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February 26, 2008

Testimony Before the Human Services Committee Opposing Section 2 of SB 34, AA Implementing the Governor's Budget Recommendation with Respect to Social Services Programs

Members of the Human Services Committee:

I am Randi Faith Mezzy, an attorney with Connecticut Legal Services, one of four legal aid organizations working to enforce the rights of Connecticut's poor people.

I want to address the subtle and seemingly innocuous change in wording contained in Section 2 of SB 34, implementing the Governor's budget proposals, that would change the long-standing definitions of "medically appropriate services" and "medically necessary services."

The following proposal as contained in the Governor's budget narrative, will do nothing less than cut out the heart and soul of our state's Medicaid program:

Update Medical Necessity and Appropriateness Definition under Medicaid

This proposal allows DSS to replace the current outdated medical necessity definition under Medicaid with a definition used under both Medicare and private commercial health care plans. This definition was adopted as part of the restructuring of the SAGA program. The proposed definition incorporates the principle of providing services which are "reasonable and necessary" or "appropriate" in light of clinical standards of practice.

This is seems like a reasonable proposal, until you ask someone who works with Medicaid recipients every day to share what that really means. I am about to tell you exactly that.

This so-called "modernization" of the Medical Necessity (MN) definition is simply a license for DSS and its subcontractors to issue **MORE DENIALS OF ESSENTIAL MEDICAL SERVICES**. There will be no benefit whatsoever to Connecticut's Medicaid recipients. In the long run, there is no benefit to Connecticut's taxpayers either, if necessary preventive and treatment services are denied. You know



that, eventually, we all end up paying for those untreated health conditions, after they have worsened and become critical.

Medicaid is not Medicare, nor is it private insurance. Using those programs' definitions will restrict medical care to people who have no alternatives - who can't pay out of pocket and fight the insurance company later.

Well, so what? People often ask me: "Why shouldn't poor people have to suffer under the same limited standard as the rest of us, all the working stiffs who have private commercial health care plans? Why should THEY get better health care than we do?" It's a reasonable question, and a very popular one. Everywhere I go, whether it is to do an in-service presentation, an outreach to a community group or even to our own Supreme Court, I am asked: "Why should THOSE PEOPLE - who don't work and don't pay taxes - why should THOSE PEOPLE be given what I can't get?"

I know that the members of this committee have heard enough Medicaid horror stories to know that THOSE PEOPLE - the poor, the elderly, the disabled and the children living in poverty in CT, the richest state in the country, are not getting "better health care" than anyone else in the state. THOSE PEOPLE are waiting months to see a medical provider. THOSE PEOPLE can't find a dentist who is willing to fill the holes in their aching teeth. THOSE PEOPLE are kids sitting in school who can't pay attention because the administrator of their health insurance program - you know, the one that is so enviable - refused to fill a prescription, offered no explanation why and sent them away.

It is time to reject the "us versus them" tactic. "Those people" ARE US. Who among us could support our families if we were struck down by an unexpected illness that doesn't seem to go away, that worsens and worsens until one day we find can't work any more? Who among us knows what it's like to have to take care of a child with multiple disabilities around the clock, so that holding down a regular job becomes impossible? Anyone who has been in that situation and has had to turn to the government for assistance knows that nobody chooses the state welfare lifestyle. No one with any other options is clamoring for membership in the exclusive Medicaid Club. My clients ask the taxpayers of Connecticut to help them only when they are victims of circumstance, illness, abuse, lack of proper nutrition and education and yes, inadequate medical care.

The Governor's budget projects "savings" as a result of changing this definition. Those savings are the result of kids with earaches being denied their antibiotics. It comes from disabled people in pain being denied an operation that could lessen that pain. It comes from a suicidal teenage girl

being released from the hospital the morning after she tried to slit her wrists, because staying in the hospital long enough for therapists to figure out why she tried to kill herself is neither “reasonable” nor “necessary” when she can simply take antidepressants instead. In the short run, the change will keep DSS’s budget line down.

Legal services lawyers have represented many people who were denied treatment under the PRESENT definition of medical necessity, until we intervened and took them through the very technical appeal process. Once confronted with the wording of our present definition, the HMOs often understood that our clients’ needs are covered by Medicaid, and paid for the services. If not, we then proceed with the appeal, which can take months, while the client suffers without the care. **The current definition of medical necessity is the key to helping Connecticut’s Medicaid recipients get essential medical care that has been improperly denied.**

Thank you for this opportunity to be heard.

FACTS about **Changing the Definition of Medical Necessity in Medicaid**

The Governor's budget proposes to change or "update" the medical necessity definition for Medicaid to conform to that used by Medicare, commercial plans, and more recently, SAGA.

The Issue:

- **This proposal will require the use of a definition of "medical necessity" that is *far more limited* than the current definition used for Medicaid clients.**
- **The definition of "Medical Necessity" in the Governor's budget will reduce access to health care for needy HUSKY recipients with no other resources. That will result in more costly hospital-based care and will take away current protections for kids.**
- **The Appropriations Committee rejected proposals to change the current Medicaid medical necessity definition during the last two legislative sessions.**

A new limited definition would negatively impact all 310,000 low-income children and parents in the HUSKY A and B programs.

Weakening the Medicaid definition of medical necessity may also be illegal under federal Medicaid law, in two ways:

- **Medicaid law says the state must pay for all treatment needed for "maximizing independence and self-care . 42 U.S.C. § 1396. The definition proposed by the Governor is too narrow to provide the medical equipment and services needed to meet this standard.**
- **Medicaid law says that coverage for **all** Medicaid recipients **must be the same**. This bill could allow HUSKY HMOs to apply a more limited definition of medical necessity to the children and parents enrolled in their plans. However, Medicaid recipients served by DSS would still fall under the current, more broadly construed definition of medical necessity. 42 U. S. C. § 1396a(a)(10)(B).**