

11-1998

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Recommended Citation

Rosenbaum, Sara J.; Teitelbaum, Joel B.; Kirby, Christopher; Priebe, Linda; and Klement, Tal, "An Overview of Medicaid Managed Care Litigation" (1998). *Health Policy and Management Issue Briefs*. Paper 19.
http://hsrc.himmelfarb.gwu.edu/sphhs_policy_briefs/19

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BEHAVIORAL HEALTH ISSUE BRIEF SERIES

An Overview of Medicaid Managed Care Litigation

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November, 1998

Executive Summary

Since the enactment of Medicaid in 1965, states have had the option of offering beneficiaries enrollment in managed care arrangements. With the advent of mandatory managed care reaching millions of beneficiaries (including a growing proportion of disabled recipients), the amount and scope of litigation involving Medicaid managed care plans can be expected to grow. A review of the current litigation regarding Medicaid managed care reveals two basic types of lawsuits: (1) those that challenge the practices of managed care companies under various federal and state laws that safeguard consumer rights, protect health care quality, and prohibit discrimination; and (2) suits that assert claims arising directly under the Medicaid statute and implementing regulations, as well as claims related to Constitutional safeguards that undergird the program.

Lawsuits asserting claims arising under Medicaid tend to raise two basic questions: (1) the extent to which enrollment in a Medicaid managed care plan alters existing Medicaid beneficiary rights and state agency duties under federal or state Medicaid law; and (2) the extent to which managed care companies, as agents of the state, act under “color of law” (i.e., undertaking to perform official duties or acting with the imprimatur of state authority).

Additionally, states might see an increase in litigation brought by prospective and current contractors who assert that they have been wrongfully denied contracts or improperly penalized for poor performance. These assertions may involve claims that are grounded in federal and state law, the Medicaid statute, and the Constitution. Moreover, in light of the consumer protection elements of the managed care reforms contained in the Balanced Budget Act, future managed care litigation may focus on the manner in which companies carry out states’ obligations toward managed care enrollees.

Resolution of Medicaid managed care cases involves the application of general principles of administrative and regulatory law. Thus, Medicaid managed care cases have implications for other public purchasers of managed care arrangements, including state mental health and alcohol and substance abuse agencies.

A Note on This Issue Brief

This Issue Brief is intended as one of several in the *Managed Behavioral Health Care Issue Brief Series* that deals with managed behavioral health care from a purely legal point of view. Indeed, the Issue Brief Series is designed in part to draw attention of the behavioral health care community to important judicial developments that are shaping public managed health care systems. While many legal decisions discussed do not include factual patterns involving mental health and/or substance abuse per se, they are included because of the nature of the law(s) they interpret, because they could apply with equal force to managed behavioral health care situations, or because they have implications for several public programs (e.g., Medicare, Medicaid, Tri-Care/CHAMPUS, etc.). It is important to keep in mind that while similar factual patterns can lead to different legal outcomes depending on the particular law(s) implicated (e.g., legal protections for Medicaid beneficiaries are different from those for persons whose care is paid for by a block grant program), in some instances factual patterns cut across various laws and the legal outcomes of two similar but separate cases may be the same (e.g., an unlawful procurement under Medicaid may be an unlawful procurement under a block grant program because the Department of Health and Human Services grants management regulations govern both types of procurements).

Because a multitude of different laws and stakeholders are implicated by the intersection of managed care and publicly-financed health care, this Series will include other Issue Briefs on the law. For example, future Issue Briefs will focus on Medicare, the Americans With Disabilities Act, and the Employee Retirement Income Security Act. Additionally, there is a forthcoming Issue Brief on the new Balanced Budget Act regulations promulgated by the Health Care Financing Administration. Although we realize that any given fact pattern or case can involve more than one of the above laws, we decided for the sake of organization to dedicate an Issue Brief to each law in turn.

As you consider even the non-behavioral health care cases outlined below, keep in mind that they may have direct implications for mental health and substance abuse agencies and services, because these judicial opinions clarify the legal rights and responsibilities of public agencies, managed care organizations, and consumers of publicly-sponsored health care.

Introduction

Medicaid managed care litigation is nearly as old as the Medicaid program itself. Since the enactment of Medicaid in 1965, states have had the option of offering beneficiaries voluntary enrollment in managed care arrangements.¹ With the advent of mandatory

¹ In the early days of the program, prior to enactment of the Medicaid health maintenance organization amendments of 1976, these arrangements were termed prepaid health plans and competitive medical plans. See David F. Chavkin and Anne Treseder, "California's Prepaid Health Plan Program: Can the Patient be Saved?" 28 *Hastings L.J.* 685 (1977).

managed care, first through federal demonstration authority beginning in the early 1980s,² and more recently as a state plan option,³ Medicaid managed care has become commonplace. As Medicaid managed care grows--and particularly as managed care systems reach disabled and medically vulnerable populations with significant health care needs--policy-makers can expect an increase in cases raising coverage, access, and quality claims. Because managed care combines health care coverage with a contractual duty to furnish health care, the types of litigation that can arise against managed care companies actually exceeds those that were commonplace under the traditional program. And as is probably true in any maturing health care system, the more common Medicaid managed care becomes, the more common litigation will become.

Nonetheless, the litigation up to this point regarding Medicaid managed care can be summed up in three legal principles: State Medicaid agencies retain ultimate responsibility for providing health care services sufficient in scope to achieve Medicaid's intended purpose; the potential liability of Medicaid agencies for failure to provide sufficient services is not only statutory in nature--it is also Constitutional in nature, and therefore sometimes beyond Congress' ability to take away; and generally speaking, as far as the courts are concerned, private health care companies providing services to Medicaid beneficiaries are acting as agents of the states and their actions will be viewed as state actions.

Indeed, companies that furnish managed health care services to Medicaid beneficiaries assume various legal obligations which apply to their operations regardless of who buys the managed health care services--Medicaid agencies, state mental health agencies, employers which buy insurance for their employees, and even employers who self-insure.⁴ For example, state law may create broad consumer protections, which apply across the board to companies that sell insurance, including health maintenance organization (HMO) plans and other forms of managed care. Depending on how they are drafted, laws may create individual rights on the part of current or prospective health care recipients to sue a company for legal violations.⁵ Similarly, a managed care company may face legal challenges to the quality of its health care services under state tort law from any recipient,⁶ including

2 Sections 1115 and 1915(b) of the Social Security Act have both been used over the past two decades to establish mandatory managed care systems. See generally Congressional Research Services, *Medicaid Source Book* (GPO, Washington, DC 1993); S. Rosenbaum et al., *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts* (2d ed.) (The George Washington University Medical Center, Center for Health Policy Research, Washington, DC 1998).

3 Section 1932(a) of the Social Security Act (42 U.S.C. § 1396u-2(a)) as added by the Balanced Budget Act of 1997.

4 The federal Employee Retirement Income Security Act (ERISA) preempts certain types of claims that arise under state laws. ERISA preemption can occur in the case of self-insured employee benefit plan arrangements as well as those that involve the purchase of insurance. At the same time, in recent years, courts have identified certain types of claims against managed care companies, even in the case of self-insured employee health benefit plans, that survive ERISA preemption. Rand Rosenblatt, Sylvia Law, and Sara Rosenbaum, *Law and the American Health Care System* (Foundation Press, Old Westbury, NY 1997; 1998 Supplement) (Chs. 2(C) and (3)(H)).

5 See, e.g., *Broughton v Cigna Health Plans*, 76 Cal. Rptr. 2d 431 (Cal. App. 2d Dist. 1998), holding that California's Consumers Legal Remedies Act, which prohibits deceptive advertising practices, precludes insurers from using mandatory arbitration clauses to compel arbitration in a case seeking injunctive relief against deceptive practices.

6 *Ardary v Aetna Healthplans of California, Inc.*, 98 F.3d 496 (9th Cir. 1996); *Wickline v State of California*, 228 Cal. Rptr. 661 (Cal. Ct. App. 1986); *Wilson v Blue Cross of Southern California*, 271 Cal. Rptr. 876 (Cal. Ct. App.

Medicaid beneficiaries, although studies suggest that as a general matter, poor persons may be less likely to file medical malpractice lawsuits.⁷ Finally, certain federal laws, such as the Americans with Disabilities Act, create individually enforceable legal rights that apply regardless of whether a company's services are purchased by a Medicaid agency or some other purchaser. In short, managed care companies which provide Medicaid services can expect to face legal challenges by beneficiaries, health care providers, and other stakeholders based on federal and state laws which apply generally to all managed care plans irrespective of the source of the managed health care premiums.

At the same time, the Medicaid statute, and the implementing regulations and federal Constitutional principles on which the law rests, may directly give rise to claims against managed care companies, as well as against the state Medicaid agencies on whose behalf the companies administer managed care plans. As with tort claims, such lawsuits may be brought by beneficiaries, providers, and other Medicaid stakeholders who allege that their legal rights under federal and state Medicaid law have been violated by one or more company practices. Moreover, Medicaid managed care plans themselves, as well as managed care companies which seek the right to participate in a state Medicaid program, may also have legal rights against state agencies that arise under federal or state Medicaid law as well as Constitutional due process principles.

The earliest Medicaid managed care litigation involved claims of consumer fraud directed at managed care companies for fraudulent and deceptive marketing practices, coercion, and other unfair trade practices. However, this early litigation also raised claims that were aimed at state Medicaid agencies themselves and alleged violation of federal and state law as a result of their general failure to oversee the quality of care and conduct of the plans. These early lawsuits were concentrated in California and most of the suits were pending at the time that federal and state Medicaid agencies and business and insurance regulators stepped in to shut down the 1970s generation of prepaid health plans.⁸ As a result, there are virtually no court decisions to review from this first generation of Medicaid managed care litigation.

With the emergence of mandatory managed care has come a new generation of lawsuits. Not surprisingly, some of the earliest cases arose in Arizona, which operates what is probably the nation's most mature Medicaid managed care system, having been in place for more than 15 years. The managed care system in Arizona has also given rise to parallel forms of litigation involving the Medicare program, again a testament to the maturity of the market.

The number and frequency of Medicaid managed care cases, which often raise complex questions of administrative law, can probably be expected to grow in scope and depth for two reasons. First, managed care has become a principal means of providing health care to millions of Medicaid beneficiaries. As a result, managed care systems have become directly involved in coverage determinations, a historic area of Medicaid litigation because of the

1990).

⁷ See Sylvia Law and Steven Polan, "Pain and Profit: The Politics of Malpractice," (Harper and Row, NY 1978); Dana Hughes, Sara Rosenbaum, David Smith, and Cynthia Fader, "Obstetrical Care for Low-Income Women: The Effects of Medical Malpractice on Community Health Centers," Institute of Medicine, *Medical Professional Liability and the Delivery of Obstetrical Care, Vol. II*, (National Academy Press, Washington, DC 1989).

⁸ *Can the Patient be Saved?*, *supra* note 1.

enforceable rights that the statute creates,⁹ as well as in the delivery of care. Second, state Medicaid agencies have a legal duty to administer their programs (including the managed care components of their programs) in accordance with state and federal law. Emerging court decisions suggest that courts view companies as administrative contractors acting under “color of law”. Taken together, judicial decisions to date reflect courts’ conclusion that state agencies have a duty to ensure compliance with federal law which remains in effect regardless of whether the agency directly administers its program or contracts for administrative services on a risk basis.¹⁰ Furthermore, where a company’s practices conflict with laws that state officials either knew or should have known made such conduct unlawful, such officials may be liable in their individual capacities for damages proximately caused by the improper conduct.¹¹

Thus, for example, the court in *J.K. v Dillenberg*,¹² a case involving the termination of mental health benefits for disabled children, held that managed care contractors are not simply private providers but instead act under color of law and are legally liable (along with the state agency itself) for violations of federal fair hearing regulations. These regulations in turn reflect and codify basic Constitutional principles, embodied in the Fourteenth Amendment, against deprivation of property without due process of law.¹³

A Survey of Medicaid Managed Care Cases

Managed care cases involving claims by Medicaid beneficiaries can be grouped into several basic categories, none of which is exclusive. That is, any one lawsuit can raise several issues at the same time, some of which arise under Medicaid, and some of which arise under other laws.

1. Cases involving the basic legality of a mandatory managed care program, which limits beneficiaries’ choice of provider

9 See cases cited in *Law and the American Health Care System*, *supra* note 4, Ch. 2(H). The scope of what is considered a legally enforceable individual right under federal law has changed considerably following the decisions in *Wilder v Virginia Hosp. Ass’n*, 496 U.S. 498 (1990) and *Suter v Artist M.*, 503 U.S. 347 (1992). However, because Medicaid creates a legally enforceable entitlement to certain services among eligible persons, courts continue to consider major portions of the statute to be legally enforceable by individuals. See discussion of recent Medicaid case law developments in *Law and the American Health Care System*, *supra* note 4, Ch. 2(H).

10 Indeed, since the inception of Medicaid, state agencies have had the authority to contract with private companies to administer their programs. 42 C.F.R. § 434.20. This contracting authority has never been held to alter agencies’ fundamental legal obligations to comply with federal and state statutory and regulatory requirements.

11 Gordon Bonnyman, Jr. and Michele M. Johnson, “Unseen Peril: Inadequate Enrollee Grievance Protections in Public Managed Care Programs,” 65 Tenn. L. Rev. 359, 383 (Winter, 1998). State officials are protected by the doctrine of qualified immunity where they act in good faith. The good faith standard is an objective one that “requires compliance with all laws of which the defendant could reasonably be expected to have knowledge.” *Id.*

12 836 F. Supp. 694 (D. Ariz. 1993).

13 *Unseen Peril*, *supra* note 11, provides an excellent discussion of the statutory and Constitutional principles that govern the conduct of state Medicaid agencies and their managed care contractors, as well as cases that have addressed this issue.

Beneficiaries and providers have on occasion challenged the legality of the state's entire mandatory Medicaid managed care program, citing violations of federal Medicaid law, as well as federal statutes that permit the Secretary to conduct demonstrations under certain circumstances. These cases have generally been unsuccessful, since federal discretion to the Secretary is very broad.¹⁴ Similarly, Medicaid beneficiaries generally have not been successful in challenging Medicaid managed care programs that limit their choice of providers. In *RX Pharmacies Plus v Weil*,¹⁵ a federal district court in Colorado dismissed claims brought by Medicaid beneficiaries that the Colorado Medicaid managed care plan violated the Medicaid statute's "free choice of provider" provisions by not permitting them to utilize the pharmacy of their choice.¹⁶ The court held that once a Medicaid beneficiary selects an HMO, the Medicaid statute does not require that the beneficiary be permitted to choose pharmaceutical providers outside the HMO. The Court also held that the practice of automatically assigning non-selecting beneficiaries (known as autoassignment or autoenrollment) to an HMO did not violate Medicaid freedom of choice provisions, because the beneficiaries still had the choice of staying in the HMO or choosing a different provider.

In *Brinson v Dept. of Public Welfare*,¹⁷ a similar case brought in Pennsylvania state court, a Medicaid beneficiary appealed an order by the state's Secretary of Public Welfare denying a beneficiary's request to be excluded from an experimental managed care program. Ms. Brinson claimed that she was harmed by involuntary inclusion in the program, because she was unable to continue treatment with her existing physicians. The court rejected Brinson's argument that the state agency was required by state law to hold a public hearing before implementing the program. The court also found that despite not being able to continue with her existing physicians, Ms. Brinson still had the freedom of choice among the physicians and specialists covered by the HMO.¹⁸

2. Cases that challenge coverage under Medicaid managed care plans

One of the most complex aspects of a Medicaid managed care contract is that it frequently covers fewer than all services included in a state's Medicaid plan.¹⁹ With respect to contract services, however, managed care companies are liable to the same extent that agencies are liable for the unlawful denial, reduction, or termination of care. As a result, lawsuits that challenge coverage decisions made by managed care companies, like those that make claims against the procedural protections offered by health plans, will name both the company and the state (or solely the state) as the defendant(s). This is done on the theory that the state has a non-delegable duty to protect the entitlement to coverage created by the Medicaid statute, and a contractor that administers a plan on the state's behalf is an agent of the state acting under color of law. As a result, state agencies may be liable for allegedly unlawful denials of coverage regardless of whether the entity actually making the denial is the state or its managed care contractor.

14 However, the challengers to a state's mandatory program were successful in *Beno v Shalala*, 30 F.3d 1057 (9th Cir. 1994) and *Crane v Matthews*, 417 F. Supp. 532 (N.D. Ga. 1976).

15 833 F. Supp. 549 (D. Colo. 1995).

16 The Court also held that the pharmacists who had also brought suit lacked standing to bring a claim under this provision of the Medicaid Act.

17 163 Pa. Cmwlth. 408 (Pa. 1994).

18 The court's ruling was based on a Pennsylvania statute guaranteeing freedom of choice.

19 See *Negotiating the New Health System*, *supra* note 2.

In several states, Medicaid beneficiaries have successfully challenged the adequacy of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services provided by managed care companies participating in the state's Medicaid managed care program. Most EPSDT suits have been settled out of court through detailed agreements in which the state ensures that the managed care company will comply with existing federal EPSDT requirements.²⁰ Such a settlement was recently reached in *John B. v Menke*,²¹ a suit brought on behalf of children enrolled in TennCare, Tennessee's Medicaid managed care program. The settlement establishes specific standards and timetables for compliance with federal outreach requirements, screening, diagnosis and treatment mandates, requires a case-by-case determination of medical necessity and provision of all required service, and prohibits specific managed care cost containment practices that would limit the provision of EPSDT services. Furthermore, the settlement requires the state to monitor the managed care company's case management operations and track the receipt of EPSDT services and to conduct sample audits to ensure compliance with the terms of the consent decree. The achievement of a comprehensive negotiated settlement like the one in *Menke* is likely to become a model for beneficiaries, states, and managed care companies to follow in attempting to resolve other EPSDT managed care cases.

The *Menke* settlement illustrates the legal principal that state Medicaid agencies retain ultimate responsibility for providing health care services sufficient in scope to achieve Medicaid's intended purpose, i.e., public access to health care services. Coverage under federal Medicaid law is a complex subject which includes many issues: the classes of services that must be covered (which is determined by the contract); the amount, duration, and scope limits that may lawfully be applied to covered services and benefits (which also may be determined by the contract); and the criteria and standards that should be applied in determining whether a covered service is medically necessary for a particular beneficiary.²² As noted, all of these coverage issues have resulted in Medicaid litigation in the past, and all can be expected to arise in future litigation involving Medicaid managed care beneficiaries.

3. *Due process cases*

Courts have interpreted the federal Medicaid law to create a Constitutionally protected property right based on the "brutal need" that is required to gain welfare eligibility. Thus, in situations that involve an individualized factual determination of whether benefits are due, benefits may not be terminated or reduced without a fair hearing that meets Constitutional due process requirements. These requirements include an understandable notice of agency action with the reasons stated for the action, an opportunity for an informal hearing before an impartial decision-maker at a "meaningful time" and in a "meaningful manner", the opportunity to be represented by counsel, the right to personally appear and present evidence and to confront and cross examine witnesses, and a final decision that is in writing and that includes the reasoning underlying the ruling. Most

²⁰ EPSDT suits that have been settled with detailed agreements about the provision of services in Pennsylvania include *Scott v Snider*, 91-CV-7080 (E.D. Pa., Dec. 1994) and *Metts v Houston*, 97-CV-4123 (E.D. Pa., March 1998).

²¹ CV 3-98 0168 (M.D. Tenn., Feb. 1998).

²² For a review of medical necessity issues in Medicaid managed care, see *Coverage Decision-Making in Medicaid Managed Care: Key Issues in Developing Managed Care Contracts* (Issue Brief No.1), Managed Behavioral Health Care Issue Brief Series, Center for Health Policy Research, (Washington, DC, May, 1998).

importantly, these principles, which are embodied in Medicaid fair hearing regulations,²³ provide that assistance cannot be reduced or terminated in such an instance until a final decision is reached, if the hearing is requested in a timely fashion.

Currently, state agencies do not contract with private companies to conduct their fair hearings for them but instead, consistent with the Medicaid statute and regulations, require only that companies administer grievance systems. Typically, a managed care company's complaint and grievance system may fail to track the federal procedural requirements of the regulations, and the company may fail to provide continued benefits for beneficiaries who make a timely request for a hearing.

To date, several cases, including *J.K. v Dillenberg*, have successfully challenged the legal sufficiency of grievance systems, holding that states have a non-delegable duty to provide such hearings prior to termination of coverage.²⁴ As noted, states have attempted to argue that the denials and reductions are simply the result of private provider conduct and thus do not constitute agency action.²⁵ Courts have consistently rejected this argument on non-delegable duty and agency theories.²⁶

4. Medicaid litigation by managed care companies

Federal and state law, as well as Constitutional due process principles, create rights not only for Medicaid beneficiaries, but for managed care companies, as well. However, until recently, federal statutes and regulations generally have provided much more limited due process protection for companies than those owed to beneficiaries. Prior to the Balanced Budget Act of 1997 (BBA), for example, a state could terminate a provider contract without affording a company a pre-termination hearing. However, the BBA codifies²⁷ the holding in *Medicare HMO v Bradley*,²⁸ in which a federal district court for Illinois found that the state's own Medicaid law created a property right in a provider agreement that could not be terminated without a prior fair hearing and struck down as *ultra vires* a state contract that provided for termination "at will" by the state.

Another notable case brought by a managed care company, in this instance against state mental health and substance abuse administrators, is *Value Behavioral Health, Inc. v Ohio*

23 42 C.F.R. §§ 431.200-431.246.

24 See *Perry v Chen*, CIV 95-140 TUC RMB (D. Ariz., August 12, 1996); *Daniels v Wadley*, 926 F. Supp. 1305 (M.D. Tenn. 1996), vacated on other grounds; and *Daniels v Menke*, 1998 WL 211763 (6th Cir., April 22, 1998).

25 The United States Supreme Court in fact reached such a decision in *Blum v Yaretsky*, 457 U.S. 991 (1982), which involved the eviction of nursing home residents by institutions that had determined that they no longer satisfied the level of care requirements needed to remain in the institution.

26 A similar argument was made by the Secretary of Health and Human Services in the case of Medicare grievances but rejected by the United States Court of Appeals in *Grijalva v Shalala*, 1998 U.S. App. LEXIS 18591 (9th Cir., Aug. 1998). Other courts, adhering to the decisions in Medicare cases and rejecting the private provider theory set forth in *Blum v Yaretsky*, have held that in many cases private providers in fact assume the role of the state because of the scope of their administrative duties and thus cannot simply be viewed as private contractors. See, e.g., *Catanzano v Wing*, 103 F.3d 223 (2nd Cir. 1996).

27 42 U.S.C. § 1396u-2(4)(B). This provision of the BBA may lead states to write contracts with shorter terms in order to avoid lengthy and arduous termination battles. Short-term contracts may, however, reduce the number of willing plan participants.

28 788 F. Supp. 1460 (N.D. Ill. 1992).

Department of Mental Health.²⁹ After losing a bid to furnish care, VBH sued, claiming that the state's bidding process had not been "open and free" as required by federal procurement regulations. VBH alleged that the state had (1) accepted the bid of a competing company which did not meet the requirements of the RFP; (2) disclosed to the competitor the amount of administrative overhead contained in VBH's bid; and (3) allowed the competitor to revise its bid to match VBH's overhead costs after the closing date for submission of the proposals. The court held that federal procurement regulations created enforceable property interests in *potential* bidders, and thus enjoined the state from entering into any contract resulting from a defective bidding process and ordered the appointment of a special monitor to oversee the new process.³⁰

Future directions for Medicaid managed care litigation

The Balanced Budget Act of 1997 allows state Medicaid programs to create mandatory managed care systems for most beneficiaries as a state option and without federal waivers. At the same time, the law establishes standards and safeguards for state Medicaid programs that elect to administer state option programs. The BBA standards address, coverage, access, enrollment, and quality.³¹ Federal regulations implementing the BBA are pending as of September, 1998. However, while the regulations will provide more definitive answers to certain questions, the legislation itself is self-executing. As a result, litigation in "state option" states for breach of the BBA standards would be permissible regardless of the status of the regulations, which are expected to be issued only in proposed form. The extent to which individuals can enforce the BBA safeguards through direct legal action is unclear and recent decisions by courts considering Medicaid challenges to state administrative practices are inconsistent.³² To the degree that the BBA standards are enforceable by individuals, litigation probably can be expected to arise in the future.

29 966 F. Supp. 557 (S.D. Ohio 1997).

30 Although the state appealed the case, the United States Court of Appeals for the Sixth Circuit on July 13, 1998 dismissed the appeal as moot and vacated the injunction and judgment of the district court. The Appellate Court's order was based on the fact that VBH was purchased by Ohio Behavioral Health Partnership (OBHP) after the district court's decision, and OBHP advised the Appellate Court that it no longer sought to uphold the injunction and did not intend to further pursue the litigation. The Ohio Department of Mental Health subsequently advised the Appellate Court that the case was moot and that the appeal should be dismissed. While technically the *Value Behavioral Health* case has no legal significance, it should nonetheless be noted that at least one court—the district court in *Value Behavioral Health*—determined that disaffected *potential* bidders for state contracts enjoyed enforceable property interests stemming from federal procurement regulations. It thus seems likely that other potential bidders for state and local government procurements will advance the theory used by VBH in the hope of halting allegedly defective bidding processes. See also *Health Right v Barry*, (D.C. Contract App. Bd., 1997), a decision in which the District of Columbia Contract Appeals Board overturned a Medicaid procurement award because of violations of federal procurement rules, including the absence of any factual record on which the award was based.

31 For a memorandum summarizing key provisions of the BBA, please contact Sherrida Taylor at the Center for Health Policy Research at (202) 530-2349.

32 See, e.g., *Blessing v Freestone*, 117 S. Ct. 1353 (1997); *Harris v James*, 883 F. Supp. 1511 (M.D. Ala. 1995); *Haymons v Williams*, 795 F. Supp. 1511 (M.D. Fla. 1992); *Steele v Magnant*, 796 F. Supp. 1143 (N.D. Ind. 1992); *Jordano v Steffen*, 787 F. Supp. 886 (D. Minn. 1992); *Audette v Sullivan*, 19 F.3d 254 (6th Cir. 1994).