

FACT SHEET
MEDICAID'S AMOUNT, DURATION AND SCOPE REQUIREMENT:
CHALLENGING CUTS TO SERVICES FOR ADULTS

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I. Introduction

This fact sheet will describe how courts and the federal Department of Health and Human Services have interpreted and applied Medicaid's requirements addressing sufficiency of services provided under state Medicaid programs. In particular, it discusses the requirement that services be provided in a sufficient amount, duration and scope to reasonably achieve their purpose. It will also provide tips for advocates who are dealing with state cuts to Medicaid services.

II. Medicaid Background

The Medicaid Program was established by Title XIX of the Social Security Act in 1965 to enable states to provide medical services to individuals with limited ability to pay for health care.¹ Medicaid is a cooperative federal-state program in which the federal government shares the cost of health care provided by states through the program. The agency charged with administering the Medicaid program is the Centers for Medicare & Medicaid Services (CMS)² While states are not obligated to participate in the Medicaid program, if they do they must operate their programs in compliance with federal statutory and regulatory requirements.³ States are required to

¹42 U.S.C. § 1396 - 1396v.

²Until 2002, CMS was known as the Health Care Finance Administration, or HCFA. Agency guidance and court decisions issued before the change will refer to HCFA.

³42 U.S.C. § 1396a. For an overview of the Medicaid program administration, services and eligibility, see National Health Law Program, *An Advocates Guide to the Medicaid Program* (June 2001).

provide coverage of certain categories of individuals and have the option of covering others.⁴ Similarly, states must offer certain basic services and have the option of providing others.⁵

Congress did not establish a specific minimum level of each service that states must provide. Instead, states are required to establish reasonable standards, comparable for all eligibility groups, to determine the extent of the medical assistance provided.⁶ These standards must be consistent with the objectives of the Medicaid Act.⁷ In addition, regulations require that services be “sufficient in amount, duration and scope to reasonably achieve their purpose.”⁸ Moreover, states cannot “arbitrarily deny or reduce the amount, duration or scope of services to an otherwise eligible individual solely because of diagnosis, type of illness or condition.”⁹

Beneficiaries have challenged the sufficiency of Medicaid services numerous times over the past thirty years, however, no concrete rule has emerged as to what constitutes a sufficient amount of services. The limits of some particular services have been more clearly drawn, however, courts and administrative law judges continue to evaluate the individual service and beneficiary circumstance in each situation. Courts have in large part given states leeway in determining the limits of services but, however, may not hesitate to strike down arbitrary or unreasonable classifications. In the late 1970s and early 1980s, a series of important cases upheld statewide numerical limits on hospital days and doctor visits covered under Medicaid programs.¹⁰ During the mid 1980s, the trend appeared to reverse and a number of challenges to limitations on the amount, duration and scope of services succeeded.¹¹ In the 1990s, judges and CMS found irrebuttable presumptions that particular services

⁴42 U.S.C. § 1396a(a)(10).

⁵42 U.S.C. § 1396d(a).

⁶42 U.S.C. § 1396a(a)(17).

⁷*Id.*

⁸42 C.F.R. § 440.230(b). *See also* 42 U.S.C. § 1396a(a)(10)(B).

⁹42 C.F.R. § 440.230(c).

¹⁰*See e.g. Charleston Memorial Hospital v. Conrad*, 693 F.2d 324 (4th Cir. 1982); *Curtis v. Taylor*, 625 F.2d 645 (5th Cir. 1980); *Virginia Hosp. Ass’n v. Kenley*, 427 F. Supp. 781 (E.D. Va. 1977).

¹¹*See e.g. Meyers v. Reagan*, 776 F.2d 241 (8th Cir. 1985); *Vogel v. Perales*, No. 81 Civ. 7992, 1983 U.S. Dist. LEXIS 15303 (S.D. N.Y. 1983); *Jeneski v. Meyers*, 163 Cal. App. 3d 18 (1984); *cert. denied sub nom Vizer v. Jeneski*, 105 S. Ct. 2677 (1985); *Kirk v. Dunning*, 370 N.W.2d 2677 (Neb. 1985).

could never be medically necessary to be troublesome. Meanwhile, as managed care has become an integral part of many state Medicaid programs, these issues have taken on even greater importance.

Amount, duration and scope issues can arise in several contexts. First, advocates might challenge state Medicaid program limitations services provided on behalf of a class of beneficiaries in a systemic attempt to invalidate the limitation itself. Second, advocates may challenge such limitations in representing an individual client requesting a services not covered by the state. Third, advocates can challenge refusals to provide services to a particular client without arguing that the state's coverage rules themselves are illegal. For example, a state may decide to make cuts in its personal care services (PCS) and may create a policy restricting coverage of PCS to beneficiaries who cannot ambulate without a wheelchair. Advocates may contemplate a class action on behalf of Medicaid beneficiaries who need PCS but who do not have disabilities affecting their ability to walk. Advocates may also challenge the policy on behalf of an individual client. Another alternative would be to argue that an individual client beneficiary who does not meet the new state criteria needs PCS, without challenging the policy itself.

III. Legal Theories

The following sections discuss frequently-used amount, duration and scope theories. All apply to mandatory medicaid services. It is open to question whether one of the theories applies to optional services, as will be discussed below. As discussed above, states are required to provide "mandatory services" including physician services, inpatient hospital services, outpatient hospital services and home health services for severely disabled individuals.¹² Optional services are those that the state may choose to cover, such as prescription drugs, personal care services, and dental services.¹³

The three most commonly-used theories are: (1) all medically necessary treatment within a covered service area must be covered; (2) a service must be covered in an amount sufficient to achieve its purpose; (3) particular illnesses cannot be singled out for restricted coverage; and (4) states must use reasonable standards in administering their Medicaid programs. In addition, another possible federal and state theories will be discussed.

¹²42 U.S.C. § 1396d(a)(1)-(5), (17) and (21). 42 U.S.C. §§ 1396d(a)(1) (inpatient hospital services); 1396d(a)(2)(A) (outpatient hospital services); 1396d(d)(a)(5)(A) (physician services); 1396d(a)(7).

¹³42 U.S.C. §§ 1396d(a)(10) (dental services); 1396d(a)(12) (prescription drugs); 1396d(a)(24) (personal care services).

A. Medical Necessity

Courts have recognized that the “basic objective” of the Medicaid program is to provide individuals with medically necessary care and, moreover, that the “touchstone” for evaluating whether a state plan is reasonable is whether medically necessary procedures are covered.¹⁴ Courts have split on the issue of whether, within a covered service area, all “medically necessary” treatment must be provided. Because this requirement is neither stated in the Medicaid statute nor the regulations, different courts have based medical necessity theory upon different legal provisions.¹⁵ Advocates may find it more useful to cite various cases supporting this theory, rather than attempting to tie the requirement to a specific statutory or regulatory source.

Several courts have held that, when the patient’s physician and the state agency’s decision maker disagree about whether requested treatment is medically necessary, the treating physician’s opinion should be given more weight. Courts have so held for two essential reasons. First, the provider is generally “intimately familiar” with the patient’s medical history and needs, unlike the “clerical personnel or government officials” reviewing the request for treatment.¹⁶ Second, the provider is frequently more qualified than the reviewer as, for example, when the provider is a physician and the reviewer is not, or when the provider specializes in the condition at issue and the reviewer does not.¹⁷ It can be helpful to advocates to cite one or both of these reasons if applicable. Advocates should also point to the Senate Report on the original Medicaid bill, which confirms that Congress intended that states show deference, stating: “The 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.”¹⁸

¹⁴*Hern v. Beye*, 57 F.3d 906, 910-911 (10th Cir. 1995)

¹⁵See e.g. *Hern*, 57 F.3d 906; *Weaver v. Reagan*, 886 F.2d 194 (8th Cir. 1989); *Pinneke v. Priesser*, 623 F.2d 546, 548 n. 2 (8th Cir. 1980) (apparently relying on 42 U.S.C. §§ 1396, 1396a(a)(10)(c)); *Vogel v. Perales*, (relying on 42 C.F.R. § 440.320(b)); *Meyers*, 776 F.2d at 244; *Roe v. Casey*, 464 F. Supp. 487, 499-501 (E.D. Pa. 1978) (relying on 42 U.S.C. § 1396, 42 C.F.R. § 440.320(b)).

¹⁶*Dodson*, 427 F. Supp. at 108; *Pinneke*, 623 F.2d at 550.

¹⁷*Dodson*, 427 F. Supp. at 107, 108; *Jeneski*, 163 Cal. App. 3d at 32.

¹⁸S. Rep. No. 404, 89th Cong., 1st Sess., reprinted in 1965 U.S. Code Cong. And Ad. News, 1943, 2986. For cases discussing applying this deference, see *Holman v. Ohio Dep’t Human Services*, 757 N.E.2d 382, 388 (Ohio Ct. App. 2001); *A.M.L. v. Utah Dep’t Health*, 863 P.2d 44, 48 (Utah Ct. App. 1993); *Pinneke*, 623 F.2d at 550; *Dodson v. Parham*, 427 F. Supp. 97, 108 (N.D. Ga. 1977); *Jeneski*, 163 Cal. App. 3d at 32.

Further, when challenging policies or rules of state Medicaid agencies, advocates should note a still-valid Ninth Circuit decision holding that general determinations by administrative agencies concerning medical necessity are unpersuasive when compared to the judgment of a treating provider.¹⁹

The Supreme Court has not spoken directly on this issue in its 1977 opinion, *Beal v. Doe*.²⁰ Two principles emerged from this case. First, the Court noted that states are given broad discretion in determining the extent of medical services they will offer. However, the Court also noted that “serious statutory questions might be presented if a state Medicaid plan excluded necessary medical treatment from its coverage.”²¹ Decisions dealing with medical necessity must grapple with the tension between the “broad deference” given to a state in choosing the services it will cover with the deference accorded a treating physician. To harmonize these apparently competing concepts, it may be useful for advocates to think about the concept of medical necessity as having two levels of judgment. The first is the structural decision of whether a particular service is sufficiently necessary to fall under the coverage of its plan while the second is the patient-specific decision of the physician that the condition of a particular patient warrants treatment which the state plan makes available.²² While the first decision is not necessarily completely insulated from judicial or agency scrutiny, a state will be afforded more deference in this area. This concept will be discussed more fully below in connection with the requirement that states have “reasonable standards.”

B. Coverage Sufficiency

The second theory of amount, duration and scope cases is based on the regulation requiring that “[e]ach service must be sufficient in amount, duration and scope to reasonably achieve its purpose.”²³ Restrictions on covered services that prevent the services from achieving their objectives have been

¹⁹*Vista Hill Found., Inc. v. Heckler*, 767 F.2d 556, 560-61 (9th Cir. 1985).

²⁰*Beal v. Doe*, 432 U.S. 438, 448 (1977) (holding that the requirement that two physicians concur in attending physician’s conclusion that abortion is medically necessary may not have been “contemplated by Congress,” remanded for determination of “precise role” of two additional physicians.)

²¹*Id.*, at 444.

²²*See Preterm, Inc. v. Dukakis*, 591 F.2d 121, 125 (1st Cir. 1979); *McCoy v. Idaho Dep’t Health & Welf.*, 907 P.2d 110, 113-114 (Idaho 1995) (characterizing these two levels as the “macro-decision” and the “micro-decision.”)

²³42 C.F.R. § 440.230(b). The statutory source for this requirement is 42 U.S.C. §1396a(a)(10)(B), although the statute does not contain this regulatory language.

held to violate this regulation.²⁴ The question becomes, how to determine what those objectives are.²⁵ To ascertain the purpose of a particular service, courts have looked to federal provisions concerning the service, including those defining the service.²⁶ Others have looked at legislative history.²⁷ Guidance from CMS, from its *State Medicaid Manual* or from its periodic letters to state Medicaid directors may also be helpful.²⁸ State statutes and regulations can be helpful as well, unless advocates are asserting that the state definition itself violates the requirement.²⁹ Courts and administrative law judges have also discerned the purpose of a covered service even without reference to any statutory or regulatory provision.³⁰

A state may defend a coverage restriction from challenge under this regulation by arguing that most patient's needs for services are met and, although a particular patient's needs may not be met, the

²⁴See e.g. *Esteban v. Cook*, 77 F. Supp. 2d 1256, 1261 (S.D. Fla. 1999) (holding that \$582 cap on wheelchairs prevented service from fulfilling its purpose of minimizing effects of mobility problems); *Cushion v. Path*, 807 A.2d 425, 478 (Vt. 2002) (holding that restriction on partial dentures prevented service from achieving purpose of providing dental services to those most in need); *Jackson v. O'Bannon* No. 80-500 (E.D. Pa. Feb. 8, 1980) (available from NHeLP); *Kirk v. Dunning*, 370 N.W.2d at 115-6.

²⁵See *Sobky v. Smoley*, 855 F. Supp. 1123, 1143 (E.D. Cal. 1994) (nothing that "what is considered "reasonable [to achieve the purpose] is not defined" and reviewing decisions interpreting this requirement).

²⁶*Detsel v. Sullivan*, 895 F.2d 58 (2d Cir. 1990) (federal regulatory definition of private duty nursing); *Cushion*, 807 A.2d at 428; *Dodson*, 427 F. Supp. at 108; *Philadelphia Welfare Rights Org. v. Schapp*, 602 F.2d 1114, 1122-23 (3d Cir. 1979), cert. denied, 444 U.S. 106 (1980); *Simpson v. Wilson*, 480 F. Supp. 97, 102 (D. Vt. 1979).

²⁷But see *Detsel*, 895 F.2d at 64 (noting that definition of private duty nursing that prevailed when Medicaid was enacted in 1965 would not necessarily remain reasonable when case was decided in 1990).

²⁸CMS, *State Medicaid Manual*, available at www.cms.gov. See also *Philadelphia Welfare Rights Org.*, 602 F.2d at 1122.

²⁹*Esteban*, 77 F. Supp. 2d at 1260-1261; *Morgan v. Idaho Dep't Health & Welf.*, 813 P.2d 345, 349 (Id. 1991) But see *Hines v. Sheehan*, No. 94-326-P-H, 1995 U.S. Dist. LEXIS 11031, *5 (D. Me. July 26, 1995) (holding that Maine's policy of providing liquid diet supplements only to those with end stage renal disease or receiving the supplement through a feeding tube does not violate Medicaid Act).

³⁰*Kirk*, 370 N.W.2d at 115-116.

covered services do, generally speaking, “reasonably achieve their purpose.” This argument is based upon cases like *Curtis v. Taylor*, in which the Fifth Circuit upheld coverage of only a certain number of hospital days or physician visits per year because the vast majority of patients’ needs for services were satisfied despite the challenged limitations.³¹ However, these cases deal with numerical limits applicable across the board to medical care of all kinds, rather than with restrictive criteria applied to a particular treatment. In fact, cases invalidating limited coverage of particular services have examined *individuals’* needs for services, expressly finding it irrelevant whether *most* patients’ needs could be satisfied.³²

States have frequently attempted to buttress their arguments in this area with language from the Supreme Court’s decision in *Alexander v. Choate*: “Medicaid programs do not guarantee that each recipient will receive that level of health care precisely tailored to his or her needs.”³³ Advocates must keep in mind that this case was interpreting Section 504 of the Rehabilitation Act of 1973, however, and that the Court expressly declined to rule on whether the state policy at issue - a 14 day annual limit on hospital care - violated the Medicaid statute.³⁴ The Court did reason that even though people with disabilities frequently require hospital stays longer than 14 days, the 14 day limit did not deny meaningful benefit to them because the “benefit” provided under Medicaid is “a particular package of health services” rather than “adequate health care.”³⁵

C. Discrimination by Condition

The third federal amount, duration and scope theory stems from the regulatory prohibition that “the Medicaid agency may not arbitrarily deny or reduce the amount, duration or scope of a required service under §§ 440.210 and 440.220 to an otherwise eligible recipient solely because of the diagnosis, type of illness or condition.”³⁶ In other words, as one court explained, “[T]he regulations

³¹*Curtis v. Taylor*, 625 F.2d 645 (5th Cir. 1980). *See also*, *Charleston Memorial Hospital*, 693 F.2d at 324; *Virginia Hosp. Ass’n*, 427 F. Supp. At 781. *But see Community Service Society v. Cuomo*, 561 N.Y.S.2d 461 (N.Y. 1990) (holding that covering only a certain number of physician visits according to the nature of the specialty involved might not afford access to medically necessary services, upholding entry of preliminary injunction).

³²*Jeneski*, 163 Cal. App. 3d at 33 (holding that “judgments of medical necessity . . . must be made in individual cases.”)

³³*Alexander v. Choate*, 469 U.S. 287 (1985).

³⁴*Id.* at 303 n. 23.

³⁵*Id.* at 303.

³⁶42 C.F.R. § 440.230(c).

permit discrimination in benefits based upon the degree of medical necessity but not upon the medical disorder from which the person suffers.”³⁷ A number of courts have relied upon this regulation in invalidating coverage limitations.³⁸ And, although on its face the regulation applies only to mandatory services, several courts have applied the regulation to strike down restricted coverage of optional benefits as well.³⁹ Making such a claim may be a risky strategy in the current judicial climate, however.

D. Reasonable Standards

As discussed above, state plans must set “reasonable standards . . . which are consistent with the objectives of [the Medicaid Act].”⁴⁰ While courts and CMS do afford states significant deference in this area, there is a reluctance to find standards reasonable that they establish irrebuttable presumptions or that allow for no exceptions. The most important example comes from the coverage of durable medical equipment (DME). Connecticut’s Medicaid agency had developed a list of DME items that could be covered and denied requests for any items not on the list. In *Dasario v. Thomas*, the Second Circuit held that Connecticut was not required to cover medically necessary DME items under its plan as long as the health care provided was adequate with respect to the needs of the Medicaid population as a whole.⁴¹ In response to this decision, CMS made it clear that this was an incorrect interpretation of the Medicaid Act. In a letter to state Medicaid directors, CMS indicated that states could develop a list of pre-approved DME items “as an administrative convenience because such a list eliminates the need to administer an extensive application process for each [DME] request submitted.” However, the letter went on to state that a DME policy “that provides no reasonable and meaningful procedure for requesting items not on the approved list is inconsistent with 42 U.S.C. §

³⁷*White v. Beal*, 555 F.2d 1146, 1152 (3d Cir. 1977); *cited with approval in Jeneski v. Meyer*, 163 Cal. App. 3d at 33.

³⁸*White*, 555 F.2d at 1151-52; *Pinneke*, 623 F.2d at 549, 550; *Hodgson v. Board of County Comm’rs*, 614 F.2d 601, 608 (8th Cir. 1980); *Simpson v. Wilson*, 480 F. Supp. 97, 101; *Jeneski*, 163 Cal. App. 3d at 33.

³⁹*White v. Beal*, 555 F.2d at 1152, n. 6; *Simpson*, 480 F. Supp. at 102; *Jeneski v. Meyer*, 163 Cal. App. 3d at 30, n. 9, *Weaver v. Reagan*, 886 F.2d 194 (8th Cir. 1989). *But see Ledet v. Fischer*, 548 F. Supp. 775, 786 (M.D. La. 1982). *But see Dexter v. Kirschner*, 984 F.2d 979 (9th Cir. 1993) (holding that Medicaid Act gives discretion for covering organ transplants and state is within its discretion to fund one type of bone marrow transplant but not another).

⁴⁰42 U.S.C. § 1396a(a)(17).

⁴¹*DeSario v. Thomas*, 139 F.3d 80 (2d Cir. 1998).

1396a(a)(17), 42 C.F.R. § 440.230(b) and 42 C.F.R. § 440.230(c).⁴² Following issuance of this letter, the United States Supreme Court, in *Slekis v. Thomas*, vacated the lower court's ruling and remanded for consideration in light of CMS' guidance.⁴³

The Supreme Court's remand and CMS' guidance have been of great help to advocates challenging DME lists and exclusions.⁴⁴ States have generally been reluctant to apply this reasoning outside of the DME context, however, even after *Slekis*. However, in individual cases where clear medical need is demonstrated, courts have shown a reluctance to accept categorical exclusions of certain types of treatment or procedures.⁴⁵ "A state law that categorically denies coverage for a specific, medically necessary procedure except in those rare instances when the patient's life is at stake is not a "reasonable standard. . . ."⁴⁶

E. Other Federal Theories

Another argument based on federal law involves procedural issues. If the coverage limitation at issue in a particular case resulted from a state's reduction in services, advocates should determine

⁴²CMS, *Dear State Medicaid Director Letter*, Sept. 4, 1998, available at <http://www.cms.hhs.gov/states/letters/smd90498.asp>

⁴³*Slekis v. Thomas*, 525 U.S. 1098 (1999).

⁴⁴See e.g. *T.L. v. Colo. Dep't Health Care Policy*, 42 P.3d 63 (Colo. Ct. App. 2001) (striking down state exclusion of hot tubs from Medicaid coverage regardless of medical necessity); *Fred C. v. Texas Health and Human Services Comm'n*, 924 F. Supp. 788 (W.D. Tex. 1996), vacated on other grounds 117 F.3d 537, on remand, 988 F. Supp. 1032 (W.D. Tex. 1997), *aff'd without opinion* 167 F.3d 537 (5th Cir. 1998) (striking down denial of coverage of augmentive communicative device).

⁴⁵See e.g. *Holman*, 757 N.E.2d at 386 (noting that "by presuming non-coverage to all cosmetic surgeries, [the state Medicaid agency] erred as a matter of law."); See also *Allen v. Mansour*, 681 F. Supp. 1232 (E.D. Mich. 1986) (finding that requiring a two-year period of abstinence from alcohol before allowing a liver transplant for alcoholic cirrhosis arbitrary and unreasonable). *But see Smith v. Rasmussen*, 249 F.3d 755 (8th Cir. 2001) (upholding Iowa Medicaid agency's categorical exclusion of sex reassignment surgery as consistent with Medicaid Act).

⁴⁶*Visser v. Taylor*, 756 F. Supp. 501 (D. Kan. 1990) (holding that state Medicaid agency's refusal to cover prescription drug Clozaril for beneficiary despite demonstrated medical necessity violated sufficiency requirement).

whether a state satisfied federal requirements for making such reductions. According to the regulations, before a state agency takes action to terminate, suspend, or reduce services, it must provide notice to each affected beneficiary.⁴⁷ Unless the reduction is the result of a change in law [or policy] beneficiaries must be afforded an opportunity for a hearing.⁴⁸ The notice must contain: (1) a statement of the action that the state or facility intends to take; (2) the reasons for the intended action; (3) the specific regulation that supports, or the change in federal or state law that requires the action; (4) an explanation of the individual's right to request a hearing; (5) the circumstances under which a hearing will be granted; and (6) an explanation of the circumstances under which Medicaid is continued if a hearing is requested.⁴⁹

The concept of "service reduction" subject to these regulations has been broadly construed to include, for example, the imposition of copayments.⁵⁰ Service reductions have been invalidated and states ordered to return to prior service levels for failure to furnish advance notice,⁵¹ or adequate notice, or for failure to give notice in a proper manner, and for failure to provide an opportunity for a hearing.

F. State Theories

In addition to these federal approaches, advocates should explore theories available under the laws of their particular states. State statutes and regulations requiring provision of particular benefits, as well as more general language from state Medicaid statutes and regulations, can prove useful in amount, duration and scope cases.⁵² Advocates should also investigate whether the Medicaid agency has complied with applicable state Administrative Procedures Acts (APAs). State APAs, like the federal APA,⁵³ usually requires that general policy changes be preceded by notice to the general public and an opportunity for the public to comment. Particular state statutes may impose other requirements as well.

IV. Practical Considerations

⁴⁷42 C.F.R. §§ 431.201, 431.211.

⁴⁸42 C.F.R. §§ 431.206, 431.210, 431.220.

⁴⁹42 C.F.R. § 431.210

⁵⁰*Becker v. Toia*, 439 F. Supp. 324, 331 (S.D. N.Y. 1978).

⁵¹*Eder. v. Beal*, 609 F.2d 695 (3d Cir. 1979); *Toia*, 439 F. Supp. At 324.

⁵²*See e.g. Jeneski*, 163 Cal. App. 3d at 31.

⁵³5 U.S.C. §§ 551-76.

When determining whether a restriction is illegal, advocates should, if possible, request all recent internal memoranda concerning the service restriction at issue under state public records acts.⁵⁴ Such memoranda may help identify state officials who disagree with the state's restrictions and who can be subpoenaed for hearing or deposed. Such memoranda may also help to show that the restrictions are based upon financial rather than medical considerations, and are thus unrelated to the purposes of the Medicaid program. The records request should seek all documents concerning the state's compliance with federal and state procedural requirements before implementing the questioned policy.

Given the uncertainty that currently surrounds the enforceability of Medicaid requirements, advocates should strongly consider challenging restrictions on individual bases at fair hearings.⁵⁵ Such a course would avoid any issue of exhaustion of remedies. Moreover, a fair hearing allows for more effective discovery than anything possible after filing a lawsuit. For example, the states' witnesses will usually not have received the advice of counsel and will be unaware of the arguments that might be made and will frequently make astonishing admissions. It can be helpful to think out theories carefully and determine in advance what kind of admissions might be particularly useful. Moreover, to the extent possible, advocates should attempt to have the treating provider (or another knowledgeable provider) present at the hearing. Failing that, participation by phone can be helpful. The informality of hearings allows such providers to respond immediately to statements by state witnesses. These responses usually should be followed up by cross-examination of state witnesses, which can be quite effective in hearings when opposing counsel is not present.

The key to an amount, duration and scope case is the factual record. If possible, advocates should show that the requesting provider knows the patient very well or possesses expertise concerning the treatment. Pursuing the latter angle may also involve establishing that the state employee rejecting the treatment request possesses little expertise or few qualifications. Accordingly, advocates should find out as much as possible about the state employee rejecting the treatment. The requesting provider should phrase his or her conclusions in terms consistent with applicable legal principles. The provider should state that, based on considered medical judgment and personal knowledge of the patient, the treatment at issue is (1) medically necessary and (2) required in order to achieve a particular purpose - the purpose of the particular benefit category. For example, in challenging a state's refusal to cover a particular prescribed drug, one might argue, based upon the regulation, that the purpose of the state's coverage of prescribed drugs is "the cure, mitigation or prevention of disease."⁵⁶ The treating provider could then state that the drug is necessary to cure, mitigate or prevent a particular disease. The

⁵⁴See e.g. Cal. Govt. Code. §§ 6250-65

⁵⁵For cases discussing challenges enforcing Medicaid requirements through 42 U.S.C. § 1983, see Jane Perkins, *42 U.S.C. § 1983 and Enforcement of the Medicaid Act*, available from NHeLP's Chapel Hill office.

⁵⁶See 42 C.F.R. 440.120(a).

provider should phrase additional conclusions in terms of state law requirements. For example, in challenging a state's refusal to approve a request for speech therapy where the state covers that service and state law requires the approval of treatment whenever "necessary to prevent significant disability," the treating provider should state that the therapy is indeed necessary to do so. Of course, it is also essential that the provider set forth in full detail the basis for these conclusion, spelling out precisely what it likely to happen to the patient if the request treatment is not provided.

It is also crucial to focus on the inadequacies of alternative treatments that the state may provide. Amount, duration and scope cases have been lost because advocates failed to provide evidence that state-furnished treatments would not meet the patients' medical needs. Further, to the extent possible, provider declarations should also be included to document the consequences of restricted state coverage. Relevant university providers or provider organizations can be helpful in obtaining such expert assistance.

For more information on this issue contact National Health Law Program's Chapel Hill office.