STATE OF CONNECTICUT

OFFICE OF POLICY AND MANAGEMENT

TESTIMONY PRESENTED TO THE APPROPRIATIONS, FINANCE, REVENUE AND BONDING, HUMAN SERVICES AND PUBLIC HEALTH COMMITTEES
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Testimony Supporting Hospital Settlement Agreement and Implementing Legislation

AN ACT CONCERNING THE IMPLEMENTATION OF THE APPROVED SETTLEMENT AGREEMENT IN THE CONNECTICUT HOSPITAL ASSOCIATION ET AL. V. CONNECTICUT DEPARTMENT OF SOCIAL SERVICES ET AL.
AND MAKING APPROPRIATIONS THEREFOR

Good afternoon, honorable chairs, ranking members and distinguished members of the Appropriations, Finance, Revenue and Bonding, Human Services, and Public Health Committees, my name is Melissa McCaw and I am the Secretary of the Office of Policy and Management. I am very pleased to be before you this afternoon to discuss the recent settlement agreement for The Connecticut Hospital Association et al. v. Connecticut Department of Social Services et al. and other related legal claims and to outline the provisions of that agreement.

The legal claims filed by the Connecticut Hospital Association (CHA) and the hospitals challenged: (1) the validity of the first user fee on the hospitals and almost $1.7 billion in claims for refunds; and (2) the adequacy of Medicaid rates for inpatient and outpatient services and the request for retroactive rate increases to remedy the perceived inadequacies. If CHA and the hospitals were to have fully prevailed on their claims, the state would have faced substantial unbudgeted costs, potentially totaling multiple billions of dollars.

The Lamont administration came into office after a period of tension between the hospitals and the state. All of us, including legislators, have been impacted by the lack of resolution between the parties. It was unclear if our attempt to forge an agreement would be successful because there were many seemingly insurmountable issues that had to be worked through but, to protect the fiduciary interests of the taxpayers, it was important that we reset the relationship and work through the unresolved issues. To that end, I believe the agreement before you today is the best outcome for both the state and the hospitals because it avoids the risk, uncertainty and expense of ongoing litigation and provides predictable, stable revenues and expenditures through the term of the agreement. As the costs of the settlement exceed $2.5 million, legislative approval of the agreement is required pursuant to Conn. Gen. Stat. § 3-125a. Legislation is also required to implement pieces of the agreement.

My testimony (and PowerPoint presentation) will review the specifics of the agreement and you have on the Appropriations Committee's website the complete agreement with its seven exhibits, which provide additional information on the hospitals signing the agreement, the refunds to each hospital, rate increases, the proposed legislation, one-time payments, supplemental payments, and credit for performance if the state exercises its option to terminate the agreement. We have also provided a summary of the settlement agreement and the fact sheet that summarizes the implementing legislation. This settlement impacts both tax and Medicaid policies and therefore Commissioners Scott Jackson of Revenue Services and Deidre Gifford of Social Services and their very capable staff are here with me today to help answer any more detailed questions you may have.

Before describing the settlement agreement to you, I'd like to start by reviewing some background information and set some context regarding hospital user fees and Medicaid payments to hospitals. When I refer to hospitals in my testimony, I am referring to those included in the settlement agreement.

User Fees

The state's authority to levy health care-related taxes (or provider taxes) is regulated by the federal government; an impermissible tax can result in Medicaid matching funds being withheld by the federal Centers for Medicare and Medicaid Services (CMS). Revenue generated by provider taxes may be reinvested in the health care system to address uncompensated or undercompensated care. Thus, through the receipt of provider tax revenues, the state can make additional investments in health care activities for Medicaid clients which are then reimbursable under Medicaid – some as much as 90% for services provided to the Medicaid expansion population.

As I described previously, the hospitals challenged the first hospital user fee. This user fee, which was in effect from July 1, 2011 through June 30, 2017, was assessed at a total of $349.1 million annually from SFY 2012 through SFY 2015 and $556.1 million annually in SFYs 2016 and 2017. The second hospital user fee (enacted effective July 1, 2017) was assessed at $900 million per year for SFYs 2018 and 2019. All told, between SFYs 2012 and 2019, hospitals were assessed a total of over $4.3 billion in user fees.

In addition to the second hospital user fee, Connecticut currently has user fees on nursing homes and intermediate care facilities and a tax on ambulatory surgical centers. In total, health care provider taxes are expected to generate over $1.0 billion in revenue for Connecticut in FY 2020.

Medicaid Payments to Hospitals

In SFY 2019, Medicaid payments to hospitals totaled $2.396 billion, which included inpatient payments of $1.021 billion, outpatient payments of $881.2 million, and hospital supplemental payments of $493.3 million. Hospital payments represented 29.7% of the Medicaid account in SFY 2019 (excluding hospital supplemental payments, which are funded under a separate account), making payments to hospitals the largest portion of the Medicaid account by far for any provider type. As part of budget negotiations in 2017, the second hospital user fee was enacted at a level that was $343.9 million higher than the first hospital user fee. Total Medicaid payments to hospitals were budgeted to increase $553.9 million in both SFY 2018 and 2019, through a combination of increased supplemental payments, a 31.65% increase on the inpatient base rate, and

a 6.5% increase on most outpatient rates. Between the additional user fee revenue and the additional federal reimbursement generated by the higher Medicaid payments, the fees and payments improved the state's overall SFY 2019 balance by nearly $160 million.

Now I would like to walk through some of the specifics of the settlement agreement.

Overall

- The agreement spans seven years from SFYs 2020 through 2026.
- Once all the signatures, legislative processes, court filings and federal approvals have been achieved (described in greater detail later in the presentation), the hospitals will release all legal claims related to the first hospital user fee and Medicaid rate and supplemental payments.
- The agreement sets second hospital user fee levels and Medicaid rate and supplemental payments for the full term of the agreement.

Overview of Financial Terms

- The agreement gradually reduces the second hospital user fee from $900 million in SFY 2019 to $820 million in SFY 2026.
- Effective January 1st of each year, rate increases of 2.0% on inpatient rates and 2.2% on most outpatient rates will be implemented over the seven-year term of the agreement.
- Hospital supplemental payments will be increased from the $493.3 million expended in SFY 2019 to $548.3 million for SFYs 2020 and 2021 and to $568.3 million for SFYs 2022 through 2026.
- In addition, as part of the settlement agreement, $70.0 million in one-time user fee refunds and $9.3 million in one-time payments will be made.
- Adjustments are also made to the rate setting structure to ensure greater consistency over the term of the agreement. Specifically, the Medicare wage index values used to set most inpatient and outpatient rates are modified and held constant for the term of the agreement with mutually agreed-upon discount factors to be applied to offset the impact of these wage index values.

Settlement Funding

- For the current biennium, the settlement requires $180.7 million in resources set aside to assist with hospital negotiations ($160 million transferred from SFY 2019 and $20.7 million from unappropriated General Fund resources in SFY 2020, both available pursuant to section 50 of Public Act 19-117).
- Annual new state costs above the SFY 2019 baseline and the SFY 2020 enacted budget levels are detailed in the following chart:

SETTLEMENT AGREEMENT - FINANCIAL SUMMARY *(in millions)*

	Enacted		Settlement Agreement						
	SFY 2019	SFY 2020	SFY 2020	SFY 2021	SFY 2022	SFY 2023	SFY 2024	SFY 2025	SFY 2026
Hospital User Fee	$900.0	$900.0	$890.0	$882.0	$850.0	$850.0	$850.0	$850.0	$820.0
Supplemental Payments	493.3	453.3	548.3	548.3	568.3	568.3	568.3	568.3	568.3
Projection of Hospital Rate Increase	175.1	175.1	180.7	202.7	235.9	269.7	304.3	339.5	375.4
One-Time Payments to Certain Hospitals			9.3	-	-	-	-	-	-
User Fee Refunds			70.0	-	-	-	-	-	-
Net Hospital Position	($231.6)	($271.6)	($81.7)	($131.0)	($45.8)	($12.0)	$22.6	$57.8	$123.7

								Cumulative Total
State Impact (from SFY 2019)	($107.9)	($46.0)	($95.7)	($107.0)	($118.5)	($130.3)	($172.3)	($777.7)
Hospital Impact (from SFY 2019)	149.9	$100.6	185.8	219.6	254.2	289.4	355.3	1,554.8
State Impact (from SFY 2020 enacted budget)	($121.3)	($59.4)	($109.1)	($120.4)	($131.9)	($143.7)	($185.7)	($871.5)
Hospital Impact (from SFY 2020 enacted budget)	189.9	$140.6	225.8	259.6	294.2	329.4	395.3	1,834.8

- Medicaid payments to all hospitals totaled $2.396 billion in SFY 2019.
- Funding to cover state costs of $180.7 million in current biennium available pursuant to PA 19-117.
- Estimates above assume 66.6% federal reimbursement on hospital payments.
- Estimates above assume no enrollment/utilization increases after SFY 2021.

Non-Financial Taxation Terms

- For the term of the agreement, any new tax the state imposes – or any amendment to a tax – may not generate more than 15% of revenue from the hospitals.
- In addition, for the term of the agreement, the state may not enact any changes to tax exemptions currently enjoyed by the hospitals, including, but not limited to, applicable exemptions from municipal property taxes, corporation business tax, sales and use taxes, and motor vehicle fuels tax.

Non-Financial Medicaid Payment Terms

- For the term of the agreement, the current Medicaid payment methodology for hospitals cannot be reduced or restructured, except as specifically authorized under the agreement.
- This restriction applies to all Medicaid hospital payments – inpatient and outpatient rates and supplemental payment amounts and distribution methodologies.

Mitigating Unanticipated State Costs Due to Federal Actions

- The agreement includes provisions to protect the state's financial interests if there are unanticipated state costs due to federal actions that occur during the term of the agreement.
- Federal changes that could result in increased state costs during the term of the agreement could include one or more of the following:
  - Changes affecting the federal Upper Payment Limit (UPL), which prohibits federal reimbursement on certain state Medicaid payments above what Medicare would have paid for the same services;
  - Repeal, modification, or invalidation of the Affordable Care Act; or
  - Changes in federal Medicaid law regarding: provider payments, rules for states receiving federal financial participation (*i.e.*, federal match), or health care related taxes.
- The state can negotiate with hospitals for mutually-agreed upon adjustments at any level and at any time. If hospitals do not agree to adjustments, state costs could increase up to $50 million per year beyond costs assumed in the agreement.
- The state can seek to modify the agreement if federal compliance issues (as defined in the agreement) increase the state costs beyond projections, including the option to seek a court-

ordered modification if the state costs would increase by more than $50 million but less than or equal to $100 million in any SFY.
- The state can terminate the agreement if federal compliance issues increase the state costs by more than $100 million in any SFY. If the state terminates, the hospitals can reinstate their legal claims, reduced by a calculated percentage depending on when the termination occurs (Exhibit 7).

Value-Based Payments / Payment Reform
- Under the agreement, the state and the hospitals will work together to implement payment and care delivery strategies to improve Medicaid and Children's Health Insurance Program (CHIP) member outcomes and care experiences; improve coordination, quality, and efficiency of care; and reduce unnecessary utilization and costs.
- For the term of the agreement, DSS is prohibited from imposing mandatory downside risk of any kind on payments to the hospitals, including, but not limited to, penalties for expenditures above aggregate cost or utilization targets and quality withholds or penalties.
- Starting in SFY 2023, DSS may implement upside-only value-based payment initiatives with hospitals after consulting with them and CHA and complying with all applicable public and stakeholder engagement requirements.
- Hospitals may voluntarily choose to participate in any DSS payment reform initiative.

Required Legislative Changes
Our proposed legislation, which was negotiated with CHA and the hospitals, addresses the statutory and appropriation changes needed to comply with the settlement agreement. Specifically, the bill:
- Revises the second hospital user fee amounts and the base year;
- Delineates the taxation limitations on hospitals agreed to in the settlement;
- Waives the state's sovereign immunity and establishes the Superior court's jurisdiction to enforce the settlement agreement;
- Provides contingencies for the user fee, supplemental payments and rate increases promised the hospitals if federal approvals are not received;
- Updates the Medicaid hospital rate methodology and incorporates annual hospital rate increases;
- Updates Medicaid hospital supplemental payment total amounts; and
- Updates appropriations and revenue schedules.

Timing
There are two effective dates in the agreement that trigger significant events and activities per the agreement.
- The "First Effective Date" occurs after all of the following have been completed:
  - All parties have signed agreement;
  - The agreement has been approved or deemed approved by the General Assembly pursuant to Conn. Gen. Stat. § 3-125; and
  - Implementing legislation has been enacted by the General Assembly and signed by the Governor.
- As soon as possible after the First Effective Date, DSS will submit the necessary Medicaid state plan amendments and tax waiver to implement the entire term of the agreement.

- If the Centers for Medicare and Medicaid Services (CMS) approvals are denied or otherwise not received by June 30, 2020 (or later if agreed to by the parties), then the state and the hospitals will discuss. If the parties are unable to reach agreement, then the agreement will terminate automatically on July 30, 2020 (or other applicable date) unless the parties extend such timeframe by mutual agreement.

- The "Second Effective Date" occurs after all of the following have been completed:
    - The state has received all necessary federal approvals from CMS; and
    - The Superior Court has entered the agreement as an order of the Court.
- After the Second Effective Date:
    - DRS issues $70 million in user fee refunds and DSS makes $9.3 million in one-time payments.
    - The hospitals and CHA release all legal claims that were or could have been raised against the first or second hospital user fee and Medicaid hospital payments.

Enforcement

- For the term of the agreement, the Court retains jurisdiction to enforce the agreement and any party to the agreement can seek a court order to enforce the agreement.

I want to thank you for your time today and the opportunity to present testimony. I recognize that this is a lot of information to absorb and that there are many layers to the agreement. By working collaboratively with CHA and the hospitals these many months, I do believe the proposed agreement best positions the state going forward by avoiding the risk, uncertainty and expense of ongoing litigation and providing both the state and the hospitals with predictable, stable revenues and expenditures through the term of the agreement. I respectfully request that the legislature takes favorable action on the agreement and the implementing legislation and would be happy to answer any questions you may have.