



NATIONAL ASSOCIATION OF
Community Health Centers

Promising Practices # 6

Increasing Private Payment Rates to Health Centers in Hawaii

July 2009

Background and Summary of Legislation

In January 2009, legislation (S.B.1140) was introduced in the Hawaii Senate that would require all health plans, including government payors and limited benefit health insurance policy insurers licensed to do business in the State, to pay FQHCs no less than their respective Medicaid PPS rates. Federal law requires FQHCs to be paid a PPS rate for Medicaid beneficiaries, which takes into account health center costs for a full range of services. Nationally, health centers charged private insurers about \$1.16 billion in 2007 and collected just a little over half of that (58% or ~\$670 million). Medicaid reimburses health centers approximately 85% of costs on average. In Hawaii, that number is upwards of 97%. Roughly 23% of health center patients in the State are privately insured and private reimbursements mirror the national annual average.¹

The legislation overwhelmingly passed both the Senate and House in early March and mid April, respectively, but pressure from the health plans effectively killed the bill. The Hawaii Primary Care Association (HPCA) estimates that with this legislation, health centers could have brought in about \$7 million in additional reimbursement from private insurers.

Despite its failure, this legislation was supported by a majority of members of the Senate and House and is a promising model for future efforts to achieve adequate reimbursement rates for FQHCs from all payor types.

Strategy

The Critical Access Hospitals (CAH) initially approached HPCA about joining them in the effort to establish better reimbursement rates from certain payors. Health centers in Hawaii enjoy broad support in the legislature and their inclusion in the bill was a strategic move on the part of the CAHs. While at first, the idea seemed out of reach, the legislation had a lot of merit.

HPCA decided that the best tactic was to keep a low profile and let the bill work its way through the legislature without too much public discussion. It was determined that making a big public

¹ Source: Federally-funded health centers only. 2007 Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS.

push could be politically harmful to the bill's prospects because at the same time, the Hawaii Blue Cross Blue Shield Plan was announcing 3rd quarter losses and proposing double-digit rate increases.

In testimony, the PCA (referencing NACHC data) pointed out that insurers would save money in the long run because health centers use care management to reduce duplicative diagnostic testing, specialty referrals, emergency room use and hospitalizations. Further, HPCA noted that health centers wouldn't need to use their federal grant dollars to subsidize the cost of care for the privately insured.

Opposition by the private insurers and health plans focused on the inequity of paying certain types of providers differently for the same services. The legislation would, in effect, regulate the industry with regard to payment for services

Lessons Learned

HPCA is not discouraged by the loss on this bill on its first outing, since it often takes several years to build momentum in support of good legislation. From lessons learned this year, HPCA plans to have pre-session discussions with the health plans later this year on the merits of the bill, estimated costs, and areas of common agreement. At the same time, they hope to gather some data from Hawaii health centers that substantiate the national data citing health center cost savings.

Contact

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Attachments

S.B.1140, S.D.2, H.D.2

Testimony

- Beth Giesting, CEO, Hawaii Primary Care Association, April 3, 2009
- Jennifer Diesman, Assistant VP, Government Relations, Hawaii Medical Services Association, March 17, 2009
- Rick Jackson, President, Hawaii Association of Health Plans, March 17, 2009
- Thomas M. Driskill, Jr., President & CEO, Hawaii Health Systems Corporation, March 17, 2009

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NACHC mission statement

To promote the provision of high quality, comprehensive and affordable health care that is coordinated, culturally and linguistically competent, and community directed for all medically underserved populations.

A BILL FOR AN ACT

RELATING TO HEALTH CARE.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

1 SECTION 1. The legislature finds that rural hospitals and
2 federally qualified health centers are essential to the State's
3 health care system. All health care providers are affected by
4 low reimbursement rates, but rural hospital facilities and
5 publicly supported health centers that serve the economically
6 disadvantaged are especially neglected because of the high cost
7 of providing health care in remote areas with low patient volume
8 and providing comprehensive care to underserved populations with
9 complex health and socio-economic needs. In recognition of
10 these difficulties, the federal government created critical
11 access hospitals and federally qualified health centers to
12 assist the states with improving access to essential health care
13 services.

14 Critical access hospitals and federally qualified health
15 centers serve those who are covered under the medicare and
16 medicaid programs as well as those with other types of health
17 coverage. State and federal law determine the reimbursement



1 rates for medicare and medicaid provided services. The federal
2 Department of Health and Human Services, through the Centers for
3 Medicare and Medicaid Services, pays critical access hospitals
4 one hundred and one per cent of costs for acute care service to
5 medicare recipients. The state department of human services
6 also calculates payments to critical access hospitals for
7 services to medicaid beneficiaries based on the actual cost of
8 the service. Pursuant to state and federal law, reimbursements
9 for medicaid services reflect both an estimated average cost and
10 the actual cost of providing services, with the State making up
11 the difference between managed care payments and the federal
12 reimbursement rate.

13 The purpose of this Act is to require health plans,
14 including government payors, and limited benefit health
15 insurance policy insurers, licensed to do business in this
16 State, to reimburse critical access hospitals and federally
17 qualified health centers at rates consistent with medicare and
18 medicaid reimbursement rates.

19 SECTION 2. Chapter 431, article 10A, Hawaii Revised
20 Statutes, is amended by adding a new section to be appropriately
21 designated and to read as follows:



1 "§431:10A- Cost-based payments to critical access
2 hospitals and federally qualified health centers. (a) Health
3 insurers shall reimburse critical access hospitals as defined in
4 section 346D-1 at a rate not less than per cent of
5 costs, consistent with the medicare reimbursement rate for all
6 services rendered to health plan beneficiaries.

7 (b) Health insurers shall pay federally qualified health
8 centers as defined in Section 1905(l) of the Social Security Act
9 (42 U.S.C. 1396d) no less than their respective prospective
10 payment system rates determined pursuant to sections 346-53.6 to
11 346-53.64.

12 (c) Nothing in this section shall be construed to
13 determine a maximum amount that a health insurer may pay to a
14 critical access hospital or federally qualified health center
15 for services to plan beneficiaries.

16 (d) The commissioner may adopt rules pursuant to chapter
17 91 to effectuate the purpose of this section. The commissioner
18 may require health insurers to annually demonstrate compliance
19 with this section, including validation of payment rates in
20 accordance with medicare interim rate letters.

21 The commissioner may require critical access hospitals and
22 federally qualified health centers to provide information upon



1 request to clarify, supplement, or rebut information supplied by
2 a health insurer; provided that the release of information by a
3 critical access hospital or federally qualified health center
4 shall be subject to the provisions of the Health Insurance
5 Portability and Accountability Act of 1996."

6 SECTION 3. Chapter 432, article 1, Hawaii Revised
7 Statutes, is amended by adding a new section to be appropriately
8 designated and to read as follows:

9 "§432:1- Cost-based payments to critical access
10 hospitals and federally qualified health centers. (a) Mutual
11 benefit societies shall reimburse critical access hospitals as
12 defined in section 346D-1 at a rate not less than _____ per
13 cent of costs, consistent with the medicare reimbursement rate,
14 for all services rendered to health plan beneficiaries.

15 (b) Mutual benefit societies shall pay federally qualified
16 health centers as defined in Section 1905(1) of the Social
17 Security Act (42 U.S.C. 1396d) no less than their respective
18 prospective payment system rates determined pursuant to sections
19 346-53.6 to 346-53.64.

20 (c) Nothing in this section shall be construed to
21 determine a maximum amount that a mutual benefit society may pay



1 to a critical access hospital or federally qualified health
2 center for services to plan beneficiaries.

3 (d) The commissioner may adopt rules pursuant to chapter
4 91 to effectuate the purpose of this section. The commissioner
5 may require mutual benefit societies to annually demonstrate
6 compliance with this section, including validation of payment
7 rates in accordance with medicare interim rate letters.

8 The commissioner may require critical access hospitals and
9 federally qualified health centers to provide information upon
10 request to clarify, supplement, or rebut information supplied by
11 a mutual benefit society; provided that the release of
12 information by a critical access hospital or federally qualified
13 health center shall be subject to the provisions of the Health
14 Insurance Portability and Accountability Act of 1996."

15 SECTION 4. Chapter 432, article 2, Hawaii Revised
16 Statutes, is amended by adding a new section to be appropriately
17 designated and to read as follows:

18 "§432:2- Cost-based payments to critical access
19 hospitals and federally qualified health centers. (a)
20 Fraternal benefit societies shall reimburse critical access
21 hospitals as defined in section 346D-1 at a rate not less than
22 per cent of costs, consistent with the medicare



1 reimbursement rate, for all services rendered to health plan
2 beneficiaries.

3 (b) Fraternal benefit societies shall pay federally
4 qualified health centers as defined in Section 1905(1) of the
5 Social Security Act (42 U.S.C. 1396d) no less than their
6 respective prospective payment system rates determined pursuant
7 to sections 346-53.6 to 346-53.64.

8 (c) Nothing in this section shall be construed to
9 determine a maximum amount that a fraternal benefit society may
10 pay to a critical access hospital or federally qualified health
11 center for services to plan beneficiaries.

12 (d) The commissioner may adopt rules pursuant to chapter
13 91 to effectuate the purpose of this section. The commissioner
14 may require fraternal benefit societies to annually demonstrate
15 compliance with this section, including validation of payment
16 rates in accordance with medicare interim rate letters.

17 The commissioner may require critical access hospitals and
18 federally qualified health centers to provide information upon
19 request to clarify, supplement, or rebut information supplied by
20 a fraternal benefit society; provided that the release of
21 information by a critical access hospital or federally qualified



1 health center shall be subject to the provisions of the Health
2 Insurance Portability and Accountability Act of 1996."

3 SECTION 5. Chapter 432D, Hawaii Revised Statutes, is
4 amended by adding a new section to be appropriately designated
5 and to read as follows:

6 "§432D- Cost-based payments to critical access hospitals
7 and federally qualified health centers. (a) Health maintenance
8 organizations shall reimburse critical access hospitals as
9 defined in section 346D-1 at a rate not less than per
10 cent of costs, consistent with the medicare reimbursement rate,
11 for all services rendered to health plan beneficiaries.

12 (b) Health maintenance organizations shall pay federally
13 qualified health centers as defined in Section 1905(1) of the
14 Social Security Act (42 U.S.C. 1396d) no less than their
15 respective prospective payment system rates determined pursuant
16 to sections 346-53.6 to 346-53.64.

17 (c) Nothing in this section shall be construed to
18 determine a maximum amount that a health maintenance
19 organization may pay to a critical access hospital or federally
20 qualified health center for services to plan beneficiaries.

21 (d) The commissioner may adopt rules pursuant to chapter
22 91 to effectuate the purpose of this section. The commissioner



1 may require health maintenance organizations to annually
2 demonstrate compliance with this section, including validation
3 of payment rates in accordance with medicare interim rate
4 letters.

5 The commissioner may require critical access hospitals and
6 federally qualified health centers to provide information upon
7 request to clarify, supplement, or rebut information supplied by
8 a health maintenance organization; provided that the release of
9 information by a critical access hospital or federally qualified
10 health center shall be subject to the provisions of the Health
11 Insurance Portability and Accountability Act of 1996."

12 SECTION 6. New statutory material is underscored.

13 SECTION 7. This Act shall take effect on July 1, 2009.



Report Title:

Health Plan Payments; Critical Access Hospitals; Federally
Qualified Health Centers

Description:

Requires all health plans in the State, including government
payors, to pay to critical access hospitals no less than %
of costs for all services provided to plan beneficiaries, and to
pay to federally qualified health centers no less than their
respective prospective payment system rates. (SB1140 HD2)





Hawai'i Primary Care Association

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To: **The House Committee on Finance**
The Hon. Marcus R. Oshiro, Chair
The Hon. Marilyn B. Lee, Vice Chair

Testimony in Support of Senate Bill 1140, SD 2, HD 2 **Relating to Health Care**

Submitted by Beth Giesting, CEO
April 3, 2009, 4:30 p.m. agenda, Room 308

The Hawaii Primary Care Association asks your support for this measure, which would provide appropriate compensation for Hawaii's health care safety net. Both Critical Access Hospitals and Federally Qualified Health Centers (FQHCs) are recognized by the federal government as essential community providers and are guaranteed enhanced reimbursement rates from public insurance (Medicare and Medicaid) to cover costs.

Speaking for FQHCs, these enhanced rates are provided both so that they won't have to use federal grants to subsidize the cost of public insurance programs but also in recognition of the additional services that are needed by and provided to FQHC patients. These include offering care with linguistic and cultural competence; ensuring that transportation is available; and providing extensive care management that includes outreach, follow-up, referral arrangements, and application assistance. FQHCs also provide medical, behavioral health, and dental care all on the same site, which increases the likelihood that patients will get all the primary care they need in a timely and appropriate way. The integration of behavioral health with medical care is particularly clinically and financially effective. Some FQHCs serve geographically isolated places where it isn't economically feasible for other care providers to practice and this may result in higher unit costs as well.

IN 2007, 24% of FQHC patients – 25,000 individuals – had private insurance. Neighbor Island FQHCs tend to have higher percentages of privately insured patients because they are more frequently the only providers in the communities they care for. We estimate that FQHCs earn about \$7 million less per year from private insurers than it costs to deliver care to their patients. At the same time the FQHCs saved more than \$46 million¹ for the plans because of the care they delivered to privately insured patients. These savings are due to the FQHC model of care that provides comprehensive and timely primary clinical and management services which greatly reduce duplicative diagnostic testing, specialty referrals, ER use, and hospitalization.

We believe this measure deserves your thoughtful consideration and appreciate the opportunity to provide this testimony.

¹ A study prepared by the Robert Graham Center using Medical Expenditure Panel Survey data for 2007 shows that FQHCs save an average of \$1,914 per privately insured patient per year when compared to the private practice system. \$1,914 x 24,364 privately insured patients served by FQHCs in 2007 = \$46.6 million.

LATE

HMSA



An Independent Licensee of the Blue Cross and Blue Shield Association

March 17, 2009

The Honorable Ryan Yamane, Chair
The Honorable John Mizuno, Chair

House Committees on Health and Human Services

Re: SB 1140 SD2 – Relating to Health Care

Dear Chair Yamane, Chair Mizuno and Members of the Committees:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on SB 1140 SD2. This measure will require health plans to pay Critical Access Hospitals (CAH) no less than 101% of costs for services and Federally Qualified Health Centers (FQHC) at rates considerably higher than independent practicing physicians.

HMSA values the inclusion of both CAHs and FQHCs in both our government programs and private networks. This bill, however, would favor these facilities over all other existing health care resources thereby creating an inequity in the way we manage our network relationships. Several issues in particular are noted below:

Self-Reporting of Costs

The bill mandates health plans reimburse CAHs for their costs that are self-reported. The measure contains no quality control or standardization criteria to verify that costs being reported by each facility are appropriate and in-line with other similarly situated health care facilities in the community.

Inequity of Payments

For a health plan to pay a CAH or an FQHC at a reimbursement rate that is greater than that of any other nearby health care provider is difficult, if not impossible, to justify to the greater provider community. These facilities are providing the same basic services to our members regardless of the government's designation of a CAH or FQHC.

The point has been made that the FQHCs are providing more services than an individual may typically be able to receive at a physician's office. While this may be the case under programs such as QUEST and Medicaid, it's important to note that such services are not included in HMSA's private business health plans. When FQHCs provide services to HMSA's private plan members for benefits which are not covered under the individual's plan we do not believe that employers should have to pay additional costs since these are not plan benefits. For example, if an HMSA private plan member were to visit their physician's office and the physician had arranged transportation for the member to visit a specialist, HMSA would not cover that cost. Under this bill, if that same member visited an FQHC, HMSA would be forced to pay for this service.

Thank you for the opportunity to testify on SB 1140 SD2.

Sincerely,

A handwritten signature in black ink, appearing to read 'JD', with a long horizontal flourish extending to the right.

Jennifer Diesman
Assistant Vice President
Government Relations

LATE



March 17, 2009

The Honorable Ryan Yamane, Chair
The Honorable John Mizuno, Chair
House Committees on Health and Human Services

Re: SB 1140 SD2 – Relating to Health Care

Dear Chair Yamane, Chair Mizuno and Members of the Committees:

My name is Rick Jackson and I am President of the Hawaii Association of Health Plans (“HAHP”). HAHP is a non-profit organization consisting of seven (7) member organizations:

AlohaCare
Hawaii Medical Assurance Association
HMSA
Hawaii-Western Management Group, Inc.

MDX Hawai‘i
University Health Alliance
UnitedHealthcare

Our mission is to promote initiatives aimed at improving the overall health of Hawaii. We are also active participants in the legislative process. Before providing any testimony at a Legislative hearing, all HAHP member organizations must be in unanimous agreement of the statement or position.

HAHP appreciates the opportunity to testify in opposition to SB 1140 SD2 which would establish in statute a reimbursement level for private health plans to reimburse Critical Access Hospitals (CAHs) at no less than 101% of their self-reported costs and Federally Qualified Health Centers (FQHCs) at no less than their respective prospective payment system rates.

HAHP members agree with the federal government in its belief that CAHs and FQHCs provide vital services to segments of the community. In Hawaii, these facilities often provide services to QUEST and Medicaid populations who may have difficulty accessing health care in more traditional settings. That said, HAHP member organizations fundamentally disagree with the notion of setting reimbursement rates for providers of any type in employer sponsored health plans in Hawai‘i statute. We believe instead that rate negotiations which determine the cost of covered services in commercial insurance plans, which are in place today, are the appropriate method to deal with this subject.

Thank you for the opportunity to offer comments today. We respectfully request the Committee hold SB 1140 SD2.

Sincerely,

A handwritten signature in black ink, appearing to read "Rick Jackson", is written over a white rectangular area.

Rick Jackson
President

• AlohaCare • HMAA • HMSA • HWMG • MDX Hawaii • UHA • UnitedHealthcare •
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HAWAII HEALTH SYSTEMS
C O R P O R A T I O N

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LATE

Joint Hearing

House Committee on Health
Representative Ryan I. Yamane, Chair
Representative Scott Y. Nishimoto, Vice Chair

House Committee on Human Services
Representative John M. Mizuno, Chair
Representative Tom Brower, Vice Chair

Tuesday, March 17, 2009
10:45a.m.
Conference Room 329
Hawaii State Capitol

Testimony on SB 1140, SD2 Relating to Health Care

Requires commercial health plans licensed to do business in the State to pay no less than 101% of costs for all services provided to plan beneficiaries by critical access hospitals and federally qualified health centers. Exempts limited benefit health insurance policies from the minimum reimbursement requirement.

Thomas M. Driskill, Jr.
President & Chief Executive Officer
Hawaii Health Systems Corporation

On behalf of the Hawaii Health Systems Corporation (HHSC) Corporation Board of Directors, thank you for the opportunity to present testimony in strong support of the intent of SB 1140, SD2.

The purpose of this bill is to require health plans, other than government payers, licensed to do business in this state, to reimburse critical access hospitals and federally qualified health centers at rates consistent with Medicare and Medicaid reimbursement rates. The bill would require insurers other than government payers to reimburse critical access hospitals as defined in section 346D-1 at a rate not less than one hundred and one percent of costs, consistent with the Medicare reimbursement rate, for all services rendered to health plan beneficiaries and to pay federally qualified health centers as defined in section 1905 (1) of the Social Security Act (42 USC 1396d) no less than their respective payment system rates determined pursuant to sections 346-53.6 to 346-53.64.

Currently, government is subsidizing the costs for healthcare services provided to beneficiaries of health plans, other than government payers, by critical access hospitals (CAHs) and federally qualified health centers (FQHCs), because health plans in Hawaii, other than government payers, are not paying for the full costs of care provided to plan beneficiaries.

It is estimated that the enactment of this legislation could provide for approximately \$5 million annually in increased reimbursements to critical access hospitals and an aggregate \$47,475,544 in increased reimbursements over eight years to critical access hospitals, assuming same service levels and 5% inflation per year. It is estimated that the enactment of this legislation could provide for approximately \$7.3 million in increased reimbursements to federally qualified health centers, and an aggregate \$67,708,495 in increased reimbursements over eight years of federally qualified health centers, assuming same service levels and 5% inflation per year.

All hospitals are adversely affected by declining reimbursement trends, but rural facilities are especially disadvantaged, due to the low volume of patients and high expense of providing care in remote areas. Federally qualified health centers (health centers) are especially disadvantaged due to low payments from commercial health plans, even though enhanced payments from government programs (Medicare and Medicaid) tend to cover operating costs. Recognizing the financial challenges faced by rural hospitals, the federal government passed 42 United States Code 1395i-4, which established the Medicare rural hospital flexibility program, a national program designed to assist states and rural communities in improving access to essential health care services through the establishment of limited service hospitals and rural health networks. The program creates the critical access hospital as a limited service hospital eligible for Medicare certification and reimbursement, and supports the development of rural health networks consisting of critical access hospitals, acute general hospitals, and other health providers.

Congress also established federally qualified health centers as a category of provider that specializes in comprehensive primary health care for underserved communities. Among mandated provisions for federally qualified health centers are cost-related reimbursement for Medicaid and Medicare services.

The U.S. Department of Health and Human Services Medicare and Medicaid Services pays Critical Access Hospitals on the basis of one hundred and one per cent of costs for acute care inpatient and outpatient services. The State of Hawaii department of human services calculates payments to critical access hospitals on a cost basis for acute inpatient and long term care services to beneficiaries of the Medicaid program.

The state's ability to provide safety net services will significantly degrade, if commercial health plans continue to refuse to pay amounts that cover the costs for providing care, unless the state continues to provide special subsidies to CAHs and FQHCs to cover operating losses of CAHs and FQHCs from providing services to beneficiaries of mutual

and fraternal benefit societies, and health maintenance organizations, and health plans other than government payers. Financial and social burdens will fall increasingly on agencies of the state and county governments because of the health and economic impact of declining and degrading healthcare services if government would not continue to subsidize costs of healthcare services provided to beneficiaries of mutual and fraternal benefit societies, and health maintenance organizations, and health plans other than government payers.

Limited benefit health insurance policies should not be exempted from the minimum reimbursement requirement as proposed in SB 1140, SD2. It is particularly inappropriate to exclude Medicare supplement plans from paying same as Medicare. We respectfully request that SB 1140, SD2 be amended to remove this exemption and that the measure be passed with an effective date of July 1, 2009.