HMS/HUS Joint Information Briefing
April 26, 2011

Testimony

From: Desiree Puhi [dpuhi@molokaichc.org]
Sent: Thursday, April 21, 2011 2:33 PM
To: HMS Testimony
Subject: DHS Testimony Regarding Potential Medicaid Cuts

MOLOKA'I 'OHANA HEALTH CARE, Inc.
dba MOLOKA'I COMMUNITY HEALTH CENTER
P.O. Box 2040
Kaunakakai, HI 9674

TO: The Honorable Suzanne Chun Oakland
Senate Chair, Human Services
State Capitol, Room 226
Honolulu, HI 96813

The Honorable John M. Mizuno
House Chair, Human Services
State Capitol, Rm. 436
Honolulu, HI 96813

DATE: April 21, 2011

RE: Joint Informational Briefing on Potential Medicaid Changes

Chairs Oakland and Mizuno, and members of the committees:

Thank you for the opportunity presented today to provide information on how the potential Medicaid changes could negatively affect the people of Molokai. I regret that a prior commitment has rendered me unable to attend today's informational briefing in person.

Moloka'i 'Ohana Health Care, Inc., a multi-service, fully-accredited 501(c)(3) non-profit health care agency that does business as the Moloka'i Community Health Center (MCHC). Currently, MCHC serves over 3,000 registered patients in which 60% are Medicaid recipients. Poverty, geographical isolation, lack of available health care professionals and the high cost of travel are the primary barriers to the access of comprehensive health care on Moloka'i. The island suffers from one of the lowest overall rankings in the state in terms of economic health, socio-economic stability, and food security. At 14.1%, its official unemployment rate is more than double that of the State of Hawai'i in general. Potential State Medicaid budget cuts will fracture years of progress made to stabilize and improve access to health care on Moloka'i. Moreover, the detrimental affects to society of leaving the most vulnerable without health care is unfathomable.

In 1932, Franklin Delano Roosevelt said, "The success or failure of any government in the final analysis must be measured by the well-being of its citizens. Nothing can be more important to a state than its public health." MCHC serves as a classic social safety net for the island's most vulnerable populations, emphasizing both holistic, preventative and patient-driven health care and professional collaboration with other health and human service organizations whenever necessary, to address the primary health care needs of Moloka'i residents, with particular focus on the needs of children and elderly. Without Medicaid, the most vulnerable will go without desperately needed medical, dental and vision care. Likewise, the proposed cuts will cause more providers to exit the Medicaid program, making it more difficult to obtain care for Medicaid patients and increasing the patient load of the remaining providers that do accept Medicaid patients. As a result, more people will end up in hospital emergency rooms increasing the overall cost of health care or patients will forgo health care completely, resulting in loss of life.

The potential Medicaid cuts could also destabilize Community Health Centers. Community Health Centers provide care to some of the most complex socially challenged patients and are expected to do so with dwindling reimbursements, decreased funding streams and increased overhead expenses. Although health care is not free at Community Health

Centers, it is difficult to collect co-payments from a person who is unemployed and in ill health; especially in a small, rural community such as Moloka'i, where everyone is considered ohana. In my opinion, trimming the budget through Medicaid cuts is short sighted and will ultimately create a higher cost to the taxpayer while hurting all aspects of rural healthcare.

Thank you for your time and consideration. We recognize the difficult decisions to be had; however, we certainly hope the informational briefing has brought the committee closer to a sound decision. Should your committees require further information, please fell free to give me a call at (808) 553-4505.

Aloha,

Desiree Puhi

Live. Well.
Executive Director
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Mission Statement: To provide and promote accessible comprehensive individual and community health care to the people of Molokai with respect and aloha.

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From: Stephen Kemble [sbkemble@hawaii.rr.com]
Sent: Thursday, April 21, 2011 10:48 PM
To: HMS Testimony
Cc: Suzanne Chun Oakland; Rep. John Mizuno; Pat McManaman; Lauren Suzanne Zirbel; Christopher Flanders; Gary A. Okamoto; Joseph ZOBIAN; Linda J. Rasmussen; Morris Mitsunaga MD (E-mail); Roger Kimura
Subject: Informational Briefing on Medicaid

Re: Informational Briefing on Medicaid, April 26, 2011, 8-9 AM, Conf Rm 229

I am testifying as a physician who treats Medicaid patients in Queen Emma Clinic.

We are facing a budget crisis for Medicaid. Most of the proposals put forward by by DHS to address this crisis involve cuts in benefits and/or reimbursement for providers. Medicaid is already failing to provide adequate access to necessary care for beneficiaries, in violation of Federal requirements. Although many physicians have signed participating provider contracts with the Medicaid plans on behalf of their existing patients, very few are accepting new Medicaid patients, and this is especially true for the QExA plans, for the reasons discussed below. As time goes on, a higher and higher percentage of Medicaid patients will be "new," and will be unable to find any doctor willing to take their insurance. The only options for care for these patients are emergency rooms and overwhelmed clinics such as the Federally Qualified Health Centers and Queen Emma Clinic, where waiting lists are often months long. Private sector physicians have already been largely driven out of Medicaid. Anyone can confirm this by calling all the primary care doctors in the phone book and asking if they can be accepted as a new patient with Medicaid. Emergency rooms are by far the most expensive site for primary care, so this cannot be a cost-effective way to deliver health care. Cutting benefits and provider reimbursement will only exacerbate this situation.

Where is the waste in Medicaid spending? As far as I can see, there is far more under-treatment than over-treatment for this population, but there is massive administrative waste. The Medicaid managed care plans, and especially the QExA plans, have promised to improve the cost-effectiveness of care by improving care coordination, but they have utterly failed to do this. Their strategies for "managing" care consist entirely of hiring bureaucrats to deny and obstruct care, almost of all of which is actually appropriate and medically necessary. Every day I am confronted with senseless demands from these plans for prior authorizations. If one of my patients is having side effects or inadequate improvement on one generic drug and I write a prescription for another, equally inexpensive generic drug, I am required to fill out a prior authorization form and document all the other drugs tried and what happened with each. This is a waste of my time, and the QExA plan has to hire people to process these prior authorizations. Queen Emma Clinic has a full-time pharmacist who spends all of her time dealing with these senseless PA requests. I continue to encounter numerous instances of patients being unable to fill prescriptions for crucial medications, disruption in long-term successful doctor-patient relationships, disruptions in coverage when patients switch plans, erroneous dis-enrollments and problems getting re-enrolled, numerous claims processing problems, imposition of step-therapy requirements for antipsychotic medications in violation of Hawaii law, and frequent transportation problems preventing patients from making their appointments. Every single individual working in Queen Emma Clinic and other clinics serving Medicaid, including doctors, nurses, social workers, pharmacists, and also the patients themselves, agrees that the effects of Medicaid managed care in Hawaii have been 100% destructive to the actual delivery of health care.

The QExA plans claim they are spending 93% of their budgets on health care, and only 7% on administration. This is simply not believable. The Obama administration cut a deal with the health insurance plans to allow managed care costs to be counted as "health care" and not

administration, so they are free to hire as many people as they want to obstruct health care, and call it "health care" and not administration. Other health plans with far less intrusive managed care policies spend around 1.5% of their premiums on "medical management." Based my experience with the QExA plans, they must be spending at least 3-4 times this much on managed care administration, and they don't count any of this as administrative costs in the figures they report to the State. They are also forcing doctors and hospitals who are willing to see their patients to spend far more than they should have to on administration. No matter what they claim with doctored statistics, it is very obvious to any observer on the "front lines" that they are spending much less than they should on primary care and outpatient specialty care, and much more than they should on emergency room and hospital care.

The QExA plans cover the ABD population, most of whom are "dual eligibles" with both Medicare and Medicaid. ALL of my dual eligible patients tell me these plans have been aggressively marketing their Medicare Advantage plans to them. Many of these patients are elderly, chronically mentally ill, and easily confused. The plan marketers promise improved benefits and tell the beneficiary that they can see all their present doctors. The patients who sign up for these plans then discover that none of their doctors are actually participating in these Medicare Advantage plans, and they then face a nightmare trying to dis-enroll in the plan. The marketers never tell the patients that the plan gets a much bigger profit from the Medicare Advantage plan than from the regular QExA plan. This is blatant marketing fraud.

Instead of cutting benefits and provider reimbursement, Hawaii should go after the fraud and administrative waste in the Medicaid Managed care plans. It is time DHS and the legislature start focused on optimizing health care, simplifying administration for providers, and reducing administrative waste, instead of listening to the health plans who are wasting our money on obstructing necessary care and siphoning off profits that don't contribute any value to health care.

Stephen Kemble, MD

From: jz [jzobian@yahoo.com]
Sent: Friday, April 22, 2011 8:16 AM
To: HMS Testimony
Cc: Suzanne Chun Oakland; Rep. John Mizuno; Pat McManaman; Lauren Suzanne Zirbel; Christopher Flanders; Gary A. Okamoto; Linda J. Rasmussen; Morris Mitsunaga MD (E-mail); Roger Kimura; Sen. Josh Green; Stephen Kemble
Subject: Informational Briefing on Medicaid, April 26, 2011, 8-9 AM, Conf Rm 229

Re: Informational Briefing on Medicaid, April 26, 2011, 8-9 AM, Conf Rm 229

Honorable Senators, Representatives and colleagues:

I am testifying as a physician who has been caring for patients covered by various Quest/medicaid programs in an "economically-challenged" area of Oahu since 2004.

Based on casual observations over the past seven years, I believe that current funding for the Quest programs may actually be adequate. Please consider that improved means testing would almost certainly reveal a significant prevalence of inappropriate enrollment in these programs, specifically by those capable of bearing their own medical costs or at least a portion of them.

It is quite common for many taking advantage of our Quest programs, particularly but not exclusively the elderly who utilize them as 'secondary insurance' to pay for their deductibles and copayments, to openly demonstrate the trappings of relative wealth, i.e. wearing expensive jewelry, offspring bringing them to appointments in expensive vehicles, or taking frequent pleasure trips to the mainland and elsewhere.

A failure to accurately confirm the true financial status of applicants may be jeopardizing the state's ability to provide adequate coverage for those who truly need it. Many are harmed by such fraudulent utilization, i.e.:

-the actual indigent in need who can't find a physician willing to take on yet another Quest patient

-the physicians who are forced to provide care at a loss to people capable of adequate payment

-the tax-payer forfeiting ever greater levels of hard-earned income to subsidize the lifestyles of the fraudulent.

Are our legislators and administrators effectively fulfilling their responsibility to properly steward the money they take from our citizens? Rather than further restricting benefits to those who actually need them, and further decreasing already inadequate payments to providers, might they not more diligently apportion coverage to only the truly indigent?

By removing the fraudulent from the Quest rolls, there may well be enough money to cover those for whom these programs were actually created.

Faithfully and respectfully submitted,

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TO: The Honorable Suzanne Chun Oakland
Senate Chair, Human Services
State Capitol, Room 226
Honolulu, HI 96813

The Honorable John M. Mizuno
House Chair, Human Services
State Capitol, Rm. 436
Honolulu, HI 96813

DATE: April 24, 2011

RE: Joint Informational Briefing on Potential Medicaid Changes

Chairs Oakland and Mizuno, and members of the committees:

Mahalo for the opportunity presented today to provide information on how the potential Medicaid changes could negatively affect the people of Moloka'i.

Community health centers are not simply doctors' offices. CHCs are an integral part of the social safety net for the communities they serve, with the primary mission of serving un- and underinsured residents of their communities. CHCs serve their communities by providing integrated health care, with team of medical, dental and behavioral health providers working together to ensure optimal health for their clients. Sometimes, these teams also include traditional Native Hawaiian and alternative healers, as well as nutritionists, social workers, and other professionals and paraprofessionals who provide complete primary care to their patients. And this care facilitates savings to the Federal and State governments by preventing expensive emergency room and inpatient visits. Equally importantly, many CHCs go farther, serving as engines of growth to their communities, through investment, hiring, and training opportunities for community members.

On Moloka'i, as well as in other areas which CHCs serve, the Moloka'i CHC is the provider of last resort for community residents. MCHC serves over 3,000 patients, of which 60% are Medicaid recipients. Additionally, MCHC sees a vast majority of the island's residents who have neither private nor Medicaid or Medicare insurance. Without MCHC, these residents would have no primary care provider, and instead would use the services of the emergency room, which does not provide a health home, and which is far more expensive.

The difficulties facing Moloka'i are well known, from more than 14% of residents without health insurance to high unemployment and poverty, and low educational achievement. Although a flight from Moloka'i to Maui or O'ahu is only 20 minutes, the cost is considerable for many families, a factor multiplied if there is a medical emergency. Significant cuts in Medicaid and other benefits would only exacerbate this situation.

It is important to contextualize the proposed cuts to Medicaid. Not only is the State proposing to cut Medicaid, but the Federal government is also cutting funds for Medicaid, as well as reducing the funding for the uninsured and general funding to CHCs. As a result, CHCs, which by law cannot refuse service to

clients regardless of their ability to pay, are faced with doing more for more people with less resources. Clients with chronic medical and mental health problems will be forced to choose between which of their problems they seek care. With restrictions on available medications, clients will often be forced to choose between medications and other necessities. Cuts in Medicaid, in the context of other cuts which CHCs confront, may have multiplicative effects, necessitating layoffs which will result in more unemployed uninsured community members, thus further reducing the resources available to already impoverished communities. Medicaid cuts could potentially impact on the availability of providers, who may choose to exit the Medicaid program because of financial non-viability. Eventually, the impact is very real, with more community members encountering more illness, and potentially more mortality.

As the committee knows, Medicaid cuts of definition fall not only to the poor, but to the most disadvantaged groups, particularly on Moloka'i to Native Hawaiians and Filipinos. Unfortunately, these are two groups which are also disproportionally impacted by chronic diseases such as diabetes, high blood pressure, heart disease, and cancer. Thus, cuts to Medicaid will significantly impact the ability of CHCs to care for the groups who already face high health inequities.

The potential Medicaid cuts could also destabilize Community Health Centers. Community Health Centers provide care to some of the most complex socially challenged patients and are expected to do so with dwindling reimbursements, decreased funding streams and increased overhead expenses. Although health care is not free at Community Health Centers, it is difficult to collect co-payments from a person who is unemployed and in ill health; this is particularly true in a small, rural community such as Moloka'i, where everyone is considered 'ohana. While there may be short term budgetary impacts to the State in cutting Medicaid, the long term impact, particularly with potential Federal cuts, may be devastating.

Mahalo for your time and consideration. Difficult choices need to be made; however, we certainly hope the informational briefing has brought the committee closer to a sound decision. Should your committees require further information, please fell free to call me at (808) 553-5308.

'O wau iho me ka ha'aha'a,

Kawika Liu, MD, PhD, JD
Executive Director
Moloka'i Community Health Center

April 25, 2011

To: **Senate Committee on Human Services**
Senator Suzanne Chun Oakland, Chair
Senator Les Ihara, Jr., Vice Chair

To: **House Committee on Human Services**
Representative John M. Mizuno, Chair
Representative Jo Jordan, Vice Chair

RE: **TESTIMONY FOR JOINT INFORMATIONAL BRIEFING ON POTENTIAL CHANGES TO THE MEDICAID PROGRAM:**
Tuesday, April 26, 2011; 8:00am; Room 229

Submitted by: Richard P. Bettini, MPH, MS, President and Chief Executive Officer
Waianae Coast Comprehensive Health Center
Contact – 697-3457 or wcchc@wcchc.com

Thank you for the opportunity to submit testimony regarding the potential changes to the state Medicaid program and their implications for patient care in our communities.

The Waianae Coast Comprehensive Health Center is the medical home for 16,000 QUEST patients and we remain deeply concerned about the potential focus of the proposed cuts. In general any cuts in the state share of the Medicaid program have a double impact by reducing matching federal dollars into our state.

We believe the adults in the QUEST population we serve are not only quite poor they also come to us with highly complex medical and psycho-social conditions. Any cuts in Medicaid should be equally spread across both the QUEST and QUEST Expanded (QExA) programs. Our Native Hawaiian community in general has a low utilization of expensive nursing home services and a high utilization of primary care.

A. <u>QUEST Expanded Plans</u>

If the QExA plans receive contract extensions these should only be awarded with specific conditions. At least a portion of the reported $100 million fee increase these plans received post bid process should be withheld in the contract extension. The burden of poor actuarial work should not be placed on the taxpayers of Hawaii but rather on the corporations that underbid their service contract. Additional conditions placed on any contract extension should include the following:

1. An immediate cut of 1% in the administrative expense allowance.
2. A commitment to the revised generic drug formulary.
3. Imposition of the Premium Tax passed by our legislature through Act 69.
4. Requirement that all QExA enrollees are assigned a primary care provider (including Medicare dual eligible enrollees).

5. Requirement of an audit of eligibility on all patients receiving nursing home benefits to assure asset test conditions were not met based on a transfer of assets within a family.

B. Enrollment Issues

We are deeply concerned about the proposed method of mailing out a request for documentation to all QUEST patients and removing from eligibility those that do not respond to the mail-out. To assure that this will be not used as a device to remove from QUEST enrollment those people actually eligible for QUEST but who are not in a position to receive mail, we ask assurance that health plans will receive retroactive capitation for any patient inappropriately removed from QUEST membership through this mail-out process. Please also see the attached letter to the director of the Department of Human Services offering our services to automate this enrollment documentation process.

C. Potential Savings

In the area of potential cuts we would support Dr. Fink's proposal to reform the pharmacy benefit to emphasize generic drugs whenever possible. We understand there would be exclusions when laws or regulations require the dispensing of brand drugs. This support is conditioned on the same formulary being applied to both the QUEST and the QExA programs.

The limitation on behavioral health visits is a little more difficult to structure and care must be given to prevent avoidable institutionalization. We suggest a limit on welfare-mandated visits. For patients with a Severe Mental Illness (SMI) diagnosis we assume no visit cap is proposed.

The Medicaid program in Hawaii is a $1.5 billion dollar per year program. Costs are not increasing at anywhere near the rate of commercial health plans (about 3% for Medicaid). Benefits in basic QUEST are already thin. Our emphasis in the coming years should be focused on how to get more value from these taxpayer supported expenditures.

Thank you for accepting our testimony.

April 22, 2011

Patricia McManaman, Esq., Director
Hawaii State Department of Human Services
Via email: pmcmanaman@dhs.hawaii.gov

Dear Pat,

On behalf of our Board of Directors, patients, and staff, thank you for attending our Town Meeting Monday evening. We deeply appreciate your willingness to listen to our concerns. As we stated at the meeting we look forward to a new spirit of cooperation in addressing the economic as well as healthcare challenges facing our state.

It has been very difficult for us to anticipate and plan for proposed cuts that may be made in the QUEST program. At the February 14th meeting with the Governor it was announced that cuts in the Med-QUEST programs would total $150 million and that we could assume that QUEST Expanded (QExA) programs would be excluded from this reduction. A list of areas of potential cuts was identified. Savings were largely associated with reducing the number of people enrolled in QUEST and by placing limitations on benefits including pharmacy and primary care visits.

One challenge we are having is that there has been no corresponding financial savings presented with these somewhat ambiguous options and therefore it is difficult for us to project the most likely scenario. Given that we have 16,000 QUEST patients this puts our Health Center in a precarious financial situation.

We support Dr. Fink's decision to pursue a largely generic formulary for the QUEST program and see no reason why this could not be extended to QExA. We are less optimistic that rationing primary care is the answer. We believe that for highly complex patients, frequent and integrated primary care visits (along with behavioral health visits) are actually the key to reducing hospital admissions and are where true cost savings can be realized.

It appears that the largest savings can be found by removing from membership those who are no longer eligible for QUEST and QExA because their financial situation changed. As we expressed Monday night we do not believe that a paper mail-out to QUEST patients will get at the target group of potentially ineligible patients. Rather it will eliminate from the program the neediest members who are homeless or move frequently to homes of friends and family. We believe you should consider the offer made to you Monday night to automate this system of enrollment verification through outstationed workers. If DHS plans to move forward with a paper mail-out, we assume that in the event that an eligible patient is mistakenly disenrolled through the paper system that health plan capitation would be retroactive to the point of the mistaken disenrollment.

We have several other recommendations that we will submit to you under separate cover and as a part of our communications with our elected officials. Ultimately we believe you would agree that our efforts should focus on getting the most value from Hawaii's $1.5 billion annual Medicaid program and that working with all stakeholders will help us realize this value.

Mahalo,

Richard P. Bettini, MPH, MS
President and Chief Executive Officer

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Visit our website at: www.wcchc.com

Family Health Centers

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April 25th, 2011

Committee on Human Services
State Capitol
415 South Beretania Street
Honolulu, HI 96816

RE: Testimony for Informational Briefing on proposed changes to Medicaid.
Tuesday April 26th, 2011 8:00 a.m. – 9:00 a.m. Room 229

Dear Committee Members and Chairs Mizuno and Chun Oakland,

As the CEO and volunteer Board of Directors of Bay Clinic, Inc., we testify to you as representatives of the 155 physicians, providers, and health care professionals and the 18,000 low-income, underserved, and under and uninsured patients living on Hawai'i Island who receive care at Bay Clinic, Inc.

We are extremely concerned about the proposed changes to Medicaid, which will affect the most disadvantaged in our community. Community Health Centers, like Bay Clinic, Inc. provide a safety net of services to those who face multiple barriers to care. The services we provide keep patients out of the publicly funded emergency rooms, prevent illnesses and diseases from taking a costly toll on individuals, families, and society through regular access to care and medications, and ensure the people in our community can maintain their health so that they can work, take care of their families and maintain productive active lives in our community.

The proposed cuts to Medicaid benefits, enrollment support, and access will force Medicaid beneficiaries, who are primarily the working poor, into uninsured status. With an increase in uninsured rolls, individuals will not get the care they need when they need it, and they will over utilize the emergency department when illnesses become too severe to treat elsewhere. In addition, we as community health centers will struggle to care for the many people who seek our services if benefits are cut.

Community Health Centers, like Bay Clinic, Inc. will experience the highest burden of care from the proposed cuts. 74% of patients of community health centers are uninsured or covered by Medicaid, including children. We act as the primary safety

Administrative Offices	Bay Clinic Family Health Center	Hilo Family Health Center	Ka'u Family Health Center	Kea'au Family Health Center	Pahoa Family Health Center	Pahoa Women's Health Center
224 Haili Street	73 Pu'uhonu Pl. Ste. 204	1178 Kino'ole St.	95-5583 Mamalahoa Hwy.	16-192 Pilimua St.	15-2866 Pahoa Vil. Rd. Bldg. C. Ste. A.	15-2866 Pahoa Vil. Rd. Bldg. F. Ste. A.
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www.bayclinic.org **Email:** bcicomments@bayclinic.org
Bay Clinic, Inc. is a nonprofit 501 (c) 3 organization.

Family Health Centers

net of care for those most in need. The proposed cuts to Medicaid could be devastating for us and for our patients. They are a short sighted solution to the budget crisis, which inevitably will lead to higher societal costs overall. Proposed solutions have been presented by the Hawai`i Primary Care Association, which we and other community health centers support.

We ask you to please reconsider the proposed changes and to seriously consider solutions proposed by the Hawai`i Primary Care Association including reducing the size and scope of cuts, provide support for uninsured care, and provide maximum support for primary care and patient centered health care homes which would mitigate damage from cuts by investing health care dollars wisely.

Mahalo for your time and consideration.

Bay Clinic, Inc. CEO and Board of Directors

Paul Strauss: CEO
Mike Gleason: Board Chair
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Dixie Kaetsu: Treasurer
Yvonne Gilbert: Secretary
Board Members: Tanya Aynessazian, Raylene Moses, Dr. Ed Montell, Samuel M. Nathan, and Rev. Johnson Jetton

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Bay Clinic, Inc. is a nonprofit 501 (c) 3 organization.

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Tuesday, April 26, 2011

To: The Honorable Suzanne Chun Oakland
Chair, Senate Committee on Human Services

The Honorable John M. Mizuno
Chair, House Committee on Human Services

From: 'Ohana Health Plan

Re: Potential Changes to the Medicaid Program Due to Budget Cuts

Hearing: Tuesday, April 26, 2011, 8:00 a.m.
Hawai'i State Capitol, Room 229

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 health care professionals who embrace cultural diversity, advocate preventive 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 has been able to take the national experience and develop an 'Ohana care model that addresses local members' healthcare and health coordination needs.

We appreciate this opportunity to provide these brief comments on the potential changes to the Medicaid program and how such proposed changes may impact the public.

'Ohana Health Plan understands the dire budget situation that we as a State are currently facing and the difficult position that the Administration and the Legislature must balance. We have also heard Governor Abercrombie's message loud and clear and understand that changes must be made, and we stand ready to support and implement the final decisions made by the Administration and the Legislature.

In this process, we respectfully request that two important points be recognized. First, it is surprising to hear many groups insist that the same reductions be made to both low-income able-bodied adults as well as to the disabled and elderly. While it is understandable that we seek equitable treatment, the needs of the disabled and elderly are clearly different.

Services offered to disabled children, medically complex elders, someone on a ventilator, or someone receiving intensive long-term care services should not be compared to other populations who do not require these critical services. Thus, we would strongly caution against the notion of attempting to look at all of the Medicaid populations through the same lens, as so many have insisted on. These populations must be looked at separately.

Second, as we look to make these challenging decisions, we must do our best not to jeopardize the integrity of the overall program. We are proud to report to you today that the program we have been contracted by the State to operate, the Quest Expanded Access (QExA) program, is achieving its objectives of both saving the State money while providing integrated, quality care for our members.

For example, over the last two years, we have reduced the number of members in long-term care facilities saving the State nearly $20k ***per day*** in long-term care facility costs while allowing members to stay in the community or at home longer at a much lower cost. It is important that we continue to try our best to assure that the core elements of this program stay intact through this very challenging time.

We understand that reductions must be made, but ask that services delivered to Hawai'i's most vulnerable population be looked at independent of other programs, and that we maintain the integrity of these programs that are saving significant dollars for the State of Hawai'i while improving the quality of life for our members. We are committed to supporting the State's decisions during these challenging times, both in making the necessary adjustments to the Medicaid program and in exploring other mechanisms that the Administration and Legislature may propose. We look forward to working together with the State in managing the health care needs of our State's most vulnerable populations. Thank you for this opportunity to provide these comments.

KOKUA KALIHI VALLEY COMPREHENSIVE FAMILY SERVICES
2239 N. SCHOOL STREET ◆ HONOLULU, HAWAI`I 96819 ◆ TEL: 808-791-9400 ◆ FAX: 808-848-0979 ◆ www.kkv.net

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Mission
Working together toward healing, reconciliation and the alleviation of suffering in Kalihi Valley, by serving communities, families and individuals through strong relationships that honor culture and foster health and harmony.

Serving
Kalihi Valley since 1972

April 26, 2011

Dear Senators Chun Oakland and Ihara, Representatives Mizuno and Jordon,

Thank you for holding a "briefing" on the QUEST Medicaid budget and its implications for patient care in our communities. I am writing to share my deep concern with you both about proposals being floated by DHS regarding eligibility procedures for Medicaid.
As I understand it, the concern is that some several thousand (7-10,000 has been quoted) people are believed to be inappropriately enrolled at present in the Medicaid program, costing the state millions in over-payments to the health plans, but the specific details of an assessment that is girding that assessment have to my knowledge not been made public. Because of this, the proposal is being made to have a policy of blanket "administrative renewal" in which all patients would at least annually, and perhaps more often be required to reapply or resubmit paperwork for eligibility to DHS or be dropped from Medicaid.
My concerns are as follows:
1) DHS has for many years now had serious difficulties with enrollment procedures and eligibility determinations, the result I believe of a combination of a serious lack of manpower, outdated and defective information systems and lack of leadership to fix these problems. This manifests in a wide variety of ways which I will not delve into here, but suffice it to say that legally eligible patients are often, (even routinely) not enrolled in Medicaid in a timely fashion, and even more ominously, are often disenrolled without adherence to proper due process, as well as erroneously. For example, a recent review of Kokua Kalihi Valley's applications for Medicaid benefits in the past 4 months indicates that fully 25% of applications (for which we have stamped copies indicating receipt by DHS) have been lost or misplaced and are not in the system. Moreover, DHS staff have recently publicly acknowledged a "software glitch" which apparently disenrolls patients from Medicaid in error simply through the actions of BESDE case workers opening a food stamp file for that patient.

2) Our experience is that the patients least able to comply with these sorts of planned changes to eligibility include the homeless, severely ill, LEP, illiterate, and mentally ill. Something as seemingly simple as opening the mail, reading the mail, and knowing how to respond to a request for information can be fraught with significant difficulties for these individuals. Moreover, it requires someone to have a working mail address that has been updated and is in the system, and while patients do have a responsibility under current rules to notify DHS of address changes, we have heard

increasing anecdotal reports from case workers that DHS workers have told them not to send anymore address changes, since they are so backlogged that they cant get to them anyhow. Hence, any system that relies on a mail-out for proper determination of eligibility is likely to fail a significant number of patients whom are most at risk and most in need of the access to care that Medicaid can bring: either they won't get the mail in the first place or they will get it and not know how or be unable to respond. I know first hand of patients who have died over the years due at least in part if not entirely, to improper disenrollment. I can assure you, this is not an academic exercise, these processes if not properly thought through and carried out can and will have dire consequences for those who most need our assistance.

3) I can not see the merits of building a system around the outliers: even if we imagine that 5-10% of the Medicaid population is improperly enrolled at present, that would mean that 90-95% are properly enrolled. Those who wish to scam the system tend to be able to do so no matter the tweaks that are made. Those who are truly eligible and in need of assistance should not be made to pay the price of a broken system, nor to pay the price for a state budget crisis.

I appreciate the recent announcement of added positions to eligibility staff and the apparent commitment of the new Director to improve the eligibility system. It is long overdue and much needed. It is unlikely that this alone will alleviate in any significant way my concerns enumerated above, given the tremendous backlog of patients and broken information systems in place. Moving ahead with plans for automatic disenrollment will only make the current problems dramatically worse.

The community health centers, and at least some health plans stand ready to work in close partnership with the State to make sure that those enrolled in Medicaid are those who are legally eligible. Let us design processes that best serve the MAJORITY of Medicaid users. At the very least, I call on DHS to at least test these proposed processes within a limited population and under close scrutiny to make sure that we do not jeopardize the health and well being of those who are legally eligible for Medicaid and in need of its support, and to build in safeguards that would easily allow overrides to be made to immediately re-enroll individuals that have been improperly disenrolled before harm comes to them. The well-being of many people is dependent upon making the right decisions here.

Thank you for your attention to this matter!

--

David D Derauf MD MPH

Executive Director

Kokua Kalihi Valley

WAIKIKI HEALTH CENTER

Compassionate Healing. Expert Care.

TO: Sen. Suzanne Chun-Oakland, Chair
Sen. Les Ihara, Jr., Vice-Chair
Senate Committee on Human Services

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

FROM: Sheila Beckham, RD, MPH
Executive Director

DATE: April 22, 2011

RE: Informational Briefing on Impact of Proposed Medicaid Cuts

Waikiki Health Center has over 1000 clients enrolled in QUEST who incurred a total of 8700 encounters during 2010. The top five diagnoses for this population are hepatitis C, diabetes, hypertension, hyperlipidemia, and depression.

Two hundred nineteen individuals (44% of Waikiki Health Center's total QUEST population) will lose eligibility under the Administration's proposed eligibility reduction. Of those currently below the proposed 133% of poverty level, the average number of primary care visits are **17.4** per person with a range of 5-56 visits and an average of **9.6** behavioral health visits with a range of 1-25 visits during 2010. A benefit reduction package could render many of these individuals into a highly labile physical and mental state which will likely result in increased stress; job loss; homelessness; and increased crime and violence.

The long-term result of cuts to basic primary and preventive services is that physical and mental health illnesses will exacerbate, requiring more costly hospital-based treatments; increased utilization of emergency room services. More homeless individuals and families living on the streets will impact tourism and business by further eroding a fragile economic base. Increased instability will involve more law enforcement personnel to ensure the safety of our visitors, residents, and newly homeless populations.

The impact of these Medicaid benefit and eligibility reductions will result in an additional 4500 individuals joining the ranks of the uninsured. Waikiki Health Center alone realized a 400% increase in newly uninsured individuals seeking medical care during 2010. Yet while thousands more will become uninsured, funding for uninsured is also in jeopardy during this legislative session.

The math is simple. Healthy people can work, the sick cannot adding to a snowball affect of losing their jobs, losing their homes, losing control. Dysfunctional decisions will result in dysfunctional communities. These cuts affect us all. We need the administration to make better decisions for us now and the future of our community. Health care is not a luxury. Everyone deserves to be healthy. Community health centers are the solutions to our community's medical, behavioral health and homeless issues. Please support us.

277 Ohua Ave. Honolulu, HI 96815 • 808 922 4787 • Providing Low-Cost Medical and Social Services

SENATE COMMITTEE ON HUMAN SERVICES
Senator Suzanne Chun Oakland, Chair

HOUSE COMMITTEE ON HUMAN SERVICES
Rep. John Mizuno, Chair

Informational Briefing on Medicaid
April 26, 2011 at 8:00 a.m.
Conference Room 229

The Healthcare Association of Hawaii advocates for 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. Our members employ more than 40,000 people statewide, delivering quality care to the people of Hawaii. Thank you for this opportunity to participate in this informational briefing.

The Healthcare Association appreciates the efforts of the House and Senate Human Services Committees to update health care insurers, providers, advocacy agencies, and other interested parties on changes being considered to Hawaii's Medicaid program. The Administration has announced Medicaid budget reductions and possible ways in which those reductions might be implemented. Since Medicaid is such a large program, the entire health care system will be impacted, so there is substantial interest in understanding those changes as implementation draws closer.

Statistics show that Hawaii's Medicaid program is being managed well by the Department of Human Services (DHS) when compared with other states. For example, Hawaii's Medicaid budget is a relatively small part of the entire State budget when compared with other states. Also, Hawaii's Medicaid program covers a greater proportion of low income people, and Hawaii's Medicaid benefits are more extensive than other states.

Enrollment in Medicaid has increased in recent years due to the struggling economy. Today Hawaii's Medicaid program covers about 250,000 people, or about one out of five Hawaii residents. Any reductions to Medicaid enrollment would increase the uninsured population in Hawaii, which would in turn likely increase the uncompensated care provided by health care providers. Uncompensated care for hospitals alone totalled $114 million in 2009. Furthermore, overall community health would likely decline, as those who are excluded from Medicaid would no longer have access to primary care, preventive care, or wellness opportunities.

Although Medicaid is a significant component of Hawaii's health care system, the decision-making process of DHS can be improved by involving the Legislature, insurers, providers, and advocates in shaping changes to the Medicaid program. Typically, these parties are informed only after the changes have been made. We believe that changes to Hawaii's Medicaid program can be optimized with the involvement of all interested parties.

As a means of ensuring more involvement, the Healthcare Association requested the introduction of SB 794. The bill is no longer alive, but we intend to have it introduced again next

year. The bill would require the DHS to notify the House and Senate Committees on Human Services of intended changes to Hawaii's Medicaid program. The idea is that these committees would be able to inform other interested parties. The bill also authorizes the House and the Senate to hold hearings on the intended changes. In addition, the bill authorizes the Legislature, by statute, to prohibit DHS from making changes it intends to make to the Medicaid program. This bill represents a new concept of collaborative decision-making for Medicaid, and we recognize that, with more discussion, it can be improved. We hope those discussions will take place next year.

Thank you for the opportunity to comment on Hawaii's Medicaid program.

Attention Senate Sergeant At Arms

Re

THE SENATE
THE TWENTY-SIXTH LEGISLATURE
REGULAR SESSION OF 2011

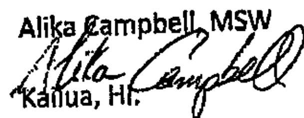
COMMITTEE ON HUMAN SERVICES
Senator Suzanne Chun Oakland, Chair
Senator Les Ihara, Jr., Vice Chair

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

NOTICE OF INFORMATIONAL BRIEFING

DATE: Tuesday, April 26, 2011
TIME: 8:00 a.m. – 9:00 a.m.
PLACE: Conference Room 229
State Capitol
415 South Beretania Street

I am writing regarding the potential changes that are being considered to the Medicaid Program. I am not certain of the exact details of the proposed changes, but I have heard that one possible change is that renewal/change notifications are going to be mailed to participants and that individuals who do not respond will have their coverage dropped. I believe this is a bad idea that will result in too many people losing their health insurance. Additionally, the people most at risk for being dropped would probably be the ones who most need the service, such as individuals experiencing homelessness who lack a stable address, those with English as a second language challenges, and people with serious mental health issues who may not understand the content of the letter. The initial cost savings will be outweighed by the expenses of having to address the more serious medical needs of the uninsured. Hawaii has made great strides over the years to provide health coverage for as many people as possible, and it seems like it would be a step backwards to un-qualify some of the most needy in our extended ohana. Please take this in consideration as the proposed changes are addressed. Thank you for allowing me share my testimony.

Alika Campbell, MSW

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