SB 2384

Measure Title:	RELATING TO HEALTH INSURANCE.
Report Title:	Human Services; Medicaid; Quest; CHIP
Description:	Requires the department of human services to implement certain cost-savings programs and technologies in the medicaid, QUEST, and children's health insurance programs. Requires report to legislature.
Companion:	
Package:	None
Current Referral:	HMS/CPN, WAM
Introducer(s):	GALUTERIA, ESPERO, RYAN, TOKUDA, Dela Cruz, Ige, Slom, Taniguchi

NEIL ABERCROMBIE
GOVERNOR

PATRICIA MCMANAMAN
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STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
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February 7, 2012

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

The Honorable Rosalyn H. Baker, Chair
Senate Committee on Commerce and Consumer Protection

FROM: Patricia McManaman, Director

SUBJECT: **S.B. 2384 - RELATING TO HEALTH INSURANCE**

Hearing: Tuesday, February 7, 2012; 1:15 p.m.
Conference Room 016, State Capitol

PURPOSE: The purpose of the bill is to require DHS to implement certain cost-saving programs and technologies in its Medicaid, QUEST, and children's health insurance programs to increase the department's ability to detect and prevent waste, fraud, and abuse in the programs.

DEPARTMENT'S POSITION: The Department of Human Services (DHS) opposes this bill because it would increase provider burden, could worsen recipient access, and would require a substantial appropriation.

Hawaii's medical assistance is based on a managed care model with more than 99% of its recipients enrolled in a managed care health plan, and each health plan maintains its own claims and payment system. This bill would require: the end of managed care (i.e QUEST and QUEST Expanded Access); or that each contracted health plan adopt a new system; or a whole new system for the remaining fee-for-service program.

Ending managed care would require an enormous increase in funding. Since the implementation of Medicaid managed care, the State has saved a cumulative of nearly $1 billion.

If required of health plans, they would either operate two systems or apply the new system to their commercial business as well. Because DHS pays the health plans on a capitated basis, it is in their best interest to ensure that the capitation is not wasted on fraudulent activities by their providers using predictive analytics, claims audits, historical claims data, medical reviews, etc.-tools that they use in their commercial business. DHS would have to pay the health plans to implement this requirement.

If applied solely to the less than 1% of individuals in Medicaid fee-for-service, it would apply to claims for the carved-out services of dental, behavioral health, developmentally disabled/intellectually disabled, and organ transplantation. The providers and recipients of these services would be the ones negatively impacted. Because of the extremely small volume of fee-for-service claims, the cost of implementation, for which there is no appropriation, would be expected to greatly exceed any identified fraud, waste, and abuse.

DHS already has a claims processing system that checks claims against the recipient's eligibility and provider's participation. The system has edits in place including for non-covered services, utilization limits, and prior authorization. In addition, the DHS now has a data storage warehouse and recently, in partnership with Arizona, has purchased a Surveillance and Utilization Review Section (SURS) subsystem. With both of these tools the DHS will have the ability to run algorithms on paid claims and on encounter data from the health plans. Any concerns in regards to provider fraud and abuse not identified by the health plans can be shared with them.

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

HMSA

Blue Cross Blue Shield of Hawaii

An Independent Licensee of the Blue Cross and Blue Shield Association

February 7, 2012

The Honorable Suzanne Chun Oakland, Chair
The Honorable Rosalyn H. Baker, Chair
Senate Committees on Human Services and Commerce and Consumer Protection

Re: SB 2384 – Relating to Health Insurance

Dear Chair Chun Oakland, Chair Baker, and Members of the Committees:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on SB 2384. While we truly understand the intent of this legislation, HMSA opposes this Bill.

SB 2384 mandates the Department of Human Services (DHS) to procure and implement a technology-based system to that includes a process to screen and verify the appropriateness of provider billing to prevent fraud, waste, and abuse in the QUEST and Children's Health Insurance programs. While we believe the intent of the legislation is laudable and absolutely important, this Bill seems to be based on a misunderstanding of the Medicaid system's operation in Hawaii. The claims review process is not housed in DHS but with the individual plans that are contracted to implement the Medicaid program. Claims review must occur prior to the expenditure of funds – reimbursement to the providers by the plans. Having this new process that places the claims review process with DHS alters the whole system and lends itself to inefficiencies that will be counterproductive to the legislation's intent. Alternatively, if the intent is to have DHS require the plans to use the new system, that would involve a tremendous investment of time and dollars by the plans to integrate the system into our individual IT systems.

HMSA fully understands the need for the Medicaid program to have a system in-place to properly detect and prevent waste, fraud, and abuse. And, as a QUEST contractor, HMSA has a stringent, automated system that identifies questionable billings, and we have a Benefits Integrity Department that oversees this process that also includes vetting questionable claims and a formal appeals process.

We also note that the Bill does not include an appropriation, but suggests that the new system will be paid for from shared savings achieved by this system. This could only work if the contracted system vendor up-fronts the total cost of development and implementation of the new system and waits until savings are generated and the Legislature appropriates those savings to pay the vendor. And, the diversion of Medicaid dollars (from saving) to pay for this new system is seemingly counterintuitive to the theory behind this legislation that poses that savings generated should be used to properly pay for direct services for Medicaid clients.

Finally, this Legislature last year authorized funding to match federal grant monies to finance the replacement of MedQUEST's antiquated eligibility system. We would hope that that new eligibility system would be designed to integrate with the contracted plans and the Hawaii Health Connector to, in part, accomplish much of what this legislation is intended to address.

Thank you for the opportunity to allow us to express our concerns and opposition to SB 2384.

Sincerely,

Jennifer Diesman
Vice President, Government Relations