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Seventh Circuit Rules that Medical Necessity Trumps State-Imposed Cap on "Optional" Medicaid Coverage

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In a class action lawsuit, the U.S. Court of Appeals for the 7th Circuit recently affirmed a lower court decision granting a preliminary injunction that prevented the state of Indiana from enforcing a $1,000 annual cap on Medicaid coverage for medically necessary dental services, and concluded the cap most likely violated rights granted to Medicaid beneficiaries under federal law. *Bontrager v. Indiana Family and Social Services Administration*, 2012 U.S. App. LEXIS 20157 (September 26, 2012).

Under federal Medicaid law, coverage of "dental services" (like prescription drug coverage) is optional. Indiana elected to cover certain dental services that are medically reasonable and necessary and not listed as non-covered or otherwise excluded. However, the state imposed a $1,000 per recipient annual limit on such services. Plaintiffs brought suit under 42 U.S.C. § 1983, alleging that the cap violated federal and state law because it prevented Medicaid beneficiaries from receiving medically necessary services above the cap.

The 7th Circuit found that the $1,000 cap prevents Indiana from providing coverage for all medical necessary services. By way of example, a medical necessary dental procedure that costs $1,200 is not "covered" since Indiana's cap prevents full reimbursement to the provider and an indigent Medicaid beneficiary will likely be unable to pay the remaining $200. Although the state asserted that over 99 percent of the state's Medicaid recipients will still receive all medically necessary services despite the cap, the court found that the dental services provided are "not sufficient in amount, duration and scope" to reasonably achieve their purpose, because in some cases the cap results in services being completely excluded from coverage. Further, the court condemned fixed payment limits, even for optional services, that are "not in any way based on degree or consideration of medical necessity." In effect, the 7th Circuit – a well-respected and generally conservative court – found that once a state opts to cover a service under Medicaid, it may not arbitrarily deny coverage based on a fixed limit.

The 7th Circuit also rejected the state's classification of the $1,000 cap on medically necessary services as a valid "utilization control" measure, observing that it could also not be considered a prior authorization process or a procedure designed to prevent fraud or control access. Such a procedure cannot be used to "allow[] a state to shirk its primary obligation to cover medically necessary treatments." Ultimately, the 7th Circuit opined that the while Indiana's potential budgetary concerns were entitled to some consideration, they did not outweigh the potential harm to the Medicaid beneficiaries or the fact that the state's position is likely in violation of state and federal law.

Bontrager is a timely decision that is of crucial importance as states throughout the country continue to grapple with how to reduce the costs of their Medicaid programs and seek to balance growing Medicaid budgets on the backs of providers to cope with maintenance of effort requirements (*i.e.*, rules against reducing eligibility below March 23, 2012 levels) imposed under the Affordable Care Act. This decision can serve as a potent weapon against all-too-ready federal approvals of provider payment reductions.

To discuss any questions you may have regarding the opinion discussed in this Alert, or how it may apply to your particular circumstances, please contact:
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