

## Amount, duration and scope requirements

States do not usually attempt to drop mandatory Medicaid services. The federal statute, CMS regulations and case law are clear in prohibiting such an option. Far more common—particularly when they are facing budget deficits-- is for states to limit the amount, duration and scope of a mandatory or optional service, such as limiting Medicaid patients to a certain number of dental visits a year, or a certain number of doctor visits a month, or by putting a set dollar limit on the cost of a certain service, such as \$500 in dental costs per year. Since the Medicaid statute does not explicitly define the minimum level of services a state must provide under its program, these kinds of service or monetary limitations may not be **per se** contrary to federal law. However, Medicaid regulations do require that states provide a Medicaid service in “sufficient in amount duration and scope to reasonably achieve their purpose,” and prohibit a state from arbitrarily denying or reducing a service to a recipient because of his/her diagnosis, type of illness or condition. 42 CFR 440.230(b) and (c)

There is a great deal of case law in which states have been challenged in their limiting the amount, duration or scope of a certain service, and decisions in these cases have not been uniform. Nonetheless, there appears to be controlling case law that allows a state to limit a service with regard to amount duration and scope if that limitation is sufficient to serve the needs of the great majority of Medicaid patients in need of the service. Apparently, CMS has determined, as a rule of thumb, that if a service limitation is sufficient to meet the needs of 90% of the Medicaid patients in need of the service it is sufficient in amount, duration and scope.

There are a number of additional considerations in evaluating whether a state’s service limitation is in violation of amount, duration and scope requirements. For example, it appears that any such limitation would be inappropriate when applied to a child who has been determined in need of the service by virtue of an EPSDT screen (i.e. the service is an EPSDT service). In addition, states may be able to provide fewer services to medically need recipients than to the categorically needy. The critical point is, however, that there is a good legal basis for PCAs and other advocates in a state to maintain that a state should not be able to arbitrarily limit the amount or cost of a particular service (particularly a mandatory service) without being able to demonstrate that the service limitation is sufficient for the great majority of Medicaid patients in need of the service. **This would appear to be particularly true if a state were to limit the total number of FQHC services per patient, since FQHC services are a mandatory service and can include such a broad array of services (such as medical, mental health and dental).**

Since a state decision to cut back on a service is often solely a reflection of budgetary considerations, the state is likely not to have factored in amount, duration and scope criteria—consequently, this issue may be one the PCA would raise in negotiations with various state officials or in providing its expertise to state legislators.