State of Connecticut

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ATTORNEY GENERAL

Hartford

October 5, 2005

Honorable Patricia A. Wilson-Coker
Commissioner
Connecticut Department of Social Services
25 Sigourney Street
Hartford, CT 06106

Honorable Darlene Dunbar
Commissioner
Connecticut Department of Children and Families
505 Hudson Street
Hartford, CT 06106

RE: Behavioral Health Coverage Guidelines

Dear Commissioner Wilson-Coker and Commissioner Dunbar:

We are writing to express our concern that the Departments of Children and Families (DCF), and Social Services (DSS), working with the Behavioral Health Subcommittee of the Connecticut Managed Care Council, may be supporting the development of substantive coverage rules, and a coverage determination process, that will lead to the denial of medically necessary behavioral health care needed by Connecticut children.

We applaud the decision to stop using risk-bearing managed care companies to administer behavioral health benefits under the Husky A, Husky B, and Voluntary Services programs. We have seen in the past, in both the Medicaid and commercial insurance contexts, how unfair and destructive traditional managed care can be where crucial mental health services are at risk. We are concerned, however, that the new process may also permit harmful and unwarranted coverage restrictions.

This subject has been the focus of much debate among healthcare providers, agency officials, and patient advocates. A central focus of these discussions has been the apparent discrepancy between the behavioral health coverage mandated by Medicaid law, and the coverage likely to be approved by Connecticut's new behavioral health administrator (called the "ASO" because this subcontractor will not act as an insurer but instead will provide "administrative services only.")

Medicaid regulations establish a broad definition of "medically necessary" care, which includes "...healthcare provided to correct or diminish the adverse affects of a medical condition or mental illness; assist an individual in attaining or maintaining an optimal level of health; diagnose a condition; or prevent a medical condition from occurring." Conn. Reg. § 17b-262-523(15). Federal regulations provide that "[t] he Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service ... to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition." 42 CFR 440.230(c). In the past DSS has vigorously enforced these provisions. For example, DSS Policy Transmittal MS 00-08, effective July 1, 2000, mandates that "[u]tilization review decisions must be based upon an individual assessment of the member and the member's medical condition. Arbitrary time periods or arbitrary limitations on number of service visits are inconsistent with an individualized determination of medical necessity." *Id.* at 3. (emphasis in original). The same Transmittal directs that managed care organizations "...may not deny services on the basis that the goods or services requested are for a chronic condition, rather than a service that is short-term or acute in nature." *Id.* at 4. The Transmittal also provides that "partial denials" trigger an appealable denial notice: "[i]f the MCO does not approve the request [for coverage] as submitted, the MCO must send a denial notice to the member at the time of the partial denial." *Id.* at 2.

The coverage guidelines that have been developed by the Behavioral Health Oversight Committee's Provider Work Group, however, neglect the spirit of the Medicaid law in favor of narrow -- sometimes impermissibly narrow -- coverage criteria. To mention just one such instance, the draft coverage criteria for intermediate care provide that coverage for partial hospital, intensive outpatient, and extended day treatment levels of care, may not be continued unless:

> Patient has met admission criteria within the past three (3) days for PHP, five (5) days for IOP, and thirty (30) days for EDT evidenced by:
>
> > the child or youth's symptoms or behaviors persist at a level of severity documented at the most recent start for this episode of care; or the child or youth has manifested new symptoms or maladaptive behaviors that meet admission criteria and the treatment plan has been revised to incorporate new goals ...."

Here we see the type of arbitrary coverage criteria forbidden by Medicaid law. If, for example, a child goes three days at a partial hospitalization level of care during which he or she shows less severe symptoms or behavior than those that justified admission to the PHP Program initially, that child will be arbitrarily presumed not to need partial hospitalization treatment. Nowhere in the dense thicket of rules describing coverage for intermediate care is the decision-maker reminded that Medicaid coverage is mandated for care "...to correct or diminish the

adverse effects of a medical condition or mental illness; assist an individual in attaining or maintaining an optimal level of health; diagnose a condition; or prevent a medical condition from occurring." Conn. Reg. § 17b-262-523(15). The coverage guidelines for other levels of care contain similar restrictions. In effect, the full meaning of "medical necessity" contained in the law has been suppressed and superseded by the much more restrictive guidelines.

If the coverage rules to be used by the new ASO seem excessively restrictive, the coverage determination procedure to be used by the ASO also appears likely to restrict covered care. When a care provider submits an authorization request to the ASO, the request is first reviewed by an ASO employee who grants coverage only if the authorization request describes circumstances that satisfy the restrictive coverage criteria. This first-line employee, however, will not be permitted to grant coverage based upon the more expansive Medicaid law. Instead, according to DSS Medical Policy Director Mark Schaefer writing in a July 28, 2005 email, the case will be referred to "doctoral level ASO staff," who will, if possible, consult with the patient's clinician. In other words, the unduly restrictive coverage criteria are used first, and only later will the correct legal standard be applied to the claim. Inevitably, approval of that authorization request, even though it may fully satisfy the requirements of the law, will be delayed and subjected to an additional, and for some providers, an intimidating, level of scrutiny. This process appears to be purposely designed to suppress coverage of meritorious authorization requests, and to coerce care providers to limit their requests to those whose facts satisfy the narrow coverage criteria.

Moreover, Mr. Schaefer tells us that the contract with the ASO "...does not get into the nitty gritty of the UM [utilization management] policies and procedures. These will be presented by the ASO to the Departments for review and approval after the contract is executed, but prior to implementation." Depending on their final form, these "policies and procedures" are sure to have an enormous impact on the integrity of the coverage determination process. Vigorous scrutiny of these provisions will be required to ensure that children are treated fairly.

The new behavioral health ASO coverage determination process has often been touted as a way to improve the care delivered to children. The existence of the defects we have described, however, raises the darker possibility that another powerful motivation underlying the ASO contract is an intent to restrict coverage, evade the legal definition of medical necessity, and coerce providers to self-censor the care they deliver so that it conforms to unfairly restrictive guidelines.

We hope and believe that the new ASO structure can fulfill its promise, and provide the foundation for a Medicaid behavioral health benefit that delivers the care patients need, and to which they are legally entitled. We look forward to working with you to make better care a reality.

Very truly yours,

RICHARD BLUMENTHAL
ATTORNEY GENERAL

JEANNE MILSTEIN
CHILD ADVOCATE

cc: Kenneth Fellenbaum, Chief Executive Officer, Boys and Girls Village, Inc.
Dr. Steven Kant, Medical Director, Boys and Girls Village, Inc.
Mark Schaefer, Director Medical Policy, Connecticut State Department of Social Services
Senator Toni Harp, Chair, Medicaid Managed Care Advisory Council, Co-Chair, Appropriations Committee
Senator Christopher Murphy, Co-Chair, Behavioral Health Oversight Subcommittee of the MMCAC, Co-Chair, Public Health Committee
Representative Peter Billano, Co-Chair, Human Services Committee
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Rep. Vickie Nardello