State of Connecticut

GENERAL ASSEMBLY

MEDICAL INEFFICIENCY COMMITTEE

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

MEETING MINUTES

Thursday, January 7, 2010

10:00 AM in Room 2B of the LOB

The meeting was called to order at 10:07 AM by Chairman Kevin Kinsella.

The following committee members were present:

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

Absent were:

The committee welcomed a new member, Dr. William Handelman. Chairman Kevin Kinsella requested that the committee members and Department of Social Services (DSS or the Department) staff reintroduce themselves.

Mr. Kinsella then went through a list of housekeeping issues by first notifying the members that the next meeting would be held on January 21, 2010, at 10:00 AM in Room 2B of the LOB, and that the following two meetings would be held on February 3, 2010, and March 3, 2010. He also discussed the report that was due from the committee on January 1, 2010. Due to time constraints, he explained, the committee was not able to produce a report by the deadline. But the committee is working hard to get an interim report out in February. He and the Clerk reviewed the three missing appointments to the committee, and Mr. Kinsella mentioned that he and Ms. Woodsby would work to fill them. The Chairs will send the interim report to those who have not yet made their appointments, so that they have the opportunity to review the work of the committee and make their appointments accordingly.

The goal of this meeting was to discuss the preliminary drafting of the report that was due on January 1, 2010. The committee possibly may hold a public hearing on the preliminary report on February 3, 2010.

Ms. Mezzy called for approval of the minutes. Mr. Kinsella asked the members for any corrections. Ms. Mezzy noted that the minutes summarized the opposite of what she stated in the last meeting, but acknowledged that there was a lot of information given during the last meeting. Mr. Toubman also mentioned a few additional corrections: that air conditioners are medically necessary but are not covered under Medicaid because they're not durable medical equipment; that we discussed asking the Attorney General for his opinion about whether or not to explore medical appropriateness; and that he did not remember promising to look at the Tennessee medical necessity definition, but he might have, so leave that as is.

Kevin asked folks to send their corrections to the Clerk. Dr. Schaefer mentioned that Dr. Zavoski is quoted in the minutes, and that the comments were accurate, but it does not represent the view of the Department of Social Services at this time. They don't believe that they have to wait for the recommendations of the committee before implementing a new definition. They have not yet determined whether they will wait for the committee's recommendations. They reserve the right to implement before July 1, 2010, as the statute specifically provides.

Mr. Toubman commented that it is true that the statute allows the Department to implement a new definition on July 1, 2010, but that this does not mean that the Department is allowed to move forward without taking into consideration the recommendations of the committee. The charge of the committee is to make recommendations on changes to the definition, and if the Department does not take them into consideration it undermines one of the basic purposes under the statutory scheme.

Dr. Booss agreed that it would be unwise for the Department to move so rapidly without accounting for the recommendations of the committee.

Mr. Kinsella then turned the floor over to Ms. Cohen of the Office of Legislative Research. Ms. Cohen assembled a research report delineating the definitions of medical necessity for the states of Massachusetts, New York and Rhode Island. She offered to answer any questions.

Mr. Kinsella identified that there was a common thread within each of the definitions, and noted that the Centers for Medicare & Medicaid Services (CMS) are the federal authority over the Medicaid program. He asked Ms. Cohen if she had found a CMS definition. Ms. Cohen indicated that she would look into that definition for the next meeting.

Dr. Schaefer did not think that there was a CMS standard for medical necessity as it relates to the Medicaid program. Indeed, there are fifty states and thus fifty different variations in the definition. CMS also administers the Medicare program, however, so that definition could be used as a touchstone as well.

Mr. Toubman pointed out that Dr. Schaefer was correct. He explained that the only federal written definition that exists is outlined in the introduction to the federal Medicaid statutes. It enables each state, in accordance with other state regulations, to furnish rehabilitation and other services to help eligible families or individuals to attain or retain independence and self care. This is a very broad definition, and having attorneys sit on the committee may be advantageous as they are familiar with case law that has developed a standard to this concept.

Ms Mezzy added that there is a [EPSDT] section of the federal Medicaid law that is a little more elaborate, applies to children and may give an idea of what the CMS definition could be.

Mr. Kinsella then asked Dr. Koenigsberg if he had luck finding the American Medical Association (AMA) or Connecticut Medical Society definitions. Dr. Koenigsberg indicated that he was actively working on it and should have the definitions within the next few days. He also requested that committee members receive the meeting handouts prior to the start of the meeting. Mr. Kinsella agreed to make every effort to get the members the material before the meeting.

Dr. Schaefer had in his possession the AMA definition it recommends for Model Managed Care Contracts, but acknowledged that the Department did not find one for the Connecticut Medical Society. Ms. Woodsby pointed out that the members were in possession of the State Medical Society's proposed definition as outlined in an OLR Report.

Dr. Handelman commented that the State Medical Society used the AMA definition in a court settlement with managed care companies, so they do not have a separate definition other than the AMA definition.

Mr. Toubman has found that the statutory definition governing commercial managed care contracts in Connecticut is very similar to the AMA definition. He inquired as to whether or not they were the same definition.

Dr. Handelman explained that the definition governing commercial managed care contracts was enacted a couple of years ago at about the same time as the court settlement. One can deduce that the insurance companies agreed to that commercial managed care language, as they agreed to it in the court settlement (AMA definition). They are most likely the same definition.

Mr. Kinsella pointed out that we have a wealth of definitions to look at when putting draft recommendations together. He then turned the table over to Dr. Zavoski, so that he could speak to any problems for both providers and patients with the current medical necessity definition.

Dr. Schaefer commented that the current definition was not as good as it could be, and acknowledged that in 2003 or 2004 the Department took the opportunity of the launch of State Administered General Assistance (SAGA) managed care program to take away the requirement that SAGA be defined the same way as Medicaid. During the redefinition, they knew that it would be beneficial to get the opinions of the physicians who practice in the field, so they contracted with a group of physicians at UConn Medical School, under Dr. Peter Deckers, to help with the task. Their work produced the current SAGA definition. The Department made no changes to their proposed definition.

Medical necessity and medical appropriateness are inextricably combined; any health care decision is the nature of the problem presented by the patient and the intervention used to address the health issue. The Department researched some forty states' definitions and most included the element of medical appropriateness in their definition of medical necessity. The fact the Connecticut has two separate definitions is an

arbitrary distinction that does not help facilitate its application. The Department would like to integrate the two definitions.

The Department also thinks that the definition should be more specific in outlining the type of care that can be provided. The current definition does not allow for screening or services to identify health issues when you don't yet know that they exist within the patient. He used mental illness as an example, where it is included as a health condition in the beginning of the definition, but excluded from the sections of the definition that refer to prevention and diagnosis of a condition.

Dr. Koenigsberg then asked about the Department's reasoning for having two separate definitions for SAGA and Medicaid, since they are both administered by roughly the same government agencies. Dr. Schaefer responded that there are key distinctions between the two populations of people that the definitions serve, although the Department believes that we could have one definition. The creation of the SAGA program gave the Department the opportunity to introduce a new definition. Within that the same year, DSS also proposed the new definition for Medicaid, but it was not addressed by the legislature until this year.

The Department also feels as though the word "optimal" sets an unrealistic standard of care. Most other medical necessity definitions do not use this term, and the Department believes that it could lead to the excessive use of resources in a situation where there is markedly diminishing benefit or no benefit at all.

Additionally, the existing definition makes no reference to scientific evidence, and the Department thinks that consideration of scientific evidence is the way of the future. The Department engaged in discussions with the Oregon Health Sciences University to join their Medicaid Evidence Based Decisions Project in order to become more informed about what they're covering and what they shouldn't be covering. Dr. Schaefer pointed out that in current health care reform legislation, the insurer's tax is designed to support increases in comparative effectiveness research, which bolsters using scientific evidence as the basis on which to make health care decisions. Scientific evidence allows room to compare a recommended treatment and a treatment alternative.

The Department also believes that the least costly alternative should be pursued when the outcomes are comparable. Dr. Schaefer is of the opinion that the term "equally" does not exist in the realm of health care; one will never find that two different products have an identical effect. They suggest using the terms "similar" or "comparable." These terms are present in other definitions.

Lastly, our definition of medical necessity makes no reference to discouraging waste or inefficiency. There is no provision that expects some benefit with regard to the patient. The UConn physician's group felt strongly that this should be considered when revising the definition.

The Department stressed that this definition is a communication tool between the physician and patient and it will set the tone for how health care is administered in Connecticut over the next decade through our publicly funded programs.

Dr. Booss referenced HB 5460 from the 2006 legislative session, An Act Concerning Medically Necessary Health Care Services in Managed Care Contracts. The definition outlined in that bill and the definition agreed upon in the insurance settlements are

different, and throughout the meeting the committee identified three additional definitions. Dr. Booss thought that the committee needed the opportunity to compare the multitude of definitions out there.

Mr. Kinsella asked for volunteers to examine the various definitions. Several members raised their hands to participate in a policy subcommittee that would meet between this Medical Inefficiency Committee meeting and the next. The draft to come out of this subcommittee meeting would not necessarily be the committee's recommendations. Mr. Kinsella invited the Department of Social Services to attend the subcommittee meeting as well.

Ms. Mezzy thanked Dr. Schaefer for his explanation of what the Department wanted from the definition. She appreciates the thoroughness the Department used in examining the definitions. Ms. Mezzy did feel that the Department left out the money saving part. The SAGA definition was designed to cut costs as well as increase efficiency and consolidate the definitions of medical necessity and medical appropriateness. Ms. Mezzy was interested to know how the Department's recommended changes would save money.

Dr. Schaefer indicated that DSS did not initially take cost into consideration when creating the SAGA definition. Saving funds by not paying for services that are unnecessary or wasteful was not the driver in drafting this definition, although reducing inefficiency will reduce cost -- assuming there is not an adverse effect on quality of care, i.e., readmission or conditions that are exacerbated for lack of treatment.

The definition shouldn't get in the way of quality of care. It should promote appropriate care. Excessive and unnecessary services are iatrogenic effects associated with many of the procedures that people undergo.

Ms. Mezzy discussed the statement that Dr. Schaefer made about optimal level of care being an unrealistic standard. She assumes there would be some (claim) denials based on that because the last part of the SAGA definition says "are not likely to produce benefit." You would be anticipating denying something that is not likely to produce benefit even if it meant the person would have an optimal level of health. She requested clarification on how that would not increase denials.

Dr. Schaefer did not entirely understand the question, but did not suggest that the definition wouldn't result in more denials. The prospect of savings is probably why amending the definition was picked up this year. He believes that the Governor has had it in her proposed budgets for a number of years.

Ms. Mezzy then questioned who decides what treatments are necessary and what treatments are defensive.

Dr. Schaefer indicated that the Department or its contractors would make that decision after reviewing the clinical case. If prior authorization is required, there would be a higher level of scrutiny in deciding what is necessary and what is defensive.

Ms. Mezzy then commented that she understood why the Department saw this new definition as a communication tool. The Department wants the new definition to be a rubric for doctors because there is no prior authorization mechanism for some services.

Dr. Schaefer acknowledged that it offers the potential to be a self-policing tool, but the Department is not expecting a significant change in the way that medical decision making is practiced. It is one piece of our medical policy that should be consistent with the direction that health care is taking.

Ms. Mezzy countered that, aside from the omission on mental illness and other clean-up proposals, if the Department is not expecting a significant change in the way that medical decision making is practiced, then why not leave the definition the way it stands?

Dr. Schaefer reinforced his reasoning on unrealistic standards set by the word "optimal."

Dr. Booss then posed a question from a provider's perspective. What is medically necessary for a patient, rather than a broader interpretation, not in any of the definitions discussed at the meeting? Dr. Booss finds that looking at each patient individually is important, as you can't always fit a patient into a predefined slot. He asked the Department if there was some reason that this consideration is not incorporated into the Department's definition.

Dr. Schaefer admitted that the Department didn't consider that, as it did not come up at the time.

Dr. Handelman answered that, as a provider, it is hard to understand the nuances between the two definitions currently used ("necessity" and "appropriateness"). Providers do not necessarily refer to them when they are taking care of a patient. Once a provider has agreed to treat a patient, they most likely won't treat the patient differently based on a legal definition of what care they should provide. His concern with shrinking the standard down to one definition without the term "optimal" is that it may eliminate referrals to necessary specialists. It does not set an appropriate standard of care. Dr. Handelman noted that the community standard of care has been eliminated from the lexicon and it is now a national standard. One cannot say, at least in Connecticut, that a standard of care varies from community to community.

Mr. Kinsella then discussed the community standard of care from a hospital's perspective. If a majority of the hospitals in Connecticut follow certain protocols, then most hospitals will follow suit. Hospitals are also judged by the community they are in for their availability of services. He argues that there are variations in community standards because certain facilities may not be equipped with certain technology and patients may have to travel to another region to get it.

Mr. Toubman addressed Dr. Booss' concern that medical necessity is not assessed on an individual patient basis. Looking at the current definition, Mr. Toubman believes that, from a broader perspective, individual patients are addressed, and he cited the Marchetti case from the Connecticut Superior Court as evidence. He is concerned that the proposed definition takes away from individualized care. For example, one must demonstrate that care is necessary through scientific evidence. There is now a burden of proof placed upon the provider to demonstrate the need for the care being provided.

He referred to Ms. Mezzy's comments on denying claims, and noted that a claim will be denied if the provider cannot justify the care based on scientific evidence, even if the care works for the patient. HMOs are governing the claims and will deny them if they do not follow the language set in the definition.

Mr. DeFazio, a pharmacist, applauds the Department for having one definition for all of the entitlement programs, as it is difficult to operate under a different set of rules for each carrier.

Mr. DeFazio acknowledged that the prior authorizations in the pharmaceutical world have saved the Department millions of dollars. He also noted that evidence-based decisions are always retroactive in nature. Providers look back at the scientific evidence and determine what worked and what did not. Maybe we could phase in their determinations and not have drop deadlines. These deadlines hurt both the patient and the provider. He suggests that the Department take a proactive look at scientific evidence as it comes along, and notify the patient and provider if certain care will not be covered. Mr. DeFazio suggests that discontinued care should be phased out.

Mr. DeFazio also urged the Department to put pressure on the commercial industry and itself to have clear, quick, easy appeal and prior authorization processes. Mr. Kinsella echoed Mr. DeFazio's sentiments on the appeal processes.

Dr. Koenigsberg then took the floor and added commentary on community care. He acknowledged that there are regional variations in preferences among the providers and patients on the care administered.

Dr. Koenigsberg then asked if the committee could think outside the parameters of semantics when reviewing these definitions. He wonders if we should have a little bit more in the way of qualifying language, and he expressed concern that the definitions may become too broad.

Mr. Toubman then asked Dr. Zavoski for specific examples of a real problem where services had to be provided due to this definition of medical necessity. Dr. Zavoski indicated that it was difficult to discuss these sorts of things in a public setting. Mr. Toubman suggested not using names, but Dr. Zavoski still declined to discuss specific cases. Dr. Schaefer said that this is not driven by the specific administrative cases and hearings that the Department has lost, but by the reasons he previously outlined during the meeting. Mr. Toubman expressed concern with the Department's credibility if they could not cite specific examples for the recommendations that made for the definition of medical necessity.

Mr. Toubman also discussed his perspective on how the SAGA definition came to fruition. Many services from the SAGA program were removed, and the definition was changed as another mechanism to reduce the program.

Mr. Toubman then offered the Department a compromise in regards to using the term "equally" within the definition. Dr. Schaefer preferred, at that time, not to draw lines around what the Department would and would not accept for the definition. For the record, Mr. Toubman pointed out that this compromise definition was found in the language that the insurance companies agreed to use during the court settlement with managed care companies.

Ms. Woodsby asked Dr. Schaefer for clarification on how the new definition could be used as a communications tool. He noted that it could be used in coverage, it could be used in utilization review, and it is the frame within which a physician's care is rendered outside of those processes.

Ms. Woodsby then asked if the HMOs and ASOs would have the ultimate authority over denying claims. Dr. Schaefer answered that the Department will be requiring more detailed accounting of every medical necessity denial, regardless of whether it is appealed or is assigned an administrative hearing. They will request that every definition be tagged as to the basis for the decision made. Ultimately, they would like to track, over time, if the kinds of determinations that are being made are consistent with the definition.

Upon request of Ms. Mezzy, Dr. Schaefer indicated that this reporting requirement will take effect within the HUSKY contracts. The contract amendment is not yet complete.

Dr. Schaefer offered to share with the committee the reporting grids, and Ms. Woodsby accepted, noting that they will be helpful to the committee in its work.

Ms. Woodsby then revisited a topic of discussion from the December 10, 2009, meeting, where the question was raised as to whether or not it was the committee's charge to address medical appropriateness along with medical necessity. The Chairs informally addressed the issue with the Attorney General's office, which acknowledge that it was a valid question. The Chair's next step may be to draft a formal request to the Attorney General for an opinion on this issue.

Ms. Mezzy liked the idea, as the committee had so much work to do that it would be great to have clarification on work that they are not supposed to do.

There was then discussion on the logistics of the subcommittee meeting and informational/public hearing on the draft recommendations of the committee. It was determined that the subcommittee would meet to discuss draft recommendations, that the recommendations would be brought back to the committee at the January 21, 2010, meeting and that the committee would convene at a later date for the informational/public hearing.

The meeting was adjourned at 11:39 AM.

Brie Johnston
Committee Clerk