NHeLP
NATIONAL HEALTH LAW PROGRAM

Q&A
EPSDT, Deference to Providers, and Moore v. Reese

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Q. My client has an 11-year-old daughter whose doctor requested coverage for 80 hours per week of private duty nursing. The state Medicaid agency denied the request, stating that 80 hours were unnecessary and authorizing 30 hours per week. The state's attorney cited *Moore v. Reese*. Please explain this case and how it could affect my clients who depend on EPSDT.

A. *Moore v. Reese* is a recent case decided by the Eleventh Circuit Court of Appeals. The case requires the impartial decision-maker (administrative or judicial) to weigh both the treating provider and the state's arguments when there is a disagreement as to the proper amount of a covered Medicaid service.

Discussion[2]

Moore v. Reese was filed after the Georgia Medicaid agency reduced coverage of Callie Moore's private duty nursing services from 94 to 84 hours per week over the objection of Callie's long-time treating physician. *See Moore v. Reese*, 637 F.3d 1220, 1224-29 (11th Cir. 2011) (petition for rehearing denied, May 15, 2011).

Sixteen-year-old Callie is severely disabled and requires continuous treatment, monitoring and interventions by her caregivers. The Medicaid agency's medical director testified that Callie's services were reduced based on community norms regarding medical necessity and the cost of care. He also testified that Callie's condition was relatively stable and her mother could assume responsibility for her care. *Id.* at 1227-28. After hearing testimony in the case, the district court determined that the state agency needed to defer to the recommendation of the treating physician and granted summary judgment for Callie. According to the district court,

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[2] For additional discussion, see Sarah Somers, National Health Law Program, *Medicaid and Deference to Treating Providers* (Nov. 2008) (discussing relevant case law and identifying *Moore* as a case to watch) (available from TASC or NHeLP-NC).

[t]he state must provide for the amount of skilled nursing care which the Plaintiff's treating physician deems necessary to correct or ameliorate her condition. The Defendant may not deny or reduce the hours of skilled nursing care that is medically necessary based upon cost or the lack of a secondary caregiver.

Moore v. Medows, 563 F. Supp. 2d 1354, 1357 (N.D. Ga. 2008). The district court relied on 1989 amendments to the Medicaid Act's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) provisions, which require states to cover necessary services listed in the Medicaid Act (§ 1396d(a)) when needed to "correct or ameliorate" a child's physician or mental condition. *Id.* (citing 42 U.S.C. § 1396d(r)(5)). The court concluded that these amendments strictly limited the state's discretion not to provide physician-prescribed treatments for individuals under age 21. *Id.*

The state agency appealed the decision to the Eleventh Circuit Court of Appeals, which reversed and remanded the case in a brief, unpublished order. 324 F. App'x 773 (11th Cir. 2009). The Court held the state was not excluded from the determination of medical necessity, the private doctor's word was not the final decision, and both the state and provider had roles to play. Left unanswered were questions as to exactly what these roles are when there are conflicting opinions between the doctor and the state's medical experts about the *amount* of care that Medicaid will cover. On remand, the district judge recognized the state's role in the coverage review but limited that role to determining whether the treating physician's recommendation was the result of fraud or in conflict with reasonable standards of medical care. 674 F. Supp. 2d 1366, 1370 (N.D. Ga. 2009).[3]

Again, the state agency appealed. On April 7, 2011, the Eleventh Circuit once again reversed and remanded the case. *See Moore v. Reese*, 636 F.3d 1220 (11th Cir. 2011). The Court's opinion focuses on the "hotly disputed" issues concerning what amount of private duty nursing hours the state must provide under the Medicaid Act, the parameters of the roles played by the treating physician and the state Medicaid agency in making that determination, and what happens when the treating physician and the state's medical expert disagree as to the amount of services that are necessary. *Id.* at 1235. The Eleventh Circuit takes a methodical, if not entirely correct, approach to reviewing these questions. The Court assesses the 1989 Medicaid EPSDT amendments, 42 U.S.C. § 1396d(r)(5); federal regulations that require states to cover a sufficient amount duration and scope of services and allow them to place limits on services based on medical necessity, 42 C.F.R. § 440.230; and CMS, *State Medicaid Manual* § 5122, which provides that states must cover EPSDT services to "correct or ameliorate" conditions, but also notes, "You [the state] make the determination as to whether the service is necessary. You are not required to provide any items or service which you determine are not safe and effective and which are considered experimental." *Id.* (quoting CMS, *State Medicaid Manual* § 5122)*; See also Id.* (stating § 440.230 allows states to establish amount, duration, and scope of benefits, so long as the limits are reasonable and comport with the statutory "correct or ameliorate" requirements). The Court also reviewed previous cases that decided Medicaid coverage disputes: *Beal v. Doe*, 432 U.S. 438 (1977) (allowing state's Medicaid plan to limit coverage of non-therapeutic abortions); *Curtis v. Taylor*, 625 F.2d 645 (5th Cir. 1980) (allowing state's Medicaid plan to

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[3] For additional discussion of this case history, *see* Sarah Somers, National Health Law Program, *EPSDT Case Developments from Georgia* (Jan. 2010) (available from TASC or NHeLP-NC).

impose three visit per month limit on physician services);[4] *Rush v. Parham*, 625 F.2d 1150 (5th Cir. 1980) (holding state Medicaid agency may adopt a reasonable definition of medical necessity and exclude experimental treatments); and *Pittman v. Department of Health and Rehabilitative Services*, 998 F.2d 887 (11th Cir. 1993) (holding EPSDT required coverage of medically necessary organ transplant). Ultimately, the Court joined these legal strands together to form guiding principles for decision makers:

1. Georgia is required to adhere to the Medicaid EPSDT provisions and must cover private duty nursing services under EPSDT when they are medically necessary to correct or ameliorate a child's condition.

2. The state's Medicaid plan must include reasonable standards for determining the extent of medical assistance that must be consistent with Medicaid's objectives, specifically EPSDT.

3. The state can adopt a definition of medical necessity that places limits on a service based on medical necessity, therefore limiting a physician's discretion so long as the state does not discriminate based on condition. The state can also establish standards for a physician to use when determining what services are necessary in a particular case.

4. The state can establish the amount, duration and scope of services required under EPSDT (citing 42 C.F.R. § 440.230 and the State Medicaid Manual) and is not required to provide medically unnecessary, though desired, EPSDT services.

5. The treating physician assumes the primary responsibility for determining the child's treatment needs, but both the state and physician have roles to play. If there is a dispute over the proper amount of a service that Medicaid will cover, the decision-maker should review the recommendation of the treating physician on a case-by-case basis and allow the state agency to present its own evidence of medical necessity.

Applying these principles, the circuit court concluded that the district court acted improperly when it restricted the Georgia Medicaid agency's role to only reviewing the treating physician's determination for fraud or whether it fell within reasonable standards of medical care. According to the Court, the State can review the treating physician's recommended amount of care for medical necessity and make its own determination of medical necessity. After that review, the State can limit a child's services based on its medical expert's opinion of medical necessity so long as the limits do not discriminate on the basis of medical condition and services are provided in sufficient amount and duration to reasonably achieve the purpose of the service. The Court remanded the case to allow evidence on the medically necessary *amount* to be presented and considered. The Court also noted that, on remand, general federal court civil rules would apply, and the plaintiff would bear the burden of persuasion to establish by a preponderance of the evidence that 94 hours of nursing care are medically necessary.

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[4] The Eleventh Circuit was created in 1981 from the former Fifth Circuit, and it adopted as binding precedent all decisions of the former Fifth Circuit handed down prior to the close of business on September 30, 1981. *See Bonner v. City of Prichard*, 661 F.2d 1206, 1209 (11th Cir. 1981).

The Court concluded it decision with two final observations. First, it rejected an argument made in *amicus* brief submitted by Well Care of Georgia that, due to escalating Medicaid costs and the need to manage the public fisc, the state must be the "final arbiter" on coverage: "However, pressing budgetary burdens may be, we have previously commented that cost considerations alone do not grant participating states a license to shirk their statutory duties under the Medicaid Act." 637 F.3d at 1259 (citing *Tallahassee Mem'l Reg'l Med. Ctr. v. Cook*, 109 F.3d 693, 704 (11th Cir 1997)). Finally, the Court restated its belief that it is a "false dichotomy" to say that one or the other, the state's medical expert or the treating physician, must have complete control when assessing whether a service is medically necessary under the Medicaid Act. *Id.* at 1260.

Recommendations and Conclusion

If there is a dispute regarding the amount of a Medicaid-covered service that a child needs, the case should be carefully presented to the impartial decision-maker:

1. <u>Prepare a strong affirmative case.</u> Work with the treating providers to help them write the best possible recommendations/prescriptions justifying coverage of the service under EPSDT correct or ameliorate medical necessity standard. The providers should describe the individual's condition, her need for the service, alternatives that have been tried and/or rejected, and explain how the service will "correct or ameliorate" the child's condition.

2. <u>Pay attention to the state's experts early and often.</u> Learn as much as you can as early as you can about the rationale of the state's expert, and seek to pin them to their rationale in writing (so that you are not working against a moving target). Make sure to take advantage of your right to review the individual's entire case file prior to the hearing. *See* 42 C.F.R. § 431.242(a) (authorizing review of the case file and all documents or records to be relied upon by the state at the hearing). Track the testimony of the state's expert reviewers over time. If this testimony is consistently at odds with various treating physicians' recommendations, then there is an argument that the expert has a conflict of interest such that the decision-maker should not give weight to his opinions.

3. <u>Review the rules on the burden of proof</u>. While the *Moore* panel stated the plaintiff bore the burden of persuasion in federal court, the rules differ from state-to-state court. For additional discussion, *see* Sarah Somers & Jane Perkins, National Health Law Program, *Fact Sheet: The Burden of Proof in Medicaid Cases* (Sept. 2004) (available from TASC or NHeLP-NC).

4.. <u>Understand and account for the *Moore* reasoning.</u> Legal argument should highlight these aspects of the *Moore* decision.

- While *Moore* cites a federal Medicaid regulation, 42 C.F.R. § 440.230(d), that allow states to place limits on services based on medical necessity, it also holds that the state's definition of medical necessity must be consistent with EPSDT and that the Medicaid EPSDT statute requires coverage of services "necessary … to correct or ameliorate" a child's physical or mental condition. While the opinion could certainly have done a better job of consistently reminding parties that the "correct or ameliorate" standard applies to medical necessity decisions for children, *Moore* never

intimates that the EPSDT standard does not apply. Nor does it hold or even imply that a state can apply the medical necessity definition it uses for adults in EPSDT cases. Even after *Moore*, the EPSDT "correct or ameliorate" medical necessity standard still applies to services needed by children and youth under age 21.

- Arguably, the Court has incorrectly applied the amount, duration and scope regulation , 42 C.F.R. § 440.230(b), which states: "Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose." First, the Court applies the regulation to the micro-level determination of whether care and services are needed for an individual. However, the regulation is addressing state decision-making at the macro-level, providing that the *state Medicaid plan* must specify the amount, duration and scope of services. Second, the Court applies the regulation to the wrong service, repeatedly focusing its comments on private duty nursing, a listed Medicaid service at 42 U.S.C. § 1396d(a)(8). However, the service at issue in the case is EPSDT, listed in the Medicaid Act at 42 U.S.C. § 1396d(a)(4)(B). The purpose of EPSDT is to achieve early diagnosis and treatment of physical and mental illnesses and conditions so as to "correct or ameliorate" their effects on children. Introducing EPSDT, President Johnson stated its purpose as follows: "… to discover, as early as possible, the ills that handicap our children. There must be continuing follow-up treatment so that handicaps do not go untreated… [so that] every child, no matter what his color or his family's income … goes as far as his talents will take him." 13 Cong. Rec. 2883, 2885 (Feb. 8, 1967) (Statement of President Lyndon B. Johnson). In other words, when determining the amount, duration and scope of the EPSDT service under § 440.230(b), early prevention and ameliorative treatment must be at the core of the decision; otherwise, the state's coverage will not be reasonable to achieve EPSDT's purpose.

- *Moore* does not erase the need for the state Medicaid agency to give significant weight to the treating physician's recommendation. *Moore* places primary responsibility for determining a child's needs with the treating physician. And while the Court held the state need not give the treating physician "unilateral discretion to define medical necessity" for payment purposes, it also held the state does not have unilateral discretion to make the coverage decision. Nevertheless, citing *Moore,* state agency personnel may argue that deference to the treating provider will cause them to relinquish control over their Medicaid programs. In calling on decision-makers to weigh both the plaintiffs' and the state's evidence, *Moore* rejected this reasoning. Indeed, there are numerous controls in place to assure that EPSDT services are covered when needed to correct or ameliorate a problem. First, to be covered under EPSDT, services must fall within one of the categories listed in 42 U.S.C. § 1396d(a). Second, states do not have to cover treatment that is unsafe or experimental. *See, e.g.,* CMS State Medicaid Manual § 5122; Letter from Rozann Abato, Acting Director Medicaid Bureau, to State Medicaid Directors (May 26, 1993) (stating that services are not covered if they are unsafe or experimental or not generally recognized as accepted treatment). Third, states may choose to cover a service in the most economic mode, as long as it is "similarly efficacious" to alternative services, does not delay services and does not violate other federal laws such as the Americans with Disabilities Act. *Id.* Finally, the state need not cover a service if it will not correct or ameliorate the child's condition. *See* 42 U.S.C. § 1396d(r)(5).

- Decision-makers should be reminded of the federal and state standards imposed on physicians and other treating providers as a precondition of participation in the Medicaid program. *See, e.g.,* 42 C.F.R. §§ 447.1–447.31, 447.46, 447.56 (requirements regulating quality of care and economic efficiency). Accordingly, physicians who are eligible to receive Medicaid reimbursement for providing services should already be meeting numerous quality and ongoing practice requirements. These requirements imposed on Medicaid providers limit waste and ensure that only qualified providers participate in Medicaid and only medically necessary care is covered.

- *Moore* does not undermine numerous court decisions that have recognized the primary role of the treating physician, and these cases should continue to be cited. *E.g., Collins v. Hamilton,* 349 F.3d 371 (7th Cir. 2003) (holding that a state's discretion to exclude services that have been deemed medically necessary under EPSDT by a treating provider has been "circumscribed by the express mandate of the statute"); *Pediatric Specialty Care, Inc. v. Ark. Dep't of Human Servs.,* 293 F.3d 472 (8th Cir. 2002) (reminding state that it has a duty to "arrange for corrective treatments prescribed by physicians"); *Rosie D. v. Romney,* 410 F. Supp. 2d 18, 26 (D. Mass. 2006) (holding 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"); *S.D. v. Hood,* 2002 WL 31741240 at *7 (E.D. La. Dec. 5, 2002), *aff'd*, 391 F.3d 581 (5th Cir. 2004) (rejecting agency decision to deny Medicaid coverage where the state's expert had never examined the patient and did not have the same qualifications as the patient's treating providers); *Urban v. Meconi*, 930 A.2d 860, 865 (Del. S. Ct. 2007) (holding that the administrative decision-maker must give "'substantial weight' to the opinions of treating physicians; … generally should give less probative weight to the opinion of a physician who has never examined the patient; … and should not substitute its expertise for the competent medical evidence.") (citations omitted).[5]

4. Do not hesitate to consult with NHeLP. The National Health Law Program attorneys have experience working with the EPSDT program. They are available to assist Protection & Advocacy offices with their EPSDT cases.

[5] For in depth citation, see NATIONAL HEALTH LAW PROGRAM, THE ADVOCATE'S GUIDE TO THE MEDICAID PROGRAM (May 2011).