Q&A
Responding to Medicaid Coverage Exclusions and Monetary Caps: A Review of Recent Cases[1]

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Q: Our state Medicaid agency implemented a coverage policy that excludes certain items of medical equipment and places a monetary cap on the amount it pays for some other services. As justification, the State is relying on federal Medicaid regulations, 42 C.F.R. § 440.230(a), which allows states to establish the amount, duration and scope of services, and § 440.230(d), which allows states to use "utilization control procedures." The State also points out that its state Medicaid plan has been approved by the Secretary of Health and Human Services (HHS). We are considering how to respond when individuals' requests for medically necessary services are denied. We have reviewed cases cited in the Services chapter of NHeLP's *Advocate's Guide to the Medicaid Program* (May 2011) (update forthcoming). Are there more recent court cases?

A. Yes. Three opinions issued in September 2012 call the legality of these state policies into question. This Q&A describes these cases and provides an annotated list of other relevant decisions issued since May 2011.

Discussion

Three recent decisions prohibit the state Medicaid agency from denying medically necessary services to Medicaid beneficiaries:

- *Bontrager v. Indiana Family & Social Services Admin*., _ F.3d _, No. 11-3710, 2012 WL 4372524 (7th Cir. Sept. 26, 2012)

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- *Koenning v. Suehs*, _ F. Supp. 2d _, No. V-11-6, 2012 WL 4127956 (S.D. Tex. Sept. 18, 2012)
- *Conley v. Department of Health*, _ P.3d _, No. 20100496-CA, 2012 WL 4450154 (Utah Ct. App. Sept. 27, 2012)

***Bontrager*, No. 11-3710 (7th Cir. Sept. 26, 2012):**
Monetary cap ≠ Utilization control procedure

Sandra Bontrager needed significant dental work, including dental implants. The Indiana Medicaid agency acknowledged that it covers adult dental services and that Ms. Bontrager's requested treatments were medically necessary. However, the State denied her request for Medicaid coverage because the requested treatments exceeded its $1,000 annual cap on dental services for adults. Ms. Bontrager was left without services because the procedures she needed exceeded the cap.

She filed suit challenging the cap, seeking relief under 42 U.S.C. § 1983 for a violation of 42 U.S.C. § 1396a(a)(10)(A), a Medicaid provision that requires states to make covered Medicaid services available to all individuals who meet Medicaid's eligibility requirements. The district court granted her a preliminary injunction preventing the State from enforcing the $1,000 annual cap. *See* 829 F. Supp. 2d 688 (N.D. Ind. 2011). The State filed an interlocutory appeal, making two separate arguments, first, that Ms. Bontrager did not have a private cause of action under § 1983 to enforce the Medicaid provision, and second, that she was not entitled to a preliminary injunction. The Seventh Circuit Court of Appeals rejected both arguments and affirmed the district court.

Private enforcement under § 1983

The Seventh Circuit held Ms. Bontrager has an enforceable federal right capable of redress through § 1983. The Court expressly reaffirmed, *Miller v. Whitburn*, 10 F.3d 1315 (7th Cir. 1993), which previously held the Medicaid provision at issue, 42 U.S.C. § 1396a(a)(10)(A), was privately enforceable. The Indiana Medicaid agency argued that *Miller* no longer governed because it relied on *Wilder v. Virginia Hospital Association*, 496 U.S. 498 (1990), a case allowing private enforcement of a Medicaid Act. According to the State, post-*Wilder* Supreme Court cases changed the standard for determining when Congress has authorized private enforcement under § 1983. *See Bontrager*, slip op. 4-5 (discussing State's position, citing *Blessing v. Freestone*, 520 U.S. 329 (1997), and *Gonzaga University v. Doe*, 536 U.S. 273 (2002)). But while the *Bontrager* panel acknowledged that *Gonzaga* "may have taken a new analytical approach," it found that

Wilder has not been overruled by the Supreme Court and, thus, *Miller* continues to set the precedent. Slip op. at 5. The panel also cited the "persuasive" reasoning of several other circuit courts that, post-*Blessing* and post-*Gonzaga*, have held § 1396a(a)(10)(A) creates an enforceable federal right under § 1983. *Id*. at 6 (collecting cases).[2]

Preliminary injunction

The Court also found that Ms. Bontrager met the requirements for a preliminary injunction. The discussion focused on the plaintiff's likelihood of success on the merits. Indiana argued that the $1,000 annual cap was appropriate because it did not categorically exclude beneficiaries from receiving medically necessary treatments but rather operated as an appropriate utilization control under 42 C.F.R. § 440.230. The Seventh Circuit rejected this argument, stating, "This is a bizarro-world notion of insurance coverage: once the insurance provider (the State) meets the initial deductible ($1,000), the insured is left coverage all the remaining costs." Slip op. at 10 (quoting *Bontrager*, 829 F. Supp. 2d at 699). The Court further explained the problem with this notion of "some coverage" noting that if a needed procedure costs $1,200, the cap prevents reimbursement to the provider altogether because the indigent individual will likely be unable to pay the remaining $200. *Id*. Moreover, the record in the case showed that a number of dental procedures cost more than $1,000, thus categorically excluding them from coverage. *Id*.

The Court distinguished cases cited by the State that allowed quantitative limits on services, for example 12 inpatient hospital days each year. *Bontrager* pointed out that the records in these cases established that these limits would still meet the needs of most eligible recipients; in contrast, the $1,000 annual cap "denies coverage for medically necessary services outright by functionally excluding certain procedures … and is not in any way based on degree or consideration of medical necessity." Slip op at 12 (citing and discussing cases).

Finally, the Court rejected the State's classification of the cap as a "utilization control procedure." While noting that the federal law does not define phrase, the Court found that the cap was not such a procedure because it "serves to exclude medically necessary treatment," in contrast to accepted utilization controls such as prior authorization to assure medical necessity and fraud prevention. *Id*. at 13-14.

[2] For in-depth discussion, *see* Jane Perkins, National Health Law Program, *Fact Sheet: Update on Private Enforcement of the Medicaid Act Pursuant to 42 U.S.C. § 1983* (Sept. 26, 2012) (available from TASC or NHeLP).

***Koenning v. Suehs*, 2012 WL 4127956 (S.D. Tex. Sept. 18, 2012): Exclusive list of DME ≠ Reasonable Medicaid Standard**

Bradley Koenning and two other adults sought Medicaid coverage of custom power wheelchairs with integrated mobile standers. Although Texas Medicaid covered a number of power wheelchair features, it rejected their requests citing their policy to cover separate, standalone standing frames but categorically exclude mobile standers. The individuals filed suit, alleging that the policy violated Medicaid requirements for states to use reasonable standards when making coverage decisions (42 U.S.C. § 1396a(a)(17)). District Judge John D. Rainey granted the plaintiffs most of the relief they sought.

Private enforcement under the Supremacy Clause

As an initial matter, the State argued that the Plaintiffs could not obtain relief from the court because they did not have a federal right under 42 U.S.C. § 1983. However, as the Court pointed out, the Plaintiffs were proceeding under Supremacy Clause, not § 1983. *See* 2012 WL 4127956, at *9-10 (quoting U.S. Const. art. VI, cl. 2). The Court rejected the State's argument that a recent case, *Douglas v. Independent Living Center of Southern California*, 132 S.Ct. 1204 (2012), bars private actions under the Supremacy Clause to enforce the Medicaid Act. As the Court pointed out, *Douglas* did not rule on the Supremacy Clause question but rather remanded for the lower court to address whether a plaintiff can bring a Supremacy Clause action when the allegedly non-compliant state law has been approved by the federal Centers for Medicare & Medicaid Services (CMS). Citing standing precedent, the Court allowed the Supremacy Clause claim to proceed. Id. at *12. The State also argued that *Douglas* should "give courts pause" in allowing a Supremacy Clause action where CMS has approved the state plan and cited an email from CMS purporting to support its position that the challenged policy had indeed been approved. However, as the Court noted, later email from CMS had asked the State how it could justify absolute coverage exclusions and otherwise created ambiguity. Thus, the Court said the situation was different from that in *Douglas*, and it refused to find that the policy had been approved by CMS. *Id*.

Summary judgment

The Court then moved to the merits. It began by reasoning: Once a state decides to participate in Medicaid, it must adhere to the federal rules for participation, including the requirements to use reasonable standards for determining coverage, 42 U.S.C. §

1396a(a)(17), and ensure that coverage for each service that is sufficient in amount, duration and scope, 42 C.F.R. § 440.230(b). *See* 2012 WL 4127956, at *1. One of the mandatory services that participating states must cover are home health services for individuals who are entitled to nursing facility services. See 42 U.S.C. § 1396a(a)(10)(D). These home health services, in turn, must include "medical supplies, equipment and appliances suitable for use in the home." 42 C.F.R. § 440.70(b)(3). This includes durable medical equipment (DME). The Court further noted that, although federal law does not define the scope of DME, CMS has issued the "DeSario Letter" that sets forth official guidance on the legal requirements governing DME coverage. The DeSario Letter allows states to develop lists of covered DME "as an administrative convenience" but requires states to have a "reasonable and meaningful procedure" for individuals to request and obtain items not on the list. Letter from Sally K. Richardson, Director of Centers for Medicaid and State Operations (Sept. 4, 1998)).[3] *See* 2012 WL 4127956, at *13.

Judge Rainey assessed the merits of the case and found the blanket exclusion to violate the federal Medicaid reasonable standards requirement. Texas argued that its exclusion of mobile standers complied with the requirements set forth in the DeSario Letter because it had reasonably concluded that there were safety concerns with the devices and that the standers are "comfort luxury or convenience items." *Id*. at *14. The Court easily rejected this argument as inconsistent with the DeSario Letter's prohibition on blanket exclusions. *Id*. The Court also noted that Texas's arguments are undercut by its coverage of mobile standers for Medicaid beneficiaries under age 21. The Court agreed with numerous other courts that have refused to allow a state to use a blanket exclusionary policy based on age. *Id*. at *14-16 (collecting cases); *compare id*. at *16 (noting that Texas "failed to cite a single case supporting its position that states have broad discretion to categorically exclude an item of medical equipment that meets its definition of DME from Medicaid coverage for adult beneficiaries, regardless of medical necessity").

Finally, it should be emphasized that the Court was clearly persuaded by the plaintiffs' extensive expert testimony explaining the purposes of the integrated standing devices (so effective that the State's attorneys tried to label the expert an "evangelist" for standing wheelchairs). *See* 2012 WL 4127956, at *4, n.3.[4] The Court remanded the

[3] The DeSario Letter responded to a Second Circuit decision that allowed Connecticut to use an exclusive list of covered DME that categorically excluded some medically necessary items. *See DeSario v. Thomas*, 139 F.3d 80 (2d Cir. 1998), *vacated by*, *Slekis v. Thomas*, 525 U.S. 1098 (1999) (citing DeSario Letter).

[4] *Koenning* also finds the plaintiffs did not need to exhaust their administrative remedies, *see* 2012 WL 4127956, at *18-20, and includes an interesting constitutional due process holding, finding that the Texas "fair hearing" was not in fact fair because hearing officers were required

case for a determination of whether the Plaintiffs' requests for the mobile standers would be granted. The case has been appealed to the Fifth Circuit Court of Appeals.

***Conley v. Dep't of Health*, 2012 WL 4450154 (Utah Ct. App. Sept. 27, 2012)**

Age ≠ Sole Basis for Deciding Coverage

The plaintiffs in *Conley* sought Medicaid coverage of speech augmentative communication devices (SACDs). The Utah Medicaid agency denied the coverage on the ground that SACDs "are not a covered benefit." 2012 WL 4450154, at *1. The plaintiffs brought a state court action arguing that these policies violated the Medicaid Act's reasonable standards requirement, 42 U.S.C. § 1396a(a)(17), and comparability requirement, *id*. at § 1396a(a)(10).

Conley involves a circumstance that often arises with respect to contested Medicaid claims. The Medicaid Act lists 29 categories of mandatory and state-optional services, 42 U.S.C. § 1396d(a), but does not describe specific medical treatments, procedures or equipment that fall within those categories. For example, the Act lists physician's services as a mandatory Medicaid service and does not list the various clinical procedures that a physician may perform (e.g. vaccines, examinations, surgery). Therefore, to determine whether particular service or medical equipment must be covered by the state Medicaid program, the reviewer must decide if it fits within one or more of the broad list of service categories.

The Utah Court of Appeals found SACDs to fit within a number of the service categories recognized by the Medicaid Act and the State: home health services and medical equipment, physical therapy and related services, prosthetic devices, and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. 2012 WL 44500154, at *5-12. As the Court notes, however, within these categories, Utah restricted who could get the service. Specifically, an individual under age 21 could obtain coverage through EPSDT by fitting the SACD within any of these potential Medicaid boxes. By contrast, SACDs would not be covered for non-pregnant individuals over age 21. Utah supported the policy as a decision to cover SACDs for adults exclusively in one category of Medicaid service—speech language pathology services—and, because these are optional services under federal law, it could treat SACDs as an optional service as well and exclude them for those over age 21. *Id*. at *13. The Court rejected the argument, finding that "SACDs cannot reasonably be prosthetics and communication equipment for those individuals under age twenty-one and pregnant women, but only be speech pathology services for non-pregnant individuals age twenty-

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to uphold the state agency denial if it was in accordance with Texas policy, regardless of whether the policy complies with federal law, *id*. at *20-21.

one and older." *Id*. at *15. The Court further decided that because Utah had "opted into the categories of home health services, physical therapy and related services, and prosthetic devices, it is obligated to cover the same services and equipment for categorically and medically needy non-pregnant individuals age twenty-one and older that it does for individuals eligible under the EPSDT program [for individuals up to age 21]." *Id*. at *17; *see also id*. at *12 (citing opinions refusing to recognize age-based coverage distinctions).

Importantly, the Court rejected the proposition that covered services can be meted out based on the age of the individual: "Simply put, it is unreasonable for the State to opt into the categories in which SACDs could be categorized for all categorically and medically needy individuals but then to limit coverage of certain services within those categories by the age of the recipient." *Id*. at *15.

Utah also argued that the Court had to find it in compliance with federal law because the Secretary of HHS had approved the state Medicaid plan. The Court rejected this notion, finding that "HHS's general approval of a state plan does not insulate or immunize that plan from judicial scrutiny of how the plan is specifically administered." *Id*. at *14. The State did not appeal the decision.

Additional authority

Strouchler v. Shah, _ F. Supp. 2d _, 2012 WL 3838159 (S.D.N.Y. Sept. 4, 2012) (holding plaintiffs likely to succeed on claims that criteria used to determine need for personal care services violate Medicaid reasonable standards requirements).

Davis v. Shah, No. 12-V-6134 CJS, 2012 WL 1574944 (May 3, 2012) (holding plaintiffs likely to succeed on claim that exclusion of prosthetic shoes and compression stockings is inconsistent with Medicaid reasonable standards requirement).

Hiltibran v. Levy, 793 F. Supp. 2d 1108 (W.D. Mo. 2011) (holding failure to cover necessary adult diapers violates Medicaid reasonable standards requirement).

Alvarez v. Betlach, No. 4:09-cv-00558 (D. Ariz. May 21, 2012) (holding failure to cover medically necessary adult diapers violates Medicaid reasonable standards requirement) (on appeal).

*Samantha A. v. Dep't of Soc. & Health Servs.,*256 P.3d 1138 (Wash. 2011) (holding limits on services were not valid utilization controls because they were not aimed at targeting unnecessary utilization and were not based on individual needs).

But see B.N. ex rel. A.N. v. Murphy, No. 3:09-CV-199-TLS, 2011 WL 4838976 (N.D. Ill. Nov. 16, 2011) (refusing to determine whether cap on waiver respite services violated amount, duration, and scope requirement, but noting federal agency had determined cap comported with Medicaid Act and suggesting deference).

Conclusion and recommendations

Not all decisions by the State to restrict or limit covered services will be illegal. However, if your State does implement harmful restrictions, consider whether the policy is a violation of the Medicaid reasonable standards and amount, duration and scope requirements. As part of the consideration:

1. If the state offers the policy as a utilization control procedure, assess whether that is in fact the case. States are increasing justifying service cuts as utilization control procedures. Advocates need to focus intently on this concept and explain to policy makers and courts what utilization control procedures are intended to do—curb fraud, waste, and unnecessary services—and what they are not intended to do—restrict coverage of necessary services. Citation to *Bontrager* will help in this regard.

2. Clarify the role of the approved state Medicaid plan. Since the Supreme Court's remand of the *Douglas* case, states are claiming that the Secretary of HHS's approval of the state Medicaid plan means that the state is complying with the federal law. Merely having an approved plan, however, does not insulate the state's actions from judicial review. *Conley* and *Koenning* make this point.

3. Present strong, compelling evidence of the individual's need. In addition to statements from the individual, family members and treating providers, in-depth explanations from experts in the field are helpful to explain to the court how the coverage has developed over time, why it is considered to be the standard of care for individuals like the plaintiffs, and how there are important differences between the requested service and potential alternatives. *Koenning* is instructive in this regard.

4. Obtain consultation and legal support. If the Medicaid agency denies your client's request for coverage and you believe that the denial an error, you can obtain help from support centers if you need it. In addition to NDRN, www.ndrn.org, the National AT Advocacy Project has extensive knowledge and resources on assistive technology, www.nls.org/natmain.htm, and the National Health Law Program can provide assistance on Medicaid generally and with civil procedure/court access issues, www.healthlaw.org