



**TESTIMONY OF  
CONNECTICUT HOSPITAL ASSOCIATION  
SUBMITTED TO THE  
HUMAN SERVICES COMMITTEE  
Thursday, March 14, 2019**

**HB 7164, An Act Implementing The Governor's Budget Recommendations  
For Human Services**

The Connecticut Hospital Association (CHA) appreciates this opportunity to submit testimony concerning **HB 7164, An Act Implementing The Governor's Budget Recommendations For Human Services**. CHA opposes several sections of HB 7164.

Before commenting on the bill, it's important to point out that Connecticut hospitals and health systems provide high quality care for everyone, regardless of their ability to pay. By investing in the future of Connecticut's hospitals, we will strengthen our healthcare system and our economy, put communities to work, and deliver affordable care that Connecticut families deserve.

The provisions that affect hospitals are in Sections 14, 16, and 17.

Section 14 limits appeal rights from rate decisions of the Commissioner to only rates that are unique to the specific provider. CHA is opposed to this section. Appended to this testimony is CHA's joint testimony with LeadingAge Connecticut, The Connecticut Association for Healthcare at Home, and the Connecticut Association of Healthcare Facilities in strong opposition to Section 14.

Section 16 allows the Department of Social Services (DSS) to implement one or more value-based payment programs over time to reduce payment by 15% for a readmission within 30 days for the same or a similar diagnosis or diagnoses, as well as to limit payment to no more than what would be able to be matched by the federal government. Section 16 provides DSS with complete and unrestrained ability to establish such programs and to reduce such payments. CHA opposes these changes.

Section 17 deletes the current protections provided for the hospital tax and related supplemental payments. It deletes the timely filing requirements for filing SPAs and making payments to hospitals. Moreover, it allows the Commissioner to vary supplemental payments for quality performance but provides no specificity regarding the criteria that will be used. CHA opposes the changes in Section 17.

In 2017, Connecticut faced operating deficits projected to be as high as \$317 million in the current fiscal year and \$3.5 billion over the next biennium. At the same time, Connecticut hospitals were plagued by an onerous hospital tax that was never intended to be a direct tax on healthcare services. When the tax was originally enacted in 2011, the state intended to use the revenue collected to make supplemental benefit payments to hospitals for healthcare services provided to patients enrolled in the Medicaid program. These supplemental payments would qualify the state for increased federal reimbursement. Unfortunately, the previous Administration abandoned this strategy within a year of its adoption, and opted instead to keep larger and larger portions of the tax payments received from hospitals while reducing supplemental payments to hospitals, thus foregoing the opportunity to qualify for increased federal funding.

Rather than shying away from the dual challenges of (1) placing government on a path forward to fiscal stability and (2) addressing what had become a direct tax on healthcare services, Connecticut hospitals stepped forward and volunteered to work with legislative leadership and the Administration. The results were an historic bipartisan three-year agreement – one that Connecticut hospitals continue to support strongly. Section 17 contains the critical implementation language of that agreement. This agreement helped both the state and hospitals. In 2017, this three-year agreement was passed in the Senate by a unanimous 34-0 vote and in the House by a vote of 123-12, receiving overwhelming support from a majority of members of all four caucuses. The governor signed it into law.

The 2017 agreement has helped address the chronic and persistent operating deficits in the state budget by enabling the state and hospitals to benefit from increased federal reimbursement, while diminishing the state's reliance on a direct tax on healthcare services. **HB 7146** proposes to abandon the agreement between hospitals and the state during its third and final year. If enacted into law, hospitals will experience a \$516 million increase in the hospital tax, with a corresponding reduction in supplemental payments amounting to \$43 million – to \$453 million.

Connecticut hospitals implore this General Assembly to honor the state's commitment to hospitals by keeping our agreement in place. We urge you to reject any and all efforts to deviate from our 2017 hospital agreement.

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



CONNECTICUT ASSOCIATION FOR  
**HEALTHCARE AT HOME™**



**TESTIMONY SUBMITTED  
TO THE  
HUMAN SERVICES COMMITTEE  
Thursday, March 14, 2019**

**HB 7164, An Act Implementing The Governor's Budget Recommendations  
For Human Services**

The Connecticut Hospital Association, LeadingAge Connecticut, The Connecticut Association for Healthcare at Home, and the Connecticut Association of Healthcare Facilities have come together as the **CT Healthcare Association Collaborative – the united voice for providers on healthcare issues impacting Connecticut residents.**

We strongly oppose Sections 14 and 15 in HB 7164, An Act Implementing The Governor's Budget Recommendations For Human Services, which reduce provider appeal rights. These sections seek to shut down completely the rights of certain types of providers to appeal decisions of the DSS Commissioner. Moreover, Section 14 would dramatically curtail the rights of providers that can appeal rates under the proposal.

Section 17b-238(b) *currently* permits hospitals, nursing homes, residential care homes, home health care agencies, homemaker-home health aide agencies (as well as certain other institutions and agencies that receive Medicaid payments) to request a rehearing when the provider is aggrieved by “any decision of the commissioner.”

The Governor first seeks to limit the types of providers that have appeal rights under Section 17b-238(b). Section 17b-238(b) identifies the types of providers with appeal rights by referencing statutes that authorize Medicaid payments to those providers. Included under Section 17b-238(b) and the revisions in Section 14 are hospitals, nursing homes, residential care homes, intermediate care facilities for individuals with intellectual disabilities (“ICF-IIDs”), and residential facilities for individuals with intellectual disabilities. However, Section 14 has removed statutes governing payments to certain other types of providers, including home health care agencies, homemaker-home health aide agencies and other Medicaid waiver providers such as adult day centers and meals on wheels programs, as well as mental health and substance abuse treatment facilities.

In addition, Section 15 proposes to eliminate the specific additional appeal rights for home healthcare agencies and homemaker-home health aide agencies. As a result, home healthcare agencies and homemaker-home health aide agencies no longer have the right to appeal to the DSS Commissioner.

Next, the Governor proposes to limit the right to request a rehearing to only two narrow circumstances: (i) “provider-specific rates” and (ii) certain appeal rights required under federal law for nursing facilities and ICF-IIDs involving the denial or termination of the Medicaid provider agreement, or the imposition of civil monetary penalties for these types of facilities.

While providers have invoked appeal rights under Section 17b-238(b) primarily to challenge Medicaid rates and payments, they have also relied on this provision to challenge other DSS decisions, such as the DSS “integrity reviews” that have been conducted outside the procedures set forth in the statute governing Medicaid audits, Conn. Gen. Stat. § 17b-99. By limiting the appeal rights to “provider specific rates,” providers covered by Section 14 will no longer have the right to appeal decisions that are not related to Medicaid rates.

Yet even for Medicaid rate appeals, the Governor’s proposal would severely curtail provider appeal rights. Nursing homes, residential care homes, hospitals, and the other providers covered by the statute will only be able to appeal “provider-specific rates.” Under the proposed definition of “provider-specific rate,” there would be no opportunity to challenge the overall payment methodology. Providers could only challenge rate issues specific to that provider, such as a calculation error or unique reimbursement rate.

- Section 14 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.*” (emphasis added).
- 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.”

If Section 14 is enacted into law, hospitals, nursing homes, and residential care homes will have no ability to file appeals and claim retrospective relief when they believe that the Department’s rate methodology violates state or federal laws, or when they are aggrieved by a decision of the DSS Commissioner that does not involve rates. Moreover, under Sections 14 and 15, home healthcare agencies, homemaker-home health aide agencies, adult day centers, Meals on Wheels programs, and certain other providers will have no appeal rights at all.

Finally, under the U.S. Supreme Court’s decision two years ago in *Armstrong v. Exceptional Child Ctr., Inc.*, 135 S. Ct. 1378 (2015), Medicaid providers cannot sue state Medicaid agencies in federal courts for failing to comply with federal requirements that Medicaid payments be “consistent with efficiency, economy, and quality of care” and to enlist a sufficient number of providers to provide access to Medicaid services (42 U.S.C. § 1396a(a)(30)(A) (“Section 30(A)”). Justice Breyer emphasized in his concurrence in *Armstrong* 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). **These passages stress the importance of state administrative appeal procedures for Medicaid providers.**