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August 15, 2005

Mark Schaefer, Ph.D.
Director, Medical Policy
Medical Care Administration - 11th Floor
Department of Social Services
25 Sigourney Street
Hartford, CT 06106

RE: Level of Care Guidelines under the Behavioral Health Partnership and the Proper Use of the Department's Medical Necessity Definition

Dear Dr. Schaefer:

We are writing to follow-up on your e-mail message of July 28, 2005 to the Behavioral Health Oversight Council's provider work group concerning utilization management under the ASO contract (attached). That e-mail was a follow-up to an e-mail that Sheldon Toubman sent to the group on July 28, 2005 (attached), raising concerns about the proper application of the Department's regulatory definitions of "medical necessity" and "medical appropriateness" in the determination of the level of care provided to Medicaid recipients. We write to request that the Department clarify for care managers and providers the proper procedure for level of care reviews in order to ensure that all behavioral health care that meets the Medicaid medical necessity criteria is provided promptly and without the need for **external** peer review.

In reference to the first and second enumerated statements in your July 28th e-mail message, we appreciate the Department's acknowledgment that a) the regulatory definition of "medical necessity" applies to Medicaid covered services under the Partnership and b) the ASO contract will clearly establish the primacy of the medical necessity definition – stipulating that "where the guidelines conflict with the medical necessity definition, that the definition shall prevail."

Despite the Department's acknowledgment of the primacy of the medical necessity definition, the third statement in your e-mail message raises a serious issue regarding the procedure that should be followed in determining the medically necessary level of care for a

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Recipient. You state the following: "The guidelines simply enable the care managers to identify individuals that may not be appropriate for the level of care in question. The ASO will not be able to issue a denial until there has been peer review (between doctoral level ASO staff and the pt's clinician), which allows individual consideration of the request at hand." This statement implies that a request for a particular level of care will not be individually reviewed under the regulatory definition of medical necessity **unless** peer review is initiated and then such review actually occurs; if it does not occur, there will effectively be an impermissible denial under the more restrictive guidelines.

The level of care guidelines should be used to quickly identify individuals that are appropriate for care. The guidelines should not be used as a way to **exclude** individuals who **may** not be appropriate for a particular level of care. If the guidelines are used in the manner that you described, there will be inappropriate denials or partial denials of medically necessary services because the peer review mechanism will not be triggered unless the ASO or the provider requests it and the review actually occurs.

It is unclear how the peer review mechanism you described is triggered. Must an individual provider take the additional step, besides requesting prior authorization, of requesting peer review after an initial denial or partial denial of a request, or will the peer review be automatic for every request for a particular level of care that does not meet the guidelines?

If the former, this process is clearly unacceptable because the Department must act on all requests from providers, up or down, within a short window (usually 24 hours), and can't require further steps on the part of providers in order for that decision to be made. And, when it so acts, as you have acknowledged, no denial or partial denial may be based on the guidelines alone, but rather must be based on lack of satisfaction of the department's regulatory definition of medical necessity, such as whether a particular level of care will help a recipient attain or maintain an optimal level of health or will prevent a condition from occurring. Yet, under this scenario, services will effectively be denied or partially denied, whenever the provider fails to initiate such a review, based only on the guidelines.

In addition, even if the peer review is automatically triggered, there remains the fundamental problem of delay in conducting these reviews, the lack of approval in the meantime, and potential lack of approval if no contact is made. Again, the net effect is that a request for services is denied or partially denied, based **not** on the Department's definition of medical necessity but instead on the far more restrictive guidelines.

Therefore, the peer review process should be not only an automatic process but also an **internal process only**. Providers should not be subject to having to repeat the submission of information, resulting in the delay of the onset of treatment. The peer review process described in your e-mail implies that what is needed to authorize care is more information when what should only be needed in a peer review process is the same application of the appropriate criteria -- the medical necessity definition -- that care managers should be using. The process you describe, however, means that there will be a shifting of the burden onto the provider to give additional information to justify a request before the request is completely reviewed using the guidelines and the medical necessity definition.

In addition, to avoid delays in authorizing needed services, a peer review should only be conducted when the information given to the care manager was not clearly sufficient to authorize care under the medical necessity definition. The only way to avoid improper denials of timely access to needed services covered under Medicaid is to require the Department's medical necessity criteria to be considered on an individual basis by ASO care managers **before** a peer review is conducted. It should not take a separate level of peer review to trigger the individualized medical necessity determination. In other words, the guidelines must only be used by care managers as **inclusive** criteria, i.e., if a person meets the guidelines, they are presumed to meet the Department's definition of medical necessity without a further individualized review. **Only if the care manager determines the Department's medical necessity criteria are not met should the request be sent to an automatic internal peer review, to be acted upon one way or the other within the timelines for action by the ASO, with a notice of action issued for any denial or partial denial.**

We acknowledge that the Department is entitled to use utilization management tools in the delivery of Medicaid services, and that it is permissible for it to use narrow guidelines as a screening tool to quickly identify individuals who **meet** the Department's medical necessity criteria. However, the guidelines must not be used as a method of utilization management that skirts the requirement of an individualized determination of medical necessity before denying or partially denying requested services, in every case.

If care managers are not instructed to always apply the Department's medical necessity and medical appropriateness criteria before sending on a request for a peer review, the serious problem of providers believing that the guidelines in fact define medical necessity will be compounded. As it is, some providers who have attended the provider work group meetings, and other providers that we have spoken to, are under the false impression that the guidelines are to be used as the only method to rule-in or rule-out a particular level of care for an individual. While we strongly urge you to correct this misunderstanding by notifying all participating providers in writing at the appropriate time that the Department's regulatory definitions of medical necessity and medical appropriateness are the **only** permissible bases for denial, the strong possibility of such continuing misunderstandings reinforces the need for your agency to correct the apparent flaws in your proposed peer review process.

Therefore, we request that prior to the implementation of the carve-out, the Department (1) inform all providers of the primacy of the medical necessity definition in as clear a fashion as you did in the second statement of your e-mail: " ... in any case where the guidelines conflict with the medical necessary definition, the definition shall prevail"; and (2) clarify that any peer review mechanism (a) will be utilized only after a care manager first determines that the Department's regulatory criteria for medical necessity and medical appropriateness are not met, (b) will at that juncture be automatic and internal to the ASO, and (c) will result in a written denial whenever the peer review is not completed promptly or results in a continued non-approval or partial denial, as described in MS 00-08.

Thank you for your attention to this matter. We are hopeful that the Department will respond in a manner that ensures that the Behavioral Health Partnership begins on the proper footing for all involved. Our clients are depending on all of us to ensure a successful transition

to and implementation of the program. If you have any questions, please feel free to contact either of us.

Sincerely,

Vicki Veltri
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(860)541-5037

Sheldon V. Toubman
Staff Attorney
New Haven Legal Assistance Ass'n
stoubman@nhlegal.org
(203)946-4811

Encls.

cc: 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
Susan Walkama, Chair, Behavioral Health Oversight Council Provider Work Group
Jeff Walter, Co-Chair Behavioral Health Oversight Subcommittee of the MMCAC
Jeanne Milstein, Child Advocate
Richard Blumenthal, Attorney General

Vicki Veltri

From: Schaefer, Mark C. [Mark.Schaefer@po.state.ct.us]

Sent: Thursday, July 28, 2005 5:22 PM

To: Walkama, Susan

Cc: bert.plant@po.state.ct.us; ctiffany@ctnonprofits.org; CatroCO@CI.Bridgeport.CT.US; brian.mattiello@po.state.ct.us; WMartin@waterfordcs.org; dsalvatore@learn.k12.ct.us; Irvin.Jennings@fcaweb.org; Jbenson@chrhealth.org; Karen.andersson@po.state.ct.us; philguzman@cgcgb.org; Mariette.McCourt@cga.ct.gov; wimpatota@usmhs.org; NancyDimauro@nafi.com; rsimmons@villageforchildren.org; Sheldon Toubman; sgreenbaum@mfcgc.org; tedelstein@ccpa-inc.org; Doug DeCerbo; Karen Sylvia; Christine Bouey; Sheldon Toubman; Dr. Kant; Karen Snyder (E-mail); Vicki Veltri; Heather Gates (E-mail); Parrella, David S.; Ciarcia, Rose T.; Piccione, Paul M.

Subject: RE: Medicaid Acute Psychiatric Hospitalization 0605

Dear Susan,

Mariette forwarded to me the latest correspondence from Sheldon, which for some reason never made it to my inbox. I would like to comment on a couple of issues about UM under the Partnership:

1) DSS understands that the Department's medical necessity definition applies to Medicaid covered services under the Partnership. I believe that the introduction to the level of care guidelines adequately establishes the definition for the purpose of the guidelines.

2) The ASO contract will require use of the guidelines for review purposes, but it will clearly establish the primacy of the medical necessity definition. The contract stipulates that in any case where the guidelines conflict with the medical necessity definition, the definition shall prevail and the Contractor should note such occurrences so that these can be taken into consideration by the Clincal Management Committee.

3) The guidelines simply enable the care managers to identify individuals that may not be appropriate for the level of care in question. The ASO will not be able to issue a denial until there has been peer review (between doctoral level ASO staff and the pt's clinician), which allows individual consideration of the request at hand. These peer reviewers will be required to consider factors that may not be addressed in the guidelines. The peer reviewers will consider the unique circumstances of the member in the context of the Medicaid medical necessity definition.

4) While the ASO contract clearly establishes the points in #2, it does not get into the nitty gritty of the UM policies and procedures. These will be presented by the ASO to the Departments for review and approval after the contract is excecuted, but prior to implementation. This is where the Departments will ensure that the UM program procedures or operations provide for all of the above, and it is also the vehicle for refining these policies and procedures over the life of the contract.

5) The Departments provide in the contract for performance review on a regular basis. During this performance review, we will be ensuring that the ASO is following the policies and procedures, including documentation that supports that the Medicaid medical necessity definition is applied as it should be.

I hope that the Clinical Management Committee can maintain its focus on the substance of the guidelines, since there is still much to do on that front prior to implementation. I think that there will be many opportunities down the road to consider whether the program is fulfilling the above medical necessity related requirements in letter and spirit.

Mark

Mark Schaefer
Director, Medical Policy
Medical Care Administration

Vicki Veltri

From: Sheldon Toubman
Sent: Thursday, August 11, 2005 4:03 PM
To: Vicki Veltri
Subject: FW: BH Carveout Provider Advisory Group/Medicaid Medical Necessity Criteria
Attachments: CHN.MedicalNecessityDemand.Letter.Final.7.20.05..doc

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From: Sheldon Toubman
Sent: Thursday, July 28, 2005 3:01 PM
To: 'Heather Gates'; Sharpe, Patricia
Cc: Vicki Veltri; Alice Farrell; Barbara C. Sheldon; Bill Martin, Ass't Exec Dir, Waterford Country School; Brian Mattiello, DCF; Connie Catrone; Connie Tiffany, CAN; Dana-Marie Salvatore, Southeast Mental Health Soc; Dona Mercadante, Director, Gray Lodge; Donna Campbell, CGC Northwest Centers; Gina Hoff; Gloria Merritt, RW, MSN, New England Home Care; Irvin Jennings, MD, Exec & Med Director; Janice Perkins, Health Net; Jean Adnopoz, Yale Child Study Center; Jill Benson; 'aurele.kamm@po.state.ct.us'; Jim Rush, CHA; John Harper, MD, Health Net; Karen Andersson, DCF; L. Philip Guzman, Pres/CEO, CGC Greater Bpt; Laurie Reisman, LCSW; Linda Pierce, Value Options; Linda Russo; Mariette McCourt; Mark Schaefer, DSS; Michael Patota, Clinical Services Div Dir, United services, Dayville, CT; Nancy DiMauro, Dir.Clinical Services, North American Family Institute, CT; Paul Piccione, Ph.D., DSS; Reginald Simmons, Ph.D.; Rick Calvert, Child & Family Agency of Southeastern CT; Robert Zavoski, MD, CT AAP; Steven Kant, M.D.; Stuart Greenbaum, MSW, Exec DIr, CGC of Mid-Fairfield County; Susan Halpin, Robinson & Cole; Susan Walkama, Dir.MC; Terry Edelstein, President/CEO CCPA; Theresa Nicholson, Ass't VP Behavioral Health, CRT; 'Parrella, David S.'; 'Toni Harp'; 'Chris Murphy'; 'Jwalter@rushford.org'
Subject: BH Carveout Provider Advisory Group/Medicaid Medical Necessity Criteria

Heather Gates' comments (particularly comment #3) reflect a fundamental, but entirely common and reasonable, misunderstanding regarding the guidelines being developed by the behavioral health carveout provider work group. Heather understandably expresses grave concern with "the exclusionary criteria of E.2.1.3 as an absolute. I would add language like 'in most circumstances' or 'where an alternative program is in fact available.' "

The misunderstanding may arise because some DSS folks have failed to appreciate that the **guidelines** are inherently just that- they are intended to always be read as "in most circumstances" and may **never** be used as the basis for **denying** any requested behavioral health services. Such a denial is only permissible under the Department's clear and long-standing regulatory definition of medical necessity, which defines medically necessary services as services "provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition or prevent a medical condition from occurring." The only other permissible basis for denial under state law would be if the requested services were determined not to be "medically appropriate," defined in state regulations as services that meet "professionally recognized standards of acceptable care," are "delivered in the appropriate medical setting" and are the "least costly of multiple, equally-effective alternative treatments or diagnostic modalities."

Thus, turning to Heather's specific concern, even if the guideline criteria for **exclusion** of treatment under E.2.1.3 are met in a particular case, the ASO, under the guidelines, **must** then go on to make an individualized determination as to whether the Department's definitions of medical necessity and medically appropriate are met by the specific request for services. It may not deny the requested treatment unless it concludes that these standards are not so met.

Providers understandably are afraid that the guidelines **will** be used as the final determinant of requests for approval, and that the ASO will not look at DSS's broad regulatory definition of medical necessity. This is entirely

reasonable based on history. The Medicaid MCOs have a poor record of complying with this requirement, particularly in the area of behavioral health services. For example, CHNCT was very recently found to have been allowing its behavioral health managed care subcontractor, Magellan Behavioral Health, to use an improper standard of medical necessity, based on an unspecified private "*national professional criteria for medical necessity*" standard: the absence of "*reported evidence of the member representing [sic] any potential serious harm to him self, or being a risk to him self or others if not in a partial hospital program.*"

The three legal services programs have written to DSS urging it to immediately take corrective action against CHNCT, specifically by imposing monetary sanctions against it, as DSS has done in the past regarding the same type of illegal conduct by another MCO- Health Net (previously Physicians Health Services). The letter to Commissioner Wilson-Coker dated July 20, 2005, to which no response has yet been received, is attached hereto.

In light of this recent illegal conduct, I believe that the only way that DSS will be able to make the promised break from the failure of the managed care model in the provision of behavioral health services will be by making a firm commitment to ensuring, through an air-tight contract and aggressive monitoring, including clear sanctions for any violations, that its new ASO will **never** deny a request for services except based upon a determination that the services are not medically necessary or are not medically appropriate, as defined by the Department's regulations (above).

In this regard, I am reproducing an excerpt of the statements of Dr. Steven Kant in his e-mail correspondence with this group dated July 18th, the substance of which has not to my knowledge been addressed by DSS. His comments confirm the very real concern among providers that the Department's regulatory definition of medical necessity will not be applied in a protective way to ensure that services are not improperly denied:

"At Bridgeport Hospital I directly treat all the children in REACH's PHP/IOP program (the only such one in Fairfield County). My experience as a direct care provider is extensive and my involvement with MCO's, particularly as it concern's the Medicaid product has also been quite extensive. I also have for years reviewed the managed care criteria for McKesson Health, a large national healthcare firm. The guidelines you are proposing are operationally unclear. Further the specific content is almost a carbon copy of criteria which I review for large national commercial MCO's. **The proposed guidelines ignore[ ] the much broader Medicaid Medical Necessity obligations which require that treatment be provided for the purposes of improving children's ability to function, in fact it requires we do so "to their optimal level of health". This benefit lies at the heart of the Medicaid benefit.** Ongoing use of intensive treatments allow children to repair their extensively damaged coping skills, impaired self-image, and interpersonal skills. We must be able to treat them for a long enough period of time and an effective level of care to ensure some success into the future. The guidelines you propose quite often requires quick step downs from treatments that are helping well before these goals have been achieved.

* * *

I hope your committee will still be willing to reinstate in a meaningful way the Medicaid Medical Necessity within your guidelines so they are in fact operationally evident and not just words buried in a document.
Steven M. Kant, M.D."

DSS has an opportunity to make a clean break from the past and to ensure a meaningful behavioral health benefit, one which is provided in a manner which is both recipient and provider-friendly, as it has made clear is its intention. But this can only be accomplished if it takes seriously its obligation to ensure that its own regulatory definition of medical necessity is individually applied in every case, before any services are denied, with the guidelines being expressly recognized as being only that-- guidelines that may be used only for quick **approvals**. I can't imagine that any on-the-ground provider of behavioral health services would disagree with the fundamental need for DSS to make that commitment now – before the ASO is operational, before the ASO contract is finalized, and before any further confusion and concern is sown among providers.

Thank you for considering these comments.

Sheldon V. Toubman
New Haven Legal Assistance Association

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From: Heather Gates [mailto:Hgates@CHRHEALTH.ORG]
Sent: Tuesday, July 26, 2005 4:30 PM
To: Sharpe, Patricia
Cc: Vicki Veltri; Alice Farrell; Barbara C. Sheldon; Bill Martin, Ass't Exec Dir, Waterford Country School; Brian Mattiello, DCF; Connie Catrone; Connie Tiffany, CAN; Dana-Marie Salvatore, Southeast Mental Health Soc; Dona Mercadante, Director, Gray Lodge; Donna Campbell, CGC Northwest Centers; Gina Hoff; Gloria Merritt, RW, MSN, New England Home Care; Irvin Jennings, MD, Exec & Med Director; Janice Perkins, Health Net; Jean Adnopoz, Yale Child Study Center; Jill Benson; Jim Rush, CHA; John Harper, MD, Health Net; Karen Andersson, DCF; L. Philip Guzman, Pres/CEO, CGC Greater Bpt; Laurie Reisman, LCSW; Linda Pierce, Value Options; Linda Russo; Mariette McCourt; Mark Schaefer, DSS; Michael Patota, Clinical Services Div Dir, United services, Dayville, CT; Nancy DiMauro, Dir.Clinical Services, North American Family Institute, CT; Paul Piccione, Ph.D., DSS; Reginald Simmons, Ph.D.; Rick Calvert, Child & Family Agency of Southeastern CT; Robert Zavoski, MD, CT AAP; Sheldon Toubman; Steven Kant, M.D.; Stuart Greenbaum, MSW, Exec DIr, CGC of Mid-Fairfield County; Susan Halpin, Robinson & Cole; Susan Walkama, Dir.MC; Terry Edelstein, President/CEO CCPA; Theresa Nicholson, Ass't VP Behavioral Health, CRT
Subject: RE: Provider Advisory Group

My comments are as follows:
PRTF looks fine with the changes noted.
IICAPS:

1. I think a rate should be established for the case, not by the hour. The language for the authorization is unnecessarily complicated and could be avoided by establishing a case rate. This does not prevent auditing of charts to insure adherence to the minimum required number of hours per family etc., but rather insures that the provider will be adequately reimbursed and be able to continue to deliver this level of care.
2. I cannot comment on the GAF number choosen, but did remember that we agreed at one of our early meetings to use the descriptive language rather than the number given questions about validity of GAF scoring;
3. I disagree with the exclusionary criteria of E.2.1.3 as an absolute. I would add language like " in most circumstances" or "where an alternative program is in fact available";
4. Continued Care Criteria – Since this is a service that is available for up to six months, when would the continued care criteria kick in? At the end of month 5?

I look forward to the meeting on the 3rd to hear the other feedback.

Heather

> -----Original Message-----
> **From:** Sharpe, Patricia [mailto:PSharpe@Wheelerclinic.org]
> **Sent:** Tuesday, July 26, 2005 12:54 PM
> **Cc:** Vicki Veltri, Staff Attorney, Greater Hfd Legal Aid; Alice Farrell; Barbara C. Sheldon; Bill Martin, Ass't Exec Dir, Waterford Country School; Brian Mattiello, DCF; Connie Catrone; Connie Tiffany, CAN; Dana-Marie Salvatore, Southeast Mental Health Soc; Dona Mercadante, Director, Gray Lodge; Donna Campbell, CGC Northwest Centers; Gina Hoff; Gloria Merritt, RW, MSN, New England Home Care; Heather Gates; Irvin Jennings, MD, Exec & Med Director; Janice Perkins, Health Net; Jean Adnopoz, Yale Child Study Center; Jill Benson; Jim Rush, CHA; John Harper, MD, Health Net; Karen Andersson, DCF; L. Philip Guzman, Pres/CEO, CGC Greater Bpt; Laurie Reisman, LCSW; Linda Pierce, Value Options; Linda Russo; Mariette McCourt; Mark Schaefer, DSS; Michael Patota, Clinical Services Div Dir, United services, Dayville,

CT; Nancy DiMauro, Dir.Clinical Services, North American Family Institute, CT; Paul Piccione, Ph.D., DSS; Reginald Simmons, Ph.D.; Rick Calvert, Child & Family Agency of Southeastern CT; Robert Zavoski, MD, CT AAP; Sheldon Toubman; Steven Kant, M.D.; Stuart Greenbaum, MSW, Exec DIr, CGC of Mid-Fairfield County; Susan Halpin, Robinson & Cole; Susan Walkama, Dir.MC; Terry Edelstein, President/CEO CCPA; Theresa Nicholson, Ass't VP Behavioral Health, CRT
Subject: Provider Advisory Group

Everyone:

Attached please find the group's final recommendations for the PRTF level of care. We are currently reviewing the Intensive In-home Child Adolescent Psychiatric Service (IICAPS) level of care and the attached document incorporates the recommendations made to date. **Recommendations for the IICAPS level of care will be finalized at the the next meeting on August 3. All comments on this level of care must be submitted prior to that date.** As always, the recommended changes are noted in bold, violet colored type within the documents.

Next meeting

Final IICAPS LOC/ Review of Outpatient LOC

August 3, 2005

3:00 - 4:30

Legislative Office Building (LOB), Hartford
Room 3800

Susan Walkama

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