SCR179

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DEPARTMENT OF HUMAN SERVICES
P. O. Box 339
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March 25, 2010

MEMORANDUM

TO: Honorable David Y. Ige, Chair
Senate Committee on Health

Honorable Suzanne Chun Oakland, Chair
Senate Committee on Human Services

FROM: Lillian B. Koller, Director

SUBJECT: **S.C.R. 179/S.R. 80 – REQUESTING THE DEVELOPMENT OF PROPOSED LEGISLATION MANDATING THE SIZE AND EXTENT OF A MANAGED CARE PLAN'S SPECIALTY NETWORK**

Hearing: Thursday, March 25, 2010, 1:45 P.M.
Conference Room 016, State Capitol

PURPOSE: The purpose of this resolution is to request that the Governor develop proposed legislation to mandate the size and extent of a managed care plan's specialty network based upon the California managed care law known as the "Knox-Keene Health Care Service Plan Act of 1975, as amended"; and that the Governor is requested to direct the participation and assistance of any appropriate agencies and personnel within the executive branch needed to develop the proposed legislation.

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

Concerns regarding network adequacy in the QUEST Expanded Access (QExA) health plans are unfounded. Accusations that DHS does not perform its due diligence

in developing Requests for Proposals (RFPs) and in monitoring the QExA health plans insults hard working civil servants. In fact, the federal government has reviewed the matter in court and concluded that the claims against the State of Hawaii are meritless.

The Federal District Court has entered an order rejecting contentions of various plaintiffs that the QExA health plan provider networks are not compliant with applicable federal law and regulations. The Court also ruled that the decision to limit the number of QExA health plans to two was valid.

These rulings are the latest in what by now is a lengthy list of court actions, in three separate lawsuits, rejecting a variety of legal objections that have been put forward by an unsuccessful applicant for a QExA contract, and by a small number of providers and advocates who object to the extension of the State's managed health care program to the elderly and disabled categories of recipients. The rulings vindicate the State's position that its QExA program, which was years in the planning and has been implemented in a careful and sensitive manner over a several month period, will significantly expand and improve health services for our most vulnerable populations in the most cost-effective way for the State.

There are still a few issues remaining in the most recent lawsuit. DHS hopes they will be resolved expeditiously, without unnecessary litigation burdens on the State. The time for litigating over the QExA program is now over. All parties involved in the delivery of health care services to the elderly and disabled should devote themselves to providing the best possible service to the people the program is designed to serve.

Given the nearly bankrupt financial condition of California and the expected termination of their Children's Health Insurance Program, one must question the wisdom of this resolution proposing that Hawaii follow California's doomed healthcare path.

Thank you for this opportunity to testify.

AlohaCare
Aloha is the difference

March 25, 2010
1:45pm
Conference room 016

To: Sen. David Ige, Chair
Sen. Josh Green, M.D., Vice Chair
Committee on Health

Sen. Suzanne Chun Oakland, Chair
Sen. Les Ihara, Jr., Vice Chair
Committee on Human Services

From: Paula Arcena
Director of Public Policy

Re: SCR 179 Requesting the development of proposed legislation mandating the size and extent of a managed care plan's specialty network; and

SR 80 Requesting the development of proposed legislation mandating the size and extent of a managed care plan's specialty network

Thank you for the opportunity to testify in support of SCR 179 and SR 80.

AlohaCare is a non-profit, Hawaii based health plan founded in 1994 by Hawaii's community health centers to serve low-income families and medically vulnerable members of our community through government sponsored health insurance programs. We serve over 70,000 statewide beneficiaries of Medicaid and Medicare.

We support these measures because inadequate provider networks, especially on the neighbor islands, have been a major barrier to access to care for Hawaii's Medicaid eligible members.

Absent adequate provider networks, it is impossible to establish an effective and efficient Medicaid health insurance program that maximizes the benefit of State and Federal tax dollars. Therefore, as specified by these resolutions, we believe it is appropriate and timely to request the Governor to develop a definition of an adequate managed care plan specialty network.

We understand that the primary proponents of the resolutions plan to request an amendment to omit reference to the California Knox-Keene Health Care Service Plan Act of 1975 and instead reference the Hawaii QUEST and QUEST Expanded Access request for proposal requirements for the managed care health plan services as a starting point. We support this amendment.

Thank you for this opportunity to testify.

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www.alohacarehawaii.org

March 25, 2010

To: Comm. on Health – Sen. David Ige, Chair; Sen. Josh Green, M.D., Vice Chair
Comm. on Human Services – Sen. Suzanne Chun Oakland, Chair; Sen. Les Ihara, Jr., Vice Chair

RE: Testimony in SUPPORT of SCR179 with AMENDMENTS - REQUESTING THE DEVELOPMENT OF PROPOSED LEGISLATION MANDATING THE SIZE AND EXTENT OF A MANAGED CARE PLAN'S SPECIALTY NETWORK

Upon reviewing the language of SCR179 it appears references to the Knox-Keene legislation are inflated at best. The legislation is very general and does not specifically address Specialty Network Standards. Instead of following California's lead, Hawaii should follow Hawaii's lead. For SCR179, my recommendations are as outlined below:

Remove all references to the California Knox-Keene Health Care Service Plan Act of 1975 - the plan gives no standards to follow and the "Knox-Keene WHEREAS" should be replaced with:

- *WHEREAS, a source precedent is the Current QUEST RFP Requirements (see Attached), one of whose purposes is to ensure that subscribers and enrollees are able to access and receive health and medical services rendered in a manner providing continuity of care; and*
- *WHEREAS, under the Hawaii legislation, the Current QUEST RFP Requirements were issued to potential health care service plans to assure the public that these plans meet certain minimum standards; now, therefore,*
- *BE IF RESOLVED by the House of Representatives of the Twenty-fifth Legislature of the State of Hawaii, Regular Session of 2010; the Senate concurring, that the Governor is requested to develop proposed legislation to mandate the size and extent of a managed care plan's specialty network based upon the Hawaii QUEST RFP Requirements for both QUEST and QUEST Expanded Access Plans.*
- *BE IT FURTHER RESOLVED that plans will need to certify that they have a contracted network that at least meets these standards PRIOR to receiving any contract award for either QUEST or QUEST ExA. This is to protect beneficiaries and providers of care from being taken advantage of or forced to contract.*
- *BE IT FURTHER RESOLVED that for Federally designated Medically Underserved Areas, access to transportation, translation and outreach services will be provided in a timely manner. Additionally, for QUEST Expanded Access additional requirements of case management agencies, nursing facilities and long term care would be applicable*

A synopsis of the QUEST RFP related to Specialty Network Standards is below:

QUEST SPECIALTY PROVIDER NETWORK REQUIREMENTS:
40.200 Provider Network
40.210 Required Providers. The health plan shall develop and maintain a provider network that is sufficient to ensure that access and appointment wait times defined in Section 40.220 will be met. This network of providers shall provide the benefits defined in Section 40.300. The health plan shall have written policies and procedures for the selection and retention of providers. In developing and maintaining the network, the health plan must consider the following:

- The anticipated enrollment;
- The expected utilization of services, taking into consideration the characteristics and health needs of specific populations in the health plan;
- The number and types (in terms of training, experience and specialization) of providers required to furnish the contracted services;
- The numbers of network providers who are not accepting new patients; and
- The geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for members with disabilities.

The health plan shall not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. This is not to be construed as requiring that the health plan contract with providers beyond the number necessary to meet the needs of its members, precluding the health plan from using different reimbursement amounts for different specialties or for different practitioners in the same specialty, or precluding the health plan from establishing measures that are designed to maintain quality of services and control costs and is consistent with its responsibilities to members. If the health plan will not include individuals or groups of providers of a specialty grouping in its network, it shall provide the information in its proposal.
If the health plan decides during the contract period that it no longer will include individuals or groups of providers in its network, the health plan shall give the affected providers written notice of the reason for its decision thirty (30) days prior to the effective date and shall notify the DHS at least forty-five (45) days prior to the effective date if the individuals or providers represent five percent (5%) or more of the total providers in that specialty or if it is a hospital.

The following is a listing of the minimum required components of the provider network. This is not meant to be an all-inclusive listing of the components of the network, rather the health plan may add components, or the DHS may require that the health

plan add components as required based on the needs of the members or due to changes in federal or state statutes. At a minimum, the network shall include the following:

- Physician specialists, including psychiatrists, cardiologists, neurologists, surgeons, ophthalmologists, pulmonologists, orthopedists;

At a minimum, the health plan shall have the following in its network:

Provider Type	**Number of Providers Required**
Physician Specialists	
Cardiology	1 per 5,000 members
Nephrology	1 per 10,000 members
Neurology	1 per 10,000 members
Gastroenterology	1 per 7,500 members
Hematology/Oncology	1 per 10,000 members

Surgical Specialists	
Ophthalmology	1 per 5,000 members
Otolaryngology	1 per 7,500 members
General Surgery	1 per 5,000 members
Orthopedics	1 per 5,000 members
Obstetrics/Gynecology	1 per 3,000 women members
Urology	1 per 10,000 members
Neurosurgery	1

In addition, for Oahu, Maui, Kauai, and Hawaii each health plan shall have the following:

Provider Type	**Minimum # Required**
Cardiology	1 per hospital
Obstetrics/Gynecology	2 per island*
Gastroenterology	1 per hospital
Ophthalmology	1 per hospital
Otolaryngology	1 per hospital
General Surgery	1 per hospital
Orthopedics	1 per hospital

* For Hawaii, the requirement of 2 means 1 for East Hawaii (i.e., Hilo) and 1 for West Hawaii (i.e., Waimea-Kona).

The physician specialties must be available at the hospital to which the health plan's PCPs admit if the specialty is available in the community. If the specialty is not available in the community, the requirement is not applicable.

ADDITIONAL QExA PROVIDER NETWORK REQUIREMENTS:

40.220 Specific Minimum Requirements

The health plan is solely responsible for ensuring it (1) has the network capacity to serve the expected enrollment in the service area, (2) offers an appropriate range of services and access to preventive, primary and long-term care services, and (3) maintains a sufficient number, mix, and geographic distribution of providers of services. The following is a listing of the minimum required components of the provider network. This is not meant to be an all-inclusive listing of the components of the network, rather the health plan may add provider types, or the DHS may require that the health plan add providers as required based on the needs of the members or due to changes in federal or state statutes.

At a minimum, the network shall include the following long-term care providers:

- Adult day care facilities;
- Adult day health facilities;
- Assisted living facilities;
- Chore or homemaker service providers;
- Community care foster family homes;
- Community care management agencies;
- Environmental adaptation providers;
- Expanded adult residential care homes (ARCHs);
- Home delivered meals providers;

- Home health agencies;
- Home maintenance providers;
- Home modification providers;
- Hospice care agencies;
- Non-medical transportation providers;
- Nursing facilities;
- Nutritional counseling providers;
- Personal care assistance providers;
- Personal emergency response systems providers;
- Private duty nursing providers;
- Providers of lodging and meals associated with obtaining necessary medical care;
- Respiratory therapy providers;
- Respite service providers; and
- Specialized medical equipment and supply providers.

I was digging through some boxes at my mom's place last night and came across a very auspicious memento. If you would like to have an "Official QUEST POG", circa 1993, just let me know.

Mahalo,

Ricardo C. Custodio, M.D., M.P.H.
Medical Director, Waianae Coast Comprehensive Health Center

Evercare
by UnitedHealthcare

March 25, 2010

The Honorable David Ige
Chair, Senate Committee on Health
State Capitol
Honolulu, HI 96813

The Honorable Suzanne Chun Oakland
Chair, Senate Committee on Human Services
State Capitol
Honolulu, HI 96813

Regarding: SCR 179 and SR 80 – Requesting the Development of Proposed Legislation Mandating the Size and Extent of a Managed Care Plan's Specialty Network

Chair Ige and Chair Chun Oakland and Committee Members:

Thank you for the opportunity to submit comments on Senate Concurrent Resolution 179 and Senate Resolution 80 – Requesting the Development of Proposed Legislation Mandating the Size and Extent of a Managed Care Plan's Specialty Network.

UnitedHealthcare is a licensed insurer that has been offering services in Hawaii for over thirty years. In February 2009, Evercare, offered by UnitedHealthcare, was one of two plans selected by the State to launch the QUEST Expanded Access (QExA) Program, through which we now serve over 19,000 of Hawaii's frail, disabled and aged population. We have established a seasoned local management team with years of health care experience in Hawaii, with over 120 locally based staff supporting the program.

Evercare offers QExA enrollees a comprehensive and integrated network of providers, comprised of over 1,600 physicians, behavioral health providers, pharmacies, home and community based providers and skilled nursing facilities who have historically served the Medicare and Medicaid population. Our network has been certified by the State Department of Human Services (DHS) and meets the rigorous standards already set forth in the QExA contract requirements.

While we appreciate the intent of the resolutions before the committee, we believe that legislation to codify standards for provider networks is unnecessary. The State's contracts with Evercare and 'Ohana already impose stringent geographic and timely access standards for QExA provider networks. For example, plans are required to contract with sufficient providers to ensure that QExA enrollees are able to obtain physician or hospital services within set time periods and travel to providers within set driving times. Failure to

meet these and other contract requirements subject the plans to sanctions or other DHS actions.

In addition, setting forth these provider network requirements in the plan contracts ensures that the State has quick and ready means to modify or strengthen the standards, based on changes in the local market or delivery system. By contrast, placing standards in legislation limits the State's ability to ensure that local provider network requirements are current and adequate to protect Hawaii's consumers.

While Evercare is fully compliant with the State's QExA contract requirements for provider networks, we agree that Hawaii's physician shortage is a problem that faces all local health plans serving the commercial, Medicaid and Medicare populations. On the outer islands and in certain more rural areas, finding sufficient providers to care for all our patients is a challenge.

We respectfully request that the Committee consider an alternative resolution that would direct the Administration, Legislature, health plans, consumers, providers and other stakeholders to study and offer solutions to Hawaii's provider access challenges. To the extent that the State undertakes such a review, we would like to make you aware that Joy Higa, United's Vice President of Government Affairs, is the former Deputy Director of the Department of Managed Health Care, the California agency that enforces the Knox-Keene Act. She is very familiar with these HMO laws and would be pleased to serve as a resource to this effort.

Thank you for the opportunity to provide these comments on this measure.

Sincerely,

David W. Heywood

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