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***359 UNSEEN PERIL:**

INADEQUATE ENROLLEE GRIEVANCE PROTECTIONS IN PUBLIC MANAGED CARE PROGRAMS

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• ***360** Katie was born with a rare heart and lung disease, and her oxygen levels are precarious. She has been rushed repeatedly to the hospital in respiratory distress. Until Katie's lungs become more developed, her life depends on the constant monitoring and adjustment of her oxygen and the immediate suctioning of her airways when they become obstructed. Her mother has learned to perform these tasks, but she cannot single-handedly care for Katie around the clock. Consequently, Katie's physician prescribed twelve hours of home nursing care daily.

Katie is covered by Medicaid, the nation's largest single health insurer of medically fragile children. Her state contracted with private companies to manage the care of its Medicaid beneficiaries.

During a routine file review of high-cost cases, Katie's Medicaid managed care organization (MCO) concluded that Katie's home nursing care was excessive and should be reduced to four hours per day, five days per week. This decision was communicated to the home health agency, whose staff nurse informed Katie's mother of the change the following day. The baby's nurses and physicians told the panicked mother that they disagreed with the MCO's decision, but there was nothing they could do.

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Katie's mother called the state Medicaid agency where, after being routed to several different divisions, she was told that she should file a grievance with the MCO. She then contacted the company, whose representative told her that he would send her a grievance form to complete and mail to the MCO. She was promised a decision within thirty days of receipt of the completed form. If still dissatisfied, she could then request review by the state Medicaid agency, which would render its decision within an additional sixty days. The MCO was confident that in the meantime, Katie would do just fine with the reduced hours of care. The company's representative assured Katie's mother that the grievance process complied with all applicable state and federal regulations.

On a Sunday night two weeks later, after staying awake for thirty hours continuously caring for the baby, Katie's mother dozed fitfully. She awoke to find her daughter in respiratory distress, already blue and unconscious. Katie was rushed to the hospital and she survived, but prolonged oxygen deprivation had caused severe, permanent brain injury.

I. INTRODUCTION

The rapid movement to managed health care in America profoundly alters the conditions affecting consumer access to medical treatment. [FN1] Fee-*361 for-service health insurance plans have traditionally limited their role to paying claims, and they have largely left decisions about patient care to providers and patients. [FN2] By contrast, managed care organizations (MCOs) assume important responsibilities for the actual control of patient

care. [FN3] Managed care patients typically are directed to providers selected by the MCO, and the plan's representative controls referrals for specialty care or high-cost treatments. Managed care also injects a new element of ambiguity into the sensitive doctor-patient relationship upon which most medical care is based: MCOs subject providers to deliberate, explicit pressure to adjust clinical practice to financial considerations. [FN4]

MCOs' broad responsibility for the management of patient care is especially daunting when the health plan's beneficiary population includes vulnerable individuals with heavy care needs. Managing the care of these patients can require significant case management resources in order to ensure coordination of services from an array of providers for a complex variety of conditions. [FN5] Missteps can have fatal consequences for the patient. [FN6]

Nowhere exists a greater concentration of these difficult-to-manage medical needs than in the nation's two largest publicly funded health care *362 programs, Medicare and Medicaid. [FN7] One in four Americans is enrolled in one or both of these programs. [FN8] Although both programs cover millions of healthy beneficiaries, Medicare and Medicaid are designed to include precisely those groups which private insurers avoid: the elderly, the disabled, the mentally impaired, pregnant women, medically fragile children, and people with AIDS. [FN9] Many beneficiaries face additional obstacles posed by limited education and/or cultural differences.

Because risk contracting creates incentives for MCOs to deny care, health policy experts generally agree that effective grievance and appeal procedures are essential for the protection of beneficiaries. [FN10] Grievance and appeal procedures enable beneficiaries to question denials of coverage or other perceived lapses in service and to obtain fair and timely review of their complaints. [FN11] The President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry has identified such safeguards as essential and has recommended that they be made available to consumers in all health care plans, regardless of whether the plans are public or private. [FN12]

The vulnerability of many Medicaid and Medicare beneficiaries makes the availability of effective due process mechanisms especially vital in those programs. Unfortunately, ill-considered government agency policy and lax industry practice have resulted in the establishment of Medicaid and Medicare appeal procedures that are both legally and operationally deficient. As this article will explain, those deficiencies not only imperil beneficiaries, but they expose program administrators and contractors to unforeseen risks of legal liability.

II. THE MEDICARE AND MEDICAID PROGRAMS

A. Medicare

Medicare was enacted in 1965 to provide health insurance for the elderly and was subsequently amended to extend coverage to disabled *363 workers. [FN13] With an annual budget of more than \$200 billion, [FN14] Medicare is now the single largest purchaser of health care in the United States. Medicare is based upon a social insurance model, [FN15] which means that a person's wealth or poverty does not affect eligibility. Eligibility is based instead on the individual's employment history or that of a relative within a legally prescribed degree of kinship. [FN16] Medicare is an exclusively federal program: states play no role in the funding or administration of Medicare, which operates as an adjunct to the federal Social Security pension system. [FN17]

Medicare provides two discrete packages of benefits, differing in how each is administered and funded. [FN18] Inpatient hospital and skilled nursing facility services are covered under Part A. [FN19] Payments are made from the Hospital Trust Fund, [FN20] created and continuously funded by payroll tax revenues. [FN21] Claim processing is contracted to private insurance contractors, known as fiscal intermediaries. [FN22]

Physicians and certain other outpatient providers are reimbursed under Part B of Medicare, which is financed by beneficiary premiums and general federal appropriations. [FN23] Unlike Part A, Part B benefits are available only to those who elect to pay the beneficiary premiums. [FN24] However, ninety- seven percent of all beneficiaries sign up for Part B. [FN25] Claims are processed by private insurance contractors that are similar to the intermediaries which handle Part A claims, except that Part B contractors are referred to as "carriers." [FN26]

***364 B. Medicaid**

The same 1965 legislation that established Medicare also created Medicaid. [FN27] Medicaid's purpose is to provide medical assistance to certain individuals "whose income and resources are insufficient to meet the costs of necessary medical services." [FN28] Thus, Medicaid was conceived as a public assistance program primarily for the poor, as contrasted with the social insurance model on which Medicare is based. [FN29] Medicaid is jointly funded and administered by the state and federal governments. [FN30] All states have elected to establish Medicaid programs for their residents, and the program now covers 37 million people nationwide with an annual state-federal budget of \$160 billion. [FN31]

Medicaid's vulnerable constituency spans the entire age spectrum, from premature infants to infirm elderly in nursing homes. [FN32] Nationally, children comprise nearly half of Medicaid's enrollment and of the program's adult beneficiaries, over half are elderly, blind, or disabled. [FN33] Eligibility is means-tested, which means that the program's beneficiaries are all poor or near-poor. [FN34]

Medicaid mandates that states cover a core package of health care benefits, with optional coverage for additional types of medical services. [FN35] Traditionally, Medicaid agencies have functioned largely as passive payers. Fee-for-service beneficiaries can, and must, arrange for their own

medical care. Inadequate access to care has been endemic to Medicaid throughout *365 the country since the program's inception. [FN36] However, beyond establishing minimally attractive rates for providers, traditional Medicaid programs have little direct responsibility for ensuring the adequacy of access to care for beneficiaries.

In addition, fee-for-service Medicaid programs fail to bear much responsibility for the quality of beneficiary care. The states fulfill several roles which indirectly implicate patient care: credentialing providers, reviewing utilization and controlling fraud, and enforcing nursing facility standards. However, these quality assurance functions have a systemic focus, and they do not imply responsibility to any particular individual beneficiary.

Despite their differences, Medicare and Medicaid share several important characteristics. Like Medicaid, many of Medicare's beneficiaries are quite vulnerable because Medicare covers disabled adults and people over the age of sixty-five. [FN37] Moreover, although eligibility does not depend on poverty, a disproportionately large number of Medicare beneficiaries are poor. [FN38] Nearly 6 million of Medicare's 37.7 million enrollees also qualify for Medicaid on the basis of their poverty. [FN39] Beneficiaries who qualify for both programs are often referred to as "dual eligibles." [FN40]

Both programs are moving from fee-for-service into risk-contracted managed care, [FN41] although the switch to managed care is occurring more rapidly in Medicaid than in Medicare. Managed care enrollment of Medicaid beneficiaries quadrupled between 1991 and 1996, and the rate of growth *366 accelerated over the period. [FN42] By 1996 over one-third of all Medicaid beneficiaries were enrolled in risk-contracted managed care plans, and almost every state was in the process of moving more of its beneficiaries into such plans. [FN43]

Medicare beneficiaries are also moving in increasing numbers from fee-for-service into managed care. Currently, thirteen percent of the

program's beneficiaries have elected to enroll in Medicare-approved health maintenance organizations (HMOs), which are a type of risk-contracted MCO. [FN44] This relatively small number masks the magnitude of change taking place, however. HMO enrollment has doubled since 1993; growth, which previously was limited to a small number of states, is beginning to occur across the country. [FN45] The Balanced Budget Act of 1997 [FN46] contains provisions designed to accelerate the conversion of both Medicare and Medicaid from fee-for-service to managed care. [FN47]

This conversion dramatically transforms both programs' traditional roles as passive purchasers of care. As each program restricts its beneficiaries' choices and takes over the management of their care, it assumes a much greater responsibility for the accessibility and quality of the medical services they receive. That responsibility is no longer limited to systemic quality assurance functions, but reaches all the way to the individual beneficiary. With these increased responsibilities come new sources of potential liability for plans and administrators.

III. DUE PROCESS PROTECTIONS IN FEE-FOR-SERVICE MEDICAID AND MEDICARE

Due process safeguards attendant to "adverse actions," including denial, delay, reduction, or termination of medical services, were developed for both Medicaid and Medicare beneficiaries more than a quarter century ago, when both programs operated exclusively on a fee-for-service basis. For both programs, seminal Supreme Court decisions have defined the constitutional framework of protections owed to beneficiaries. [FN48]

***367 A. The Metes and Bounds of Due Process: The Goldberg and Mathews Rulings**

In 1970 the Supreme Court ruled in *Goldberg v. Kelly* [FN49] that federal and state laws and regulations governing public assistance create a legal entitlement on behalf of any person who fits within the eligibility standards prescribed by law. [FN50] This legal entitlement was recognized as a species of "property," for which taking by government is constitutional only if it is in accordance with due process of law. [FN51]

The Supreme Court stressed the "'brutal need'" of recipients of public assistance: [FN52] such assistance "provides the means to obtain essential ... medical care ... [and] the very means by which to live." [FN53] Therefore, the Court reasoned that only a pre-termination hearing can afford such individuals timely and meaningful protection of their rights. [FN54]

The ruling elaborated the due process right by specifying a number of protections which must be accorded recipients. [FN55] These protections include written notice of a proposed adverse action, with a written statement of the reasons for the agency's intended action. [FN56] The notice must be "tailored to the capacities and circumstances" of the beneficiary. [FN57] The beneficiary must also be given an opportunity for an informal hearing before an impartial administrative decision-maker "'at a meaningful time and in a meaningful manner,'" [FN58] and the beneficiary may be represented by counsel. [FN59] The hearing must afford the appellant a chance to appear personally, to present evidence, and to confront and cross-examine adverse witnesses. [FN60] The final decision must include a written justification supporting the outcome. [FN61]

The type of public assistance at issue in *Goldberg* was Aid to Families with Dependent Children (AFDC). [FN62] Subsequent court decisions have applied the same reasoning to other means-tested programs, including *368 Medicaid. [FN63] Hearing requirements were imposed not only in cases in which eligibility was at risk, but also those in which state representatives attempted to reduce or deny coverage for particular medical treatments. [FN64]

In 1976 the Supreme Court revisited the due process question in the context of social insurance. [FN65] In Mathews v. Eldridge, [FN66] Social Security disability pensioners sought the same protection accorded recipients of public assistance in the Goldberg case. [FN67] Instead, the Mathews Court drew a distinction between means-tested programs such as AFDC and social insurance programs such as Social Security Disability Insurance. [FN68] The Court reasoned that Social Security benefits are not based on individual need and the temporary loss of those cash benefits does not, therefore, implicate a "brutal need." [FN69] In weighing what level of procedural protection should attend the denial of Social Security benefits, the Court considered three factors which have been cited frequently in subsequent due process rulings: the private interest at stake; the "risk of an erroneous deprivation"; and the probable value of additional or alternative procedural safeguards, as well as "the fiscal and administrative burdens" which such safeguards would entail. [FN70]

Applying those factors, the Mathews court concluded that due process is satisfied by affording the Social Security beneficiary a hearing after, rather than before, certain types of adverse actions are taken. [FN71] Moreover, affected individuals are entitled to only a limited hearing, compared to that which Goldberg mandates for recipients of public assistance. [FN72] In some circumstances, individuals have no right to appear personally before the decision-maker to present and refute evidence, but are limited to the submission of written materials. [FN73]

B. Medicare

The appeal procedures for Medicare beneficiaries aggrieved by denials of fee-for-service medical coverage are similar to those afforded Social Security pensioners and upheld in Mathews. However, Medicare appeal *369 procedures lack crucial elements required by Goldberg. The appeal mechanisms available to Medicare beneficiaries differ depending on the nature of the benefits at issue. [FN74] For hospitalization and post-hospitalization services covered by Part A, the intermediary makes an initial determination whether to approve a provider's claim. [FN75] A

beneficiary dissatisfied with the intermediary's action may seek administrative reconsideration by the Health Care Financing Administration (HCFA). [FN76] In disputes involving more than \$100, the beneficiary may obtain a hearing before an administrative law judge of the Social Security Administration and is entitled to further review by the Appeals Council. [FN77] Cases in which the amount at issue is \$1,000 or more are subject to judicial review by the District Court. [FN78] Over the years, the Medicare fee-for-service appeal process has provoked a number of challenges to its sufficiency under the Due Process Clause of the Fifth Amendment. [FN79]

The process does not apply to those cases in which access to fee-for-service care is most often implicated--cases in which hospitals, physicians, or skilled nursing facilities seek to reduce or terminate care over the objection of the patient. [FN80] Instead, the fee-for-service appeal process is designed primarily to resolve after-the-fact disputes about financial liability for care already rendered. This has proven to be an important limitation, because Medicare has attempted to use the same process in the very different context of managed care, where access to care is often at issue.

***370 C. Medicaid**

HCFA, which administers both Medicaid and Medicare, promulgated regulations elaborating the Goldberg hearing requirements [FN81] and applied them to instances in which medical assistance is denied, reduced, or terminated. [FN82] Those regulations guarantee beneficiaries a right to adequate advance notice, an opportunity for a fair hearing before an impartial arbiter, and the continuation of existing services pending the hearing. [FN83] Though often invoked against state Medicaid programs, these procedures were not themselves the object of due process challenges of the type which have embroiled the Medicare grievance and appeal process.

The combined effect of these laws and regulations was to establish two tiers of hearing protections for beneficiaries of federal health programs, with the rights accorded Medicare beneficiaries being substantially inferior to those guaranteed to their Medicaid counterparts. However, even with Medicare's weaker safeguards, so long as beneficiaries continue to receive services on a fee-for-service basis, any shortcomings in the appeal process do not directly affect access to health care. Appeals regarding payment disputes can have important financial consequences for beneficiaries, of course, but do not usually implicate the "brutal need" which is involved when actual medical treatment hangs in the balance.

IV. BENEFICIARY APPEAL PROCEDURES UNDER MANAGED CARE

A. Industry Norms in Commercial Managed Care Plans

Managed care began in the private sector, and the industry developed procedures and standards for dealing with beneficiaries without regard to the constitutional considerations which apply to government activity. It is not surprising, therefore, that the standards and practices of the commercial managed care industry afford enrollees few procedural protections. The two major pieces of federal legislation which establish requirements for commercial plans are the Health Maintenance Organization Act (HMO Act) [FN84] and the Employee Retirement Income Security Act (ERISA). [FN85]

The HMO Act applies only to plans which seek designation as federally qualified HMOs. [FN86] Even for those plans, there is no provision for individual *371 enrollee appeals. [FN87] Complaints about a plan's general failure to meet the requirements of the Act can be sent to HCFA's Office of Managed Care. However, there is no remedy under the HMO Act for wrongful denial of care to an individual enrollee.

The other major federal law governing private-sector MCOs is notable primarily for insulating those organizations from state consumer protection laws. ERISA preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" governed by the federal pension law. [FN88] This provision effectively prohibits states from regulating, whether by statute, regulation, or court ruling, any employee group health plan provided by an employer who is classified as "self-insured." [FN89] Forty percent of America's privately insured employees and dependents are now insured through employers deemed by ERISA to be "self-insured," and their health insurance plans are beyond the jurisdiction of state laws. [FN90] ERISA not only protects MCOs from state regulations that mandate the establishment of timely and fair hearing procedures, but it also protects plans from state civil liability that arises from negligent denial of benefits. [FN91]

ERISA itself imposes few standards on the health plans which it purports to regulate. [FN92] Commercial managed care plans subject to ERISA must give their enrollees a summary plan description, and the plan administrator must respond to a request for information within thirty days. [FN93] ERISA managed care plans must also provide a written explanation of reasons for adverse decisions affecting coverage and they must establish an administrative hearing process for appeals. [FN94] However, ERISA provides none of the standards necessary to ensure that the hearing process is timely or independent. Some state insurance regulations prescribe hearing procedures more stringent than those established under federal law. [FN95] However, many commercial managed care beneficiaries remain unprotected by such laws because of the effect of ERISA preemption. [FN96]

***372 Thus, Medicare and Medicaid are in the position of buying managed care from an industry which lacks a "culture" of procedural due process. [FN97] Strong compensating government guidance and regulation are needed to ensure the procedural protection of the programs' managed care enrollees. Unfortunately, guidance has been notably lacking.**

B. Medicare Prepaid Plans' Grievances and Appeals

When Medicare began to offer beneficiaries the option to enroll in prepaid health plans, [FN98] the program provided limited review of disputed denials, reductions, or terminations of coverage. [FN99] Significantly, the new procedures bore crucial similarities to those used in Part B fee-for-service coverage disputes and to grievance procedures which had developed in the commercial managed care industry. The primary similarity was that initial dispute resolution procedures were conducted by the contractor administering benefits, rather than by an independent decision-maker provided by the government. Like fee-for-service Medicare and commercial managed care plans, however, the due process requirements for Medicare HMOs and competitive medical plans (CMPs) made no provision for the continuation *373 of disputed care pending appeal of the health plan's intent to reduce or terminate such care. [FN100]

All beneficiary complaints regarding a plan's denial, reduction, or termination of care must be directed initially to the plan whose refusal of services gave rise to the dispute. [FN101] Subsequent processing of complaints depends on the services at issue. HCFA guidelines distinguish between beneficiary complaints by categorizing them as either "grievances" or "appeals." [FN102] A grievance is handled internally by the HMO or CMP, and the beneficiary has no recourse to review by anyone outside of the plan. [FN103] Refusals of coverage for optional supplemental services can be challenged only through the plan's grievance process. [FN104]

All complaints regarding a plan's initial determination to refuse coverage of services in the basic Medicare benefits plan are handled through the same Medicare appeal process that applies to Part A fee-for-service benefits. [FN105] As noted, this process is attended by substantial delays and was not designed to resolve disputes affecting immediate access to care. [FN106]

Given these limitations, the appeal process available to Medicare managed care beneficiaries does not lend itself to the resolution of disputes regarding present or future provision of necessary care. Disputed care is withheld while the appeal is pending. Reconsideration, which is only the first step in processing an enrollee appeal, can take as many as sixty calendar days. [FN107] If the enrollee has a present need for medical care, the delays alone are likely to rob the process of its practical value.

***374 For these reasons, the Medicare HMO appeal process is of practical use only in contesting the retrospective denial of a claim for services already rendered. Even then, its value is limited due to the difficulty of persuading a clinician to provide care in the face of the HMO's refusal of coverage.**

C. Medicaid Managed Care Appeals

HCFA has given states only limited formal guidance about meeting Goldberg's requirements in the context of Medicaid managed care. Medicaid's fair hearing regulations remain in effect. The regulations require the states to provide aggrieved beneficiaries access to the full panoply of Goldberg appeal rights. [FN108] However, reflecting the fact that they were written for a fee-for-service context in which most coverage disputes arose after care had already been provided, the regulations allow the states up to ninety days within which to afford a fair hearing and render a decision on a denial of newly prescribed health care services. [FN109] HCFA requires all states with Medicaid managed care programs to review the internal grievance procedures of participating MCOs to ensure that those procedures operate in a timely fashion and have the capacity to correct MCO errors. [FN110] The definition of "timely" has been left to the states. Most state managed care contracts explicitly obligate MCOs to comply with these fee-for-service standards. [FN111]

Unfortunately, the reality of Medicaid managed care falls short of the requirements of the Constitution and the regulations. Two national surveys reveal a pattern of appeal procedures which "exist on paper, but [are] nonfunctional in practice." [FN112] Recurring problems identified in the most recent survey include:

(1) [C]onsumers are unaware of grievance procedures and are not informed of them when a service is denied at the plan/provider level; (2) Grievance procedures exist only on paper--managed care organizations are unaware of their notice and hearing obligations; (3) In-plan procedures, when they do exist, are lengthy and confusing; (4) Complaints get buried at the plan level and when members try to complain to the state, they are simply *375 referred back to the plan; (5) State Medicaid agencies lack ongoing mechanisms to monitor complaints and grievances and include them in their accountability loops; [FN113] (6) Managed care organizations that have not historically served the Medicaid population do not understand the constitutional and other fair hearing requirements that attach to the Medicaid program.

....

... [R]equirements to exhaust in-plan grievance processes [before gaining access to a state hearing] cause members' complaints to become "lost," "stale," and "abandoned." [FN114]

Some of these deficiencies are failures in implementation rather than program design. However, there is an inherent problem in any system in which primary responsibility for processing complaints is placed on the very organization whose denial of care is being challenged and which, in a risk-sharing arrangement, has a financial incentive to stand by its original denial. This design, similar to HCFA's Medicare HMO appeal process, is in use in nearly all states. [FN115]

V. CONSTITUTIONAL ANALYSIS OF MEDICAID AND MEDICARE MANAGED CARE BENEFICIARY

APPEAL PROCEDURES

A. Goldberg and Mathews Revisited

As the Supreme Court emphasized, due process, "unlike some legal rules, is not a technical conception with a fixed content unrelated to time, place and circumstances." [FN116] Rather, "due process is flexible and calls for such procedural protections as the particular situation demands." [FN117] The substantial changes wrought by managed care necessitate a reassessment *376 of what due process requires of publicly administered health programs. In determining what process is due in this new environment, the factors to be considered are the private interest at stake; the risk of an erroneous deprivation; and the probable value of additional or alternative procedural safeguards, as well as the fiscal and administrative burdens which such safeguards would entail. [FN118]

1. The Beneficiary Interests at Stake

The private interests at stake amount to "brutal need" akin to those found to exist in the AFDC program. The fact that the denial of AFDC benefits could deprive recipients of access to life's essentials--explicitly including medical care--led the Supreme Court to mandate the due process protections set out in Goldberg. [FN119] Managed care, regardless of whether eligibility for such care is means-tested, controls access to essential medical treatment even more directly than did AFDC. No longer may the beneficiary obtain services and argue later about whether, or how much, the government program will pay. Under a capitation system, the beneficiary's doctor, who works for or under contract with the plan, is now told by the MCO--up front--that the beneficiary cannot receive the care sought. The MCO member's "brutal need" for medical care, when faced with the plan's denial of prior authorization for treatment, is essentially the same for both Medicaid and Medicare members. [FN120] Therefore, the due process protections to which managed care beneficiaries are entitled should be the same in each program.

2. The Additional Procedural Safeguards Needed

Other factors to be considered involve weighing the costs and benefits of affording beneficiaries additional procedural protections. What new procedures are necessary to adequately protect a beneficiary's interests in a managed care system?

***377 Notice--Even the best system of administrative review is of little value without timely notice informing the beneficiary (1) that the plan intends to take adverse action and (2) that review for purposes of contesting the proposed action is available. [FN121] As required by existing Medicaid regulations, a plan should provide written notice whenever it intends to take an action potentially adverse to the beneficiary's interests. However, Medicaid regulations do not require notice when a reduction or termination of services occurs pursuant to an order of the beneficiary's physician. [FN122] This exemption reflects the relationships prevalent in fee-for-service, in which the prescribing physician's loyalty to the beneficiary is assumed, and in which the prescriber is expected to operate independently of any utilization control mechanisms that the program or its fiscal agent may employ. [FN123]**

Managed care blurs the former dichotomy between clinical judgment of the provider and utilization control functions of the program or its fiscal agent. MCOs are negotiating contractual relationships with network providers which increasingly align the providers' financial interests with those of the plan, with the goal of limiting beneficiaries' utilization. These relationships create situations in which the physician's clinical judgment may be that a patient needs a particular treatment, but the physician is influenced by financial interests (his or her own and the MCO's) to nonetheless cease or limit the treatment. [FN124] In such circumstances, the physician acts as the alter ego of the plan and takes actions potentially adverse to the beneficiary's interests. The beneficiary should, therefore, be notified of the proposed action and of the availability of a fair hearing if he objects. [FN125]

***378 Timeliness--If (as is usually the case) the need for a disputed medical service is immediate, delay alone can fatally undermine the value of the process. Therefore, the appeal process must be capable of accommodating requests for expedited review of plan denials. In some cases, the sixty-or ninety-day processing time now provided by regulation will simply not afford review which is sufficiently timely to be meaningful.**

Impartiality--Entitlement to review by an impartial arbiter--the very cornerstone of due process--is implicated by requiring beneficiaries to initially grieve within their plan. Under a risk contract, the plan has a strong pecuniary interest in denying care, an interest that persists throughout an appeal--especially when expensive ongoing care is at issue. In-home nursing care for a medically fragile child, for example, saves the plan money every day that goes by without the beneficiary receiving the disputed service. [FN126]

A process that requires the beneficiary to resort to a plan's internal grievance is, therefore, constitutionally problematic. The defect is not cured by the fact that the beneficiary, following exhaustion of the grievance process, may ultimately access a fair hearing outside of the plan. Passage of time while awaiting conclusion of the grievance process imposes hardship without any compensating benefit: the delay is extraneous to the time needed by the state to process a case through its fair-hearing procedure. [FN127]

***379 If plans are to have a role in administering the appeal process, there must be carefully designed sanctions for MCOs that fail to resolve grievances quickly and fairly, in order to counterbalance capitation's inherent incentive to uphold the original denial of care. [FN128]**

Maintenance of services pending appeal--Even an expedited appeal process may consume several days or even weeks, given the delays inherent in preparation and development of an evidentiary record. Where a plan

proposes to reduce or terminate existing services, those services should be continued pending a hearing decision. This is a requirement under current Medicaid regulations and should apply to Medicare as well.

3. The Costs of Additional Protections

While managed care increases the need for procedural protections, it partially insulates the government from the cost of providing those additional safeguards. Medicare and Medicaid pay prepaid plans an all-inclusive capitation payment which covers administration as well as the costs of clinical care. In- plan enhancements in procedural safeguards do not, therefore, directly add to the public expense of those programs. [FN129]

Even where improved safeguards involve additional burdens on public agencies, net public expenditures may actually be reduced. Procedures that increase the ability of beneficiaries to obtain medically necessary care to which they are entitled by law, and for which the MCO has already been paid, prevent poorly performing plans from shifting costs to the government.

When beneficiaries cannot obtain satisfactory resolution of coverage disputes, some will leave the prepaid plan and return to the fee-for-service side of Medicare or Medicaid. Parents of children who are denied Medicaid benefits may place their children in state custody to obtain services, greatly increasing the state's costs. The elderly whose medical needs are unmet may be forced into nursing homes, saving the Medicare HMO, but costing *380 the state's Medicaid long-term care program. Thus, one consequence of a deficient due process mechanism is that the public pays at least twice: once for a capitation payment to the prepaid plan and again for the actual care of the patient in the fee-for-service system. [FN130]

Weighing the benefit of each increment of procedural reform against its costs, the balance falls on the side of enhancing the protection of managed care beneficiaries.

Notice--When a denial of care is authorized by the patient's physician and this action may be adverse to the patient's interests, rescinding the automatic exemption from notice requirements and placing the burden on the MCO to give notice is likely to have a valuable "sentinel effect." A provider who knows notice must be given to the patient if denial of care may be adverse to the patient's interests will likely be deterred from denying care except in cases when a denial is well-justified. Thus, unless the relationship between plan and provider has completely compromised the provider's clinical independence, the volume of cases in which notice is required should be small.

Timeliness--Creating an expedited review mechanism will, to some extent, merely accelerate appeals that ultimately would be heard at a later point anyway, without affecting costs. Practical constraints inherent in the preparation for a fair hearing force aggrieved beneficiaries to "trade off" more elaborate development of the record in order to obtain early review. Therefore, one effect of expedited review will often be to resolve disputes less formally (and expensively) than would be the case under current procedures.

However, expedited review will also elicit beneficiary appeals where none might occur presently, due to the current futility of invoking available appeals where the disputed care is immediately necessary. The additional costs associated with such appeals are justified by their absolute necessity for protection of beneficiaries' acknowledged interests: unless due process is available on a timely basis, it might as well not be available at all.

Impartiality--The government has two cost-free options that would remove the vital function of initial handling of beneficiary complaints from MCOs and reassign the function to an impartial entity. A prepaid plan's capitation payment includes the cost of processing complaints through the

in- plan grievance process. If the plan is relieved of that administrative responsibility, then its capitation payment could be reduced by a commensurate amount. That portion of the capitation payment can either be retained by the government agency to defray the cost of processing the complaints *381 in- house, or it can be used to contract with another entity, independent of the MCO, to perform that function.

Maintenance of services pending appeal--This crucial safeguard will involve no cost to the government, since any expense will be borne by the prepaid plan. The plans' principle objection to such a requirement--that it will be difficult to recover the costs of providing services pending meritless appeals--has already been disposed of in Goldberg v. Kelly. [FN131] When, as here, "brutal need" is implicated, the burdens are simply an unavoidable cost of fulfilling constitutional guarantees. [FN132]

B. Case Developments

1. Medicare

The constitutional sufficiency of Medicare's HMO grievance and appeal procedures is currently being litigated in Grijalva v. Shalala, [FN133] pending before the Ninth Circuit Court of Appeals. The district court analyzed managed care and its implications for the due process rights of beneficiaries. [FN134] This analysis led the court to conclude that when a private HMO denies a Medicare beneficiary coverage for medical services, the plan is acting under color of law. [FN135] Therefore, denials are subject to the constraints of the Fifth Amendment. [FN136] The court further concluded that although Medicare is not a means-tested program, an HMO's denial of medically necessary care implicates a "brutal need" worthy of enhanced procedural protection under Goldberg. [FN137] The Grijalva court held that Medicare's procedures were constitutionally defective and ordered their revision. [FN138]

HCFA subsequently issued new regulations that partially addressed shortcomings identified in the trial court's ruling. [FN139] Nevertheless, the new *382 rules still do not meet the standards set in Grijalva, most notably by failing to provide for the continuation of existing services pending an opportunity to be heard. [FN140]

2. Medicaid

Emerging case law regarding Medicaid managed care is in accordance with Grijalva's finding that actions taken by a prepaid health plan in the administration of a public program constitute government action and must, therefore, conform to due process. [FN141] In the most recent of these cases, Daniels v. Wadley, [FN142] the district court reviewed the appeal process in TennCare, Tennessee's Medicaid managed care program, [FN143] and found that MCOs were indeed engaged in "state action." [FN144] Therefore, an MCO cannot reduce, suspend, or terminate care without affording the beneficiary a prior opportunity to be heard. [FN145] Central to the ruling was the court's analysis of managed care and its conclusion that risk contracting gives MCOs "a direct and substantial pecuniary interest in denying" care. [FN146] For that reason, the state could not rely on a plan's internal grievance process to fulfill TennCare's due process responsibilities to its enrollees. [FN147] In an unpublished opinion, the court of appeals vacated the finding of state action as unnecessary to the trial court's ruling without reaching the merits, but left the rest of the ruling intact. [FN148]

*383 VI. LIABILITY FOR CONSTITUTIONAL TORTS

A. Doctrines of Official Immunity and Liability

Reconstruction-era civil rights law [FN149] provides a federal cause of action for the violation of federally protected rights by persons acting under color of state law. [FN150] State Medicaid officials are considered to be acting under color of law and, therefore, are subject to suit when their

acts or omissions violate the federal constitutional rights of program beneficiaries. [FN151] Because state governments are generally immune from suit, but their officials are not, § 1983 litigation against state administrators has provided the most common legal vehicle for enforcement of Medicaid compliance with federal law. [FN152] In such cases, the named official is usually merely a surrogate for the state program.

A body of judicially created law clothes state officials with qualified immunity from personal, as distinct from official, liability under § 1983. [FN153] Qualified immunity protects officials from personal legal liability so long as they act in good faith. [FN154] "Good faith" is an objective legal standard that requires compliance with all laws of which the defendant could reasonably be expected to have knowledge. [FN155] Once the Supreme Court has established clear constitutional standards, state officials are expected to know and comply with them. [FN156] If officials adopt policies that violate settled constitutional principles, even if they do so in ignorance, they lose qualified immunity and become personally liable to those whose rights they have impaired. [FN157]

*384 Government contractors cannot assert qualified official immunity under § 1983. [FN158] The Supreme Court has reserved the question of whether there is a separate basis on which contractors might claim limited immunity when acting in good faith. [FN159]

The case of *Bivens v. Six Unknown Named Agents of Federal Bureau of Narcotics* [FN160] recognizes, as a counterpart to § 1983, a common law cause of action against federal officials who, acting under color of law, violate the constitutional rights of an individual. [FN161] *Bivens* liability borrows § 1983's principles and rules of application, including a grant of qualified immunity for officials acting in good faith. [FN162] The law is unsettled as to whether federal contractors are subject to *Bivens* liability. [FN163]

Given these authorities, what is the potential liability of Medicare or Medicaid officials for violations of beneficiaries' due process rights under the Constitution or federal statutes and regulations? What is the potential liability of private managed care contractors?

B. Medicare

Grijalva is the first Medicare case to squarely address the due process sufficiency of HCFA's managed care rules, and the trial court's decision is on appeal. [FN164] Therefore, the law in this area will not support a Bivens claim for damages against federal Medicare officials for violation of clearly established constitutional rights.

However, when there is a failure to comply with currently established procedural requirements, Medicare HMOs may be liable under Bivens. [FN165] *385 The viability of such a claim appears to vary by judicial circuit. In contexts other than managed health care, four circuits have held that private individuals who are federal agents may be liable in a Bivens action, [FN166] one circuit has refused to allow claims against private parties, [FN167] and at least four circuits have expressly reserved the question. [FN168]

C. Medicaid

The grievance procedures used by most Medicaid managed care plans fall far short of the constitutional due process requirements applicable to Medicaid. The lack of timeliness, fairness, and protection of beneficiaries pending appeal all transgress the standards established in Goldberg and incorporated into federal regulations.

There is no official immunity for a state official who administers a Medicaid managed care plan in a manner that violates the due process

standards established in Goldberg. [FN169] That decision, now more than a quarter- century old, so clearly established the relevant legal principles that no one should be permitted to violate its requirements and still successfully plead good faith. [FN170] The MCOs that participate in such programs are even more exposed because they cannot invoke qualified immunity even if they act in good faith. [FN171]

Because urgent medical needs may be at stake, constitutionally defective MCO denials or reductions of Medicaid-covered services can give rise to *386 substantial damages. On any given day, MCOs throughout the country make thousands of decisions regarding approval or continuation of treatment for individual enrollees. Many decisions affecting very sick patients involve continuation of services--for example, psychiatric medication or in-home nursing, which, due to their high cost, invite especially aggressive utilization review. If a reduction, denial, or termination of coverage is not attended by due process and the patient's condition materially worsens, the plan may discover itself liable for violation of the enrollee's civil rights. If state officials countenanced the denial of due process by establishing or approving grievance and appeal procedures that fail to satisfy Goldberg standards, they too could be held liable.

Enrollees could obtain damages for due process violations without having to prove medical malpractice. Malpractice is difficult and costly for plaintiffs to establish because it requires expert medical evidence that the defendant's care was so negligent that it violated minimally acceptable professional standards. Recovery of damages also requires medical evidence that the defendant's negligence caused the plaintiff's injury.

By contrast, proof of a civil rights claim based upon deprivation of due process is markedly less demanding. If the failure to provide due process is systemic--based on established state policy--proving a civil rights violation should be quite simple. Proof of damages would involve evidence that had the beneficiary been afforded an opportunity to be heard, she could have demonstrated that the discontinued service was medically necessary and should have been continued. [FN172] She must also demonstrate that her injury or deterioration was a foreseeable consequence of the denial of

disputed care. [FN173] However, if the plaintiff has already demonstrated the medical necessity of the service, it is but a short step to infer that its denial harmed the patient. If the plaintiff carries that burden, she can recover compensatory damages, including an award for mental suffering and emotional anguish. [FN174] In appropriate cases, punitive damages are also available. [FN175] Furthermore, in contrast to malpractice cases in which the treating professionals are nearly always adversaries, the plaintiff will usually be able to rely on her prescribing provider for medical evidence needed to prove her civil rights due process case.

***387 VII. CONCLUSION**

For the protection of Medicaid managed care beneficiaries, and to reduce their own legal exposure, state officials and MCOs should immediately conform their grievance and appeal procedures to the standards imposed by the Constitution and federal Medicaid regulations. HCFA should correct any guidance given to the states or Medicare HMOs which is inconsistent with relevant due process standards.

More fundamentally, policy makers and administrators must understand that ensuring the availability of an effective due process mechanism is only one part of the much larger responsibility to beneficiaries that they assume when states enroll those beneficiaries in managed care. Failure to recognize and fulfill those duties imperils both beneficiaries and program administrators.

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[FN1]. This article focuses on those managed care arrangements that involve "risk contracting" by managed care organizations (MCOs). Under such arrangements, insurance entities or groups of affiliated providers, referred to generically as MCOs, accept a fixed prospective payment for each beneficiary or member they enroll. In return for these per capita or "capitation" payments, MCOs assume responsibility for providing all medically necessary services specified in their contract with the purchaser. If the aggregate cost of meeting the covered medical needs of all beneficiaries is less than the total amount of capitation payments, the MCO retains the difference as profit. However, if the costs of medically necessary care exceed capitation payments, the MCO must absorb the loss. MCOs may share the risk with a network of providers that they pay to deliver the actual medical care to beneficiaries. This risk-sharing can be achieved through "subcapitation" payments from the MCO to providers or by other contractual devices.

Contractual transfer of financial risk from purchasers to MCOs and providers most clearly distinguishes the currently ascendant form of managed care from other arrangements such as preferred provider organizations (PPOs), which offer purchasers volume discounts but continue to pay on a fee-for-service basis. Risk contracting reverses the incentives inherent in fee-for-service plans-- increasing profits by providing more revenue-generating services. Under risk contracts, revenues of MCOs and providers with whom they contract are generally fixed, enabling MCOs to expand profits only by reducing their costs. Hence, there is an incentive to provide less, rather than more, care to beneficiaries. See generally American Medical Association Council on Ethics and Judicial Affairs, *Ethical Issues in Managed Care*, 273 JAMA 330 (1995) [hereinafter AMA Council]; Stephen R. Latham, *Regulation of Managed Care Incentive Payments to Physicians*, 22 AM. J.L. & MED. 399 (1996).

[FN2]. See Latham, supra note 1, at 400.

[FN3]. See AMA Council, supra note 1, at 330-31.

[FN4]. See id.; Latham, supra note 1, at 400-05.

[FN5]. See U.S. GEN. ACCOUNTING OFFICE, MEDICAID MANAGED CARE: SERVING THE DISABLED CHALLENGES STATE PROGRAMS 40-41 (1996).

[FN6]. See generally Sheldon M. Retchin et al., Outcomes of Stroke Patients in Medicare Fee for Service and Managed Care, 278 JAMA 119 (1997).

[FN7]. See 42 U.S.C. §§ 1395-1395ccc (1994) (Medicare); 42 U.S.C. §§ 1396-1396u (1994) (Medicaid).

[FN8]. See HEALTH CARE FIN. ADMIN., 1997 HCFA STATISTICS 4 (1997).

[FN9]. See, e.g., BARRY R. FURROW ET AL., HEALTH LAW 604-07 (1995).

[FN10]. See, e.g., Marc A. Rodwin, Consumer Protection and Managed Care: Issues, Reform Proposals, and Trade-Offs, 32 HOUS. L. REV. 1319, 1342 (1996).

[FN11]. See generally id.; Susan J. Stayn, Securing Access to Care in Health Maintenance Organizations: Toward a Uniform Model of Grievance and Appeal Procedures, 94 COLUM. L. REV. 1674, 1676 (1994).

[FN12]. ADVISORY COMM'N ON CONSUMER PROTECTION & QUALITY IN THE HEALTH CARE INDUSTRY, CONSUMER BILL OF RIGHTS AND RESPONSIBILITIES: REPORT TO THE PRESIDENT OF THE UNITED STATES 57-62 (1997).

[FN13]. 42 U.S.C. §§ 1395-1395ccc (1988 & Supp. V 1993).

[FN14]. HARRIET L. KOMISAR ET AL., THE HENRY J. KAISER FAMILY FOUND., MEDICARE CHART BOOK i (1997).

[FN15]. See FURROW ET AL., supra note 9, at 604.

[FN16]. 42 U.S.C. § 1395(c) (1994); see also FURROW ET AL., supra note 9, at 564, 604.

[FN17]. See FURROW ET AL., supra note 9, at 604-05.

[FN18]. 42 U.S.C. §§ 1395d(a), 1395j.

[FN19]. Id. § 1395d(a).

[FN20]. Id. § 1395g(a).

[FN21]. Id. § 1395i.

[FN22]. Id. § 1395h(a).

[FN23]. Id. § 1395j.

[FN24]. *Id.*; see also § 1395r.

[FN25]. **What Is Medicare and How Is It Financed?, THE MEDICARE PROGRAM** (The Henry J. Kaiser Family Found., Washington, D.C.), Dec. 1995, at 1. In addition, 89% of all beneficiaries purchase some form of private Medicare supplement, or "Medigap," coverage for some or all of the services and expenses not covered by either Part A or Part B. *Id.* at 2.

[FN26]. 42 U.S.C. § 1395u; 42 C.F.R. §§ 405.501-.535, 421.200-.212 (1995). Carriers have been able to invoke sovereign immunity against a variety of claims. See, e.g., *Bushman v. Seiler*, 755 F.2d 653, 655 (8th Cir. 1985) (granting carrier's consultant immunity from claim of libel); *Anderson v. Occidental Life Ins. Co.*, 727 F.2d 855, 856 (9th Cir. 1984) (granting carrier immunity from claim of negligent infliction of mental anguish); *Peterson v. Weinberger*, 508 F.2d 45, 50-52 (5th Cir. 1975) (granting carrier immunity from claim of malicious interference with contractual rights). But cf. *Ardary v. Aetna Health Plans, Inc.*, 98 F.3d 496, 501 (9th Cir. 1996) (denying carrier immunity from liability for denials of medically necessary services), cert. denied, 117 S. Ct. 2408 (1997); *Rochester Methodist Hosp. v. Travelers Ins. Co.*, 728 F.2d 1006, 1012 (8th Cir. 1984) (denying carrier immunity because a suit "'against the sovereign is [not] the effect of the relief sought'" (quoting *Pennhurst State Sch. & Hosp. v. Halderman*, 465 U.S. 89, 107 (1984) (emphasis added by Eighth Circuit))).

[FN27]. 42 U.S.C. §§ 1396-1396v (1994).

[FN28]. *Id.* § 1396.

[FN29]. See FURROW ET AL., *supra* note 9, at 604-05.

[FN30]. See *id.* at 604.

[FN31]. U.S. GEN. ACCOUNTING OFFICE, MEDICARE AND MEDICAID: MEETING NEEDS OF DUAL ELIGIBLES RAISES DIFFICULT COST AND CARE ISSUES 3 (1997) [hereinafter GAO DUAL ELIGIBLES]; The Medicaid Program at a Glance, MEDICAID FACTS (The Henry J. Kaiser Family Found., Washington, D.C.), Apr. 1997, at 1 [hereinafter Medicaid at a Glance].

[FN32]. See FURROW ET AL., supra note 9, at 604-07.

[FN33]. See Medicaid at a Glance, supra note 31, at 1.

[FN34]. GAO DUAL ELIGIBLES, supra note 31, at 3.

[FN35]. 42 U.S.C. § 1396a(a)(10)(A) (1994).

[FN36]. See CONGRESSIONAL RESEARCH SERV., 103D CONG., MEDICAID SOURCE BOOK: BACKGROUND DATA AND ANALYSIS 343-51, 1052-72 (Comm. Print 1993) [hereinafter MEDICAID SOURCE BOOK]. See generally E. Kathleen Adams, Effect of Increased Medicaid Fees on Physician Participation and Enrollee Service Utilization in Tennessee, 1985-1988, 31 INQUIRY 173 (1995).

[FN37]. 42 U.S.C. § 1395c (1994).

[FN38]. See Gray Panthers v. Schweiker, 652 F.2d 146, 166 (D.C. Cir. 1980) ("[T]he significant percentage of Medicare claimants disadvantaged by disability, illness and poverty [is] a substantially higher figure than is true of the population at large.").

[FN39]. In addition, Medicare beneficiaries whose income is below the poverty level are categorized as "qualified Medicare beneficiaries" (QMBs) or, if income is below 120% of poverty, "specified low-income Medicare beneficiaries" (SLMBs). PATRICIA B. NEMORE, VARIATIONS IN STATE MEDICAID BUY-IN PRACTICES FOR LOW-INCOME MEDICARE BENEFICIARIES 5 (1997). QMBs and SLMBs can apply to have their states partially or completely defray their Medicare premium and cost-sharing expenses. Id. The 562,000 Medicare beneficiaries who have applied and been approved for such subsidies are believed to be only a small percentage of the number whose incomes fall below 120% of poverty. See id. at 1.

[FN40]. See generally id.

**[FN41]. Health Care Fin. Admin., Managed Care in Medicare and Medicaid (last modified Jan. 28, 1997)
<<http://www.hcfa.gov/facts/f960900.htm>> [hereinafter Managed Care].**

[FN42]. Id.

[FN43]. Medicaid and Managed Care, MEDICAID FACTS (The Henry J. Kaiser Family Found., Washington, D.C.), June 1997, at 1.

[FN44]. See Managed Care, supra note 41.

[FN45]. Id.; U.S. GEN. ACCOUNTING OFFICE, MEDICARE HMOS: RAPID ENROLLMENT GROWTH CONCENTRATED IN SELECTED STATES 12, 27 (1996).

[FN46]. Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 489 (1997).

[FN47]. Early Medicaid experience with managed care in the 1970s, most notably in California, was marred by scandal and abuse. **MEDICAID SOURCE BOOK**, supra note 36, at 1011. That experience prompted Congress to enact restrictions which have inhibited the growth of Medicaid managed care. *Id.* at 1011-15. The Balanced Budget Act repealed those safeguards. See Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 489 (1997).

[FN48]. See *Mathews v. Eldridge*, 424 U.S. 319 (1976); *Goldberg v. Kelly*, 397 U.S. 254 (1970).

[FN49]. 397 U.S. 254 (1970).

[FN50]. *Id.* at 262.

[FN51]. *Id.* at 261.

[FN52]. *Id.* (quoting *Kelly v. Wyman*, 294 F. Supp. 893, 900 (S.D.N.Y. 1968)).

[FN53]. *Id.* at 264.

[FN54]. *Id.* at 267.

[FN55]. *Id.* at 268-71.

[FN56]. *Id.* at 268.

[FN57]. *Id.* at 268-69.

[FN58]. *Id.* at 267 (quoting *Armstrong v. Manzo*, 380 U.S. 545, 552 (1965)).

[FN59]. *Id.* at 270.

[FN60]. *Id.* at 268.

[FN61]. *Id.* at 271.

[FN62]. *Id.* at 255-56.

[FN63]. See, e.g., *Smith v. Miller*, 665 F.2d 172, 175 (7th Cir. 1981); *Eder v. Beal*, 609 F.2d 695, 699-700 (3d Cir. 1979); *Kimble v. Solomon*, 599 F.2d 599, 601 (4th Cir. 1979).

[FN64]. See, e.g., *Caldwell v. Wallace*, 755 F.2d 870 (11th Cir. 1985); *Phillips v. Noot*, 728 F.2d 1175 (8th Cir. 1984); *Eder v. Beal*, 609 F.2d 695 (3d Cir. 1979).

[FN65]. See *Mathews v. Eldridge*, 424 U.S. 319, 323 (1976).

[FN66]. 424 U.S. 319.

[FN67]. Id.

[FN68]. Id. at 340-42.

[FN69]. Id.

[FN70]. Id. at 334-35.

[FN71]. Id. at 343.

[FN72]. Id. at 344-47.

[FN73]. Id. at 344-45.

[FN74]. 42 C.F.R. § 405.701-.750 (Part A benefits); 42 C.F.R. § 405.801-.872 (1974) (Part B benefits); Alfred J. Chiplin & Patricia B. Nemore, *Due Process Considerations for Medicare and Medicaid Beneficiaries in Managed Care Systems*, 29 CLEARINGHOUSE REV. 629, 632 (1995).

[FN75]. 42 U.S.C. § 1395ff(a) (1994); 42 C.F.R. § 405.705; HEALTH CARE FIN. ADMIN., MEDICARE INTERMEDIARY MANUAL § 3781.1 (1992).

[FN76]. 42 C.F.R. § 405.710-.716.

[FN77]. 42 U.S.C. § 1395ff(b); 42 C.F.R. § 405.720.

[FN78]. 42 U.S.C. § 1395ff(b); 42 C.F.R. § 405.730.

[FN79]. See *Schweiker v. McClure*, 456 U.S. 188 (1982) (challenging impartiality of hearing officers appointed by Part B carriers); *Kraemer v. Heckler*, 737 F.2d 214 (2d Cir. 1984) (termination of Part A benefits); *Monmouth Med. Ctr. v. Harris*, 646 F.2d 74 (3d Cir. 1981) (Medicare denial of acute care where there was a dearth of nursing home beds available); *Gray Panthers v. Schweiker*, 652 F.2d 146 (D.C. Cir. 1980) (lack of opportunity to be heard on denials of \$100 or less); *Himmler v. Califano*, 611 F.2d 137 (6th Cir. 1979) (challenge to lack of notice or hearing prior to rejecting payment for Part B services already rendered); *Vorster v. Bowen*, 709 F. Supp 934 (C.D. Cal. 1989) (carrier's use of utilization screens under Part B); *Fox v. Bowen*, 656 F. Supp 1236 (D. Conn. 1987) (denial of physical therapy services).

[FN80]. In such circumstances, the beneficiary is relegated to a summary review process administered by a regional peer review organization (PRO). That process does not effectively protect the beneficiary's access to care. See U.S. GEN. ACCOUNTING OFFICE, *MEDICARE: PRO REVIEW DOES NOT ASSURE QUALITY OF CARE PROVIDED BY RISK HMOS* (1991).

[FN81]. See *supra* notes 55-61 and accompanying text.

[FN82]. 42 C.F.R. § 431.200-.250 (1993). The Medicaid statute also contains a general provision according applicants and beneficiaries a hearing right when they are aggrieved. 42 U.S.C. § 1396a(a)(3) (1994).

[FN83]. 42 C.F.R. § 431.200-.250.

[FN84]. 42 U.S.C. §§ 300e, 300e-1 (1994).

[FN85]. 29 U.S.C. §§ 1001-1461 (1994).

[FN86]. 42 U.S.C. § 300e-9(d); 42 C.F.R. §§ 417.142(a), . 143(b)(2) (1996); see Stayn, *supra* note 11, at 1702.

[FN87]. See Eleanor D. Kinney, *Procedural Protections for Patients in Capitated Health Plans*, 22 AM. J.L. & MED. 301, 314-15 (1996); Stayn, *supra* note 11, at 1701-02.

[FN88]. 29 U.S.C. § 1144(a) (1994).

[FN89]. Wendy K. Mariner, *Liability for Managed Care Decisions: The Employee Retirement Income Security Act (ERISA) and the Uneven Playing Field*, 86 AM. J. PUB. HEALTH 863, 864 (1996).

[FN90]. Gregory Acs et al., *Self-Insured Employer Health Plans: Prevalence, Profile, Provisions, and Premiums*, 15 HEALTH AFF. 266, 275 (1996).

[FN91]. See Mariner, *supra* note 89, at 864-65.

[FN92]. *Id.* at 864.

[FN93]. 29 U.S.C. §§ 1021-1031 (1994).

[FN94]. *Id.* § 1133; 29 C.F.R. § 2560.503-1(f) (1996).

[FN95]. See, e.g., Cal. Health & Safety Code §§ 1340-1395 (West 1990 & Supp. 1998).

[FN96]. Some commercial MCO enrollees have practical remedies that partially offset the shortcomings of the law. For example, some group health beneficiaries can elect other insurance options if they believe that their MCO is providing poor service. The threat of such competition provides a partial check on potential MCO abuses. Some beneficiaries can also rely on an employer or union, armed with the influence of a major purchaser, to serve as an advocate in dealing with their managed care plans. These mitigating factors are largely lacking in government managed care programs, where the beneficiary must fend for himself or herself, and where, in the case of many Medicaid managed care programs, beneficiaries are mandatorily enrolled in an MCO, with little ability to switch plans.

[FN97]. MCOs that have previously served commercial populations are also unlikely to be prepared for the wide range of disabilities or the extent of cultural and linguistic diversity encountered in Medicaid. Those characteristics of the Medicaid population require accommodation in the administration of the beneficiary appeal process. See *infra* text accompanying note 118.

[FN98]. Although there had been earlier, limited experiments with managed care, it was not until enactment of § 114 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Pub. L. No. 97-248, 96 Stat. 341, that Medicare was authorized to enroll beneficiaries in risk contract health plans on a significant scale. The law approved voluntary enrollment of beneficiaries in plans that meet the definition of a federally qualified HMO under the Public Health Service Act, 42 U.S.C. § 300e-9(d) (1994).

TEFRA also authorized participation in the Medicare program by another category of risk-contracted prepaid health plans, known as competitive medical plans (CMPs), which have most of the attributes of HMOs but do not meet all of the criteria for federally qualified HMOs.

[FN99]. HEALTH CARE FIN. ADMIN., U.S. DEP'T HEALTH AND HUMAN SERVS., MEDICARE HEALTH MAINTENANCE ORGANIZATION/COMPETITIVE MEDICAL PLAN MANUAL §§ 2400-2419 (1989) [hereinafter HMO/CMP MANUAL].

[FN100]. 42 C.F.R. § 417.600-.638 (1996); see also HMO/CMP MANUAL, supra note 99, §§ 2400-2412, amended by 42 C.F.R. pt. 417 (1996).

[FN101]. 42 C.F.R. § 417.606. In some instances an intermediary or carrier may assume the role of receiving such complaints.

[FN102]. 42 C.F.R. § 417.600; see HMO/CMP MANUAL, supra note 99, § 2400.

[FN103]. See HMO/CMP MANUAL, supra note 99, § 2400(B).

[FN104]. Id. Medicare prepaid plan contractors are limited in the amount of profit they are allowed to make on their Medicare contracts. They have the option of using excess profits to offer beneficiaries supplemental benefits not covered in the Medicare basic package, and plans frequently do so for marketing purposes. While referred to as "optional" and "supplemental," these services (for example, prescription drugs) can be quite important in a beneficiary's decision to enroll in managed care, and erroneous denial or reduction of the services can have serious adverse health consequences.

[FN105]. 42 C.F.R. § 417.606; see HMO/CMP MANUAL, supra note 99, § 2400(A).

[FN106]. See supra note 78 and accompanying text..

[FN107]. See HMO/CMP MANUAL, supra note 99, § 2407(B). New amendments to Medicare regulations do not amend this section. The new rules give expedited review in some circumstances; however, the HMO has a right to decide which services are urgent and which are not--a decision which is not reviewable by an impartial person. See Medicare Program; Establishment of an Expedited Review Process for Medicare Beneficiaries Enrolled in Health Maintenance Organizations, Competitive Medical Plans, and Health Care Prepayment Plans, 62 Fed. Reg. 23,368 (1997) (to be codified at 42 C.F.R. pt. 417).

[FN108]. 42 C.F.R. § 431.200-.250 (1996).

[FN109]. Id. § 431.244.

[FN110]. Id. § 434.32.

[FN111]. See 1 SARA ROSENBAUM ET AL., NEGOTIATING THE NEW HEALTH SYSTEM: A NATIONWIDE STUDY OF MEDICAID MANAGED CARE CONTRACTS iv-vii (Kay A. Johnson ed., 1997).

[FN112]. JANE PERKINS ET AL., MAKING THE CONSUMERS' VOICE HEARD IN MEDICAID MANAGED CARE: INCREASING PARTICIPATION, PROTECTION, AND SATISFACTION 55 (1996). See generally 1 GERALDINE DALLEK ET AL., CONSUMER PROTECTIONS IN STATE HMO LAWS: ANALYSIS AND

RECOMMENDATIONS (1995); Jane Perkins & Lourdes Rivera, Medicaid Managed Care and Due Process Guide: Best Practices (draft, on file with the National Health Law Program/Families USA).

[FN113]. The "accountability loop" refers to an important systems' management function which appeals procedures should fulfill, in addition to resolving problems for individual grievants. Program managers should review beneficiary appeals to identify systemic problems or issues of plan non-compliance, which affect many beneficiaries other than those who file complaints. If the appeal process is not working, managers are deprived of this important source of information on program and plan performance.

[FN114]. PERKINS ET AL., supra note 112, at 55, 56.

[FN115]. Id. An exception is found in Minnesota, which affords beneficiaries a statutory right to invoke a state appeal process without having to first exhaust an in-plan grievance process. Minn. Stat. Ann. § 256B.031 (West 1992). Tennessee, under compulsion of a federal court order, has developed an appeal process which retains a limited role for the MCOs, but which subjects them to oversight and potential financial sanctions for making erroneous appeal decisions. Daniels v. Wadley, 926 F. Supp. 1305, 1308-14 (M.D. Tenn. 1996); Medicaid: Notice, Hearing, and Appeal Concerning Benefits, [1995-1996 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 44,195 (May 30, 1996).

[FN116]. Mathews v. Eldridge, 424 U.S. 319, 334 (1969) (quoting Cafeteria Workers v. McElroy, 367 U.S. 886, 895 (1961)).

[FN117]. Id. (quoting Morrissey v. Brewer, 408 U.S. 471, 481 (1972)).

[FN118]. Id. at 334-35.

[FN119]. *Goldberg v. Kelly*, 397 U.S. 254, 261, 264 (1969).

[FN120]. *Grijalva v. Shalala*, 946 F. Supp. 747, 757 (D. Ariz. 1996). Cases decided in the fee-for-service context have noted the high cost of medical care and the consequential financial barriers to care that confront even relatively affluent Medicare beneficiaries when Medicare denies coverage. See, e.g., *Kraemer v. Heckler*, 737 F.2d 214, 222 (2d Cir. 1984). The problem is compounded by nonfinancial aspects of managed care and the relationship between a plan and its providers. When the plan refuses to authorize care, a well-to-do beneficiary is likely to be unable to obtain care within the network, even at individual expense. The managed care enrollee thus may be without a provider if treatment not approved by the plan is sought. Being forced to find a new physician can be a serious adverse event in itself, especially if the patient has been receiving ongoing treatment for a complex condition.

[FN121]. 42 C.F.R. § 431.210-.211 (1996).

[FN122]. *Id.* § 431.213. However, a denial by a clinician is appealable. See 42 U.S.C. § 1396a(a)(3) (1994); Jane Perkins et al., *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities* (1998). Regulations promulgated under Title VI of the Civil Rights Act of 1964 require that a plan offer translation services as needed for the participation of linguistic minorities in publicly funded programs, including Medicare and Medicaid. See *id.* § 2000d (1994); 45 C.F.R. pt. 80 (1996). This requirement would apply to the internal grievance process, which means that exhaustion of the process may be burdensome to plans, as well as beneficiaries, especially in states with substantial numbers of non-English speaking residents. *Id.* When a government program is aware that it is communicating with beneficiaries who lack English language proficiency, the Constitution may also require translation into the language of the beneficiary because due process requires that notice "be of such nature as reasonably to convey the required information." *Mullane v. Central Bank & Trust Co.*, 339 U.S. 306, 314 (1950).

[FN123]. Cf. Wickline v. California, 239 Cal. Rptr. 810, 811-12 (Ct. App. 1986).

[FN124]. In a 1995 survey of 1100 California physicians, 79% acknowledged being influenced in their patient care decisions by reimbursement or capitation issues. CALIFORNIA MED. ASS'N, SURVEY OF 1100 PHYSICIANS UNDER AGE 40 (1995).

[FN125]. One approach is to place the burden on the plan and its network providers to recognize those circumstances in which a proposed action (with or without physician authorization) is potentially adverse to the beneficiary and should, therefore, trigger notice and the right to an appeal. An alternative, adopted by North Carolina's Medicaid managed care program, is to direct providers to routinely supply their patients with notice of the availability of the appeal process whenever they deny, reduce, or terminate a course of treatment. See MANAGED CARE UNIT, THE STATE OF NORTH CAROLINA, MEDICAID MANAGED CARE RISK CONTRACT app. IX (1997):

The Plan shall establish an internal grievance process to resolve complaints from Members whose claims for medical assistance are denied, terminated, reduced, inappropriate to needs, or not acted upon promptly. A denial includes any instance in which a request for a medical service has been made in which a Member has been told "no."

Id.

[FN126]. Cf. Schweiker v. McClure, 456 U.S. 188, 196 (1982). In Schweiker, the Court upheld the use of administrative law judges (ALJs) hired by Medicare Part B carriers against charges of bias arising from their relationship to the carriers. Id. The Court noted that, in assessing the impartiality of the ALJs, their connections with the carriers "would be relevant only if the carriers themselves are biased or interested." Id. The carriers lack such bias or interest, since they (in contrast to HMOs) do not contract on a risk basis. Id.

[FN127]. If a particular step in the appeal process, such as a plan's internal grievance procedure, does not address due process needs, requiring its exhaustion as a precondition to obtaining due process appears to be constitutionally difficult to justify. Moreover, such a requirement has potential implications under other laws. With regard to the operation of a public program like Medicaid, the Americans with Disabilities Act, 42 U.S.C. §§ 12101-12213 (1994 & Supp. I 1996), bars imposition of administrative requirements which are difficult for qualified people with disabilities to satisfy and which cannot be "shown to be necessary for the provision of the service, program, or activity being offered." 28 C.F.R. § 35.130(b)(8) (1996). Many Medicare and Medicaid beneficiaries have physical or mental disabilities that would make it difficult to negotiate the administrative requirements of a plan's internal grievance procedure.

[FN128]. Managed care is premised on the careful design of policy around a system of financial incentives and disincentives. Therefore, one would expect that, if Medicare or Medicaid were going to partially delegate to MCOs the responsibility for handling beneficiary appeals, attention would be given to correctly aligning the financial incentives to ensure the integrity of such an appeal process. However, almost no attention appears to have been given to this important policy issue.

[FN129]. Of course, if procedural enhancements involve more costs than plans are willing or able to absorb, plans might respond by putting pressure on the government to increase their rates. Some plans might decide to cease their participation in the program; however, a contractor's decision to forego further business with the government would not normally be regarded as a cost to the public.

[FN130]. Grijalva v. Shalala, 946 F. Supp. 747, 753 n.8 (D. Ariz. 1996). In those Medicaid programs that do not give beneficiaries the option of returning to fee-for-service, the effect is to encourage plan-switching and adverse selection of those plans which fulfill their contractual obligations. PERKINS ET AL., supra note 112, at 55.

[FN131]. See 397 U.S. 254, 266 (1970).

[FN132]. See *id.* Cases in which beneficiaries receive services pending unsuccessful appeals are likely to be rare. Few beneficiaries will pursue an appeal in the face of their treating physician's refusal to support their position. In addition, given the relationship between the physician and the MCO, few providers will support their patients in an appeal unless there is strong merit to the beneficiary's position.

[FN133]. 946 F. Supp. 747.

[FN134]. *Id.* at 759.

[FN135]. *Id.* at 755.

[FN136]. *Id.*

[FN137]. *Id.* at 759-60.

[FN138]. *Id.*

[FN139]. See Medicare Program; Establishment of an Expedited Review Process for Medicare Beneficiaries Enrolled in Health Maintenance Organizations, Competitive Medical Plans, and Health Care Prepayment Plans, 62 Fed. Reg. 23,368 (1997) (to be codified at 42 C.F.R. pt. 417). The new rules became effective June 30, 1997 and plans were required to comply by August 28, 1997. *Id.*

[FN140]. See *id.*

[FN141]. See *Catanzano v. Dowling*, 60 F.3d 113, 117-19 (2d Cir. 1995); *Daniels v. Wadley*, 926 F. Supp. 1305, 1311-12 (M.D. Tenn. 1996); *J.K. v. Dillenberg*, 836 F. Supp. 694, 697-98 (D. Ariz. 1993); *Perry v. Chen*, No. CV 95-140-TUC-RMB, 1996 WL 159808, at *4 (D. Ariz. Feb. 9, 1996); *Rodriguez v. Chen*, No. CV 95-130-TUC-RMB, 1996 WL 159810, at *4-5 (D. Ariz. Feb. 7, 1996). Plan involvement in state action also subjects plans to liability under 42 U.S.C. § 1983 (1994), discussed *infra* notes 149-57 and accompanying text.

[FN142]. 926 F. Supp. 1305.

[FN143]. *Id.* at 1306-07.

[FN144]. *Id.* at 1311.

[FN145]. *Id.* at 1310.

[FN146]. *Id.* at 1313; cf. *Schweiker v. McClure*, 456 U.S. 188, 196 (1982).

[FN147]. *Daniels*, 926 F. Supp. at 1313. The state appealed the finding of the *Daniels* court that the MCOs were state actors and the appeal is currently pending before the Sixth Circuit Court of Appeals.

[FN148]. *Daniels v. Menke*, No. 96-5887 (6th Cir. Apr. 22, 1998) (not for publication).

[FN149]. 42 U.S.C. § 1983 (1994).

[FN150]. *Id.*

[FN151]. See *Maine v. Thiboutot*, 448 U.S. 1, 4-8 (1980) (discussing Aid to Families with Dependent Children).

[FN152]. State law generally creates sovereign immunity for state governments in their own courts and the Eleventh Amendment protects states from most types of federal court litigation. See U.S. Const. amend. XI.

[FN153]. *Elder v. Holloway*, 510 U.S. 510, 514 (1994); *Wyatt v. Cole*, 504 U.S. 158, 163-64 (1992); *Wood v. Strickland*, 420 U.S. 308, 318 (1975).

[FN154]. *Wood*, 420 U.S. at 318-22. If entitled to immunity, officials are protected not only from liability, but from the burdens of trial. *Harlow v. Fitzgerald*, 457 U.S. 800, 807-08 (1982). Therefore, in federal courts, and in those state courts with interlocutory appeal procedures comparable to those in the federal system, a state official need not wait until after trial to obtain appellate review of the trial court's decision denying immunity. See *Johnson v. Fankell*, 117 S. Ct. 1800, 1806-07 (1997).

[FN155]. *Elder*, 510 U.S. at 513-16; *Wood*, 420 U.S. at 321-22. See generally *Crawford-El v. Britton*, 66 U.S.L.W. 4311 (1998).

[FN156]. *Elder*, 510 U.S. at 513-16; *Wood*, 420 U.S. at 321-22.

[FN157]. *Elder*, 510 U.S. at 513-16; *Wood*, 420 U.S. at 321-22.

[FN158]. **Richardson v. McKnight**, 117 S. Ct. 2100, 2107-08 (1997).

[FN159]. **Id.** at 2108.

[FN160]. **403 U.S. 388** (1971).

[FN161]. **Id.** at 390-97.

[FN162]. See **Carlson v. Green**, 446 U.S. 14, 24 n.11 (1980) (same procedural rules apply); **Butz v. Economou**, 438 U.S. 478, 485-96 (1978) (same standard of qualified immunity); **Doe v. District of Columbia**, 697 F.2d 1115, 1123 (D.C. Cir. 1983) (similar rules apply to the calculation of damages); **Tarpley v. Greene**, 684 F.2d 1, 9-11 (1982) (same rules govern liability); **Paton v. LaPrade**, 524 F.2d 862, 871 (3d Cir. 1975) (same standards for defining compensable injuries).

[FN163]. See **infra** notes 169-71 and accompanying text.

[FN164]. See **supra** notes 133-40 and accompanying text. An earlier challenge to Medicare HMO appeal procedures was resolved without effecting major change in those procedures. See **Levy v. Sullivan**, No. CV-88-3271 DT, 1989 WL 92032 (C.D. Cal. Mar. 14, 1989).

[FN165]. Widespread HMO noncompliance with federal grievance and appeal requirements has been reported in the past and continues to be documented. See **Carol S. Jimenez, Medicare HMOs: A Consumer Perspective**, 26 SETON HALL L. REV. 1195, 1211-12 (1996); **Medicare HMO Appeals Validate Claims of Systemic Problems**, 23 NAT'L SENIOR CITIZENS L. CTR. WASH. WKLY. 74 (1997) (reporting on data

compiled by the Center for Health Dispute Resolution, which contracts with HCFA to evaluate beneficiaries' requests for reconsideration).

[FN166]. See *Schowengerdt v. General Dynamics Corp.*, 823 F.2d 1328, 1332- 33, 1337-38 (9th Cir. 1987); *Wagner v. Metropolitan Nashville Airport Auth.*, 772 F.2d 227, 229 (6th Cir. 1985) (by implication); *Reuber v. United States*, 750 F.2d 1039, 1054-57 (D.C. Cir. 1984); *Dobyns v. E-Systems, Inc.*, 667 F.2d 1219, 1223-27 (5th Cir. 1982); *Yiamouyiannis v. Chemical Abstracts Serv.*, 521 F.2d 1392, 1393 (6th Cir. 1975).

[FN167]. See *Fletcher v. Rhode Island Hosp. Trust Nat'l Bank*, 496 F.2d 927, 932 n.8 (1st Cir. 1974). But see *Gerena v. Puerto Rico Legal Servs., Inc.*, 697 F.2d 447, 450 (1st Cir. 1983) (court assumed a cause of action would lie against a private corporation if it were in fact a federal actor).

[FN168]. See *DeVargas v. Mason & Hanger-Silas Mason Co.*, 844 F.2d 714, 720-22 (10th Cir. 1988); *Morast v. Lance*, 807 F.2d 926, 930-31 (11th Cir. 1987); *McNally v. Pulitzer Publ'g Co.*, 532 F.2d 69, 75-76 (8th Cir. 1976); *Holodnak v. AVCO Corp.*, 514 F.2d 285, 292 (2d Cir. 1975); *Gleave v. Graham*, 954 F. Supp. 599, 604 (W.D.N.Y. 1997) (appearing to reserve the issue); *Lovelace v. Whitney*, 684 F. Supp. 1438, 1441 (N.D. Ill. 1988); *Mahoney v. National Org. for Women*, 681 F. Supp. 129, 132-33 (D. Conn. 1987) (assumes that a Bivens action lies if state action can be found); *Stevens v. Morrison-Knudsen Saudi Arabia Consortium*, 576 F. Supp. 516, 520- 21 (D. Md. 1983), *aff'd mem.*, 755 F.2d 375 (4th Cir. 1985).

[FN169]. *Davis v. Mansfield Metro. Hous. Auth.*, 751 F.2d 180, 187 (6th Cir. 1984).

[FN170]. See *id.*

[FN171]. See *Richardson v. McKnight*, 117 S. Ct. 2100, 2107-08 (1997).

[FN172]. Carey v. Piphus, 435 U.S. 247, 263-64 (1978). A deprivation of due process is per se compensable, even if the deprivation of liberty or property was otherwise justified and would have been sustained had there been a proper hearing. Id. at 266. In such circumstances, the plaintiff is entitled only to nominal damages. Id. An award of attorney's fees under 42 U.S.C. § 1988 (1994) is usually not appropriate unless additional damages are awarded. Farrar v. Hobby, 506 U.S. 103, 115 (1992).

[FN173]. Carey, 435 U.S. at 263-64.

[FN174]. Id.

[FN175]. Smith v. Wade, 461 U.S. 30, 51 (1983) (standard for awarding punitive damages is "reckless or callous disregard" or indifference).

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