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The Early and Periodic Screening, Diagnostic, and Treatment Program and Managed Medicaid Mental Health Care: The Need to Reevaluate the EPSDT in the Managed Care Era

John A. Flippen

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I. INTRODUCTION

For a majority of Medicaid recipients, managed health care[1] is fast becoming a reality.[2] As state governments seek to control Medicaid costs in a world of limited resources, unlimited reimbursement for any treatment a doctor deems necessary is no longer feasible.[3] One major tool for cost containment has been the privatization of the delivery of Medicaid coverage into managed care organizations.[4] The shift to a managed plan means that services will be rationed. This rationing occurs because capitated rates,[5] for example, require that private managed care organizations[6] ("MCOs")

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1. "Managed health care" refers to a systom of health insurance combined with controls over the delivery of the health services via Managed Care Organizations ("MCOs"). Marc A. Rodwin, *Managed Care and Consumer Protection: What Are the Issues?*, 26 Seton Hall L. Rev. 1007, 1009 n.1 (1996). MCOs "manage" health care services by controlling the kind, volume, and manner in which services are provided. Id. They control the dispensing of these services by choosing providers and by controlling the providers' behavior through financial incentives, rules, and organizational control. Id. Managed care shifts from a traditional "fee-for-service" system, which reimburses providers based on services provided at their discretion, to a system in which the MCO either directly provides a set of contracted services, or manages the provider of the services in exchange for a fixed monthly premium per enrollee. Id. See also Eleanor D. Kinney, *Medicare Managed Care from the Beneficiary's Perspective*, 26 Seton Hall L. Rev. 1163, 1173-81 (1996) (discussing managed care in the context of Medicare).

2. The shift to managed care delivery systems fundamentally changes Medicaid. By 1994, forty-three states and the District of Columbia had some form of managed care initiative, placing 32% of all Medicaid enrollees in managed care systems. See Marsha Gold, Michael Sparer, and Karyen Chu, *Medicaid Managed Care: Lessons from Five States*, 15 Health Affairs 153 (Fall 1996). See also Philip Boyle, *Managed Care in Mental Health: A Cure, or a Cure Worse Than the Disease?*, 40 St. Louis U. L. J. 437, 437 (1996) (positing that "[b]y most accounts this move towards managed care, including managed care in mental health, is unstoppable") (citation omitted)).

3. Mark A. Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. Pa. L. Rev. 431, 435 (1988).

4. As states seek to control costs, some believe the states will discriminate against severely mentally ill citizens outright. They assert that the limitations inherent in rationing managed care systems and block grants will subject those systems to challenge under the Americans with Disabilities Act. For a complete discussion, see Leonard S. Rubenstein, *Ending Discrimination Against Mental Health Treatment in Publicly Financed Health Care*, 40 St. Louis U. L. J. 315, 318 (1996).

5. Under commonly used capitated rato schemes, a provider group, usually an MCO, receives a set fee per enrollee. The provider then supplies all necessary physician services, with the primary care physician serving as the "gatokeeper" to hospital services and specialists. If the enrollee's expenses exceed the amount of the fee, the provider group, and sometimes the provider, is financially liable for the difference. Because the payments are separate from the services actually rendered, the provider group acts as an insurer. Thus to make money on the flat fee paid as the capitated rate, it is in the provider group's best interest to control costs. Vernellia Randall, et al., *Section 1115 Medicaid Waivers: Critiquing the State Applications*, 26 Seton Hall L. Rev. 1069, 1132 n.353 (1996).

6. For purposes of this Note, an MCO is an organization that, through an organized system of health care, provides or ensures the delivery of an agreed upon set of health maintenance and treatment services for an enrolled group of persons under a capitation arrangement. Daniel Y. Patterson and Steven S. Sharfstein, *The Future of Mental Health Care*

bear the risk of providing services to the Medicaid population and attempt to profit from a flat-rate fee system.[7]

The managed care trend is causing a paradigm shift for Medicaid.[8] Medicaid originated in an era when the government was not as concerned about controlling health care costs.[9] Today, Medicaid's mandates sometimes conflict with efforts to control health care costs.[10] This conflict manifests itself in the Early and Periodic Screening, Diagnostic, and Treatment ("EPSDT") mandate of the Medicaid Act.[11] The "T" in the EPSDT provides broad coverage. Treatment is available to Medicaid-eligible children under twenty-one years of age, and the EPSDT requires states to provide any service that Medicaid offers and a physician has deemed "medically necessary."[12] Such treatment is required even if the state does not provide it to the adult Medicaid population.[13]

This Note attempts to demonstrate how the EPSDT, as a broad mandate created before managed care, has the potential to diminish the effectiveness of managed care's cost saving efforts, particularly in the area of managed mental health care. Part II of this Note provides the background of Medicaid, describing the fiscal problems it has presented and the solution offered by Tennessee's attempt to control costs through managed care. Part III discusses Medicaid's EPSDT requirement and the challenges it may present to Medicaid managed care cost containment efforts. The Note then suggests two steps to

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in Judith L. Feldman and Richard J. Fitzpatrick, eds., *Managed Mental Health Care* 336 (American Psychiatric Press, 1992). Such an organization may also he called a Health Maintenance Organization ("HMO"). Id. In Tennessee, however, this third party payer is labeled an MCO. The mental health care services in Tennessee are provided through similarly functioning "behavioral health organizations" ("BHOs").

7. The health care industry has developed three models for Medicaid managed-care systems. Diane Rowland and Kristina Hanson, *Medicaid: Moving to Managed Care*, 15 Health Affairs 150, 150 (Fall 1996). First, under a "fee-for-service" arrangement, the provider is also the primary care physician. The physician receives a monthly fee to approve and monitor medical services but is not financially liable for the patient's care. Id. Second, in a capitated or full-risk plan, a fixed monthly fee goes to the provider, which may be an organization that, in turn, provides all care for the patient and assumes full financial risk for each enrollee's care. Id. Third, a limited risk prepaid health plan allows clinics to contract on a prepaid, capitated risk basis for a limited range of services. Id.

8. By 1995, nearly one-third of Medicaid beneficiaries were enrolled in managed care arrangements, compared to 3% in 1983. Id.

9. For example, in 1965, the year Medicaid began, health care costs comprised about 4% of the gross national product. By 1985, they had doubled to eight percent. Patterson and Sharfstein, *The Future of Mental Health Care*, in Feldman and Fitzpatrick, eds., *Managed Mental Health Care* at 336 (cited in note 6).

10. Randall, et al., 26 Seton Hall L. Rov. at 1070 (cited in note 5).

11. Medicaid Act, 42 U.S.C. § 1396 (1994 ed.).

12. Id. § 1396d(r)(5).

13. Id.

reconcile the goals of the EPSDT with the goals of Medicaid managed mental health care. First, it encourages states seeking to meet the EPSDT's requirements to do so by adopting an incentive program for the screening portion of the EPSDT. Second, Part IV suggests that mental health care presents some unique challenges in a capitated system faced with full enforcement of the EPSDT. Therefore, in order to realize an active and willing enforcement of the EPSDT in the managed mental health care environment, Congress must allow states to define which services are "medically necessary" for purposes of a managed mental health care program. In addition, Congress clearly must allow that definition to apply to the EPSDT. Only then can a state ensure fulfillment of the EPSDT while meeting its goal of controlling costs in a managed care environment.

Part V reviews Tennessee's "TennCare Partners" program for managed Medicaid mental health care in light of the two suggested steps. Tennessee has introduced its Medicaid mental health care coverage within a relatively unique system of "carving out" a separate mental health care delivery system.[14] This carve-out system allows this Note to focus on the EPSDT within managed mental health care, where unique concerns about effective and necessary diagnosis and treatment clash with efforts to save costs through managed care. The Note first addresses how the TennCare Partners program, like many other managed care programs, is fumbling its responsibility to execute the EPSDT, in part because the state did not properly contract for the EPSDT, and in part because MCOs are often not fully aware of the EPSDT's breadth. Second, the Note analyzes how TennCare Partners defines "medically necessary." It then explains how Tennessee's definition of medical necessity would operate if Congress allowed it to apply to the treatment portion of the EPSDT.

II. BACKGROUND ON MEDICAID

In 1965, Congress established Medicaid as a cooperative federal and state program to provide necessary medical services to low-income persons.[15] State governments are primarily responsible for administering the program, but to qualify for receipt of federal Medicaid funds, a state must abide by federal guidelines.[16] These

14. See note 157 and accompanying text.

15. Randall, et al., 26 Seton Hall L. Rev. at 1070 (cited in note 5).

16. *Beltran v. Myers*, 701 F.2d 91, 92 (9th Cir. 1983) (noting that participating states must abide by federal Medicaid guidelines). See also Randall, et al., 26 Seton Hall L. Rev. at 1071

guidelines require a state's plan to provide that the amount, duration, and scope of each covered service must remain sufficient to reasonably achieve the purpose of the service provided.[17] The federal government therefore prevents states from denying or reducing the amount, duration, or scope of Medicaid-covered services based on the diagnosis, type of illness, or condition of the enrollee.[18] Coverage is not limitless, however. A state "may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures."[19]

Medicaid is expensive. The program costs $131 billion per year to cover thirty-three million low-income Americans.[20] Furthermore, the cost continues to rise, with Medicaid spending doubling between 1988 and 1992, and projected to double again in the next five to seven years.[21] Much of that increase stems from Medicaid's structure as a fee-for-service program.[22] In a Medicaid fee-for-service program, a doctor decides what treatments are necessary, provides them, and is reimbursed for the procedures.[23] Such a program places few restrictions on the doctor's choices and decisions.[24] Thus, the doctor often has no incentive to limit the treatment ordered, which leads to rising costs.[25]

In 1994, Tennessee, like every state,[26] faced the dilemma of trying to control rapidly increasing health care costs and, at the same

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(cited in note 5) (stating that as long as states remain within federal guidelines, they can structure their own Medicaid programs).

17. 42 C.F.R. § 440.230(b) (1995). See Randall, et al., 26 Seton Hall L. Rev. at 1071 nn.5-7 (cited in note 5) (outlining federal guidelines for state Medicaid programs covering the amount, duration, and scope of services; eligibility; and payment structures).

18. 42 C.F.R. § 440.230(c).

19. Id. § 440.230(d). Whenever a state takes actions that reduce, suspend, or terminate Medicaid services, the state must give the enrollee ten days' written notice and an opportunity to appeal, and the state must maintain services during the appeals process. See generally 42 U.S.C. § 1396(a). For a discussion of how "medically necessary" serves as a limiting principal, see Part III.B.2.

20. Randall, et al., 26 Seton Hall L. Rev. at 1072 (cited in note 5) (citation omitted).

21. Id.

22. Patterson and Sharfstein, *The Future of Mental Health Care*, in Feldman and Fitzpatrick, eds., *Managed Mental Health Care* at 336 (cited in note 6).

23. For a more detailed explanation, see noto 7.

24. Medicaid's fee-for-service payment structure was "retrospective, usual, and customary." Patterson and Shaftstein, *The Future of Mental Health Care*, in Feldman and Fitzpatrick, eds., *Managed Mental Health Care* at 336 (cited in note 6). In other words, most treatments a provider prescribed were reimbursed without the third party controls present in managed care.

25. Id.

26. For a discussion of the role and growth of managed care in the United States, see generally John K. Iglehart, *The American Health Care System: Managed Care*, 327 New Eng. J. Med. 742 (1992).

time, meet the needs of a growing Medicaid population.[27] The uncontrolled growth of Medicaid costs threatened both the quality of health care and the financial stability of the state.[28] In response, Tennessee sought a section 1115 waiver[29] to the Medicaid program in order to transfer its Medicaid population, as well as a certain number of uninsured Tennesseans, into a managed care program.[30]

The program, named TennCare,[31] moved all of Tennessee's Medicaid enrollees into managed care organizations.[32] In doing so, Tennessee moved away from Medicaid's traditional fee-for-service payment structure into a managed care program with capitated rates. The state implemented TennCare on an extremely short timeline and encountered several glitches in the beginning.[33] Now entering its fourth year, TennCare generally is deemed a success. Tennessee is

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27. For a review of four states' responses to the health care crisis, see Jean I. Thorne, et al., *State Perspectives on Health Care Reform: Oregon, Hawaii, Tennessee, and Rhode Island*, 16 Health Care Financial Rev. 121 (Spring 1995). See also John K. Iglehart, *Medicaid and Managed Care*, 332 New Eng. J. Med. 1727, 1728-31 (1995).

28. Don Sundquist, Governor of the State of Tennessee, Testimony to the House Commerce Health and Environment Medicaid and Revisions (June 8, 1995) (on file with the Author). See also *TennCare: A New Direction in Health Care* Web Site <http://www.state.tn.us/health/tenncare> (visited Jan. 23, 1997) ("[S]imply maintaining the previous level of Medicaid Services would have required annual tax increases and/or annual reductions in services that were unacceptable."). In fiscal year 1990, Tennessee's Medicaid program cost $1.4 billion in federal and state money. By 1993, the cost had doubled to $2.8 billion, and it was estimated that it would soar te $4.6 billion by fiscal year 1998. Sidney D. Watson, *Medicaid Physician Participation: Patients, Poverty, and Physician Self-Interest*, 21 Am. J. L. & Med. 191, 203 (1994) (assessing the design and implementation of TennCare).

29. A section 1115 waiver, pursuant to the Social Security Act, 42 U.S.C. § 1315 (1994 ed.), seeks to cut costs by eliminating "unnecessary care." The Health Care Financing Administration ("HCFA"), as the governing body for Medicaid, will waive the federal requirements of the Medicaid Act if the stato's proposed plan "promote[s] the objectives of the Medicaid program." Randall, et al., 26 Seton Hall L. Rev. at 1075 (cited in note 5). Waivers seek to offer "cost neutrality for the federal government, reduce health care costs for the state, and increase services without reducing the quality of service for enrollees." Id. See also 42 U.S.C. § 1315(a). Presently fifteen states have obtained section 1115 waivers, with ten more under review. *TennCare: A New Direction in Health Care* (cited in note 28). In the Medicaid system, states may also seek section 1915(b) "freedom of choice" waivers, which allow states to require Medicaid beneficiaries to enroll in managed care only in part of a state or for certain categories of benefits. Rowland and Hanson, 15 Health Affairs at 152 (cited in note 7).

30. For an overview of the TennCare program, see generally Martin Goltleib, *The Cutting Edge: Tennessee's Health Care Revolution*, N.Y. Times 1 (Oct. 1-2, 1995).

31. Id.

32. Id.

33. For an overview of the implementation and structure of the TennCare program, see Watson, 21 Am. J. L. & Med. at 205, 208 (cited in note 28) (attributing many start-up difficulties to Tennessee's lack of managed care experience).

currently one of the most heavily insured states in the country,[34] and most consumers and consumer advocates are pleased with the program.[35]

III. MENTAL HEALTH, MEDICAID, MANAGED CARE, AND THE EPSDT PROGRAM

When Tennessee sought to convert its Medicaid program from a fee-for-service medical assistance system to a managed care program, the Health Care Financing Administration ("HCFA") approved the new system with the caveat that the approval did not effectively waive any Medicaid provisions other than those waived expressly.[36] Tennessee did not seek to waive the EPSDT program's services for eligible individuals under twenty-one years of age.[37]

The EPSDT became a part of the Medicaid program during the War on Poverty in 1967.[38] Its goal is to provide children on welfare with the greatest amount of health care possible through the use of periodic checkups, immunizations, and needed corrective treatments.[39] In particular, the statute requires early and periodic screens for a range of medical, vision, hearing, and dental conditions.[40] In addition, the EPSDT covers diagnostic and treatment services for

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34. *TennCare Receives Guarded Praise, Problems Persist*, 3 Health Care Pol. Rep. 37, S-27 (Sept. 18, 1995) (quoting Rusty Siebert, TennCare Bureau Director, as stating that the TennCare program has successfully reduced double-digit increases in Medicaid spending to increases of only 1% to 2% while expanding coverage to 400,000 previously uninsured Tennesseans).

35. Watson, 21 Am. J. L. & Med. at 209 (cited in note 28).

36. "[A]pproval of the TennCare demonstration does not have the effect of waiving any provision of law or regulation . . . that [has] not been expressly waived." Letter from George J. Scheiber, HCFA Director of Office of Research and Demonstrations, to H. Russell White (Apr. 21, 1994) (on file with the Author) ("Scheiber Lettor").

37. Tennessee could have asked for a waiver from the EPSDT program, as Florida and Oregon did. Randall, et al., 26 Seton Hall L. Rev. at 1085 (citod in noto 5).

38. Roberta Riportella-Muller, et al., *Barriers to the Use of Preventive Health Care Services for Children*, 3 Pub. Health Rep. 71, 71 (Jan. 1996). The program was introduced by President Lyndon Johnson in 1967. Sara Rosenbaum and Kay Johnson, *Providing Health Care for Low Income Children: Reconciling Child Health Goals with Child Health Financing Realities*, 64 Milbank Q. 442, 453 (1986).

39. See Jane Perkins, *An Advocate's Medicaid EPSDT Reference Manual* 1 (National Health Law Program, 1993). The program seems to save money on medical expenses. In Michigan, one study found that children who utilized the screening program had lower aggregate medical costs than those children who did not use EPSDT services. William J. Keller, *Study of Selected Outcomes of the Early and Periodic Screening, Diagnostic, and Treatment Program in Michigan*, 98 Pub. Health Rep. 110, 114 (Mar./Apr. 1983).

40. 42 U.S.C. § 1396d(r)(1)(B). Medical screens must include a comprehensive health and development screen for physical and mental health, an unclothed physical exam, appropriate immunizations, lead poisoning testing, and health education. Id.

both physical and mental conditions.[41] The definition of treatment services is broad, and it includes access to all services that Medicaid covers, regardless of whether the same services are covered for adults over twenty-one.[42] In short, if the treatment is effective, it must be covered.[43] Even a "screen" is broadly interpreted to mean almost any contact between a child and a health care professional.[44] A child on Medicaid therefore has access to a broad range of treatments for ailments discovered during most any contact between the child and a health care professional.[45] This broad coverage was bolstered by the 1989 Omnibus Budget Reconciliation Act ("OBRA"), which prohibits states from excluding any service that federal Medicaid law recognizes.[46] OBRA in effect revokes a state's authority to restrict the EPSDT's benefits to those offered by the state's Medicaid program, as determined by the state's definition of "medically necessary."[47]

In addition to the screens, the EPSDT requires states to provide assistance in services such as transportation[48] and case management,[49] as well as to collect data reporting EPSDT eligibility and

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41. The EPSDT requires "necessary health care, diagnostic services and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services." Id. § 1396d(r)(5).

42. Necessary treatments must be covered if they are among those listed in 42 U.S.C. § 1396d(r)(5) "whether or not such services are covered under the State plan."

43. Treatments must be covered if they "correct, compensate for, or improve a condition, or prevent a condition from worsening—even if the condition cannot be prevented or cured." Perkins, *EPSDT Reference Manual* at 6 (cited in note 39).

44. 58 Fed. Reg. 51291 (1993). See *Hinds v. Blue Cross and Blue Shield of Tennessee*, Slip Op. 3:95-0508 at 17 (M.D. Tenn. 1995).

45. The state may also limit EPSDT treatments to the most economical mode through which it can offer services. In addition, the state may cover only those treatments which are medically necessary. Perkins, *EPSDT Reference Manual* at 7 (cited in note 39). Medical necessity as a limiting factor is discussed in Part III.B.2.

46. Pub. L. No. 101-239, § 6403, 103 Stat. 2106, 2262-64, codified at 42 U.S.C. 1396d(r) (1994 ed.). For a description of the act, see Sara Rosenbaum, *Mothers and Children Last: The Oregon Medicaid Experiment*, 18 Am. J. L. & Med. 97, 113 (1992). Rosenbaum points out that while the preventive purpose of EPSDT is best known, an equally important purpose is assuring maximum access to medically necessary health care. Id. at 115.

47. Compare 42 U.S.C. § 1396d(r)(5) (stating that the necessary treatment services must be covered "whether or not such services are covered under the state plan"), with Rosenbaum and Johnson, 64 Milbank Q. at 454 (cited in note 38) (stating that, in 1986—before the OBRA—EPSDT treatment options were limited to the services the state offered). See also Rosenbaum, 18 Am. J. L. & Med. at 101 (cited in note 46) (citing OBRA as a "major expansion of the EPSDT program").

48. See 42 U.S.C. § 1396(a)(25) (listing any other medical or remedial care recognized under state law and specified by the Secretary of Health and Human Services as a Medicaid-reimbursable service); 42 C.F.R. § 440.170 (specifying transportation services that are necessary to secure medical examinations and treatment).

49. Jane Perkins and Lourdes A. Rivera, *EPSDT and Managed Care: Do Plans Know What They Are Getting Into?*, 28 Clearinghouse Rev. 1248, 1255 (Mar. 1995) (noting that case management is a mandatery EPSDT service).

utilization.[50] Finally, in order to reap the benefits of the EPSDT, a state must inform all children eligible for Medicaid that EPSDT services are available.[51]

Assessments and screening for the treatment of mental illness traditionally have been weak areas of the EPSDT program.[52] Reasons for the lack of mental health screening reportedly include confusion about what type of screening to perform, primary care physicians' inadequate training for mental health evaluations, and insensitivity to low-income children's mental stress.[53]

Within the managed care environment, the EPSDT program as a whole can often be overlooked or greatly minimized in the rush to control spending.[54] Many managed care providers are not accustomed to dealing with the EPSDT's undefined benefits package.[55] Often, managed care providers are misled about the costs of the EPSDT for purposes of calculating capitation rates because historical reporting data is insufficient.[56] Thus, in the contract with the MCO, specificity and clarity regarding the EPSDT's broad mandates become critical tools for furthering the goals of the EPSDT.[57]

As states move away from the traditional Medicaid programs, they move into contractual relationships that form the basis of

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50. 42 U.S.C. §§ 1396a(a)(43)(D), 1398d(r)(5).

51. Perkins, *EPSDT Reference Manual* at 2 (cited in note 39). Congress intended the state's notification efforts to be aggressive. See 135 Cong. Rec. S13234 (Oct. 12, 1989). See also *Bond v. Stanton*, 504 F.2d 1246, 1251 (7th Cir. 1974) (pointing out that EPSDT programs must be brought to the recipient, as the recipient will not likely go to get the services until it is too late to achieve the congressional purposes of prevention and treatment).

52. Perkins, *EPSDT Reference Manual* at 3-4 (cited in note 39).

53. Id. at 4.

54. Id. at 9-10. But see *Some Lessons Emerge on Managed Care, But Impact on Quality Still Uncertain*, 4 Health Care Pol. Rep. 1891 (Dec. 9, 1996) (finding that Wisconsin has had a "substantially better record" of providing EPSDT services under their managed care program than under a fee-for-service program). See also Gary Taylor, *Settlements Seen Boosting Kids Health Programs*, Nat'l L. J. A9 (Aug. 28, 1995) (stating that ensuring that the EPSDT is not lost to managed care in the shuffle is the next line of work for EPSDT advocates).

55. *Children, AIDS Patients, and the Future of the Safety Net*, Medicine & Health (available on LEXIS, NEXIS library, CURNWS file) (March 18, 1996).

56. Terry Savela, *Calculating Physician Capitation Rates: Advice for Medicaid Managed Care Plans*, 6 Managed Care Week (May 20, 1996). By the state's own admission, Tennessee's calculations for the amount of service historically given are unreliable. See *Tennessee's Early and Periodic Screening, Diagnostic and Treatment Annual Report for the Reporting Period Oct. 1, 1993-Sept. 30, 1995*, in Letter to the Health Care Financing Administration from the Bureau of TennCare (Oct. 28, 1996) (on file with the Author) ("EPSDT Annual Report") (stating that the "uniqueness" of Tennessee's situation results in a need to repair the gaps in the EPSDT reporting).

57. Savela, 6 Managed Care Week (cited in note 56). See also note 39 and accompanying text (stating the goals of the EPSDT).

managed health care.[58] Under traditional Medicaid plans, states were "sovereigns" and could write the rules for exactly how doctors offered Medicaid services.[59] In the contract-based relationship that exists in managed care, however, a state may not be able to enforce terms against the managed care organization that the parties did not spell out explicitly in advance.[60] Because the state itself may be liable for providing Medicaid benefits that are not explicitly included in the health plan contract,[61] specific terms and definitions of covered benefits become very important.

A. Judicially Enforcing the EPSDT

If a state's managed care contract does not require the MCO to provide EPSDT services, people may turn to the courts for enforcement. If a court mandates such a broad and expensive program, the state will either finance the shortfalls of the program[62] or, perhaps, share the expenses with an MCO. An MCO may or may not have calculated for such expenses in the contract-negotiating process.[63] Since the OBRA strengthened the EPSDT in 1989, class action suits on behalf of children who did not receive their EPSDT benefits increasingly have forced several states to step up their EPSDT spending.[64]

A recent case in the District of Columbia demonstrates the courts' role in enforcing the EPSDT as states have moved to managed care programs.[65] In *Salazar v. District of Columbia*,[66] the federal district court found that the District of Columbia's managed care program violated federal law because the program failed to implement fully the federal requirements for the EPSDT.[67] The District had lagged behind HCFA screening goals by eleven to twenty-eight

58. *The Art of the Deal*, 50 Medicine & Health (Oct. 14, 1996) (availahle on LEXIS, NEXIS library, CURNWS file).

59. See Part VI.

60. *The Art of the Deal*, 50 Medicine & Health (cited in note 58).

61. Id.

62. The state's incremental costs will come in addition to the capitated rates already paid to the MCOs.

63. *The Art of the Deal*, 50 Medicine & Health (cited in note 58).

64. Savela, 6 Managed Care Week at A9 (cited in note 56) (outlining settlements on behalf of Pennsylvania, Texas, and West Virginia for failing to fully implement their EPSDT program).

65. *Salazar v. District of Columbia*, 938 F. Supp. 926, 928-83 (D.D.C. 1996) (holding that recipients could seek reimbursment for medical payments because the city failed to comply with EPSDT requirements).

66. 938 F. Supp. 926 (D.D.C. 1996).

67. Id. at 980. The system failed to "operate efficiently, economically, and in accordance with federal law." Id. at 931.

percent in the years leading up to the suit.[68] The MCO contract mentioned the EPSDT, but the contract did not require the MCO to screen Medicaid children as frequently as required by the District's periodicity schedule.[69] In sum, the court found the number of shortcomings in the EPSDT program sufficient to impose liability on the District under a standard of a "persistent, pervasive practice, attributable to a course deliberately pursued by official policymakers."[70] Because the District did not carefully monitor and ensure that the MCOs were fulfilling their EPSDT duties,[71] the *Salazar* court found the District liable for violating the Medicaid Act in the presence of a managed care contract outlining only general EPSDT coverage.[72]

B. Proactive Planning for the EPSDT: Incentives for Screening and the Need for Congressional Clarification

Without proper planning the EPSDT program can be an expense that limits the savings a capitated system creates. Whether a state remains liable for insufficient levels of EPSDT performance as it did in *Salazar* or whether the EPSDT clauses of the managed care contract are sufficient to create joint liability between the state and the MCO, civil lawsuits conld undermine managed care's cost-cutting goals.[73]

In the managed mental health care realm, the concern over a benefits package as broad as the EPSDT can be even greater, particularly if the MCO relies on incomplete data from the state for past

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68. Id. at 953.

69. Id. at 957. A periodicity schedule outlines a state's (or in this case, the District's) yearly requirements for performing screenings under the EPSDT. Id.

70. Id. at 972. Such shortcomings included failure to monitor screenings, failure to perform screenings according to periodic schedules, and failure to collect data on EPSDT treatment. Id. at 981.

71. Id. at 977-79.

72. Id. at 973. The District's contract with the MCO only generally outlined the EPSDT and its requirements. Id.

73. Paul Grimaldi, *Navigating the Waters of Medicaid Managed Care Contracting*, 49 Healthcare Financial Management 72, 75 (June 1995) (describing desired economic effects of managed health care). Grimaldi points out that managed care providers often misunderstand the EPSDT, and that unexpectod costs, in addition to other Medicaid mandates, could overwhelm the per-person, per-month managed care savings, causing aggregate Medicaid spending to rise. Id. at 72, 74. Medicaid managed care companies are paid on a per-person, per-month capitated rate. Id. at 76. A company is at risk for any care an enrollee may require above the capitated rate. Thus, a program like the EPSDT, with practically unlimited benefits, could limit the profitability of an MCO, particularly if such capitated rates are calculated too low because of insufficient information about the costs of the EPSDT, eventually causing the company's rates to rise. Id. at 74, 77, 80.

expenditures in computing capitation rates.[74] In addition, MCOs may fear that mental health care is more costly because of the perceived, chronic nature of mental illness.[75] Although much of that stigma may be unwarranted, compared to physical care, mental health care within a capitated rate structure remains an area of relatively uncertain risks.[76] As a result, a broad and fairly unlimited benefit program like the EPSDT, if fully enforced, may substantially increase expenses within mental health care[77] unless the state and the MCO implement plans to ensure realization of the EPSDT's goals within a cost-saving and cost-efficient capitated health care system.

A section 1115 waiver allows a state to attempt to save on health care expenditures while expanding coverage through managed care programs.[78] Even after the attainment of a waiver, however, the federal government often still requires that the state adhere to the non-waived Medicaid mandates, including the EPSDT's broad benefits of screening and treatment services.[79] The EPSDT's offer of nearly universal access to treatment clearly conflicts with managed Medicaid's promised cost-saving efforts.[80] Reconciling them requires two steps. First, states must understand and prepare for the EPSDT when structuring an MCO's contract. To ensure that they satisfy the

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74. See EPSDT Annual Report (cited in note 56) (stating that gaps in the EPSDT data need to be found and repaired).

75. This stigma has been characterized as fear of the four "uns" of mental health—undefinable, untreatable, unpredicatable, and unmanageable. David A. Pollack, et al., *Prioritization of Mental Health Services in Oregon*, 72 Milbank Q. 515, 516 (1994) (discussing perceived problems in providing mental health care). While most experts tend to disregard such stigmas, covering mental health care in a capitated environment is a riskier proposition. The relative lack of proof of the effectiveness of mental health treatments, plus disagreement within the mental health community as to the effectiveness of varying treatments illustrate the risk. See Boyle, 40 St. Louis U. L. J. at 440 (cited in note 2) (discussing the lack of agreement, even among health care advocates, regarding the effectiveness of certain treatments).

76. For a discussion of mental health's uncertain costs, see Part IV.B.

77. Several studies have shown that, over time, the EPSDT actually generates savings on health care costs. See note 39 and accompanying text. This Note, however, focuses more on the situations present in many states where either a managed care company has entered into an agreement and a capitated rate with incomplete knowledge of the EPSDT's broad mandates or a state has been suddenly forced to comply with increased EPSDT expenses after converting to managed care. See, for example, *Salazar*, 938 F. Supp. at 926 (requiring the District of Columbia to adhere te EPSDT goals after converting to managed care). See also Perkins and Rivera, 28 Clearinghouse Rev. at 1251 (cited in note 49) (noting that "the responsibility for assuming the EPSDT is often not clearly defined in the managed care rules and contracts"). This situation is particularly germane as advocates seize on the EPSDT as a way to circumvent managed care's rationing.

78. Perkins and Rivera, 28 Clearinghouse Rev. at 1249 (cited in note 49).

79. See Scheiber Letter (cited in note 36).

80. Moreover, particularly in the short term, if screenings were to increase to expected levels (80%), increased costs from the resulting treatments would certainly strain a managed care system that was not designed with high EPSDT participation in mind.

preventive thrust of the EPSDT program, states should create an incentive in the MCO's contract that encourages screenings instead of waiting for a court to enforce the EPSDT. Second, Congress must allow states that seek waivers to effectively apply their definitions of "medically necessary" as a discretionary tool for the treatments provided under the EPSDT.

1. The Carrot and Stick Approach to Screening

Because managed care programs employ "gatekeeping" primary care providers,[81] an enrollee in a managed care system often has more frequent contact with a single primary physician than in a fee-for-service environment.[82] This increased contact offers more opportunities to perform EPSDT screenings. Even with the increased contact, however, states employing managed care systems continue to lag behind federal screening targets.[83] Because the standard approach of referencing the EPSDT in managed care contracts has not succeeded in increasing the number of screenings,[84] waiver states should consider setting up an incentive program to encourage the required screenings.

In the United Kingdom, public health authorities faced difficulties implementing an immunization program. In response to low immunization rates, the government instituted a program of financial incentives to primary care physicians who met the ninety percent immunization rate the government set as a goal.[85] Similarly, to control enforcement of the EPSDT in a managed care environment

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81. A gatekeeper may be a primary care physician or another specialist to whom a defined population is assigned. The gatekeeper is required either to supply all the health care to that population or te decide that that patient can see another specialist. Patterson and Sharfstein, *The Future of Mental Health Care*, in Feldman and Fitzpatrick, eds., *Managed Mental Health Care* at 406 (cited in note 6).

82. Thomas E. Bottker, *The Emergence of Prepaid Psychiatry*, in Judith L. Feldman and Richard J. Fitzpatrick, eds., *Managed Mental Health Care* 8 (American Psychiatric Press, 1992) (stating that one study found there are three times as many outpatient visits per thousand members in a capitated rate program than a fee-for-service program).

83. See Scheiber Letter (cited in note 36) (citing the low rate of EPSDT screening in TennCare).

84. Id. See also *Salazar*, 938 F. Supp. at 953 (declaring that in the two years of the District of Columbia's managed care program—1994 and 1995—the District's participation in the EPSDT was well below the HCFA's 80% screening goal).

85. The government program offered a $4,000 bonus to every physician who immunized 90% of the children on that physician's "eligibility list." See Richard H. Nicholson, *UK Moves Toward Compulsory Vaccination*, 6 Hastings Centor Rep. 4, 4 (Mar./Apr. 1996). The program also included a mandatory immunization campaign which has been criticized for forcing immunization on children. Others argne that a voluntary immunization program is simply more effective. The program is successful enough, however, that several Canadian provinces since have duplicated it. Id.

without the threat of an injunction,[86] a state could institute a program of financial incentives for providers or managed care organizations[87] in order to increase EPSDT screenings.[88] Ideally, the cost of such an incentive program would be offset by lower capitated rates. Lowering the capitated rates would allow states to use the money previously allocated for the higher capitated rates to fund an incentive program. The "reduction" in the capitated rate would be returned to the MCO for its physicians' performance of the federally mandated screenings.

A state needs the incentive program in addition to clear contractual language concerning the EPSDT requirements because courts may continue to hold a state liable for providers' failure to implement mandated Medicaid programs.[89] A court theoretically could impose joint liability if contracts were clear on the EPSDT requirements, but,

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86. There is some debate as to whether a court is the most effective regulator in public law litigation because the nature of a court's decision is fashioned on such broad remedial lines that it takes on a legislative effect. *Beth V. v. Carroll*, 155 F.R.D. 529, 530-31, 533 (E.D. Pa. 1994), rev'd on other grounds, 87 F.3d 80 (3d Cir. 1996) (warning that consent decrees often go beyond the minimum required by law and into a gray area better left to the politically accountable branches of government). Such questions are particularly difficult when the plaintiffs are advocates for the same people the defendant governmental unit is supposed to serve. Knowing that a court will fashion a remedy that may encourage a defendant department to acquiesce in litigation to get an increased budget by way of a court order instead of through the political process. See James F. Blumstein, *Constitutional Perspectives on Governmental Decisions Affecting Human Life and Health*, 40 Law & Contemp. Probs. 231, 302 (Autumn 1976) (arguing that courts, not constrained by a budget, will often be more receptive to the "needs" of a governmental program).

87. While most cost reduction efforts are targeted at the more easily regulated MCO because they are more easily regulated, it is also possible to target physicians themselves. See Hall, 137 U. Pa. L. Rev. at 483 (cited in note 3) (stating that a financial incentive program targeting physicians is a workable method for cost containment). See also Savela, 6 Managed Care Week (cited in note 56) (positing that mangaged medical physician contracts must tie reimbursment to key performance requirements to ensure that state regulations are met).

88. The suggested contract language already includes punitive measures for failing to meet minimum EPSDT levels. See *Sample Contract Language for EPSDT*, 2 Managed Medicare & Medicaid (Oct. 21, 1996) (available on LEXIS, NEXIS library, CURNWS file). Whether to prod or to entice is an eternal debate of motivational techniques that is beyond the scope of this Note. Some authorities believe financial incentives excessively encouraging physicians to conserve resources will not work in the medical realm because the professional nature of the field requires a doctor to react to non-economic stimuli—namely the patient's needs. Alan L. Hillman, *Financial Incentives for Physicians in HMOs: Is There a Conflict of Interest?*, 317 New Eng. J. Med. 1743, 1748 (1987). Those commentators, however, tend te focus on incentives to withhold services. David Mechanic, *Models of Rationing: Professional Judgmcnt and the Rationing of Medical Care*, 140 U. Pa. L. Rev. 1713, 1748 (1992) (advocating prohibition of physician payment arrangements that alter "medical decision-making by providing economic incentives to withhold services"). A financial incentive to screen children as a preventive measure should not be as troublesome.

89. Ultimately though, the state will probably remain liable. In *J.K., by and through R.K. v. Dillenberg*, 836 F. Supp. 694 (D. Ariz. 1993), the court said that it is "patently unreasonable" to presume that Congress would allow a state to disclaim federal liability for Medicaid programs by contracting its responsibilities to a private MCO.

ultimately, the court will look to the state for implementation.[90] Thus, the more the state can do to ensure that the MCO meets EPSDT requirements, the less likely it is that the state will have to pay twice to fulfill the EPSDT mandate—once to an MCO in the capitated fee payments and again to satisfy a judicial order when the MCO fails to perform the EPSDT requirements.

2. Congressional Clarification of "Medically Necessary" as a Way to Limit the EPSDT in the Managed Mental Health Care Environment

Irrespective of the course a state takes to increase screenings,[91] the EPSDT's requirement that "necessary" treatment be supplied for any condition found in the screening process will result in higher costs.

Within the EPSDT, the states have no specific authority to limit the allocation of services once a doctor determines the services are necessary to treat an illness discovered in a screening.[92] Before OBRA, the EPSDT essentially required that states provide children under twenty-one with all necessary services that the state plan offered.[93] With the amendments to OBRA, however, Congress expanded the EPSDT to provide coverage for any service Medicaid covers[94] that

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90. Id. See also *Salazar*, 938 F. Supp. at 978 (finding the District of Columbia's failure to oversee the provider in meeting the EPSDT screening requirements resulted in a violation of Medicaid regulations).

91. As discussed above, a state may choose to implement a proactive incentive program to increase screenings, or a state may be forced to react to a judicial mandate to increase screenings. See Part III.B.1.

92. The courts are very deferential to doctors' determinations of medical necessity. Often a state's only defense to a doctor's decision of medical necessity is to claim that the treatment is "experimental." *Rush v. Parham*, 625 F.2d 1150, 1155-56 (5th Cir. 1980) (stating that a medically established doctrine permits a Medicaid-participating state to refuse to pay for experimental procedures). For example, a body of precedent has developed around a state's refusal to pay for a doctor's request for experimental organ transplants to ameliorate conditions discovered in EPSDT screenings. For an overview, see C. David Flower, Note, *State Discretion in Funding Organ Transplants Under the Medicaid Program: Interpretive Guidelines in Determining the Scope of Mandated Coverage*, 79 Minn. L. Rev. 1233, 1246-54 (1995) (outlining a split in federal courts of appeals as to the "extent to which the Medicaid statute requires states to fund organ transplants"). In Tennessee, a federal district court required Medicaid payment under TennCare when a doctor determined that an arguably experimental organ transplant was medically necessary to treat a condition found in EPSDT screening. Although funding of organ transplants is discretionary in Medicaid, the court said that anything found to be "medically necessary" must be covered. *Hinds*, Slip. Op. 3:95-0508 at 9. The court found that the doctor's determination of medical necessity under the EPSDT transcends whether the state had previously chosen not to fund the transplant. Id. at 19.

93. Rosenbaum and Johnson, 64 Milbank Q. at 454 (cited in note 38).

94. The services that states must provide under the Medicaid are listed in 42 U.S.C. § 1936(13)(B).

is deemed "medically necessary."[95] In enacting OBRA's expansion of the EPSDT's coverage, Congress stated that "in implementing this provision, states may utilize prior authorization and other limitations related to ensuring that all care and treatment is medically necessary."[96] Traditionally under Medicaid, states have had the right to set appropriate limits on the Medicaid services offered by defining what services are "medically necessary."[97]

IV. THE STATES' TRADITIONAL RIGHT TO DEFINE "MEDICALLY NECESSARY" FOR MEDICAID

The Supreme Court stated in oft-quoted dicta that a "medically necessary" standard is an acceptable one for regulating Medicaid benefits as long as the definition still allows a state to meet Medicaid's objective of furnishing, as far as practical, medical assistance to the poor.[98] The Court explained that "it is hardly inconsistent with the objectives of the Act for a State to refuse to fund *unnecessary*—though perhaps desirable—medical services"[99] by defining what is medically necessary.

Some courts have found two levels of medical necessity inherent in the Medicaid statute.[100] First, the state decides which services are "medically necessary," and Medicaid covers those services.[101] Second, the physician then determines which treatments are medi-

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95. 135 Cong. Rec. at 13057.

96. Id. Prior authorization requires a provider to justify delivering a particular service before providing it if the provider desires reimhursement. Authorization for the service is given either by an MCO or by a third party monitor. Patterson and Sharfstein, *The Future of Mental Health Care*, in Feldman and Fitzpatrick, eds., *Managed Mental Health Care* at 409 (cited in noto 6).

97. Medicaid regulations permit state limitations based upon the degree of medical necessity. 42 C.F.R. § 440.230(d) (stating that a state cannot deny benefits based on a diagnosis but that appropriate limits may be based on such criteria as "medical necessity"). But see *Pinneke v. Preisser*, 623 F.2d 546, 550 (8th Cir. 1980) (deciding that detormining medical necessity is not the job of the government but of the individual physician).

98. *Beal v. Doe*, 432 U.S. 435, 444 (1977) (citing 42 U.S.C. § 1396a(10)(C) (1970 ed., Supp. V)). See also *Pinneke*, 623 F.2d at 547 (stating that the medical necessity standard is not in the Medicaid statute but that it has "become judicially acceptod as implicit to the legislative scheme and is apparently endorsed by the Supreme Court") (citing *Beal*, 432 U.S. at 444-45 n.9).

99. *Beal*, 432 U.S. at 444-45.

100. *Cowan v. Myers*, 187 Cal. App. 3d 968, 978 (1986).

101. Id. In California, the definition of "medically necessary" services includes those services "reasonable and necessary to protect life, to prevent significant illness or siguificant disability, or to alleviate severe pain through diagnosis or treatment of disease, illness, or injury which require preventative health services of treatment to prevent serious deterioration of health." Id. at 982 (citing 22 Ca. Admin. Code § 51303(a)). The court found that this definition was not too restrictive for the purposes of the Medicaid Act. Id. at 978.

cally necessary for a particular diagnosis.[102] The federal Medicaid Act permits the state to have discretion in defining the first of the two levels.[103] In other words, a state may properly decide what *services* are necessary, leaving a physician to determine what *treatments* are necessary.[104] When making the decision about what services will be covered under the Medicaid plan, a state cannot eliminate specific treatments on the basis of the underlying medical condition.[105] For example, the courts have held that when a state decides "medically necessary" includes the general services of surgery, it cannot then exclude a sex reassignment surgery for purposes of curing transsexuality.[106] If a doctor determines that such surgery is the only treatment for the condition of transsexualism, thus finding the surgery to be "necessary," the state cannot interfere with that determination.[107]

A. "Medically Necessary" and the EPSDT

Under the EPSDT, however, Congress seemingly took away the states' traditional method of limitation. After first stating that states could use controls such as "prior authorizations and other limitations" to determine what services are "medically necessary,"[108] Congress went on to specify that any such limitations could not interfere with the EPSDT's objectives of identifying and correcting problems before they become serious.[109] This creates a contradiction. A state has traditionally been free to define the scope of its Medicaid

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102. Id.

103. Id. at 976. Changing the doctor's role as the sole arbiter of a patient's needs is not without precedent. With the doctrine of informed consent, the doctor's power to decide "what is best" for the patient shifted from the doctor to the patient. John Petrilla, *Ethics, Money and the Problem of Coercion in Managed Behavioral Health Care*, 40 St. Louis U. L. J. 359, 359 (1996). In addition, by introducing a third party, the MCO, into the physician's traditional diagnosis, the very nature of managed health care demands that the doctor consider financial implications of treatment options. Id. at 361.

104. *Cowan*, 187 Cal. App. 3d at 978. See also *Preterm, Inc. v. Dukakis*, 591 F.2d 121, 125 (1st Cir. 1979) (reading the Supreme Court's dicta in *Beal*, 432 U.S at 438, to indicate that there are two levels of judgment as to medical necessity in the statutory scheme of Medicaid, a macro-level decision of the legislature and a micro-level decision of the physician). But see *Pinneke*, 623 F.2d at 550 ("The decision of whether or not certain treatment or a particular type of surgery is medically necessary rests with the individual recipient's physician and not with clerical personnel or government officials.").

105. *Cowan*, 187 Cal. App. 3d at 980 (quoting *Curtis v. Taylor*, 625 F.2d 645, 652 (5th Cir. 1980)).

106. See, for example, id. at 977-78.

107. Id. (interpreting *Pinneke*, 623 F.2d at 550).

108. 135 Cong. Rec. at 13234.

109. Id.

services by defining which services are "medically necessary."[110] Furthermore, in a guide for integrating the EPSDT into managed care systems, HCFA indicated that a state should clearly define "medically necessary" for an MCO.[111] Yet, as previously outlined, that definition cannot effectively limit the broad treatment options available under the EPSDT.[112] Thus, on a practical level, controlling costs with a clear definition of what the state considers "medically necessary" is not feasible without conflicting with the comprehensive treatment options available under the EPSDT.

For example, the EPSDT states that any treatment that "corrects or ameliorates" a mental condition discovered in a screening must be covered.[113] Thus, when a doctor or provider decides that a specified treatment is required to "ameliorate" a mental deficiency and the MCO, in turn, assesses whether that treatment is medically necessary, neither the MCO nor the doctor can effectively consider the definition of "medically necessary" found in the MCO contract if that definition at all restricts the "preventative purposes" of the EPSDT. As previously noted, the EPSDT's treatment options have been expanded to include most federally-recognized treatments.[114] Thus, although Congress stated that states could use "other limitations" to ensure that only medically necessary treatments are covered under the EPSDT,[115] the breadth of the statutory language renders the states' ability to define "medically necessary"—one of the states' most important cost-allocation tools—powerless to contain mental health care expenditures in the face of the EPSDT.

As a result, in a managed care environment, when a state defines in its contract which services will be considered "medically necessary," that definition essentially will be disregarded for purposes of the EPSDT. The EPSDT takes away a state's traditional ability to define "medically necessary" to control its Medicaid services. Furthermore, it delegates that discretion to the provider, who can then force the state to pay for any "items and services allowed under

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110. *Rush*, 625 F.2d at 1156 ("[A] state may establish standards for individual physicians to use in determining what services are appropriate in a particular case." (citing *Beal*, 432 U.S. at 438)). The state's responsibility extends at least to the shaping of a reasonable definition of medical necessity. Id.

111. Office of Managed Care and Medicaid Bureau, Health Care Financing Administration, *Integrating EPSDT and Medicaid Managed Care: Strategies for States and Managed Care Plans* 9 ("*Integrating EPSDT*") (on file with the Author).

112. See Part III.B.2.

113. 42 U.S.C. § 1396d(r)(5).

114. 135 Cong. Rec. 13234.

115. Id.

federal law."[116] Any challenge to the provider's decision by the MCO would be moot, as the provider need only claim that the particular treatment sought somehow "ameliorates" the condition.[117] The provider's absolute control neutralizes managed care's mechanism for controlling costs, that is, the presence of a third party that monitors the delivery of health services.[118] Therefore, if fully implemented, the EPSDT becomes an "escape hatch" for the necessary rationing that comes with managed care. As providers and enrollees discover and utilize this "escape hatch," the costs of providing such a broad array of treatments will threaten the ability of states to use managed care to control debilitating health care costs.

The only limiting factors that HCFA has recognized as possible limits on the EPSDT appear to be prior authorization[119] and perhaps peer review.[120] In peer review, practicing physicians or other professionals evaluate the effectiveness and efficiency of treatments ordered or performed by other physicians to decide if the treatments are indeed "medically necessary."[121] Peer review, however, runs into the same problem because without a limiting definition of "medically necessary" to serve as a reference for the peer evaluation, the breadth of the EPSDT ensures that the providers will remain the ultimate arbiters of what services are medically necessary.

B. "Medically Necessary," the EPSDT, and Managed Mental Health Care

Within the context of managed mental health care, the EPSDT's array of treatment options, constrained only by a doctor's determination of necessity, could become an expensive proposition, and conflict with the cost-saving goals of managed Medicaid mental health care. Defining the criteria for "medically necessary" services is a particularly important method for controlling costs in the managed

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116. Id.

117. 42 U.S.C. § 1396(d)(r).

118. Randall, et al., 26 Seton Hall L. Rev. at 1130 (cited in note 5) (stating that with utilization review, like capitated programs, the third party payor primarily determines appropriato services, refusing to pay for what they determine inappropriate).

119. Congress mentioned prior authorization when passing the OBRA. See 135 Cong. Rec. at 13234. See noto 96.

120. The HCFA outlined peer review in the aforementioned guide to managed care, and Congress provided for prior authorization in the EPSDT. *Integrating EPSDT* at 11 (cited in noto 111).

121. Pattorson and Sharfstoin, *The Future of Mental Health Care*, in Feldman and Fitzpatrick, eds., *Managed Mental Health Care* at 408 (cited in note 6).

mental health care environment.[122] In mental health care, however, experts often disagree about what constitutes a standard course of treatment or even a good outcome. This lack of consensus has made deciding what is "medically necessary" difficult for managed mental healthcare organizations and providers.[123] The absence of a clear definition of success in mental treatment often results in inflated costs for the MCO[124] and would undoubtedly lead to even higher costs under a strictly enforced EPSDT system. The state and its MCOs cannot rely on a contractual definition of "medically necessary" to allocate services because they are effectively required to defer to the provider's determination of necessary services.[125] In effect, the EPSDT forces a return to the fee-for-service system of nearly unquestioned reimbursement for services provided to Medicaid children under twenty-one years of age. This system necessarily clashes with managed care's goal of cost reduction and, if the EPSDT were fully enforced, might result in the same cost increases states experienced under Medicaid's fee-for-service plans.[126]

The states' power to delineate criteria for medically necessary services is the key to managing both the broad EPSDT mandate and the managed mental health care costs. To ensure that states seeking a section 1115 waiver meet both the requirements of the EPSDT and the goals of a capitated mental health program,[127] Congress must return to the waiver states the ability to use "medically necessary" as a factor to limit the EPSDT.

C. The Options for "Medically Necessary" in Managed Mental Health Care

If Congress allowed a state to actually apply its definition of "medically necessary" to the EPSDT, the process of defining "medically necessary" in the managed care contract would become

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122. James E. Sabin and Norman Daniels, *Determining "Medical Necessity" in Mental Health Practice*, 24 Hastings Center Rep. 5 (Nov./Dec. 1994). Many insurance companies feel that judgments about medical necessity in mental health are much less precise than judgments in physical health. Thus, cost controls require a clear understanding of what the provider considers necessary. Id.

123. Petrilla, 40 St. Louis U. L. J. at 391-92 (cited in note 103).

124. Id. The American Psychiatric Association recently developed guidelines for mental health treatment for some major depressive disorders. Some supporters have advocated the use of these guidelines as a standard in acceptable mental health care treatment. Id. at 403.

125. See Part IV.A.

126. For a fuller discussion, see Part II.

127. See Part III (discussing requirements of the EPSDT); Part II (discussing the goals of a capitated mental health care program).

even more critical. Because the definition of effective treatment in mental health care is often not as clear as in physical health care, any definition of what services are considered "medically necessary" requires close scrutiny of the state's goals for its Medicaid managed mental health care coverage.

Three models describe the options for defining "medically necessary" in the managed mental health care realm: the normal function model, the capability model, and the welfare model.[128] Each model focuses on the role that managed health care insurance plays in treating illness.[129] Of the three models, the normal function model offers the fairest, most administerable, and most affordable model for defining "medically necessary" within managed Medicaid mental health care.[130]

The normal function model stresses that the central purpose of mental health care should be to maintain, to restore, or to compensate for the restricted opportunity caused by a disease or disability.[131] Thus, mental health care coverage should have as its goal the restoration of a person to the level he would have achieved without the conditions caused by a diagnosable mental disorder.[132] For example, the normal function model recognizes that in the "natural lottery" of life, some people are simply socially inept or shy in ways that may cause suffering.[133] Only those with medically defined deviations underlying their disorders, however, require treatment at the cost of the mental health care system.[134] The goal of the normal function model,

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128. Sabin and Daniels, 24 Hastings Center Rep. at 10-11 (cited in note 122).

129. Id. The authors explain that defining medical necessity as a method for financing and setting mental health coverage priorities necessitates examination of the goals of the coverage. Id. at 12.

130. Id. at 11 (asserting that the normal function model allows society to "draw a plausible boundary around the potential scope of insurance coverage for mental health care").

131. Id. at 10.

132. Id.

133. While these people deserve compassion, the normal function model recognizes that the health care system is not the only avenue open to them. It expects that other social institutions such as churches, schools, and families will work with such individuals to help them overcome their problems. Id.

134. Id. at 11. The underlying deviations are suggested to be those deviations listed as a disorders in the Diagnostic and Statistical Manual of Mental Disorders. Id. at 12. The official nomenclature of the "DSM-IV" is based on defined criteria for classifying mental disorders. Id. at 12.

A system in which necessity depends on the diagnosis of an underlying illness is not without its detractors. See David Mechanic, *Mental Health Services in the Context of Health Insurance Reform*, 71 Milbank Q. 349 (1993) (calling it unethical to require an underlying defined illness because the list of "defined" illnesses is itself somewhat arbitrary). Additionally, the requirement of a diagnosable illness might be too limiting, as psychotherapy is arguably the only treatment needing a system of controls (like an escalating co-payment) because it is

then, is to align coverage with the common meaning of the term "medically necessary." Taken at its common meaning, a medically necessary activity is one essential to improving or curing a disease,[135] or to decreasing the impact of a disease or disability.[136]

In comparison, the capability model mandates that the goal of mental health care should be to give people equal personal capabilities. The model encourages giving people with diminished capabilities the priority of treatment, regardless of the underlying causes of their difficulties.[137] Such a model would define a treatment as "medically necessary" if it would help the patient become an equal competitor in life without requiring a diagnosable underlying disease.[138] The capability model has a broader goal for managed mental health care than simply treating disease; it seeks to enhance mental performance.[139]

Finally, if the patient suffers because of attitudes or behaviors that the patient did not choose to develop and could not have overcome independently, the welfare model would include treatment for those attitudes and behaviors as necessary.[140] As the most expansive model, the welfare model seeks to enhance the patient's potential for happiness.[141] Instead of an underlying mental disease or an unequal lot in life, the welfare model requires only "present distress" as sufficient mental incapacity to warrant coverage for attendant medical necessities.[142] The welfare model strives to alleviate almost all disadvantages and reduce suffering.[143]

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particularly susceptible to the dangers of "moral hazards." Id. at 350. A "moral hazard" is the overuse of a benefit because of the lack of constraints on the benefit. Id.

135. William M. Glazer, *Psychiatry and Medical Necessity*, 22 Psychiatric Annals 362, 362 (1992).

136. Sabin and Daniels, 24 Hastings Center Rep. at 5. (citod in note 122).

137. Id. at 10.

138. Id.

139. For example, the capability model would advocate that a short child who was free of any growth hormone abnormality should nonetheless receive growth hormones because short stature can be a mentally handicapping condition to some people. Id. The normal function model, however, would not cover hormone treatment for short children unless they had an underlying deficiency in growth hormones. Id.

140. Id.

141. Id. at 11.

142. Id. at 10.

143. For example, a child who is shy as a result of a bipolar disorder would be covered under the normal function model, but if the child were simply shy because of his disposition, the normal function model would not allow the child to be covered. Id. at 11. However, because the welfare model seeks to reduce suffering caused by mental conditions that the child may not have independently chosen, treatment of the shyness would qualify as medically necessary under the welfare model. Id.

A definition based on requiring an underlying disease, as the normal function is, is not without complications. For example, in the field of psychiatry and chemical dependency treatment, there are no standard, external "biological validators" of psychiatric and chemical dependency illnesses, and there are few controlled studies that indicate the most efficacious treatments.[144] Psychiatric professionals, therefore, recommend that in the absence of a recognizable illness, the definition of "medically necessary" should consider the degree to which a person's behavior is a danger to himself, to others, or to objects.[145]

When the presence of disease or the effectiveness of treatment is not clear, collective values determine the outcome.[146] Thus, it is critical that when a state defines what is "medically necessary," it considers the opinions of doctors, health care professionals, and even laypersons to understand what the community wants, as well as what the community can afford.[147]

D. The Normal Function Model Definition of "Medically Necessary" as an Effective Restraint on the EPSDT

If a state adhered to the normal function model for its definition of "medically necessary," and, in turn, the state could effectively apply such a definition to the EPSDT, a state could then take large steps towards controlling the costs that will presumably result from heightened screening.[148] As a tool for allocating resources, the definition of "medically necessary" must recognize that resources are limited and, particularly in the mental health care realm, cannot necessarily cover all the benefits that the capability or welfare models demand.

As the EPSDT presently stands,[149] the requirement that a state's definition of "medically necessary" not limit the "purposes" of the EPSDT means that the EPSDT, in the mental health care realm, has essentially adopted the welfare model. This becomes particularly

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144. Glazer, 22 Psychiatric Annals at 362 (cited in note 135).

145. Id. at 364.

146. Id.

147. Boyle, 40 St. Louis U. L. J. at 453 (cited in note 2). The state of Oregon utilized such a model when it implemented a managed care system that essentially prioritized managed mental health care on a list of services that the system would cover. See generally Pollack, MacFarland, George, and Angell, 72 Milbank Q. at 515 (cited in note 75).

148. See Part III.A (explaining that increased screening can result from judicial edict); Part III.B.1 (outlining a financial incentive plan for increased screening).

149. This includes the 1989 Omnibus Budget Reconciliation Act's amendments.

clear when one considers that the statute itself offers treatment for any condition that "correct[s] or ameliorate[s] defects . . . and mental illness."[150] "Ameliorate" could be read broadly to include any action that makes a condition better.[151] Mental illness, without the requirement of an underlying diagnosable disease, can also be defined very broadly, particularly with the statute's vague reference to correcting or ameliorating any "defect."[152] Essentially, then, the EPSDT's purpose can be interpreted to require that a state improve any mental defect found during the screening of a child, much like the welfare model. Any state efforts to control costs by defining "medically necessary" based on a model other than the welfare model would necessarily be far more limiting than the pursuit of such an expansive purpose.

Therefore, particularly in the managed mental health care environment, Congress must take steps to allow a state to define "medically necessary," and to allow a state to apply that definition to the EPSDT effectively. As they currently read, HCFA guidelines for integrating the EPSDT into managed care allow states to define what is medically necessary,[153] but the reality is that any application of that definition within the EPSDT would conflict with the EPSDT itself and thus be meaningless as a cost containment measure.[154] Therefore, as the EPSDT's screening requirements increasingly are enforced through judicial edict or proactive planning, Congress must give the states an effective mechanism to control the treatment costs resulting from increased screenings.[155] To do so, Congress should allow states

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150. 42 U.S.C. § 1396d(r)(5).

151. Frederick C. Mish, *Webster's Ninth New Collegiate Dictionary* 78 (Merriam-Webster, 1990).

152. 42 U.S.C. § 1396d(r)(5).

153. *Integrating EPSDT* at 9 (cited in note 111).

154. See Part IV.A.

155. It is worth noting that President Clinton's proposed Health Security Act of 1993 set the level of insurance for his national health care plan for mental and substance abuse in accord with the normal function model, stating that coverage would be provided if an individual has had a "diagnosable mental disorder or a diagnostic substance abuse disorder." The Health Security Act of 1993, H.R. No. 103-174, 103d Cong., 1st Sess., Title I, Subtitle B, § 115(b)(1A). See also Sabin and Daniels, 24 Hastings Center Rep. at 11 (cited in note 122). Therefore, if the President recognized that a national program of managed mental health coverage required defining "medically necessary" as requiring a diagnosable mental illness, then Congress must also recognize the need te allow states to apply such a definition to the potentially expansive EPSDT.

The definition of "medically necessary" does not end with the decision of whether te follow the normal function model or another model for service standards. Because of the wide variety of mental health care practitioners, one must also consider the credentials of reimbursable providers, the settings for treatment, and the effectiveness or expected effectiveness of the treatment. Glazer, 22 Psychiatric Annals at 363-65 (cited in note 135).

to effectively apply their definitions of "medically necessary" to the EPSDT.[156]

V. THE "TENNCARE PARTNERS" MANAGED MEDICAID MENTAL HEALTH CARE PROGRAM

Tennessee serves as a good example of a state that did not completely plan for the EPSDT when moving to managed care. The structure it chose to deliver mental health care and the contract it signed with the mental health care suppliers, demonstrates the confusion that can result when a state does not properly plan for the EPSDT while moving to managed Medicaid mental health care. Moreover, as a state that chose to deliver the mental health care through a system separate from its physical care, Tennessee created a separate definition of "medically necessary" for mental health, allowing this definition to be analyzed within the aforementioned models and demonstrating its applicability to the EPSDT.

Tennessee chose to deliver its managed health care system through two entities, one for general health care and one for mental health care.[157] This "carve-out" system is controversial.[158] Supporters argue that carve-outs help overcome the concern that non-psychiatric gatekeepers do not understand mental health issues and thus are ineffective in diagnosing and treating mental illness.[159] Detractors maintain that such a separation only creates confusion and difficulties in getting treatment, in addition to dual administrative costs.[160] It seems, however, that Tennessee chose a carve-out system primarily to expedite the initial operation of TennCare's managed mental health care system.[161]

Under the Tennessee managed mental health care program, TennCare Partners, two behavioral health organizations ("BHOs")

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156. Id.

157. *TennCare: A New Direction in Health Care* (cited in note 28).

158. For a discussion of the two sides of the debate on the carve out of mental health care, see Petrilla, 40 St. Louis U. L. J. at 369 n.22 (cited in note 103).

159. Boyle, 40 St. Louis U. L. J. at 446 (cited in note 2).

160. Petrilla, 40 St. Louis U. L. J. at 370 (cited in note 103).

161. Tammie Smith, *Behavioral Health Back to TennCare*, Tennessean 1A (Oct. 7, 1996). Tennessee's TennCare program has been marked by a rush teward implementation. Only months after receiving its waiver, Tennessee introduced TennCare. Though TennCare Partners experienced some delays, it too was implemented in a matter of months after the waiver was approved. Gordon Bonnyman, *Status of TennCare—May 1996* <http://www.chcs.org/CHCS/gb_may.htm> (visited Jan. 23, 1997).

manage the mental health needs of the enrollees.[162] The state pays the BHOs a set monthly fee per enrollee to provide each enrollee's mental health needs.[163] The TennCare Partners program offers two levels of coverage, a "Basic Benefit Package" for all enrollees, which places limits on most services, and an "Enhanced Benefit Package" for enrollees with chronic mental health needs.[164] The Enhanced Benefit Package enrollee can receive all the benefits offered under the TennCare Partners program without mandated limits, so long as the benefit is "medically necessary."[165] The Enhanced Benefit Package is available to children who meet the state's definition of "seriously emotionally disturbed"[166] and who are not in the legal custody of the state.[167]

The TennCare Partners program has received mixed reviews.[168] While the state maintains that the carve-out program has been a success, it recently announced that the BHOs will integrate

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162. These two BHOs are a consolidation of the five behavioral organizations that were originally approved to offer services. The two organizations are Premier Behavioral Systems of Tennessee and Tennessee's Behavioral Health. Bonnyman, *Status of TennCare* (cited in note 161).

163. Andy Sher, *Mental Care Plan Could Trigger New State Trends, Add Controversies*, Nashville Banner A9 (June 28, 1996).

164. Tennessee Department of Mental Health and Mental Retardation, TennCare Partners Pamphlet, *Mental Health and Substance Abuse Benefits* (on file with the Author). For example, the Basic Benefit Package limits inpatient facility services to thirty days per occasion and sixty days per year per enrollee. Id. Inpatient and outpatient substance abuse treatment services are limited to ten days' detox and a maximum lifetime limit of $30,000. Id. A few services, however, like psychiatric pharmacy services and pharmacy-related lab services, are available for the Basic Benefit enrollee "as medically necessary." Id.

165. For a discussion of what constitutes "medically necessary" under the TennCare Partners program, see Part V.B.

166. The contract between the state and the BHO considers a child under eighteen years of age "seriously emotionally disturbed" if he or she is diagnosed with a psychiatric disorder and a Global Assessment of Functioning score of fifty or less in accordance with the DSM-IV. *A Provider Risk Contract Between the State of Tennessee Department of Mental Health and Mental Retardation and (Name of Contractor)* 11-12 (Feb. 29, 1996) (on file with the Author) ("Provider Risk Contract"). The DSM-IV is further discussed in note 134 and accompanying text.

167. Bonnyman, *Status of TennCare* (cited in note 161).

168. Community mental health centers have been particularly critical of the program. These centers once received funding directly from the state but now must compete with other mental health providers for contracts with the BHOs. With the advent of TennCare Partners, the centers' state funding dropped from 55% to 20% of the total state budget for mental health care. *TennCare Carve Out off to Rocky Start in First 90 Days*, 6 Mental Health Weekly 1, 2 (Oct. 7, 1996). In addition, Charles R. Blackburn, director of the Tennessee Association of Mental Health Organizations, has testified that TennCare Partners is a failure for destroying the service network provided by the community health centers instead of working with the network to implement BHOs. Charles R. Blackburn, Testimony presented to the HJR 448 Mental Health Study Committee (Dec. 18, 1996) (on file with the Author). See also Tammie Smith, *Is TennCare Partners Working?*, Tennessean 4B (Oct. 3, 1996) (stating that officials claim TennCare Partners is running smoothly while providers complain of slow reimbursement).

back into the regular TennCare program by 1998.[169] Administrative savings from reducing the two delivery systems into one seem to be the factor compelling the return to a carve-in program.[170]

A. The EPSDT and the TennCare Partners Program

Under TennCare, Tennessee has not effectively met its EPSDT mandates. Tennessee stated in its 1996 annual EPSDT report that since the implementation of TennCare in 1994, it had screened eight to fifteen percent of children eligible for screening,[171] while the HCFA guidelines have a stated goal of eighty percent EPSDT participation by 1995.[172] The TennCare Partners program appears to be headed toward similarly low EPSDT participation.[173] One reason seems to be the confusion created by the two-tiered benefits scheme. The Enhanced Benefit Package does not cap the services provided in the Partners program if a doctor deems them "medically necessary."[174] But a child must be deemed "seriously emotionally disturbed"[175] to receive the Enhanced Benefit Package. According to regulations, all other children receive the Basic Benefit Package, which contains caps on several services.[176] It is quite possible that the BHOs or the providers could misinterpret the regulations and restrict children in the Enhanced Benefit Package to the specific benefits listed in the contract[177] or restrict the children in the Basic Benefit Package to the caps placed on the benefits they receive.[178] In reality, the broad benefits of the EPSDT require that any child be offered any federally recognized Medicaid treatment for a mental illness found in the screening process.[179]

In addition to the confusing structure of the program itself, the contract for the TennCare Partners program between the state and the BHOs does not effectively convey the requirements of the EPSDT. In the TennCare Partners program, the contract terms addressing the EPSDT are vague and do not specify all of the elements that the

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169. Tammie Smith, *TennCare Arm to Disband*, Tennessean 1E (Feb. 14, 1997).
170. Smith, Tennessean at 1A (cited in note 161).
171. EPSDT Annual Report (cited in note 56).
172. See *Salazar*, 938 F. Supp. at 952-53.
173. EPSDT Annual Report (cited in note 56).
174. See note 165 and accompanying text.
175. See note 166 and accompanying text.
176. Provider Risk Contract at 12 (cited in note 166). The caps for the Basic Benefit Package include visit and dollar limits for certain mental health services. Id.
177. Id.
178. See id.
179. See Part III.

complex EPSDT mandate requires.[180] The EPSDT is mentioned only twice in the hundred-page contract,[181] and the two passages are inconsistent. First, and most comprehensively, the contract states:

> In accordance with EPSDT requirement, the Contractor shall provide medically necessary services to children under the age of twenty-one (21) when such services are required to correct or ameliorate mental illnesses and conditions, whether or not such services are covered under the TennCare Program Stato plan and without regard to any service limits otherwise established in this Contract. This requirement shall be met either by direct provision of the service by the contractor, or by referral in accordance with 42 C.F.R. 441.61.[182]

Second, the contract refers to the EPSDT in a footnote, reminding the BHO that three particular services in the Basic Benefit Package are unlimited when medically necessary.[183] The conflict in these clauses occurs because the first clause addresses the breadth of the EPSDT by stating that all "medically necessary" treatments must be covered, whether or not covered under the TennCare program, yet the second clause implies that only the named benefits are unlimited if "medically necessary." The first clause is closer to the expectations of the EPSDT.[184]

Because Tennessee did not fully clarify the expectations of the EPSDT program in its behavioral health care contract, the BHOs have not effectively executed the EPSDT.[185] Tennessee undoubtedly could have benefited from constructing an incentive-based EPSDT program instead of relying on two conflicting and relatively short clauses to ensure that BHOs obey the EPSDT's mandate. Instead, a court may have to step in to ensure that BHOs implement the EPSDT.[186]

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180. For an overview of the terms that a provider contract must include, see Perkins and Rivera, 28 Clearinghouse Rev. at 1252-60 (cited in note 49).

181. Provider Risk Contract at 11-12 (cited in note 166).

182. Id. at 11. 41 CFR § 441.61 states that providers must be qualified and willing to perform EPSDT services.

183. Those services are limitations on outpatient mental health services and substance abuse. Provider Risk Contract at 12 (cited in note 166).

184. See Part III.

185. See EPSDT Annual Report (cited in note 56) (citing lower than mandated screening numbers under the EPSDT).

186. See Part III.

B. TennCare Partners and "Medically Necessary"

In the TennCare Partners program, the two BHOs decide what is medically necessary in accordance with the definition in their contract with the state. The contract uses one definition of "medically necessary" for the entire BHO agreement:

> [m]ental health and/or substance abuse services provided by an institution, physician, or other qualified provider that are required to treat a TennCare Partners Program Participant who meets certain mental health diagnostic and impairment criteria. These services are necessary to maintain the Participant in the least restrictive setting that is appropriate for his special needs, to prevent unnecessary hospitalizations, and to improve his or her functioning level and quality of life.[187]

While it is doubtful that Tennessee considered the previously described models[188] in preparing its managed care contract, the definition does not require an underlying mental disorder to qualify for mental treatment and thus does not follow the normal function model.[189] Although the contract may vaguely refer to an enrollee's need to meet "certain" mental health criteria, it does not specify the criteria.[190] In fact, the standard that a medically necessary service is one needed to improve the enrollee's "functioning level" and "quality of life" seems to be closer to the expansive welfare model, with enhanced potential for happiness as the standard for what is "medically necessary."[191] Therefore, Tennessee's definition does not necessarily conflict with the EPSDT. As discussed earlier, however, any attempt by a state to apply a more limiting definition of "medically necessary" would probably conflict with the EPSDT's broad coverage and would not be a permissible method for denying care that the provider deems necessary.[192]

As a result, were Tennessee required to meet the HCFA's eighty percent screening goal, the number of mental defects discovered by screening would undoubtedly rise. Without a limiting definition of "medically necessary" in line with the normal function model, the breadth of mental deficiencies open for discovery during the screening process could be very wide. Then, after a provider found

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187. Provider Risk Contract, Attachment A "Definitions" (cited in note 166).

188. For discussion of the models, see Part IV.A.

189. Compare the proposed Health Security Act, see note 155, te the definition quoted in note 187 and accompanying text.

190. Provider Risk Contract, Attachment A "Definitions" (cited in note 166).

191. See Part IV for a complete discussion of the welfare model.

192. See Part IV.D.

mental deficiency, the treatments that Tennessee would be required to cover could be equally broad.[193] While peer reviews or prior authorization might limit the providers' decisions, if Medicaid covers the treatment for anyone else, effectively, Tennessee would have no say in the provider's decision. As a result, the cost of meeting the EPSDT requirements could offset the savings of managed care.[194]

VI. CONCLUSION

As more states move to managed care to control Medicaid costs, they must plan for expansive programs like the EPSDT which may yield increased, and sometimes unexpected, costs. As Tennessee's contract demonstrates, states often fail to convey effectively the EPSDT requirements in their contracts with managed care organizations. When the MCO then fails to meet the requirements of the EPSDT, the state is exposed to liability for not meeting its federal obligations.

With some planning in the contractual agreement, a state can do more to ensure that the MCO carries out the preventive thrust of the EPSDT. States can specify the requirements of the EPSDT in the contract and encourage screenings with a financial incentive program. But whether the state proactively steps up screening or a court enforces the EPSDT's provisions, states may face increased costs from the treatments flowing from the screenings. Congress must therefore provide a clear mechanism for states seeking to control Medicaid costs through a managed care system to use as one of the "limiting principles" of the EPSDT, the states' traditional discretion to define "medically necessary." As a state's most effective allocation tool, and as a discretionary bulwark against expansive programs like the EPSDT, the definition of what is "medically necessary" for mental

193. The EPSDT requires that any service that makes the defect better and is recognized by Medicaid be covered if the provider finds it medically necessary. See Part IV.D.

194. To offset the savings of managed care, the EPSDT requirements must result in a great increase in the number of screenings leading to utilization of the treatment options under the EPSDT. This increase in screenings could come from either the state incentive program or a court's injunction. As the EPSDT presently stands in Tennessee, however, the costs are not a major threat as only 15% of over 630,000 children who qualified for screenings received at least one screening between Octeber 1, 1994 and September 30, 1995. EPSDT Annual Report (cited in note 56). Approximately 95,000 children were screened in that period. Id. Such low numbers probably do not imply the downfall of TennCare at this stage. However, if Tennessee were suddenly required to meet HCFA's 80% screening requirements, or if another similarly positioned state were te implement incentive programs, then the necessity for limits by way of applying the "medically necessary" definition te the EPSDT would become apparent.

health care is a critical component in allowing managed care to meet its financial goals while still meeting the goals of the EPSDT.

John A. Flippen[*]

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