THE QUEEN'S MEDICAL CENTER

LATE TESTIMONY

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Senator Josh Green M.D., Chair
Senator Clarence K. Nishihara, Vice Chair
COMMITTEE ON HEALTH

February 16, 2011 – 2:45 p.m.
State Capitol, Conference Room 229

In Strong Support of SB 792, Relating to Health Care Payments

Chair Green, Vice Chair Nishihara and Members of the Committee:

My name is Rick Keene, Executive VP and Chief Financial Officer for The Queen's Health Systems. I am testifying for The Queen's Medical Center in strong support of SB 792, which requires insurers, mutual benefit societies, and health maintenance organizations to pay health care providers directly regardless of the health care provider's participatory status, and also requires nonparticipating providers who provide emergency services to be paid promptly and directly for the treatment rendered.

Queen's is the largest private tertiary care hospital in the State of Hawaii. We offer specialized care in the areas of cardiology, oncology, orthopedics, neuroscience, behavioral health, women's health, emergency and trauma. Our emergency department is the largest and busiest in the State, with over 50,000 visits a year. As the heart of the State's trauma care system, we serve the needs of our community and visitor population, often receiving patient transfers from other hospitals across the State and the Pacific. Queen's provides emergency care to all patients who are ill or injured – regardless of their insurance status, or ability to pay.

Passage of this measure will improve the timeliness of payments to providers and reduce the incidence of nonpayment. Annual losses to Queen's related to lack of direct payment by health plans is estimated to exceed $500,000. When payment to health care providers is delayed or refused, it further weakens an already fragile health care system.

We respectfully ask for your support and approval of SB 792 and thank you for the opportunity to testify.

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55 Merchant Street
Honolulu, Hawai'i 96813-4333

HAWAI'I PACIFIC HEALTH
Kapi'olani • Pali Momi • Straub • Wilcox

Wednesday – February 16, 2011 – 2:45pm
Conference Room 229

LATE TESTIMONY

The Senate Committee on Health

To: Senator Josh Green, M.D., Chair
Senator Clarence Nishihara, Vice Chair

From: Keka Sanborn
Vice President – Contracting & Reimbursement

Re: SB 792 RELATING TO HEALTH CARE PAYMENTS - Testimony in Strong Support

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My name is Keka Sanborn, Vice President for Contracting & Reimbursement at Hawai'i Pacific Health (HPH). Hawai'i Pacific Health is a nonprofit health care system and the state's largest health care provider, committed to providing the highest quality medical care and service to the people of Hawai'i and the Pacific Region through its four affiliated hospitals, 49 outpatient clinics and more than 2,200 physicians and clinicians. The network is anchored by its four nonprofit hospitals: Kapi'olani Medical Center for Women & Children, Pali Momi Medical Center, Straub Clinic & Hospital and Wilcox Memorial Hospital.

We are writing in strong support of SB 792 Relating to Health Care Payments which – most importantly - requires out-of-network providers who provide emergency room services to be paid promptly and directly for treatment already rendered to patients. This bill is fundamentally linked to our ability to sustain community access to emergency room services and further reduce costs within the healthcare system. As the state's largest private non-profit health care network, Hawai'i Pacific Health's ability to deliver emergency room services at any of our 4 hospitals to any community member - *regardless of their ability to pay* - relies on a health care reimbursement environment that facilitates prompt and direct payment from a patient's insurer for care that has already been provided.

A patient's decision to access emergency care is driven solely by medical need. Patients will therefore access our emergency services regardless of their insurer's status with a particular hospital. In the current environment – if a hospital is not part of the patient's insurer's provider network – the insurer has the option of paying the patient directly whereby the hospital must then rely on collecting its reimbursement for care already provided directly from the patient. This additional step of the hospital collecting reimbursement owed directly from the patient results in additional costs due to risk of patient non-payment and places an additional burden on the patient to act as an intermediary for payment to the hospital.

We also want to be clear that direct payment will not raise the cost of health care to the patient. From a hospital provider perspective, the cost of delivering care to a patient is not affected by a provider's participatory status with any particular insurer. Direct payment simply assures that the reimbursement for medical care already provided is paid directly to the hospital rather than indirectly to the patient who accessed the service.

This bill will ensure patient access to vital health care services remain viable by facilitating common sense business practices to improve the efficiency of health care payments throughout the state's health care

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Wednesday, February 16, 2011

To: The Honorable Joshua B. Green, M.D.
Chair, Senate Committee on Health

From: 'Ohana Health Plan

Re: Senate Bill 792-Relating to Health Care Payments

Hearing: Wednesday, February 16, 2011, 2:45 p.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 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 2.3 million Medicaid and Medicare members nationwide. 'Ohana has utilized WellCare's national experience to develop an 'Ohana care model that addresses local members' healthcare and health coordination needs.

We appreciate this opportunity to testify in opposition to Senate 792-Relating to Health Care Payments Companies.

The purpose of this bill is to require insurers, mutual benefit societies, and health maintenance organizations to pay health care providers directly regardless of the health care provider's participatory status with the insurer, mutual benefit society, or health maintenance organization. It also requires nonparticipating providers who provide emergency services to be paid promptly and directly for the treatment rendered.

While we understand the intent, we must oppose the bill as it would dissolve any incentive for a health care provider to contract with a health insurance plan. A network of contracted providers is a key component to the concept of managed health care. Eliminating the component that allows managed care plans to develop a network of participating providers would essentially revert health care back to a fee-for-service model of care that is proven to be less effective in coordinating and managing care of patients and is more costly. In the Medicaid program particularly, when the State is struggling to balance a budget with an estimated $884m deficit and we are working together to develop solutions to reign in cost, it would be counterproductive to enact "direct pay" legislation.

Furthermore, we do not require an authorization for any services conducted as part of or in conjunction with an ER visit (meaning the hospital or physician services) and therefore have to pay the services. The provider would submit a claim to us and we set up a non-par provider ID and load them based on the information on the claim (if they aren't already set up in our system from previous claims). 'Ohana then pays the provider at 100% of Medicaid. The only time these claims would be denied is if the member was not eligible or the provider billed the claim incorrectly (coding errors, claim form errors, etc.).

Additionally, we have concerns about the language requiring plans to "promptly adjudicate the claim and forward the reimbursement required by this section directly to the provider regardless of whether the provider is out-of-network." This particular component of the bill could potentially repeal the clean claims exemption in Medicaid. We are also concerned as there is no definition of "promptly" in the bill. Currently, plans have 365 days to process and pay out claims to out-of-network providers, though the vast majority of them are processed and paid within 30 days of receiving a correctly completed claim, similarly to how claims are adjudicated to providers that are participating with our plan. Our contract with the State requires that all clean claims are paid within 30 days upon submittal.

We respectfully request that this measure be held. Thank you for this opportunity to testify in opposition to Senate Bill 792-Relating to Health Care Payments.