State of Connecticut

GENERAL ASSEMBLY

MEDICAL INEFFICIENCY COMMITTEE
LEGISLATIVE OFFICE BLDG. SUITE 2000
STATE CAPITOL
HARTFORD, CONNECTICUT 06106
240-0490

MEETING MINUTES

Thursday, December 10, 2009

10:00 AM in Room 2B of the LOB

The meeting was called to order at 10:09 a.m. by Chairman, Kevin Kinsella.

The following committee members were present:

Kinsella, K.; Woodsby, A.; Booss, J; DeFazio, A; Koenigsberg, D; Mezzy, R; Toubman, S

Absent were: Handelman, W

Mr. Kinsella introduced himself as a Co-Chair to this committee, explaining that he is the Administrator at Hartford Hospital and was appointed to this committee by President Pro Tempore Williams. He said that he was honored to be selected as Chair of this committee and looked forward to working with us all.

Mr. Kinsella then introduced our colleagues at the Department of Social Services (DSS), Dr. Robert Zavoski and Ms. Brenda Parella; and the Committee Clerk, Brie Johnston.

He then turned the floor over to his Co-Chair, Alicia Woodsby, who identified herself as the Public Policy Director for NAMI-CT and the appointment of House Speaker Donovan. She echoed Mr. Kinsella's gratitude and enthusiasm. Ms. Woodsby requested that each of the committee members take their turn in introducing themselves and their goals for the committee.

Mr. Angelo DeFazio introduced himself as the owner of four Arrow Pharmacies and expressed his concern with the medical necessity definition being used inconsistently among pharmacists. The pharmacists may use their discretion in which drugs to give, but they are "handcuffed" to the least costly alternative. Pharmacists may also be overly cautious due to the fear of audits, and ultimately the quality of care decreases. Mr. DeFazio suggested creating a medical necessity hotline for prior authorization on

prescription drugs; where pharmacist could call in and receive approval on what drug they give to their client.

Dr. John Booss, a retired physician from the Veterans Affairs (VA) Medical Center in West Haven, noted that he has served on panels within the VA that examined drugs and efficacy. He prefers to enter into this process of redefining medical necessity with as much data as possible. Dr. Booss would like to have a mechanism in place where physicians can make exceptions to the types of drugs prescribed. The reasoning for this mechanism is derived from genomic variations: where a drug will work for one individual, but not all people, due to nuances in individual body chemistry. Both Dr. Boos and Mr. DeFazio agreed that it was more important to look at the prescriptions category by category, not drug by drug.

Mr. Sheldon Toubman, a Staff Attorney at New Haven Legal Assistance, shared that he has represented many Medicaid clients in court and in administrative hearings and has experienced real examples of issues seen under the current definition of medical necessity. He said that one issue he has seen that is NOT a medical necessity definition issue, though sometimes claimed to be in support of changing that definition, is access to air conditioners under Medicaid. For example, there may be a clear medical need for an asthmatic individual to use an air conditioner, but it would not be covered under Medicaid because air conditioners don't meet the Department's separate definition of "durable medical equipment." That is not to say that air conditioners don't provide relief for someone suffering from asthma and aren't necessary; just that they are not covered for other reasons and so should not be cited as an example of a problem with the current medical necessity definition.

Mr. Toubman also pointed out that the definition of medical necessity is different for the State Administered General Assistance program (SAGA). The Legislative Regulation Review Committee several years ago approved the SAGA definition of medical necessity proposed by DSS (cited as the "New" definition in one of the hand outs), but this was done around the time that several changes were made to the SAGA program to substantially reduce the benefits and coverage under that program (SAGA used to have the same medical necessity definition as currently used under Medicaid).

Amidst discussion about the SAGA definition of medical necessity, the question was raised about whether it is the committee's charge to also make recommendations regarding medical appropriateness. It was suggested that, statutorily, it was only within DSS' authority, and thus the committee's charge, to examine or make changes to the medical necessity definition.

Ms. Mezzy introduced herself as a Staff Attorney for Connecticut Legal Services. She hopes that we can preserve the current definition of Medical Necessity because it applies to real people in real situations. Each word in the definition has a significant legal meaning that comes into play when denials are appealed and lawyers for the poor must justify the doctor's prescribed treatment for the particular patient. The words in the current definition presently help Medicaid recipients to gain access to excellent treatment, and she hopes we will remember to think, for example, of children who would be bedbound for life if the state and the HMOs were allowed to provide anything less than a level of care that will produce an optimal result for those children.

Dr. Koenigsberg established that he was former Chairman of the Department of Psychiatry at St. Raphael's Hospital and had also sat on the Anthem Blue Cross, Blue Shield committee to revise Medicaid Necessity criteria. His purpose is to advocate that the definition recommendations not negatively impact quality for the population it serves. The definition must work for all specialties.

Dr. Zavoski and Ms. Parella explained that many states are in the process of changing their definitions, and that, as it stands, each state has a slightly different definition.

Dr. Zavoski also commented that DSS no longer plans to move forward with implementation of their own definition on January 1, 2010. Mr. Kinsella explained that the target date for the report would be February 1, 2010.

As homework for the next meeting, Mrs. Robin Cohen from the Office of Legislative Research will look into the definitions of the surrounding states: Massachusetts, New York and Rhode Island. Dr. Koenigsberg will look at the non-proprietary definitions, and Mr. Toubman will look at Tennessee's definition, which governs Health Maintenance Organizations (HMOs).

The meeting was adjourned at 11:27 a.m.

Brie Johnston
Committee Clerk