

**NEW HAVEN LEGAL ASSISTANCE ASSOCIATION, INC.**

426 STATE STREET

NEW HAVEN, CONNECTICUT 06510-2018

TELEPHONE: (203) 946-4811

FAX (203) 498-9271

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**TESTIMONY OF SHELDON TOUBMAN BEFORE THE HUMAN SERVICES COMMITTEE IN SUPPORT  
OF HB 5296 WITH SUBSTITUTE LANGUAGE (MEDICAL NECESSITY)**

Good afternoon, members of the Human Services Committee. My name is Sheldon Toubman, and I am a staff attorney with New Haven Legal Assistance Association. I am a member of the state's Medical Inefficiency Committee established in last year's special session of the legislature in order to advise DSS on a proposed new Medicaid medical necessity definition, which must "reduc[e] inefficiencies in the administration of the program while not reducing the quality of care provided to Medicaid beneficiaries." P.A. 09-03 section 81 (b) and PA 09-07 section 107 (b). The statute also requires the committee to provide feedback to the General Assembly on the impact of the amended definition over the next two years. I am here to testify in support of HB 5296, which would codify the results of our committee's work to date, with some amendments shown at the very end of my testimony.

Our Committee has worked diligently for the past few months to develop recommendations for a new definition of medical necessity which meets the above statutory standard. We held a public hearing and sought input from a wide variety of professional and advocacy organizations, and of course the Department of Social Services. We also consulted other definitions from around the country. As a result of that effort, the Committee has just finalized an alternative Medicaid Medical Necessity definition to that proposed by DSS, designed to comply with last year's legislative mandate.

Although the statute under which our committee operates does not require that the new medical necessity definition be codified in state statute, we believe that this is critical for several reasons, and therefore urge passage of 5296 with our amendments. Primarily, it is because, despite all the work of our Committee, the Governor has gone back to proposing, in both her next year's budget and the deficit mitigation package being heard right now, as she has for years now, that the highly restrictive SAGA medical necessity definition be imposed on the entire Medicaid population-- even though that definition clearly cannot satisfy the statutory standard of "not reducing the quality of care." Of course, the Governor proposes to take care of that conflict by simply eliminating that protective statutory standard-- as well as our Committee's existence-- per Sections 36 and 67 of SB32. In addition, under the current statute, DSS has no obligation to follow any of our committee's recommendations, including with respect to the definition itself.

The Committee's proposed definition has been modified somewhat, relative to what is in HB5296 which was based upon our preliminary recommendations, after further meetings and extensive work with the Department of Social Services.

One of our guiding principles was provided by the Connecticut State Medical Society: "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.”

Accordingly, for example, our definition rejects the Department’s proposed change from “equally effective” to “similarly effective,” applicable to deciding whether a cheaper treatment can be substituted for a requested treatment. Instead, the Committee uses the standard of “equivalent therapeutic or diagnostic results”, which is the exact standard governing hundreds of thousands of commercial managed care enrollees in Connecticut.

Other areas where the Committee had no choice but to reject the Department’s proposed definition as violative of the quality of care statutory standard include the SAGA definition’s declaration about “refraining from provision of services that, on the basis of the best available scientific evidence, are not likely to produce benefit.” There are two huge problems with this: (1) for many well-accepted effective treatments, there are no hard scientific studies that have been done which can be cited by the treating provider requesting approval for the treatment; and (2) even if there is such hard evidence, for many treatments, including for various cancers, the best treatment actually works in less than 50% of patients, and therefore it is “not likely to produce benefit” in any given patient with that kind of cancer.

In addition, the SAGA definition does away with the current requirement of providing treatments designed to provide “optimal health” while replacing it with nothing, removing any requirement that individuals be restored to or maintained at the highest level of health that is possible for that individual. Accordingly, the committee’s alternative definition replaces “optimal health” with a requirement that services be assessed relative to the standard of “*attain[ing] or maintain[ing] that individual’s achievable health and independent functioning.*”

Here is the Committee’s full substitute 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.**

Thank you for the opportunity to speak with you today.