

Journal of Contemporary Health Law & Policy (1985-2015)

Volume 29 | Issue 1

Article 7

2012

In Whose Hands Are We Placing Children's Health?: An Examination of "Medical Necessity" for Medicaid's EPSDT Provision

Meghan C. Casey

Follow this and additional works at: <https://scholarship.law.edu/jchlp>

Recommended Citation

Meghan C. Casey, *In Whose Hands Are We Placing Children's Health?: An Examination of "Medical Necessity" for Medicaid's EPSDT Provision*, 29 J. Contemp. Health L. & Pol'y 89 (2013).

Available at: <https://scholarship.law.edu/jchlp/vol29/iss1/7>

This Note is brought to you for free and open access by CUA Law Scholarship Repository. It has been accepted for inclusion in Journal of Contemporary Health Law & Policy (1985-2015) by an authorized editor of CUA Law Scholarship Repository. For more information, please contact edinger@law.edu.

IN WHOSE HANDS ARE WE PLACING CHILDREN'S HEALTH?: AN EXAMINATION OF "MEDICAL NECESSITY" FOR MEDICAID'S EPSDT PROVISION

*Meghan C. Casey**

I. INTRODUCTION

In a perfect world, every child would have an equal chance at success. Every child would have equal resources, opportunities, and fair treatment. Although the world is not perfect, the imperfections should not materialize in a court system that perpetuates injustice and inequality. Unfortunately, through the state-by-state administration of Medicaid programs, the courts embody these imperfections. This process of state-by-state administration allows for differing opinions and inconsistent decisions by judges, and, in turn, leads to unequal medical services provided to children.

Imagine a child who is severely disabled, has been diagnosed with mental retardation, and is both blind and nonverbal – a child so physically limited that she cannot feed herself, she requires continuous care to monitor her medications, and she must be repositioned throughout the day. Now imagine that child's parents being told that the child's physician does not have the authority to decide what treatment and services the child needs, but instead, the parents must present evidence to the court as to why their child requires a certain number of hours of nursing care at home.

This is the reality for some children in jurisdictions where courts fail to uphold Congress's intent in the administration of Medicaid's Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program.¹ In other

* Meghan C. Casey is a J.D. and M.S.W. Candidate of the class of 2013 at The Catholic University of America, Columbus School of Law and National Catholic School of Social Service. She received her B.A. in Criminology and Psychology from Stonehill College in 2009. She would like to thank her parents, Richard and Christina Casey, and her friends and family, especially Brian, for their unparalleled patience, encouragement, and support in all of her academic pursuits. She would also like to personally thank her Expert Reader, Ms. Lauren Onkeles-Klein, Senior Supervising Attorney at Children's Law Center. In addition, she would like to thank the editors and staff of *The Journal of Contemporary Health Law and Policy* for all their edits, feedback, and guidance in the completion of this note.

1. Early, Periodic Screening, Diagnosis, and Treatment Services (EPSDT), 42 U.S.C. § 1396d(r) (2006).

jurisdictions, children are properly served and cared for through this program the way Congress intended.²

Now, imagine a child who is lucky enough to have insurance reimburse his family for his physical therapy services. Even with regular physical therapy, he will never walk, but therapy will keep his muscles from severely tightening and will prevent loss of all functionality. Or imagine a child whose insurance pays for incontinence briefs – not because they will cure her incontinence, but because it makes her condition a little more bearable by preventing skin conditions and infection.

In the first scenario, a child is denied nursing services necessary for the management of her severe disabilities which require continuous care and frequent administration of medication.³ In the second and third scenarios, the children are provided services that will not correct their problems, but will make their problems more manageable.⁴ All three examples are real life stories of children enrolled in Medicaid, but all three are facing vastly different realities due to court decisions.⁵

Medicaid has a specific provision for care of individuals under the age of twenty-one known as Early, Periodic Screening, Diagnosis, and Treatment (EPSDT).⁶ EPSDT has two threshold requirements that limit the services a state must provide to children.⁷ First, the medical treatment must be medically necessary.⁸ Second, the service must be used to “correct or ameliorate” a condition discovered through prior screening or diagnosis.⁹ All courts use these requirements to determine what services are medically

2. *Salazar v. District of Columbia*, 954 F. Supp. 278, 303 (D.C. Cir. 1996) (explaining that “[t]he purpose of the EPSDT program is to ensure that poor children receive comprehensive health care at an early age, so that they will develop fewer health problems as they get older.”).

3. *Moore v. Reese*, 637 F.3d 1220, 1220 (11th Cir. 2011).

4. *See generally* *A.M.T. v. Gargano*, 781 F. Supp. 2d 798 (S.D. Ind. 2011); *see also* *Eklhoff v. Rodgers*, 443 F. Supp. 2d 1173, 1180-81 (D. Ariz. 2006).

5. *See generally* *Moore*, 637 F.3d at 1220.; *see also* *A.M.T.*, 781 F. Supp. 2d 798; *Eklhoff v. Rodgers*, 443 F. Supp. 2d 1173, 1180-81 (D. Ariz. 2006).

6. 42 U.S.C. § 1396d.

7. *Id.* § 1396d(r).

8. *Id.* § 1396d(r)(5).

9. *Id.*

necessary under the Medicaid statute. If services do not meet this standard, Medicaid is not required to provide coverage.

The Early, Periodic Screening, Diagnosis, and Treatment program was intended by Congress to be an expansive and comprehensive program.¹⁰ However, children are still being denied access to medically necessary services. Specifically, there are two important and inconsistent trends. First, administrators of certain state Medicaid programs are successfully challenging the medical services provided to children, and those courts are implementing higher standards to prove necessity of treatments. Second, some courts are liberally interpreting the statutory condition of "to correct or ameliorate" and are approving maintenance therapies and preventive care for children with chronic conditions.

In regards to the first trend, by granting states more power to determine the medical necessity of a particular service, courts are moving away from Congress's intent to have a comprehensive program and are consistently providing less coverage than the statute requires. In this way, the statutory language alone is not enough to convey Congressional intent. For that reason, it is important that the statutory language be clarified and courts subsequently be required to apply a more expansive view, covering the services that children need, and retracting state power to challenge the necessity of these services.

The second trend is radically different from the first as it conforms to Congressional intent and furthers the goals of the EPSDT program. Here, courts are correctly interpreting the statutory requirement "to correct or ameliorate," but are inconsistent in their interpretation of "medically necessary." Without statutory clarification that emphasizes the ultimate goals of the EPSDT program, children will continue to be at risk of being denied necessary services.

This note seeks to explore the recent case law involving EPSDT in various jurisdictions and to propose an appropriate solution to courts' application of medical necessity for children afflicted by medical conditions. Part II provides a short history of the Medicaid program and explains how and why EPSDT was incorporated into the statute. Part III explores the standard of medical necessity used in the Medicaid program and compares various approaches, recent changes, and their implications. Part IV applies the medical necessity standard to EPSDT cases specifically and discusses the

10. S. REP. NO. 89-404, at 1943-44 (1965), *reprinted in* 1965 U.S.C.C.A.N. 1943, 1986; *see also* Salazar v. District of Columbia, 954 F. Supp. 278, 303 (D.C. Cir. 1996) (explaining that "[t]he purpose of the EPSDT program is to ensure that poor children receive comprehensive health care at an early age, so that they will develop fewer health problems as they get older").

move toward increased state power in determining medical necessity and less coverage for children. Part V incorporates the issue of maintenance therapy in applying the medical necessity standard and illustrates a trend toward more expansive coverage for children and, ultimately, less discretion for states. Lastly, Part VI analyzes how the application of this standard undermines Congressional intent in creating the EPSDT program. Part VI provides a recommendation on how to bridge these two differing approaches to medical necessity and how to balance state and physician discretion through a clarification of the Medicaid statutes and a uniform guideline for all jurisdictions on which services are eligible under EPSDT.

II. A BRIEF HISTORY

A. Medicaid

Medicaid was enacted by Congress in 1965 as part of the Social Security Act.¹¹ In general, Medicaid is a federal assistance program providing medical services to “the needy and medically needy aged, blind, disabled, and families with dependent children.”¹² The goal of the program is

to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose incomes and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care....¹³

Currently, Medicaid provides coverage to approximately 53 million people.¹⁴ All states and the District of Columbia have opted into the

11. S. Rep. No. 89-404.

12. *Id.* For a complete discussion of eligibility guidelines and program criteria, see John Bigler, Diane Archer, & John Regan, *An Overview of Social Security, Medicare, and Medicaid*, 65 N.Y. ST. B.J. 14 (1993).

13. 42 U.S.C. § 1396-1; see also *Meyers v. Reagan*, 776 F.2d 241, 243 (8th Cir. 1985) (citing the purpose of Medicaid as laid out in 42 U.S.C. § 1396 and stating that “[t]o achieve this goal, Congress requires participating states to provide financial assistance in a number of general categories of medical treatment” pursuant to 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(1)-(5), (17)).

14. The Kaiser Comm’n on Medicaid and the Uninsured, *Ten Myths About Medicaid*, KAISER FAMILY FOUNDATION 1 (2012), http://www.kff.org/medicaid/upload/7306%20Ten%20Myths%20about%20Medicaid_Final-3.pdf.

program.¹⁵ While participation in Medicaid is optional for all states, the federal government establishes guidelines that all participating states must follow to receive Medicaid funds.¹⁶ Specifically, states must provide services of a sufficient "amount, duration, and scope"¹⁷ to reasonably achieve the purpose of the service being provided.¹⁸ In addition, federal law describes the form of "medical assistance" provided as "payment of part or all of the cost of the following care and services or the care and services themselves."¹⁹ Medicaid's care and services include a vast array of medical services as listed in 42 U.S.C. § 1396d(a)(1) through § 1396d(a)(29).

B. Early, Periodic Screening, Diagnosis, and Treatment

EPSDT is a provision of Medicaid added in 1967²⁰ that provides services for individuals under the age of twenty-one.²¹ Under the statute as enacted in 1967, EPSDT was an optional provision and some states chose not to provide these services to children in their state Medicaid plans.²² Congress amended Medicaid in 1989 with the Omnibus Budget Reconciliation Act to provide more comprehensive and consistent services to children in states that did not participate in EPSDT. This Act established EPSDT services as mandatory under state Medicaid programs, and that individuals under age

15. *Id.*

16. *R.K. v. Dillenberg*, 836 F. Supp. 694, 696 (D. Ariz. 1993) (clarifying that "state governments possess primary responsibility for administration of the program, but in so doing must abide by the requirements of the Act to qualify for receipt of federal Medicaid funds").

17. 42 C.F.R. § 440.230(b) (2006).

18. *Id.*; *see also* *Weaver v. Reagan*, 886 F.2d 194, 197 (8th Cir. 1989) (referring to 42 CFR § 440.230(b) and forbidding states from arbitrarily reducing the amount or scope of services).

19. 42 U.S.C. § 1396d(a) (2006); *see also* S. REP. NO. 89-404.

20. Rachel Min Luke, *Reading Between the Lines: Medicaid, Early Periodic Screening Diagnosis and Treatment, and Section 1983*, 7 SEATTLE J. FOR SOC. JUST. 737, 739 (2009).

21. 42 U.S.C. § 1396d(a)(43)(A).

22. *S.D. ex rel. Dickinson v. Hood*, 391 F.3d 581, 589 (5th Cir. 2004).

twenty-one are entitled to such services.²³ Consequently, any state participating in the federal Medicaid program must include EPSDT services to children in their state program.

The EPSDT provision of Medicaid calls for states to seek out children eligible for covered services, provide appropriate screenings, and implement the necessary treatment for conditions diagnosed via the screenings.²⁴ The statute sets out required intervals at which screening services are to be provided²⁵ and lists the types of screening services required, including physical and mental exams, immunizations, and laboratory tests.²⁶ EPSDT also requires state programs to provide vision tests,²⁷ dental screenings,²⁸ hearing screenings,²⁹ and treatment for all three.³⁰

The more commonly litigated and debated provision of EPSDT is section 1396d(r)(5), which states that EPSDT programs in each state must include “[s]uch other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section 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.”³¹ Understanding this section of the Medicaid statute is crucial to fully grasping the vast range of services encompassed within the EPSDT provision. Section 1396d(r)(5) is a catch-all, as it covers necessary services, treatments, and measures that improve or treat conditions for children, regardless of whether the state plan provides those services to adults enrolled in Medicaid. Thus, children are entitled to more services than adults and are provided with all necessary services.

23. *Id.* at 589-90.

24. 42 U.S.C. §1396d(a)(43); *see also* Chisholm v. Hood, 110 F. Supp. 2d 499, 508 (E.D. La. 2000) (requiring the state to ensure children who need and are entitled to services under EPSDT actually receive them).

25. 42 U.S.C. § 1396d(r)(1)(A).

26. *Id.* § 1396d(r)(1)(B).

27. *Id.* § 1396d(r)(2).

28. *Id.* § 1396d(r)(3).

29. *Id.* § 1396d(r)(4).

30. *Id.* § 1396d(r)(2)-(4).

31. *Id.* § 1396d(r)(5).

In *S.D. ex rel. Dickson v. Hood*, the state Medicaid agency did not dispute that a sixteen-year-old who lacked sensation below his waist was eligible for EPSDT, or that the treatment sought – incontinence underwear – was medically necessary, as it served to “correct or ameliorate” the child’s condition.³² Instead, the state argued that, *inter alia*, Louisiana’s Medicaid plan explicitly excluded such incontinence products from EPSDT coverage.³³ Louisiana took the position that it had the authority to limit the services provided by Medicaid.³⁴ The Fifth Circuit disagreed, explaining that:

The natural reading of § 1396d(r)(5)’s phrases is that all of the health care, services, treatments and other measures described by § 1396d(a) must be provided by state Medicaid agencies when necessary to correct or ameliorate unhealthful conditions discovered by screening, regardless of whether they are covered by the state plan.³⁵

The court determined that states cannot limit the services Medicaid must provide to children, even when those children would not otherwise be covered by the state’s Medicaid plan.³⁶ In other words, children who are eligible for Medicaid are entitled to receive any other medically necessary service, even if adults in the same state’s Medicaid plan are not entitled to such services. Thus, while the EPSDT provision greatly expands the array of services available to children on Medicaid, the amended EPSDT provision limits those services through the medical necessity provision.

In spite of the medical necessity limitation placed on the services under EPSDT, the program was intended to be preventive in nature. In the first of a string of lawsuits brought on behalf of children for a state’s failure to provide EPSDT services, the court clarified that the nature and purpose of the EPSDT program is “to ensure that poor children receive comprehensive

32. *Dickinson*, 391 F.3d at 585.

33. *Id.* at 587.

34. *Id.*

35. *Id.* at 589.

36. *Id.* at 590 (“Every Circuit which has examined the scope of the EPSDT program has recognized that states must cover every type of health care or service necessary for EPSDT corrective or ameliorative purposes that is allowable under § 1396d(a)” (citing *Collins v. Hamilton*, 349 F.3d 371, 376 n. 8 (7th Cir. 2003)); see *Collins*, 349 F.3d at 376 n. 8 (noting that “a state’s discretion to exclude services deemed ‘medically necessary’ . . . has been circumscribed by the express mandate of the statute.”)).

health care at an early age, so that they will develop fewer health problems as they get older.”³⁷ EPSDT provides screenings to detect potential problems for children early on, then later provides a diagnosis of any problems detected, and treats any developing conditions. As the court notes, “[p]reventive health care identifies health problems that may respond to early treatment but, if left undiagnosed and untreated, may instead lead to serious disorders or conditions.”³⁸ Therefore, the primary purpose of Medicaid’s EPSDT program is to avoid the onset of health problems and to eliminate the discomfort and affliction affecting so many young people.

III. DEFINING “MEDICALLY NECESSARY” FOR MEDICAID PURPOSES

Medicaid established the medical necessity standard to be applied to all populations to whom it provides services. EPSDT then incorporates additional standards to determine which services it will provide for children. Thus, it is critical to first set forth the standards by which the general Medicaid program determines which services are medically necessary for patients before discussing EPSDT standards and analyzing medical necessity in that realm. The Medicaid statute lays out twenty-eight categories of medical services for which state programs will provide monetary assistance to patients.³⁹ A state must provide the “amount, duration, and scope”⁴⁰ of

37. *Salazar v. District of Columbia*, 954 F. Supp. 278, 303 (D.C. Cir. 1996).

38. *Id.*

39. 42 U.S.C. §§ 1396d(a)(1)-(29) (Supp. IV 2011). These categories are: inpatient hospital services; outpatient hospital services; laboratory and X-ray services; nursing facility services; physicians’ services furnished by a physician; medical care; home health care services; private duty nursing services; clinic services furnished by or under the direction of a physician; dental services; physical therapy and related services; prescribed drugs, dentures, prosthetic devices, and eyeglasses; other diagnostic, screening, preventive, and rehabilitative services; inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases; services in an intermediate care facility for the mentally retarded; inpatient psychiatric hospital services for individuals under age 21; services furnished by a nurse-midwife; hospice care; case-management services; respiratory care services; services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner; home and community care for functionally disabled elderly individuals; community supported living arrangements services; personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease; primary care case management services; services furnished under a PACE program; primary and secondary medical strategies and treatment and services for individuals who have Sickle Cell Disease;

the service that is sufficient "to reasonably achieve the purpose"⁴¹ of that service. However, given the breadth of services eligible for coverage by Medicaid, the federal government *does not* prohibit states from limiting the duration or scope of services. It *does*, however, prevent states from denying coverage or reducing the amount or scope of services based on the diagnosis or condition of the patient.⁴² Specifically, it suggests that "medical necessity" is an appropriate limit on services provided.⁴³ In the 1977 Supreme Court case, *Beal v. Doe*, the Supreme Court determined that the medical necessity standard is proper and that states are free to limit services provided by Medicaid through this standard.⁴⁴

Beal v. Doe addressed whether states were required to provide Medicaid funds for abortions.⁴⁵ The question turned on whether abortions were medically necessary. Ultimately, the Court decided that only where there was documentation or medical evidence that the abortion was necessary⁴⁶ were states required to fund such procedures using Medicaid assistance.⁴⁷ This case also determined that the state may give deference to a physician's opinion, so long as there is evidence that the procedure is medically necessary, as opposed to merely a desirable procedure to the patient.⁴⁸ Since *Beal v. Doe*, courts have taken various approaches in answering the question of who may determine whether a procedure is "medically necessary."

freestanding birth center services; and "any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary." *Id.*

40. 42 C.F.R. § 440.230(a) (2006).

41. *Id.* § 440.230(b).

42. *Id.* § 440.230(c).

43. *Id.* § 440.230(d).

44. *Beal v. Doe*, 432 U.S. 438, 444 (1977).

45. *Id.* at 443-44.

46. Examples might include situations where the mother's health is at risk, where the child may have a physical or mental deficiency, or where the pregnancy was a product of incest, rape, or other legally established violation.

47. *Beal*, 432 U.S. at 445-48.

48. *Id.*

Additionally, courts have attempted to find ways to give states more control over determining the amount of medically necessary services.

A. The Two-Level Approach: Giving Physicians Discretion

One such approach conceptualizes the determination of medical necessity as a two-level process, ultimately giving physicians the freedom to make the determinations of what care is medically necessary for a patient. In *Cowan v. Myers*, the Court of Appeals for the Third Circuit in California explains that, “[f]irst, the state must decide which services are necessary; then, out of the covered services, the physician may determine which treatment is necessary for a particular condition.”⁴⁹ Therefore, clarifying a previous decision, the *Cowan* court states, “once a state plan has agreed to cover certain types of services, it may not exclude covered services for one particular condition where the physician determines the treatment is necessary.”⁵⁰

An example of this type of decision-making approach is found in the 1980 U.S. Court of Appeals for the Eighth Circuit’s decision, *Pinneke v. Preisser*.⁵¹ In this case, the plaintiff sought Medicaid assistance for the cost of his sex reassignment surgery, a procedure prohibited from Medicaid assistance under his state’s Medicaid program.⁵² When funding was denied, the court found that the surgery was a treatment that could not be prohibited, as it fell under the umbrella of “inpatient hospital services” and “physicians’ services,”⁵³ which are two of the five categories that states are required to provide assistance for through Medicaid programs.⁵⁴

The analysis used by this approach begins with an umbrella of services – the state determines what range of services will be provided under the state plan. Then, once under that umbrella, anything determined by physicians to be medically necessary must be covered. Therefore, the determination

49. *Cowan v. Myers*, 187 Cal. App. 3d 968, 978 (Cal. Ct. App. 1986) (referring to the two-part test established in *Preterm, Inc. v. Dukakis*, 591 F.2d 121, 125-27 (1st Cir. 1979)); *see also Pinneke v. Preisser*, 623 F.2d 546, 550 (8th Cir. 1980).

50. *Cowan*, 187 Cal. App. 3d at 978.

51. *Pinneke*, 623 F.2d at 546.

52. *Id.* at 547.

53. *Id.* at 550.

54. 42 U.S.C. §§ 1396d(a)(1)-(5) (2006).

begins with the state and is then handed off to physicians to make a final decision about medical necessity. Allowing the physicians to use their discretion in making such determinations requires the state to put its trust in these physicians not to abuse the privilege by committing fraud or causing Medicaid to provide funds for services that are not medically necessary for patients. At the same time, however, the provision allows physicians – the individuals in arguably the best position to make medical decisions regarding diagnosis and treatment of a patient – to make such decisions freely. Here, the physician has an advantage as he or she can find a way to categorize a treatment that fits under the umbrella.

B. The Stricter Approach: State Review of Physicians' Decisions

Rush v. Parham, a Fifth Circuit case also from 1980, involved a similar set of facts as *Pinneke*, but the court arrived at a different conclusion.⁵⁵ The court decided that transsexual surgery was experimental and therefore not medically necessary, opposing the physician's determination that the procedure was proper. The court in *Rush* applied a different approach by holding "a state Medicaid agency can review the medical necessity of treatment prescribed by a doctor on a case-by-case basis."⁵⁶ This case-by-case limitation is in clear opposition to the two-level approach, which places a preliminary limitation upon entire types of treatment. The state review approach works in reverse, granting physicians discretion but subjecting their decisions to approval and review by the state.

This strict approach allows a state to review a physician's determination, in contrast to the two-level approach, which requires physicians to adhere to the state's pre-approved treatments and services. Specifically, the stricter approach grants states the power to limit a physician's discretion in determining such services. This analysis starts by allowing the physician to make a recommendation of services or treatment for a particular patient. According to *Rush*, a physician has "the primary responsibility of determining what treatment should be made available to his patients."⁵⁷ The physician's recommendation is then subject to state approval, as the state has the authority to determine whether the physician's treatment is actually medically necessary, or if the services recommended are not within the scope of Medicaid coverage.⁵⁸ While this strict approach resembles the two-

55. *Rush v. Parham*, 625 F.2d 1150, 1150 (5th Cir. 1980).

56. *Id.* at 1155.

57. *Id.* at 1156.

58. *Id.* at 1154-56.

level approach in that there are state limits on the treatments, the approaches differ in that the strict approach permits the physicians to first make a recommendation before it is subject to a review by the state. The strict approach is advantageous to the two-level approach because it permits a state to find ways to categorize treatments and place limits on doctors' decision-making.

C. Increase in State Power: What Amount of Services is Medically Necessary?

Shortly after the *Beal* Supreme Court decision, the Fifth Circuit charted a different course on the same topic. In *Curtis v. Taylor*, the Fifth Circuit determined that the state could limit the amount of services provided to a patient, even when those services were determined to be medically necessary.⁵⁹ Specifically, in this case, plaintiffs challenged a limit on the amount of doctor visits Medicaid patients were allowed under the Florida plan.⁶⁰ The plan limited the number of medical visits to three per month.⁶¹ The Fifth Circuit upheld the limit, saying that while physicians' services are medically necessary, three visits per month was a reasonable limit on the amount of services that Medicaid was required to cover.⁶² Thus, this approach to medical necessity gives the state standing to challenge the amount of services that are medically necessary to reasonably achieve the purpose of the service being provided.⁶³

D. Implications

As seen from this trend of cases and the different approaches taken by courts to determine who has the power to decide what services are medically necessary, the courts have clearly moved toward an increase in state power and away from *Beal v. Doe*'s instruction to give deference to physicians' treatment decisions. While it is important to have a monitoring system in place to prevent fraud and abuse of Medicaid funds, having such a system will also result in a higher medical necessity standard (or a more strict review of such services), potentially decreasing the amount of services

59. *Curtis v. Taylor*, 625 F.2d 645, 652-53 (5th Cir. 1980).

60. *Id.*

61. *Id.*

62. *Id.*

63. 42 C.F.R. § 440.230(b) (2011).

provided to patients under the Medicaid program as a result of requiring more stringent criteria to be met in order to qualify for services. Specifically, this becomes problematic for children who are eligible for services under EPSDT.

IV. MEDICAL NECESSITY STANDARDS FOR EPSDT PURPOSES

EPSDT, a specific provision of Medicaid, offers broader services to children who are eligible for Medicaid. Therefore, the standard for determining which services are offered is different than the standard used for general Medicaid assistance. On its face, the Medicaid statute extends the number of available services by including those that are not otherwise offered under the state's Medicaid plan.⁶⁴ EPSDT's statutory definition requires the provision of any services that are needed to "correct or ameliorate" a condition.⁶⁵ Thus, even treatment that does not survive the "medically necessary" Medicaid standard may be covered if it is used to correct or ameliorate a problem. Congress indicates that the intent of EPSDT is the identification of and prevention of medical problems for children.⁶⁶ Thus, while states are free to implement limitations on their services as a method of ensuring only medically necessary treatment is provided for children, those limitations shall not impede EPSDT's purpose of prevention.⁶⁷ Further support for the role of a physician is the Senate report from 1986, which states "the physician is to be the key figure in determining utilization of health services...it is the physician who is to decide upon admission to a hospital, order tests, drugs, and treatments[.]"⁶⁸

Yet, the reality of the situation is much more complex than Congress may have anticipated when the statute was enacted. Some courts have properly allowed physicians to make the medical necessity determination and required states to comply and reimburse the treatment involved. This approach honors the statute's purpose: to provide expansive coverage to children on Medicaid through EPSDT. Despite the fact that there are very few limits on what can be defined as medically necessary under EPSDT,

64. 42 U.S.C. § 1396d(r) (2006).

65. *Id.* § 1396d(r)(5).

66. Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106 (1989).

67. *Id.*

68. S. Rep. No. 89-404, at 128 (1965) (Conf. Rep).

courts have decided recent cases in a seemingly inequitable way that deprives children of necessary medical care by giving states more power in limiting physicians' discretion.

A. Physician as Sole Arbiter

In the 2003 Seventh Circuit decision of *Collins v. Hamilton*,⁶⁹ the court completely deferred to the physician when determining medical necessity.⁷⁰ *Collins* involved a class action suit against the state of Indiana for its failure to provide long-term residential psychiatric treatment under Medicaid's EPSDT provision for individuals under the age of twenty-one.⁷¹ The court held that residential treatment might be necessary for some children.⁷² If an EPSDT screening determined this form of treatment is medically necessary for a child, the state is required to fund the treatment.⁷³ Thus, the court deferred to the determination by a physician, which it referred to as a "competent medical service provider."⁷⁴

Rosie D. v. Romney was a 2006 class action lawsuit brought in the United States District Court for the District of Massachusetts against the state on behalf of children with emotional disturbances for a failure to provide services under Medicaid's EPSDT program.⁷⁵ The court held that "if a licensed clinician finds a particular service to be medically necessary to help a child improve his or her functional level, this service must be paid for by a state's Medicaid plan pursuant to the EPSDT mandate."⁷⁶ The court elaborated on the medical necessity requirement stating, "so long as a competent medical provider finds specific care to be 'medically necessary'

69. *Collins v. Hamilton*, 349 F.3d 371, 371 (7th Cir. 2003).

70. *Id.* at 376.

71. *Id.* at 372.

72. *Id.* at 376.

73. *Id.*

74. *Id.*

75. *Rosie D. v. Romney*, 410 F. Supp. 2d 18, 22 (D. Mass. 2006).

76. *Id.* at 26.

to improve or ameliorate a child's condition, the 1989 amendments to the Medicaid statute require a participating state to cover it."⁷⁷

Finally, in *Pediatric Specialty Care, Inc. v. Arkansas Department of Human Services*, providers for and parents of children who were being denied reimbursement and Medicaid coverage of an early intervention program brought a lawsuit against the Arkansas agency and other state officials.⁷⁸ The Eighth Circuit Court found that a state must provide all services necessary to correct or ameliorate conditions discovered by EPSDT screenings, "whether or not such services are covered under the State plan."⁷⁹ Specifically, the court stated that eligible children are entitled to services recommended by a physician and Arkansas state plans must reimburse the costs of such treatment.⁸⁰

These three cases are examples of the treating physician having the final word on whether services must be provided by the state due to medical necessity. However, despite these cases aligning with Congressional intent and the purpose of the EPSDT program, a far greater number of courts have recently limited physicians' authority to determine medical necessity.

B. State Limits on Physicians' Determinations

Consider the case of a severely disabled 16-year-old girl named Callie.⁸¹ After surviving a stroke in utero, Callie has spent her life afflicted by numerous medical conditions and disabilities,⁸² including cerebral palsy, mental retardation, and six other chronic conditions.⁸³ Callie is not only blind and nonverbal, but also experiences frequent seizures and has trouble swallowing and breathing on her own.⁸⁴ Callie requires multiple

77. *Id.*

78. *Pediatric Specialty Care, Inc. v. Ark. Dep't. of Human Servs.*, 293 F.3d 472, 476-77 (8th Cir. 2002).

79. *Id.* at 480 (quoting 42 U.S.C. § 1396d(r)(5)).

80. *Id.* at 480-81.

81. *Ex rel. Moore v. Reese*, 637 F.3d 1220, 1223 (11th Cir. 2011).

82. *Id.*

83. *Id.*

84. *Id.*

medications per day, needs to be fed by another person, and requires repeated repositioning of her body throughout the day.⁸⁵ These conditions are more than most parents or individuals with little medical training can accommodate. In fact, Callie received ninety-four hours of specialized private nursing services through Medicaid's Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) program.⁸⁶ However, a judge decided that the state, not Callie's doctor, had the power to decide the number of hours of nursing services that were needed,⁸⁷ and her parents now have the burden of proving to the court that she needed such extensive care.⁸⁸

In *ex rel. Moore v. Reese*, the issue was not whether the medical services provided to the patient were necessary, but rather what amount of the prescribed services the state was required to provide under Medicaid.⁸⁹ Here, the physician prescribed ninety-four hours of private nursing services to the young patient, and the state agency's medical expert contested that ninety-four hours were not required.⁹⁰ The Fifth Circuit followed the reasoning in *Curtis* and *Rush*, holding that the state has the "authority to place limits on a service based on . . . medical necessity[.]"⁹¹ Here, the court placed the burden on the child's representatives to prove that this specific number of nursing service hours is necessary and remanded the case for further evidence.⁹² Ultimately, the court allowed the state to limit the amount of services the state was responsible for providing, even with a

85. *Id.* at 1224.

86. *Id.* at 1225.

87. *Ex rel. Moore v. Reese*, 637 F.3d 1220, 1257 (11th Cir. 2011) (holding that "the state may limit required private duty nursing services based upon a medical expert's opinion of medical necessity" pursuant to 42 C.F.R. § 440.230(b), (c) (2006)).

88. *Id.* at 1258 (holding that "the plaintiff will have to show that the limits the state imposed on her physician's discretion in reducing her nursing hours from ninety-four to eighty-four hours a week are not reasonable – that these limits are not sufficient in amount, duration, and scope to reasonably achieve the treatment's purpose.").

89. *Id.* at 1235.

90. *Id.* at 1231.

91. *Id.* at 1261.

92. *Id.* at 1258.

showing that the type of services are medically necessary.⁹³ Here, the issue goes beyond determining what kind of services Medicaid will cover, but rather challenges the amount of duration of those services.

Moore demonstrates the court's misplaced reliance on the general Medicaid standard of medical necessity in determining what services the program should provide to patients under EPSDT. The Eleventh Circuit found that the nursing services were a medically necessary service, but the number of hours prescribed by the treating physician was in dispute and subject to further evidence of necessity.⁹⁴ The problem with this, and the reasoning behind the court's holding in the *Moore* decision, is that EPSDT was intended to cover more services than typical state Medicaid plans for adults. While it may be appropriate to require proof of necessity for extensive nursing service hours for adults, such proof undermines Congress's intent for EPSDT to be an expansive and comprehensive program. The language of the EPSDT statute extends the number of available services by including those not otherwise offered under the state's Medicaid plan⁹⁵ and uses the phrase "to correct or ameliorate"⁹⁶ as an additional standard for its definition for medical necessity. Therefore, applying the general Medicaid standard of necessity could disadvantage countless children across the country.

Callie's case illustrates a critical point in the controversial area of Medicaid coverage. Physicians' opinions will inevitably vary greatly from a state's opinion on what qualifies as medical necessity in certain cases. However, the standard for determining necessity under the EPSDT program does not change. Where a particular service is agreed by both physician and state to be medically necessary, states should refrain from placing restrictions on the amount of a medically necessary service that the state is willing to cover. Not only does this go beyond the simple determination of what is medically necessary, but it also adds a complication by considering amount and scope of coverage by the state. This additional dimension undermines Congressional intent and will ultimately create inconsistencies throughout EPSDT cases.

93. *Id.* at 1257.

94. *Id.* at 1261.

95. 42 U.S.C. § 1396d(r) (2006).

96. *Id.* §1396d(r)(5).

C. Current Interpretation of Medical Necessity Undermines Congressional Intent

EPSDT is meant to be a comprehensive, preventative program. The statute specifically calls for EPSDT to provide “such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section 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.”⁹⁷ In establishing this program, Congress intended EPSDT to be a more comprehensive program than state Medicaid programs for adults.⁹⁸ That intent is evident in the statute’s additional provision for “such other necessary”⁹⁹ services, which the Medicaid statute does not include for adults.¹⁰⁰ Therefore, inferring from nothing but the content of the statutory language, applying the same medical necessity standard courts use for Medicaid at large would be inappropriate for a program as comprehensive as EPSDT. This would defeat the purpose of EPSDT as a preventative and inclusive program for children.

Further, allowing the state to have the authority to challenge physicians’ determinations of what treatment is medically necessary for their patients minimizes the credibility of these physicians and challenges their ability to diagnose and treat their patients. States’ challenges of physicians’ determinations of medical necessity likely lies in the economic and budget crisis facing government and health care in recent years. However, making these cuts, specifically within Medicaid and EPSDT services, may not be cost-effective in the long run. Because EPSDT aims to prevent medical conditions from developing, cuts within the EPSDT program will only result

97. *Id.*

98. S. Rep. No. 89-404, pt. 1, at 1 (1965) (stating that the purpose of the law is “to expand the services for maternal and child health, crippled children, child welfare, and the mentally retarded....”). See also Rachel Min Luke, *Reading Between the Lines: Medicaid, Early Periodic Screening Diagnosis and Treatment, and Section 1983*, 7 SEATTLE J. FOR SOC. JUST. 737, 739-40 (2009).

99. 42 U.S.C. § 1396d(r)(5).

100. The general Medicaid statute lists fourteen categories of required or mandatory services. See 42 C.F.R. Part 440. The adult Medicaid program does not include a “medically necessary” provision. Therefore, EPSDT allows much more opportunity for states to provide necessary services that may not be included in a particular listed category.

in greater costs for state Medicaid plans later when the conditions that develop need to be treated. Thus, cutting state costs now will undermine the preventative purpose of the EPSDT program.

V. EPSDT AS MAINTENANCE

In addition to the broad issue of "medical necessity," a new topic has recently emerged – one that is detrimental to EPSDT and how those services will continue to be provided in the future. While courts have inconsistently decided the issue of medical necessity, courts have so far remained constant in their approach to maintenance therapies and have repeatedly declared that such services are to be included in the scope of the EPSDT provision of state Medicaid programs.¹⁰¹ Not only do maintenance therapy issues depend upon the interpretation of the EPSDT statute, but they also specifically rely on how courts define "medical necessity" for children.

A. Overview of Maintenance Therapy

Maintenance therapy is often beneficial for children with chronic conditions that affect their motor functioning, such as cerebral palsy. In these children, physical motions and capabilities are limited, and maintenance therapy can help prevent the loss of functioning or regression.¹⁰² These children often receive physical and occupational therapies as part of the treatment regimen for their condition. However, this type of therapy works differently than traditional therapy for an acute condition, such as a broken leg, where the purpose is to strengthen muscles that have not been used in weeks. For such traditional patients, the muscles quickly improve and the therapy is discontinued. In contrast, for children with cerebral palsy or other chronic conditions, the physical or occupational therapy serves to prevent regression of the condition; these therapies keep a child's muscles moving to prevent further loss of function. They do not, however, improve one's range of motion or overall functioning. Therefore, these therapies do not necessarily correct or treat a chronic medical condition, and are technically not required to be covered under Medicaid's EPSDT program.¹⁰³ Nonetheless, these therapies prevent chronic conditions

101. See generally *A.M.T. v. Gargano*, 781 F. Supp. 2d 798 (S.D. Ind. 2011); see also *Elkoff v. Rodgers*, 443 F. Supp. 2d 1173, 1180-81 (D. Ariz. 2006).

102. See generally *A.M.T.*, 781 F. Supp. 2d at 805.

103. See 42 U.S.C. § 1396d(r)(5) (limiting services under EPSDT to those that are "medically necessary to correct or ameliorate" an illness or condition).

from deteriorating or regressing and keep children from becoming nonfunctioning.

B. Case Law

Two courts have defined EPSDT to include maintenance therapies. The most recent case involving maintenance therapies and Medicaid's EPSDT program is *AMT v. Gargano*¹⁰⁴ from the United States District Court for the Southern District of Indiana. Decided in 2011, this case involved a class-action suit against Indiana for failure to reimburse for the costs of maintenance therapy for children with cerebral palsy.¹⁰⁵ The Indiana Medicaid program provides that physical therapy will not be covered for more than two years unless a significant change in the medical condition is shown.¹⁰⁶ In determining how to rule on these facts, the court resorted to its own interpretation of the phrase "to correct or ameliorate" in Medicaid's EPSDT provision.¹⁰⁷ The court relied on the interpretations of other courts and held that the phrase "to correct or ameliorate" means "to make better or more tolerable."¹⁰⁸ Children need not demonstrate that their conditions have regressed without physical therapy and maintenance measures. Rather, they need only show that the therapies prevent regression, even if no further progress is expected to be made and full functioning is not likely to be restored.¹⁰⁹ The court held that the "practice and policy of denying or limiting prescribed therapies as maintenance therapy without considering a disabled child's potential for regression violates federal Medicaid law."¹¹⁰

104. *A.M.T.*, 781 F. Supp. 2d at 798.

105. *Id.*

106. *Id.* at 803.

107. *Id.* at 806-07; see 42 U.S.C. § 1396d(r)(5).

108. *A.M.T.*, 781 F. Supp. 2d at 806. In *Collins v. Hamilton*, the court stated that "[r]equired treatment includes anything which is to make a condition, even a long-term condition like mental illness, more tolerable." 231 F. Supp. 2d at 849, aff'd 349 F.3d 371 (7th Cir. 2003). The court in *Elkoff v. Rodgers* emphasized the inclusive and expansive nature of Medicaid's EPSDT program and the preventive purpose of the program and rejected the state's attempt to interpret that statute "in an extremely narrow manner that is also impossible to integrate within the wider framework of Medicaid law." 443 F. Supp. 2d 1773, 1180-81 (D. Ariz. 2006).

109. *A.M.T.*, 781 F. Supp. 2d at 807.

110. *Id.*

In a second case, *Ekloff v. Rodgers*, the United States District Court for the District of Arizona considered whether incontinence briefs, another medical service that does not restore functioning or provide treatment for a condition, were covered under Medicaid's EPSDT program.¹¹¹ Here, the court relied heavily on the intent of Congress in creating the EPSDT provisions and emphasized the preventative, inclusive, and expansive purpose of the program.¹¹² The court recognized the important role incontinence briefs play in maintaining hygiene for children and preventing infections or skin conditions. While the briefs do not correct a problem, they do prevent other conditions from worsening and enable children to live more healthy, social, and functional lives.

In *Pediatric Specialty Care, Inc. v. Arkansas Dept. of Human Services*, the Eighth Circuit relied on the language of 42 U.S.C. § 1396d(a)(13) in making its decision on whether early intervention day treatment was medically necessary and covered under EPSDT.¹¹³ The court reasoned the state must reimburse the costs of any physician-recommended "service that would lead to the maximum reduction of medical and physical disabilities and restoration of the child to his or her best possible functional level."¹¹⁴ Here, the court focused on the statutory term "ameliorate," rather than the corrective requirement, and found these therapeutic interventions in the Arkansas program were necessary to restore the child to the best functioning possible.¹¹⁵ The court did not find a requirement that the child be restored to *full* functionality, but merely to his or her *best* functional level. Thus, the court found that this early intervention program must be covered by Arkansas' Medicaid program because it serves to ameliorate the conditions and disabilities of the children enrolled.¹¹⁶

111. *Ekloff*, 443 F. Supp. 2d at 1180-81.

112. *Id.*

113. *Pediatric Specialty Care, Inc. v. Ark. Dep't. of Human Servs.*, 293 F.3d 472, 480-81 (8th Cir. 2002); *see also* 42 U.S.C. § 1396d(a)(13) (2006) (stating that among the services covered by Medicaid are "diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services ... recommended by a physician ... for the maximum reduction of physical and mental disability and restoration of an individual to the best possible functional level.").

114. *Pediatric Specialty Care, Inc.*, 293 F.3d at 481.

115. *Id.* at 480-81.

116. *Id.* at 481.

In these maintenance therapy cases, in contrast to the medical necessity cases discussed previously, the courts adopt a liberal interpretation of the statute and rely on the expansive intent of the EPSDT program. In doing so, children receive more favorable outcomes and the results further the purpose of the program. This contrast in outcomes underscores serious problems: inconsistent interpretation and unpredictable outcomes for Medicaid's neediest children. These problems can only be remedied through clarity in the statute or by precedent requiring all lower courts to interpret statutes in congruence with Congress's intent.

C. Maintenance Therapy Cases are in Furtherance of Congressional Intent

These maintenance therapy cases (*Gargano*, *Elkoff*, and *Pediatric Specialty Care*) interpreted the same statute as the medical necessity cases, but allowed a more expansive view of the statutory language in the EPSDT provisions. By looking at the intent of Congress, and interpreting the statutory language accordingly, the courts arrived at decisions that favored coverage of services that neither correct nor improve the children's conditions. This outcome differs greatly from the medical necessity cases, which limit the scope of coverage under EPSDT. The very different outcomes of these two lines of cases were reached while purporting to interpret the same statutory provision.

The facts and reasoning in *Pediatric Specialty Care* are similar to those in *Gargano*. Both *Pediatric Specialty Care* and *Gargano* involve the issue of whether Medicaid is required to cover services that are meant to improve conditions but not necessarily to correct a condition or restore full functioning. Fortunately, both courts have rightly determined that these services are medically necessary under Medicaid's EPSDT program. These cases properly serve Congress's intent for the EPSDT program and provide children access to the services they are entitled to.

VI. PRACTICAL IMPLICATIONS

A. Need for Clarity

The cases analyzing medical necessity and considering the necessity of maintenance therapies purport to look at the same language in the statute and consider the same evidence of Congressional intent, while somehow arriving at different conclusions about the expansiveness of the coverage to children under Medicaid's EPSDT provision. Where courts are looking at the same statute but arriving at varied answers, a change needs to be made. Such large discrepancies in the outcomes of cases, especially cases involving Medicaid and the health of children, are intolerable. Judges in various circuits and jurisdictions are free to interpret this federal legislation as they see fit, which ultimately leads to unpredictable outcomes and inconsistent

results for children. Children with the same conditions in two different states might not be given the same treatment as a result of how a particular state determines what is medically necessary.

With a move toward increased state power and decreased physician discretion, uniformity is needed. Additionally, with the emerging use of maintenance therapy, it is crucial that courts continue to include therapy services for disabled and poorly functioning children. The only way to ensure medically necessary services are provided uniformly and expansively is to make changes in the law. A mandate needs to be issued, in the form of a Supreme Court ruling or an amendment to the federal legislation, which clarifies the terms of the EPSDT provision and expresses the intended result.

B. Money Matters

One of the most obvious concerns surrounding this topic is money. Financial constraints are often a cause of programs being limited in scope. Not surprisingly, one of the likely arguments against clarifying and interpreting the terms of the EPSDT legislation in a more expansive way is that it will result in states being required to provide more services for children under the state Medicaid programs. Not only will states be compelled to provide a greater range of services, but they will also need to provide services that are broader in scope and duration. This will, of course, increase the cost of the state programs.

In addition, there is potential for abuse and fraud within the framework of state Medicaid programs. Allowing physicians to retain complete discretion in determining what type of and how much treatment is medically necessary lends itself to the potential for abuse of such discretion. Abuse and fraud can result in states paying for services that are not medically necessary or services beyond the scope of the legislative standards. This risk must be balanced with the need for expansive services for children as well as the intent of the legislature in choosing the medical necessity standard.

According to a report by the Center on Budget and Policy Priorities, most fraud is committed by providers and not by individuals.

An estimated 80 percent of health care fraud — in both public programs like Medicaid and Medicare and in private insurance — is committed by health care providers, not individuals, according to the National Health Care Fraud Association. The most common types of provider fraud include billing for services that were not provided or for more expensive procedures than were actually performed, performing medically unnecessary services to generate insurance payments, and falsifying a patient's diagnosis to justify services or procedures that are not medically necessary. When

individuals are involved in health care fraud, they frequently are unwitting participants — or even victims.¹¹⁷

Therefore, if the reason for stricter state oversight is to save money and prevent fraud, it is not likely that rejecting physicians' decisions regarding what is medically necessary is going to accomplish that end. Fraud frequently exists in the billing practices of providers, not in the requests for services of children in need. The result of this ineffective attempt to curb abuse and fraud is that children are being victimized and underserved. Instead, the judgment of physicians should not be second-guessed by states. Allowing physicians to make the decisions in accordance with the Medicaid statute and the intent of Congress would properly serve children.

The Medicaid statute includes no monetary limits on medical services or treatment, nor does it mention a cap on services to individuals.¹¹⁸ With few limits within the twenty-eight listed categories of services to be provided by Medicaid to adults, Congress made clear that EPSDT should include "such other 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."¹¹⁹ The only limitation on what these services may include is that the services must be used to "correct or ameliorate" a problem.¹²⁰ In creating such a broad provision, Congress was likely aware that the services would be more numerous and would therefore increase costs for states and the federal government.

Decreasing physicians' discretion will likely cut state costs, an important consideration given today's economy and the severe constraints on governmental budgets. However, limiting discretion would also undermine the purpose of the EPSDT program and pose two important problems for states. First, while a policy of increased physician oversight and increased state review of medical necessity determinations may limit abuse, fraud, and result in monetary savings, it would impose more administrative costs. States would have to routinely review physicians' determinations and to do so would need to establish a system of review (such as a board, panel, or

117. Sarah Lueck, *Medicaid Maintenance-of-Effort Provisions Do Not Stop States from Fighting Fraud*, CENTER ON BUDGET AND POLICY PRIORITIES, 3-4 (Apr. 24, 2012), <http://www.cbpp.org/files/6-6-11health.pdf>.

118. 42 USC § 1396d(a).

119. *Id.* §1396d(r)(5).

120. *Id.*

agency) that would approve each service. While exact costs of such a system have not been determined or estimated at this time, the review process would represent a cost increase from current state spending levels.

Second, a strict review of EPSDT services may result in fewer preventative treatments being provided to children. Prevention programs, such as EPSDT, provide screenings, diagnosis, and treatment for conditions early in life in an effort to prevent the higher cost of treatment when conditions worsen later in life. Cutting costs in the prevention arena, then, would increase treatment costs for older children and adults later in life. Thus, it ultimately becomes a question of when the states choose to pay for the services – immediately in order to save money, or in the future at a potentially higher cost. While it may be helpful to allow states the power to limit treatment and services that physicians deem necessary, it is not wise in the long run nor is it in line with Congressional intent.

C. Federal Versus State Power

In addition to raising financial concerns, a discussion of proper interpretation of the EPSDT statute inevitably leads to constitutional concerns. None of these arguments have merit nor can they serve to negate the fact that Congress can and should clarify the terms of the statute that provide for Medicaid's EPSDT program. At the most basic level, two constitutional provisions provide for Congress's authority and power to enact and enforce Medicaid's statutory provisions: (1) the Spending Clause; and (2) the Necessary and Proper Clause.

On a basic level, Article I Section 8 of the Constitution expressly grants Congress the power "to pay the [d]ebts and provide for the common [d]efence and general [w]elfare of the United States."¹²¹ Further, the Necessary and Proper Clause serves as an additional grant of power for Congress to pass any laws that are necessary to carry out its obligations, such as promoting the general welfare. First, it is important to define the purposes for which Congress is allowed to spend money, namely, what the "general [w]elfare" constitutes. This power has been interpreted broadly by the Supreme Court in *Helvering v. Davis*, which upheld the constitutionality of the Social Security Act of 1935.¹²² The Supreme Court explained:

The problem is plainly national in area and dimensions. Moreover, laws of the separate states cannot deal with it effectively. Congress, at least, had a basis for that belief. States and local governments are often lacking in the resources that are necessary

121. U.S. CONST. ART. I § 8, cl. 1.

122. See generally *Helvering v. Davis*, 301 U.S. 619 (1937).

to finance an adequate program of security for the aged.... A system of old age pensions has special dangers of its own if put in force in one state and rejected in another. The existence of such a system is bait to the needy and dependent elsewhere, encouraging them to migrate and seek a haven of repose. Only a power that is national can serve the interests of all.¹²³

The reasoning of *Helvering* can be applied to Medicaid, another national program intended for the benefit of the needy, disabled, and elderly. Because health care programs satisfy the definition of “general [w]elfare” and *Helvering* upheld such federal programs, Congress clearly acted within the authority granted to it by the Spending Clause of the Constitution when it created the Medicaid program.

The second important constitutional consideration is whether or not, in enacting a federal program, Congress has the authority to define what actions states can and cannot perform, or what they must or must not do. In essence, the question to be considered is whether or not Congress can so closely regulate the conduct of each state within its own individualized Medicaid plan. Here, the answer is a resounding “yes,” and Congress, in fact, *must* set such guidelines and standards. In *Pennhurst State School and Hospital v. Halderman*,¹²⁴ the Supreme Court relies on a string of cases that “have long recognized that Congress may fix the terms on which it shall disburse federal money to the States.”¹²⁵ The Court expands on this foundation by stating that:

. . . legislation enacted pursuant to the spending power is much in the nature of a contract: in return for federal funds, the States agree to comply with federally imposed conditions. The legitimacy of Congress’ power to legislate under the spending power thus rests on whether the State voluntarily and knowingly accepts the terms of the “contract.”¹²⁶

The structure of Medicaid requires states that choose to participate in the program to conform to the guidelines set forth by the federal legislation.¹²⁷

123. *Id.* at 644.

124. *Pennhurst State School and Hosp. v. Halderman*, 451 U.S. 1, 1 (1981).

125. *Id.* at 17 (citing *Rosado v. Wyman*, 397 U.S. 397, 397 (1970); *King v. Smith*, 392 U.S. 309, 309 (1968); *Okl. v. CSC*, 330 U.S. 127, 127 (1947)).

126. *Pennhurst*, 451 U.S. at 2.

127. *R.K. v. Dillenberg*, 836 F. Supp. 694, 696 (D. Ariz. 1993) (clarifying that “state governments possess primary responsibility for administration of the program, but in so

There is no requirement that a state participate in this program. Medicaid is a voluntary program that supplies federal funds to states that provide medical care and services to needy, disabled, and elderly residents. States agree to the terms of the program and, therefore, agree to provide the services that Congress requires.

In this way, Congress sets a floor, but not a ceiling. Specifically, the federal legislation provides a list of services that must be provided by all state Medicaid plans and also sets forth a standard by which a state may reasonably limit those services. States are free to provide more expansive services under Medicaid, but may not, under any circumstance, provide less than what the federal legislation mandates.¹²⁸ Given the powers granted by the Constitution and interpreted over the years through Supreme Court decisions, the structure of the Medicaid program and the limitation of Medicaid programs by Congressional legislation are constitutional. It would also be constitutional and within the powers of Congress to clarify the standards currently used to determine which services are to be provided by Medicaid (such as "medically necessary"). Because Congress had the authority to create and regulate such a program, Congress also has the authority to define the terms used in the legislation and set specific requirements on participating states. The clarification of these limitations and terms would solve the inconsistencies resulting from court decisions and ensure that Congressional intent is upheld through the EPSDT program.

D. Public Policy Concerns

While this note bases much of its analysis on statutory language, Congressional intent, and judicial decisions, there is a more basic, humane reason why the issue of Medicaid coverage of children must be considered. The reason is not only the ease of jurisdictions having uniform procedures or the ease of predictability that comes with such uniformity. The reason lies outside of judicial interpretation or applicable precedents, and lies instead within the realm of public policy, social justice, and human nature. Children should be entitled to healthy lives.¹²⁹

doing must abide by the requirements of the Act to qualify for receipt of federal Medicaid funds").

128. *Id.*; see also 42 U.S.C. § 1396(d)(r)(5) (2006).

129. See Convention on the Rights of the Child, G.A. Res. 44/25, art. 23-24, 1577 U.N.T.S. 3 (Nov. 20, 1989), <http://www2.ohchr.org/english/law/pdf/crc.pdf>; see also Universal Declaration of Human Rights, G.A. Res. 127/111A, U.N. Doc.A/RES/217(111) (Dec. 18, 1992), available at <http://www.un.org/en/documents/udhr/index.shtml>.

Public policy should protect and care for children. The health of a person is the cornerstone upon which many other measures of success rely. The physical health of a person, especially of a child, determines, in part, the future of that child. A healthy body is the first step toward a healthy mind. Both of those are important in helping to shape positive members of society. And the legal system, indeed, cares about the character and actions of members of society. Thus, the EPSDT provision should be preserved as it is an important vehicle in this effort to make positive changes today for the benefit of society tomorrow.

VII. CONCLUSION

The issues of medical necessity and maintenance therapy are not new to EPSDT and Medicaid law. These issues are litigated in courts throughout the country each year and, because each state has its own Medicaid program, each jurisdiction has relied on its own precedent to determine the proper answer. State discretion within each state's own Medicaid and EPSDT program has led to inconsistent results for needy children. Some states have strictly interpreted the statute and found truly necessary services to be outside of the scope of EPSDT, while other states have liberally interpreted the statute and defined maintenance therapy as a necessary service. The trending increase in state power to determine medical necessity will mean less coverage for children in need of medical treatment. An increase in state power undermines the intent of Congress in creating the EPSDT mandate. Therefore, the federal government needs to once again take action to protect children and clarify the intent and the scope of the EPSDT program. This can be done through legislation that clarifies the EPSDT statute and provides uniform guidelines for all states to follow.

Though Medicaid programs vary among states, Medicaid (and EPSDT) was a federal initiative. Thus, Congressional intent should control the limits and scope of state programs. State courts need federal guidelines to direct them in ensuring that children across the country receive equal, comprehensive services as needed under EPSDT. This issue is critical and relevant today, and will continue to be an emerging and pressing problem as more children are denied necessary services. More importantly, this is an issue that should be promptly addressed and clarified by federal statute to ensure equitable and consistent services to children across the country.