest*, E.D.La. C.A. No. 93-3780, Consent Order, February 22, 1997 (Rec. Doc. 131).

¹⁹⁶ Compare 42 C.F.R. § 431.221(b).

¹⁹⁷ Compare Memorandum of Understanding between La. DHH and La. DAL, Oct. 1, 2010, §§ 3.3(C) (providing for such decisions to be reached through dispositive motions).

¹⁹⁸ Compare 42 C.F.R. § 231.245(b).

¹⁹⁹ 42 U.S.C. § 1396a(a)(3) (requiring appeals for "any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness").

²⁰⁰ CMS's State Medicaid Manual, §2903.3.A. ALJ decisions in favor of the client are binding unless agency rehearing procedures are invoked within ten days. See La.R.S. 49:959. This is because the APA does not define agencies as "persons" and they are therefore not entitled to judicial review of ALJ decisions. La.R.S. 49:964(A)(1,2) and 49:951(5).

The federal regulations require “corrective payments” after a favorable hearing decision or settlement of an appeal.²⁰¹ This has been interpreted to include direct payments to recipients reimbursing them for costs they incurred, as well as payments to providers. In this state the opportunity for retroactive coverage usually begins with an agency notice, included as part of the local office’s certification notice, allowing 30 days for the recipient to claim payment for bills they already paid in the period covered by their certification.²⁰²

The agency’s reimbursements to recipients are made at the Medicaid rate. If recipients paid for their services, they will usually have paid more, often about double this amount. Recipients therefore do better to request refunds from the providers, and have the providers obtain payment from Medicaid. This way the provider, rather than recipient, takes the loss. But nothing requires most providers do this. (Nursing facilities, doctors accepting QMB Medicaid, and hospitals built with Hill-Burton funds would be required to.)

3.8. POSSIBILITY OF GETTING A STATE COURT STAY WHILE A FAIR HEARING IS PENDING.

A stay can be sought from state court in conjunction with a state court judicial review proceeding.²⁰³ The state court proceeding can be filed immediately if a non-final agency ruling (such as the decision to terminate continued benefits) will otherwise inflict irreparable injury.²⁰⁴ Such a proceeding could be concurrent with an ongoing fair hearing proceeding.

Most state courts will want all administrative remedies exhausted before injecting the court into an agency proceeding, so it is prudent to have exhausted as many as possible before seeking such relief. Even so, getting a court to issue the stay while other proceedings are still pending and with little record to rule on is bound to be an uncertain proposition. When there is a viable federal claim a federal TRO would likely be easier to obtain.

The agency, too, can issue a stay, in lieu of the court’s doing so.²⁰⁵ Since a stay is not exactly a preliminary injunction, there is no automatic requirement that security be posted in order for the relief to issue.

3.9. STATE COURT JUDICIAL REVIEW OF HEARING DECISIONS.

3.9.1. Beginning suit and time limitations

Appellants can file for judicial review under the state Administrative Procedure Act within 30 days of an adverse fair hearing decision.²⁰⁶ As noted above, a timely filed petition for rehearing extends the period. A two page, non-substantive form petition is usually used to start the proceeding. Petitions are often styled “in re” the claimant, or the Office of the Secretary of DHH can be named as defendant. The Division of Administrative Law is not named as a party in cases avail-

²⁰¹ 42 C.F.R. § 431.246.

²⁰² Sometimes this is on the certification notice, other times as a separate “Form 1-rrp.” The form was created to comply with the requirements of *Blanchard v. Forrest*, 71 F3d 1163, 1167-68 (5th Cir.), cert. denied 518 U.S. 1013 (1996).

²⁰³ La.R.S. 49:964(C); *Division of Administration v. Department of Civil Service*, 345 So.2d 67 (La. App. 1 Cir. 1977) (granting stay of administrative order); *Summers v. Sutton*, 428 So.2d 1121, 1125 (La App. 1 Cir. 1983) (denying stay of administrative order).

²⁰⁴ La.R.S. 49:964(A)(1).

²⁰⁵ La.R.S. 49:964(C).

²⁰⁶ La. R.S. 49:964(B); 46: 107(C). As noted above, a timely filed petition for rehearing extends the period.

able on Westlaw (seeking review of adverse actions by other agencies). This is consistent with La. R.S. 49:992(B)(3).²⁰⁷ Service of the petition on DHH must be arranged.²⁰⁸

Judicial review is of the existing administrative record, including hearing transcript. Though not permitted by statute, the defendant often takes 75 days or longer to answer.²⁰⁹ Court review cannot take place until the record is received.²¹⁰ But the petitioner can file a motion to stay the adverse action in the meantime, if enough evidence can be presented to the court to justify this²¹¹, or other sanctions can be ordered by the court for transcript delays.²¹²

If the petition is filed in Baton Rouge (as well as some other parishes), the Local Rules require that the plaintiff's attorney "immediately notify" the Judge that a judicial review proceeding is pending.²¹³ On receiving this notice, the judge often schedules a status conference to set a briefing schedule.

3.9.2. Venue

Unlike most Administrative Procedure Act suits, the plaintiff can choose between Baton Rouge venue and the parish of his or her domicile.²¹⁴ But if the proceeding will seek a declaratory judgment that an agency rule or policy is invalid or inapplicable, exclusive venue may be in Baton Rouge.²¹⁵

3.9.3. Limitations on judicial review

Judicial review is limited to the record from the fair hearing.²¹⁶ The governing statute does not require that courts accept agency fact-findings, but just give them "due regard," which is lessened when the hearing was not conducted in person.²¹⁷ There is a split as to whether the Court of Appeal should defer to the District Court as to the facts.²¹⁸ The First Circuit has noted that an ALJ's disbelief of the recipient or applicant does not create sufficient evidence to support an agency ruling.²¹⁹

The closed records of APA judicial review cases will not usually evidence the broad-scale system facts which can be dispositive under Medicaid case-law. Judi-

²⁰⁷ "Nothing in this Section shall affect the right to or manner of judicial appeal in any adjudication, irrespective of whether or not such adjudication is commenced by the division or by an agency."

²⁰⁸ La. R.S. 49:964(B).

²⁰⁹ Compare La. R.S. 49:964(D).

²¹⁰ *Id.*

²¹¹ La. R.S. 49:964(C).

²¹² *In re Forgione*, 36130 (La. App. 2 Cir. 6/12/02), 821 So. 2d 673, 677; *Bruce v. State, Department of Health and Hospitals*, 95-1175 (La. App. 3 Cir. 3/6/96) 670 So.2d 680.

²¹³ See e.g., Louisiana Rules for District Courts, Appendix 9.14, 19th JDC, "Judicial Reviews and Appeals."

²¹⁴ La.R.S. 46:107(C).

²¹⁵ La.R.S. 49:963(A)(1); *Star Enterprises v. State, Department of Revenue*, 95-1980 (La. App. 1 Cir. 6/28/96) 676 So.2d 827, 833.

²¹⁶ La. R.S. 49:964(F).

²¹⁷ La. R.S. 49:964(G)(6).

²¹⁸ *Carpenter v. State, Dept. of Health and Hospitals*, 2005-1904 *8 (La.App. 1 Cir. 9/20/06), 944 So.2d 604, 610 (approving District Court's reversal of ALJ credibility decision, and holding that appellate court need not defer to District court in APA proceedings); *Wild v. State, Dept. of Health and Hospitals*, 2008-1056 *6 (La.App. 1 Cir. 12/23/08), 7 So.3d 1, 4-5 (Court of Appeal's review is plenary, without deference); *Compare Bueche v. Dep't of Health & Hospitals*, 2000-1473 (La.App. 1 Cir. 6/21/02), 822 So. 2d 25 (Court of Appeal defers to the District Court on facts in APA proceeding); *Multi-Care, Inc. v. Multi-Care, Inc. v. State, Dept. of Health & Hospitals*, 2000-2001 *4 (La.App. 1 Cir. 11/9/01), 804 So.2d 673, 675 (deference runs to the District Court, not the agency); *St. Martinville, L.L.C. v. Louisiana Tax Com'n*, 2005-0457 *4 (La.App. 1 Cir. 6/10/05) 917 So.2d 38, 41-42; but see *Feliciana Consultants, Inc. v. State, Dept. of Health & Hospitals*, 2009-1098 *5 (La. App. 1 Cir. 12/23/2009) 2009 WL 4981283 (concurrency articulating this position, but majority not).

²¹⁹ *Carpenter v. State, Dept. of Health and Hospitals*, 2005-1904 *8 (La.App. 1 Cir. 9/20/06), 944 So.2d 604, 610, quoting *Stroik v. Ponseti*, 97-2897, p. 11 (La. 9/9/97), 699 So.2d 1072, 1080, citing *New Orleans & Ne. R.R. Co. v. Redmann*, 28 So.2d 303, 309 (La.App. 4 Cir. 1946)

cial review is therefore best for dealing with state agency failure to adhere to its own policies or its own regulations or for seeking reversals based on the equities of a particular case.

An absence of relevant facts in the record can defeat the legal claim for relief or can reduce the judge's comfort level (that he or she understands everything he or she needs to in order to avoid making a mistake), thus increasing deference to the agency, which will argue that its decision is based on important policy concerns. Such policy concerns are not usually raised at the fair hearing level. Because the record is closed, there may be no evidence or opportunity to disprove the agency's policy claims. For example, the agency often *asserts* in court that if current policy were not adhered to, federal funding for the program would be lost or jeopardized. Unless evidence on the issue was introduced at the administrative hearing, courts are left in the difficult position of having to deal with this concern without proof one way or another, and often defer to the agency on it.²²⁰ In a federal suit with an open record, such an assertion can be challenged.

In addition, it is unlikely that class-wide relief can be sought in an APA proceeding.²²¹ However, declaratory relief, which can be sought in a Baton Rouge APA proceeding,²²² may benefit others. In one case, including a request for an injunction in the petition and obtaining it thwarted the state's attempt to suspensively appeal a favorable District Court judgment.²²³

Nonetheless, because the Eleventh Amendment bars federal court jurisdiction over non-federal claims against a state, state court will usually be the only forum for pursuing issues regarding APA rule-making requirements, agency compliance with its own policies (like the state plan or Medicaid Eligibility Manual), claims that actions violate "public policy," or are arbitrary and capricious, and state statutory or constitutional requirements.²²⁴

3.10. CIVIL RIGHTS ACTIONS UNDER 42 U.S.C. §1983²²⁵

Federal-question suits are available for persons who have been denied "any rights, privileges, or immunities secured by the Constitution and [federal] laws" under color of state law.²²⁶ This authorizes suit if a federal statutory provision which conveys "rights" (discussed *infra*) or a constitutional requirement has been violated, but not for violations of regulations.²²⁷

²²⁰ See e.g., *Case of Hamner*, 427 So.2d 1188, 1191-1192 (La. 1983) in which the state Supreme Court describes actions that occurred when the appellant's application was supposedly submitted to the federal Medicaid agency for review—most likely a misunderstanding by the Court of the application processing procedure, and then basing its decision on the supposed inevitability of the federal agency's position on the matter.

²²¹ But see *D'Agostino v. City of Baton Rouge*, 504 So.2d 1082 (La.App. 1 Cir.,1987)(allowing class action on a mandamus claim).

²²² La.R.S. 49:963.

²²³ *Feliciana Consultants, Inc. v. State, Dept. of Health and Hospitals*, 2009-0379 (La.App. 1 Cir. 5/20/09), 16 So.3d 379. The case does not discuss whether this might have been an improper cumulation of actions.

²²⁴ But see *Women's and Children's Hosp. v. State, Dept. of Health and Hospitals* 2008-946 p. 15(La. 1/21/09), 2 So.3d 397, 407 (stating the state plan is not even enforceable in state court, since not an APA rule).

²²⁵ An excellent reference concerning §1983 litigation is the *Federal Practice Manual for Legal Aid Attorneys*, <<http://federalpracticemanual.org>>.

²²⁶ 42 U.S.C. § 1983.

²²⁷ *Alexander v. Sandoval*, 532 U.S. 275 (2001)(regulations cannot convey a private right of action); *Gonzaga University v. Doe*, 536 U.S. 273 (2002)(the test for whether there is an right enforceable through §1983 is similar to private right of action analysis).

As set out below, there are numerous technical challenges available to defendants and to court for challenging a federal court Medicaid action. Some advocates may be averse to a federal suit because of the chances that it gets dismissed without reaching a decision on the merits.

What should be remembered and explained to the client is that a win is a win and a loss is a loss. The chance of a procedural dismissal in federal court is worth taking if the overall chance of a favorable decision is higher there. In specific cases the chance of procedural loss is more than outweighed by factors below, like getting access to an open record, more clerk power available to the federal court, and usually a vision that the court is at least equal in the constitutional scheme to the agency being reviewed.

3.10.1. Correct defendant(s)

The state agency is not an appropriate defendant in a §1983 action.²²⁸ Instead, the Secretary of DHH should be sued, in his or her “official” capacity.

The proper relief to seek against such officials is injunctive relief: ordering the officials to comply with federal law. (Sometimes this can result in “ancillary” benefits with retroactive effect, such as declaratory relief that can be used to claim corrective payments in later state administrative proceedings²²⁹ (if no time limit has passed for invoking such proceedings), or correction of the Medicaid file, which can result in providers being able to claim payment for past services.)

Damages can be available in an action against an individual worker (named as defendant in his or her “individual capacity”) if he or she has violated a **clearly established** constitutional right of the client.²³⁰ This type of claim should be supportable, for example, based on a denial of due process if a Medicaid application was denied though the agency had information to establish that the client was clearly eligible, or if Medicaid was terminated without a realistic review of whether the recipient qualifies under categories other than the one previously certified. Claims against workers must be pleaded carefully: they are susceptible to dismissal or interlocutory appeal for not adequately pleading that the constitutional violation was one a reasonable official should have known was illegal.

Damages are unlikely to be available for violations of the Medicaid regulations or statute, even as to clearly established rights. The Fifth Circuit has held that spending clause legislation (like the Medicaid Act) does not create a right of action for damages against individuals.²³¹

3.10.2. More than 30 day filing period.

The §1983 cause of action picks up the analogous state law prescriptive period, which in Louisiana should be the general one year tort period. It should **not** be the 30 day administrative appeal or judicial review period, since less preparation is needed to file those actions.²³³ But to avoid an argument that rights lapsed with the passage of the 30 days, suit should be filed within that period if possible.

²²⁸ *Will v. Michigan Department of State Police*, 491 U.S. 58 (1989).

²²⁹ See *Will v. Michigan Department of State Police*, 491 U.S. 58, 71 n. 10 (1989); *Quern v. Jordan*, 440 U.S. 332, 347-49 (1979).

²³⁰ *Hafer v. Melo*, 502 U.S. 21 (1991).

²³¹ *Sossamon v. Lone Star State of Texas*, 560 F.3d 316, 328-29 (5th Cir. 2009), *aff'd on other grounds* 131 S.Ct. 1651 (2011).

²³² See *Wilson v. Garcia*, 471 U.S. 261 (1985); *Martin v. Demma*, 831 F.2d 69, 71 (5th Cir. 1987).

²³³ *Burnett v. Grattan*, 468 U.S. 42 (1984).

3.10.3. Open record

Use of §1983 also allows discovery and the introduction of new facts. In many states, facts that were decided by an Administrative Law Judge after full and fair procedures are binding, and if a fair hearing was requested, issues which could have been introduced at the hearing, but were not, *may* be precluded.²³⁴ But based on a state Supreme Court decision, that should not be the case in Louisiana.²³⁵

3.10.4. Lack of jurisdiction over state-law and state-plan claims in federal court

State-law claims cannot be raised in federal court, since the Eleventh Amendment has been interpreted to preclude federal courts from enforcing state-law claims against states and state officials sued in their official capacity.²³⁶ This includes claims for violations of the Louisiana Administrative Procedure Act. Since Louisiana's Medicaid agency often fails to follow APA rule-making requirements, the loss of this claim can be significant.

Sometimes the same actions that violate the state APA can still be brought in federal court, not as APA violations, but as denials of due process, if improved procedures could have prevented the harm.²³⁷

There is a reasonable argument that a suit seeking to make the state adhere to details set out in its state plan is not a suit enforcing requirements of federal law, but obligations the state has imposed on itself. Like other state law claims this would not present a claim enforceable in federal court.²³⁸

3.10.5. Federal “enforceable rights,” that meet standards under the Wilder and Blessing Supreme Court cases, must be at issue

The remedy for violations of law by state and local officials under 42 U.S.C. § 1983 is for deprivation of “rights...secured by the Constitution and laws.”²³⁹ The Supreme Court has ruled that for a provision to be enforced against states, Congress must have deliberately and clearly imposed a duty on states.²⁴⁰

Previous Medicaid cases in the Fifth Circuit and one by the Supreme Court have held that the 3 part *Wilder* or *Wilder-Blessing* test determines whether a right is enforceable under 42 U.S.C. § 1983. The test has been tightened by the 2003 Supreme Court *Gonzaga* decision, discussed *infra*. The requirements for enforceability under *Wilder* and *Blessing* are generally stated as being that the statutory provision at issue:

- 1) was intended to benefit the plaintiff;
- 2) specifies a binding obligation, rather than a Congressional preference or goal; and

²³⁴ *University of Tennessee v. Elliott*, 476 U.S. 7880 (1986).

²³⁵ *Wooley v. State Farm Fire and Cas. Ins. Co.*, 2004-CA-882 p. 36 (La. 1/19/05) 893 So.2d 746, 771 (ALJ decisions not entitled to res judicata in Louisiana).

²³⁶ *Pennhurst State School and Hospital v. Halderman*, 465 U.S. 89 (1984).

²³⁷ See *Zinerman v. Burch*, 424 U.S. 113, 128 (1990).

²³⁸ See *Concourse Rehabilitation and Nursing Center, Inc., v. DeBuono*, 179 F.3d 38, 44 (2d Cir. 1999); compare *Oklahoma Nursing Home Ass'n v. Demps*, 792 F.Supp. 721, 728 (W.D.Okl. 1992). But see *Women's and Children's Hosp. v. State, Dept. of Health and Hospitals* 2008-946 p. 15 (La. 1/21/09), 2 So.3d 397, 407 (stating the state plan is not even enforceable in state court, since not an APA rule).

²³⁹ 42 U.S.C. § 1983.

²⁴⁰ *Suter v. Artist M*, 503 U.S. 347 (1992). Dicta in *Suter* suggested that the only “right” might be to have states file a paper plan saying the state will comply with Social Security statutes. Congress seems to have rejected such implications. 42 U.S.C. § 1320a-2; see also H.Conf.Rep. No. 103-761, 103rd Cong., 2d Sess., 926, reprinted in 1994 U.S. Code Cong. & Ad. News, 2807, 3257.

- 3) is not vague and amorphous, so that it would be beyond the competence of the judiciary to enforce.²⁴¹

As an important additional gloss on these requirements, the Supreme Court and Fifth Circuit have held that statutory requirements that are clearly meant to impose specific and binding obligations on the states and to benefit persons *like* the plaintiff do not create a “right” if they require only particular efforts or only that certain percentages of persons be helped, affected, or protected. The reasoning is that even if the state complies with the statutory obligation, any particular plaintiff could be within the percentage as to which compliance is not required—so Congress has enacted no requirement that the particular plaintiff has a *right* to the service.²⁴²

To deal with these requirements, it is crucial for the plaintiff to plead the specific statutory provision(s) supporting the relief sought.²⁴³ The National Health Law Program maintains, and is willing to share with Legal Services staff, a comprehensive table of holdings as to Medicaid provisions that have been found judicially enforceable and unenforceable.

Avoid relying on vague Medicaid mandates, like the one requiring states to have safeguards as “necessary to assure that eligibility for care and services... will be determined...in a manner consistent with simplicity of administration and the best interests of recipients.”²⁴⁴ If one has to rely on one of the less specific statutory mandates, to the extent possible cite regulations that have added more specificity to the statutory requirement.²⁴⁵

For eligibility and service denials, cite a violation of 42 U.S.C. § 1396a(a)(8), which requires that “assistance shall be furnished with reasonable promptness to all eligible individuals.” This language is parallel to now-repealed AFDC statutory language that the Supreme Court has cited as model language for creating enforceable rights.²⁴⁶

3.10.6. Meeting the Wilder-Blessing test may no longer be enough: *Gonzaga* and state sovereignty issues

In *Gonzaga Univ. v. Doe*, 536 U.S. 273, 283 (2002), the Supreme Court held that even though § 1983 explicitly provides a private right of action for violation of enforceable rights, the determination of whether such rights exists is as stringent a test as must be met in implying a private right of action, where Congress has provided none. There were at least several strong grounds on which the lower court opinion could have been reversed by the Supreme Court. So perhaps the *Gonzaga* language may be akin to dicta that did not get close scrutiny. Even so, it presents a potential threat to most §1983 actions based on statutory rights, and the Court’s composition has become still more conservative since the decision.

²⁴¹ *Wilder v. Virginia Hospital Association*, 496 U.S. 498, 509 (1990); *Frazar v. Gilbert*, 300 F.3d 530, 538 (5th Cir. 2002), *rev’d on other grounds sub nom Frew ex rel. Frew v. Hawkins*, 540 U.S. 431 (2004); *Resident Council of Allen Parkway Village v. HUD*, 980 F.2d 1043, 1051 (5th Cir.), *cert. denied* 510 U.S. 820 (1993).

²⁴² *Blessing v. Freestone*, 520 U.S. 329, 343 (1997); *see also Frazar v. Gilbert*, 300 F.3d 530, 545 (5th Cir. 2002), *rev’d on other grounds sub nom Frew ex rel. Frew v. Hawkins*, 124 S. Ct. 899 (2004).

²⁴³ *See Blessing v. Freestone*, 520 U.S. 329, 342-46 (1997).

²⁴⁴ 42 U.S.C. §1396a(a)(19). *Compare Stewart v. Bernstein*, 769 F.2d 1088, 1093 (5th Cir. 1985) (holding the provision unenforceable).

²⁴⁵ *See Wright v. Roanoke Redevelopment & Housing Authority*, 479 U.S. 418 (1987) (majority holding that in light of the interpretive federal regulations, the statutory mandate at issue was specific enough to be enforceable). *Wright* was the first case in the *Wright-Wilder-Suter* trilogy concerning rights enforceable under §1983.

²⁴⁶ *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1, 17-18 (1981).

Separate from *Gonzaga*'s possible change to the standard used to apply §1983 are concerns raised by the Supreme Court's ongoing state sovereignty case law. Supreme Court cases in and since the 1990s hold that Congress' powers under Article I of the Constitution cannot infringe on states' sovereignty.²⁴⁷ Most of the cases have been damages actions, but the initial case, *Seminole Tribe of Florida v. Florida*, was not.²⁴⁸ The Court has stated that these state sovereignty cases do not preclude official capacity suits seeking injunctive relief against state officials, and do not infringe on Congress' power to impose enforceable rights against the states under the "spending clause" (which is the basis for Medicaid legislation).²⁴⁹ But the line preserving official capacity actions and spending clause legislation involves only a policy choice, and enjoys no secure Constitutional distinction from the other types of congressional authority that have been invalidated.

Since *Gonzaga*, some Medicaid provisions have been found not to support a private right of action, and others to support one. Any adverse ruling threatens not just parties to the suit but Medicaid litigation across the nation. The precedents in all Circuits need to be checked as to any provision relied on before filing a federal suit. If a serious *Gonzaga* or state sovereignty challenge is made in a suit, the National Health Law Program and/or the author may be willing to assist with strategizing or briefing on the issue.

3.10.7. Avoid relying solely on regulations or interpretive materials

The Supreme Court has held that rights of action must be created by Congress, and so cannot be created by regulations alone.²⁵⁰ Using §1983 for a right of action, plaintiffs must still source their federally enforceable "right" to an enactment by Congress.²⁵¹

As a result, care should be taken to use regulations, manuals, regulatory materials, or case-law not as the basis for any claims, but as setting out guidance as to the requirements imposed by a statutory mandate that meets the three criteria for a right of action under *Wilder/Blessing*.

3.10.8. Include constitutional claims, if possible

To help minimize the "enforceable rights" issue, include any available claims based on violations of constitutional rights, since the enforceable rights analysis does not pose a problem for these claims. The presence of the constitutional violation can help make the court more comfortable with a statutory claim that it might otherwise be hesitant to entertain.

Many denials of Medicaid assistance are accompanied by denials of a property interest (in the assistance) without due process of law. To make the due process claim cognizable, the plaintiff needs to avoid the *Parratt/Hudson* line of

²⁴⁷ See e.g., *Seminole Tribe of Fla. v. Florida*, 517 U.S. 44 (1996); *Kimel v. Florida Board of Regents*, 528 U.S. 62 (2000).

²⁴⁸ In *Seminole*, in response to the plaintiff's argument that injunctive relief should be available, the Court found that application of such a §1983 remedy had been displaced by another comprehensive remedial scheme enacted by Congress. 517 U.S. 44, 71. See also *Federal Maritime Commission v. South Carolina State Ports Authority*, 535 U.S. 743, 765 (2002) ("sovereign immunity applies regardless of whether a private plaintiff's suit is for monetary damages or some other type of relief").

²⁴⁹ *Verizon v. Public Service Commission of Maryland*, 535 U.S. 635, 645 (2002); *Alden v. Maine*, 527 U.S. 706, 755, 757 (1999) (recognizing the continuing validity of official capacity actions to enforce valid federal laws against states and recognizing the federal government's authority to regulate even non-funded activities (states' permissible drinking ages) in exchange for accepting federal funding).

²⁵⁰ *Alexander v. Sandoval*, 532 U.S. 275 (2001).

²⁵¹ *Gonzaga University v. Doe*, 536 U.S. 273, 283-284 (2002); see also *Casas v. Am. Airlines, Inc.*, 304 F.3d 517 (5th Cir. 2002) (refusing to infer right of action from A.D.A. regulation).

cases, which hold that due process is not violated by random and unauthorized acts of state actors.²⁵² Plead and be prepared to evidence that the violation could be prevented by proper pre-deprivation process.²⁵³

3.10.9. Complications from requesting a fair hearing before going to federal court

If relief under 42 U.S.C. §1983 is available, other administrative or judicial remedies need not be exhausted first.²⁵⁴ In fact, when another administrative or judicial proceeding has been invoked, abstention and other jurisdictional issues arise that can complicate or defeat the §1983 claim.

Under *Younger v. Harris* a federal court is to abstain from entertaining a case if “important” state interests are at issue in the proceedings, and there is a pending state proceeding which is judicial in character.²⁵⁵ In *Ohio Civil Rights Commission v. Dayton Schools*, the Supreme Court denied jurisdiction based on the doctrine even though the state proceeding was administrative and could not rule on all the legal claims being raised in federal court.²⁵⁶

There are at least two recent federal Medicaid precedents explicitly finding jurisdiction for the federal suit to go forward even though a fair hearing request is pending before the state agency.²⁵⁷ Those suits distinguish *Ohio Civil Rights Commission v. Dayton Schools*, 477 U.S. 619 (1986). But the distinctions between the cases in which *Younger* abstention is ordered or denied are not clear; so abstention remains a risk if another proceeding is pending.²⁵⁸ And at least one Federal Circuit has ruled that an administrative proceeding remains “ongoing” if remaining remedies have not been exhausted, which could nearly always preclude federal jurisdiction.²⁵⁹ Some courts have also rejected jurisdiction over a federal court proceeding when a fair hearing request was pending, for lack of ripeness.²⁶⁰

Even after a fair hearing has resulted in a decision, having invoked the state administrative proceeding can cloud federal jurisdiction to seek further review.

There is an argument that some or all of the hearing officer’s factual findings are conclusive *and* that claims not raised in the fair hearing are precluded.²⁶¹ But a Louisiana Supreme Court decision states that Louisiana does not accord res judicata to administrative decisions.²⁶² The claim preclusion accorded a decision is supposed to be decided based on the law of the forum of the earlier decision. So the state

²⁵² *Parratt v. Taylor*, 451 U.S. 527, 541 (1981); *Hudson v. Palmer*, 468 U.S. 517, 520-521 (1984).

²⁵³ See *Zinerman v. Burch*, 424 U.S. 113, 128 (1990); but see *Johnson v. Louisiana Department of Agriculture*, 18 F.3d 318, 322 (5th Cir. 1994).

²⁵⁴ *Patsy v. Board of Regents*, 457 U.S. 496 (1982); *Monroe v. Pape*, 365 U.S. 167, 172, 183 (1961); *McNeese v. Board of Ed. for Community Unit School Dist. 187, Cahokia, Ill.*, 373 U.S. 668, 672 (1963); *Curtis v. Taylor*, 648 F.2d 946, 949 (5th Cir.1980).

²⁵⁵ 401 U.S. 37 (1971).

²⁵⁶ See *Ohio Civil Rights Comm’n v. Dayton Schools*, 477 U.S. 619, 627-29 (1986).

²⁵⁷ *Brown ex rel. Brown v. Day*, 555 F.3d 882 (10th Cir. 2009); *Moore, ex rel. Moore v. Medows*, 2007 WL 1876017 (N.D.Ga. 2007), *rev’d on other grounds, Moore ex rel. Moore v. Medows*, 324 Fed.Appx. 773 (11th Cir. 2009).

²⁵⁸ Compare e.g., *Hudson v. Campbell*, 663 F.3d 985 (8th Cir. 2011) (ordering abstention in Medicaid case).

²⁵⁹ *Hudson v. Campbell*, 663 F.3d 985, 988 (8th Cir. 2011).

²⁶⁰ *McGhee v. Director, Department of Mental Health and Hygiene*, 153 F.3d 721, 1998 WL 403329 (4th Cir. 1998) (table); *Tammy W. v. Hardy*, 681 F.Supp.2d 732 (S.D.W.Va.,2010). It appears the latter was likely proceeding on a Supremacy Clause theory rather than under §1983.

²⁶¹ *University of Tennessee v. Elliott*, 476 U.S. 788 (1986); *Astoria Federal S. & L. Ass’n v. Solimino*, 501 U.S. 104 (1991); see Lawler and Vera, “The Limits of the Elliott Doctrine: Preserving Civil Rights Claims in the Wake of a State Agency Decision” 24 *Clearinghouse Review*, 194 (July 1990); see also *Medina v. INS*, 993 F.2d 499, 503-04 (5th Cir. 1993), *rehearing denied* 1 F.3d 312; *Olson v. Morris* 188 F.3d 1083 (9th Cir. 1999) (Judge Skagg, of the Western District of Louisiana was a member of the panel); see also *Hughes v. Arveson*, 924 F.Supp. 735 (M.D.La. 1996) (federal suit precluded by administrative proceeding unsuccessfully appealed into state court).

Supreme Court decision should be dispositive. In addition, one can argue that a court suit should not be precluded by a hearing decision issued after a hearing that may have been preceded by no discovery, often slotted for one hour, and resulted in a brief written decision.²⁶³ But discovery is available and the hearings can take more than a day, so the arguments are not necessarily dispositive. (Requesting discovery before the fair hearing may help show that the court case should not be pre-determined by the fair hearing, if the ALJ refuses to compel responses.)

There is also some chance that problems may be raised as to federal jurisdiction after a fair hearing under other equitable rubrics, like “election of remedies,” ripeness, or *Younger* abstention.²⁶⁴ The Supreme Court ruled in *Monroe v. Pape* that a § 1983 plaintiff need not exhaust state court remedies before filing a § 1983 action.²⁶⁵ That may be a sufficient reply, but there is no guarantee.

3.10.10. State court §1983 actions

In state court, a § 1983 claim may be cumulated with an APA summary proceeding.²⁶⁶ If the cumulation is timely challenged, the worst outcome should be that the plaintiff would get to elect which form of proceeding he or she wants to pursue.²⁶⁷ There is a strong argument that the plaintiff should not have to choose between the two remedies (but just have them severed for trial), since the state Administrative Procedure Act remedy is not supposed to limit other rights.²⁶⁸

But to establish the § 1983 claim, specific underlying facts that justify the claim for relief must be pled, rather than just adding §1983 citations to a boilerplate judicial review petition that says nothing about the facts. Otherwise, especially since Louisiana courts traditionally require “fact pleading”, the § 1983 claim is subject to dismissal in state court for no cause of action.²⁶⁹

Combining the two forms of action may confuse the differing standards of review. Along a similar vein, while the § 1983 action can be filed directly in state court, without exhausting state administrative remedies,²⁷⁰ many judges would attempt to require exhaustion, because of their greater familiarity with Administrative Procedure Act suits, where exhaustion is required.

If state law claims are combined with federal claims, the whole suit may be removed to federal court.²⁷¹ This poses some risk of losing review of the state law claims, though the federal court could either remand the latter or find that the removal itself waives the state’s Eleventh Amendment sovereign immunity.²⁷²

²⁶² *Wooley v. State Farm Fire and Cas. Ins. Co.*, 2004-CA-882 p. 36 (La. 1/19/05) 893 So.2d 746, 771; see also La. R.S. 49:964(A) (providing that the Louisiana state administrative procedure act does not limit any other remedies).

²⁶³ *Accord Burnett v. Grattan*, 468 U.S. 42 (1984) (the short period for filing administrative employment discrimination complaints should not be borrowed as the deadline for filing a § 1983 action, given the more comprehensive preparation that should precede filing of court suit).

²⁶⁴ See *Moore v. City of Asheville, N.C.* 396 F.3d 385, 395-96 (4th Cir.) cert. denied 546 U.S. 819 (2005) (applying *Younger* abstention even though the state judicial remedy had not been exercised after adverse hearing decision, and no longer could be); *Hudson v. Campbell*, 663 F.3d 985 (8th Cir. 2011) (holding the unexercised chance to administratively appeal, followed by judicial review, adequate to merit *Younger* abstention).

²⁶⁵ 365 U.S. 167 (1971).

²⁶⁶ Louisiana adopted a res judicata standard like that of common law states in La. R.S. 13:4231; but see C.C.P. 462.

²⁶⁷ C.C.P. 464, and 926.

²⁶⁸ La. R.S. 49:964(A)(1).

²⁶⁹ La. C.C.P. 927(4).

²⁷⁰ *Felder v. Casey*, 487 U.S. 131, 147-52 (1988).

²⁷¹ See *Wisconsin Department of Corrections v. Schacht*, 524 U.S. 381, 392 (1998).

²⁷² See *Lapides v. Bd. of Regents*, 535 U.S. 613 (2002) (holding state waived sovereign immunity by removing suit to federal court); but see *Meyers ex rel. Benzling v. Texas*, 410 F.3d 236, 255 (5th Cir. 2005) (Texas waived its immunity from suit in federal court by removing, but may retain a separate immunity from liability).

3.10.11. State court inability to grant relief if agency certifies no funds are available

State codal provisions may preclude a state court from issuing an injunction or mandamus if the agency head certifies that it would cause a deficit.²⁷³ Especially if relief for the client would require relief for others as well, this may be an issue.

3.10.12. Precluding removal to federal court by avoiding federal claims

If judicial relief is sought *primarily* on state grounds, removal can usually be precluded by pleading the case as a straight state-law APA suit, naming the Department of Health and Hospitals or the “Office of the Secretary” of DHH as the defendant (since the decision is issued over that title). Under the Eleventh Amendment there should then be no federal court jurisdiction over either the claim or the defendant.²⁷⁴ The state could attempt to get around these limitations by attempting to join the federal Medicaid agency as a party, which would then as a matter of course attempt removal to federal court. There are open issues as to whether a third party defendant can remove the original action, to which it is not actually a party.

3.11. FEDERAL COURT JURISDICTION BASED ON THE SUPREMACY CLAUSE MAY BE AVAILABLE IF A STATE POLICY IS IN CONFLICT WITH FEDERAL LAW.

While many Medicaid statutory provisions are no longer considered to convey “enforceable rights” needed for a §1983 action, there is often an alternative. The Fifth Circuit (and all Circuits that have ruled on the issue) have recognized federal jurisdiction over suits alleging that state or local laws or policies are preempted by federal laws they conflict with.²⁷⁵ Such a suit requires not just that the state Medicaid agency’s action on the individual case violates federal law, but also that there is a policy that violates federal law.

In these cases the “Supremacy clause”²⁷⁶ of the U.S. Constitution provides the cause of action. Such a suit is maintainable even where the state or local policy conflicts with a federal regulation.

The suit should clearly challenge the state or local policy as in conflict with, and preempted by, federal law. It would also be prudent to choose at the outset *between* a claim under §1983 and under the Supremacy clause, so that the Supremacy clause claim does not seem like an attempt to save a failing §1983 claim.

A Supremacy clause claim is injunctive only; damages cannot be claimed. In addition, it does not support a claim for attorney fees.²⁷⁷

²⁷³ La. C.C.P. Art. 3601, 3862; La. R.S. 13:4062; *Evergreen Presbyterian Ministries, Inc. v. Louisiana Dept. of Health and Hospitals*, 2000-0852 (La.App. 1 Cir. 6/22/01), 808 So.2d 681 (denying plaintiff right to traverse the affidavit). The provisions presumably implement the state constitution’s balanced budget requirements. But if a state constitutional provision or federal requirement has been violated, application of the Legislature’s ban may be precluded by countervailing constitutional requirements.

²⁷⁴ *See Will v. Michigan Department of Police*, 491 U.S. 58 (1989); *Pennhurst State School and Hospital v. Halderman*, 465 U.S. 89 (1984). *But see, Lapidus*, cited two footnotes above.

²⁷⁵ *Planned Parenthood of Houston and Southeast Tex. v. Sanchez*, 403 F.3d 324, 331-35 & n. 46 (5th Cir. 2005) (Medicaid case finding *Gonzaga* inapplicable, because the claim was for preemption under the Supremacy clause rather than § 1983, citing precedents from other Circuits).

²⁷⁶ Article VI, clause 2.

²⁷⁷ For an overview of the theory and limitations, see Saunders, “Preemption as an Alternative to Section 1983,” 38 *Clearinghouse Review* 705 (March-April, 2005).

Perhaps most importantly, because there has not been much litigation in the public assistance context over the past forty years, many issues that have been favorably resolved under § 1983 can be relitigated by defendants in the Supremacy clause context. A notable example is whether exhaustion of administrative remedies is required.

No position commanded a clear majority in a 2012 U.S. Supreme Court case concerning the viability of using the Supremacy clause to enforce Medicaid requirements.²⁷⁸

3.12. Complications if the federal agency is made a party to any court proceeding

In any court case, if the defendant starts claiming that the federal government must be brought into the suit, this would mean tremendous procedural complications. If not already in federal court, the federal agency will attempt to remove the suit to federal court and once removed by the federal agency, the client may lose access to retroactive relief and claims based on state law.²⁷⁹ (As noted above, there are open issues as to whether a third party defendant can remove the original action, to which it is not actually a party.)

Unless joinder is absolutely necessary, it should be strenuously opposed, to avoid these complications and the attendant delays and work.²⁸⁰

4. FINDING THE GOVERNING LAW

4.1. OVERVIEW

One of the most important mistakes in considering Medicaid issues is to rely on common sense as the basis for coming to a conclusion. The result will often be wrong.

Similarly, if questioning an agency decision, one of the most unlikely sources for finding out whether an agency decision is correct is to go to the agency personnel who made it.²⁸¹ Relying on agency personnel for an evaluation of its correctness would also be derelict, since, as noted above, they are usually unfamiliar with all or most federal requirements governing their actions.

4.2. THE EASY CASE: VIOLATION OF LOUISIANA'S MEDICAID ELIGIBILITY MANUAL STANDARDS

The easiest source for determining the state agency's policies on most eligibility matters is Louisiana's Medicaid Eligibility Manual (MEM), which is now maintained on-line.²⁸² As of 2012, the agency is keeping the Manual up to date; there have been times in the past when that has not been the case. Agency updates had often been issued and distributed outside of the Manual, through memoranda and emails.

²⁷⁸ *Douglas v. Independent Living Center of Southern California, Inc.* 132 S.Ct.1204 (2012).

²⁷⁹ But if it is the state that *files for* (as opposed to having caused the removal) the removal, then by filing for removal, the state may have waived the Eleventh Amendment bars to relief that is retroactive or based on state law. See *Lapides*, cited seven footnotes above.

²⁸⁰ See Perkins, "Dispensing With The Dispensable: Rule 19 Motions in Medicaid Cases," 22 *Clearinghouse Review* 488-491 (October 1988).

²⁸¹ *Accord Goldberg v. Kelly*, 397 U.S. 254, 269 (1970) ("since the caseworker usually gathers the facts upon which the charge of ineligibility rests, the presentation of the recipient's side of the controversy cannot safely be left to him").

²⁸² <http://bhsfweb.dhh.la.gov/onlinemanualspublic/>

The MEM deals mostly with eligibility for the Medicaid card (as opposed to dealing with what services one gets with the card). There are a few other lettered sections dealing with other issues.

When the Medicaid Eligibility Manual policy favors the client, relief should usually be available quickly from DHH agency staff, usually without the need for a fair hearing (by seeking relief from higher-ups in the supervisory chain) since the Medicaid Eligibility Manual is a source all agency staff are familiar with. Always bear in mind, however, the deadlines for seeking relief through court or a fair hearing.

Unfortunately, even when the Manual favors the client, it is not necessarily dispositive. For example, the agency may have issued instructions superseding the Manual's through emails. But under federal law, governing policies must be accessible to the public at agency offices.²⁸³ Since this manual is the only format in which policy is available for public inspection at agency offices, there is a strong argument that its policies should trump those issued in less formal ways.²⁸⁴ In addition, much of the Manual parallels rules that have been formally promulgated under the state Administrative Procedure Act. If instructions supposedly superseding the Manual have not been promulgated, they should be legally trumped by any promulgated policies.²⁸⁵

4.3. IS THE MEDICAID ELIGIBILITY MANUAL LEGALLY BINDING WHEN ADVERSE?

One can be tempted to think that if a policy set out in the Medicaid Eligibility Manual is adverse to the client, the case is without merit. But as set out below, relief may be available. In fact, challenges to the Manual's policy provide the opportunity to provide relief for other similarly situated individuals, not just the client.

First, if inconsistent with federal statutes, federal regulations, or other state law, the Manual provisions are invalid. Thus the need to research beyond the Manual to the underlying federal law.

Secondly, provisions of the Manual are invalid if they determine substantive policy issues, but have not been properly promulgated.

The agency purported to promulgate the Manual under the state Administrative Procedure Act in 1995.²⁸⁶ This purports to give the August 1995 Manual the force of law.

Changes to the Manual since 1995 may not have that same validation, if not promulgated in the Louisiana Register. If not formally promulgated, they do not have the force of law to displace the 1995 provisions, unless required by federal law.²⁸⁷

As to provisions in remaining in the Manual since 1995, the rule purported to adopt the Manual merely by reference, without notifying Register readers of what "Rule," policy choices, and fiscal impacts it purported to promulgate. (Thus,

²⁸³ 42 C.F.R. § 431.18(c & d).

²⁸⁴ If one identifies a particular email or memorandum, the local agency may be able to make those available. But this does not give the consumer or advocate the chance to review all policies and determine their applicability. The author does not believe that the availability of a policy after it has been specifically identified, fulfills the purposes and mandate of the accessibility requirements in § 431.18(c). And the emails and memoranda certainly are not provided to libraries and other entities, as set out in § 431.18(d).

²⁸⁵ La.R.S. 49:954(A).

²⁸⁶ La.Reg. 370 (7/20/96); 21 La.Reg. 868 (8/20/95).

²⁸⁷ La.R.S. 49:954(A).

advocates can raise questions about the validity of such generalized notice; but the agency should be estopped from disavowing the 1996 policies, when advocates seek to rely on them.²⁸⁸) The final rule did not even specify which version of the manual was ultimately promulgated: the policies in effect when the Rule was proposed (including those superseded by the time the Rule was issued) or the changed one in effect when the rule was finalized.

In addition, if the Medicaid Eligibility Manual policies are inconsistent with federal guidance (regardless of whether such guidance is set out in the federal regulations) or with the state plan, these federally recognized sources would trump the Manual.

4.4. AS TO ELIGIBILITY ISSUES FOR PERSONS WHO ARE AGED, BLIND, OR DISABLED: THE SOCIAL SECURITY ADMINISTRATION POMS

As will be explained more fully *infra*, in determining the eligibility of persons who are aged, blind, or disabled, the Medicaid program must adhere to the policies of the SSI program.²⁸⁹ Those policies, as set out in the “Program Operations Manual System” (POMS),²⁹⁰ have details and favorable interpretations on many issues that are either never reached in the Louisiana Medicaid Eligibility Manual, or are even inconsistent with those of the MEM. Based on the cited regulation, the policies set out in the POMS should displace those of the MEM.

Local office personnel are likely to be unfamiliar with this, but state-level staff in DHH’s policy section are familiar with it and will authorize adherence to the POMS. Administrative Law Judges reviewing Medicaid appeals may not be familiar with this and may be unwilling to do the legal analysis to recognize that the POMS should bind.

4.5. FEDERAL STATUTES, REGULATIONS, AND OTHER REGULATORY MATERIALS

If the client’s case is not resolved favorably by provisions of Louisiana’s Medicaid Eligibility Manual or the POMS, the next most relevant standards to review are usually the federal ones, both because they are readily accessible, and because if favorable they will preempt any contrary state policies.

Advocate manuals

If they address the point, the best place to start for determining federal law would be the National Health Law Project’s *The Advocate’s Guide to the Medicaid Program*, June 2011 ed.,²⁹¹ or because it is addressed specifically to Louisiana’s program, this Desk Manual section.

²⁸⁸ In promulgating regulations, the agency’s Notices of Intent continually refers to the MEM promulgation as authoritative. See e.g., 30 La.Reg. 1088 (May 20, 2004); 29 La.Reg. 1884 (Sept. 20, 2003). Courts have repeatedly held it arbitrary and capricious for an agency to disregard its own policies. *Washington-St. Tammany Elec. Co-op., Inc. v. Louisiana Public Service Com’n*, 1995-1932 p. 11, n. 3 (La. 4/8/96); 671 So.2d 908, 915 (“it is arbitrary and capricious for the Commission to fail to apply its own rules in an adjudication before it”); *Central Louisiana Electric Co. v. Louisiana Public Service Com’n*, 377 So.2d 1188, 1194 (La.1979) (“If a public agency is not required to abide by its own rules and procedures, then the standard of review for ‘arbitrary and capricious’ action is without meaning.”); *Carpenter v. Dept. of Health and Hospitals*, 2005-1904 p. 14 (La.App. 1 Cir. 9/20/06); 944 So.2d 604, 613 (agency rejection of document that met the terms of agency’s published policies presented an “unwarranted exercise of discretion”); *Doc’s Clinic v. Dept. of Health and Hospitals*, 2007-0408 p. 36-37 (La.App. 1 Cir. 11/2/07); 984 So.2d 711, 726 (agency issuance of decision through procedures that did not conform to its own policies found “arbitrary and capricious and based on improper procedure”).

²⁸⁹ 42 C.F.R. § 435.601(b).

²⁹⁰ <https://secure.ssa.gov/apps10/poms.nsf/partlist!OpenView>

²⁹¹ <http://www.medicaidguide.org> (paid subscription required).

Federal regulations

If not covered there, the federal Medicaid regulations are often the best starting place because they are well-organized and relatively clear.²⁹² But they are terribly out of date and therefore cannot be relied on if adverse. As an example of how out of date they are, in 1989 Congress amended the statute to require that states cover all Medicaid services necessary to correct or ameliorate health conditions of recipients under age 21, even if they would normally be “optional” services.²⁹³ Yet the federal regulations governing this “EPSDT” benefit inaccurately say, based on prior law, that such coverage is optional.²⁹⁴ Regulations implementing the statutory change were proposed in 1993,²⁹⁵ but *still* have not been promulgated. Similarly, eligibility for Disabled Adult Children, enacted in 1986, is still not described in the mandatory categories.²⁹⁶ Other changes are also absent from the regulations.

Federal agency’s “State Medicaid Manual,” on the CMS website

The federal agency responsible for overseeing Medicaid is the “Centers for Medicare and Medicaid Services,” and is given the acronym CMS.

Even before regulations are published, it passes official interpretations to the states as part of its “State Medicaid Manual.” This is a unified body of federal guidance, organized much like the federal regulations, but more current and detailed. Its interpretations are treated as authoritative and binding on the states by the federal and state agencies. This Manual can be accessed on the internet.²⁹⁷

Other interpretive guidance that can be searched on the CMS website.

Other CMS interpretive materials are available by searching the CMS website.²⁹⁸ Particularly important, when they apply are the “Letters to State Medicaid Directors” or “Letters to State Officials”.²⁹⁹ These letters are typically 2 - 4 pages in length and often contain guidance helpful to beneficiaries. The interpretation in such a letter has been the basis for the Supreme Court’s vacating a Second Circuit decision for reconsideration by the Circuit.³⁰⁰

Other memoranda and transmittals, particularly from the Regional Offices to their respective states, may be available through the National Health Law Program or Public Record, Freedom of Information Act, or discovery requests.

Federal Medicaid statutes

Though obviously the most authoritative source, the Medicaid statutes are so long and disorganized that direct reference to them is usually imprac-

²⁹² 42 C.F.R. Parts 430-483; the relevant portions are usually in Parts 431, 435, and 440 - 447.

²⁹³ 42 U.S.C. § 1396d(r)(5).

²⁹⁴ 42 C.F.R. § 441.57.

²⁹⁵ 58 Fed.Reg. 51288 (10/1/93).

²⁹⁶ 42 C.F.R. § 435.120-138. *Compare* e.g. 42 U.S.C. 1383c(c), added by Pub.L. 99-643 in 1986. Qualified Medicare Beneficiary (“QMB”) eligibility for Medicare recipients with incomes under the poverty line was mandated by Congress, effective January 1, 1989. 42 U.S.C. § 1396a(10)(E)(i); 42 U.S.C. 1396d(p). The eligibility was not added to the regulations’ list of mandatory eligibility categories until 2012, and still is listed only for states that do not give Medicaid to all SSI recipients. 42 C.F.R. § 435.121(b)(2).

²⁹⁷ Publication 45 on the following page: <<http://www.cms.gov/Manuals/PBM/list.asp>>.

²⁹⁸ <<http://www.cms.gov>>.

²⁹⁹ Both can be searched at <http://www.medicaid.gov/Federal-Policy-Guidance/Federal-Policy-Guidance.html#Search>.

³⁰⁰ *Slewis v. Thomas*, 525 U.S. 1098 (1999) (referring to the “State Medicaid Directors” letter of September 4, 1998); *see also Esteban v. Cook* 77 F.Supp.2d 1256, 1260 (S.D.Fla. 1999) (citing and enforcing that same guidance).

ticable without some lead-in as to where to look.³⁰¹ A helpful source laying out most program categories, citing the relevant statutes, regulations and case law, is *The Advocate's Guide to the Medicaid Program*.³⁰²

Officially published explanations of the regulations.

If interpretation is needed regarding matters covered by the regulations, background is usually published in the Federal Register as part of the promulgation process: when the proposed rule is first announced, and then responses to comments and criticisms from the public and interest groups are published with the final rule making notice.³⁰³ These materials can often clarify the meaning of regulations or how they apply to certain controversial situations.

4.6. OTHER STATE-LEVEL MATERIALS.

Even if an action is permissible under federal law, the Louisiana agency must also comply with:

- how it has promised to administer the state's program,
- state statutes that bind it, and
- regularity – treating each recipient consistently with how others are treated.³⁰⁴

The State plan, which can be searched on the internet

The state plan reflects how the state has assured the federal Medicaid agency that its program will be run, particularly with respect to options it has chosen. The plan does not reach the level of detail at issue in most clients' claims, but occasionally it assures that the agency will apply a particular, favorable standard, which has not been fully implemented by the state agency. Often, the plan, federal or state regulations, and state policies are not in accord with respect to what standard governs. The state plan is available by subscription to legal services offices. It can also be searched or browsed on the internet.³⁰⁵

Challenging a failure to comply with the state plan may require state proceedings (fair hearing and judicial review) rather than a federal court suit.³⁰⁶ The author does not encourage challenges to state plan compliance that amount to a "race to the courthouse" – where one knows that the state will amend the state plan to incorporate a policy one is challenging, but simply has not done so yet. Courts have held that the state's failure to submit a state plan amendment for CMS's review and approval may invalidate a pro-

³⁰¹ 42 U.S.C. §§ 1396-1396w-5. Most issues are covered in §§ 1396a & 1396d, but they, by themselves, are quite lengthy.
³⁰² <http://www.medicaidguide.org> (paid subscription required).

³⁰³ The latter can be found through the annotations in the particular section and at the beginning of each subpart in the Code of Federal Regulations (or using Shepards and/or the Code of Federal Regulations List of Sections Affected). The former can be found from a reference in the final rule making notice.

³⁰⁴ Federal rights are also implicated by a failure to treat all recipients equally. See 42 U.S.C. § 1396a(a)(8) (requiring assistance be provided to *all* eligible individuals) and 42 U.S.C. § 1396a(a)(10)(B) (the comparability requirement, that assistance provided to recipients within the federally mandated eligibility categories not be less than that provided to others in the categories and not be less than that provided those not in the mandatory categories).

³⁰⁵ <<http://bhswfweb.dhh.la.gov/onlinemanualspublic>>.

³⁰⁶ *Concourse Rehabilitation and Nursing Center, Inc., v. DeBuono*, 179 F.3d 38, 44 (2d Cir. 1999); but see *Oklahoma Nursing Home Ass'n v. Demps*, 792 F.Supp. 721, 728 (W.D.Okl. 1992).

³⁰⁷ E.g., *St. Tammany Parish Hospital Service District v. Department of Health and Human Resources*, 677 F. Supp. 455 (E.D.La. 1988).

gram change.³⁰⁷ Material changes to a State's Medicaid program effected without CMS approval are supposedly invalid.³⁰⁸ But there is no clear deadline for the state to submit the plan amendment. As to reductions, the federal regulation merely provides that CMS may make the plan amendment effective on a date requested by the state.³⁰⁹

The absence of any requirement that changes be submitted and approved *in advance* makes it difficult to claim that a client's rights have been violated if the state makes changes before submitting a plan amendment or getting its approval.³¹⁰

Administrative Regulations

The Medicaid agency announces most changes in federal "options" it is exercising and new federal mandates the state is implementing in the *Louisiana Register*, through rulemaking notices.

Unfortunately, there is no up-to-date codification of the promulgated provisions. Some, but not all promulgated regulations have been codified.³¹¹ Even as to those codified, one needs to check recent Louisiana Registers to be sure no amendments have been made, by either Rule or temporary Emergency Rule. (Emergency rules can be in effect for four months.) The Louisiana Register editions since 1997 can be searched on the internet, though closely focusing the searches is not easy.³¹² Also, each December Louisiana Register has a cumulative year-to-date index, but the index poorly labels the rules and notices issued.

In Westlaw, one can simultaneously search the codified rules and the Louisiana Registers by designating the database as "la-adc; la-adr".

The rules promulgated often are not very detailed. The lack of published details could make even the announced program changes vulnerable, for failure to effectively invite public input on agency policy choices.

State statutes

Relevant statutory provisions are scattered within La.R.S. 46: 53-160.11. The legislature has left program details to the agency, so the statutes are rarely helpful or dispositive.

Internet materials describing the services Louisiana offers

For the most complete single listing of what services Medicaid currently covers for recipients, see the "Medicaid Services Chart," developed to comply with Medicaid "informing" requirements dealt with in the *Chisholm* litigation.³¹³ The Chart lists services, eligibility and access requirements, and even staff contact numbers.

The search function on DHH's website can also often locate descriptions of particular services.³¹⁴

³⁰⁸ *Oregon Association of Homes for the Aging, Inc. v. Oregon*, 5 F.3d 1239 (9th Cir. 1993) (invalidating State's temporary regulation reclassifying certain nursing home services into lower rate categories, because State failed to submit a plan amendment on this for federal approval).

³⁰⁹ 42 C.F.R. § 430.20(b)(3).

³¹⁰ See the discussion of §1983 and enforceable rights, *supra*.

³¹¹ <<http://doa.louisiana.gov/osr/lac/50/50.doc>>

³¹² <<http://doa.louisiana.gov/osr/reg/register.htm>>

³¹³ <http://new.dhh.louisiana.gov/assets/docs/BayouHealth/Medicaid_Services_Chart2012.pdf>.

³¹⁴ <<http://new.dhh.louisiana.gov>>.

Instructions to providers, especially about fairly new policies, are posted on a separate internet site by DHH's contractor in charge of provider relations.³¹⁵ When materials are on the site, this is a much faster way to obtain them than through calls or public record requests to the agency. The training manuals distributed at annual trainings for most types of providers are included on the site. These focus mostly on billing issues, but also address some more substantive issues, like the state agency's general rules governing eligibility for or appropriateness of services.

Contracts governing Managed Care offerings

Both Bayou Health and the Louisiana Behavioral Health Partnership (sometimes called Magellan, CSoC, or Coordinated System of Care) are administered through private entities. In addition to being governed by state and federal regulations, the contract governing the offerings consist of a state "Request for Proposals" and Q&As clarifying the proposals, contracts with the contracting entities, as well as policy Guides, made binding by reference in the contracts, and later issued addenda to the Requests for Proposals. Most of these are currently accessible through the MakingMedicaidBetter.com website. The Request for Proposals include many more requirements than the regulation, such as the access standards. In addition, the contracting entities have their own materials, such as member handbooks, posted.

Public record requests

The state circulates other types of administrative memoranda and manuals to its staff, including but not limited to E-mail messages that sometimes go out state-wide.

Under state law, agencies must respond to requests for copies of public records within 5 days.³¹⁶ Usually the offices in Baton Rouge return a response within weeks. Advocacy concerning the client's situation can be included, since the request will usually be answered by someone with authority over the issue. An attorney from the agency's Legal Unit is usually involved in developing any agency response.

For issues regarding the proper scope of a service, in addition to memoranda, there are "Medical Services Manual" sections for each type of Medicaid provider that can be requested. (The sections are not combined into a single Manual; many but perhaps not all are available at lamedicaid.com.) Like the annual training materials mentioned above, these focus mostly on billing issues, but also address some issues of eligibility for or appropriateness of the service.

4.7. CASE LAW

Case law can provide additional grounds for entitlement, not explicitly developed in the above regulatory materials. As one example, there is a strand of cases suggesting that recipients cannot be denied "medically necessary" services.³¹⁷

Case law can also help one identify pertinent statutory provisions.

³¹⁵ <http://www.lamedicaid.com>. (Most of the site is publicly accessible; another part allows providers to access confidential recipient information.)

³¹⁶ La.R.S. 44:1, 32, 33, 35.

³¹⁷ See e.g., *Hope Medical Group for Women v. Edwards*, 63 F.3d 418, 421 (5th Cir. 1995), cert. denied, 517 U.S. 1104 (1996); but see *Curtis v. Taylor*, 625 F.2d 645, 651 (5th Cir. 1980) (noting that the limitation it found not to violate federal law would deny some recipients medically necessary treatment).

But case law is not a primary source to look to in establishing recipients' rights. Because case law is sparse, one is almost always dealing with persuasive authority rather than binding authority. In addition, rights established *only* by case law are challengeable as not creating "enforceable" rights.³¹⁸

4.8. DRAW NO ADVERSE CONCLUSIONS

Even if you find no authority, and therefore make an appropriate decision to decline a case, it is unwise to conclude or advise that the client has no entitlement. Because Medicaid involves the interplay of diverse policy strands, it can take just one additional perspective to turn a seemingly "dead" claim into a clear entitlement.

5. APPLYING FOR MEDICAID

The Medicaid agency has an obligation to assist applicants with its application process, and cannot deny applicants who fail to comply with its procedural requirements because of disabilities.³¹⁹

5.1. THE AGENCY MUST ASSESS EVERY APPLICATION FOR ALL ELIGIBILITIES, EVEN IF IT IS A SHORTENED APPLICATION.

There are at least forty different categories under which a person can qualify for Medicaid in Louisiana. DHH has folded multiple categories within the categories set out in its Medicaid Eligibility Manual setting out categories: § H Eligibility Determinations. Unless the details of the "sub"categories have been committed to memory, one cannot just skim the titles of the major categories in considering whether a client is eligible.

Yet Medicaid is a single federal program, and *any* application entitles the applicant to assistance if eligible under *any* of the categories. It is not up to the client to identify which obscure category he or she should be considered for. As a result, if the client is eligible for any type of Medicaid, it is error to deny the application. The client's application is for Medicaid, not just a particular category of Medicaid.³²⁰

Similarly, even if an applicant's Medicaid application starts through the health insurance "exchanges" that should be in place in 2014, the Medicaid agency cannot re-verify information already verified by the exchange unless there are clear problems with it or the insurance exchange had relied on an unverified self-attestation.³²¹

Also, as discussed in § 6.1 below, once certified the recipient remains eligible for Medicaid until ineligible under *every* category.

In order to reduce its and applicants' paperwork, the Louisiana Medicaid agency now relies heavily on shortened applications aimed at collecting the information needed to assess particular eligibility categories that include the largest numbers of recipients ("Medicare Savings", LaChip, LaMoms, etc.)³²²

³¹⁸ See *Harris v. James*, 127 F.3d 993 (11th Cir. 1997) (holding that even entitlements supported by the federal regulations are not enforceable unless there is a statute establishing the same requirement).

³¹⁹ MEM, §§ G-810, 1100-1150.

³²⁰ See 42 C.F.R. § 435.404 ("The agency must allow an individual who would be eligible under more than one category to have his eligibility determined for the category he selects.") While this may seem to support making the applicant choose the category he or she will be evaluated for, the applicant is only required to choose among categories *for which he or she is eligible*. Selecting among eligible categories has little significance in Louisiana, except in certain households with both children and SSI recipients it can affect how many household members get Medicaid or the amount of any "spend-down."

³²¹ See 42 C.F.R. §§ 435.948(a)(2) (eff. Jan. 1, 2014), 435.952(b) (eff. Jan. 1, 2014).

³²² The shortened applications and a general application can currently be found at <http://new.dhh.louisiana.gov/index.cfm/page/220/n/20>.

DHH has stripped the questions from most of the short applications from which it could determine eligibility under other categories. It has also stopped using the screening form that had been required under a *Blanchard v. Forrest* consent agreement,³²³ to make sure all eligibilities were assessed. As a result, it is up to the workers to, before denying an application or certifying recipients for only a limited form of Medicaid, solicit and review the facts relevant to other possible eligibilities. This is fertile ground for staff errors.

The agency's use of the "Medicare Savings" shortened application is particularly problematic. This is meant to get the Medicare-supplement coverage to elderly and disabled people receiving Social Security retirement or disability insurance and with incomes under 135% of poverty, not currently receiving SSI. **Most** in this group will not be eligible for other Medicaid. But **any** in the group who used to receive SSI should be assessed for "Pickle" and other coverages for former SSI recipients. See § 2.1.4.1, *supra*. Similarly, LaCHIP children may be living with parents whose eligibility should be assessed, etc.

Attorneys who find applicants who have not been assessed for all eligibilities should not simply have the client reapply, because if the local office did not assess all eligibilities for one client, it is likely not doing so for others, as well. Many of those applicants would not know to or make the effort to contact an attorney. Potential clients in this situation should be advised of the possibility of pursuing class-wide relief through law offices able to represent classes, to help others who are similarly situated.³²⁴

5.2. INFANTS BORN TO A MEDICAID MOTHER NEED NOT APPLY

Infants born to a mother on Medicaid need not file an application. They are automatically eligible for Medicaid for a year,³²⁵ and the hospital is responsible for submitting information to the agency to prompt this certification.

5.3. SOME OTHER CHILDREN GET CERTIFIED WITHOUT APPLYING, AS WELL

Louisiana has opted to provide "Express Lane Eligibility" through the end of the year 2013.³²⁶ This is a federal option allowing the agency to certify children for Medicaid without requiring an application, based on information available through nine other federal programs. But if the information from the other agency appears to be adverse, the Medicaid agency cannot rely on it, but must instead develop its own information.³²⁷

5.4. THE RIGHT TO APPLY FOR MEDICAID WITHOUT DELAY

In most parishes Medicaid applications are now taken by mail and by "Application Centers"—usually by employees of a hospital or clinic. Applications can also be submitted on-line.³²⁸ Some parishes no longer have Medicaid offices. (Those that do are still supposed to accept walk-in applicants, but some may not.)

³²³ *Blanchard v. Forrest*, E.D.La. C.A. No. 93-3780, Rec. Doc. 124, Consent Judgment, entered September 30, 1996, ¶III.A. All consent judgments in the case have been sunsetted.

³²⁴ Louisiana Rules of Professional Conduct, Rules 1.2(a, b), 1.7(b)(2).

³²⁵ See the discussion of Deemed Eligible Children in the eligibilities section of this Chapter.

³²⁶ 50 LAC Part III, § 1101-1107.

³²⁷ 50 LAC Part III, § 1103(D).

³²⁸ [https://bhsfweb.dhh.louisiana.gov/OnlineServices/\(X\(1\)S\(m0sshayprljuz3ioqnb2\)\)/Welcome.aspx?AspxAutoDetectCookieSupport=1](https://bhsfweb.dhh.louisiana.gov/OnlineServices/(X(1)S(m0sshayprljuz3ioqnb2))/Welcome.aspx?AspxAutoDetectCookieSupport=1)

The date that the application is “filed” is important both in establishing the date by which the agency should issue a decision on the application, and what months can be covered by the application.³²⁹

The federal regulations require that the agency afford applicants “the opportunity to apply for Medicaid without delay.”³³⁰ If an applicant goes to the parish office and is sent elsewhere to apply or is given a list of places where they might possibly be able to apply (but depending on the schedules of the particular staff there who take applications), then an opportunity to apply without delay is not provided. The agency used to take steps to protect the application date of persons it sent elsewhere, but policy no longer includes this.³³¹

5.5. MEDICAID ELIGIBILITY UNDER ALL CATEGORIES SHOULD BE EXPLORED AFTER ANY FITAP OR SSI APPLICATION IS FILED

Louisiana automatically provides Medicaid to those certified for FITAP, the state’s federally funded cash assistance welfare program for families, and to almost all certified for SSI. As a result, the Medicaid agency is also obligated to review for Medicaid eligibility when applications for FITAP or SSI are denied.

Under federal instructions, the state must choose whether to make the FITAP application also a Medicaid application, and if those certified for cash assistance are given Medicaid, those denied must be fully checked for Medicaid eligibility under *all* categories.³³² Most households denied FITAP would have children eligible for Medicaid; some would also have adults who qualify.

The Medicaid agency’s procedures in conducting such a review should not unnecessarily require applicants to resubmit information and verification they already submitted with respect to the application.³³³

5.6. 45 OR 90 DAYS FOR THE AGENCY TO REVIEW APPLICATIONS

The Medicaid agency has 45 days from the date of application to rule on it, unless the Medicaid agency will have to assess whether the applicant is disabled (in which case 90 days are allowed) or the applicant needs more time to collect documents.³³⁴ The agency’s failure to meet the deadlines cannot be used as a reason to deny an application.³³⁵

Destitute families with minor children may be able to get a faster Medicaid certification by applying for cash assistance under the state Department of Social Services “FITAP” program. Families and children certified for FITAP also get certified for Medicaid, and the Department of Social Services requires that FITAP applications be certified within **30** days from the date a signed application is received in the DSS local office.³³⁶

³²⁹ See 42 C.F.R. §§ 435.911(a) and 435.914.

³³⁰ 42 C.F.R. § 435.906.

³³¹ See MEM § G-700; 50 LAC Part III § 503 (application date is the date *completed* application is filed).

³³² Dear State Medicaid Directors letter of June 5, 1998, p. 2, <<https://www.cms.gov/smdl/downloads/smd060598.pdf>>.

³³³ 42 C.F.R. 435.948(a)(6); 42 C.F.R. 435.930(a). *But see* 42 U.S.C. § 1320b-7(a)(4)(C) (“no State shall be required to use such information [exchanged with other agencies] to verify the eligibility of all recipients”).

³³⁴ 45 C.F.R. § 435.911.

³³⁵ 42 C.F.R. § 435.911(e)(2).

³³⁶ 67 LAC Part III § 1205.

6. FREQUENT ISSUES IN MEDICAID TERMINATIONS

6.1. RECIPIENTS REMAIN ELIGIBLE UNTIL FOUND INELIGIBLE UNDER EVERY CATEGORY

When a person loses eligibility for the type of Medicaid he or she has been receiving, the agency is required to review whether he or she is eligible for Medicaid on any other basis before terminating Medicaid; they do not have to re-apply to have eligibility for other types of Medicaid reviewed.³³⁷ Medicaid eligibility on other grounds is particularly likely for children (through Continuous Eligibility, CHIP, or CHAMP) and for persons losing SSI, but can exist in almost any situation. The state's categories are set out in § 2.1.4, *supra*.

Relying on the regulations and the requirements of procedural due process, courts have issued strong opinions reversing or enjoining agency terminations of assistance not preceded by such a redetermination.³³⁸

6.2. CLIENT FAILURE TO RESPOND TO AGENCY PAPERWORK MAY BE IMMATERIAL IF AGENCY COULD HAVE OBTAINED THE NEEDED INFORMATION FROM ON-LINE DATABASES

Even if the agency mailed paperwork to the claimant's last known address and it was not returned, the agency cannot rely on non-receipt of paperwork as a basis for not reviewing the information already available to it. The agency must review information accessible to it in computer databases from the food stamp, SSI, and other programs before deciding to terminate Medicaid. This is based on the due process case law just discussed, as well as Louisiana Medicaid Eligibility Manual policy.³³⁹

6.3. IF CLIENT HAS MISSED THEIR 30 DAYS TO ADMINISTRATIVELY APPEAL, OTHER OPTIONS MAY BE AVAILABLE

A termination decision can be administratively reopened for agency error (such as failing to do a full redetermination) up to a year after it occurred. As discussed in § 3.1. regarding limitations periods, *supra*, suit under § 1983 can be available for at least that same period.

6.4. CHILDREN REMAIN ELIGIBLE FOR MEDICAID FOR A FULL YEAR FROM THE LAST TIME THEY WERE FOUND ELIGIBLE

Louisiana has opted to provide continued Medicaid eligibility for a twelve month period for all children except the Medically Needy. Once a child is determined eligible for Medicaid, they get 12 months of coverage, regardless of changes in circumstances, and regardless of which agency did the certification that found

³³⁷ 42 C.F.R. § 435.930(b); 42 C.F.R. §435.916(c); 42 C.F.R. 435.1003(b); *see also* 42 C.F.R. § 435.916(f)(1) (effective Jan. 1, 2014); *Jackson v. Guissinger*, 589 F.Supp. 1288, 1301 (W.D.La. 1984); MEM § K100, ¶4; State Medicaid Directors letter of April 7, 2000, <<https://www.cms.gov/smdl/downloads/smd040700.pdf>>.

³³⁸ *See, e.g., Stenson v. Blum*, 476 F.Supp. 1331 (S.D.N.Y. 1979), *aff'd* 628 F.2d 1345 (2d Cir. 1980), *cert. denied* 449 U.S. 885; *Massachusetts Association of Older Americans v. Sharp*, 700 F.2d 749 (1 Cir. 1983); *Crippen v. Kheder*, 741 F.2d 102 (6th Cir. 1984); *Jackson v. Guissinger*, 589 F.Supp. 1288, 1301 (W.D.La. 1984). Louisiana's agency agreed to conduct ex parte redeterminations before terminating Medicaid of people losing AFDC, under the now-repealed AFDC program. *Thomas v. Robinson*, M.D.La. CA No. 85-0717, Consent Decree (12/12/85), ¶ 6.

³³⁹ *Massachusetts Association of Older Americans v. Commissioner of Public Welfare*, 803 F.2d 35, 40 (1 Cir. 1986); State Medicaid Directors letter of April 7, 2000 <<https://www.cms.gov/smdl/downloads/smd040700.pdf>>; MEM §§K-100, 2nd ¶.

them eligible (DHH, DCFS, or SSA). The only common exception is Medically Needy eligibility, which can be for three months or less. A few other exceptions are specified in the Medicaid Eligibility Manual.³⁴⁰

6.5. RIGHT TO CONTINUED MEDICAID SERVICES WHILE A REQUEST FOR A FAIR HEARING IS PENDING

There are three ways to administratively maintain Medicaid services while appealing a termination of those services:

- **for persons who have lost or been denied SSI, by administratively appealing the SSI decision** within the Social Security Administration. (This is addressed in a separate subsection, a few pages below.)
- by filing a fair hearing request *within the ten days* of the notice date on the decision,³⁴¹
- by filing a fair hearing request *within the 30 day appeal period and before the agency's proposed effective date for the adverse action. Such an appeal needs to very noticeably seek the agency's immediate attention to the fact that federal regulations require continued services in this circumstance.* Agency notices terminating eligibility typically do so effective the next or second following calendar month. The federal regulations require that services be continued "If the recipient requests a hearing *before the effective date of the action.*"³⁴² Louisiana Medicaid has been advised by the federal Medicaid agency to respect the longer deadline,³⁴³ and recently issued a formal memorandum advising staff of the issue.³⁴⁴ Nonetheless, all or most notices incorrectly advise recipients that continued benefits are only available if an appeal is filed within 10 days of the adverse notice.

6.5.1. Exceptions to the right to continued benefits pending appeal:

Agency policy recognizes some exceptions to the right to continued benefits, discussed below. In some instances due process may require continued services when the regulations do not. But advocates of such a claim must carefully work within the governing Supreme Court cases.³⁴⁵

6.5.1.1. Absence of any factual dispute

The agency can terminate services as of the hearing date (earlier than the decision on the appeal) if there is a determination, at the hearing and confirmed in writing by the ALJ, that the appeal involves only issues of policy, and no factual dispute.³⁴⁶ For this reason, *if the client is receiving continued benefits, it is important to clearly establish any factual dispute between the appellant and the agency, even in appeals that primarily challenge policy.*

³⁴⁰ MEM § H-1910. Though the rule as set out in the LAC and Louisiana Register has different restrictions, the cited MEM section was amended to remove the restriction on applying this to SSI recipients, and should bind. In addition, the prior restriction against allowing this coverage to SSI recipients was probably illegal under § 504 and the Americans with Disabilities Act. Compare 34 La.Reg. 253 (Feb. 20, 1998); 50 LAC Part III § 2525.

³⁴¹ C.F.R. 431.230(a).

³⁴² C.F.R. § 431.230(a).

³⁴³ July 12, 1991 letter (designated ME 46-0) from Don Hearn, USDHHS, to Carolyn Maggio, Director Louisiana Bureau of Health Services Financing. (Copy available from the author.)

³⁴⁴ Medicaid Administrative Memorandum Number 2011-5.

³⁴⁵ See *Atkins v. Parker*, 472 U.S. 115 (1985) (general notice that food stamps were being reduced because of a change in law, without details, did not violate due process); *American Manufacturers Mutual Insurance Co. v. Sullivan*, 119 U.S. 977 (1999) (acknowledging claimant's property interest in workers' compensation payments, but denying that the property right extends to the *disputed* payments) (dicta).

6.5.1.2. Sole issue is a mass change required by law

Secondly, the state agency and CMS regulations do not respect a right to either a hearing or continued services during appeal with regard to “mass changes” caused by changes in state or federal law.³⁴⁷

Again, the key is to establish that other issues exist beside the change in state or federal law, and to do so in a manner that will immediately obtain the agency’s attention.³⁴⁸ This can include a factual dispute as to whether the claimant is properly subject to the policies at issue, or as to whether procedural rights have been violated, such as the right to have eligibility reviewed under all Medicaid categories before a termination or reduction. The “mass change” regulation only exempts changes that are required by federal or state “law.”³⁴⁹ This is distinct from the standard in other Medicaid fair hearing regulations, speaking to actions required by “law or policy.”³⁵⁰

6.5.1.3. Other exceptions in the regulations

The regulations do not require advance notice (which brings the right to continued benefits pending appeal) if:

- the agency confirms the recipient is dead or his or her whereabouts are unknown;
- the recipient is in an institution where Medicaid does not fund services, or is receiving Medicaid in another state;
- the agency has a clear written statement signed by the recipient that he or she no longer desires services or is knowingly giving information resulting in ineligibility;
- the treating physician prescribed the reduction in care;
- a nursing facility resident fails preadmission screening required under the Act;
- facts show probable fraud;
- specific exceptions for nursing facility residents (who otherwise must be notified 30 days before a discharge), usually involving the health or safety of other facility residents; or
- services have been prior authorized by one of the Bayou Health plans, and the period for which they been approved has ended.³⁵¹

6.5.1.4. Some denials of prior authorization services?

Louisiana Medicaid did not give continued benefits pending appeal with respect to prior approval services, even if the agency had previously approved similar services, until a court stipulation reached in 1996. The agency’s position had been that each prior approval period is discrete and independent, so a denial is like a denial of a new application, instead of being a termination of eligibility. However, the federal regulations exempt service reductions from advance notice

³⁴⁶ 42 C.F.R. §§ 431.230(a), 431.231(b).

³⁴⁷ 42 C.F.R. § 431.220(b).

³⁴⁸ The federal regulations recognize this in requiring that adverse action notices include, even “[i]n cases of an action based on a change in law, the circumstances under which a hearing will be granted.” 42 C.F.R. § 431.210(d)(2). See also CMS State Medicaid Directors Letter, April 22, 1997, <<https://www.cms.gov/smdl/downloads/SMD042297.pdf>>.

³⁴⁹ 42 C.F.R. § 431.220(b).

³⁵⁰ 42 C.F.R. §§ 431.222(b), 431.230(a)(1), 431.231(b), (c)(3).

³⁵¹ 42 C.F.R. §§ 431.213-214, 483.12(a)(5), 438.420(b)(4).

and continued benefits only if the treating physician has prescribed a changed level of care or where the prior approval was from a Bayou Health plan.³⁵²

Except with regard to requests for enteral formula, the agency can end the effect of the 1996 consent order by following certain procedures.³⁵³ If the agency does avail itself of the procedure, nothing in the agreement precludes relitigation of the issues by other affected Medicaid recipients.

6.6. RIGHT TO CONTINUED MEDICAID FOR PERSONS WHO ARE APPEALING SSI TERMINATIONS WITH SSA

Persons terminated from SSI and persons previously certified for Medicaid based on disability and appealing a denial of SSI are entitled to continued Medicaid benefits while their SSI administrative appeal is pending. If the recipient did not appeal the SSI termination during the fifteen day period for continuing their SSI, their later appeal, filed within the 65 day administrative appeal period, still entitles the SSI appellant to continued Medicaid benefits, even though they are no longer on SSI.³⁵⁴ No separate appeal with the Medicaid agency should be necessary.

6.6.1. Louisiana prematurely cuts off Medicaid, during the SSI appeal period

Louisiana's policy clearly differs from the federal policy in one respect. The federal instruction is that, because any timely appeal continues the Medicaid, state agencies should wait out Social Security's sixty[five] day administrative appeal period before terminating Medicaid.³⁵⁵ Thus, Medicaid is continued both during a timely appeal and during the period in which the appeal can be filed.

In contrast, Louisiana's instructions are to only continue the Medicaid if there is an SSI appeal already pending; there is no instruction to allow the client the sixty[five] day administrative appeal period to file their SSI appeal. While the worker should reopen the case if he or she becomes aware that an appeal has been filed, nothing requires that the worker re-check to see if an appeal has been lodged.

6.7 MEDICAID THAT WAS BASED ON DISABILITY SHOULD NOT BE TERMINATED WITHOUT APPLYING THE SSI "MEDICAL IMPROVEMENT" STANDARDS

Where Louisiana Medicaid is making its own determination of whether a recipient is disabled, it is required to apply SSI standards.³⁵⁶ To date the agency's practice has been to simply collect medical records and run them by its Medical Eligibility Determinations Team for a determination of whether the client meets a Listing or grids out as disabled. But under the SSI regulations, a different eight-step sequential evaluation applies to termination decisions.³⁵⁷ Issues of whether the recipient is performing substantial gainful activity and how they grid should not usually be reached unless there are signs, symptoms, and laboratory findings showing medical improvement in the recipient's condition that is related to the ability to work.³⁵⁸

³⁵² 42 C.F.R. §§ 431.213(f), 438.420(b)(4); compare 45 C.F.R. 205.10(a)(4)(ii)(I) (1974) (which exempted from continued benefits requirements time-limited special allowances, but was not made part of the Medicaid regulations which were later separately codified).

³⁵³ *McField v. Forrest*, Stipulation and Order Of Dismissal, E.D.La. No. 93-4094 (Oct. 22, 1996). As of this writing, the notices required to terminate the effect of the consent order have not been issued.

³⁵⁴ MEM § G-1610.12; CMS State Medicaid Manual § 3272.2 (general policy).

³⁵⁵ "Medicaid is continued during the 60-day period within which an SSA appeal may be filed." CMS State Medicaid Manual § 3272.2.

³⁵⁶ 42 U.S.C. §§ 1396d(a)(vii), 1396a(v) (both explicitly requiring that the standards of 42 U.S.C. § 1382c be applied, which includes a separate standard for terminations).

³⁵⁷ 20 C.F.R. § 416.994(b)(5).

³⁵⁸ *Id.*; see also *Romano v. Greenstein*, CIV.A. 12-469, 2012 WL 1745526 (E.D.La., May 16, 2012). The case is on appeal to the Fifth Circuit, not as to these issues but as to jurisdictional issues.

7. DUTY TO REPAY MEDICAID FOR CERTAIN SERVICES RECEIVED AFTER AGE 55

Federal law requires that states recover the costs for nursing facility, ICF/DD facility, and Home and Community Based services, and “related hospital and prescription drug services.” Federal law requires that states recover the costs for nursing facility, ICF/MR, and Waiver services paid for recipients age 55 or over, from the individual’s estate, even though the person was eligible when he or she received Medicaid.³⁵⁹

States are allowed to also recover the costs of Medicaid paid to others over age 55, and are allowed to impose liens on homes of persons in long term care facilities, so as to collect if the property is sold.

The legislature has expressed a continuing state policy in favor of performing estate recovery to the minimum extent allowed by federal law, (1) allowing the inheritance of family homes, (2) exempting \$15,000 of homestead or 1/2 the local parish’s median home value from seizure, (3) establishing “undue hardship” if the heir’s income is under 300% of the federal poverty guidelines, and (4) authorizing the state agency to grant waivers and compromises on good cause shown.³⁶⁰ The law is expressed as requiring this to the extent allowed by federal law. Since federal law does recognize an “undue hardship” exception, as to which no federal standards have been promulgated, advocates may be able, on a case by case basis, to protect most of what the state statute attempts to protect.

The agency’s implementing regulations can be read expansively, since they purport to protect heirs from “undue hardship.”³⁶¹ The regulations also exempt property that is the heir’s only income-producing property.

Though federal law terms the claim on the estate a “lien,” Louisiana recognizes it as a “privilege.”³⁶²

There is a form and procedure for administratively appealing an agency decision regarding estate recovery.³⁶³ If trying to clear the status of an estate where the agency has not yet issued a determination, contact DHH Legal staff.

8. WHAT MEDICAID COVERS

The state’s current services offerings are described in a variety of materials, discussed in § 4.6, above. The most complete single source of information is the “Medicaid Services Chart.”³⁶⁴ But even it is not entirely accurate as to what the state is offering, and as set out below, the current offerings may not fulfill the agency’s legal obligations.

³⁵⁹ 42 U.S.C. § 1396p(b)(1)(B). According to the CMS State Medicaid Manual home and community based services mean only services under the New Opportunities Waiver (NOW), Community Choices or other waivers through which the Department offers expanded services to persons who would be eligible for care in a facility. In Louisiana, persons receiving waiver services usually have to go through a waiting list before receiving them. “Related hospital and prescription drug services” mean those received while receiving the other specified services. CMS State Medicaid Manual § 3810(A)(2).

³⁶⁰ La.R.S. 46:153.4

³⁶¹ 50 LAC Part I, §§ 8101-8105.

³⁶² La.R.S. 46:153.4(D); 50 LAC Part I, § 8103(E).

³⁶³ 50 LAC Part I, § 8105.

³⁶⁴ <http://new.dhh.louisiana.gov/assets/docs/BayouHealth/Medicaid_Services_Chart2012.pdf>.

8.1. SOME MEDICAID CATEGORIES COVER LESS THAN THE FULL RANGE OF MEDICAID SERVICES.

The same services are currently covered, regardless of the category the recipient is in, except for certain categories. The categories with more limited coverage are: QMB, SLMB, QI, QDWI, the TB coverage, Take Charge, State Retirees' category, Greater New Orleans Community Health Connection, and Medically Needy coverage. Eligibility through the "Home and Community Based Waivers" or PACE includes additional services, depending on the specific Waiver the client is receiving under.

The services covered for the Medically Needy are, for most recipients, indistinguishable from "full" Medicaid. But there are numerous restrictions (though some are illegal).³⁶⁵

Persons who need to use the institutional deeming rules (not counting other family members' income and resources) or the medically needy "spend-down" to qualify for the Louisiana Behavioral Health Partnership are not eligible for any Medicaid services other than the mental health services.³⁶⁶

Louisiana currently covers the same services for pregnant women as other Medicaid recipients. Under federal law, it need only cover "pregnancy-related" services for pregnant women with incomes over the LIFC income levels. But states choosing to restrict services to higher income women must justify this to the federal Medicaid agency.³⁶⁷

For Medically Needy and coverage for residents of facilities, the client will usually be responsible to cover the cost of large portions of their care.

8.2. MEDICAID AS PAYMENT IN FULL

For whatever services are covered, the provider's accepting a client as a Medicaid client relieves the client of all liability for the services, except: waiver and residential facility services (as to which there may be a "patient liability"), copayments charged for prescriptions, and the medically needy "spend-down" (which is like a deductible). The federal regulation's payment in full protection is a requirement on the state, which in turn passes the obligation through to providers through its contracts and enrollment agreements with providers.³⁶⁸

8.2.1. Providers cannot pick and choose which services they bill to Medicaid.

While providers other than Hill-Burton hospitals can generally choose to refuse to take Medicaid as payment for services, there are a few restrictions. First, providers are prohibited from accepting Medicaid for particular services for a client (which they find remunerative) and then privately charging the same client in the same encounter for other services (as to which they do not like the Medicaid rates).³⁶⁹

8.2.2. QMB providers cannot refuse to accept Medicaid.

Also, Medicare providers cannot refuse to accept a recipient's "QMB" coverage. QMB is a form of Medicaid that covers a recipients' Medicare premiums,

³⁶⁵ For the list of Louisiana's Medically Needy service limitations, which has not been updated by the agency to reflect changes since, see 24 La.Reg. 955 (May 1998).

³⁶⁶ <http://bhsfweb.dhh.la.gov/onlinemanualspublic/stateplan/services/attachment%203.1-g.pdf>, p. 9.

³⁶⁷ 77 Fed. Reg. 17144, 17148-49 (March 23, 2012).

³⁶⁸ 42 C.F.R. §§ 447.15; 447.20(a)(1) (latter regarding persons with other insurance coverage).

³⁶⁹ 17 La. Reg. 271 (March 20, 1991).

deductibles, and coinsurance. Medicare providers may want to refuse the QMB coverage because Medicaid pays substantially less than Medicare, and providers will generally be paid nothing towards the 20% coinsurance. But federal law requires they accept the patient's QMB coverage.³⁷⁰ This leaves the recipient liable for none of the bill.

8.2.3. The agency and providers cannot discriminate against recipients for having other medical coverage.

Some clients have had difficulty receiving Medicaid services because they have other medical coverage in addition to Medicaid: either through Medicare or a private provider. For most services, Medicaid pays towards the balance after the other medical coverage pays. But because Medicaid's rates are low, the provider may actually receive no additional payment, but lose the chance to bill the patient for deductibles or coinsurance. This causes some providers to refuse to provide services to affected recipients. But the Medicaid statute prohibits Medicaid providers from denying services to recipients because they have other medical coverage.³⁷¹

8.3. GETTING COVERAGE FOR OLD BILLS

8.3.1. Eventual retroactive coverage for those certified for SSI.

The Medicaid statute requires coverage for medical expenses incurred "in or after the third month before" an application was filed.³⁷² An SSI certification can begin no earlier than the month *after* the SSI application was filed.³⁷³ Medicaid for the four months covered by the Medicaid application but not the SSI application (the month of SSI application plus the three months prior to that) is not barred; these months are routinely extended as "retroactive Medicaid," and properly so, as benefits barred by the SSI program, but not by the Medicaid program.³⁷⁴ (All certified for SSI should be assessed for this retroactive coverage by the state Medicaid agency. If this does not happen, it may be because the applicant said they had no medical expenses in the last three months when they applied for SSI, or because of improper inaction by the local office.³⁷⁵)

This Medicaid coverage remains called for even if the client is later notified by Social Security that on calculation of his or her Title II benefits, he or she is no longer eligible for retroactive SSI, and that the money originally paid as SSI will be treated as a Title II payment.³⁷⁶ Under the Medicaid program only income that is "available" can be counted.³⁷⁷ The Social Security income was not available during the retroactive period, and therefore cannot be unrealistically attributed back in time so as to deny Medicaid eligibility.³⁷⁸

³⁷⁰ 42 U.S.C. §§ 1396a(n)(3)(B), 1395w-4(g)(3)(A); <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-01-06-12.pdf>.

³⁷¹ 42 U.S.C. § 1396a(a)(25)(D); *see also* 42 C.F.R. § 447.20(b).

³⁷² 42 U.S.C. 1396a(a)(34); 1396d(a).

³⁷³ 42 U.S.C. 1382(c)(7).

³⁷⁴ 42 C.F.R. 435.122 requires that the agency "must provide Medicaid to individuals who would be eligible for SSI or optional State supplements except for an eligibility requirement used in those programs that is specifically prohibited under title XIX."

³⁷⁵ The SSI application's question about whether there were medical expenses in the prior three months is no longer enough to properly relieve the state agency of reviewing for retroactive Medicaid eligibility. Medicaid should be available for any expenses in the month of application, and the retroactive SSI certification no longer covers that month.

³⁷⁶ 51 Fed.Reg. 12326 (April 10, 1986; *see also* the correspondence available from Clearinghouse Review, under Accession No. 43,365.

³⁷⁷ 42 U.S.C. 1396a(a)(17)(B).

³⁷⁸ 42 U.S.C. 1396a(a)(17)(C) requires a "reasonable evaluation" of income and resources.

8.3.2. For services in the 3 months before the month in which an application is filed

An application covers not only the period while the application pends, but also the three calendar months before the application was filed, if the applicant was otherwise eligible during this period.³⁷⁹ This retroactive coverage is not available for QMBs.³⁸⁰ Thus, if an application was filed December 15, it readily covers bills from September 1 forward.

Medically needy spend-down coverage is limited to this same period, but bills before the date in which the spend-down was met do not get covered. (The spend-down is like a deductible amount.)

One reason the agency may fail to certify a recipient for this retroactive coverage period is that the Medicaid or SSI application may have asked if the applicant received medical services in the previous three months. If the applicant responded “No”, then the agency is not to explore whether the applicant would have been eligible in those months.³⁸¹

Another reason can be agency failure to pay attention to a positive response on the application. In addition, a client, particularly SSI applicants, may have no bills in that three month period, but may have incurred other bills since then and before having been certified.

8.3.3. Is there something earlier that should have been treated as an application?

If the client is seeking coverage for still earlier bills, one should look carefully for any other activity that should be regarded as the filing of an application. Remember, as discussed in the section of this Chapter regarding applications, that SSI and FITAP applications should be counted as Medicaid applications. Thus, if the above applicant who applied for Medicaid on December 15 had, before filing the Medicaid application, applied for and been denied SSI or FITAP in April, that other application could result in coverage for medical services received any day of the year, provided other eligibility requirements were met.

This is particularly helpful if the client ever filed for SSI, since SSI applications pend so long before resulting in a final decision. Medicaid is not immediately notified of the SSI application, and it may be that even once an SSI denial was issued, no worker at Medicaid took steps to develop whether the client should be certified for Medicaid despite the SSI denial.³⁸² In these cases, there can be quite a bit of retroactive coverage available to the applicant, which the agency has never even reviewed. Even if the SSI application was coded to say the client had no bills in the three months before the application, if that is not the case, the agency might be persuaded to look past the response. The client has no incentive to deliberately lie about this. It should not be important to determine whether the error was by the client or by someone else assisting with the application (like agency staff).

³⁷⁹ 42 U.S.C. § 1396a(a)(34); 42 C.F.R. § 435.914. The three month retroactive period is not available for QMB eligibility. SLMB and Qualified Individuals coverage only covers payment of Medicare premiums, and will not cover old bills at all.

³⁸⁰ 42 U.S.C. 1396d(a), first parenthetical.

³⁸¹ See 42 C.F.R. § 435.914(a)(1).

³⁸² Compare MEM § H-710.

8.3.4. Was there an earlier, improper Medicaid termination?

Another way to extend coverage backwards is to look for a termination in the last year that can be reopened, possibly for failing to conduct an adequate redetermination (*see* § 6.1). One may be able to go back only one year in looking at improper terminations, because there agency policies probably allow re-opening of old improper actions for only a year. In parallel to this, a § 1983 suit regarding the improper termination has a one year statute of limitation. *See* § 3.10.2.

In contrast, the agency's failure to fully develop an earlier *application* is more like a continuing tort: there has never been any final action taken or appealable notice issued.

8.3.5. Client has been retroactively certified for Social Security Disability over the SSI amount; does that preclude eligibility for retroactive Medicaid?

If the client had medical bills and applied for SSI and Social Security, but was certified for Social Security at a monthly amount that exceeds the SSI maximum, does that preclude him or her from getting retroactive coverage for the medical bills? It is likely in this situation that there are no other Medicaid categories the person would qualify under, with a higher income eligibility line. Nonetheless, there are two reasons why back-coverage for the bills should be available (assuming they were incurred within the three calendar months before the month of SSI/SS application). First, there is a five month waiting period for Social Security Title II Disability. No Title II check gets issued for these months. As a result, if the applicant is not over-resource and lacks other income, they should be certified for SSI for these first five months (unless they failed to respond to SSA requests to "complete" their SSI application). Except in the rare case where someone does not apply for SS/SSI until after the five months have passed, this five months of SSI eligibility may already be certified on the system, and as discussed above, Medicaid should then develop whether the eligibility should extend back still further. Second, and more fundamentally, though retroactively certified for SSDI, the applicant had no income at the time they incurred their medical bills. Medicaid law requires that state agencies take "into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, *available to the applicant or recipient.*"³⁸³ The Title II income that was later retroactively awarded was not available to the applicant at the time they incurred the bills, and so does not make them over-income for those months.

8.3.6. Mechanics of getting the old bills paid, once certification has been issued

Once certified, the applicant can present their Medicaid card to providers to ask that they submit for bills already incurred during their eligibility period. In order to submit for payment, the providers are first required to refund to the Medicaid recipient any payments the recipient already made. Providers may not be willing to do this, based on the fact that Medicaid will pay them less or the risk that Medicaid will find some reason to deny payment (usually based on flaws in the paperwork the provider submits). Only nursing homes, Hill-Burton hospitals, and disproportionate share hospitals, are *required* to refund and submit. Pharmacies are often willing to refund and submit.

³⁸³ 42 U.S.C. § 1396a(a)(17)(B).

Providers can submit for payment through normal means for up to a year after services were rendered. Where the services were received even further back, the payment may have to be mailed in to designated staff at the Bureau of Health Services Financing in Baton Rouge for “manual processing.”

The agency also notifies the applicant that they can submit to the agency for reimbursement for bills within their retroactive coverage period that they already paid.³⁸⁴ *Usually the notice allows 30 days to submit.* This may be on the certification notice or on a separate notice mailed with the certification notice. Because Medicaid will only reimburse the applicant at Medicaid rates, the recipient does best if he or she can get the provider to fully refund any money already paid; the provider can then submit for Medicaid’s payment.

States’ policies of reimbursing recipients at only the rate that Medicaid would have paid, and only for services received from Medicaid providers have been challenged, with mixed results.³⁸⁵ Cases in other states are similarly mixed with regard to recipients’ entitlement to full compensation.³⁸⁶ Some CMS guidance also says that reimbursement should be for what recipients actually paid.³⁸⁷

Persons with applications pending should maintain their proof of payment of medical bills and should be ready to submit for repayment by Medicaid within 30 days of being certified for Medicaid if they cannot get their medical providers to refund their payments and submit to Medicaid. This is particularly important for SSI recipients, as their applications pend the longest.

Providers cannot refuse to take the Medicaid because private insurance has paid part of the claim and they want full payment from the recipient on the balance.³⁸⁸

8.4. BAYOU HEALTH –“COORDINATED CARE” THROUGH PRIVATE COMPANIES FOR MEDICAID RECIPIENTS

In 2012, Louisiana transitioned about two-thirds of the state’s Medicaid recipients to have most of their care paid for and coordinated through private health plans. The plans are called coordinated care networks and the Louisiana implementation is called “Bayou Health.” There are two types of Bayou Health plans.

Recipients in the “shared” plans (“CCN-S”) can use any Medicaid providers, except that their primary care physician (PCP) must be in their particular plan. The plan also controls prior approval of most services that are subject to prior approval. (If it is not obvious from the client’s fact situation, a chart setting out which entity is responsible for which services is posted on probononet.³⁸⁹) Currently, the shared plans are those whose names do not begin with Louisiana or “Ameri”: Community Health Solutions of America, Inc., and UnitedHealthcare of Louisiana, Inc.

³⁸⁴ MEM §G-2100.

³⁸⁵ *Compare Riley v. Cerise*, 19th JDC No. 514.830, Judgment, December 16, 2004 (requiring Louisiana Medicaid reimburse the full amount the recipient paid); and *Vessier v. Office of Secretary of Louisiana Dept. of Health and Hospitals*, 2010-0847 (La.App. 1 Cir. 10/29/10) 2010 WL 4273100 (affirming agency decision denying such relief). The rates issue was reserved without prejudice in the *Blanchard* class action requiring that DHH cover bills recipients have paid. “Stipulation of the Parties Regarding the Defendant’s Use of Medicaid Rates”, E.D.La. CA No. 93-3780, June 18, 1996; Order entered July 22, 1996.

³⁸⁶ Favorable cases include *Schott v. Olszewski*, 401 F.3d 682 (6th Cir.2005); *Greenstein by Horowitz v. Bane*, 833 F.Supp. 1054 (S.D.N.Y. 1993); *Kurnik v. Department of Health and Rehabilitative Services*, 661 So.2d 914 (Fla. App. 1995); accord *Salazar v. District of Columbia* 954 F.Supp. 278 (D.D.C. 1996). Unfavorable cases include *Settleman v. Sabol* 91 N.Y.S.2d 618, 627-629 (1998); *Conlan v. Sheury*, 131 Cal.App.4th 1354, 1385, (Cal.App. 2 Dist.2005).

³⁸⁷ State Medicaid Directors letter of April 7, 2000, <<https://www.cms.gov/smdl/downloads/smd040700.pdf>>.

³⁸⁸ 42 U.S.C. § 1396a(a)(25)(D); see also 42 C.F.R. § 447.20(b).

Recipients in the “prepaid” plans (“CCN-P”) must receive all services except a few that are not yet wrapped into Bayou Health (see chart referenced above), through providers who are enrolled with their particular plan. In addition, prior approval for those services must be through the plan. Currently, the prepaid plans are those whose names begin with Louisiana or “Ameri”: Amerigroup Louisiana, Inc., LaCare, and Louisiana Healthcare Connections, Inc.

8.4.1 Plans must provide at least what other Medicaid offers, and can provide more

The Bayou Health plans are required to cover services of at least the amount, duration, and scope that Louisiana provides recipients not in Bayou Health.³⁹⁰ But the plans are also permitted to provide more. For example, Louisiana covers 12 physician visits per year. All the plans have announced that they will not apply this limit to visits with the Primary Care Physician. If you can convince a plan that providing an additional service would save it money in the long run, the plan can exceed Medicaid’s other service limitations.

8.4.2 Plans are obligated to provide recipients with increased access to services

The “Prepaid plans must make provision for obtaining urgent care 24 hours per day, 7 days per week.”³⁹¹ Requirements are specified as to how fast patients must be seen, like 24 hours for “urgent care,” 72 hours for non-urgent sick care, etc. These plans are also subject to requirements as to proximity of providers, and must make any needed specialists available. (The plan can pay enhanced rates to draw particular providers in as needed.)

Even under the Shared plans, because the PCPs are to coordinate other care, they remain responsible to “strive to achieve ...Specialty care consultation within one... month of referral or as clinically indicated.”³⁹²

8.4.3 Coordinating with other private insurance

Recipients who also have private insurance may have difficulties complying with the network and PCP requirements of both their Bayou Health plan and their other private insurance plan.

As to CCN-S, there will be little additional problem, since a late 2012 Emergency Rule provides that, “Members for whom a CCN is the secondary payor will not be assigned to a PCP by the CCN, unless the members request that the CCN do so.”³⁹³ Since the PCP is the only provider that CCN-S recipients have to use in-plan, this leaves only the problem of needing prior approval from both Bayou Health and the private plan. Coordinating these two prior approvals is not necessarily any worse than the problem outside of Bayou Health, of needing prior approval from both Medicaid and the private plan.

But for those in CCN-P, all medical providers for *all* services that are under Bayou Health must be in the recipient’s particular Bayou Health plan. This is likely to be most or all services that are covered under their private insurance plan. As a result, to get full coverage, they are limited to providers who happen to be in both their particular private plan and their Bayou Health plan.

³⁸⁹ <http://www.probono.net/la/civillaw/library/attachment.224105>

³⁹⁰ 50 LAC Part 1, §§ 3305(A)(CCN-S), 3507(B)(5)(CCN-P).

³⁹¹ Prepaid, Request for Proposals, § 7.5.2.

³⁹² Shared Request for Proposals, § 8.6.2.

³⁹³ 38 La. Reg. 1893 (Aug. 20, 2012).

8.5. “ALL MEDICALLY NECESSARY” SERVICES FOR CHILDREN, AND SOMETIMES ADULTS

The Supreme Court has stated “the benefit provided through Medicaid is a particular package of health care services, such as 14 days of inpatient coverage[,]. . . . *not adequate health care.*”³⁹⁴ This was the basis for denying a §504 handicap-discrimination challenge to a uniform numerical limit on Medicaid services, in a 9-0 opinion written by Justice Marshall,

There are, however, limited contexts in which all medically necessary services must be provided, and other claims that can bring relief, even when there is no right to all medically necessary services. Therefore, situations in which all medically necessary services must be covered will be discussed, then other legal requirements that may require services beyond those the state is covering will be discussed.

8.5.1. Right to all medically necessary services for recipients under age 21

All Medicaid recipients under age 21 are eligible for “early and periodic screening, diagnosis, and treatment” (EPSDT) services.³⁹⁵ This requires that state Medicaid agencies provide:

Such... necessary health care, diagnostic services, treatment, and other measures described in [42 U.S.C. §1396d(a)] to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, *whether or not such services are covered under the State plan.*³⁹⁶

This permits states to deny services to EPSDT eligibles on a rationale that they are “not a covered service” only if the services are *not medically necessary or are not federally reimbursable at all* (except under waivers) under the federal Medicaid statute.³⁹⁷ The breadth of services that are federally reimbursable is enormous, extending to “any...remedial services... recommended by a physician... for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level”³⁹⁸ and “any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice.”³⁹⁹

In Louisiana the EPSDT provision has been used to obtain coverage for an organic “ketogenic” diet prescribed to reduce seizures, and to obtain “medical foods” (low in protein) for children with PKU, among many other services.

³⁹⁴ *Alexander v. Choate*, 469 U.S. 287, 303 (1985)(emphasis added); see also *Curtis v. Taylor*, 625 F.2d 645, 651 (5th Cir. 1980)(noting that the limitation it found not to violate federal law would deny some recipients medically necessary treatment).

³⁹⁵ Though the state’s service list for Medically Needy recipients does not recognize this, Medically Needy recipients under age 21 are entitled to all EPSDT services. Louisiana Medicaid state plan, Attachment 3.1.B., pp. 1, 2. See also 58 Fed. Reg. 51288, 51291 (1993)(once some EPSDT services are provided to a group, all must be). Compare 24 La. Reg. 277, 278 (Feb. 20, 1998)(listing among covered services for the medically needy “EPSDT (KidMed) screening services,” but nothing regarding exceeding normal service limits for recipients under age 21).

³⁹⁶ 42 U.S.C. § 1396d(r)(5).

³⁹⁷ H.Conf.Rep. No. 101-386, 101st Cong., 1st Sess., 453, reprinted in 1989 U.S. Code Cong. & Ad. News, 3028, 3056; *S.D. v. Hood*, 391 F.3d 581 (5th Cir. 2004); *Hodges v. Smith*, 910 F.Supp. 646, 647 (N.D. Ga. 1995), citing *Pittman v. Secretary*, 998 F.2d 887 (11th Cir.), cert. denied 998 U.S. 887 (1993).

³⁹⁸ 42 U.S.C. § 1396d(a)(13).

³⁹⁹ 42 U.S.C. § 1396d(a)(6); but see *Texas v. Health and Human Services*, 61 F.3d 438 (5th Cir. 1995)(prohibiting payment for the board and care component of any facilities not specifically identified in the Medicaid statute).

In addition to the tools listed under “Finding the governing standards,” § 4, *supra*, to find out if a service is within those that can be funded, and therefore within those that must be covered for recipients under age 21, the state plans approved by the federal Medicaid agency can be searched.⁴⁰⁰

Nowhere is Louisiana’s implementation of the EPSDT entitlement limited to needs “discovered by the screening services.” (The federal statute does include this “discovered by” language. But federal guidance considers any encounter with a physician to qualify as a screen, so a condition needs only be confirmed by any physician.) Because there are sound reasons for such an unlimited implementation, and it has been chosen by the state, the state cannot selectively deny service requests on the basis that there has been no formal EPSDT screen.

To get coverage of services available only through EPSDT, recipients usually must have the potential provider of the service send in a request for prior approval of the service.

A Handbook describing most current EPSDT offerings and how to access them was drafted by the *Chisholm* class counsel and has been maintained since by DHH.⁴⁰¹

8.5.2. Medically necessary home health services, which include medical equipment and supplies

Home health services are a mandatory service, at least for persons who would qualify for nursing facility services.⁴⁰² The federal Medicaid agency has specified that state Medicaid agencies cannot limit the home health equipment and supplies to particular lists of items; the state agency must make individualized determinations of whether the recipient needs any requested supply.⁴⁰³ All or almost all supplies provided by the state’s “durable medical equipment” providers are home health services.⁴⁰⁴

8.5.3. Medically necessary outpatient hospital services

Louisiana’s Medicaid state plan provides that all medically necessary outpatient hospital services other than emergency room visits, clinic services, and physical, occupational, and speech therapies are covered, “with no limit imposed other than the medical necessity for the service.”⁴⁰⁵

8.5.4. Medically necessary services for pregnancy

Federal law allows coverage for all services needed to deal with complications of pregnancy.⁴⁰⁶ The state’s plan provides that “There is no service limitation for medically necessary follow-up prenatal care once the pregnancy is medically

⁴⁰⁰ Plaintiff’s reliance on these state plan materials to establish what is within the scope of the EPSDT mandate was upheld by the Fifth Circuit in *S.D. v. Hood*, 391 F.3d 581 (5th Cir. 2004).

⁴⁰¹ EPSDT – Targeted Population Support Coordination Training/Handbook.

⁴⁰² 42 U.S.C. § 1396a(a)(10)(D); 42 C.F.R. § 440.210 (referring to home health services under §440.70 as mandatory for the categorically needy), § 440.220(a)(3) (referring to home health services as mandatory for any medically needy recipients entitled to skilled nursing facility services, but note that since the statutory provision requires the services for all who qualify for any nursing facility services, its broader coverage governs).

⁴⁰³ Dear State Medicaid Director letter of September 4, 1998, <<http://www.cms.gov/smdl/downloads/SMD090498.pdf>>; 76 Fed. Reg. 41032, 41034 (7/12/2011) (reiterating the policy); *Sleakis v. Thomas*, 525 U.S. 1098 (1999) (Mem) (remanding in light of the HHS guidance); *Esteban v. Cook* 77 F.Supp.2d 1256, 1260 (S.D.Fla. 1999) (citing and enforcing the policy); *T.L. v. Colorado Dept. of Health Care Policy and Financing*, 42 P.3d 63, 67 (Colo.App., 2001) (reversing based on the policy).

⁴⁰⁴ See *Hunter v. Chiles*, 944 F.Supp. 914, 919 (S.D.Fla. 1996).

⁴⁰⁵ State Plan, Attachment 3.1-A, Item 2a, p. 1

⁴⁰⁶ E.g., 42 C.F.R. 440.250(p).

established.”⁴⁰⁷ The Fifth Circuit has ruled that states must provide all federally fundable and medically necessary services for terminating pregnancy;⁴⁰⁸ the same should presumably apply for other pregnancy-related services.

8.6. REQUIREMENTS GOVERNING LIMITS PLACED ON OTHER SERVICES

8.6.1. Caveat — if the service is an optional service under federal law, & you win a contested case, would the state choose to drop the option?

Each state develops a “plan” describing the Medicaid services it will provide. The state must cover:

- inpatient hospital services (other than in an institution for mental diseases);
- outpatient hospital, certain rural health clinic, and federally qualified health clinic services;
- physician services (and dental services that could be performed by a physician);
- laboratory and Xray services;
- nursing facility services for those over 21;
- “EPSDT” services for children, discussed above;
- family planning services;
- nurse midwife services if legal under state law;
- certified pediatric nurse practitioner and family nurse practitioner services if legal under state law;
- free standing birth center services; and
- home health care services (for those eligible for skilled nursing services).⁴⁰⁹

Any other services described in the federal statute (§1396d(a)) are optional, and need not be covered by the state or listed in its plan.

Even though the state must meet requirements discussed in sections below with regard to optional services, if it does not want to fund services won through advocacy, it can decide to withdraw funding entirely for the service in question. This is unlikely with regard to mainstay services, like prescription drug coverage, but quite possible with more incidental services. Thus, in *Ledet v. Fischer*,⁴¹⁰ the plaintiffs succeeded in tremendously expanding the number of recipients who were eligible for eyeglasses under Louisiana’s Medicaid program. But the result was that the state stopped funding eyeglasses entirely, except as required for EPSDT children.

8.6.2. Any service a state covers must be provided in a way that is sufficient to achieve the purpose of the service (for most recipients)

Federal regulations require that any service a state supplies must be “sufficient in *amount, duration, and scope* to reasonably achieve its purpose.”⁴¹¹ Based on this language, the Fifth Circuit invalidated restrictions in Texas’ Medicaid den-

⁴⁰⁷ State Plan, Attachment 3.1-A, Item 20.a.

⁴⁰⁸ *Hope Medical Group for Women v. Edwards*, 63 F.3d 418, 427-28 (5th Cir. 1995), cert. denied, 517 U.S. 1104 (1996).

⁴⁰⁹ 42 U.S.C. §§1396a(a)(10)(A), 1396d(a)(1-5), (17), (21), (28), 1396a(a)(10)(D); 42 C.F.R. 440.210. (The categorically needy are all recipients other than those certified as medically needy. In Louisiana, the medically needy receive a paper card good for up to three months.)

⁴¹⁰ *Ledet v. Fischer*, 548 F.Supp. 775 (M.D.La. 1982), later opinion 638 F.Supp. 1288.

⁴¹¹ 42 C.F.R. § 440.230(b).

tal program for children, finding that program restrictions to save funds failed to meet the services' purpose of preventing tooth decay.⁴¹² However, it has also been held that any numerical, etc., limitations on a service need only be adequate to meet the needs of *most* of the state's Medicaid recipients.⁴¹³

This "amount, duration, and scope" requirement can be used to challenge a totally unreasonable limit on the amount or type of a service the state will cover or the incompleteness of what the state provides, because it is not covering some crucial component.⁴¹⁴ For example, the state used to cover insulin for diabetics, but not the syringes needed to inject it and testing strips and devices needed to monitor its provision. As to children, the restrictions were challenged based on the EPSDT requirements set out above. As a follow-up, the state agency was advised that a similar challenge would be brought on behalf of adults, under the amount, duration, and scope requirement, and because the failure to cover needed complements in effect assessed an illegally high "copay" on recipients. In response, the agency extended coverage to adults, as well.⁴¹⁵

The amount, duration, and scope regulation can be seen as based on either the statutory "comparability" requirement or the "reasonable standards" requirement, both discussed below.⁴¹⁶

This requirement nonetheless falls short of covering all services medically necessary. Under the Medicaid statute some courts have supplied a liberal interpretation that a state must supply any "medically necessary" services within a category the state covers.⁴¹⁷ Similarly, there is some legislative history that treating physicians are to decide what care Medicaid recipients need.⁴¹⁸ But there is no statutory basis for either requirement, which poses a problem under the *Wilder-Blessing-Gonzaga* line of cases previously discussed.

One regulation can be read to support a medical necessity doctrine.⁴¹⁹ But the federal agency does not interpret it this way.⁴²⁰ In cases with strong equities, the medical necessity jurisprudence may give the Court room to exceed the strict

⁴¹² *Mitchell v. Johnston*, 701 F.2d 337 (5th Cir. 1983).

⁴¹³ *Curtis v. Taylor*, 625 F.2d 645 (5th Cir. 1980) (upholding the denial of Medicaid funding for more than three non-emergency physician visits per month). *But see* "State Medicaid Directors" letter of September 4, 1998, posted at <<http://www.cms.gov/smdl/downloads/SMD090498.pdf>> (holding the test inapplicable to home health services because it would undermine coverage).

⁴¹⁴ *See also Atkins v. Rivera*, 477 U.S. 154, 157 (1986) ("AFDC and SSI assistance are intended to cover basic necessities, but not medical expenses. Thus, if a person in this category also incurs medical expenses during that month, payment of those expenses would consume funds required for basic necessities.")

⁴¹⁵ As to copays, *see* 42 U.S.C. § 1396o(a); 42 C.F.R. §§ 447.50-56.

⁴¹⁶ The comparability requirement uses the same phrase: "amount, duration, or scope." 42 U.S.C. 1396a(a)(10)(B)(i & ii).

⁴¹⁷ *See e.g., Hope Medical Group for Women v. Edwards*, 63 F.3d 418, 427-28 (5th Cir. 1995), *cert. denied*, 517 U.S. 1104 (1996) (requiring that state fund medically necessary abortion service); *Lanckford v. Sherman*, 451 F.3d 496, 511 (8th Cir. 2006); *Weaver v. Reagan*, No. 87-4314-CV-C-5 (W.D. Mo. Sept. 29, 1988) (preliminary injunction ordering coverage of AZT even though it was only an "experimental" drug); *Meyers by Walden v. Reagan*, 776 F.2d 241 (8th Cir. 1985); *Montoya v. Johnston*, 654 F.Supp. 511 (W.D. Tex. 1987).

The Fifth Circuit has given a conservative gloss to the medical necessity doctrine in dicta of *Rush v. Parham*, 625 F.2d 1150, 1155-58 & n. 9 (5th Cir. 1980), but leaves plaintiffs ground to work with, especially if prevailing medical opinion would favor the treatment in question. *But see Curtis v. Taylor*, 625 F.2d 645, 651 (5th Cir. 1980) (noting that the limitation it found not to violate federal law would deny some recipients medically necessary treatment).

⁴¹⁸ S.Rep. No. 404, 89th Cong., 1st Sess., *reprinted in* 1965 U.S. Code Cong. and Admin. News 1943, 1986 ("The Committee's bill provides that the physician is to be the key figure in determining utilization of health services - and provides that it is a physician who is to decide upon admission to a hospital, order tests, drugs, and treatments, and determine the length of stay."). *But see Rush v. Parham*, 625 F.2d 1150, 1154-55 (5th Cir. 1980) (state can define medical necessity and can review appropriateness of prescribing physician's medical necessity determination).

⁴¹⁹ 42 C.F.R. § 440.230(d).

⁴²⁰ *See Curtis v. Taylor*, 625 F.2d 645, 652-53 (5th Cir. 1980).

grounds of the amount, duration, and scope regulation. But since it has no explicit statutory basis, the claim is probably not enforceable using 42 U.S.C. 1983, which provides the right of action for most federal Medicaid claims.⁴²¹

Also, the EPSDT statutory provisions, noted above concerning children's' services, create a two-edged sword for medical necessity arguments. If the state is approving for children services like those your adult client needs, then cross-examination as to why the service is being approved should be able to establish medical necessity. But the explicit requirement to cover all "necessary" services of the 42 U.S.C. § 1396d(r)(5) EPSDT provision seems superfluous if coverage of all medically necessary services is already required for all Medicaid recipients. Yet some courts have invalidated aged-based restrictions that limited particular services to recipients under age 21.⁴²²

8.6.3. The agency must not deny a service to persons who need it more than those for whom it covers the service ("comparability")

The Medicaid statute requires that Medicaid services available to any recipient who is receiving Medicaid under a category other than as 'Medically Needy' "not be less in amount, duration, or scope than" those provided any other recipient whether or not Medically Needy.⁴²³ This is termed a "comparability" requirement. It has been said to require that those other than the Medically Needy get "first call on the limited supply of public funds for medical assistance."⁴²⁴ It does not apply to the partial coverages for Medicare recipients (the "Medicare Savings Programs: "QMB, SLMB, and QI).

The comparability requirement can be used as a means for broadening who gets services the state is already providing to some recipients. If the assistance a non-medically needy client seeks is adequately provided to any Medically Needy recipients whose need for the service is no greater, it can be proven that those Medically Needy recipients receive a greater scope of services than your client, violating comparability.

EPSDT, case management, Waiver, Medicare buy-in services and some other services expressly mandated for specific groups are exempted from the comparability requirement.⁴²⁵

The language cannot reasonably be interpreted to mean that just because the state chooses to provide a hearing aid to one recipient, it must provide one to every other Medicaid recipient in the state who is not medically needy. Instead, the mandate is necessarily understood as meaning that services shall be equal among those of equivalent medical need⁴²⁶ and as prohibiting the state from

⁴²¹ See *Blessing v. Freestone*, 520 U.S. 329, 342-46 (1997); *Harris v. James*, 127 F.3d 993 (11th Cir. 1997).

⁴²² *Fred C. v. Texas Health and Human Services Commission*, 988 F.Supp. 1032, 1036 (W.D. Tex. 1997), *aff'd* 167 F.3d 537 (5th Cir. 1998); *Esteban v. Cook*, 77 F.Supp.2d 1256, 1261-62 (S.D.Fla. 1999); *Hunter v. Chiles*, 944 F.Supp. 914, 920 (S.D.Fla. 1996); *Salgado v. Kirschner*, 179 Ariz. 301, 878 P.2d 659 (1994) (the Fifth Circuit has rejected the *Salgado* court's exposition of the EPSDT requirements, which differs from the EPSDT explanation set out above in this Chapter, and finds no support in any other cases, administrative interpretations, or legislative history. *S.D. ex rel. Dickson v. Hood*, 391 F.3d 581, 593 (5th Cir. 2004).

⁴²³ 42 U.S.C. § 1396a(a)(10)(B).

⁴²⁴ *Camacho v. Perales*, 786 F.2d 32, 39 (2d Cir. 1986).

⁴²⁵ 42 U.S.C. § 1396a(a)(10)(I-XVII) (the final paragraph of (10), beginning with "except that"); 42 U.S.C. § 1396n(c)(3), (d)(3), (e)(3), (g)(1), (i)(3).

⁴²⁶ *White v. Beal*, 555 F.2d 1146, 1151 (3d Cir. 1977) (invalidating the state's allowing eyeglasses to one group and not another, since those in the favored group were not necessarily the ones with the greatest medical need for the glasses). See also *Clark v. Kizer*, 758 F.Supp. 572, 580 (E.D. Cal. 1990) (reimbursement rate making services more available in some counties than other violated comparability); *King by King v. Fallon*, 776 F.Supp. 645, 653-54 (D.R.I. 1991), *later opinion* 801 F.Supp. 925, 934 (1992); *Curtis v. Taylor*, 625 F.2d 645, 652 (dicta).

imposing eligibility requirements for services that are not based on either degree of medical need or requirements set out in the statute.⁴²⁷ For example, the agency agreed in a consent order not to require tube-feeding as a condition for recipients to receive enteral formula (including Ensure), even though Medicare imposes such a requirement.⁴²⁸ The premise for the litigation was that some persons not tube-fed need the formula as much as persons who are tube fed.

Nor can the comparability provision be interpreted to merely forbid the Medically Needy from being treated more favorably, as a group, than others. (Under this view, as long as the same set of policies applies to all groups, services are comparable for all.) Existing Fifth Circuit case law is inconsistent with such a narrow reading.⁴²⁹

8.6.4. For mandatory services, lines drawn must not arbitrarily discriminate by diagnosis or condition—for example, surgery cannot be denied because it is to deal with obesity

The Medicaid regulations provide that the state “may not arbitrarily deny or reduce the amount, duration, or scope of a required service...solely because of [an individual’s] diagnosis, type of illness, or condition.”⁴³⁰ A Louisiana federal court has reasonably found that this discrimination provision applies only to the “mandatory” services, listed above.⁴³¹

This regulation is probably based on either the statutory “comparability” requirement, discussed above, or the “reasonable standards” requirement, discussed below.⁴³² Any relief an advocate seeks using this regulation might also be pursued directly as a comparability challenge.

This provision was violated by Louisiana’s past practice of severely restricting access to surgery when the diagnosis is obesity. Hospital services are a mandatory service, and obesity is a diagnosis or condition. As a result, surgery to correct this condition should be as available as other surgeries.

8.6.5. Standards must be “reasonable” and designed to achieve the goals of the program.

The Medicaid Act also requires that states have “reasonable standards...for determining eligibility for and the extent of medical assistance under the plan which...are consistent with the objectives of” the Medicaid Act.⁴³³ All the Circuits that have reviewed this provision since *Gonzaga* have found it fails to create privately enforceable rights.⁴³⁴ Nonetheless, where there is a formal state policy that violates the provision, a Supremacy clause claim can currently be brought, to establish that it is preempted by the federal statute.⁴³⁵

⁴²⁷ *Blanchard v. Forrest*, 71 F.3d 1163, 1167 (5th Cir.), cert. denied 518 U.S. 1013 (1996); see also *Greenstein by Greenstein v. Bane*, 833 F.Supp. 1054, 1072-74 (S.D.N.Y. 1993).

⁴²⁸ *McField v. Forrest*, Stipulation And Order Of Dismissal, E.D.La. No. 93-4094 “M” (5).

⁴²⁹ See *Blanchard v. Forrest*, 71 F.3d 1163, 1167 (5th Cir.), cert. denied 518 U.S. 1013 (1996).

⁴³⁰ 42 C.F.R. 440.230(c).

⁴³¹ *Ledet v. Fischer*, 548 F.Supp. 775, 786 (M.D.La. 1982), later opinion 638 F.Supp. 1288. But see *Meyers v. Reagan*, 776 F.2d 241, (8th Cir. 1985); *White v. Beal*, 413 F.Supp. 1141 (E.D. Pa. 1976), aff’d 555 F.2d 1146, 1151-52, n. 6 (3d Cir. 1977); *Simpson v. Wilson*, 480 F.Supp. 97, 102 (D. Vt. 1979); *Jeneski v. Meyers*, 163 Cal. App. 3rd 18, 209 Cal. Rptr. 178 (1984).

⁴³² Alternatively, it might be based directly on the requirement in 42 U.S.C. § 1396a(a)(10)(A) that certain services are mandatory.

⁴³³ 42 U.S.C. § 1396a(a)(17)(D).

⁴³⁴ *Watson v. Weeks*, 436 F.3d 1152, 1162-63(9th Cir. 2006); *Lankford v. Sherman*, 451 F.3d 496, 509 (8th Cir. 2006); *Hobbs ex rel. Hobbs v. Zenderman*, 579 F.3d 1171, 1182-83 (10th Cir. 2009).

⁴³⁵ *Lankford v. Sherman*, 451 F.3d 496, 509-13 (8th Cir. 2006); *Koenning v. Suehs*, — F.Supp.2d —, 2012 WL 4127956 (S.D.Tex., 2012) (discussing Fifth Circuit and Supreme Court precedent).

8.6.6. ADA and §504 claims to extend services.

The Americans with Disabilities Act prohibits discrimination in public services against persons on the basis of their having a disability, and requires reasonable accommodations be made on behalf of those with disabilities.⁴³⁶ The implementing regulations require that public services be made available in the most integrated setting appropriate.⁴³⁷ Section 504 of the 1974 Rehabilitation Act imposes similar requirements on recipients of federal funding, which includes both state Medicaid programs and possibly the providers participating in them.⁴³⁸

This means that a recipient should not have to move into a medical institution to receive services that could be made available in the community.⁴³⁹ But it does not mean that the Medicaid program has to be reconfigured to meet all the needs of disabled persons or that it must always design its services packages around their needs.⁴⁴⁰

8.7. SPECIFIC SERVICE OFFERINGS:

8.7.1. Prescription drug coverage

Covering prescription drugs is optional under the federal Medicaid statute.⁴⁴¹ But once the state opts to cover drugs, the federal statute sets out extensive requirements regarding what drugs are covered.⁴⁴²

8.7.1.1. Medicare, not Medicaid covers drugs for recipients who also have Medicare

Medicaid recipients who also have Medicare are not eligible for prescription coverage through Medicaid.⁴⁴³ They must receive their prescriptions through the Medicare Part D benefit. Medicaid will pay their monthly premium to get the Part D coverage.

Under Part D, a private carrier, which the recipient can choose during “open enrollment,” near the end of each calendar year, provides the prescription coverage. Which drugs are covered varies depending on which particular plan the recipient signs up with. Medicare has appeal procedures to seek approval for a drug not on the carrier’s list.

8.7.1.2. No Medicare prescription copays for full benefit Medicaid recipients in facilities or on waivers

Under the Affordable Care Act, “full benefit” Medicaid recipients have no Medicare prescription copays if they are in a facility or on a home and community based waiver.⁴⁴⁴ This just ends the co-pays, not the monthly premiums to get the Medicare Part D coverage. But Medicaid should be paying the Part D premiums. See § 8.1 for a list of the current categories not providing the full benefit. The most important ones are the “Medicare Savings” categories of QMB, SLMB, and QI. (But QMB’s may have full Medicaid along with their QMB coverage.)

⁴³⁶ 42 U.S.C. § 12132.

⁴³⁷ 28 C.F.R. § 35.130(d); *Olmstead v. L. C.*, 527 U.S. 581 (1999).

⁴³⁸ 29 U.S.C. § 794; 28 C.F.R. § 41.51(d).

⁴³⁹ *Olmstead v. L. C.*, 527 U.S. 581, 601 (1999). But the Court held that states have an affirmative defense to this ADA liability if they have in place a plan for successfully reducing their waiting lists for community services. *Id.* at 603-06.

⁴⁴⁰ See *Alexander v. Choate*, 469 U.S. 287, 303-04 (1985). This case and proposition is cited favorably in the legislative history to the Americans with Disabilities Act.

⁴⁴¹ See 42 U.S.C. § 1396d(a)(12), not listed as a mandatory service in 42 U.S.C. 1396a(a)(10)(A).

⁴⁴² 42 U.S.C. § 1396r-8(d).

⁴⁴³ 42 U.S.C. § 1396u-5(d).

⁴⁴⁴ 42 C.F.R. § 423.782(a)(2)(ii).

8.7.1.3. Federal law requires access to nearly all FDA approved drugs

As set out below the state has issued a “formulary” of drugs it prefers to cover. Similarly, the Bayou Health “Prepaid” plans are authorized to issue their own formularies. Medicaid and the plans can place some hoops in front of recipients, which must be run to obtain other drugs. But ultimately, federal law requires coverage of almost all FDA approved drugs, even if they are not on Medicaid’s or a plan’s formulary.⁴⁴⁵

8.7.1.4. Getting prescriptions exceeding the monthly limit

Louisiana limits the number of prescriptions recipients can receive per month *without meeting additional criteria*. The number of prescriptions that can be obtained without meeting the additional restrictions has varied over time, generally going down.⁴⁴⁶ The current limit should be obtainable with the following search in the Louisiana Register database or site: Medicaid and “prescription limit.”⁴⁴⁷ If the most current result is an emergency rule, be sure to check subsequent Registers to confirm it has not been legislatively overridden.

The limit can be harsh for recipients with multiple chronic conditions, because Louisiana only allows recipients to get a month’s supply of a prescription at a time. This is true of all prescriptions, even though the prescription may be longstanding and for a chronic need.⁴⁴⁸

Some recipients are exempt from the limit

The prescription limit currently does not apply to:

- recipients under age 21 (because of the EPSDT mandate discussed above),
- pregnant women (the prescription should note they are pregnant), and
- residents in long-term care facilities (nursing facilities and ICF/DDs).⁴⁴⁹

The fact that it applies to persons in the community, but not those in nursing homes may make it subject to challenge under the Americans with Disabilities Act, because it allows fewer services to those in the most community-integrated setting.⁴⁵⁰ The availability in long term care facilities may also violate the comparability requirement, discussed above, since “medically needy” recipients in facilities can receive more prescriptions than “categorically needy” recipients outside facilities. But given the exceptions to the limit discussed below, any challenge may be difficult and unnecessary.

⁴⁴⁵ 42 U.S.C. § 1396r-8(d)(4)(C, D) (allowing exclusion of drugs if drug compendia show they have no significant, clinically meaningful benefit over approved drugs, there is a written explanation of the exclusion available to the public, and the drug can nonetheless be obtained through prior approval procedures). Certain classes of drugs like weight loss drugs are excluded from Medicaid coverage regardless. 42 U.S.C. § 1396r-8(d)(2, 3). And drugs can be excluded if the manufacturer will not enter rebate agreements with the federal government. 42 U.S.C. § 1396r-8(a)(1).

⁴⁴⁶ See e.g., 37 La.Reg. 3270 (Nov. 20, 2011) (4 per month); 35 La.Reg. 1901 (Sept. 20, 2009) (5 per month); 29 La. Reg. 2115 (Oct. 20, 2003) (8 per month).

⁴⁴⁷ In Westlaw the database is la-adr. The Register site is <http://doa.louisiana.gov/osr/reg/register.htm>.

⁴⁴⁸ For persons with chronic conditions this one-month limit might be challenged as beyond the authorization of the federal statute, which permits limits on the maximum quantities per prescription “necessary to discourage waste... or abuse.” 42 U.S.C. § 1396r-8(d)(6).

In addition, the problems caused by this one-month limitation, when coupled with the prescription limit, could be challenged as precluding recipients from getting all medical assistance “without any delay caused by the agency’s administrative procedures.” But since, as set out below, the prescription limit can be exceeded case-by-case, any challenge predicated on it cannot be a facial one, but needs to deal with tangible problems a recipient has experienced and why the availability of exceptions is not sufficient.

⁴⁴⁹ 37 La.Reg. 3270 (Nov. 20, 2011).

⁴⁵⁰ *Fisher v. Oklahoma Health Care Auth.*, 335 F.3d 1175 (10th Cir. 2003).

Even for those not exempt, prescriptions exceeding the limit can be filled

The limit can be exceeded unless a drug is prescribed for off-label use. The physician must endorse the prescription with the words “Medically necessary override” and gives a “valid ICD-9-CM diagnosis.”⁴⁵¹ The pharmacist keys these in to a Medicaid-linked computer, which approves payment if the diagnosis code is an approved match for the drug. Even prescriptions which have been prior authorized by Medicaid (see below) must comply with these requirements.

Because obtaining the override depends on computer approval of the validity of the prescription, *if a drug is prescribed for any off-label or non-standard use, the recipient should have the prescription filled before they turn in any prescriptions exceeding the monthly limit.* Recipients needing prescriptions above the monthly limit should be advised to ask that the doctor put the information needed for an override on their prescriptions.

The needed information can be given by the prescriber even with a phoned-in prescription. So if originally omitted, phoning the information can get a problem resolved.

There is a secure web page on which Medicaid providers can determine what other drugs have been received by a recipient.⁴⁵² But rarely would a prescribing professional check the internet during an appointment or consultation. Pharmacists might be more likely to access this information if they receive an “over-limit” message when trying to fill the prescription. But by that time, the information needed for an override will likely not have been provided, complicating the process.

If Medicaid denies the override, the recipient will get no notice of this besides being told by the pharmacist, and no appeal rights. But since problems may be easily correctable, the state has a possible argument that this may not deny due process.⁴⁵³ Presumably, if an error was made by the prescriber, the pharmacist, who gets the denial message by computer, can explain the problem to the recipient and/or prescriber. Unfortunately, if an error was made by the pharmacist in failing to properly key information in that could get the override, he or she may not understand the problem and may be unable to explain this to the recipient. Many recipients may not even be told that there is a way to exceed the prescription limit.⁴⁵⁴

8.7.1.5. Even within the monthly prescription limit, some require special approval.

Louisiana Medicaid has also enacted what is known as a “preferred drug list” (PDL). This requires that Medicaid’s prior approval be obtained by the prescriber for certain prescription drugs. The drugs restricted are more expensive ones for

⁴⁵¹ 37 La.Reg. 3270 § 113(C) (Nov. 20, 2011).

⁴⁵² This can be accessed by providers through <http://www.lamedicaid.com>.

⁴⁵³ *Accord Mathews v. Eldridge*, 424 U.S. 319, 346 (1976) (holding that pretermination hearings were unnecessary for disability recipients because they had “full access to the information relied on by the state agency...the reasons underlying its tentative assessment, and ... an opportunity to submit additional arguments and evidence”). *But see Finberg v. Sullivan*, 634 F.2d 50 (3d Cir. 1980) (en banc) (due process denied by failure to give notice of available exemptions to garnishment); *Memphis Light, Gas & Water Div. v. Craft*, 436 U.S. 1, 14 n.14 (1978) (word of mouth notice of availability of procedures denies due process)

⁴⁵⁴ Recipient’s dependence on provider actions makes access to their medical assistance dependent on a third party, somewhat akin to the situation challenged in *Blanchard v. Forrest*, 71 F.3d 1163 (5th Cir.), *cert. denied* 518 U.S. 1013 (1996) (finding “comparability” violation in recipients’ voluntary action by providers determining whether recipients obtain the benefit of Medicaid’s three month retroactive coverage provision). In most cases it would be much faster and easier to find another provider than to litigate this.

which alternatives are supposedly available.⁴⁵⁵ The intent is that most prescribers will follow the path of least resistance, by prescribing drugs they do not have to complete prior approval paperwork on. A minority of Justices on the U.S. Supreme Court has stated that “curtailing the State’s Medicaid costs...would not provide a sufficient basis for upholding the program if it severely curtailed Medicaid recipients’ access to prescription drugs.⁴⁵⁶ Early on, Department records show that some pharmacists were telling recipients that these drugs were not covered by Medicaid, instead of advising about the prior approval process.⁴⁵⁷

Newly introduced drugs are not initially subject to the prior approval process. State law requires that the Medicaid formulary include (exempting them from prior approval) new drugs as soon as they are approved by the federal Food and Drug Administration.⁴⁵⁸

If prior approval is needed, the prescribing doctor must request it. If he or she forgets, the pharmacist alone is unable to request and obtain the prior approval. (The pharmacist could, though, by phone obtain a prescription for a replacement drug that does not need prior approval.)

The prescribing doctor can seek prior approval by phone, fax, or mail, explaining why the prescription drugs that do not need prior approval would not be adequate.⁴⁵⁹ (This unit is not the one that does most of Medicaid’s other prior approvals.) The unit is then to phone or fax their decision to the prescribing doctor within 24 hours.⁴⁶⁰ The 24 hour delay imposes an additional barrier that may discourage use of these drugs, since it complicates the process for the recipient to get a prescription filled.

Pharmacists can release a 72 hour supply of a drug without prior approval if they or the prescriber determine and endorse that it is an emergency situation. (They might decline to do so for fear that Medicaid may not pay if it does not agree it was an emergency.) Emergencies can occur not only because of the 24 hour delay but also because Medicaid’s pharmacy prior approval unit is only open Monday through Saturday, 8-6.⁴⁶¹

Prescribers may not realize that a drug they prescribe is on the restricted list, especially since Louisiana continues to expand the list.

A list of restricted drugs, updated about every six months, is on the LaMedicaid.com website.⁴⁶²

Louisiana Medicaid revises the restricted drug list without doing rule making under the state Administrative Procedures Act. This may make the list invalid since changes to the Preferred Drug List clearly meet the Act’s definition of a rule, and are therefore invalid unless promulgated through rulemaking.⁴⁶³ The only relevant exception would be if a judge (or ALJ) felt that a drug’s restriction is merely an “agency... requirement... regulating only the *internal* management of the agency.”⁴⁶⁴

⁴⁵⁵ Which drugs get off the restricted list may be affected by whether the manufacturer agrees to make give Medicaid a higher rebate for the purchases than is otherwise required under federal law.

⁴⁵⁶ *PHARMA v. Walsh*, 538 U.S. 644, 664-65 (2003), citing 42 U.S.C. 1396a(a)(19) (requiring that Medicaid be provided in a manner “consistent with... the best interests of the recipients”).

⁴⁵⁷ See e.g., <http://www.lamedicaid.com/RAMessages/2_18_03.htm>.

⁴⁵⁸ R.S. 46:153.3(D)(5)(c).

⁴⁵⁹ <http://www.lamedicaid.com/provweb1/Pharmacy/rxpa/instructions.htm>.

⁴⁶⁰ *Id.*; 42 U.S.C. § 1396r-8(d)(5); La.R.S. 46:153.3(B)(2); 50 LAC Part XXIX, § 107(C).

⁴⁶¹ <http://www.lamedicaid.com/provweb1/Pharmacy/rxpa/instructions.htm>.

⁴⁶² http://www.lamedicaid.com/provweb1/Pharmacy/preferred_list.htm

⁴⁶³ La.R.S. 49:954(A).

⁴⁶⁴ La.R.S. 49:951(6) (emphasis added).

The state statute prohibits requiring prior approval on certain HIV, Hepatitis C, and anti-psychotic medications that the recipient was already receiving for six months before they were placed on the restricted list.⁴⁶⁵

If approval is denied, written notice is faxed *or mailed* to the prescriber. The doctor can invoke a phone conference with the pharmacy prior approval staff. A new decision is issued to the doctor within 48 hours of the phone conference.⁴⁶⁶

No notice of the denial is sent to the recipient, and no appeal rights (or even access to a conference call) is provided to the affected recipient. The lack of recipient notice and appeal rights may deny due process.

For prescriptions within a recipient's retroactive eligibility period, the prior approval requirement does not apply. Instead, the pharmacist must submit for Medicaid payment by hard copy, instead of electronically.⁴⁶⁷

8.7.1.6. Exemptions from copayments for prescriptions

Most Louisiana Medicaid recipients are charged "copayments" of up to \$3 per prescription. Pregnant women, children under age 18, and those applying their income towards the cost of facility care are exempt, as are prescriptions for family planning and sudden emergencies.⁴⁶⁸

Payment is not required at the time of service if the recipient is unable to pay; the Department's State Plan provides that inability to pay is established by the recipient's statement.⁴⁶⁹ But the recipient remains liable to pay the amount that was not collected.⁴⁷⁰ (Remember, though, that for recipients who also have Medicare, drug coverage is through that other program and Medicaid rules like this do not apply.)

8.7.1.7. Challenge to the multiple levels of administrative barriers, all trying to accomplish the same thing?

Consider the levels of administrative barriers that recipients must overcome in order to obtain needed prescription drugs, all of which are aimed at preventing excess Medicaid costs:

1. most recipients have been assigned to a primary care physician through "Bayou Health," who controls prescriptions directly or indirectly by controlling what other providers the recipient is referred to;
2. Medicaid's prior approval is required to fill prescriptions not on the state's preferred drug list, including that drugs are not purchased from manufacturers unless they agree to give the state rebates, essentially regulating their pricing;⁴⁷¹
3. only a one month supply is provided each time prescription is filled;
4. mechanized prior approval must be obtained for each prescription filled in excess of the monthly limit;

⁴⁶⁵ La.R.S. 46:153.3(C).

⁴⁶⁶ <http://www.lamedicaid.com/provweb1/Pharmacy/rxpa/instructions.htm>

⁴⁶⁷ <<http://www.lamedicaid.com/provweb1/Pharmacy/rxpa/instructions.htm>>.

⁴⁶⁸ 42 C.F.R. § 447.53(b).

⁴⁶⁹ State plan, Attachment 4.18-A, p. 2, [http://bhsfweb.dhh.la.gov/onlinemanualspublic/stateplan/gpa/attachment 4.18.pdf](http://bhsfweb.dhh.la.gov/onlinemanualspublic/stateplan/gpa/attachment%204.18.pdf).

⁴⁷⁰ 42 C.F.R. § 447.15; State plan, Attachment 3.1-A, Item 12.a, p. 6, [http://bhsfweb.dhh.la.gov/onlinemanualspublic/stateplan/services/attachment 3.1-a item 12a.pdf](http://bhsfweb.dhh.la.gov/onlinemanualspublic/stateplan/services/attachment%203.1-a%20item%2012a.pdf).

⁴⁷¹ 42 U.S.C. § 1396r-8(a-c).

5. drug use is subject to review by state computers, both at the point of sale and periodically over time, which can invoke counseling and other measures;⁴⁷²
7. recipients whose drug use patterns indicate inappropriate use of drugs are placed under “lock-in”, allowing only one physician to prescribe for them;⁴⁷³
8. most recipients are obligated for a copayment when they have the prescription filled.

At some point, a recipient hurt by these hurdles may be able to make a claim that there are too many hurdles set up in the name of preventing over-use of services, and that *arbitrary* effects of one particular hurdle should be overridden by an ALJ or state court.⁴⁷⁴

8.7.1.8. Non-Medicaid avenues for prescription drug assistance

Medicare “Extra Help” (formerly called the Low Income Subsidy)

Medicare recipients with incomes or resources exceeding the Medicaid limits can receive subsidized coverage for their Medicare Part D, which covers prescription drugs. Applications are made through the Social Security Administration. To qualify one must:

- be a Medicare recipient;
- have *countable* income under 150% of poverty. This limit for March 2012, and for at least a year thereafter is \$16,755 for an individual (\$1,396.25 a month) or \$22,695 for a married couple living together (\$1,891.25 a month).⁴⁷⁵ Most earnings and some money to support other family members who live with the recipient are excluded. SSI rules are followed, except that payments occasioned by the death of another person are exempted.⁴⁷⁶
- have resources under the program limit. The limit for March 2012, and for at least a year thereafter is 2012 \$13,070 for an individual or \$26,120 for a married couple. (These figures can get adjusted for inflation each Spring.⁴⁷⁷)

Other prescription assistance programs

Pharmaceutical manufacturers have been offering low income recipients various routes to obtain their drugs at discounts that are sometimes extraordinary. Some possible referral sources are in the footnote.⁴⁷⁸

⁴⁷² 42 U.S.C. § 1396r-8(g)(2).

⁴⁷³ See 42 C.F.R. § 431.54(e).

⁴⁷⁴ See 42 U.S.C. § 1396a(a)(19) (“eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients” –this provision has been held not privately enforceable by the Fifth Circuit, but was cited in the Supreme Court’s plurality opinion in *PHARMA v. Walsh*); 42 U.S.C. § 1396a(a)(30)(A) (requiring “methods and procedures relating to the utilization of, and the payment for, care and services... to safeguard against unnecessary utilization of such care and services *and* to assure that payments are consistent with efficiency, economy, and *quality of care* ... (emphasis added)) —this provision, too, has been held not privately enforceable by the Fifth Circuit. Therefore, recourse is most likely in state court.

⁴⁷⁵ Updated figures may be at <http://ssa.gov/pubs/10525.html#a0=0>.

⁴⁷⁶ 42 U.S.C.A. § 1395w-114(a)(3)(C)(i).

⁴⁷⁷ Updated figures may be at <http://ssa.gov/pubs/10525.html#a0=0>.

⁴⁷⁸ See e.g. <http://www.pparxla.org>; <http://www.pparx.org>; <http://www.rxassist.org/patients/default.cfm>; <http://www.pfiz-erhelpulanswers.com/pages/misc/Default.aspx>.

8.7.2. Dental services for pregnant women

Louisiana covers a specific list of dental services for pregnant women.⁴⁷⁹ A referral from the doctor monitoring the pregnancy is required, on a specific Medicaid form.⁴⁸⁰ This service is not available for those whose only eligibility is through the Medically Needy eligibility, QMB, SLMB, and QI categories.⁴⁸¹

8.7.3. Prosthetic dentures

A state statute requires that the state's Medicaid program cover prosthetic dentures needed by Medicaid recipients.⁴⁸²

Federal law makes denture coverage a state option, for those with "full" Medicaid coverage and the Medically Needy.⁴⁸³ The federal government pays most of the cost of covered services.

There is no federal option to cover dental care for the "Medicare Savings" eligibilities (QMB, SLMB, QI-1, etc.) or for the Qualified Disabled Working Individual (QDWI) categories. For each of these, the services covered are determined by Medicare, not Medicaid rules.

Nonetheless, Louisiana's Second Circuit has ruled that the language of the state statute is universal, and does not exclude individuals in these categories.⁴⁸⁴ DHH is not applying the decision to other individuals, so appeal to either the Division of Administrative Law or state court is probably needed to extend the decision to other clients.

8.7.4. Payment for private health insurance premiums

Most Medicaid recipients can have any Medicare premiums they owe paid by Medicaid. But coverage is also available in limited instances for private insurance premiums, if the agency determines that paying the private insurance premiums would be cost-effective for it: meaning that Medicaid would save more than the cost of the premiums.⁴⁸⁵

If this determination is made, the agency *reimburses* for premiums the family pays. This may be to the recipient's advantage: (1) if the covered recipient wants to stay out of Bayou Health (persons whose private health insurance premiums are covered by Medicaid are exempt); (2) if the insurance policy covers additional services; (3) if different doctors participate under the policy; or (4) if the family wants to maintain the policy for later when they may be off of Medicaid. The agency staff administering this benefit may be unreceptive, even to meritorious requests that will save the state money. They have in the past taken the position that if the family would pay the premiums even if Medicaid does not, it is not cost-effective for Medicaid to pay them. So the help of an advocate, as well as persistence, may be required in order to get enrolled.

Louisiana calls this coverage the Louisiana Health Insurance Premium Payment (LAHIPP) Program. Applications are processed through staff in Baton Rouge.

⁴⁷⁹ 50 LAC Part XV, §§ 16101-161005.

⁴⁸⁰ 50 LAC Part XV, § 16103.

⁴⁸¹ See 42 C.F.R. § 435.404 (recipient eligible under more than one category can choose which category they are certified under).

⁴⁸² La.R.S. 46:157

⁴⁸³ 42 U.S.C. §1396d(a)(10).

⁴⁸⁴ *Law v. Department of Health & Hospitals*, 43,417 (La.App. 2 Cir. 8/13/08), 989 So.2d 871.

⁴⁸⁵ 50 LAC Part III, § 2311; see also 42 U.S.C. § 1396e.

8.7.5. Psychological services for children needing them:

The *Chisholm* case is a class action seeking all medically necessary services for Medicaid children on waiting lists for DHH’s “Home and Community Based Services” waivers. The court found that the state’s failure to cover psychological services needed by class members with autism violated the EPSDT obligation to provide all coverable services necessary to correct or ameliorate their autism.⁴⁸⁶ After the state failed to obtain enough treatment teams to provide the services under an agreed-upon plan, the Court ordered the state to cover psychologists’ services. Services are available to recipients under age 21 who meet certain functional criteria; there is no requirement that one be a class member.⁴⁸⁷

If a Medicaid recipient under age 21 *needs* psychological services not covered under this and the state’s offerings, or if he or she does not meet the functional criteria to qualify for services, they would nonetheless be entitled to any services state Medicaid programs can cover, under the EPSDT mandate.⁴⁸⁸

8.7.6. Louisiana Behavioral Health Partnership

Louisiana has currently restructured its Medicaid (and some non-Medicaid) mental health offerings under the “Louisiana Behavioral Health Partnership.”⁴⁸⁹ The goal is to take fuller advantage of Medicaid match, and enhance community services balancing the cost with reduced payments for psychiatric hospitalizations. One part of the initiative is the “Coordinated System of Care” (CSoC), bringing under one umbrella the behavioral health offerings for at risk youth of the justice, education, Medicaid and foster care systems. The contractor managing many aspects of the LBHP is Magellan. So the terms CSoC, Magellan, and LBHP are sometimes used interchangeably, though they are differing aspects of a single initiative.

Even Medicaid recipients must have specific authorization to receive services under the LBHP. (For individuals in the community over age 21 their individual income must be under 150% of poverty. For those under 21, their individual income must be under three times the maximum SSI payment, and they must be in one of the categories receiving “full” Medicaid.⁴⁹⁰) Authorization involves a finding as to the necessity of the services.

For recipients under age 21, all medically necessary services must be provided.⁴⁹¹ In addition, specific services are available for recipients under age 22 who are in or at risk of out of home placement.⁴⁹²

In addition to the added services under existing programs, a new eligibility group with full Medicaid coverage has been established for children and a new eligibility group has been established for adults with limited Medicaid coverage which will pay for behavioral health services only.⁴⁹³ Children meeting a level of care for placement in a nursing facility or psychiatric hospital and not eligible under other full Medicaid programs should be considered for the CSoC-SED HCBS

⁴⁸⁶ *Chisholm v. Hood*, 133 F. Supp. 2d 894 (E.D.La. 2001).

⁴⁸⁷ 50 LAC Part XV, § 7701.

⁴⁸⁸ 42 U.S.C. § 1396d(r)(5).

⁴⁸⁹ The state plan amendment implementing the change is found at <http://bhswfweb.dhh.la.gov/onlinemanualspublic/stateplan/services/attachment%203.1-g.pdf>.

⁴⁹⁰ MEM § H-2710.

⁴⁹¹ 42 U.S.C. §§ 1396d(a)(4)(B), 1396d(r)(5).

⁴⁹² MEM § H-2710.

⁴⁹³ MEM § H-2720.

waiver.⁴⁹⁴ The waiver is for full Medicaid coverage with additional behavioral health services.⁴⁹⁵ Adults not otherwise eligible for full Medicaid qualify only if they meet the very low Medically Needy Income Levels.

At the time of publication, the LBHP is fairly new and experience under it is still developing.

8.7.7. “Personal care services” to assist with transferring, bathing, feeding, and similar care in the home:

“Personal care services” are to help with activities such as transferring, bathing, feeding, medication reminders, food preparation, and some housekeeping in the home that the recipient is unable to perform for him or herself. But there are eligibility criteria for the services, based on certain specific needs of the recipient. While a personal care services worker can do all of these activities if approved to be on site, a recipient does not qualify just because at least one of the forms of assistance is needed.

Under federal guidance, the services can involve “cueing” to remind persons with cognitive impairments of activities they need to perform.⁴⁹⁶ But these aspects are not central to the service, and so presumably need not be covered by the state, unless necessary for an EPSDT recipient (under the age of 21).⁴⁹⁷ Louisiana’s regulations do not recognize cueing as part of the service.

Louisiana conceives personal care services as dealing with the physical aspects of these activities, and requires that the recipient or their representative be able to direct the personal care worker. For recipients under age 14 and older children not able to direct their care, Louisiana Medicaid requires that another caretaker (usually a parent) be on-site at all times to direct the worker.⁴⁹⁸

Louisiana’s personal care services offerings differ based on a recipient’s age. For recipients under age 21 service is through “EPSDT-PCS.” For recipients over age 21 service is through “LT-PCS.” LT stands for “Long Term.” The two offerings are very different, both as to eligibility standards and services.

State policy used to put a 4 hour a day limit on the services for EPSDT recipients. States cannot place numerical limits on services for EPSDT recipients. The limit has been rescinded, but few recipients receive over 4 hours a day.

One seeks EPSDT-PCS by finding a provider, which submits paperwork to the state, including a form from the recipient’s physician, seeking prior approval of the service.⁴⁹⁹

The LT-PCS for non-EPSDT recipients currently allows up to 32 hours a week of the service.⁵⁰⁰ The Department has repeatedly been reducing the maximum over time, as a budget-saving measure. Reductions may have Americans with Dis-

⁴⁹⁴ MEM §§ H-2720, H-900.

⁴⁹⁵ MEM §H-2720.

⁴⁹⁶ CMS State Medicaid Manual § 4480(C), <<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>>.

⁴⁹⁷ See *Rodriguez v. City of New York*, 197 F.3d 611 (2d Cir.), cert. denied 531 U.S. 864 (1999). *Rodriguez* preceded the CMS “cueing” guidance. But in *Rodriguez* the Court left it to the state to define the purpose of a service, so the federal guidance might not affect the outcome. The author believes that the purpose of a service is a matter of federal law, not state discretion. See *Ledet v. Fischer*, 638 F.Supp. 1288, 1291 (M.D.La. 1986).

⁴⁹⁸ LAC. title 50, part XV, § 7305(A)(4).

⁴⁹⁹ Providers can be found through http://www.lamedicaid.com/provweb1/provider_demographics/provider_map.aspx

⁵⁰⁰ 38 La.Reg. 329 (February 2012), § 12915(A).

abilities Act implications if they result in recipients having to move into a nursing facility to get the care they need.⁵⁰¹

In fact, Louisiana originally implemented LT-PCS as part of the settlement of a suit challenging the state's not covering services in the community, which are covered in facilities.⁵⁰²

One seeks LT-PCS by calling a corporation that has contracted to do evaluations of eligibility.⁵⁰³ (The state has created a bottlenecked system for arranging services. Federal law requires that services be available with reasonable promptness.⁵⁰⁴)

Louisiana's eligibility criteria require that recipients over age 21.⁵⁰⁵

- A. qualify for nursing facility care under the Department's standards and need assistance with at least one or more specified "activities of daily living,"
- B. be age 65 or older or meet the SSI disability criteria, and
- C. be in a nursing home, or likely to be placed in one within 120 days, or have a caregiver (usually a relative living with them) who is disabled or over age 70.

Currently, an obtuse scoring instrument is used to determine if the recipient meets the nursing facility level of care, and to determine the number of hours for which the applicant will be certified.

If others, denied services have a greater need for the service than some who are certified, they too should be entitled, because of Medicaid's comparability requirement.⁵⁰⁶ In particular, persons with *no* caregiver living with them are at least as needy as those whose caregiver is disabled or over age 70, and so should not be denied coverage on that basis.

In challenging a denial of services, realize that *only the "late loss ADLs" determine whether one qualifies* for LT-PCS. (These are transferring, toileting, bed mobility, and eating). The answers to other questions on the survey instrument, establishing other needs, are not gateways to eligibility.

In challenging denials of services it can be important to obtain the current copy of the state's surveying manual. There are at least two problems with the recorded responses. The first is that they are subjective. Terms like moderate difficulty are subjectively determined. The manual has examples that can be used to help question whether the number assigned in characterizing a response is correct. Secondly, the manual instructs workers to "drill down" behind certain responses, rather than accept statements at face value. This can help in both cross-examining the surveyor and in developing contrary client testimony. If used, include portions of the manual in the hearing record.

⁵⁰¹ See e.g., *Pitts v. Greenstein*, 2011 WL 1897552 (M.D.La., 5/18/2011); Med & Med Guide (CCH) P 303,789, 43 NDLR P 71 (denying state's motion for summary judgment in suit alleging that reductions violate the ADA integration mandate).

⁵⁰² *Barthelemy v. Louisiana Department of Health and Hospitals*, E.D.La. Civil Action No. 00-1083.

⁵⁰³ Currently 1 (877) 456-1146.

⁵⁰⁴ 42 U.S.C. § 1396a(a)(8); 42 C.F.R. § 435.930(a).

⁵⁰⁵ LAC Title 50, Part XV §§ 12901 *et. seq.*, as amended through Louisiana Register notices.

⁵⁰⁶ 42 U.S.C. § 1396a(a)(10)(B), discussed elsewhere in this Chapter.

In challenging terminations of services, obtain the reporting sheets (including narrative notes) from all past times the client's eligibility was reviewed. Determine if any relevant "better" scores on the current report make sense. If the recipient has a chronic condition, the presence of improved scores should be a cause for further questions; it does not necessarily mean there has been improvement.⁵⁰⁷

8.7.8. "Hospice care" for persons with terminal illnesses:

Louisiana Medicaid currently covers the optional service of hospice care. Instead of continuing aggressive (and all other) attempts to cure a condition that has been determined incurable, hospice offers comfort care, to make the end of life easier and more comfortable. Under Louisiana Medicaid, the services added include additional in-home nursing (for non-EPSTD recipients, Louisiana usually covers only 50 visits *a year*), case management, counseling, and additional and more promptly arranged personal care services. In essence, the hospice provider takes over most care for the recipient, which should mean that care is coordinated better with a special eye to the needs of one who is dying.

To receive hospice services, the recipient must *elect* to have them replace other "related" Medicaid services they would otherwise receive.⁵⁰⁸ As a practical matter, Louisiana Medicaid seems to block payment for nearly all other Medicaid services during a hospice period. But recent federal guidance takes the term "related to" more seriously. Guidance states that even though hospice includes personal care services, the hospice provider is only responsible for the additional personal care services needed as a result of the hospice decision; previously approved personal care services should continue.⁵⁰⁹

Another route for reducing the loss of other services concerns the election the recipient signs. It is likely to just mirror the statutory language. As a result, the electing recipient may have no idea that he or she is giving up eligibility for, as an example, home and community based waiver services. In addition, at the current time no clear notice goes out to the recipient and their other providers advising of this consequence. This raises due process issues.

Who is liable for the services is important because the hospice provider may not be paid enough to be able to replace a recipient's prior services that need to continue. The hospice provider is compensated on a flat rate basis, with the rate set by which of several tiers is found to represent the recipient's needed level of care.

Under the federal statute, in addition to being able to opt to cover hospice services, states can also cover an additional eligibility group: granting Medicaid to persons receiving hospice care, if their resources are under the SSI resource level and their income is under 300% of the maximum SSI federal benefit amount.⁵¹⁰ Louisiana has *not* chosen this option – it covers hospice as a service, but does not at this time recognize the additional eligibility group.

⁵⁰⁷ See *Weaver v. Colorado Department of Social Services*, 791 P.2d 1230, 1235 (Colo.App.1990).

⁵⁰⁸ CMS State Medicaid Manual §4305.2; Louisiana state plan Attachment 3.1-A, Item 18, page 2. See also 42 U.S.C. § 1395d(d)(2)(A)(ii), referred to within Medicaid's 42 U.S.C. § 1396d(o).

⁵⁰⁹ See 42 C.F.R. § 418.76(i)(2,3); 73 Fed. Reg. 32095, 32133 (6/5/2008).

⁵¹⁰ 42 U.S.C. § 1396a(a)(10)(ii)(VII).

8.7.9. Programs for All-inclusive Care for the Elderly (“PACE”)

If a PACE non-profit health center is available in their area, recipients over age 55 who meet the agency’s standard to receive services of a nursing facility can elect to receive their care from a Program for All-inclusive Care for the Elderly.⁵¹¹ To qualify, the PACE services must be able to maintain the recipient’s health and safety in the community. By enrolling, the PACE center takes over responsibility for meeting all of the recipient’s medical needs, and the recipient can get neither Medicaid (nor Medicare, if eligible) services from other providers. All non-emergency services must be authorized by an interdisciplinary team. The PACE receives a flat payment from Medicaid and Medicare, depending on which the recipient is eligible for. (If the recipient does not have Medicaid, they will be liable for a prohibitive copayment. Not having Medicare is not a problem, though at least one PACE center has claimed otherwise.)

There are two advantages for recipients. The first is that receiving PACE can make one eligible for Medicaid though having income over the usual income limits. Those in PACE qualify for Medicaid if their income is under 300% of the federal SSI benefit amount (and have resources under the SSI resource limits). The second advantage is that the PACE can provide care exceeding the Medicaid state plan limitations, like social workers, physical, occupational and speech therapies, glasses, hearing aids, and additional and greater or more promptly arranged in-home care. The intent is that by providing additional services, recipients can continue to live in the community, instead of entering long term care facilities.

8.7.10. Obtaining services beyond normal limits, with Medicaid’s prior approval

The agency can, in its discretion, make exceptions to numerical limits on some services. For example, the physicians’ section of the Medical Services Manual includes a form for requesting payment for visits beyond the normal limit of 12 physician visits per calendar year for recipients over age 21; requests are supposed to be approved if medically necessary.⁵¹² The Bayou Health plans will likely let recipients exceed this limit, at least for visits to the primary care physician, without any paperwork. They also have authority to waive any other limit and are likely to if convinced it would be cost-effective. (As to recipients who also have Medicare or private health insurance, the cost-effectiveness argument is hard to make. Medicaid pays almost nothing towards services when these other sources are also paying.)

Other services do not have fixed numerical limits, but recipients must obtain case-by-case prior approval of the services. One such service is hospital stays; the length of stay is approved in advance, subject to approved extensions. (No notice of the prior approval decision as to hospital stays or extensions on stays is sent to the affected recipient. Nor is the recipient given a right to appeal a denial. But providers are given certain rights.⁵¹³ The lack of recipient notice and appeal rights may deny due process, as well as denying the statutory right to a fair hearing.⁵¹⁴)

⁵¹¹ 30 La. Reg. 244 (Feb. 20, 2004); 42 C.F.R. Part 460; 42 U.S.C. § 1396u-4; 42 U.S.C. § 1396d(a)(26). As noted in the section above regarding personal care services, qualifying for a nursing facility level of care is largely dependent on needing assistance with some “late loss ADLs.”

⁵¹² State Plan, Attachment 3.1-A, Item 5, p. 1; the Department’s medical necessity criteria are at 50 LAC Part I, § 1101. A major problem with this provision is that the Department decides whether to pay after the visit, and many physicians will not schedule the visit without assurance of payment.

⁵¹³ 50 LAC Part V, § 30120, especially at H.

⁵¹⁴ 42 U.S.C. § 1396a(a)(3); 42 C.F.R. §§ 431.206(c)(2), 431.201.

For those outside of Bayou Health, requests for prior approval must be submitted by the medical provider that would be supplying the service (who must be enrolled as a Medicaid provider). Bayou Health procedures may vary plan to plan.

8.7.11. Prior approval denials outside of Bayou Health are usually because of documentation problems, and often do not mean the recipient is ineligible for the service.

There is not yet enough experience under Bayou Health to know how well its plans' prior approval systems work.

Requests outside of Bayou Health occur both for recipients who are exempt from Bayou Health and for some "carved out" services, not covered by the Bayou Health processes. Once a prior authorization request with documentation from a physician is submitted, most denials are technical or hyper technical, regarding what documentation has been submitted or even what particular words or acronyms were included. Such procedural denials may violate Medicaid requirements, including requirements that medical assistance be furnished to all eligible individuals or be furnished "without any delay caused by the agency's administrative procedures."⁵¹⁵

Protections against such denials have been established for Medicaid recipients under age 21 who are on the waiting lists for the state's waivers for persons with mental retardation or developmental disabilities. These are the class members in the *Chisholm* lawsuit. One of its consent agreements prohibits denying prior approvals for its class members unless:

- the service is beyond the scope of what EPSDT can cover (discussed in § 8.5.1, *supra*),
- the service is not medically necessary, or
- Medicaid notified the recipient of what specific additional information is needed and the type of provider from whom it can be obtained, but the recipient failed to notify Medicaid that an appointment had been set.⁵¹⁶

The relief in *Chisholm* is limited to those on the MR/DD waiting lists only because that was the scope of the class, not because there is some reason that other Medicaid recipients should not get the same protection. Both the hyper-technical grounds for denial, and the poor notices sent to non-*Chisholm* recipients continue to present ripe grounds for litigation.

8.7.12. Prior approval requests for medical equipment, appliances and supplies are "automatically approved" if not ruled on within 25 days, and other procedural rights.

Under a class action consent decree the Department has entered, the decision granting or denying a non-emergency request for prior approval for any medical equipment, appliances, or supplies must be ruled on within 25 days of a recipient's making the request, and emergency requests not ruled on within a working day

⁵¹⁵ 42 U.S.C. § 1396a(a)(8); 42 C.F.R. § 435.930(a).

⁵¹⁶ *Chisholm v. Jindal*, No. 97-3274 (E.D.La. 1998), Stipulation and Order of Partial Dismissal, July 19, 2002, ¶20.d. Violations of these requirements should be brought to the attention of the class counsel.

are supposed to be automatically approved.⁵¹⁷ All requests where a 25 day delay would jeopardize the health of the recipient are to be treated as emergency requests.⁵¹⁸

Denials for lack of sufficient information must identify the information needed to process the request.⁵¹⁹ The medical reviewers are supposed to be accessible to recipients, medical professionals, and facility staff by telephone to discuss requests.⁵²⁰

Many of the current prior approval procedures and mechanisms are *not* the ones incorporated in the consent order governing the Department's prior approval procedures for equipment, appliances, and supplies. As a result, attorneys with clients with significant prior approval problems may want to examine the consent decree and consider contempt sanctions (including any actual damages caused the client) or may be able to use the violations of the decree as additional reason for the Department to focus more attention on the client's request.⁵²¹

As discussed in the section of this Chapter regarding forum options, if a prior approval request is denied, in addition to other options, the recipient can request reconsideration within *at least* 30 days of the denial. This is not stated on the notices.⁵²² New appeal rights follow the new decision.

8.7.13. Few limitations on coverage for emergency room visits

Louisiana has traditionally limited (non-EPSTD) recipients to three emergency room visits a year.⁵²³ But federal laws prevent Medicaid managed care plans from regulating Bayou Health participants' access to emergency rooms.⁵²⁴

For those under Bayou Health or, as to mental health needs, those under the "Behavioral Health Partnership," any ER visits should be covered that were appropriate under a "prudent layperson" standard, meaning that a prudent layperson would have thought that without immediate medical attention the health, bodily functions, or any bodily organ was in serious jeopardy.⁵²⁵

If services not meeting that standard were performed, the recipient may be able to claim the protection of Medicaid's "payment in full" provision against the provider.⁵²⁶ By accepting the recipient's Medicaid card (evidenced by its swiping the card, not having stated and put in writing any other payment arrangement, and having submitted the bill to the agency or Bayou Health plan for approval or payment), the provider has committed to take Medicaid as the payment in full. Before Bayou Health, Louisiana's state agency did not take this position. Instead, as to ER visits with a low level of care, if there was not an after-the-fact approval that the services met the prudent layperson standard, the agency's position was that the client is liable for the bill.

⁵¹⁷ *Richard M. Dickson v. George Fischer, et al*, E.D.La. CA No. 81-563, June 3, 1981, ¶¶3, 4 (copy available on probononet/la).

⁵¹⁸ *Id.*, ¶ 3.

⁵¹⁹ *Id.*, ¶8.

⁵²⁰ *Id.*, ¶11.

⁵²¹ Legal Services attorneys are not barred from filing contempt charges on behalf of individual class members under a class action judgment. 45 CFR § 1617.2(b)(2) ("Initiating or participating in any class action does not include representation of an individual client seeking to withdraw from or opt out of a class or obtain the benefit of relief ordered by the court ...").

⁵²² Compare *Richard M. Dickson v. George Fischer, et al*, E.D.La. CA No. 81-563, June 3, 1981, ¶¶7, 9.

⁵²³ See http://new.dhh.louisiana.gov/assets/docs/BayouHealth/Medicaid_Services_Chart2012.pdf p. 11.

⁵²⁴ 42 U.S.C. § 1396u-2(b)(2); 42 C.F.R. § 438.114.

⁵²⁵ 42 U.S.C. § 1396u-2(b)(2)(C).

⁵²⁶ 42 C.F.R. § 447.15

It is very clear these federal protections intend to make sure no *advance* referral from the health plan is needed to obtain Emergency Room services.

8.7.14. For certain facility residents, a way to pay for needed services not usually covered by Medicaid

Medicaid recipients residing in medical facilities (nursing facilities, ICF/MRs, and hospitals) are required to contribute nearly all of their income towards payment for the facility services.⁵²⁷

Federal law requires that in computing the amount of income a recipient must contribute to the facility, the recipient must also be allowed to deduct amounts they have incurred for medical expenses not covered by Medicaid.⁵²⁸ The primary uses for this “incurred medical expense option” are to cover glasses, hearing aids, and some dental care Louisiana Medicaid does not cover.

The state issued a regulation to partially recognize the option.⁵²⁹ But CMS denied approval of the state’s proposed details, so the state has never issued instructions to implement the regulation. The state has implemented the option more liberally than set out in the regulation, which is appropriate, since any limitations have to be approved by CMS.⁵³⁰

To use the option, one must be paying part of one’ income to the facility and be on Medicaid. Those whose only income is SSI and those on Medicare skilled care do not pay part of their income to the facility, and so cannot use this option.

The recipient’s liability to the facility is reduced by the amount incurred for the services not covered by Medicaid; Medicaid’s contribution to the facility is increased by that same amount. If the item costs more than one month of the patient’s share of the cost of care the reduction can be extended for more than one month.

The state’s position is that the incurred medical expense option does not apply for ICF/MR residents, because the state requires that the facilities cover all care needed by their residents.

8.7.15. Dealing with inability to find a willing provider

8.7.15.1. Children under age 21

Recipients under age 21 can call the “KidMed” line (1-877-455-9955) for assistance finding providers that take Medicaid. DHH “Program Operations” (1-225-342-5774) will provide additional assistance where there are not already providers.⁵³¹

8.7.15.2. The Bayou Health plans

The three “prepaid” Bayou Health plans have an obligation to provide access to any type of specialist the recipient needs, as to services covered by the state plan; this includes contracting with the needed provider, even if not already in the plan.⁵³² The other two Bayou Health plans have an obligation to help a recipient find services, but no obligation as to services for which there are no providers that accept Medicaid.

⁵²⁷ 42 C.F.R. § 435.725(a).

⁵²⁸ 42 U.S.C. § 1396a(r)(1)(A)(ii); 42 C.F.R. § 435.725(c)(4); Louisiana eligibility policies recognize the health insurance deduction set out at (i), but not the provision for other medical costs in (ii) of each of these provisions.

⁵²⁹ 29 *La.Reg.* 710 (May 20, 2003).

⁵³⁰ CMS State Medicaid Manual, §3703.8.

⁵³¹ <http://new.dhh.louisiana.gov/index.cfm/page/322>

⁵³² 50 LAC Part I, § 3505(B). The prepaid plans are Louisiana Healthcare Connections, LaCare, and Amerigroup.

Recipients not excluded from Bayou Health may be able to prevail on Medicaid (through Maximus, its “enrollment broker”) to move them into one of the pre-paid plans, if not already in one.⁵³³ The regulations allow recipients to switch plans for “good cause,” including inability to obtain a service.⁵³⁴ Ideally, one would ask to switch to a plan that has the needed provider. Plans’ lists of providers are supposed to be accessible on the internet. If one cannot identify a plan already having the needed provider, one would seek to switch to one of the three “prepaid” plans, which has the obligation to enlist needed providers.

8.7.15.3. Limited requirements that providers must accept Medicaid.

In general, providers are not required to accept Medicaid as a payment source from their patients. There are some notable exceptions. One exception is that hospitals built with Hill-Burton funds are required to accept Medicaid as a payment source.⁵³⁵ This includes most hospitals built or added to in the 1950s and 1960s.⁵³⁶ These hospitals’ obligations to give *free* services (“uncompensated care”) have been cleared by now. But the obligation to accept Medicaid patients continues indefinitely.

Finally, laws prohibiting discrimination may preclude a provider from refusing to take Medicaid patients. (This may include prohibiting a provider from refusing to take *new* Medicaid patients, even if he or she will take Medicaid from those who used to be its private-pay or privately insured patients.) Such refusals may result in disparate effects against minorities, and so run afoul of regulations implementing Title VI of the federal civil rights acts.⁵³⁷ (Since this aspect of Title VI is no longer considered privately enforceable, relief from such disparate impact claims may have to either be negotiated or sought through an administrative filing with the HHS federal civil rights office.⁵³⁸)

Apart from these obligations, providers are not generally required to take Medicaid.

8.7.15.4. Litigation

The state Medicaid agency, however, is required to fund a system that provides reasonable access to providers.⁵³⁹ The statutory provision has been found not to convey a private right of action.⁵⁴⁰ It remains an open question whether it might preempt a state law that prevents adequate access, such as a rate reduction.⁵⁴¹ The federal Medicaid agency is in the process of promulgating regulations to give more teeth to the statutory requirement.⁵⁴² They seek to have the states develop proof on factual issues related to the adequacy of access. These regulations are unlikely to give a private right of action (except possibly a federal Administrative Procedure Act suit against the federal Medicaid agency for approving a bad plan amendment).

⁵³³ 50 LAC Part I, § 3103(D). Recipients receiving Medicare is the largest group of persons not eligible to participate in Bayou Health.

⁵³⁴ 50 LAC Part I, §§ 3105(C), 3107 (A)(C), (D), especially (D) (i) (iii).

⁵³⁵ 42 C.F.R. § 124.603(c).

⁵³⁶ For those who do not have access to an older list of these hospitals, from when uncompensated care obligations were being claimed for patients, the National Health Law Project has a list of all Hill-Burton hospitals.

⁵³⁷ 42 U.S.C. § 2000d; accord *Linton and Carney v. Commissioner of Health and Environment*, 779 F.Supp. 925, 932 (M.D. Tenn. 1990).

⁵³⁸ *Alexander v. Sandoval*, 532 U.S. 275 (2001).

⁵³⁹ 42 U.S.C. § 1396a(a) (30)(A).

⁵⁴⁰ *Equal Access for El Paso, Inc. v. Hawkins*, 509 F.3d 697 (5th Cir. 2007).

⁵⁴¹ See *Douglas v. Independent Living Center of Southern California, Inc.*, 132 S.Ct. 1204 (2012).

⁵⁴² 76 Fed. Reg. 26342-01 (5/6/2011).

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In dealing with budget crunches, the state has repeatedly cut payment levels to providers (though often increasing them later, in response to problems this causes). Recipients who cannot access a service because not enough providers are willing to participate in the program may have legal claims under the just-discussed provisions to the effect that the state or federal agency is violating its adequate access obligations. Evidencing such a suit is usually a massive undertaking, because there is usually no violation in a single provider's unwillingness to take Medicaid; instead a systemic lack of access needs to be evidenced.⁵⁴³ Perhaps some instances may be so stark that they can be more readily evidenced.

In the *Chisholm* suit, to deal with shortages of home health providers and personal care services (PCS) providers, a court enforceable stipulation requires that if a class member cannot find a home health or Personal Care Services provider who will promptly provide services by calling the KidMed line, DHH will find a provider for them.⁵⁴⁴ The class members are Medicaid recipients under age 21 on the waiting lists for the state's MR/DD waivers. Class counsel have been able to resolve all identified problems.

⁵⁴³ See *Evergreen Presbyterian Ministries Inc., v. Hood*, 235 F.3d 908, 933-34 (5th Cir. 2000), *overruled Equal Access for El Paso, Inc. v. Hawkins*, 509 F.3d 697 (5th Cir. 2007).

⁵⁴⁴ *Chisholm v. Jindal*, No. 97-3274 (E.D.La. 1998), Stipulation and Order of Partial Dismissal, December, 2000, ¶6.