Health and Human Services Committee
LB 1063
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Good morning/afternoon, Senator Campbell and members of the Health and Human Services Committee, my name is Vivianne Chaumont (V-I-V-I-A-N-N-E-C-H-A-U-M-O-N-T), Director of the Division of Medicaid and Long-Term Care for the Department of Health and Human Services. I am here to testify in opposition to LB 1063.

LB1063 appears to try to do two things. First, it requires the Department to provide Early and Periodic Screening, Diagnostic and Treatment services, known as EPSDT, to all Medicaid eligible children under the age of 21. Second, it legislates a definition of medically necessary for all services provided to children.

You should first note that, in Nebraska, children are eligible for Medicaid and CHIP to age 19. The reference to 21 in the statute is confusing and could be misleading. Every state Medicaid program is required to offer EPSDT services to eligible children. Nebraska already recognizes that mandate in Section 68-911 of the Nebraska statutes which states that medical assistance shall include EPSDT services for children. It is a mandatory service under federal law. It is a mandatory service under Nebraska law.

Medical necessity is a fundamental concept underlying all health insurance programs, including Medicaid. Although federal law does not define medical necessity, the states definitions of medical necessity are strikingly similar. The medical necessity definition of Nebraska's Medicaid program is similar to that of many states and is almost word for word the definition of the largest health insurer in Nebraska.

Nebraska Medicaid defines medical necessity with a comprehensive definition set forth in the Nebraska Administrative Code. Medical necessity is defined as health care services and supplies which are medically appropriate and

1. Necessary to meet the basic needs of the client;
2. Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service;
3. Consistent in type, frequency, duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies;
4. Consistent with the diagnosis of the condition;
5. Required for means other than the convenience of the client or his or her physician;

6. No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
7. Of demonstrated value; and
8. No more intense level of service than can be safely provided.

Additionally, health insurance companies as well as other Medicaid programs specifically state that the fact that provider has prescribed, recommended, or approved medical care, goods or services does not, in and of itself, make such care, goods or services medically necessary.

This concept has been upheld by federal courts which have upheld State Medicaid determinations of medical necessity where the program and the physician disagreed. I provide you with two examples. In 1979, the United States First Circuit Court of Appeals held that federal Medicaid statutes grant states some discretion to limit medical services based on their judgment as to whether a particular medical service is medically necessary. The court rejected the argument that a state Medicaid program must cover any medical procedure certified by a doctor as medically necessary.

In 2009, the United State Court of Appeals for the 11th Circuit made short shrift of the argument that the physician's opinion regarding medically necessary treatment was the end of the discussion. The Court held that the Medicaid agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures. It stated "A private physician's word on medical necessity is not dispositive."

We are, therefore, very concerned about the provision in the bill that states that, in making a medical necessity determination, there shall be "a presumption" in favor of the medical judgment of the treating physician or treating provider. A "presumption" assumes that the provider's opinion is correct. Is the presumption envisioned in the bill a rebuttable presumption? Is there room for the Department to do prior authorization? Is there room for utilization control? Every state's Medicaid program is required by federal statutes and regulations to have a utilization review program that safeguards against unnecessary or inappropriate use of Medicaid services. This is particularly true of admission to, and continued stay in, institutional care settings such as hospitals, ICF/MRs and mental health facilities. A presumption that a provider is correct is contrary to those requirements.

If the inquiry ends with the presumption that the provider's opinion is correct, there are several important consequences. First, Nebraska Medicaid could be in violation of federal law as discussed above. Also, the bill establishes a standard of medical necessity for children. This standard is different than would be applied to adults. I know of no insurance company or other state Medicaid program that creates different standards of medical necessity for children and adults. Federal regulations require comparability of services to clients within categories. There is a good chance that federal regulations do

not allow different medical necessity criteria between adults and children and we would be out of compliance with federal requirements on this issue.

Second, if the discussion on medical necessity begins and ends with the opinion of the provider, there are serious implications to the Medicaid program. The rationale for managed care programs would disappear. If we were to take children out of the managed care contracts, it would be difficult to sustain managed care contracts only for adults. This is equally true for physical health and behavioral health managed care contracts. Physical health managed care contracts save money. Without a behavioral health at-risk contract, our Medicaid program will not be able to comply with our corrective action plan related to Institutes for Mental Disease (IMDs).

Lastly, there would be a fiscal impact to the state the extent of which cannot be determined today. In FY 11, Nebraska spent approximately $500 million providing services to children through the Medicaid and CHIP program. This bill appears to be intended to provide children with more services. If the bill results in a 10% increase in services, that is a $50 million fiscal impact. If it is a 5% increase in services that is a $25 million fiscal impact. If it is a 1% increase, that is a $5 million impact. To these numbers add the loss of savings from managed care and other programs to review utilization that the Department currently has for children and adults.

LB 1063 overturns standard practices of health insurance companies and Medicaid programs around the 50 states. It puts the Nebraska Medicaid program at risk of being out of federal compliance and it will cause an indeterminate but substantial fiscal impact. For all the mentioned reasons, the Department opposes LB 1063.

I appreciate the opportunity to voice our concerns and I am happy to answer questions.