

Legislative Update

Week of June 14, 2010



Representing California's Catholic
Health Systems and Hospitals

State Issues	Description
State Budget	<p>To no one's surprise, the Legislature missed the June 15th constitutional deadline to pass and submit a budget to the Governor. The Budget Conference Committee continued to meet this week, focusing on education and hearing more from the Legislative Analyst's Office on the state's revenues and spending. Today (Friday), the Committee hopes to get through the first pass through of the various budget issues that will need to be reconciled. Governor Schwarzenegger continues to insist that the budget package contain a \$1.2 billion reserve, as well as a budget and pension reform package. It has been reported that the Governor met this week with the four Democratic and Republican leaders from both the Senate and Assembly (the "Big 5").</p>
Hospital Provider Fee	<p>Last week, a representative from the Department of Health Care Services (DHCS) met with the Centers for Medicare & Medicaid Services (CMS) to discuss the additional package of information and analysis submitted to the federal agency that would demonstrate that the California hospital provider fee program satisfied all federal requirements including avoidance of any "hold harmless" provisions. In a follow up response, this week CMS sent a letter to DHCS (<i>attached</i>). As stated in the one-page letter, and outlined in the recommendations for changes, CMS continues to express concern that the proposed fee structure and payment methodologies are not consistent with the statutory hold harmless requirements. As stated in the letter, "These [hold harmless] requirements stipulate that permissible health care-related taxes may not have arrangements in which collected taxes are returned to the taxpayers directly or indirectly."</p> <p>In a memo to its members, the California Hospital Association indicated that it will be working with DHCS to address the remaining outstanding issues including: 1) further analysis on the fee-for-service supplemental payment methodologies; 2) addressing concerns related to the managed care supplemental pass-through payments; and 3) clarification on the use of funds to make direct grants to the designated public hospitals. Although the desire has been to negotiate an agreement with CMS that would preclude having to open the provisions under AB 1383 (the hospital provider fee statute), it appears that it may be unavoidable in order to make the necessary technical changes to obtain approval from CMS.</p>
Federal Issues	Description
"Extenders" Bill	<p>As of this writing, the Senate failed to garner the necessary votes to move forward the extenders bill that would, among other things, provide \$24 billion in federal assistance to states for their Medicaid programs (extending FMAP). Other key issues include an extension of a delay in the cuts in Medicare reimbursements to physicians, extension of unemployment benefits and extensions of COBRA subsidies for unemployed workers. Although the Senate Democratic leaders offered a "slimmed down" version of the original bill (after it failed earlier in the week), the approximately \$120 billion measure needed 60 votes to advance, but garnered only 56 votes, with all Republicans and Senators Lieberman (I-CT) and Nelson (D-NE) voting against it. And early on Thursday, the Republicans offered an alternative bill that would have extended unemployment benefits but eliminated the FMAP extension; but it failed on a vote of 41-57.</p>

For more information please contact Lori Dangberg at 1215 K Street, Suite 2000 ▪ Sacramento, CA 95814
 Direct line: 916.552.2633 or fax: 916.552.7652 ▪ e-mail: ldangberg@thealliance.net

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



Center for Medicaid, CHIP and Survey & Certification

Mr. Toby Douglas
Chief Deputy Director
Health Care Programs
1501 Capitol Avenue, Suite 4000
P.O. Box 997413
Sacramento, California 95814

JUN 16 2010

Dear Mr. Douglas:

Thank you for the information the State of California has submitted in response to the Center for Medicaid, CHIP and Survey & Certification's (CMCS) questions on the State's proposed hospital provider tax and implementing legislation. We also appreciate the meetings that were held in May and June to walk through the State's responses.

In order for CMS to render a final decision on the waiver request, California would need to submit the actual State plan reimbursement methodologies funded by the tax. However, based upon the information submitted, CMCS does not believe that the proposed tax structure and associated reimbursement methodologies are consistent with the statutory hold harmless requirements. These requirements stipulate that permissible health care-related taxes may not have arrangements in which collected taxes are returned to the taxpayers directly or indirectly.

Enclosed with this letter you will find our reiteration of those concerns as well as suggestions for changes to the taxing structure and reimbursement methodologies. We have discussed the issues identified in the enclosure internally including with our counsel. We believe these suggestions will help the State develop an approvable proposal and we are available to offer continued technical assistance on this matter.

Please let me know if you have any questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Dianne E. Heffron". The signature is fluid and cursive, with a large loop at the end.

Dianne E. Heffron
Director
Financial Management Group

Enclosure:

Recommendations for Changes to California Proposed Hospital Tax

Taxing Structure:

- The State has demonstrated that the current variable tax structure passes the linear regression described in regulation. We want to express our concern however that, given that the tax rate varies based on Medicaid days and supplemental payments must be based on Medicaid, it is more difficult to demonstrate in the payment context that the payments are not repaying tax liability. Ordinarily, a State would modify its tax structure, but the current legislation provides little flexibility for the State to modify the structure to meet the federal requirements for provider taxes.

Taxing Structures Other States Have Used Include:

- Varying the tax rate within hospitals based upon whether a day is FFS or managed care. One tax rate would be applied for all FFS days (Medicaid and commercial) and another tax rate would be applied for all managed care days (Medicaid and commercial).
- Impose a uniform rate for all taxpaying hospitals.
- Both options could still allow exclusion of certain providers entirely (specialty hospitals, governmental) and similar waivers have been approved in other States.

FFS Reimbursement Methodologies:

- The specific methodologies set forth in current legislation appear to us to return the taxes to the hospitals and thus to raise a hold harmless issue. State has little flexibility to modify reimbursement methods that appear to provide repayment of the tax. The State must demonstrate that the reimbursement methodologies are clearly linked to actual service delivery variations in targeted providers and that the payments target those relationships and not individual provider tax liabilities. The State has provided an aggregated cost analysis detailing all hospital costs (inpatient hospital, outpatient hospital and managed care) for Medicaid and uninsured, which while useful, does not fully explain the rationale for the differences between individual payment rates between hospitals. Further, this analysis relies on an overall assumption of justifying Medicaid payments by demonstrating unmet uninsured costs.
- Payment methodologies appear to target lower Medicaid utilized facilities (high acuity payment for certain hospitals that have Medicaid utilization between 41.1% and 5%, subacute low utilization payment for hospitals with Medicaid utilization between 5% and 26.1%, private hospitals being reimbursed 3 times per Medicaid day amount than the non-designated public hospitals). Unless the State can provide detailed analysis to demonstrate disparity of cost coverage between these facilities for these types of services and why it is necessary that they be reimbursed at higher per Medicaid amounts, the payments appear to create an inverse methodology that would allow the State to ensure

that lower utilization hospitals receive higher payments thus ensuring that the provider is made whole for the tax paid. Similar inverse payments which result in hospitals with a lower Medicaid utilization receiving a higher per Medicaid payment have been considered problematic in other States. The State must demonstrate for each individual payment methodology and individual facility why any disparity in the rates is warranted.

- Please explain the interaction of these supplemental payments and the Selected Provider Contracting Program. This program has relied on waivers of Federal regulatory requirements regarding rate setting, particularly public notice, freedom of choice and disclosure of State plan rates. These waivers have been provided to the State since the 90's based on the State's claims that the program provided greater efficiencies associated with payment negotiations similar to those that exist in commercial markets. We still do not understand that if this process has been as successful as it has remained in place for so many years, how the addition of significant supplemental payments doesn't undermine the theory and rationale for the program.
- The legislation appears to direct that supplemental Medicaid payments to designated public hospitals (those utilizing CPEs) would not have to count the supplement as Medicaid revenue. The State must follow CMS guidance regarding the use of CPEs to fund Medicaid payments. Such guidance requires that the cost incurred to a provider using CPEs account for all Medicaid payments for a service be included prior to the actual cost calculation and must be offset against that provider's ultimate cost for delivering the Medicaid service. States are not prevented from making such supplemental payments but the effect is to simply reduce the provider's cost incurred for a service by the amount of payment actually received for the service.
- The State has not provided a current upper payment limit demonstration to support the supplemental payments. This UPL must use the most recent available data and incorporate not only State plan spending but also the Safety Net Care Pool limit that was derived from the diversion of non-State government supplemental payments.

Managed Care Supplemental Payments:

- California proposes to fund supplemental payments to hospitals through managed care organizations. The legislation requires that the department make "enhanced payments to managed care health care plans exclusively for the purpose of making supplemental payments to hospitals". Further, the enhanced payments to MCO are "pass through enhanced payments to hospitals in a manner determined by the department."
- CMS contends that the supplemental payments authorized by the legislation are not part of the capitation rate. The legislation directs the department (State's agent) to control the amount and the recipient of the payments. Further the legislation directs the managed care company to make the payments to hospitals identified by the State within 30 days

and also indicates that the enhanced amounts should not be considered part of the capitation (no reductions to current contract rates or consideration in developing medical loss percentages). Plans can be penalized by reducing their administrative portion of the premium or the premium itself if the plan earns interest on the supplement payments from the State or fails to follow the State payment notice once the enhanced payments is received. CMS contends that this cannot be considered part of the capitated rate in a risk model. Instead, the payments are controlled by the State and therefore violate 438.60 which precludes the State from making direct payments to providers for services included in the capitation rate.

- Actuarially certified rates have not been provided to support the managed care supplements described in the legislation. Mercer provided two letters presenting information to support a process to incorporate the rates. Concerns regarding these documents are listed below.
 - AAA practice note which allows premiums to include, "...any state-mandated assessments and taxes..." as a reasonable cost. However, AB1383 does not include and MCO assessment or tax. Indeed, an MCO tax is already included in the rates calculated for the MCO. The CA law mandates targeted hospital supplemental payments that MCOs are required to make in order to participate in Medicaid managed care. It is not a reasonable to consider these payments as an assessment.
 - Mercer states that the supplemental payments by Medi-Cal fee for service and MCO are legitimate costs of business, however, the MCOs will not see these payments as part of their rates. Instead, the MCO would merely act as a conduit, receiving a check from the State with a list of particularly hospitals for which the check must fund direct payments. The FFS payments in this case would not increase rates.
 - The payments appear to be calculated based on historical data (2008-2009 managed care days in most cases) and thus not even paid for services delivered during the contract period for which the rate would be certified. This further suggests that the payment is not for services provided under the contract.
 - The State does not incorporate the payments into the actual premiums paid to the MCO; the state provides the funding via "supplements" indicating which particular hospitals qualify for the increased payment and how much qualifying hospitals receive. Normally, MCO determine how they utilize increased premiums, in this case, the State dictates the payment amounts and prohibits the MCO from reducing current hospital payment arrangements.
 - Both letters focus on treating the AG 1383 as an "aggregate" increase in cost. However, you cannot treat this as an aggregate since the MCO has no authority to pay the increase for anything other than inpatient days. MCOs cannot use the payments in the aggregate nor do the enhanced payments affect all contracted hospitals equally. The demographic analysis including all maternity, care outside

hospitals, FQHC wrap-around, general acuity within a comprehensive benefit package is inappropriate to the analysis since the increase cannot be applied to any of these costs.

Miscellaneous Provisions:

There are several provisions in the legislation that raise questions about consistency with federal regulations. They are listed as follows:

- Defines managed mental health plan days as distinct from managed care days though the payment mechanisms for mental health plans are similar to those in the managed care supplemental section. The Department will calculate amounts due and pass those supplements through the managed mental health plans. Are these plans managed care PIHPs or PAHPs at risk for mental health days? If so, are the rates actuarially sound? If not, why are they not considered FFS days subject to the UPL? Why would managed mental health plans be paid an administrative fee to make the supplemental payments in the legislation?
- The legislation describes grants available to designated public hospitals of \$310 million per year (not subject to federal match) however, the legislation goes on to say that grant amounts will be reduced by a percentage equal to that of the months that UPL payments are supported for private hospitals. Please explain the linkage between the grants, and reductions based on reduced supplemental payments to private hospitals and what happens to the funding that was not paid to in a grant because of a reduction.
- Please explain language in legislation related to interaction of payments to OBRA '93 limits. CMS has no authority to waive these statutorily limits.
- The legislation directs that any revenue collected by the fee which cannot be used to support payments under the law shall be returned to the hospitals making the payments on a pro rata basis. Such a return could impact the linear regression model since hospitals may not have paid the fee in the manner assumed within the model. How will the state reconcile the returned amounts with the waiver test?

Alternatives:

Suggest more uniform supplements to taxpaying hospitals that do not vary based upon Medicaid utilization. Most other States have used across the board supplements per Medicaid day which directly relate to actual Medicaid utilization within facility. The State could mirror all payments similar to how the outpatient add-on is structured, which is just a fixed percentage based upon the hospital's 2007 Medicaid outpatient reimbursement.

Other examples could include analyzing different cost centers within hospitals and narrowing supplements according to those cost centers or different types of days – such as trauma, neo-natal intensive care, ER care. Payments could be based upon geographic variations to rectify historical disparities in Medicaid payment rates.

Along with any changes that may be made in the State statute, we would also recommend a greater degree of flexibility be given to the State Medicaid Agency to make further changes if necessary. Most waivers submitted to fund new supplemental payment methodologies require some level of modifications within the State plan methodologies themselves. Statutory language that has very little room for change is not conducive to making modifications that allow the State to achieve an approvable methodology.