STATE OF HAWAII
STATE COUNCIL
ON DEVELOPMENTAL DISABILITIES
919 ALA MOANA BOULEVARD, ROOM 113
HONOLULU, HAWAII 96814
TELEPHONE: (808) 586-8100 FAX: (808) 586-7543
March 3, 2009

The Honorable Marcus R. Oshiro, Chair
House Committee on Finance
Twenty-Fifth Legislature
State Capitol
State of Hawaii
Honolulu, Hawaii 96813

Dear Representative Oshiro and Members of the Committee:

SUBJECT: HB 1525 HD1 – RELATING TO MEDICAID

The position and views expressed in this testimony do not represent nor reflect the position and views of the Departments of Health (DOH) and Human Services (DHS).

The State Council on Developmental Disabilities **DOES NOT SUPPORT HB 1525 HD1**. The purpose of the bill is to require all future Medicaid procurement contracts to be awarded only to qualified nonprofit entities.

The Council is concerned with the proposed language to be added as a new section to Chapter 103F, Hawaii Revised Statutes. On page 2, lines 2 through 5, it states, "For the procurement of all medicaid contracts in the State, the department of human services shall solicit proposals only from nonprofit insurance entities and award contracts only to nonprofit insurance entities."

The language as written seems too broad and could be interpreted to include contracts between DHS and service providers for the Medicaid Home and Community-Based Services waiver programs. This would include the following waivers administered by DHS:

1. Developmental Disabilities/Mental Retardation (DD/MR) - administered and implemented by DHS and DOH
2. HIV Community Care Program
3. Medically Fragile Community Care Program
4. Nursing Home Without Walls
5. Residential Alternatives Community Care Program

Although Section 1 of the bill specifically refers to the QUEST Expanded Access (QExA) for the aged, blind and disabled population, Section 2 addresses all Medicaid contracts in the State. If it is interpreted and implemented to apply to all Medicaid contracts, then only nonprofit insurance entities may be awarded contracts that could include the above Medicaid waiver programs. For the DD/MR waiver program, this provision would affect over 50 nonprofit and for-profit service provider agencies that have contracts with DHS. An unintended consequence would be that this bill would penalize all nonprofit and for-profit entities that provide quality services and are in good standing with the State. Furthermore, we don't consider that nonprofit or for-profit status equates to quality of care.

If it is the Legislature's intent to single out the QExA program to limit awards of contracts to only nonprofit insurance entities, then there should be language to state it. We defer to the State Procurement Office on the legality of that procurement process. Passage of this bill will amend the competitive bid process under Chapter 103F and may not assure that the procurement process addresses fairness, efficiency, effectiveness, and accountability.

The Council appreciates the opportunity to present testimony opposing HB 1525 HD1.

Sincerely,

Waynette K.Y. Cabral
Executive Administrator

Rosie Rowe
Chair

LINDA LINGLE
GOVERNOR

JAMES R. AIONA, JR.
LT. GOVERNOR

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LAWRENCE M. REIFURTH
DIRECTOR

RONALD BOYER
DEPUTY DIRECTOR

TO THE HOUSE COMMITTEE ON FINANCE

TWENTY-FIFTH LEGISLATURE
Regular Session of 2009

Tuesday, March 3, 2009
6:30 p.m.

TESTIMONY ON HOUSE BILL NO. 1525, HD 1 – RELATING TO MEDICAID.

TO THE HONORABLE MARCUS R. OSHIRO, CHAIR, AND MEMBERS OF THE COMMITTEE:

My name is J.P. Schmidt, State Insurance Commissioner ("Commissioner"), testifying on behalf of the Department of Commerce and Consumer Affairs ("Department"). The Department opposes this bill.

The Department believes that there should be a level playing field for insurance companies in Hawaii. We would be concerned with any bill that created a special franchise from some insurers over others because it interferes with the kind of free and open competition that can benefit consumers.

Both for-profit insurers and not-for-profit insurers have engaged in bad acts at various times. It is important to have healthy competition in all types of business and for health insurance that includes a mix of both for-profit and not-for-profit companies. Appropriate due diligence in the procurement process can screen out insurers with a proven record of problems.

We thank this Committee for the opportunity to present testimony on this matter and ask that this bill be held.

LINDA LINGLE
GOVERNOR

LILLIAN B. KOLLER, ESQ.
DIRECTOR

HENRY OLIVA
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
P. O. Box 339
Honolulu, Hawaii 96809-0339

March 3, 2009

MEMORANDUM

TO: Honorable Marcus R. Oshiro, Chair
House Committee on Finance

FROM: Lillian B. Koller, Director

SUBJECT: **H.B. 1525, H.D. 1 – RELATING TO MEDICAID**

Hearing: Tuesday, March 3, 2009, 6:30 PM.
Conference Room 308, State Capitol

PURPOSE: The purpose of this bill is to require the Department of Human Services to award Medicaid contracts to non-profit insurance entities only.

DEPARTMENT'S POSITION: The Department of Human Services strongly opposes limiting the choice of Med-QUEST program clients and limiting the State's ability to provide those clients with the best health care possible.

For-profit or non-profit status has not been shown to be associated with quality of care. Although half of the worst performing hospitals are for-profit, half of the best performing nursing homes are for-profit (Federal reviewers give 6 nursing homes in Hawaii poor scores, Honolulu Advertiser, December 18, 2008). In Hawaii, most physicians and pharmacies, many nursing homes, and some hospitals are for-profit.

These comments are in no way to imply that non-profits are in any way inferior to for-profits. But it should likewise not be assumed that a non-profit would always be superior to a for-profit. Through healthy competition, the best proposal should be selected.

This bill may be in the best interest of non-profit health plans, but it is not in the best interest of Med-QUEST program clients or the State. Limiting potential bidders decreases competition. That competition works to improve quality and decrease costs. This bill could have the impact of clients' receiving lower quality care while costing the State more. In addition, taxes paid by for-profits generate substantial additional revenue for the State to provide increased services to its residents.

Another impact on Med-QUEST program clients would be reducing their ability to receive optimal care coordination. This bill is discriminatory against the Medicaid population age 65 and older, blind and/or disabled who are also Medicare beneficiaries (i.e. dual eligible persons aka "duals"). The Federal government allows Medicare Advantage (MA) plans are offered by both for-profit and non-profit health insurers, and duals benefit most by having their Medicaid and Medicare insurance through the same insurer. If Med-QUEST could not contract with for-profit insurers, then the duals who choose a for-profit MA plan could not receive the benefit of care coordination.

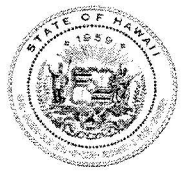
Additionally, the Department of Human Services has numerous contracts including fiscal agent, prescription benefit manager, and many providers including case management agencies servicing our waiver clients who are not non-profit insurance companies. This bill would result in the loss of contracts to many small businesses; people would lose jobs and small businesses might go out of business.

The Department of Human Services believes in fair competition in order to provide the greatest value in terms of quality and cost to our clients and to the State. This bill benefits a few select large businesses at the expense of small businesses, the vulnerable clients served by Med-QUEST programs, and Hawaii taxpayers.

Thank you for the opportunity to comment on this bill.

LINDA LINGLE
GOVERNOR

AARON S. FUJIOKA
ADMINISTRATOR



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TESTIMONY
OF
AARON S. FUJIOKA
ADMINISTRATOR
STATE PROCUREMENT OFFICE

TO THE
HOUSE COMMITTEE
ON
FINANCE

March 3, 2009

6:30 PM

HB 1525, HD 1

RELATING TO MEDICAID.

Chair Oshiro, Vice-Chair Lee and committee members, thank you for the opportunity to testify on HB 1525, HD1. This bill requires the department of human services to award Medicaid contracts to nonprofit insurance entities only.

The State Procurement Office (SPO) does not support this bill. HRS Chapter 103F applies to all state agencies, and should not place restrictions on a specific procurement for one agency. Additionally, if there is justification for this particular procurement to be restricted to non-profit organizations, it should be addressed in the competitive request for proposals document, or if it has a broader application, in the Medicaid administrative rules. As a public entity, the state must maintain an open, fair and equitable treatment of all providers who deal with the procurement processes of the state, maximize the purchasing value of public funds, and foster broad-based competition within the free enterprise system.

The SPO recommends this bill be held. Thank you.

Hawai'i Primary Care Association

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www.hawaiipca.net

To: **The House Committee on Finance**
The Hon. Marcus R. Oshiro, Chair
The Hon. Marilyn B. Lee, Vice Chair

Testimony in Support of House Bill 1525, HD 1
Relating to Medicaid
Submitted by Beth Giesting, CEO
March 3, 2009, 6:30 p.m. agenda, Room 308

The Hawaii Primary Care Association supports this bill, which would limit State contracts for Medicaid services to nonprofit health plans. We believe that this is sound State policy because:

- As taxpayers we expect our public resources for health, which continue to be inequitably and inadequately available, to be used for the public good, not for shareholder profits. This is especially true for Medicaid where the QUEST program has a cap on enrollment because not enough money is available to cover all the low income people who are eligible. It is also important in both QUEST and QUEST-Ex where providers are routinely asked to sacrifice their profits for the good of serving enrollees in this public program. It cannot sit well with these physicians and hospitals to see the health plan enjoy profits at the same time that they are suffering losses.
- Nonprofit organizations are motivated by mission rather than profit. That means that they are likely to be intrinsically invested in the enterprise as opposed to doing the job only as long as it is profitable. It is certainly the goal of nonprofits to earn a margin on their work but a nonprofit will continue to function when that margin is small as opposed to a for-profit, particular one with shareholders who expect a return on their financial investments. The profit motive has resulted in for-profit health plans coming into an area, sweeping up profits when the going was good, and abandoning the market when business became less profitable. Nonprofits will stick around because of their mission and their ability to survive on a smaller margin.
- All of the nonprofit health plans in Hawaii are based here and provide good jobs to people in Hawaii. They are not supporting an infrastructure in another state or country as a for-profit might be.
- Nonprofits must reinvest their margin in improving or expanding their services or in providing community support to other charities.
- The State has more regulatory and investigatory authority over nonprofits, which would result in few instances of rampant opportunism.
- Nonprofits are restricted from lobbying so there are no questions about contracts awarded due to political contributions.

Thank you for the opportunity to testify in support of this measure.

HAWAII GOVERNMENT EMPLOYEES ASSOCIATION
AFSCME Local 152, AFL-CIO

AFSCME
LOCAL 152, AFL-CIO

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The Twenty-Fifth Legislature, State of Hawaii
Hawaii State House of Representatives
Committee on Finance

Testimony by
Hawaii Government Employees Association
March 3, 2009

H.B. 1525, H.D. 1 – RELATING TO MEDICAID

The Hawaii Government Employees Association supports the purpose and intent of H.B. 1525, H.D. 1. As drafted, the bill would require the Department of Human Services (DHS) to restrict Medicaid contract awards only to non-profit insurance entities. Non-profit organizations serve the public good rather than operate for profit. While it is a goal of non-profits to earn a margin on their work, they will continue to provide that service even if the margin becomes smaller.

This is very different from for-profit organizations who expect a sizeable return on their investment. The profit motive encourages the rationing of health care and paying enormous sums on executive compensation. A recent article in the Honolulu Star-Bulletin reported an assortment of problems with the new Medicaid managed care program for the aged, blind and disabled provided through for-profit companies. Thousands of Medicaid recipients have not been assigned a primary-care physician, while others have been turned away from their regular physician who chose not to participate in the program for various reasons.

The two for-profit companies, United Health Group, Inc. and WellCare Health Plans, Inc., have been accused of fraud on the Mainland. Last month, the federal Centers for Medicare and Medicaid Services (CMS) stopped WellCare from marketing and enrolling new members in its Medicare-backed drug and medical plans. CMS said that WellCare used forged enrollment applications and provided misleading or inaccurate information to potential customers of these plans. CMS also found WellCare's performance to be substandard in numerous areas and one of the worst performers among all plans. They also had complaints numbering three times the national average.

The profit motive encourages for-profit health plans to go into an area, collect profits when times are good, but leave the market once they earn a lower return on investment. In contrast, non-profit health plans will remain in a community because of their mission and ability to survive on a smaller margin.

Thank you for the opportunity to testify in support of H.B. 1525, H.D. 1.

Respectfully submitted,

Nora A. Nomura
Deputy Executive Director

March 3, 2009

Representative Marcus R. Oshiro, Chair
House Finance Committee
Hawaii State Capitol, Room 306
415 South Beretania Street
Honolulu, HI 96813

Representative Marilyn B. Lee, Vice-Chair
House Finance Committee
Hawaii State Capitol, Room 306
415 South Beretania Street
Honolulu, HI 96813

Regarding: HB 1525- Requires the Department of Human Services to Award Medicaid Contracts to Non-Profit Insurance Entities only.

Chair Oshiro and Vice-Chair Lee and members of the House Finance Committee:

Thank you for the opportunity to provide testimony and comment with regard to HB 1525. I am Rick Jackson, Chief Operating Officer of MDX Hawai'i, a local for-profit third party administrator of health benefit plans. We have two (2) local clients that have been customers of our company for 20 years: The Queen's Health Systems and United Healthcare.

MDX Hawai'i has had a business relationship with United Healthcare and its predecessor companies in Hawai'i for the past 20 years, beginning with Travelers Insurance in 1989. Currently, we are contracted to support a number of United's Hawai'i insurance programs, including commercial insurance administration for local employers such as AT&T, Hawaiian Telcom, Home Depot and IBM. We also help administer United's Medicare plans offered under the AARP, SecureHorizons and Evercare brand names. Finally, we are part of the team that is supporting start-up of the Evercare QUEST Expanded Access (QExA) program which began operations on February 1, 2009.

MDX Hawai'i is opposed to HB 1525 which would require DHS to solicit proposals from and award Medicaid contracts only to non-profit insurance entities. We oppose HB 1525 for the following reasons:

1. If the legislation under discussion today had been in force in 2008, there would be no QUEST Expanded Access Program in place today.

Discussion
The RFP terms and conditions for the QExA program were discussed and debated in local community meetings for over 10 years prior to the award in February 2008 of two (2) contracts, one to Wellcare, the other to Evercare. Only one of the five (5) bidders for QExA was not-for-profit; no other local not-for-profit companies submitted a bid. AlohaCare's bid

was deemed not to have met the technical requirements of the RFP to understand and deliver a successful, medically integrated program for Hawai'i's aged, blind and disabled. Currently, only the for-profit sector has the required experience and expertise necessary to run such programs in Hawai'i.

2. If the legislation under discussion today is in force in 2011, there may be no qualified non-profit QUEST Expanded Access Program bidders in place to take over from Wellcare and Evercare, and the QExA program will be disbanded at the end of its first three years.

Discussion
Under the terms of the CMS waiver, there need to be two (2) technically qualified plans offered so that QExA beneficiaries are offered a choice of health plans; otherwise, the waiver CMS waiver will be withdrawn. There were no such bids from local non-profits in 2007-8. Neither HMSA nor Kaiser chose to bid. Under the terms of the proposed legislation, neither Wellcare nor Evercare can compete for follow-on contracts. So, without at least two qualified, competent for-profit company's bids in 2011, QExA may not be able to continue delivering services.

3. The economic performance of the two for-profit companies delivering QExA services may permit significant gain sharing with local providers before the end of the initial QExA contract period. This is a good, local-style, win-win situation that happens regardless of profit status.

Discussion
QExA profit is capped at three (3) percent and, by the way, there is no theoretical "maximum loss". Both Wellcare and Evercare are hopeful, but not certain, of reaching the profitability during the initial contract. If this happens, both companies have every reason and incentive to share a significant portion of any savings above the 3% cap with their contracted provider networks. Neither company can make an excess profit.

4. Amending the state procurement code in this fashion virtually guarantees that future Medicaid QExA contracts would be awardable only to AlohaCare and HMSA.

Discussion
The current QExA contracts awarded to Wellcare and Evercare are both in excess of $200 million. The State has gain-sharing provisions in these contracts which permit a maximum profit of three percent of revenue, but there is no protection against poor financial performance in excess of 3% of revenues. For this reason, only large not-for-profit health plans can bid for such contracts because they have significant reserves. Only three (3) health plans in Hawai'i meet this criteria: AlohaCare, HMSA and Kaiser. Kaiser has announced that it will no longer service their aged, blind and disabled patients on Maui, effectively withdrawing from this market. That leaves only AlohaCare and HMSA to compete for two (2) contracts. This is clearly not "competition".

5. Finally, if this bill is passed, in three years my company will be required to lay off over forty (40) full time employees who have been hired specifically for the QExA program.

In summary, it is difficult for MDX Hawai'i to see any public benefit to limiting competition for DHS QUEST contracts to the non-profit sector, and we see significant downside risks for the community if this legislation is enacted.

Thank you for the opportunity to submit testimony.

Best regards,

Rick Jackson
Chief Operating Officer

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March 3, 2009

HOUSE OF REPRESENTATIVES
THE TWENTY-FIFTH LEGISLATURE
REGULAR SESSION OF 2009

COMMITTEE ON FINANCE
Rep. Marcus R. Oshiro, Chair
Rep. Marilyn B. Lee, Vice Chair

Rep. Henry J.C. Aquino	Rep. Scott Y. Nishimoto
Rep. Karen Leinani Awana	Rep. Roland D. Sagum, III
Rep. Tom Brower	Rep. James Kunane Tokioka
Rep. Isaac W. Choy	Rep. Jessica Wooley
Rep. Denny Coffman	Rep. Kyle T. Yamashita
Rep. Sharon E. Har	Rep. Kymberly Marcos Pine
Rep. Gilbert S.C. Keith-Agaran	Rep. Gene Ward
Rep. Chris Lee	

DATE: Tuesday, March 03, 2009
TIME: 6:30 p.m.
PLACE: Conference Room 308
State Capitol
415 South Beretania Street

HB 1525, HD1
RELATING TO MEDICAID

Good evening Chair Oshiro and members of the Committee on Finance.

I am Rev. Bob Nakata. I am here today as the President of FACE (Faith Action for Community Equity). While FACE has supported this bill in the past, FACE is now aware that the measure needs to be more focused on ongoing transparency as it relates to ***only*** Insurance Companies, which contracts to provide Medicaid Insurance to our Medicaid population. This measure should not impact the for-profit and non-profit companies that continue to provide all other needed services to Medicaid beneficiaries.

Health Insurance that is provided through taxpayers dollars should be held to a higher standard of business (both locally and nationally), history of quality of the delivery of healthcare and their track record of proper, prompt reimbursement to physicians, pharmacies, hospitals, and other providers. Insurance companies that

make the business decision to respond to any future Medicaid RFPs should be prepared to have ongoing disclosures of their financial, business practices and relationships in all areas in the United States. For-profit companies that decide to be just that, a for-profit in the State of Hawaii, must be prepared to pay its GET and Premium tax as do all other for-profit insurance companies. If the tax structure of the State of Hawaii is such that it prevents competition in providing Medicaid health insurance, than businesses and the administration must allow public policy dialog to defer these taxes through the legislative process.

This bill as originally drafted, is to broad and fails to define the true intent of its need. Full public disclosure and transparency should be the backbone of this measure, for non-profits and for-profits alike.

To bring clarity to a change in the manner in which Hawaii has delivered healthcare to our neediest, clarity must be brought to the language of SB 1525. This bill should not be about the philosophical differences of a non-profit and a for-profit corporation. Both entitles are able to deliver quality healthcare services. As healthcare is our fourth largest industry, both are able to create jobs and help to bring economic stability to our state. However, both must be subject to complete public disclosure of all parts of their corporate structure including third party administrators, corporate home offices, and all subsidiaries in all areas of the nation.

FACE welcomes health insurance business competition that will control cost, but it cannot be to the detriment of the beneficiaries and the healthcare providers.

FACE request that this bill be passed with the amendments contained in a proposed HB 1525, HD2. If that is impractical at this juncture of the legislative process, FACE request that the language be inserted into the committee report to create further public discussion on full disclosure and transparency all for-profit and non-profit publicly funded health insurers.

Thank you.

DRAFT HD 2 FOR FINANCE COMMITTEE

Report Title:
Medicaid; Procurement; Health and Human Services

Description:
Requires the department of human services to award Medicaid contracts to nonprofit insurance entities only. (HB1525 HD1)

HOUSE OF REPRESENTATIVES
TWENTY-FIFTH LEGISLATURE, 2009
STATE OF HAWAII

H.B. NO. 1525 H.D. 1 H.D.2

A BILL FOR AN ACT

RELATING TO MEDICAID.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

SECTION 1.

WHEREAS, recently, the state department of human services contracted for the administration of a new managed care program, QUEST Expanded Access, for the aged, blind, and disabled population. Of the awarded contracts, only two contracts were awarded and both were awarded to out of state for-profit insurance companies to provide Medicaid coverage for Hawaii's 37,000 aged, blind, and disabled residents.

WHEREAS, several states have found a number of serious law violations and instances of Medicaid fraud in administering similar Medicaid programs through for-profit

insurance companies. As a result, legislation has surfaced that permits only nonprofit and government-related entities to bid on Medicaid contracts.

WHEREAS, the State of Minnesota has limited Medicaid Health Plans (HMO) to non-profit organizations by defining that a HMO must be a non-profit entity. Minnesota Statutes, 2007, 62D.03, subd.4 states:

> (A) nonprofit corporation...which provides, either directly or through arrangements with providers or other person's comprehensive health maintenance services, or arranges for the provision of these services, to enrollees on the basis of a fixed prepaid sum without regard to the frequency or extent of services furnished to any particular enrollee."

WHEREAS, the DHS has determined that for-profit entities are an allowable entity as Medicaid Health Insurance Plans under the QExA program.

WHEREAS, it is important to the taxpayers of the State of Hawaii that there be state laws and rules that will give state agencies latitude for determine how to evaluate the reasonableness of the administrative spending of for-profit health insurance plans.

WHEREAS, it important to the taxpayers that public awareness the National corporate integrity and citizenship

of for-profit corporations that provide health insurance to Hawaii's Medicaid population is necessary to the continuity of care the continuation of the cultural history of caring for those that are less fortunate.

WHEREAS, for-profits that are willing to do business in the State of Hawaii with the cultural understanding and compassion that Hawaii as the "Health State" has fostered, should be willing to disclose all financial activities of its Hawaii subsidiaries and its national corporate entities as a gesture of good faith and local corporate integrity.

WHEREAS, the purpose of this Act is to require all future Medicaid procurement contracts to be awarded only to qualified nonprofit and for-profit entities with the following reporting requirements to be disclosed to administrative agencies which shall be required in any future Request for Proposals for Medicaid funding for healthcare for the people of Hawaii.

SECTION 2. Chapter 103F, Hawaii Revised Statutes, is amended by adding a new section to be appropriately designated and to read as follows:

"**§103F- Procurement of Medicaid contracts; nonprofits and for-profits.** The department of human services shall solicit proposals for the procurement of all Medicaid contracts in the State to include the following transparency and disclosure requirements for for-profit and

non-profit entities on an annual basis, under oath to the DCCA (Insurance Commissioner) and DHS:

All health insurers whether for profit or non-profit who contract with the DHS MedQUEST Division for health insurance contracts under Medicaid, QUEST, or QUEST ExA shall provide a certified audited report in regard to the contracted services that they provide under MedQUEST within 180 days following each fiscal year to the Department of Human Services, Department of Insurance, and the Legislature and provide public notice that such information is available to the public.

The following information will be provided based on contracts held with the State of Hawaii and reports will be based on the expenditure of revenue from these Hawaii contracts:

Annually, provide an audited report as follows:

1. Medical Loss Ratio: The percentage of revenue and dollars paid out for medical services.
2. Administrative Cost: The percentage of revenue and dollars paid out for administrative costs
3. Profit Margin: The percentage of revenue and dollars held in reserves and/or paid out to share holders
4. Return to Investors: The percentage of revenue and dollars paid out to shareholders
5. Full Time Equivalent employees (FTE): Total count devoted to contract
6. total count based in Hawaii
7. total count based on the mainland and a description of titles and functions performed
8. List and Description of any and all current State or Federal Sanctions and all on-going Civil and Criminal investigations involving the plan or any subsidiaries

occurring anywhere. Report on disposition of resolved criminal, civil, and/or State or Federal sanctions.

9. Contributions to the Community: List and percent of revenue and dollars devoted to Hawaii community development and health enhancements over and above contract expenditure requirements

10. Total Compensation: (in all forms salary and bonuses) of top five Hawaii based employees and top five corporate headquarter based employees (if different).

11. List all Management and Administrative Service Contracts held with entities outside the State of Hawaii and the purpose and dollar value of those contracts.

12. Political Contributions: List all contributions and amounts made by the corporation and its executive staff to Hawaii elected officials during the last four years.

Within 90 Days of receipt of these reports from the contracted insurance entity, DHS will provide a written analysis and comparative report to the Legislature and hearings and reviews will be held by Legislative subject matter committees during the next proximate legislative session.

SECTION 3. This Act does not affect rights and duties that matured, penalties that were incurred, and proceedings that were begun, before its effective date.

SECTION 4. This act shall be known and cited as the Medicaid Transparency Act.

SECTION 5. New statutory material is underscored.

SECTION 6. This Act shall take effect on January 1, 2050.

LĀNA'I WOMEN'S CENTER DBA LĀNA'I COMMUNITY HEALTH CENTER

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House Finance hearing
Tuesday, March 3, 2009
6:30 p.m.
Conference room 308

Testimony in Support

HB1525 Relating to Medicaid: Requires the department of human services to award Medicaid contracts to nonprofit insurance entities only.

As the Executive Director of the **Lāna'i Women's Center dba Lāna'i Community Health Center**, and an executive in health care for over 25 years, I well understand the critical importance of non-profits — especially in the health insurance market. True non-profits continue to operate when profits dwindle because they are dedicated to their mission rather than profit and they can survive on smaller margins. Especially in this time of economic need, this attribute provides important stability for Hawaii's Medicaid population, which is comprised of some of Hawaii's most medically fragile and vulnerable. Non-profits put their proceeds back into the community — again critical for Hawaii for improving or expanding healthcare services or supporting charities. This is an important benefit given Hawaii's shrinking budget due to our economic crisis.

Healthy competition exists amongst Hawaii's non-profit health plans thus ensuring that taxpayers are getting the most benefit for their taxpayer dollars. By contracting with non-profits, government insures that tax supported healthcare resources will be used for public purposes rather than shareholder profits. All of Hawaii's non-profit health plans provide good jobs to Hawaii residents and are an important part of Hawaii's economy. They are not underwriting infrastructure in another state or a foreign country as a for-profit might. Again, of critical importance during this time of economic stress. The State of Hawaii has more regulatory and investigatory authority over nonprofits, which helps to control the opportunity for abuse. And non-profits are restricted from lobbying so there are no questions about contracts awarded based on political contributions.

I strongly urge you to support this bill and ensure that our health insurance providers are non-profit companies. For-profit companies are interested in a market so long as it produces profits. Hawaii has experienced over and over again, for-profit insurance companies that leave when profits dwindle. For-profit companies are obligated to stockholders who expect a return on their investment.

Hawaii's Medicaid program expects providers to sacrifice profits in order to serve needy Medicaid enrollees. To continue to ask providers to make these sacrifices while the program contracting with for-profit entities that enjoy profits, wears on provider generosity. I strongly urge your support in passing HB1525 unchanged.

Sincerely, Diana V. Shaw, PhD, MPH, MBA, FACMPE

E Ola nō Lāna'i

LIFE, HEALTH, and WELL-BEING FOR LĀNA`I

Evercare®
by UnitedHealthcare

March 3, 2009

Representative Marcus R. Oshiro, Chair
House Finance Committee
Hawaii State Capitol, Room 306
415 South Beretania Street
Honolulu, HI 96813

Representative Marilyn B. Lee, Vice-Chair
House Finance Committee
Hawaii State Capitol, Room 306
415 South Beretania Street
Honolulu, HI 96813

Regarding: HB 1525- Requires the Department of Human Services to Award Medicaid Contracts to Non-Profit Insurance Entities only.

Chair Oshiro and Vice- Chair Lee and members of the House Finance Committee:

Thank you for the opportunity to provide testimony and comment with regard to HB 1525. I am Dave Heywood, United Healthcare's Executive Director for Hawaii. United Healthcare Insurance Company has been a licensed insurer, providing health care benefits to the people of Hawaii for many years. Evercare, by United Healthcare, serves the frail, disabled and aged and those with chronic conditions across the country through contracts with the Centers for Medicare and Medicaid Services (CMS) and State Medicaid agencies. Evercare is one of two health plans selected by the Department of Human Services (DHS) through a competitive procurement process to provide services to Hawaii's aged, blind and disabled population under the State's new QUEST Expanded Access (QExA) Program.

Evercare has a very strong local team who understands Hawaii's health care system and its Medicaid and Medicare population. The members of my staff, including myself, have many years of experience working for local health plans and health care providers here in Hawaii. We have partnered with MDX Hawaii (formerly Queen's Health Plans), to serve our Medicaid and Medicare members. For the QExA program, Evercare with MDX has hired over 100 new employees on Oahu, Maui, Kauai and the Big Island.

Evercare is <u>opposed</u> to HB 1525 which would require DHS to solicit proposals from and award Medicaid contracts only to non-profit insurance entities. We do not support HB 1525 for the following reasons:

Open Competition Best Serves Consumers, Government, Taxpayers and the Community
Open competition in healthcare insurance programs improves access, quality, innovation and value. This is true not only for Medicaid programs, but also for Medicare, employer group coverage and individual plans. Restricting competition to only non-profit entities prevents fully qualified and capable entities from competing for contracts, even though they may be able to provide better quality and value to the State and to the community.

Moreover, there is no evidence that correlates tax status with quality. For example, only one non-profit insurance entity submitted a proposal in response to DHS's recent Request for Proposals for the Quest Expanded Access (QExA) program for aged, blind and disabled beneficiaries and this proposal from a non-profit insurance entity was deemed to be deficient. The two largest non-

profit health plans in Hawaii did not even submit proposals. Therefore, if passed, HB 1525 could have the unintended consequence of actually lowering quality, reducing choice, and increasing costs to the State for the Medicaid program.

State Already Has a Mechanism in Place to Protect Consumers and Providers
Second, HB 1525 is unnecessary to protect the state from unethical or criminal contractors. The state already has in place proper contract award processes and procedures that would eliminate any offerors who have engaged in misconduct, regardless of for-profit or not-for-profit status. The QExA request for proposal required a very comprehensive response from the applicants, including 14 separate categories of technical requirements. It was a rigorous process, and the best proposals by responsible offerors emerged.

In addition, Medicaid health plans are highly regulated by the State of Hawaii and the Federal Government to ensure health plan responsibility and performance. DHS has a comprehensive regulatory and quality oversight framework in place to monitor and report on Medicaid health plan performance, program outcomes and adherence to DHS contract requirements as well as federal Medicaid requirements. It is also important to note that through Medicaid's a federal and state partnership, the Centers for Medicare and Medicaid Services (CMS) offers another layer of quality oversight for QUEST and QExA Medicaid managed care programs in Hawaii.

Continuity of Care for Consumers
Third, HB 1525 has the potential to disrupt services and continuity of care for Medicaid consumers served by for-profit providers in the state as well as for-profit insurance entities Quest Expanded Access and QUEST health plans today. Under HB 1525, current for-profit Medicaid providers, vendors and health plans would be prohibited from participating in any new Medicaid procurements and re-procurements for current contracts. We maintain that if the current QUEST and QExA plans perform well and meet DHS's procurement requirements, consumers should be afforded this option to maintain continuity of care. HB 1525 eliminates this option for consumers.

In summary, for-profit health plans have accomplished well documented positive outcomes in managed Medicaid and long term care programs in many other States. If plans perform well relative to outcomes important to purchasers and consumers, these outcomes, not tax status, should be the criteria the State employs to select health plans to serve the Medicaid population.

Evercare and Ohana health plan have each hired more than 100 local people to work on the new QExA initiative. As proposed, HB 1525 would prohibit both plans from participating in the re-procurement of the QExA program when it comes up for re-bid. The result is over 200 local employees would be out of work regardless of whether or not the current QExA plans have been providing the highest quality care for Hawaii's kapuna, disabled and medically fragile children.

It is for these reasons we are opposed to HB 1525. Thank you for hearing our testimony.

Sincerely,

David W. Heywood

David Heywood
Executive Director, Evercare Hawaii
david_w_heywood@uhc.com

HOUSE OF REPRESENTATIVES
THE TWENTY-FIFTH LEGISLATURE
REGULAR SESSION OF 2009

COMMITTEE ON FINANCE
Rep. Marcus R. Oshiro, Chair
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Rep. Chris Lee	

NOTICE OF HEARING

DATE: Tuesday, March 03, 2009
TIME: 6:30 p.m.
PLACE: Conference Room 308
State Capitol
415 South Beretania Street

HB 1525, HD1
RELATING TO MEDICAID

Good evening Chair Oshiro and members of the Committee on Finance.

I am Judy Ott. I am the Statewide Secretary for FACE and a member of the FACE healthcare committee. **I am here to support this bill with the amendments that have been introduced by FACE.**

As a member of FACE and as a citizen of the State of Hawaii I am here to advocate for the rights of Hawaii's most vulnerable population. It is becoming increasing difficult for me to be optimistic that the selection of two for-profit corporations from the mainland is ever going to work. The State believes that the QExA program will improve healthcare services while bringing down costs. The reality is that healthcare costs continue to rise while the quality of healthcare has

declined. At a recent informational hearing, DHS reported that 34,750 calls from clients and providers have been received due to enrollment issues, disruptions of inpatient transportation services, incorrect charging for co-pay for prescriptions, and other disruptions. Thousands of Medicaid recipients still have not been assigned a primary-care physician and others have been turned away from their longtime doctors who have chosen not to participate in the program. (Attached is a brief overview of the business practices of Ohana (WellCare) and Evercare (UnitedHealth).

It is my concern that money is the bottom line of medical decisions for the patients. The reality is that for-profit corporations are driven by profits. We have seen that the HMO model for Medicaid/Medicare has not driven down costs. If anything, it has driven doctors and other providers from the market because of low reimbursements.

We need to maintain the healthcare system that we have. Our non-profit system has worked and is working. Let's maintain and improve what we have.

Thank you.

The Mainland Business Practices of UnitedHealth Group and WellCare Health Plan

About UnitedHealth Group (operating in Hawaii as "Evercare")

UnitedHealth's Executive Compensation & Revenues

William W. McGuire, the previous CEO of UnitedHealth, was the healthcare industry's highest paid CEO for two consecutive years, earning peak compensation of $58.1 million in 2002.[1] By then, McGuire had amassed nearly $1.8 billion in unexercised stock options.[2]

In 2001, he earned the highest base salary ($1.79 million), the largest bonus ($3.72 million), and the biggest gain from stock exercises ($50.5 million), among other compensation, in the health insurance industry.[3]

McGuire stepped down as chairman and resigned as CEO in late 2006 after it became public that he had received hundreds of millions of dollars in backdated stock options.[4] McGuire agreed to forfeit $618 million in backdated stock, and paid a record $7 million fine to the Securities and Exchange Commission. He is still fighting to keep UnitedHealth stock options worth an estimated $800 million.[5]

Placing second to McGuire in 2001 was UnitedHealth Chief Operating Officer Stephen Hemsley, who received $21.2 million in total compensation.[6] Hemsley is now UnitedHealth's president and CEO. In 2007, he received $13 million in total compensation[7], including a salary of $5 million.[8]

In 2007, UnitedHealth reported revenue of $4.7 billion[9] – almost as much as the current state budget of Hawaii.

Investigations into Reimbursement Fraud by UnitedHealth

In February 2008, New York Attorney General Andrew M. Cuomo announced an investigation into a scheme by UnitedHealth to cheat patients and providers by using faulty data to reduce out-of-network payments.[10]

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[1] John Olsund, "Minnesota's 100 highest-paid CEO$," *Star Tribune*, 19 May 2002.
[2] Mark Zdechlik, "UnitedHealth's stock drops after announcement of McGuire's departure," *Minnesota Public Radio*, 16 October 2006.
[3] Olsund, "Minnesota's 100 highest-paid CEOS$."
[4] "CEO leaves UnitedHealth after stock backdating report release," *Managed Healthcare Executive*, 1 November 2006.
[5] Vince Galloro et al., "Still making their ascent," *Modern Healthcare*, 28 July 2008.
[6] Olsund, "Minnesota's 100 highest-paid CEOS$."
[7] Steve Eder and Julie Mckinnon, "Patients suffer as care, coverage limits collide," *McClatchy- Tribune Regional News*, 24 August 2008.
[8] Galloro et al., "Still making their ascent."
[9] Steve Eder and Julie Mckinnon, "Patients suffer as care, coverage limits collide."
[10] Daniel J. Costello et al., "Shedding risks: The battle over bills," *Los Angeles Times*, 23 October 2008.

Exhibit A

At the center of the probe is a UnitedHealth company called Ingenix, Inc., the nation's largest provider of healthcare billing information. Ingenix allegedly serves as a conduit for pricing data used by the largest insurers in the country. Cuomo said his investigation found that two subsidiaries of UnitedHealth used Ingenix to intentionally manipulate reimbursement rates and dramatically under-reimburse their members for out-of-network medical expenses.[11]

American Medical Association's President Nancy Nielsen M.D. praised Cuomo's effort, saying it "calls into question the validity of a system that health insurers have used for years to reimburse physicians and their enrolled members. Patients have a right to expect fair and accurate payment for services promised by health insurers. The AMA greatly appreciates the Attorney General's interest and leadership in protecting consumers, and we offer our full cooperation in any effort to hold UnitedHealth accountable to New York state laws."[12]

UnitedHealth's Other State Reimbursement Issues

In June 2008, the American Medical Association released its first rating of insurers' billing patterns. It found that United Healthcare paid physicians the contracted fee 62 percent of the time and Medicare paid 98 percent of the time.[13]

In September 2008, UnitedHealth agreed to pay 36 states approximately $20 million for claims-processing problems. Meanwhile, in California, UnitedHealth is reportedly under investigation by the state and could face fines of up to $1.3 billion for allegedly unfairly denying and mis-processing claims. [14]

Allegations of UnitedHealth's Misleading Sales Tactics among Disabled Seniors

In July 2008, UnitedHealth suspended marketing of a private Medicare plan, called the Evercare Special Needs Plan for People with Limited Income, amid numerous complaints that the company was using abusive and misleading sales tactics.[15]

Senior citizen advocates said some sales representatives refused to leave people's homes without getting a signature on a policy. Other UnitedHealth representatives allegedly misrepresented the plan, claiming it would pay for care that is not actually covered. And some agents repeatedly called seniors, despite requests from younger family members that they stop.[16]

"This is just out of control," said Al Norman, executive director of Massachusetts Home Care, an umbrella group for 30 nonprofit agencies that assist seniors. "It shouldn't be

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[11] "Cuomo announces industry-wide investigation into health insurers' fraudulent reimbursement scheme," *Office of the Attorney General*, 13 February 2008.
[12] Ibid.
[13] Daniel J. Costello et al., "Shedding risks: The battle over bills."
[14] "UnitedHealth faces fines in California investigation," *Trading Markets*, 31 January 2008.
[15] Jeffrey Krasner, "Abuse cited as insurer halts sales to seniors," *The Boston Globe*, 26 July 2008.
[16] Jeffrey Krasner, "Abuse cited as insurance halts sales to seniors."

happening. These brokers are using high-pressure tactics, bait-and-switch, and intimidation. They were inappropriately pushing people into a product they didn't want and didn't understand." [17]

The Evercare plan, sold in Massachusetts since 2006, is intended for seniors who have significant disabilities, such as long-term illnesses. Most enrollees are so-called dual-eligibles; they qualify for benefits under both the federal Medicare plan for people over 65 and the joint federal-state Medicaid program for low-income and disabled people.[18]

About WellCare Health Plan (operating in Hawaii as Ohana Health Plans)

WellCare's Executives Compensation & Revenues

WellCare Health Plan reported revenue of $1.9 billion in 2005 and $3.8 billion in 2006. The company's estimated revenue is $5.4 billion in 2007 and $6.6 billion in 2008 – an amount larger than the entire current state budget of Hawaii.[19]

By the end of 2006, the value of stock and options held by Todd S. Farha, who was then the company's CEO, reportedly totaled $77 million.[20] WellCare's three top executives, including Farha, resigned in January 2008 under suspicion as part of a Medicaid fraud investigation. The company is restating more than three years of financial results in the wake of faulty accounting related to alleged fraud.[21]

Investigations into Reimbursement Fraud by WellCare in Florida

In October 2008, federal authorities released details of what they called a scheme by WellCare to defraud Florida health agencies of more than $20 million. The disclosure was the latest development in an ongoing state and federal Medicaid fraud investigation into WellCare.[22]

In October 2007, an estimated 200 state and federal agents raided WellCare's corporate headquarters in Tampa, Fla. The investigation reportedly centered at least in part on allegations that WellCare inflated the amount it spent on mental health care in order to keep money it should have refunded to Florida's Medicaid program.[23]

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[17] Ibid.
[18] Ibid.
[19] "WellCare Health Plans, Inc: Earnings," *BusinessWeek*, http://investing.businessweek.com/businessweek/research/stocks/earnings/earnings.asp?symbol=WCG (accessed October 30, 2008).
[20] Barbara Martinez, "Health-Care Goldmines: Middlemen Strike It Rich," *The Wall Street Journal*, 15 November 2006.
[21] Laurie Brannen, "The month in finance," *Business Finance*, 1 September 2008.
[22] Richard Mullins, "Health Fraud 'Scheme' Detailed," *Tampa Tribune*, 7 October 2008.
[23] Matt Phillips, "The Evening Wrap: Carolina Countdown," *The Wall Street Journal Online*, 25 January 2008, Factiva.

HOUSE OF REPRESENTATIVES
THE TWENTY-FIFTH LEGISLATURE
REGULAR SESSION OF 2009

COMMITTEE ON FINANCE
Rep. Marcus R. Oshiro, Chair
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Rep. Gilbert S.C. Keith-Agaran	Rep. Gene Ward
Rep. Chris Lee	

NOTICE OF HEARING

DATE: Tuesday, March 03, 2009
TIME: 6:30 p.m.
PLACE: Conference Room 308
State Capitol
415 South Beretania Street

HB 1525, HD1
RELATING TO MEDICAID

Good evening Chair Oshiro and members of the Committee on Finance.

I am Mary Talon and I am testifying as a healthcare professional, a citizen of Hawaii and a member of the FACE Healthcare Committee. **I am here in support of this measure with the changes to the bill that is being proposed by FACE.**

As a professional in healthcare I have had many experiences as a nurse in Hawaii and other states, with for-profit and non-profit health insurers. While working in a hospital in Kentucky, I recall a patient that was admitted for a spinal procedure, had changed clothes and ready for the procedure. We then received notification that the for-profit insurance company had declined the procedure and the patient was sent home. On a personal note, I have a daughter that had to file

bankruptcy not because of her credit issues, but because she did not have insurance and her husband got sick and they could not pay the medical fees.

Here in Hawaii, we are a state of caring people and have always had ample doctors and health care for our Medicaid population. With the decision of the State of Hawaii to award the QExA program to two for profits from the mainland brings me great concern. The former CEO of Evercare (UnitedHealth Care) amassed nearly $1.8 billion in stock options, received a base salary of $1.79 million and a bonus of $3.72 million. The current CEO of Evercare received $13 million in compensation which included a salary of $5 million.

The CEO of WellCare (Ohana) received $77 million in stock and options. WellCare (Ohana) has just been suspended by the federal government and they are no longer allowed to sell Medicare policies anywhere in the United States, including Hawaii. (A copy of the letter from Medicare is attached as Exhibit A) Is this a company with corporate integrity that should be providing care to Hawaii's most vulnerable without transparency and oversight?

It is immoral to allow a for-profit corporation to put its stock options and multi million dollar salaries between a patient and their doctor.

Please pass this bill with the changes provided by FACE that will bring transparency and public disclosure from any company that wants to do business in the State of Hawaii providing health insurance with government funding.

Thank you.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Drug and Health Plan Choice
7500 Security Boulevard, Mail Stop C4-23-07
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

PROGRAM COMPLIANCE AND OVERSIGHT GROUP

February 19, 2009

VIA:
FEDERAL EXPRESS DELIVERY
EMAIL (heath.schiesser@wellcare.com)
AND FACSIMILE (813-290-6306)

Mr. Heath Schiesser
CEO & President
WellCare Health Plans, Inc.
8735 Henderson Road
Tampa, FL 33634
Phone Number: (813) 290-6205

Re: Notice of Intent to Impose Intermediate Sanctions (Suspension of Enrollment and Marketing) For: Contract Numbers H0117, H0712, H0913, H0967, H1032, H1112, H1216, H1264, H1340, H1416, H1657, H1903, H2491, H3361, H4577, H6499 and S5967.

Dear Mr. Schiesser:

Pursuant to 42 C.F.R. §422.756 and 42 C.F.R. §423.756, the Centers for Medicare & Medicaid Service (CMS) hereby provides notice to WellCare Health Plans, Inc. (WellCare) of CMS' imposition of intermediate sanctions for contract numbers H0117, H0712, H0913, H0967, H1032, H1112, H1216, H1264, H1340, H1416, H1657, H1903, H2491, H3361, H4577, H6499, and S5967. These intermediate sanctions will consist of the suspension of enrollment of Medicare beneficiaries (42 C.F.R. §422.750(a)(1), 42 C.F.R. §423.750(a)(1)) and the suspension of all marketing activities to Medicare beneficiaries (42 C.F.R. §422.750(a)(3), 42 C.F.R. §423.750(a)(3)). This determination to impose intermediate sanctions will be effective 15 calendar days after the date of this notice, or on March 7, 2009, and will remain in effect until CMS is satisfied that the deficiencies upon which the determination was based have been corrected and are not likely to recur.

Exhibit A

Summary of WellCare Noncompliance

WellCare has demonstrated a longstanding and persistent failure to comply with CMS' requirements for the proper administration of its Medicare Advantage Prescription Drug Plan (MA-PD) and Prescription Drug Plan (PDP) contracts. As a result, WellCare has demonstrated numerous deficiencies in serving its enrollees in the following areas, including, but not limited to: enrollment and disenrollment operations, appeals and grievances, timely and proper responses to beneficiary complaints and requests for assistance, and marketing and agent/broker oversight activities. In imposing this sanction, CMS is relying upon the following types of information, including but not limited to: CMS' 2007 and 2008 audits of WellCare, beneficiary complaints via the CMS Complaints Tracking Module, CMS performance data, and WellCare's own acknowledgement of compliance failures through its written and verbal contacts with CMS.

CMS has afforded WellCare numerous opportunities to bring its MA-PD and PDP contracts into compliance with CMS requirements. CMS has brought these compliance issues to the attention of WellCare's management on a number of occasions, including in person meetings with senior management on November 20, 2008 and February 4, 2009, a conference call with senior management on January 26, 2009, regular bi-weekly conference calls with the Atlanta Regional Office and several corrective action plans (CAPS) resulting from audits in March 13, 2007, June 26, 2007, and July 29, 2008, none of which have resulted in sufficient improvement in WellCare's operations or correction of the underlying deficiencies.

Pursuant to CMS requirements, MA-PD and PDP plans are required to maintain accurate and up-to-date information regarding enrollment and disenrollments and to be responsive to beneficiary complaints and requests for assistance. From January 1, 2009 through February 1, 2009, CMS has received over 2,500 complaints from Medicare beneficiaries enrolled under WellCare's contracts. CMS believes that the large number of prescription drug access complaints is attributable to WellCare's failure to conduct proper and timely enrollment operations that meet CMS requirements. Almost 800 of these complaints were designated as "immediate need" complaints, which are required to be resolved within 2 calendar days of receipt in the CMS Complaints Tracking Module. WellCare failed to resolve approximately 300 of these complaints within CMS required timeframes.

CMS audits conducted in 2007 demonstrated deficiencies with WellCare's marketing procedures. CMS concluded that WellCare engaged in activities which misled and confused beneficiaries and engaged in door-to-door solicitation. Although WellCare assured CMS these problems had been corrected, a July 2008 audit found the same marketing deficiencies.

In addition, beneficiary complaint data for an extended period of time shows that WellCare has the highest rate of marketing complaints among MA plans with 100,000

enrollees or more, with a significant number of the complaints involving alleged marketing misrepresentations. The most recent marketing casework report, adjusted for enrollment, shows that WellCare's complaints are three times the national average. Of the marketing misrepresentation cases reviewed across all WellCare contracts from October 2008 through mid-January 2009, WellCare's two Private Fee-For-Service (PFFS) plans (H1340 and H4577) contributed to 52% of the reviewed sample. In addition, CMS' concerns about marketing misrepresentation have been reinforced by recent developments, including but not limited to reports from several State Departments of Insurance about enrollment application forgeries, Congressional inquiries, reports of agent and marketing misrepresentations from State Health Insurance Assistance Programs, and additional CTM complaints. These finding demonstrate WellCare's continued failure to exercise proper oversight of its agent and broker activities. CMS' review of marketing events monitored under CMS' Secret Shopper program further demonstrate that WellCare agents provided inaccurate or misleading information to potential enrollees on a number of occasions.

CMS' 2008 audit also found WellCare substantially failed to comply with CMS requirements by failing to properly process grievances, organization determinations, and appeals. These deficiencies include, but are not limited to, WellCare failing to properly forward adverse claims reconsiderations to the IRE for independent review and WellCare failing to timely effectuate a third-party reversal of an expedited reconsideration.

CMS routinely monitors data relating to the performance of Medicare Advantage Plans and Part D Prescription Drug Plans. The data includes customer service indicators, the reliability of data provided to beneficiaries and health providers, beneficiary complaints concerning access to covered items and services, the proper handling of appeals and the accuracy of pricing and Medicare beneficiary out of pocket costs. The data is used by CMS to compare the performance of Medicare Advantage Plans and Prescription Drug Plans. The data is also used to provide comparative information to Medicare beneficiaries through the CMS website that can be used by Medicare beneficiaries to make informed choices about the plan that they select. For the past two years, CMS performance data showed that WellCare's performance was substandard in numerous areas and WellCare was one of the overall worst performers among all plans.

Basis of Proposed Intermediate Sanctions

CMS has determined that WellCare's compliance deficiencies, as described above and further detailed below, provide sufficient basis for intermediate sanctions (42 C.F.R. §422.752(b) and 42 C.F.R. §423.752(b)). CMS' determination to impose intermediate sanctions is based on the following regulatory violations, each of which provides an independent basis for the imposition of an intermediate sanction, and which are supported by examples of WellCare's noncompliance, as described below:

1. **WellCare substantially failed to comply with marketing requirements in 42 C.F.R. Part 422 Subpart V (formerly 42 C.F.R. §422.80) and 42 C.F.R. Part 423 Subpart V (formerly 42 C.F.R. §423.50).**

    - WellCare engaged in activities that misled and confused Medicare beneficiaries and misrepresented its organization. 42 C.F.R. §422.2268 and 42 C.F.R. §423.2268;
    - WellCare engaged in unauthorized door-to-door solicitation. 42 C.F.R. §422.2268 and 42 C.F.R. §423.2268;
    - WellCare failed to establish and maintain a system for confirming that enrolled beneficiaries have, in fact, enrolled in its plan, and understand the rules applicable to the plan. 42 C.F.R. §422.2272 and 42 C.F.R. §423.2272.

    These determinations are supported by:

    - WellCare's failure to comply with CMS marketing requirements as demonstrated in both the 2007 and 2008 audits;
    - WellCare's consistently high number of marketing misrepresentation complaints (adjusted for enrollment) by beneficiaries (WellCare is approximately three times the national average);
    - WellCare's agents misleading beneficiaries and misrepresenting WellCare plans at sales events in December 2008 during CMS' secret shopping activities;
    - WellCare's failure to report marketing events to CMS; and
    - WellCare's failure to adequately identify, monitor, and correct the practices of agents who misrepresented WellCare's plans, including, WellCare's failure to discover forged applications through its own monitoring systems.

2. **WellCare violated CMS enrollment and disenrollment requirements at 42 C.F.R. §422 Subpart B and 42 C.F.R. §423 Subpart B and, therefore, substantially failed to carry out the terms of its Medicare Advantage contracts and its Prescription Drug Plan contracts with CMS (42 C.F.R. §422.510(a)(1) and 42 C.F.R. §423.509(a)(1)) and is carrying out its contracts with CMS in a manner that is inconsistent with the effective and efficient implementation of the program (42 C.F.R. §422.510(a)(2), 42 C.F.R. §423.509(a)(2)).**

    - WellCare substantially failed to carry out the terms of its contract, as demonstrated in the 2008 audit, which requires proper processing of enrollment and disenrollment requests.
        - As discovered in both the 2007 and 2008 audits, WellCare failed to send enrollment confirmations and denial notices to beneficiaries within the timeframe specified by CMS under 42 C.F.R. §422.60 and 42 C.F.R. §423.32.

  - WellCare failed to follow CMS regulations with processing disenrollments for members moving out of service areas under 42 C.F.R. §422.74 and 42.C.F.R. §423.44.
  - WellCare failed to correctly submit requests for retroactive disenrollments under 42 C.F.R. §422.66.
- WellCare failed to properly ensure enrollments had been processed timely as required by CMS, demonstrated by:
  - WellCare's failure to download online enrollments, resulting in delays in beneficiary enrollments and receipt of services pursuant to 42 C.F.R. §422.60 and 42 C.F.R. §423.32;
  - WellCare's failure to properly ensure their own telephonic enrollment processes were carried out, resulting in delays in beneficiary enrollments and receipt of services pursuant to 42 C.F.R. §422.60 and 42 C.F.R. §423.32;
  - The excessive number of complaints due to beneficiaries not being properly enrolled and unable to receive access to their prescription drugs pursuant to 42 C.F.R. §422.60 and 42 C.F.R. §423.32.
- WellCare failed to ensure beneficiaries had a valid Special Election Period prior to enrolling pursuant to 42 C.F.R. §422.62 and 42 C.F.R. §423.38.

3. **WellCare substantially failed to comply with the requirements related to grievances, organization determinations and appeals in 42 C.F.R. Part 422 Subpart M.**

- WellCare failed to properly forward adverse claims reconsiderations to the IRE for independent review and failed to notify members that adverse claims reconsiderations were forwarded to the IRE as required by 42 C.F.R. §422.590.
- WellCare failed to timely notify members about decisions of expedited reconsiderations under 42 C.F.R. §422.590.
- Wellcare failed to timely effectuate a third party reversal of an expedited reconsideration as required by 42 C.F.R. §422.619.
- WellCare failed to properly notify enrollees of adverse expedited organization determinations as required by 42 C.F.R. §422.572.
- WellCare failed to correctly distinguish between organization determinations, reconsiderations and grievances as required by 42 C.F.R. §422.561, §422.564, §422.566 and §422.580.
- WellCare, based on misclassified cases, failed to demonstrate to CMS that it processes grievances timely and accurately as required by 42 C.F.R. §422.564.
- WellCare, based on misclassified cases, failed to demonstrate to CMS that it properly identified, processed and timely responded to members regarding pre-service reconsiderations as required by 42 C.F.R. §422.590 and §422.618.

4. **By failing to adhere to numerous CMS requirements, WellCare substantially failed to carry out the terms of its Medicare Advantage contracts (Article II) and its Prescription Drug Plan contracts (Article I) with CMS (42 C.F.R. §422.510(a)(1) and 42 C.F.R. §423.509(a)(1)) and is carrying out its contracts with CMS in a manner that is inconsistent with the effective and efficient implementation of the program (42 C.F.R. §422.510(a)(2) and 42 C.F.R. §423.509(a)(2)).**

    - WellCare failed to adhere to CMS notification requirements concerning security breaches.
    - WellCare failed to adhere to CMS requirements concerning beneficiary complaint resolution timelines.
    - WellCare has failed to respond in a timely manner to requests from CMS and State Departments of Insurance

Opportunity to Respond to Notice

Pursuant to 42 C.F.R. §422.756(a)(2) and 42 C.F.R. §423.756(a)(2), WellCare has ten (10) calendar days from the date of receipt of this notice to provide a written rebuttal, or on March 2, 2009. If the 10th day falls on a weekend or federal holiday, you have until the next regular business day to provide a written rebuttal. Please note that CMS considers receipt as the day after the notice is sent by fax, e-mail, or overnight mail, or in this case, February 20, 2009. If you choose to submit a rebuttal, please send it to the attention of Brenda J. Tranchida at the address noted below.

Right to Request a Hearing

WellCare may also request a hearing before a CMS hearing officer in accordance with the procedures outlined in 42 C.F.R. §§422.660 through 684 and 42 C.F.R. §§423.650 through 662. Pursuant to 42 C.F.R. §422.756(b) and 42 C.F.R. §423.756(b), your written request for a hearing must be received by CMS within 15 calendar days of your receipt of this notice, or by March 7, 2009. Please note, however, a request for a hearing will not delay the date specified by CMS when the sanction becomes effective. If the 15th day falls on a weekend or federal holiday, you have until the next regular business day to submit your request. Your hearing request will be considered officially filed on the date that it is mailed; accordingly, we recommend using an overnight traceable mail carrier.

WellCare must submit a request for hearing to the following CMS official:

Brenda J. Tranchida
Director
Program Compliance and Oversight Group
Centers for Medicare & Medicaid Services
7500 Security Boulevard
MAIL STOP: C1-22-06

Baltimore, MD 21244
Email: brenda.tranchida@cms.hhs.gov
FAX: 410-786-6301

You must also send a courtesy copy of your request by e-mail to the CMS Hearing Officer on the date you mail your request. CMS will consider the date the Office of Hearings receives your e-mail or the date it receives the fax or traceable mail document, whichever is earlier, as the date of receipt of your request. Your request for a hearing must include the name, fax number and e-mail address of the contact within your organization (or the attorney who has a letter of authorization to represent your organization) with whom you wish us to communicate regarding the hearing request. The courtesy copy of the request for a hearing must be sent to the CMS Hearing Office at the following address:

Benjamin Cohen
CMS Hearing Officer
Office of Hearings
ATTN: HEARING REQUEST
Centers for Medicare and Medicaid Services
2520 Lord Baltimore Drive
Suite L
Mail Stop LB-01-22
Baltimore, MD 20244-2670
Phone: (410) 786-3169
E-Mail: Benjamin.Cohen@cms.hhs.gov

Please note that we are closely monitoring your organization and WellCare may also be subject to other applicable remedies available under law, including the imposition of additional sanctions, penalties, or other enforcement actions as described in 42 C.F.R. Part 422, Subparts K and O and 42 C.F.R. Part 423, Subparts K and O.

If you have any questions about this determination, please do not hesitate to contact Brenda Tranchida at (410) 786-2001.

Sincerely,

Abby L. Block

Abby L. Block
Director
Center for Drug and Health Plan Choice

cc: Ms. Carol Bennett, DHHS/OS/OGC
Mr. James Kerr, CMS/OA/CMHPO
Ms. Nancy Brown DHHS/OIG/OCIG
Ms. Carol Messick, CMS/OA
Mr. Robert Tagalicod, CMS/OA
Mr. Peter Ashkenaz, CMS/OEA
Ms. Kimberly Brandt, CMS/OFM/Program Integrity
Ms. Mary Agnes Laureno, CMS/OBIS
Mr. Louis Polise, CMS/CPC/MCAG
Ms. Cynthia Tudor, CMS/CPC/MDBG
Mr. Anthony Culotta, CMS/CPC/MEAG
Ms. Gloria Parker, CMS/CMHPO/Region IV
Ms. Colleen Carpenter, CMS/CMHPO/Region IV
Ms. Laurie McWright, CMS/OL
Mr. Randy Brauer, CMS/CPC/MPPG

Committee on Finance
Testimony in Support of HB 1525 HD 1: Relating to Medicaid
Submitted By: Richard Bettini, Chief Executive Officer
Contact: wcchc@wcchc.com or 697-3457

The Waianae Coast Comprehensive Health Center supports the intent of HB 1525 HD 1.

We believe the recent QUEST Expanded Access Bid Process produced poor value for both tax payer and citizen. Changes must be made to assure that insurance companies with poor performance records in other States do not receive contracts to provide healthcare to Hawaii's most vulnerable.

We believe the QUEST Expanded Access bid process needs to be investigated to determine why a health plan under federal investigation for fraud, with questionable financial stability and without a proven network of medical providers in Hawaii, receives a bid for hundreds of millions of dollars.

Unless stronger regulation related to disclosure is firmly in place, a limitation on for-profits doing business in Medicaid in Hawaii may be appropriate.

Mahalo.