

**STATE EFFORTS TO LIMIT EPSDT SERVICES
PURSUANT TO MEDICAID'S REASONABLE STANDARDS PROVISION**

Center for Public Representation
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I. Introduction

As part of each State's Medicaid Plan (State Plan) required by 42 U.S.C. §1396a(a), State's must provide at least seven mandatory services.¹ They may provide up to twenty optional services.² All services that are included in the State Plan ordinarily must be provided consistent with the other requirements of the statute, such as its reasonable promptness,³ amount, duration, and scope,⁴ and statewideness provisions,⁵ absent a waiver by CMS of a particular requirement.⁶ In addition, the statute requires -- and permits -- the State to establish standards and eligibility criteria for services offered in its State Plan.⁷ This section, commonly called the reasonable standards provision, generally affords the State considerable discretion to define and describe covered services, including the medical necessity criteria for each service. Medical necessity is a basic concept in the Medicaid program, although it does not appear anywhere in the statute, is only referenced in the Medicaid regulations,⁸ and is left to the States to define in their State Plan.⁹

¹ 42 U.S.C. §§1396a(a)(10)(A); 1396d(a)(1)-(5), (17), and (21).

² 42 U.S.C. §§1396a(a)(10)(A); 1396d(a)(6)-(16), (18)-(20), (22)-(27).

³ 42 U.S.C. §1396a(a)(8).

⁴ 42 U.S.C. §1396a(a)(10)(B).

⁵ 42 U.S.C. §1396a(a)(1)

⁶ CMS waiver authority under the Act is broad and potentially becoming broader. *See* 42 U.S.C. §§ 1315(a), 1396n(c). While a detailed discussion of demonstration waivers, home and community-based services waivers, and other waiver provisions is beyond the scope of this paper, States such as Florida and Oregon are testing the limits of this authority to transform the Medicaid benefit from an entitlement to federal grant program, with limited enrollment, capped expenditures, and restricted access to services. For a good discussion of this trend see "Overview of 1115 Waivers: Legal Concerns, by Jane Perkins, on the public page of the NAPAS website under "Disability Issue Areas/Medicaid."

⁷ 42 U.S.C. §1396a(a)(17).

⁸ 42 C.F.R. §440.230(d). Because this regulation has been interpreted as affording States latitude in defining medical necessity, State Plan definitions of the need for medical assistance varies widely, with some States including cost and cost-effectiveness as a relevant factor in weighing the need for a

The Medicaid Act contains a unique benefit for children that substantially exceeds the services which must be provided to adults. Pursuant to the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) provisions, States must provide all Medicaid covered services to children, regardless whether they are specifically enumerated in its State Plan.¹⁰ Thus, the EPSDT mandate effectively obliterates the distinction between mandatory and optional services for children. In addition, the statute establishes a broader obligation to provide such services, requiring that any treatment that is necessary to prevent, as well as to ameliorate, physical and mental conditions must be offered. In effect, EPSDT's broad scope expands what is "medically necessary" for children.¹¹

Neither the legislative history nor the text of the EPSDT provisions address the discretion retained by States to establish eligibility standards for the specific services and treatments they provide to children. As a result, many States have invoked the reasonable standards provision, §1396a(a)(17) [hereafter § (a)(17)], to justify not only service definitions but also access limitations on EPSDT treatments. Clearly, some description of general eligibility criteria for a particular treatment are permitted.¹² But exclusionary standards that preclude access to a medically necessary, non-experimental treatment, are not.¹³ And the wholesale failure to offer an accepted treatment

particular treatment.

⁹ For a detailed analysis of emerging trends in State medical necessity definitions, *see* NHELP Q&A: Defining "Medical Necessity" in State Medicaid Programs, June 2004, available on the NAPAS website.

¹⁰ 42 U.S.C. §§1396(a)(43), 1396d(a)(4)(B), and 1396d(r)(5).

¹¹ For a detailed analysis of the history, purpose, and scope of the EPSDT benefit, *see* Sara Rosenbaum, "Medical Necessity Under the EPSDT Program: When is Coverage Required," George Washington University Medical Center, School of Public Health and Health Services, December 10, 2002 (available on GWUMC/PH&HS website).

¹² For instance, a State may reasonably define the purpose, clinical need, intensity of service (caseload levels), actual activities, and staff qualifications for its intensive case management program. But it could not do so in a manner that excluded altogether a child who needed case management services. It is less clear whether it can define case management in a manner that precludes the provision of a particularly important activity, such as attending a treatment team meeting. Arguably, if such a limitation undermines the effectiveness of the service or is inconsistent with the accepted purpose and functions of case management, the limitation is unreasonable.

¹³ Limiting a particular type of treatment to children over a certain age or in a discrete portion of the State is not reasonable, absent medical evidence that age or residency is fairly related to the need for, or effectiveness of, the treatment.

intervention for children, such as homebased services,¹⁴ cannot be rationalized as an exercise of allowable discretion under §(a)(17). There remains, however, the difficult issue of exactly what discretion States may exercise under this provision in regulating services for children.

II. The Reasonable Standards Provision of the Act

The statute requires that State Plans must “include reasonable standards for determining eligibility for and the extent of medical assistance under the plan.” 42 U.S.C. §1396a. Those standards, furthermore, must be “consistent with the objectives” of the Medicaid Act. *Id.* Significantly, the broader objectives of the EPSDT program inform the measure of reasonableness of standards for children.

Congress included §(a)(17) in the Medicaid statute in order to ensure that States were not arbitrary or overly stringent in their provision of Medicaid services. While Medicaid is a partnership between the States and the federal government, §(a)(17) can best be understood as an effort to cabin state discretion, in order to facilitate the provision of services to Medicaid recipients. The provision should be construed as a safeguard against both intentional and unintentional state parsimony. Based on the language of the provision, courts have scrutinized state standards to assure conformance with Congress’ intent that State Medicaid programs provide necessary medical services to those who cannot afford them, and to children who need either preventive or remedial services.

The reasonable standards provision has twin aims: to ensure that States correctly employ eligibility standards and to ensure that States correctly set standards for determining the extent of medical assistance provided under their State Plans. The language on eligibility has been revised several times, indicating that Congress has taken an active role in ensuring that those who are entitled to Medicaid benefits actually receive them.

A. *Standards That Define What Services Are Covered*

One function of state standards under §(a)(17) is to establish and describe the programs it

¹⁴ Home-based services for children are designed to treat the child in his home or home community and prevent out of home placement through a proven model of care. Although they are an accepted and effective treatment intervention, some States do not cover home-based services under their Medicaid program or as part of the EPSDT benefit. Litigation to compel States to offer this service have resulted in impressive settlements and court orders. *See Emily Q. v. Bonta*, 208 F.Supp.2d 1078 (C.D.Cal. 2001); *Risinger v. Concannon*, 201 F.R.D. (D.Me. 2001). A major class action to force the Commonwealth of Massachusetts to create a statewide program of home-based services is scheduled for trial this month. *See Rosie D. v. Romney*, 310 F.3d 230 (1st Cir. 2002). The State is defending the case based, in part, on its discretion under § (a)(17) to determine what type of mental health services it will cover under its Medicaid program.

covers under Medicaid. In effect, this statutory section is the authority for States to define the type of services it will provide to eligible recipients. States may invoke this section for its decision to offer one type of treatment (hospitalization), but not another (personal care). While States possess the discretion not to provide any of the twenty optional services for adults, they cannot decline to offer mandatory services. However, since this distinction is irrelevant for children pursuant to the EPSDT mandate of the Act, States cannot invoke their discretionary authority under §(a)(17) to refuse to provide a particular form of non-experimental treatment for children, such as home-based services. As long as a particular type of treatment or service is necessary, States have no flexibility under §(a)(17) to decline to offer that service to children.

Both the Supreme Court and the courts of appeals have emphasized that §(a)(17) imposes a mandate on States to establish eligibility standards that prevent an unjust denial of Medicaid benefits to individuals who should receive assistance under the Act. *See Schweiker v. Hogan*, 457 U.S. 569 (1982) (undertaking a comprehensive review of the 1965 Congressional understanding of comparability requirements for eligibility determinations); *see also Hogan v. Heckler*, 769 F.2d 886 (1st Cir. 1985) (reviewing the legislative history of the eligibility requirements of the provision, when determining that a six-month spend-down requirement for eligibility was not invalid). In *Schweiker*, the Supreme Court cited to Congressional testimony illustrating that Congress sought to prevent States from denying Medicaid to individuals who had a higher income than those typically granted Medicaid benefits, but also had higher medical costs, such that “the excess of the individual’s income [was] small when compared with the cost of the medical care needed.” *Schweiker*, 457 U.S. at 573. The denial of benefits to such people, according to the 1965 House Report cited by the *Schweiker* court, was “one of the weaknesses identified in the medical assistance for the aged program.” *Id.* at n. 7 (citing 1965 House Report at 68).

B. Standards That Describe Access Criteria for Services

States have considerable latitude to describe the eligibility criteria and access restrictions for a particular service. This flexibility is particularly broad with respect to the optional services it elects to offer to adults. In addition to allowing for a review of these eligibility criteria, Congress also intended §(a)(17) to impose constraints on State discretion to establish standards for the medical services provided under State Plans. As the statute makes clear, a State’s decision to deny services must be “consistent with the objectives of the Act” and “reasonable.” Courts have carefully scrutinized the extent of medical services provided under State Plans to determine whether service descriptions and access restrictions are reasonable and consistent with the purpose of the Act. Most descriptions and restrictions are incorporated in the definition of medical necessity (or need) for a specific service.

In *Beal v. Doe*, the Supreme Court used the statutory language regarding consistency and reasonableness as a two-factor test for reviewing a State’s refusal to fund abortions that were not deemed medically necessary according to the State’s three-physician certification process. *See* 432 U.S. 438 (1977). The Court decided that the denial of funding was consistent with the objectives of the Medicaid Act, stating that the “broadly stated primary objective” of the Medicaid Act was “to

enable each State, as far as practicable, to furnish medical assistance to individuals whose income and resources are insufficient to meet the costs of *necessary* medical services.” *See Beal*, 432 U.S. at 444 (emphasis added). The determination that the abortions in question were not deemed medically necessary by physicians was critical to the Court’s analysis. The Court noted, “Although serious statutory questions might be presented if a state Medicaid plan excluded necessary medical treatment from its coverage, it is hardly inconsistent with the objectives of the Act for a State to refuse to fund unnecessary though perhaps desirable medical services.” *See Beal*, 432 U.S. at 444-445.¹⁵

1. Who determines medical necessity

Although States may be able to establish eligibility criteria and access requirements for categories of services as well as specific treatment programs, it is less clear whether they can control access to treatment by displacing individual determinations of medical necessity by treating doctors. Courts have differed widely in their deference to the decisions of treating clinicians. The trend, however, is toward State discretion rather than deference to the treating professional. This trend is of limited relevance to Children seeking services. *See* List of Judicial Decisions re: Medical Necessity, prepared by the Center for Public Representation, May 2002, attached to this Fact Sheet. Some circuits, notably the Eighth, have afforded medical professionals the ultimate, unreviewable decision of whether a person needs, and therefore must be provided, treatment, regardless of access standards established by the State under §(a)(17). Other circuits, most notably the Second, have allowed States wide discretion to establish standards, define medical necessity, and ultimately determine whether a recipient is qualified for the program and entitled to the treatment.

The Court in *Beal* was careful to note that the decision of whether to fund the abortions was based “solely on the physician's determination of medical necessity” and that “nothing in the Pennsylvania Medicaid plan” indicate[d] state interference with the physician's initial determination. *Beal*, 432 U.S. at 446. In the one facet of the program where the state might have been seen as interfering with the physician’s determination -- the State’s procedure that required two additional physicians to approve the medical necessity determination of the recipient’s initial physician -- the Court concluded that it was unable to determine whether the requirement “interferes with the attending physician's medical judgment in a manner not contemplated by the Congress.” *Id.* at 448.

Following *Beal*, several courts have held that the treating physician and not the State should make the final determination of whether a treatment is medically necessary. *Weaver v. Reagan*, 886 F.2d 194 (8th Cir. 1989); *Pinneke v. Preisser*, 623 F.2d 546 (8th Cir. 1980). This interpretation is based, in part, on the legislative history of the Medicaid Act. As noted in *Pinneke*, “[t]he legislative history also supports the conclusion that Congress intended medical judgments to play a primary role in the determination of medical necessity.” *Pinneke*, 623 F.2d 549. The relevant legislative

¹⁵ The Court in *Beal* also did not find the denial of funding unreasonable, given the State had an “unquestionably strong and legitimate interest in encouraging normal childbirth.” *Id.*

report indicated that: “[t]he Committee’s bill provides that the physician is to be the key figure in determining utilization of health services - and provides that it is a physician who is to decide upon admission to a hospital, order tests, drugs and treatments and determine the length of a stay.” See S.Rep. No. 404, 89th Cong., 1st Sess., reprinted in 1965 U.S.Code Cong. & Admin.News 1943, 1986. See also *Holman v. Ohio Department Human Services*, 757 N.E.2d 382, 388 (Ohio Ct. App. 2001); *A.M.L. v. Utah Department Health*, 863 P.2d 44, 48 (Utah Ct. App. 1993); *Dodson v. Parham*, 427 F. Supp. 97, 108 (N.D. Ga. 1977).

In addition to the legislative history and statutory text in support of deference to treating physicians, courts have also found physicians to be better suited than state agencies in determining what specific services are medically necessary for individual patients. Courts have relied upon the fact that treating physicians are “intimately familiar” with their patients’ specific medical situation and, therefore, can make more informed, better determinations of what services are medically necessary than the State.¹⁶ See *Dodson*, 427 F. Supp. at 108; *Pinneke*, 623 F.2d at 550. Courts prefer to rely on treating clinicians as the final arbiters of medical necessity because they specialize in the conditions at issue and are most informed about effective and appropriate treatments. See *Dodson*, 427 F. Supp. at 107, 108.

While physician discretion is not entirely unbounded -- physicians cannot, for example, require the state to provide services such as non-therapeutic abortions that are not medically necessary when the State has a compelling countervailing interest in refusing to provide such treatment -- courts have carefully reviewed limits on physician discretion in terms of whether they are reasonable and consistent with the objectives of the Medicaid Act. In *Weaver v. Reagen*, for example, the Eighth Circuit found that Missouri’s rule that AZT could never be a medically necessary treatment for AIDS patients with certain T cell levels was unreasonable, in light of the record establishing that AZT was widely recognized as the only known antiviral treatment for individuals with AIDS. It also concluded that the rule was inconsistent with the objectives of the Medicaid Act, because it reflected “inadequate solicitude for the applicant's diagnosed condition, the treatment prescribed by the applicant's physicians, and the accumulated knowledge of the medical community.” See *Weaver*, 886 F.2d at 200, citing *Pinneke*, 623 F.2d at 549. The court noted that “[t]he Medicaid statute and regulatory scheme create a presumption in favor of the medical judgment of the attending physician in determining the medical necessity of treatment.” The *Weaver* Court went on to add that several courts require state Medicaid agencies to recognize a presumption “in favor of the medical judgment of the attending physician in determining the medical necessity of treatment.” *Weaver v. Reagen*, 886 F.2d 194, 200 (8th Cir.1989). See also *Pinneke*, 623 F.2d 546, 550 (8th Cir.1980); *Frey v. Bowen*, 816 F.2d 508, 513 (10th Cir.1987); *Worthington v. Idaho Dep't of Health and Welfare*, No. 69458, slip op. at 5 (2d Dist. Idaho Feb. 20, 1992) (holding

¹⁶ This is especially true when dealing with the provision of mental health services: unlike a determination whether to provide glasses or contacts, the determination of whether to provide services in a child’s community as opposed to an institutional setting can have permanent effects on the child’s progress.

that "the legislative history, Medicaid case law, and the mechanics of the Medicaid program itself require that an attending physician's opinion as to what constitutes medical necessity in a given case be given deference"); *A.M.L. v. Department of Health, Division of Health Care Financing*, 863 P.2d 44, 48 (Utah App.,1993); *Rush v. Parham*, 440 F.Supp. at 389.

C. *The Limits on State Discretion Under §(a)(17)*

State discretion to define medical necessity is constrained by certain limitations applicable to all populations. The first limitation is a requirement that a State's medical necessity standard be reasonable. 42 U.S.C. §1396a(a)(17)(A). The second is a requirement that the state standard be consistent with the purpose of the particular Medicaid benefit at issue. 42 C.F.R. §440.230. Third, federal regulations prohibit States from arbitrarily discriminating on the basis of a condition in the case of a required service. 42 C.F.R. §440.230.

While States may have broader discretion to determine what adult services are appropriately considered medically necessary, even this discretion is constrained by the more general purposes of the Act. Thus, in the context of adult services, the First Circuit held that medical necessity determinations are made at two levels: the first is a "macro-decision" by the legislature to deem certain kinds of medical assistance as sufficiently necessary to be included in the state plan and the second is a "micro-decision" made by the physician to administer a type of medical assistance that the legislature has made available. *See Pre-term v. Dukakis*, 591 F.2d 121 (1st Cir. 1979).¹⁷ State macro-decisions are reviewed according to the reasonableness and consistency requirements of §a)(17), as set forth in *Beal*. In *Pre-term*, the First Circuit held that the State violated the purposes of the Medicaid Act when it singled out specific forms of abortion as excluded from coverage under the State Plan. The macro-decision was "unreasonable" and wholly "(in)consistent with the objectives of the Act". *See Pre-term*, 591 F.2d at 126 (citing 42 U.S.C. 1396a(a)(17)). The court found no "rational social objective" served by providing services to only one subset of a population that required them. *Id.* The court also found that the decision to deny abortions was inconsistent with the Medicaid statute "which provides for a central role for the physician in determining proper treatment" because it drastically circumscribed the physician's role. *Id.* at 126-127.

Pre-term, like *Beal*, was concerned with State discretion in light of the more general goals of the Medicaid Act, which allows States to exclude coverage of optional services and bypass other State Plan requirements if waived by CMS. The EPSDT mandate, however, erases the distinction between mandatory and optional services and, at least arguably, cannot be waived and is not affected by approved waivers.¹⁸ Both *Pre-term* and *Beal* were decided before the 1989 expansion of EPSDT

¹⁷ In *Pre-term*, the First Circuit reviewed the legislature's "macro-decision" to refuse funding for abortions that did not involve rape or incest or were not deemed necessary to save the woman's life.

¹⁸ Indeed, there is a persuasive argument that EPSDT requirements *cannot* be waived as a matter of law. Section 1115 (42 U.S.C. §1315(a)) authorizes the Secretary to waive only sections of Medicaid law dealing with a State Plan under Section 1902. EPSDT requires the provision of

required States to provide *all* necessary measures to recipients, *regardless* of whether the measures were formally included in the State Plan.¹⁹ *See* 42 U.S.C. §1396d(r)(5)(requiring states to provide “necessary health care, diagnostic services, treatment, and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.”). Thus, the objectives of the Medicaid Act for adults, and the EPSDT provisions applicable to children, impose different constraints on a State's discretion to establish standards pursuant to §(a)(17) that are "consistent with the provisions of the Act." Consequently, more recent appellate and lower court decisions that afford considerable latitude to States in defining eligibility criteria or in determining medical necessity for specific treatments are of limited relevance to children. Because State decisions as to whether or not a service should be included in their State Plan is irrelevant to children under §1396a(d)(5), the macro-level discretion has effectively been displaced by Congress' command that all services necessary to prevent or ameliorate a medical or mental health condition must be provided. *See S.D. ex rel Dickenson v. Hood*, 391 F.3d 581 (5th Cir. 2004).

III. The Expanded Purpose and Scope of the EPSDT Provisions of the Act

services regardless of “whether or not such services are covered under the State plan.” 42 U.S.C. §1396d(r)(5). Therefore, since EPSDT services cannot be limited by the State Plan, waiver of plan requirements cannot restrict or affect a State’s EPSDT obligations.

In *John B. v. Menke*, the court concluded that:

Although the state has received a federal Medicaid waiver, it is still bound to comply with the federal EPSDT requirements, even if the state utilizes a managed care system. EPSDT services are not optional, and may not be limited, even pursuant to a Medicaid waiver.

176 F. Supp. 2d 786, 800 (M.D. Tenn. 2001). While the court noted that CMS had granted waivers of State Plan requirements concerning EPSDT in two states in the past, it expressed uncertainty as to “current feasibility of obtaining an EPSDT waiver.” *John B.*, 176 F. Supp. 2d at 800, n.106, 804, n. 119.

¹⁹ As more fully discussed below, as part of the Omnibus Budget Reconciliation Act of 1989, Congress substantially expanded the purpose and scope of Medicaid's EPSDT requirements. Most significantly, it added a broad and unconditional obligation to provide all necessary treatment to the pre-existing informing, screening, and diagnosis requirements.

In 1989, frustrated with the inability of states to provide adequate health services for children, Congress significantly amended the EPSDT section of Medicaid statute, via the Omnibus Budget Reconciliation Act of 1989, to require States “to provide Medicaid coverage for any services” “identified as medically necessary through the EPSDT program.” *Rosie D. v. Swift*, 310 F.3d 230 (1st Cir., 2002)(citing 135 Cong. Rec. S6899, 6900 (daily ed. June 19, 1989)). *See also*, e.g. H.R. Conf. Rep. 101-386, p. 453, 1989 U.S.C.C.A.N. 3018, 3056 (“States are required to provide *any service* that a State is allowed to cover with Federal matching funds under Medicaid that is required to treat a condition identified in the screen, *whether or not* the service is included in the State’s Medicaid plan.”)(emphasis added). The 1989 amendments both required States to provide a comprehensive package of preventive services and expanded the available services under EPSDT to include “[s]uch other necessary health care, diagnostic services, *treatment*, and other measures described” to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services....§1396d(r)(5)(emphasis added).

Congress adopted the 1989 OBRA changes in response to the continued failure of States to provide for aggressive preventive and ameliorative services for the Nation’s most economically disadvantaged children. Legislators emphasized that “[t]he EPSDT benefit is, in effect, the Nation’s largest preventive health program for children” during the OBRA hearings. *See, e.g.*, H.R. Rep. No. 101-247 at 398 (1989), 1989 U.S.C.C.A.N. 1906, 2124. The legislative history of the 1989 amendments support the proposition that States have less discretion with regards to EPSDT than other mandatory services: the legislative record and the subsequent adoption of amendments indicate that Congress sought to cabin the discretion of States when determining to what extent services would be provided. To permit States final control for determining which services are medically necessary would contravene Congress’ intent in enacting an amendment that was designed to circumscribe the States’ discretion under EPSDT. By including language that required States to provide all medically necessary services, Congress distinguished the EPSDT program from the rest of the Medicaid statute, where States have broader discretion to establish standards, define medical necessity, and limit access, particularly for optional services.

Two distinct aspects of EPSDT are relevant to the treatment component of the statute. The first is the range of diagnostic treatments and services to which children are entitled under EPSDT. This range encompasses all forms of medical assistance which fall within the very broad federal definition of medical assistance found at 42 U.S.C. §§1396d(a) and 1396d(r). *See* Conf. Comm. Rep. to Accompany H.R. 3299, Omnibus Budget Reconciliation Act of 1989, Title VI. These provisions enumerate literally dozens of classes of medical assistance, each one of which can encompass hundreds of sub-classes of reimbursable procedures.

The second distinctive aspect of EPSDT is its special medical necessity standard, which is used to measure when covered services actually will be provided. In this regard EPSDT stands in contrast to adult Medicaid coverage rules, which authorize States to exercise considerable discretion over standards of medical necessity. The interaction of the general limitations on State discretion, noted above, with EPSDT’s specific purpose and mandated coverage leads to the unique medical necessity requirements which govern EPSDT.

Understanding how the purpose test contained in 42 C.F.R. §440.230 expands the meaning of medical necessity under EPSDT requires an understanding of the unique purpose of EPSDT. EPSDT's fundamental preventive purpose acts as a powerful check on state discretion over matters of medical necessity. These constraints on State discretion -- in particular the reasonableness standard -- which when applied to the purpose and scope of the EPSDT benefit itself -- distinguishes the EPSDT medical necessity from that which may be used for adults. This fundamental understanding of EPSDT has been a feature of judicial decisions involving the program virtually since its inception. This history is also captured in the legislative history to the 1989 EPSDT amendments, when Congress reiterated the preventive purpose of EPSDT by substantially expanding the scope of the program. H. Rep. No. 101-247, §4213 to accompany HR. 3299 (The Omnibus Budget Reconciliation Act of 1989) ("The EPSDT benefit is, in effect, the Nation's largest preventive health program for children.")

The 1989 amendments effectively limit the role of state legislatures and agencies in setting standards, establishing criteria, and making medical necessity determinations that restrict a child's access to a needed service. Given that one of the main objectives of EPSDT is to provide medically necessary services to children -- regardless of whether those services are included in the State Plan -- States cannot justify a failure to offer or even create a needed treatment that a physician has deemed medically necessary as a "macro-decision" authorized by §(a)(17). Thus, a State cannot properly argue that, pursuant to § (a)(17), it can decline to offer home-based services, or fail to create a statewide home-based services program, if there are children who need this type of treatment.

Courts have relied on the language of §1396d(r)(5) when reviewing State claims that the statute granted them "discretion" to determine which services to provide. *See, e.g., Pediatric Specialty Care, Inc. v. Arkansas Department of Human Services*, 293 F.3d 472 (2002) (holding that the State was required to pay for early intervention treatment services and therapy, and stating that the state plan "must pay part or all of the cost of treatments to ameliorate conditions discovered by the screening process when those treatments meet the definitions set forth in §1396a." *See Collins v. Hamilton*, 349 F.3d 371, 376 (7th Cir., 2003); *Pereira v. Kozlowski*, 996 F.2d 723, 725-26 (4th Cir., 1993) ("In section §1396d(r)(5), the Congress imposed upon the states, as a condition of their participation in the Medicaid program, the obligation to provide to children under the age of twenty-one all necessary services, including transplants."); *Pittman v. Secretary of Florida Department of Health & Rehabilitation Services*, 998 F.2d 887, 891 (11th Cir., 1993).

In the EPSDT context, the physician's determination of medical necessity is paramount. In *Collins v. Hamilton*, the plaintiffs sought injunctive and declaratory relief requiring Indiana to cover psychiatric residential treatment that was considered medically necessary as a result of an EPSDT screening. The Seventh Circuit rejected the State's argument that it could elect to provide needed services through its inpatient psychiatric hospitals, thereby obviating the need for residential treatment. The court determined that, "[a]s an initial matter, there is a distinction between the acute care available in a psychiatric hospital setting and the less restrictive treatment provided by a residential facility." 349 F.3d at 376. The court then added that "in order for a child to qualify for

residential treatment an EPSDT screening by a competent medical service provider must determine that residential treatment is required,” thereby emphasizing that the provider was the proper decisionmaker as to the need for hospitalization and the appropriateness of residential placement. *Id.*

Similarly, in *Pereira*, 996 F.2d 723, the Fourth Circuit Court of Appeals decided that under EPSDT, the State was required to provide a three-year old with a heart transplant, notwithstanding the contention that the State had discretion in determining which transplants it would fund. The State attempted to argue that 42 U.S.C. §1396b(i)(1), which at the time provided that federal Medicaid payments would not be made for organ transplants unless States promulgated specified written procedures, gave the State complete discretion to provide as little or as much transplant coverage as it chose. Judge Luttig, writing for the Fourth Circuit, disagreed. The court determined that the EPSDT provisions “imposed upon the States, as a condition of their participation in the Medicaid program, the obligation to provide to children under the age of twenty-one all necessary services, including transplants.” *Id.* at 725-726. The *Pereira* court was sensitive to the fact that it was holding that all medically necessary organ transplants under EPSDT were required, acknowledging that: “We are not unaware of the potential consequences of our decision today.” *See also Pittman v. Secretary of Department of Health & Rehabilitation Services*, 998 F.2d 887, 891 (11th Cir., 1993) (adopting with approval the *Pereira* court’s argument that the 1989 amendment to the Medicaid Act removed a State’s discretion to deny treatment found to be “medically necessary” for individuals under the age of twenty-one).

IV. Conclusion

State discretion under §(a)(17) is not entirely eviscerated by the purpose and scope of the EPSDT mandate. States still retain the authority to establish service standards and program criteria, provided these are consistent with the preventive and ameliorative purpose of EPSDT. Thus, they can determine the most appropriate and effective model for providing home-based services. In addition, States can determine access requirements for the provision of services, in order to ensure that the available services are sufficient in amount, duration, and scope. States can, for example, determine qualification criteria for providers, basic conditions like program eligibility criteria, utilization review, and payment mechanisms and rates. Therefore, they can establish reasonable eligibility criteria for home-based services, such as the agreement of the family (biological or foster) to participate in the program and clinical indicators that it is safe for the child to remain in the home. Finally, States are not required to provide services that clinicians have not deemed medically necessary. But they cannot rely on the absence of such determinations when they have totally failed to make a service available, failed to inform individuals and clinicians that such service is covered by the EPSDT benefit, and offered no effective means to request and obtain a needed service.

LIST OF JUDICIAL DECISIONS RE: MEDICAL NECESSITY

I. Court of Appeals

(1) *Smith v. Rasmussen*, 249 F.3d 755, 759 (8th Cir. 2000): Court reaffirms finding that medical necessity is the proper standard for assessing State discretion under the Medicaid Act; upholds Iowa regulation which denies coverage for sex change surgery, even though medically necessary for plaintiff, since regulation reflects expert panel's conclusions that there is no consensus in the medical community that surgery is effective, that there are other available treatment options, and that 36 other States deny coverage

(2) *Rodriguez v. City of New York*, 197 F.3d 611, 617 (2d Cir. 1999): New York is not required to provide safety monitoring as part of its personal care service, even though the class plaintiffs cannot participate in the personal care program without safety monitoring and, therefore, safety monitoring is medically necessary for the plaintiffs; State has broad discretion to define and implement optional services

(3) *DeSario v. Thomas*, 139 F.3d 80, 90-96 (2d Cir. 1998): State can define durable medical equipment (DME) for purposes of its State plan; its determination that certain items are not properly considered DME, even if the item is medically necessary for a particular individual, is rational. State can also exclude from its coverage schedule an item which clearly fits within its definition of (DME), even if medically needed by certain recipients, provided that coverage exclusions are consistent with the Act's objective of ensuring a fair distribution of Medicaid resources to all eligible recipients, based upon valid criteria like cost controls, and still result in a reasonable amount of DME services for the Medicaid population taken as a whole.

There is no requirement that State fund all medically necessary treatment, since medical necessity and Medicaid coverage are entirely different concepts; Act's objective is to provide medical services *as far as practical*; regulation's constraints on State's discretion includes, but are not limited to medical necessity and utilization review procedures. Court rejects view of other circuits that doctor's individual medical necessity determination is relevant to the State's coverage decision or discretion

(4) *Skubel v. Fuoroli*, 113 F.3d 330, 336-7 (2d Cir. 1997): State's refusal to pay for home health care services outside an individual's home is unreasonable and not a valid exercise of its discretion

(5) *Tallahassee Memorial Regional Medical Center v. Cook*, 109 F.3d 693 (11th Cir. 1997): Boren Amendment requires States to reimburse provider hospitals even for medically unnecessary hospitalization for children under EPSDT program, where State rules require hospitals to admit patients who initially need care and prevent hospitals from discharging these individuals to inadequate settings when they no longer need that level of care; State

agency's failure to provide adequate alternatives results in continued hospitalization and, therefore, requires reimbursement

(6) *State of Texas v. U.S. Department of Health and Human Services*, 61 F.3d 438, 441 (5th Cir. 1995): Federal government properly rejected a proposed amendment to State plan to cover room and board expenses because State cannot exercise discretion to cover services in contravention to purpose of Act and Congressional intent in allowing coverage of certain medical but not other expenses

(7) *Hope Medical Group for Women v. Edwards*, 63 F.3d 418, 425 (5th Cir. 1995): State statute which precludes abortions except to save life of mother conflicts with Medicaid Act, which, after Hyde Amendment, provides funding for broader class of abortions; but States are not required to fund all abortions, or any other service, just because a physician deems it medically necessary, as long as restrictions comply with 42 C.F.R. 440.230

(8) *Hern v. Beye*, 57 F.3d 906, 909-11 (10th Cir. 1995): Colorado statute which precludes abortions except to save life of mother conflicts with Medicaid Act and Hyde Amendment; States are not required to fund all medical services, even in the mandatory categories, but any coverage limitations must be consistent with federal regulations; because limitations on abortion are based on the illness or condition and create an irrebuttable presumption that abortions can never be reasonable except when someone's life is at stake, they are not consistent with these regulations

(9) *Dexter v. Kirschner*, 984 F.2d 979, 983-4 (9th Cir. 1992): States are generally required to cover all mandatory services which are medically necessary for eligible persons; Arizona policy which provides coverage for one type of bone marrow transplants but not another which is medically necessary for certain individuals with a similar disease is reasonable since Congress afforded States special latitude in deciding whether, and to what extent, they would fund organ transplants

(10) *Weaver v. Reagen*, 886 F.2d 194, 197-9 (8th Cir. 1989): State agency's limitation of certain medication to FDA approved group (persons with AIDS and certain T cell levels) violates Act because it denies only available treatment to persons who medically need the drug treatment; medical necessity is properly determined by the treating physician and statute creates a presumption of in favor of the judgment of the attending physician

(11) *Meyers v. Reagan*, 776 F.2d 241, 243-44 (8th Cir. 1985): Iowa could not arbitrarily exclude an electronic speech device from its optional physical therapy program which is deemed to be medically necessary for an individual by his treating clinician

(12) *Mitchell v. Johnston*, 701 F.2d 337, 351 (5th Cir. 1983): State cutbacks of dental program for children violated EPSDT provisions of the Act by failing to provide services

which are sufficient in amount, duration, and scope to achieve their purpose

(13) *Pinneke v. Preisser*, 623 F.2d 546, 549-50 (8th Cir. 1980): Iowa's rule precluding payment for gender identity surgery violates the Act because it overrides the judgment of the treating physician. Medical necessity standard is not explicit in statute but is accepted as implicit in legislative scheme. *Beal v. Doe*, 432 U.S. 438, 444-45 (1977). State must pay for surgery which is medically necessary for individual, as determined by the treating doctor; decision of whether a particular treatment is medically necessary and, therefore, must be provided by the State "rests with the individual recipient's physician and not with clerical personnel or government officials."

(14) *Rush v. Parham*, 625 F.2d 1150, 1155 (5th Cir. 1980): Court of appeal reverses lower court's holding that State must pay for all treatment found by a doctor to be medically necessary, but declines to decide whether the State must provide all medically necessary services. State may adopt definition of medical necessity that places reasonable limits on physician's discretion and can review, on a case by case basis, a physician's determination of needed treatment. Nevertheless, the court acknowledges that the legislative history of the Medicaid Act indicates that "the physician is to be the key figure in determining utilization of health services." 1965 U.S.C.C. & Admin. News pp. 1943, 1986; State's role is limited to reviewing physician's determination that a particular treatment is needed is without any basis in fact. State's definition of medical necessity could reasonably exclude experimental treatment like sex change surgery; "experimental" means a treatment which is rarely used, novel, or relatively unknown

(15) *Curtis v. Taylor*, 625 F.2d 645, 652 (5th Cir. 1980): State may limit services based upon a reasonable judgment of degree of medical necessity so long as it does not discriminate based on medical condition or diagnosis

(16) *PreTerm v. Dukakis*, 591 F.2d 121, 124-27 (1st Cir. 1979): Medicaid Act does not include requirement to provide all medically necessary services. On macro level, State may impose limitations on mandatory services, which include EPSDT services, if consistent with the objectives of the Act to provide medical services to eligible individuals who need treatment but cannot afford it; on micro level, the physician determines which services are medically necessary for the patient. However, State's discretion must be exercised in a manner which is consistent with professional judgment and standards in the medical community. Limitation on abortion funding to cases where mother's life is at risk contravenes the purpose of the Act and the regulatory provisions (42 C.F.R. 440.230) prohibiting limitations based on diagnosis or condition. Because Hyde Amendment substantively modifies the Medicaid Act, and because the Act does not guarantee payment for all medically necessary services determined by a physician, the Amendment is consistent with the Act's permission to allocate funding to the most needy individuals and the most needy conditions

(17) *White v. Beal*, 555 F.2d 1146, 1159 (3d Cir. 1977): Agency rule which covers eyeglasses for persons with eye disease but not with eye defects violates the objective of the Medicaid Act -- to equitably distribute limited resources among all in need of a service; although degree of medical need may be a valid basis for limiting coverage, the distinction drawn by the State here is not factually consistent with that standard since it is based on etiology not need. State has broad but not unfettered discretion to distribute resources and determine coverage based upon need; discretion must be exercised in a manner which bears a rational relationship to the underlying federal purpose of providing medical services to those in greatest need

II. District Court Decisions

[Note: There are a number of lower court decisions which held that under the Medicaid Act, the State is required to provide all medically necessary services and that physicians are the primary if not the final arbiter of whether a service is necessary for an individual patient. Many of these decisions, including those in *Smith*, *DeSario*, *Hope*, *Rush*, and *PreTerm*, have been reversed by the court of appeals in the above cases]

(1) *Bryson v. Shumway*, 177 F.Supp. 2d 78, 89 (D.N.H. 2001): Statutory flexibility to set reasonable standards [42 U.S.C. §1396a] primarily addresses the State's right to establish income eligibility standards, as well as the choice of which procedures and treatment a State will cover in its State plan, as long as the choice is reasonable. The First Circuit has only addressed the income eligibility aspect of this provision. *Lamore v. Ives*, 977 F.2d 713 (1st Cir. 1992); *Hogan v. Heckler*, 769 F.2d 886 (1st Cir. 1985). Because plaintiffs' challenge to inadequate supply of home and community based waiver slots does not implicate either aspect of this provision, they have failed to State a claim under §1396a, and the corollary regulations, 42 C.F.R. §440.230(b) and (d)

(2) *DeLuca v. Hammons*, 927 F.Supp. 132, 136 (S.D.N.Y. 1992): State regulation imposing four hour limit on personal home care services violates medical necessity regulation, 42 C.F.R. §440.230(d); arbitrary caps on services cannot substitute for valid utilization control process

(3) *Miller v. Whitburn*, 816 F.Supp. 505, 509-11 (W.D.Wis. 1993): State plan's exclusion of liver-bowel transplant, even when necessary to save the life of a child, does not violate the Medicaid Act and the 1989 EPSDT amendments; Congress entrusted transplant coverage decisions to the States, and did not intend to further limit that discretion with the subsequent enactment of the mandatory treatment provisions of EPSDT, 42 U.S.C. §1396d(r)(5). Court relies on outdated and unamended regulations, 42 C.F.R. §§441.56(c) and .57, as well as the lack of any legislative history explaining any intention to withdraw all discretion from the States

(4) *Pereira v. Kozlowski*, 805 F.Supp. 361, 362-63 (E.D.Va. 1992): EPSDT provisions are

unambiguous and require States to fund any medically necessary treatment for children, regardless of whether State plan covered the requested service; court approves heart transplant operation, since State did not contest the medical necessity of the procedure or contend that it was experimental. While State may have discretion to decide how to allocate scarce medical resources for adult, Congress precluded this discretion for children in enacting the 1989 amendment to the Act; 42 U.S.C. §1396d(r)(5) unambiguously removes all discretion to deny any medically necessary treatment for a person under the age of 21

(5) *McLaughlin v. Williams*, 801 F.Supp. 633, 637-38, 643-44 (S.D.Fla. 1992): State agency's policy precluding payment for liver-bowel transplant because it is experimental is contrary to medical opinion and, therefore, arbitrary and unreasonable; procedure is safe, effective, and is not novel or rarely used. States are required to fund all medically necessary services, at least for children pursuant to the substantive obligations contained in the EPSDT amendments, 42 U.S.C. 1396d(r)(5); whatever discretion may apply to medical care for adults does not extend to treatment for children

(6) *Visser v. Taylor*, 756 F.Supp. 501, 507 (D.Kan. 1990): State policy denying coverage of certain psychotropic drugs prescribed by physician violates Medicaid Act; prescription drug program, or other procedures, which do not make necessary services available to recipients in a speedy and efficient manner violate Act and regulations, because they are not sufficient in amount, duration, and scope to reasonably achieve their purposes [citing all cases from 1976-1986]. Medical necessity is to be liberally construed in favor of the recipient and is determined by the treating physician exercising professional judgment; States may not eliminate funding for medical services certified by a qualified physician to be medically necessary

(7) *Montoya v. Johnston*, 654 F.Supp. 511, 513-14 (W.D.Tex. 1987): Agency financial cap of \$50,000/child for inpatient hospital expenses is arbitrary and unreasonable, in violation of the amount, duration and scope regulation; State must cover all medically necessary services for children, which includes any procedure which is not experimental and which is medically appropriate

(8) *Allen v. Mansour*, 681 F.Supp. 1232, 1237, 1239 (E.D.Mich. 1986): Agency rule requiring liver donee to have two year documented abstinence from alcohol is arbitrary and unreasonable; since transplant is medically necessary for individual, and since blanket rule is not supported by consensus of medical opinion, blanket denial of coverage violates the Act. Although Medicaid Act does not require funding for all medically necessary services, even in the mandatory categories, medical necessity is the "touchstone for evaluating the reasonableness of the standards in State Medicaid plans." "Cost containment through utilization control was not intended to restrict necessary medical procedures" but only to limit unnecessary or unduly expensive procedures

(9) *Ledet v. Fischer*, 638 F.Supp. 1288, 1291-93 (M.D.La. 1986): Agency policy limiting

coverage for eyeglasses to persons recovering from cataract surgery violates Medicaid Act and regulations; restriction denies sufficient amount, duration, or scope of service to achieve purpose of program, which court concludes is the broader goal of improving vision rather than the narrower objective of providing assistance to those who have had surgery. Recognizing that the definition of the "purpose of the program" often determines the outcome of the analysis, court hold that States are not free to define the purpose of the program since this is a federal responsibility. However, since purpose must be defined in reference to the Medicaid population as a whole, rather than individual, State rules limiting access to a service (hospitalization) to a certain number of days is reasonable only if it that limits ensures meaningful access for most recipients

(10) *Simpson v. Wilson*, 480 F.Supp. 97, 101 (D.Vt. 1979): State's prohibition against payment of funds for corrective eyeglasses violates amount, duration, and scope regulation; there is no medical necessity or utilization control justification for restriction