Connecticut Bar Association

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Re: Practical and Legal Problems with Proposed Harmful Change in Medicaid Medical Necessity Definition

Dear Legislator:

We are writing to you on behalf of the Elder Law Section of the Connecticut Bar Association to express our grave concerns with the proposed changes to the long-standing Medicaid definition of medical necessity. The proposed changes in the definition, as originally proposed by the Governor and as unfortunately adopted by the Appropriations Committee in its draft budget, would fundamentally alter this essential consumer protection upon which all 420,000 Medicaid enrollees rely, including the approximately 90,000 low-income individuals who qualify for Medicaid due to disability or being over 65. Particularly since the proposed change also would raise serious concerns with compliance with federal law, we urge you to reject this proposal in the final budget adopted by the legislature.

The Elder Law Section consists of 500 members of the Bar who primarily represent individuals age 65 or better, some of whom require Medicaid to pay for essential medical treatment, including clients who are participants in one of the several Medicaid waivers intended for individuals who, without the services available under these Medicaid programs, would otherwise be institutionalized at state expense under Medicaid usually at a much higher cost than providing care in the community. These individuals are generally in a frail medical state, and must rely upon both medical equipment and home health services, as well as an array of other traditional Medicaid services, to avoid such institutionalization.

We understand that the state is in a serious budget crisis and, given the large size of the Medicaid budget, it is entirely reasonable to look to the Medicaid program for potential savings to balance the budget. Nevertheless, we believe that this particular proposed cut will cause significant harm and, in the end, will not save any money but rather drive up costs, as individuals who are denied essential Medicaid services which allow them to remain in the community are forced into more expensive institutional placements both in hospitals and in nursing homes.

Although it has been suggested that these changes simply bring the Medicaid definition into line with the commercial Medical Necessity definition, this is not correct. The proposed definition is actually more restrictive than the commercial definition of medical necessity under state law. For example, under Connecticut law governing commercial insurance, as with the current Medicaid definition, a less expensive treatment cannot be substituted for one prescribed by a treating provider unless the cheaper treatment is **equally** effective. Conn. Gen. Stat. §38a-482a. But under the proposal, substitution with treatments which are similarly effective will be permitted. Thus, under the change, elderly and other Medicaid recipients will actually have **more** restrictions on access to care than the commercially insured population. This is despite the fact that all 420,000 Medicaid clients are low income, and therefore lack resources to pay out of pocket when insurance coverage is denied.

Because of this special circumstance, the Medicaid program was intended by Congress to be broader than the commercial insurance covering individuals with generally higher income, who have at

least some means to pay for denied services. Thus, apart from the restrictiveness of the proposed Medicaid definition compared to the commercial Medicaid definition applicable in Connecticut, that proposed definition also raises serious concerns of compliance with federal law.

1. Removing the requirement to pay for all services necessary to attaining or maintaining an optimal level of health

DSS recognized in a 2003 bulletin about access to medical equipment under Medicaid that "one of the purposes of the Medicaid program is to enable each state, in accordance with all applicable statutory and regulatory requirements, to furnish rehabilitation and other services to help eligible families and individual *attain or retain capability for independence or self-care.*" This in turn is based on 42 U.S.C. §1396 of the federal Medicaid Act, which refers to the obligation of states participating in Medicaid to furnish rehabilitation and other services to help individuals attain or retain capability for independence or self-care. The language in the current Medicaid medical necessity definition, providing that all services necessary to "*attaining or maintaining* an *optimal level of health*" must be provided, has always been understood as the means for implementing this federal "independence" requirement in Connecticut. That requirement also is imposed by the Americans with Disabilities Act (ADA), which, under its integration mandate, requires that states maintain disabled individuals in the least restrictive setting appropriate to their needs.

Yet, under the proposal, the requirement of bringing Medicaid clients to, or maintaining them at, an "optimal level of health" would disappear, replacing it with the vague obligation to "*maintain health and functioning,*" implying both that sub-optimal health is acceptable under Medicaid and that independence is no longer a priority. This presents the potential for a serious conflict with the requirements of 42 U.S.C § 1396.

For example, in Skubel v. Fuoroli, 113 F.3d 330, 336-37 (2d Cir. 1997), the Second Circuit Court of Appeals invalidated Connecticut DSS's refusal to pay for home health services for severely disabled children outside the home as an unreasonable interpretation of the federal Medicaid statute, in light of "the consensus among health care professionals that community access is not only possible but desirable for disabled individuals" and an earlier decision of that same court invalidating a prohibition on Medicaid paying for private duty nursing care in schools (Detsel v. Sullivan, 895 F.2d 58 (2d Cir. 1990)). See also Estaban v. Cook, 77 F. Supp.2d 1256, 1261 (S.D. Fla. 1999)($582 limit on payment for wheelchairs under Florida's Medicaid program invalidated as violative of §1396); Rickaby v. Wisconsin Dept. of Health, 297 N.W 2d 36, 37, 39-40 (Wisc. 1980)(violation of §1396 to deny motorized wheelchair to nursing home resident because such equipment "would promote his maximum potential for independence (within the nursing home)").

2. Placing the Burden on Treating Providers to Affirmatively Justify All of their Treatments

Placing the affirmative burden on providers to justify their medical treatments in order to get approval, an element of the proposed new definition, runs counter to the intent behind the federal Medicaid statute that the primary decision-maker on health care for Medicaid recipients should be the treating provider. "'The decision of whether or not certain treatment or a particular type of surgery is "medically necessary" rests with the individual recipient's physician and not with clerical personnel or government officials.'" Weaver v. Reagan, 886 F.2d 194, 199 (8th Cir. 1989), quoting *Pinneke v. Preisser*, 623 F.2d 546, 550 (8th Cir. 1980).

The legislative history of the Medicaid Act is the source for this precedent. *See* S.Rep. No. 404, 89th Cong., 1st Sess., *reprinted in* 1965 U.S.Code Cong. & Admin. News 1943, 1986 ("the physician is to be the key figure in determining utilization of health services"). See also A.M.L. v.

Department of Health, 863 P.2d 44, 48 (Utah 1993). This principle has been recognized by at least one court in Connecticut. See Marchetti v. Aronson, 7 Conn. L. Rptr. No. 7, 203, 204 (Conn. Super. 1992)(□[T]he Medicaid statute and regulations create a presumption in favor of the medical judgment of the attending physician in determining the medical necessity of treatment.□).

Prior authorization has long been an accepted part of the Medicaid program. See 42 C.F.R. §440.230(d). But fundamentally altering the long-standing rule regarding who has the burden of proof in **conducting** such prior authorization reviews, by requiring treating providers to affirmatively justify their treatments with detailed scientific evidence or be denied, would upset the long-standing recognition in federal Medicaid law of the appropriate placement of the burdens.

3. Removing the Prohibition on Forcing Substitution with Cheaper Treatments Unless They are □Equally Effective□

The proposed new definition also eliminates the current prohibition on a cheaper treatment being substituted for the treatment requested by the treating provider **unless** the substitution is the □least costly of multiple, ***equally***-effective alternative treatments or diagnostic modalities.□The current standard is consistent with federal law standards. See Dodson v. Parham, 427 F.Supp. 97, 109-110 (N. D. Ga. 1977). See also McCoy v. Dept. of Health and Welfare, 907 P.2d 110, 114 (Idaho 1995)(excluding "the only treatment, or even the best treatment, available" for a particular condition would be an unreasonable exclusion). By contrast, the proposed definition requires only that a substituted treatment be the □least costly among ***similarly*** effective alternatives,□potentially conflicting with this federal standard. As noted, this proposed definition is not even as protective as the commercial medical necessity definition adopted by the legislature for individuals with generally higher incomes.

The settled definition of medical necessity has served the Medicaid program and its 420,000 enrollees very well for many years, including with respect to both the elderly and people with disabilities, and the over three-fourths of the Medicaid population which is required to get its health care through capitated HMOs with a financial incentive to deny requested treatment (children and families on HUSKY A). Most importantly from our perspective, it has been the means by which people with severe disabilities of all ages have been able to gain access to the right kinds of medical equipment and services to allow them to maintain themselves in the community. As we celebrate the 10th anniversary of the United States Supreme Court□s decision in the *Olmstead* case, which enforced the requirement of the ADA that states maintain disabled individuals in the least restrictive setting, we urge you to reject this proposed change which would send Connecticut backwards in its efforts to comply with this mandate, while threatening harm to a large percentage of Connecticut□s low-income population.

Thank you for considering our serious concerns with this harmful proposal.

Sincerely,

Attorney Sharon L. Pope
Vice-Chair and Legislative Liaison
Elder Law Section, CBA