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TESTIMONY

BILL: Assembly Bill 269 BDR # 57-813

HEALTH CARE FINANCING & POLICY DIVISION

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Good Afternoon Chairman Goldwater and members of the Commerce and Labor Committee. I am Phil Nowak, Chief of Business Lines of the State of Nevada Health Care Financing & Policy Division.

I am here today to provide testimony regarding Assembly Bill 269, which requires certain health care plans and insurance policies to provide, under certain circumstances, coverage for medical care if confirmation of coverage and prior authorization is obtained. The Division contracts with health maintenance organizations (HMOs) to provide health care services to both Medicaid and State Children's Health Insurance Program (SCHIP) recipients. The Division is responsible for ensuring that Nevada's Medicaid and SCHIP recipients have access to all medically necessary covered services and due process required by both federal law and their respective State Plans.

The Division's position regarding AB 269 is neutral regarding implications it may pose for the commercial managed care organization community. The Division recognizes that Assembly Bill 269, as currently written, may provide protections to both providers and patients regarding services requested and rendered to participants in health plans. The bill specifies that it is the health care provider's

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responsibility to confirm enrollment of the recipient in the health plan, confirm that the service required is a covered benefit, and/or seek prior authorizations, when required, for covered services. HMOs are required to verify that the requested benefit is a covered service and can be made available to the patient, help ensure timely provision of the requested care, and afford a consistent policy to health care providers. However, while the legislative concept is worthwhile, practical implementation for the Medicaid/SCHIP managed care programs would be problematic.

The Division opposes the application of this legislation to the State Medicaid and SCHIP programs. HMOs may have a contract with the Division to provide coverage to Medicaid and SCHIP recipients in addition to contracts that cover commercial populations. I would propose that the Medicaid/SCHIP business line of HMO contracts be exempt from the provisions of this bill for the following reasons:

1. HMOs that provide managed care to the Medicaid/SCHIP population in Nevada operate under stringent Federal and State regulations regarding eligibility, enrollee income and location of residence, continuity of care standards, access and availability of services, and other service provisions and limitations that do not apply to commercial HMOs.

   Medicaid/SCHIP eligibility determination is a crucial compliance issue in this bill that cannot be controlled by the contracted Medicaid HMOs. Eligibility status can and does change on a monthly basis. The health care

provider cannot be guaranteed future eligibility status for a recipient, as provided in this bill. A Medicaid health care provider is required to check eligibility status each time a person presents for care. Verification must occur prior to the decision to furnish care. The Division cannot use Federal or State funds to pay for health care provided to a person deemed to be ineligible for Medicaid. Therefore, Medicaid HMOs cannot be held fiscally responsible for care provided to an ineligible person.

2. Similar concerns exist regarding prior authorizations for medical or dental procedures or services. Due to the eligibility concerns previously expressed, a Medicaid HMO can only be held accountable for those prior authorizations that are requested and utilized within the same month. A prior authorization for a Medicaid/SCHIP recipient is only valid during the period of time that the recipient is eligible.

   In Section 5.2, the bill seeks to amend Chapter 695 of NRS to state that the coverage required must be provided regardless of whether the person who received the particular medical care was covered by the health care plan on the date the provider of health care received confirmation of eligibility or received prior authorization, if required, from the health plan or provided the particular medical care to the person. It is not possible for an HMO to predict eligibility in advance and guarantee that a prior authorization issued for a subsequent month will be honored.

For the reasons stated above, I again propose that the Medicaid business line of HMOs be exempt from the provisions of this bill. The determination of Medicaid

eligibility is significantly different from eligibility determination in the commercial HMO population. and is not within the HMOs' control. It is not reasonable to hold the contracted Medicaid HMOs accountable for provision of services to a person or persons who are not eligible to receive the service under terms of the Medicaid or SCHIP programs.

Thank you for the opportunity to provide testimony regarding this bill. I would be pleased to answer any questions the committee may have.