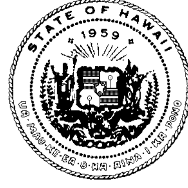
DAVID Y. IGE
GOVERNOR



CATHY BETTS
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DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
P. O. Box 339
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February 28, 2022

TO: The Honorable Senator Donovan M. Dela Cruz, Chair
Senate Committee on Ways & Means

The Honorable Senator Karl Rhoads, Chair
Senate Committee on Judiciary

FROM: Cathy Betts, Director

SUBJECT: **SB3039 SD1 - RELATING TO PROCUREMENT**

Hearing: March 2, 2022, 9:30 a.m.
Via Videoconference, State Capitol

DEPARTMENT'S POSITION: The Department of Human Services (DHS) supports this administration measure, provides a comment, and defers to the State Procurement Office and other departments.

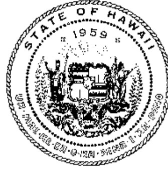
PURPOSE: The purpose of this measure requires cost or pricing analysis for purchase of health and human services; adds definition of "policy board;" increases the small purchase threshold for purchase of health and human services; authorizes heads of purchasing agencies to issue requests for statement of qualifications and to establish lists of qualified providers for treatment purchase of services; and abolishes the Community Council for health and human services. Effective date 7/1/2050 (SD1). The SD1 amended the measure by defecting the date and making technical nonsubstantive changes.

Section 5 of the proposed measure seeks to increase the small purchase of health and human services threshold from $25,000 to $100,000. The change will allow DHS to expedite and reduce administrative costs of its purchases of health and human service expenditures of

$25,000 to $100,000 based upon bid quotation submissions from vendors, instead of the competitive request for proposal process that often takes up to several months to complete and allows offerors the opportunity to protest the award.

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

DAVID Y. IGE
GOVERNOR



LATE

BONNIE KAHAKUI
ACTING ADMINISTRATOR

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TESTIMONY
OF
BONNIE KAHAKUI, ACTING ADMINISTRATOR
STATE PROCUREMENT OFFICE

TO
THE SENATE COMMITTEES
ON
WAYS AND MEANS
AND
JUDICIARY

MARCH 2, 2022, 9:30 A.M.

SENATE BILL 3039 SD1
RELATING TO PROCUREMENT

Chair Dela Cruz, Chair Rhoads, Vice Chair Keith-Agaran, Vice Chair Keohokalole, and members of the committees, thank you for the opportunity to submit testimony on SB3039 SD1. The State Procurement Office (SPO) **strongly supports** this bill, which promotes fair and reasonable cost and prices for health and human services purchases, increases the small purchases threshold for health and human services, increases efficiency of short-term treatment purchase of service, and abolishes the community council on purchase of health and human services by repealing section 103F-202 Hawaii Revised Statutes (HRS).

Thank you

SB3039 SD1 Procurement Cost Analysis for Health and Human Services

COMMITTEE ON WAYS AND MEANS
Senator Donovan M. Dela Cruz, Chair
Senator Gilbert S.C. Keith-Agaran, Vice Chair

COMMITTEE ON JUDICIARY
Senator Karl Rhoads, Chair
Senator Jarrett Keohokalole, Vice Chair
Wednesday, Mar 2 2022: 9:30 : Videoconference

Hawaii Substance Abuse Coalition comments SB3039 SD1:

ALOHA CHAIR, VICE CHAIR AND DISTINGUISHED COMMITTEE MEMBERS. My name is Alan Johnson. I am the current chair of the Hawaii Substance Abuse Coalition (HSAC), a statewide organization for substance use disorder and co-occurring mental health disorder treatment and prevention agencies.

Comments:

For Section 2

1. The State already requires budgets and supporting data for Health and Human services contracts.
2. The state sets maximum rates in the RFP and almost always, providers apply at the maximum rates – mostly because the rates are historically low.
3. In multi-year contracts, there aren't any cost of inflation adjustments, so it becomes increasingly difficult to provide services when costs, insurances, and salaries go up, but the rates stay the same.
4. Providers often must hire other qualified medical providers to help with counseling because our uninsured patients need this care, but it is not compensated.
5. Every so many years (up to 8 years), the State does a periodic rate analysis on providers that considers salaries based on market rates, and general administrative costs to determine fee for service rates, which are good for a point in time but do not consider cost of living adjustments for the next several years.
6. Administration efforts have gone up 4-fold over the last 4-5 years. Increasing more administrative work detracts from time to provide clinical care.
7. Moreover, let's examine more work efficient ways for the state to have assurances that rates are reasonable. (Quite frankly, they are low.)
8. Lastly, the previous Assistant Secretary of Health stated that the biggest challenge for states is to shift towards giving higher priority to being "stewards of effective care" rather than just being "stewards of the people's money."

Providers often fund raise to cover costs because the rates are not sufficient.

1. The state pays for the uninsured or underinsured patients. Such patients come to substance use disorder treatment often having a multitude of illnesses. They have co-occurring mental health conditions such as PTSD, depression, anxiety and more including some that have psychosis, bi-polar and severe mental illness. Moreover, many patients have diabetes, hypertension, COPD, cancer, cardiac conditions and more. They don't have insurance, so residential facilities must provide their own doctor and nurse care that is expensive and not reimbursed.
2. Agencies must fund raise to cover costs not adequately covered by state rates because some of the patients have greater needs with multiple chronic illnesses.
3. Moreover, rates are not adequate to cover depreciating assets, the rates only cover operations.
4. Agencies who fund raise to refurbish or expand their building must record fund raising as revenue while the costs are depreciated over 30 years. This accounting rule artificially inflates revenue and net result because it looks like agencies are making money during the years of fund raising while they are not, it's an accounting procedures issue with costs spent but recorded as expenses over long periods of time.

For Section 5

1. Good idea.

We appreciate the opportunity to provide testimony and are available for questions.

Testimony to the Senate Committees on Ways and Means and on Judiciary
Senators Donovan Dela Cruz and Karl Rhoads, Chairs
Senators Gilbert Keith-Agaran and Jarrett Keohokalole, Vice-Chairs
Wednesday, March 2, 2022, 9:30 a.m.
Via Videoconference
SB 3039, SD1, Relating to Purchases of Health and Human Services

Dear Chairs Dela Cruz and Rhoads, Vice-Chairs Keith-Agaran and Keohokalole, and members of the WAM and JDC Committees:

On behalf of the Hawai`i Alliance of Nonprofit Organizations, I would like to offer our comments on SB 3039, SD1, Relating to Purchases of Health and Human Services.

Hawai`i Alliance of Nonprofit Organizations (HANO) is a statewide, sector-wide professional association of nonprofits. Our mission is to unite and strengthen the nonprofit sector as a collective force to improve the quality of life in Hawai`i. Our member organizations provide essential services to every community in the state.

SB 3039, SD1 would make various amendments to Chapter 103F, HRS. HANO provides the following comments on Sections 2 and 5 only.

Section 2 of this bill inserts language with the intent to ensure "fair and reasonable costs and pricing." This language appears to be nearly identical to that of Section 103D-312, HRS. HANO opposes Section 2 of this bill as it will unnecessarily create additional burden on nonprofits responding to procurement requests.

For the purchase of health and human services, departments already require proposers to provide a full detailed budget which includes line item expenses, staff positions, and salary amounts. It is our understanding that such a detailed price breakdown is not normally required from or provided by vendors via the Chapter 103D, HRS, procurement processes. Therefore, the State agencies are already receiving detailed cost data for evaluative purposes when proposals are submitted for health and human service purchases, and no additional work should be placed on the providers by this bill.

HANO further notes that while nonprofits provide these itemized budgets in contract proposals or renewals, the budgets the agencies are working with underestimate the actual cost of delivering quality services, including the increases in labor costs over time. Our providers are currently providing this cost data but are not seeing contract amounts

that reflect fair and reasonable costs. HANO is concerned that Section 2 of this bill will be used to justify further diminishment of health and human service contract amounts.

Section 5 of this bill would increase the small purchase threshold for health and human services from $25,000 to $100,000. HANO supports this increase as it will make the procurement of these small purchase more efficient for nonprofit organizations.

Mahalo for the opportunity to provide written testimony.

Lisa Maruyama

President and CEO

Bill: SB3039 SD1
Date: February 26, 2022
Position: COMMENTS

To the Honorable Senate President Kouchi and Chairs San Buenaventura and Moriwaki,

I am writing in my individual capacity as an expert in health insurance, health care financing, and health economics as well as based on my expertise in health analytics and data science. Health economists are particularly concerned about the economics of contracting or purchasing between health care payers and health care providers. In this case, the State is serving as a health care *payer*, although it also functions as a provider in some circumstances.

I am in full support of SB3039 and provide suggestions to improve the bill's effectiveness. My key messages are summarized as follows and explained in greater detail herein:

(1) Require that the cost data—which are crucial for assessing value for money—to be collected using existing federal standards for institutional cost data.
(2) Require SHPDA to participate in the state procurement interagency committee to help verify the accuracy of cost data submitted.
(3) Eliminate loopholes in the central database for health and human services contracts and ensure implementation of a complete database.
(4) Eliminate discrepancies between facilities submitting to SHPDA versus to Medicare.

(1) Require that the cost data—which are crucial for assessing value for money—to be collected using existing federal standards for institutional cost data.

Bill SB3039 is extremely important because mandating submission of certified cost or pricing data will help to ensure value for money and efficiency of public spending funded by taxpayers. There is a broader trend

across the United States in the regulation of health care prices through understanding cost data. At the national level, the US Centers for Medicare and Medicaid Services (CMS) mandates the submission of hospital cost reports on a quarterly basis to CMS for all facilities. At the national level, the submission of such cost data is nationally standardized. Should the applicant be an institutional provider such as a hospital or a skilled nursing facility, the applicant should submit their last Medicare cost report or otherwise a cost report in a format similar to the Medicare cost report. Thus, I would thus recommend language to be inserted as follows:

"In establishing whether a cost or price is fair and reasonable, the procurement officer shall obtain:

(1) Certified cost or pricing data for every contract to which subsection (c) applies; and

(2) Other data as necessary to perform a cost or price analysis of the data and determine a fair and reasonable cost or price, regardless of whether subsection (c) applies to the contract. If the applicant is an institutional provider participating in Medicare, the cost report shall submit provider data including facility characteristics, utilization data, cost and charges by cost center (in total and for the State), payer settlement data (i.e. paid amounts), and financial statement data. If the applicant is an institutional Medicare provider, the applicant shall submit data in accordance 42 CFR § 413.24 and shall submit their latest Medicare cost report submitted to the federal Healthcare Provider Cost Reporting Information System (HCRIS), i.e. data for the Hospital Cost Report (CMS-2552-96 and CMS-2552-10), Skilled Nursing Facility Cost Report (CMS-2540-96 and CMS-2540-10), Home Health Agency Cost Report

(CMS-1728-94 and CMS-1728-94), Renal Facility Cost Report (CMS-265-94 and CMS-265-11), Health Clinic Cost Report (CMS-222-92), Hospice Cost Report (CMS-1984-99 and CMS-1984-14), Federally Qualified Health Clinic Cost Report (CMS-224-14), Rural Health Center Cost Report (CMS-222-17) and Community Mental Health Center Cost Report (CMS-2088-92 and CMS-2088-17)."

(2) Require SHPDA to participate in the state procurement interagency committee to help verify the accuracy of cost data submitted.

Duplication of efforts across state agencies is not uncommon. Thus, at the state level, the State Health Planning and Development Agency (SHPDA) is authorized to collect data on cost data of hospitals and facilities. SHPDA is statutorily responsible "to promote accessibility for all the people of the State to quality health care services *at reasonable cost*" (author's emphasis) in accordance with §323D-1. There is some potential duplication in the information submitted to the Procurement Officer under this proposed bill SD3039 and the Interagency Committee on Purchase of Health and Human Services as established under §103F-201. In order to ensure greater integration and coordination within the state of Hawaii, SHPDA should be a statutorily required member of this Interagency Committee established under §103F-201. This Committee participation by SHPDA would enable greater communication and coordination between the state procurement officer and SHPDA that would help to lower costs and prices. Collection of standardized cost data is necessary before costs can be regulated. A leading state for health care reform, the Commonwealth of Massachusetts first began collecting hospital cost data before it established a benchmark cap for hospital cost growth, expressed as a year-on-year percentage growth in costs, for all hospitals in the state.

(3) Eliminate loopholes in the central database for health and human services contracts and ensure implementation of a complete database.

Centralized data on procurement is an essential tool for assessing value for money. §103F-301 prescribes authority to "Establish and maintain a central health and human services contracts database." While in practice this appears to be HANDS database, there remain several omissions from this including Memoranda of Agreement or contracts between state agencies which are exempt due to state-state procurement exemption §103D-102(b) as well as purchases below a certain threshold. These two major omissions from the HANDS results in departments using ad hoc data systems, including rudimentary spreadsheets, to track specific division MOA or small purchases, making it very challenging to track the universe of procurements. Information on the number and size of small purchase contracts would also help to reveal whether agencies are potentially parceling (unintentionally or intentionally) as well as whether there is any gaming at the specific threshold cut-off. I note that the statute in §103F-301 does not specifically exclude contracts for small purchases or exempt contracts. Therefore, in order to increase transparency of procurement, the central contracts database should include these notable omissions. I would urge the Senate to follow-up on the full and complete implementation of §103F-301 by the State Procurement Office.

(4) Eliminate discrepancies between facilities submitting to SHPDA versus to Medicare.

Finally, it should also be noted that there are discrepancies between what the federal government collects for Medicare cost reports compared to the cost reports collected under SHPDA under §323D-54. I would strongly urge the Senate to review the list of exemptions and reconsider those exempted to, at a minimum, submit the data that are already submitted to the federal government. This will ensure that the state agency also receives data that are submitted by institutional providers to the federal government and helps to close inconsistencies between facility cost data collected by SHDPA compared to CMS. This would require revision under §323D-54.

SB-3039-SD-1
Submitted on: 2/27/2022 6:53:47 PM
Testimony for WAM on 3/2/2022 9:30:00 AM

Submitted By	Organization	Testifier Position	Remote Testimony Requested
Gerard Silva	Individual	Oppose	No

Comments:

The Health Service is not as important as keeping the comunity involved in the Process!!