

Testimony before the Human Services Committee
March 11, 2010
Support for HB 5296 with Substitute Language

Good afternoon, Chairs and members of the Human Services Committee. My name is Alicia Woodsby, and I am the Public Policy Director for the National Alliance on Mental Illness, CT (NAMI-CT). I am also co-chair of the state's Medical Inefficiency Committee established in last year's special session of the legislature as P.A. 09-03 section 81 (b) and PA 09-07 section 107 (b) to "advise the Department of Social Services on the amended definition of "medically necessity" utilized in the administration of the State Medicaid program. The statute also required the committee to provide feedback to the General Assembly on the impact of the amended definition.

The Committee is comprised of physicians, attorneys, and advocates, and has worked diligently for the past several months to develop balanced recommendations for the Department of Social Services and the state. The Committee has just finalized its first report with an alternative Medicaid Medical Necessity definition designed to comply with last year's legislative mandate. The Committee strongly recommends that this definition be in statute, especially in light of the Governor's proposal in SB 32 which would not only eliminate our Committee and its monitoring function but require the adoption of the SAGA definition in statute. This would clearly reduce the quality of care, and necessitates a statutory protection.

Thank you for raising this bill on the Committee's behalf based upon our preliminary recommendations, which have been modified after further meetings and extensive work with the Department of Social Services. DSS attended all of the meetings of the Medical Inefficiency Committee and was an integral part of the process of developing the Committee's final recommendations. The Committee strongly supports and recommends the following language for HB 5296:

Not later than July 1, 2010, the Department of Social Services shall utilize in the administration of Medicaid the following definition of "medically necessary" or "medical necessity": those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain that individual's achievable health and independent functioning, provided such services are:

- 1. consistent with generally accepted standards of medical practice, which are defined as standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, the views of physicians practicing on relevant clinical areas, and any other relevant factors;**
- 2. clinically appropriate in terms of type, frequency, timing, site, extent and duration, and considered effective for the individual's illness, injury, or disease;**
- 3. not primarily for the convenience of the patient, physician, or other health care providers;**
- 4. not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that individual's illness, injury or disease; and**
- 5. based on an individualized assessment of the recipient and his or her medical condition.**

Clinical policies, medical policies, clinical criteria, or any other generally accepted clinical practice guidelines used to assist in evaluating the medical necessity of a requested service shall be used solely as guidelines and shall not be the basis for a final determination of medical necessity.

Upon a denial of a request for services, the individual or healthcare provider shall be notified that upon request, they shall be provided with a copy of the specific guideline or criteria, or portion thereof, other than the published medical necessity definition, considered by the Department of Social Services or its agent in making its determination.

The Committee reviewed definitions of medical necessity from federal law, surrounding states, and Connecticut's commercial insurance industry, and the recommendations of the Connecticut State Medical Society and the American Medical Association as part of a national settlement of class action litigation brought by physicians against the largest HMOs. The Committee's definition of medical necessity combines critical elements in the current Medicaid Medical Necessity definition with the Medical Necessity definition adopted in the class action settlements. The Committee's definition is consistent with the definition adopted for commercial health plans in Connecticut in Public Act 07-75. As noted by the Connecticut State Medical Society (CSMS), "the Medicaid population, which is generally more vulnerable than the commercial population and possesses fewer resources to pay for denied services, should be afforded at least the same protections as the commercial managed care population is entitled to under state law."

The Committee's definition rejects the Departments change from "equally effective" to "similarly effective." The term "similarly effective" sets a lesser standard, and therefore does not meet the statutory requirement that any new definition maintains the same quality of care. Instead, the Committee uses the standard of "equivalent therapeutic or diagnostic results", which, according to the CSMS, "is broadly supported by national medical groups and has also been adopted by other states across the country." The Committee's definition also addresses the need to consider independence as one of the goals of the Medicaid program, as required by federal law, while still allowing the Department the ability eliminate inefficiencies that may result from the inclusion in the current regulation of the somewhat vague "optimal" levels of health and functioning.

In order for HB 5296 to reflect the Committee's recommended definition of Medical Necessity for Medicaid, the following changes to the bill are necessary:

(Section 1) change "a medical condition or mental illness" to "***an individual's*** medical condition, ***including*** mental illness"

(Section 1) change "in order to attain or maintain maximum achievable health, functioning and independence" to "in order to attain or maintain ***that individual's achievable health and independent functioning***"

(Subsection (1)(a)(1)(D)) change "any other relevant factors, ***as determined by the Department of Social Services***" to "any other relevant factors"

Separate Subsection (a)(3) so that Subsection (a)(3) reads "**not primarily for the convenience of the patient, physician, or other health care providers;**" and Subsection (a)(4) reads "**not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or**

diagnostic results as to the diagnosis or treatment of that individual's illness, injury or disease; and”

Section (1)(b) remove the language in (b) and replace with Subsection (a)(5) ***“based on an individualized assessment of the recipient and his or her medical condition.”***

Add Sections (1)(b) and (c)

(b) “Clinical policies, medical policies, clinical criteria, or any other generally accepted clinical practice guidelines used to assist in evaluating the medical necessity of a requested service shall be used solely as guidelines and shall not be the basis for a final determination of medical necessity.”

(c) “Upon a denial of a request for services, the individual or healthcare provider shall be notified that upon request, they shall be provided with a copy of the specific guideline or criteria, or portion thereof, other than the published medical necessity definition, considered by the Department of Social Services or its agent in making its determination.”

Thank you for your time and attention to this important issue. I am happy to answer any questions.