Connecticut
State Medical Society

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Connecticut State Medical Society Testimony on
Senate Bill 130 An Act Concerning Cancelled Doctors' Appointments
General Law Committee
February 23, 2009

Senator Doyle, Representative Walker and members of the Human Services Committee, on behalf of the more 7,000 members of the Connecticut State Medical Society (CSMS) thank you for the opportunity to present this testimony to you on **Senate Bill 32 An Act Concerning the Governor's Budget Recommendations Concerning Social Services.** We appreciate opportunity to provide you will comments on several provisions of the bill.

While several sections of the proposed legislation warrant comment, we must first and foremost raise concerns about Section 36 and the proposed change to the definition of Medical Necessity within the Medicaid program. CSMS was involved in the settlement of several lawsuits in which most of the nation's largest insurers agreed to a standard and relatively consistent definition of medical necessity. Although there are small word variations, these definitions are almost identical to the one proposed by the Committee that allow for a certain standard of care, as well as flexibility associated with the patient's medical condition(s) and treatment protocol. A similar definition also was codified for commercial health plans in Connecticut in Public Act 07-75.

To our knowledge, insurers have complied with the Connecticut Law and we know that individually health plans for the past 2 to 5 years, depending on the settlement, have used the settlement definition to make determinations without the appearance of any significant problem.

The language before you today not only eviscerates the current definition of Medical Necessity within the program, but pre-empts the work of the Medical Inefficiency Committee established in last year's budget adjustment language. Members of this committee have been working hard to develop an alternate definition of Medical Necessity as directed by Public Act 09-7. CSMS and the American Medical Association recently testified before this committee in support of their work and proposed definition that the Committee had recommended. Attached for your review is a copy of our written testimony provided by CSMS. We ask that this committee accept and implement the Committee's final recommendations associated with a definition of medical necessity.

CSMS continues to support the adequate provision of interpreter services as a way to increase access to health care for various patient populations. Section 37 of this proposed law alters language requiring the provision of foreign language interpreter services within the Medicaid program. While it removes requirements that DSS develop medical billing codes for such services by 2011, it states that DSS must enter into a contract for the provision of such services. Provided such services are funded through appropriations to the department, CSMS would support the DSS entering into these arrangements for interpreter services for those patients who require them to access medical care. CSMS recently completed a comprehensive survey regarding racial and ethnic healthcare disparities. Responding physicians indicate that the need

for interpretation is one of the most significant barriers to care facing certain minority populations in Connecticut. If these services were provided through one source at DSS, we believe there could be cost savings achieved as well as consistency of interpreter services across care sites. This proposed language has the potential to eliminate the administrative burden and associated cost of physician's obtaining and then billing for such services.

The bill before you today would also remove risk based HMOs from the Medicaid program and replace them with non-risk bearing Administrative Service Organizations (ASO). We applaud the recognition that capitated HMOs are in fact more expensive than other models of health care delivery for the HUSKY population such as the Primary Care Case Management system (PCCM). However, we must point out that over the past three years the state Medicaid program has undergone several significant changes and often left physicians and patients in flux. CSMS has worked hard with legislators and policy makers during that period to address short comings and where appropriate promote participation by physicians.

Done hastily and without the input and involvement of physicians, we fear that already fragile networks and physician participation will be lost. We ask that this bill be strengthened by including opportunities to work with the provider community, including CSMS, to promote the changes and explain them in greater detail to the network providers as well as those physicians who currently are not participating in the HUSKY program. In addition, we must use this opportunity to address the discrepancy given to insurers to manage enrollees ($18.18 per member per month) and physicians participating in PCCM ($7.50). Physicians participating in PCCM are committed to their patients and we should use this opportunity to remove barriers to promoting the PCCM system along with participation in ASOs.

Finally, we must raise concern regarding the implementation of copayments for HUSKY A recipients. While CSMS continually promotes methods to increase the involvement of patients in responsibility of their healthcare, such efforts should not serve as a barrier to care and with this population there continues to be evidence that co-payments reduce access to care through the delay in seeking care- this only delays costs and in fact could lead to additional costs to the system. Furthermore, understanding the limited means of the HUSKY A population, we remain concerned that such copayments would serve as a reduction in reimbursement when physicians are unable to collect and serve to increase administrative costs within the already underfunded program.

Thank you for the opportunity to present this testimony to you today. We stand ready to continue working with this committee and DSS to strengthen the Medicaid program.