State of Connecticut

GENERAL ASSEMBLY

MEDICAL INEFFICIENCY COMMITTEE

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

MEETING MINUTES

Thursday, January 21, 2010

10:00 AM in Room 2B of the LOB

The meeting was called to order at 10:10 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:

Co-chairman Kevin Kinsella called the meeting to order at 10:10 AM.

Dr. Handelman introduced people present from the Connecticut State Medical Society (CSMS) and American Medical Association (AMA). Then, at the request of the Chairman, committee members introduced themselves, detailing their professional associations. Representatives of the Department of Social Services (DSS) also introduced themselves: Mark Schaeffer, Ph.D., acting director of Medicaid; Rob Zavoski, M.D., medical director; Trish McCooey, staff attorney.

Mr. Kinsella noted minor changes in the agenda order. He warmly thanked Clerk Brie Johnston and Office of Legislative Research (OLR) Analyst Robin Cohen "for some really outstanding work," as well as committee Co-chair Alicia Woodsby and all who participated with her in the work of the subcommittee, which "produced a lot of good documents."

Mr. Kinsella noted that copies of the minutes from the committee meeting on December 10, 2009, a report from Ms. Cohen comparing different medical necessity definitions, a letter from himself and Ms. Woodsby to Attorney General

Richard Blumenthal regarding the authority of DSS to change the definition of Medicaid "medical appropriateness," and a draft of the subcommittee report are in the packets of information on the members' desks. He said he would ask Ms. Woodsby to comment on the draft report.

Edward Langston, M.D., a former Chairman of the Board of AMA who is a family physician in Flora, Indiana, and also is a trained pharmacist, is in Connecticut for medical meetings and attended this meeting. He is part of American Health Network in Indiana, an incorporated, electronically connected "group practice without walls." He said there are two hundred physicians in Indiana who belong to the network and are in "care groups" ranging from two to twenty individual physicians and nurse practitioners. These groups are separately administered but use the same electronic platform for businesses and the same provider number. Half use electronic record-keeping; it is expected that within eighteen months all will. It started out when a group of physicians primarily in family practice thought they could provide quality care more efficiently through this type of network connection; it is part of the reason he returned to active practice in 2000. Now there are sub-specialists in several areas as well as radiologists who read all their radiographs and nutritionists on staff available for every practitioner. He acknowledged that there are different models for practice, but he said the "group practice without walls" model can address quality and efficiency while maintaining the individual physician-patient relationship. "It is very instrumental in our success. . . . Every time we submitted data for PCQI we received a bonus payment for quality." He said Connecticut has the largest number of solo practitioners of any state; around 80 percent are in groups of four or fewer. Nationally, the number is seventy five percent in groups of eight nine or fewer and fifty five percent in groups of four or fewer.

Dr. Langston explained that the focus of "the new AMA" is to prevent, diagnose or treat an illness, injury or disease in accordance with generally accepted and clinically appropriate medical practice. "It is not primarily for the economic benefits of the health plans, purchases or the convenience of the patient or the treating physician other health care providers." He emphasized that, while quite broad, it is physician-directed and "very patient-centered."

In response to a question, Dr. Langston said that for Medicaid, Indiana's DSS uses the AMA definition of medical necessity or a derivation of that. He will send a copy of it to the committee. After privatizing Medicaid two years ago, Indiana now has decided to use a combined public/private accounting system, because under the private system "the process lost contact with the patient."

In response to questions from Mr. DeFazio, Dr. Langston said he has not found determination of medical necessity to be an issue in the group practice. "We're all fairly sensitized as to what the rules are and how they're interpreted." He said that using electronic medical records can cause about a fifteen to twenty percent slowdown in practice flow. What is helpful is the increased access to data to

measure whether the physician is meeting the desired goal in treatment. "If you can't measure it, you can't improve it."

Mr. Toubman asked a question regarding substitutions. He said the current state Medicaid definition regarding medical necessity says that "substitution is okay if it is the least costly of equally effective medical treatment alternatives;" whereas the new CSMS definition regarding commercial managed care says "treatments can be replaced if they're likely to produce equivalent therapeutic or diagnostic results." Dr. Langston prefers the latter definition. He said physicians inherently mistrust something coming from the insurance industry because "it may not be a quality issue, but it certainly is a money issue." That's why, he said, it is helpful to have "an independent, trustworthy entity" to set standards that physicians (and others) can trust, and it is the task of the committee to set such trustworthy definitions.

In response to a question, Dr, Langston said electronic access to medical data is extraordinarily helpful in making diagnoses and determining the best treatment, medication, etc. "This little machine (he held up his BlackBerry) has changed how you practice medicine. . . . It's cost-effective, it's fast and it doesn't affect patient flow." He said there are a number of data bases to access for information.

Mr. Kinsella said the next meeting is scheduled for February 3, 2010. "We're trying to schedule some sort of public forum; we might have an abbreviated meeting next time and then have an extended meeting for people who want to testify." After discussion, it appeared that February 3, 2010 would not be not a good date for a meeting or public forum at either 10:00 AM or 1:00 PM. After February 3, 2010 the next regular meeting date is not until March 3, 2010. Mr. Kinsella said the matter will be revisited via e-mail.

Mr. Kinsella made a motion, duly seconded, to accept minutes of the December 10, 2009 meeting as printed. Motion carried. Ms. Mezzy commented that the Clerk "did a fabulous job with these minutes."

Ms. Woodsby said the subcommittee met January 13, 2010 when it reviewed, "piece by piece," the current definitions of "medical necessity" and "medical appropriateness" and the definition that DSS has proposed, to try to draft language to present today for discussion. She said it is a preliminary draft. In particular, she noted that the opening definition is "pretty much" the same as the one that DSS has; mental illness specifically is included, lest some services not be covered; the importance of an individual's independence is recognized; it specifies where the burden of proof regarding medical appropriateness should lie; and says the assessment should be individualized.

They considered whether DSS has the statutory authority to define medical appropriateness (combining "medical appropriateness" with "medical necessity");

the Co-chair's January 13, 2010 letter to the Attorney General poses that question.

Mr. Toubman commended the "excellent job" Ms. Woodsby did in synthesizing the work of the subcommittee. He noted there are several definitions of medical necessity/medical appropriateness already (the Rhode Island Medicaid definition of medical necessity and the Connecticut commercial definition of medical necessity are the same), and we do not need "to reinvent the wheel."

Ms. Mezzy expressed concern about the meaning of the word "extent," and hoped the committee could preempt any need for an ultimate court ruling on that.

Dr. Handelman said that having yet another definition of medical necessity would be problematic for practicing physicians, who don't necessarily understand the "nuances" of differing definitions of medical necessity and do not look up a definition when treating a patient. He said the definition in the agreement with commercial carriers and used in adjoining states' Medicaid programs seems to be a universal one that everyone can agree on, and much of the language in this document coincides with that.

Dr. Schaefer said, "I recognize the importance of getting an integrated definition that moves the ball forward and overcomes some of the problems with the previous definition. . . . I think we (DSS) haven't sat with this long enough to have an opinion about the preliminary recommendation. One thing I question is the continued tendency to invent the word 'dualize' to represent as a duality medical conditions from mental health conditions. Where do addiction disorders lie? Where is mental retardation? How about autism? What's a mental illness? Why spike it out as though mental illness is not necessarily a medical condition? . . . I would prefer we use a term and recognize a term that subsumes health conditions or problems without having to qualify it by saying what's included, because it does raise a question about what you didn't mention as being included. . . . The three components of the recommendation all touch on areas that are in the current medical appropriateness definition, so if it's determined we can't fiddle with that there's not much we really can do at this stage." Finally, he wondered what the committee considered to be the difference between "equally" and "equivalent" in part three.

Mr. Kinsella said he appreciated Dr. Schaefer's comments regarding mental illness.

Ms. Woodsby agreed the question of specifying mental illness is something to look at further. They could leave the "slicing and dicing of words" for the future.

Mr. Kinsella noted that "equal" is a mathematical term, thus "is a standard that could never be met," whereas "'equivalent' speaks to evidence-based guidelines"

and therefore is more appropriate. He added that they also considered and rejected the word “similar.”

Dr. Schaefer noted that Dr. Langston had said comparative effectiveness is in the lexicon. He said he is not aware of comparative effectiveness research that actually establishes equivalency of options. “Equivalent is a very high standard; it is very difficult to establish equivalency, depending on what one construes as equivalent.” Does comparative effectiveness research establish different interventions as comparable or equivalent? “What should happen is what is likely to produce a comparable effect. It’s not true that you can ever establish for an individual equivalency among options. If a definition is going to be useful in helping us fund our way in the future, it shouldn’t establish what I think would be a standard of equivalency that can’t actually be attained. We can never prove equivalency, and therefore it would support the more costly of comparable alternatives.”

Ms. Woodsby asked Dr. Schaefer if he had any particular examples he could cite.

Dr. Schaefer said he did not have a particular intervention in mind. He imagined there could be a brand vs. generic SSRI, where clinical trials suggest a variance in effectiveness between 7.9 and 8 on a scale of 1 to 10. “If you give the $400 drug or the $5 or $10 drug, you’re not doing to have an identical response.”

Then in response to a question from Ms. Woodsby, he said SSRI’s are not the basis of his concern regarding an alternative definition to what DSS is proposing, nor is it driven by a particular medical situation. But why not go with the less expensive option when comparative effectiveness studies show it will be comparable?

Dr. Booss, using the example of seven similar drugs that are used to treat migraine headaches wherein the effectiveness of one over the others varies from patient to patient, stressed, “Decisions must be made to an individual patient.”

Dr. Koenigsberg observed that “what is important isn’t so much exactly whether it is equivalent or equal.” It is important for a physician to keep in mind that whether the cost to the patients is $5 with a co-pay or $8 per tablet, they’re going to have to pay for it themselves. Physicians should keep in mind that there is a cost factor in their decisions. Is there a way to put that in the language? Then he said the reason specifically to include mental illness is that it is more vague. “Autism surely is an illness if you have it . . . but it’s not covered by many companies. . . . Behavioral health frequently is an (insurance) carve-out and highlighting it is a good idea. Perhaps it could be ‘medical’ with an asterisk saying ‘including mental illness.’”

Mr. Kinsella asked, “How about dental?” It seems there is agreement on the committee that all medical care is covered and all dental care is covered.

Dr. Schaefer said it is not a part of a “medical necessity” definition to stake out the range of conditions that are covered or the benefits. That is a different area. He detailed various conditions that have been “carved out” in the mental health parity legislation, such as some addictions and learning disorders. “I don’t think this is the place to put in mental illness that’s undefined; (however) . . . it is the Department’s intent to fund medically necessary services to treat any covered (health) condition.” He added that he understood the committee’s desire for coverage parity with mental illness and other illnesses, but believes “it is not operative” for the purpose this definition serves.

Mr. DeFazio asked Dr. Schaefer if he thought the fiscal note anticipating a saving of $4.5 million would be changed by this definition. He replied that the saving could be affected by the definition and therefore the fiscal note might need to be reassessed before a definition is finalized.

Mr. Toubman said DSS’ claim that there were problems with the current definition – hence, the need for a new definition – was unsubstantiated because, when asked, DSS could not give any examples of problems with the current definition. He said to change “equally effective” to “similarly effective” sets a lesser standard and therefore does not meet the statutory requirement that any new definition maintains the same quality of care. He said the AMA, CSMS and the state legislature have concluded the “equivalent” definition is workable and is being applied. Therefore, he asked Dr. Schaefer what his professional basis was for saying it was unworkable.

Dr. Schaefer countered there are examples regarding such matters as SSRI medical equipment and supplies, and inpatient admissions. He said the aim is a definition that can be used going forward, while addressing the limitations discussed at the meeting two weeks ago.

Dr. Zavoski asked what the intent was with the use of the word “independence” in the preamble.

Ms. Woodsby said it was important to assure that people were able to maintain their maximum possible level of independence. Mr. Toubman reminded that it also is in the Federal Medicaid guideline.

Dr. Schaefer described the guidelines presently in place regarding HUSKY prior authorization when sought by a provider: 1) consideration by HMO clinical reviewer; 2) physician peer consultation; 3) reference to “medical necessity” definition. If care still is denied, a letter to that effect is sent and an authorized alternative may be proposed (such as hospital outpatient care instead of inpatient care). At this point, an administrative hearing may be requested with the DSS

legal office if the member completes a request form and sends it in to DSS. DSS may send notice of the appeal to the MCO, which may undertake an internal review. A hearing must be held within 30 days, with both the MCO and the appellant member presenting evidence, and the final DSS decision must be followed by the contractor. Ms. McCooey said it is "a full evidentiary hearing," with right to legal counsel, etc. If still dissatisfied, the member can appeal the decision to the Superior Court. Dr. Zavoski gave several examples of areas wherein prior authorization may be disputed.

Mr. DeFazio described an instance of a dually eligible client who needed drug authorization. Dr. Schaefer explained that Medicare Part D is a Federal program; hence, DSS has no authority to intervene, though they do advocate for patients within the limits of their scope of authority. DSS' pharmacy management unit does oversee prior authorization for drugs for HUSKY A and B enrollees. NAMI-CT also has been "very helpful" in that process.

DSS' draft reporting structure grid, which is "based on the original definition," then was passed out.

Dr. Schaefer said they "fully intend to track" all instances in which requested authorization has been denied by DSS or managed care organizations "and to make sure as time goes on that whatever definition we're using is working for the purposes of both the program and the clients." In response to questions, he said that ultimately, reporting would be quarterly, but at first reporting would be monthly. The draft has to go to the Medicaid Managed Care Council "shortly," and then they would go forward with implementation on or before July 1, 2010 – "hopefully, with a definition that has consensus support of this committee."

July 6, 2009, was the date the draft reporting structure grid was last amended. Ms. Mezzy asked, "Can this be used now with the current definition of medical necessity . . . and if not, why not?

Dr. Schaefer said, "We already monitor the managed care plans and it is reported annually. . . . Still, it is our intent to hold off on implementing until we have a definition we can agree on."

Ms. Woodsby said, "We have a gap in understanding insofar as the current definition has been problematic. . . . Will you be able to provide feedback and information to us moving forward?"

Dr. Schaefer, said, "I'll get back to you. At this point I'm not ready to commit to providing particular examples." He continued, "The template you see before you will enable us to look at whether any of the plans are outliers in terms of the types of decisions that they are denying in a particular area. . . . That will be the basis for further quality review. (Also), DSS will be requesting a spreadsheet that provides a record on every decision made. (The grid in hand) is only a

percentage of overall denials made under a new definition. We want to have the details so we can learn about the types of decisions that were made, the kinds of alternative treatments that were authorized . . . that sort of thing. That will be a case-specific summary. It will be the kind of data we can mine and use in discussions here."

Then he asked a question of the committee: "With regard to number three in your preliminary recommendation, whether there are clinical circumstances where you feel the Department could uphold a denial for requested authorization because a service, although it is less costly it is not equivalent. I am concerned about whether in real life we would ever actually be able to, in a hearings context, uphold a decision to deny authorization on the basis of number three. I am not convinced that we can. . . . I think the committee ought to know, or have some idea, as to whether they're essentially proposing a definition that would make it impossible for us ever to intervene in a health care decision in light of this. . . . Our interest here is in being able to make the case for the less costly alternative. And if that's something that we're not going to be able to do, then it goes back to Angelo's point that I'm not sure we'd actually expect to realize much in the way of savings as a function of implementing this."

Mr. DeFazio said he would like to see specific information on the number of appeals filed, how many go through the full appeal process and how many finally are denied. He mentioned the need to know if specific procedures are more likely to be appealed. "I'd like to see that number in the future."

Dr. Schaefer said a third report does show the number of authorizations that were requested in any area, how many were denied, how many then were appealed internally, and how many went on to administrative hearings. He agreed, "We ought to be able to see what the denial rates are for various things." Then, if it appears that a particular procedure prompts an unusually high number of appeals, DSS would look into it and monitor it.

Mr. Toubman noted that commercial insurers thought "equivalent" was reasonable. "Why, therefore, do you think you could not deny if the definition included that word? . . . If you do not provide examples (of denials), the committee is going to be inclined to conclude that none were available…We meant real examples, with no names, so we can actually look at that…and keep in mind that the SSRI example is not comparable."

Ms. Woodsby suggested that perhaps the OLR could find out what the experience regarding appeals and denials has been in other states which use that definition. Mr. Kinsella suggested that the Office of the Health Advocate could research it: "That would put the concerns of the Department at rest, I hope."

Ms. Woodsby thanked the DSS staff for their participation.

She said, “We had a request from the Medicaid Managed Care Council to look into the implications of the medical necessity definition for Medicaid on EPSDT. After consulting with those with legal expertise on the committee, it seems that the definition of EPSDT refers to whatever is considered necessary in the state. So it would appear that whatever the definition is would have an impact on coverage of services for children covered with the EPSDT definition.” She said she would follow up with the Medicaid Managed Care Council on that item.

Ms. Woodsby said, “The last item is an update on medical appropriateness.” She drew committee members’ attention to copies of the letter that she and Ms. Kinsella sent last Friday to the office of the Attorney General. “We are waiting to hear from them what their conclusion is based on DSS’ authority to change medical appropriateness definitions…Hopefully, we will have an answer to that question in the very near future.”

Ms. Woodsby said the Clerk will follow up with committee members regarding the date and time of the next meeting, informational forum and public hearing. “We really need feedback from the committee and any stakeholders regarding who would be good invited expert speakers.” She noted that it would be helpful for the committee to hear from both experts in the field and the general public regarding DSS’ proposed definition and the committee’s draft recommendation.

There being no further business, the meeting was adjourned at 12:10 PM.