HAWAII HEALTH SYSTEMS
CORPORATION
"Touching Lives Everyday"

House Committee on Finance
Representative Marcus R. Oshiro, Chair
Representative Marilyn B. Lee, Vice Chair

Monday, February 27, 2012
Conference Room 308, 2:00 p.m.
Hawaii State Capitol

Testimony Supporting House Bill 2275, HD1, Relating to Hospitals Establishes the Hospital Sustainability Program into which hospital sustainability fees shall be deposited. Requires the Department of Human Services to charge and collect a provider fee on health care items or services provided by hospitals.

Bruce S. Anderson, Ph.D.
President and Chief Executive Officer
Hawaii Health Systems Corporation

On behalf of the Hawaii Health Systems Corporation (HHSC) Corporate Board of Directors, thank you for the opportunity to present testimony in support of the concept of HB 2275, HD1 that establishes the Hospital Sustainability Program into which hospital sustainability fees shall be deposited.

Given that health care provider reimbursements are declining at both the federal and state level, it is imperative that health care providers find innovative ways to generate revenues to offset the decline in reimbursements. We believe that the concept of a provider fee on health care items or services provided by hospitals would be a good financing mechanism that could leverage federal funds to increase the reimbursements to hospitals from the QUEST and QUEST Expanded Access (QEXA) programs.

However, we have several concerns that will need to be addressed before we can provide our full support of this bill. First, the bill requires that the hospitals would pay the sustainability fee 45 days after the end of each calendar quarter. That means that there would be a gap of approximately three months at a minimum before a nursing facility would be able to recoup the amount of the sustainability fee paid from the enhanced reimbursements from the QUEST and QEXA plans. This would create a severe cash flow issue for HHSC's hospitals, since they do not have adequate cash reserves to make the initial payment and then wait for the reimbursements to come in over the next three months.

Second, the bill does not contain any language that requires deadlines for the Department of Human Services (DHS) to facilitate the drawdown of federal funds or to pay the enhanced capitation rates to the QUEST and QEXA plans. Also, the bill does not contain any language that requires deadlines for the QUEST and QEXA plans to make the enhanced reimbursements to the providers. Further, while the bill contains penalties for hospitals for lack of timely payment, there are no such penalties for DHS or the QUEST and QEXA plans to make sure that the hospitals receive the enhanced reimbursements due them.

Third, the bill does not specify what data source will be used to assess the hospital sustainability fee. While the bill specifies that the fee will be assessed on the hospital's "net patient service revenue," the data source is critical for hospitals to know in order for them to determine whether the amount of the fee assessed to them is correct or not.

Fourth, the bill assumes that all hospitals are participating providers with the QUEST and QEXA plans. It is unclear how hospitals that are not participating providers would receive enhanced reimbursements under this bill.

These concerns have been communicated to the Healthcare Association of Hawaii, whom we understand will be providing technical amendments to this bill to address these concerns as the bill moves through the Legislative session.

Thank you for the opportunity to testify before this committee. We would respectively recommend the Committee' s support of this measure.

HAH
Healthcare Association
of Hawaii

HOUSE COMMITTEE ON FINANCE
Rep. Marcus Oshiro, Chair

Conference Room 308
February 27, 2012 at 2:00 p.m. (Agenda #4)

Supporting HB 2275 HD 1: Relating to Hospitals

The Healthcare Association of Hawaii advocates for its member organizations that span the entire spectrum of health care, including all acute care hospitals, as well as long term care facilities, home care agencies, and hospices. In addition to providing quality care to all of Hawaii's residents, our members contribute significantly to Hawaii's economy by employing over 40,000 people. Thank you for this opportunity to testify in support of HB 2275 HD 1, which creates the Hospital Sustainability Program, which strengthens the financing of hospitals in Hawaii by drawing down federal funds.

Provider fee programs are used in 46 states and the District of Columbia as a means of drawing down additional federal funds to sustain their Medicaid programs. Hawaii is one of only four states without such a program, at a time when state budget deficits are rising due to increasing health care costs and expanding Medicaid rolls. The implementation of a provider fee in Hawaii could assist in stabilizing declining Medicaid payments to facilities and slow down the erosion of access to care for those beneficiaries served by the program. I must emphasize that supporting access to care via this program can only be accomplished if it is implemented in the manner supported by the Health Care Association of Hawaii and its members.

Provider fee programs use NO state funds and no taxpayer funds. The funds to draw down federal funds are those of the hospitals. They will have to pay an up front assessment, and as such some of them will be draining what little, if any, funds they have in reserve to utilize this program. But the current situation is so dire that these providers are willing to take the risks involved with implementing a provider fee program.

Why do I say that there is a risk involved? Besides the cash flow issue this could cause for some facilities there is a risk that the Department of Human Services will ask for more than the 5% administrative concession to the state currently contained in the bill. This concession is to recognize any administrative burden that DHS may incur in supporting the program. Although we are still finalizing our model, 5% of the Hospital Sustainability Program would likely net the state between $1.5 million and $2.5 million which, if used for Medicaid services, would be eligible for a federal match thus netting the state between $3 million and $5 million total. The MedQuest Director has stated that two full time employees would be needed to administer the program. This would be more than enough funding to hire two FTEs.

Medicaid is jointly financed by the states and the federal government. By statutory formula, the federal government pays between 50% and 76% of Medicaid costs incurred by states for care delivered to their Medicaid beneficiaries, based on each state's Federal Medical Assistance

Percentage (FMAP). Under federal rules, the state share must be public funds that are not federal funds. The non-federal public funds may come from three sources:

Category 1: Direct appropriations to the state Medicaid agency;
Category 2: Intergovernmental transfers (IGTs); or
Category 3: Certified public expenditures (CPEs).

Provider fees fall under Catetory 1 above. The provider fee program may be utilized by 19 different classes of health care services, including inpatient/outpatient hospital and nursing facility services. Fee programs produce revenues that flow into special funds and are then directly appropriated to the state Medicaid agency in order to draw down matching federal funds for Medicaid covered services.

In the past few years, states have increasingly relied on provider fee revenues to fund their Medicaid programs. This growth is a direct result of the downturn in state revenues during the last two recessions. Provider fees have served as the primary vehicle for maintaining and enhancing Medicaid funding during the last two recessions.

Federal regulations allow states to use revenue from provider fees to help fund Medicaid, as long as they satisfy the following requirements established by the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments (P.L. 102-234):

(1) They must be broad-based. In order to be considered broad-based, a provider fee must be imposed on all the health care items or services furnished by all the non-federal, non-public providers in the class in the state.

(2) They must be uniformly imposed. In general, a provider fee is uniformly imposed if it is the same amount or rate for each provider in the class.

(3) There is a hold harmless prohibition. A fee program may not hold providers harmless. A provider fee is considered to hold the provider harmless if the providers paying the fee receive a non-Medicaid payment from the state or any offset or waiver that guarantees to hold the provider harmless for the fee.

The Secretary of Health and Human Services is authorized to waive the broad-based and uniformity provisions, provided that a state can demonstrate through a quantitative statistical test that its fee program is generally redistributive in nature. This means that the increase in Medicaid reimbursements a provider would receive are not positively correlated to the amount of fees paid by the provider. Obtaining a waiver from CMS permits a state to exempt certain providers from the fee, or reduce their assessment amounts to reduce the financial impact on net contributors (i.e. fee paid is greater than the distribution earned).

In Hawaii a provider fee would increase Medicaid payments at a time when constraints on the State budget have forced a reduction in payments and benefits. The additional federal funds obtained via the fee program would reduce the amount of losses incurred by hospitals and long term care facilities. As such, the provider fee would help to preserve access to health care for the Medicaid population and to preserve our health care system.

This bill creates a provider fee for hospitals. Another bill being considered by the Legislature creates a separate provider fee for nursing facilities.

It should be noted that this bill is still in the process of being finalized. The model for the Hospital Sustainability Program is still being developed because the data required to design it is still being gathered. The data is expected shortly, and at that time the Healthcare Association of Hawaii will propose amendments to the bill. We would like to thank the Department of Human Services and the Hawaii Health Systems Corporation for working cooperatively with the Healthcare Association to complete the model.

Thank you for the opportunity to testify in support of HB 2275 HD 1.

HMSA

Blue Cross Blue Shield of Hawaii

An Independent Licensee of the Blue Cross and Blue Shield Association

February 27, 2012

The Honorable Marcus R. Oshiro, Chair
The Honorable Marilyn B. Lee, Vice Chair

House Committee on Finance

Re: HB 2275, HD1 – Relating to Hospitals

Dear Chair Oshiro, Vice Chair Lee and Members of the Committee:

The Hawaii Medical Service Association (HMSA) appreciates your allowing us to testify on HB 2275, HD1. HMSA understands and appreciates the intent of this legislation but has questions with the Bill as drafted, and we have an objection to two specific provisions in the Bill.

HB 2275, HD1 authorizes hospitals to charge a fee of up to 3 percent of "net patient service revenue," known as the Hospital Sustainability Fee. The revenue generated from this fee is to be transferred to the State Department of Human Services (DHS) for deposit into the Hospital Sustainability Special Fund (Fund). DHS is allowed to retain up to 5 percent of those deposits to pay for administrative overhead. And, no less than 95 percent of those deposits are to be used to match federal Medicaid funds to increase Medicaid hospital payments.

As drafted, the Bill seems to be only an outline of the concept of the Hospital Stabilization Program (Program), and it lacks specificity regarding how the Program will be administered and will operate such as:

- While revenues from the fee and federal funds are to be used for exclusive purposes, the Bill leaves open the possibility that other deposits into the Fund may not necessarily be held in trust and subject to purposes outside of the Program.
- How will expenditures from the Fund be made?
- What will be the role of the plans that implement the QUEST and QUEST Expanded Access contracts for MedQUEST?

While we understand the need for a State overhead charge to administer the Fund, we are concerned that the Bill does not acknowledge that this program also creates an administrative burden on the health plans. The fee structure should be drafted to also accommodate the additional administrative plan costs.

We do have an objection to two provisions in the Bill. The first authorizes a private entity to authorize an exemption from the fee. And, the second mandates QUEST and QUEST expanded access plans to provide reimbursement documentation to that private entity. The fee is a State mandated levy, and it would be irregular for a private entity to either alter the fee or exempt anyone from the levy. Furthermore, while we understand the need for plans to certify the appropriate use of funds to DHS, we would find it highly inappropriate for plans to be required to report and provide documentation to a private entity that represents the providers that receive payments from the Fund. Attached for your consideration is a suggested draft amendment to the offending sections of the Bill.

We truly understand and appreciate this innovative proposal to enhance the effectiveness of our state's Medicaid program. While we do have questions regarding the details behind this proposal, we look forward to working with this Committee and with everyone who have an interest in seeing such innovations proceed.

Thank you for allowing us to comment on this measure, and your consideration of our concerns is appreciated.

Sincerely,

Jennifer Diesman
Vice President
Government Relations

Attachment

Proposed Amendments to
HB 2275, HD1, Section 2, Page 8, Section ___-5(c)

§ -5 Hospital sustainability fee. (a) Effective July 1, 2012, the department shall charge and collect a provider fee on health care items or services provided by hospitals.

(b) The hospital sustainability fee shall be based on the net patient service revenue of all hospitals that are subject to the hospital sustainability fee.

(c) The hospital sustainability fee shall not exceed three per cent of net patient service revenue; provided that certain hospitals shall be exempted from the fee or pay a reduced fee, as determined by the department [~~and the Healthcare Association of Hawaii or its successor organization~~] within the broad-based and uniformity waiver requirements imposed by federal law.

Proposed Amendment to
HB 2275, HD1, Section 2, Page 11, Section ____-10(2)

§ -10 Enhanced rates to QUEST and QUEST Expanded Access plans. In accordance with Title 42 Code of Federal Regulations section 438, the department shall use revenue from the hospital sustainability fee and federal matching funds to enhance the capitated rates paid to the QUEST and QUEST expanded access plans for the subject fiscal year, consistent with the following objectives:

(1) The rate enhancement shall be used exclusively to increase hospital reimbursements to support the availability of hospital services and to ensure access for medicaid beneficiaries;

2) The rate enhancement shall be made part of the monthly capitated rates by the department to the QUEST and QUEST expanded access plans, which shall provide documentation to the department [~~and the Healthcare Association of Hawaii~~] certifying that funds received are used in accordance with this section;