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 700 – Relating to Nongovernment Health Plan Payments to Critical Access Hospitals and Federally Qualified Health Centers

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

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on HB 700 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.

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.

Hawaii Medical Service Association 818 Keeaumoku St.• P.O. Box 860 Honolulu, HI 96808-0860 (808) 948-5110 Branch offices located on Hawaii, Kauai and Maui Internet address www.HMSA.com

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 700, 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.

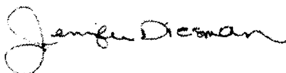
Additionally, reported costs from each facility may not be relevant to the services being provided to the member. For example, the health plan would not know if the cost for a member who receives a blood test at a facility includes direct charges for staffing.

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 700.

Sincerely,



Jennifer Diesman
Assistant Vice President
Government Relations

LATE

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

COMMUNITY CLINIC OF MAUI

Where Aloha is more than just a word

48 Lono Ave
Kahului, HI 96732
(808) 871-7772
Fax (808) 872-4029

SATELLITE CLINICS

Ka Hale A Ke Ola
Resource Center
670-A Waiale Dr.
Wailuku, HI 96793

Lahaina Comprehensive
Health Center
15 Ipu Amakua Lane
Lahaina, HI 96761

Testimony in Support of House Bill 700
Relating to Nongovernment Health Plan Payments to Critical Access Hospitals and Federally Qualified Health Centers

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[1] for the plans in the care they delivered to privately insured patients. These savings are due to the FQHC

[1] 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 x 24,364 privately insured patients served by FQHCs in 2007 = $46.6 million.

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.

January 4, 2009

LATE

TO: Rep. Ryan I. Yamane, Chair
Committee on Health

Rep. John M. Mizuno, Chair
Committee on Human Services

FROM: Summerlin Life & Health Insurance Company, Lori Naylon

RE: HB700, Relating to nongovernment health plan payments to critical access hospitals and federally qualified health centers

Chair Yamane, Chair Mizuno and Members of the Committees:

Thank you for the opportunity to testify in opposition of HB700.

Summerlin has established contracts with hospitals and health centers. Facilities are contracted individually and the reimbursement rate is a negotiated rate. Summerlin has always been open to negotiating with our providers, including critical care facilities and health centers. Is the intent of HB700 to invalidate existing contracts and set a standard rate for all carriers?

At issue is at what rate should Critical Care Access Hospitals and Federally Qualified Health Centers be reimbursed. Government programs have negotiate rates with these facilities and health centers. Are these rates fair? Should the government's negotiated rate be the same rate for health insurance carriers?

HB700 would allow facilities to charge one hundred and one per cent of cost. Who determines "cost" and "101% of cost"? Does "cost" change from day to day? Does "cost" include a profit for the facility? This sounds like an administrative nightmare to determine who gets paid at what level.

During these tough economic times, drastic increases in rates will hurt businesses and subscribers. Since subscribers pay a percentage of the charges, they would pay more for these services. Employers would see the rate increase in higher premiums.

I urge you to not pass HB700. Thank you very much for the opportunity to testify on this measure.