
Is it lawful to use Medicaid to pay for circumcision?

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Since 1965, tens of millions of boys have been circumcised under the Medicaid program, most at birth, at a cost to the United States Federal Government, the States and taxpayers of billions of dollars. Although 18 States have ended coverage since 1982, the United States Government and 32 States continue to pay for non-therapeutic circumcision, even though no medical association in the world recommends it. Many cite American medical association policy that the procedure has potential medical benefits as well as disadvantages, and that the circumcision decision should be left to parents. This article shows that Medicaid coverage of circumcision is not a policy issue because it is prohibited by federal and State law. As American medical associations concede, non-therapeutic circumcision is unnecessary, elective, cosmetic surgery on healthy boys, usually performed for cultural, personal or religious reasons. The fundamental principle of Medicaid law is that Medicaid only covers necessary medical treatments after the diagnosis of a current medical condition. Physicians and hospitals face severe penalties for charging Medicaid for circumcisions. Medicaid officials and the Federal and State Governments are also required to end coverage. It is unlawful to circumcise and to allow the circumcision of healthy boys at the expense of the government and taxpayers.

INTRODUCTION

Since 1965, tens of millions of boys have been circumcised under the Medicaid program in the United States, most at birth, at a cost to the Federal Government, the States and taxpayers of billions of dollars.¹ Since 1982, 18 States have ended Medicaid coverage of circumcision, reasoning that it is an unnecessary expense, and that the savings should be allocated to necessary medical care.² Among the 32 States that continue to provide coverage, many cite the policy statements of American medical associations that the procedure has potential medical benefits as well as disadvantages, and that the circumcision decision should be left to parents. These States appear to believe that it is within their discretion as a policy matter to continue or end coverage.³

Clearly, this is a current, controversial and important issue. It involves the health and rights of boys and men, and the rights, obligations and finances of parents, physicians, hospitals and the Federal and State Governments. This article does not discuss policy matters, other than to express the opinion that the government should not be paying for risky, harmful, elective cosmetic surgery that no medical association in the world recommends, or incurring any unnecessary medical expenses in an era of spiralling medical costs. The article asks: what is the applicable law? Is it lawful for Medicaid to pay for neonatal and other non-therapeutic circumcision?

OUTLINE

The first part of this article discusses the controversy between the States, and the reasons that some have given for continuing coverage for what is commonly referred to as routine infant circumcision. It

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¹ See below, text at nn 8-12.

² See below, text at nn 13-17.

³ See below, text at nn 18-33.

then discusses the relevant facts, taken mostly from the policy statements of American medical associations. Routine infant circumcision is non-therapeutic, elective and unnecessary surgery. It also is painful and risks serious injury and death. Few men benefit from it at all, and all men can achieve the same benefits more easily, effectively and inexpensively without it.

The second part of this article discusses the applicable law. Medicaid only covers surgery when medically necessary, after the diagnosis of a medical condition, and as a treatment of last resort. Federal and State Medicaid offices are required to determine what services are necessary and covered based on scientific evidence, and to exclude those that are not.

The analysis that follows is straightforward. Medicaid does not cover unnecessary surgery on healthy children. Addressing the States' concerns, however, if circumcision were the parents' decision to make, this proves that it is unnecessary and not covered. Medicaid also does not cover routine circumcision because it benefits only a small percentage of men, and because any benefits can be achieved for all men more effectively, more conservatively, and less expensively without it.

The article concludes that physicians and hospitals are liable to the Federal Government and the States for false Medicaid claims for circumcision, and that they face severe penalties per occurrence, while the Federal Government and the remaining States in turn are required by federal and State law to end coverage.

THE CONTROVERSY BETWEEN THE STATES

In 1949, a British physician wrote in a landmark study that routine circumcision is medically unnecessary, causes complications and deaths, and should not be performed.⁴ The article led the British National Health Service to end free coverage.⁵ Currently, Great Britain pays for circumcision only when necessary as a treatment of last resort for a small number of medical conditions.⁶ Canada also does not pay for routine infant circumcision,⁷ which is now rarely performed outside the United States⁸ except for religious reasons.⁹

As stated, in the United States, by contrast, the jointly federal and State funded *Medicaid Act*¹⁰ has been used to pay for routine infant circumcision since 1965. More than one million boys have been circumcised in America every year since 1965.¹¹ In 2003, circumcision was the most common medical procedure in American hospitals, and 29% of these surgical procedures were billed to Medicaid.¹² Accordingly, tens of millions of American boys have been circumcised under the Medicaid program.

⁴ Gairdner D, "The Fate of the Foreskin, a Study of Circumcision" (1949) 2 *BMJ* 1433.

⁵ Giannetti M, "Circumcision and the American Academy of Pediatrics: Should Scientific Misconduct Result in Trade Association Liability?" (2000) 85(4) *Iowa Law Review* 1507, fn 8.

⁶ British National Health Service website, <http://www.nhs.uk/Conditions/Circumcision/Pages/Introduction.aspx> viewed 2 February 2011.

⁷ Health Canada, *Canada Health Act Annual Report 2009-2010*: "[T]he following is a list of non-insured physician services: ... circumcision of newborns", <http://www.hc-sc.gc.ca/hcs-sss/pubs/cha-lcs/2010-cha-lcs-ar-ra/index-eng.php> viewed 19 March 2011.

⁸ And South Korea, where American soldiers were stationed.

⁹ World Health Organization, *Information Package on Male Circumcision and HIV Prevention, The Global Prevalence of Male Circumcision* (the major determinant is religion, although it is also performed for cultural reasons), http://www.who.int/hiv/pub/malecircumcision/infopack_en_2.pdf viewed 14 February 2011.

¹⁰ Title XIX of the *Social Security Act*, 42 USC § 1396s et seq.

¹¹ Although circumcision rates have been declining, more than one million boys were circumcised in 2010. See Bollinger D, "Lost Boys: An Estimate of US Circumcision-related Infant Deaths" (Spring 2010) 4(11) *Thymos: Journal of Boyhood Studies* 78. Calculation: 117 deaths, 9.01 deaths per 100,000 circumcisions = 1.3 million circumcisions.

¹² See below, text at nn 86-87.

Since 1982, however, especially since 2000, and most recently in 2011, 18 States have ended Medicaid funding of routine infant circumcision,¹³ either through legislation,¹⁴ including budget appropriations Bills,¹⁵ or by administrative action of Medicaid officials.¹⁶ North Carolina legislators, interviewed after their vote to end coverage, reasoned that circumcision is not medically necessary, and that, because of a budget shortfall, necessary services should take priority.¹⁷

Of the remaining 32 States, at least one, Texas, has taken the matter under advisement.¹⁸ New York State established a task force to reduce Medicaid costs, but although the most frequently made suggestion by the public was to end coverage of circumcision, the panel was visibly uncomfortable discussing the subject, and circumcision was removed from the list of possible cuts.¹⁹ The 10 State Medicaid offices that have replied to questions²⁰ have cited and relied upon the current, 1999 Circumcision Policy Statement of the American Academy of Pediatrics (AAP)²¹ that the decision should be left to parents, in consultation with their physicians,²² and that the procedure has potential benefits.²³ (Some States refer instead to, and sometimes list, “benefits” rather than “potential benefits”.) The AAP Policy Statement provides in relevant part:

The American Academy of Pediatrics believes that circumcision has potential medical benefits and advantages, as well as risks. The existing scientific evidence is not sufficient to recommend routine circumcision. Therefore, because the procedure is not essential to a child’s current well-being, we

¹³ “The 16 States that do not provide Medicaid coverage for male circumcision as of January 2009 were California, Oregon, North Dakota, Mississippi, Nevada, Washington, Missouri, Arizona, North Carolina, Montana, Utah, Florida, Maine, Louisiana, Idaho and Minnesota.” See “Circumcision Rates Lower in States Where Medicaid Does Not Cover Procedure”, *ScienceDaily* (27 January 2009), <http://www.sciencedaily.com/releases/2009/01/090128092346.htm> viewed 14 February 2011. The 17th and 18th States, South Carolina and Colorado, ended coverage in 2011. From 2005 to 2009, Tennessee regulation 1200-13-1-.03(gg) provided: “Routine newborn circumcision is not covered under any circumstances.” See eg http://www.tennessee.gov/sos/rules_archived/1200/1200-13/1200-13-01.20050701.pdf viewed 4 March 2011, but according to the Tennessee Medicaid office, the rule is no longer in effect: letter to P Fadel (28 February 2011).

¹⁴ See eg *Arizona Revised Statutes Annotated*, § 36-2907(B)(1): “Beginning on October 1, 2002, circumcision of newborn males is not a covered health and medical service”; and *Minnesota Statutes Annotated* § 256B.0625, Covered services, Subd 3f: “Circumcision is not covered, unless the procedure is medically necessary.”

¹⁵ California (1982), Arizona (2002), North Carolina (2002), Florida (2003), Utah (2003), Maine (2004), Idaho (2005) and Minnesota (2005). Email from Jeff Brown, 4 January 2011.

¹⁶ Missouri (2002), Montana (2002), Louisiana (2005) and South Carolina (2010). South Carolina became the 17th State to end coverage of routine infant circumcision, by means of a letter from the Deputy Director of Medical Services. See <http://www.4eric.org/south-carolina-to-end-medicaid-funding-of-ric> viewed 23 January 2011.

¹⁷ North Carolina ended Medicaid coverage of routine infant circumcision in 2002. “Legislators say they eliminated the circumcision part of Medicaid for two reasons: Increasingly, doctors’ groups have said the procedure is not medically necessary. And because of a budget crunch, necessary services had to be prioritized.” See Stobbe M, “Circumcision Funding Halted”, *Charlotte Observer* (21 September 2002).

¹⁸ On 10 January 2001, a Texas Medicaid official wrote to P Fadel: “Texas currently covers routine neonatal and infant circumcisions . . . As a result of your letter, I will work with my staff to review the Texas Medicaid policy and determine whether to make changes to the current benefit.”

¹⁹ See eg Gershman J, “Cuomo Criticized Over Medicaid Team”, *Wall Street Journal* (7 January 2011), <http://www.nypr.org/e-news-bulletins/2011/2011-01-10-WSJ-Cuomo-Criticized-Over-Medicaid-Team.cfm> viewed 9 February 2011. Among 274 ideas under consideration, the most frequent recommendation was to end routine infant circumcision: see <http://www.crainsnewyork.com/article/20110210/PULSE/110209858> viewed 14 February 2011. However, the chairman of a panel was dismissive of the idea, http://www.youtube.com/watch?v=9rb_Motw8eA, and it is no longer on the list of possible cuts: see http://www.nyhealth.gov/health_care/medicaid/redesign/docs/approved_proposals.pdf viewed 4 March 2011.

²⁰ Replies by email to P Fadel in 2011, available from the author.

²¹ American Academy of Pediatrics, Task Force on Circumcision, “Circumcision Policy Statement” (1999) 103 *Pediatrics* 686 (AAP Policy Statement), <http://www.aappolicy.aappublications.org/cgi/reprint/pediatrics;103/3/686.pdf> viewed 4 March 2011.

²² For example, the chief Massachusetts Medicaid official wrote that coverage would remain in effect, and quoted the current Circumcision Policy Statement of the American Academy of Pediatrics. Kentucky’s Medicaid office replied, “[T]he procedure should remain an elective benefit to Kentucky’s Medicaid recipients. Allowing parents and providers to make a determination about whether or not to perform the procedure is the best course of action.” Letter from the Acting Commissioner to P Fadel (14 January 2011).

²³ See eg letter from a Pennsylvania Medicaid official dated 9 February 2011, listing “potential benefits” as a reason.

recommend the decision to circumcise is one best made by parents in consultation with their pediatrician, taking into account what is in the best interests of the child, including medical, religious, cultural, and ethnic traditions.

The following reply by the Wisconsin Medicaid office is typical:

At this time, the Department has decided to continue coverage of routine neonatal circumcision. Research indicates that neonatal circumcision can offer certain medical benefits, such as decreased risk of both urinary tract infections and sexually transmitted diseases ... Consistent with the recommendation of the American Academy of Pediatrics, the Department allows parents to determine what is best for their child after weighing the benefits and risks of this procedure.²⁴

Other Medicaid officials have reasoned that routine infant circumcision is a standard medical practice, that they rely upon physicians and the medical profession, and that the issue should not be decided arbitrarily by a payer agency.²⁵ Another official relied upon the fact that his State legislature did not pass a Bill in 2003 that would have ended coverage.²⁶ Other officials have stated that it would be discriminatory not to make any benefits of circumcision available to Medicaid recipients who cannot afford to pay themselves.²⁷

As one Medicaid official has noted, State Medicaid programs have struggled with this issue.²⁸ In North Carolina, eg, the legislature voted to end coverage in 2001. More physicians supported the law than opposed it, but medical organisations pressed to renew coverage, made campaign donations, and the law was quietly rescinded.²⁹ Then the legislature ended coverage again.³⁰ From 2005 to 2009, Tennessee's Medicaid rules excluded routine newborn circumcision "under any circumstances",³¹ but currently it is covered again.³² In Colorado in 2011, Medicaid officials debated both sides of the issue. A proposal was made to cover circumcision only when medically necessary; then a proposal was made to cover it when medically necessary or "alternatively, if ordered by the physician for prevention of

²⁴ Letter from Wisconsin Medicaid Director to P Fadel (28 February 2011).

²⁵ In a letter to P Fadel (10 January 2011), a nurse in Kentucky replied, in part, that circumcision is controversial, and that "The medical efficacy and appropriateness of the procedure should be a subject for debate within the medical community as opposed to an issue which should be decided arbitrarily by a payer agency. In general, the Medicaid Program relies upon expertise of the medical profession in such matters."

²⁶ Letter from Virginia Medicaid official to P Fadel (26 January 2011): "It is currently the policy of the Virginia Department of Medical Assistance Services (DMAS) to reimburse providers for performing newborn male circumcisions. The Virginia General Assembly considered several Bills during its 2003 session that would have limited Medicaid coverage of circumcisions. None of these Bills passed, and the General Assembly has not revisited this issue. For this reason, DMAS has no immediate plans to alter its policy of covering these procedures."

²⁷ Letter from Pennsylvania Medicaid Office to P Fadel (9 February 2011).

²⁸ Comment of Annie Lee, minutes of a meeting of the Department of Health Care Policy and Financing in Colorado (23 July 2010), <http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application/pdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251658702729&ssbinary=true> viewed 7 August 2011.

²⁹ See Gathercole R, "Making the Cut", *Independent Weekly* (Raleigh, NC) (12 June 2002), <http://www.cirp.org/news/independentweekly06-12-02> viewed 18 March 2011.

³⁰ See North Carolina Department of Health and Human Services, Division of Medical Assistance, Clinical Coverage Policy No 1A-22, Medically Necessary Circumcision, stating that Medicaid only covers circumcision when medically necessary; consistent with symptoms or confirmed diagnosis of the illness or injury under treatment; the procedure can be safely furnished; no equally effective and more conservative or less costly treatment is available statewide; and the procedure is furnished in a manner not primarily intended for the convenience or non-medically indicated desire of the recipient, the recipient's caretaker, or the provider. "The conditions justifying medical necessity are extremely rare" and are subject to individual review: <http://www.ncdhhs.gov/dma/mp/1A22.pdf> viewed 19 March 2011.

³¹ Rules of Tennessee Department of Finance and Administration, Bureau of TennCare, Rule 1200-13-1-.03: "(gg) Medically necessary circumcision will be covered only on an outpatient basis ... Routine newborn circumcision is not covered under any circumstances." See also Rule 1200-13-1-.07, Medicaid Exclusions: "(1) Medicaid will not provide or pay for: (a) Provision of medical assistance which is not medically necessary or justified ... (u) Routine newborn circumcision." See http://www.tennessee.gov/sos/rules_archived/1200/1200-13/1200-13-01.20050701.pdf viewed 19 March 2011. In 2003, subs (gg) remained in effect. See <http://www.tennessee.gov/sos/rules/1200/1200-13/1200-13-01.20090719.pdf> viewed 19 March 2011.

³² See <http://www.tennessee.gov/tenncare/forms/quickguide.pdf>, citing Tennessee Rules 1200-13-13-.04 and 1200-13-14-.04.

infectious disease". In 2011, Colorado decided to end coverage.³³ Thus, States have given a variety of policy reasons for continuing and for ending coverage.

THE FACTS

Circumcision is non-therapeutic, elective, unnecessary surgery on the normal genitalia of healthy newborn boys

Circumcision may have begun as long as 15,000 years ago as a ritual sacrifice to the gods.³⁴ More than 2,000 years ago, it became a sacred Jewish sacrificial ritual.³⁵ Thus, for thousands of years, it was performed for non-medical reasons. From 1865 to 1915, physicians claimed that it cured a long list of diseases, including impotence and other sexual problems, epilepsy, nightmares, and "excess masturbation", but they were mistaken.³⁶

The male and female genitalia, including the "prepuce" (the male foreskin and female clitoral hood) have evolved over 65 to 100 million years,³⁷ and, of course, are normal. No medical opinion is needed to prove that it is unnecessary to remove boys' foreskins or other healthy body parts. Most men who have ever lived have been intact, with no ill effects. In addition, intact men virtually never ask to be circumcised,³⁸ showing that they do not need to be.

Physicians agree. The non-profit Doctors Opposing Circumcision has written that infant boys are born with healthy genitalia, free of disease, and that circumcision is never clinically indicated for them.³⁹ The American Medical Association (AMA) wrote in its only circumcision policy statement, in 1999,⁴⁰ that circumcision removes the foreskin from the "normal penis". The AAP Policy Statement provides: "*Should circumcision become necessary* after the newborn period because problems have developed ...",⁴¹ meaning that it is not necessary during the newborn period, or thereafter unless problems develop. The AAP and AMA reports both state that "the procedure is not essential to the child's current well-being", again meaning that it is not necessary. Both reports call circumcision "elective", meaning "not required or necessary". They also call it "non-therapeutic".

The Canadian Paediatric Society states, "circumcision is a 'non-therapeutic' procedure, which means it is not medically necessary".⁴² The Canadian Paediatric Society also states, and the AMA Report and Federal Government agree,⁴³ that "[p]arents who decide to circumcise their newborns

³³ The Colorado Medicaid office drafted a policy to end coverage of routine infant circumcision unless medically necessary. The Department of Health Care Policy and Financing debated the issue. Some officials argued that parents should make the decision, that routine infant circumcision has potential benefits, and that ending coverage was potentially discriminatory. Others argued that the clinical evidence does not support the "benefits" argument, and that "patient preference is not an adequate test for a benefit from a governmental agency". See <http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application/pdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251658702729&ssbinary=true> viewed 7 August 2011. On 20 September 2010, the Colorado Medicaid office proposed to continue coverage: see <http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application/pdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251658692563&ssbinary=true> viewed 7 August 2011. Effective 1 July 2011, Colorado eliminated Medicaid coverage of circumcision. See *Colorado Government Provider Bulletin*, Reference B1100302 (June 2011).

³⁴ Dunsmuir W and Gordon EM, "The History of Circumcision" (1999) 83(S1) *BJU International* 1 at 1-2.

³⁵ Gairdner, n 4; Dunsmuir and Gordon, n 34, Fig 2.

³⁶ Dunsmuir and Gordon, n 34 at 4.

³⁷ Cold CJ and Taylor JR, "The Prepuce" (1999) 83(S1) *BJU International* 34.

³⁸ Bollinger D: personal communication to Attorney Steven Svoboda (26 February 2010).

³⁹ Letter from Doctors Opposing Circumcision to Massachusetts and Other Medicaid Officials (January 2011).

⁴⁰ American Medical Association, *Report 10 of the Council on Scientific Affairs* (1999) (AMA Report), <http://www.ama-assn.org/resources/doc/csaph/csai-99.pdf> viewed 18 October 2011.

⁴¹ AAP Policy Statement, n 21 at 688 (emphasis added).

⁴² Canadian Paediatric Society, *Circumcision: Information for Parents* (November 2004), <http://www.caringforkids.cps.ca/pregnancybabies/Circumcision.htm> viewed 19 March 2010.

⁴³ AMA Report, n 40.

often do so for religious, social or cultural reasons”;⁴⁴ that is to say, not for medical reasons. In addition, the federal hospital admission code for elective circumcision, which physicians use, is ICD-9-CM V50.2. Code V50 is defined as “Elective surgery for purposes other than remedying health states”, while V50.2 is defined as, “Routine or ritual circumcision” and “circumcision in the absence of significant medical indication”.⁴⁵

Finally, no medical association in the world recommends the procedure,⁴⁶ while some condemn it.⁴⁷ If it were necessary, they would all have to recommend it, for all men as well as for all boys. In short, the Federal Government and American medical associations acknowledge the obvious, that neonatal circumcision is not medically necessary.

Circumcision is also painful, risky and harmful

Both the AAP Policy Statement and the AMA Report state that anaesthetics should be used for infant circumcision,⁴⁸ although, according to the AMA in 1999, 45% of physicians do not do so.⁴⁹ Studies show that it causes excruciating pain to infants,⁵⁰ especially as the foreskin is fused to the glans at birth, and the two must be torn apart.

The AMA Report states that cutting boys’ genitals poses serious risks, which include bleeding, infection, necrosis, sepsis, meningitis, and partial amputation of the glans penis.⁵¹ The AMA fails to mention choking,⁵² complete amputation of the glans penis or the entire penis,⁵³ herpes,⁵⁴ gangrene,⁵⁵ gastric rupture,⁵⁶ heart damage,⁵⁷ shock,⁵⁸ coma⁵⁹ and death.⁶⁰ A 2010 study found that approximately

⁴⁴ Canadian Paediatric Society, n 42.

⁴⁵ Admissions codes, [http://www.icd9data.com/2011/Volume2/A/Admission-\(encounter\).htm](http://www.icd9data.com/2011/Volume2/A/Admission-(encounter).htm) viewed 2 February 2011.

⁴⁶ The conclusion of the AAP and AMA policy statements is that the scientific evidence and data “are not sufficient to recommend routine neonatal circumcision”, meaning that they do not recommend it. See AAP Policy Statement, n 21, and AMA Report, n 40.

⁴⁷ For example, the Royal Dutch Medical Association calls circumcision a “painful and harmful ritual” and a violation of children’s rights, and discourages the practice in The Netherlands: “Dutch Doctors Urge End to Male Circumcision” (23 September 2011), see <http://www.reuters.com/article/2011/09/23/us-dutch-circumcision-health-idUSTRE78M3R620110923> viewed 18 October 2011.

⁴⁸ See AAP Policy Statement, n 21; and AMA Report, n 40.

⁴⁹ “Based on 35 clinical trials involving 1,997 newborns, it can be concluded that DPNB and EMLA do not eliminate circumcision pain”: Brady-Fryer B, Wiebe N and Lander JA, “Pain Relief for Neonatal Circumcision” (2004) 4 *Cochrane Database of Systematic Reviews*, Art No CD004217. DOI 10.1002/14651858.CD004217.pub2.

⁵⁰ “There is no doubt that circumcisions are painful for the baby. Indeed, circumcision has become a model for the analysis of pain and stress responses in the newborn. Not only does the unanesthetized newborn cry vigorously, tremble, and, in some cases, become mildly cyanotic because of prolonged crying, but other stress-related physiological reactions have also been demonstrated, including dramatic changes in heart and respiratory rates and in transcutaneous oxygen and plasma cortisol levels.” See Stang HJ et al, “Local Anesthesia for Neonatal Circumcision” (1988) 259 *JAMA* 1507.

⁵¹ AMA Report, n 40.

⁵² Lander J et al, “Comparison of Ring Block, Dorsal Penile Nerve Block, and Topical Anesthesia for Neonatal Circumcision” (1997) 278 *JAMA* 2158.

⁵³ Touloukian R (ed), *Pediatric Trauma* (John Wiley & Sons, New York, 1978).

⁵⁴ Gesundheit B et al, “Neonatal Genital Herpes Simplex Virus Type 1 Infection After Jewish Ritual Circumcision: Modern Medicine and Religious Tradition” (2004) 114(2) *Pediatrics* E259.

⁵⁵ *Doctors Opposing Circumcision*, <http://www.doctorsopposingcircumcision.org/info/foreskin.html> viewed 18 October 2011.

⁵⁶ Connelly KP, Shropshire LC and Salzberg A, “Gastric Rupture Associated with Prolonged Crying in a Newborn Undergoing Circumcision” (1992) 31 *Clin Pediatr* 560.

⁵⁷ Ruff ML, Clarke TA, Harris JP, Bartels EK and Rosenzweig M, “Myocardial Injury Following Immediate Postnatal Circumcision” (1978) 144 *Am J Obstet Gynecol* 850.

⁵⁸ *Doctors Opposing Circumcision*, n 55.

⁵⁹ *Doctors Opposing Circumcision*, http://www.doctorsopposingcircumcision.org/DOC/circumcision_quiz.htm viewed 18 October 2011.

117 neonatal circumcision deaths occur annually in the United States (9.01 per 100,000 boys).⁶¹ In addition, four studies estimate that after circumcision, additional revision surgery is required for between 1% and 9.5% of cases,⁶² surgery which is often funded by Medicaid. Researchers at Harvard's Massachusetts General Hospital confirmed that complications are common: they found that 4.7% of its operations on children from 2003 to 2007, and 7.4% of its cases at a paediatric urology outpatient clinic, resulted from complications of a previous neonatal circumcision.⁶³

Research also shows that circumcision harms all men. It removes 15 square inches or more of penile covering in the adult,⁶⁴ and thus deforms the normal penis. It damages circulation, causes nerve damage⁶⁵ and changes in the brain,⁶⁶ and increases overall sensitivity to pain, possibly for life.⁶⁷ It reduces the length of the flaccid penis by 3/8th of an inch,⁶⁸ and of the erect penis by 5/16th of an inch, as well as its width, and thus is penile reduction surgery. It pits the coronal ridge, leaves the penis hanging at a wider angle, and often reduces the size of the urethral opening, which can split the urinary stream.⁶⁹ In addition, the healthy glans becomes calloused and turns gray, and the surgery leaves a scar. Van Howe lists the various complications caused by circumcision.⁷⁰ The surgery also sometimes causes psychological harm (eg, regret by and conflict among parents, anger in men, and anger at their parents), and some claim that it causes post-traumatic stress disorder.⁷¹

Research in 1999 also showed that circumcision removes the most sensitive parts of the penis.⁷² Since 1980, researchers have known that circumcision impairs sexual function as well. In the intact male, the moist and elastic foreskin can move with minimal effort, and essentially without friction, to and fro over the glans and down the penile shaft, known as the "gliding action".⁷³ Hill and Taylor found that this stimulates fine touch receptors, and generates highly pleasurable erotic sensations.⁷⁴ Circumcision permanently separates the foreskin from the glans, preventing normal masturbation, foreplay and intercourse. The "sheath within a sheath" nature of the intact penis in sexual intercourse is reportedly more pleasurable for female partners as well.⁷⁵ In short, circumcision impairs sexual sensitivity and function.

⁶⁰ Gairdner, n 4.

⁶¹ Bollinger, n 11 at 78-90.

⁶² Van Howe RS, "A Cost-utility Analysis of Neonatal Circumcision" (2004) 24 *Medical Decision Making* 584.

⁶³ Pieretti RV et al, "Late Complications of Newborn Circumcision: A Common and Avoidable Problem" (2010) 26(5) *Pediatric Surgery International* 515, <http://www.springerlink.com/content/9w834626551u8087> viewed 26 June 2010.

⁶⁴ See CIRP, <http://www.cirp.org/library/anatomy>, citing medical research.

⁶⁵ Fitzgerald M, "The Birth of Pain" (Summer 1998) *MRC News* 20 (London).

⁶⁶ Fitzgerald M and Walker S, "The Role of Activity in Developing Pain Pathways" (2003) 24 *Proceedings of the 10th World Congress on Pain. Progress in Pain Research and Management* 185.

⁶⁷ Taddio A et al, "Effect of Neonatal Circumcision on Pain Response During Subsequent Routine Vaccination" (1997) 349 (9052) *Lancet* 599. See also Porter F et al, "Long-term Effects of Pain in Infants" (1999) 20(4) *J Dev Behav Pediatr* 253.

⁶⁸ Fletcher C, Presentation at 11th International Symposium on Circumcision, Genital Integrity and Human Rights, Berkeley, CA, 29-31 July 2010.

⁶⁹ Fletcher, n 68.

⁷⁰ Van Howe, n 62, Table 1 and medical citations.

⁷¹ See generally Goldman R, *Circumcision: The Hidden Trauma* (Vanguard Publications, Boston, 1997).

⁷² Sorrells ML, Snyder JL, Reiss MD et al, "Fine-touch Pressure Thresholds in the Adult Penis" (2007) 99 *BJU International* 864. The authors also state: "When compared to the most sensitive area of the circumcised penis, several locations on the uncircumcised penis (the rim of the preputial orifice, dorsal and ventral, the frenulum near the ridged band, and the frenulum at the muco-cutaneous junction) that are missing from the circumcised penis were significantly more sensitive."

⁷³ Lakshmanan S and Prakash S, "Human Prepuce: Some Aspects of Structure and Function" (1980) 44 *Indian J Surg* 134.

⁷⁴ See Hill G, "Foreskin Motion Generates Meissner Corpuscle Stimulation" (16 December 2003) *BMJ Rapid Response*; Taylor JR, "Fine Touch Pressure Thresholds in the Adult Penis" (2007) 100(1) *BJU International* 218.

⁷⁵ O'Hara K and O'Hara J, "The Effect of Male Circumcision on the Sexual Enjoyment of the Female Partner" (1999) 83(S1) *BJU International* 79. See also Sorrells et al, n 72. This likely causes dissatisfaction between American men and their partners.

Circumcision does not benefit most men, and any benefits can be achieved easily and inexpensively without it

There is debate among medical researchers as to whether circumcision benefits anyone.⁷⁶ In any event, American medical associations do not claim (as some Medicaid officials write) that it prevents urinary tract infections, cancer of the penis or sexually transmitted diseases, including HIV. Importantly, they do not refer to “benefits”, but to “potential benefits” or reduced risks.

For example, as to penile cancer, the AMA Report⁷⁷ states that approximately 100,000 circumcisions would need to be performed to prevent one case of cancer of the penis. The remaining 99,999 boys and men would derive no benefit in that regard. Cancer of the penis also is rare, occurs late in life, and intact men who wash their penises are at no higher risk of it than circumcised men.⁷⁸ The AMA Report concludes that using circumcision as a preventive practice for penile cancer is not justified, while the American Cancer Society has written to the AAP that the belief that circumcision prevents cancer of the penis is mistaken.⁷⁹

Likewise, as to HIV and other sexually transmitted diseases, the AMA Report concludes that “behavioral factors are far more important risk factors for acquisition of HIV and other sexually transmissible diseases than circumcision status, and *circumcision cannot be responsibly viewed as ‘protecting’ against such infections*”.⁸⁰ Circumcision does not prevent HIV/AIDS, while abstinence, monogamy, and safe sex do.

As to urinary tract infections, the AMA states that approximately 100 to 200 circumcisions would need to be performed to prevent one urinary tract infection,⁸¹ which could be treated with antibiotics.

The AMA Report and the AAP Policy Statement both conclude that although circumcision has potential medical benefits, “these data are not sufficient to recommend routine neonatal circumcision”.⁸²

Circumcision is expensive, especially when hidden costs are considered

In 2004, Van Howe undertook a cost-utility analysis of neonatal circumcision.⁸³ He determined that US\$4.75 million (US\$5.5 million in current dollars)⁸⁴ must be spent on circumcision to prevent a single case of HIV, US\$1.42 million (US\$1.64 million today) to prevent a single case of penile cancer, and US\$69,000 (US\$80,000 today) to prevent a single urinary tract infection. He also found that “penile cancer and urinary tract infections played only a small role in total financial analysis because *more common penile problems [caused by circumcision] had a much larger impact*”.⁸⁵ He concluded

⁷⁶ For example, although the AAP Policy Statement and the AMA Report claim a lower rate of urinary tract infections among the circumcised, other researchers report the opposite. See Van Howe, n 62; Van Howe RS, “Effect of Confounding in the Association Between Circumcision Status and Urinary Tract Infection” (2005) 51(1) J Infect 59, <http://www.ncbi.nlm.nih.gov/pubmed/15979493> viewed 18 October 2011; see also Prais D, Shoov-Furman R and Amir J, “Is Ritual Circumcision a Risk Factor for Neonatal Urinary Tract Infections?” (6 October 2008) *Archives of Diseases in Childhood* doi:10.1136/adc.2008.144063. As to sexually transmitted diseases, Van Howe, n 62, states: “Overall, circumcised men may have a greater number of sexually transmitted diseases.” Gisselquist argues that many cases of HIV in Africa are blood-borne: Gisselquist D, *Points to Consider: Responses to HIV/AIDS in Africa, Asia, and the Caribbean* (Adonis & Abbey, London, 2007). The author also hypothesises that circumcised men, having lost sensitivity, and perhaps believing that they are protected against HIV, may be less likely to use condoms and otherwise to practise safe sex.

⁷⁷ See above, n 40.

⁷⁸ Frisch M, Friis S, Kjaer SK and Melbye M., “Falling Incidence of Penis Cancer in an Uncircumcised Population (Denmark 1943–90)” (1995) 311 BMJ 1471.

⁷⁹ Letter from American Cancer Society to American Academy of Pediatrics (16 February 1991).

⁸⁰ AMA Report, n 40 (emphasis added).

⁸¹ AMA Report, n 40.

⁸² AMA Report, n 40; AAP Policy Statement, n 21 at 686.

⁸³ Van Howe, n 62.

⁸⁴ See <http://www.usinflationcalculator.com/inflation/current-inflation-rates> viewed 7 August 2011.

⁸⁵ Van Howe, n 62, sentence preceding Table 7.

that the cost of routine infant circumcision far exceeds the savings from any benefits, and that it would not be cost-effective even if it were cost-free, pain-free and without complications. He concluded that it cannot be justified financially (or medically).

In a nationwide survey of Medicaid funding for circumcision in 2003,⁸⁶ researchers determined that Medicaid funded 351,548 or 29% of 1.2 million circumcisions in America, at an approximate cost of US\$443 million per year, or US\$528 million per year currently.⁸⁷ This calculation includes the physicians' fee, longer hospital stays, circumcision repairs, and other incremental costs determined by Van Howe in his cost-utility analysis.⁸⁸ Even excluding lengthier hospital stays and incremental expenses, routine infant circumcision has cost the Federal and State Governments, and ultimately taxpayers, at a minimum, tens of billions of dollars since 1965.

THE LAW

Medicaid only covers surgery when necessary, as a last resort, to treat diagnosed medical conditions

All medical services must be necessary

The United States Supreme Court has stated repeatedly, citing the federal Medicaid statute, that Medicaid's objective is to enable each State to meet the costs of *necessary medical services* for individuals whose income and resources are insufficient.⁸⁹ All services under the Medicaid program must be medically necessary.⁹⁰ Federal regulations also require physicians to show evidence of medical necessity for all services provided.⁹¹ Since "federal law stands as the supreme law of the land, the State's courts are obliged to enforce it".⁹²

The federal *Medicaid Act* also requires State laws to specify that only medically necessary services are covered. Searching for the words "Medicaid" and "medically necessary" in all State statutes yielded 466 results. To cite three examples:

- Texas regulations provide that "Medicaid services or supplies that are not medically necessary will not be considered for Medicaid reimbursement".⁹³
- Tennessee regulations provide that Medicaid will not pay for "services that fail fully to satisfy all criteria of 'medically necessary'".⁹⁴
- Colorado excludes "Services or articles not medically necessary".⁹⁵

⁸⁶ Bollinger D, Craig A, Cruz R, Hill G and Svoboda J, "Of Waste and Want: A Nationwide Survey of Medicaid Funding for Medically Unnecessary, Non-therapeutic Circumcision" in Denniston GC, Gallo PG, Hodges FM and Milos MF (eds), *Bodily Integrity and the Politics of Circumcision: Culture, Controversy, and Change* (Springer, New York, 2006) pp 233-246.

⁸⁷ See Inflation Calculator for 2005 to 2011, <http://www.usinflationcalculator.com/inflation/current-inflation-rates> viewed 7 August 2011.

⁸⁸ Van Howe, n 62.

⁸⁹ *Schweiker v Hogan* 457 US 569 at 573 (1982), citing 42 USC 42 USC § 1396a(a)(10)(C); *Beal v Doe* 432 US 438 (1977) (emphasis added).

⁹⁰ See 42 USC § 1396 et seq (practitioners must furnish only medically necessary care); and 42 CFR § 456.1; CHMS Manual, § 142 (8) ("All services provided must be based on medical necessity.")

⁹¹ See 42 USC § 1320c-5, subs (3): "It shall be the obligation of any health care practitioner and any other person (including a hospital or other health care facility, organization, or agency) who provides health care services for which payment may be made (in whole or in part) under this chapter, to assure, to the extent of his authority that services or items ordered or provided by such practitioner or person to beneficiaries and recipients under this chapter - ... (3) will be supported by evidence of medical necessity and quality in such form and fashion and at such time as may reasonably be required by a reviewing peer review organization in the exercise of its duties and responsibilities."

⁹² *Employees of Dept of Public Health and Welfare Mo* 411 US 279 at 298 (1973).

⁹³ 1 TX ADC § 354.1149(a).

⁹⁴ Tennessee ADC 1200-13-14-.01(78), Definitions, "Medically Necessary".

⁹⁵ CRSA § 10-8-527(1)(g).

Many States further define “medically necessary”, and thus construe it more narrowly than federal law. In Guam, eg, which is subject to the *Medicaid Act*, the treatment “must be certain to save lives or significantly alter an adverse prognosis”.⁹⁶

Physicians must diagnose a medical condition and recommend a treatment

Under federal regulations, federal utilisation and quality control organisations also must determine “[w]hether these services are or were *reasonable* and medically necessary for the *diagnosis and treatment of illness or injury* or to *improve the functioning of a malformed body member*”, and whether the hospital has provided valid diagnostic information.⁹⁷ The *Medicaid Act* also “provide[s] federal financial assistance to States that choose to reimburse certain costs of *medical treatment for needy persons*”.⁹⁸

Likewise among the States, in New York “medically necessary” means “necessary to prevent, diagnose, correct or cure *conditions in the person*”.⁹⁹ In South Carolina, covered services include “inpatient hospital services ... for the care and *treatment of illness, injuries or disabilities* certified medically necessary by a physician”.¹⁰⁰ Nebraska regulations similarly provide that its Medicaid agency “does not cover items and services which are not reasonable and necessary for the *diagnosis and treatment of illness or injury*, or to improve the function of a *malformed body member*”.¹⁰¹ Likewise, in Massachusetts, services must be

reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure *conditions* in the MassHealth member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity.¹⁰²

A Mississippi Appeals Court has written similarly, although not in the context of Medicaid:

Surgery deals with the diagnosis and treatment of injury, deformity, and disease through an operation or procedure. A patient sees a surgeon because there is the need for an invasive procedure. The patient comes to the surgeon, through a referral or emergency room admission, and the surgeon determines whether a surgical procedure is medically necessary.¹⁰³

In short, under both State and federal law, physicians can only provide medical services under the Medicaid program that they recommend to treat diagnosed medical conditions, and that are reasonable and necessary.

Medicaid does not cover cosmetic surgery, except to treat defects

A medical dictionary defines “cosmetic surgery” as “surgery that modifies or improves the appearance of a physical feature, irregularity, or defect”.¹⁰⁴ An English dictionary defines it as “surgery performed to improve the appearance, rather than for medical reasons”.¹⁰⁵ Massachusetts regulations similarly define cosmetic surgery as “a surgical procedure that is performed for the exclusive purpose of altering appearance and is unrelated to physical disease or defect, or traumatic injury”.¹⁰⁶ Circumcision is performed to change the appearance of the normal penis, usually for religious, cultural or personal

⁹⁶ Guam Statutes T 10, § 2903.

⁹⁷ 42 CFR § 476.71(a)(1) (emphasis added).

⁹⁸ *Harris v McRae* 448 US 297 at 297 (1980) (emphasis added).

⁹⁹ *McKinney’s Consolidated Laws of New York Annotated*, Social Services Law, § 365-a (emphasis added).

¹⁰⁰ SC Code R § 126-310 (emphasis added).

¹⁰¹ 471 Nebraska ADC Ch 10, § 00410-004.04 (emphasis added).

¹⁰² 130 Mass CFR § 450.204 (emphasis added).

¹⁰³ *Meeks v Miller* 956 So 2d 942 at 947 (2006).

¹⁰⁴ The American Heritage® *Stedman’s Medical Dictionary*, http://www.dictionary.reference.com/browse/cosmetic_surgery viewed 10 March 2011.

¹⁰⁵ *Collins English Dictionary* (complete & unabridged 10th edition), http://www.dictionary.reference.com/browse/cosmetic_surgery viewed 10 March 2011.

¹⁰⁶ 130 MA ADC 433.401.

reasons, and never to remedy any defect. The AMA Report states that the primary justification parents give is the desire of parents that the son “look like the father”,¹⁰⁷ a purely cosmetic reason. Non-therapeutic circumcision meets these definitions of, and is, cosmetic surgery.

Most States, such as Alabama,¹⁰⁸ Indiana,¹⁰⁹ Massachusetts,¹¹⁰ Nebraska,¹¹¹ New Jersey,¹¹² Tennessee¹¹³ and Texas,¹¹⁴ to cite a few examples, expressly exclude cosmetic surgery from Medicaid coverage, except when necessary to improve the function of a malformed member.¹¹⁵ In Massachusetts, eg, Medicaid “does not pay a physician for performing ... any experimental, unproven, cosmetic, or otherwise medically unnecessary procedure or treatment”.¹¹⁶

In *Beal v Doe* 432 US 438 at 438 (1977), the United States Supreme Court upheld Pennsylvania’s refusal to cover non-therapeutic abortions. The court stated: “[I]t is hardly inconsistent with the objectives of the Act for a State to *refuse to fund unnecessary though perhaps desirable medical services*” (emphasis added). In short, Medicaid does not cover cosmetic surgery for several reasons: it is expressly excluded by statute; it is unnecessary; it does not treat a defect; and even if circumcision were desirable, merely desirable services are not covered.

The most conservative and economical treatment must be used

In addition, pursuant to 42 USC § 1320c-5 of the *Medicaid Act*, physicians and hospitals must ensure that Medicaid services are “*provided economically and only when, and to the extent, medically necessary*” (emphasis added). Accordingly, medical services cannot be provided to newborns or others because they might become necessary for some or even all of them, in the future. Federal regulations also require federal utilisation and quality control organisations to determine:

(3) Whether those services furnished ... on an inpatient basis *could ... be effectively furnished more economically on an outpatient basis*

... and

(6) The medical necessity, *reasonableness* and *appropriateness* of hospital admissions.¹¹⁷

The efficiency, economy and utilisation control mandates are designed to benefit the Medicaid program, not its beneficiaries or providers.¹¹⁸ 42 USC § 1396a(a)(30)(A) also requires the States “to assure that payments are consistent with *efficiency [and] economy*” (emphasis added).

Likewise among the States, in Rhode Island, eg, medical services are not necessary or covered if they are “*more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results*”.¹¹⁹ In Idaho, a service is medically necessary only if “[t]here is no other equally *effective course of treatment* available or suitable for the participant

¹⁰⁷ AMA Report, n 40.

¹⁰⁸ Alabama Administrative Code 420-5-6-.04(4).

¹⁰⁹ Cosmetic surgery is not covered “unless provided as a result of an injury or medically necessary surgical procedure”. See IC 27-8-10-3(f)(2).

¹¹⁰ Commonwealth of Massachusetts, MassHealth Provider Manual Series, Physician Manual, 130 CMR 433.000, http://www.mass.gov/Eeohhs2/docs/masshealth/regs_provider/regs_physician.pdf viewed 11 February 2011.

¹¹¹ 471 NE ADC Ch 10, § 010.11D.

¹¹² NJ ADC 10:74-3.13.

¹¹³ TN ADC 1200-13-13-.10, Exclusions, 21.

¹¹⁴ 1 TX ADC § 354.1149(a)(8).

¹¹⁵ 1 TX ADC § 354.1149(a)(8); TN ADC 1200-13-13-.10, Exclusions, 21.

¹¹⁶ Commonwealth of Massachusetts, n 110.

¹¹⁷ 42 CFR § 476.71 (a)(1) (emphasis added).

¹¹⁸ *Burlington United Methodist Family Services Inc v Atkins* 227 F Supp 2d 593 at 596 (2002).

¹¹⁹ 2010 Rhode Island government research report comparing the definitions of “medically necessary” in New York, Massachusetts and Rhode Island (emphasis added): see <http://www.cga.ct.gov/2010/rpt/2010-R-0010.htm> viewed 19 March 2011.

requesting the service which is *more conservative or substantially less costly*.¹²⁰ Massachusetts defines a service as medically necessary only if “there is *no other medical service ... that is more conservative or less costly*”.¹²¹ The State covers breast reduction surgery, eg, only when a physician documents that “*prior treatments have been tried and have not been effective in managing medical symptoms*”.¹²² Massachusetts also prohibits unnecessary hospital admissions.¹²³ Connecticut law requires that services be “demonstrated through scientific evidence to be *safe and effective*”.¹²⁴ Thus, surgery is only covered when it is likely to be effective, and when no more conservative or less costly treatment options are available. That is to say, circumcision is covered by Medicaid, as in Great Britain, only when other treatments have failed, and it is the last resort.

Summary

Tennessee has a comprehensive definition of medical necessity which encapsulates federal Medicaid law and the laws of many other States. Specifically, in Tennessee, a qualified person must have a medical condition, and there must be a diagnosis, a treatment plan, and a physician’s recommendation that the treatment is necessary. The convenience of the enrollee’s family is not a factor or justification. The treatment must be safe and effective. It cannot be experimental, but must be based on empirically based, objective clinical or scientific evidence. The reasonably anticipated medical benefits of treatment must outweigh the reasonably anticipated medical risks based on the enrollee’s condition and scientifically supported evidence. The least costly treatment must be used: inpatient services cannot be provided when the same service can be provided in a less costly or alternative setting. An alternative course of treatment may include observation, lifestyle or behavioural changes or, where appropriate, no treatment at all.¹²⁵

Medicaid’s purpose is to improve the health of the greatest number of needy people at the lowest cost

The *Medicaid Act* requires States to develop plans that comply with all federal mandates related to covered services, including the fundamental principles of the Act.¹²⁶ Each covered medical service must be sufficient to “reasonably achieve its purpose”.¹²⁷ Medicaid’s purpose, as the Eighth Circuit succinctly stated, citing the Supreme Court, is “to provide the largest number of necessary medical services to the greatest number of needy people”.¹²⁸ Accordingly, Medicaid does not fund surgery, even to prevent death, which has “a small chance of success and carr[ies] an enormous price tag”.¹²⁹

In addition, as the Supreme Court of California has stated, Medicaid must provide medical services to qualified individuals at a level which “does not lead to unnecessary suffering or endanger

¹²⁰ ID ADC 16.03.09.011.14 (emphasis added).

¹²¹ 130 Mass CFR § 450.204 (2009) (emphasis added).

¹²² *Massachusetts Guidelines for Medical Necessity Determination for Breast Reduction Surgery* (emphasis added), <http://www.mass.gov> (search for “determination for breast reduction”) viewed 22 March 2011.

¹²³ 130 CMR § 450.204, Medical Necessity, provides: “The MassHealth agency will not pay a provider for services that are not medically necessary and may impose sanctions on a provider for providing or prescribing a service or for admitting a member to an inpatient facility where such service or admission is not medically necessary.”

¹²⁴ Connecticut Agency Reg’s, § 17b-192-2(14) (emphasis added), cited in a state report on the definition of “medical necessity”: see <http://www.cga.ct.gov/2010/rpt/2010-R-0010.htm> viewed 19 March 2011.

¹²⁵ TCA § 71-5-144(b).

¹²⁶ *Social Security Act*, § 1 et seq, 42 USCA § 301 et seq.

¹²⁷ 42 CFR § 440.230(b).

¹²⁸ *Ellis v Patterson* 859 F 2d 52 at 55 (1988).

¹²⁹ *Ellis v Patterson* 859 F 2d 52 at 55 (1988): “Surely Congress did not intend to require the states to provide funds for exotic [in that case] surgeries which, while they might be the individual patient’s only hope for survival, would also have a small chance of success and carry an enormous price tag. Medicaid was not designed to fund risky, unproven procedures, but to provide the largest number of necessary medical services to the greatest number of needy people.”

life and health”.¹³⁰ Likewise, New York law defines covered Medicaid services as those “necessary to prevent, diagnose, correct, or cure *conditions* in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person’s capacity for normal activity, or threaten some significant handicap”.¹³¹

In short, insofar as Medicaid’s purpose is to treat the largest number of qualified individuals with medical conditions, it is contrary to Medicaid’s purpose to perform unnecessary medical procedures, and procedures that endanger life, or cause unnecessary suffering, injury, deformity or malfunction.

The Federal Government and the States must independently, objectively, safeguard against unnecessary care

The government must safeguard against unnecessary care

The burden of proof in substantiating necessity on medical grounds is on physicians and hospitals. Nonetheless, pursuant to 42 CFR § 455.14 (emphasis added):

If the federal Medicaid agency receives a complaint of Medicaid fraud or abuse from any source or identifies any questionable practices, it *must* conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation.

Pursuant to 42 CFR § 455.15, if the Federal Government, after preliminary investigation, has reason to believe that a recipient has abused the Medicaid program, the federal Medicaid agency “*must* conduct a full investigation of the abuse” (emphasis added). If it believes that fraud has occurred, it must refer the matter to the appropriate law enforcement agency.¹³² In addition, if the federal agency’s preliminary investigation indicates that abuse or fraud has occurred or is occurring, it must refer the matter to the State’s Medicaid fraud control unit for a full investigation under 42 CFR § 455.15.¹³³

States participating in the Medicaid program also must comply with federal Medicaid law.¹³⁴ State medical agencies are “responsible for establishing a plan for the review by professional health personnel of the appropriateness of all Medicaid services”.¹³⁵ Utilisation controls include “appropriate limits on a service based on such criteria as medical necessity”.¹³⁶ Federal regulations require that the States identify and investigate suspected cases of Medicaid abuse and fraud.¹³⁷ Oregon, eg, has established an integrity program for that purpose.¹³⁸ In Oklahoma, the Attorney General is required to “diligently investigate a violation under the Oklahoma *Medicaid False Claims Act*”.¹³⁹ Responsibility for conducting preliminary State investigations rests exclusively with each State’s Medicaid agency.¹⁴⁰

The government must determine independently what care is necessary

Medicaid law is clear that the Federal and State Governments cannot merely rely upon treating physicians and hospitals to determine medical necessity. The federal Medicaid agency may place appropriate limits on a service based on such criteria as medical necessity or on utilisation control procedures.¹⁴¹ “A private physician’s word on medical necessity is not dispositive.”¹⁴² States also

¹³⁰ *Hunt v Superior Court* 987 P 2d 705 (1999).

¹³¹ *McKinney’s Consolidated Laws of New York Annotated*, Section 365-a(2) (emphasis added).

¹³² 42 CFR § 455.15(b).

¹³³ *Simonyan v Connell* WL 562861 (CD Cal 2000).

¹³⁴ *Smith v Benson* 703 F Supp 2d 1262 (2010); *Atlanticare Medical Centre v Commissioner of Division of Medical Assistance* 785 NE 2d 346 (2003).

¹³⁵ 42 CFR § 456.6(a).

¹³⁶ 42 CFR § 440.230(d).

¹³⁷ 42 CFR § 455.13.

¹³⁸ Oregon ADC 407-120-0310 (Provider Requirements), (4)(a)(J).

¹³⁹ 3 Okl St Ann § 5053.2(A).

¹⁴⁰ See 42 CFR § 455.14.

¹⁴¹ *Moore; Ex rel Moore v Medows* 324 Fed App 773 (2009).

have a role in determining what medical measures are actually necessary to correct a medical condition. See also *Rush v Parham* 625 F 2d 1150 at 1155-1156 (1980) (a State may adopt a definition of medical necessity that places reasonable limits on a physician's discretion in determining what services are appropriate in a particular Medicaid case). Tennessee regulations state to the same effect:

It is the responsibility of the bureau of TennCare ultimately to determine what medical items and services are medically necessary for the TennCare program. The fact that a provider has prescribed, recommended or approved a medical item or service does not, in itself, make such item or service medically necessary.¹⁴³

Necessity must be determined based on objective medical evidence

The federal Office of the Inspector General oversees State Medicaid and Medicare fraud control units. In 1991, it conducted an independent medical review of cataract surgeries, and determined a small percentage to have been unnecessary. In doing so, it relied in part on the guidelines of many professional organisations outlining medical necessity criteria.¹⁴⁴ In Massachusetts, “[t]he decision to admit is a *medical determination* that is based on factors, including the member’s medical needs, severity of symptoms, and medical predictability of an adverse clinical event”.¹⁴⁵ In Guam, “medical necessity” is to be determined by considering available research findings, health care practice guidelines, and standards issued by professionals, recognised organisations, or government agencies. Oregon’s integrity program conducts medical or professional review, including evaluating care in accordance with “*evidence-based principles*”.¹⁴⁶ Analogously, TriCare military health insurance¹⁴⁷ determines medical necessity based in part on well-controlled, published, *peer reviewed clinical studies*.¹⁴⁸ Likewise, Rhode Island only covers services provided in accordance with standard medical practice, defined as “standards that are based on credible scientific evidence”.¹⁴⁹ In short, medical necessity must be determined based on objective, scientific, medical evidence.

ANALYSIS

It is unlawful to use Medicaid to pay for neonatal and other non-therapeutic circumcision

Healthy newborns do not have any medical condition requiring surgery

The fundamental provision of federal and State Medicaid law is that only medically necessary services are covered, while American medical associations state that circumcision is non-therapeutic, not essential, elective, and usually chosen by parents for non-medical reasons. In short, they concede the obvious, that circumcision is unnecessary. Medicaid also does not cover cosmetic surgery, except to remedy an injured or malformed body part. The conclusion is straightforward and definitive that Medicaid cannot be used to pay for circumcision.

For circumcision to qualify for Medicaid funding, in addition to being medically required, as proven by objective evidence, the following conditions would need to be met as well. Every boy would have to have, at birth, an injured, diseased or malformed penis. His physician would need to diagnose the medical condition. (A jointly federal- and State-funded health care cost review

¹⁴² *Smith v Benson* 703 F Supp 2d 1262 at 1271 (2010).

¹⁴³ TCA § 71-5-144 (2)(c).

¹⁴⁴ See Department of Health and Human Services, Office of Inspector General, *Outpatient Surgery: Medicare Payments for Unnecessary and Poor Quality Cataract Surgeries, Management Advisory Report* (1991) (emphasis added), <http://www.oig.hhs.gov/oei/reports/oei-09-88-01005.pdf> viewed 11 February 2011. This was a Medicare investigation.

¹⁴⁵ 130 MA ADC 415.414(C) (2011).

¹⁴⁶ Oregon ADC 407-120-0310 (4)(a) (emphasis added).

¹⁴⁷ <http://www.tricare.mil> viewed 5 August 2011.

¹⁴⁸ <http://www.tricare.mil/mybenefit/Glossary.do?F=M> viewed 5 August 2011. TriCare also takes into consideration the policies of national medical associations, medical policy organisations and expert opinions.

¹⁴⁹ Rhode Island study, n 119.

organisation has actually written that the most common diagnosis and condition in hospitals is “newborn infant”, and that the most common procedure and treatment for “newborn infant” is circumcision.)¹⁵⁰ The physician would need to recommend surgical removal of the entire foreskin as the best treatment option, and the treatment would have to be proven and effective in treating the condition. American medical associations agree that newborn boys have normal genitalia, and thus do not have any medical condition requiring treatment, and they do not recommend circumcision. Physicians who perform routine infant circumcision also use the code for surgery in the absence of a medical condition. Accordingly, none of these additional requirements for Medicaid coverage of routine infant circumcision are met.

Neonatal circumcision thwarts Medicaid’s purpose

The foregoing ends the analysis, but Medicaid also does not cover non-therapeutic circumcision because it is contrary to the Act’s purpose, namely to provide the largest number of necessary medical services to the greatest number of needy people. Circumcision impairs health, by causing unnecessary suffering,¹⁵¹ deformity, harm,¹⁵² and by risking serious injury and death.¹⁵³ It is also expensive, and circumcision repairs charged to Medicaid add to the cost. Funding routine infant circumcision diverts billions of dollars from necessary medical care, thwarting Medicaid’s purpose.¹⁵⁴

The counterarguments are contrary to the law

The preceding analysis shows that Medicaid does not cover non-therapeutic circumcision. Nonetheless, it may help the States to address their concerns, which fall into two categories. First, Medicaid officials argue that they do not have the authority to end coverage, or that they must or should defer to physicians, medical associations, parents or their own legislatures. Secondly, they argue that routine infant circumcision has actual or potential benefits which should be available to everyone. The following discusses these counterarguments.

“Medicaid officials lack of authority to end coverage”

The concern of some Medicaid officials that they lack the authority to end coverage is unwarranted, if only because numerous States have ended coverage by administrative action of their Medicaid officials. For example, the South Carolina Medicaid office simply announced the policy change in a brief letter.¹⁵⁵ In any event, as discussed, Medicaid offices, and their utilisation review boards, have primary responsibility under federal and State law to discover, investigate and end Medicaid abuse.¹⁵⁶ Medicaid officials must be aware of their primary responsibility, and accordingly their argument that they lack the authority to end coverage appears to be made in bad faith.

“States must defer to physicians or their medical associations”

The claim that the States must or may defer to physicians or their medical associations also fails. It is irrelevant under Medicaid law whether some physicians recommend circumcision, whether it is a common or standard medical practice, whether American medical associations or national organisations such as the Centers for Disease Control are reviewing their circumcision policies, or

¹⁵⁰ Stranges E (Thomson Reuters), Holmquist L (Thomson Reuters) and Andrews RM (AHRQ), *Inpatient Stays in Rural Hospitals, 2007. HCUP Statistical Brief #85* (Agency for Healthcare Research and Quality, Rockville, MD, January 2010). Under the heading “principal diagnoses and principal procedures” in hospitals, the authors state: “The three most common conditions in rural hospitals – newborn infant, pneumonia, and congestive heart failure, were among the most common conditions in urban hospitals as well The two most frequent procedures performed in rural hospitals – circumcision and cesarean section – were also the two most frequent procedures performed in urban hospitals.” See <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb85.pdf> viewed 22 March 2011. See p 3 and p 10, Table 3, listing “Newborn infant” first under “Principal Diagnosis”.

¹⁵¹ See above, text at nn 48-50.

¹⁵² See above, text at nn 51-75.

¹⁵³ See above, text at nn 51-61.

¹⁵⁴ *Ellis v Patterson* 859 F 2d 52 at 55 (1988).

¹⁵⁵ See above, n 16.

¹⁵⁶ See above, text at nn 135-143.

whether they decide in the future to recommend circumcising all boys. To safeguard against abuse, the Federal Government and the States, foremost their Medicaid offices but otherwise their legislatures, are required to determine medical necessity, and to do so independently, based on objective medical evidence.¹⁵⁷ In any event, the Federal Government, medical associations, and physicians who circumcise all agree that neonatal circumcision is non-therapeutic and unnecessary. The remaining States are not disputing this medical determination, and they would not be able to do so. What they are actually deferring to is the American medical policy that the decision should be left to parents.¹⁵⁸

“The decision should be left to parents”

As discussed, although the AAP does not recommend circumcision, it goes on to state:

[I]t should be the parents who determine what is in the best interest of the child ... [I]t is legitimate for the parents to take into account cultural, religious, and ethnic traditions, in addition to medical factors, when making this choice.¹⁵⁹

The AMA likewise leaves the decision to parents, and notes that most parents circumcise their sons for non-medical reasons.¹⁶⁰ Even if physicians were allowed to act as cultural brokers and take orders from parents to operate on healthy children, when their medical associations do not recommend it and call it unjustified, this proves that circumcision is elective, unnecessary and not covered.

“Medicaid offices must defer to their legislatures”

As discussed, all States are subject to the provisions of federal Medicaid law cited above. The *Medicaid Act* also requires that State laws specify that only medically necessary services are covered. State laws often construe “medically necessary” more narrowly than federal law, such as in expressly prohibiting cosmetic surgery. In addition, many State laws, like federal law, require the diagnosis of a medical condition, that treatments must be effective, and that the most conservative and economical treatments must be used. Federal Medicaid law also requires Medicaid offices to establish utilisation review boards and integrity offices, and gives them primary responsibility for discovering, investigating and preventing Medicaid abuse.

Accordingly, it is irrelevant whether States have passed laws allowing Medicaid claims for non-therapeutic circumcision. Those laws are invalid as violations of federal and State Medicaid law. It is likewise irrelevant whether States have considered but failed to pass laws to end Medicaid coverage or to make non-therapeutic circumcision unlawful, or pass laws providing providing that parents have the right to circumcise their sons.

“Circumcision has benefits”

Although some State Medicaid offices write about, or list, the supposed “benefits” of circumcision, as stated, it does not actually benefit most men at all.¹⁶¹ American medical associations do not claim that it does: they do not write about “benefits”, but about “potential benefits”. At best, routine infant circumcision reduces the risk of a male contracting urinary tract infections, penile cancer, and HIV and AIDS. The Federal Government agrees, stating that research suggests “a *slightly decreased risk* of developing penile cancer, a *lower chance* of urinary tract infections in newborns, and a *potentially lessened risk* of HIV transmission”.¹⁶² Moreover, few people would call it beneficial to remove any other healthy, functional body part, even if that would prevent it from becoming diseased. For example, the American Academy of Periodontology has found that gum disease is linked to heart

¹⁵⁷ See above, text at nn 144-149.

¹⁵⁸ AAP Policy Statement, n 21; AMA Report, n 40.

¹⁵⁹ AAP Policy Statement, n 21 at 691.

¹⁶⁰ AMA Report, n 40.

¹⁶¹ See above, text at nn 76-82.

¹⁶² “Circumcision Rates Highest in Midwest, Lowest in West”, *AHRQ News and Numbers* (16 January 2008) (emphasis added), <http://www.ahrq.gov/news/nn/nn011608.htm> viewed 22 March 2011.

disease and stroke,¹⁶³ but the Academy has not proposed removing everyone's, or boys', teeth and gums at birth. Physicians do not remove other functional body parts from healthy children, nor would the States allow it.

“Circumcision has potential benefits”

Given that medical associations claim that routine infant circumcision has potential *medical* benefits, the claim that Medicaid covers it deserves careful consideration. The argument fails, however, for several reasons. Most importantly, even if circumcision has potential benefits, it remains unnecessary, elective, cosmetic surgery, and not covered. In addition, since it only has “potential benefits”, and will benefit a very small percentage of men, usually many years or decades later, it is the opposite of a necessary service.

It is also dispositive that Medicaid only covers the treatment of current medical conditions, whereas newborns do not have or need treatment for urinary tract infections, penile cancer or HIV. They do not even risk contracting HIV for many years, unless and until they become sexually active, or penile cancer until they are old. Medicaid also only covers procedures that physicians recommend, while American medical associations do not recommend it, and call it unjustified, even if it has potential benefits. In addition, Medicaid only covers effective treatments, while circumcision is not effective in preventing urinary tract infections, penile cancer or HIV. For example, it has a one in 100,000 chance of preventing penile cancer.

Even ignoring the foregoing arguments, under Medicaid law, surgery is not covered when more conservative or less costly treatments are available.¹⁶⁴ Circumcision is not conservative at all: it is invasive, painful, risky and harmful surgery. It is also expensive. Any benefits that it may have for a few men at great expense can be achieved easily for all men, much more conservatively and inexpensively without it (eg, antibiotics, good hygiene, and safe sex).

“Ending coverage discriminates against or harms the poor”

Since Medicaid does not cover routine infant circumcision, even if it has potential benefits, one does not reach this argument. Even if one did, it is difficult to argue in the 21st century that ending coverage of elective circumcision harms the poor. It is usually performed for religious, cultural or personal reasons, especially so the son will “look like the father”, which is to say, for the parents' benefit, not the child's. Medical associations do not recommend it and call it unjustified. It seriously injures and kills boys, not a “reasonable and appropriate” outcome, as the law requires, for an elective, cosmetic procedure. Few men benefit from it, those who do lose normal sexual function for life, and any potential benefits can be achieved easily without it. Intact men do not consider themselves to have been harmed, and if they did, they could volunteer for circumcision as adults. In any event, even assuming that circumcision were desirable, Medicaid does not cover merely desirable benefits that may be available to the privately insured or well-to-do.¹⁶⁵

LIABILITIES AND RESPONSIBILITIES FOR FALSE MEDICAID CLAIMS

Physicians and hospitals are liable for false Medicaid claims

42 USCA § 1320a-7a establishes substantial civil monetary penalties, up to treble damages, and a US\$10,000 penalty per occurrence, for any person or organisation – thus including physicians and hospitals – that presents any claim to any federal or State agency for payment for services under a federal health care program that “(E) is for a pattern of medical or other items or services that a person knows or should know are not medically necessary”. Since American medical associations have stated publicly for the past 40 years that routine, ritual and neonatal circumcisions are non-therapeutic, and physicians who circumcise certify that they are doing so without medical need, they do know, or they

¹⁶³ American Academy of Periodontology, *Gum Disease Links to Heart Disease and Stroke*, <http://www.perio.org/consumer/mbc.heart.htm> viewed 23 March 2011. Similarly, breast cancer is thousands of times more common than penile cancer, but doctors do not remove the breasts of healthy girls, nor would they be allowed to do so.

¹⁶⁴ See above, text at nn 117-124.

¹⁶⁵ See above following n 116.

should know, that it is not medically necessary. At US\$10,000 per occurrence, and assuming 1 million circumcisions per year for three years, approximately 30% paid for by Medicaid, this would equate to penalties approaching US\$10 billion, plus treble damages. The Federal Government also can enjoin the unnecessary services, exclude the provider from the Medicaid program, and when intent to defraud is present, prosecute the provider criminally. The Federal Government may have claims against physicians and hospitals under the *False Claims Act* as well,¹⁶⁶ unless they have viable defences.

In addition, every State that has paid physicians and hospitals for unnecessary medical services has claims against them for injury to the State government. Many States have Medicaid False Claims Acts, and some have False Claims Acts similar to the federal *False Claims Act*.¹⁶⁷ State laws provide that physicians and hospitals that make false Medicaid claims to the State can be held liable for restitution, civil penalties, including sometimes multiple damages, and excluded from Medicaid, disciplined, or suspended from medical practice. As under federal law, they may subject to criminal prosecution. In Michigan, eg, a provider that submits claims to Medicaid is certifying that the claims are true, and that they comply with all of Michigan's Medicaid policies, procedures and guidelines. Actions against providers are often brought under the Michigan *Medicaid False Claims Act*.¹⁶⁸ It requires proof that the accused knowingly made, presented or caused a false claim to be made or presented to Medicaid. "Claim" is defined as any attempt to cause Michigan's Medicaid program to pay money. "False" is defined as wholly or partially untrue or deceptive. "Knowing and knowingly" means that a person is aware or should be aware that her or his conduct is substantially certain to cause the payment of a Medicaid benefit. "It is a felony to submit a claim to Medicaid for providing goods or services that are not medically necessary."¹⁶⁹ The felony is punishable by imprisonment for up to four years and \$50,000, it appears, per occurrence.¹⁷⁰

The Federal and State Governments must investigate and prosecute false claims

As discussed above, whenever the federal Medicaid agency receives a complaint of Medicaid fraud or abuse, from any source identifying any questionable practice, it must conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation. Pursuant to 42 CFR § 455.15, if the Federal Government after preliminary investigation has reason to believe that a recipient has abused the Medicaid program, the federal Medicaid agency *must* conduct a full investigation of the abuse. If it believes that fraud has occurred, it must refer the matter to the appropriate law enforcement agency.¹⁷¹ In addition, if the federal agency's preliminary investigation indicates that abuse or fraud has occurred or is occurring, it must refer the matter to the State's Medicaid fraud control unit for a full investigation under 42 CFR § 455.15.¹⁷²

¹⁶⁶ 31 USC §§ 3729-3733. Pursuant to the *False Claims Act*, any person who knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval is liable to the United States Government for a civil penalty of not less than \$5,000 and not more than \$11,000 [per claim], plus 3 times the amount of damages which the Government sustains because of the act of that person. 31 USC § 3729(a)(1). Section 3729(c) of the *False Claims Act* defines "claim" broadly to include "any request for money made to a contractor or other recipient if the United States Government provides any portion of the money requested, or if the Government will reimburse such contractor or other recipient." "Knowing" and "knowingly" include actual knowledge, deliberate ignorance, and reckless disregard of the truth, and require no proof of specific intent to defraud. 31 USC § 3729(b).

¹⁶⁷ National Conference of State Legislators, *Incentivising State False Claims Acts* at [1], <http://www.ncsl.org/default.aspx?tabid=14748> viewed 22 March 2011.

¹⁶⁸ MCL 400.601-MCL 400.613.

¹⁶⁹ MCL 400.607(2).

¹⁷⁰ Fraleigh M, "State Response to Medicaid Fraud and Abuse: An Overview of State Criminal, Civil, and Administrative Remedies" (Nov 2002) 81 *Michigan Bar Journal* 34, containing citations.

¹⁷¹ Fraleigh, n 171.

¹⁷² *Simonyan v Connell* WL 562861 (CD Cal 2000).

Each State's medical agency also must establish a plan to detect and prevent inappropriate Medicaid claims.¹⁷³ Under federal and State regulations, each State must identify and investigate suspected cases of Medicaid abuse and fraud.¹⁷⁴ In some States, when overpayments are identified, the Department of Health and Human Services must begin procedures to recoup the overpayment amount.¹⁷⁵ In addition, suits can be brought against individual State officers for relief to end ongoing violations of federal law.¹⁷⁶

CONCLUSION

Tens of millions of boys have been circumcised under the Medicaid program since its inception in 1965, almost half a century ago. It has been assumed that physicians and hospitals have the right to do so, and that each State has the right to decide, as a policy matter, whether to continue or end Medicaid coverage of the surgery. These assumptions are mistaken.

The fundamental principle of Medicaid law is that only necessary medical services are covered, while circumcising or operating on healthy boys is, by definition, unnecessary. Medicaid law requires that physicians and hospitals end the practice. Since they have not done so, federal and State Medicaid offices, otherwise the federal and State legislatures, are required by law to end the practice, to hold physicians and hospitals liable for false Medicaid claims, and to recoup their losses. This article calls upon the Federal Government and the remaining 32 States to stop making policy arguments and to enforce the law.

This is no small matter, insofar as the tens of millions of boys circumcised under the Medicaid program at government expense since 1965 all had the right to be left alone and intact. The purpose of Medicaid is to treat the largest possible number of sick and injured people, in the most conservative and economical way possible, not to perform unnecessary surgery on millions of healthy boys, and injure them all, at very high and unnecessary expense. It is unlawful to circumcise healthy boys at the expense of the Federal and State Governments and the taxpayers.

¹⁷³ 42 CFR § 456.6(a).

¹⁷⁴ 42 CFR § 455.13.

¹⁷⁵ New Jersey regulations, eg, provide that the commissioner "is authorized and empowered ... to accomplish the purposes of this act, including specifically the following: h. To take all necessary action to recover any and all payments incorrectly made to or illegally received by a provider ... and to assess and collect such penalties as are provided for herein". NJSA 30:4D-7.

¹⁷⁶ *MCI Telecommunication Corp v Bell Atlantic Pennsylvania Pa* 271 F 3d 491 (2001), cert denied 537 US 941; 123 S Ct 340 (2002).