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TESTIMONY

BILL: Assembly Bill 320 BDR # 57-868

HEALTH CARE FINANCING & POLICY DIVISION

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Good Morning Chairman Anderson and members of the Judiciary 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 320, which proposes various changes in public policy regarding malpractice issues. The Division is very aware of the difficulties that many Nevada providers of health care encountered as a result of last summer's malpractice insurance crisis and is supportive of efforts to find lasting solutions to the precipitating causes. It is in the best interest of all Nevada residents to establish public policies that result in the provision of quality health care. It is the Division's responsibility to ensure that Nevada's Medicaid and State Children's Health Insurance Program (SCHIP) recipients have access to the medically necessary covered services required by both federal law and their respective State Plans. In order to assure access to care, there must be a stable and adequate health care provider base from which Medicaid providers can be recruited.

The Division's position regarding AB 320 is neutral regarding implications it may pose for the commercial health maintenance organization (HMO)

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ASSEMBLY JUDICIARY
DATE: 4/4/03 ROOM: 3138 EXHIBIT F
SUBMITTED BY: PHIL NOWAK

community. However, the Division opposes the application of this legislation to the State Medicaid and SCHIP programs. I would propose that the Medicaid/SHCIP 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 even more stringent regulations than commercial HMOs. Contracted Medicaid HMOs must comply with additional Federal and State regulations regarding enrollee income and location of residence, access to and continuity of care standards, availability of services, and other provisions and limitations that do not apply to commercial HMOs. Provisions in this bill conflict with stipulations in the contract between the HMOs and the Division.

2. The Division is committed to provide quality health care to Medicaid and SCHIP recipients. This bill would allow providers who have been terminated by the HMO to continue provision of medical care to Medicaid/SCHIP recipients for up to 180 days after contract termination or, in the case of pregnancy, for 45 days after the date of delivery or the date the pregnancy ended. This stipulation conflicts with the Medicaid HMO requirement to transition recipients, in the event of provider termination or closure, to another Medicaid provider in a timely manner. The proposed timeframe of 180 days for retention of care for most acute medical conditions is excessive. Furthermore, these timeframes could be construed as a severance clause for terminated providers.

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3. Reimbursement provisions in this bill are problematic when applied to the Medicaid/SCHIP managed care programs. If a patient treated by a terminated provider should become ineligible for Medicaid during the course of treatment, an HMO cannot be held financially liable for medical services provided after the determination date. Further, Medicaid recipients can and do change HMOs during the course of eligibility. Financial responsibility for care provided during the 180 day, or in the case of pregnancy, the 45 day time extension is not clarified for cases involving a recipient's decision to choose another HMO during of the course of care rendered by the terminated provider.

4. Termination rights provided in this bill are also troublesome when applied to the Medicaid/SCHIP managed care programs. In order to be a member of a Medicaid HMO network, a provider must first be a qualified Medicaid provider. If the provider application is terminated due to Federal or State mandate, the HMO is required to conclude its contractual relationship with the provider as well. Under terms of this bill, it is not clear whether the HMO would still be required to allow a provider terminated at the behest of the State to continue to provide care to Medicaid/SCHIP recipients.

5. The HMO's ability to provide case management and to monitor care through prior authorization of services would be severely diminished as this bill does not stipulate that the terminated provider would continue to be bound by the HMO's prior authorization policies and procedures. HMOs contracted with the Division are required to develop utilization review policies and procedures that maximize access to quality health

care in a cost-effective manner. Provisions in this bill severely restrict the HMO's obligation to monitor and control provision of health care to Medicaid/SCHIP recipients.

6. A significant portion of the TANF/CHAP Medicaid population are at-risk pregnant women who require both medical and social case management services in order to more fully assure the most positive birth outcome. The Division's contract with the HMOs requires that a pregnant woman in the first two trimesters of pregnancy be transitioned to the care of a network provider in order to ensure that the required case management services are available and provided to her. A pregnant woman in the third trimester of pregnancy may elect to maintain the medical relationship with a non-network provider to allow continuity of care in the final stage of pregnancy. Retention times for terminated providers in this bill conflict with provisions in the contract between the Division and the HMOs that recognize and provide for differences in the patient/provider relationship that result from different requirements due to stage of pregnancy.

7. Section 30 of AB 320 includes provisions that control various aspects of contract development between private entities. These provisions raise a question regarding whether passage of this bill would constitute good public policy. The bill incorporates specific items that must be included and excluded in contract terms and provides conditions under which the contract must be amended. An HMO could plausibly argue that a private enterprise has the right to exercise reasonable controls over its own contracting process, particularly in regard to inclusion of

internal documents such as manuals, policies, and procedures that must be referenced in the contract. Pursuant to this bill, any change in the references would necessitate amendment of each provider contract affected by the change.

Provider payment schedules have also been stipulated for inclusion in the contract. Since many HMO provider contracts may be linked to the Medicaid rates established by the State, any change in the State rate schedules occurring during the term of the private contract would result in amendment to all HMO contracts with providers. Amending all health care provider contracts would necessitate significant expenditure of HMO time and expense. Such expenditures ultimately increase the cost to the State for HMO contracts to provided managed health care to Medicaid/SCHIP recipients. Additional State staff time would also be required to ensure HMO contact compliance.

It can be argued that this bill represents an implicit increase in the contractual rights of the health care provider relative to the contracting entity (HMO). While the HMO's right to terminate a provider is restricted and regulated, the provider's right to terminate the contract is unqualified.

For the reasons stated above, I again propose that the Medicaid business line of HMOs be exempt from the provisions of this bill. The HMOs contracted to manage and provide health care services to the Medicaid/SCHIP recipients must comply with federal and State regulations that often conflict with provisions in this bill. Once again, the most important conflict involves

Medicaid eligibility determination which is significantly different from commercial HMO enrollment verification. Medicaid eligibility determination is not within the HMOs' control. The contracted Medicaid HMO cannot be held accountable for the provision of services to a person who is not eligible to receive medical care under terms of the Medicaid or SCHIP programs.

I respectfully propose the following language be added to this bill to eliminate the impact on Nevada Medicaid.

Thank you for the opportunity to provide testimony regarding Assembly Bill 320. I would be pleased to answer any questions the committee may have.

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PROPOSED AMENDMENTS TO A.B. 320
DRAFT DATED APRIL 2, 2003

THE AMENDED LANGUAGE BELOW FOR A.B. 320, SECTIONS 28, 32 AND 42 IN PINK BOLD TYPE RESOLVES CONFLICTS WITH MEDICAID:

Sec. 28. NRS 695C.050 is hereby amended to read as follows:

695C.050 1. Except as otherwise provided in this chapter or in specific provisions of this title, the provisions of this title are not applicable to any health maintenance organization granted a certificate of authority under this chapter. This provision does not apply to an insurer licensed and regulated pursuant to this title except with respect to its activities as a health maintenance organization authorized and regulated pursuant to this chapter.

2. Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, must not be construed to violate any provision of law relating to solicitation or advertising by practitioners of a healing art.

3. Any health maintenance organization authorized under this chapter shall not be deemed to be practicing medicine and is exempt from the provisions of chapter 630 of NRS.

4. The provisions of NRS **chapter 686A,** 695C.110, 695C.170 to 695C.200, inclusive, 695C.250 and 695C.265, **subsections 2, 3, 4, 6 and 7 of 695C.125 and section 27 of this act** do not apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid or insurance pursuant to the Children's Health Insurance Program pursuant to a contract with the Division of Health Care Financing and Policy of the Department of Human Resources. This subsection does not exempt a health maintenance organization from any provision of this chapter for services provided pursuant to any other contract.

5. The provisions of NRS 695C.1694 and 695C.1695 ~~*and section 27 of this act*~~ apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid.

...

Sec. 32. NRS 695C.330 is hereby amended to read as follows:

695C.330 1. The Commissioner may suspend or revoke any certificate of authority issued to a health maintenance organization pursuant to the provisions of this chapter if he finds that any of the

...

(j) ***The health maintenance organization fails to provide the coverage, if required by section 27 of this act; or***

...

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Sec. 42. NRS 695G.090 is hereby amended by adding thereto a new subsection to read as follows:

3. Subsections 2 through 9 of section 695G.270 of the NRS and section 33 of this act shall not apply to any managed care organization that provides health care services to recipients of Medicaid under the state plans for Medicaid or the children's health insurance program pursuant to a contract with the division of health care financing and policy of the department of human resources. This section does not exempt an organization from any provision of this section for services provided pursuant to any other contract.

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