Bill as Introduced

SB 165-FN – AS INTRODUCED

2011 SESSION

11-1045
01/03

SENATE BILL ***165-FN***

AN ACT relative to the Medicaid uncompensated care fund and the Medicaid enhancement tax.

SPONSORS: Sen. Odell, Dist 8; Sen. Morse, Dist 22; Sen. Larsen, Dist 15; Sen. Lambert, Dist 13; Sen. Bradley, Dist 3

COMMITTEE: Finance

ANALYSIS

This bill removes rehabilitation hospitals from the uncompensated care fund and clarifies the application of the Medicaid enhancement tax.

- -

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

SB 165-FN – AS INTRODUCED

11-1045
01/03

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Eleven

AN ACT relative to the Medicaid uncompensated care fund and the Medicaid enhancement tax.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 1 Statement of Purpose. The general court hereby finds that the health and well-being of the
2 people of this state is dependent on the availability and accessibility of health care services and the
3 viability of health institutions while maintaining and improving health care quality. The general
4 court notes that federal Medicaid law recognizes that additional resources are necessary to support
5 the financial stability of safety net providers for uninsured and Medicaid recipients. Therefore, the
6 general court hereby creates a Medicaid disproportionate share plan and revenue methodology that
7 are in compliance with federal regulations, that provides more resources for those hospitals that
8 serve more uninsured and Medicaid patients, and that minimizes, to the greatest extent possible, the
9 impact on individual hospitals.
10 2 Uncompensated Care Fund; Definitions. Amend RSA 167:63, IV to read as follows:
11 IV. "Hospital" means general hospitals [~~and special hospitals for rehabilitation~~] required to
12 be licensed under RSA 151 and receiving Medicaid diagnosis related group (DRG) payments, but not
13 including government facilities ***and specialty hospitals***.
14 3 Uncompensated Care Fund; Rehabilitation Hospitals Deleted. Amend RSA 167:64, I(d) to
15 read as follows:
16 (d) The commissioner may provide reimbursement for uncompensated care costs in
17 accordance with the approved schedule of payments through either Medicaid fee for service rate
18 adjustments or disproportionate share hospital payment adjustments, or a combination thereof.
19 Funds available under this section shall be first allocated to ensure that critical access hospitals [~~and~~
20 ~~rehabilitation hospitals~~] receive reimbursement for reported uncompensated care costs at the rate of
21 100 percent of the individual hospital limit for disproportionate share payments as determined by
22 the commissioner consistent with the provisions of 42 U.S.C. section 1396r-4(g). Non-critical access
23 hospitals shall receive reimbursement at the highest uniform percentage of each hospital limit as the
24 funds made available under this section permit. The commissioner may create additional categories
25 of need and make further reasonable distinctions among hospitals when determining the
26 methodology for payments under this section, as necessary, to ensure that no hospital is unduly
27 burdened by the fiscal effect of uncompensated care costs.
28 4 Uncompensated Care Fund; Duties of Commissioner. Amend RSA 167:65, II to read as
29 follows:

II. Seek input from the chairman of the senate health and human services committee, the chairman of the house health, human services and elderly affairs committee, the chairmen of the house and senate finance committees, the insurance department, and representatives of hospitals currently participating in the uncompensated care program in developing the uncompensated care payment system required under paragraph I, and present a report ***not later than June 1, 2011 and annually thereafter,*** detailing all the options and making recommendations to the oversight committee on health and human services, established under RSA 126-A:13[~~, not later than January 1, 2010~~].

5 Medicaid Enhancement Tax. Amend RSA 84-A:1, III-IV-a to read as follows:

III. "Hospital" means general hospitals [~~and special hospitals for rehabilitation~~] required to be licensed under RSA 151 and receiving medicaid diagnosis related group (DRG) payments, but not including government facilities ***and specialty hospitals***.

IV. "Medicaid enhancement tax" means the tax imposed upon net patient services revenue pursuant to this chapter.

IV-a. "Net patient services revenue" means the gross charges of the hospital ***and shall be limited to the inpatient and outpatient hospital classes of health care services consistent with the requirements of 42 C.F.R. section 433.56,*** less any deducted amounts for [~~bad debts,~~] charity care[~~,~~] and payor discounts.

6 Repeal. RSA 84-A:3, I and II, relative to the Medicaid enhancement tax as it was applied in 1991-1992, is repealed.

7 Effective Date. This act shall take effect July 1, 2011.

LBAO
11-1045
02/10/11

SB 165-FN - FISCAL NOTE

AN ACT relative to the Medicaid uncompensated care fund and the Medicaid enhancement tax.

FISCAL IMPACT:

The Office of Legislative Budget Assistant is unable to complete a fiscal note for this bill as it is awaiting information from the Department of Revenue Administration. When completed, the fiscal note will be forwarded to the Senate Clerk's Office.

SB 165-FN - AS AMENDED BY THE SENATE

03/30/11 1179s

2011 SESSION

11-1045
01/03

SENATE BILL ***165-FN***

AN ACT relative to the Medicaid uncompensated care fund and the Medicaid enhancement tax.

SPONSORS: Sen. Odell, Dist 8; Sen. Morse, Dist 22; Sen. Larsen, Dist 15; Sen. Lambert, Dist 13; Sen. Bradley, Dist 3

COMMITTEE: Finance

AMENDED ANALYSIS

This bill allows exclusion of rehabilitation hospitals by federal waiver from the uncompensated care fund and clarifies the application of the Medicaid enhancement tax.

- -

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

SB 165-FN – AS AMENDED BY THE SENATE

03/30/11 1179s

11-1045
01/03

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Eleven

AN ACT relative to the Medicaid uncompensated care fund and the Medicaid enhancement tax.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 Statement of Purpose. The general court hereby finds that the health and well-being of the people of this state is dependent on the availability and accessibility of health care services and the viability of health institutions while maintaining and improving health care quality. The general court notes that federal Medicaid law recognizes that additional resources are necessary to support the financial stability of safety net providers for uninsured and Medicaid recipients. Therefore, the general court hereby creates a Medicaid disproportionate share plan and revenue methodology that are in compliance with federal regulations, that provides more resources for those hospitals that serve more uninsured and Medicaid patients, and that minimizes, to the greatest extent possible, the impact on individual hospitals.

2 Uncompensated Care Fund; Definitions. Amend RSA 167:63, IV to read as follows:

IV. "Hospital" means general hospitals and special hospitals for rehabilitation required to be licensed under RSA 151 [~~and receiving medicaid diagnosis related group (DRG) payments~~], but not including government facilities ***and hospitals excluded from taxation under RSA 84-A pursuant to federal approval of a waiver of the broad-based requirement as described in 42 C.F.R. section 433.68***.

3 Uncompensated Care Fund; Rehabilitation Hospitals Deleted. Amend RSA 167:64, I(d) to read as follows:

(d) The commissioner may provide reimbursement for uncompensated care costs in accordance with the approved schedule of payments through either Medicaid fee for service rate adjustments or disproportionate share hospital payment adjustments, or a combination thereof. Funds available under this section shall be [~~first~~] allocated to ensure that critical access hospitals [~~and rehabilitation hospitals~~] receive reimbursement for reported uncompensated care costs at the rate of 100 percent of the individual hospital limit for disproportionate share payments as determined by the commissioner consistent with the provisions of 42 U.S.C. section 1396r-4(g). Non-critical access hospitals shall receive reimbursement at the highest uniform percentage of each hospital limit as the funds made available under this section permit. The commissioner may create additional categories of need and make further reasonable distinctions among hospitals when determining the methodology for payments under this section, as necessary, to ensure that no hospital is unduly burdened by the fiscal effect of uncompensated care costs.

4 Uncompensated Care Fund; Duties of Commissioner. Amend RSA 167:65, II to read as follows:

II. Seek input from [~~the chairman of~~] the senate health and human services committee, [~~the chairman of~~] the house health, human services and elderly affairs committee, [~~the chairmen of~~] the house and senate finance committees, [~~the insurance department,~~] and [~~representatives of~~] ***the*** hospitals currently participating in the uncompensated care program [~~in developing~~] ***during the development of*** the uncompensated care payment system required under paragraph I, and present a report [~~detailing all the options and making recommendations~~] ***describing the planned payment methodology*** to the oversight committee on health and human services, established under RSA 126-A:13[~~, not later than January 1, 2010~~] ***prior to payments being made***.

II-a. Submit a waiver calculation pursuant to the process outlined in 42 C.F.R. section 433.68 for the purpose of waiving RSA 84-A, Medicaid enhancement tax liability for Hampstead hospital, Healthsouth Rehabilitation hospital, Northeast Rehabilitation hospital, and New Hampshire hospital, no later than September 30, 2011.

5 Medicaid Enhancement Tax. Amend RSA 84-A:1, III to read as follows:

III. "Hospital" means general hospitals and special hospitals for rehabilitation ***that provide inpatient and outpatient hospital classes of health care services consistent with the requirements of 42 C.F.R. section 433.56 and the Medicaid state plan definitions of inpatient hospital and outpatient hospital services,*** required to be licensed under RSA 151 [~~and receiving medicaid diagnosis related group (DRG) payments~~], but not including government facilities ***and hospitals excluded from taxation under this chapter pursuant to federal approval of a waiver of the broad-based requirement as described in 42 C.F.R. section 433.68***.

6 Repeal. RSA 84-A:3, I and II, relative to the Medicaid enhancement tax as it was applied in 1991-1992, is repealed.

7 Effective Date. This act shall take effect July 1, 2011.

LBAO
11-1045
Amended 04/20/11

SB 165-FN - FISCAL NOTE

AN ACT relative to the Medicaid uncompensated care fund and the Medicaid enhancement tax.

FISCAL IMPACT:

The Department of Health and Human Services estimates this bill, **as amended by the Senate (Amendment #2011-1179s)**, will reduce state restricted revenue by $5,948,640 in FY 2012, $6,424,531 in FY 2013, $6,938,493 in FY 2014, and $7,493,573 in FY 2015. State unrestricted revenue would decrease by $1,982,880, in FY 2012, $2,141,510 in FY 2013, $2,312,831 in FY 2014, and $2,497,858 in FY 2015. State expenditures will decrease by $3,965,760 in FY 2012, $4,283,021 in FY 2013, $4,625,662 in FY 2014, and $4,995,715 in FY 2015. There will be no fiscal impact on county and local revenue and expenditures.

METHODOLOGY:

The Department of Health and Human Services states this bill removes rehabilitation hospitals from the definition of hospitals subject to the Medicaid Enhancement Tax (MET) and entitled to Disproportionate Share Hospital (DSH) payments for uncompensated care. The Department indicated New Hampshire has two rehabilitation hospitals that had a combined Medicaid Enhancement tax liability of $3.4 million in FY 2010. Based on the current law, $1.7 million of the MET tax revenue is deposited into the state general fund and $1.7 million is matched with an additional $1.7 million of federal Medicaid revenue providing $3.4 million for uncompensated care payments to hospitals. The rehabilitation hospitals were entitled receive DSH payments totaling $1.8 million for uncompensated care in FY 2010. In past years, these facilities have not paid the total MET, but instead were able to negotiate their tax payments down to equal the DSH payments they receive for uncompensated care. This analysis assumes the hospitals would pay the full tax and receive payments equal to their uncompensated care. The Department states removal of the rehabilitation hospitals from the tax will impact the state general fund and the remaining hospitals entitled to receive a DSH payment for uncompensated care. Removal of Hampstead Hospital and the New Hampshire Hospital will have no impact since neither has contributed to the MET or collected payments under this program. The Department states the removal of the bad debts deduction from the calculation of Net Patient Services Revenue is consistent with federal law and assumes it will not result in a significant fiscal impact. The Department assumes an 8% growth in net patient revenue in

each year, but does not assume any growth in uncompensated care provided by the rehabilitation hospitals. Based on these assumptions the Department estimates the following fiscal impact:

	FY 2012	FY 2013	FY 2014	FY 2015
Reduction in MET revenue from rehabilitation hospitals	($3,965,760)	($4,283,021)	($4,625,662)	($4,995,715)
Reduction in federal revenue that was matched by one-half of the MET	($1,982,880)	($2,141,510)	($2,312,831)	($2,497,858)
Reduction in unrestricted revenue to the general fund (one-half of the MET)	($1,982,880)	($2,141,510)	($2,312,831)	($2,497,858)
Reduction in Uncompensated Care Payments to Hospitals	($3,965,760)	($4,283,021)	($4,625,662)	($4,995,715)

The Department of Revenue Administration states this bill will decrease state revenue by an indeterminable amount. The Department is not able to disclose the decrease in revenue that would result from exempting the special hospitals for rehabilitation from the Medicaid Enhancement Tax. The Department assumes it can administer the provisions of this bill without additional resources.

LBAO
11-1045
Amended 04/20/11

SB 165 FISCAL NOTE

AN ACT relative to the Medicaid uncompensated care fund and the Medicaid enhancement tax.

FISCAL IMPACT:

The Department of Health and Human Services estimates this bill, **as amended by the Senate (Amendment #2011-1179s)**, will reduce state restricted revenue by $5,948,640 in FY 2012, $6,424,531 in FY 2013, $6,938,493 in FY 2014, and $7,493,573 in FY 2015. State unrestricted revenue would decrease by $1,982,880, in FY 2012, $2,141,510 in FY 2013, $2,312,831 in FY 2014, and $2,497,858 in FY 2015. State expenditures will decrease by $3,965,760 in FY 2012, $4,283,021 in FY 2013, $4,625,662 in FY 2014, and $4,995,715 in FY 2015. There will be no fiscal impact on county and local revenue and expenditures.

METHODOLOGY:

The Department of Health and Human Services states this bill removes rehabilitation hospitals from the definition of hospitals subject to the Medicaid Enhancement Tax (MET) and entitled to Disproportionate Share Hospital (DSH) payments for uncompensated care. The Department indicated New Hampshire has two rehabilitation hospitals that had a combined Medicaid Enhancement tax liability of $3.4 million in FY 2010. Based on the current law, $1.7 million of the MET tax revenue is deposited into the state general fund and $1.7 million is matched with an additional $1.7 million of federal Medicaid revenue providing $3.4 million for uncompensated care payments to hospitals. The rehabilitation hospitals were entitled receive DSH payments totaling $1.8 million for uncompensated care in FY 2010. In past years, these facilities have not paid the total MET, but instead were able to negotiate their tax payments down to equal the DSH payments they receive for uncompensated care. This analysis assumes the hospitals would pay the full tax and receive payments equal to their uncompensated care. The Department states removal of the rehabilitation hospitals from the tax will impact the state general fund and the remaining hospitals entitled to receive a DSH payment for uncompensated care. Removal of Hampstead Hospital and the New Hampshire Hospital will have no impact since neither has contributed to the MET or collected payments under this program. The Department states the removal of the bad debts deduction from the calculation of Net Patient Services Revenue is consistent with federal law and assumes it will not result in a significant fiscal impact. The Department assumes an 8% growth in net patient revenue in each year, but does not assume any growth in uncompensated care provided by the rehabilitation hospitals. Based on these assumptions the Department estimates the following fiscal impact:

	FY 2012	FY 2013	FY 2014	FY 2015
Reduction in MET revenue from rehabilitation hospitals	($3,965,760)	($4,283,021)	($4,625,662)	($4,995,715)
Reduction in federal revenue that was matched by one-half of the MET	($1,982,880)	($2,141,510)	($2,312,831)	($2,497,858)
Reduction in unrestricted revenue to the general fund (one-half of the MET)	($1,982,880)	($2,141,510)	($2,312,831)	($2,497,858)
Reduction in Uncompensated Care Payments to Hospitals	($3,965,760)	($4,283,021)	($4,625,662)	($4,995,715)

The Department of Revenue Administration states this bill will decrease state revenue by an indeterminable amount. The Department is not able to disclose the decrease in revenue that would result from exempting the special hospitals for rehabilitation from the Medicaid Enhancement Tax. The Department assumes it can administer the provisions of this bill without additional resources.

Amendments

Senate Finance
March 17, 2011
2011-0998s
01/09

IF this amendment is adopted by the Committee, please deliver to the House Clerk (Room 317) or Senate Clerk (Senate Chamber), the 2 originals and 2 copies.

Amendment to SB 165-FN

1 Amend the bill by replacing section 4 with the following:

2

3 4 Uncompensated Care Fund; Duties of Commissioner. Amend RSA 167:65, II to read as
4 follows:

5 II. Seek input from the [~~chairman of the~~] senate health and human services committee, the
6 [~~chairman of the~~] house health, human services and elderly affairs committee, the [~~chairmen of the~~]
7 house and senate finance committees, [~~the insurance department~~] ***the department of revenue***
8 ***administration,*** and [~~representatives of~~] ***the*** hospitals currently participating in the
9 uncompensated care program [~~in developing~~] ***during the development of*** the uncompensated care
10 payment system required under paragraph I, and present a report [~~detailing all the options and~~
11 ~~making recommendations~~] ***describing the planned payment methodology*** to the oversight
12 committee on health and human services, established under RSA 126-A:13, [~~not later than January~~
13 ~~1, 2010~~] ***prior to the payments being made.***

14

15 Amend RSA 84-A:1, IV-a as inserted by section 5 of the bill by replacing it with the following:

16

17 IV-a. "Net patient services revenue" means the gross charges of the hospital ***and shall be***
18 ***limited to the inpatient and outpatient hospital classes of health care services consistent***
19 ***with the requirements of 42 C.F.R. section 433.56, and consistent with the federal and state***
20 ***definition under the approved state plan of an inpatient hospital service or outpatient***
21 ***hospital service,*** less any deducted amounts for [~~bad debts,~~] charity care[~~,~~] and payor discounts.

Senate Finance
March 17, 2011
2011-0998s
01/09

Amendment to SB 165-FN

Amend the bill by replacing section 4 with the following:

4 Uncompensated Care Fund; Duties of Commissioner. Amend RSA 167:65, II to read as follows:

II. Seek input from the [~~chairman of the~~] senate health and human services committee, the [~~chairman of the~~] house health, human services and elderly affairs committee, the [~~chairmen of the~~] house and senate finance committees, [~~the insurance department~~] ***the department of revenue administration***, and [~~representatives of~~] ***the*** hospitals currently participating in the uncompensated care program [~~in developing~~] ***during the development of*** the uncompensated care payment system required under paragraph I, and present a report [~~detailing all the options and making recommendations~~] ***describing the planned payment methodology*** to the oversight committee on health and human services, established under RSA 126-A:13, [~~not later than January 1, 2010~~] ***prior to the payments being made***.

Amend RSA 84-A:1, IV-a as inserted by section 5 of the bill by replacing it with the following:

IV-a. "Net patient services revenue" means the gross charges of the hospital ***and shall be limited to the inpatient and outpatient hospital classes of health care services consistent with the requirements of 42 C.F.R. section 433.56, and consistent with the federal and state definition under the approved state plan of an inpatient hospital service or outpatient hospital service,*** less any deducted amounts for [~~bad debts,~~] charity care[~~,~~] and payor discounts.

Senate Finance
March 17, 2011
2011-0998s
01/09

Amendment to SB 165-FN

Amend the bill by replacing section 4 with the following:

4 Uncompensated Care Fund; Duties of Commissioner. Amend RSA 167:65, II to read as follows:

II. Seek input from the [~~chairman of the~~] senate health and human services committee, the [~~chairman of the~~] house health, human services and elderly affairs committee, the [~~chairmen of the~~] house and senate finance committees, [~~the insurance department~~] ***the department of revenue administration***, and [~~representatives of~~] ***the*** hospitals currently participating in the uncompensated care program [~~in developing~~] ***during the development of*** the uncompensated care payment system required under paragraph I, and present a report [~~detailing all the options and making recommendations~~] ***describing the planned payment methodology*** to the oversight committee on health and human services, established under RSA 126-A:13, [~~not later than January 1, 2010~~] ***prior to the payments being made.***

Amend RSA 84-A:1, IV-a as inserted by section 5 of the bill by replacing it with the following:

IV-a. "Net patient services revenue" means the gross charges of the hospital ***and shall be limited to the inpatient and outpatient hospital classes of health care services consistent with the requirements of 42 C.F.R. section 433.56, and consistent with the federal and state definition under the approved state plan of an inpatient hospital service or outpatient hospital service,*** less any deducted amounts for [~~bad debts,~~] charity care[~~,~~] and payor discounts.

IF this amendment is adopted by the Committee, please deliver to the House Clerk (Room 317) or Senate Clerk (Senate Chamber), the 2 originals and 2 copies.

Sen. Odell, Dist. 8
March 23, 2011
2011-1160s
01/10

Amendment to SB 165-FN

1 Amend the bill by replacing sections 2 -5 with the following:
2
3 2 Uncompensated Care Fund; Definitions. Amend RSA 167:63, IV to read as follows:
4 IV. "Hospital" means general hospitals and special hospitals for rehabilitation required to be
5 licensed under RSA 151 [~~and receiving medicaid diagnosis related group (DRG) payments~~], but not
6 including government facilities ***and hospitals excluded from taxation under RSA 84-A***
7 ***pursuant to federal approval of a waiver of the broad-based requirement as described in 42***
8 ***C.F.R. section 433.68.***
9 3 Uncompensated Care Fund; Rehabilitation Hospitals Deleted. Amend RSA 167:64, I(d) to
10 read as follows:
11 (d) The commissioner may provide reimbursement for uncompensated care costs in
12 accordance with the approved schedule of payments through either Medicaid fee for service rate
13 adjustments or disproportionate share hospital payment adjustments, or a combination thereof.
14 Funds available under this section shall be [~~first~~] allocated to ensure that critical access hospitals
15 [~~and rehabilitation hospitals~~] receive reimbursement for reported uncompensated care costs at the
16 rate of 100 percent of the individual hospital limit for disproportionate share payments as
17 determined by the commissioner consistent with the provisions of 42 U.S.C. section 1396r-4(g). Non-
18 critical access hospitals shall receive reimbursement at the highest uniform percentage of each
19 hospital limit as the funds made available under this section permit. The commissioner may create
20 additional categories of need and make further reasonable distinctions among hospitals when
21 determining the methodology for payments under this section, as necessary, to ensure that no
22 hospital is unduly burdened by the fiscal effect of uncompensated care costs.
23 4 Uncompensated Care Fund; Duties of Commissioner. Amend RSA 167:65, II to read as
24 follows:
25 II. Seek input from [~~the chairman of~~] the senate health and human services committee, [~~the~~
26 ~~chairman of~~] the house health, human services and elderly affairs committee, [~~the chairmen of~~] the
27 house and senate finance committees, [~~the insurance department~~], and [~~representatives of~~] ***the***
28 hospitals currently participating in the uncompensated care program [~~in developing~~] ***during the***
29 ***development of*** the uncompensated care payment system required under paragraph I, and present
30 a report [~~detailing all the options and making recommendations~~] ***describing the planned payment***
31 ***methodology*** to the oversight committee on health and human services, established under RSA 126-
32 A:13[~~, not later than January 1, 2010~~] ***prior to payments being made.***

II-a. Submit a waiver calculation pursuant to the process outlined in 42 C.F.R. section 433.68 for the purpose of waiving RSA 84-A, Medicaid enhancement tax liability for Hampstead hospital, HealthSouth, Northeast Rehabilitation, and New Hampshire hospital, no later than September 30, 2011.

5 Medicaid Enhancement Tax. Amend RSA 84-A:1, III-IV-a to read as follows:

III. "Hospital" means general hospitals and special hospitals for rehabilitation required to be licensed under RSA 151 [~~and receiving medicaid diagnosis related group (DRG) payments~~], but not including government facilities ***and hospitals excluded from taxation under this chapter pursuant to federal approval of a waiver of the broad-based requirement as described in 42 C.F.R. section 433.68.***

IV. "Medicaid enhancement tax" means the tax imposed upon net patient services revenue pursuant to this chapter.

IV-a. "Net patient services revenue" means the gross charges of the hospital ***limited to the inpatient and outpatient hospital classes of health care services consistent with the requirements of 42 C.F.R. section 433.56 and the Medicaid state plan definitions of inpatient and outpatient services,*** less any deducted amounts for bad debts, charity care, and payor discounts.

2011-1160s

AMENDED ANALYSIS

This bill allows exclusion of rehabilitation hospitals by federal waiver from the uncompensated care fund and clarifies the application of the Medicaid enhancement tax.

Sen. Odell, Dist. 8
March 23, 2011
2011-1160s
01/10

Amendment to SB 165-FN

1 Amend the bill by replacing sections 2 -5 with the following:

2

3 2 Uncompensated Care Fund; Definitions. Amend RSA 167:63, IV to read as follows:

4 IV. "Hospital" means general hospitals and special hospitals for rehabilitation required to be
5 licensed under RSA 151 [~~and receiving medicaid diagnosis related group (DRG) payments~~], but not
6 including government facilities ***and hospitals excluded from taxation under RSA 84-A***
7 ***pursuant to federal approval of a waiver of the broad-based requirement as described in 42***
8 ***C.F.R. section 433.68.***

9 3 Uncompensated Care Fund; Rehabilitation Hospitals Deleted. Amend RSA 167:64, I(d) to
10 read as follows:

11 (d) The commissioner may provide reimbursement for uncompensated care costs in
12 accordance with the approved schedule of payments through either Medicaid fee for service rate
13 adjustments or disproportionate share hospital payment adjustments, or a combination thereof.
14 Funds available under this section shall be [~~first~~] allocated to ensure that critical access hospitals
15 [~~and rehabilitation hospitals~~] receive reimbursement for reported uncompensated care costs at the
16 rate of 100 percent of the individual hospital limit for disproportionate share payments as
17 determined by the commissioner consistent with the provisions of 42 U.S.C. section 1396r-4(g). Non-
18 critical access hospitals shall receive reimbursement at the highest uniform percentage of each
19 hospital limit as the funds made available under this section permit. The commissioner may create
20 additional categories of need and make further reasonable distinctions among hospitals when
21 determining the methodology for payments under this section, as necessary, to ensure that no
22 hospital is unduly burdened by the fiscal effect of uncompensated care costs.

23 4 Uncompensated Care Fund; Duties of Commissioner. Amend RSA 167:65, II to read as
24 follows:

25 II. Seek input from [~~the chairman of~~] the senate health and human services committee, [~~the~~
26 ~~chairman of~~] the house health, human services and elderly affairs committee, [~~the chairmen of~~] the
27 house and senate finance committees, [~~the insurance department~~], and [~~representatives of~~] ***the***
28 hospitals currently participating in the uncompensated care program [~~in developing~~] ***during the***
29 ***development of*** the uncompensated care payment system required under paragraph I, and present
30 a report [~~detailing all the options and making recommendations~~] ***describing the planned payment***
31 ***methodology*** to the oversight committee on health and human services, established under RSA 126-
32 A:13[~~, not later than January 1, 2010~~] ***prior to payments being made.***

1 ***II-a. Submit a waiver calculation pursuant to the process outlined in 42 C.F.R.***
2 ***section 433.68 for the purpose of waiving RSA 84-A, Medicaid enhancement tax liability for***
3 ***Hampstead hospital, HealthSouth, Northeast Rehabilitation, and New Hampshire***
4 ***hospital, no later than September 30, 2011.***

5 5 Medicaid Enhancement Tax. Amend RSA 84-A:1, III-IV-a to read as follows:

6 III. "Hospital" means general hospitals and special hospitals for rehabilitation required to be
7 licensed under RSA 151 [~~and receiving medicaid diagnosis related group (DRG) payments~~], but not
8 including government facilities ***and hospitals excluded from taxation under this chapter***
9 ***pursuant to federal approval of a waiver of the broad-based requirement as described in 42***
10 ***C.F.R. section 433.68.***

11 IV. "Medicaid enhancement tax" means the tax imposed upon net patient services revenue
12 pursuant to this chapter.

13 IV-a. "Net patient services revenue" means the gross charges of the hospital ***limited to the***
14 ***inpatient and outpatient hospital classes of health care services consistent with the***
15 ***requirements of 42 C.F.R. section 433.56 and the Medicaid state plan definitions of***
16 ***inpatient and outpatient services,*** less any deducted amounts for bad debts, charity care, and
17 payor discounts.

2011-1160s

AMENDED ANALYSIS

This bill allows exclusion of rehabilitation hospitals by federal waiver from the uncompensated care fund and clarifies the application of the Medicaid enhancement tax.

Sen. Odell, Dist. 8
March 23, 2011
2011-1160s
01/10

Amendment to SB 165-FN

Amend the bill by replacing sections 2 -5 with the following:

2 Uncompensated Care Fund; Definitions. Amend RSA 167:63, IV to read as follows:

IV. "Hospital" means general hospitals and special hospitals for rehabilitation required to be licensed under RSA 151 [~~and receiving medicaid diagnosis related group (DRG) payments~~], but not including government facilities ***and hospitals excluded from taxation under RSA 84-A pursuant to federal approval of a waiver of the broad-based requirement as described in 42 C.F.R. section 433.68.***

3 Uncompensated Care Fund; Rehabilitation Hospitals Deleted. Amend RSA 167:64, I(d) to read as follows:

(d) The commissioner may provide reimbursement for uncompensated care costs in accordance with the approved schedule of payments through either Medicaid fee for service rate adjustments or disproportionate share hospital payment adjustments, or a combination thereof. Funds available under this section shall be [~~first~~] allocated to ensure that critical access hospitals [~~and rehabilitation hospitals~~] receive reimbursement for reported uncompensated care costs at the rate of 100 percent of the individual hospital limit for disproportionate share payments as determined by the commissioner consistent with the provisions of 42 U.S.C. section 1396r-4(g). Non-critical access hospitals shall receive reimbursement at the highest uniform percentage of each hospital limit as the funds made available under this section permit. The commissioner may create additional categories of need and make further reasonable distinctions among hospitals when determining the methodology for payments under this section, as necessary, to ensure that no hospital is unduly burdened by the fiscal effect of uncompensated care costs.

4 Uncompensated Care Fund; Duties of Commissioner. Amend RSA 167:65, II to read as follows:

II. Seek input from [~~the chairman of~~] the senate health and human services committee, [~~the chairman of~~] the house health, human services and elderly affairs committee, [~~the chairmen of~~] the house and senate finance committees, [~~the insurance department~~], and [~~representatives of~~] ***the*** hospitals currently participating in the uncompensated care program [~~in developing~~] ***during the development of*** the uncompensated care payment system required under paragraph I, and present a report [~~detailing all the options and making recommendations~~] ***describing the planned payment methodology*** to the oversight committee on health and human services, established under RSA 126-A:13[~~, not later than January 1, 2010~~] ***prior to payments being made.***

II-a. Submit a waiver calculation pursuant to the process outlined in 42 C.F.R. section 433.68 for the purpose of waiving RSA 84-A, Medicaid enhancement tax liability for Hampstead hospital, HealthSouth, Northeast Rehabilitation, and New Hampshire hospital, no later than September 30, 2011.

5 Medicaid Enhancement Tax. Amend RSA 84-A:1, III-IV-a to read as follows:

III. "Hospital" means general hospitals and special hospitals for rehabilitation required to be licensed under RSA 151 [~~and receiving medicaid diagnosis-related group (DRG) payments~~], but not including government facilities ***and hospitals excluded from taxation under this chapter pursuant to federal approval of a waiver of the broad-based requirement as described in 42 C.F.R. section 433.68.***

IV. "Medicaid enhancement tax" means the tax imposed upon net patient services revenue pursuant to this chapter.

IV-a. "Net patient services revenue" means the gross charges of the hospital ***limited to the inpatient and outpatient hospital classes of health care services consistent with the requirements of 42 C.F.R. section 433.56 and the Medicaid state plan definitions of inpatient and outpatient services,*** less any deducted amounts for bad debts, charity care, and payor discounts.

2011-1160s

AMENDED ANALYSIS

This bill allows exclusion of rehabilitation hospitals by federal waiver from the uncompensated care fund and clarifies the application of the Medicaid enhancement tax.

Sen. Odell, Dist. 8
March 23, 2011
2011-1171s
01/04

IF this amendment is adopted by the Committee, please deliver to the House Clerk (Room 317) or Senate Clerk (Senate Chamber), the 2 originals and 2 copies.

Amendment to SB 165-FN

Amend the bill by replacing sections 2-5 with the following:

2 Uncompensated Care Fund; Definitions. Amend RSA 167:63, IV to read as follows:

IV. "Hospital" means general hospitals and special hospitals for rehabilitation required to be licensed under RSA 151 [~~and receiving medicaid diagnosis related group (DRG) payments~~], but not including government facilities ***and hospitals excluded from taxation under RSA 84-A pursuant to federal approval of a waiver of the broad-based requirement as described in 42 C.F.R. section 433.68.***

3 Uncompensated Care Fund; Rehabilitation Hospitals Deleted. Amend RSA 167:64, I(d) to read as follows:

(d) The commissioner may provide reimbursement for uncompensated care costs in accordance with the approved schedule of payments through either Medicaid fee for service rate adjustments or disproportionate share hospital payment adjustments, or a combination thereof. Funds available under this section shall be [~~first~~] allocated to ensure that critical access hospitals [~~and rehabilitation hospitals~~] receive reimbursement for reported uncompensated care costs at the rate of 100 percent of the individual hospital limit for disproportionate share payments as determined by the commissioner consistent with the provisions of 42 U.S.C. section 1396r-4(g). Non-critical access hospitals shall receive reimbursement at the highest uniform percentage of each hospital limit as the funds made available under this section permit. The commissioner may create additional categories of need and make further reasonable distinctions among hospitals when determining the methodology for payments under this section, as necessary, to ensure that no hospital is unduly burdened by the fiscal effect of uncompensated care costs.

4 Uncompensated Care Fund; Duties of Commissioner. Amend RSA 167:65, II to read as follows:

II. Seek input from [~~the chairman of~~] the senate health and human services committee, [~~the chairman of~~] the house health, human services and elderly affairs committee, [~~the chairmen of~~] the house and senate finance committees, [~~the insurance department,~~] and [~~representatives of~~] ***the*** hospitals currently participating in the uncompensated care program [~~in developing~~] ***during the development of*** the uncompensated care payment system required under paragraph I, and present a report [~~detailing all the options and making recommendations~~] ***describing the planned payment methodology*** to the oversight committee on health and human services, established under RSA 126-A:13[~~, not later than January 1, 2010~~] ***prior to payments being made.***

II-a. Submit a waiver calculation pursuant to the process outlined in 42 C.F.R. section 433.68 for the purpose of waiving RSA 84-A, Medicaid enhancement tax liability for Hampstead hospital, Healthsouth Rehabilitation hospital, Northeast Rehabilitation hospital, and New Hampshire hospital, no later than September 30, 2011.

5 Medicaid Enhancement Tax. Amend RSA 84-A:1, III to read as follows:

III. "Hospital" means general hospitals and special hospitals for rehabilitation ***that provide inpatient and outpatient hospital classes of health care services consistent with the requirements of 42 C.F.R. section 433.56 and the Medicaid state plan definitions of inpatient hospital and outpatient hospital services,*** required to be licensed under RSA 151 [~~and receiving medicaid diagnosis related group (DRG) payments~~], but not including government facilities ***and hospitals excluded from taxation under this chapter pursuant to federal approval of a waiver of the broad-based requirement as described in 42 C.F.R. section 433.68.***

2011-1171s

AMENDED ANALYSIS

This bill allows exclusion of rehabilitation hospitals by federal waiver from the uncompensated care fund and clarifies the application of the Medicaid enhancement tax.

Sen. Odell, Dist. 8
March 23, 2011
2011-1171s
01/04

Amendment to SB 165-FN

Amend the bill by replacing sections 2-5 with the following:

2 Uncompensated Care Fund; Definitions. Amend RSA 167:63, IV to read as follows:

IV. "Hospital" means general hospitals and special hospitals for rehabilitation required to be licensed under RSA 151 [~~and receiving medicaid diagnosis related group (DRG) payments~~], but not including government facilities ***and hospitals excluded from taxation under RSA 84-A pursuant to federal approval of a waiver of the broad-based requirement as described in 42 C.F.R. section 433.68.***

3 Uncompensated Care Fund; Rehabilitation Hospitals Deleted. Amend RSA 167:64, I(d) to read as follows:

(d) The commissioner may provide reimbursement for uncompensated care costs in accordance with the approved schedule of payments through either Medicaid fee for service rate adjustments or disproportionate share hospital payment adjustments, or a combination thereof. Funds available under this section shall be [~~first~~] allocated to ensure that critical access hospitals [~~and rehabilitation hospitals~~] receive reimbursement for reported uncompensated care costs at the rate of 100 percent of the individual hospital limit for disproportionate share payments as determined by the commissioner consistent with the provisions of 42 U.S.C. section 1396r-4(g). Non-critical access hospitals shall receive reimbursement at the highest uniform percentage of each hospital limit as the funds made available under this section permit. The commissioner may create additional categories of need and make further reasonable distinctions among hospitals when determining the methodology for payments under this section, as necessary, to ensure that no hospital is unduly burdened by the fiscal effect of uncompensated care costs.

4 Uncompensated Care Fund; Duties of Commissioner. Amend RSA 167:65, II to read as follows:

II. Seek input from [~~the chairman of~~] the senate health and human services committee, [~~the chairman of~~] the house health, human services and elderly affairs committee, [~~the chairmen of~~] the house and senate finance committees, [~~the insurance department,~~] and [~~representatives of~~] ***the*** hospitals currently participating in the uncompensated care program [~~in developing~~] ***during the development of*** the uncompensated care payment system required under paragraph I, and present a report [~~detailing all the options and making recommendations~~] ***describing the planned payment methodology*** to the oversight committee on health and human services, established under RSA 126-A:13[~~, not later than January 1, 2010~~] ***prior to payments being made.***

1 *II-a. Submit a waiver calculation pursuant to the process outlined in 42 C.F.R.*
2 *section 433.68 for the purpose of waiving RSA 84-A, Medicaid enhancement tax liability for*
3 *Hampstead hospital, Healthsouth Rehabilitation hospital, Northeast Rehabilitation*
4 *hospital, and New Hampshire hospital, no later than September 30, 2011.*
5 5 Medicaid Enhancement Tax. Amend RSA 84-A:1, III to read as follows:
6 III. "Hospital" means general hospitals and special hospitals for rehabilitation ***that provide***
7 ***inpatient and outpatient hospital classes of health care services consistent with the***
8 ***requirements of 42 C.F.R. section 433.56 and the Medicaid state plan definitions of***
9 ***inpatient hospital and outpatient hospital services,*** required to be licensed under RSA 151 [~~and~~
10 ~~receiving medicaid diagnosis related group (DRG) payments~~], but not including government facilities
11 ***and hospitals excluded from taxation under this chapter pursuant to federal approval of a***
12 ***waiver of the broad-based requirement as described in 42 C.F.R. section 433.68.***

2011-1171s

AMENDED ANALYSIS

This bill allows exclusion of rehabilitation hospitals by federal waiver from the uncompensated care fund and clarifies the application of the Medicaid enhancement tax.

Sen. Odell, Dist. 8
March 23, 2011
2011-1171s
01/04

Amendment to SB 165-FN

Amend the bill by replacing sections 2-5 with the following:

2 Uncompensated Care Fund; Definitions. Amend RSA 167:63, IV to read as follows:

IV. "Hospital" means general hospitals and special hospitals for rehabilitation required to be licensed under RSA 151 [~~and receiving medicaid diagnosis related group (DRG) payments~~], but not including government facilities ***and hospitals excluded from taxation under RSA 84-A pursuant to federal approval of a waiver of the broad-based requirement as described in 42 C.F.R. section 433.68.***

3 Uncompensated Care Fund; Rehabilitation Hospitals Deleted. Amend RSA 167:64, I(d) to read as follows:

(d) The commissioner may provide reimbursement for uncompensated care costs in accordance with the approved schedule of payments through either Medicaid fee for service rate adjustments or disproportionate share hospital payment adjustments, or a combination thereof. Funds available under this section shall be [~~first~~] allocated to ensure that critical access hospitals [~~and rehabilitation hospitals~~] receive reimbursement for reported uncompensated care costs at the rate of 100 percent of the individual hospital limit for disproportionate share payments as determined by the commissioner consistent with the provisions of 42 U.S.C. section 1396r-4(g). Non-critical access hospitals shall receive reimbursement at the highest uniform percentage of each hospital limit as the funds made available under this section permit. The commissioner may create additional categories of need and make further reasonable distinctions among hospitals when determining the methodology for payments under this section, as necessary, to ensure that no hospital is unduly burdened by the fiscal effect of uncompensated care costs.

4 Uncompensated Care Fund; Duties of Commissioner. Amend RSA 167:65, II to read as follows:

II. Seek input from [~~the chairman of~~] the senate health and human services committee, [~~the chairman of~~] the house health, human services and elderly affairs committee, [~~the chairmen of~~] the house and senate finance committees, [~~the insurance department,~~] and [~~representatives of~~] ***the*** hospitals currently participating in the uncompensated care program [~~in developing~~] ***during the development of*** the uncompensated care payment system required under paragraph I, and present a report [~~detailing all the options and making recommendations~~] ***describing the planned payment methodology*** to the oversight committee on health and human services, established under RSA 126-A:13[~~, not later than January 1, 2010~~] ***prior to payments being made.***

1 *II-a. Submit a waiver calculation pursuant to the process outlined in 42 C.F.R.*
2 *section 433.68 for the purpose of waiving RSA 84-A, Medicaid enhancement tax liability for*
3 *Hampstead hospital, Healthsouth Rehabilitation hospital, Northeast Rehabilitation*
4 *hospital, and New Hampshire hospital, no later than September 30, 2011.*
5 5 Medicaid Enhancement Tax. Amend RSA 84-A:1, III to read as follows:
6 III. "Hospital" means general hospitals and special hospitals for rehabilitation *that provide*
7 *inpatient and outpatient hospital classes of health care services consistent with the*
8 *requirements of 42 C.F.R. section 433.56 and the Medicaid state plan definitions of*
9 *inpatient hospital and outpatient hospital services,* required to be licensed under RSA 151 [~~and~~
10 ~~receiving medicaid diagnosis related group (DRG) payments~~], but not including government facilities
11 *and hospitals excluded from taxation under this chapter pursuant to federal approval of a*
12 *waiver of the broad-based requirement as described in 42 C.F.R. section 433.68.*

2011-1171s

AMENDED ANALYSIS

This bill allows exclusion of rehabilitation hospitals by federal waiver from the uncompensated care fund and clarifies the application of the Medicaid enhancement tax.

Senate Finance
March 23, 2011
2011-1179s
01/09

Amendment to SB 165-FN

Amend the bill by replacing sections 2-5 with the following:

2 Uncompensated Care Fund; Definitions. Amend RSA 167:63, IV to read as follows:

IV. "Hospital" means general hospitals and special hospitals for rehabilitation required to be licensed under RSA 151 [~~and receiving medicaid diagnosis related group (DRG) payments~~], but not including government facilities ***and hospitals excluded from taxation under RSA 84-A pursuant to federal approval of a waiver of the broad-based requirement as described in 42 C.F.R. section 433.68.***

3 Uncompensated Care Fund; Rehabilitation Hospitals Deleted. Amend RSA 167:64, I(d) to read as follows:

(d) The commissioner may provide reimbursement for uncompensated care costs in accordance with the approved schedule of payments through either Medicaid fee for service rate adjustments or disproportionate share hospital payment adjustments, or a combination thereof. Funds available under this section shall be [~~first~~] allocated to ensure that critical access hospitals [~~and rehabilitation hospitals~~] receive reimbursement for reported uncompensated care costs at the rate of 100 percent of the individual hospital limit for disproportionate share payments as determined by the commissioner consistent with the provisions of 42 U.S.C. section 1396r-4(g). Non-critical access hospitals shall receive reimbursement at the highest uniform percentage of each hospital limit as the funds made available under this section permit. The commissioner may create additional categories of need and make further reasonable distinctions among hospitals when determining the methodology for payments under this section, as necessary, to ensure that no hospital is unduly burdened by the fiscal effect of uncompensated care costs.

4 Uncompensated Care Fund; Duties of Commissioner. Amend RSA 167:65, II to read as follows:

II. Seek input from [~~the chairman of~~] the senate health and human services committee, [~~the chairman of~~] the house health, human services and elderly affairs committee, [~~the chairmen of~~] the house and senate finance committees, [~~the insurance department,~~] and [~~representatives of~~] ***the*** hospitals currently participating in the uncompensated care program [~~in developing~~] ***during the development of*** the uncompensated care payment system required under paragraph I, and present a report [~~detailing all the options and making recommendations~~] ***describing the planned payment methodology*** to the oversight committee on health and human services, established under RSA 126-A:13[~~, not later than January 1, 2010~~] ***prior to payments being made.***

1 *II-a. Submit a waiver calculation pursuant to the process outlined in 42 C.F.R.*
2 *section 433.68 for the purpose of waiving RSA 84-A, Medicaid enhancement tax liability for*
3 *Hampstead hospital, Healthsouth Rehabilitation hospital, Northeast Rehabilitation*
4 *hospital, and New Hampshire hospital, no later than September 30, 2011.*
5 5 Medicaid Enhancement Tax. Amend RSA 84-A:1, III to read as follows:
6 III. "Hospital" means general hospitals and special hospitals for rehabilitation ***that provide***
7 ***inpatient and outpatient hospital classes of health care services consistent with the***
8 ***requirements of 42 C.F.R. section 433.56 and the Medicaid state plan definitions of***
9 ***inpatient hospital and outpatient hospital services,*** required to be licensed under RSA 151 [~~and~~
10 ~~receiving medicaid diagnosis related group (DRG) payments~~], but not including government facilities
11 ***and hospitals excluded from taxation under this chapter pursuant to federal approval of a***
12 ***waiver of the broad-based requirement as described in 42 C.F.R. section 433.68.***

2011-1179s

AMENDED ANALYSIS

This bill allows exclusion of rehabilitation hospitals by federal waiver from the uncompensated care fund and clarifies the application of the Medicaid enhancement tax.

Committee Minutes

Printed: 02/17/2011 at 12:19 pm

SENATE CALENDAR NOTICE
FINANCE

Senator Chuck Morse Chairman
Senator Bob Odell V Chairman
Senator John Barnes, Jr.
Senator Peter Bragdon
Senator Lou D'Allesandro
Senator Jeanie Forrester
Senator John Gallus

For Use by Senate Clerk's Office ONLY
- [ ] Bill Status
- [ ] Docket
- [ ] Calendar

Proof: [ ] Calendar [ ] Bill Status

Date: February 17, 2011

HEARINGS

Thursday 2/24/2011

FINANCE	SH 103	1:00 PM
(Name of Committee)	(Place)	(Time)

EXECUTIVE SESSION MAY FOLLOW

1:00 PM SB183-FN-L amending the calculation and distribution of adequate education grants, repealing fiscal capacity disparity aid, and providing stabilization grants to certain municipalities.

1:30 PM SB165-FN relative to the Medicaid uncompensated care fund and the Medicaid enhancement tax.

Sponsors:

SB183-FN-L

Sen. Jim Rausch	Sen. Nancy Stiles	Rep. Ralph Boehm	Rep. Peter Bolster
Rep. Joseph Fleck	Rep. Gene Chandler	Rep. Kenneth Weyler	Sen. Jeb Bradley
Sen. Sharon Carson	Sen. Andy Sanborn	Sen. Peter Bragdon	Sen. Jim Luther
Sen. John Gallus			

SB165-FN

Sen. Bob Odell	Sen. Chuck Morse	Sen. Sylvia Larsen	Sen. Gary Lambert
Sen. Jeb Bradley			

• 2:15pm
Presentation by Sheriffs' Association

Shannon Whitehead 271-4980

Sen. Chuck Morse
Chairman

Finance Committee

Hearing Report

TO: Members of the Senate

FROM: Shannon Whitehead, Legislative Aide

RE: Hearing report on SB 165-FN – **relative to the Medicaid uncompensated care fund and the Medicaid enhancement tax.**

HEARING DATE: 2-24-11

MEMBERS OF THE COMMITTEE PRESENT: Senators: Morse, Odell, D'Allesandro, Barnes, Bragdon, Gallus, and Forrester.

MEMBERS OF THE COMMITTEE ABSENT: No one was absent at this time

Sponsor(s): Sen. Odell, Dist 8; Sen. Morse, Dist 22; Sen. Larsen, Dist 15; Sen. Lambert, Dist 13; Sen. Bradley, Dist 3

What the bill does: This bill removes rehabilitation hospitals from the uncompensated care fund and clarifies the application of the Medicaid enhancement tax.

Who supports the bill: Katie Dunn Medicaid Director from Dept. of HHS, Steve Ahnen for NH Hospital Association, Catherine Devaney for HealthSouth Rehabilitation Hospital from Concord, NH, John Prichillo and James Murphy for NorthEast Rehabilitation Network from Salem, NH

Who opposes the bill: No one appeared in opposition

Summary of testimony received:
Senator Morse opened the hearing at 1:34 pm

Senator Odell: Prime sponsor. This bill deals with Medicaid disproportionate shared program, a placeholder and discussion of revenue of the local hospitals. This is also looking at the net patient services and what is in federal statute. A bill to seek input of state government policy and a vehicle to discuss DHS payments and Medicaid Enhancement Tax as part of the senate budget

Steve Ahnen:. The federal government created the Medicaid Disproportionate Share (DSH) program to help alleviate the funding

challenges for hospitals as a result of the growing numbers of uninsured and Medicaid patients they were serving. The intent of DSH is that hospitals and the communities they serve should not suffer as a result of the lack of payment from those without insurance and the low reimbursement rates paid by Medicaid. In New Hampshire, hospitals are reimbursed, on average, just over 50 percent of the actual cost of treating a Medicaid patient.

When this federal program was created many states were unable to access the additional federal DSH dollars because states were suffering as a result of the difficult economy and could not generate general fund dollars that were needed to access the federal money. Congress created new mechanisms to allow states to use alternative mechanisms to generate the states portion of Medicaid financing, including a tax on various provider classes, such as hospitals, nursing homes, physicians, pharmacies, managed care organizations and others that could be used as the states share of financing for Medicaid.

Mr. Ahnen explained how DSH is supposed to work: a state generates funding, through general appropriations or a provider tax, or assessment which creates the states share of Medicaid financing. Since NH's Medicaid DSH program began in 1991 it has been funded through a hospital assessment the Medicaid Enhancement Tax (MET). In the past, the state used the proceeds from the tax to make DSH payments to hospitals. The state then filed a claim with the federal government for the DSH payments made and received a matching payment from the federal government that amounted to 50% of the states share of financing. The intent of federal match is for states to use the additional funds to further support the uncompensated care program and make payments to hospitals that qualify for the DSH program.

But that is not the reality of how DSH has worked here in NH -since it was enacted. Instead of the money intended for Medicaid going back to the hospitals, the state had historically put the value of all of those federal matching dollars into the general fund. Other than the first few years, New Hampshire was the only state that didn't use the value of the federal Medicaid matching dollars for their Medicaid DSH program. New Hampshire's DSH program was never really intended to do much more than use this federal money to help fund other parts of state government and to balance the budget. For nearly twenty years, the State of NH received nearly $1.7 billion in federal funds that were used for purposed other than what was intended under this program.

As a result of changes in federal laws and regulations as well as the need to respond to federal audits of NH's DSH program, the State of NH was required to make changes to DSH program to bring it into compliance with federal regulations. The NH Hospital Association worked with DHHS over the past year to try to come up with a solution to the challenges presented by

the DSH program that would be compliant with federal rules: to provide more resources and support to hospitals that provide more care to Medicaid beneficiaries and to those without insurance, while minimizing the negative impact on any one individual hospital.

The changes that were ultimately adopted last November for state fiscal year 2011 did make some changes to this process, but still created the same set of challenges for hospitals by taking money out of this program intended to support hospitals that provide disproportionate share of care to the uninsured and using it for other purposes. The revenue raised by the MET in the current fiscal year was approximately $186 million, of which the state used half to generate a federal matching payment, while the other half was deposited into the General Fund to help support other programs. Other payments are made to hospitals under the state's model, but stated for many hospitals, especially those who provide the most care to uninsured patients; all of the costs associated with caring for those without insurance are being recognized.

Mr Ahnen continued to say that many hospitals in NH including some of those who provide the most amounts of uncompensated care, received DSH payments that were below the amount of care provided to the uninsured and medicaid patients while nine community and inpatient acute rehabilitation hospitals saw a loss of more than $14 million- meaning they paid more in their MET than they received in DSH benefits.

Mr. Ahnen wanted to make note to the committee that the State of New Hampshire did not compensate hospitals fully for the amount of care provided to uninsured and Medicaid patients which is the intent of the DSH program. $92 million in DSH or uncompensated care funds could have been distributed to NH hospitals to fully compensate them for the care they provided if the state had the resources to pay them. The state did not have sufficient resources because $89 million from the tax on hospitals intended to support the Medicaid DSH program had been diverted into the general fund.

Mr. Ahnen stated the Governor's budget proposal was to reduce $20 million in each of the next two state fiscal years the amount of money that would go to support the uncompensated care hospitals provide would only serve to make the challenge we faced last year even greater. Until we are willing to follow the intent of the Medicaid DSH program to support hospitals that provide a significant amount of care uninsured and medicaid patients this program will continually be a problem for NH hospitals. It is our understanding that no other state has a provider assessment and Medicaid DSH program more than 10-15% of states hospital, paid more in taxes than they received in benefits, which is far less than the 30% of hospitals in NH. Hospitals are not asking to be held harmless, but rather work with the state to design a DSH program that more adequately and appropriately supports the intent of the Medicaid DSH program. We understand the difficulties of

any of these options to generate additional resources to support DSH program, but those options such as an assessment on other class providers or a reduction in the amount of revenue that is diverted to the General Fund to support other programs may have issues in the current economic environment. Mr. Ahnen stated to the committee that if we were to start over from scratch, we wouldn't create the DSH program that is in place today.

SB 165 seeks to serve as a starting point for legislation that could be formed to create a new DSH program that would more adequately support hospitals and their ability to serve all of their patients, including those with Medicaid and those with out insurance. Mr. Ahnen wanted to say thank you to Senator Odell in his efforts to try to create a system that more adequately and appropriately utilizes the Medicaid DSH program for the purposes for which it is intended. One of the most significant issues Senator Odell's legislation attempts to address, is the definition of "Net patient revenue, for purposes of determining the Medicaid Enhancement Tax. New Hampshire's MET has not been clearly defined which results in inconsistencies with reporting of new patient services revenue on which the MET is calculated. We are working with the Department of Revenue to seek more clarity.

SB 165 would also remove the two inpatient acute rehabilitation hospitals from the Medicaid Enhancement Tax and the Medicaid DSH program. Other states that have enacted these programs have often excluded specialty hospitals like rehabilitation hospitals because of the significant differences they have with general acute care hospitals. Doing so- requires that the state receive a waiver from the federal government based upon compliance with federal regulations

Senator Odell asked Mr. Ahnen about the revenues that were scheduled to come in on a certain month but came in late in November. The budget had called for 100 million dollars, the actual number was lower. There were lower results of lower revenues. Response from Mr. Ahnen: Revenues are down, procedures are down, and clarifying bad debt payment was pulled out and reporting inconsistencies that may have contributed to a lower number

Senator Odell asked about a 5.5 rate in fiscal year 2012. Is that possible to do? Response from Mr. Ahnen:_We are working to pull information as of what revenue would be available and the federal guidelines and what the revenue would be.

Senator D'Allesandro questioned on how the money gathers from each hospital. Is there a clear methodology in place following federal guidelines and service? Response from Mr. Ahnen: It is a challenge. Senator D'Alessandro added that uniformed methodology can be implemented, you know the percent and you know what the tax would be.

Senator Morse expressed his concern that Mr. Ahnen was communicating to the committee that we were taking from the hospitals.

Katie Dunn: Katie Dunn wanted to add from previous speaker that uniformed methodology is fundamental and can run into a dangerous course of action.

Senator D'Allesandro asked if we had an audit? Katie Dunn responded: that would be for the DRA. Under federal audit regulations what ever you had in the state plan. Come in last year to be audited 05, 06, 07. 2008 is being configured.

State Medicaid Director in DHHS. DHHS is appreciative of Senator Odell's leadership on this issue and looks forward in working with the NH Hospital Association to make the DSH program responsive to both federal regulations as well as trying to address the impact of uncompensated care on the hospital network.

Two elements of the bill that as drafted pose a conflict with federal law. The first component pertains to the provision of the bill found in section 5 Medicaid Enhancement Tax that would exempt the states two rehabilitation hospitals from payment of the MET. The MET as a provider tax is subject to detailed and prescriptive federal medicaid regulations because it is used as the matching state funds to draw down federal disproportionate share hospital (DSH) funds. The exemption criteria for a facility lie in federal regulation and ultimate approval to exempt a facility from participation in the MET resides with the federal government.

DHHS is in the process of conducting an analysis pursuant to those same federal regulations to see if the two rehab hospitals meet the exemption criteria. The analysis will be shared with the hospitals as well as the NH Hospital Association. This bill if passed as is- could violate federal regulations if the two rehab hospitals do not qualify for federal exemption.

DHHS recommends amending the bill to ensure that the final legislation is not in conflict with federal regulations and allows any hospital that wishes to seek exemption to the MET to make that request through the department citing that the federal exemption regulations and documenting how the criteria are satisfied.

Katie Dunn continued with the department's second concern of where net patient services are defined. The Center for Medicare and Medicaid Services is presently considering the same issue as CMS officials in the course of reviewing our recently submitted DSH state plan amendment- raised this question. CMS has the end of March to respond to this. Katie Dunn stated

that she does not know that the definition will meet CMS; approval. (They know we are on a time crunch)

Katie Dunn added that you don't want to be on the list to have 50 percent of funding be taken away. This state hasn't presented itself well, Long term and sustainable. Making sure we are doing what can to reimburse for care. What are the options going forward? We need a place holder to come forth with some recommendations. The fiscal and Health and Human Services Oversight committee are interested in our work.

John Pichello and James Murphy: We treat individuals who are recovering from a stroke, brain injury, amputation, neurological disease. Inpatient out patient services for physically and cognitively disabled. Average length of state is about 16 days, 85% of our patients go home, but continue services with us on an outpatient basis. 15% of our patients get transferred to lower level post acute facilities to continue with their recovery. Patients are referred to us from local acute care hospitals. Our hospital network is owned by local individuals. This year in addition to the MET ($1.2 Million) we paid local, state, and federal taxes in the amount of $1.9 million per year.

Mr. Pichello explained how they differ from acute care community hospitals: by licensure and regulation, out type of specialty hospital is not allowed to offer the types of services that are most commonly accessed by underserved populations; and DSH is a program to fund the care needs of underserved populations. In many other states, rehab hospitals like Northeast, do not participate in the DSH and MET programs.

Further Complications limiting the amount of free care rehab hospitals in NH are able to deliver: Patients have to meet both financial and clinical criteria to be approved for Medicaid. Beyond meeting the financial criteria patients have to meet criteria about the severity and permanency of their disability in order to be considered Medicaid eligible for admission to a rehab hospital. If the financial clinical criteria are met there are then strict criteria about how long a person can stay in the rehab hospital and be covered by Medicaid. Mr. Pichello made note to the committee that they have problems about restriction of patients and denial of services quite clear to DHHS going back to at least 1996. We remain committed to working with DHHS to find more acceptable solutions.

Northeast Rehab's expenditure does deliver uncompensated care. Last year expenditures was $1.4 million dollars. If we were exempted from the DSH and MET as a result of this bill, Northeast Rehab will continue to deliver this level of uncompensated care. One criticism that I have heard about exempting the rehabs from MET and the DSH is the rehabs don't offer enough uncompensated care. Hopefully the committee will come to a different conclusion after what we have shared.

DSH and MET have been linked since at least 1992. NRH has participated solely for the benefit of the state to acquire additional federal funds. DRS has wired DSH funds to NRH's bank in the morning and then NRH wired the identical amount back to the DRA to pay the MET Tax (scheduled on the same day).

Things have changed: We participated in this program with the understanding that would not create with a liability or a benefit for us. Now since the program has changed we are faced with a significant liability for reasons such as DHHS, the state redesigned the DSH program. Now the DSH would no longer be tied to MET – 2 separate and distinct transactions.

On Friday September 3, at 7pm we learned for the first time, via a letter from DHHS that NRH would be subject to a $2.7 million dollar shortfall as a result of the difference in DSH funds received and MET assessed, and that we had to pay $2.7 million in 60 days by October 3.

This new $2.7 million tax burden would be in addition to NRH paying $177k in BPT, $294k in local property taxes and approximately $1.5 million in federal income taxes. Mr. Pichello also stated that prior to September 3rd they were unaware of the significant tax burden. At 5.5% MET rate they anticipate that will incur $1.9 million shortfall every year going forward as an additional tax burden on the facility. If the state ere to increase the MET to 6% our tax burden would only increase proportionately, instead of a $1.9 million tax burden. NRH estimates $2.3 Million each year.

Mr. Pichello closed saying they would have never agreed to participate in the DSH program in 1992 if they knew that in 2010 and 2011 would be the result of our participation in the program. We believe the assumption in the fiscal note that our revenue will grow 8% next year is very aggressive which could result in overstating the potential loss of revenue by exempting the rehab hospitals from the DSH and MET our actual rate of increase in Net Revenue the last 3 years have been 3.8 %

Catherine Devaney: HealthSouth takes in patients on the average age of 70 years old. Stroke patients- they are not typically your Medicaid population. We are on the same page of what Mr. Pichillo in what he stated to the committee earlier. We do not have the opportunities that hospitals have to matching the tax

Senator Morse closed the hearing at 2:25pm.

Funding: Please refer to Fiscal Note

SGW
[file: SB 165-FN report]
Date: 2-28-11

Speakers

SENATE FINANCE COMMITTEE

Date 2/24/11	Time 1:30 p.m.	Public Hearing on	SB165-FN

(AN ACT relative to the Medicaid uncompensated care fund and the medicaid enhancement tax.)

Please check box(es) that apply.

SPEAKING	FAVOR	OPPOSED	NAME (Please print)	REPRESENTING
☑	☑	☐	Steve Ahnen	NH Hospital Association
☑	☑	☐	Katie Dunn	NH DHHS
☑	☑	☐	John Prochilo of James Murphy	Northeast Rehabilitation Health Services
☑	☑	☐	Catherine Devaney	HealthSouth Rehab. Hospital
☐	☑	☐	Sen. Lambert	
☐	☑	☐	Sen. Larsen	
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		
☐	☐	☐		

Testimony

STATE OF NEW HAMPSHIRE
OFFICE OF LEGISLATIVE BUDGET ASSISTANT
FISCAL NOTE WORKSHEET

Date Sent to Agency: 01/14/2011

LSR #: 11-1045.1

Agency: Department of Revenue Administration

Bill #:

Due to LBAO: 01/20/2011

Amendment #(s):

Correction to a prior response? (Y/N): No

State Fund(s) Affected:

(1) Indicate here what state funds will be affected by the bill: general funds, federal funds, or any special fund. If it is a special fund, please specify.

General: XXX Federal: Other: Education Trust Fund

		FIRST BIENNIUM		SECOND BIENNIUM	
	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
State Revenue	Not Applicable	Cannot Be Determined	Cannot Be Determined	Cannot Be Determined	Cannot Be Determined
State Expenditure					
Net State Impact	Not Applicable	Cannot Be Determined	Cannot Be Determined	Cannot Be Determined	Cannot Be Determined

County Revenue	Not Applicable				
County Expenditure					
Net County Impact	Not Applicable				

Local Revenue	Not Applicable				
Local Expenditure					
Net Local Impact	Not Applicable				

NOTE: (1) List only the amount of change in the appropriate column.
(2) Place all negative numbers in parenthesis.
(3) You may replicate this worksheet.
(4) Refer to Guidelines for Fiscal Note Worksheets for further information.

(A) **ASSUMPTIONS:** Explain how estimate was derived. Describe costs that can be absorbed without additional funding. If no estimate can be prepared, **explain why in detail**. If no fiscal impact, **explain why in detail**.

1. This bill would remove "special hospitals for rehabilitation" from the definition of "hospital" within RSA 84-A the Medicaid Enhancement Tax (MET) and RSA 167 the Uncompensated Care Fund. It would appear that this disparate treatment of hospitals may be **unconstitutional**. See Section E, Technical or Mechanical Defects.

2. This law could be administered by the Department of Revenue Administration without any additional cost for the portion which applies to the Department.

3. **The Department of Health and Human Services is responsible for administering RSA 167 and, therefore, they should be consulted as to the effect these changes would have upon their agency.**

4. Special hospitals for rehabilitation currently pay the MET and their exemption under this bill would result in a loss of millions of dollars of tax revenue.

5. This bill also amends the definition of "net patient services revenue" under the MET RSA 84-A by limiting the services to inpatient and outpatient services and removing bad debt from the calculation of net patient services revenue. The Department does not have the specific data relating to inpatient/ outpatient services and bad debt within the net patient services revenue calculation in order to determine the impact of this bill.

(B) **METHOD:** Show calculations used to determine fiscal impact. **Calculations must agree with and explain totals on first page.**

The fiscal impact of this bill cannot be estimated. The exact amount of revenue loss for exempting "special hospitals for rehabilitation" cannot be disclosed by the Department as it appears the taxpayers affected consist of less than 10 hospitals out of the 28 hospitals that pay the MET.

In addition, the Department does not have the specific data relating to inpatient/outpatient services and bad debt within the net patient services revenue calculation in order to determine the impact of this bill.

(C) **ESTIMATED FISCAL IMPACT (from A and B): Estimated Fiscal Impact must agree with the totals on first page.**

The fiscal impact cannot be determined.

(D) ADDITIONAL COUNTY, LOCAL OR LONG-RANGE EFFECTS:

(E) TECHNICAL OR MECHANICAL DEFECTS: Note any conflicts with existing law. Do not comment on the merits of the legislation.

A review by a constitutional tax lawyer should be performed on this bill.

Potential Constitutional Issues: MET is a provider tax and, as such, providers have to be taxed uniformly. "Distinctions in tax treatment must rest upon reasonable classifications of property, not upon classifications of taxpayers owning a common class of property." Opinion of Justices, 132 N.H. 777 (1990) citing Opinion of Justices, 115 N.H. 306 (1975).

Special hospitals for rehabilitation have been taxed under the MET. This bill seeks to exempt them from taxation. However, similarly situated organizations that are hospitals would still pay the tax.

In addition, under federal law, a state's ability to use a provider tax to fund the state share of Medicaid expenditures has limits. Please refer to the federal provisions of 42 CFR § 433.

(F) OTHER COMMENTS: Include tax variables, federal mandates, etc.

AGENCY REPRESENTATIVE PREPARING WORKSHEET: John C. Lighthall NHDRA 271-1321

Approval Name/Signature

Asst. Commissioner NHDRA 271-2318

Title, Agency and Phone Number

2/11/11

Date

Senate Finance Committee
February 24, 2011

SB165-FN
Relative to the Medicaid uncompensated care fund and the Medicaid enhancement tax.

Testimony

Good afternoon, Mr. Chairman and members of the Committee. My name is Steve Ahnen and I am president of the New Hampshire Hospital Association, representing the state's 32 acute care community and specialty hospitals.

I want to thank Senator Odell for his leadership and willingness to take on this very challenging issue. We appreciate the thoughtful and collaborative approach he is taking to address this issue, which has significant and far reaching implications for the State, the Medicaid program, our hospitals and the patients and communities they serve.

The federal government created the Medicaid Disproportionate Share (DSH) program to help alleviate the funding challenges for hospitals as a result of the growing numbers of uninsured and Medicaid patients they were serving. The intent of DSH is that hospitals and the communities they serve should not suffer as a result of the lack of payment from those without insurance and the low reimbursement rates paid by Medicaid. In New Hampshire, hospitals are reimbursed, on average, just over 50 percent of the actual cost of treating a Medicaid patient.

When this federal program was created, many states were unable to access the additional federal DSH dollars because, like today, states were suffering as a result of the difficult economy and could not generate general fund dollars that were needed to access the federal money. As a result, Congress created new mechanisms to allow states to use alternative mechanisms to generate the state's portion of Medicaid financing, including a tax on various provider classes, such as hospitals, nursing homes, physicians, pharmacies, managed care organizations and others, that could be used as the state's share of financing for Medicaid.

Here's how DSH is supposed to work: A state generates funding, through general appropriations or a provider tax or assessment, which creates the state's share of Medicaid financing. Since New Hampshire's Medicaid DSH program began in 1991, it has been funded through a hospital assessment, the Medicaid Enhancement Tax (MET). Historically, the state used the proceeds from the tax to make DSH payments to hospitals. The State then filed a claim with the federal government for the DSH payments made and received a matching payment from the federal government that amounted to 50 percent of the state's share of financing. The intent of the

federal match is for states to use the additional funds to further support the uncompensated care program and make payments to hospitals that qualify for the DSH program.

But that's not the reality of how DSH has worked here in New Hampshire since it was enacted back in 1991. Instead of the money intended for Medicaid going back to hospitals, the state had historically put the value of ALL of those federal matching dollars into the General Fund. Other than the first few years, New Hampshire was the only state that didn't use the value of the federal Medicaid matching dollars for their Medicaid DSH program. New Hampshire's DSH program was never really intended to do much more than use this federal money to help fund other parts of state government and to balance the budget. For nearly twenty years, the State of New Hampshire received nearly $1.7 billion in federal funds that were used for purposes other than that which were intended under this program

As a result of changes in federal laws and regulations, as well as the need to respond to federal audits of New Hampshire's DSH program, the State of New Hampshire was required to make changes to its DSH program to bring it into compliance with federal regulations. The New Hampshire Hospital Association and our members worked with the New Hampshire Department of Health and Human Services (NH DHHS) over the past year to try to come up with a solution to the challenges presented by the DSH program that would be compliant with federal rules, provide more resources and support to hospitals that provide more care to Medicaid beneficiaries and to those without insurance, while minimizing, to the greatest extent possible, the negative impact on any one individual hospital.

The changes that were ultimately adopted last November for State Fiscal Year (SFY) 2011 did make some changes to this process, but in the end, still created the same set of challenges for hospitals by taking money out of this program intended to support hospitals that provide a disproportionate share of care to the uninsured and using it for other purposes. The revenue raised by the MET in the current Fiscal Year was approximately $186 million, of which the state used half to generate a federal matching payment, while the other half was deposited into the General Fund to help support other programs. Other payments are made to hospitals under the state's model, but for many hospitals, especially those who provide the most care to uninsured patients, all of the costs associated with caring for those without insurance are not being recognized.

As a result, many hospitals in New Hampshire, including some of those who provide the most amounts of uncompensated care, received DSH payments that were below the amount of care provided to the uninsured and Medicaid patients, while nine community and inpatient acute rehabilitation hospitals saw a loss of more than $14 million, meaning they paid more in their MET than they received in DSH benefits.

It is important to note that last year the State of New Hampshire did not compensate hospitals fully for the amount of care they provided to uninsured and Medicaid patients, which is the intent of the DSH program. In fact, approximately $92 million in DSH, or uncompensated care funds, could have been distributed to New Hampshire hospitals to fully compensate them for the care they provided if the State had the resources to pay them. The State did not have sufficient

resources because $89 million from the tax on hospitals intended to support the Medicaid DSH program had been diverted into the General Fund for other purposes.

The Governor's budget proposal that was announced last week to reduce by $20 million in each of the next two State Fiscal Years the amount of money that would go to support the uncompensated care hospitals provide would only serve to make the challenge we faced last year even greater.

Unless and until we are willing to follow the intent of the Medicaid DSH program to support hospitals that provide a significant amount of care to uninsured and Medicaid patients, this program will continually be a problem for New Hampshire's hospitals. We need to find a way for the resources generated by this program to be used for the purpose for which they were intended. Otherwise, there will always be a large number of hospitals who provide more uncompensated care than are able to be recognized under this program and still others will pay more in taxes than they receive in benefits from the DSH program. It is our understanding that no other state that has a provider assessment and Medicaid DSH program have more than 10-15% of a state's hospitals paid more in taxes than they received in benefits...far less than the more than 30% of hospitals in New Hampshire.

Hospitals are not asking to be held harmless, but rather to work with the State to design a DSH program that more adequately and appropriately supports the intent of the Medicaid DSH program. There are ways to generate additional resources to support the DSH program, but those include options such as an assessment on other classes of providers or a reduction in the amount of revenue that is diverted to the General Fund to support other programs. We understand the difficulty that any of these options might raise in the current economic and political environment, but if we were to start over from scratch, we certainly wouldn't create the DSH program that is in place today.

SB 165 seeks to serve as a starting point for legislation that could be fashioned to create a new DSH program that would more adequately support hospitals and their ability to serve all of their patients, including those with Medicaid and those without insurance. We applaud Senator Odell in his efforts and we are working closely with the DHHS Commissioner Nick Toumpas and Medicaid Director Katie Dunn, their staff and consultants to try to create a system that more adequately and appropriately utilizes the Medicaid DSH program for the purposes for which it is intended.

As in most legislative and regulatory matters, the technical details and definitions are very important, and that is certainly the case here. One of the most significant issues that Senator Odell's legislation attempts to address is the definition of "net patient services revenue" for purposes of determining the Medicaid Enhancement Tax (MET). Federal guidance is clear on what states can use to calculate their tax to determine what can be used to generate a federal matching payment. New Hampshire's MET has not been clearly defined and as such has likely resulted in inconsistencies with reporting of net patient services revenue on which the MET is calculated. Based upon feedback from the federal government as a result of the changes that were made to the DSH program last year, it is clear that this is an issue the State must address.

We will be working with the Department of Revenue Administration to seek more clarity and guidance on this issue.

It is important to note that the impact of this clarification will result in a smaller net patient services revenue number since non-hospital services that are currently being included in the State's definition of net patient services revenue will be pulled out of those numbers. The outcome of that will be a smaller tax base and, therefore, a smaller matching payment from the federal government.

SB 165 would also remove the two inpatient acute rehabilitation hospitals from the Medicaid Enhancement Tax and the Medicaid DSH program. Historically, other states that have enacted these programs have often excluded specialty hospitals like rehabilitation hospitals because of the significant differences they have with general acute care hospitals. Doing so requires that the state receive a waiver from the federal government based upon compliance with federal regulations.

Mr. Chairman, I appreciate the opportunity to share our thoughts and concerns with you on this important subject. I would be happy to respond to any questions that you or other members of the Committee might have.

70 BUTLER STREET SALEM, NEW HAMPSHIRE 03079
(603) 893-2900 FAX (603) 893-1628
www.northeastrehab.com

Northeast Rehabilitation Hospital
Salem, NH

Testimony on SB- 165-FN
February 24, 2011

1) **Introduction- who we are and what we do**
   a. Thank you for the opportunity to testify on how the Medicaid Disproportionate Share ("DSH") and Medicaid Enhancement Tax ("MET") programs affect NRHN.
   b. Northeast Rehabilitation Hospital Network founded > 25 years ago,
      i. Inpatient and Outpatient services for physically and cognitively disabled patients.
      ii. Number of facilities and locations
   c. **Types of patients we treat**
      1. We treat individuals who are recovering from a stroke, brain injury, amputation, neurological disease, multiple trauma, prolonged illness resulting in loss of ability to function, etc.
      2. Patients in our facility receive intensive PT, OT, Speech Language, rehab nursing and other services and their care is managed by physicians who specialize in rehabilitation.
      3. The average Length of Stay in our facility is about 16 days. 85% of our patients go home but continue services with us on an outpatient basis. 15% of our patients get transferred to lower level post acute facilities to continue with their recovery.
   d. **Where we get our patients** – Patients are referred to us from the local acute care hospitals.
   e. Our hospital network is owned by local individuals. This year, **in addition to the MET** ($1.2 mil) we paid local, state and federal taxes **in the amount of $1.9 mil per year.**

2) **How we differ from acute care community hospitals and why this is important in the context of this discussion on DSH and MET** – By licensure and regulation, our type of specialty hospital is not allowed to offer the types of services that are most commonly accessed by underserved populations; and DSH is a program to fund the care needs of underserved populations.
    a. We do not have primary care adult or pediatric physician services
    b. We do not have obstetrical or gynecological services
    c. We do not have an emergency room or surgical services.
    d. In an acute care community hospital a patient can come from home and access services directly. For inpatient care in a rehab hospital, the usual course of patient entry is by a referral from an acute care hospital. Patients do not access services on their own.
    e. The above factors combine to place a very real limit to the amount of free care a rehab hospital can actually deliver.
    f. IN MANY OTHER STATES, REHAB HOSPITALS LIKE NORTHEAST DO NOT PARTICIPATE IN THE DSH AND MET PROGRAMS FOR THE REASONS SET FORTH ABOVE.

3) **Further complications limiting the amount of free care rehab hospitals in New Hampshire are able to deliver.**
    a. Patients have to meet both financial and clinical criteria to be approved for Medicaid. Beyond meeting the financial criteria, patients have to meet criteria about the severity and permanency of their disability in order to be considered Medicaid eligible for admission to a rehab hospital.
    b. If the financial and clinical criteria are met, there are then strict criteria about how long a person can stay in the rehab hospital and be covered by Medicaid.
    c. An example of a typical catastrophic Medicaid patient who is referred to Northeast Rehab:
        i. Young male 19-24 years old who incurs a traumatic brain injury from an auto accident. This patient is severely compromised.
        ii. Patient typically has no private or public medical insurance, family now has to begin the application process for Medicaid (which at times can take a minimum of 90 days or longer).
        iii. The patient is stabilized at the acute care hospital, is ready for transfer to a rehab hospital and his payor status is "Medicaid Pending". We as the rehab provider now incur the risks of whether this patient meets the Medicaid eligibility criteria described above because there is no precertification process (and no ongoing stay review).

iv. Northeast Rehab provides all of the necessary services for the rehabilitation of this patient, the cost of which could amount to tens of thousands of dollars.

v. This type of patient requires ongoing care after their stay at Northeast Rehab. Typically this patient is not able to function independently so we seek a longer term facility for ongoing care and or community services. In many cases, we are unsuccessful in placing these patients in alternative settings because openings are not available. Northeast continues to care for the patient until they can return to a supervised setting with family or acquaintances.

vi. One year after discharge, New Hampshire Medicaid reviews the case against their established criteria and denies payment for a portion of the stay because "care could have been rendered in a less intense setting" (irrespective of the fact that there was no less intense setting available).

vii. This is just one type of case. There are numerous examples of how a rehab hospital is limited in its ability to treat the number of underserved patients who would be required to mitigate the corresponding MET obligation.

viii. In 2009 Northeast Rehab had 1/3 of its Medicaid days denied because of scenarios similar to that above.

ix. To anticipate an obvious question, we have made these problems about restriction of patients and denial of services quite clear to DHHS going back to at least 1996. We remain committed to working with DHHS to find a more acceptable solution.

4) **Northeast Rehab does deliver uncompensated care**

a. **Last year, Northeast Rehab's expenditure for uncompensated care was $1.4 Million dollars.**

b. If we are exempted from the DSH and MET as a result of this bill, Northeast Rehab will continue to deliver this level of uncompensated care.

c. In our area of specialization and the type of specialty hospital that we are, we will always be limited in the numbers of underserved patients that we are allowed to treat in our specialty area.

d. One criticism that I have heard about exempting the rehabs from the MET and the DSH is that the rehabs don't offer enough uncompensated care. Hopefully with the facts that I just reviewed, you will come to a different conclusion.

5) **An historic perspective regarding NRH and the DSH and MET.**

a. DSH and MET have been linked since at least 1992. And NRH has participated solely for the benefit of the State to acquire additional federal funds.

b. In all cases, the DRA has wired the DSH payment funds to NRH's bank in the morning and then NRH wired the identical amount back to the DRA to pay the MET tax.
c. The wire in- wire out transactions were always scheduled on the same day.
d. In all cases where the tax exceeded the DSH payment, NRH requested and was granted a reduction of the tax to match the DSH amount.
e. In 10 of the last 14 years, NRH's tax exceeded the DSH payment and the tax was subsequently reduced.
f. Essentially for several years, we have been operating in a fashion where our participation in the program **would not cause any financial harm or benefit** to NRH.

6) Now the Rules have changed

a. We participated in this program with the understanding that it would not create either a liability or a benefit for us. Now since the program has changed- we are faced with a significant liability. For several reasons which have been explained previously by DHHS, The State redesigned the DSH program. **Now DSH would no longer be tied to MET -2 separate and distinct transactions.**

b. **On Friday, Sept 3rd at 7 PM (Labor Day weekend) we learned for the first time via a letter from DHHS that NRH would be subject to a $2.7 million dollar shortfall as a result of the difference in DSH funds received and MET tax assessed, and that we had to pay this $2.7M in 60 days (by 10/31)!! This would be like finding out on Feb 15th that the IRS had changed the way income taxes are calculated and that on April 15th of this year –and every year thereafter--you owed the IRS $2.7M or more! .**

c. For us, a new tax of $2.7 mil would be due in less than 60 days from this notice. And under the new rules, this shortfall is real money – not to be reduced down by any process.
d. This new $2.7 mil tax burden would be in addition to NRH paying $177k in BPT, $294k in local property taxes and approx $1.5 mil in Federal income taxes.
e. Prior to September 3rd we were totally unaware of the significant tax burden that we were going to being asked to shoulder.
f. To lessen the sting, DHHS introduced a transitional plan for the first year which reduced our shortfall to $1.2 mil.
g. However now that the transition is behind us, at a 5.5% MET tax rate, I would anticipate that we will incur a $1.9+ mil shortfall each and every year going forward as an additional tax burden to our facility. This is unsustainable for us.
h. If the State were to increase the MET tax to 6% our tax burden would only increase proportionally. Instead of a $1.9 mil tax burden, we estimate 2.3+ mil each and every year.

7) **We would have never agreed** to participate in the DSH program in 1992 (which was solely for the benefit of the State) if we knew that in 2010 and 2011 this would be the result of our participation in the program.
   a. At a 5.5% tax rate, NRH's burden is significant and unsustainable. Our ability to continue to operate under a 6% MET tax with the same factors in place would be unfair and unjust to NRH and other rehab hospitals.
   b. Also, we believe that the assumption found in the fiscal note that our revenue will grow by 8% next year is a very aggressive assumption which would result in overstating the potential loss of revenue by exempting the rehab hospitals from the DSH and MET. Our actual rate of increase in Net Revenue over the last 3 years has been 3.8%.

8) Thank you.

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF MEDICAID BUSINESS AND POLICY

129 PLEASANT STREET – BROWN BUILDING, CONCORD, NH 03301-3857
603-271-8166 1-800-852-3345 Ext. 8166
Fax: 603-271-8431 TDD Access: 1-800-735-2964

Nicholas A. Toumpas
Commissioner

Kathleen A. Dunn
Director

Testimony of Katie Dunn, Medicaid Director
on behalf of the NH Department of Health & Human Services to the Senate Finance Committee

Senate Bill 165: An Act relative to the Medicaid uncompensated care fund and the Medicaid enhancement tax
February 24, 2011

Good afternoon. For the record my name is Katie Dunn and I serve as the State's Medicaid Director in the Department of Health and Human Services. I am here today to offer commentary on SB 165. DHHS is appreciative of Senator O'Dell's leadership on this issue and looks forward to working with him and the NH Hospital Association as we strive to make the NH DSH program responsive to both federal regulations as well as trying to address the impact of uncompensated care on the hospital network. I would like to speak to two elements of the bill that as drafted pose a conflict with federal law.

The first comment pertains to the provision of the bill found in Section 5 Medicaid Enhancement Tax (MET) that would exempt the state's two rehabilitation hospitals from payment of the MET. Setting aside concerns about any reduction in general fund revenue as a result of making such a change, the MET as a provider tax is subject to detailed and prescriptive federal Medicaid regulations because it is used as the matching state funds to draw down federal disproportionate share hospital (DSH) funds. Thus, the exemption criteria for a facility lies in federal regulation and ultimate approval to exempt a facility or facilities from participation in the MET resides with the federal government. To that point, DHHS is in the process of conducting an analysis pursuant to those same federal regulations to see if the rehab hospitals meet the exemption criteria. The analysis will be shared with the hospitals as well as the NH Hospital Association. This bill, if passed as is, could violate federal regulations if the two rehab hospitals do not qualify for a federal exemption. In the instance of a state law in conflict with a federal law, federal law will apply. DHHS recommends amending the bill to ensure that the final legislation is not in conflict with federal regulations and allows any hospital that wishes to seek an exemption to the MET to make such a request through the Department citing the federal exemption regulations and documenting how the criteria are satisfied.

The second comment pertains to the Section 5 (IV-a) where net patient services revenue is defined. DHHS appreciates the sponsors' efforts at clarifying this definition. The Centers for Medicare and Medicaid Services (CMS) is presently considering this very issue as CMS officials in the course of reviewing our recently submitted DSH state plan amendment raised this question. CMS has until the end of March to respond to our request for approval of the state plan amendment. At this time we cannot confirm that the definition as contained in the draft legislation will meet CMS' approval. DHHS respectfully requests that this committee either delay further action on this bill until the CMS definition is available or if not possible due to legislative timelines, be willing to embrace the CMS definition once it is available which may happen after the bill crosses over to the Senate. In so doing, New Hampshire avoids another potential point of inconsistency with federal authority, which bears ultimate control over the DSH program.

Thank you for the opportunity to speak to you today. I will be happy to take any questions the committee may have.

Committee Report

STATE OF NEW HAMPSHIRE

SENATE

REPORT OF THE COMMITTEE

Date: March 23, 2011

THE COMMITTEE ON Finance

to which was referred Senate Bill 165-FN

AN ACT relative to the Medicaid uncompensated care fund and the Medicaid enhancement tax.

Having considered the same, the committee recommends that the Bill:

OUGHT TO PASS WITH AMENDMENT

BY A VOTE OF: 6-0

AMENDMENT # 1179s

Senator Chuck Morse
For the Committee

Shannon Whitehead 271-4980

New Hampshire General Court - Bill Status System

Docket of SB165

Docket Abbreviations

Bill Title: relative to the Medicaid uncompensated care fund and the Medicaid enhancement tax.

Official Docket of **SB165**:

Date	Body	Description
2/3/2011	S	Introduced and Referred to Finance, **SJ 5**, Pg.46
2/17/2011	S	Hearing: 2/24/11, Room 103, State House, 1:30 p.m.; **SC12**
3/24/2011	S	Committee Report: Ought to Pass with Amendment **#2011-1179s**, 3/30/11; **SC17**
3/30/2011	S	Committee Amendment 1179s, AA, VV; **SJ 11**, Pg.226
3/30/2011	S	Ought to Pass with Amendment 1179s, MA, VV; **SJ 11**, Pg.226
3/30/2011	S	Pending Motion OT3rdg
3/30/2011	S	Sen. Morse Moved Laid on Table, MA, VV; **SJ 11**, Pg.226

NH House NH Senate

Other Referrals

SB165

COMMITTEE REPORT FILE INVENTORY

✓ ORIGINAL REFERRAL _____ RE-REFERRAL

---

1. THIS INVENTORY IS TO BE SIGNED AND DATED BY THE COMMITTEE AIDE AND PLACED INSIDE THE FOLDER AS THE FIRST ITEM IN THE COMMITTEE FILE.
2. PLACE ALL DOCUMENTS IN THE FOLDER FOLLOWING THE INVENTORY IN THE ORDER LISTED.
3. THE DOCUMENTS WHICH HAVE AN "X" BESIDE THEM ARE CONFIRMED AS BEING IN THE FOLDER.
4. THE COMPLETED FILE IS THEN DELIVERED TO THE CALENDAR CLERK.

✓ DOCKET (Submit only the latest docket found in Bill Status)

✓ COMMITTEE REPORT

✓ CALENDAR NOTICE

✓ HEARING REPORT

✓ HANDOUTS FROM THE PUBLIC HEARING

✓ PREPARED TESTIMONY AND OTHER SUBMISSIONS

✓ SIGN-UP SHEET(S)

ALL AMENDMENTS (passed or not) CONSIDERED BY COMMITTEE:

3/23 - AMENDMENT # 1179s 3/23 - AMENDMENT # 1160s
3/23 - AMENDMENT # 1171s 3/17 - AMENDMENT # 0798s

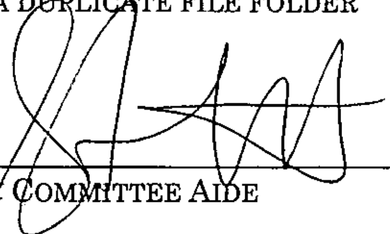
ALL AVAILABLE VERSIONS OF THE BILL:

✓ AS INTRODUCED ____ AS AMENDED BY THE HOUSE
____ FINAL VERSION ✓ AS AMENDED BY THE SENATE

____ OTHER (Anything else deemed important but not listed above, such as amended fiscal notes): Fiscal note attached

IF YOU HAVE A RE-REFERRED BILL, YOU ARE GOING TO MAKE UP A DUPLICATE FILE FOLDER

DATE DELIVERED TO SENATE CLERK 7-21-11



BY COMMITTEE AIDE

Revised 2011