



**TESTIMONY OF
CONNECTICUT HOSPITAL ASSOCIATION
SUBMITTED TO THE
HUMAN SERVICES COMMITTEE
Thursday, March 2, 2017**

**HB 7040, An Act Implementing The Governor's Budget Recommendations For
Human Services Programs**

The Connecticut Hospital Association (CHA) appreciates this opportunity to submit testimony concerning **HB 7040, An Act Implementing The Governor's Budget Recommendations For Human Service Programs**. CHA opposes the bill.

Before commenting on the bill, it's important to point out that Connecticut hospitals provide high quality care for everyone, regardless of ability to pay. Connecticut hospitals are finding innovative solutions to integrate and coordinate care to better serve patients and communities, as well as achieve health equity. These dynamic, complex organizations are working to build a healthier Connecticut. That means building a healthy economy, community, and healthcare system. By investing in the future of Connecticut's healthcare and hospitals, rather than continuing to cut away at them, we will strengthen our economy, put communities to work, and deliver affordable care that Connecticut families deserve.

HB 7040 proposes to curtail dramatically the rights of hospitals and other Medicaid providers to appeal decisions of the Department of Social Services (DSS). Section 17b-238(b) currently permits a hospital (and other institutions and agencies that receive Medicaid payments) to request a rehearing when the hospital is aggrieved by "any decision of the commissioner."

Over the last three years, hospitals alone have filed hundreds of appeals under this provision to challenge the extreme inadequacy of the State's Medicaid payments to hospitals. The appeals largely center on legal disputes over the State's reimbursement methodology.

In these appeals, the hospitals claim that the state has violated state and federal laws because its reimbursement systems for inpatient and outpatient services fail to provide for payments that are adequate to allow hospitals to provide quality services efficiently and economically to ensure access to Medicaid services. Instead, the state's hospital Medicaid reimbursement methodologies have been strictly budget-driven. The state has frozen hospital inpatient rates since 2008 – for the last nine years. And when inpatient rates were increased in 2008, the increase was limited to 80% of hospitals' allowable 2005 Medicare costs, with some hospitals receiving even less. Outpatient hospital rates have long been based on outdated fee schedules that, in some cases, have not been revised in 10-20 years; the new hospital outpatient payment methodology rolled out last year has perpetuated these underpayments.

While the state has made supplemental payments to hospitals, it has reduced these supplemental payments significantly in the last few years. At the same time, the state has increased the provider tax on hospitals to the point where hospitals paid approximately \$556 million in taxes in 2016. Due to significant underfunding for hospital Medicaid rates and the unreimbursed cost of the tax, Medicaid payments to hospitals currently cover only about 43% of the costs that hospitals incur to care for Medicaid patients. And we note that these are costs that Medicare, through its cost finding rules, has determined should be allowable.

In addition to appealing Medicaid rate decisions under Section 17b-238(b), hospitals have also relied on this provision to challenge other decisions of DSS. For example, hospitals filed appeals to challenge DSS's determinations regarding the hospital tax, supplemental payment cuts, and DSS "integrity reviews" that have been conducted outside the statute governing DSS Medicaid audits, Section 17b-99.

In Section 21, the Governor proposes to limit the right to request a rehearing to only two circumstances: (i) "provider-specific rates" and (ii) certain appeal rights required under federal law for nursing facilities and intermediate care facilities for individuals with intellectual disabilities ("ICF-IIDs") involving the denial or termination of the Medicaid provider agreement, or the imposition of civil monetary penalties for these types of facilities.

CHA strongly opposes these revisions. The Governor's proposal would limit hospital appeal rights to decisions affecting Medicaid rates. As a result, other types of appeals, such as the integrity review appeals, would not be permitted. Even more concerning, however, the right to appeal Medicaid rates would be *drastically limited* to only "provider-specific decisions." Under the proposed definition of "provider-specific rate," a hospital would not have the ability to challenge the overall payment methodology. It could only challenge rate issues specific to that hospital, such as a calculation error or unique reimbursement rate. Section 21 defines a "provider-specific rate" as a "rate or other payment methodology that applies *only to one provider* and was set or revised by the department based on cost or other information *specific to such provider*." The proposed language then states that "provider-specific rate" "*does not include any rate or payment methodology that applies to more than one provider or that applies statewide to any category of providers.*"

Section 21 will virtually decimate an important vehicle for holding the state in check to ensure that Medicaid payment methodologies comply with applicable state and federal requirements.

This is especially problematic because DSS already has the authority under Section 17b-239 to issue hospital rate revisions as policies and to implement those policies *before* going through the process for implementing those changes as regulations, with notice and opportunity for comment and review by the General Assembly's Legislative Regulation Review Committee. DSS has implemented rate reductions routinely and taken money from hospitals with little to no advance notice. For example, DSS issued letters to the hospitals just a few days before the end of calendar year 2016 announcing revised rates taking effect January 1, 2017. The hospitals have appealed these decisions based on arguments that the DSS methodology violates state and federal law. If enacted, Section 21 *will not permit* these appeals.

There are no viable alternatives for hospitals to challenge Medicaid payment methodologies. Given state law restrictions on the ability to challenge administrative agency decisions in court, hospitals likely will not be able to seek redress in the state court system. While hospitals could request declaratory rulings from DSS on rate methodology issues, those rulings are prospective only, and there would be no ability to recover funds retrospectively under Section 21 if a hospitals challenges rate methodology.

Hospitals are also significantly limited in their ability to challenge the adequacy of Medicaid payments in federal courts. In *Armstrong v. Exceptional Child Ctr., Inc.*, 135 S. Ct. 1378 (2015), the Supreme Court held that there could be no private enforcement in federal courts of the Medicaid Act requirement that state Medicaid agencies must provide methods and procedures to ensure that Medicaid payments are consistent with efficiency, economy, and quality of care and to enlist a sufficient number of providers to provide access to Medicaid services in accordance with 42 U.S.C. § 1396a(a)(30)(A) (“Section 30(A)”). Justice Breyer’s concurrence in *Armstrong* was explicit that providers could bring Section 30(A) claims in agency adjudications since “administrative agencies are far better suited to this task” due to their expertise. *Id.* at 1388. *See also, Douglas v. Independent Living Center of Southern California, Inc.*, 132 S. Ct. 1204, 1210 (2012) (Justice Breyer, writing for the majority, noted that a provider aggrieved by an agency’s failure to comply with Section 30(A) could first seek relief from the agency and then seek judicial review of the agency action). Given these rulings, the ability of Medicaid providers to bring substantive rate challenges before state agencies has become exceedingly important.

HB 7040 flies in the face of this guidance. It proposes to strip away the fundamental due process rights of hospitals under Section 17b-238(b) to such an extent that the provision will be virtually meaningless, leaving hospitals with no viable alternatives for challenging Medicaid payments. The Committee should oppose Section 21.

Thank you for your consideration of our position. For additional information, contact CHA Government Relations at (203) 294-7310.