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LATE

January 29, 2010

MEMORANDUM

TO: Honorable Ryan I. Yamane, Chair
House Committee on Health

FROM: Lillian B. Koller, Director

SUBJECT: **H.B. 2208 – RELATING TO INSURANCE**

Hearing: Friday, January 29, 2010; 9:30 A.M.
Conference Room 329, State Capitol

PURPOSE: The purpose of this bill is to require health insurers to promptly pay claims for services to Medicaid recipients, by repealing the exemption for Medicaid claims from the clean claims law.

DEPARTMENT'S POSITION: The Department of Human Services (DHS) has concerns about this bill.

DHS foremost cares about maintaining access to health care for its recipients.

DHS believes that health care providers contracted with health plans operating under DHS contracts should receive prompt payment for their services. For that reason, DHS included prompt payment requirements in its contracts with the health plans. The health plans contracted by DHS are required to pay 90% of clean claims in thirty days and 99% in ninety days. This is the same prompt payment requirement that

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the federal government imposed on Medicaid fee-for-service under the American Recovery and Reinvestment Act. Health plans that do not meet these requirements are subject to sanctions. No health plan has not met these requirements.

While we understand the intent of this bill and support providers who care for our clients, we recognize that a health plan new to a program, such as one of the QUEST health plans being awarded a QUEST Expanded Access contract, would be potentially contracting with a new array of provider types. Testing claims processing systems is difficult until providers actually begin submitting claims. We believe that there should be a period of six months after beginning a new contract in a program should remain exempt from the State prompt pay requirement.

However, our position on this bill is closely tied to S.B. 2030 that would exempt health plans contracted with DHS from the prompt pay requirement if the health plan's payment delay results from a delayed payment from DHS to the health plan.

DHS understands the implications to a contracted health plan if payments to it are delayed. While a health plan might decide not to utilize its reserve and stop payments to providers, this could potentially result in providers stopping serving DHS recipients until reimbursement recommences.

As DHS faces a substantial budget shortfall and anticipates deferring health plan payments for three months, the issues raised in these bills are not academic. Protecting the providers means health plans suffer; protecting the health plans means providers suffer. Given these extraordinary times, the more broadly the impact can be distributed, the less severe it will be for any one group.

For the current situation, a potential compromise in a collaborative attempt to minimize negative impact on patients could be that health plans continue payment for a portion of the period, say two of the three months to all providers and perhaps to more

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vulnerable providers during the third month, and less vulnerable providers would accept a delay in payments for one month.

This potential approach is merely an example of how a community could work together in a time of need. Passage of either H.B. 2208 or S.B. 2030 would make such an approach untenable, and it could end up being the patients who suffer.

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

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LATE

January 29, 2010

The Honorable Ryan Yamane, Chair
The Honorable Scott Nishimoto, Vice Chair
House Committee on Health

Re: HB 2208 – Relating to Insurance

Dear Chair Yamane, Vice Chair Nishimoto and Members of the Committee:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on HB 2208 which would repeal the clean claims exemption for Medicaid claims.

As you are aware, recently the Department of Human Services (DHS) stated that due to budgetary shortfalls, they will withhold payments to contracted QUEST plans, beginning in April and extending through June. While we understand the budgetary restrictions the State is facing, DHS' decision significantly impacts a health plan's ability to pay for services in the timeframes noted in this measure. This has caused great concern, not only for the QUEST plans, but for our members and participating providers as well.

HMSA is committed to working with the other stakeholders affected by DHS' statement of non-payment. However, at this time we do need to voice our opposition to this measure as drafted.

Thank you for the opportunity to testify today.

Sincerely,

Jennifer Diesman
Vice President
Government Relations

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Friday, January 29, 2010 – 9:30am
Conference Room 329

LATE

The House Committee on Health

To: Representative Ryan H. Yamane, Chair
Representative Scott Y. Nishimoto, Vice Chair

From: Hilton Raethel
Vice President, Contracting & Decision Support
Hawai'i Pacific Health

Re: Testimony in Support of HB 2208 with Suggested Amendments

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My name is Hilton Raethel, Vice President & Decision Support 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, 44 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, Kapi'olani Medical Center at Pali Momi, Straub Clinic & Hospital and Wilcox Memorial Hospital. Collectively, they lead the state in the areas of women's health, pediatric care, cardiovascular services, bone and joint services and cancer care. Hawai'i Pacific Health ranks among the top 3.8 percent of hospitals nationwide in electronic medical record adoption, with system-wide implementation that allows its hospitals to offer integrated, coordinated care throughout the state. Learn more at: http://www.hawaiipacifichealth.org

We are writing in strong support of HB 2208 Relating to Insurance which would require health insurers to promptly pay claims for services to Medicaid recipients by repealing the exemption for Medicaid and Medigap claims from the clean claims law found at Hawaii Revised Statutes (HRS) 431:13-108. HRS 431:13-108 requires health plans to pay providers on a timely basis when uncontested or "clean" claims are submitted. When clean claims are submitted in writing, payment must be made within thirty (30) days, and when the claims are submitted electronically payment must be made within fifteen (15) days. However, the law exempts Medicaid and Medigap claims from this requirement. As a result, payment to health care providers is delayed for a lengthy period of time. The delay in payment creates a financial hardship for health care providers, making it difficult for them to continue providing quality health care. Increasingly health care providers have begun declining to treat Medicaid patients because of payment issues.

While the deletion of references to "Medicaid and Medigap" would greatly assist providers in receiving payment for services on a timely basis, health plans may continue to delay payment in situations where the state fails to pay the required premiums. Therefore, in order to assure that payment on clean claims is timely made, we respectfully also suggest amending the bill to delete lines 16-17 in Section 2, so that the bill would read:

""Clean claim" [~~means~~]:

(1) Means a claim in which the information in the possession of an entity adequately indicates that:

[~~(1)~~] (A) The claim is for a covered health care service provided by an eligible health care provider to a covered person under the contract;

[~~(2)~~] (B) The claim has no material defect or impropriety;

[~~(3)~~] (C) There is no dispute regarding the amount claimed; and

[~~(4)~~] (D) The payer has no reason to believe that the claim was submitted fraudulently.

[~~The term does~~] (2) Does not include:

[~~(1)~~] [~~(A) Claims for payment of expenses incurred during a period of time when premiums were delinquent;~~]

[~~(2)~~] (B) Claims that are submitted fraudulently or that are based upon material misrepresentations; and

[~~(3) Medicaid or Medigap claims; and~~

~~(4)~~] (C) Claims that require a coordination of benefits, subrogation, or preexisting condition investigations, or that involve third-party liability."

While we recognize that the health plans are placed in a difficult position when the state does not make timely payment of the premiums, providers are unfairly penalized with nonpayment for services rendered when they do not receive timely payments on clean claims which are undisputed for services already rendered.

HB 2208 would enable health care providers to receive payment promptly and decrease the financial burden they face. Therefore, we ask that the Committee consider our proposed amendment and urge the passage of HB 2208.

Thank you for the opportunity to testify on this measure.

WRITTEN ONLY

LATE

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January 29, 2010

To: The Honorable Ryan I. Yamane
Chair, House Committee on Health

From: 'Ohana Health Plan

Re: House Bill 2208-Relating to Insurance

Hearing: Friday, January 29 2010, 9:30 a.m.
Hawai'i State Capitol, Room 329

'Ohana Health Plan (OHP) is a health plan offered by WellCare Health Insurance of Arizona, Inc. WellCare is a leading provider of managed care services dedicated to government-sponsored health care programs, focusing on Medicaid and Medicare. We operate a variety of health plans for families, children, the aged, blind or disabled as well as prescription drug plans and private fee-for-service plans. Our local team of 150 Hawai'i residents have been serving approximately 22,500 low-income, aged, blind, and disabled clients through the QUEST Expanded Access (QExA) program since February 1, 2009.

We appreciate this opportunity to submit comments on House Bill 2208-Relating to Insurance.

While we support the intent of this measure, which is to assist in securing timely payments to healthcare providers contracted with Medicaid plans, we do have a number of concerns that should be considered.

As one of the QUEST Expanded Access (QExA) plans in the State of Hawai'i, we are aware that providers have expressed concerned with the timeliness of claims. There are a number of reasons that some providers have experienced longer processing times, including delays in the contracting and credentialing process. Until the contracting and credentialing process is complete, we are required to consider a provider as non-participating, and we require authorizations for all services provided by nonparticipating providers.

Additionally, even though we assumed responsibility for claims payment for our members as of February 1, 2009, we did not transition the payment of Medicare to Medicaid cross-over claims from ACS to the QExA health plans until November 1, 2009. To restate, until November 1, providers were receiving payment for cross-over claims for 'Ohana members from ACS, the previous payer under the state's fee-for-service system. This transition may have caused some confusion among providers, but we are confident that claims payments issues are being addressed and that communication to providers has been remedied in the time since November 1.

We diligently measure our claims processing turn around times and for clean claims that are submitted electronically we have averaged 11.5 days from receipt to payment and 11 days from receipt to payment for clean claims that are submitted on paper. A clean claim is defined as one that can be processed without requiring additional information from the provider.

For clean claims that take longer than the average 11 days there are factors such complicated hospital claims, manual claims adjudication that are required for Medicare-Medicaid dual eligible (DE) clients, and manual data verification for new claims. It is also important to note that the QExA program services the aged, blind and disabled population, meaning the greater majority of our claims processing must be done manually. Because of these factors repealing the exemption for Medicaid plans to submit clean claims payments within fifteen (15) calendar days could mean that plans could be forced to submit claims payment without proper verification or become subject to interest penalty payments.

We are working to improve our claims performance on several fronts. First, we are conducting a weekly review of the providers with the highest occurrences of claims rejections and claims denials. While both rejections and denials might be appropriate in some cases, a higher volume is a risk factor that could indicate problems. We analyze the claims data to identify if anything was processed incorrectly, and take the appropriate action steps to resolve any issues.

We continuously analyze the root cause of any claims issues that are identified, and put the appropriate processes in place to prevent the same type of issue from occurring in the future. Sometimes this takes the form of communicating to providers about common error types and how to prevent them.

Another big concern relates to the Department of Human Services' (DHS) intention to defer payment to the five (5) health care plans contracted under QUEST and QExA by 3-4 months beginning this March. This 4 month delay in payments to the plans will significantly hinder our ability to provide timely payment to our providers. It would be unfair to subject the healthcare plans to interest penalty payments when the State themselves are unable to pay the plans in a timely manner. We intend to continue working with the DHS on this matter and hope to resolve the issue of payment before the intended payment deferral date.

Due to these developments, we respectfully request that you hold this legislation and allow us time to continue to work directly with the providers and the DHS to resolve these issues first. Thank you for the opportunity to testify on this measure.

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Government Relations

Testimony of
John M. Kirimitsu
Legal and Government Relations Consultant

LATE

Before:
Senate Committee on Health
The Honorable Ryan I. Yamane, Chair
The Honorable Scott Y. Nishimoto, Vice Chair

January 29, 2010
9:30 am
Conference Room 329

Re: HB 2208 Relating to Insurance

Chair Yamane and committee members thank you for this opportunity to provide testimony on this bill relating to the repealing of the Medicaid claims from the clean claims law.

Kaiser Permanente does not support this bill.

Quality health care is vital to the welfare of Hawaii's citizens and its economy. It is the fourth largest private industry in Hawaii, and plays a crucial role in the economic development and sustainability of our state and its businesses.

It has been reported that in 2006, healthcare contributed more than $3.9 billion to Hawaii's Gross State Product, which did not include state and federal hospital facilities in Hawaii. Furthermore, healthcare in Hawaii attracts outside revenue through our Hawaii hospitals serving mainland members, generating $63 million in payments in 2006 for outside services.

However, following the growing trend of our nation, the quality healthcare that Hawaii has enjoyed for years is now in grave jeopardy. At the forefront, Medicaid spending has become the biggest issue in state budgets.

The State Department of Human Services already announced last spring that it had to delay $43.5 million in payments for medical care because of a serious budget shortfall. Nearly one year later, the state is still unable to catch up with our Medicaid funding deficit, and it has only gotten worse. On Jan. 1, 2011, the boost to states for Medicaid programs from the national stimulus funding will come to an abrupt end after nine quarters. This means that Hawaii will stop receiving more than $350 million in federal funds.

Given the state's own acknowledgement of a budget shortfall to fund Medicaid, the passing of this bill would unfairly penalize health insurance plans by forcing the insurance plans to fund the Meidcare payments on its own in order to meet this new mandatory 30 day Medicaid claims deadline. These payments would have to be made by health insurance plans without any assurances of reimbursement

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from the State. Any delay by the State in issuing its capitated payments to the health plans due to its budget shortfall will then cause a ripple effect in delaying health plan's ability to pay the provider.

Health plans are already subsidizing the shortfall in government reimbursements by using its own company reserves to pay for the lack of Medicaid funding by the State, but in this economy, how long can that last? Hawaii's more favorable Medicaid plans will likely erode if the legislature passes this bill because health plans will be penalized for untimely payment, through no fault of their own, which will result in financial hardships requiring additional compromising and sacrificing of needed services at the expense of the Medicaid participants.

Thank you for your consideration.

LATE

January 29, 2010
9:30am
Conference room 329

To: Rep. Ryan Yamane, Chair
Rep. Scott Nishimoto, Vice-Chair
House Committee on Health

From: Paula Arcena
Director of Public Policy

Re: HB2208 Relating to Insurance

Thank you for the opportunity to offer our comments on HB2208.

AlohaCare is a non-profit, Hawaii based health plan founded in 1994 by Hawaii's community health centers to serve low-income families and medically vulnerable members of our community through government sponsored health insurance programs. We serve beneficiaries of Medicaid and Medicare on all islands.

AlohaCare has been contracted by the Hawaii Department of Human Services since the QUEST program started in 1994 to provide insurance coverage for Medicaid eligible beneficiaries through the QUEST program. We serve approximately 70,000 QUEST enrollees statewide.

Last week, DHS informed AlohaCare it plans to delay payments to all Medicaid health plans for at least three months starting April 2010 in order to prevent a deficit at the end of the fiscal year. Whether DHS' payments are on-time or delayed, AlohaCare is contractually required to pay providers within certain time limits.

We understand that health care providers are concerned that payment for their services may be jeopardized during this period. During this economic crisis, we would like to work closely with our partners in the health care community to find ways to address issues and concerns. We have a meeting with the proponents of the bill scheduled for next week and hope that we can find a non-legislative way to address this important issue. At this time, we do not believe that removal of the exemption for Medicaid claims from HRS Section 431:13-108, Hawaii's Clean Claim law is necessary.

Thank you for this opportunity to testify.

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