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UNCONSTITUTIONAL OR IMPOSSIBLE: THE IRRECONCILABLE GAP BETWEEN MANAGED CARE AND DUE PROCESS IN MEDICAID AND MEDICARE

Jennifer L. Wright*

THESIS AND ABSTRACT

Managed care, as currently constituted, is inherently unconstitutional in the Medicaid and Medicare context. The due process rights of Medicaid and Medicare beneficiaries are violated because each medical treatment decision is conflated with a Medicaid/Medicare coverage decision, and these decisions are made by care providers and managed care organizations that are subject to systematic incentives to deny even covered care. Medicaid and Medicare coverage decisions are subject to constitutional due process requirements which, at a minimum, include the requirement of an unbiased decision maker. For managed care to pass constitutional muster in the Medicaid and Medicare contexts, the coverage decision must be made by a decision maker who is not subject to incentives to deny necessary care. The constitutional infirmity of managed care in the Medicaid and Medicare context cannot be cured simply by providing more or better notice and hearing rights. It is logically impossible to provide adequate notice and hearing for every treatment decision, which logically includes every decision not to prescribe care.

I. INTRODUCTION AND SUMMARY OF ARGUMENT

The Medicaid and Medicare programs are a crucial part of our health care system, providing health care benefits to approximately seventy-five million Americans, most of whom would otherwise be uninsured.¹ The

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¹ U.S. Health Care Financing Administration [hereinafter HCFA Home
enormous recent increase in medical costs has caused all providers of
health insurance, including the federal government, to shift more and
more health insurance beneficiaries into managed care plans.2 The
Medicaid and Medicare programs have embraced managed care as a
means of controlling the rapid increases in the costs of these programs.3
However, Medicaid and Medicare beneficiaries differ from other health
insurance enrollees because the beneficiaries are entitled to procedural
due process rights that are required by the federal Constitution and by
federal statutes and regulations, before their benefits can be terminated,
reduced or denied.4 The procedural due process rights of Medicaid and
Medicare beneficiaries are not altered by the change to managed-care-
based systems.5 Medicaid and Medicare are government entitlements.6
Due process protections must be provided when an individual's Medicaid
or Medicare benefits are denied, terminated or reduced.7 The detailed
procedural requirements that have developed in state and federal
regulations have their basis in federal constitutional mandates, which
require, at a minimum, effective notice of every denial, reduction or
termination of benefits, and a chance to be heard before an unbiased
decision maker.8

Traditionally, treatment decisions, regarding what medical care is
indicated for an individual, and coverage decisions, regarding whether
Medicaid and/or Medicare will cover such treatment, have been made by

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2. See generally, Jonathan B. Oberlander, Managed Care and Medicare
Reform, 22 J. HEALTH POL'Y & L. 595 (1997); Lisa Axelrod, Note, The Trend
Toward Medicaid Managed Care: Is the Government Selling Out the Medicaid
Poor?, 7 B.U. PUB. INT. L. J. 251 (1998); Allen Buchanan, Managed Care:
Rationing Without Justice, But Not Unjustly, 23 J. HEALTH POL'Y & L. 617,

3. 53.64% of Medicaid beneficiaries were enrolled in managed care as of


5. See J.K. v. Dillenberg, 836 F. Supp. 694, 699 (D. Ariz. 1993); see also


7. Id. at 261-62; Mathews, 424 U.S. at 332.

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different entities. Coverage decisions were made by state Medicaid agencies, Medicare carriers, or fiscal intermediaries contracting with the federal government. Due process notice and hearing rights attached to these decisions. On the other hand, treatment decisions were made by medical professionals according to expert judgment. Medical professionals had no financial incentive to deny needed treatment, but conversely, had a financial incentive to assist the individual to obtain the prescribed treatment. Due process rights generally were not triggered by treatment decisions.

Under managed care, the coverage decision is conflated with the treatment decision. The entities which previously made Medicaid and Medicare coverage decisions have delegated the initial treatment/coverage decision to the managed care organizations and their care providers through capitated payment systems. The Medicaid or Medicare entity generally pays the managed care organization a fixed amount per covered individual. It is left to the managed care organization and its medical providers to make the initial determination about what care will be provided in return for the capitated payment received. The individual doctor or managed care organization makes coverage and treatment decisions at the same time. It is no longer logically possible to distinguish between the coverage decision, which involves due process rights, and the treatment decision, which traditionally does not. Therefore, in a managed care context, every decision made by a doctor as to medical treatment of a Medicaid or Medicare beneficiary becomes subject to the notice and hearing requirements required by federal statutes and regulations for coverage.

10. Id. §§ 405.702, 405.720, 405.801, 431.205-206.
13. Kevin Visocan, Recent Changed in Medicare Managed Care: A Step Backward for Consumers?, 6 ELDERS L. J. 31, 33 (1998); Axelrod, supra note 2, at 258-59 (1998); 42 C.F.R. §§ 417.584(a), 434.2.
14. 42 CFR 417.600 (1999); Daniels, 926 F. Supp. at 1308.
15. Pegram, 120 S. Ct. at 2154-55.
Reducing or eliminating statutory notice and hearing requirements in Medicaid and Medicare would not solve the problem because one of the minimum requirements of constitutional procedural due process is the right to an unbiased decision maker. Under managed care, the coverage/treatment decision is made, in the first instance, by individual doctors and managed care organizations who are subject to direct financial incentives to deny care. The objective validity of the medical treatment decision and the health insurance coverage decision becomes deeply suspect in light of these incentives. Therefore, the traditional reasoning that medical treatment decisions have an objectively reliable basis and are not subject to the requirements of due process is not applicable under managed care. In order to provide procedural due process, Medicaid and Medicare beneficiaries need to be given access, in every coverage/treatment decision, to an unbiased decision maker to determine whether the care at issue is covered and whether the care is medically indicated. In a managed care system, this would mean each beneficiary would be entitled to seek the unbiased opinion of a doctor who is not subject to a financial incentive to deny care for each treatment/coverage decision.

When every treatment decision becomes subject to due process requirements, these requirements apply equally to decisions not to treat. It is insufficient to provide notice and hearing only when a Medicaid or Medicare beneficiary requests treatment and when the physician or managed care organization refuses to provide such treatment. The decision by the health care provider not to recommend or even mention a specific treatment deprives the beneficiary of Medicaid or Medicare coverage for that treatment. Therefore, this decision not to prescribe care is also subject to the requirements of due process. It is impossible, even in theory, to provide notice and hearing rights for each decision not to prescribe a specific treatment, since the set of possible decisions at each point in time is infinite. Accordingly, it is logically impossible, even if it were attempted, to provide the due process rights required under the Fourteenth Amendment in the context of Medicaid and Medicare managed care.

To provide Medicaid and Medicare beneficiaries with due process without running into the wall of logical impossibility, treatment and coverage decisions in Medicaid and Medicare again must be separated.

17. Daniels, 926 F. Supp. at 1313.
Treatment decisions must be made by doctors who do not make the coverage decision and who are not subject to systematic bias to deny necessary health care. In order to comply with the demands of the Constitution, managed care, as it currently exists, can no longer be a part of Medicaid or Medicare.

First, the basic structure of the Medicaid and Medicare programs is briefly discussed. Second, the traditional due process analysis in these programs, and the constitutional, statutory notice, and hearing requirements for each program are examined. Third, the types of health care decisions that are subject to due process requirements are analyzed through examination of the leading cases in both the Medicaid and Medicare contexts. Fourth, the effect of third party involvement, including Medicaid and Medicare managed care organizations (MCOs), in the decision-making process is addressed. Included in this discussion is an analysis of the question of when state action is found and when an entitlement arises.

Fifth, the nature of the medical treatment decision and the health care coverage decision is examined, as is, the conflation of the two decisions in Medicaid and Medicare managed care. Sixth, the minimum requirement of constitutional due process, that decisions be made by an unbiased decision maker, and the effect of managed care in creating systematic incentives for the decision maker to deny both care and coverage are then discussed. Finally, the significance, in due process terms, of each decision not to provide medical treatment, and the logical impossibility of providing notice and hearing rights in every instance of non-treatment are noted. The article concludes that it is impossible to comply with the requirements of constitutional due process under current Medicaid and Medicare managed care systems.
II. BACKGROUND: THE MEDICAID AND MEDICARE PROGRAMS

Together the Medicaid and Medicare programs provide health insurance coverage to approximately seventy-five million individuals. These two programs alone make the federal government by far the largest single health insurer in the country.

A. Medicaid

The Medicaid program is the insurer of last resort for very low-income elderly and disabled individuals, children and their families. The program is funded and administered jointly by the federal government and by states that choose to participate. Until 1997, state Medicaid programs generally were not permitted to limit Medicaid recipients in their choice of doctors, unless they received a specific waiver of this requirement from the Health Care Financing Administration (HCFA). States may now require Medicaid recipients who also are not eligible for Medicare to enroll in managed care organizations (MCOs). Over the past ten years, more and more Medicaid recipients have been moved into managed care.

The state agency makes the eligibility determination in traditional


20. The federal government provides health insurance through other programs as well, including the Veterans’ Administration health care system, the Indian Health Service and the federal employees’ health insurance program. See Health Care Financing Administration, *Highlights, National Health Expenditures, 1998*, http://www.hcfa.gov/stats/nhe-oact/hilites.htm (last visited Oct. 27, 2000).

21. All fifty states participate in the Medicaid program.


24. 53.64% of Medicaid beneficiaries were enrolled in managed care as of 1998. See HFCA Home Page, *supra* note 1, at http://www.hcfa.gov/medicaid/trends98.htm.
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Medicaid programs. Denials of Medicaid eligibility entitle applicants to a fair hearing before a decision maker who was not directly involved in the original eligibility determination. At this hearing, the individual is entitled to see all the documentary evidence in the state agency's possession. The individual is entitled to present and cross-examine witnesses and may be represented by an attorney or assisted by a non-attorney spokesperson. The hearing officer's decision must be both in writing and based solely on the record. If the hearing decision is unfavorable, the individual may appeal to state court. In addition, if the state rules, statutes, and/or procedures upon which a denial is based violate federal Medicaid law, the individual may sue in federal district court under 42 U.S.C. section 1983, for deprivation of rights provided by federal law.

If, instead of the denial of an application for Medicaid benefits, there is a termination or reduction of Medicaid benefits, federal law requires that notice be given prior to the termination or reduction. If the Medicaid recipient requests a fair hearing, the Medicaid benefits must generally be continued until the hearing decision is rendered.

B. Medicare

Medicare provides health insurance benefits to persons sixty-five years of age and older who are entitled to receive Social Security retirement benefits and to persons who have been entitled to Social Security disability insurance benefits for at least two years. Medicare is a strictly

25. This decision maker may be an employee of the state Medicaid agency. See 42 C.F.R. § 431.233.
26. Id. § 431.242(a).
27. Id. § 431.206(b)(3).
28. Id. §§ 431.244(a),(d) (1999).
31. 42 C.F.R. § 431.211; Goldberg, 397 U.S. at 262.
32. If there is no factual issue to be resolved at the hearing, and the only issue to be decided is one of federal or state law or policy, then Medicaid benefits may be terminated or reduced prior to the hearing. 42 C.F.R. § 431.230.
33. Medicare also provides coverage to some other groups, including persons eligible for Railroad Retirement benefits, federal civil service retirees, and certain
federal program, administered by contract through private insurance providers, without regulation or involvement by the states. There are three distinct parts to Medicare (A, B & C), with different procedures and regulations governing each. Under each part, Medicare covers only treatment that is medically "reasonable and necessary." Medicare Parts A and B are administered by private insurance companies (frequently, Blue Cross/Blue Shield insurance companies) under contract with HCFA. These private contractors handle all administrative matters, make initial coverage decisions, send notices, and issue reimbursements in accordance with highly detailed federal regulations. They also conduct the initial stages of appeal for denial of benefits. Subsequent appeal procedures may include the right to an Administrative Law Judge hearing, review by the Social Security Appeals Council, and federal district court review, depending on the amount in controversy.

Under traditional Medicare, payment for medical care is generally made on a retrospective basis. This means the care is provided before Medicare determines whether to cover the care. The retrospective compensation system means that either the patient or the provider must bear the risk that the medical care will not be covered. This risk may result in some needed care effectively being denied without the question of coverage ever being addressed within the Medicare system itself.

Since 1982, Medicare beneficiaries have had the option of enrolling in a Medicare Health Maintenance Organization (HMO). Enrollees generally agree to receive treatment from providers who participate in the HMO, and to select a primary care physician to act as "gatekeeper" for all referrals for testing and treatment by specialized providers. Historically, enrollees have been free to enroll and disenroll in Medicare HMOs on a monthly basis. Beginning in 2001, enrollees who chose managed care


35. Id. at 68
37. Baker, supra note 34, at 70.
38. Id. at 70; see generally 42 C.F.R. §§ 400-24 (1999).
41. Id. § 424.34.
42. 42 U.S.C. § 1395(mm) (Supp. 2000).
43. Visocan, supra note 13, at 35.
44. 42 C.F.R. § 406.21 (1999); see also id. §§ 407.12-15.
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will have a limited open enrollment period and will only be entitled to change their Medicare HMO plan once per year.45

In 1997, the Medicare program was expanded to include Medicare Part C, also called Medicare + Choice.46 Under Part C, Medicare beneficiaries can choose among Medicare HMOs, and various other managed care organizational forms.47

III. BASIC DUE PROCESS IN MEDICAID AND MEDICARE

A. Due process and entitlements

The United States Supreme Court has long held that when an individual is deprived of liberty or property by the state, “due process requires that there be a regular course of judicial proceedings, which imply that the party affected shall have notice and an opportunity to be heard . . .”48 Early procedural due process cases dealt with situations where the state incarcerated an individual or deprived the individual of tangible property.49 In the last thirty years, the courts have extended due process protections to liberty or property interests created under government entitlement programs.50 If the government statutorily creates an entitlement, procedural due process protections must apply,51 even where an individual would not otherwise have a constitutional right to a particular benefit. A benefit is an entitlement when an individual who meets specific eligibility criteria is entitled by statute to receive that

45. Id. § 422.62.


47. Id. at 61-62.

48. Hagar v. Reclamation District, 111 U.S. 701, 708 (1884); see U.S. CONST. amend. V, XIV.


benefit.\textsuperscript{52}

In cases in which the extension or deprivation of an entitlement depends on a medical determination, that medical determination is not exempt from the notice and hearing provisions of the due process clauses.\textsuperscript{53}

\textbf{B. Traditional Medicaid and Medicare Due Process Analysis}

Exactly what procedures due process requires is a practical question, varying greatly from situation to situation.\textsuperscript{54} The determination focuses on: 1) the nature of the right or interest of which the individual is being deprived; 2) the risk of error in the determination of ineligibility; 3) the cost to the individual and to society of such error; and 4) the cost to the government in providing additional procedural protections.\textsuperscript{55} On several occasions, the Supreme Court has set out the basic minimum procedural protections generally required by due process.\textsuperscript{56} At a minimum, due process requires notice of the deprivation of the right or interest and an opportunity to be heard. A formal hearing may or may not be required, but in order to be effective, the right to be heard must include the right to examine the evidence relied upon in making the decision, the right to present contrary evidence, and the right to an impartial and unbiased decision maker.\textsuperscript{57}

In determining the nature of the hearing constitutionally required in a given situation, courts have addressed the question of whether the hearing should be held before or after the individual is deprived of the entitlement

\textsuperscript{52} Goldberg, 397 U.S. at 262.

\textsuperscript{53} Vitek v. Jones, 445 U.S. 480, 495 (1985). "We recognize that the inquiry ... involves a question that is essentially medical ... The medical nature of the inquiry, however, does not justify dispensing with due process requirements. It is precisely '[t]he subtleties and nuances of psychiatric diagnoses' that justify the requirement of adversary hearings." Id. (quoting Addington v. Texas, 441 U.S. 418, 430 (1979)). See generally West v. Atkins, 487 U.S. 42 (1988).


\textsuperscript{55} See Mathews, 424 U.S. at 336.


\textsuperscript{57} Fuentes, 407 U.S. at 80 (1972); see also Goss v. Lopez, 419 U.S. 565, 578-81 (1975); Vitek, 445 U.S. at 494-95.
interest. Generally, there must be some opportunity to be heard before a final deprivation of liberty or property occurs. However, under many circumstances, an initial action can be taken or an initial determination can be made before the individual receives the opportunity to be heard. In each case, the cost to the individual of a possibly erroneous deprivation before a hearing must be weighed against the cost to the state or federal government of providing a pre-termination hearing. The more essential the liberty or property interest is to the individual's survival and well-being, and the more likely that even a temporary deprivation of that interest will result in irremediable harm to the individual, the more prone the courts are to require a pre-termination hearing.

The requirements of due process in the context of Medicaid and Medicare benefits were established in two pivotal Supreme Court cases: *Goldberg v. Kelly* (Medicaid) in 1970, and *Mathews v. Eldridge* (Medicare) in 1976. *Goldberg* focuses on the procedural protections required by the Fifth and Fourteenth Amendments in the specific context of welfare benefits. The *Mathews* Court begins with an analytical framework for determining the procedures required by due process in any given context and then applies this framework to determine the obligatory procedural protections in the context of Title II Social Security benefits.

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64. The *Goldberg* case dealt with notice and hearing rights in the context of Aid to Families with Dependent Children (AFDC) benefits. 397 U.S. 254. The Court held that the *Goldberg* due process requirements applied to "welfare" or "public assistance" benefits. See *Mathews*, 424 U.S. at 341, 343. Medicaid has traditionally been considered a part of the "welfare" benefits provided to indigent individuals by state and federal governments. Therefore, the due process analysis of *Goldberg* in the AFDC context has been applied to Medicaid benefits as well. Congress incorporated the *Goldberg* requirements into the Medicaid statute. 42 U.S.C. § 1386a(a)(3) (1995); 42 C.F.R. §§ 431.200, 431.205(d) (1999). Courts have held that the *Goldberg* constitutional requirements apply in the Medicaid context. See Daniels v. Wadley, 926 F. Supp. 1305, 1312 (M.D. Tenn. 1996).
1. Medicaid Notice and Hearing Rights – Goldberg

Medicaid benefits are statutory entitlements, requiring procedural due process prior to termination. The Goldberg Court examined what kind of hearing must be provided in the context of welfare benefits, and whether an evidentiary hearing prior to termination of such benefits was constitutionally required. The Court noted that "welfare provides the means to obtain essential food, clothing, housing, and medical care . . .," and "that termination of aid pending resolution of a controversy over eligibility may deprive an eligible recipient of the very means by which to live while he waits." The Court further found that the government has an interest in the uninterrupted provision of these benefits to eligible individuals and that pre-termination hearings would reduce the risk of erroneous termination. The interest of the welfare recipient together with the interest of the government in avoiding erroneous termination was held to outweigh the government's interest in reducing administrative costs by deferring the hearing until after benefits are terminated.

The Court quoted with approval the district court's weighing of the relevant costs and benefits of pre-termination hearings. The Court stated that the termination of benefits essential to an individual's daily

These are cash benefits accruing to individuals who have the requisite work history and who meet Social Security disability criteria. See Mathews, 424 U.S. at 332-49. Unlike the AFDC or Medicaid benefits, income or other financial resources of the Title II beneficiary are irrelevant in determining eligibility for Title II disability benefits. See 42 C.F.R. § 405.701 et seq. While some Medicare beneficiaries qualify based on their eligibility for Title II disability benefits, the majority of beneficiaries qualify based on eligibility for Title II retirement benefits. See id. § 405.801 et seq. The due process requirements of Title II disability benefits defined in Mathews have been applied to Medicare benefits in the Medicare statute and regulations, and by the courts. See Grijalva v. Shalala, 946 F.Supp. 747, 752 (D. Ariz. 1996), aff'd, 152 F.3d 1115 (9th Cir. 1998), rev'd and remanded, 119 S. Ct. 1573 (1999), rev'd and remanded, 185 F.3d 1075 (9th Cir. 1999).

66. Goldberg, 397 U.S. at 263. "Such benefits are a matter of statutory entitlement for persons qualified to receive them." Id.

67. Id. at 265.

68. Id. at 264-65.

69. Id. at 265-267.


To cut off a welfare recipient in the face of . . . 'brutal need' without a prior hearing of some sort is unconscionable unless overwhelming considerations justify it . . . . Against the justified desire to protect public funds must be weighed the individual's overpowering need in this unique situation not to be wrongfully deprived of assistance. Id.
existence would throw him or her into a crisis situation that would make it very difficult for the person to pursue effectively his or her procedural rights. The Court also adopted the district court's conclusion that "[t]he stakes are simply too high for the welfare recipient, and the possibility for honest error or irritable misjudgment too great" to allow pre-hearing termination of benefits.

Before termination of welfare (including Medicaid) benefits, timely and detailed notice must be given specifying the reasons for termination. Prior to termination, the beneficiary has the right to an in-person hearing. The hearing includes: the opportunity to present evidence, confront and cross-examine witnesses, the right to be represented by counsel at the hearing, the right to have the decision based solely on the hearing record, the right to have a written hearing decision indicating the reasons for the decision and the evidence relied upon, and the right to an impartial decision maker.

2. Medicare Notice and Hearing Rights – Mathews

Title II disability benefits (and, by extension, Medicare benefits) are also entitlements to which the requirements of procedural due process apply. The Court established a three-part analysis to determine the procedural protections required by due process in any given situation.

71. Id. at 264.
72. Id. at 266.
73. Id. at 268-69.
74. Id. at 269-70.
76. Goldberg, 397 U.S. at 271-72 (citing Powell v. Alabama, 287 U.S. 45, 68-69 (1932)).
78. Id. (citing Wichita R. & Light Co. v. PUC, 260 U.S. 48, 57-59 (1922)).
79. Id. at 272. "And, of course, an impartial decision maker is essential." Id. (citing In re Murchison, 349 U.S. 133 (1955)) (emphasis added); Wong Yang Sung v. McGrath, 339 U.S. 33, 45-46 (1950).
81. Id. at 334-35 (citing Goldberg, 397 U.S. at 263-71).
First, courts must consider the nature of the private interest at stake and its importance to the individual concerned.\textsuperscript{82} Second, they must examine the risk that the procedures used by the government will erroneously deprive the individual of the interest at issue.\textsuperscript{83} Included in this step is a consideration of how efficacious additional procedural protections would be in reducing such error.\textsuperscript{84} Courts must evaluate the government's interest in a more streamlined procedure, including the interest in reducing administrative costs.\textsuperscript{85}

The Court in \textit{Mathews} held that Title II disability benefits are sufficiently different from the welfare benefits at issue in \textit{Goldberg}. Therefore, due process does not require the government to grant a hearing to disability benefit recipients prior to termination.\textsuperscript{86} The Court concluded that benefits which are not based on financial need are less crucial to the survival and well-being of the recipient.\textsuperscript{87} The \textit{Mathews} Court noted that recipients whose benefits were erroneously terminated were entitled to receive retroactive benefits after winning a post-termination hearing.\textsuperscript{88}

The Court concluded that the risk of erroneously denying benefits was reduced when eligibility determinations depended largely on "routine, standard, and \textit{unbiased} medical reports by physician specialists."\textsuperscript{89} Such a determination, according to the \textit{Mathews} Court, presented a "more sharply focussed and easily documented decision than the typical determination of welfare entitlement," and therefore "[t]he potential value of an evidentiary hearing, or even oral presentation to the decision maker, is substantially less in this context."\textsuperscript{90} Finally, the court concluded that the potential cost of pre-termination hearings "would not be insubstantial."\textsuperscript{91}

The \textit{Mathews} opinion did not address the other specific procedural requirements for notice and hearing stated in \textit{Goldberg}, but explicitly limited its consideration to the question of whether an evidentiary hearing

\textsuperscript{82} \textit{Id.} at 335.
\textsuperscript{83} \textit{Id.}
\textsuperscript{84} \textit{Id.}
\textsuperscript{85} \textit{Id.}
\textsuperscript{86} \textit{Mathews}, 424 U.S. 340-43.
\textsuperscript{87} \textit{Id.} at 341-43.
\textsuperscript{88} \textit{Id.} at 340.
\textsuperscript{89} \textit{Id.} at 345 (emphasis supplied).
\textsuperscript{90} \textit{Id.} at 344-346.
\textsuperscript{91} \textit{Id.} at 348.
must be held prior to the termination of benefits. The other requirements of Goldberg were already embodied in the Medicare rules at issue in Mathews.

C. Due process in Medicaid and Medicare Managed Care

When Medicaid or Medicare beneficiaries enroll in a MCO, they remain entitled to the same range of health insurance as those beneficiaries in a fee-for-service arrangement. The MCO (or its employee or contracting healthcare provider) makes the initial decision regarding coverage of a particular medical service, based on Medicaid or Medicare regulations. These federal regulations make reference to medical standards; however, MCOs must refer to and comply with not only these medical standards, but also with the relevant government regulations. Accordingly, the “medical” component of the coverage decision (e.g., whether a given treatment is “medically reasonable and necessary”) is the same in the MCO context as it is in the traditional fee-for-service arrangement. However, with the advent of managed care, initial responsibility for the coverage decision previously made by a Medicaid agency or Medicare carrier or intermediary has been transferred

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94. 42 C.F.R. §§ 434.20(c)(2); § 417.414(b) (Medicaid and Medicare HMOs must provide beneficiaries all the coverage to which they are entitled). MCOs may opt to offer more expansive benefits than available in traditional Medicaid/Medicare. See id.
95. Id. § 405.702 (stating that the States “intermediary” makes initial determination regarding coverage.).
96. 42 U.S.C. § 1395y(a)(1)(A) (“No payment may be made . . . for any expenses incurred for items or services which . . . are not reasonable and necessary for the diagnosis or treatment of illness or injury.”).
97. Grijalva v. Shalala, 152 F.3d 1115, 1120 (9th Cir. 1998), rev’d and remanded, 119 S. Ct. 1573 (1999), rev’d and remanded, 185 F.3d 1075 (9th Cir. 1999). “HMOs are following congressional and regulatory orders and are making decisions as a governmental proxy – they are deciding that Medicare does not cover certain medical services.” Id.; see also, Timothy P. Blanchard, “Medical Necessity” Denials as a Medicare Part B Cost-Containment Strategy: Two Wrongs Don’t Make It Right or Rational, 34 ST. LOUIS U. L.J. 939, 973 (1990). “Whether a particular service is reasonable is a policy question not unlike those Congress is presented with every year.” Id.
from the government entity to the MCO.98

IV. THE CONSTITUTIONAL BOTTOM LINE: DUE PROCESS REQUIREMENTS IN MEDICAID AND MEDICARE MANAGED CARE

A. When Does Due Process Apply?

1. Strictly medical treatment decisions are not subject to due process protections – Blum v. Yaretsky

Physicians and other medical providers make many decisions about individual patients' medical treatment. While a patient may desire a second opinion, the doctor's decision regarding appropriate medical care in a given situation has not traditionally been seen as a decision requiring procedural protections of notice and hearing. However, when the medical providers' decision regarding medical treatment results in the termination or reduction of publicly-financed health insurance benefits, the issue of whether and when such a decision implicates due process arises. In Blum v. Yaretsky,99 the Supreme Court addressed this issue in the context of Medicaid.

At issue in Blum was a state created system under which doctors and nursing homes were required to determine, using state-mandated forms and procedures, the appropriate state-defined level of care for nursing home patients.100 When a doctor or nursing home determined that a patient's needs fell into a lower category of care, the state Medicaid regulations required the nursing home to "make all efforts possible"101 to transfer the patient to a facility providing the lower level of care. Upon such transfer, the state would automatically terminate payments to the nursing home.102 In addition, nursing homes were inspected periodically

98. See Gordon Bonneyman, Due Process and Grievance Procedures in Publicly Financed Managed Care, in Balancing the System: Consumer Rights in Managed Care 3 (June 20, 1997).

Managed care organizations frequently deny, reduce or terminate services prescribed by providers, as the Medicaid agency itself seldom or never did in the days of fee-for-service. By creating a managed care program and delegating management of patient care to MCOs, the state interposes its agent (the MCO) between the consumer and the provider. Id.

100. Id. at 994-95.
101. Id. at 1007 (quoting 10 N.Y. COMP. CODES R. & REGS. TIT. 10, §§ 416.9(d)(1), 421.13(d)(1) (1980)).
102. Id. at 995.
by the state Medicaid agency to determine whether they were complying with state regulations regarding transfer of patients. 103 Failure to comply with state regulations resulted in penalties imposed on the nursing home by the state. 104 

In *Blum*, nursing home patients argued that the doctor's or nursing home's determination that a patient needed a lower category of care was equivalent to a decision to terminate Medicaid payments for the current nursing home placement, and that therefore patients were entitled to due process in that determination. 105 The patients also argued that they should receive notice of the determination to transfer them to a lower level of care, should be informed of the reasons for the decision, and should have the opportunity to present evidence and argument that the determination was in error. 106 The Court held that patients were not entitled to such notice and hearing rights because the decision to transfer patients to a lower level of care was a purely private decision by the medical care providers based on purely medical criteria, which did not amount to state action. 107 If no state action is involved, due process rights do not apply. 108 

*Blum* turns upon the notion that the treatment decision, made according to medical principles by the medical provider, remains distinct from the coverage decision made according to Medicaid statutes and regulations by the state agency. Only the latter decision is entitled to the protections of due process. 109 In asserting the independence of these two decisions, the Court noted that the state exerted no coercive power in the decision making process in any individual case. 110 The medical providers making the level-of-care determination in a given case were not subject to state-created incentives to deny care. 111 However, as the Court's own

103. *Id.* at 1009 n.21.
104. *Id.* at 1009-10.
105. *Blum*, 457 U.S. at 996.
106. *Id.*
107. *Id.* at 1005.
108. *Id.* at 1002-03.
109. See generally *id.* at 991.
110. *Id.* at 1004-05.
111. *Id.* at 1005 (1982). "There is no suggestion that those decisions were influenced in any degree by the State's obligation to adjust benefits in conformity with changes in the cost of medically necessary care." *Id.* The merging of the treatment decision and the coverage decision in *Blum* subjected the decision to the requirements of due process. The lack of decision maker bias is relevant to what kind of process is due, not to whether due process is required. Under the
analysis makes clear, once the treatment decision had been made in these
cases, there was no coverage decision left for the state to make. A
coverage standard for eligibility for benefits was defined by the state, and
doctors were required to make the determination as to whether or not
individuals met that standard. That determination was then
characterized as a purely medical treatment decision, immune from the
requirements of due process.

However, as the dissent in Blum argues, the decisions made by the
doctors and nursing homes in cases involving medical eligibility clearly are
not purely medical treatment decisions, entirely divorced from Medicaid
coverage issues. The medical providers' decisions cannot be made
without reference to Medicaid eligibility rules. In fact, the decisions are
based on categories of care which are created and defined solely by
Medicaid eligibility rules. Such care levels are not diagnostic terms used
by medical professionals outside of the Medicaid and Medicare contexts.
Rather, the level-of-care decision necessarily involves the interpretation
of Medicaid program requirements, and therefore involves the application
of standards created and defined by the government. Under the Blum
analysis, by merging treatment and coverage decisions, and placing them
in the hands of private actors, all due process requirements imposed by
the Constitution, statutes and regulations on the coverage decisions no

facts in Blum, a notice and hearing process could pass constitutional muster
without necessarily requiring access to a different decision maker, which would
not be the case in the managed care context.

112. Id. at 1010. "Nothing in the regulations authorizes the officials to
approve or disapprove decisions either to retain or discharge particular
patients... the State is obliged to approve or disapprove continued payment of
Medicaid benefits after a change in the patient's need for services." Id.
113. Id. at 1005-1006.
114. Id. at 1007-09.
115. Id. at 1016-17 (Brennan, J., dissenting).

With respect to patients whose expenses are not reimbursed through
Medicaid, these attempts to assign the patient to one of two mutually
exclusive 'levels of care' would be anomalous. While the criteria used...

obviously have a medical nexus, those criteria are not geared to the
specific needs of particular residents as determined by a physician. Id.
116. Id. at 1016-17.
117. Blum, 457 U.S. at 1015.
practical terms, these eligibility decisions cannot be untangled from physicians'
judgments about reasonable medical treatment... The eligibility decision and
the treatment decision [are] inextricably mixed." Id.
longer apply.

The Court erred in *Blum* because it assumed that once the decision at issue was identified as a treatment decision, the due process inquiry was over. The Court based this assumption on the traditional rule that treatment decisions are exempt from due process requirements for lack of state action. It failed to acknowledge the reality that, in the *Blum* context, the treatment decision had been merged with the coverage decision. Coverage decisions remain subject to the requirements of due process, even when they are intertwined with treatment decisions. The decisions in *Blum* are a hybrid, involving both Medicaid eligibility questions and questions of medical diagnosis. In other cases where important liberty rights turn on difficult questions of medical diagnosis, the Court has held that due process requirements still apply.\(^1\)

The fact that a decision turns in part on professional expertise does not in itself immunize the decision from the demands of due process. A decision as to how an individual patient fits into eligibility categories created by a government entitlement program can never be a purely medical treatment decision.

2. **Due process in Medicaid Benefits Provided Through Private Entities**

If medical decisions that result in reduction or termination of entitlement benefits may be subject to due process requirements, what of decisions by private entities that contract with the government to provide entitlement benefits? The Fifth and Fourteenth amendments apply only to governmental entities or state actors.\(^2\) Therefore, the question becomes whether due process requirements are included in the package when medical entitlements programs are turned over to managed care organizations.

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"We recognize that the inquiry involved in determining whether or not to transfer an inmate to a mental hospital for treatment involves a question that is essentially medical . . . . The medical nature of the inquiry, however, does not justify dispensing with due process requirements. It is precisely '[t]he subtleties and nuances of psychiatric diagnoses' that justify the requirement of adversary hearings." *Id.*

This issue was first addressed in *J.K. v. Dillenberg.* In this case, the state contracted with private entities to provide mental health services to Medicaid beneficiaries. These entities were created and existed only to provide Medicaid-covered mental health services. The state had entirely delegated its authority over these particular Medicaid-covered services to the private entities. These private entities established time limits on mental health treatment provided and covered under the state Medicaid program. When these time periods for covered treatment ended, treatment was terminated without notice or hearing to the Medicaid beneficiaries.

The state and the private entities argued that the decision as to the length of treatment was purely a private action, not subject to due process. However, the federal district court correctly determined that the decision was a Medicaid coverage decision, which required due process protection. The court focused on the fact that the state had delegated entirely its Medicaid coverage decisions to the private entity, and that the private entity served as an agent of the state. The court was emphatic in its decision that the state could not evade due process requirements by turning over its decisions to a private entity. Because Medicaid coverage for a beneficiary’s treatment was determined entirely by the decision regarding the length of treatment, this decision was subject to due process notice and hearing requirements.

In this situation, the “treatment” decision was not based on individualized expert assessment of the medical needs of the Medicaid beneficiary, but was based on a general policy determination of how much

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121. 836 F. Supp. 694 (D. Ariz. 1993). This case has been extremely influential in other courts' decisions as to whether due process protections apply to decisions made by medical providers to whom the state has delegated the responsibility for determining Medicaid and Medicare coverage. It is cited in nearly every case discussed below.

122. *Id.* at 697.
123. *Id.* at 698.
124. *Id.*
125. *Id.* at 697.
126. *Id.*
127. *Id.* at 697-99.
128. *Id.* at 700.
129. *Id.* 698-99.
130. *Id.* at 699. “It is patently unreasonable to presume that Congress would permit a state to disclaim federal responsibilities by contracting away its obligations to a private entity.” *Id.*
131. *Id.* at 698-700.
Due Process and Managed Care

Due Process and Managed Care

Due process would be provided to Medicaid beneficiaries as a group. Thus, the determination more closely resembled a pure coverage decision than the decisions at issue in Blum. The court explained that "certain duties are non-delegable" as a matter of law. Medicaid coverage decisions, even when delegated to private parties, remain the responsibility of the delegating agency. The attendant due process requirements follow the coverage decision, regardless of what entity actually makes the decision.

Similarly, in Catanzano v. Dowling, the state delegated the decision whether to provide Medicaid-covered home health care to home health care agencies. The agencies were required to review the home health care prescription of the treating physicians in order to determine whether or not the care was medically necessary and whether the home care was cost effective. Again, the state and the home health care agencies argued that the agencies were merely "private entities that make only independent professional judgments regarding the care that each patient requires and therefore that no fair hearing rights are triggered by their determinations." The court focused on the fact that the determinations made by the home health agencies were not based on "independent professional judgment," but on Medicaid standards, statutes and regulations. The home health agencies' analysis of the cost effectiveness of treatment (not part of traditional medical treatment decision making, nor within medical providers' field of professional expertise) clearly indicated that the decision being made was not purely a treatment decision, but was also a Medicaid coverage decision.

The first (and so far, the only) case addressing the issue of the interconnection of Medicaid treatment and coverage decisions in the context of Medicaid managed care is Daniels v. Wadley. Here, the state

132. Id. at 699.
133. Id. at 698; Grijafka v. Shalala, 152 F.3d 1115, 1121 (1998), rev'd and remanded 119 S. Ct. 1573 (1990), rev'd and remanded, 185 F.3d 1075 (9th Cir. 1999).
134. 60 F.3d 113 (2d Cir. 1995).
135. Id. at 119.
136. Id. at 115.
137. Id. at 118.
138. Id. at 119.
139. 926 F. Supp. 1305 (M.D. Tenn. 1996), vacated in part by Daniels v. Menke, 145 F.3d 1330 (6th Cir. 1998) (holding that lower court could have reached the same result without having to reach the issue of state action and vacating constitution decision on grounds of judicial economy).
contracted with MCOs to provide covered treatment to Medicaid beneficiaries. The court found that the MCOs had taken on the role of the state in determining Medicaid coverage, and that therefore the MCO determinations were subject to the requirements of due process.

The MCO determinations failed to meet these due process requirements in two respects: 1) the lack of pre-termination notice and hearing rights, and, more importantly, 2) the lack of an unbiased decision maker. The MCOs' determinations as to whether care was covered by Medicaid were inherently violative of due process because "Managed Care Organizations ('MCOs') have financial incentives to deny enrollees health care even when such health care is medically appropriate." Such decision-making violates the beneficiaries' rights because due process cannot be provided by a decision maker who has "a 'direct, personal, substantial pecuniary interest' in the ruling against one party in the action. In the current action the MCOs have a direct and substantial pecuniary interest in denying or delaying costly services for which the MCOs must pay." In order to comply with due process requirements, the beneficiary must be provided with a termination notice and MCO coverage/treatment determinations must be appealable to an unbiased decision maker.

These cases indicate that due process requirements apply to treatment/coverage determinations made by Medicaid MCOs. The same notice and hearing rights outlined in federal regulations for traditional Medicaid must be provided in Medicaid managed care. The crucial question is whether it is possible, even in theory, for managed care to provide these due process rights in every decision in which they are constitutionally required.

3. Due process in Medicare Benefits Provided Through Private Entities

The first case to address Medicare due process rights in situations where coverage decisions are made by entities other than Medicare

140. Daniels v. Wadley, 926 F. Supp. at 1307
141. Id. at 1311-12. This portion of the opinion was vacated by the subsequent holding. See Daniels v. Menke, 145 F.3d 1330 (6th Cir. 1998).
142. Daniels v. Wadley, 926 F. Supp. at 1312-13. This portion of the opinion was vacated by the subsequent holding. Daniels v. Menke, 145 F.3d 1330 (6th Cir. 1998).
144. Id. at 1313.
carriers or intermediaries was *Kraemer v. Heckler*. Kraemer dealt with hospital and nursing home Utilization Review Committees' (URCs') decisions to discharge Medicare beneficiaries from care. The Medicare statute required hospitals and nursing homes to create URCs to periodically review the medical necessity of care for each beneficiary. A URC's decision that care was no longer medically necessary, terminating Medicare coverage, generally was binding upon the Medicare fiscal intermediary, while a decision to continue coverage was subject to independent review by the Medicare entity. However, beneficiaries received neither notice of the URC decision process nor an opportunity to present evidence or arguments during the process.

The Second Circuit reversed the lower court's summary judgment decision that URC decisions are not subject to due process. The court noted the extent to which URC procedures and standards are defined by the Medicare statute and regulations. URC decisions look more like Medicare coverage decisions, based on Medicare statutes, regulations and policies, than like medical treatment decisions made according to objective medical standards. The court also noted the incentives placed on medical providers in the URC process to deny Medicare coverage.

Next, the court applied the *Mathews* due process test to the procedures

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145. 737 F.2d 214 (2d Cir. 1984).
146. *Id.* at 216.
147. *Id.*
148. *Id.*
149. *Id.*
150. *Id.* at 218-19. A determination as to the applicability of due process to URC decisions was specifically reserved in *Blum*, because a consent decree entered into by the parties with regard to such decisions had settled that issue in the case. *Blum v. Yaretsky*, 457 U.S. 991, 1007 n.17 (1982).
152. *Id.* at 220.
153. *Id.* at 221-22. Medicare rules, known as "waiver of liability" rules, provide that if more than 5% (for nursing homes) or 2.5% (for hospitals) of a medical provider's URC decisions to continue Medicare coverage are ultimately reversed, the provider becomes financially responsible for all care provided which proves to be not covered by Medicare. If the error rate of the URC is below the applicable threshold, Medicare pays for the care provided in error by the medical provider. Erroneous decisions to terminate Medicare coverage are generally not figured into the error rate. Thus, the URC is under a direct incentive to deny Medicare coverage in any case where eligibility is not obvious.
at issue in the case.\textsuperscript{154} The court indicated that when the benefits at issue may determine the ability of the beneficiary to obtain needed medical treatment, the private interests are far greater than the disability benefits interest in \textit{Mathews}.\textsuperscript{155} Because of the extremely high cost of medical care, denial of coverage will frequently mean denial of access to care.\textsuperscript{156} The court further doubted that URC coverage decisions based on Medicare statutes, regulations and policies provided the degree of fairness and reliability in the initial decision making process found in \textit{Mathews}.\textsuperscript{157} Finally, the court found that the complete absence of notice, explanation and the chance to be heard in the URC process clearly distinguished the case from the situation in \textit{Mathews}, such that a pre-termination notice and right to be heard might be applicable.\textsuperscript{158}

This possibility was adopted several years later in \textit{Grijalva v. Shalala}.\textsuperscript{159} \textit{Grijalva} was the first case to address directly the issue of due process requirements in the context of Medicare managed care. Both the federal district court and the Ninth Circuit Court of Appeals found that Medicare HMO coverage decisions are subject to constitutional due process requirements.\textsuperscript{160} The district court pointed out that "[i]n risk based managed care, the HMO performs two functions: direct provider of medical care and insurer. In the fee-for-service system, separate entities perform these functions: medical providers, i.e., doctors, and insurance companies. This case questions the performance of the latter function by private provider HMOs."\textsuperscript{161} The Ninth Circuit agreed that the crucial issue which distinguished \textit{Grijalva} from the \textit{Blum} case was that "[t]he decisions in the case at hand are more accurately described as coverage decisions – interpretations of the Medicare statute – rather than merely medical judgments."\textsuperscript{162} In other words, when private entities make decisions which determine Medicare coverage, they are subject to the requirements of due process, even though such requirements would not apply to purely medical treatment decisions made by the same entities.

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154. \textit{Id.} at 222.
155. \textit{Id.}
156. \textit{Id.}
157. \textit{Kraemer}, 737 F.2d at 222.
158. \textit{Id.}
160. \textit{Grijalva}, 152 F.3d at 1121.
162. \textit{Grijalva}, 152 F.3d at 1120.
The courts in the Grijalva decisions also addressed the issue of what specific notice and appeal rights must be provided by Medicare HMOs. Since Medicare beneficiaries' benefits and due process rights are not reduced simply because the benefits are provided by a Medicare HMO, rather than a fee-for-service medical provider, the same degree of due process protection must be provided to Medicare HMO enrollees as to Medicare beneficiaries in fee-for-service plans. Federal statutes indicate that hearing rights must be extended to any beneficiary "who is dissatisfied by reason of his failure to receive any health service to which he believes he is entitled ..." This triggering condition for when an individual is entitled to a hearing is extremely broad. Whenever a Medicare beneficiary believes that coverage for medical care has been improperly denied, he or she is entitled to a hearing.

Both the district court and the Ninth Circuit reviewed the Mathews factors and concluded that: 1) the individual interest at stake was significantly greater than in Mathews; 2) the notice and hearing rights provided by Medicare HMOs failed to comply with statutory requirements and failed to provide assurance that the decision making process was reliable; and 3) there was no undue burden placed on the government by requiring Medicare HMOs to comply with the due process requirements already detailed in the Medicare statute. The court required that Medicare HMOs provide timely notice for each and every denial of coverage. The Ninth Circuit, upholding the district court, required that Medicare HMOs provide timely notice for each and every denial of coverage. The district court required Medicare HMOs to

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163. Id. at 1123 ("... the Eldridge factors point to a need for additional procedural protections for Medicare beneficiaries in HMO's ...")


165. 42 U.S.C. § 1395mm(B) (1995). The right to a full hearing is limited to cases in which the amount in controversy is $100 or more. See 42 C.F.R. § 405.701. However, in Gray Panthers v. Schweiker, 652 F.2d 146, 158-59 (D.C. Cir. 1980), the court found that some kind of in-person hearing must be provided even in cases with smaller amounts in controversy.

166. Grijalva v. Shalala, 152 F.3d 1115, 1121-28 (9th Cir. 1998), rev'd and remanded, 119 S. Ct. 1573 (1999), rev'd and remanded, 185 F.3d 1075 (9th Cir. 1999); see also 42 C.F.R. § 417.600(a).

167. Grijalva, 152 F.3d at 1121.

168. Id.

169. Id. The notice must include information about the reason for the denial, a description of appeal and hearing rights, and information regarding how to obtain evidence to challenge the denial. Id.
provide expedited hearings when acute care was at issue, including, under some circumstances, pre-termination hearings.170

4. Recent Developments in Due Process Analysis—American Manufacturers Mutual Insurance Co. v. Sullivan171

The Supreme Court has yet to address directly the issues raised by managed care in Medicaid and Medicare. The first of the cases raising these issues to reach the Court, Grijalva, was reversed and remanded for reconsideration in light of its decision in American Manufacturers Mutual Ins. Co. v. Sullivan.172 The American Manufacturers decision indicates a possible new direction which the Court may pursue in analyzing when due process is required in decisions affecting Medicaid and Medicare entitlements. Moving in such a direction would be a serious error.

In American Manufacturers, claimants asserted that a change in state workers' compensation regulations violated their due process rights.173 The new regulations permitted an insurer to suspend payment of workers' compensation benefits while an appeal was pending to determine the reasonableness and necessity of a treating doctor's prescription of medical treatment.174 The Court found that there was no entitlement to worker's compensation benefits, until after the treating doctor's prescription was confirmed on appeal.175 Since there was no entitlement, the worker had no property interest in such coverage; therefore, no due process protections were constitutionally required.176

As discussed above, government entitlements have long been recognized as property rights, requiring due process protection.177 However, the Court's decision in American Manufacturers appears to suggest a novel and revolutionary conception of what constitutes an

172. Id. at 48.
173. Id. at 45-46.
174. Id. at 60-61.
175. Id.
176. Id.
177. Goss v. Lopez, 419 U.S. 565, 572-73 (1975). “Protected interests in property are normally 'not created by the Constitution. Rather, they are created and their dimensions are defined' by an independent source such as state statutes or rules entitling the citizen to certain benefits.” Id. (quoting Bd. of Regents v. Roth, 408 U.S. 564, 577 (1972)).
According to this reasoning, no entitlement, and therefore no property interest, exists until a determination has been made that the individual is entitled to the specific benefit sought. Therefore, the requirements of due process cannot apply to the entitlement determination itself, since the property interest does not arise until after that determination has been made in the individual’s favor.

If this reasoning is followed to its logical conclusion, it is hard to see when due process protections could apply in any entitlement context. The American Manufacturers decision distinguished cases such as Goldberg and Mathews by pointing out that in those cases, the eligibility for benefits had already been established, and the issue was whether or not current benefits could be terminated. However, an individual is only entitled to receive any government benefit so long as he or she continues to meet the eligibility criteria required by statute. The mere fact that a person was eligible in the past does not entitle that person to current or future benefits. The application of American Manufacturers reasoning would appear to indicate that, once the government found that an individual’s eligibility to receive the benefits had ended, the individual would have no property interest in the benefits. Therefore, the individual would have no due process rights in their termination, until it had been determined that the individual continued to be eligible (a determination that might never be made, considering that the individual would have no due process right to notice and a hearing regarding their eligibility).

The implications of the American Manufacturers argument are profound. In that case, the Court did not find that the due process rights of the individuals were adequately protected by the existing legal procedures. Instead, the Court held that those individuals were not entitled to any due process at all with regard to unemployment benefits, until their eligibility for the particular benefit claimed had already been established. The crucial question is: When does a claim to receive

178. See Am. Mfrs. Mutual Ins. Co. v. Sullivan, 526 U.S. 40, 59-60 (1999). [A]n employee is not entitled to payment for all medical treatment once the employer’s initial liability is established.... Instead, the law expressly limits an employee’s entitlement to ‘reasonable’ and ‘necessary’ medical treatment, and requires that disputes over the reasonableness and necessity of particular treatment must be resolved before an employer’s obligation to pay – and an employee’s entitlement to benefits – arise. Id. at 60.

179. Id.

180. The Court presumably did not intend to go so far. The Court made the
government benefits become an entitlement requiring due process? According to American Manufacturers, the physician's medical treatment prescription does not establish the reasonableness and necessity of that treatment to a degree of certainty required to make the payment for that treatment an entitlement.\textsuperscript{181} This determination can only be made upon appeal.\textsuperscript{182} Only then, according to the Court, do the requirements of due process come into play.\textsuperscript{183} Accordingly, no due process scrutiny may be applied to any of the procedures for determining eligibility prior to that point. The Court permits the government to set a higher standard of proof of eligibility which the individual must meet before due process comes into play. It is not apparent from the American Manufacturers decision that there is any limit to where this initial standard may be set.\textsuperscript{184}

The American Manufacturers decision becomes more notable when examined against the backdrop of prior due process cases. In other cases concerning entitlements, the courts have looked to the reasonable expectations of individuals, to establish whether or not a particular claim had become an "entitlement" triggering due process protection.\textsuperscript{185} While

\begin{itemize}
\item \textsuperscript{181} Id. at 60 n.13.
\item \textsuperscript{182} Id. at 60.
\item \textsuperscript{183} "[D]isputes over the reasonableness and necessity of particular treatment must be resolved before an employer's obligation to pay – and an employee's entitlement to benefits – arise."
\item \textsuperscript{184} After the original appeal, there were other levels of review as to whether an individual was eligible for payment for a particular medical treatment. Why could the government not establish that the entitlement does not come into being until all administrative review, or indeed, all judicial review, is completed? Only then would all "disputes over the reasonableness and necessity of particular treatment . . . be resolved."
\item \textsuperscript{185} See Goldberg v. Kelly, 397 U.S. 254, 253 n.8 (1970). "Much of the existing wealth in this country takes the form of rights which do not fall within traditional common-law concepts of property . . . 'Such sources of security . . . are
there is, of course, an ineluctable element of circularity in such a standard (an expectation of receiving a benefit is "reasonable" when the individual is entitled to receive the benefit), the factual inquiry is a familiar one. What do most people expect under similar circumstances? For what reasons do they expect it? Are such expectations generally borne out? Do we wish, as a matter of policy, to encourage such expectations? This traditional standard, if it were applied in the cases involving due process rights in medical treatment, would focus the inquiry where it belongs.

Do people generally rely on their doctors' prescription of treatment as proof that the treatment is reasonable and necessary? Is such prescription in itself a good measure of medical reasonableness and necessity? What might make a doctor's prescription of treatment questionable as a measure of medical reasonableness and necessity? Is the doctor's prescription generally accepted in other contexts as establishing the reasonableness and necessity of treatment? Do we want, as a matter of public policy, people to be able to rely on their doctors' treatment prescriptions?

American Manufacturers attempts to return due process jurisprudence to the pre-Goldberg era, when the government was free to extend or restrict entitlement benefits arbitrarily, without being subject to due process requirements. These benefits are created by the government. Absent the government's creation of the entitlement, individuals would have no right to receive such benefits and no property interest in them. Due process requirements would therefore not apply when an individual is denied such benefits. It is clear that legislative bodies can constitutionally modify or eliminate entitlement systems, and can change the requirements for eligibility. However, prior to American Manufacturers, it had long been understood that the government's ability to modify entitlements by restricting procedural notice and hearing rights was strictly limited by the constraints of due process. 186 Once a beneficiary showed a prima facie basis for eligibility under the applicable

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entitlement rules, the entitlement was established, and due process protections attached.\textsuperscript{187} If governments can limit entitlement benefits by limiting when due process protections apply, it is unclear what role the courts have to play in enforcing due process in any entitlement eligibility process.

\textbf{B. The Treatment Decision and the Coverage Decision}

The essential distinction which has run through this analysis of the requirements of due process in Medicaid and Medicare is the distinction between the treatment decision and the coverage decision. The treatment decision was traditionally made by a medical professional, in the unfettered exercise of her/his professional judgment. That decision did not turn on interpretation of legal definitions or eligibility rules, but on objective, scientific standards of proper medical treatment. The medical professional was not subject to systematic incentives to decide to forego providing medical treatment.\textsuperscript{188} Accordingly, the doctor-patient relationship was essentially closed, with duties and obligations flowing between the two, unaffected by outside parties.

By contrast, the coverage decision in Medicaid and Medicare was traditionally made by a bureaucrat, trained in the interpretation and application of complex statutory and regulatory rules and standards.\textsuperscript{189} The initial decision maker's interpretation of these statutes and rules was subject to reconsideration by higher level decision makers and, ultimately, to judicial review.\textsuperscript{190} While individual decision makers were not subject to personal incentives to deny coverage, the system of decision making included mechanisms intended to limit program costs. The decision maker had responsibilities to the program, as well as to the beneficiary.

It has long been established that constitutional due process requirements that apply to the coverage decision are inapplicable to the medical treatment decision.\textsuperscript{191} So long as those two decisions were clearly distinguishable, the requirements of due process were fairly straightforward. It is when the distinction between the treatment decision and the coverage decision has broken down, such that the two decisions

\begin{itemize}
\item \textsuperscript{187} See, e.g., \textit{Goldberg}, 397 U.S. at 261-62 ("Appellant does not contend that procedural due process is not applicable to the termination of welfare benefits. Such benefits are a matter of statutory entitlement to those qualified to receive them.").
\item \textsuperscript{188} Orentlicher, supra note 11, at 158.
\item \textsuperscript{189} 42 C.F.R. §§ 431.10(c); 405.702, 405.801 (1999).
\item \textsuperscript{190} §§ 405.720, 405.730, 431.205.
\item \textsuperscript{191} Blum v. Yaretsky, 457 U.S. 991, 1003-05 (1982).
\end{itemize}
are made at the same time, and/or by the same decision maker, that the requirements of due process in this context become confused and unclear.

By focusing on this distinction, it is possible to make sense of the due process jurisprudence which has developed in the Medicaid and Medicare context, and to determine the constitutional implications of managed care in these programs. The Medicaid/Medicare coverage decisions deal with a constitutionally protected right, the property right of an eligible beneficiary to receive covered benefits in an entitlement program. Decisions that deal only with whether or not a particular patient should receive a particular medical treatment do not directly implicate constitutionally protected rights. By examining when decisions relating to medical treatment also affect constitutionally protected rights, we can determine when such decisions are subject to due process requirements.

In Goldberg and Mathews, constitutional rights were undisputedly at stake in the eligibility decision, and due process was required in the decision making process. The degree of due process protection required depended in part on the degree to which the decision at issue was seen to be mainly a coverage decision or mainly a treatment decision. In other cases involving medical treatment decisions in non-Medicaid/Medicare contexts, due process is required when constitutional rights are at stake, such as the liberty interest in not being committed to a mental hospital, or the right not to be subjected to cruel and unusual punishment through deprivation of adequate medical care in prison.

192. It is for this reason that the analysis offered here is not applicable to cases involving managed care for privately insured individuals. Due process is not implicated because no constitutional right is at stake. Traditionally, treatment decisions were also presumed to be more reliable and less subject to error or bias than coverage decisions. Managed care has dramatically changed this presumption, leading to much of the current policy debate and litigation regarding privately insured patients' rights to challenge managed care treatment/coverage decisions. Discussion of these issues in the context of private insurance is beyond the scope of this article.

193. Mathews v. Eldridge, 424 U.S. 319, 322 (1976). "[T]he decision whether to discontinue disability benefits will turn, in most cases, upon 'routine, standard, and unbiased medical reports by physician specialists,' concerning a subject whom they have personally examined." Id. (quoting Richardson v. Perales, 402 U.S. 389, 404 (1971)).

In *Blum*, the Court erred when it failed to acknowledge that all coverage decisions are subject to due process protections even when the coverage decision is merged with a treatment decision. The merger of the two decisions does not deprive affected individuals of their constitutional right to due process protections in the coverage decision. Rather than the treatment decision immunizing the coverage decision from due process requirements, the coverage decision infects the treatment decision with constitutional considerations.

Lower courts have recognized that the merger of the treatment and coverage decisions required that due process protections be extended to the merged decision.95 *Grijalva* is the only case in which a court has specifically identified the merging of the treatment decision with the coverage decision as giving rise to due process rights in the decision-making process,96 although other cases and commentators have implicitly recognized the importance of this integration of different decisions.97

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97. See, e.g., *Catanzano*, 60 F.3d at 119. “[T]he URC’s decision did not resemble an independent professional judgment, because the record indicated that the judgement was ‘governed largely by statute, regulation, [federal government] manuals, and transmittal letters.’” *Id.* (citing *Kraemer*, 737 F.2d at 220); see also *Herdrich v. Pegram*, 154 F.3d 362, 372 (7th Cir. 1998), rev’d ___ U.S. ___, 120 S. Ct. 2143 (2000).

The Plan dictated that the very same HMO administrators vested with the authority to determine whether health care claims would be paid, and the type, nature, and duration of care to be given, were those physicians who became eligible to receive year-end bonuses as a result of cost-savings. *Id.*

The Supreme Court decision in *Pegram* re-emphasized the integration of the treatment and coverage decisions, although it reversed the lower court’s conclusions as to the effect of such integration on the application of ERISA to managed care. Constitutional rights, and due process requirements, were not at stake in that case. *See also* Marc. A. Rodwin, *Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System*, 21 AM. J.L. & MED. 241, 253-54 (1995).
For these reasons, to the extent that managed care conflates the treatment and coverage decision by allowing the initial coverage decision to be made by the medical provider, managed care in the Medicaid and Medicare context subjects the treatment decision to statutory and constitutional due process requirements. Even if Congress were to amend the notice and hearing rights currently required by statutes and regulations for Medicaid and Medicare denials and terminations, the Constitution imposes a minimum due process standard on Medicaid and Medicare coverage decisions. In order for managed care to pass constitutional scrutiny in the Medicaid and Medicare context, each combined coverage/treatment decision must meet the minimum constitutional standard.

C. The Requirement of the Unbiased Decision Maker

The most basic requirement of procedural due process under the Fifth and Fourteenth Amendments is that of an unbiased decision maker.\footnote{198. See Goldberg v. Kelly, 397 U.S. 254, 271 (1970) ("[O]f course, an impartial decision maker is essential."); Tumey v. State of Ohio, 273 U.S. 510, 523 (1927) ("[I]t certainly violates the Fourteenth Amendment . . . to subject . . . liberty or property to the judgment of a court, the judge of which has a direct, personal, substantial pecuniary interest in reaching a conclusion against him in his case.").} No matter what other procedural protections may exist, a determination cannot meet the minimum requirements of fairness if the decision is made by someone who has a financial stake in the outcome.\footnote{199. In considering and denying a due process challenge to Medicare Part B carrier hearings, the Court indicated that, while due process required that the carrier hearing officer be unbiased and impartial, neither the carriers nor their hearing officers failed to meet that requirement, because neither had any pecuniary interest in denying coverage. See Schweiker v. McClure, 456 U.S. 188, 196 (1982). Clearly, if the decision maker in Schweiker had had such an interest, the decision making process would have violated the due process requirement of an unbiased decision maker.} The complex systems of notice and appeal rights which have been developed through Medicaid and Medicare statutes and rules are not constitutionally mandated in their entireties. Congress can modify the notice and hearing rights to which Medicaid and Medicare beneficiaries are entitled, within the due process constraints imposed by the Fifth and Fourteenth Amendments. Modifications or limitations on those rights have been proposed as a way to make due process requirements less burdensome in
the managed care context. However, no notice and hearing system can pass constitutional muster if the minimum requirements of due process, including the requirement of an unbiased decision maker, are not met.

Medical providers in traditional fee-for-service medical practice had no financial incentive to deny medical treatment to patients. Rather, providers gained financially from prescribing treatment. This financial incentive to treat resulted in concerns that the providers’ decisions authorizing treatment were affected by the providers’ financial interest and were not simply objective exercises of medical expertise. Because of this feared bias in favor of prescribing more care than necessary, many Medicaid and Medicare entities created procedural systems to review medical providers’ treatment decisions in order to correct for this potential bias. Essentially, additional procedural protections were added to protect the government programs from the unfairness of doctors’ financial biases in treatment decisions and to reduce the cost of care.


201. See Emanuel & Goldman, supra note 200, at 637-38.

Conflicts of interest by commission occur when physicians have a financial or other incentive to provide more care than is appropriate. Conflicts of interest by commission are inherent in the fee-for-service system of reimbursement. Conflicts of interest by omission occur when physicians receive payments or some other benefit to provide less care than is appropriate. Conflicts of interest by omission are inherent in capitated health systems. Id.


203. Managed care in theory reduces the costs of providing medical care by avoiding unnecessary treatments, tests, and institutionalizations, seeking more cost-effective forms of care, providing preventative care, thereby reducing the need to treat more costly illness, and by using market power to reduce payments to providers. Managed care can also reduce the cost of medical care for Medicaid and Medicare beneficiaries by denying necessary covered care in violation of the rights of those beneficiaries. Failing to provide constitutionally mandated due process to Medicaid and Medicare beneficiaries results in a decline in the amount of care provided to such beneficiaries, as well as a decline in the administrative costs of the programs (notices, appeals, hearings, etc.). The procedural requirements of due process in Medicaid and Medicare in themselves cost money, just as in any other context. In addition, given the frequent lack of alternative means to pay for medical services, and the possibly fatal consequences of non-
With the advent of managed care, these financial incentives affecting medical providers' treatment decisions were reversed. Most MCOs receipt, denial of due process saves money not only intrinsically, but also by serving as an invisible reduction in health care. The actual effect of managed care on the cost to the federal government of insuring Medicare beneficiaries is unclear. It is estimated that health care costs are 11% less for Medicare managed care enrollees than for fee-for-service beneficiaries, controlling for the health status of the patient population. However, Medicare has paid MCOs approximately 5.7% more per enrollee than it would have paid had these individuals received the same care under a fee-for-service plan. See Oberlander, supra note 2, at 606. The discrepancy is due to excessively high Medicare capitation rates, resulting from biased selection of Medicare HMO enrollees. Medicare's adjusted average per capita cost (AAPC) risk adjustment system has been unable to successfully approximate the average cost of treating different populations of Medicare HMO enrollees. The cost of care for Medicare beneficiaries is distributed extremely unevenly: 10% of beneficiaries account for 70% of Medicare spending. Id. at 605. Medicare beneficiaries enrolled in HMOs have come from a disproportionately healthy segment of the Medicare population. Id. at 606-607. This biased selection of HMO enrollees is due in part to self-selection. Beneficiaries suffering from chronic health problems are less likely to enroll in a plan which will restrict their choice of health care providers, often requiring that they change doctors or depriving them of access to specialists. Id. Medicare HMOs also engage in activities collectively known as "cherry-picking," to ensure a biased selection of healthier-than-average enrollees. HMOs market selectively to healthier beneficiaries, through their advertising and through the kinds of coverage they offer (e.g., fitness programs rather than diabetes care). Id. HMOs also have an incentive to create barriers to utilization and to make appeal rights as ineffective as possible. So long as beneficiaries have the freedom to opt out of Medicare managed care and into fee-for-service at any time, they will not pursue a difficult and time-consuming appeals process. Rather, they will simply switch to fee-for-service if they become sick and encounter difficulties in receiving care.

204. Buchanan, supra note 2, at 619. A managed care organization combines health care insurance and the delivery of a broad range of integrated health care services for populations of plan enrollees, financing the services prospectively from a predicted, limited budget. At present the following cost-containment techniques are often identified with managed care: (1) payment limits (e.g., diagnosis-related groupings [DRGs] for Medicare hospital fees); (2) requirement of preauthorization for certain services (e.g., surgeries); (3) the use of primary care physicians as "gatekeepers" to control referral to specialists; (4) so-called "de-skilling" (using less highly trained providers for certain services than was customary during the pre-managed care, third-party fee-for-service era); and (5) financial incentives for physicians
(including those in which the vast majority of Medicaid and Medicare beneficiaries are enrolled) receive a fixed payment per enrollee per year, regardless of the amount of care provided to that enrollee. The MCO assumes the risk that the enrollee might require care that would exceed the capitated rate of compensation. The MCO profits to the extent that it provides care costing less than the capitation rate to an enrollee. MCOs require pre-authorization before they will pay for certain medical care. Accordingly, MCOs have a direct financial incentive to refuse authorization.

MCOs pass those incentives along to their contracting medical providers in various ways. Since physicians' treatment decisions are estimated to control approximately 75% of all health care spending, most attempts to limit spending have focused on influencing and/or controlling those decisions. Physicians providing care under contract with an MCO may be compensated fixed amounts for treating patients with specific diagnoses. If the provider can provide fewer days of care to a patient than expected for that patient's diagnosis, the provider pockets the

to limit utilization of care (e.g., year-end bonuses or holdbacks of payments that physicians receive only if they do not exceed specified utilization limits). In addition, managed care increasingly employs data from outcome (efficacy) studies to develop practice guidelines and for the ongoing assessment and refinement of diagnostic services and treatment services. Id.


206. Id.

207. Daniels v. Wadley, 926 F. Supp. 1305, 1308 (M.D. Tenn. 1996). "MCOs make a profit to the extent that their total income in flat fees exceeds the amount that the MCO pays . . . for treating sick enrollees." Id.

208. Buchanan, supra note 2, at 619.

209. A July 1997 study in the Journal of the American Medical Association indicated that, while 79% of doctors in fee-for-service practice felt that they were able to treat patients according to their best judgment, only 51% of doctors in managed care organizations felt the same. See Kerr et al., Primary Care Physicians' Satisfaction with Quality of Care in California Capitated Medical Groups, 278 JAMA 308 (1997).

210. See generally Emanuel & Goldman, supra note 200.

211. See, e.g., 42 C.F.R. § 412.60 et seq. (1999) (describing Medicare hospital Diagnostic Related Groups, or DRGs.) While Medicare DRGs are not always categorized under the rubric of managed care, they present a similar attempt to limit health care costs by shifting the risk of "excessive" care to the health care provider.
additional profit.\textsuperscript{212} If the patient receives more care than the fixed payment for that patient's condition, the provider loses money.\textsuperscript{213} Alternatively, physicians' compensation may be on a capitated basis, so that the doctors directly assume the risk of "excessive" care.\textsuperscript{214} The doctors may also be rewarded with financial incentives, such as bonuses for low utilization of medical care by a doctor's patients, or may be threatened with penalties for prescribing "excessive" care, including withholding of payments and "de-listing."\textsuperscript{215}

Primary care doctors act as "gatekeepers," whose approval must be obtained before patients can be referred to specialists.\textsuperscript{216} Plan doctors who provide too much care, who advocate for their patients to obtain care denied by the MCO, or who otherwise increase health care costs above the level established by the MCO, may be terminated from the MCO at will, depriving those doctors of access to their patient base.\textsuperscript{217} Given the market power of MCOs in the health care sector today, doctors who are de-listed may lose their livelihood.\textsuperscript{218}

Due to this complex arrangement of financial incentives for medical providers under managed care to reduce or deny care, medical providers' treatment decisions, traditionally assumed to be without personal bias and based purely on professional expertise,\textsuperscript{219} must be seen in a new light. The

\begin{itemize}
\item \textsuperscript{212} Id.
\item \textsuperscript{213} 42 C.F.R. § 412.42(a).
\item \textsuperscript{214} Orentlicher, supra note 11, at 155; M.R. Gold et al., \textit{A National Survey of the Arrangements Managed-Care Plans Make with Physicians}, 333 \textit{New Eng. J. Med.} 1678, 1680 (1995).
\item \textsuperscript{215} Over 60\% of MCOs withhold a percentage of participating physicians' salaries as a penalty for prescribing "excessive" care. Over 35\% of all MCOs give physicians bonuses as a reward for limiting care. Emanuel & Goldman, supra note 200, at 636-37; see also, Orentlicher, supra note 11, at 160.
\item \textsuperscript{216} John P. Little, \textit{Note, Managed Care Contracts of Adhesion: Terminating the Doctor-Patient Relationship and Endangering Patient Health}, 49 \textit{Rutgers L. Rev.} 1397, 1411 (1997).
\item \textsuperscript{217} See Kinney, supra note 200, at 156. "[MCOs] exercise considerable power over physicians because they directly control the supply of insured patients." Id.
\item \textsuperscript{219} As the \textit{Blum} Court stated, in upholding the state Medicaid program's reliance on doctors' evaluations to determine Medicaid eligibility, "[t]here is no suggestion that those [medical] decisions were influenced in any degree by the State's obligation to adjust benefits in conformity with changes in the cost of
\end{itemize}
treatment/coverage decision is no longer based on the unbiased exercise of professional judgment, but is potentially based in part on considerations of personal financial benefit. Under managed care, frequently the MCO, directly or indirectly, makes the decisions as to whether care will be provided.\textsuperscript{220}

Not only are MCOs subject to direct financial incentives to deny care, they have also had considerable success in avoiding tort liability damages resulting from negligent decision making by asserting that their affiliated medical providers are independent contractors.\textsuperscript{221} In addition to the independent contractor shield, MCOs have argued that they should not be held liable in tort for treatment decisions because the Medicaid and Medicare statutes and regulations pre-empt state court jurisdiction and remedies.\textsuperscript{222} Thus, not only do MCOs have a financial incentive to deny care, they generally are not subject to the countervailing incentives to provide quality care traditionally provided by liability for medical malpractice. Substantial financial incentives influence both MCOs and their contracting medical providers to deny or fail to prescribe medical care. Because of this inherent bias, the determinations of MCOs and their providers present a serious “risk of erroneous deprivation”\textsuperscript{223} of Medicaid and Medicare benefits.


\textsuperscript{221} Liang, \textit{supra} note 218, at 51-56. At common law, employers could not be held liable for actions of independent contractors. “It is important that the actual decisionmakers involved in authorizing or denying health care benefits face liability.” \textit{Id.} at 80.

\textsuperscript{222} In the private managed care context, ERISA has proved a potent, though not impregnable, shield to MCO liability for coverage denials. \textit{See generally} Liang, \textit{supra} note 218. Discussion of the vexing issue of ERISA preemption in the private managed care context is beyond the scope of this article. While claims for Medicare benefits are preempted by the Medicare statute, requiring exhaustion of administrative remedies before judicial review may be sought, U.S. v. Erika, Inc., 456 U.S. 201 (1982); Heckler v. Ringer, 466 U.S. 602 (1984), other claims which are not “inextricably intertwined” with claims for benefits do not require such exhaustion. Bowen v. Michigan Academy of Family Physicians, 476 U.S. 667 (1986). In recent decisions, some courts have allowed publicly financed MCOs to be sued for medical malpractice in state court. Schlier v. Kaiser Foundation Health Plan, 876 F.2d 174 (D.C. Cir. 1988); Ardary v. Aetna Health Plans of California, 98 F.3d 496 (9th Cir. 1996); Wartenberg v. Aetna U.S. Healthcare, 2 F. Supp. 2d 273 (E.D.N.Y. 1998).

The issue of the biased managed care decision maker has been raised in many of the recent cases dealing with managed care issues.\textsuperscript{224} Courts have noted that
\begin{quote}
[d]ue process is not met when a claim dispute is resolved by an adjudicator who has a 'direct, personal, substantial pecuniary interest' in the [sic] ruling against one party in the action . . . .
\end{quote}
MCOs have a direct and substantial pecuniary interest in denying or delaying costly services for which MCOs must pay.\textsuperscript{225} Courts have also found that third-party treatment/coverage decision-making which deprives patients of the unbiased, independent medical judgment of their physician may result in medical malpractice liability of third-party insurer.\textsuperscript{226}

\begin{itemize}
\item \textsuperscript{224} Herdrich, 154 F.3d at 372; Daniels v. Wadley, 926 F. Supp. 1305, 1308 (M.D. Tenn. 1996), vacated in part by Daniels v. Menke, 145 F.3d 1330 (6th Cir. 1998).
\item \textsuperscript{225} Daniels v. Wadley, 926 F. Supp. at 1313 (citing Tumey v. State of Ohio, 273 U.S. 510, 523 (1927)) (additional citations omitted).
\item \textsuperscript{226} Wickline v. California, 239 Cal. Rptr. 810, 819 (Cal. Ct. App. 1986). One of the most serious consequences of managed care is that, by imposing incentives on doctors to deny treatment, it deprives the Medicaid/Medicare beneficiary of the assistance of the treating physician as an advocate within the coverage decision-making process. The formal due process system of notice and hearing places the burden of enforcing and protecting rights to receive covered treatment on the patient – someone who, in the Medicaid and Medicare context, is likely to be poor, elderly and/or disabled, and sick. This same objection applies to the many proposed reforms which seek to increase consumer information and market competition as a means of protecting the rights of managed care consumers. A complex procedural system is best suited to protecting the rights of the well-informed, the healthy and energetic, and those with the confidence to use the system to their advantage. To the extent that the individual must pursue and defend his or her rights in a complex, formal system without outside assistance, the most vulnerable individuals will receive the least protection. For such a system to provide effective protection to even the most vulnerable, these individuals must have access to the assistance of an advocate possessing the knowledge and experience needed to participate in the system.
\end{itemize}
For all of these reasons, minimum constitutional due process requires that Medicaid and Medicare beneficiaries be able to appeal each determination of medical coverage to an impartial entity outside the MCO incentive structure. Because MCOs and their medical providers determine Medicaid and Medicare coverage at the same time that they determine medical treatment, and because they are subject to systematic financial incentives to deny coverage and treatment, these decisions inherently violate constitutional due process.227 In all such decisions,

Little, supra note 216, at 1397.

Managed care deprives Medicaid and Medicare beneficiaries of their best potential advocate, one who is present in all health care decision-making, and is therefore, at least in theory, available to assist the beneficiary in all disputes. Under managed care, not only are sick and vulnerable beneficiaries deprived of this assistance in pursuing their rights to receive covered care, but the medical provider often opposes the beneficiary in the coverage dispute. Thus, the ability of the sick, the poor, the uneducated, and the frail elderly to make effective use of the formal due process system is substantially reduced under managed care.

227. If Medicaid or Medicare beneficiaries do request treatment from the MCO, or if the treating physician orders treatment, which is then denied by the MCO, then the obligation to give notice and extend hearing rights falls to the MCO itself. Most MCOs are for-profit businesses which primarily provide private health insurance. MCO employees have no necessary experience or familiarity with Medicaid and Medicare rules and statutes.

MCOs which come into Medicaid markets from private managed care settings may be used to dealing with enrollees in a much more peremptory fashion than is permitted in a public program . . . . Concepts of due process are alien to their experience, and to their expectations as to how managed care should operate. Bonneyman, supra note 98, at 4.

Few MCOs are accustomed to provide basic due process requirements such as notices of denial of coverage and impartial hearings to their private plan enrollees. As the district court found in Grijalva v. Shalala, 946 F. Supp. 747, 757-58 (D. Ariz. 1996), aff'd, 152 F.3d 1115 (9th Cir. 1998), rev'd and remanded, 119 S. Ct. 1573 (1999), rev'd and remanded, 185 F.3d 1075 (9th Cir. 1999), most notices issued by Medicare MCOs are illegible, fail to give specific reasons for the denial of services, fail to give accurate and complete information about appeal and hearing rights, and/or are otherwise legally inadequate. A large proportion of Medicaid and Medicare MCO enrollees are not effectively made aware of their appeal rights in adverse coverage decisions, or of how to pursue those rights.

The interest at stake in Medicaid and Medicare managed care is a most crucial one – it can be literally a matter of life and death. "[T]he private interest at stake [in receiving Medicare coverage of hospitalization] should be weighed more heavily than in Eldridge because of the astronomical nature of medical costs." Kraemer v. Heckler, 737 F.2d 214, 222 (2d Cir. 1984). "[T]he potential for irreparable damage is surely great when it comes to denial of medical services . . . . In many, if not most, cases, the denial of coverage may result in total failure to
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Medicaid and Medicare beneficiaries are entitled to immediate and effective notice of all decisions by medical providers to deny treatment/coverage, and to a prompt appeal to an unbiased decision maker.

V. THE CONSTITUTIONAL SIGNIFICANCE OF THE DECISION NOT TO TREAT

In the traditional fee-for-service context, the event which triggers notice and hearing rights is the government's denial of payment for a particular medical treatment. In Medicaid and Medicare managed care, the due process rights of beneficiaries are unchanged. However, in the

receive the services.” Grijalva v. Shalala, 152 F.3d 1115, 1122 (9th Cir. 1998), rev’d and remanded, 119 S. Ct. 1573 (1999), rev’d and remanded, 185 F.3d 1075 (9th Cir. 1999). Given the high cost of medical care, denial of coverage, in many cases, is equivalent to denial of medical care.

Mistakes or poor performance by MCOs can result in denials of needed medical care. In other words, in a managed care environment, what is at stake is no longer just money and the disposition of provider claims, but the actual lives and health of program beneficiaries. In such circumstances, due process becomes critically important as the chief means for beneficiaries to protect themselves from erroneous or improper denials of care. Bonneyman, supra note 98, at 1.

The wrongful denial of Medicaid or Medicare coverage will frequently inflict serious injury on the beneficiary, which may not be remediable. Irremediable injury is more likely for Medicaid and Medicare beneficiaries than for other health insurance enrollees because such a disproportionately high number of these beneficiaries are elderly and/or disabled. These groups tend to have more pressing health care needs than the general population.

The elderly require, on average, substantially more medical treatment than the younger, employed enrollees who have historically constituted the bulk of HMO memberships. It is therefore feared that HMO cost-containment strategies, such as reducing hospitalization and restricting access to specialists, will have especially adverse effects on health care for the elderly. Oberlander, supra note 2, at 604.

The effects of the denial of either Medicaid or Medicare benefits is like the effects of the denial of welfare benefits in Goldberg. “[T]ermination of aid pending resolution of a controversy over eligibility may deprive an eligible recipient of the very means by which to live while he waits.” Goldberg v. Kelly, 397 U.S. 254, 264 (1970). “Unlike Mathews, the deprivation suffered from an HMO denial to provide care cannot so easily be remedied by retroactive recoupment of benefits,” Grijalva, 152 F.2d at 1121 (quoting Grijalva, 946 F. Supp at 757).


229. Grijalva, 946 F. Supp at 753.
managed care context, it is often much less clear when an event occurs which should trigger due process notice and hearing rights. Medicaid MCO enrollees are entitled to hearing rights whenever a "claim for assistance is denied or not acted upon promptly."\textsuperscript{230} Medicare MCO enrollees have the right to a hearing when they are "dissatisfied because they do not receive health care services to which they believe they are entitled to, at no greater cost than they believe they are required to pay."\textsuperscript{231} The statutory language describing the triggering event for due process protections to arise is very broad and inclusive.

However, in the managed care context, the initial "denial" of a request for health care services comes most often not from an official in a Medicaid or Medicare agency, presumably versed in the statutes and rules governing those programs, but from a primary care physician.\textsuperscript{232} Health care coverage is "denied" by the doctor, who fails or refuses to order a test, prescribe a treatment, or make a referral to a specialist.\textsuperscript{233} Unless

\begin{itemize}
\item [\textsuperscript{T}]he Secretary of the Department of Health and Human Services\] has not referred this Court to, and this Court has not found, any provision in the Medicare statutes or regulations pertaining to HMOs, to suggest that beneficiaries of Medicare who are denied services by HMOs are entitled to any less procedural due process than beneficiaries who are denied fee-for-service coverage. \textit{Id.};

Daniels v. Wadley, 926 F. Supp. 1305, 1312-13 (M.D. Tenn. 1996). "[\textsuperscript{T}]he state Medicaid managed care program violate[s] the Fourteenth Amendment's procedural due process requirements when they deprive enrollees of benefits prior to a hearing in which the Medicaid Act would require continuation of benefits pending a fair hearing." \textit{Id.}

\textsuperscript{230} 42 C.F.R. § 431.200 (1999).

\textsuperscript{231} § 417.600(a)(2)(ii).

\textsuperscript{232} Eleanor D. Kinney, \textit{Consumer Grievances and Appeal Procedures in Managed Care Plans}, 10 (3) \textit{HEALTH LAW}. 17, 19-20 (1998). "In a managed care plan, the crucial action defining the appealable event becomes the clinical decision of the physician regarding the amount, duration and scope of services provided to the patient." \textit{Id.}

\textsuperscript{233} "Denial" is treated here as something of a misnomer, since the physician with an incentive to minimize treatment may effectively "deny" treatment by failing to tell the Medicaid or Medicare beneficiary of the possibility of treatment. Laypersons cannot request treatment which they do not know exists. \textit{See id.} at 19.

\textsuperscript{[U]nder traditional payment arrangements in which payers paid for all services ordered unless specifically not covered, coverage disputes were generally clearly delineated. But now, many managed care plans impose financial or incentives on physicians not to order services, so the physician may simply determine not to provide a service to a patient, often without indicating that the service is ostensibly available in the arsenal of medical treatment modalities. The patient does not know that
there is an effective means for the beneficiary to register a request for treatment with the MCO when the treating physician fails or refuses to order the treatment, this "denial" of Medicaid or Medicare benefits will fail to trigger the legally required notice and hearing rights. 234

In order to make the due process protections guaranteed by the Constitution and statutes effective in protecting beneficiaries from unlawful deprivation of their rights, there must be a way to notify individuals each and every time those protections are triggered. Due to the seriousness of the need for medical care, the inability of most beneficiaries to pay the extremely high cost of care out of pocket, and the risk of irremediable harm due to delay in access to medical care, constitutional due process requires that Medicaid and Medicare beneficiaries receive immediate and effective notice of every denial of benefits and speedy review of all denials.

In fact, under the standards set out in Mathews and applied to managed care in Grijalva, such review should, in at least some circumstances, occur prior to the termination of benefits. 235 Therefore, MCOs or their participating medical care providers should be required to notify beneficiaries each and every time a treatment/coverage decision is made of the beneficiaries' right to appeal that decision. Under a managed care system, there is a substantial financial incentive to fail to give such notice, which requires some means of enforcing this notice requirement on MCOs and their medical providers.

This type of effective enforcement would require that an unbiased observer, with the medical expertise necessary to be able to determine what kind of medical treatment could be prescribed at each point in

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Managed care settings such as HMOs are less likely to produce coverage disputes, even though they are more likely to deny treatment, because coverage decisions are frequently made by treating physicians or by a medical director in the physician's practice group ... HMOs and other forms of managed care ... use corporate and financial incentives to motivate physicians not to make treatment recommendations in the first place. This absence of patient knowledge that potentially beneficial care is being foregone could easily account for the lack of coverage disputes arising from managed care settings. Id.

treatment, be continuously involved in the beneficiary's care, in order to ensure that at each decision, proper notice of alternatives not chosen by the care provider, and information about the right to appeal the provider's decision, could be provided to the beneficiary.

An examination of the kind of a system that would be required in order to meet the demands of due process in Medicaid and Medicare managed care clearly demonstrates the logical and practical impossibility of such a system. The number of medical treatment decisions made by a physician in the care of each patient is infinite. Even in theory, it is impossible to give Medicaid and Medicare beneficiaries notice and hearing rights for every treatment/coverage decision which excludes other potential treatments. Yet, every such decision involves a decision by the care provider to deny Medicaid or Medicare coverage for the treatments not chosen.

In order to provide effective notice for all coverage/treatment decisions, a system similar to the traditional fee-for-service system would have to be superimposed on the managed care system, with an impartial doctor observing all choices of the treating doctor and informing the patient of all potential treatment choices not prescribed. The resulting system would not be a managed care system as that term is currently understood. It would certainly not provide the cost savings which are the major justification for adoption of managed care in Medicaid and Medicare. Furthermore, a system where a third party is introduced into the doctor/patient relationship, to constantly warn and counsel the patient regarding the treatment prescriptions, or lack thereof, by the patient's own doctor, would be utterly destructive of the doctor/patient therapeutic relationship. For all of these reasons, no one advocates the creation of this kind of a hybrid of fee-for-service and managed care systems. Such a hybrid system is neither practicable nor desirable. However, absent such a system, there is no way even in theory to assure the due process mandated by the Constitution in every Medicaid/Medicare treatment/coverage decision.

236. See discussion of the therapeutic importance of this relationship in Little, supra note 216, at 1449-52.

237. The analysis in the Medicaid/Medicare context differs from that outlined by the Supreme Court in Pegram, 530 U.S. ___ (2000), 120 S. Ct. 2143 (2000). In that case, the Court dealt with the interpretation of a statute (ERISA) creating a scheme for regulating privately-provided health insurance benefits. The Court concluded that extending ERISA's definition of fiduciary duty to include the duty to make treatment/coverage decisions solely for the benefit of the covered person would completely eliminate for-profit HMOs. Id. at 2156. The Court did not
CONCLUSION

Medicaid and Medicare are entitlement programs, creating property rights for qualified beneficiaries to receive covered medical treatment. Under both the Fifth and Fourteenth Amendments of the U.S. Constitution, and under the detailed Medicaid and Medicare statutory and regulatory systems, beneficiaries are entitled to notice, hearing, and decision by an impartial decision maker when health care coverage is denied. These rights of Medicaid and Medicare beneficiaries are unaltered by the change from fee-for-service health care to managed care. Many critics of Medicaid and Medicare managed care have focused on how the system of due process protections has broken down and how beneficiaries’ rights have been violated as a result. Many suggestions have been made as to how such protections may be effectively reinstituted in a managed care regime. However, under managed care, constitutionally mandated due process protections cannot be provided at each point at which such protections are required.

Managed care, by its very nature, conflates the medical treatment decision with the Medicaid/Medicare coverage decision, and imposes financial incentives on the decision maker to deny coverage. Once the coverage decision is inextricably entwined with the treatment decision, all of the due process requirements attendant on the coverage decision are also imposed on the treatment decision. Aside from statutory and regulatory requirements, at an absolute minimum, the Constitution requires that the Medicaid/Medicare coverage/treatment decisions be made by an unbiased decision maker and be subject to basic notice and appeal requirements.

All treatment decisions have also become coverage decisions; therefore notice and hearing rights and an impartial decision maker must be provided for every care decision made by a treating physician, including believe that it could interpret the statute in a way which would so completely contradict Congress’ express intentions to promote the formation of HMOs. Id. at 2157. In the Medicaid/Medicare context, both the Supreme Court and Congress are constrained by the mandates of the Constitution. Congress’ desire to encourage MCO participation in health care entitlement programs cannot override constitutional due process requirements.


239. See, e.g., Jost, supra note 18, at 39; Gladieux, supra note 46, at 61; Emanuel & Goldman, supra note 200, at 636; Kinney, supra note 200, at 145.
all decisions not to prescribe a given treatment. The set of all decisions to prescribe or not to prescribe treatment is infinite. Any attempt to provide notice, hearing and access to an unbiased decision maker in all decisions would be logically impossible. If an attempt were made to provide due process rights in all such decisions, the resulting system would no longer be considered managed care as managed care is currently defined. Such a system would be excruciatingly expensive, destructive of the doctor/patient relationship, and both impracticable and undesirable.