

Testimony before the Human Services Committee
March 11, 2010
Support for HB 5296 With Substitute Language
John Booss, MD

Good afternoon, Chairs and Members of the Human Services Committee. I am Dr John Booss, a resident of Bethany and a member of the Committee established to review the definition of Medical Necessity revised by the Department of Social Services. My testimony is in support of that provided by Ms Alicia Woodsby, Co-Chairperson of the Committee.

Organization of testimony.

Allow me to present my testimony in three parts. First, I will relate my experience as it pertains to the work of the Committee in defining Medical Necessity. Second, let me report on the Committee's work as I observed it. This is particularly pertinent in light of the Governor's proposal in SB 32 to eliminate the Committee and its monitoring function. Under that proposal the aggregated expertise, experience, and deliberations would be lost as a resource for the Department and the Legislature. Third, let me highlight what I view as the crucial issues in sustaining quality care while efficiently guarding against medical inefficiency.

Experience that relates to the work of the Committee.

As the National Program Director of Neurology for the Department of Veterans Affairs, I was appointed to first Medical Advisory Committee for its Pharmacy Benefits Program. I observed that certain categories of pharmaceuticals, such as those for the treatment of mental health conditions, saved great resources by averting hospitalizations and emergency room visits.

After retiring from DVA, I set up a Neurological Consultation Clinic at the Cornell Scott-Hill Health Center in New Haven which serves an underprivileged population. I fear the human and societal costs of worsening disease that could occur with intemperate changes in the definition of Medical Necessity.

At Yale New Haven Hospital and at Leeway, the only skilled nursing facility in the state exclusively for persons with HIV/AIDS, I serve as the Neurological consultant. These populations will suffer disproportionately if injudicious cuts are made in Medicaid due to a faulty re-definition of Medical Necessity.

For many years I have worked on behalf of persons with a chronic disabling disease, multiple sclerosis. People with MS require a full range of care,

medicines, physical therapy and durable medical equipment. An adverse re-definition of Medical Necessity will be particularly punishing to them and to their families.

Work of the Committee.

The work of the Committee was at once wide ranging and intensive. Current Connecticut Medicaid Medical Necessity and Medical Appropriateness definitions were reviewed and compared with the SAGA definition. In order to gain some perspective, Federal Medicaid laws and regulations, and the definitions from the adjacent states of Massachusetts, New York and Rhode Island were compared and discussed. The Committee had the benefit of skilled input from the Office of Legislative Research. Judicial decisions that bore on the definition of Medical Necessity were reviewed. Opinion was sought from the Office of the Attorney General concerning the authority of DSS to change the definition of Medical Appropriateness. Definitions used by Connecticut's commercial insurance industry, the AMA, and the Connecticut State Medical Society were reviewed. A public informational forum was held to gain expert organizational opinions and give the public opportunity to have input. It was in short an extremely comprehensive process. Throughout the process DSS was an engaged participant.

It would be unfortunate if the accumulated experience, the aggregated expertise of the administrators, lawyers, pharmacist, and physicians who made up the Committee, and their deliberations were to be discarded as proposed in SB 32. That body of experience and expertise is particularly important as the state moves forward with monitoring the outcomes of the definition and its implementation.

The definition in the proposed legislation went through several iterations, reflecting carefully considered perspectives. Co-Chairperson Woodsby's testimony gives the definition of Medical Necessity crafted by the Committee and reviews the process by which it was derived. Her testimony addresses certain points that arose in consideration of the Department's definition and notes the changes necessary in HB 5296 to reflect the Committee's recommended definition.

Crucial Issues.

Individualized Assessment. Much mischief can arise in rigidly applying general guidelines to individual patients. There are several ways in which this may occur. First, an individual's illness may not fit neatly into a simple diagnostic category. Application of the closest fit may result in an inappropriate set of diagnostic and therapeutic directions. Second, the patient's primary condition may be complicated by a confounding secondary condition. The secondary condition may preclude certain interventions which on their own could have been effective and inexpensive. Third, individual variability may play a significant role in the response to any intervention. The attention to individualized assessment is noted repeatedly in the

definition. For example it is noted that clinical practice guidelines be used solely as guidelines. The Department was supportive of emphasizing individual assessments.

Equivalent Therapeutic or Diagnostic Results. The Committee wished to assure that focus be kept on the outcome for the patient. The term “similarly effective” used by the Department appeared to offer too much variability in quality of care.

Mental Illness. Despite society’s avowed intent to treat mental illness on an equal par with other classes of medical illness, it simply hasn’t happened. One sees the disproportion in many settings. Reimbursement for psychiatric co-morbidities was a particularly egregious example cited by the State Healthcare Advocate. Hence while clearly medical in nature, we do not subscribe to the suggestion that mental health is implied in medical illness and hence needn’t be specified. We strongly maintain the need to explicitly identify mental illness in the definition of medical necessity.

Individual’s Achievable Health. The Committee appreciated the Department’s dilemma in dealing with defining the sufficiency of care for its clients. As a provider, one does clearly aim for an individual’s best outcome with a maximization of independence. This is the goal for example in rehabilitation of a person with MS who suffers an exacerbation. The key to the conundrum relates to individualizing care and that is how the Committee presented the definition.

Transparency. It is a practice to be condemned if an individual is turned down on a claim for health benefits and the basis of that denial not be explicitly identified. Hence the Committee includes a requirement that on notification of denial the person be informed that they may request the criteria on which the denial was based.

Summary

This testimony has been offered in support of HB 5296. That bill presents the Committee’s recommendation for the definition of Medical Necessity. Its goals are to sustain high quality care and to markedly reduce medical inefficiency.

Thank you,
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