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F I S C A L I M P A C T R E P O R T

SPONSOR: HBIC DATE TYPED: 03/15/01 HB 671/HBICS/aSFl #1

SHORT TITLE: Medical Necessity Act SB

ANALYST: Dunbar

APPROPRIATION

Appropriation Contained		Estimated Additional Impact		Recurring or Non-Rec	Fund Affected
FY01	**FY02**	**FY01**	**FY02**		
		See Narrative			

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION

Workmen's Compensation Commission
Health Policy Commission
Human Services Department (HSD)
Department of Health (DOH)

SUMMARY

Synopsis of SFl #1 Amendment

Senate Floor amendment No. 1 amends the HBIC Substitute for HB 671 by:

- Changing the definition of "covered benefits" to services provided "by authorized health care provider".
- Adding language in the Determination of Medical Necessity Section (24-22-3) that takes into account " alternative courses of treatment" in making a medical or utilization review determination.
- Adding clarifying language in the Incentives Section (24-22-5) to the effect that "nothing in the section shall be construed to prohibit a risk-bearing entity from making medical or utililization review determinations".
- Adding a subsection "B" under Section 24-22-6. This language included in subsection (B) clarified existing language and provides for a more prominent location in the bill. The language indicates that "nothing in the Act shall be construed to apply to a health care provider making decisions while directly providing services to a client".

Synopsis of Original Bill

The House Business and Industry Committee substitute for Senate Bill 671 enacts a "Medical Necessity Act", and new statutory sections intended to mandate criteria for determination of "medical necessity" in decisions about authorizing health care services made by health care insurers, plan administrators, "risk-bearing entities", and state-administered or participating health care programs, including those funded under Title 19 and 21 of the Social Security Act, (Medicaid and Medicare) to the extent permitted by federal law. The bill would provide a definition of medical necessity, specify who may make determinations and on what basis, and provide for notice requirements. The bill further states that determinations will be made "on a timely basis as required by the exigencies of the situation." The bill provides for decisions to deny, modify, reduce, limit or terminate health care services on grounds of medical necessity to be made by telephone if the exigencies of the situation require.

<u>Significant Issues</u>

The bill provides that medical necessity decisions be based on a standard of care and to the extent possible on information provided by a health care professional.

The plan administrator or the state health program shall make notification of a medical necessity decision to both the provider and the person. This notification would include an explanation of the determination, and information about the right to appeal and the appeal process.

The standards of care would be consistent with national standards, if national standards are not available, be based on information and research, be approved by an institutional research entity, and be evidence-based.

The bill prohibits the use of direct or indirect incentives to influence decision-makers concerned medical necessity that could adversely affect the health and well-being of the person's case that is being considered.

HSD identifies the following concerns with the bill:

- Does not propose strict time constraints. This means those involved will create, experience or impose various definitions of "timely basis" and create a problem with enforcement interpretation.

- Requires the Medical Assistance Division (MAD)to substantially change policy section 606.1.1 (33) to incorporate the new standard. This would require federal approval from the Health Care Financing Administration (HCFA). New Mexico must submit a state plan which sets forth the state Medicaid regulations which are drafted to conform to federal statute. Since these changes would substantially change said state plan, the department would have to appeal to HCFA to approve our state action.

- HSD reports that the department is considering changing the definition of "medically necessary services" and has made this fact known through its current RFP formulation. However, any change in the definition, or any other policy, would be preceded by the formal rulemaking process, which would include an opportunity for public comment.
  Although the proposed definition included within the RFP does not mirror the proposed amended statutory definition, HSD states that these definitions are not necessarily in conflict with one another.

The bill substitute specifically excludes casualty insurance providers or workers'compensation from the definition of "health care insurer".

FISCAL IMPLICATIONS

HSD writes that the new definitions proposed would cover a larger number of services and also open the doors to litigation. Thus, HSD could potentially experience a severe rise in costs specifically related to servicing the expanded population.

The Department of Health comments that the department has largely been a provider rather than a payer and has experienced fiscal as well as administrative consequences of adverse, delayed, unreasonable or incomprehensible determinations as to what services would be compensated as medically necessary. Professional control of professional decisions is a tenet of public health and the health care professions. On the other hand, as an executive agency of the state, DOH understands the need to control health care costs, fiscally and administratively – in its public programs and its employee programs as well as a matter of public policy. DOH could balance payers' control of the health care decision process with requirements on how, by what standards, and by whom the decisions are made within the payer organization.

ADMINISTRATIVE IMPLICATIONS

HB 671 would require HSD to file for an amendment to the state plan and seek HCFA approval. Furthermore, HSD notes that it would have to deal administratively with the increased number of services rendered.

TECHNICAL ISSUES

DOH suggests a revision to the definition of "state health program"to specify "federally or state funded entitlement and waiver programs".

OTHER SUBSTANTIVE ISSUES

HSD is concerned that the "Determination of Medical Necessity," includes the phrase "…based on standards of care."

Although the Department of Health agrees for the most part with the definition of medical necessity as contained in the bill, DOH believes the preferable way to address such a definition is through regulation and adherence to nationally accepted standards of care. DOH writes that the state of the art in medicine changes rapidly, sometimes on a monthly basis. Placing definitions such as that of medical necessity in statute deters New Mexico from responding in a timely fashion to the changing state of the art.

The Health Policy Commission provided the following comments:

C Development of criteria defining "medical necessity" are essential if meaningful patient protections are to exist. New Mexicans may experience serious obstacles to getting the care they need, or may be denied it completely, or necessary care may be defined in such a narrow manner that individuals, especially those with disabilities may not get adequate services to maintain a certain level of functional ability.

- Development of a medical necessity standard has already been addressed in many other states. HB 671 would be the first legislation in New Mexico addressing medical necessity.

AMENDMENTS

HSD proposes to amend the definition of "Medical Necessity" to duplicate the language proposed in the HSD RFP. HSD points out that this is the language that Managed Care Organizations etc. are relying on in their bids to the State.

BD/ar