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February 18, 2016

**TESTIMONY OF SHELDON TOUBMAN BEFORE THE HUMAN SERVICES
COMMITTEE IN OPPOSITION TO CERTAIN PROVISIONS IN SB 17**

Senator Moore, Representative Abercrombie and Members of the Human Services Committee:

My name is Sheldon Toubman and I am an attorney with New Haven Legal Assistance Association specializing in access to health care under Medicaid. I am here to testify in opposition to two specific provisions in the Governor's bill, SB 17.

Opposition to proposal to eliminate all legislative committee review and approval of Medicaid waivers prior to submission to the federal Medicaid agency, CMS.

Section 32 of SB 17 would take away a critical protection for Medicaid enrollees and applicants, and would remove the long-standing role of this committee (and of the Appropriations Committee) to ensure that a waiver or waiver amendment is in the public interest, before it is submitted to the Centers for Medicare and Medicaid Services for approval. Several harmful waiver provisions have been wisely revised by the legislature because of this careful review process, set forth at Conn. Gen. Stat. § 17b-8, and there is no reason to change it now.

Indeed, this statute provides for legislative committee review of other kinds of federal waivers as well, and there is no justification for removing the legislative review process in these areas either. Having a review by the legislative branch of government, along with a public hearing where any concerns with a proposed waiver or waiver amendment can be aired, ensures transparency and that the best decisions in the public interest can be made. I therefore urge you to reject this proposal to repeal the statutory waiver review process.

Opposition to Further Restrictions on Access to Orthodontia for Children on Medicaid in Section 19

We also oppose Section 19 of SB 17, under which the Governor proposes to further tighten access for poor children to orthodontia services.

Under the recently created statutory scheme, a child must have a certain score on the Salzmann Assessment, an antiquated test that was created in the 1960s. This test was

not created for the purpose of determining “medical necessity,”¹. There is no relationship between a Salzmann score and a child’s actual need for orthodontic treatment.

Nevertheless, DSS has, for years, used a regulation that employs this arbitrary² scale to determine eligibility for orthodontic treatment. Last year, the administration successfully lobbied to change the standard from 24 points to a higher standard of 26, and this change was codified in statute. As a result, children in need of orthodontia have been denied access to these medically necessary services under the stricter test.

Now the Governor proposes to make this test even harder for Connecticut’s needy children to meet, by increasing the required number of points needed to qualify for medically necessary orthodontic treatment, with the sole purpose of denying services to more children.

Orthodontia corrects medically determinable oral deviations. These may cause a negative impact on speech or on a child’s ability to eat food, and often cause pain for the child. It is not simply cosmetic treatment. It is necessary medical/dental treatment, just like every other medical treatment covered by Medicaid.

In 2010, the legislature adopted C.G.S. § 17b-259b, which defines “medical necessity” specifically for the Medicaid program. This definition was the product of a select committee of knowledgeable providers and others authorized by the legislature to create an updated, legally sufficient definition of “medical necessity” for the Department of Social Services to use in administering the Medicaid program, for **all** categories of medical services. DSS staff, including its medical director, participated in crafting this definition.

The resulting statutory standard provides:

(a) “medically necessary” and “medical necessity” mean 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 the individual’s achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally

¹ J.A. Salzmann, D.D.S., F.A.P.H.A., Orthodontics in Public Health and Prepayment Programs in Orthodontics in Daily Practice 628 (1974)

² Two examples of the arbitrariness of this test:

- Under the Assessment’s instructions, a crowded tooth receives a score of one point, recognizing that it is a condition which is not normal and needs correcting. A rotated tooth receives a score of one point, recognizing that it, too, is a condition which is not normal and needs correcting. But a tooth which is both crowded and rotated receives not two points, but only one point. **The assessment deliberately ignores one of the two oral deviations which require correction.**
- The Assessment assigns no points at all for tooth pain or excessive pressure.

recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) 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." (emphasis added).

As a further set of protections against payment for inappropriate services, the statutory standard also requires that the treatment be:

(3) not primarily for the convenience of the individual, the individual's health care provider 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 the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition. (emphasis added).

Significantly, cosmetic services were **NOT** intended to be covered under this detailed statutory standard for medical necessity. Equally significantly, the medical necessity determination was intended to be based on an assessment of **each individual** and his or her medical condition, not on an arbitrary test assigning points to some, but not all, orthodontic problems.

The 2015 law, C.G.S. § 17b-282e, which provides for the Salzmann assessment as a measure of medical necessity, does provide an exception whereby orthodontia can be covered where the numerical test is not met. But this statutory exception, which requires "the presence of other **severe** deviations affecting the oral facial structures;" or "the presence of **severe** mental, emotional or behavioral problems or disturbances, as defined in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association" (emphasis added), is extremely limited. It does not comport with the carefully crafted statutory definition of medical necessity in 17b-259b, which is not limited to only "severe" medical conditions. There is no justification for such a heightened standard for this one category of services needed by poor children.

Accordingly, we strongly oppose the increase in the numerical requirement for receiving orthodontia under the statute from 26 to 29 points. We further request that the legislature change C.G.S. § 17b-282e so that it is in harmony with the broader medical necessity statute passed by the legislature in 2010, by adopting this language:

If a recipient's score on the Salzmann Handicapping Malocclusion Index is less than twenty-six [or twenty-nine] points, the Department of Social Services shall consider additional substantive information when determining the need for orthodontic services, based on the definition of medical necessity applicable to all Medicaid services in Conn. Gen. Stat. Section 17b-259b.³

³ The easiest method of achieving statutory harmony is to simply repeal C.G.S. § 17b-282e so that C.G.S. Sec. 17b-259b applies to all categories of Medicaid services, including orthodontia, as it was designed to do. But, in the alternative, the legislature should add this language to the existing orthodontia provision.