

# Defining and Determining Medical Necessity in Medicaid Managed Care



**WHAT'S KNOWN ON THIS SUBJECT:** Clinical decisions must be medically necessary to be approved by insurers. There is a federally mandated medical necessity standard for children in Medicaid, but not in private plans. American Academy of Pediatrics policy calls on pediatricians to help define pediatric medical necessity.



**WHAT THIS STUDY ADDS:** This study reviewed pediatric medical necessity definitions in Medicaid state statutes, regulations, and provider manuals. The federal standard was not replicated on all levels, and provider manuals were least likely to have it. Pediatricians should engage in defining pediatric standards.

## abstract

**OBJECTIVES:** In 2013, the American Academy of Pediatrics published a policy statement calling for pediatricians to be informed about the need for specific pediatric medical necessity language because children deserve “the intent embedded in Medicaid.” This study aims to explore the definitions and determinations of medical necessity in Medicaid Managed Care (MMC), document the relevant language used throughout Medicaid, and investigate whether the federal standard of medical necessity for children is replicated in related state documents.

**METHODS:** We conducted a desk review of state statutes, model MMC contracts, and 2 provider manuals per state, for 33 states with a full-risk MMC model.

**RESULTS:** The federal “to correct and ameliorate” standard was replicated in 100% of state regulations, 72% of MMC model contracts ( $n = 13$  of 18 MMC model contracts available online), and 54% of provider manuals ( $n = 30$  of 56 available and sampled online). Only 9 states had an explicit “preventive” pediatric medical necessity standard in their state regulations that exemplified “the intent imbedded in Medicaid.”

**CONCLUSIONS:** The federal medical necessity standard for children is not replicated consistently within MMC programs from the state, to health plans, to network providers. Although the majority of the documents reviewed included the standard, the presence of the standard decreased by almost half between state-level and network-provider-level regulations. Having a single, explicitly defined pediatric medical necessity definition replicated at all levels of the health system would reduce confusion and increase the ability of pediatricians to apply the standard more uniformly. *Pediatrics* 2014;134:516–522

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### KEY WORDS

pediatrician, medicaid, medical necessity, child health

### ABBREVIATIONS

AAP—American Academy of Pediatrics

ACA—Affordable Care Act

EHB—essential health benefits

EPSDT—early and periodic screening, diagnosis and treatment

MMC—Medicaid Managed Care

Dr Markus conceptualized and designed the study, drafted the initial manuscript, and reviewed and revised the manuscript; Ms West performed the data collection, carried out the initial analysis, and reviewed and revised the manuscript; and both authors approved the final manuscript as submitted.

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The standard of medical necessity in health insurance plans defines the limits of benefit coverage for enrollees and varies between public and private insurance.<sup>1–3</sup> Title XIX of the Social Security Act mandates the use of a federal standard of pediatric medical necessity applicable to children enrolled in Medicaid under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit, which specifically includes vision, hearing, dental, and developmental and mental health screenings, as well as comprehensive diagnostic and treatment care.<sup>4</sup> The standard applies to state Medicaid agencies in administering their fee-for-service and Primary Care Case Management programs, as well as to individual managed care organizations (MCOs) contracting with state Medicaid agencies to furnish services to children. The pediatric medical necessity standard is “built in” to the federal statutory definition of the EPSDT benefit (42 U.S.C. §1396d(r)(5)) and is defined as a range of services that can “correct or ameliorate defects and physical and mental illnesses and conditions.” Furthermore, determinations of medical necessity in the case of Medicaid-covered children extend to all categories of Medicaid benefits that are federally defined in statute, regardless of whether such care is covered under the state Medicaid plan. The preventive nature and comprehensive scope of the EPSDT benefit is supported in guidance documents from the Centers for Medicare and Medicaid Services and in judicial decisions issued by federal courts, which have repeatedly interpreted the EPSDT benefit as providing coverage for preventive care and comprehensive treatment.<sup>1</sup> In contrast, private MCOs, such as health maintenance organizations and preferred provider organizations, do not have restrictions on how medical necessity for children is defined. They are more likely than Medicaid MCOs to include additional considerations regarding the cost of services, to have more restrictive

preventative care and mental health coverage, and to use stricter interpretations of the standard of care that limits coverage to rehabilitative care.<sup>5</sup>

In practice, medical necessity criteria are individually defined by health insurance plans and used by pediatricians and other authorized clinicians to determine in individual cases whether a child should receive needed and recommended care. Historically, physicians have had great professional autonomy in making medical necessity determinations.<sup>6</sup> However, with the advent, and the almost uniform use of managed care in health insurance programs, including Medicaid, insurers have increasingly gained control over physician decision-making and have constricted physicians’ ability to make decisions uniquely based on needs.<sup>7,8</sup> In the case of Medicaid, federal law mandates that the treating health professional’s recommendation for a medically necessary service carry great weight in the evaluation of subsequent diagnosis, treatment, or prevention options, although private contracting with health plans is likely to have diminished that weight by imposing additional authorizations.<sup>1</sup> In private insurance, most health insurance plans require additional approval, part of so-called utilization review, after an initial determination by the provider. In addition, in the case of a denial of care by a health plan, federal Medicaid law requires that states remain liable for the coverage of medically necessary care that falls within the scope of Medicaid coverage of benefits, a “fallback” or safety net that is not typically available to enrollees in private insurance.

Because most medical practices have patients from a variety of health insurance plans, both Medicaid and private, physicians need to be well informed of the distinctions between the medical necessity policies for child health that each plan applies. With the Affordable Care Act (ACA), the addition of qualified health plans to the US health

system makes a renewed emphasis on medical necessity all the more important for pediatricians to understand to serve their patients, especially considering the expected frequent churning of families with lower socioeconomic status and the overlapping eligibility levels between types of health insurance (Fig 1).<sup>9,10</sup>

In an effort to aid pediatricians in navigating the multiplicity of federal and state regulations and statutes that govern the concept of medical necessity, the American Academy of Pediatrics (AAP) issued a statement on contractual language for medical necessity for child health.<sup>11</sup> According to the AAP, it is imperative to have medical necessity definitions for children that “recognize ... that the needs of children differ from those of adults.”<sup>11</sup> The policy highlights the importance of having a “comprehensive, fully inclusive set of services” for children, similar to the standard in Medicaid’s EPSDT benefit for children.<sup>11</sup>

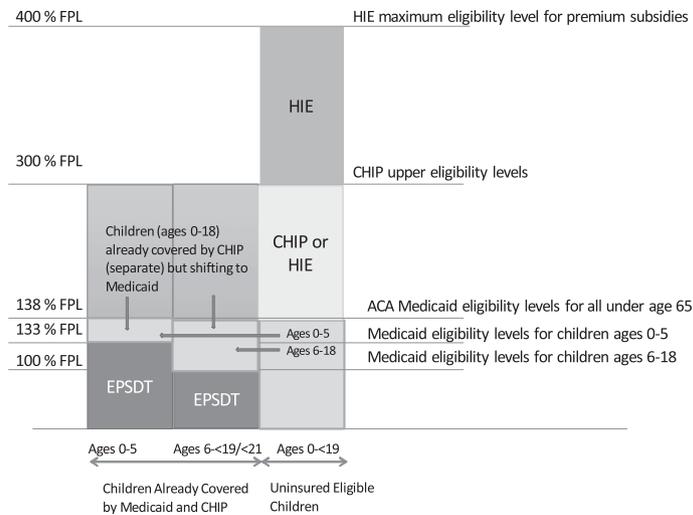
The aim of this study is to document the medical necessity language used throughout the Medicaid EPSDT benefit and to investigate if the federal standard of medical necessity for child health is replicated in state statutes, regulations and Medicaid Managed Care (MMC) provider documents. As the AAP policy statement emphasizes, “the expectations of all health plans, including Medicaid ... , should be clear in anticipation of medical necessity requirements, and similarly, the decision-making process should be transparent” and “the right of a child to optimal growth and development should be a universal expectation.”<sup>11</sup> The consistent application of clear medical necessity guidelines is all the more important in the abundance of new contractual arrangements with providers and health care organizations expected in the context of health reform.

## METHODS

Our conceptual and analytic approach draws from the legal discipline, which we augmented with content analysis, to

Frequent “churning” predicted under ACA

Documented “churning” with up to 30% of families <200% FPL changing eligibility 4+ times within 2-3 years



**FIGURE 1**

Low-income families experience frequent changes in eligibility. From Markus AR, West K. Pediatric Medical Necessity Criteria as a Coverage Coordination Mechanism between Medicaid and the Health Insurance Exchanges. Academy Health Annual Research Meeting Child Health Services Pre-Conference Podium Presentation, Baltimore, MD: June 2013. CHIP, Children’s Health Insurance Program; FPL, federal poverty level; HIE, health insurance exchange.

answer the following main research question: Do states replicate in their state administrative codes or codes of regulation the mandatory federal standard of medical necessity expressed in 42 U.S.C. §1396d(r) (5) as care that is necessary to correct and ameliorate a child’s condition? Furthermore, we asked: Do states replicate this standard in their model MMC contracts? Finally, do Medicaid health plans replicate this standard in their provider manuals, which they use to communicate expectations to network providers?

To answer these questions, we followed the general principle of the hierarchy of laws, whereby the Constitution prevails over statutes, which in turn prevail over regulations. In the context of a federal system, each state has the power to govern as a sovereign entity. However, federal law prevails if there is a conflict between a federal and a state statute. Medicaid is a joint federal-state program to which both federal and state laws apply. If federal law includes certain mandates then these mandates should be replicated in state legal documents to ensure consistency and to avoid the appearance of a legal void. Figure 2 provides a simplified way to visualize these legal, regulatory, and contractual relationships. The left box represents the

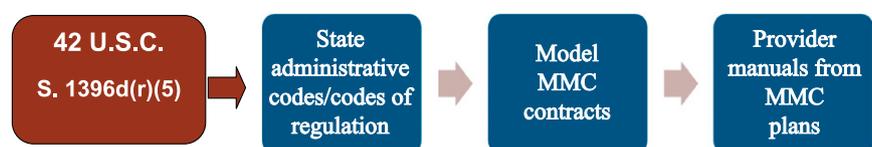
federal legal mandate on medical necessity, and the next 3 boxes represent in sequence state administrative codes/codes of regulation, model MMC contracts, and provider manuals from MMC plans.

We set out to collect legal documents in effect as of Spring 2012 and were able to collect and review regulations in 33 states (100% of all states with MMC), MMC model contracts in 18 of 33 states with online access to these documents (55% of all states with MMC), and 56 provider manuals available online with at least 1 provider manual collected for each state (Table 1). We were not able to obtain provider manuals from 2 of the 33 states, but for 25 states (78%) we were able to obtain 2 provider manuals each (Table 1).

When analyzing state regulations and MMC documents, we counted the federal standard as replicated in the reviewed text if the language from the federal statute was included verbatim, or if there was a reference

to the federal statute, or if the state had its own medical necessity definition that covered the requirements of the federal standard and was included in the reviewed document. In addition, we analyzed the content of the provisions and determined in each case whether the medical necessity definition and standard met the essence of the EPSDT set of requirements. Although some subjectivity is involved in this assessment, we were able to distinguish state definitions and standards by clarity and explicitness of the criteria each state spelled out in law. This research also reviewed the consistency in the application of the federal standard for pediatric medical necessity within state Medicaid documents.

We synthesized all of the information into key findings, relating them back to our conceptual and analytical approach. First, we determined the extent to which states replicated the federal “built-in” EPSDT benefit standard of “to correct and ameliorate” by level of regulation, that is,



**FIGURE 2**

Hierarchy of laws and legal documents.

**TABLE 1** Summary of Legal and Policy Documents Collected and in Effect as of March 2012, by State

States With Full-Risk MMC Programs ( <i>n</i> = 33)	State Regulations or Administrative Codes	Model MCO Contract	First MCO Provider Manual	Second MCO Provider Manual
Arizona	Yes	— <sup>a</sup>	Yes	Yes
California	Yes	Yes	Yes	Yes
Colorado	Yes	Yes	Yes	Yes
Delaware	Yes	— <sup>a</sup>	Yes	Yes
Florida	Yes	Yes	— <sup>a</sup>	— <sup>a</sup>
Georgia	Yes	Yes	Yes	Yes
Hawaii	Yes	Yes	Yes	— <sup>a</sup>
Illinois	Yes	Yes	Yes	Yes
Indiana	Yes	— <sup>a</sup>	Yes	Yes
Kansas	Yes	— <sup>a</sup>	Yes	— <sup>a</sup>
Kentucky	Yes	— <sup>a</sup>	Yes	Yes
Maryland	Yes	— <sup>a</sup>	Yes	Yes
Massachusetts	Yes	— <sup>a</sup>	Yes	Yes
Michigan	Yes	Yes	Yes	Yes
Minnesota	Yes	Yes	Yes	Yes
Missouri	Yes	— <sup>a</sup>	— <sup>a</sup>	Yes
Nebraska	Yes	— <sup>a</sup>	Yes	Yes
Nevada	Yes	Yes	— <sup>a</sup>	— <sup>a</sup>
New Jersey	Yes	Yes	Yes	Yes
New Mexico	Yes	Yes	Yes	Yes
New York	Yes	Yes	Yes	Yes
Ohio	Yes	— <sup>a</sup>	Yes	Yes
Oregon	Yes	Yes	— <sup>a</sup>	Yes
Pennsylvania	Yes	Yes	Yes	Yes
Rhode Island	Yes	— <sup>a</sup>	Yes	Yes
South Carolina	Yes	Yes	Yes	Yes
Tennessee	Yes	Yes	Yes	Yes
Texas	Yes	Yes	Yes	Yes
Utah	Yes	— <sup>a</sup>	Yes	Yes
Virginia	Yes	— <sup>a</sup>	— <sup>a</sup>	Yes
Washington	Yes	Yes	Yes	Yes
West Virginia	Yes	— <sup>a</sup>	Yes	— <sup>a</sup>
Wisconsin	Yes	— <sup>a</sup>	Yes	Yes
Total (%)	33 (100%)	18 (55%)	28 (85%)	28 (85%)
			56/66 (85%)	

<sup>a</sup> Not able to locate and download document from state or Medicaid MCO Web site or not able to access document because of requirements for providers to have an ID and a password.

whether it could be found in state administration codes or regulations, state MMC model contracts, and a sample of MMC provider manuals. Second, we singled out specific, stand-alone medical necessity definitions and standards and determined whether they met a pediatric standard, which consists of preventing health conditions and developmental problems from worsening (what the AAP policy refers to as “the intent imbedded in Medicaid”).<sup>11</sup>

## RESULTS

### Replication of the Federal “to Correct and Ameliorate” Standard by Level of Regulation

All of the analyzed state regulations (*n* = 33) replicated the federal “to correct

and ameliorate” standard. As the analysis moved to the MMC model contracts (*n* = 18 of the 33 states with online access to their model contracts), we found that almost three-quarters of the contracts also replicated the federal standard. In summary, the federal “to correct and ameliorate” standard was replicated in 100% of the state regulations and 72% of the MMC model contracts (*n* = 13 of the 18 MMC model contracts available online).

### Replication of the Medical Necessity Standard in Provider Manuals

We found that few states replicated the federal “to correct and ameliorate”

standard at all levels of regulations and in provider manuals. A little more than half of all provider manuals reviewed (*n* = 30, 54% of *n* = 56 available and sampled online) did replicate the federal standard. In addition, among the states that had 2 provider manuals available (*n* = 25), only 8 (32%) had the standard replicated in both manuals. Although the majority of the documents at every examined level of regulation included the standard, it is important to note that the presence of the standard decreased by almost half between the level of state regulation and the level of network provider regulation by the MMC health plans (Table 2).

### Presence of an Explicit Preventive Pediatric Medical Necessity Standard

Few states (*n* = 9; 27%) had an explicit preventive pediatric medical necessity standard in their state regulations, which embodied “the intent imbedded in Medicaid.” Even fewer consistently replicated this more comprehensive standard at all levels of regulations, that is, in the MMC model contracts and the MMC provider manuals developed by health plans contracting with Medicaid. However, among those states that had a specific definition, there were several good examples of how to codify the essence of the pediatric standard.

One example of pediatric, preventive medical necessity standard and definition (which is separate from the federal “to correct and ameliorate” standard that is “built-in” the EPSDT benefit definition) was found in the Pennsylvania Code and MMC model contract for both adults and children. It addresses special needs regardless of age and is replicated here verbatim:

A service, item, procedure or level of care that is necessary for the proper treatment or management of an illness, injury or disability is one that:

- (1) Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.

**TABLE 2** Replication of the Federal Pediatric Medical Necessity Standard in Reviewed State Documents

State (n = 33)	State Law	MCO Contract	First MCO Provider Manual	Second MCO Provider Manual
Arizona	Yes	—	Yes	No
California	Yes	No	Yes	No
Colorado	Yes	Yes	No	No
Delaware	Yes	—	Yes	Yes
Florida	Yes	No	—	—
Georgia	Yes	Yes	No	No
Hawaii	Yes	Yes	Yes	—
Illinois	Yes	Yes	Yes	No
Indiana	Yes	—	Yes	No
Kansas	Yes	—	Yes	—
Kentucky	Yes	—	No	No
Maryland	Yes	—	Yes	Yes
Massachusetts	Yes	—	Yes	No
Michigan	Yes	Yes	No	No
Minnesota	Yes	Yes	No	No
Missouri	Yes	—	—	No
Nebraska	Yes	—	Yes	Yes
Nevada	Yes	Yes	—	—
New Jersey	Yes	Yes	Yes	Yes
New Mexico	Yes	Yes	No	No
New York	Yes	Yes	Yes	Yes
Ohio	Yes	—	Yes	No
Oregon	Yes	Yes	—	No
Pennsylvania	Yes	Yes	Yes	Yes
Rhode Island	Yes	—	Yes	Yes
South Carolina	Yes	No	Yes	No
Tennessee	Yes	No	Yes	Yes
Texas	Yes	No	Yes	No
Utah	Yes	—	Yes	No
Virginia	Yes	—	—	No
Washington	Yes	Yes	Yes	No
West Virginia	Yes	—	Yes	—
Wisconsin	Yes	—	Yes	No
Total (%)	33/33 (100%)	13/18 (72%)	22/28 (79%)	8/28 (29%)
			30/56 (54%)	

—, not able to locate and download document from state or Medicaid MCO Web site or not able to access document because of requirements for providers to have an ID and a password.

- (2) Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- (3) Will assist the recipient to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient and those functional capacities that are appropriate of recipients of the same age.

## DISCUSSION

On the basis of our analysis of available legal and policy documents, we conclude

that in states with MMC, the federal medical necessity standard of “to correct and ameliorate” is not replicated consistently from state documents, to health plan contracts, to network provider manuals. Although all state statutes replicate the federal standard and some states even have their own pediatric medical necessity standard that is consistent with the federal statute, the standard is less often replicated at lower levels of regulation. This means that at the physician, clinician, or other provider level, the requirement will most likely not be evident. Indeed, we have found in previous (unpublished) research that pediatricians in a large health care system in Delaware serving

a large percentage of Medicaid-covered children were not necessarily aware of EPSDT, its benefit components, and medical necessity standard.

Provider manuals were the least likely of all reviewed documents to have the Medicaid medical necessity standard for children, calling into question how well physicians are informed of the application of medical necessity in child health. The vast majority of the provider manuals we were able to review also lacked an explicit “preventive” pediatric medical necessity standard within the EPSDT benefit in Medicaid. Although not the norm in state administrative codes or at lower levels of regulation within state MMC programs, it is important to have such an explicit standard, as the AAP policy statement calls for.

This lack of guidance has implications for health coverage for children under the ACA. Currently, ACA is silent on the features of what might constitute a fair and acceptable medical necessity standard in qualified health plans. Despite the mandatory inclusion of Essential Health Benefits (EHBs) in all qualified health plans, federal regulations allow significant flexibility to plans to include hearing services, habilitative care and dental care in child health coverage, which is not comparable to the comprehensive coverage for children in Medicaid.<sup>12,13</sup> Hearing services, dental care and habilitative services were commonly restricted even before the start of the health insurance exchanges.<sup>14</sup> The restriction of these benefits will largely affect children with multiple chronic conditions who have complex developmental needs and use specialty care.

This analysis is limited to legal documents. Our research did not address how the requirements found in these documents are implemented, nor did it examine the application and translation of the medical necessity criteria into actual coverage or, alternatively, denial of needed care. It was also limited to model contractual agreements and therefore

did not examine the actual executed contracts between the Medicaid agencies and their health plan contractors, which would include specific terms and conditions agreed on by the 2 parties and different from health plan to health plan. In addition, it was restricted to contracts that are accessible online as of March 2012. From the 33 states with MMC we reviewed, 15 MMC model contracts could not be located online and were thus not reviewed. Still, we were able to look at the majority of the MMC model contracts ( $N = 18$ ) for states with full-risk managed care in their Medicaid programs. Finally, we sampled 2 provider manuals per state on average, which are one of several ways state and health plans communicate expectations with their providers.

## CONCLUSIONS

Our study has several implications for practice and policy. It is important to have an explicit and separate definition and standard to eliminate any confusion for the physician and the health plan regarding the application of medical necessity. Having a single, explicitly defined, pediatric medical necessity definition that is replicated at all levels of the health care system, within and across subsidized programs, plans,

and payers, would ensure more consistent and correct application of coverage options for children regardless of which health plan they are using.

For Medicaid state programs and AAP state chapters, it would seem important to review existing regulations, model contracts, and provider manuals side-by-side to ensure that the definition is replicated and that the language is uniform and consistent, to assist pediatricians when treating children, especially children with complex conditions. The prevalence of managed care arrangements in Medicaid requires special attention to the consistency with which the standard is replicated throughout the Medicaid program within a state and across states. Pediatricians, through their AAP chapters, can negotiate with state administrators and MMC plans the inclusion of a pediatric medical necessity standard in the next round of amendments to the MMC contracts and regulations. Pediatricians can advocate for the adoption of medical necessity language consistent with the Medicaid statute or the AAP policy statement, both being similar in intent, and for the inclusion of specific language that clarifies the provider's role when making medical necessity determinations.

As AAP states in its policy, the implementation of health reform will require contractual arrangements between providers, health plans and medical group practices, which presents another opportunity for pediatricians to inform medical necessity definitions for pediatric care. In the context of the implementation of EHBs, the law gives certain flexibility to states in defining their EHB standards, which would likely allow variations in the minimum guaranteed benefits for children by state. Pediatricians, through their local AAP chapters, can help preserve the generous coverage for children afforded by EPSDT and the federal pediatric medical necessity standard by helping inform the development of EHB standards to ensure that proper attention is paid to child health.

In its policy statement on medical necessity, AAP emphasizes the important role that pediatricians can play in defining "not only the overall health care benefits but also the medical necessity decisions that affect pediatric care" in the new health insurance exchanges.<sup>11</sup> The era of health reform can turn into an important opportunity for child health providers to define more clearly their role in making medically necessary decisions about patient care in both public and private health insurance plans.

## REFERENCES

- Rosenbaum S, Markus A, Sonosky C. Public health insurance design for children: the evolution from Medicaid to SCHIP. *J Health Biomed Law*. 2004;1(1):1–46
- Rosenbaum S, Wise PH. Crossing the Medicaid-private insurance divide: the case of EPSDT. *Health Aff (Millwood)*. 2007;26(2):382–393
- Goldstein M, Rosenbaum S. From EPSDT to EHBs: the future of pediatric coverage design under government financed health insurance. *Pediatrics*. 2013;131(suppl 2):S142–S148
- Center for Medicare and Medicaid Services. Medicaid benefits. Available at [www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Medicaid-Benefits.html](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Medicaid-Benefits.html). Accessed March 13, 2014
- Fox HB, McManus MA. A national study of commercial health insurance and medicaid definitions of medical necessity: what do they mean for children? *Ambul Pediatr*. 2001;1(1):16–22
- Paul Starr. The Growth of Medical Authority. In: Brown L, ed. *Perspectives in Medical Sociology*. 2nd ed. Prospect Heights, IL: Waveland Press; 1996
- Scheid T. Rethinking professional prerogative: managed mental health care providers. *Sociol Health Illn*. 2001;22(5):700–719
- Rosenbaum S. The impact of United States law on medicine as a profession. *JAMA*. 2003;289(12):1546–1556
- Graves JA. Better methods will be needed to project incomes to estimate eligibility for subsidies in health insurance exchanges. *Health Aff (Millwood)*. 2012;31(7):1613–1622
- Sommers BD, Rosenbaum S. Issues in health reform: how changes in eligibility may move millions back and forth between medicaid and insurance exchanges. *Health Aff (Millwood)*. 2011;30(2):228–236
- Long TF; Committee on Child Health Financing; American Academy of Pediatrics. Essential contractual language for medical

- necessity in children. *Pediatrics*. 2013;132(2):398–401
12. Rosenbaum S. Essential health benefits update. *Health Reform GPS*. November, 29, 2012. Available at: <http://healthreformgps.org/resources/essential-health-benefits-update-proposed-regulations-implementing-the-aca-and-application-of-the-proposed-ehb-regulations-to-medicaid-benchmark-plans>. Accessed March 13, 2014
  13. Dolatshani J, Hess C, Lee J. *Health Care Reform and Children: Planning and Design Considerations for Policymakers*. Washington, DC: National Academy for State Health Policy; June 2013. Available at: <http://www.nashp.org/publication/health-care-reform-and-children-planning-and-design-considerations-policymakers>. Accessed March 13, 2014
  14. McManus P. *A Comparative Review of Essential Health Benefits Pertinent to Children in Federal, State and Small Group Health Insurance Plans: Implications for Selecting State Benchmark Plans*. Elk Grove, IL: American Academy of Pediatrics; July 2013. Available at: [http://statepolicyoptions.nga.org/policy\\_article/comparative-review-essential-health-benefits-pertinent-children-large-federal-state-and-small-group-health-insurance-plans-implications-selecting-state-benchmark-plans](http://statepolicyoptions.nga.org/policy_article/comparative-review-essential-health-benefits-pertinent-children-large-federal-state-and-small-group-health-insurance-plans-implications-selecting-state-benchmark-plans). Accessed March 13, 2014

**SKIN DEEP BEAUTY:** *I was at a market the other night buying tomatoes. There was a large pile and I grabbed several. One of the tomatoes, however, had a long, shallow brown crease along its length. I was not sure whether I should buy it or not. As reported in The New York Times (Europe: May 24, 2014), were I living in Europe I might not have seen such a tomato. The European Union has established a set of standards for shape, size, and color of the fruits and vegetables that can be sold in grocery stores. While the original goal was to promote uniformity across the European Union, an unfortunate result has been a staggering amount of food waste. For example, up to one-third of the produce grown in Portugal may go to waste as the products do not meet the standards.*

*At least one Portuguese food cooperative has stepped into the void. The cooperative, named Fruta Feia (“Ugly Fruit”), buys fruits and vegetables from farmers that do not meet European Union standards and would otherwise go to waste. The cooperative then sells the produce to consumers at reduced prices. The farmers are happy as they get some money for their produce and are pleased that the food is not going to waste. The consumers are happy as they are purchasing perfectly edible and tasty, if not perfectly apportioned, produce at a reduced price. The leaders of the cooperative are not skirting European Union rules because none of the produce is labeled or packaged. So far Ugly Fruit has been remarkably successful and has a long waiting list for customers. I am all for reducing food waste. I bought my tomato and my hopes were justified as it was delicious.*

*Noted by WVR, MD*

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