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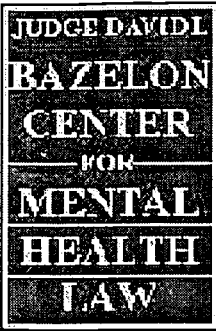
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ABSTRACT

This issue paper is designed to help families, advocates and policymakers ensure that "medically necessary" standards in public-sector contracts for managed mental health care protect children's rights, particularly the rights of children who have serious emotional disturbance. Fundamental principles for developing sound contracts for public mental health services for children are provided and include: (1) families should be treated as partners in treatment planning; (2) even where the mental health system has been privatized, the ultimate responsibility for its operation should lie with the public agency; (3) family members and child advocates must have a voice in how the system is designed and run; (4) the managed care plan must address fragmentation in services for children with serious emotional disturbance; and (5) preserving families must be a central goal of child mental health services. Problems with the current definition of "medically necessary" in managed care and in Medicaid law are explained, and court decisions are discussed. A different approach to defining medically necessary services is proposed that addresses the goals of services, purposes of services, standards of service delivery, arbitrary limits, process to determine when services are medically necessary, and links to an appeal system. (Contains 36 references.) (CR)

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Civil Rights and Human Dig-

Protecting Consumer Rights in Public Systems **MANAGED MENTAL HEALTH CARE POLICY**

A Series of Issue Papers on Contracting for Managed Behavioral Health Care

#5

DEFINING MEDICALLY NECESSARY SERVICES TO PROTECT CHILDREN

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April 1998

As Medicaid, mental health and child welfare systems are redesigned to adopt a managed care approach, important shifts occur in how services for children with mental health care needs are regulated. This paper addresses a critical part of public-agency contracting for managed behavioral health care services for children: the definition of “medically necessary” and the procedures used to determine when a service is medically necessary.

The concept of “medical necessity” is critically important because managed care entities use definitions of medical necessity either to approve or to deny provision of mental health services. It is especially important for children because of EPSDT (Early Periodic Screening, Diagnosis and Treatment), which affords all Medicaid-eligible individuals under the age of 21 a strong legal entitlement to medical screening, including an assessment of mental health development, and to any necessary treatment of mental health conditions discovered by that screen.¹ Children are thus entitled to “necessary...diagnostic services, treatment, and other measures...to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services....”² The statute, however, fails to further describe or define “necessary.”

Many states have responded with inappropriately narrow definitions of medical necessity. Yet they remain legally bound to provide all needed services to Medicaid-eligible children. However, a great many families will not understand that their children have this right, and it is often hard for them to access needed services. This paper is designed to help families, advocates and policymakers ensure that “medically necessary” standards in public-sector contracts for managed mental health care³ protect children’s rights. It particularly emphasizes the rights and needs of children who have serious emotional disturbance.

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The Bazelon Center for Mental Health Law is the leading national legal-advocacy organization representing people with mental disabilities. Through precedent-setting litigation, in the public-policy arena and by assisting legal advocates across the country, the center works to define and uphold the rights of adults and children who rely on public services and ensure them equal access to health and mental health care, education, housing and employment. The Bazelon Center was founded in 1972; its work is funded by private foundations and individual donors.

- Fundamental to developing sound contracts for public mental health services for children are the following principles:
 - ◆ Children’s services are sufficiently different from the services offered by the adult system that specific attention should be paid to planning how to address the needs of children and adolescents and their families.
 - ◆ Families should be treated as partners in treatment planning and the development of service plans.
 - ◆ Even where the mental health system has been privatized, the ultimate responsibility for its operation still lies with the public agency.⁴ This includes ensuring compliance with federal EPSDT requirements and with state law.
 - ◆ Family members and child advocates must have a voice in how the system is designed and run, and policymakers should draw upon their knowledge of how systems can best serve children. The state should use existing planning processes, open public forums and other opportunities for public comments in developing requests for proposals (RFPs), reviewing bids and negotiating contracts.
 - ◆ The managed care plan must address, and seek to overcome, the current fragmentation in services for children with serious emotional disturbance. Effective mechanisms to coordinate across service systems—especially mental health, education, child welfare and juvenile justice systems—must be developed, including pooled funding.
 - ◆ Preserving families and preventing out-of-home placement must be a central goal of child mental health services.

State plans for the child mental health system that were developed prior to the shift to managed care, generally with significant public input, should be considered when moving to a restructured system. There is no need to reinvent the wheel if these plans are still appropriate. At the same time, improvements can be made.

BACKGROUND

Children are still in their developmental period and dependent upon their families. Families must therefore be involved in treatment planning for their child. Also, the children’s service system itself is significantly different from the adult system—primarily because myriad agencies have major responsibilities for serving children, leaving the children’s system without a central authority. Even though Medicaid-eligible children have a legal entitlement to treatment, this fragmentation among agencies creates serious gaps and often leads to confusion as to re-

sponsibility and accountability. Boundary disputes between child welfare, mental health and education, for example, can leave children unserved or served inappropriately or inadequately.

Under a fee-for-service system, some attempts have been made to address the fragmentation through pooled funding and coordinated systems of care created through demonstration projects funded by the federal government and private foundations.⁵ Other initiatives were established by settlements in class-action lawsuits, such the *Willie M* case in North Carolina and *R.C.* in Alabama.⁶ But the same kind of fragmentation is now encouraged by managed care entities, which have an incentive to save resources by denying mental health services to children who are in the child welfare, special education or juvenile justice systems. Often, the other agency is told that the service requested is not “medically necessary.”

However, as noted above, children who are eligible for Medicaid are entitled to the full array of health and mental health services and supports described in the federal Medicaid law.⁷ Under the EPSDT provisions, states must cover all services necessary to treat or ameliorate health needs identified through screening, even if those services would not be covered under the state’s Medicaid plan for adults. For example, even if a state plan did not contain the option of case management for adults, this service would have to be available to children who needed it.⁸

The EPSDT provisions of Medicaid apply with full force even when states operate the mental health system under a waiver from the federal Health Care Finance Administration (HCFA). Although the 1997 Balanced Budget Act changed federal rules about when states must apply for a waiver of Medicaid rules, they are still required to do so before they can move children with special needs into managed care plans.⁹ The act defined “children with special needs” to include children with serious emotional disturbance but not children whose need for mental health services would be modest, such as children with mild anxiety or depression who can be treated through routine medication visits or brief psychotherapy.

WHAT IS
MEDICALLY
NECESSARY
IN MANAGED
CARE SYSTEMS?

Medical necessity is not a new concept. It has been used in Medicaid, Medicare and private insurance rules for many years. Because managed care plans agree to deliver covered services to covered individuals whenever those services are needed, they cannot refuse to serve a child who is a member of their plan, as providers operating under a grant or in a fee-for-service system frequently do. Managed care plans therefore need to devise mechanisms for making decisions about what services to provide to whom, under what circumstances. Otherwise, the plan would have no control over utilization and expenditures and could not operate effectively.

Typically, managed care firms agree to provide an array of services (specified in the contract) to a defined group of individuals (also described in the contract) for a flat fee or payment negotiated in advance. Most often, the firm receives a fee, known as a capitation payment, for each individual enrolled in the plan. If the company provides fewer services, it will make a greater profit or save more money because its payments are fixed by the capitation rate. This directly, and deliberately, creates the opposite incentive to that in a fee-for-service system, where providers' income increases as more services are furnished.

Managed care plans use various mechanisms to hold down their costs. Some put their provider network under pressure to control costs by making capitated payments to the providers, thereby passing on to them a substantial part of the risk. (Providers "at risk" face the possibility that their revenues will not be sufficient to cover the expenditures they incur in the delivery of necessary services.) Another way is for managed care plans to negotiate discount rates to pay their providers. However, Medicaid rates are generally low to begin with, so plans must also increase efficiency through stringent controls on the use of services. Some plans set specific limits on the duration of care (such as no more than 20 outpatient sessions or 30 inpatient hospital days per year).

Under EPSDT, the state remains liable for all needed services and cannot place arbitrary limits on the duration of services to children.¹⁰ Tentative limits may be placed on coverage, however, to be exceeded only with prior approval by the managed care plan. But this or any other utilization control must still be consistent with the "preventive thrust" of EPSDT and must ensure that children get the services they need. Services cannot be delayed and there must be an expeditious process to allow children to obtain services above the tentative limits. To

do this, managed care plans set up internal systems to determine when a service is medically necessary for a particular child. Utilization review and prior authorization are two common mechanisms for doing this.¹¹

Medicaid Law on the Definition of Medically Necessary Services

When creating a definition of medically necessary services, states must take into account Medicaid law and regulations and the courts' interpretations of those rules. In the statute and through regulations and guidance to the states issued by HCFA, Medicaid defines the rights and entitlements of eligible children and their families.¹² While Medicaid law permits states to define the "amount, duration and scope" of any covered service, states may only "place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures."¹³ A covered service must be provided in sufficient amount, duration and scope "to reasonably achieve its purpose."¹⁴

Courts have required that decisions about authorizing services rely heavily on treating physicians' judgments; they may not be made by clerical personnel or government officials. States are also prohibited from denying or reducing the amount or scope of covered services based on an individual's diagnosis, type of illness or condition suffered.¹⁵ Medical-necessity determinations cannot be used to deny needed services arbitrarily or to discriminate invidiously in the provision of services or to deny services that are in fact needed to ameliorate or treat a condition or illness. Under Medicaid law, states cannot avoid liability for fulfilling their responsibilities by shifting all operating authority to managed care entities. As one court found:

*It is patently unreasonable to presume that Congress would permit a state to disclaim federal responsibility by contracting away its obligations to a private entity.... The law demands that the designated state Medicaid agency must oversee and remain accountable for uniform statewide utilization review procedures conforming to bona fide standards of medical necessity.*¹⁶

In addition, Medicaid has a defined system of appeals and fair hearings for Medicaid-covered individuals, and these rules cannot be overridden by a move into managed care. States must ensure that parents and older children receive written notice when services are denied, reduced or terminated and that they be given the opportunity to appeal such actions. If an action is appealed, a formal administrative hearing must be

held promptly, at which the child's interests may be represented by counsel.¹⁷

How Courts Have Ruled on Medically Necessary Services

Courts have held that a broad interpretation of the term “medical necessity”¹⁸ is required to carry out the remedial goals of the Medicaid program.¹⁹ Although most court decisions have concerned adults, these rulings are equally applicable to children. Perhaps the most thoughtful of these decisions is *Visser v. Taylor*, in which a federal judge ordered the state of Kansas to provide Medicaid payment for the prescription drug Clozapine when a doctor had determined that it was the last remaining therapy appropriate for his patient. The court wrote:

*The touchstone of the [amount, duration and scope cases] is medical necessity. Federal statutes and regulations providing for medically necessary treatment are to be liberally construed in favor of the intended beneficiaries of the Medicaid program.... The determination of whether a treatment is medically necessary, for purposes of Medicaid, is a professional judgment which must be decided and certified by the treating physician. A state may not eliminate funding for medical services certified by a qualified physician as being medically necessary.*²⁰

In *Lawrence K. v. Snider*, filed in Pennsylvania in 1991, a child sued when he remained confined to a hospital because other services were not available, even though they were considered medically necessary by the child's psychiatrist. The case, which proceeded as a class action, settled and led to the creation of a broader array of alternative services, such as wraparound services and residential treatment.

The U.S. Supreme Court has not squarely addressed the issue, but in *Beal v. Doe*, it expressed serious concerns about state Medicaid plans that did not include medically necessary treatment in their coverage:

*[S]erious statutory questions might be presented if a state Medicaid plan excluded necessary medical treatment from its coverage.*²¹

The courts have interpreted the federal EPSDT mandate to require states to ensure that children receive *early* diagnosis and treatment, before conditions become serious. States must conduct aggressive outreach and cannot wait until there is a severe illness or an emergency situation.²²

Courts have also considered the process by which “medically necessary” determinations are made and have held that, in enacting the Medi-

caid program, Congress intended to invest broad discretion in treating physicians—but not other individuals or entities—to determine what treatment is medically necessary. For example, in *Weaver v. Reagen*, a federal appeals court ordered the state of Missouri to fund AZT treatment for Medicaid recipients with AIDS whose doctors had determined that the treatment was medically necessary. The court declared that:

*The Medicaid statute and regulatory scheme create a presumption in favor of the medical judgment of the attending physician in determining the medical necessity of treatment.*²³

In an earlier decision, the same court held:

*The decision of whether or not certain treatment or a particular type of surgery is ‘medically necessary’ rests with the individual recipient’s physician and not with clerical personnel or government officials.*²⁴

In a case involving a child, a court struck down arbitrary caps on reimbursement for medically necessary inpatient services for a liver transplant.²⁵ The court defined “medically necessary” surgery as treatment that 1) is not experimental and 2) is medically appropriate. In making its determination that the child should receive a transplant, the court relied heavily on the child’s treating physicians.

Accordingly, federal rules, supported by court decisions, prevent states from using definitions or processes that deny access to needed services.

WHO DEFINES WHAT IS NECESSARY?

States, as guardians of the public trust, decide what services are to be covered in the managed care plan when they define the benefit package and set the parameters as to who receives these services, when and for how long.²⁶ The state, with appropriate public input, must develop the definition the managed care entity will use to determine when services are medically necessary, incorporate the definition into the contract with the managed care entity, and then monitor and enforce its application. Alternatively, the state can use its existing definition and reference it in the contract. Two states—Minnesota and Wisconsin—have adopted the approach of cross referencing the state’s own definition of medical necessity, set forth in Medicaid regulations.

There is a disturbing trend, however, for states to contribute little or nothing to medical-necessity definitions. Many contracts give detailed descriptions of the array of services available, but little guidance on how to determine whether such services are medically needed. According to a survey by the National Association of State Mental Health Program Directors (NASMHPD), 85% of state contracts refer to medical necessity but only 75% define the term.²⁷

Of these, most definitions are not specific, are adult-oriented and afford managed care companies too much discretion. While some states specifically include language to indicate that children are eligible for all Medicaid services under EPSDT, others do not. The states that have a separate definition of medical necessity in their contracts for services to children (Hawaii, Missouri, Montana, North Carolina, Pennsylvania, Utah and Vermont), repeat the language of the EPSDT statute but do not provide further clarification.

CURRENT
DEFINITIONS
IGNORE
CHILDREN'S
NEEDS

The NASMHPD study shows that, unless states make clear that managed care entities must comply with EPSDT requirements, children will not receive services to which they are entitled. According to that study, 19% of state definitions restrict coverage to acute-care situations and only 12% include rehabilitation, although 56% include some psychosocial services.

A survey of state waivers by the Bazelon Center found that only a few definitions reflect the comprehensive approach to children's services that Congress desired when it enacted the EPSDT program.²⁸ Using language that is almost boilerplate, states describe medically necessary services as those needed to prevent, diagnose and treat certain illnesses or conditions. (Some states use the phrase "correct, cure, alleviate or prevent deterioration of...") Many require that services reflect good medical practice or be consistent with accepted practice and be expected to be effective.

Generally, medical-necessity definitions authorize provision of a service only if there is not an equally effective but less costly alternative and exclude coverage of services provided solely for the convenience of the plan member. They often stipulate the qualifications required of providers. A very few require services to be individualized and specifically tailored to an individual's symptoms.

Many of the definitions also identify services that the state does *not* consider medically necessary, such as experimental or investigational treatment. One definition specifically states that a physician's prescription of a treatment does not automatically mean that the plan will consider it medically necessary.

These brief definitions allow the plans much discretion and may leave a state liable for mandated Medicaid services that the managed care entities will not provide—in particular, services that go beyond the plan's very limited concepts of what is necessary.²⁹

To fill the void in direction from the state, many managed care plans have chosen to operate their public-sector contracts initially under standards similar to those they use for their private-sector business clients. However, an employed population of adults has behavioral health service needs that are very different from the needs of children in public systems. Managed care plans in the private sector heavily emphasize short-term hospital stays, traditional outpatient therapy and the use of medications. While these are important components of a comprehensive system of care, they are far from the full array of services necessary for children with serious emotional disturbance. As a result, under these plans, children enrolled in public-sector managed care tend to have access only to a limited part of the more comprehensive Medicaid benefit package the state previously created for them under the fee-for-service system.

A further complicating factor arises when a child is in the state's custody and state or local child-serving systems, acting as guardians or under child-protection mandates, have the authority and responsibility to make health care decisions. Although the use of the term "medical necessity" is not itself a bar to providing comprehensive services to children in state care, the services needed to meet the child's mental health needs frequently overlap with those designed to ensure safety and permanency or prevent harm to the community. State mental health, child welfare and juvenile justice agencies have used Medicaid to fund many of the intensive services needed to adequately meet the needs of children with serious emotional disturbance and their families. States, however, have generally failed to establish a single point of decisionmaking—necessary to prevent cost-shifting and fragmentation. Although the Medicaid statute prohibits discrimination based on diagnosis, children with certain conditions, such as conduct disorder, are almost always in multiple systems and are thus particularly vulnerable. A full discussion of these

Medicaid Services for Children

States have used Medicaid to fund a broad array of services including prevention, outpatient treatment, intensive home-based and community services, home-like residential programs, crisis and hospital care. Using a few Medicaid service categories, many states have funded a full array of mental health care services for children.

◆ *Clinic services: office-based assessments, psychotherapy, medications and crisis services.*

◆ *Rehabilitation services: a full array of intensive home-based and community services can be funded through this category, including: intensive in-home services, behavioral aides, school-based and other day treatment programs, therapeutic foster care, therapeutic nurseries, speech therapy, occupational therapy, social skills training, independent living skills training.*

◆ *Case management: services to assist the child and family access needed medical, social, educational and other services.*

problems is beyond the scope of this paper. However, the detailed medical-necessity definition suggested below should promote better services for Medicaid-eligible children in state care. It is particularly important for these children to have access to the wide variety of individually tailored services described in the box at left.

Also, most state contracts fail to deal with clashes between the managed care company and other state systems over what services a child needs—such as when a juvenile court orders services that the managed care entity says are not medically necessary. Few state medical-necessity definitions (in contracts for behavioral health care services) specifically reference this situation. For example, Nebraska deals with court-ordered treatment by permitting the managed care entity to certify whether or not the court-ordered treatment is medically necessary. If the managed care entity says the treatment is not necessary, it does not have to pay for services. Virginia and Iowa, on the other hand, stipulate that when a court orders treatment, the managed care entity must pay for it.

Overall, only a few states have moved to develop adequate medical-necessity language in their requirements for children's managed mental health services (and these, too, could be improved). Some of the best are: Pennsylvania, which has specific guidelines on child mental health services for managed care entities and county programs; Arkansas (in an RFP for children's services); and Michigan (in its draft concept paper for behavioral health care). Useful concepts from these states will be discussed more fully below.

TAKING A DIFFERENT APPROACH

Outside the managed care context, definitions of what constitutes an appropriate service are more detailed. They encompass considerably more than “medical” services in the strict definition of the term, and they address a host of service-delivery issues, such as requiring care to be furnished in the least restrictive setting and in a culturally competent manner.

States should base their managed care definitions of medical necessity on similar concepts and on their considerable past experience in defining the services for which public funds will be spent. They should use the “medically necessary” definition to protect children’s access to a comprehensive array of home-based and community services, with an eye to preventing out-of-home placement, promoting success in school and preventing scrapes with the law, thus furthering the overall goals of their mental health system.

The most important characteristic of an effective mental health service system is the appropriate matching of services and need, based on individual circumstances and choice.

The benefit package of a managed care plan can provide incentives encouraging desired patterns of utilization to promote cost-effective care, such as substituting lower-cost equivalent services. However, a judicious mix of benefit design and individualized decisionmaking is still needed to match children and services correctly. Benefits must be flexible, but financial incentives promoting lower-cost services (such as in-home services, day treatment, therapeutic foster care and medications) must be balanced by controls on the use of such services by individuals who do not need them. Selecting the right match of services to effectively address children’s individual problems, while respecting preferences, is the purpose of “medically necessary” criteria.

To accomplish such an end, this paper suggests a different approach to defining medically necessary services—one more consistent with the law. In place of broad but short stipulations requiring plans to ensure that services adhere to professional standards, are safe and effective and emphasize less costly alternatives (as the typical contract definition does today), states should incorporate more of the essential values and operating principles they desire in their mental health service system. The section of the contract that deals with medical necessity should stipulate:

- ◆ the desired goals of services (e.g., to arrest symptoms, to promote age-appropriate development and improve functioning so as to enable children to, for example, live at home and succeed in school);
- ◆ the range of services that are to be considered “medically” necessary (e.g., day treatment and social-skills training as well as clinical treatment);
- ◆ principles for service delivery (e.g., families should be fully engaged in services planning and given choices); and
- ◆ that plans are prohibited from subverting desired goals through arbitrary restrictions on amount, duration and scope of services.

There should be links between the definition of medically necessary services and other contract stipulations. Too often, the medical-necessity definition has little or no connection to other provisions in the final contract. The definition of “medically necessary” must be linked to (or re-stated in) the state’s concepts regarding individual rights, the benefit package, approaches to service delivery, quality of care and mechanisms for appeal. Cross-referencing these items in the medical-necessity definition will greatly enhance the state’s (and the beneficiaries’) ability to enforce the standards in individual cases. The medical-necessity definition is thereby grounded in the underlying principles and standards of the contract, and the state ensures that other important provisions of the contract will be considered as a plan reviews whether a particular service is medically necessary.

The definition of medically necessary services should also include standards for the process of making these determinations. Further, a system of appeals should be linked to the definition. Standards for the appeal system can then be set elsewhere in the contract.

States may also wish to include stipulations of what is *not* considered to be a medically necessary service (e.g., custodial care).

The specific definition of medical necessity for children can be included in the same section that sets out the definition for adults or in a separate section of the contract. However, in either approach, the unique needs of children and their families should be addressed.

CREATING A DEFINITION OF MEDICALLY NECESSARY

The narrow array of services currently offered by managed care plans has led to discussions about changing “medically necessary” to a term that might suggest a broader range of services. Several have been recommended, such as “clinical necessity,” “social necessity” (particularly for child welfare systems) or “biopsychosocial necessity.” Another option is to drop the adjective and cover all “necessary” services.

However, changing the terminology is probably neither required nor advisable. With the wrong definition, any term will fail to protect plan members. The key to ensuring appropriate delivery of care is to have the right criteria. With the right definition, “medical” necessity is preferable because it builds on current Medicaid law, which creates a strong legal entitlement to services under EPSDT and considers a wide array of services to be “medically necessary.”

What Is Medical?

It is important to note that Medicaid itself recognizes as “medical” clinical services (such as services of psychologists and psychiatric social workers), case management and rehabilitation services for children with serious emotional disturbance. Using the term “medically necessary services” in a Medicaid context therefore does not substantially limit the range of mental health services covered.

Elements of a Definition of Medically Necessary

Below is a proposed definition of medically necessary services for children that can be included in managed care contracts. It presents the elements of a definition and provides suggestions, meant to be useful and provocative, for specific clauses in the contract. The sections that follow lay out issues to address under each facet of the definition, illustrating the new approach with suggested language. This material is not intended as a “model” definition. Each state definition will need to be crafted individually to reflect the unique aspects of a state’s current legal code, contract goals, family and advocate aspirations, and the organization of the state’s service system.

Definition of Medically

Necessary Services

A medically necessary service is a service:

- ◆ *furnished in accordance with the goals of services, described in paragraph (A);*
- ◆ *furnished for the specific purposes described in paragraph (B), and*
- ◆ *that meets the standards of service delivery in paragraph (C).*

Medically necessary services shall be provided in accordance with paragraph (D), which prohibits arbitrary actions by the contractor to limit services, and through a process that meets the requirements in paragraph (E), and shall be appropriately linked to the grievance and appeal system as required in paragraph (F).

A. Goals of Services

The first question a “medically necessary” definition must answer is: necessary for what end? Services and supports are provided to achieve certain goals, both for the individual and for society. Articulation of these goals in the medical-necessity definition will enable the state to clearly lay out the overall objectives of its mental health system and provides the foundation for addressing other critical issues.

Many states have articulated goals in their federal waiver requests or in their requests for proposals, and a few include them in their contract language. However, including this language in the contract does not necessarily create a legally enforceable requirement on the managed care plan. To achieve that goal, the definition of medically necessary services should directly reference the goals of services which, in turn, should relate to the goals of EPSDT.

Each covered child (defined as individuals under the age of 21) shall be eligible for services, as defined in section _____, provided in sufficient amount, duration and scope to enable the child to function at the highest possible age-appropriate level, given the severity of the child’s disorder, in the least restrictive setting of their choice, and to progress developmentally as individually appropriate.

Medically necessary services:

(a) are designed to promote recovery and healing, improve functioning and behavior to enable the child to attain or maintain an optimal level of functioning, enhance the quality of life and promote wellness;

(b) enable the child to progress developmentally as individually appropriate, and to live at home or in a homelike setting, succeed in school and avoid encounters with the justice system;

(c) address the needs both of the child and of the child's family;

(d) reflect the choice of the child and family and be designed to achieve outcomes desired by the child and family; and

(d) are offered in the most integrated settings appropriate to the child's needs and with the goal that the child live at home or in a homelike setting.

B. Purpose of Services

In addition to being directed toward global goals, services must be designed to accomplish specific objectives. The definition of medically necessary services must be broad, yet explicit. It must encompass not only clinical treatment but also screening, prevention and rehabilitation. Most state definitions address these issues to some degree and the language below is based on language that appears in several.

Medically necessary services are services reimbursable under Title XIX of the Social Security Act, and described in detail in Section ____ (Benefit Package), supplies and technologies, furnished by or under the supervision of a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, that are provided consistent with the child and family's desires and that are sufficient in amount, duration and scope to effectively:

(a) identify children with mental illnesses or conditions in accordance with the outreach and screening procedures identified in Section ____ of the contract.

(b) assess the needs of children identified in (a) and their families;

(c) treat, ameliorate, diminish or stabilize symptoms of mental illnesses or conditions;

(d) alleviate suffering or pain;

(e) prevent, arrest or delay the development or progression of a mental illness and prevent or delay relapse;

(f) provide rehabilitation and other services to improve functioning (including functioning in all important areas of life, such as daily activities, social relationships, and age-appropriate behavior including, for older adolescents, independent living);

(g) provide anticipatory guidance to parents of children at risk with respect to mental health and emotional development and provide family education and guidance concerning their child's mental disorder;

(b) provide, for eligible children in the child protection and juvenile justice systems (including those whose situation is under investigation to determine if they should be in the child protection system, or who are being considered for foster care placement or adoption), the specific services and assessments required in Section _____ (Benefit Package);

(i) affirmatively ensure access to and promote appropriate utilization of services (including overcoming barriers caused by inability to obtain transportation).³⁰

C. Standards of Service Delivery

In addition to describing the goals and purposes of services, the definition of “medically necessary” should ensure compliance with important service-delivery standards. For example, the definition should make clear that medically necessary services must be responsive to the child’s unique strengths and needs, provide choice among possible alternatives, and be furnished in an appropriate manner. Such standards are incorporated into law in many states or reflected in mental health system regulations or planning documents.

Medically necessary services must be:

(a) based upon an individualized assessment of the child’s assets, strengths, desires, needs and environmental supports;

(b) provided as early as possible in the child’s life in order to address conditions in their early stages;

(c) furnished in accordance with an individualized services plan, which is based on a comprehensive assessment, developed in partnership with the child and family and designed to attain specific outcomes desired by the child and family; the services plan shall be monitored, reassessed and revised periodically, based on progress, outcomes and child and family satisfaction; the child and the family shall have ultimate authority to approve or reject the services plan consistent with law;³¹

(e) for children with serious emotional disturbance, the plan shall include family education and support services, as defined in section _____;

(f) services of the child’s and family’s choice. The child and family have the right to refuse services consistent with law and such refusal may not be used as grounds to deny other services; the plan may deny services that would be ineffective or for which there is a cost-effective alternative that otherwise satisfies the standards for medically necessary services, as set forth herein and in Sections (A), (B), (D), (E) and (F);

(g) provided in the least restrictive appropriate setting and in the most natural environment possible.

(h) provided in the child's home or home community (including child care centers or preschool programs), except in limited extraordinary circumstances. Inpatient and residential treatment shall be used only when all less restrictive levels of treatment have been unsuccessful or cannot be safely provided;

(i) designed to prevent the need for, or continuation of, institutionalization or residential care and involuntary treatment;

(j) delivered in a timely manner, with an immediate response in emergencies in a location that is convenient and accessible to child and family;

(k) responsive to unique needs of linguistic and cultural minorities and furnished in a culturally relevant manner;

(l) furnished with accommodations to the needs of children with mental and physical disabilities, as required under the Americans with Disabilities Act and other applicable law;

(m) provided in a manner that facilitates continuity and coordination of services (including coordination with Head Start, child care and vocational rehabilitation programs);³²

(n) provided in a manner that ensures coordination with the child's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP); the plan shall consider services covered in the child's benefit package to be medically necessary by virtue of their inclusion in the IEP or IFSP;³³

(o) consistent with national standards of practice, including standards of practice in community child and adolescent psychiatry, as defined by standard clinical references, generally accepted professional practice or empirical professional experience;

(p) consistent with the plan's Quality Assurance standards and procedures in Sections _____ of the contract; and

(q) consistent with the standards for confidentiality in Section _____ of the contract.

D. Arbitrary Limits

Managed care is a delivery mechanism intended to facilitate individualized care decisions. Placing arbitrary caps on mental health services, such as limiting outpatient services to 20 visits or hospital days to 30 per year, is inconsistent with individualization and may result in the denial of necessary care in violation of EPSDT.

On the other hand, in place of caps, many plans use a system of triggers or tentative limits to guard against overutilization of services. The continued need for a particular service is reviewed after a child receives a certain quantity of the service—for example, five days in a crisis facility. In some cases, additional services may be pre-authorized. While it may be appropriate for a plan to use tentative limits, their use should be carefully monitored to ensure that they do not become de facto pre-set limits on care, which would violate the purposes of EPSDT.³⁴

To protect against arbitrary limits states should make clear that:

- (a) all services shall be provided in sufficient amount, duration and scope to reasonably achieve their purpose;*
- (b) services shall not be reduced or denied based on pre-set limits on the duration of services; instead, reviews of the continued need for services shall be conducted on an individualized basis;*
- (c) the length of care stipulated in any trigger for review or any tentative limit may not be used as a de facto limit on the duration of services;*
- (d) services may not be denied or reduced in scope based on an individual's diagnosis, type of illness or condition suffered; and*
- (e) services may not be reduced or denied pending appeal.³⁵*

E. Process to Determine When Services Are Medically Necessary

The best definition of “medically necessary” will be of no avail if the managed care entity’s process of determining necessity results in inadequate or inappropriate implementation of the criteria.

Managed care plans may use a variety of methods to make determinations of medical necessity. Prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeper screenings, case management and designated-provider networks are all methods used by managed care plans to limit access to services. Errors in implementation of any of these mechanisms can deny access to needed services.

To guard against improper denials, states, in consultation with families and advocates, should establish standards in their contracts with managed care entities for the process by which medical-necessity determinations are made. For example, some managed care contracts require that personnel who make medical-necessity determinations have specific

credentials. In addition, some states have enacted relevant statutes; such laws should be referenced in the contract.

Medical-necessity determinations shall be made in accordance with the following standards:

(a) decisions should initially be made by the child and family and the child's treating provider; however, the plan may establish protocols for when further approval is necessary;

(b) when further approval is necessary, decisions shall be made in a timely fashion and the plan shall respond within _____ to pre-authorization requests;

(c) decisions shall be made by appropriately trained child mental health professionals with sufficient clinical experience (including experience in treating children with serious emotional disturbance);

(d) the plan shall document how decisionmakers considered the recommendations regarding medically necessary services from the treating professionals as well as the desires of the child and family and document specific reasons for overriding such recommendations and desires;

(e) if the plan uses written practice guidelines, determinations of medically necessary services shall be based on practice guidelines developed specifically for children and child mental health disorders that are consistent with the provisions of Sections AC;

(f) criteria for medically necessary services and any practice guidelines used are distributed to all providers who participate in the plan and, upon request, are available for review by plan Members and prospective plan Members; plan Members and prospective plan Members shall receive information describing the method for obtaining access to the criteria and guidelines.

F. Link to an Appeal System

Regardless of how well the plan does, there will always be disputes between the managed care entity and families about decisions on medical necessity. The contract should therefore clearly spell out an appropriate grievance and appeal mechanism, and the contract's definition of "medically necessary" should form the basis for resolving such disputes.

(a) decisions as to whether a particular service, supply or technique is medically necessary shall be subject to appeal by a Member under section _____ (appeal provisions); the definition of medical necessity set forth in _____ shall form the basis for resolving such disputes;³⁶

(b) Members may also use the plan's grievance process set out in _____ (grievance process) to complain about medical necessity decisions. The definition of medical necessity set forth in Section _____ shall form the basis for resolving such grievances;

Sanctions

In developing contracts for managed mental health care, states will need to address the issue of what sanctions are applied should the plan fail to comply with the provisions of the contract. Unless specific sanctions apply if a plan violates the requirements of the medical-necessity criteria, the state will have only limited options: to ignore the violations, to pressure the plan to address the violations or to cancel the entire contract. A better approach would be to delineate specific interim sanctions, such as monetary penalties, for failure to follow the medical-necessity criteria appropriately.

Failure of a plan to deliver services according to the above criteria shall be cause for sanctions, as described in Section _____ of the contract.

CONCLUSION

The material in this paper covers a significant range of issues, expanding the definition of medical necessity beyond those in most current state contracts. The document is meant to stimulate policymakers to think differently about the decisionmaking process for determining what services will be furnished to a child in a public-sector managed care plan using Medicaid funds, when and for how long. The elements discussed in sections (A) through (F) above should all be addressed in any state contract for such services. The language is offered as an example, which states may adapt to reflect their current mental health policies and definitions or to fit the approach to managed mental health care being taken in the state.

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Judge David L. Bazelon Center for Mental Health Law, April 1998

NOTES

1. 42 U.S.C. § 1396d(r)(1)(B).
2. 42 U.S.C. § 1396d(r)(5). The Medicaid EPSDT statute, regulations and HCFA interpretations address myriad issues, such as outreach, quality assurance and transportation. This paper, however, will only discuss medical necessity.
3. Throughout this paper reference is made to mental health services. However, these recommendations are equally applicable in concept to addiction treatment services and could be adapted to address both types of services (behavioral health services) in states that have managed care plans addressing both needs.
4. See *J.K. v. Dillenberg*, 836 F. Supp. 694 (D. Ariz 1993).
5. See Stroul, Beth A., *Children's Mental Health: Creating Systems of Care in a Changing Society*. Paul H. Brookes Publishing Co., Inc., Baltimore MD (1996).
6. See Soler, Mark, and Warboys, Loren, Services for Violent and Severely Disturbed Children: The Willie M. Litigation, in *Stepping Stones: Successful Advocacy for Children* 61 (S. Dicker ed. 1990); *R.C. v. Hornsby*, No. 88-H-1170-N, (M.D. Ala. June 11, 1991)(consent decree)(on file with authors).
7. 42 U.S.C. §§ 1396d(a)(6), 1396d(a)(11), 1396d(a)(13), 1396d(r)(5).
8. Under federal law, case management is mandatory as a covered medical service for children, even though it is an optional service for adults. 42 U.S.C. §§ 1396d(a)(19), 1396d(r)(5), 1396n(g)(2). Case management must include 1) informing about EPSDT, 2) assistance in appointment scheduling and transportation and 3) assistance in obtaining access to needed medical, social, educational and other services. *Id.*
9. The definition of children with special needs includes all children who receive federal disability payments under the Supplemental Security Income (SSI) program, children in the custody of the state child welfare system and other children with significant health care problems.
10. Public managed care arrangements can be set up at the state, local or regional level. For the sake of simplicity, the word "state" is used in this document for any government entity contracting for managed behavioral health care.
11. Utilization reviews evaluate the necessity and appropriateness and efficiency of services, such as reviewing appropriateness of admissions, services ordered and provided, length of stay on a concurrent or retrospective basis. Prior authorization is the approval a provider must obtain from a payor before furnishing certain services, used particularly for inpatient hospital care.
12. In addition, under the U.S. Constitution, individuals have a right to mental health care when they are confined by the government, *Youngberg v. Romeo*, 457 U.S. 307 (1982), or when the government otherwise plays a dominant role in their lives, *Spivey v. Elliott*, 41 F. 3d 1497 (11th Cir. 1995) ("the question is...the extent the State exercised dominion and control over that individual"). See also *Thomas S. v. Flaherty*, 902 F.2d 250 (4th Cir.), cert. denied, 498 U.S. 951 (1990); *Halderman v. Pennhurst State School and Hospital*, 784 F. Supp. 215, 222-23 (E.D. Pa.), aff'd, 977 F. 2d 568 (3d Cir. 1992); *McNamara v. Dukakis*, 1990 WL 235439 (D. Mass. 1990). State constitutions and statutes may also create entitlements to mental health care.
13. 42 C.F.R. § 440.230(d).

14. 42 C.F.R. § 440.230(b).
15. 42 C.F.R. § 440.230(c)(1). The U.S. Supreme Court has used a similar standard in defining the scope of the constitutional “right to treatment.” *Youngberg v. Romeo*, 457 U.S. 307 (1982). See generally Stefan, Susan, Leaving Civil Rights to the “Experts”: From Deference to Abdication Under the Professional Judgment Standard, 102 *Yale Law Journal* 639 (1992).
16. *J.K. v. Dillenberg*, 836 F. Supp. 694, 699 (D. Ariz. 1993).
17. See *Daniels v. Wadley*, 926 F. Supp. 1305 (D.Tenn. 1996) (managed care entities must comply with procedural due process requirements of Medicaid).
18. The term medical necessity is used in other related areas of law. For example, several courts have considered the meaning of “medical necessity” when it appears in private insurance contracts.
19. The judicial opinions cited here are binding only within the territory over which the deciding court has jurisdiction. However, these opinions are likely to influence other courts. In deciding a legal issue, courts review how other courts have handled the matter and often defer to the reasoning of the other court’s decisions. Thus, the opinions cited in this section can be considered as guidance as states develop their policies for setting standards with regard to when a service is medically necessary.
20. 756 F. Supp. 501, 507 (D. Kan. 1990) (internal citations omitted).
21. 432 U.S. 438, 444 (1977).
22. See *Stanton v. Bond*, 504 F.2d 1246, 1251 (7th Cir. 1974)(criticizing Indiana’s “somewhat casual approach to EPSDT”). EPSDT law, regulations and the State Medicaid Manual (HCFA policy guidance) contain specific provisions regarding outreach, which should be incorporated into that section of the contract. See 42 U.S.C. § 1396a(a)(43)(A); 42 C.F.R. § 441.56, State Medicaid Manual §5121.
23. 886 F.2d 194, 200 (8th Cir. 1989).
24. *Pinneke v. Preisser*, 623 F.2d 546, 550 (8th Cir. 1980). See also S. Rep. No. 404, 89th Cong., 1st Sess., reprinted in 1965 *U.S. Code Cong. & Admin. News* 1943, 1986 (“the physician is to be the key figure in determining utilization of health services”).
25. *Montoya v. Johnston*, 654 F. Supp. 511 (W.D.Tex. 1987).
26. Although the state can decide which services are carved out of the managed care plan, it remains obligated to provide the full array of services mandated under federal law by EPSDT.
27. “Medical Necessity Criteria Survey.” Study conducted by Tom Hester, Georgia Division of Mental Health, Mental Retardation and Substance Abuse, Department of Human Resources, reported at the National Association of State Mental Health Program Directors Winter Commissioners Meeting, December 1997. NASMHPD, Alexandria, VA.
28. *Medicaid Managed Mental Health Care: Survey of the States (II)*, Bazelon Center for Mental Health Law, Washington DC. (March 1997).
29. Rosenbaum, Sara, Teitelbaum, Joel, *Overview of Medical Necessity in Managed Care Contracting*, George Washington University Center for Health Policy Research, Washington DC (1997).

30. EPSDT regulations require that Medicaid agencies must offer EPSDT-eligible individuals “necessary assistance” with transportation and actually provide such assistance if requested. 42 C.F.R. § 441.62.
31. The issue of a minor’s consent to treatment and confidentiality of medical decisions is complex and beyond the scope of this paper. Accordingly, we reference both the family and child as the locus of decisionmaking, recognizing that this may not be appropriate for adolescents in some cases. All states have enacted statutes authorizing minors to consent to certain medical services. These services frequently include mental health treatment, especially outpatient care. Some states have age limits, which typically fall between age 12 and 15. States should incorporate or reference their state law in the contract where appropriate. For a detailed discussion, see National Center on Youth Law, *State Minor Consent Statutes: A Summary* (April 1995); for a copy, write to the National Center for Youth Law, 211 North Columbia Street, Chapel Hill, NC 27514.
32. Federal regulations require coordination of EPSDT service with “related programs.” 42 C.F.R. § 441.61. HCFA State Medicaid Manual § 5230. These include: Title V Maternal and Child Health programs, vocational rehabilitation programs, Head Start, WIC, school health programs including special education, and Title XX Social Service programs such as child care and in-home support services.
33. Under Medicaid Law and the Individual with Disabilities Education Act (IDEA), Medicaid, not the school system, must pay for covered services to a child, even when these services have been found necessary and included in the child’s IEP or IFSP. See 42 U.S.C. § 1396b(c) (stating that Medicaid law shall not restrict payment for covered services because such services are included in an IEP or IFSP); § 612(a)(12) of the amendments of 1997 to IDEA, 20 U.S.C. § 1400 et seq. (stating that if any public agency other than the educational agency is responsible for providing services under federal and state law, such public agency should fulfill that responsibility).
34. H.R. Rep. No. 247, 101st Cong., 1st Sess. 399 (Sept. 20, 1989).
35. A Medicaid recipient who requests a hearing within 10 day of receiving a written notice of reduction or termination of services must continue to receive those services pending the fair hearing decision. 42 C.F.R. § 431.230, 431.210(e).
36. Medicaid law and regulations provide detailed requirements for notice and hearing when a claim for medical assistance is denied. See 42 U.S.C. § 1396a(a)(3); 42 C.F.R. §§ 431.200et seq., 434.32, 431.244(f), 431.230 and 431.210(e). These provisions should be incorporated in the section of the contract setting forth the managed care entity’s responsibilities in this area.

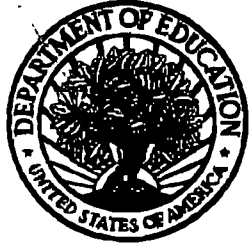
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