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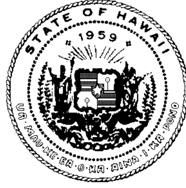

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P. O. Box 339
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February 5, 2018

TO: The Honorable Representative John M. Mizuno, Chair
House Committee on Health and Human Services

FROM: Pankaj Bhanot, Director

SUBJECT: **HB 1525 – RELATING TO PROSPECTIVE REVIEW**

Hearing: Wednesday, February 7, 2018, 10:30 a.m.
Conference Room 329, State Capitol

DEPARTMENT'S POSITION: The Department of Human Services (DHS) offers comments with concerns.

PURPOSE: The purpose of the bill is to require all health carriers and utilization review organizations to provide a fair, transparent, and consistent prospective review process to ensure optimal patient care.

Per federal Medicaid regulations, the Medicaid program has limitations on services that it covers tied to medical necessity. We need to ensure that services are provided at the right time, right setting etc., to ensure optimal care with the best health outcomes.

Medicaid does not cover all services or treatments. For example, experimental treatments are not covered. Thus, utilization management such as prospective reviews are a requirement of the health plans contracted with the State's Medicaid agency, the Med-QUEST division (MQD) of DHS. Hawaii's Medicaid program, QUEST Integration (QI), is a managed care model.

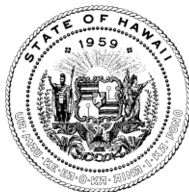
Medicaid has timeliness of prior authorization and utilization management requirements in place that are at least as strict as federal requirements. The requirements in the bill are both less restrictive (e.g. prescription drugs) and far more restrictive (urgent care

that appears to have a similar definition to emergent care) than federal and national standards. In the latter case, it can be useful to have additional time to provide reasonable documentation to demonstrate medical necessity.

As part of the QI contracts, and in accordance with federally required language, there are specific provisions that outline timeframes in which a health plan must respond to a prior authorizations, to utilization management programs, as well as to access standards for emergent, urgent, and other care. MQD monitors and provides oversight of the QI plans' adherence to these requirements.

We also note that the American health care system is the most costly health care system in the world with only adequate health outcomes. There are also estimates that about 20 percent of all care is unnecessary. While it is essential that we analyze all the cost drivers for our health care delivery system, this bill will likely lead to increased costs and appeals

Thank you for the opportunity to provide comments on this measure.



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TO THE HOUSE COMMITTEE ON
HEALTH AND HUMAN SERVICES

TWENTY-NINTH LEGISLATURE
Regular Session of 2018

Wednesday, February 7, 2018
10:30 a.m.

TESTIMONY ON HOUSE BILL NO. 1525, RELATING TO PROSPECTIVE REVIEW.

TO THE HONORABLE JOHN M. MIZUNO, CHAIR, AND MEMBERS OF THE COMMITTEE:

The Department of Commerce and Consumer Affairs (“Department”) appreciates the opportunity to testify on H.B. 1525, Relating to Prospective Review. My name is Gordon Ito, and I am the Insurance Commissioner for the Department’s Insurance Division. The Department takes no position on this bill and offers the following comments.

The purpose of this bill is to specify procedural, disclosure, notice and other requirements for prospective reviews required by health carriers or utilization review organizations prior to certification of coverage for health care services.

Medical determinations are complex and not conducive to blanket regulation by Hawaii Revised Statutes (“HRS”) title 24. These medical decisions seek to balance patient safety, effectiveness, and medical appropriateness and are outside the purview of HRS title 24. The Patient Protection and Affordable Care Act also recognizes that services, except in the case of emergency and patient access to obstetrical and gynecological care, may require preauthorization.

Furthermore, the bill amends the definition of "medical necessity" in section HRS 432E-1.4 by adding an additional paragraph at page 11, lines 9-12: "Not primarily for the economic benefit of a health carrier or purchaser or for the convenience of a patient, treating provider, or other health care provider." Using the standard "not primarily for the economic benefit of" or "for the convenience of" a party is a determination that would be vague and difficult to enforce. Furthermore, inserting this vague language into the definition of "medical necessity" may have unintended consequences for the external review process, provided for in part IV of HRS chapter 432E, which requires consideration of medical necessity.

Additionally, the expansion in the definition of "prospective review" at page 9, line 20 to page 10, line 3, includes "***any*** health carrier or utilization review organization's requirement that an enrollee or health care provider ***notify*** the carrier or organization prior to providing a health care service" (emphasis added). Mere notice appears inconsistent with the term "review."

Thank you for the opportunity to testify on this measure.

February 7, 2018

COMMITTEE ON HEALTH & HUMAN SERVICES
Representative John M. Mizuno, Chair
Representative Bertrand Kobayashi, Vice Chair

House Bill 1525 – Relating to Prospective Review

Chair, Vice Chair and Members of the Committees:

The Hawai'i Association of Health Plans (HAHP) respectfully submits comments in opposition to HB 1525. HAHP has significant concerns about with HB 1525 in terms of its impact on the quality and cost of care in Hawai'i.

Specifically:

1. Health plans are involved in the quality of care, access to health care, health outcomes, ensuring program integrity and many other facets of healthcare – in addition to fiduciary responsibilities including cost containment. It is inappropriate to define the authorization processes as only a cost control mechanism.

2. The timelines for the health plan to make a decision in this bill are extremely short, in particular for non-urgently needed services. The health plan may need to get additional information from the patient's other providers, other appropriate sources and even from the patient - which is not considered. The unintended consequence could be a rise in adverse determinations to providers just to meet the timeline.

3. "Pre-hospital transportation" is not defined – is this related to emergency ambulance only, and is it for both air and ground transport? Or is this related to any transportation to a healthcare facility for any reason?

4. The bill as written gives presumptive authorization of any admission to a facility through the emergency room. There are inpatient admissions that are not medically necessary – e.g. the patient should have been either discharged from the emergency room or held for observation – inpatient admission was not needed.

5. While we agree that medical necessity should not vary based on whether a provider participates with a health plan or not, the challenge for health plans is often getting timely and complete information from non-par (non-contracted) facilities.

6. The bill as drafted does not allow a health plan to "revoke, limit, condition…etc." an authorization once issued for 45 days. This effectively "locks" an authorization and can have unintended consequences if additional information/documentation comes to light, the patient is identified as having other coverage; the patient loses eligibility retro-actively, etc. Providers do not "lock in" a course of treatment for 45 days if during the treatment additional information/conditions indicate a modified direction for the patient.

7. The bill as drafted "voids" anything that may contradict the bill's language. This in effect would void State, Federal, NCQA and many other requirements both public and private currently in place.

8. The bill as drafted requires health plans to publicly post "disclosure requirements" of information that may be copyrighted and/or otherwise proprietary and confidential. This is not to suggest that health plans do share such information and criteria with their provider networks. As a side note, there is nothing in this bill that would also require providers to post their own criteria for admission, concurrent review, discharge planning, level of care management, etc.

9. The bill defines "urgent services" in part as what is already in the definition of "emergency services" and also as it relates to severe pain. Note that urgent care centers provide services much broader than this definition. This definition may create unintended consequences and limitation on the actual scope of urgent care.

In summary, HAHP does not support HB 1525. While health plans recognize that some providers can be frustrated with authorization requirements, we believe there are alternative avenues to address this issue, primarily through provider and health plans communicating and collaborating with each other. There are already significant requirements about the authorization process as set forth in many government and employer group contracts with health plans, as well as health plans adhering to accreditation standards on authorization processes such as with NCQA.

Sincerely,

HAHP Public Policy Committee

Cc: HAHP Board Members

February 7, 2018
10:30 a.m.
Conference Room 329

The Honorable John M. Mizuno, Chair
The Honorable Bertrand Kobayashi, Vice Chair
House Committee on Health and Human Services

Re: HB1525 Relating to Prospective Review

AlohaCare respectfully **opposes** HB1525, which specifies procedural, disclosure, notice, and other requirements for prospective reviews required by health carriers or utilization review organizations prior to certification of coverage for health care services.

AlohaCare is a non-profit, Hawaii based health plan founded in 1994 by Hawaii's community health centers. We serve Medicaid and Medicare Special Needs beneficiaries in all counties.

We are concerned HB1525 will have unintended consequences. The medical request for prior authorization and notification are important processes in the coordination of care. AlohaCare takes issue with the following:

> ***Timeliness*** *(page 2, lines 12-13)*
> With regard to special provisions for prospective review (non-emergency services), the bill proposes that a health carrier or utilization review organization approve a prior authorization and notify the enrollee and the enrollee's health care provider within two business days for non-urgent services and one business day for urgent services.
>
> For non-urgent services, AlohaCare believes the two business day requirement is too stringent. We currently practice existing Med-QUEST Division (MQD) requirements of 14 calendar days for standard authorization decisions, and three business days for expedited requests. Furthermore, the proposed requirements are more stringent than the National Committee for Quality Assurance (NCQA) utilization management standards (15 calendar days of receipt of the request for non-urgent pre-service decisions).
>
> AlohaCare encourages an open dialogue with all our providers. Given the time constraints proposed in HB1525, if AlohaCare receives an incomplete prior

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authorization from a provider, the provider may not be able to respond to all review questions; additionally, there does not seem to be any language around an extension based upon a request for additional information—if one is needed—to determine medical necessity.

For emergency and urgent services, under existing MQD requirements and current AlohaCare practices, a prior authorization is not required.

Form of Notice *(page 5, lines 2-7)*
HB1525 proposes that the provider may elect to receive the notice by fax, mail, electronic submission or verbally.

Documentation is an important part of effective care. AlohaCare takes issue with the proposed verbal notification since MQD and NCQA standards require that determinations and denial notices must be sent in written form. Additionally, Federal law requires that adverse determinations be in writing.

Retrospective Denial; Waiver Prohibited *(page 7, line 9)*
In the proposed language for HB1525, once a prior authorization is approved, no changes can be made for a period of 45 working days in order to avoid restriction of the original prior authorization.

Under existing MQD requirements and AlohaCare current practices for standard authorization decisions, the health plan shall provide notice as expeditiously as the member's health condition requires but no longer than 14 calendar days following the receipt of the written request for service. An extension may be granted for up to 14 additional calendar days if the member or the provider requests the extension, or if the health plan justifies a need for additional information and the extension is in the member's best interest.

We believe providers may object to this 45-day period. The provider would lose flexibility in managing his/her patients and AlohaCare would not be able to change the service for 45 days. For example, if the provider receives an approval for a prior authorized drug and it turns out that the drug is not effective, by law, are we both locked into an ineffective and wasteful treatment?

If a provider does not act on a prior authorized medication or service shortly after receiving the approval, the provider hopefully is addressing the unanticipated delay. In addition, the provider may also change their mind regarding the treatment itself.

AlohaCare believes in and supports the role of the primary care physician (PCP). The PCP's responsibility is to both provide and coordinate care to ensure that members receive medically appropriate services.

AlohaCare recognizes that a successful partnership with our providers depends on acceptance of responsibility and a commitment to open, effective communication by both parties. We appreciate the willingness of the provider community to partner with us to assure access to quality care for the most disadvantaged members of our community.

Thank you for the opportunity to testify on this measure.

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www.AlohaCare.org

February 7, 2018

The Honorable John M. Mizuno, Chair
The Honorable Bertrand Kobayashi, Vice Chair
House Committee on Health and Human Services

Re: HB 1525 – Relating to Prospective Review

Dear Chair Mizuno, Vice Chair Kobayashi, and Members of the Committee:

The Hawaii Medical Service Association (HMSA) opposes HB 1525, which specifies procedural, disclosure, notice, and other requirements for prospective reviews required by health carriers or utilization review organizations prior to certification of coverage for health care services.

HMSA and providers share the same goal – protecting the health and safety of people who trust us with their care. Every day we work to balance the needs of our members, providers, employer groups, and government partners. In the end, our first priority is always the needs and safety of our members. The use of preauthorization is integral to helping our members secure the safest and most efficient care.

HB 1525 raises serious concerns for how plans and providers would be able to provide services in our state. This bill would likely increase cost, downgrade the quality of our member's experience, slow down the delivery of care, and reduce the quality of care. Having medical necessity focus on the speed of the decision rather than the quality of care does not serve the provider or member well. This Bill would likely increase the number of denials (due to insufficient information submitted by the provider at the time of the request) and result in an increase of appeals which, would contribute to overall time and costs to our healthcare system. In the end it would delay the care that this Bill intends to speed up.

We currently operate under time requirements consistent or better than those required by Medicare, Med-Quest, and NCQA. Language in the Bill requires turnaround times that are not realistic for non-emergent services.

HMSA has instituted a Fast Pass program for physicians who have demonstrated medical best practice procedures for ordering medically necessary tests and procedures. We have committed to continuous outreach and education to our providers to increase the Fast Pass program to better serve our members. As part of our education effort we have ensured that there are resources available to our providers at all times to assist with any aspect of our preauthorization process. As awareness of the guidelines has increased, fewer medically unnecessary cases are being requested and performed, which has improved the quality, cost, and experience of medical care in Hawaii.

We respectfully request the Committee to defer HB1525. Thank you for allowing us to comment.

Sincerely,

Pono Chong
Vice-President, Government Relations