

# HMSA



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LATE

February 6, 2009

The Honorable Ryan Yamane, Chair  
The Honorable John Mizuno, Chair  
House Committees on Health and Human Services

## Re: HB 708 – Relating to Health Care

Dear Chair Yamane, Chair Mizuno and Members of the Committees:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on HB 708 which requires health plans pay Critical Access Hospitals (CAH) no less than 101% of costs for services Federally Qualified Health Centers (FQHC) no less than their respective prospective payment system rates. HMSA has concerns with this measure.

While HMSA supports assisting CAHs and FQHCs, we do foresee some issues with the way in which payment determinations would be calculated. This measure is addressing two different payment methodologies which are worth outlining.

CAHs are limited to 25 beds and primarily operate in rural areas. Unlike traditional hospitals (which are paid under prospective payment systems), Medicare pays CAHs based on each hospital's reported costs. Each CAH receives 101 percent of its costs for outpatient, inpatient, laboratory and therapy services, as well as post-acute care in the hospital's swing beds. For Medicare beneficiaries the government pays 101% of the self-reported costs incurred for services after performing reviews and audits to validate the costs before making a final payment. This measure would require that private plans pay CAHs the same way that Medicare does. The problem with implementing this payment structure is that the reporting of cost is left up to each facility with no standardization in place to ensure accuracy.

Currently FQHCs do not use the same cost based payment structure that CAHs use. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 established a prospective payment system for FQHCs. This system, which has been in place since January 2001, replaced the previous cost-based reimbursement system for health centers under Medicaid. The prospective payment system establishes a per visit payment rate for each FQHC in advance. The 2001 payment rate was based on the average of each FQHC's reasonable costs per visit in FY 1999 and FY 2000. Since FY 2002, payments made under this system have been adjusted annually for inflation using the Medicare Economic Index. Payments also are adjusted based on increases or decreases in change in scope of services provided. The problem with implementing this payment structure is that the reimbursement rate would be set in statute.

The changes in payments to CAHs and FQHCs raise many issues including:

#### Regulating Reimbursements

A health plan's reimbursement rates to providers are not in statute. We believe that a health plan should have the ability to set its own rates. Additionally, placing reimbursement rates in statute may cause problems in the long run as they will be difficult to revise to react to changes in the health care environment.

#### Self-Reporting of Costs

Under the payment structure outlined in HB 708, the payments for CAHs would be tied to their costs which are self-reported. On the surface this may seem to make sense, however the measure contains no quality control or standardization to verify the costs being reported by each facility are appropriate. Without any oversight or standardization the cost of the same item could vary from facility to facility. For example an aspirin at Ka'u Hospital could be reported at a cost of 1 dollar while an aspirin at Kohala Hospital could be reported at a cost 5 dollars. Health plans would have to reimburse based on these variable costs.

Additionally, reported costs from each facility may not be relevant to the services being provided to the member. For example, the health plan would not know if the cost for a member who receives a blood test at a facility includes direct charges for staffing.

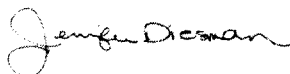
#### Additional Administrative Burden

Both health plans and facilities must comply with a myriad of state and federal regulations. Including the Insurance Commissioner as the entity which would have to reconcile cost reimbursements would be an additional administrative and regulatory burden to health plans and the facilities.

It is important to note that the administrative burden for HMSA to comply with HB 700 could be quite large while the number of HMSA members who utilize services from CAHs is quite small. It is unlikely that changes to the payments to CAHs for private plan members would change enough to truly make a difference for the facilities themselves.

While we appreciate the legislature's proactive approach in assisting CAHs and FQHCs we do not believe that this measure will be able to accomplish this worthy goal. Thank you for the opportunity to testify on HB 708.

Sincerely,



Jennifer Diesman  
Assistant Vice President  
Government Relations



# WAIKIKI HEALTH CENTER

REACHING OUT FROM THE HEART OF WAIKIKI.

LATE

TO: House Committee on Health  
The Hon Ryan Yamane, Chair  
The Hon Scott Nishimoto, Vice Chair

RE: Testimony in Support of House Bill 708  
Relating to Health

FROM: Sheila Beckham, RD, MPH  
Executive Director

DATE: February 6, 2009, 9 am agenda, room 329

Waikiki Health Center supports this bill that provides fair compensation for Hawaii's health care safety net. Federally Qualified Health Centers and Critical Access Hospitals provide access to comprehensive and enhanced services for Hawaii's vulnerable population and yet, receive compensation from private insurers that comes no where near the cost of providing these services.

This measure would enable FQHCs and critical access hospitals to receive 101% of the cost of providing these needed services.

We appreciate your support of this measure and thank you for the opportunity to provide testimony.

To: **The House Committee on Health**  
The Hon. Ryan I. Yamane, Chair  
The Hon. Scott Y. Nishimoto, Vice Chair

CATE

**Testimony in Support of House Bill 708**  
**Relating to Health**  
**Submitted by Dana Alonzo-Howeth, Executive Director**  
**February 6, 2009, 9:00 a.m. agenda, Room 329**

The Community Clinic of Maui asks your support for this measure, which would provide appropriate compensation for Hawaii's health care safety net. Both Critical Access Hospitals and Federally Qualified Health Centers (FQHCs) are recognized by the federal government as essential community providers and are guaranteed enhanced reimbursement rates from public insurance (Medicare and Medicaid) to cover costs.

Speaking for FQHCs, these enhanced rates are provided both so that they won't have to use federal grants to subsidize the cost of public insurance programs but also in recognition of the additional services that are needed by and provided to FQHC patients. These include offering care with linguistic and cultural competence; ensuring transportation is available; and providing extensive care management that includes outreach, follow-up, referral arrangements, and application assistance. FQHCs also provide medical, behavioral health, and dental care all on the same site which increases the likelihood that patients will get all the primary care they need in a timely and appropriate way. The integration of behavioral health with medical care is particularly clinically and financially effective. Some FQHCs also serve geographically isolated places where it isn't economically feasible for other care providers to practice and this may result in higher unit costs as well.

We estimate that FQHCs earn \$5-7 million less per year from private insurers than it costs to deliver care to patients covered by these plans. At the same time the FQHCs saved more than \$46 million<sup>1</sup> for the plans in the care they delivered to privately insured patients. These savings are due to the FQHC model of care that provides comprehensive and timely primary clinical and management services which greatly reduce duplicative diagnostic testing, specialty referrals, ER use, and hospitalization.

We believe this measure deserves your thoughtful consideration and appreciate the opportunity to provide this testimony.

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<sup>1</sup> A study prepared by the Robert Graham Center using Medical Expenditure Panel Survey data for 2007 shows that FQHCs save an average of \$1,914 per privately insured patient per year when compared to the private practice system.  $\$1,914 \times 24,364$  privately insured patients served by FQHCs in 2007 = \$46.6 million.