

Center for Children's Advocacy

University of Connecticut School of Law
65 Elizabeth Street, Hartford, CT 06105

TESTIMONY IN OPPOSITION TO THE GOVERNOR'S DEFICIT MITIGATION PLAN

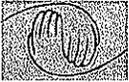
March 11, 2010

By Jay E. Sicklick, Esq.

**Deputy Director – Center for Children's Advocacy, Inc.
Project Director, Medical-Legal Partnership Project**

Thank you for providing the **Center for Children's Advocacy** with an opportunity to submit testimony to this committee. I submit this testimony as the Deputy Director of the Center for Children's Advocacy and Director of the Center's *Medical-Legal Partnership Project*. The Center for Children's Advocacy ("CCA") is the state's largest non-profit legal advocacy organization that is exclusively dedicated to the representation of at-risk children. CCA is based at the University of Connecticut School of Law, and our mission is to provide holistic legal services for poor children in Connecticut communities through individual representation, education and training, and systemic advocacy. CCA's *Medical-Legal Partnership Project* ("MLPP") is a collaborative endeavor that teams the legal advocacy and expertise of the Center for Children's Advocacy with the medical expertise of the pediatric and family medicine clinicians at Saint Francis Hospital & Medical Center, the Connecticut Children's Medical Center, Charter Oak Health Center, Inc., Community Health Services, Inc., the Burgdorf/Bank of America Health Center, the Hospital of Central Connecticut, and Community Mental Health Affiliates, Inc. of central and northwest Connecticut. The MLPP is a medical-legal collaborative program that was the second of its kind in the nation, and we have been working on behalf of Connecticut's children in the clinical setting since April 2000.

We strongly oppose the passage of the Governor's Deficit Mitigation Plan, specifically those parts that aim to drastically cut Medicaid services to Connecticut's children enrolled in the HUSKY Plans and the Title XIX program. Specifically, we oppose the Governor's proposal to change the Medical Necessity definition for those children enrolled in the state's Medicaid/HUSKY programs, the elimination of non-emergency Medicaid transportation, the funding for HUSKY outreach (Infoline 2-1-1), funding for HUSKY monitoring (including Brain Injury Association and Children's Health Council) and the reduction in funding for School Based Health Clinics (SBHC's).



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First and foremost, CCA, in conjunction with our medical partners and in concert with the Connecticut State Medical Society, firmly believe that any determination of what is medically necessary for a pediatric patient must be made by the medical clinician treating the child patient. Furthermore, for purposes of insurance coverage, any established definition must be based on the premise that if determined by the clinician, there is a presumption of necessity. Medically necessary services are not only those for the actual treatment of a condition, but also for the purposes of preventing, evaluating, diagnosing and/or treating an illness, injury, disease or its symptoms. The most cost-effective treatment method is not always the least expensive. Allowing appropriate medical

decisions to be made on the basis of cost, rather than medical appropriateness, is not in the best interest of pediatric patients.

Our Medical-Legal Partnership Project has worked on behalf of children insured through the state's HUSKY A and Medicaid programs since its inception in April 2000. We are particularly concerned with the Governor's attempt to change the medical necessity definition because of the negative impact it would have on access to care needed to treat the multitude of childhood diseases and conditions our clients face. For example, our clinical partners who treat sickle cell and other hematological diseases indicate that there are many medications where the Food and Drug Administration have not approved usage for a specific age group or a dedicated medical problem, but yet the medication clearly benefits those targeted groups and diseases (e.g. sickle cell disease). If the Medicaid managed care organizations (MCO's) are allowed to interpret "medical necessity" based on purely "scientific evidence" (as per the requested change in the medical necessity definition) rather than the present standard of "optimal level of health," many children who face chronic pain and other debilitating consequences due to sickle cell and other complex diseases will be denied these vitally important medications.

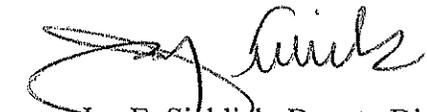
Hospital admissions are often required for a combination of reasons – from a patient history of unpredictable disease patterns to medical concerns that adherence to a treatment plan may be challenging for a family at home. Our clinician colleagues often partner with our client families about discharge criteria – and because there are many factors that determine discharge readiness (e.g. cultural, medical, social etc.), these criteria can differ from family to family. Medical necessity under the Governor's proposed change could be interpreted as not needing to include family preference and capacity when deciding on admitting or discharging a patient.

Finally, we would urge you to view DSS's interpretation of the medical necessity definition change with great skepticism and err on the side of providing pediatric patients with optimal care. At a Medicaid Managed Care Council meeting on June 12, 2009, Dr. Marc Schaefer, DSS's director of medical policy and behavioral health, described to the Council that the present definition of medical necessity used in HUSKY A and Medicaid, which "assist[s] in attaining or maintaining an *optimal level of health*; to diagnose a condition or prevent a medical condition from occurring" (emphasis supplied), creates a system where "inappropriate" and "excessive" health care is provided to children. Yet despite this claim, DSS has failed to present data to support the Department's contention that children's healthcare in Connecticut is at present "excessive" or "inappropriate" or that this critical change in the medical necessity definition will result in a measurable expenditure reduction *without potentially causing clinical harm to patient care*. Reliance on "future data" is short-sighted and ill-advised when balancing the interests of providing optimal healthcare to the state's most vulnerable populace. Equating the state's long-time goal of ameliorating children's health to an optimal level with "inappropriate" and "excessive" care also ignores the premise upon which the successful HUSKY A and children's Medicaid programs have been built. Given the plethora of data that supports the proposition that low-income children achieve poorer health outcomes and given the present economic crisis facing all of the state's residents, now is not the time to reduce the quality of healthcare provided to the state's pediatric population.

CCA supports collateral efforts to revise the Medical Necessity definition, such as that contained in **HB 5296, AN ACT CONCERNING THE DEFINITION OF MEDICAL NECESSITY.**

This bill, with the amendments proposed by the Medical Inefficiency Committee, improves efficiency while protecting vulnerable child Medicaid enrollees, as an alternative to DSS's proposed harmful definition taken from the restrictive SAGA program.

Respectfully Submitted,



Jay E. Sicklick, Deputy Director
Center for Children's Advocacy

