SB 2030, SD1

WRITTEN ONLY

TESTIMONY BY GEORGINA K. KAWAMURA
DIRECTOR, DEPARTMENT OF BUDGET AND FINANCE
STATE OF HAWAII
TO THE SENATE COMMITTEE ON WAYS AND MEANS
ON
SENATE BILL NO. 2030, S.D. 1

February 24, 2010

RELATING TO HEALTH

Senate Bill No. 2030, S.D. 1,e xempts QUEST plans from paying interest under Hawaii's clean claims law when delays are due to non-payment by government payers to the QUEST plans. This bill also appropriates $70 million from the Hawaii Hurricane Relief Fund for FY 2011 to the Department of Human Services, to partially address the Medicaid shortfall.

We are opposed to using the Hurricane Relief Fund for this purpose. We understand that Department of Human Services is currently working on options to address the Medicaid shortfall without the need for an appropriation from the Hawaii Hurricane Relief Fund.

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

February 24, 2010

MEMORANDUM

TO: Honorable Donna Mercado Kim, Chair
Senate Committee on Ways and Means

FROM: Lillian B. Koller, Director

SUBJECT: **S.B. 2030, S.D. 1– RELATING TO HEALTH**

Hearing: Wednesday, February 24, 2010, 10:10 A.M.
Conference Room 211, State Capitol

PURPOSE: The purpose of this bill is to exempt QUEST plans from paying interest under the clean claims act when delays are due to non-payment by government payers to QUEST plans; to require the State to pay interest on late payments to health care plans related to QUEST;. to appropriate funds from the Hawaii hurricane relief fund to pay QUEST and COFA migrants and authorizes the expenditure of matching federal funds.

DEPARTMENT'S POSITION: The Department of Human Services (DHS) strongly opposes this bill.

The addition of the requirement that DHS shall pay the health plans interest on any unpaid amounts will place an economic strain on the State budget, both now and in the future. We estimate that this will increase next year's shortfall by $7.5 million due to interest payments from a three-month delay in health plan capitation payments.

As the Med-QUEST Division faces a biennium budget shortfall of nearly $150 million in State general funds at the end of State Fiscal Year 2011, not including the $7.5 million described above, difficult decisions will need to be made to close this budget gap. Adding a payment of 15% per year to health plans, when payments are already overdue, further compounds this problem.

As an entitlement, the Medicaid program is probably the most difficult budget in the State to predict for a biennium. Predictions can be made about growth and actuarially sound rate increases, but it is often factors beyond the State's ability to control, including the state of the economy and unemployment rate as well as the percentage of funds that the Federal government will contribute, that ultimately impact this budget the most.

If this bill passes with this amendment, it will have long-lasting adverse cost impacts that exceed and compound our current budget crisis.

While we understand the intent of this bill and support providers who care for our clients, this bill could have an unintended bad consequence. Instead of health plans working to resolve claims, they might deny them. Increasing the denial rate merely increases the burden on providers.

DHS believes that health care providers, with whom the health plans contract to create the plans' provider networks, should receive prompt payment for their services. For that reason, DHS included prompt payment requirements in its contracts with the health plans. The health plans contracted by DHS are required to pay 90% of clean claims in thirty days and 99% in ninety days. This is the same prompt payment requirement that the Federal government imposed on Medicaid fee-for-service under the American Recovery and Reinvestment Act (ARRA). Health plans that do not meet these requirements are subject to sanctions.

No health plan has failed to meet this prompt provider payment contractual requirement. In other words, all our health plans have been complying with our contractual prompt provider payment requirement, even last year when DHS had to defer to July the payments to health plans for the two months of May and June.

Typically DHS pays capitation payments in a month for services provided during that month. Because providers frequently do not bill the health plans immediately when they provide services, DHS is, in effect, currently giving the health plans an advance on the amount needed to pay their providers. Therefore, **DHS may need to adjust the capitation rates downward** for advance payment based on the interest rate in this bill.

This bill would also result in DHS needing to impose new reporting requirements upon the contracted health plans. DHS will need to begin tracking when each claim is received and paid relative to the date of service. DHS would also likely need to institute prompt pay reporting requirements of the health plans consistent with the guidance issued by the Centers for Medicare and Medicaid Services for the ARRA provisions. This is a

daily analysis of the percentage of clean claims received within the prior thirty days and the prior ninety days. Presently we review only aggregate monthly reports.

This bill would require DHS to know that a health plan payment to a provider was delayed because of a delay in payment from DHS to the health plan. This means that DHS would need to receive the date of service and the date of claim receipt for each individual clean claim for a service provided in a month with a payment deferred from the payment schedule in the contract. Because the health plans have thirty days to pay a clean claim, a delay in payment to the provider could not be considered to result from a delay in payment to the health plans unless DHS payment to the health plan was not made within thirty days of receipt of a claim by the health plan for a service provided during the month during which the capitation payment was not made in accordance with the contract.

We also recognize that a health plan new to a program or an existing health plan adding new services would be potentially contracting with a new array of provider types. Testing claims processing systems is difficult until providers actually begin submitting claims. Therefore, if this bill is passed, it should be amended to include a period of six months after beginning a new contract or a new service in a program during which a health plan should remain exempt from the proposed State prompt pay requirement.

DHS understands the implications to a contracted health plan if monthly capitated payments by DHS to the health plan are delayed. Health plans may need to access their reserve. In order to be licensed, a health plan is required to have funds in reserve in the unexpected event of a period in which expenditures exceed revenue so that it can continue to pay providers and medical care can continue without interruption to its Medicaid members. The DHS contracted health plans are facing such a situation now.

While a health plan might decide not to utilize its reserve and stop payments to providers in its network, this could have a negative impact on Medicaid patients. It is the responsibility of the health plans to ensure timely access to quality health care for Medicaid recipients. And it is the responsibility of DHS to ensure that the health plans meet this responsibility.

DHS defers to the Department of Budget and Finance on the use of the Hurricane Relief Fund to address the Medicaid shortfall and pay for Medicaid coverage for COFA citizens.

However, DHS would like to provide the following information on medical assistance benefits for COFA citizens and the delay in QUEST health plan payments.

The bill proposes to appropriate funding to provide Medicaid coverage to citizens of nations with a Compact of Free Association with the United States (COFAs). COFA residents are currently eligible for State-only funded medical assistance if they are currently uninsured and meet other eligibility requirements. They are ineligible for federal Medicaid medical assistance.

In Federal Medicaid programs, the Federal government provides matching Federal funds to the State funds for services to federal Medicaid-eligible recipients. Currently, for every dollar the State spends in a Federal Medicaid program, the Federal government pays approximately two dollars for services for federal Medicaid-eligible recipients. So for each State dollar spent on non-Medicaid eligible recipients, three dollars worth of services are lost for Medicaid recipients.

In SFY 2009, State general fund expenditures for COFAs for medical assistance alone were almost $51 million. In Hawai'i, more than $120 million in State funds are spent each year on health care, education and other services for COFA migrants, yet the U.S. Department of the Interior only provides the State with about $10.6 million to partially cover the costs.

In addition, DHS provides the following information regarding payments to its contracted health care plans for the rest of the State fiscal year.

DHS pays its five contracted health plans in the QUEST and QUEST Expanded Access (QExA) Medicaid programs a capitated per member per month (PMPM) payment each month in the third week of the month for that month. The QUEST health plans were paid for December using 100% State general funds because the Federal government had not yet approved the new contracts for us to draw down the matching federal funds.

In the third week of January, when the January payments would be due, the Federal government still had not approved the new contracts. Therefore, we had to lag the January payments because we did not have the State funds to cover the payments without the federal funds like we did in December. Because we strive to treat all our health plans equally and will pay none if we cannot pay one, we delayed the QExA health plans payments as well.

The good news is that the Federal government recently approved the new contracts and we are currently processing the payments for January and getting ready to make the

February payments too. Also, we will be able to make March payments to all the health plans.

However, just as we had to do last year, DHS will need to defer the May and June payments to the health plans to July. This means the May payment will be deferred for six weeks (from the third week of May) to July and the June payment will be delayed for two weeks (third week in June) to July. Timely payments will resume in July for July as well.

Therefore, our primary challenge for this fiscal year is the April health plan payments. We are actively working on strategies to be able to make the April payments or at least partial payments or provide cash flow offsets.

DHS is currently working on options to not have to defer health plan payments starting April.

Thank you for the opportunity to provide testimony on this bill.

LINDA LINGLE
GOVERNOR

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DIRECTOR

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DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Administration
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February 22, 2010

MEMORANDUM

TO: Honorable Donna Mercado Kim, Chair
Senate Committee on Ways and Means

FROM: Kenneth Fink, MD, MGA, MPH.
Med-QUEST Division Administrator

RE: BILLS REFERRED TO SENATE WAYS AND MEANS FOR 2010

The following bills affecting the Medicaid program have been referred to Senate Ways and Means for hearing. The following are the budget implications for these bills.

The following bills, if passed, will require substantial new State general fund appropriations. Given the State's current fiscal difficulties and the $1.23 billion budget shortfall for this biennium, we strongly encourage that the Senate Ways and Means Committee defer or not hear the following measures which **require new substantial State general fund appropriations.**

S.B. 2030, S.D.1 - Relating to Health. By adding the requirement that DHS shall pay the health plans 15% interest on any delays in payments to the health plans, will require a new State general funds appropriation of **$7.5 million.** The Med-QUEST Division faces a biennium budget shortfall of nearly $150 million at the end of State Fiscal Year 2011, not including the $7.5 million described above.

S.D. 1 also appropriates $70 million from the Hawaii Hurricane Relief Fund, as well as $149 in matching federal funds, to cover the Medicaid shortfall for FY 2010-2011.

S.B. 2067, S.D.1 - Relating to Medicaid Eligibility. Requires DHS to provide Medicaid presumptive eligibility to patients waitlisted for long-term care. DHS would need a new State general fund appropriation of at least **$2,000,000** per year. Additionally, it should be noted that this is funding expended for people who are not even eligible for Medicaid, therefore, we cannot receive federal funds.

S.B. 2099,S.D.1 – Relating to Health. Establishes limits on requests for proposals from health and human services providers for QUEST contracts that exceed $100,000,000 and commence after the term of the agency director expires.

This proposal will disrupt care for Medicaid clients. The purpose of this bill is not clear but seems to be based on the need for national health care reform to be enacted. The timeline for this happening is uncertain. Having our health care contracts in limbo for an unknown length of time is not good for our Medicaid recipients or for State finances.

This bill also reduces the State's ability to strengthen its oversight and accountability of the QUEST health plans to ensure better quality of health care for Medicaid clients and for efficiency, transparency and greater value to Hawaii taxpayers.

S.B. 2103, S.D.1 - Relating to the Disproportionate Share Hospital Funds. Appropriates State general funds of **$12,291,054** for the State's portion of the Federal disproportionate share hospital allowance (DSH) to offset hospital costs from the uninsured and underinsured.

DSH funds are accessed as a Federal match to a State share that can be a new State general fund appropriation or certain general fund expenditures, such as certified expenditures of the Hawaii Health System Corporation (HHSC).

With agreement from HAH, DHS is submitting a Medicaid State Plan amendment to the Federal Centers for Medicare & Medicaid Services (CMS) using excess HHSC certified expenditures to match the federal DSH allowance for the period July 1, 2008 through June 30, 2009. Federal DSH allowance is still available for the period July 1, 2009 through December 31, 2011.

Due to the efforts of Hawaii's Congressional Delegation and others, a Federal Medicaid DSH allowance of $2.5 million per quarter through December 31, 2011 has been authorized for Hawaii. DSH payments, using the distribution formula developed by the Healthcare Association of Hawaii (HAH), have been made through June 30, 2008.

Additionally, DHS has also been distributing "DSH-like" federal funds of $7.5 million per year to hospitals statewide since 2005 pursuant to a creative Medicaid 1115 waiver that DHS obtained from CMS. DHS distributes these funds based on the same DSH formula developed by the HAH. The next distribution of these funds is scheduled to occur in February 2010. To date, $xx million has been distributed to hospitals.

S.B. 2264 - Relating to QUEST Health Care Payments. This bill would require an additional **$3,100,000** in a new State general fund appropriation to restore adult dental care in Fiscal Year 2011.

S.B. 2270 - Relating to Medicaid Reimbursements. Requires Medicaid reimbursement to hospitals for patients occupying acute-licensed beds who are on a waitlist for long-term care to be at least equal to the rate paid for acute care services; requires Medicaid reimbursement to long-term care facilities for patients with medically complex conditions to be at least equal to the rate paid for subacute care; appropriates funds for increased reimbursements.

This bill would require a new State general fund appropriation of approximately **$10,000,000** to implement the reimbursement at the acute care rate for patients hospitalized and awaiting long-term care. This is based on the number of waitlisted patients from 2008 who were not found eligible for Medicaid. These payments for non-Medicaid eligible patients to nursing homes would have to be made with 100% State general funds.

Additionally, another State general fund appropriation of **tens of millions of dollars** would be required to implement paying subacute rates for those who are "medically complex." Using the definition of "medically complex condition" for paying the subacute rate means that any patient with a chronic illness taking medications would qualify for the subacute rate. This is essentially everyone in a nursing facility and would cost additional tens of millions. The difference between the average nursing facility rate ($234.62) and average subacute rate ($536.96) is an additional $302.34 per day.

S.B. 2650, S.D.1 – Relating to the Department of Human Services. Requires Medicaid contracts between DHS and its contracted Medicaid health plan to contain provisions affecting the reimbursement obligations in the policies between the Medicaid health plan and the home and community-based case management agencies. Prohibits reductions of reimbursements of more than 10%.

This bill sets a dangerous precedent, **will require a new substantial State general fund appropriation** at a time the State faces a severe budget crisis, and could worsen patient access to care. DHS is facing a substantial budget shortfall and is making every effort to minimize the need to decrease patient benefits. This bill prioritizes the interests of certain providers over the interests of our low-income vulnerable recipients. DHS would need a substantial new appropriation of State general funds to offset the expected reduced health plan expenditures through increased efficiency lost as a result of this bill, or DHS will need to further decrease patient benefits.

DHS allows health plans to coordinate patient care through case management services. Health plans can hire staff for this purpose or contract with licensed companies. As such, contracts between the health plans and a provider with whom they may contract are privately negotiated between the health plan and that provider.

By statutorily requiring certain contractual payments for certain providers in this bill, case management agencies, chore providers, and non-emergency medical transportation, this bill will essentially block health plan flexibility to reallocate funds as necessary in the best interest of its vulnerable Medicaid members and will set a

dangerous precedent in allowing special interest groups seeking self-interested legislation to protect their incomes. This will have the effect of increasing program expenditures. This bill is tantamount to statutory, anti-trust price-fixing and is not in the best interests of the State taxpayers nor our Medicaid patients.

S.B. 2810, S.D.1 – Relating to Prescription Drugs. Authorizes pharmacists to provide medication therapy management to qualified QUEST patients. Requires pharmacies to maintain prescription records and medication therapy management records electronically.

The proposed new service would need to be **entirely State general funded**. A State Plan Amendment (SPA) approval by the federal Centers for Medicare and Medicaid Services (CMS) would be needed to potentially access federal funds for this service. CMS would very likely not approve such a SPA because medication management is something already expected of providers in our managed care programs.

This bill also raises concerns about pharmacists' scope of practice. Not all pharmacists are trained to be clinical pharmacists. It is unclear if this bill would give all pharmacists prescribing authority or other new authority.

S.B. 2934 – Relating to Medicaid. Appropriates general funds to pay for QUEST coverage for citizens of compact of free association nations (COFAs).

This bill would require DHS to provide QUEST benefits for medical assistance to citizens of COFA nations at great expense and with benefits that exceed the benefits offered to many U.S. citizens in Hawaii through QUEST ACE and QUEST Net.

This bill will require a substantial new State general fund appropriation. Providing this "Cadillac coverage" will require a new State general fund appropriation of approximately **$7-10 million annually**, and it would result in further delayed payments to health plans and necessitate reductions in eligibility of benefits to Medicaid recipients.

This additional expense for services to COFAs and legal immigrants ineligible for federal Medicaid medical assistance **will result in three times the decrease in services to U.S. citizens and other immigrants eligible for federal Medicaid medical assistance.** In Federal medical assistance programs, the Federal government provides matching Federal funds to the State funds. Currently, for every dollar the State spends in a Federal medical assistance program, the Federal government pays approximately two dollars. So for each dollar of savings not realized through reductions to COFAs, three dollars worth of services will have to be cut for Medicaid recipients. **Therefore, this bill will result in the loss of Federal funds to the State, and reduce the net funding for Med-QUEST Division programs.**

This bill is also not necessary because the new Basic Health Hawaii (BHH) program covers services such as four prescription medications, either brand name or generic, and emergency services under the federal alien emergency medical assistance

program, such as dialysis. Anti-neoplastic medications, more commonly referred to as chemotherapy, are included among the covered prescription medications.

Providing all the services required in this bill can only be achieved through a reduction in services to Medicaid-eligible clients which also means a reduction in federal matching funds for the federal medical assistance programs, such as Medicaid.

In SFY 2009, State general fund expenditures for COFAs for medical assistance alone were almost $51 million. In Hawai'i, more than $120 million in State funds are spent each year on health care, education and other services for COFA migrants, yet the U.S. Department of the Interior only provides the State with about $10.6 million to partially cover the costs.

Additionally, the following bills have budget implications but were not referred to Ways and Means.

S.B. 2494, S.D. 1 – Relating to Insurance. Requires health insurers and like entities to offer at least the same drug coverage to the insured that the insured had under the insured's previous policy with a different insurer or like entity.

Prescription drugs are the fastest growing healthcare expenditure. Requiring a health plan to cover medications not on its formulary will increase that health plan's costs. Drug coverage, not defined in the bill, might extend beyond a formulary and include criteria for prior-authorization and step therapy, for example.

In the private sector, these increased health plan expenditures would be expected to be passed on through increased premiums, further taxing businesses trying to survive the current economic crisis.

In the public sector, DHS would require a substantial new State general fund appropriation. Because prescription drug coverage is included as a benefit in our QUEST and QUEST Expanded Access programs, this expansion of drug coverage would have to be done by each health plan contracted with DHS. Having the drug coverage expansion be excluded from the health plans could be done, but only if 100% State funded. Otherwise, the risk of duplicate billing of the Federal government would prevent federal approval. And if State-only funded, it would be very difficult to ensure that each claim was for a medication not covered by the individual's new DHS contracted health plan.

Other DHS programs, namely QUEST-ACE and QUEST-Net, have a limited drug benefit defined in the 1115 waiver approved by the Federal government. This bill would substantially expand that benefit, at yet another substantial additional cost, and would require an 1115 waiver amendment approved by the Federal government.

S.B. 2598, S.D. 1 - Relating to Insurance. By adding the requirement that DHS shall pay the health plans 15% interest on any delays in payments to the health plans, will require a new State general funds appropriation of **$7.5 million.** The Med-QUEST Division faces a biennium budget shortfall of nearly $150 million at the end of State Fiscal Year 2011, not including the $7.5 million described above.

Typically DHS pays capitation payments in a month for services provided during that month. Because providers frequently do not bill the health plans immediately when they provide services, DHS is, in effect, currently giving the health plans an advance on the amount needed to pay their providers. Therefore, **DHS may need to adjust the capitation rates downward** for advance payment based on the interest rate in this bill.

This bill does not have a Ways and Means referral since the funding implications were added in the S.D.1.

Thank you for considering this information.

c: Honorable Colleen Hanabusa, Senate President

HMSA

Blue Cross
Blue Shield
of Hawaii

An Independent Licensee of the Blue Cross and Blue Shield Association

February 24, 2010

The Honorable Donna Mercado Kim, Chair
The Honorable Shan Tsutsui, Vice Chair

Senate Committee on Ways and Means

Re: SB 2030 SD1 – Relating to Health

Dear Chair Kim, Vice Chair Tsutsui and Members of the Committee:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on SB 2030 SD1 which would exempt penalty payments for QUEST plans when delays are due to non-payment by a state or federal government payer, require the state to pay interest when payments to QUEST plans are delayed, and would appropriate funding.

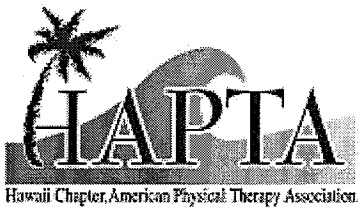
As you are aware, recently the Department of Human Services (DHS) stated that due to budgetary shortfalls, they will withhold payments to contracted QUEST plans, beginning in April and extending through June. While we understand the budgetary restrictions the State is facing, DHS' decision significantly impacts a health plan's ability to pay for services in the timeframes noted in this measure. This has caused great concern, not only for the QUEST plans, but for our members and participating providers as well. This measure is intended to protect participating QUEST plans once the state begins to withhold payments.

We are very interested in working with the other affected stakeholders. In fact, we have been meeting since this issue has arisen to determine if there is common ground on how best to deal with delayed payment since it will have a tremendous impact on the entire health care system. We appreciate the legislature's support during these difficult times and hope that the affected parties can come to an agreement on the best course of action.

Thank you for the opportunity to testify today.

Sincerely,

Jennifer Diesman
Vice President
Government Relations



Testimony by:
Patti Taira-Tokuuke, PT
SB 2030,sd1, Relating to Health
Sen WAM, Weds. February 24, 2010
Room 211, 10:10 am **Position: Comments**

Chair Mercado Kim and Members of the Sen WAM Committee:

I am Patti Taira-Tokuuke, P.T., Co-Chair of the Reimbursement Issues Committee and member of HAPTA's Legislative Committee. HAPTA represents 250-300 physical therapists and physical therapist assistants employed in hospitals, nursing homes, the Armed Forces, the Department of Education and Department of Health (DOH) systems, and private clinics throughout our community. Physical therapists work with everyone, from infants to the elderly, to restore and improve function and quality of life. We are part of the spectrum of care for Hawaii, and provide rehabilitative services for infants and children, youth, adults and the elderly. Rehabilitative services are a vital part of restoring optimum function from neuromusculoskeletal injuries and impairments.

HAPTA is comprised of members who work in facilities and small, private practice businesses, many of which wait 30 days on clean motor vehicle accident claims and 60 days on Worker Compensation Claims. **We whole-heartedly agree** with the Sen HMS/CPN Committee report comment that "..it is not good business practice to delay payments for such a long period of time with no consequences as the delays have a negative ripple effect on the provision and accessibility of health care." Support is expressed for the SD1 language that allows for the state to pay interest on delayed payments, unless certain circumstances apply. We also note that as taxpayers, the state charges businesses interest on late income tax and GET payments, no matter what the economic situation.

We disagree with the transfer of $70,000,000 from the Hurricane Relief Fund, particularly in reference to providing Medicaid coverage to Compact of Free Association immigrants. Federal reimbursement for that must be aggressively pursued with the Federal government.

I can be reached at 808-969-3811 if you have any questions. Thank you for the opportunity to testify.

Healthcare Association
of Hawaii

SENATE COMMITTEE ON WAYS AND MEANS
Senator Donna Mercado Kim, Chair

Conference Room 211
Feb. 24, 2010 at 10:10 a.m.

Supporting SB 2030 SD 1 with an amendment.

The Healthcare Association of Hawaii represents its member organizations that span the entire spectrum of health care, including all acute care hospitals, as well as long term care facilities, home care agencies, and hospices. Thank you for this opportunity to support SB 2030 SD 1 with an amendment. The bill requires the State to pay Medicaid health plans in a timely manner, suspends interest on delayed payments by Medicaid health plans to providers when the State or federal government delays payment to the health plans, and appropriates funds from the Hurricane Relief Fund to partially cover a shortfall in Medicaid appropriations.

This bill addresses a potential crisis in health care. The Department of Human Services intends to delay payments to Medicaid health plans for approximately three months, and perhaps longer, at the end of the current fiscal year. The delayed payments represent approximately $100 million per month. Delays in payments of this magnitude and for this length of time are likely to affect payments by the Medicaid health plans to providers, reducing their operating funds and affecting their ability to pay employees and purchase supplies. As a result, the health care for Medicaid's 240,000 enrollees may be placed in limbo.

Section 2 of the bill encourages the State to pay Medicaid health plans in a timely manner by imposing 15% interest on delayed payments, and we support that effort.

Section 3 of the bill exempts Medicaid health plans from paying interest on delayed payments to providers when the State (or federal government) has delayed payments to the health plans. This provision is fair because the Medicaid health plans should not be responsible for any lapses by the State. However, Medicaid health plans are already exempt from Hawaii's clean claims law, which is found in Section 431:13-108, HRS. This law requires health plans to pay providers in a timely manner, specifically within 15 days for claims filed electronically and within 30 days for paper claims. Health plans that do not comply are required to pay 15% interest on delayed payments. The exemption absolves Medicaid health plans from paying interest on delayed payments to providers.

This bill would have a clearer internal logic if that exemption were repealed. We suggest the attached amendment. With this amendment, Medicaid health plans would operate as other health plans, paying 15% interest on delayed payments to providers. As provided in Section 2 of the bill, the State would pay 15% interest on delayed payments to Medicaid health plans. Section 3 should be amended so that the suspension of interest paid by Medicaid health plans to providers takes effect only when the State does not pay the Medicaid health plans interest on delayed payments.

The Healthcare Association is engaged in ongoing discussions with Medicaid health plans the delays by the State to pay Medicaid health plans. This bill is one of the matters being discussed, and we seem to be approaching agreement on the various elements of the bill. However the issue of how to handle dual eligibles (Medicaid and Medicare) is still outstanding because of the time it takes to process those claims. We hope to have that issue resolved soon and to have an

amendment addressing that issue. Meanwhile, the Healthcare Association asks that this bill continue to advance in the legislative process.

With the suggested amendment, the Healthcare Association supports SB 2030 SD 1.

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February 24, 2010

To: The Honorable Donna Mercado Kim
Chair, Senate Committee on Ways and Means

From: 'Ohana Health Plan

Re: Senate Bill 2030, Senate Draft 1-Relating to Health

Hearing: Wednesday, February 24, 2010, 10:10 a.m.
Hawai'i State Capitol, Room 211

Since February 2009, 'Ohana Health Plan has provided services under the Hawai'i QUEST Expanded Access (QExA) program. 'Ohana is managed by a local team of experienced care professionals who embrace cultural diversity, advocate preventative care and facilitate communications between members and providers. Our philosophy is to place members and their families at the center of the health care continuum.

'Ohana Health Plan is offered by WellCare Health Insurance of Arizona, Inc. WellCare provides managed care services exclusively for government-sponsored health care programs serving approximately 2.3 million Medicaid and Medicare members nationwide. 'Ohana is able to take the national experience in providing an 'Ohana care model that addresses local members' healthcare and health coordination needs.

We appreciate this opportunity to submit our comments in strong support of Senate Bill 2030, Senate Draft 1-Relating to Health.

'Ohana Health Plan (OHP) is one of the five health care plans contract under the QUEST program through the Department of Human Services (DHS). As a new plan, operating largely with the support of government funding from the State of Hawai'i, we are deeply concerned about the potential for a three to four month payment deferral. This deferral may significantly impact our ability to pay our contracted providers in a timely manner and could cause a disruption in services to our members, which are low-income, aged, blind and disabled residents of our State. As a contracted provider of services for the State of Hawai'i, we take out federally mandated responsibility to make covered services available and accessible through a sufficient delivery network very seriously.

We greatly appreciate this measure that would exempt QUEST plans from paying interest under the clean claims act when delays are due to non-payment by government payers to QUEST plans. This legislation would alleviate us from the additional financial burden of late interest payments, but we remain concerned with the larger issue regarding our ability to compensate our direct service providers in a timely manner, thus ensuring our ability to serve our most vulnerable members' health needs.

The continued support of the Legislature thus far in identifying additional mechanisms to provide DHS with the funding needed in order to continue payment to the five QUEST health care plans in a timely manner is greatly appreciated. It is through these efforts that we are optimistic in finding a solution.

We respectfully request that this committee pass this measure as a contingency plan should the DHS choose to move forward with their proposal to defer payment to the health care plans contracted under QUEST. Thank you for the opportunity to provide these comments regarding Senate Bill 2030, Senate Draft 1.

AMENDMENT TO SB2030 SD1

Repeals exemption for Medicaid health plans from clean claims law.

Section 431:13-108, Hawaii Revised Statutes, is amended by amending the definition of "clean claim" in subsection (j) to read as follows:

""Clean claim" [~~means~~]:

(1) Means a claim in which the information in the possession of an entity adequately indicates that:

[~~(1)~~] (A) The claim is for a covered health care service provided by an eligible health care provider to a covered person under the contract;

[~~(2)~~] (B) The claim has no material defect or impropriety;

[~~(3)~~] (C) There is no dispute regarding the amount claimed; and

[~~(4)~~] (D) The payer has no reason to believe that the claim was submitted fraudulently.

[~~The term does~~] (2) Does not include:

[~~(1)~~] (A) Claims for payment of expenses incurred during a period of time when premiums were delinquent;

[~~(2)~~] (B) Claims that are submitted fraudulently or that are based upon material misrepresentations; and

[~~(3) Medicaid or Medigap claims; and~~

~~(4)~~] (C) Claims that require a coordination of benefits, subrogation, or preexisting condition investigations, or that involve third-party liability."