NEIL ABERCROMBIE
GOVERNOR

PATRICIA McMANAMAN
DIRECTOR

BARBARA A. YAMASHITA
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
P. O. Box 339
Honolulu, Hawaii 96809

February 15, 2012

TO: The Honorable Kyle T. Yamashita, Chair
House Committee on Legislative Management

FROM: Patricia McManaman, Director

SUBJECT: **H.B. 2285, H.D.1 - RELATING TO MEDICAID**
Hearing: Wednesday, February 15, 2012; 1:30 p.m.
Conference Room 423, State Capitol

PURPOSE: The purpose of this bill is to direct the Office of the Auditor to conduct a management and financial audit of the QUEST Expanded Access (QExA) plans, require the development of an equitable referral system for discharged patients with the Department of Health to care home facilities; develop a methodology to determine the level of acuity of nursing facility residents to set a fair and equitable reimbursement; and submit its findings to the 2013 Legislature.

DEPARTMENT'S POSITION: The Department of Human Services respectfully opposes this bill. As part of the condition for the QExA program, the federal government provides extensive oversight of the program. The QExA plans are required to submit quarterly as well as annual reports regarding program services to the Med-QUEST Division (MQD). MQD, in turn, reviews the reports to ensure the QExA plans are in compliance with contract requirements. The reports are also submitted to the Centers for Medicare and Medicaid Services (CMS) who also reviews the reports to ensure program services are being provided as described in 1115 waiver documents.

In addition, the federal government requires that the Department obtain an independent external quality review of all our health plans on an annual basis. Areas that they are required to review are the same areas specified in the proposed legislation: quality, timeliness, and access to health care services that the health plan furnishes to its enrollees through its network of providers. We will provide you with a copy of the most recent report for all of our health plans.

The External Quality Review Organization further validates information, data and procedures to the determine services are being provided as stated in their policies and procedures, are reliable and in accordance with valid data collection methods and analysis, and comply with federal requirements. These reports are public documents and available on our website.

The Department believes that the audit would be duplicative of the current multiple levels of review and an inefficient use of taxpayer funds. If an evaluation were to be conducted because the federal requirements are insufficient, then DHS believes all health plans in QUEST and QExA would need to be evaluated.

Attached please find a Memorandum of Law prepared by the Attorney General, dated November 25, 2011, rebutting the assertion the Department of Human Services is not in compliance with Act 69, Session Laws of Hawaii 2009, or that DHS has, at any time, violated procurement law, federal regulatory law, or any other law of the State of Hawaii.

The Department is also opposed to the requirement that the Department of Health develop a referral system for patients being discharged to community-based homes. The QUEST and QExA plans have service coordinators who work with the family/recipient to find the most appropriate setting for the recipient and work to place the individual as expeditiously as possible. Health plan staff therefore can ensure quality of care for recipients as they must also monitor those recipients on a regular basis to ensure they are doing well in their current setting.

It is in both the patients and health plans' interests to place patient in those facilities that provide the highest quality care. A methodology based on other than quality of care places the

facilities' interests above the patients'. The DHS supports increasing oversight including quality monitoring and reporting requirements of long-term care providers to inform a quality-based placement methodology.

The DHS already has an acuity-based reimbursement methodology for nursing facilities using data from the Centers for Medicare & Medicaid Services Minimum Data Set and Resource Utilization Groups.

Thank you for the opportunity to testify on this bill.

HHS

NEIL ABERCROMBIE
GOVERNOR

DAVID M. LOUIE
ATTORNEY GENERAL

RUSSELL A. SUZUKI
FIRST DEPUTY ATTORNEY GENERAL

STATE OF HAWAII
DEPARTMENT OF THE ATTORNEY GENERAL
Health & Human Services Division
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(808) 587-3050 Fax (808) 587-3077

November 25, 2011

Mr. John McComas
Chief Executive Officer
AlohaCare
1357 Kapiolani Blvd., Suite 1250
Honolulu, HI 96814

VIA FACSIMILE (973-0726) & U.S. MAIL

Re: October 25, 2011 Letter to Patricia McManaman, Director, Department of Human Services re: Insurance Premium Tax

Dear Mr. McComas:

Director of Human Services Patricia McManaman received your letter dated October 25, 2011, which enclosed a legal memo by AlohaCare's counsel, Feldesman, Tucker, Leifer, Fidell LLP (Feldesman). Director McManaman forwarded your letter and the enclosure to our office for review and response.

Your letter raises a number of concerns related to the pending procurement of QUEST Medicaid managed care services being conducted by the Department of Human Services (the Department). We understand that you believe that the Department is favoring for-profit health plans to the detriment of nonprofit health plans such as AlohaCare, and that the State is improperly using for-profit health plans to increase federal revenue to the State, putting the State's federal funding at risk. The specific assertions made by AlohaCare and Feldesman are that:

1. the Department's use of federal financial participation (FFP) to pay the State insurance premium tax to for-profit Medicaid managed care health plans is unconstitutional;

2. using FFP to pay insurance premium taxes is prohibited by federal Medicaid law;

3. the Department is disregarding Act 69, SLH 2010, codified as HRS § 103F-401.5, by paying the insurance premium tax to for-profit health plans, and that this is contrary to legislative intent and fundamentally unfair to nonprofit competitors; and,

4. the Department may "steer" more business to for-profit health plans that are subject to the tax because of the opportunity to maximize federal revenue.

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We appreciate your concern about the integrity of the Hawaii Medicaid program, and the time you have taken to bring these concerns to our attention. For the reasons stated more fully below, we disagree with the analysis and conclusion provided by Feldesman.

Using FFP to Pay the Insurance Premium Tax to QUEST Health Plans is Constitutional

Feldesman asserts that the United States is bearing the legal incidence of the State insurance premium tax, and therefore the tax violates the Supremacy Clause. That is incorrect. The legal incidence of the State insurance premium tax falls on the seller – in this case the contracted health plans – and not on the buyer, which is the State and Federal governments.

It is well-established that sellers may pass on their cost for state taxes to buyers, including the Federal Government. See, Alabama v. King & Boozer, 314 U.S. 1 (1941), and Matter of: Vermont Gasoline Tax, 1983 WL 26285, 63 Comp. Gen. 49 (1983). By so doing, the "legal incidence" of the tax is not shifted from the seller to the buyer.

The U.S. Supreme Court recognized that a state tax imposed upon a **seller** of goods or services may be passed on to the purchaser as a "normal incident" of doing business, and that "the asserted right of the one to be free of taxation by the other does not spell immunity from paying the added costs, attributed to the taxation of those who furnish supplies to the Government and who have been granted no tax immunity." Alabama, 314 U.S. at 8-9; accord, Vermont Gasoline Tax, 1983 WL 26285 at *1, 63 Comp. Gen. at 49.

Hawaii law is clear that this tax is an obligation of the **seller**:

> **Each authorized insurer**, except with respect to all life insurance contracts, ocean marine insurance contracts, and real property title insurance contracts**, shall pay to the director of finance** through the commissioner a tax of 4.265 per cent on the gross premiums written from all risks or property resident, situated, or located within this State . . ..

§ 431:7-202(a), Haw. Rev. Stat.

The legal incidence of the insurance premium tax under QUEST clearly falls on the health plans, and not on the State or Federal government. Therefore, payment of the tax does not violate the Supremacy Clause.[1]

Using FFP to Pay the Insurance Premium Tax to QUEST Health Plans is Allowed by Medicaid Law

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[1] See, also, G. parent v. State of Hawaii, 676 F.Supp.2d 1006, 1034-35 (USDC, Dist. of Haw. 2009). The federal district court in Hawaii specifically found that "the CMS did not act arbitrarily or capriciously . . . when it reviewed the actuarial soundness of the capitation rates" for the Medicaid managed care contracts in question since the insurance premium tax was not a levy against the Federal Government, and does not violate the Federal Government's immunity from state taxation.

The next assertion is that the insurance premium tax is ineligible for FFP under federal law. As acknowledged by Feldesman, the federal government has placed limitations on FFP available to states for Medicaid expenditures when a state receives health care related taxes. States may receive reimbursement for health care-related taxes in accordance with 42 CFR § 433.68. While it is not clear whether Feldesman believes the insurance premium tax is or is not a health care related tax, Feldesman argues that the insurance premium tax must be excluded from the expenditures reported by the State to calculate FFP. That is incorrect.

The insurance premium tax is not a health care-related tax. A health care-related tax is one that is "related to health care items or services, or to the provision of, the authority to provide, or payment for, such items or services."[2] 42 CFR § 433.55(a). Moreover, at least 85 percent of the burden of the tax revenue must fall on health care providers in order for it to be considered "related to health care items or services." 42 CFR § 433.55(b). Since the insurance premium tax is imposed on all insurers in Hawaii, with limited exceptions, and not just on health care insurers, it is not a health care-related tax and is, therefore, not subject to the restrictions on health care-related taxes under federal law.

But even if the insurance premium tax is considered to be a health care-related tax, it would be a permissible health care-related tax that is eligible for FFP under federal law because it is broad based, uniformly imposed, and does not violate specified hold harmless provisions. 42 CFR §§ 433.68(a) and (b), 433.70. The insurance premium tax is "broad based" because it is imposed on all insurers, including managed care organizations. 42 CFR § 433.68(c). In fact, this tax has been in place since the Hawaii Insurance Code was adopted in 1987. See, Act 347, Sess. L. Haw. (1987). The insurance premium tax is uniform because it is imposed on gross provider revenue or receipts at a uniform rate for all services, and the amount of the tax is not directly correlated to payments under the Medicaid program. 42 CFR § 433.68(d). Finally, the insurance premium tax does not violate the hold harmless provisions because there is no direct or indirect guarantee by the unit of government imposing the tax that an insurer will receive their money back. 42 CFR § 433.68(f); HRS § 431:7-202. Specifically, there is nothing in the State insurance code that guarantees that any insurer subject to the insurance premium tax will get a payment, offset, or waiver of that tax.[3] Therefore, revenue from the insurance premium tax is eligible for FFP.

Moreover, as noted on page 2 of the Feldesman memo, the Federal Government has itself confirmed that the payment of the insurance premium tax is an allowable cost for purposes of developing Medicaid reimbursement rates. See, letter dated May 21, 2008 from the Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services (CMS) to Congressman Abercrombie, attached. Therefore, it is clearly permissible for the State to claim FFP for the insurance premium tax, and the State's federal funding is not at risk.

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[2] Services of managed care organizations are considered a "class" of health care items or services. 42 U.S.C. § 1396b(w)(7)(A)(viii).

[3] Even if the insurance premium tax provided a prohibited guarantee of payment, offset or waiver, it would still be a permissible tax because the revenues from the tax are less than or equal to 5.5%. 42 CFR § 433.68(f)(3)(i)(A).

The Department's Treatment of the Insurance Premium Tax Does Not Compromise the Actuarial Soundness of Those Rates

The next assertion by Feldesman is that the rates paid to the for-profit Medicaid health plans are not actuarially sound. That is incorrect. As noted by Feldesman, 42 CFR 438.6(c)(4)(ii) requires that the State document assurances that the rates are "based" upon services covered under the State plan, or costs directly related to providing these services. It is clear that the insurance premium tax is a cost directly related to providing services, and Feldesman provides no legal support otherwise.

Moreover, this rule does not require that capitation rates be equal between plans. In order for the rates paid to the health plans to be actuarially sound, they must fairly compensate the plans for their actual expenses. This is why the QUEST request for proposals provides for risk adjustments to the base rates, including enhanced payments based on member usage of FQHC[4] and behavioral health services, and diagnosis or pharmacy based risk adjustments. Similarly, 42 CFR § 438.6(c)(4)(ii) does not prohibit the inclusion of a non-discriminatory pass-through tax in rates paid to health plans who are subject to the tax. In fact, the Department's actuary informed us that not paying the insurance premium tax would result in rates that are not actuarially sound.

The Department's Medicaid managed care capitation rates are actuarially sound because they are developed in accordance with generally accepted actuarial principles and practices, appropriate for the populations to be covered and the services to be furnished under the contract, and are certified by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board. 42 CFR § 438.6(c). We understand that the Department's actuary calculates the capitation rates for Medicaid in Hawaii in the same manner as it does for other states that it services.

As noted above, state taxes imposed on a seller are a recognized cost of doing business which may be passed on to the buyer, including the Federal Government. The tax is properly evaluated in the QUEST program's actuarial calculations, certified by the Department's actuary, and subject to review and approval by CMS. Therefore, payment of tax does not affect the actuarial soundness of the capitation rates.

Payment of the Insurance Premium Tax Does Not Violate HRS § 103F-401.5

Feldesman's next assertion is that the Department's treatment of the insurance premium tax violates HRS section 103F-401.5.[5] That is incorrect. HRS section 103F-401.5 requires proposals to include all costs, fees, and taxes, and any contract must be for the amount of the proposal. The statute clearly addresses procurements in which bidders make a price proposal.

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[4] FQHC means Federally Qualified Health Center.

[5] Feldesman asserts that HRS § 103F-401.5 "prevents a recurrence of the unlawful activity" described in its memo. As noted above, the Department has never engaged in "unlawful activity."

Feldesman acknowledges that no financial proposals are being accepted for the QUEST procurement, and therefore this provision is inapplicable.

HRS section 103F-401.5 further provides that no contract "shall include any other payment, rebate or direct or indirect consideration that is not included in the proposal, such as insurance premium or general excise tax rebates to or waivers for an applicant or bidder." HRS § 103F-401.5. Again, there are no financial proposals being submitted in the QUEST procurement, and therefore the statute does not apply. But even if financial proposals were being solicited, this provision would not prohibit payment of the insurance premium tax as long as the insurance premium tax is included in the proposal.

Contrary to Feldesman's memo, payment of the insurance premium tax to for-profit insurers does not constitute a rebate or waiver of the insurance premium tax. As noted above, the health plan remains at all times liable for paying the tax, and passing on the cost of a nondiscriminatory state tax has long been recognized as a normal part of doing business. The statute does not preclude coverage of such taxes in the contract price. Therefore, the QUEST procurement does not violate HRS § 103F-401.5.

There Is No Financial Conflict Of Interest

The final assertion is that paying the insurance premium tax to for-profit health insurers "amounts to preferential treatment of for-profit health plans." By paying the tax to for-profit health plans and not to nonprofit health plans, AlohaCare asserts that it is being compensated less than the for-profit health plans. That is incorrect.

The insurance premium tax is essentially a pass-through tax upon which the for-profit health plan makes no money. Nonprofit health plans are, by definition, exempt from paying the insurance premium tax, as well as income taxes. Since for-profit health plans are not separately reimbursed for income taxes as a pass-through cost by the State, for-profit health plans receiving the same capitation payment as a nonprofit health plan must bear the burden of income taxes that are not imposed on nonprofit health plans. This is not preferential treatment of for-profit health plans.

While the insurance premium tax is eligible for FFP, the Department is not using that eligibility for FFP to "steer[] more business to plans subject to the tax." Any health plan – whether for-profit or nonprofit – that meets the technical requirements of the RFP will be offered a contract. There is no numerical factor assigned to whether a bidder is a nonprofit or for-profit entity when analyzing the technical requirements of the contract.

You also express concern with the quality-based formula that will eventually be used by the Department to determine priority for auto-assignment of members to health plans when they do not choose their own health plan. The Department will use objective weighting for performance on externally validated Medicaid qualified measures, such as but not limited to CAHPS[6] scores and HEDIS[7] measures, consistent with financial incentives and value-driven

[6] CAHPS means Consumer Assessment of Healthcare Providers and Systems.

health care requirements. Therefore, the Department cannot and will not be "steering" business to for-profit health plans over nonprofit health plans.

Conclusion

As explained above, none of the assertions made by Feldesman are correct. The Department's procurement of QUEST services is being conducted in a neutral and fair manner for the benefit of its clients, in compliance with State and Federal law. The Department's payment of the insurance premium tax to for-profit health plans is legal, and does not disadvantage AlohaCare because the net result is that both the for-profit and nonprofit health plans are paid the same rate for the same services. In fact, for-profit health plans remain at a financial disadvantage because for-profit entities will still be liable for income taxes, while nonprofit entities will not.

We hope we have demonstrated that the Department is acting lawfully and fairly in its procurement of QUEST managed care services. Again, thank you for sharing your concerns with us.

Sincerely yours,

LEE-ANN N.M. BREWER
Deputy Attorney General

APPROVED:

DAVID M. LOUIE
Attorney General

c: Patricia McManaman, Director, Dept. of Human Services

Encl.

[7] HEDIS means Healthcare Effectiveness Data and Information Set.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Region IX
Division of Medicaid & Children's Health Operations
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

MAY 2 1 2008

The Honorable Neil Abercrombie
Congress of the United States
House of Representatives
1502 Longworth House Office Building
Washington, D.C. 20515

Dear Representative Abercrombie:

I am responding to your letter to Acting Administrator Kerry Weems, who has referred your letter to me. You had two questions related to the recent award by the Hawaii Department of Human Services of two contracts under its QUEST Expanded Access (QEXA) managed care program to serve its Medicaid Aged, Blind and Disabled (ABD) population.

Your first question concerns why the Federal government is paying state premium taxes as part of the Hawaii Medicaid program managed care contracts to serve the Aged, Blind and Disabled (ABD) population under Hawaii's QEXA program.

Under the Medicaid program, the states can consider Medicaid's portion of a permissible health care-related tax as an allowable cost for purposes of developing Medicaid reimbursement rates. We affirmed this in the preamble of our recent Medicaid final rule at 42 CFR 433 on health-care related taxes issued on February 22, 2008.

Your second question concerns the two managed care organizations (MCOs) selected by the Department of Human Services: you note that these plans have neither "significant operations in Hawaii" nor any "experience or network in the community." CMS requires States to implement a free and open competitive procurement of Medicaid services that follows applicable state procurement laws as set forth in Medicaid regulations at 42 CFR 457.940. While CMS requires states to follow their own procurement laws when contracting for Medicaid services, CMS also has extensive regulations at 42 CFR 438.206 and 42 CFR 438.207 that states must follow to ensure access to available services and adequate provider network capacity when implementing Medicaid managed care.

I hope this information is helpful. Should you need any other assistance from my staff, please contact Cheryl Young, CMS State Medicaid Coordinator for Hawaii, at 415-744-3598 or at Cheryl.Young@cms.hhs.gov.

Sincerely,

Jackie L. Glaze

Jackie L. Glaze
Acting Associate Regional Administrator
Division of Medicaid and Children's Health Operations

cc: Lillian Koller, Department of Human Services
Patty Johnson, Department of Human Services
Mary Rydell, CMS

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Wednesday, February 15, 2012

To: The Honorable Kyle T. Yamashita
Chair, House Committee on Legislative Management

From: 'Ohana Health Plan

Re: House Bill 2285, House Draft 1-Relating to the Medicaid

Hearing: Wednesday, February 15, 2012, 1:30 p.m.
Hawai'i State Capitol, Room 423

'Ohana Health Plan is managed by a local team of experienced health 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 2.4 million Medicaid and Medicare members nationwide. 'Ohana has been able to take WellCare's national experience and that of our local team to develop an 'Ohana care model that addresses local members' health care, long-term care and care coordination needs.

We appreciate this opportunity to respectfully express our concerns regarding House Bill 2285, House Draft 1-Relating to Medicaid and the misstatements contained within.

While we certainly appreciate the intent of this measure, we firmly believe that this bill is unnecessary and would be a detrimental use of taxpayer dollars that could instead be applied to helping restore and sustain recent reductions in the Medicaid program. We also find the accusations listed in Section 1 are simply not supported by data, un-researched, and concerning to our locally-based staff of 149 associates, the majority of which are locally born and raised and proud to be able to work for a company that provides quality health care services for Hawai'i's most vulnerable population.

The QUEST Expanded Access (QExA) contracted were awarded in 2007 and has been operating live since Febuary 1, 2009. It is our sincerest hope that after that much time, that those who originally protested our entry into Hawai'i's marketplace will have been able to examine facts and data and see that we have proven ourselves to be deeply rooted, community-based, locally-operated health plan who strive to provide the best possible services we can for Hawai'i's aged, blind and disabled residents.

Furthermore, 'Ohana has taken great pride in the fact that we are deeply rooted in the heart of the communities that we serve. Our O'ahu office is located in the Old Sugar Mill Plaza in Waipahu, HI, right above the Filipino Community Center. This particular location was chosen because it conveniently located and easily accessible for our aged, blind and disabled members, as well as a large number of our community-based providers. We also have satellite offices in Hilo and Kahului, with additional employees on Kaua'i and Moloka'i. We invite and encourage members of the legislature to take the time and visit our offices and meet our associates.

We have worked hard to build strong relationships with those who also serve our communities. In 2011 we co-founded **WE**...a health hui, a loosely affiliated group of like-minded organizations to form a consortium dedicated to providing real, individualized, personally relevant information to people who might otherwise not seek health care assistance, regardless of who their health care provider may be. Through these health screening events, **WE** is working to motivate people to take an active role in their health. In 2011 **WE** conducted 29 events statewide and did over 7,000 health screenings. Some of our partners include the American Diabetes Association, Consumer & Family Youth Alliance, Hawai'i COPD Coalition, Hawai'i Lions Clubs International of District 50, Hawai'i Lions Eye Bank/Makana Foundation, Hawai'i Pacific University Student Nurses, Hepatitis Support Network, Hui No Ke Ola Pono, 'Imi Hale, a division of Papa Ola Lōkahi, Ke Ola Mamo, Mental Health Transformation State Incentive Grant; DOH (MHT-SIG), National Kidney Foundation of Hawai'i, Project Vision of Hawai'i, Sage PLUS; Executive Office on Aging, The Caregivers Foundation of America, The Queen's Medical Center Women's Center, and students from the University of Hawai'i Schools of Nursing, JABSOM and the Hilo College of Pharmacy. In addition to this, in 2011, we donated monies to over 30 locally-based non-profit organizations in the State
Including, the Hawai'i Primary Care Association, Honolulu Theatre for Youth, Kapi'olani Community College Kūpuna Education Center, Muscular Dystrophy Association, Mental Health of America – Hawai'i, Waimānalo Health Center and the Waipahu Community Association.

Three years since going live, we firmly believe that we have proven that our primary loyalty is to the people of our island home state of Hawai'i. It is also disingenuous to allege that the services that we provide are traditionally performed in Hawai'i by non-profit local insurance plans – this program was traditionally administered by the state, and we would also encourage a careful examination of the reports that have been submitted as a result of HB1525, which show the ties and services that all health plans in Hawai'i have and utilize mainland-based vendors for.

It is also important that we point out on page 3 of this bill it states that, "The plans were also unable to perform the services for the price of their original bids, and were granted a large increase in fees in 2010 without the department of human services rebidding the contract." This adjustment capitated rates to the existing contracts is not an uncommon practice and is also done with the other QUEST health plans – each year, rates are examined by a third party for actuarial soundess and appropriate adjustments are made. This is standard practice.

As of Friday, January 27, 2012, 'Ohana has 149 locally-based associates with a wide range of ethnic diversity, including many associates who speak an additional language such as Tagalog, Ilocano, Cantonese, Mandarin and Korean. Our Customer Service department, located on the ground floor of our Waipahu-based office houses 20 full-time customer service representatives, most of whom live on the west side of O'ahu and are trained to handle member issues both over the phone and in-person.

The purported issues listed in this bill are not new to us and have continually been addressed since the implementation of the QUEST Expanded Access (QExA) program on February 1, 2009. Understandably, there were problems in the beginning, as there is with the launch of any new program. However, over the past three years our company has worked diligently to address and rectify any problems, real or perceived. In a recent informational briefing by this very committee on Thursday, January 12, 2012, the committee and members of the public were once again asked to please bring any issues to us to resolve, yet not a single complaint was brought to our attention, either publically or privately.

More importantly, the Department of Human Services (DHS) already contracts with the Health Services Advisory Group (HSAG), an independent, third-party health services company that is nationally recognized as an external quality review organization (EQRO) to evaluate all five (AlohaCare, Evercare, HMSA, Kaiser and 'Ohana Health Plan) QUEST managed care plans contracted with them on an annual basis. HSAG has over 30 years of experience in peer review and health services audits, with extensive experience with Medicaid programs in more than a dozen states and has a very thorough knowledge of Medicaid policies and delivery systems. Their quality review services affect more than 13 million Medicaid recipients, approximately 45 percent of the nation's Medicaid population and are recognized as one of the most successful health care quality improvement and quality review organizations in the nation. It is HSAG's mission to be a positive force in health care by providing quality expertise to those who deliver care and helpful information to those who receive health care services.

HSAG conducts a very thorough and in-depth audit on the all the contracted QUEST health plans every year. This EQRO audit is a weeklong process, which also requires several months of advanced preparation in which they thoroughly review each plan's records and data.

In 2010, the HSAG audit reviewed five standards: 1) Access and Availability; 2) Coverage and Authorization of Services; 3) Coordination and Continuity of Care; 4) Quality Assessment and Performance Improvement; and 5) Practice Guidelines. 'Ohana Health Plan scored an average 97% in 2010, while our score breakdowns in the individual areas are as follows:

1) Access and Availability: 98%
2) Coverage and Authorization of Services: 89%
3) Coordination and Continuity of Care: 100%
4) Quality Assessment and Performance Improvement: 100%
5) Practice Guidelines: 100%

(Source: 2010 Hawaii External Quality Review Report of Results, Page 6 of 154)

In 2011, 'Ohana Health Plan is very proud to have received an overall rating of 96%, higher than any of the five contracted health plans providing Medicaid services in the State. The HSAG audit reviewed five different areas: 1) Delegation; 2) Member Information; 3) Grievance System; 4) Provider Selection; and 5) Credentialing. The score breakdowns in the individual areas are as follows:

1) Delegation: 100%
2) Member Information: 98%
3) Grievance System: 95%
4) Provider Selection: 93%
5) Credentialing: 96%

(Source: 2011 Hawaii External Quality Review Report of Results, Page 4 of 208)

The detailed audits, which are several hundred pages long, can be found on the Med-QUEST website, and is publically available. We believe that this in-depth audit that the State paid an impartial, nationally recognized and utilized company that specializes in health care service reviews to conduct is sufficient in achieving a truly comprehensive evaluation of the QUEST and QExA program goals and outcomes.

Should the legislature feel compelled to continue with an audit on the contracted QExA plans, a more fiscally prudent approach would be to make recommendations to the DHS on what areas they would like to see the next HSAG audit look into. This is a more practical approach to addressing the legislature's concerns and achieving the same outcomes without having to expend additional state dollars which could then be applied towards restoring services and benefits to Hawai'i's Medicaid population.

We strongly urge the committee to take these concerns into serious consideration while making your decisions on this measure. Thank you for the opportunity to share these comments.

UnitedHealthcare
Community Plan

841 Bishop Street, Suite 725, Honolulu, Hawaii 96813
www.uhccommunityplan.com

Date: February 15, 2012

To: Rep. Kyle T. Yamashita, Chair
Rep. James Kunane Tokioka, Vice Chair
Members of the Committee on Legislative Management

Fr: Dave Heywood, VP UnitedHealthcare Hawaii

Re: HB 2285, HD1 – Relating to Medicaid
Hearing February 15, 2012, 1:15pm, CR 423, State Capitol

My name is Dave Heywood and I am the Vice President for UnitedHealthcare in Hawaii. United's offers Medicaid, Medicare and employer group health plans in Hawaii, including 21,000 aged, blind and disabled members in our QExA Plan and 20,000 members in our Medicare Advantage Plans. Our local team includes 156 employees across the four major islands including local care coordination, local customer service and local member and provider service.

We appreciate the opportunity to testify today. We have concerns of an additional audit of the QExA program as there already is significant oversight and evaluation of the QExA program by the State of Hawaii as well as oversight and evaluation by CMS. Reviews are important and necessary, but this legislation would only add cost, potentially decrease clarity, negatively impact current processes and at the end of the day does not add any real value to oversight of the QExA program.

Both QExA health plans have worked extensively to address member and provider issues and engage stakeholders and the community with a focus on continuous improvement of the QExA program. We have met often with various healthcare providers, associations and key Legislators to address issues and demonstrate the value of the QExA

We acknowledge that there were start-up issues with the QExA program in 2009, but we corrected and stabilize the program as well as being responsive to any new issues and concerns from members, providers, Med-QUEST, the Administration, the Legislature and the community. We (and Med-QUEST) continuously monitor a variety of key metrics including provider access, care coordination, call center performance, claims performance, and appeals & grievance process and compliance.

The QExA program is evaluated and monitored continuously through both formal and informal process. This includes, for example, periodic regulatory reporting to Med-QUEST, annual External Quality Review Organization evaluation, and HEDIS reports. We also meet regularly with Med-QUEST, provider associations (e.g. HAH and HLTCA), and periodic Legislative Informational Hearings on QExA/Medicaid.

In terms of oversight, control and audit of the QExA program by DHS, it is important and interesting to note that with the new QUEST contract effective July 1, 2012, the more extensive reporting already in the QExA program will now apply to the QUEST program. This includes a detailed monthly dashboard report on customer service, claims performance, frequency of complaints and utilization metrics that UnitedHealthcare and Ohana Health Plan have been reporting to the State monthly since 2009.

The oversight, monitoring, auditing, and evaluation requirements of the QExA program are so much more comprehensive than those for the QUEST program (and which have proven so much more useful to all parties involved), that they will now by applied under the new QUEST contract.

HB 2285 HD1 also proposes the development of an equitable referral system for patients being discharged from an acute care setting to alternative (to nursing facilities) long term care settings as well as developing a revised acuity reimbursement methodology for nursing home residents.

We believe that the placement of nursing facility level of care patients from hospitals to nursing facilities or alternative care settings such as community care foster homes is complex based on the patient's unique requirements, bed availability, family considerations as well as geographic considerations. We would recommend that an improved discharge system is best accomplished by continued collaborative work by DHS, the QExA health plans, provider associations and other stakeholders.

In terms of an acuity adjusted reimbursement methodology for nursing home residents, this already exists for nursing facilities. If the intent is to extend an acuity adjusted reimbursement to residents in alternative long term care settings, such as community care foster homes, we have concerns that such a system would be accurate or equitable. This is due to the limited number of residents, often only one or two, and applying an acuity adjustment. Such a methodology could result in half of the thousands of community care foster homes seeing a decrease in payment and may then choose to cease operations – creating a significant capacity crisis in our long term care delivery system.

We appreciate this opportunity to testify today and ask the Committee to seriously question the source and the need for expending funds on a duplicative audit of the QExA program as well as supporting the current efforts of DHS, the health plans, providers and stakeholders to continue to improve the discharge process and address collaboratively the complex area of long term care access, quality, and reimbursement.