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TESTIMONY

BILL: Assembly Bill 261 BDR # 57-815
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Good Morning, Chairman Goldwater and members of the Commerce and Labor Committee. I am Charles Duarte, Administrator of the State of Nevada Division of Health Care Financing & Policy.

I am here today to provide testimony regarding Assembly Bill 261, which establishes certain policies of health insurance and health care plans to provide coverage for continued medical treatment by providers of health care upon termination of the provider by a managed care health plan. 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 261 is neutral regarding implications it may pose for the commercial managed care organization community. The Division recognizes that Assembly Bill 261, as currently written, provides certain guarantees for continuity of care for those Nevadans whose health care needs are

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covered under a commercial managed care organization as well as certain protections to providers who are terminated from the insurer's network.

However, 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 more stringent regulations than commercial HMOs. These contracted HMOs must comply with both Federal and State regulations regarding enrollee income, geographic 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. Provisions in this bill conflict with stipulations in the contract between the HMOs and the Division.

2. The Division is committed to providing access to quality health care for all Medicaid and SCHIP enrolled recipients. HMOs must meet the Federal and State access and availability standards stipulated in their contract with the Division. These standards include case management and prior authorization requirements to monitor provision of necessary covered health care services. This bill would allow providers who are no longer part of the HMO network

to continue to provide medical care to Medicaid/SCHIP enrolled recipients for up to 180 days after contract termination or, in the case of pregnancy or 45 days after date of delivery or date pregnancy ended. The HMO's ability to monitor care would be severely diminished as a non-network provider would not be bound by the HMO's policies and procedures. Medicaid contracted HMOs are mandated by federal regulation to meet access-to-care standards that require, in the event of provider termination or closure, transition of Medicaid eligible recipients to another Medicaid provider.

3. 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 her pregnancy be transitioned to the care of a network provider in order to ensure the required case management services are available and provided to her. A pregnant woman in her 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. The mandated 180-day and 45-day retention times for terminated providers stipulated in this bill conflict with contract provisions that recognize and provide for differences in the patient/provider relationship due to stage of pregnancy.

4. The proposed retention of care timeframes are excessive and would negatively impact the HMO's ability to manage provision of health care to

Medicaid/SCHIP enrollees. In all but the most severe circumstances, a course of treatment for a specific episode would not extend for 180 days. Most primary care episodes require less than sixty days to complete the course of treatment and required follow-up care. Chronic care, including medication management, often extends well beyond the 180 days stipulated in the bill. If the intent of this legislation is to give the provider adequate time to complete a course of treatment for conditions that are not chronic in nature, modification of the timeframes is logical and desirable.

Additionally, the current timeframes could be construed as a "severance clause" for terminated providers. If a provider chooses to terminate the contractual relationship with the HMO, the HMO is obligated to provide for the immediate transition of patients to another provider. However, if the HMO decides to terminate, this bill would allow the provider to continue both the clinical relationship with the recipients and the fiscal relationship with the HMO for an extended period of time. This requirement abrogates the legal right of either party to a contract to reasonably terminate the contractual relationship.

5. Section 5.2.b of this bill states that the terminated provider "is entitled to receive reimbursement from the Health Maintenance Organization for medical treatment he provides to the insured pursuant to this section at the same rate and under the same conditions as before the contract was terminated." A key ingredient of any managed care cost containment strategy is the ability to monitor and control utilization through the use of

protocols, formularies, and prior authorization for services. Unless the proposed legislation also stipulates that the terminated provider is required to continue to adhere to network policies and protocols, the benefits of managed care would be eliminated.

6. AB 261 does not designate who would have fiscal responsibility for a person who loses Medicaid eligibility during the course of care by the terminated provider. The HMO cannot be held financially liable for a person who is no longer eligible for the Medicaid program. Additionally, in order to be a member of a contracted managed care HMO provider network, a provider must first be a qualified Medicaid provider. If the State were to terminate a provider application due to issues other than incompetence or misconduct, which are the only two grounds excluded in the bill, the HMO is required to terminate the provider from its network as well. Under the terms of this bill, the State would be obligated to expend only State General Funds to reimburse the provider as Federal funds cannot be used to pay for services supplied by a non-Medicaid provider.

I respectfully propose the following language be added to this bill to eliminate the impact on Nevada Medicaid. Please see amended language to Section 6 of NRS 695C.050 and Section 8.5 of NRS 695G.090 in bold print.

Thank you for the opportunity to provide testimony regarding Assembly Bill 261. I would be pleased to answer any questions the committee may have.

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