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March 16, 2010

MEMORANDUM

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

Honorable John M. Mizuno, Chair
House Committee on Human Services

FROM: Lillian B. Koller, Director

SUBJECT: **S.B. 2270, S.D. 2– RELATING TO MEDICAID REIMBURSEMENTS**

Hearing: Tuesday, March 16, 2010, 11:00 AM.
Conference Room 329, State Capitol

PURPOSE: The purposes of this bill are to 1) require Medicaid reimbursement to hospitals for patients occupying acute-licensed beds who are on a waitlist for long-term care to be at least equal to the rate paid for acute care services; 2) require Medicaid reimbursement to long-term care facilities for patients with medically complex conditions to be at least equal to the rate paid for subacute care; 3) appropriate funds for increased reimbursements.

DEPARTMENT'S POSITION: The Department of Human Services (DHS) strongly opposes this bill as it would result in a significant increase in State expenditures when the State is facing a $1.23 billion budget shortfall for the biennium.

In addition, State law currently requires that there be no distinction between hospital-based and non-hospital based Medicaid reimbursement rates for

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institutionalized long-term care. These reimbursements are equitably based on the level of care provided pursuant to section 346D-1.5, HRS.

DHS faces a currently estimated $84,000,000 shortfall this fiscal year which may potentially delay payments to health plans for three months and an estimated $146,000,000 shortfall next fiscal year if this year's shortfall is not addressed.

Section 1 of S.B. 2270, S.D.1, states that hospitals lost $72,500,000 in 2008 for care to patients waiting to be transferred to long-term care. That is, therefore, how much money will be needed to be newly appropriated to fund this bill that is extremely costly to Hawaii taxpayers. DHS does not believe that we should eliminate eligibility and coverage to low-income vulnerable populations in Hawaii or increase taxes on hard-working struggling families which would be necessary to implement this bill.

This $72,500,000 amount that hospitals would like to receive includes payment for services not provided. Paying inpatient acute care rates for a patient not requiring, by definition, acute level care because he or she is awaiting discharge, would be paying for services not needed nor provided, and this reimbursement would not be expected to be eligible for federal matching funds.

In FY 2008, there were 17,000 waitlisted days which would have meant an extra $10,000,000 per year in payments to hospitals. This is based on the number of waitlisted patients from 2008 who were not found eligible for Medicaid. These payments for non-Medicaid eligible patients to nursing homes would have to be made with 100% State general funds.

This increased payment to hospitals does not include the cost of effectively rebasing long-term care facility rates. Using the definition of "medically complex condition" for paying the subacute rate means that any patient with a chronic illness taking medications would qualify for the subacute rate. This is essentially everyone in

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a nursing facility and would cost additional tens of millions. The difference between the average nursing facility rate ($234.62) and average subacute rate ($536.96) is an additional $302.34 per day.

DHS already provides hospitals with more than $20,000,000 in supplement payments per year.

DHS believes the problem of long-term care patients occupying acute care beds will not be solved by this measure. The Department has already moved to address the waitlist problem through its QUEST Expanded Access (QExA) managed care program that started on February 1, 2009. Waitlisted patients will now have access to a service coordinator as well as increased access to expanded home and community based services. DHS also continues the Going Home Plus program which increases reimbursement to care for complex clients in the community. The future of long-term care is the expansion of home and community based services.

Because it is expected that funding will not be available this year, this bill would instead establish a different methodology for payment should funds become available. The increased rates would be a moving targeted as the rates would be reduced when the funds are exhausted which makes capitation rate development for DHS and budgeting for facilities extremely difficult.

Provider reimbursement is made by the contracted managed care health plans, and capitation rates are developed in advance and contracted for a specified period of time. Increases and decreases in rates also require approval by the federal Centers for Medicare and Medicaid Services. Changing rates when funds become available and again when they are exhausted will significantly increase administrative cost and complexity.

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Change in reimbursement methodology to hospitals and nursing facilities should not occur when the State is in a financial crisis. Statutory change to reimbursement methodology should not occur unless properly funded to allow proper planning and receipt of federal approval to allow receipt of matching federal funds.

Finally, please note that DHS has also been distributing "DSH-like" federal funds of $7.5 million per year to hospitals statewide since 2005 pursuant to a creative Medicaid 1115 waiver that DHS obtained from CMS. DHS distributes these funds based on the DSH formula developed by the Healthcare Association of Hawaii. The next distribution of these funds is scheduled to occur in February 2010.

DHS has presented private and public hospitals with nearly $84 million in federal-only funds since 2005 through the DHS "waiver." DHS has also given hospitals another $31 million in federal and matching state funds since 2007 through the Congressional Disproportionate Share Hospital program, bringing the total to $115 million to date.

As this bill requires substantial additional State appropriations and the State facing a $1.23 billion budget shortfall for the biennium, DHS strongly opposes this measure as there is not enough State money to increase reimbursements.

Thank you for the opportunity to provide this testimony.