HAWAII MEDICAL ASSOCIATION
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Friday, July 29, 2011 9:00 AM, CR 329

To: COMMITTEE ON HUMAN SERVICES
Senator Suzanne Chun Oakland, Chair
Senator Les Ihara, Jr., Vice Chair

Sen. Josh Green, M.D. Sen. Sam Slom

COMMITTEE ON HUMAN SERVICES
Rep. John M. Mizuno, Chair
Rep. Jo Jordan, Vice Chair

From: Hawaii Medical Association
Dr. Morris Mitsunaga, MD, President
Linda Rasmussen, MD, Legislative Co-Chair
Dr. Joseph Zobian, MD, Legislative Co-Chair
Dr. Christopher Flanders, DO, Executive Director
Lauren Zirbel, Community and Government Relations

Re: Briefing Of The Department of Human Services, Med QUEST Division

Chairs & Committee Members:

While we understand the Medicaid shortfall is significant, the HMA is very concerned that Medicaid reimbursements often do not meet the cost of providing care and the resulting effects on access to care. Reimbursement schedules as low as Medicaid endanger the viability of our entire healthcare system, especially on the neighbor islands where providers see a larger proportion of public payer insured patients than on Oahu.

As was emphasized by two recent Star Advertiser articles, very few providers could afford to see Medicaid patients when the fee schedule was at 60% of 2006 Medicare rates as they were in 2010. Cutting reimbursement to providers further will essentially ensure that many Medicaid patients do not have access to care by physicians who practice in individual and group settings. **It is difficult to think of any budgetary cut that DHS could make that would have a worse outcome on the state than a cut that ensures that 20% of the population will likely not have access to a doctor.** We need to be realistic about the

effect of cutting Medicaid reimbursement and re-prioritize spending in order to reflect the necessity of access to care for Medicaid patients.

Our Medicaid reimbursements should appreciate that physicians are individual small businesses who are experiencing diminishing profit margins, and are being asked to give deep discounts on their product to Medicaid. Physicians do not have financial backing that will pay employees, utility bills, and office rent absent providing care to patients at a reasonable fee.

Financial burdens for all physicians include:

- Overhead that can be as high as 75% of gross income;

- Overhead includes high medical malpractice insurance premiums (premiums vary by medical specialty but for high risk specialties can be around $70,000);

- Overhead includes increasing office staffing, office rent and other business expenses;

- Overhead costs have increased greatly due to increased administrative burdens imposed by Medicaid plans in the form of denials and prior authorizations;

- Income is based on capped and often inadequate payment for services from private and public health plans; and

- For new physicians, typical student loan debt around $160,000.

Cutting Medicaid reimbursements to levels that cannot sustain a physician's business spells disaster for the neighbor islands. It also greatly increases the likelihood that older physicians practicing in these underserved rural areas will retire or leave and young physicians will not open practices.

Inadequate access to health care on the neighbor islands has become a vitally important issue. Too many people die, or suffer poor outcomes, because there are inadequate numbers of practicing physicians. The life span of a Big Island resident is currently 2 years shorter than those in other parts of the state. The logistics of why this continues to worsen must be addressed. Thank you for the opportunity to provide this testimony.

HAWAII HEALTH SYSTEMS
C O R P O R A T I O N

"Touching Lives Everyday"

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

Committee on Human Services
Representative John M. Mizuno, Chair
Representative Jo Jordan, Vice Chair

Friday, July 29, 2011
9:00 a.m.
Conference Room 329
Hawaii State Capitol

Testimony on Department of Human Services, Med QUEST Division update on changes being proposed and/or implemented by the Department as it relates to the Medicaid programs.

Bruce S. Anderson, Ph.D.
President and Chief Executive Officer
Hawaii Health Systems Corporation

Thank you for the opportunity to present comment on the impact and/or potential impact that the State Department of Human Services (DHS) proposed changes will have on the provision of health services by the State's community hospital system.

We are deeply concerned that making major cuts in reimbursement and changed benefits and in eligibility will pose serious challenges to our financially fragile hospitals, which are already struggling to survive. With our hospitals being challenged by higher costs – for labor and new technology – and declining reimbursements, our ability to continue to perform the critical role of serving our patients and our island communities will be seriously threatened by the proposed changes planned by DHS.

HHSC's facilities are already struggling with the cost-cutting measures that the MedQUEST division of DHS is instituting to meet its decreased funding levels. Most troublesome is the 3% reimbursement cut for providers of services to MedQUEST patients. This will have a significant negative revenue impact on the HHSC Oahu region's long-term care facilities, Leahi Hospital and Maluhia, as over 80% of their patients are MedQUEST members. Additionally, DHS's three percent cut to the administrative fee that directly impacts the plans that administer the QUEST program may result in staffing shortages, delay processing of claims in a timely manner and also delay payment of claims to providers.

Of equal concern, the DHS plan to reduce benefits and eligibility of patients under the MedQUEST and Medicaid programs will have a negative financial impact on HHSC. HHSC's facilities will end up writing-off more charges for these patients as they continue to seek the

medical services they need while the provider is unable to collect sufficient reimbursement for services provided.

There are also indirect impacts to HHSC from the planned changes from DHS. For example, on any given day, about 25% of Maui Memorial Medical Center's (MMMC) medical-surgical beds are occupied by waitlist patients because MMMC does not have long term care beds available for these patients. Hale Makua, the principle long term care provider on the island of Maui, is shutting down beds because the qualifying acuity of patients for long term care is increasing and reimbursement does not cover the current cost of care. The vast majority of these patients are reimbursed through the MedQUEST program. A further 3% reduction in reimbursement will only exacerbate this problem. Hale Makua may have to continue to close LTC beds unless additional funding sources are found. If some additional funding source for Hale Makua is not found, the wait list at MMMC will continue to expand. For the most part MMMC is not paid for wait list patients. This additional cost of MMMC caring for more uninsured waitlisted patients is a huge factor in the need for MMMC to ask for additional State support. The operational impact of caring for these waitlist patients is that it limits MMMC's ability to fulfill its mission of providing care for the acute patients of Maui by restricting the number of available beds.

HHSC respectfully urges you and other legislators to work with the State's hospital community to develop fair and reasonable approaches to ensure funds in the Medicaid program are used effectively and Hawaii continues to have a strong health care system. We look forward to working with you to develop new strategies to strengthen our health care delivery system, including the Medicaid program. We have the same goal – to make the program as cost efficient and effective as possible while promoting timely, continued access to quality care with the best possible outcomes for the island communities we serve.

Thank you for the opportunity to testify before this joint-committee informational briefing.

HPCA
HAWAII PRIMARY CARE ASSOCIATION

COMMITTEE ON HUMAN SERVICES
Senator Suzanne Chun Oakland, Chair
Senator Les Ihara, Jr., Vice Chair

COMMITTEE ON HUMAN SERVICES
Rep. John M. Mizuno, Chair
Rep. Jo Jordan, Vice Chair

Testimony for the Medicaid Briefing Before the Human Services Committees

Submitted by Beth Giesting, Chief Executive Officer

July 29, 2011

The Hawaii Primary Care Association represents 14 community health centers in Hawai'i, which collectively provide primary care to 130,000 Hawaii residents every year. Of those, nearly three fourths are either covered by Medicaid or are uninsured. Consequently, we are extremely concerned with changes in Medicaid policy and procedures.

This testimony highlights three areas of concern for the Hawaii Primary Care Association.

- The impending Medicaid budget cuts and how they will affect the patient population of Hawaii;
- The upcoming Med-Quest RFPl and
- Planning and implementation of the Patient Centered Medical Home model in Medicaid.

Medicaid Cuts

Community Health Centers in Hawaii serve more than 20% of the state's Medicaid population. Any and all changes currently being discussed by the State are of great concern to us, but there are two that we would especially like to highlight.

First, the planned disenrollment of 4,500 adults in the QUEST program due to reducing eligibility requirements from 200% of the federal poverty level to 133% will place a strain on an already overburdened community health center system. Community health centers currently provide care to over 35,000 uninsured patients each year. The vast majority of newly uninsured health care consumers who will be cut from the QUEST program will either turn to health centers for their care, pushing our total uninsured patients to around

40,000 and stretching thin budgets even tighter, or they will seek out emergency department care, which, reports show, is seven times more costly to the state than providing basic coverage.

The second area that we would like to see discussed further is the elimination of passive renewal, a progressive process applauded by CMS, for households with children in QUEST. The state has commented that as many as 10% of enrollees are actually ineligible and that removing those from the Medicaid roster will return a great savings. However, we feel that this provision could be disastrously disruptive to thousands of families and actually cost nearly as much as the estimated savings. The task of dis-enrolling and later re-enrolling eligible members would be both time and labor intensive for the state and providers. Eligible families who lose coverage will likely be uninsured for months while their applications are reprocessed. Perhaps of greatest concern, is the number of children that will be dis-enrolled. At a minimum 15,000 children will lose their coverage under this provision, a number that could potentially reach as high as 55,000. In a state with ballooning health care costs and extremely high chronic disease rates, it is unacceptable to allow our keiki to go uninsured.

Med-QUEST RFP

The state is currently in the process of rebidding its QUEST plan contracts through a RFP that is expected to be released in the near future. This process will affect more than 270,000 Medicaid recipients statewide, 50,000 of whom will receive care at Community Health Centers. Since the QUEST program is a significant investment and affects 20% of the state population,we believe the State must make a concerted effort to ensure consumer protection, process transparency and financial program integrity in drafting the RFP.

The State should take several steps to achieve these goals. First, the state can protect consumers by ensuring that plans have existing contractual networks of providers throughout the state. These networks are essential for access to care and also support care coordination across communities.

Second, a conscientious effort should be made to include a variety of plans that reach into all corners of the state. In the past, plan participation has been limited and has forced patients to alter or terminate their relationship with existing providers. Such drastic measures are not only detrimental to the health and well-being of the patient, they are financially burdensome to the state. Further, sufficient plans should be included to allow for all patients to have a choice in the coverage they receive.

Next, it is our belief that any contract that is awarded under this RFP should go to those plans that are in full compliance with state licensure requirements and with all applicable state and federal laws. Together, these provisions insure that the Hawaii Insurance Commissioner has oversight over those plans doing business in Hawaii and can assure that they are solvent, pay their bills on time, and otherwise perform ethically. Additionally, the State should take into consideration the added benefit of plans that invest in the local economy.

Finally, the state must enforce Act 69 and require that plans responding to the RFP include all applicable taxes and fees. Together, these measures will provide a greater return on investment for the state, both through significant cost savings and the improved vitality of the local workforce, while ensuring good services for patients and prompt, accurate payment for providers.

Patient Centered Medical Home

In recent months Governor Neil Abercrombie emphasized his support for the Patient Centered Medical Home (PCMH) model for Hawaii;s Medicaid program. We ardently support this decision and its potential for cost control and improved patient outcomes and are pleased to work with the State and a variety of stakeholders representing providers and consumers to develop a well-considered State Plan Amendment for PCMH.

One concern we have is ensuring that the process allows time for and encourages input from a broad spectrum of stakeholders. Another is that the development of the QUEST RFP and SPA are out of sequence. We believe it is imperative to do our best to design the PCMH and ensure that both the RFP and SPA are consistent with each other.

In addition, the federal government has provided funding through the Affordable Care Act that provides 90% FMAP funding for states pursuing a medical home program. However, these funds begin the moment the SPA is published and exist for the finite period of eight fiscal quarters. Because of this, it is our belief that the state is best served by putting as much of the program in place as possible before issuing the SPA so as to maximize the use of and amount of federal dollars for this purpose.

In summary, the Hawaii Primary Care Association appreciates the opportunity to present some of our concerns regarding Medicaid and healthcare in the state right now. We fully realize and appreciate the precarious position the State finds itself in and, despite the concerns listed here, we are eager to work with DHS,providers, and others to find the improve Med-QUEST programs.

Thank you for the opportunity to provide testimony.

COMMITTEE ON HUMAN SERVICES

COMMITTEE ON HUMAN SERVICES

INFORMATIONAL BRIEFING

DATE: Friday, July 29, 2011

TIME: 9:00am

PLACE: Conference Room 329

State Capitol

415 South Beretania Street

Submitted by

Poka Laenui, Executive Director

Hale Na`au Pono

(Wai`anae Coast Community Mental Health Center)

A Health Home Program is a State Option to provide coordinated care to fund Medicaid eligible individuals with chronic health conditions. This Program is not a required service under Section 1902 for State Plans for Medical Assistance. Health Homes, under Section 1945, supplement State Medical Plans by providing the option for States to treat eligible individuals under a team approach, rather than a managed-care or fee-for-service approach which has resulted in fractured and disjointed service delivery.

Under the team approach, a designated service provider becomes the health home and is responsible for providing eligible individuals an array of services including:

(i) comprehensive care management;

(ii) care coordination and health promotion;

(iii) comprehensive transitional care, including appropriate follow-up, from inpatient to other settings;

(iv) patient and family support (including authorized representatives);

(v) referral to community and social support services, if relevant; and

(vi) use of health information technology to link services, as feasible and appropriate.

The Health Home approach is distinguishable from the managed-care/fee-for-service approach, currently utilized under State Medical Assistance Plans in that Health Homes

employ a team of health care professionals which may include physicians and other professionals, such as a nurse care coordinator, nutritionist, social worker, or behavioral health professional. This multi-disciplinary team is more than just a collection of individuals with cross-access to medical records. The team is required to treat the entire person instead of an individual facet of the professional's expertise.

This team approach is very much like what had been promoted under Hawaii's AMHD's Assertive Community Treatment program, a highly intensive Case Management approach, as well as its general "Recovery Planning" approach in development of an individual's master recovery program. However, AMHD did not fully incorporate the primary health care professional within this recovery model.

Health Homes are specialized care services provided to eligible individuals who have:

(I) 2 chronic conditions;

(II) 1 chronic condition and is at risk of having a second chronic condition; or

(III) 1 serious and persistent mental health condition.

A chronic condition includes:

(A) A mental health condition.

(B) Substance use disorder.

(C) Asthma.

(D) Diabetes.

(E) Heart disease.

(F) Being overweight, as evidenced by having a Body Mass Index (BMI) over 25.

Current Medicaid Managed-Care and Fee-For-Service Programs do not reimburse for or provide for this coordinated care approach, i.e., team meetings, case management, physician care in behavioral health settings, support and outreach services.

Federal medical assistance programs may be modified to reduce or expand funding in four ways.

First, States may apply for federal funds by submitting a state plan for medical assistance, under Section 1902.

Second, States may amend their State Plan under Section 1902 and Section 1915

Third, under Section 1915, States may apply to waive certain State Plan requirements in order to limit or modify services.

Fourth, States may apply for a waiver to conduct a demonstration project without modifying its State Plan, under Section 1115. (Note: The 8 State waiver limitation only applies to TANF related demonstration projects)

Hawai`i Department of Human Services has expressed an interest in health homes, but also has concerns and reservations about modifying its State Plan which employs a Managed Care approach. I would recommend that the State apply for a demonstration project under Section 1115. Section 1115 Demonstration Projects would allow the State

to receive additional federal funds to expand services by implementing a Health Home Program.

I believe a Section 1915 waiver would be inappropriate for a State Health Home Program because this waiver is designed to limit or modify existing programs in a State Plan, rather than to expand or initiate new programs. For example, Section 1915(b) covers Managed Care/Freedom of Choice Waivers, Section 1915(c) provides Home and Community-Based Service Waivers.

In addition to the health home program provided under Section 1945, State may also apply for planning grants in order to develop a state plan amendment. The main difference between a health home program and a health home planning grant is that States must contribute to the planning grant an amount equal to the States percentage under its State Plan. The Feds would provide up to 90% of the funds for a State Health Home Program for up to 8 quarters after it starts.

It is my understanding that the State Department of Human Services is applying for a planning grant for the primary purpose of building capacity for electronic health records and communication. I believe that choosing a planning grant over the program is short-sighted, fails to maximize the needed funding opportunities available, and increases the delay in initiating the inevitable. Health Homes fulfill these goals of the health reform: Improving the health of individuals who have multiple chronic conditions, decreasing the costs of providing care for these high-cost individuals, and minimizing the recurrence of emergency or inpatient care. Health Homes are designed to reduce costs, while improving care. To encourage States to carry out Health Home Programs, the Feds will reimburse States for up to 90% of the cost for two years. This reimbursement incentive will not only provide a budget reprieve for services, but will also demonstrate the savings available without risking State funds.

Hawai`i should apply to include Health Homes as part of its medical assistance program because the eligible individuals are the most costly and difficult to serve, service cuts usually impact these individuals earlier and more severely, and the federal government is providing payments for up to 90% of the cost for 8 quarters following the start of the program.

To provide an idea of how a health home model may work, I will use our attempt at Hale Na`au Pono. We have been preparing to embark on a similar Health Home model beginning with our application to SAMHSA in its 2010 FY in a program to expand and enhance **services** in **s**ubstance abuse, mental health, and chronic primary health. The targeted focus populations are **Native Hawaiians** and **Veterans** in the geographic area of Wai`anae, in the Leeward District of O`ahu, Hawaii.

Abstract:

Voyage to Recovery LROSC (VTR-LROSC) focuses on the Native Hawaiian and Veteran population in the Wai`anae geographic region of Hawai`i to support clients and families navigate their multiple chronic illnesses in substance, mental health and primary health. This local recovery-oriented system highlights a

holistic community approach of recovery and maintaining wellness with emphasis on Hawaiian cultural practice.

Hale Na`au Pono (HNP) will utilize an Illness Management and Self-Directed Recovery (IMSR) Practice adapted to the Native Hawaiian (NH) population in the Wai`anae Community. This community-based and culturally adapted program is known as Kumu Ola Pono, or "Voyage to Recovery." The VTR program initially combined comprehensive treatment for Mental Illness/Substance Abuse (MI/SA). With this TCE Local LROSC grant, HNP will expand this comprehensive program to include primary healthcare.

…

This LROSC program will improve the health of Wai`anae residents by distinct measurable outcomes in each of the three areas of care. The ethnicity most impacted by VTR-LROSC will be Native Hawaiians who number 49% of the community population. Within this population is a large number of Veterans also going without adequate services.

…

In addition to the IMSR adapted Kumu Ola Pono, we will also use Assertive Community Treatment (ACT) as foundational to VTR-LROSC. These two practices, recently discontinued in the State by the Department of Health, will be re-integrated into Wai`anae, filling a critical gap in service. In addition to IMSR and ACT, VTR-LROSC shall include elements of Integrated Dual Disorders Treatment (MI/SA), Medication Management, Family Psychoeducation, Peer Support, Housing Support and Supported Employment.

SAMHSA scored and approved this program but was unable to fund it due to its fiscal shortage in that program year as well as the current 2011 year. OHA, however, have approved the program and agreed to be a contributing organization to the success of such a program. We are in the early stages of rolling out this program in the Wai`anae community on a limited basis.

It appears, both SAMHSA and OHA, along with the ACA's call for Health Home models are in unison in the need for a coordinated service program as described.

For further information, please contact us at Hale Na`au Pono.

Poka Laenui, Executive Director

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Hale Na`au Pono 697-3045