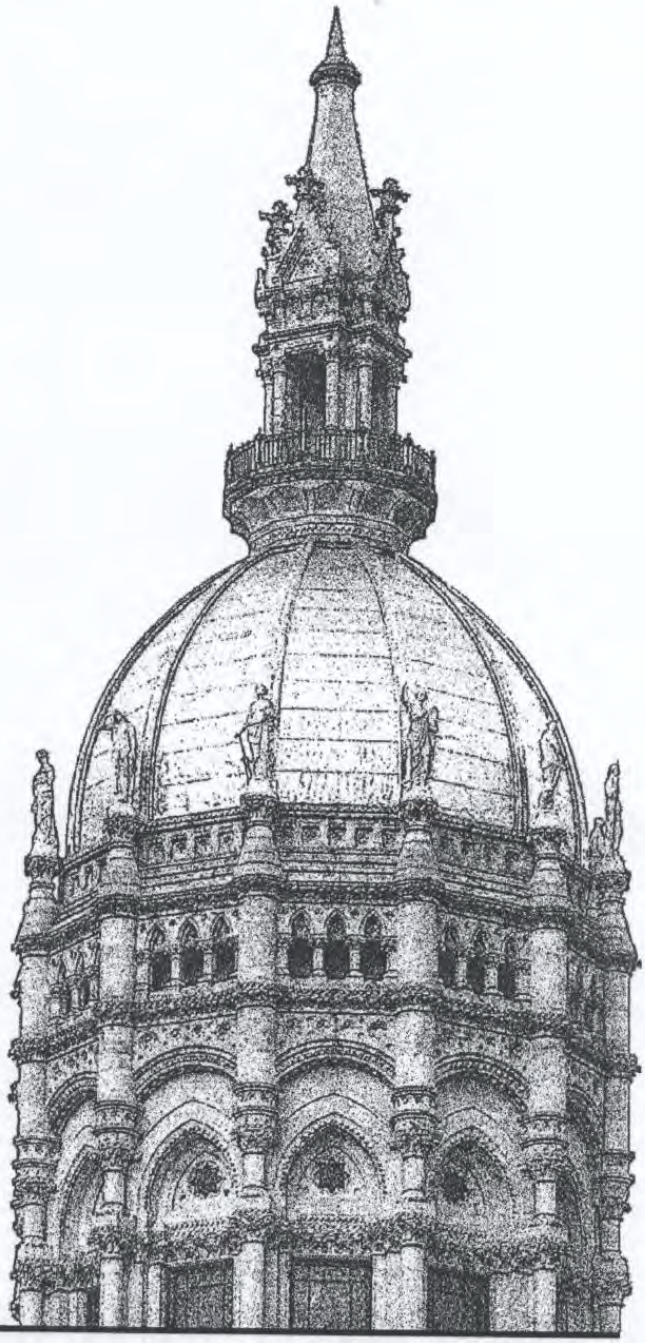
Funding of Hospital Care

December 2006



PRI

Legislative Program Review and Investigations Committee

Connecticut General Assembly

CONNECTICUT GENERAL ASSEMBLY
LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

The Legislative Program Review and Investigations Committee is a joint, bipartisan, statutory committee of the Connecticut General Assembly. It was established in 1972 to evaluate the efficiency, effectiveness, and statutory compliance of selected state agencies and programs, recommending remedies where needed. In 1975, the General Assembly expanded the committee's function to include investigations, and during the 1977 session added responsibility for "sunset" (automatic program termination) performance reviews. The committee was given authority to raise and report bills in 1985.

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LEGISLATIVE PROGRAM REVIEW
& INVESTIGATIONS COMMITTEE

Funding of Hospital Care

DECEMBER 2006

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Executive Summary

Funding Hospital Care in Connecticut

In April 2006, the Legislative Program Review and Investigations Committee voted to undertake a study of hospital funding in this state. The study's main purpose was to examine the mix of revenue sources hospitals rely on to fund services, and especially to focus on how government payments impact the financial viability of hospitals in Connecticut.

There are currently 30 acute care hospitals in Connecticut, and all except one are non-profits. (For most of the study there were 31 hospitals, and the analysis in the report is based on 31 hospitals. In October 2006, New Britain General Hospital and Bradley Memorial merged into the Hospital of Central Connecticut, although the two separate campuses are maintained).

The total amount of adjusted net revenue for all hospitals for FY 05 was approximately $6.36 billion. Using measures that examine Connecticut's hospitals in comparison with the national experience, several impressions emerge. Connecticut has a low ratio of hospitals and hospital beds for its population and, therefore, it does not appear that it has too much capacity to support. Connecticut is a small, densely populated state, though, and Connecticut residents have a hospital located closer to them than do residents in almost any other state.

Connecticut ranks very high in terms of the dollars per capita it spends on health care, but on closer examination, this state spends considerably less on hospital care as a percent of all health care expenditures than does the rest of the country. Connecticut residents spend significantly more on long-term care, partly because Connecticut has a high percentage of elderly, but also because this state has a very high number of nursing home beds per 100 people 65 years and older. Increasing competition by outpatient surgical centers and other ambulatory centers has also impacted hospitals' revenue streams.

Connecticut's hospitals appear not as healthy financially as hospitals in the rest of the country. Operating margins for Connecticut hospitals are below those nationally. There seem to be a number of reasons for this, some empirical and others anecdotal. Connecticut has very high labor costs; this is recognized by the federal government in establishing a Medicare wage index that is 15 to 35 percent higher than the standard. The wage issue for Connecticut hospitals will likely not lessen as a nursing shortage continues, and hospitals offer signing and retention bonuses.

Connecticut hospitals also are faced with higher than average energy costs, and malpractice insurance is high for hospitals in the state. The physical plant of most hospitals in Connecticut is older than hospitals in many other regions of the country. Federal government actions, including the Balanced Budget Act of 1997, have also had a negative financial impact on most hospitals in the Northeast, including Connecticut, as Medicare readjusted its rate structure to pay more to hospitals in rural areas of the country while maintaining overall budget neutrality.

The study also found that Connecticut's Medicaid payments reimburse for about only 73 percent of hospital costs for treating clients covered under Medicaid and other state medical assistance programs. This is substantially less than the average 87 percent of costs that Medicaid pays in all states. However, Medicare payments to Connecticut hospitals statewide cover about 97 percent of costs, which is a greater percentage than the 90 percent Medicare covers nationally. Historically, hospitals here and elsewhere have shifted the costs of government underpayments to private payers like commercial insurance. Nationwide, private payers account for about 130 percent of hospital costs, which is greater than the 120 percent from private payments in Connecticut, but without comparative expense data, it is difficult to assess the actual financial burden the ratios place on different payers.

The committee also found that the government underpayments account for a larger portion of Connecticut hospitals' uncompensated care expenses than the costs of treating the uninsured. While inadequate revenues can cause weakened financial conditions, hospitals may not be run as efficiently as they might be. The committee found that some hospitals in financial distress have high expenses per discharge, even when adjusted for patients' severity of illness, and while some financially weak hospitals have held the line or even cut costs in recent years, others experienced high percentage increases in expenses.

Connecticut hospitals are not all similar or equal entities, and a combination of historical, regulatory, and market forces have shaken the financial foundation of many, and likely not all hospitals will survive as currently structured. The recommendations contained in the report change the Medicaid fee-for-service payment structure, and increase accountability of Medicaid managed care organizations, but Medicaid payments are not a large source of most hospitals' revenue stream. While the recommendation should make that payment system fairer, for the smallest hospitals, serving less than one percent of all patients statewide, and a smaller portion of Medicaid clients, the payment changes from Medicaid will not help their financial situation.

Hospital care and its funding is only one part of the fragmented, partly regulated, partly competitive, multi-payer, costly health care system. Increasingly, economists and health care policy experts indicate that recent growth in health care costs is unsustainable, and that unless actions are taken to curb that growth, they predict dire consequences.

The committee found areas contributing to higher health care costs in Connecticut that need closer examination are numerous, interconnected, and complicated. Many of those cost drivers -- from nursing shortages to Connecticut's high portion of health care expenditures for nursing home care -- are discussed in the report, but the committee determined these were beyond the scope and resources of this hospital funding study. The report recommends a panel be formed to examine and recommend strategies to make private health insurance more affordable and improve access to primary and preventive health care.

In all the committee approved 13 recommendations to modify the way hospital Medicaid inpatient rates are set, establish annual increases to Medicaid outpatient rates, restructure the disproportionate share programs, and establish contractual obligations for Medicaid managed care organizations. The recommendations also require greater oversight by state agencies on payments and utilization by Medicaid clients, and broaden the development and reporting of

consumer information at the Office of Health Care Access. The committee also recommends the establishment of a panel to examine health care costs, make private insurance more affordable and improve access to primary and preventive health care. The specific 13 recommendations are listed below.

RECOMMENDATIONS

1) Beginning October 1, 2007, the Department of Social Services shall establish a hospital inpatient Medicaid Fee-for-Service reimbursement program adopting a prospective payment system that incorporates a case mix index. The system shall use as a base payment rate the most current available Medicare base rate adjusted by the Medicare wage index.

   The rate shall account for the Indirect Medical Education (IME) expense for teaching hospitals. DSS shall adjust the rate by the difference in the base rate and the rate with the IME, and apportion the percentage of the amount difference by the ratio of inpatient Medicaid discharges to the total inpatient discharges at that hospital for the most recent year reported to Office of Health Care Access.

   DSS shall then adjust the rate using the Medicare DRG case mix index for the Medicaid population for that hospital.

   DSS shall adjust the base rate annually by the same percentage as the Medicare hospital market basket adjustment for inpatient payments.

   DMHAS shall use this rate-setting structure to pay for inpatient SAGA services.

2) The Department of Social Services shall require, as part of the contracts with Medicaid managed care organizations, that rates to providers increase by at least the same percentage as the per member per month increase and limit the increase in administrative expenses to the same ratio as the increase in the per member per month rate.

   The Department of Social Services, in its contracts with Medicaid managed care organizations, shall place a cap on the number of emergency room visits per MCO client. The MCO would incur a financial penalty -- $100 a visit – for a client who uses the emergency room more than twice in a year when the visit is coded as a non-emergency. DSS should use the encounter and claims data to determine when this occurs and adjust its payments to the MCOs. The penalty adjustments would be pooled and used to supplement funding to hospitals that served those clients.
3) The committee recommends maintaining the current outpatient reimbursement structure, but believes the rates should be increased annually. DSS shall adjust the outpatient rates by increases in the Consumer Price Index (urban).

4) The committee recommends, however, that, while maintaining the per-service fee schedule, DSS through its payment contractor – Electronic Data Systems – ensure that hospitals (or any other provider) are not over-utilizing certain services per episode to

increase outpatient payments. DSS and DMHAS, as payers, should also increase monitoring of payment of inpatient care for their clients to ensure that such care is necessary and appropriate, and could not have been provided on an outpatient basis.

5) DSS shall terminate the application of the Medicaid DSH rate adjustment.

6) The urban DSH funds should be made available to hospitals with greater percentages of Medicaid discharges rather than limiting funds to hospitals in municipalities with a combination of certain population and economic aspects. At a minimum, four hospitals (Norwalk, Danbury, Mid State and Windham) should be considered for the urban/distressed DSH funds.

7) The distribution formula for urban DSH should be re-configured.

8) The state should establish a disproportionate share fund available to hospitals serving large percentages of Medicaid clients on an outpatient basis.

9) OHCA should prepare a supplemental report that summarizes all information currently filed by hospitals related to provision of service for the uninsured and underinsured. At a minimum, OHCA should conduct analysis that compares hospitals on the basis of size and/or geographical location that leads to conclusions and potential recommendations for policy makers. In particular, OHCA's review for the supplemental report should include, but not be limited to:

    - the general provisions of each hospital's policies regarding free and charitable care including bed funds;
    - the number and approval rates of free and reduced care applicants;
    - access, use, and available level of bed funds; and
    - analysis of charges and costs for free and reduced care.

10) While the committee recognizes that Medicaid fee-for-service clients are not in managed care, state agency payers should collect and analyze payment and client utilization data for a number of reasons:

    - determine where Medicaid clients are receiving treatment, and for what conditions;
    - determine whether inpatient care is disproportionately used by a small number of clients;
    - ensure that other state agencies, or those under contract to serve these clients in the community, are providing needed services;
    - conduct a cost-benefit analysis to determine if increasing rates for providers in the community, especially in the psychiatric area, may lessen the need for more intensive and expensive inpatient psychiatric care; and
    - analyze the use of Medicaid inpatient stays for psychiatric care by hospital to determine whether outcomes (e.g., longer periods between episodes requiring

hospitalization) are better at certain hospitals, especially when examined in connection with hospital costs.

The Department of Social Services should also examine the payments being made under fee-for-service that would generally be paid for under Medicaid managed care, for example for inpatient newborn and labor and delivery services. If fee-for-service rather than Medicaid managed care is reimbursing for an increasing percentage of the costs of providing care to the Medicaid population, that information should be used when renewing contracts with the Medicaid MCOs and determining any rate increases.

11) The Office of Health Care Access should broaden its oversight perspective to include requiring reporting of outpatient data from health care facilities as outlined in statute. OHCA should analyze and report on outpatient data as they do inpatient hospital data. The office should also phase in a reporting requirement of aggregate financial data from health care facilities other than hospitals.

The Office of Health Care Access shall report on indicators of hospital expenses as part of its *Annual Report on the Financial Status of Connecticut's Hospitals.* Those indicators for each hospital should include but not be limited to:

- the expense per case mix adjusted discharge and equivalent discharge,
- salary and fringe benefit expenses for the top 10 positions as reported on Attachment 25 from hospitals; and
- administrative expenses related to marketing.

12) The committee recommends that OHCA, within available staffing resources, develop and disseminate through its website, information that will assist consumers in making more informed health care decisions. Such information should be developed in concert with the Department of Insurance, where appropriate, and should include, but not be limited to:

    - managed care report card results reported by the insurance department;
    - information on average, median, and range of premiums charged by Connecticut-licensed health insurers;
    - medical loss ratios of health insurers, and to the extent possible, their profit margins;
    - the hospital expense data reported on an individual basis (as recommended above);
    - hospital performance ratings as measured in the National Healthcare Quality Report, which includes hospital grades based on a series of measures used by CMS under Medicare as well as other quality indicators;

- rating outcomes for Connecticut hospitals based on about two dozen common hospital procedures currently evaluated by Health Grades, Inc. (see rationale below); and

- OHCA's estimates of what the hospital's charges and costs for the procedure would be, using patient data OHCA obtains from hospitals and CHIME data, matched with outcome ratings.

OHCA should begin to develop and report similar information for other health care facilities and providers as the data are obtained.

13) Recognizing the breadth and severity of the problem, the committee recommends that a panel should be established and convened by March 1, 2007, to examine health care costs, make private health insurance more affordable, and improve access to primary and preventive health care.

The panel should consist of the following 40 members:

Six members of whom one each shall be appointed by the speaker of the House of Representatives, the president pro tempore of the Senate, the majority leader of the House of Representatives, the majority leader of the Senate, the minority leader of the House of Representatives, and the minority leader of the Senate;

The chairpersons and ranking members of the committees on: public health; insurance; human services; commerce; appropriations; finance, revenue and bonding;

Ten members appointed by the Governor, who shall include representatives from the Connecticut Hospital Association, the Connecticut Business and Industry Association, Connecticut Medical Society, the Connecticut Nurses' Association, Connecticut Primary Care Association, the state association representing health care plans, and the Connecticut Association of Health Care Facilities; and

The commissioners, or their designees, of the Office of Policy and Management, the Office of Health Care Access, Connecticut Insurance Department, Department of Public Health, Department of Social Services, Department of Mental Health and Addiction Services;

The panel shall be convened by the chairs of the legislature's public health and insurance committees and shall elect its co-chairs from among its members.

Areas for the panel's consideration should include but not be limited to:

- *The state's current nursing shortage* and developing strategies for enhancing the education and supply of nurses. The panel should consult the report issued in October 2005 by the Council of Deans and Directors of Nursing Programs.

- *Strategies to promote increased access to primary and preventive care, especially for Medicaid populations, which should include expanding hours of federally qualified health care clinics. (*In October 2006, approximately $14 million in state bonding money was approved to expand and improve the facilities of several FQHCs)

- *Encouraging development and approval of health insurance products* that lower costs to consumers if they maintain healthy lifestyles. For example, new policies provide discounts for persons who maintain a body mass index below a certain level. Also, current health care policies seem to emphasize high consumer deductibles and co-pays at the front end, but once the deductible level is reached, the consumer has no financial incentive to consider cost in the health care decision. Perhaps policies could combine lower initial deductibles, with a percentage of overall costs for a consultation, procedure, or diagnostic test borne by the consumer. The consumer would then have a financial interest in knowing and comparing costs.

- *The adequacy of the current level of regulation by the Insurance Department over health insurers and premium rate increases.*

- *Current statutory health insurance mandates* and analysis of whether they add to health care costs in Connecticut.

- *Strategies to assist lower-wage individuals and small businesses pay health insurance premiums.*

- *The current distribution of state Medicaid dollars* -- specifically the high proportion to nursing homes.

The panel should report its findings and recommendations to the Governor and Legislative leadership by January 1, 2008.

Introduction

Funding of Hospital Care

The Legislative Program Review Committee authorized a study of hospital funding in Connecticut in the spring of 2006. Connecticut's hospitals for the most part are facing worsening financial circumstances than the rest of the nation. More than 30 percent of Connecticut hospitals have had negative operating margins in six of the last seven years. Six hospitals are in serious financial circumstances, with negative margins for all of the past three years, or a large negative margin for the last year. The committee's study was to determine the factors that contribute to hospitals' fiscal strength or weakness, and specifically to examine how state government payments impact that stability, and make recommendations for improvements.

Methods

To conduct this study, the program review committee and its staff relied on many state and national sources of information. The report used information from the federal government agencies such as the Centers for Medicare and Medicaid Services, which collects data on both of those health care programs, primarily Medicare; the Agency for Healthcare Research and Quality, another division of the U.S. Department of Health and Human Services; and the National Center for Health Statistics. Information and comparative state data from the American Hospital Association, the Kaiser Family Foundation, and the National Conference of State Legislatures were also used.

On the state level, committee and staff collected and analyzed data from the financial reports and accompanying schedules that hospitals must file with the Office of Health Care Access (OHCA). The hospital fiscal year is identical to the federal fiscal year – October 1 through September 30 – and references to fiscal years in the report are to that period unless otherwise noted. The most recent fiscal years -- FY 03 through FY 05 – were used for analysis. The study also used Medicaid cost reports that hospitals submit to the Department of Social Services (DSS), as well as other Medicaid financial and utilization data maintained by the department. Data from CHIME, the information system maintained by the Connecticut Hospital Association were also used for the report.

In addition, committee staff interviewed personnel of OHCA, DSS, the Department of Mental Health and Addiction Services, as well as representatives of the Connecticut Hospital Association, the Connecticut Association of Health Maintenance Organizations. Program review staff also visited several hospitals and met with each facility's administrative and financial staff. The committee and staff also relied on information provided by staff in the legislative fiscal and research offices. The committee held a public hearing in September 2006 to obtain information from state agencies and interested parties on the study topic.

Report Organization

The report on the funding of hospital care contains six chapters. Chapter I includes a chronological synopsis of hospital funding and a summary profile of Connecticut's system in a national context. Chapter II provides more in-depth information of Connecticut's hospital funding by major payer source, including: a description of the populations covered; how rates and payments are determined by each payer; the amounts of revenue received from each payer group; and selected utilization statistics.

Chapter III provides a summary profile of Connecticut's hospitals on three aspects – their administrative structure, various utilization measures, as well as an analysis of general financial and efficiency measures among hospitals and the potential impact on their financial condition.

Chapter IV provides the committee's findings concerning the Medicaid Fee-For-Service inpatient hospital rates and makes recommendations the committee believes will improve fairness, equity and adequacy of Medicaid rates. The committee also recommended that the outpatient rates be increased annually to improve with access to care, and ensure a closer connection between costs and payments for service. This chapter also makes recommendations that DSS modify its contracts with Medicaid Managed Care organizations (MCOs) to require that rate increase to MCOs be passed on to providers, and to establish penalties for MCOs whose clients frequently use the emergency room inappropriately.

Chapter V discusses financial assistance available to hospitals in addition to revenues by payers for patient services, including hardship grants and the state's various disproportionate share programs. The committee found that the level and availability of these other forms of financial assistance are unpredictable and are not open to all hospitals, and made recommendations to expand the availability of the funds to hospitals serving similar clients. The committee also determined that OHCA should improve its oversight of hospital reporting on uncompensated care and use of free bed funds to ensure the accuracy and uniformity and recommends that OHCA issue an annual supplemental report on the need and distribution of free and charitable care.

Chapter VI discusses the utilization of emergency room services by payer group and the distribution of visits by hospital, and the committee believes the analysis could be used by a panel established by the legislature's Public Health Committee to examine emergency room overcrowding. In addition, the chapter analyzes inpatient hospital services by Medicaid patients and the overall population by diagnostically related groups, and the committee recommends that state agencies as payers of medical care strengthen oversight of client utilization of inpatient services, and that DSS more thoroughly examine and evaluate the Medicaid payments made under fee-for-service and those by the MCOs under contract.

The state's health care market, including health insurance, competition among hospitals themselves and other health care facilities, and other competitive pressures are discussed in Chapter VII. The committee found that hospitals are not all similar or equal entities, and that a combination of historical, regulatory, and market forces have shaken the financial foundation of many, particularly smaller, Connecticut hospitals. The committee recognized that more steps

need to be taken to broaden regulatory oversight of health care facilities as well as to expand the development and reporting of information that will help the consumer make more informed health care decisions, and makes recommendations to advance those areas. Finally, the committee found that health care costs are rising faster than the economy, and that fewer persons are being covered by employer-based health insurance. The committee determined that many of the factors contributing to this were beyond the scope, resources and timeframe of the study, and recommends a panel to examine health care costs, develop strategies to make health insurance more affordable and improve access to primary and preventive care.

It is the policy of the Legislative Program Review Committee to provide agencies included in the scope of the review with the opportunity to comment on the committee findings and recommendations prior to the publication of a study report in final form. Both the Office of Health Care Access and the Department of Social Services were offered an opportunity to comment. The Department of Social Services' response is contained in Appendix A, but the Office of Health Care Access chose not to respond.

Chapter I

Hospital Funding: A Summary Profile

Hospitals originally were most often charitable institutions reliant on donations, endowments, and the like. Frequently they were (and often still are) affiliated with a religious organization; in some states acute care hospitals were publicly owned by the state, county or city. Hospitals did bill for services for those patients who could afford to pay, but it was not a great source of their funding.

The Great Depression created the recognition of the nation's health care needs. But nationalized health insurance or any federal program to address health care was not part of the Great Society Plan. During World War II, private health insurance through employers grew rapidly, as direct wage increases were limited by the federal government and employers could attract and keep workers through offering benefit packages instead. This private insurance trend continued after the war, and while there were proposals discussed in Congress to sponsor national health insurance, none came up for a vote.

In 1965, Congress passed legislation creating the Medicare and Medicaid programs. At their inception both programs reimbursed hospitals for all costs for serving clients of either program. With the creation of these two government programs, the foundation of hospital funding—a mixture of employer-based private insurance and Medicare and Medicaid – was established and continues today.

Table I-1 provides a synopsis of key milestones in hospital funding nationally and in Connecticut.

Table I-1. Hospital Funding – A Chronological Synopsis

Early part of the 20th century -- Hospitals operate largely as charities.

WWII – to mid 20th century -- Introduction of private insurance, largely for catastrophic medical services like major hospital stays.

1946 – Passage of the federal Hill-Burton Act, designed to expand and improve the physical plant of the nation's hospital system, through grants and guaranteed loans. Hospitals that received funding prohibited from discriminating and also required to provide a "reasonable volume" of free care.

1965 – Introduction of Medicare/Medicaid. Medicare covers all persons 65 and over – 19 million enrolled at the time. Hospitals reimbursed for "reasonable costs" under Medicare/Medicaid programs.

1972 – Medicaid act modified to allow states to employ own methods of reimbursement but with stipulation that they not exceed Medicare reasonable costs payments.

Table I-1. Hospital Funding – A Chronological Synopsis

1973 – Connecticut General Assembly establishes a Commission on Hospitals and Healthcare to set maximum rates hospitals may charge and approve hospital budgets. Rates build in a portion that private insurers will pay for hospital care for public-pay patients and uninsured.

1980 – Congress passes Boren Amendment allowing states more flexibility in setting hospital rates to encourage hospital efficiency and keep Medicaid costs down. State Medicaid payments had to:

- be "reasonable and adequate";
- meet the costs of "efficiently and economically operated facilities";
- maintain enrollees' access to hospital services; and
- consider the situation of hospitals serving a disproportionate share of Medicaid and low-income patients (the Boren Amendment established the Disproportionate Share Hospital (DSH) payment program to help states do that).

1982 – Tax Equity and Fiscal Responsibility Act (TEFRA) -- Attempts to constrain the rates of increase in **Medicare** by setting target rates per case by applying an inflation factor to a hospital's base year costs. (The base year used for Medicare was 1981.) The TEFRA legislation also required that HHS present a proposal for a Medicare prospective payment system (PPS) by the end of 1982.

1983 -- Connecticut adopted the TEFRA methodology for setting its **Medicaid** inpatient hospital rates. Base year for costs was 1982.

1983 – Congress accepts the Medicare Prospective Payment System proposal; passes the PPS proposal as part of the Social Security Amendment of 1983. The **Medicare** PPS is phased in over a 3-year period. The prospective payment system continues to be the way hospitals are paid for inpatient care today under Medicare.

1985 – Congressional Omnibus Reconciliation Act (COBRA) established, including the Emergency Medical Treatment and Labor Act (EMTALA), which required hospitals participating in Medicare that operate active emergency rooms to provide appropriate medical screenings and stabilizing treatments for all persons regardless of ability to pay.

1991- Because DSH payments used "creatively" by states, and because of rapid rise in DSH spending, federal restrictions known as **upper payment limits (UPLs)** placed on DSH use – Medicaid DSH adjustments cannot exceed 12 percent of national Medicaid spending. Also, health care costs (including hospital costs) continue to increase dramatically. Beginning in the late 1980s, percentage of employers offering health coverage benefits declines, problem of expanding uninsured population.

1994 – Connecticut deregulates – A growing recognition that hospital cost regulation not effective in slowing costs. In Connecticut, the General Assembly creates a more competitive

Table I-1. Hospital Funding – A Chronological Synopsis

health care market, by deregulating hospital prices and allowing health care payers, like HMOs, to negotiate directly with hospitals on rates and payments. (CHHC becomes the Office of Health Care Access.)

1997 – federal **Balanced Budget Act (BBA)** – **Repealed the Boren Amendment,** which effectively severed the link between Medicaid rates for inpatient hospital care and hospital costs, and lowered the ceilings (UPLs) of DSH payments to hospitals. The BBA also allowed states to require Medicaid clients to participate in Medicaid managed care organizations, and it made broad changes in provider payments under Medicare effectively reducing hospital payments.

1997 – Connecticut establishes Medicaid managed care. All family Medicaid clients required to participate. MCOs under contract with DSS receive a capitated rate for each enrollee. Each MCO may negotiate rates and payments with providers including hospitals. DSS continues to set Medicaid fee-for-service using TEFRA 1982 target rates.

Late 1990s-2000 – Managed care organizations continue to negotiate steeply discounted rates from charges. In Connecticut, the average discount for private insurance was 55 percent off charges. Medicaid managed care companies now also negotiating rates with hospitals.

Since 2000 -- Expenditures to hospitals have increased sharply (see Figure 1-1 later in this chapter for annual percentage increases) most recently in response to:

- higher medical malpractice insurance costs;
- wage pressures especially for nursing staff (linked to nursing shortages and quality of care); and
- reduced fiscal pressure from private health plans as hospitals gain the upper hand again in negotiating increases through organizational restructuring, including links to private physician networks, and [nationally] hospital consolidation.

Sources: CMS Overview of Medicaid and Medicare programs; Report to Congress on the Impact of the Boren Amendment Repeal on Hospital Services; OHCA reports; KFF Medicare Timeline; Kaiser Commission on Medicaid and the Uninsured: Medicaid Legislative History; Brief Summaries of Medicare and Medicaid (Nov. 2005); CMS; Report to Congress: Medicare Payment Policy (March 2006)

CONNECTICUT'S HOSPITAL SYSTEM IN NATIONAL CONTEXT

To analyze the financial viability of Connecticut's hospitals, it is necessary to view the state and its hospitals in context with the national healthcare picture, in terms of population, hospital type and other comparative measures.

Table 1-2. Comparison of Hospitals by Population	
State	**People Per Hospital***
Maryland	119,157
Washington	118,637
New Jersey	113,220
Connecticut	**109,697**
Colorado	108,492
California	100,647
United States	74,430
Median	69,339
Source of Data: American Hospital Directory and the U.S. Census Bureau * States listed in the table are those with a similar statistic to Connecticut – i.e., plus or minus 10,000 population per hospital	

State comparison of hospital capacity. Connecticut has 31 acute care hospitals. If measured on a per capita basis, Connecticut ranks fourth from the bottom with one hospital for approximately every 110,000 people. The median nationally is fewer than 70,000 persons per hospital, and the average is one hospital for almost every 75,000 persons. Thus, by this measure, Connecticut does not appear to have too many hospitals. Table I-2 on the left shows Connecticut and the states with similar number of people served by one hospital.

Further, when hospital beds are considered, Connecticut also does not appear to be overserved. Connecticut has one hospital bed for every 550 state residents, while the national average is one bed for every 454 persons. Table 1-3 shows states with similar bed capacity to Connecticut.

Table 1-3. Comparison of Hospital Beds by Population	
State	**People Per Hospital Bed***
New Mexico	592
Arizona	589
Hawaii	581
California	579
Wyoming	565
Montana	557
Nevada	553
Connecticut	**550**
Minnesota	545
Delaware	526
Wisconsin	519
Maryland	515
Virginia	513
Georgia	499
U.S. Average	454
Median	463
Source of Data: American Hospital Directory and the U.S. Census Bureau *States listed in the table are those with a similar statistic as CT -- i.e., plus or minus 50 people per bed	

However, Connecticut is a small state with a fairly dense population. As shown in Table 1-4, Connecticut ranks 4th from the top in terms of population per square mile, and also 4th in terms of density of hospitals, with one hospital covering an average of 150 square miles, while the national average is one hospital per 890 square miles and the median is one hospital covering almost 600 square miles. Thus, Connecticut residents are very close to a hospital, and not surprisingly, other states with a high ranking also tend to be smaller, densely populated states.

Table 1-4. Comparison of Hospitals by Population and Square Mile

State	Pop Per Sq. Mile	State Rank	Sq. Miles Per Hospital (The range is + and - 100 Sq. Miles)	State Rank
New Jersey	1,175	1	96	1
Rhode Island	1,030	2	95	2
Massachusetts	816	3	109	3
Connecticut	**725**	**4**	**151**	**4**
Maryland	573	5	208	5
Delaware	432	6	326	7
New York	408	7	234	6
United States	84		890	
Median	92		599	

Source of Data: American Hospital Directory and the U.S. Census Bureau

Comparison of hospital funding. As a nation, Americans spend a great deal on health care; health care is now approximately 16 percent of the national gross domestic product. The most recent state comparison of personal health care expenditures indicates that Connecticut -- along with other states in the Northeast -- have higher health care expenditures per capita than the national average. Table 1-5 shows the top states using this measure, and indicates that Connecticut ranks 5th. (The District of Columbia is not included because of distortions in spending and population.)

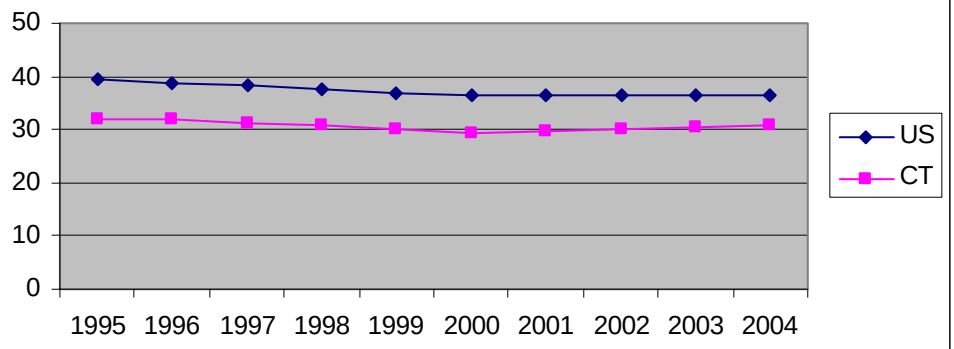
Table 1-5. States with Highest Health Care Expenditures Per Capita – 2004

State	Per Capita Spending on Health Care
Massachusetts	$7,084
New York	$6,643
Rhode Island	$6,381
Alaska	$6,367
Connecticut	**$6,260**
Delaware	$6,243
United States	$5, 394
Median	$5,242

Source of Data: Centers for Medicare and Medicaid, Office of the Actuary, National Health Statistics

Connecticut is considered a wealthy state with the highest per capita income in the nation. When health care expenses are measured as a percent of the state's 2004 gross state product (GSP), Connecticut, at 11.4 percent, is well below the national average.

Figure I-1. Hospital Care As A Percent of All Health Care Expenditures



Source of Data: CMS office of the Actuary

Further, for the last two decades, Connecticut has spent less than the national average in terms of the percentage of health care spending on hospital care. As Figure 1-1 shows, Connecticut's percentage spent on hospital care has hovered around 30 percent, while the national average has been at least 35 percent.

Table 1-6. Percent Distribution of Health Care Expenditures From All Payers – 2004

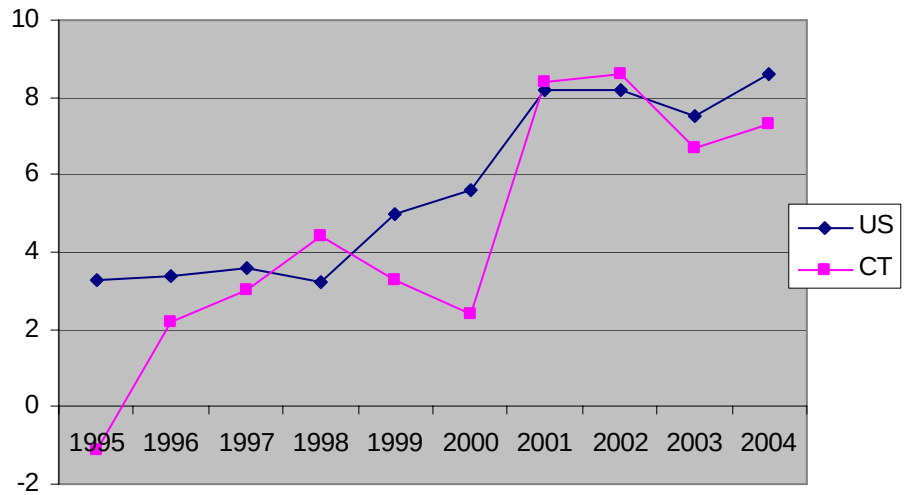
	U.S. Average	Connecticut
Hospital Care	36.6%	30.8%
Physician Services	25.6%	24.0%
Other Professional Services	3.4%	3.9%
Dental	5.2%	6.0%
Home Health Care	2.8%	3.2%
Prescription Drugs	12.1%	12.8%
Other Non-durable Medical Products	2.1%	1.9%
Durable Medical Equipment	1.5%	1.4%
Nursing Home Care	7.4%	12.5%
Other Personal Health Care	3.4%	3.5%

Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics

Table 1-6 shows the percentage break-down of health care spending between Connecticut and the nation for 2004, the most recent year available. As shown, Connecticut spends considerably less on hospital care (16 percent less) than the national average, and significantly more (69 percent more) on nursing home care. While Connecticut has a high elderly population compared to other states, it also has a high ratio of nursing home beds for its age 65 and older population.

Trends in overall hospital spending. Connecticut has also lagged behind the rest of the country in terms of the percentage increases in hospital spending for all payers. Nationally, the average annual long-term growth (1980-2004) has been 7.5 percent, while in Connecticut that growth rate has been 6.8 percent. More recent trends, as shown in Figure 1-2, indicate that the growth rate in hospital spending – for both the nation and Connecticut -- has increased from about two to four percent in the mid- to late-1990s to about seven and eight percent beginning in 2001.

Figure I-2. Annual Percentage Growth in Hospital Spending: U.S. and CT Comparison 1995 - 2004

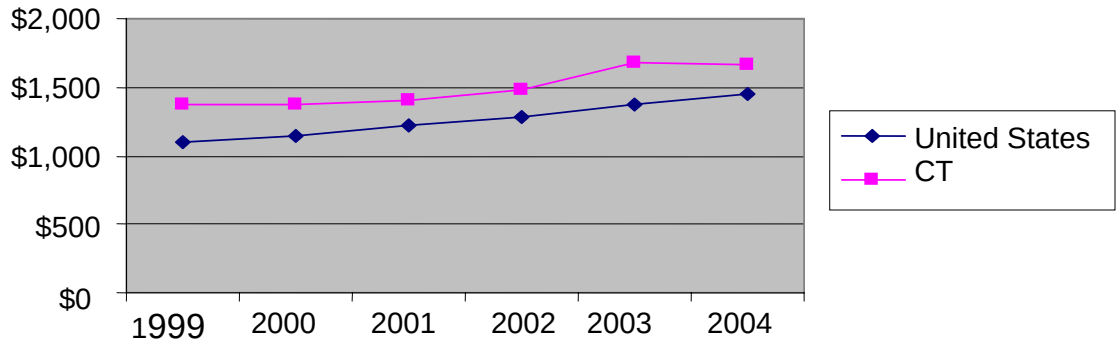


Source of Data: CMS Office of the Actuary

The other trend depicted in Figure 1-2 is that Connecticut's hospital spending is considerably more volatile than the national spending, with more dramatic spikes and drops than those experienced nationally. One of the substantial declines in Connecticut occurred between 1998 and 2000, a result of the Balanced Budget Act of 1997 that was enacted to reduce the costs of Medicare and Medicaid, including the payments made to hospitals, especially those in more urban areas.

Comparison of inpatient hospital costs. Hospital expenses in Connecticut are higher than those nationwide. As Figure I-3 shows, the cost of providing care in Connecticut hospitals in 2004 was $1,668 per inpatient day compared to $1,450 nationally (a 15 percent difference). However, the gap between Connecticut's expenses has narrowed; in 1999, Connecticut's per diem costs were almost 25 percent higher. Further analysis of hospital expenses and per diem payments is presented in Chapters II and III.

Figure 1-3. Comparison of Inpatient Hospital Expenses -- Per Day 1999-2004



Source of Data: Kaiser Family Foundation, State Health Facts

Comparison of hospital operating margins. Table I-8 shows that Connecticut hospital operating margins are less than the average nationally. (This is the percent of surplus or loss of operating revenues). Reasons contributing to this are that hospital expenses are higher in Connecticut, as shown in Figure I-3, and the percentage of health care expenditures going to hospitals is less in this state than the U.S. average, as shown in Figure I-1 and Table I-6. While hospital operating margins have improved nationally, that has not been the case in Connecticut.

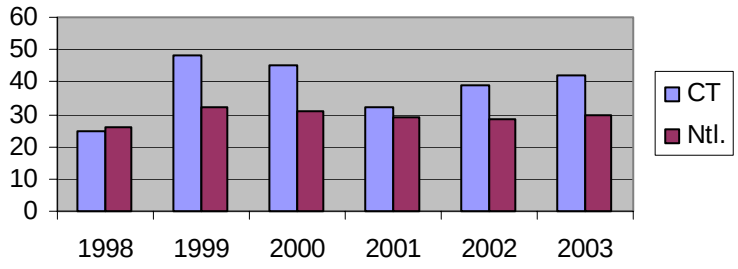
Table 1-8. Comparison of Hospital Operating Margins in Nonprofit Hospitals Nationwide and CT Hospitals -- 2001 -2005

	2001	2002	2003	2004	2005
NTL	1.2%	1.5%	1.4%	2.0%	2.8%
CT	-1.0%	0.2%	0.4%	1.4%	0.7%

Sources of Data: Moody's Investors Service and Ct. Office of Health Care Access.

The percentage of hospitals in Connecticut with negative operating margins has consistently been higher than the national average of nonprofit hospitals operating "in the red". As Figure I-4 shows, except for 1998 when the national average was slightly above Connecticut's 25 percent, the ratio of Connecticut's hospitals experiencing financial distress has been higher than the nation. Further, the scope of the problem is greater in Connecticut – with more than 40 percent of the 31 hospitals in the state experiencing negative operating margins in three of the six years examined. Chapter III analyzes in greater detail some of the aspects that appear to impact the financial viability of Connecticut hospitals.

Figure I-4. Comparison of Percentage of Hospitals with Negative Operating Margins: CT and NTL 1998-2003



Source: Lewin Group Analysis of AHA Annual Survey Data and OHCA for CT Hospitals

Chapter II

Profile of Hospital Funding by Payer Source

Hospital funding in Connecticut comes from a variety of sources, as shown in Figure II-1. The funding most relied upon is revenue for providing patient care, i.e., operating revenue, and is the major focus of this study. Patient funding streams, while varied, can be categorized into one of three major categories: private insurance, or one of the major government payers, Medicare or Medicaid.

There is tremendous variation in how and what hospitals are paid depending on the payer. Generally, a hospital will submit the bill for services to one of many private insurers, Medicare, or a Medicaid-covered program, and be paid different amounts for the same services or charges. Hospitals negotiate discounts or rate reductions with private insurers and managed care companies while government payers pre-set the rates they will pay hospitals.

As displayed in Figure II-2, the payments and utilization of the populations by payer stream vary considerably. These measures used in the graph for each major payer source are: the average inpatient per diem payment; the average length of stay (ALOS); and the rate of inpatient discharges per 100 persons in that coverage group. These measures are important to a hospital's financial condition. If a hospital is located in an area that has a high Medicaid population, for example, and a high percentage of its patients are Medicaid clients, with heavy hospitalization and low reimbursement rates, as displayed in Figure II-2, the hospital's financial condition will be more impacted by those factors than a hospital located in an area with a higher private pay population. Chapter III discusses the impact of these various factors on individual hospitals.

This chapter profiles the various major payer sources including:

- populations covered;
- how rates and payment are made;
- revenue amounts generated from the various sources;
- utilization statistics, including those shown on Figure II-2, as well as the case mix index – this reflects acuity of illness, with 1 being the standard, so an index of less than one is less sick and more than 1 means a higher severity of illness -- and emergency room use, by payer group.

The payer sources include:

- Non-governmental payers like health maintenance organizations, managed care organizations and other private health insurers;

Figure II-1.

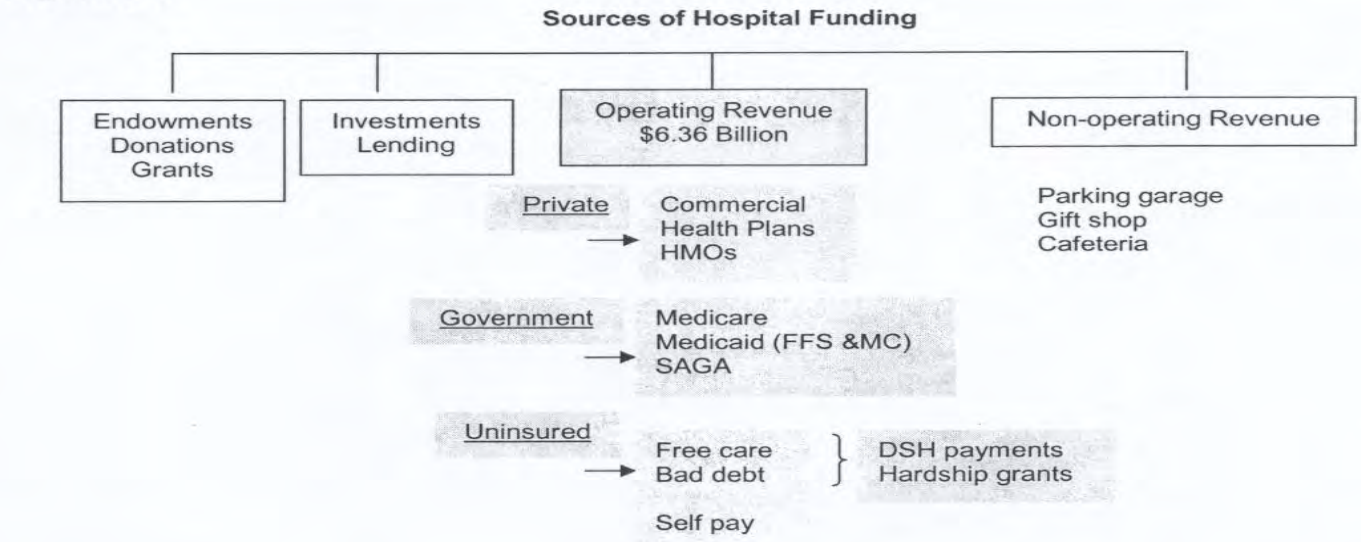
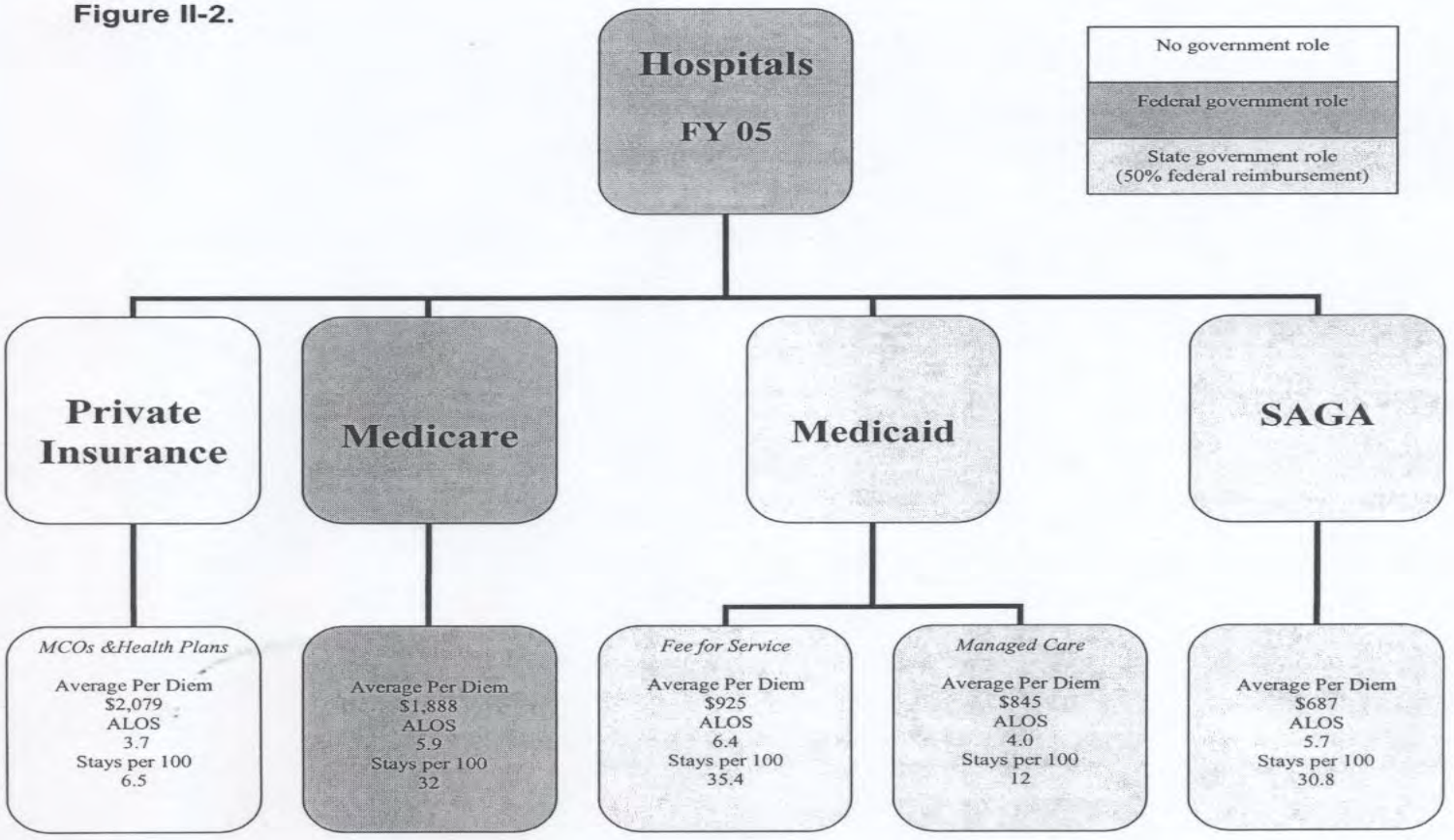


Figure II-2.



- Medicare;
- Medicaid Managed Care;
- Medicaid – fee-for-service;
- State-Administered General Assistance (SAGA); and
- Disproportionate Share Hospital (DSH) Programs.

Hospital filing requirements. Hospitals must file a number of different reports on their revenues and costs, as well as patient data, with both the federal and state governments for various purposes. In Connecticut, hospitals file audited financial statements, along with a number of schedules and attachments with OHCA. Hospitals also file extensive Medicare cost reports with the federal Centers for Medicare and Medicaid Services (CMS), and more limited Medicaid cost reports with the state Department of Social Services. Thirty of the 31 hospitals in Connecticut are nonprofit and therefore do not pay taxes on revenue, but must file a form 990 with the Internal Revenue Services to maintain that status.

Some of these reports are used in establishing rates and for adjustment of payments by Medicare and Medicaid, known as cost settlement. Some schedules are used by OHCA to determine actions on applications for additions or changes in health care services, known as "certificate of need". The data from other schedules are used in reports developed by OHCA on state utilization of services and on financial stability of hospitals in the state. PRI used the data from the schedules and reports filed with OHCA in developing the information in this report.

PRIVATE INSURANCE

While the percentage of people covered by public health insurance is increasing, the majority of persons are still covered by private health insurance (also known as non-government payers). As Table II-1 shows, about 64 percent of the state's population is covered by private insurance, compared to about 59 percent nationwide.

Table II-1. Comparison of Health Insurance Coverage (in Percent): CT (2003-2004) and U.S. (2004)

Coverage Group	Connecticut	U.S.
Employer	61%	54%
Individual	3%	5%
Medicaid	11%	13%
Medicare	13%	12%
Other Public	1%	1%
Uninsured	11%	16%

Source: *Kaiser Family Foundation Health Facts* website; based on data from Census Bureau, Urban Institute and Kaiser Commission on Medicaid and the Uninsured.

Population

Most private health insurance is offered through a person's employer; thus, most of the privately insured population is working age – under 65 – and their families. Certainly, some of these persons have disabilities, or suffer from chronic conditions, but compared to people covered by Medicare and Medicaid, many of whom are elderly or disabled by virtue of the program's eligibility requirements, the private-insured population is healthier.

Populations covered by private health insurance do not have to meet eligibility requirements *per se,* as with public health insurance. However, many employers, especially small employers, are limiting health care coverage by: covering the employee only and not dependents, and reducing benefits. Further, in recent years, health care coverage has become increasingly difficult to afford, as employees are asked to shoulder a greater percentage of the premiums, absorb higher deductibles, incur higher co-pays for service, and the like.[1]

Coverage

Coverage under private insurance can vary considerably. There are statutory mandates in Connecticut that require certain services and treatments to be covered under policies offered by private health insurance companies and managed care organizations, but employers who self-insure are exempt from those mandates.

Inpatient hospital care is a mandated covered service. Coverage of other outpatient services may or may not be required, but visits to the emergency room are a mandated coverage. By statute, Connecticut uses the "prudent layperson" definition (C.G.S. Sec. 38a-478r(c)) of when emergency room care is appropriate and must be covered. This is a fairly non-restrictive definition.

Sometimes managed care plans require a pre-certification for an elective hospital admission, an elective surgery for example. Admission through the emergency room would likely not require pre-certification.

Currently, the six health maintenance organizations licensed in Connecticut and the top 15 health insurers that offer managed care plans cover or administer coverage for about 2.9 million persons. The breakdown of coverage is shown in Table II-2. All HMOs and MCO plans offer statewide coverage in their networks, and almost all hospitals are included in the networks.

Table II-2. Connecticut's Private Health Insurance Market: Number of Enrollees: 2004

	HMO (6)	**Indemnity Managed Care Organizations (top 15)**
Fully insured	874,857	949,945
Self Insured	465,954	677,906
Coverage Area	All Statewide	All Statewide
Hospitals in Network	3 cover 30 3 cover 31	1 covers 27 4 cover 28 6 cover 30 4 cover 31

Source of Data: Connecticut Insurance Department, Report on Managed Care Organizations 2004

[1] CT HR Reports, LLC, 2006 Survey of 4210 companies nationwide (187 employers in CT) indicates that almost all employers surveyed in Connecticut adopted multiple measures – raised co-pays, raised employee premiums, increased deductibles, and capped or reduced benefits – to address health care costs.

Rates and Payments

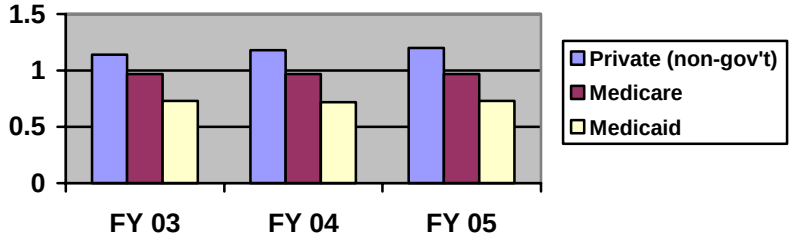
Since 1994, a competitive market has determined how private insurers pay hospitals for care. Private insurers negotiate rates (typically annually) with individual hospitals or hospital networks. These rates are discounts off a hospital's charges, and annually the hospitals file with the Office of Health Care Access the average discount rates for that year. These average discount rates have been growing, from 41 percent off charges in FY 02 to 44 percent in FY 04.

The discount off charges is not a very meaningful statistic, though, because a hospital can increase charges (adjust its charge master) when it wants, but almost no one pays full hospital charges. In fact, the overall ratio of costs to charges in FY 05 for all hospitals was 44 percent. A more relevant ratio for private insured, as well as other payers, is what hospitals are paid as a percent of their costs. Overall, most private insurers pay more than actual costs; this offsets somewhat the underpayment of costs from public payers like Medicare and Medicaid.

Figure II-3 show the ratio of payments to costs for all hospitals from FY 03 through FY 05 for the three major payer groups – private (non-government), Medicare, and Medicaid. As the figure shows, for FY 05 the average private payment-to-cost ratio is 1.2, which means that private insurers were paying hospitals 20 percent more than their costs. This is considerably higher than the .97 ratio for Medicare, and .73 for Medicaid.

Overall, FY 05 revenue from non-government payers was about $3 billion, or 48 percent of all hospital revenue, after OHCA adjustments for DSH payments, etc. The average inpatient per diem rate for private payers was $2,079 (see Figure II-2 for comparisons).

Figure II-3. Ratio of Hospital Payments to Costs: FY 03 - FY 05



Utilization

Overall, there were 420,419 inpatient discharges (stays) at all Connecticut hospitals during FY 05. Of those, private pay patients accounted for 176,440, or about 42 percent of inpatient stays. In terms of persons covered, this means there were 65.2 inpatient hospital stays for every 1,000 persons covered by private insurance, or 6.5 per 100.

The case mix index (measuring acuity of illness) shows this inpatient population – relative to overall case mix index – was not severely ill. The case mix index for this population during FY 05 was .98 compared to an overall case mix index for all inpatient stays at all hospitals of 1.14. This lower acuity is also apparent when average length of stay (ALOS) is considered. The ALOS for private pay for FY 05 was 3.7 days compared to an overall average – all hospitals, all patients -- of 4.8 days. The emergency room (ER) utilization for the private pay population was also relatively low – 21.4 visits per 100 persons – compared to overall ER visits of 39.4 per 100 persons statewide during FY 05.

MEDICARE

Medicare is a federal program that provides health insurance to elderly and some disabled people. This is the largest government health insurer. Currently, Medicare covers approximately 42.4 million people nationwide.

Population

Primarily the Medicare population is elderly – 65 years and older. Some disabled populations are also covered, no matter what the age, including those with end-stage renal disease. A percentage of the Medicare population is also eligible for Medicaid. For example, most of the long-term care Medicaid clients are also Medicare enrollees. Other low-income Medicare enrollees are also eligible for some Medicaid benefits, including having Medicaid pay for all or some of the Medicare supplementary premiums.

Currently, there are approximately 524,000 Medicare enrollees in Connecticut. This is about 15 percent of the state's population; the average for all states is 14 percent.

Coverage

There are four major components to Medicare—Part A through Part D – as outlined in Table II-3. (This study's primary focus is on hospital funding, covered by Part A).

Table II-3. Medicare Components and Coverage

Part A	Covers all primary health care including hospital care and other primary care, including some rehabilitative care (but not long-term care). Medicare does not cover the first day of a hospital stay, which is considered the deductible.
Part B	Requires a monthly premium. Covers outpatient and ancillary care, as well as physician and other services.
Part C	Covers persons in Medicare managed care plans.
Part D	Since January 2006, Medicare covers prescription drugs. This is known as Medicare Part D.

Payment Structure

The major portion of funding for Medicare comes from payroll tax contributions, with minor funding from federal General Fund revenue. Medicare is a federal program, and is administered by the Centers for Medicare and Medicaid Services of the Department of Health and Human Services.

For inpatient hospital stays (covered under Part A) the rates are established using a prospective payment system (PPS). Under PPS, a specific predetermined amount is paid for an inpatient hospital stay, depending on the patient's diagnosis and treatment class, known as a diagnostic-related group (DRG). There are approximately 500 different DRGs, and the DRGs are weighted differently, based mainly on historical hospital charges.

A hospital is paid a set amount for that DRG no matter the actual cost of providing the service or the length of stay. If it costs the hospital less than the DRG payment, the hospital makes a profit; if it costs more, the hospital absorbs the loss. For certain very expensive cases – known as outliers—the hospital may obtain a cost adjustment. Hospitals submit their bills to an entity known as a fiscal intermediary, usually an insurance company that is serving as a Medicare administrative agent, which uses a computerized system to categorize the bill into a DRG and make the appropriate payment.

The payment for each DRG is divided into two components – labor and non-labor. The labor portion is adjusted (multiplied) by an index to reflect the wages of a particular region. For example, if the wage index is 1.20, the wage portion is increased by 20 percent for hospitals in that area. Wage indexes are updated annually. Connecticut hospitals are currently assigned one of seven different wage indices, depending on the area (see Map III in the following chapter).

Each year, the costs of goods and services purchased by hospitals – the hospital "market basket"-- and quarterly percent changes in those goods and services are examined by an economic forecasting firm under contract with the Centers for Medicare and Medicaid Services. The change in the "market basket" measures inflation for hospitals in much the same way as the Consumer Price Index (CPI) does for consumers. The data are analyzed by the Medicare Payment Advisory Commission (MEDPAC) and that body makes a recommendation on what, if any, increase in the PPS for hospitals and other medical providers should be. The final rule for the PPS typically is published in the *Federal Register* in August and takes effect on October 1st – the beginning of the federal fiscal year and the fiscal year for hospital accounting.[2]

Hospitals must annually submit a Medicare cost report to CMS. These cost reports are used for cost settlement (ensuring the hospital was not overpaid, and that costs are appropriate), as well as to establish the inflation in the "market basket" of hospitals' inpatient care, and to adjust an individual hospital's wage index.

[2] The final rule published in the Federal Register in August 2006 regarding PPS reflected a 3.5% increase in the market basket. However, CMS also will begin phasing in restructuring the DRG payment system so that the DRGs are based more on hospital costs rather than charges.

The PPS is the established overall rate for services. However, there are other add-ons under Medicare that impact certain hospitals -- for example, teaching hospitals, those with unusually high-cost cases, and/or those in certain locations. Some of those are described below:

Graduate Medical Education Payments		
Type	**Includes Payment for:**	**Based on:**
Direct Medical Education (DME)	Salaries for residents, teaching physicians and class space	Ratio of use by Medicare patients by all utilization
Indirect Medical Education (IME)	Higher costs assumed at teaching hospitals, such as additional testing	Ratio of number of residents at that hospital by number of beds

- Disproportionate Share Hospitals (DSH) – Medicare allows additional payments to hospitals that treat large numbers of low-income and uninsured patients. It is important to note this is distinct from the Medicaid-reimbursed DSH program which is discussed separately.

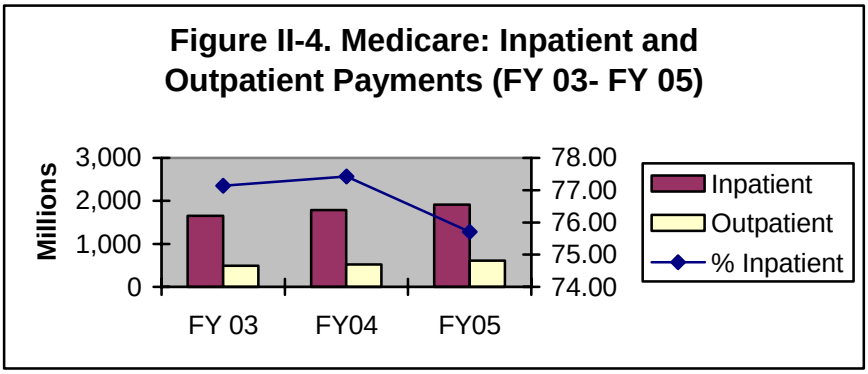
- Hospitals may be able to receive additional payments (or have their costs considered differently) if they receive a special designation such as classification as a rural hospital or as a sole community provider. In the latter case, the hospital must be a considerable distance (25-35 miles) from the nearest hospital and meet other criteria. Essent/Sharon Hospital is the only hospital in Connecticut with that designation.

- Some additional payments may be made for major new technology.

Payments and Rates

In FY 05, Medicare payments to Connecticut hospitals totaled about $2.53 billion, approximately 41 percent of all hospital payments in Connecticut. The vast majority of Medicare payments go for inpatient care as shown in Figure II-4. In both FYs 03 and 04, inpatient care accounted for more than 77 percent of Medicare hospital payments; in FY 05 inpatient payments dropped slightly -- to about 75.5 of Medicare hospital funding.

Figure II-4. Medicare: Inpatient and Outpatient Payments (FY 03- FY 05)



Total Medicare payments to hospitals grew by 8 percent in FY 04 (from FY 03) – 8 percent in inpatient and 10 percent in outpatient. In FY 05 the annual growth in Medicare payments was 7 percent in inpatient and 18 percent in outpatient for an overall increase of 10 percent. The portion of all hospital costs that Medicare covers – known as the ratio of payments to cost – has not changed over the FY 03 to FY 05 period. The average statewide ratio has been 0.97 for all three years, which means on average Medicare pays about 97 percent of hospital costs. The median has dropped slightly from 0.94 to 0.92.

Since Medicare payments are based on DRGs, or severity of illness, there is no one discharge or per diem rate. However, based on payments to Connecticut hospitals, PRI calculated average and median Medicare inpatient per diem payments for FY 03 through FY 05. The Connecticut Children's Medical Center is excluded from this analysis since it treats very few Medicare patients.

As the Table II-4 shows, the average per diem for Medicare is somewhat higher in FY 05 than FY 03 (almost 9 percent), while the average per diem for all payers increased about 9.5 percent. The average Medicare per diem is somewhat higher that the average overall per diem, for each of the three years. As the table also illustrates, the range in per diems among hospitals is great. Both Medicare and all payer per diems at one hospital can be double what another hospital receives.

Table II-4. Comparison of Inpatient Per Diems: Statewide Median and Average Medicare with All Payers FYs 03 – 05

Medicare Inpatient Per Diems			
	FY 03	**FY 04**	**FY 05**
Median	$1,498	$1,606	$1,634
Average	$1,734	$1,795	$1,888
Range (hospital)	$1,239-$2,457	$1,107-$2,668	$1,054-$2,589
All Payer Inpatient Per Diem			
Median	$1,509	$1,610	$1,675
Average	$1,613	$1,684	$1,756
Range (hospital)	$1,180-$1,903	$1,095-$2,105	$1,072-$2,112
Source of Data: PRI Analysis of Hospital Financial Schedules submitted to OHCA			

Medicare Utilization

In FY 05, there were 420,419 inpatient stays in Connecticut hospitals – Medicare patients accounted for 169,686 stays (40.3 percent). This translates to approximately 32 inpatient stays per 100 enrollees. Because Medicare patients tend to be older, they also tend to be sicker. This is reflected in a high case mix index. For FY 05 the average Medicare case mix index by hospital was 1.39; the median was 1.32, while the average case mix index for all inpatients was 1.14.

The higher acuity of illness results in longer inpatient hospital stays for Medicare. The average length of stay (ALOS) for Medicare patients was 5.9 days in FY 05 while the average for all inpatient stays was 4.8 days. The median (ALOS) inpatient stay for Medicare patients was 5.7 days, and the median overall inpatient stay was 4.5 days.

Emergency room utilization by Medicare clients is shown in Table II-5. While the overall number of ER visits by Medicare clients has increased somewhat from FY 04 through FY 06, the rate of visits has not changed much. The rate of visits for the Medicare population – 54.6 to 57.4 per 100 enrollees -- is about 45 percent higher than ER use overall, which is 37.8 to 39.4 visits per 100 persons.

In general, the vast majority of ER clients are treated and discharged. However, recent OHCA analysis of inpatient data shows that 68 percent of Medicare inpatient stays began in the ER.

Table II-5. Medicare: Emergency Room Utilization (FY 04-06)

	FY 04	FY 05	FY 06
Total Medicare Visits	281,072	295,609	296,028
Rate per 100 Medicare Clients	54.6	57.4	56.2
Percent Medicare of All Visits	21.2%	21.4%	21.7%

Source of Data: CT Hospital Association

MEDICAID MANAGED CARE

Connecticut covers its Medicaid population in one of two ways. Families with children who are in the program because they are low income are covered under managed care, while low-income adults eligible because they are aged, blind, or disabled are under Medicaid fee-for-service. As of July 1, 2006, at initial eligibility or at redetermination, all Medicaid clients must provide one-time documentation to prove they are in the country legally. This potentially may cause eligibility and coverage issues when a Medicaid client seeks medical care.

Population

The vast majority of Medicaid clients in Connecticut are covered by a Medicaid Managed Care (MMC) plan. Medicaid Managed Care, otherwise known as HUSKY A, covers primarily children and their families. As of June 2006, the MMC enrollment accounted for approximately 75 percent of all Connecticut Medicaid clients, compared to the U.S. average of 62.9 percent nationwide. The average monthly enrollment in Medicaid Managed Care for FY 05 is about 300,000. About 43 percent of the MMC clients live in five cities -- Bridgeport, Hartford, New Britain, New Haven, or Waterbury.

Coverage

Medicaid is a joint federal and state program, but to receive federal reimbursement (federal financial participation), each state must submit a plan to the federal government indicating which health care services will be covered. A number of services, including inpatient and outpatient hospital care, are mandated by the federal government, while others are optional.

The Medicaid Managed Care plans in cover all of the health care services except behavioral health which has been recently "carved out" of the managed care plans, and instead is covered under Fee-for-Service.

The Department of Social Services (DSS) is the state administrative agency for all Medicaid services. DSS contracts with four Managed Care Organizations (MCOs): 1) Anthem; 2) Community Health Network (CHN-CT); 3) Health Net; and 4) Well Care/Preferred One. All MCOs must offer statewide network coverage, and all hospitals are included in each of the Medicaid MCO networks.

Rates and Payments

DSS pays the MCOs on a per member per month (PMPM) basis. Rates are set annually – DSS has contracted with Mercer, a private consulting and actuarial firm, to assist the department with ensuring the rates are actuarially sound (a federal regulatory requirement).

Table II-6 shows payments and per-member per month rates for Medicaid Managed Care (all plans), and expenses – medical and administrative -- from 2000 to 2005. Overall the plan enrollment has increased by 38 percent but revenue to the plans has increased by 70 percent over the period. This translates to a member rate (per month) increase of 22.6 percent from 2000 to 2005.

DSS and the Medicaid MCOs negotiated a 3.88 percent rate increase effective July 1, 2006. At the same time, but effective retroactively to January 1, 2006, the four Medicaid MCOs will have their rates reduced by about $19 a month per member to reflect the behavioral health "carve out." Those services are no longer being covered by the plans, but provided on a fee-for-service basis.

Table II-6. Medicaid Managed Care: Revenues and Expenses: 2000 -2005

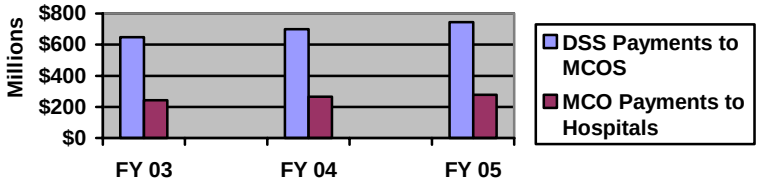
All Plans	2000	2001	2002	2003	2004	2005	% Ch
Member months	2,809,931	3,019,068	3,472,764	3,714,506	3,814,039	3,894,124	38%
Revenue	$438,048,971	$487,699,544	$595,415,309	$647,012,614	$698,919,818	$744,833,775	70%
PMPM Rate	$155.89	$161.53	$171.45	$174.18	$183.24	$191.27	22.6%
Medical Expenses	$381,003,060	$447,653,540	$531,288,294	$588,667,069	$628,984,044	$678,629,128	78%
Administrative Expenses	$43,869,414	$42,331,445	$52,993,196	$59,654,084	$69,658,661	$79,862,932	82%
Total	$424,872,474	$490,081,419	$584,281,490	$648,321,153	$698,642,705	$758,492,060	79%
Medical Loss Ratio	88%	92%	89%	91%	90%	91%	
Administrative Expense Ratio	10%	9%	9%	9.2%	10%	10.7%	
Margin	2%	0%	2%	-0.1%	0.2%	-1.2%	

Source: Medicaid Managed Care Council Analysis of MCO Plan Financial Data

Trends in Medicaid Managed Care

While PRI did not have the data to specifically determine the Medicaid Managed Care payments to hospitals back to 2000 to complement the data in Table II-6, Figure II-5 below shows the Medicaid MCO payments to hospitals from FY 03 through FY 05. The MCOs received an almost 17 percent increase in payments over the three-year period. Hospital Medicaid Managed Care payments increased from about $242 million to about $277 million, a 14.5 percent increase.

Figure II-5. Medicaid Managed Care Payments: DSS Payments to MCOs and MCO Payments to Hospitals



Each Medicaid MCO annually negotiates rates with hospitals and other health care providers and pays them that negotiated rate for services provided. Rates negotiated between the MCOs and providers are considered proprietary, a position currently being challenged in a lawsuit brought by Legal Aid.

While program review did not have the actual rates negotiated by the MCOs and the hospitals, the committee was able to analyze inpatient discharge and per diem payments for the Medicaid Managed Care population and the results are presented below. The range in Medicaid per diems among hospitals as well as the difference between MMC and all payer per diems are striking. Also noteworthy is that the average per diems for MMC clients have dropped by about 14 percent from FY 04 to FY 05.

Utilization and Hospital Payments for Medicaid Managed Care

Table II-7 provides utilization and inpatient information for the Medicaid Managed Care population for FY 03 through FY 05. As the table shows, there has been an increase in MMC inpatient stays (8.2 percent) over the three-year period.

Table II-7. Inpatient Stays and Payments for Medicaid Managed Care – FY 03 – FY 05

	FY 03	FY 04	FY 05
Total MMC Inpatient Stays	33,853	35,273	36,635
ALOS	3.9 days	4.0 days	4.0 days
Average Discharge Payment	$3,853	$3,963	$3,925
Average Per Diem MMC	$976	$983	$845
Average Per diem – All Payer	$1,613	$1,684	$1,756
Hospital Per Diem Range	$527 - $2,075	$419 -$2,165	$404 - $2,050
Source of Data: PRI Analysis of Hospital Schedules Filed with OHCA.			

Overall, the MMC population accounted for about 8.7 percent of all inpatient discharges at all Connecticut hospitals during FY 05. The rate of inpatient discharges for the MMC population is about 12 per 100 enrollees, about the same as in the general population. The average length of stay has increased slightly over the three-year period, from an average of 3.9 to 4.0 days, but that is lower than the average length of stay of 4.8 days for the overall population.

There is no case mix index for the MMC population only. The overall case mix index for all Medicaid patients for FY 05 was .81, while the overall index for all inpatients during FY 05 was 1.14. This indicates the severity of illness for Medicaid clients is less than for the overall population, and would be even lower if aged, blind and disabled clients were removed from the Medicaid index. Greater discussion of Medicaid inpatient utilization is provided in Chapter VI.

Outpatient and Emergency Room Utilization

Almost half of all hospital payments for Medicaid Managed Care is for outpatient services: 46.2 percent in FY 03; 47.5 percent in FY 04; and 48.2 percent in FY 05. Some of the payments for outpatient services are for emergency room visits, although the exact amounts are not available. However, utilization of emergency rooms by Medicaid Managed Care clients is available and is shown in the table below.

Table II-8. Medicaid Managed Care: Emergency Room Utilization (FY 04 – FY 06)

	FY 04	FY 05	FY 06
Total Visits	211,798	226,947	229,282
% of All ER Visits	16%	16.5%	16.2%
Rate per 100 Enrollees	70.5	74	76.1
Source of Data: Connecticut Hospital Association			

The emergency room utilization rate – about 74 per 100 MMC enrollees – is significantly higher than the ER usage -- about 37.8 to 39.4 visits per 100 -- by the overall population in the three years examined.

MEDICAID FEE-FOR-SERVICE (FFS)

Population

Medicaid clients remaining in the traditional fee-for-service program tend to be high users of care, with more complex medical needs. Medicaid services include remedial, preventive, and long-term medical care, as well as acute hospital inpatient and outpatient care. Medicaid FFS primarily serves aged, blind, and disabled individuals. Although there are also some adults and children not enrolled with a managed care health plan, there are approximately 68,000 aged, blind, and disabled enrollees in June 2006. Forty percent of the Medicaid FFS clients reside in five cities – Bridgeport, Hartford, New Britain, New Haven and Waterbury.

Rates and Payments

Fee-for-service payment is the traditional method of paying for medical services. Under this method, health care providers including hospitals are paid for each service they provide at a state-established rate. If a health care provider agrees to participate in the Medicaid program, the provider must accept the Medicaid payment as full reimbursement. All hospitals must accept Medicaid clients if they are certified under Medicare.

The Department of Social Services is responsible for Medicaid rate setting. In Connecticut, the Medicaid FFS program uses a TEFRA rate setting methodology (described below) and receives a 50 percent federal match.

Medicaid FFS Inpatient Services

In 1983, Connecticut adopted the federal Tax Equity and Fiscal Responsibility Act (TEFRA) methodology for setting its Medicaid inpatient rates. This method attempts to constrain rate increases by setting a target rate per discharge. The target rate is established by applying a federally prescribed inflation factor (up to 10 percent) to a hospital's base year costs. The initial base year for Medicaid costs was 1982.

For DSS to calculate rates, hospitals must submit cost reports annually that are reviewed by DSS staff. DSS makes payments directly to hospitals for services delivered to eligible individuals. The payments are based on the target rate per discharge and settled based on the number of discharges for the period. The rate and settlement period is October to September.

Medicaid pays only the adjusted target amount even if the hospital's actual allowable costs are higher. On average, DSS reimburses hospitals for approximately 70-75 percent of their Medicaid-covered inpatient services costs based on each hospital's target amount per discharge.

In 2001, DSS was authorized to adjust each hospital's target amount per discharge to the actual allowable cost per discharge based upon each hospital's 1999 cost report filing, multiplied by 62.5 percent. Hospitals would receive this updated rate if this amount per discharge were higher than the target amount per discharge as adjusted with the federally prescribed percent. Hospitals receiving the updated or "rebased" rate would not receive the federal adjustment percent. As a result, acute care hospitals today have target rates that are based on either 1982 or 1999 cost reports. In summary, Medicaid FFS hospital inpatient payment rates are hospital specific rate per discharge with annual cost settlements subject to maximum allowable amounts.

Table II-9 provides a historical overview of the Medicaid base target rates experience for Connecticut's acute care hospitals. As the table shows, 16 of the 30 hospitals were rebased in 2001 at a new target rate of 62.5 percent of their 1999 costs per discharge. From October 1, 2001 to September 30, 2006, DSS has been statutorily prohibited from applying an annual adjustment factor to the target amount per discharge. (The September 30, 2006 end date is a recent change from the 2006 legislative session. Prior law extended the moratorium until March 31, 2008.)

Since 2001, six hospitals (including four that were rebased) have submitted an exception request to DSS for a target rate per discharge increase. Four of the six requests were approved in 2004 with an effective date of October 1, 2003. Two requests were approved in 2006 but effective October 1, 2005. The three most recent adjustment requests approved in 2006 were for Hartford, Norwalk, and Windham, which had received a previous exception request in 2004.

Table II-9. Medicaid Base Target Rates

Based on 1982 cost reports	Rebased on 1999 cost reports
Bridgeport*	Backus
Bristol	Bradley
Dempsey	Danbury
Greenwich	Day Kimball
Hartford*	Griffin
Johnson Memorial	Hungerford
Middlesex	Lawrence Memorial
Norwalk*	Manchester
Rockville	Mid State
St. Francis	Milford
St. Raphael	New Britain*
St. Vincent's	New Milford
Stamford	St. Mary's*
	Sharon
	Waterbury*
	Windham*
	Yale-New Haven [1]

***** Received exception increase
[1] Refiled 1999 cost report pending
Source of Data: DSS

Table II-10 shows the range of the base Medicaid FFS target rates per discharge for acute care hospitals. (A complete listing of the base rates for each individual acute care hospital is provided in Appendix B.)

Table II-10. Range of Base Medicaid Target Rates Per Discharge

	Number of Hospitals FY ending 9/30/06	Number of Hospitals Effective 10/01/06
Minimum rate of $3,750 or less	13	0
$3,751 to $3,999	4	0
$4,000 to $4,999	9	24
Over $5,000 to $7,797	4	6
Total	30	30

Source of Data: Department of Social Services

For the fiscal year ending September 30, 2006, the minimum target rate per discharge is $3,750. Thirteen hospitals had the minimum rate while four hospitals are very close to the minimum. Thirteen hospitals had target rates exceeding $4,000 including four hospitals exceeding $5,000 (Bradley, Bridgeport, Dempsey, and Yale – New Haven). As the table shows, the range among hospitals' Medicaid target rate is extremely broad, with John Dempsey Hospital at $7,797 receiving more than double the minimum target amount.

Pursuant to Public Act 06-188, DSS must establish a new minimum floor amount for hospital target rates. Hospitals with less than a $4,000 target amount at the end of September 30, 2006, will be raised to $4,000. DSS, within available appropriations, may also adjust target

amounts for those hospitals not affected by the minimum floor amount. As the table shows, 17 hospitals increased to the new $4,000 minimum floor for a total of 24 hospitals.

Under the TEFRA system, hospitals are paid the discharge rate regardless of the individual patient's length of stay or the severity of the illness. For reimbursement purposes, the per diem rate is calculated, which is the discharge rate on a per day basis. (An example is provided below.) For FY 05, the average Medicaid FFS hospital inpatient per diem was $925 or $5,897 per discharge. In FY 05, Medicaid FFS for inpatient services were approximately $189.9 million.

The calculation of Medicaid FFS inpatient rates is complex consisting of a number of components. Table II-11 provides a brief discussion of the major components for a sample hospital.

Table II-11. Components of the Medicaid FFS Inpatient Rate Calculation.

Component	Hospital A	Discussion
Target Amount Per Discharge	**$4,900**	The rate calculation begins with the individual hospital's estimated target amount per discharge which is the established target amount per discharge multiplied by any adjustments such as disproportionate share.
Medicaid Length of Stay	**6.16**	The Medicaid length of stay is then calculated by dividing the total number of Medicaid inpatient days by the total number of Medicaid discharges.
Per Patient Day Cost	**$795.45**	A per patient day cost is determined by dividing the estimated target amount per discharge by the Medicaid length of stay.
Estimated Pass Through Cost Per Patient Day	**$162.52**	An estimate of a hospital's "pass through costs" involving capital/fixed assets, graduate medical education (GME), and provider-based physicians are tallied using recent year costs and divided by the number of Medicaid inpatient days to adjust the cost per patient day.
Medicaid FFS Inpatient Per Diem Rate	**$957.97**	The estimated pass through cost per patient day is added to the per patient day cost to arrive at the Medicaid FFS inpatient per diem rate.

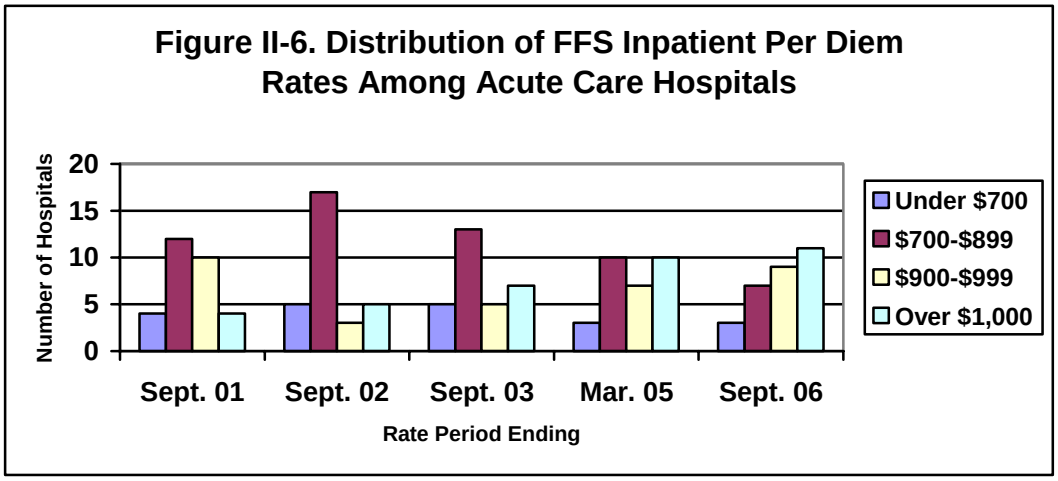
As evidenced by the sample calculation, variations of any component (e.g., the target base rate, a change in Medicaid length of stay, or pass through costs) will result in differences among hospital per diem rates. Another factor that impacts a hospital's target rate and consequently the calculation is whether the hospital is receiving a Medicaid disproportionate share adjustment. Federal law requires state Medicaid programs to take into account the hospitals

that serve a disproportionate number of low-income patients when determining payment rates for inpatient care. (This is known as the Medicaid disproportionate share (DSH) adjustment.)

The hospitals eligible for the Medicaid DSH adjustment can change from year to year, depending on the hospital's Medicaid utilization as a share of overall utilization.[3] For the fiscal year ending September 30, 2006, six hospitals received a Medicaid DSH adjustment in their target rate. Table II-12 lists these hospitals. (In addition to the Medicaid DSH, which is part of a hospital's Medicaid rate, there are additional DSH programs such as for hospitals in urban/distressed municipalities. Further discussion on DSH programs is provided later in this chapter.)

Table II-12. Hospitals Receiving Medicaid DSH adjustment in 2006
Bridgeport
Dempsey
St. Francis
St. Mary
Waterbury
Yale-New Haven
Source: DSS

Figure II-6 shows the distribution of the hospitals' Medicaid FFS rate expressed on a per diem basis for the last five rate periods. The gap in years is because Medicaid FFS inpatient rates were frozen in October 2003 until April 2005.



The number of hospitals with a FFS inpatient per diem rate over $1,000 has increased in recent years. Although individual hospitals may have experienced fluctuations in their per diem rates, the per diem rates overall have gradually increased.

Medicaid FFS Inpatient Utilization

Table II-13 provides utilization data for the Medicaid FFS inpatient population. There were slightly more than 24,000 inpatient discharges for Medicaid FFS clients in FY 05. The average length of stay for Medicaid Fee-for-Service -- 6.4 days -- is about one-third longer than the 4.8 days for ALOS overall in FY 05. The average discharge payment and average per diem has increased since FY 03 – about 10 percent and 6 percent respectively.

[3] Under the TEFRA system, states must consider DSH adjustment for hospitals that have a Medicaid inpatient utilization rate in excess of one standard deviation above the mean rate for the state or a low-income utilization rate of 25 percent. States may not include hospitals that do not have a Medicaid utilization rate of at least one percent.

Table II-13. Utilization of Inpatient Services by Medicaid Fee-for-Service Clients			
	FY 03	**FY 04**	**FY 05**
Inpatient Discharges	23,241	23,630	24,137
Inpatient Days	142,590	146,310	153,949
ALOS	6.1	6.2	6.4
Average Discharge Payment	$5,371	$5,484	$5,897
Average Per Diem	$875	$886	$925
Source of Data: PRI Analysis of Hospital Schedules Filed with OHCA			

The rate of utilization was 35.4 inpatient stays for every 100 clients, a high utilization rate -- compared to about 12 hospital stays per 100 people for the entire population and about 6.5 per 100 for the non-government insured population.

Medicaid FFS Outpatient Services

DSS also establishes a fee schedule for certain outpatient hospital services. The fee schedule is adjusted periodically, within available appropriations, to reflect necessary increases in the cost of services. Other Medicaid payments for outpatient hospital services are individually priced as a ratio of cost for the service to hospital charges and Medicaid payments are made based on that. These statutory ratios are established annually on July 1, based on the most recently filed hospital cost reports.

Outpatient rates vary along service lines but are uniformly applied among hospitals. In state FY 05, the cost of outpatient services totaled over $19 million with approximately $7 million in emergency room costs. Beginning July 1, 2006, DSS is authorized, within available appropriations, to increase Medicaid rates for hospital outpatient services including emergency room visits. (Outpatient fee-for-service rates had not been increased since 2001.)

With a $7 million appropriation, DSS has proposed to add $13 each to the clinic and emergency room service rates for FY 07, which would raise the rates to $48 and $138 respectively. Table II-14 provides the anticipated breakdown of the appropriation among the Medicaid and SAGA programs, for which DSS was also authorized to increase rates.

Table II-14. Hospital Outpatient Rate Adjustments (7/1/06-6/30/07)				
Service	**Medicaid FFS**	**Medicaid MC**	**SAGA**	**Total**
Clinic	$1,415,357	$1,536,595	$330,766	$3,282,717
Emergency Room	$504,192	$2,831,921	$405,297	$3,741,410
Total	$1,919,549	$4,368,516	$736,062	$7,024,128
Source: Department of Social Services				

Medicaid FFS Outpatient Utilization

Table II-15 provides emergency room utilization for Medicaid FFS clients from FY 04 to FY 06. As the table shows, ER usage among this population has substantially risen comprising approximately seven percent of all emergency room visits. The rate of ER visits per 100 enrollees is very high with about one visit for every enrollee in the program. This rate is more than two and half times the statewide average for all payers.

Table II-15. Medicaid FFS: Emergency Room Utilization – FY 04 – FY 06			
	FY 04	**FY 05**	**FY 06**
Total Visits	94,374	98,604	107,421
% of All ER Visits	7.1%	7.1%	7.6%
Rate per 100 Enrollees	92.8	101.8	105.3
Source of Data: CT Hospital Association			

STATE ADMINISTERED GENERAL ASSISTANCE (SAGA) MEDICAL ASSISTANCE

Population

SAGA clients are individuals who do not qualify for other government programs such as Medicare or Medicaid that serve aged, disabled, and families. As a result, many SAGA clients are low-income single men under the age of 65. The average monthly enrollment for the SAGA medical assistance program is approximately 35,000.

As of June 2006, more than half (16,318) of the SAGA clients lived in five cities – Hartford, Bridgeport, New Haven, Waterbury, and New Britain. (Thus, hospitals serving those towns are more likely to serve SAGA clients.) In 2003, SAGA medical assistance was changed from a fee-for-service system to a hybrid model where clients use the state's existing network of federally qualified health centers (FQHCs) and other health care providers in the SAGA network.

Coverage

Since October 1, 2004, the Department of Social Services (DSS) has contracted with a non-profit managed care organization, Community Health Network (CHN), to act as the medical service administrator for the SAGA program. SAGA clients receive medical care from health care providers enrolled with CHN. The core of the SAGA medical network is the state's Federally Qualified Health Centers (FQHCs). However, CHN also enlists health centers, hospitals, and individual doctors into its network.

SAGA provides all the services covered by the state's Medicaid program with the exception of long-term care and non-emergency medical transportation. Mental health and substance abuse treatment is provided by facilities including hospitals under contract with the Department of Mental Health and Addiction Services (DMHAS). DMHAS contracts with Advanced Behavioral Health as its administrative services agency.

Rates and Payments

As a state-funded program, SAGA rates and payments are limited to available state appropriations. Rate increases are provided as state funding is made available. DSS makes the payments to hospitals for medical services provided to SAGA clients while responsibility for behavioral and mental health service payments belongs to DMHAS.

DSS SAGA Medical Payments

As of 2003, DSS pays health care providers in the SAGA network, including hospitals, prospectively based on their pro rata share of the cost of services provided. Hospitals bill DSS at their Medicaid fee-for-service rate. However, due to the limited program funding, DSS divides the SAGA appropriation into 12 monthly allotments. Each month all hospitals submit bills for their services for SAGA patients. If there is a shortfall in funding, DSS reconciles each hospital's payment by adjusting all the hospitals by the same percentage to stay within the monthly allotment. Total DSS payments for SAGA inpatient medical care was $42,394,933 in FY 05.

Table II-16 shows the total inpatient days, average length of stay (ALOS), and average payments for SAGA clients. As the table shows, there has been an increase in SAGA discharges (12.2 percent) and inpatient days (7.1 percent) over the three-year period.

Table II-16. Inpatient Days and Payments for SAGA (FY 03 – FY 05)

	FY 03	FY 04	FY 05
Total SAGA Discharges	9,615	10,364	10,794
Total SAGA Inpatient Days	57,610	61,257	61,746
ALOS	6.0	5.9	5.7
Average Discharge Payment	$4,729	$4,291	$3,928
Average Per Diem	$789	$726	$687
Source of Data: PRI Analysis of Hospital Schedules Filed with OHCA.			

The rate of inpatient discharges was 30.8 stays per 100 SAGA clients, a fairly high utilization rate. The average length of stay for SAGA inpatients has decreased from a statewide average of 6.0 in FY 03 to 5.7 in FY 05. However, the ALOS for SAGA clients is about one day longer than the 4.8 days for the population overall. The average per diem rate for SAGA inpatients has also decreased from $789 in FY 03 to $687 in FY 05.

DMHAS SAGA Behavioral Health Payments

Facilities, including hospitals, providing mental health or substance abuse treatment to SAGA clients are reimbursed at the payment rate set by a DMHAS fee schedule, which varies by facility. For example, the per diem rate for acute inpatient psychiatric services ranges from $515 at St. Raphael to $649 at Hartford Hospital.

Figure II-7 shows the DMHAS paid hospital claims for behavioral health services provided to SAGA clients from July 1, 2005 through June 30, 2006. During this time period, DMHAS paid Connecticut acute care hospitals a total of approximately $13.7 million for behavioral health services. The vast majority of payments went for mental health services.

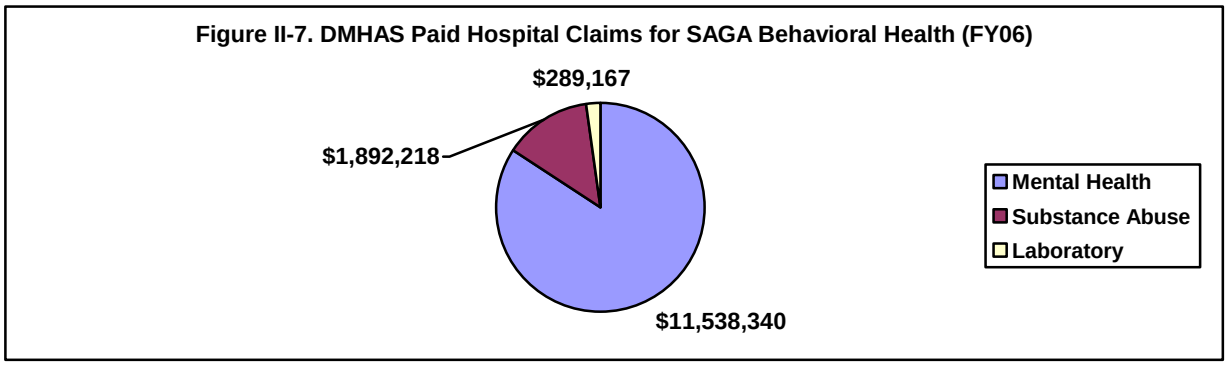


Table II-17 shows emergency room use by SAGA clients and indicates SAGA clients' use of the ER has grown significantly since FY 04 – 27 percent in two years. SAGA clients account for three percent of all emergency room visits; however, their ER usage per 100 enrollees is very high.

Table II-17. SAGA: Emergency Room Utilization – FY 04 – FY 06			
	FY 04	**FY 05**	**FY 06**
Total Visits	35,611	42,258	48,181
% of All ER Visits	2.6%	3%	3.4%
Rate per 100 Enrollees	122.4	145.2	165.6
Source of Data: CT. Hospital Association			

DISPROPORTIONATE SHARE PROGRAM (DSH)

Program

The Disproportionate Share Program (DSH) is a joint federal/state program designed to reimburse hospitals for care provided to a high volume of Medicaid and other low-income patients. (There is also Medicare DSH available to some hospitals.) In Connecticut, there are several DSH programs and accounts for specific hospital groups. The largest DSH account is for general uncompensated care (UCC). However, there are also specific DSH accounts for urban distressed hospitals, the veteran's hospital, and the children's hospital. In addition, funding for SAGA clients is also channeled separately through a DSH account.

Rates and Payments

The Department of Social Services administers the majority of Connecticut's DSH programs. In FY 05, DSH payments for Connecticut's acute care hospitals totaled $161,318,472, which is a 0.2 percent increase over DSH payments made in FY 04.

Uncompensated Care. UCC is the largest of the DSH programs and is available to all hospitals except John Dempsey because it is a state-operated hospital. UCC funding for FY 05 totaled $62.5 million, a 7 percent increase from 2004.

The program does not fund on a per-person basis, but reimburses hospitals based on a formula that recognizes a portion of uncompensated care and medical assistance underpayments. The UCC program is funded by the state through General Fund appropriations.[4] It is federally reimbursable under Medicaid at 50 percent.

Each state must have its DSH program components and the populations covered described in its State Medicaid Plan, but states are given broad discretion to administer the program. Each state is allocated an amount under the federal Medicaid program, based on DSH payments in prior years. The formula for the uncompensated care program is in state statute, and is calculated by the Office of Health Care Access, based on the numbers filed by the hospital using definitions specified in OHCA's statutes and regulations. In summary, hospitals are reimbursed for amounts of uncompensated care that each provides as a proportion of the total uncompensated care provided by all hospitals, as well as medical assistance underpayments. The total amount cannot exceed the federal DSH allotment to the state.

The basic components of uncompensated care are:

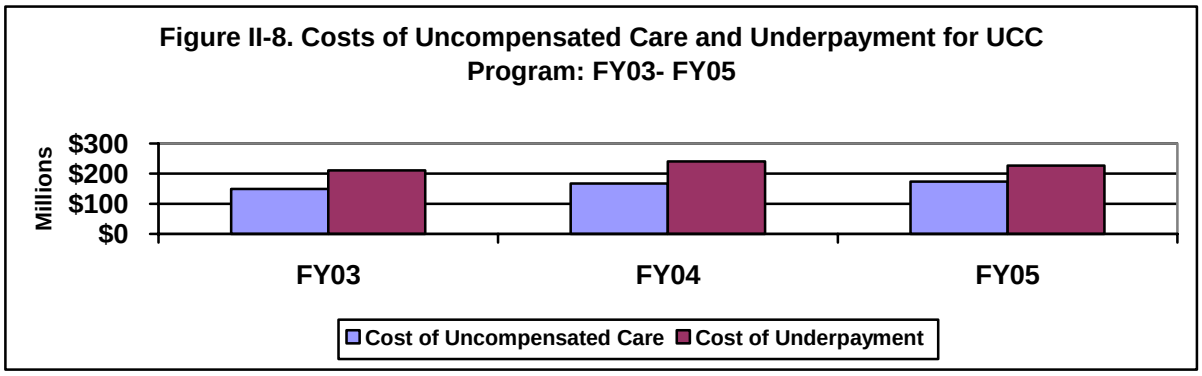
- *Bad debt*, which is defined as the costs of providing care for which the hospital expects to obtain reimbursement but learns after the fact that it will not receive payment.

- *Free care,* which is the difference between the hospital's published charges and the expected reimbursement, as defined in the hospital board approved free care policy. Courtesy discounts, contractual allowances and services provided to employees are not included.

The medical assistance amount is calculated based on the proportionate amount of care each hospital provides to Medicaid and other government payers acknowledging that the payments from the programs do not cover the hospital's costs.

As shown in Figure II-8, the portion of under-compensated medical assistance attributable to underpayment has been greater than the "uncompensated" part. The Office of Health Care Access (OHCA) calculates the DSH percentage for Connecticut's acute care hospitals (excluding John Dempsey) and provides the information to DSS for payment to the hospitals.

[4] Over the years, the UCC has been funded in different ways, including a sales tax on hospital services, which was legally challenged and eliminated.



DSH Program for Urban Distressed Hospitals

In 2001, Connecticut created a temporary DSH program aimed at assisting hospitals in distressed municipalities with populations over 70,000. In 2003, this DSH program was made permanent and the definition of a qualifying hospital was expanded to include those located in targeted investment communities with enterprise zones and populations over 100,000.

State law requires the DSH payment amount for each hospital to be based on the ratio of inpatient discharges paid on a fee-for-service basis in the most recently filed cost report to the total hospital discharges paid by Medicaid on a fee-for-service basis for all qualifying hospitals. State law prohibits payments under this program to any children's hospital. (C.G.S§ 17b-239a)

Table II-18 lists the ten hospitals receiving urban distressed DSH payments in 2005. As the table shows, a total of $31.5 million was provided in 2005, which was a two percent reduction from 2004.

Table II-18. Hospitals Receiving Urban DSH Payments (2005)

Bridgeport	$ 3,218,952
Hartford	$ 4,641,049
St. Raphael	$ 2,318,560
New Britain	$ 1,876,978
St. Francis	$ 3,989,826
St. Mary's	$ 1,639072
St. Vincent's	$ 2,321,704
Stamford	$ 2,586,771
Waterbury	$ 1,670,202
Yale New Haven	$ 7,286,886
TOTAL	**$ 31,550,000**
Source: DSS	

Other DSH Payments

In FY 05, DSH payments were also made to the Connecticut Children's hospital (CCMC) in the amount of $6,750,000. Payments for SAGA clients in acute care hospitals ($47,845,623 plus an additional $11.8 million for SAGA clients in hospitals but administered by DMHAS) were also passed through separate DSH accounts in FFY 05, so the state could receive 50 percent Medicaid reimbursement.

Further detailed discussion on the various DSH programs and other state-supported financial assistance available to hospitals (i.e. hardship grants) is provided in Chapter V.

Chapter III

Profile Summary of Acute Care Hospitals

This chapter profiles Connecticut's acute care hospitals on three aspects -- their administrative structure, basic financial indicators, and utilization measures. The discussion in this chapter focuses on generalized statewide data.

Administrative Structures

Connecticut has 30 acute care hospitals including one children's hospital. (As discussed earlier, for most of the study there were 31 hospitals, until the merger of New Britain General and Bradley Memorial hospitals). All are not-for-profit except for Essent-Sharon. Eighteen are teaching hospitals including John Dempsey Hospital, which is state-owned; four hospitals have religious affiliations.

Connecticut's acute care hospitals have a wide range of affiliations with other patient care programs, foundations, home health agencies, and various other corporate entities which may be for-profit. Nine hospitals are part of health systems that contain other hospitals (Yale New Haven, Bridgeport, and Greenwich; Hartford and Mid State; New Britain and Bradley Memorial; Manchester and Rockville). Effective October 1, 2006, New Britain and Bradley will merge as a single hospital but maintain separate campuses.

Available services. Acute care hospitals in Connecticut differ in the services that they offer. Program review obtained service information from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) which has accredited all acute care hospitals in Connecticut. The commission publishes a list of the services that were reviewed for accreditation purposes.[5]

All Connecticut hospitals provide emergency medicine, intensive care, general surgery, and diagnostic imaging. With one or two exceptions, almost all hospitals provide obstetrics/gynecology, pediatric medicine, nuclear medicine, respiratory care, pulmonary medicine, and telemetry. All of the hospitals have inpatient medical surgical beds. Although all provide emergency services, only two are certified as level one trauma centers and 10 are certified as level two trauma centers. Only Bridgeport Hospital has a certified burn unit/trauma center.

Twenty-nine of the hospitals provide maternity and newborn care. (Bradley and CCMC do not.) Only 15 hospitals, including CCMC, have neonatal intensive care units. Of the possible 57 services or types of care certified by JCAHO, the commission reports 11 Connecticut acute care hospitals offer 45 or more available services. Sixteen hospitals provide between 25 and 44

[5] The services information comes from the data the organization (e.g., hospital) provided to JCAHO for accreditation purposes. Therefore, if a hospital did not include a particular type of care in its application for accreditation or if the service has been added since the last application was submitted, the service may not be listed in JCAHO inventory.

types of care, while three hospitals (Manchester, Rockville, and Essent-Sharon) offer less than 20 types of services. (A listing of services by individual hospital is provided in Appendix I.)

Bed capacity. Hospital beds are counted in two different ways. Each hospital has an established number of licensed beds as well as "staffed" beds (i.e., they are available for use and the hospital has staff to cover them). Table III-1 provides the number of licensed and staffed beds reported in 2005 by county.

Table III-1. Licensed and Staffed Bed Capacity of CT Acute Care Hospitals (FY 05)

County	Number of Hospitals	Licensed Beds	Staffed Beds
Fairfield	6	2,142	1,671
Hartford	8	2,785	2,307
Litchfield	3	311	235
Middlesex	1	297	175
New Haven	7	2,689	2,090
New London	2	541	437
Tolland	2	216	149
Windham	2	266	159
TOTAL	31	9,247	7,223

Source: OHCA Schedule 500

As the table shows, Connecticut has 9,247 licensed hospital beds but just over 7,200 are reported as staffed beds. The smallest hospital has 84 licensed beds (Bradley) and the largest has over 900 (Yale New Haven). Nine of the 31 acute care hospitals have fewer than 100 staffed beds. The occupancy rate of the staffed beds ranges from 56 percent to 98 percent. It is important to note that hospital beds may be dedicated to certain medical services such as intensive care, newborn, and surgical. (The staffed bed capacity and occupancy rate of each individual hospital is provided in Appendix B.)

Map I shows the location of Connecticut's teaching and non-teaching hospitals. As the map demonstrates, the acute care hospitals follow the state's major transportation routes and are generally concentrated in major cities. Hartford, New Haven, Bridgeport, and Waterbury each have more than one acute care hospital.

Full-time employees (FTEs). In addition to being health care institutions, hospitals also tend to be significant employers in their communities. Table III-2 shows the number of FTEs by county in FYs 04 and 05.

As a group, acute care hospitals had 46,792 full-time employees in 2005, up approximately 2 percent from 2004. Tolland County posted the highest percent decrease while the greatest increase was seen in New Haven County. Most physicians are granted privileges to work in a hospital and are not considered employees.

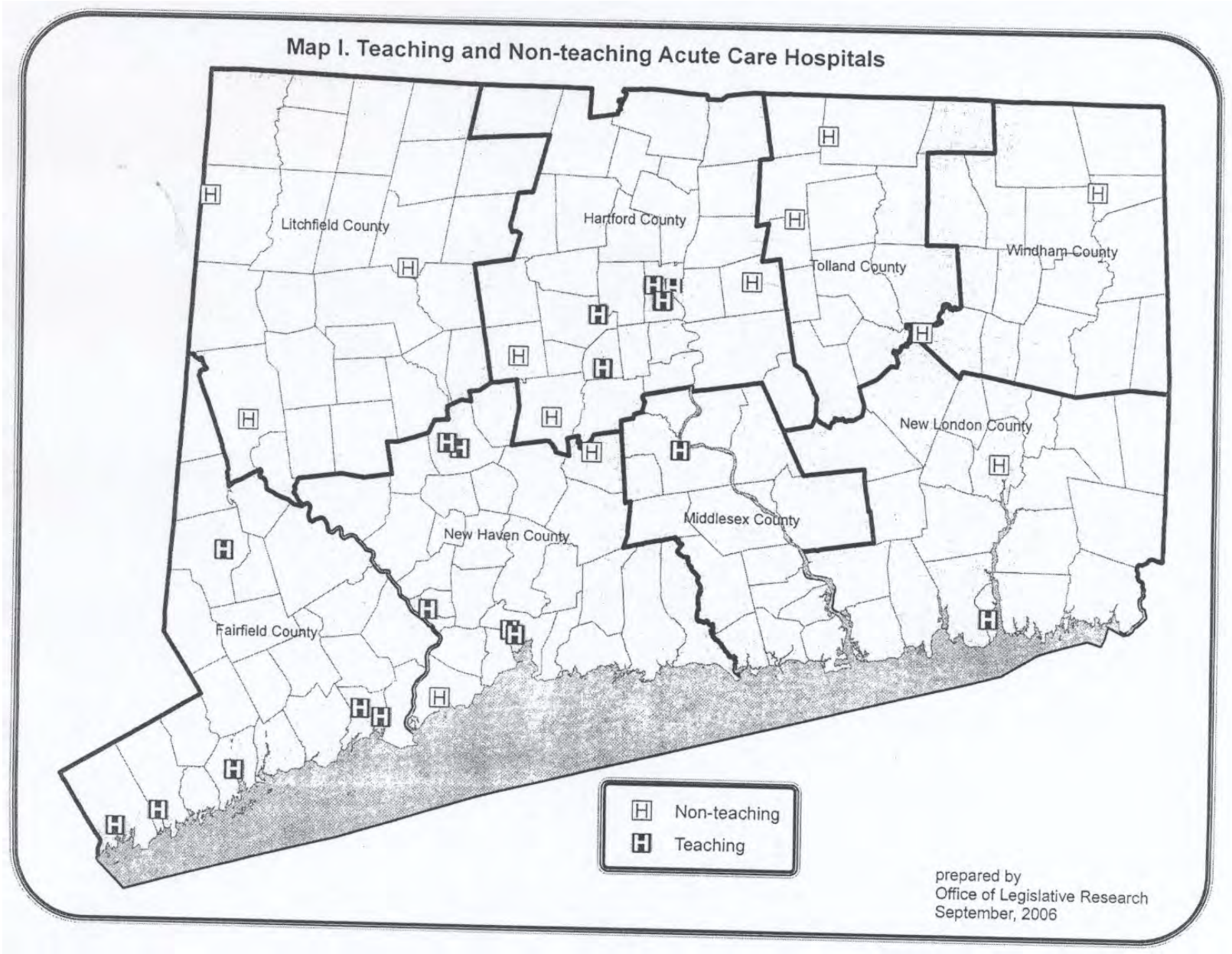

Map I. Teaching and Non-teaching Acute Care Hospitals
Litchfield County
Hartford County
Tolland County
Windham County
New London County
Middlesex County
New Haven County
Fairfield County
Non-teaching
Teaching
prepared by
Office of Legislative Research
September, 2006

Table III-2. Full-time Equivalents (FTEs) by County (FY 04-05)				
County	**Number of Hospitals**	**FY 04**	**FY 05**	**%Change**
Fairfield	6	10,214	10,542	3.2
Hartford	8	14,254	14,468	1.5
Litchfield	3	1,447	1,458	0.7
Middlesex	1	1,700	1,739	2.3
New Haven	7	12,670	13,208	4.2
New London	2	3,101	3,194	3.0
Tolland	2	1,094	919	(-16)
Windham	2	1,261	1,264	0.2
TOTAL	**31**	**45,741**	**46,792**	**2.3**
Source: OHCA Schedule 500				

Financial Indicators

In FY 05, Connecticut's acute care hospitals reported a net adjusted revenue total of approximately $6.36 billion. Hospitals generate both patient service revenue and non-operating revenue. Revenues generated from patient services are known as operating revenue. Revenues generated from other services such as parking, gift shops, or cafeterias are other operating revenues. All other revenue such as interest, dividends, charitable contributions are non-operating revenue. A hospital's profitability is typically measured by its operating margin (the surplus or loss derived from operating revenue only) and total margin (the surplus or loss from both operating and non-operating revenues). For both measures, a higher ratio suggests that the hospital has greater profitability.

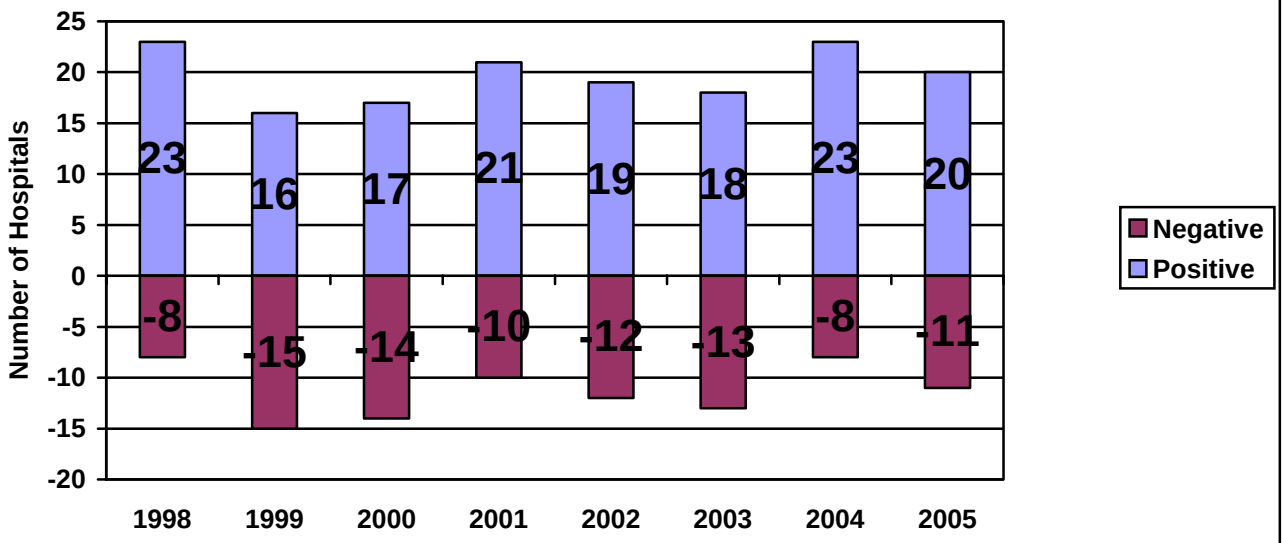
Map II charts the location of the hospitals that posted a negative operating margin in 2005 and highlights the hospitals that have experienced a negative operating margin consecutively for the last three years.

As the map demonstrates, 10 hospitals had negative operating margins in 2005 including five hospitals that had negative operating margins in the last three consecutive years. In 2005, St. Mary's, Rockville, and the children's hospital all had negative operating margins greater than three percent. (The operating margin of each hospital from 2003 to 2005 is presented in Appendix B.)

Map II. Negative Operating Margins
Negative Operating Margin (FY 03 - 05)
Negative Operating Margin (FY 05)
prepared by
Office of Legislative Research
September, 2006

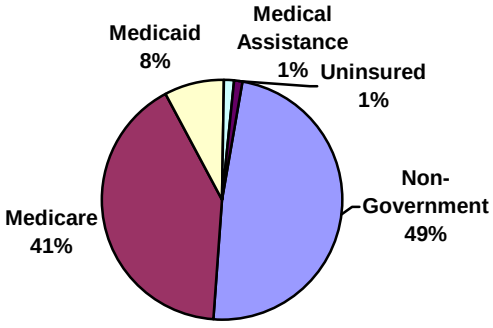
Figure III-1 shows the number of hospitals with either positive or negative operating revenue for each year from 1998 through 2005. The distribution of positive or negative operating margins among acute care hospitals has fluctuated slightly over the last eight years. In 1999, Connecticut had almost an equal number of hospitals with positive or negative operating margins. In 2004, there were eight hospitals with a negative operating margin, the lowest number the state had experienced since 1998; but this number increased to 11 hospitals in 2005. However, 12 hospitals had a positive operating margin over three percent in 2005.

Figure III-1. CT Hospitals with Positive and Negative Operating Revenue (1998-2005)



Source of Data: OHCA

Figure III-2. Net Revenue Payer Mix - FY05



Net revenue payer mix. As shown in Figure III-2, non-governmental (commercial payers) are the largest revenue source for Connecticut hospitals, representing 49 percent of total net revenue. Of the government payers, Medicare provides the largest revenue source (41 percent) while 8 percent of net revenue comes from Medicaid.

Uncompensated Care. Uncompensated care is defined as a hospital's bad debt plus free charity care and under-compensated care is defined as medical assistance underpayment. The cost of uncompensated care and medical assistance underpayment obviously impacts a hospital's financial condition. For FY 05, the average cost of total uncompensated care as a percent of total operating expense for Connecticut hospitals was 7.6 percent. The range by hospital went from 1.3 percent of the total operating expense at Bradley to greater than 12 percent at Bridgeport Hospital.

Utilization Measures

Overall demand and use of hospital services can be measured in the number of patient days and discharges, which are featured in Table III-3. In 2005, Connecticut acute care hospitals saw a 2 percent increase in both patient days and discharges from 2004. Despite the overall total increase, the two hospitals in Windham County experienced a decline in patient days while the hospitals in Litchfield County had a decrease in both patient days and discharges.

Table III-3 Patient Days and Discharges by County (FYs 04-05)

COUNTY	Number of Hospitals	PATIENT DAYS		% CHANGE	DISCHARGES		% CHANGE
		2004	2005		2004	2005	
Fairfield	6	494,043	501,303	1.5	103,242	104,298	1.0
Hartford	8	630,079	643,864	2.2	121,282	123,517	1.8
Litchfield	3	55,444	54,729	-1.3	12,708	12,564	-1.1
Middlesex	1	51,927	54,000	4.0	12,207	12,502	2.4
New Haven	7	608,954	616,600	1.3	120,640	123,404	2.3
New London	2	120,975	123,827	2.4	26,803	27,129	1.2
Tolland	2	35,149	37,207	5.9	7,771	7,819	0.6
Windham	2	43,880	42,345	-3.5	11,573	11,684	1.0
TOTAL	**31**	**2,039,295**	**2,073,875**	**2%**	**416,240**	**422,917**	**2%**

Source: OHCA schedule S10

Average length of stay (ALOS). In addition to total patient days and discharges, another important utilization measure is the average number of days a patient stays in the hospital, which is known as the average length of stay (ALOS). (This measure is the patient days divided by the patient discharges.) In FY 05, the statewide average length of stay for all hospital inpatients was 4.8 days , a slight decrease from the 4.9 ALOS reported in 2003 and 2004.

The average length of stay for all inpatients compared to the ALOS of inpatients who are in government programs was displayed in the previous chapter. (A breakdown of each hospital's discharges and ALOS for both government and non-government programs is provided in Appendix B.)

Emergency room visits. As noted previously, all Connecticut hospitals have emergency departments. Federal and state law requires Connecticut hospitals to provide emergency services to all patients regardless of their ability to pay. As noted in the utilization measures discussed in Chapter V, emergency room use has increased across the government programs. Table III-4 provides a summary comparison for FY 06.

Table III-4. Emergency Room Utilization by Payer Source (FY 2006)							
	Private Insured	Medicare	Medicaid Managed Care	Medicaid FFS	SAGA	Uninsured	TOTAL
Total Visits	563,464	302,808	229,282	107,421	48,181	159,754	1,410,910
% of All ER Visits	39.9%	21.5%	16.2%	7.6%	3.4%	11.3%	100%
Rate per 100 Enrollees	25.4	57.6	76.1	105.3	165.6	41.9	40.4
Source of Data: Connecticut Hospital Association							

ANALYSIS OF SELECTED INDICATORS AND POTENTIAL IMPACT

Obviously, hospitals must have reliable revenue streams that compensate them adequately for services provided. However, a perennial question is how to measure adequacy of payments without also considering costs and how well-run and efficient a hospital is. How efficiently a hospital is operated can obviously impact its bottom line. Yet on the other hand a hospital can be achieving maximum efficiency, but if it does not get enough full-pay patients to fill beds, it will not be financially sound.

Some of the measures examined that could indicate or impact a hospital's efficiency were reviewed by the committee study and discussed below:

- A hospital's payment-to-cost ratios for the various payer sources
- The percentage of a hospital's patients who are Medicaid clients
- How large or small percentage of underpayment of a hospital's uncompensated care
- Overall and specific types of operating costs on basis that adjusts for volume and severity of illness. To do this, staff used the case mix adjusted equivalent discharge (CMAED) hospitals report to OHCA, which takes into account both inpatient and outpatient volume and adjusts that by the hospital's case mix index, to reflect the variation in acuity. The measures include:
  - overall operating expenses
  - number of FTEs per 1,000 CMAEDs
  - salary and fringe benefits
  - percentage of salary and fringe benefits of operating expenses
  - trends in those measures.

Payment to Cost Ratios

Private Payers. As discussed in Chapter II, the ratio of payments to cost is important to a hospital's financial strength. There is ready acknowledgement that a cost-shifting occurs to private payers to help absorb the underpayments of government programs like Medicare, and especially Medicaid. Thus, the higher a payment-to-cost ratio a hospital has negotiated with its private payers, the more likely it is to be stronger financially. Table III-5 presents the hospitals

with the highest and lowest private payment to cost ratio (1=costs), compared to the state average and median for FY 05. Payments and costs are for both inpatient and outpatient services.

Table III-5. Comparison of Private Payment-to-Cost Ratios			
Highest Private Payment-to-Cost Ratio		**Lowest Private Payment-to-Cost Ratio**	
Mid State	1.45	Ct. Children's Medical Ctr.	.90
Danbury	1.40	St. Mary's	.96
Stamford	1.35	Dempsey	1.02
New Britain	1.35	Charlotte Hungerford	1.04
Backus	1.33	Griffin	1.06
		Waterbury	1.06
Statewide Average	**1.20**	**Statewide Median**	**1.22**
Source of Data: Office of Health Care Access			

Medicare. Typically, after private payers, the next biggest payer is Medicare. Therefore, it is important that hospitals realize payments from Medicare that are close to costs. As discussed, in Chapter II, Medicare does not negotiate rates or discounts. Payments are largely based on type of illness, acuity, and efficiency, although location of hospital and wage index can play key roles in Medicare payments. Table III-6 shows the highest and lowest hospital Medicare payment to cost ratios.

Table III-6. Comparison of Medicare Payment-to-Cost Ratios			
Highest Medicare Payment-to-Cost Ratio		**Lowest Medicare Payment-to-Cost Ratio**	
Ct Children's Medical Ctr.*	6.24	New Milford	0.74
Dempsey	1.19	Rockville	0.76
Yale-New Haven	1.11	Greenwich	0.79
Bridgeport	1.10	Johnson Memorial	0.80
St. Francis	1.09	Backus	0.82
		Bradley	0.82
*CCMC has very few Medicare clients, but the few it treats are very sick or disabled and very high-cost		Milford	0.82
Statewide Average	**0.97**	**Statewide Median**	**0.93**
Source of Data: Office of Health Care Access			

Medicaid. The last major payer group is Medicaid, where the state, either directly or through managed care organizations, pays the hospitals. The Medicaid MCOs pay hospitals based on negotiated rates and discounts, while DSS pays for the fee-for-service clients based on predetermined rates. For purposes of this analysis, all Medicaid payments (along with SAGA) are pooled together for this payment group. The hospitals with the highest and lowest ratios for Medicaid are presented in Table III-7.

Table III-7. Comparison of Medicaid Payment-to-Cost Ratios			
Highest Medicaid Payment-to-Cost Ratio		**Lowest Medicaid Payment-to-Cost Ratio**	
Bradley	1.04	St. Mary's	0.47
Johnson	0.97	Charlotte Hungerford	0.58
Dempsey	0.93	Backus	0.60
New Britain	0.88	Day Kimball	0.62
Windham	0.83	Lawrence & Memorial	0.65
Statewide Average	**0.72**	**Statewide Median**	**0.73**
Source of Data: Office of Health Care Access			

Percentage of Medicaid Clients

Since Medicaid reimburses at a lower percentage of costs than other payers, it is important to note which hospitals treat a high percentage of Medicaid patients, since the combination of a high Medicaid volume and low reimbursements obviously tests a hospital's financial stability. Not surprisingly, the hospitals with the highest percentage of Medicaid clients are located in cities, with more than 40 percent of the state's Medicaid population located in five cities.

Table III-8. Comparison of Hospital Percentage Medicaid Population			
Highest Medicaid Population (%)		**Lowest Medicaid Population (%)**	
CCMC	43.1	Greenwich	2.4
Bridgeport	24	Bradley	2.9
Yale-New Haven	24	Milford	6.6
St. Mary's	20.8	New Milford	6.9
Waterbury	20.3	Norwalk	8.9
Statewide Average	**16.7**	**Statewide Median**	**15.1**
Source of Data: OHCA Schedules and CHIME			

Government Underpayments

Earlier in the chapter, uncompensated care was discussed as a factor potentially affecting a hospital's financial condition. The portion of uncompensated care that is due to government underpayments is increasingly becoming more of a factor than the portion due to no compensation for care. As Table III-9 below indicates, the portion of underpayments of total uncompensated care costs now averages 56 percent statewide, and five hospitals incur underpayments that contribute about three-quarters or more to their uncompensated care costs.

Table III-9. Comparison of Hospital Underpayments As Percent of Uncompensated Care			
Lowest % of Underpayments As Part of Uncompensated Care Cost		**Highest % of Underpayments As Part of Uncompensated Care Cost**	
Greenwich	19	Dempsey	83
Bradley	21	Yale-New Haven	80
New Milford	35	Hungerford	79
Stamford	36	CCMC	76
Griffin	42	St. Mary's	73
Statewide Average	**63**	**Statewide Median**	**57**
Source of Data: OHCA UCT Schedules			

Occupancy Rates

Hospital payments can be unpredictable because they pay for medical care; if there are spikes or dips in the number of people seeking treatment that can affect revenue stability. A measure of the efficiency in this area is a hospital's long-term (annual) occupancy rate. Again, hospitals vary considerably, from New Milford's occupancy rate at barely more than half its staffed beds to Norwalk, which has almost all of its staffed beds occupied. It might be noted that hospitals with lower occupancy rates tend to be smaller community hospitals. Table III-10 compares hospital occupancy rates.

Table III-10. Comparison of Hospital Occupancy Rates			
Highest Occupancy Rate of Staffed Beds (%)		**Lowest Occupancy Rate of Staffed Beds (%)**	
Norwalk	98.4	New Milford	55.5
Griffin	97.2	Windham	63.8
Danbury	94.5	Charlotte Hungerford	64.3
Milford	93.8	Greenwich	64.3
St. Mary's	89.2	Rockville	64.9
No Average available		**Statewide Median**	**77.7**
Source of Data: OHCA Schedule 500			

Operating Costs

In addition to obtaining adequate reimbursement and filling beds, which may sometimes be beyond a hospital's control, a hospital must also try to keep costs down. This is especially important in an environment where government rates often do not cover full costs, and private payers are interested in negotiating the lowest rates for the clients they cover. PRI examined overall operating costs of all the hospitals per case-mix adjusted equivalent discharge, which accounts for all inpatient and outpatient costs adjusted for patient acuity of illness. Hospitals with the highest and lowest operating expenses using this measure are shown Table III-11 below.

Table III-11. Comparison of Hospital Operating Expenses per CMAED			
Lowest Operating Expense per CMAED		**Highest Operating Expense per CMAED**	
Johnson Memorial	$3,904	CCMC	$11,867
Charlotte Hungerford	$4,778	Norwalk	$9,575
New Britain	$5,263	Greenwich	$8,875
Windham	$5,306	John Dempsey	$8,415
Bridgeport	$5,557	Stamford	$8,380
Statewide Average	**$7,054**	**Statewide Median**	**$7,006**
Source of Data: OHCA Schedule S10			

As the table indicates, three of the five hospitals with the highest operating expenses are in Fairfield County, where wages are especially high; however, it is interesting to note that Bridgeport Hospital, also located in Fairfield County, has one of the lowest expenses of all hospitals.

Hospital care typically is labor-intensive, requiring both medical and non-medical personnel. Most often doctors are not considered hospital personnel and are not paid by the hospital. Instead, these doctors have private practices, but have admitting privileges at certain hospitals. Also, complicating the cost issue is that some hospitals have outsourced certain functions – e.g. kitchen, cleaning etc. – so those persons would not be counted in the FTE or the salary and fringe figures. For these reasons, examining both the number of FTES per 1,000 CMAEDs, and the percent salary and fringe make up of overall expenses requires a number of caveats, but still may provide an indicator of what contributes to a hospital's efficiency. Table III-12 presents a comparison of full-time equivalent staff by 1,000 case-mix adjusted equivalent discharges.

Table III-12. Comparison of Hospital FTEs per 1,000 CMAEDs			
Lowest # of FTEs per 1,000 CMAEDs		**Highest # of FTEs per 1,000 CMAEDs**	
Johnson Memorial	34.8	CCMC	94.6
Bridgeport	38.8	Manchester	76.3
New Britain	40.7	Waterbury	68
Charlotte Hungerford	41.9	Bradley	67.6
Mid-State	43.6	Norwalk	66.8
Statewide Average	**54.9**	**Statewide Median**	**52.7**
Source of Data: OHCA Schedule S10			

Personnel numbers make up part of the operating expense, but what hospitals pay in salary and fringe make up the other major part of the wage portion of operating expenses. Tables III-13 and 14 below present the list of hospitals with the lowest and highest salary and fringe per discharge (adjusted for case mix) and salary and fringe as a percentage of operating expenses.

Table III-13. Comparison of Hospital Salary and Fringe per CMAED			
Lowest $ Salary and Fringe per CMAED		**Highest $ Salary and Fringe per CMAED**	
Johnson Memorial	$2,252	CCMC	$6,692
New Britain	$2,810	Norwalk	$5,695
Bridgeport	$2,874	Greenwich	$5,248
Charlotte Hungerford	$2,884	Manchester	$5,128
Sharon	$2,940	Waterbury	$5,037
Statewide Average	**$4,087**	**Statewide Median**	**$4,162**
Source of Data: OHCA Schedule S10			

Table III-14. Comparison of Percentage of Salary and Fringe is of Operating Expense			
Lowest % of Op Exp on Sal/Fringe		**Highest % of Op Exp on Sal/Fringe**	
Sharon	40	Windham	66.9
Bridgeport	51.7	Hartford	66.8
Yale New Haven	52.5	Lawrence and Memorial	66.8
John Dempsey	52	Rockville	64.6
Mid-State	51.5	Waterbury	62.9
Statewide Average	**58**	**Median**	**58.9**
Source of Data: OHCA Schedule S10			

Interestingly, while three Fairfield County hospitals were listed above as having the highest operating expenses and two of those – Norwalk and Greenwich – are among the highest in salary for case-adjusted volume, none of the Fairfield County hospitals are among the highest when salary and fringe as a percentage of overall expenses are considered.

This is because case mix index can greatly influence how expenses are considered. It stands to reason that it should cost more to treat sicker patients so the expenses have to be considered in connection with the acuity of patients. Thus, while a hospital may have high expenses overall, when considered on the basis of the severity of illness of the patients served in that hospital, the relative expenses decrease.

Table III-15 below provides a list of hospitals with the lowest and highest case mix. This is a gauge of the factor (multiplier) overall costs should be adjusted to accurately compare among hospitals.

Table III-15. Comparison of Hospital Case Mix Index			
Lowest Case Mix index –All Inpatients		**Highest Case Mix index –All Inpatients**	
Day Kimball	0.86	St. Raphael's	1.47
Rockville	0.95	John Dempsey	1.46
Greenwich	0.96	Hartford	1.40
Stamford	0.99	St. Francis	1.39
L&M, Manchester and Griffin* (same index)	1.02	St. Vincent's	1.36
Hospital Average	**1.14**	**Statewide Median**	**1.11**
Source: 2005 CHIME Data			

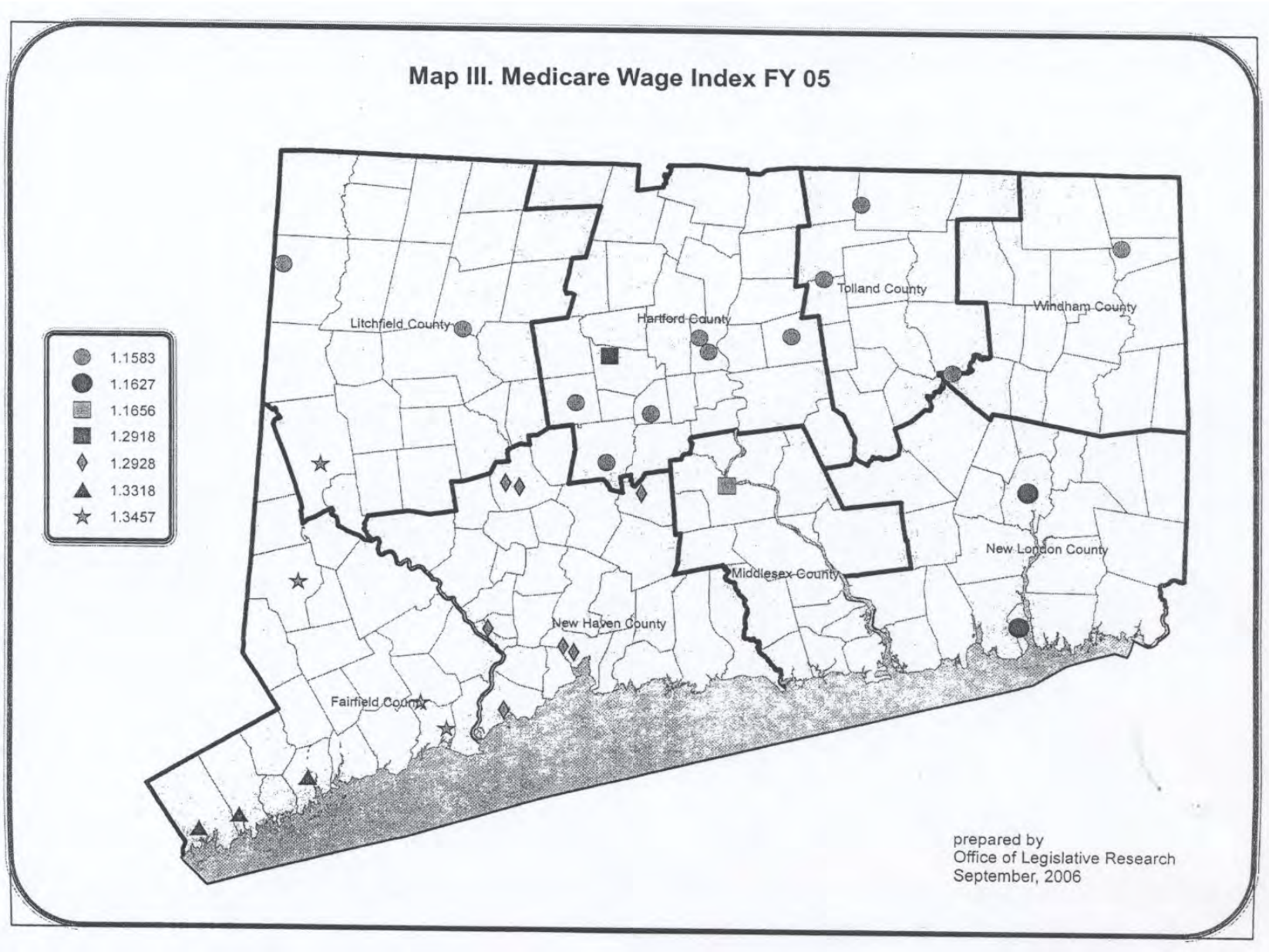
Wage Index

As discussed in Chapter II, Medicare adjusts its Prospective Payment System (PPS) to consider differences in wages across the country. While all hospitals in Connecticut are given a higher than standard wage index (with 1=standard), there is still considerable variation among Connecticut hospitals in the wage index. Recognizing that Medicare accounts for about 41 percent of hospital payments, and that direct wages and benefits account for almost 60 percent of operating costs, a difference of a wage index set at 1.30 for one hospital and another hospital's set at 1.15 can have an impact on the hospital's bottom line. Map III shows the categories of wage indices assigned to Connecticut hospitals. Twelve hospitals have the lowest index for Connecticut – 1.1583 – while three hospitals have been assigned the highest wage index in the state at 1.3457.

Trends over Time

As important as measuring a hospital's costs or expense at any one time is to also gauge whether hospitals are holding the line on increases. PRI staff measured the percentage increase in the operating expenses per CMAED over the FY 02 to FY 05 period. Table III-16 below lists the hospitals with the lowest and highest cumulative percentage increases (each year's percentage change was added to the prior year, to account for year to year changes and not just the FY 02 to FY 05 change).

Table III-16. Comparison of Percentage Increase in Operating Expense per CMAED – FY 02 – FY 05			
Lowest Cumulative % Increase (FYs 02-05)		**Highest Cumulative % Increase (FYs 02-05)**	
Johnson Memorial	- 14%	Bristol	38.9%
St. Mary's	- 5.4%	Rockville	33.9%
Day Kimball	-4.26%	Manchester	29.8%
Bridgeport	+2.25%	Lawrence & Memorial	29.6%
Mid-State	+4.55%	Waterbury	17.8%
Hospital Average	**12.08%**	**Statewide Median**	**11.6%**
Source of Data: OHCA Schedule S10			


Map III. Medicare Wage Index FY 05
1.1583
1.1627
1.1656
1.2918
1.2928
1.3318
1.3457
Litchfield County
Hartford County
Tolland County
Windham County
New London County
Middlesex County
New Haven County
Fairfield County
prepared by
Office of Legislative Research
September, 2006

Summary

While it is difficult to pinpoint any one factor that makes a hospital financially strong or weak, there are some indicators that appear to negatively impact a hospital's financial condition. Using the analysis of indicators above, the table below outlines some of the indicators that appear frequently among financially distressed hospitals. The hospitals shown in Table III-17 with negative operating margins for all three years or a negative operating margin of more than 3 percent for FY 05 are in the severely distressed column, and those with negative margins in two of the last three years are in the right column, labeled moderately distressed.

Table III-17. Measuring Hospitals Financial Distress Using Selected Indicators

Indicator of Distress	**Severely distressed hospitals**	**Moderately distressed hospitals**
Lowest private payment to cost ratio	Ct. Children's Medical Ctr. St. Mary's Waterbury	
Lowest Medicare payment to cost ratio	Rockville Bradley Milford	
Lowest Medicaid payment to cost ratio	St. Mary's	
Highest % Medicaid population	CT. Children's Medical Ctr. St. Mary's Waterbury	
Lowest occupancy of staffed beds	Rockville	Windham
Highest portion of underpayments as part of uncompensated care	Ct. Children's Medical Ctr. St Mary's	
Highest operating costs per CMAED	Ct. Children's Medical Ctr.	
Highest FTEs per 1,000 CMAEDs	Ct. Children's Medical Ctr. Waterbury Bradley	Manchester
Highest salary and fringe per CMAED	Ct. Children's Medical Ctr. Waterbury	Manchester
Highest % of operating cost on salary and fringe	Rockville Waterbury	Hartford Windham
Highest cumulative increase in operating costs per CMAED	Rockville Waterbury	Manchester
Source: PRI Staff Analysis		

As the table illustrates, most of the hospitals in severe financial distress have many of the problem indicators. Connecticut Children's Medical Center and Waterbury each has six of the 11; St. Mary's and Rockville each has four. Three moderately distressed hospitals also appear on the list.

Chapter IV

Connecticut's Hospital Payment System

As discussed in the previous chapter, hospitals depend on three major payer groups to fund services:

- Private payers;
- Medicare; and
- Medical Assistance (including Medicaid Managed Care, Medicaid Fee-for-Service and State Administered General Assistance (SAGA)).

In addition there are uncompensated care programs and disproportionate share programs that cover some of the hospital costs for the under- and uninsured. Each payer source compensates hospitals in a different way. Table IV-1 below illustrates several major features of each payer source.

Private pay. Private payers negotiate with hospitals on what they will pay; typically these payments are discounts off charges. In FY 02, those discounts averaged 41 percent off charges, by FY 05 the discounts off all charges statewide averaged 53 percent, and the median discount was 43.3 percent. However, hospitals may raise charges at any time so the increase in discounts is not that meaningful. The more meaningful statistic is the percentage of costs covered by private payers. On average, private payers compensate Connecticut hospitals for 120 percent of their costs, and pay all hospitals except St. Mary's and Connecticut Children's Medical Center for at least their costs.

Medicare. Medicare, which is a federal government program, sets payments prospectively for inpatient care and for most outpatient services as well. Medicare has on average paid Connecticut hospitals close to the costs (97 percent) of providing care to Medicare patients, but 22 hospitals receive Medicare payments that are less than their costs.

Medical Assistance. For hospital payment purposes, all state medical assistance programs are considered together, although in actuality, there are three separate programs -- two under Medicaid and the SAGA program -- for different populations. Medicaid, which is a joint federal and state program, reimburses Connecticut for 50 percent of its medical assistance costs for the three programs. As noted in Chapter II, each state administers and operates its Medicaid program differently, with eligibility and coverage criteria designed by the state in a state Medicaid plan that must be approved by the federal government.

As discussed, Connecticut operates its Medicaid program in two very different ways. Medicaid managed care covers families. Known as the HUSKY program, clients may choose from one of four different managed care plans. Single, aged or disabled Medicaid clients are in a traditional fee-for-service program.

The SAGA program covers individuals either not eligible for Medicaid, or awaiting eligibility determination. The state receives 50 percent reimbursement for SAGA medical expenses, although the coverage for clients is split. The Department of Social Services pays for SAGA *inpatient hospital medical care*, while the Department of Mental Health and Addiction Services pays for SAGA *hospital psychiatric care.* SAGA clients receive other medical care through an arrangement between Community Health Network and local federally qualified health centers.

The two Medicaid programs and the SAGA programs are considered together, and called medical assistance, for hospital payment purposes, and for the analysis in this chapter, Medicaid and medical assistance are considered the same unless noted otherwise. As the table shows, the medical assistance revenues cover on average only 73 percent of hospital costs and only one hospital is paid fully for costs.

Table IV-1. Hospital Funding by Major Payer Source

Program	Enrollees	Hospital Payment Structure	Percent of Total Hospital Revenue	Percent of Costs Covered	Percent of Inpatient stays	Percent of Inpatient Days	% of Revenue Inpatient vs. Outpatient
Medicare	524,000	Prospective Payment System (PPS) for inpatient based on DRGs with certain add-ons including indirect medical education (IME); Outpatient PPS based on ambulatory procedures classification	41%	97%	40%	50%	76.4%
Private Pay (fully covered and self – insured plans)	2,395,459	Negotiate directly with hospitals	53.5%	120%	40%	32%	47.2%
Medicaid Managed Care	300,000	Plans negotiate with hospitals	4.5%	73%	8.5%	9.8%	52%
Medicaid Fee-for-Service	68,000	DSS sets rates based on cost reports and target discharge rates for inpatient; fee schedule or overall ratio of cost to charges for outpatients	4.8%		5.7%	7.2%	64.4%
SAGA	35,000	DSS pays medical portion, DMHAS pays for behavioral health, CHN covers $ other than hospital			2.5%	3.3%	
Uninsured	About 407,000	Uncompensated Care and DSH			2%	1.6%	

Factors influencing hospital financing. Several factors impact hospital funding including: 1) the variety of payer sources, both public and private; 2) the assorted methods in which the payers compensate hospitals; 3) hospital reliance on different payers as a percentage of all revenue; and 4) the differences in payer source utilization. Table IV-1 portrays hospital funding elements statewide, but the metrics vary by individual hospital and the impact each measure (or combination) has on a hospital's financial condition. Much of the variation and impact is beyond the control of state government because the majority of revenue is from private payers or from the federal government.

The study's focus from the beginning was on the payment structures for which the state has direct responsibility. Thus, program review concentrated its findings and recommendations on Medicaid, SAGA, and uncompensated care and disproportionate share programs and the reimbursement systems covering those programs.

Medicaid Fee-for-Service Inpatient Rate-Setting

There has always been a tension between containing costs in the Medicaid programs operated at the state level, and paying providers sufficiently to assure client access to health care. As noted in Chapter II, Connecticut established its inpatient rate setting structure in 1983, adopting the methodology that the federal Medicare program was using at the time, but has since changed.

Connecticut's Medicaid Fee-for-Service program reimburses hospitals for inpatient care using target discharge rates that were based initially on 1982 cost reports, and adjusted for inflation in some years, depending on the state budget. Thus, hospitals with lower costs in that initial year have been disadvantaged, because over time the gap between payments and costs has widened.

In 1995, Connecticut established a managed care approach for its family Medicaid recipients, which essentially privatized the payment structure to medical providers for certain clients. DSS maintained the payment authority for the non-family clients under the fee-for-service reimbursement system.

In 2001, DSS was given legislative authority to update hospital target rates for Medicaid fee-for-service payments based on each hospital's 1999 cost report filing (adjusted to 62.5 percent of costs). Hospitals would receive this updated rate if the new target amounts were higher than the old rates with the federal inflation factor (up to 10 percent).

Of the 31 hospitals, 17 received the rebased rate adjustment. But hospitals with lower costs, and especially those that had kept them low from 1982 through 1999, were again penalized for payment purposes. There have been two additional readjustments since that time to raise the minimum target rate. On April 1, 2005, the target rate was set at $3,750, and on October 1, 2006, it was raised to $4,000, which adjusted the rate for 18 hospitals. CCMC does not have a target rate since it serves very few Medicaid FFS clients. (See Appendix C for FY 06 and current target rates by hospital.)

Table IV-2. Range of Base Medicaid Target Rates Per Discharge	
Effective 10/01/06	**Number of Hospitals**
Minimum rate of $4,000	18
$4,001 to $4,999	6
Over $5,000 to $7,797	6
Total	30
Source of Data: Department of Social Services	

While the range in the rates has narrowed as the minimum rates have increased over the past two years, the variation in the current target rates is still considerable. The highest target rate at John Dempsey Hospital is $7,797, almost double the new minimum target rate.

Hospitals must file detailed annual cost reports to the Department of Social Services, even though in most years their actual costs are not considered for rate increases. *Connecticut is one of only six states that continue to set inpatient Medicaid payments to hospitals based on costs.* Table IV-3 shows how different states set Medicaid rates.

Table IV-3. State Medicaid Inpatient Payment Systems	
Payment System	**States Currently Using**
Per-Stay Case-Adjusted Using Medicare Diagnostically Related Groups (DRGs)	24 states -- CA, CO, IA, IL, KS, KY, MI, MN, MT, NC, ND, NE, NH, NJ, NM, OH, OR, PA, SC, SD, TX, UT, WI, WV
Per-Stay Case-Adjusted Using All Patient or Champus (military) DRGS	5 states and DC -- DC, GA, IN, NY, VA, WA
Per Stay – Other	4 states -- DE, MA, NV, WY
Per Diem	10 states -- AK, AZ, FL, HI, LA, MO, MS*, OK, TN, VT *Moving to APR-DRGs 7/01/07
Cost-Based Reimbursement	6 states -- AL, AR, CT, ID, ME, RI
Regulated Charges Based on All Patient Refined APR (newer grouping system) DRGs	1 state -- MD

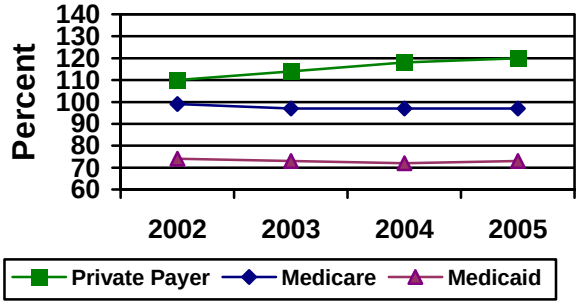
Medical assistance payment shortfall. Medicaid (i.e., all state medical assistance revenue) under-funding of hospital costs is an issue nationwide. Program review examined the payment to cost ratios for the three major payers from 2003 to 2005, and compared that to the same ratios nationwide. The results are these are shown in Figures IV-1 and IV-2.

As the figures show, nationally, Medicaid pays a greater percentage of hospital costs than the program pays in Connecticut. Nationwide, Medicaid paid about 87 percent of hospital costs, while in Connecticut, the Medicaid program reimbursed hospitals for about 73 percent of their costs.

Medicare, on the other hand, reimbursed hospitals in Connecticut for about 97 percent of hospital costs, while nationally the average was about 92 percent. For the rest of the country,

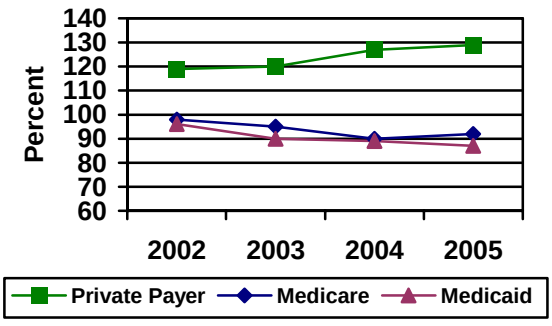
though, there has been a greater cost shift to private payers (in terms of percentages) than in Connecticut. Nationally, the ratio for private payers has increased from 120 percent of costs in 2002 to about 130 percent in 2005. In other words, private payments are about 30 percent higher than costs nationally; in Connecticut the percentage has climbed from about 110 percent in 2002 to 120 percent in 2005.

Figure IV-1. Payment to Cost Ratios: Connecticut



Source: OHCA

Figure IV-2. Payment to Cost Ratios: Nationally



Source: AHA Issue Brief

However, the ratios should not be looked at in isolation. First, Medicare is a much bigger payer source than Medicaid in Connecticut, and the rest of the country. In Connecticut, about 41 percent of hospital payments are from Medicare while slightly less than 10 percent are from Medicaid. Nationwide, Medicare averages about 39 percent of all hospital payments, while Medicaid averages about 14.5 percent. The fact that Medicare reimburses Connecticut hospitals closer to costs overall means there is less of a gap from that government program to fill here.

Connecticut also has a lower percentage of uninsured than the national average (slightly less than 12 percent versus 16 percent nationally). Thus, the financial burden on hospitals of providing care to the totally uninsured should be less here. (Programs that address the uninsured are discussed in greater detail later in this section).

While the percentage over costs that private payers in Connecticut contribute to hospitals is less than nationally, without knowing the costs in each case, the actual financial burden on private payers is difficult to gauge. As noted in the briefing, Connecticut's inpatient hospital costs are about 15 percent higher than the national average; therefore in actual dollars, the burden on private payers is probably greater in Connecticut. *However, because the gap in government payments (especially Medicaid) has not been shifted to private payers in Connecticut to the extent it has nationally has most likely been a contributing factor to the tenuous financial condition of some Connecticut hospitals.*

It became clear during this study that analyzing statewide hospital funding in the aggregate is problematic since each hospital's geographic location, service component, payer mix, and financial and utilization metrics are different, and reporting a state average or median masks the impact of any of these elements on any one hospital. Thus, a more in-depth analysis

of the state Medical Assistance payment structure and its impact on individual hospitals is provided below.

Impact of Medical Assistance Underpayment Among Connecticut Hospitals

Medical Assistance underpayments to Connecticut hospitals totaled about $226 million in FY 05, or about 3.7 percent of total statewide hospital expenses. The medical assistance underpayments exact varying burdens on hospitals in Connecticut, depending on: the percentage of Medicaid and SAGA populations the hospitals serves; whether the services provided are inpatient or outpatient; the hospital's payer mix; and the percentage of costs Medicaid is paying of the hospital's costs.

Medical assistance populations. As noted earlier, about 40 to 50 percent of the Medicaid (fee-for-service and managed care) and SAGA populations are concentrated in five Connecticut cities -- Hartford, Bridgeport, New Haven, Waterbury, and New Britain. In FY 05 there were slightly more than 70,000 Medicaid and SAGA inpatient hospital stays, about 16.7 percent of all inpatient stays statewide. Four hospitals, all located in large cities, handled about 42 percent of all Medicaid discharges and almost 47 percent of Medicaid inpatient days in the state. On the other end of the spectrum, seven hospitals in the state each have percentages of Medicaid patients below 1 percent of the total. Table IV-4 outlines that distribution.

Table IV-4. State Medicaid Volume – Hospitals with Highest Percentage of Total Statewide Medicaid

Hospital	Percentage of Inpatient Stays	Percentage of Inpatient Days
Yale-New Haven	16.6%	18.8%
Hartford	9.32%	11.7%
St. Francis	9.14%	9.1%
Bridgeport	6.80%	7.3%
Cumulative % of top volume hospitals	41.86%	46.9%
Bradley, Greenwich, Johnson, Milford, New Milford, Rockville, Sharon	Low-volume Medicaid – Each under one percent of Medicaid stays	

Source: LPR&IC Analysis

Medicaid revenues to hospitals. The committee examined the Medicaid revenues each hospital gets as a percentage of the total state Medicaid revenues (before DSH payments) and found the top five hospitals receive almost half of all Medicaid revenues as listed in Table IV-5.

Table IV-5. Hospitals Receiving Greatest Share of All State Medicaid Payments- FY 05		
Hospital	Percentage of All Medicaid Payments	Percentage of Inpatient Medicaid Payments
Yale-New Haven	17.8%	20.2%
Hartford	9.7%	10.8%
St. Francis	7.4%	7.3%
Bridgeport	6.2%	6.0%
Cumulative % of these top volume hospitals	41.1%	44.3%
CCMC	7.6%	8.9%
Cumulative with CCMC	48.7%	53.2%

With the exception of Yale-New Haven, the high volume Medicaid hospitals account for a greater percentage of the inpatient care than their percentage of Medicaid revenue. But, because the Medicaid payment structure is cost-based (albeit not recent cost) and Yale - New Haven has a higher target rate, that hospital receives a higher portion of the overall Medicaid revenues.

Some hospitals that serve a high percentage of the state's Medicaid population may be better able to shoulder that financial burden, because the Medicaid population is not that high a proportion of those hospitals' overall patient populations. The Medicaid inpatient hospital volume for FY 05 was 16.7 percent statewide and the median by hospital was 15.1 percent. For five hospitals, however, Medicaid patients accounted for more than 20 percent of their inpatient stays. These hospitals are listed in Table IV-6. Three of those hospitals also account for a high Medicaid percentage of all inpatient days, which are listed in Table IV-7. However, St Mary's and Waterbury Hospitals are among the top hospitals by percentage of discharges but not of inpatient stays.

Table IV-6. Hospitals with High Medicaid Population as a Percent of Overall Discharges -- FY 05	
CCMC	43.1%
Bridgeport	24%
Yale-New Haven	24%
St. Mary's	20.8%
Waterbury	20.3%

Table IV-7. Hospitals with High Medicaid Inpatient days as a Percentage of All Inpatient Days	
CCMC	43.4%
Yale-New Haven	21.9%
Bridgeport	20.9%
John Dempsey	18.9%
Hartford Hospital	15.6%

Inpatient and outpatient revenue. Whether a hospital serves a greater percentage of its medical assistance clients on an inpatient rather than outpatient basis may also have an impact on medical assistance revenues and the hospital's financial condition. Medicaid fee-for-service outpatient rates are set based on an established fee schedule (e.g., $57.13 for an EKG), or based

on a statewide cost to charge ratio. In either case, since the rates are not based on a specific facility's costs, all hospitals get paid the same amount for a given test or service. The outpatient fee schedules were adjusted for increases effective July 1, 2006, but prior to that date most outpatient payment rates had not been adjusted since 2001. It is difficult to specifically assess the financial impact that serving Medicaid clients on an inpatient versus outpatient basis has on a hospital, or even what the client utilization of outpatient services are because there are no comprehensive outpatient data, including for the Medicaid population.

DSS provided FY 05 claims payment information for the Medicaid fee-for-service population, and the data indicated there were 456,311 outpatient claims for which hospitals were paid about $80 million, averaging about $175 per claim. For the same period, DSS paid hospitals about $188.7 million for about 77,000 fee-for-service and SAGA inpatient claims, averaging about $2,441 per claim. Obviously, hospitals must see many more Medicaid clients on an outpatient basis to generate a similar amount of inpatient revenue.

The average percentage of payments for inpatient services for Medicaid statewide is 58.5 percent, but the median is only 51.3 percent indicating that some of the larger hospitals derive more of their Medicaid payments from inpatient care than the average. Indeed, five hospitals derive 65 percent or more of Medicaid payments from inpatient versus outpatient services – CCMC, Yale-New Haven, Hartford, John Dempsey, and Norwalk. Interestingly, while Bridgeport serves a high inpatient Medicaid population, it derives less than the average (57 percent) of its Medicaid payments for inpatient services.

Thus, even though the inpatient rates have not been adjusted to reflect higher costs in a number of years, the higher-paid hospitals like Yale New Haven and Dempsey have inpatient rates much higher than the average, so they get a disproportionate share of Medicaid inpatient payments, bringing up the statewide percentage of Medicaid revenues on the inpatient side.

Medicaid payment-to-cost ratio. Medicaid fee-for-service inpatient rates are based on a hospital's costs, but the costs have not been readjusted in years. Therefore, hospitals that had lower costs when the rates were first established have experienced a greater gap in what Medicaid pays them and their actual costs. The five hospitals that have the lowest Medicaid payment-to-cost ratio are shown in Table IV-8. Also listed in the table are the overall operating expenses per case mix adjusted equivalent discharge for each of the lowest Medicaid paid hospitals. An analysis of this measure, which includes outpatient and inpatient services, was discussed in Chapter III.

As Table IV-8 shows, these hospitals for the most part do not have high operating expenses compared to the overall state average, and, in fact, four of the five hospitals are at least $1,000 below the statewide average and only one is above. It is also worth noting that, except for Day Kimball, hospitals that receive the lowest Medicaid payment-to-cost ratio have considerably lower than the statewide average percent of revenue coming from inpatient rather than outpatient services.

Table IV-8. Lowest Medicaid Payment-to-Cost Ratio Hospitals: FY 05			
Hospital	**Medicaid Payment Ratio**	**Operating Costs per CMAED**	**% Medicaid Inpatient**
St. Mary's	0.47	$5,825	50.6%
Charlotte Hungerford	0.58	$4,778	34.5%
Backus	0.60	$5,943	47.9%
Day Kimball	0.62	$6,060	58.9%
Lawrence and Memorial	0.65	$7,514	56.1%
Statewide Average	0.73	$7,054	58.4%

Underpayment and hospital expenses. To gauge the financial impact of medical assistance underpayment on a hospital, program review looked at the amount of underpayments (before any disproportionate share payments) as a percentage of each hospital's operating expenses. Three hospitals incurred underpayments that exceeded 7 percent of operating expenses –Bridgeport (8.2 percent), Yale-New Haven (8.2 percent), and St. Mary's (7.7 percent). Another five hospitals incurred underpayments that exceeded 5 percent of hospital expenses. *For most hospitals -- 22 of the 31 -- the financial impact of medical assistance underpayments was greater than the costs of uncompensated care (free care and bad debt).*

Even after the payments from the state's disproportionate share programs are included in the analysis, the three most impacted hospitals – Bridgeport, St. Mary's, and Yale-New Haven -- still had percentages of underpayments to total hospital expenses of more than 5 percent.

Ability to shift costs. *Some hospitals are better able to withstand the impact of the medical assistance underpayments if the gap can be shifted onto their private payers.* Hospitals with the highest private payment-to-cost ratios have had positive financial margins, even those with a high Medicaid population, like New Britain General Hospital (see Table IV-9).

If a hospital is unable to shift costs to private payers, it is much less likely to have a positive operating margin, even if it has low expenses. Four of the six hospitals with the lowest private payment-to-cost ratios have negative operating margins. Two of those hospitals with the lowest private payment ratios – St. Mary's and Charlotte Hungerford – also are the lowest paid by Medicaid, and have the lowest adjusted operating expenses of all hospitals in the state. *Thus, certain hospitals have little room to negotiate with private payers on costs, and are also absorbing low reimbursement from Medicaid.*

Table IV-9. Comparison of Private Payment-to-Cost Ratios			
Highest Private Payment-to-Cost Ratio		**Lowest Private Payment-to-Cost Ratio**	
Mid-state	1.45	Ct. Children's Medical Ctr.	.90
Danbury	1.40	St. Mary's	.96
Stamford	1.35	Dempsey	1.02
New Britain	1.35	Charlotte Hungerford	1.04
Backus	1.33	Griffin	1.06
		Waterbury	1.06
Statewide Average	**1.20**	**Statewide Median**	**1.22**
Source of Data: Office of Health Care Access			

Rate exceptions. Connecticut hospitals facing deteriorating financial conditions is not a new situation. In February 2004, as part of the state mid-term budget adjustments, about $2 million was allocated for rate relief for four hospitals – Windham, New Britain, Waterbury, and St. Mary's – determined to be in "dire financial situations". The rate adjustments they received were retroactive to October 1, 2003, and increased their target rate permanently.

Also, that budget adjustment included a plan to raise the minimum target rates in three steps to reach $4,250 on October 1, 2006. However, 2005 legislation modified that floor adjustment to $4,000 to take effect on October 1, 2006.

While not specifically approved legislatively, the rate relief through exception practice introduced in FY 04 has continued. In addition to the four hospitals that received the initial exceptions in 2004, Bridgeport, Hartford and Norwalk hospitals have received rate adjustments. Further, Norwalk and Windham have had two rate adjustments from FY 04 through October 1, 2006. *The informal system does provide aid to hospitals in financial crisis, but as an informal system, it has little transparency, and provides no notification to all hospitals of its availability.* (This rate exception program for hospitals is similar to the one program review committee found when it conducted the 2001 study on Medicaid nursing home rates).

While the informal system can have advantages in cost containment (the committee reviewed rate exception files and found at least two examples where hospitals agreed to administrative salary caps), it places a great deal of financial discretion in the administrative agency. Further, while operating in an ad hoc manner, the program extends beyond grant assistance, because hospital rates are adjusted permanently.

Summary of Findings

The current Medicaid inpatient rate setting system in Connecticut:

- *is outdated and used in very few states;*
- *requires burdensome cost reporting from hospitals, even when it has little bearing on adjusting a target rate;*
- *favors higher-cost hospitals, and further favors inpatient treatment at those high cost hospitals;*
- *does not consider acuity of Medicaid patients, even in a general way;*
- *contributes to the poor financial condition of some hospitals; and*
- *has prompted a parallel informal "rate exception" process to develop.*

To address the inequitable and inadequate rate setting system, the program review committee recommends that:

Beginning October 1, 2007, the Department of Social Services shall establish a hospital inpatient Medicaid Fee-for-Service reimbursement program adopting a prospective payment system that incorporates a case mix index. The system shall use as a base payment rate the most current available Medicare base rate adjusted by the Medicare wage index.

The rate shall account for the Indirect Medical Education (IME) expense for teaching hospitals. DSS shall adjust the rate by the difference in the base rate and the rate with the IME, and apportion the percentage of the amount difference by the ratio of inpatient Medicaid discharges to the total inpatient discharges at that hospital for the most recent year reported to Office of Health Care Access.

DSS shall then adjust the rate using the Medicare DRG case mix index for the Medicaid population for that hospital.

DSS shall adjust the base rate annually by the same percentage as the Medicare hospital market basket adjustment for inpatient payments.

DMHAS shall use this rate-setting structure to pay for inpatient SAGA services.

Implementation. Medicare base rates are established using the most recent Medicare cost reports to adjust the wage indexes for areas of the country. Thus it is a current reflection of much of actual hospital costs. Further, the variability in the Medicare base rate adjusted for wage index is a lot less than the FY 05 targeted discharge under Medicaid, as shown in Table IV-10.

Table IV-10. Comparison of Medicare and Medicaid Base Rates

Medicare		**Medicaid**	
Average Base Rate per stay (with wage adjustment)	$5,499	Average Targeted discharge rate per stay	$4,313
Standard deviation	$212	Standard deviation	$963
Range	$5,301 - $5785	Range	$3,438 -- $7,797

Setting the new Medicaid FFS rate at the Medicare rate raises the overall floor for all hospitals but is more reflective of more current general costs by all hospitals. The proposed rate system would consider the extra expenses of medical education in teaching hospitals. Generally, because Connecticut has a high number of teaching hospitals, hospital costs are higher. In fact, the indirect medical cost portion adds $500 a day to the average Medicare base rate, bringing it to $5,999.

Figure IV-3 illustrates how the new Medicaid rate would be developed. The recommended Medicaid payment system would recognize the higher costs of the teaching hospitals by taking the difference in the IME-adjusted rate from the base rate and apportioning that difference by the ratio of Medicaid inpatients to the hospital's total population. For example, if a hospitals Medicare IME rate is $500 higher than its base rate, and 10 percent of the hospital's discharges are Medicaid, the IME adjustment would raise the hospital's per stay rate by $50.

Figure IV-3. Illustration of the Proposed Methodology for Medicaid Rate-Setting

Sample Hospital	*Method*
$5,500 ($500 X .10= $50) + $ 50 $5,550	1) Base Rate with Medicare Wage Index 2) With Medicare IME Adjustment (for example $500) DSS Uses Inpatient Medicaid -- example 10% -- to Apportion Medicaid teaching adjustment
$5,550 X.90 **$4,995**	3) Teaching adjusted rate is multiplied by the case mix index of the Medicaid population (all Medicaid and SAGA) as reported to OHCA on CHIME. In this example case mix is .90 4) $4,995 is prospective case mix adjusted inpatient Medicaid rate for that hospital for the year

The rate with the teaching hospital adjustment is then multiplied by the case mix adjustment factor for the Medicaid population, which hospitals report to OHCA. Hospitals use the current Medicare DRGs and weights to calculate the case mix index (CMI). The FY 05 Medicaid case mix for each hospital is shown in Appendix D. For most hospitals, the case mix index for Medicaid is less than 1.

For cost-estimating purposes, the Medicaid CMI-adjusted rate was multiplied by the number of FY 05 Medicaid discharges (which includes all Medicaid and SAGA inpatients) to arrive at the costs of the new rates through the proposed structure. While technically the new rate setting structure would not apply to Medicaid managed care, for cost estimations, the committee used all Medical assistance discharges and revenues. Appendix D shows what the new payment rate adjustments would be for each hospital and the total hospital inpatient payments under the proposed system. The committee estimates the new inpatient payment structure would increase inpatient Medicaid costs by about $30.8 million dollars, but since Medicaid reimburses 50 percent of Connecticut Medicaid costs, net state costs would be about $15.4 million.

Rationale

The committee believes the proposed prospective payment system, with a case mix adjustment, is a fairer system that offers more stability to the state's overall funding of hospitals and more closely ties the payments to the patients' illnesses, rather than to a particular hospital's costs.

The proposed recommendation acknowledges that hospitals would not be held harmless. Some hospitals would experience an increase in Medicaid inpatient revenues, while Medicaid payments to other hospitals would decrease. However, the committee believes the proposal levels out the payment system by recognizing all hospitals' basic costs. Using a case mix adjustment recognizes the acuity of the Medicaid population, as well as Medicaid's portion of the extra costs at teaching hospitals.

The committee chose the Medicare DRG case mix adjustments because of its simplicity, and because all hospitals already use it to code for payment for Medicare patients. Further, 24 states currently apply the Medicare DRGs to set state Medicaid rates. There are newer, sophisticated grouping systems (e.g., APR-DRG) that more accurately categorize severity of illness, especially for a non-Medicare population. But the committee believes requiring that a newer grouping system be adopted would create a costly administrative burden, especially on smaller hospitals, for a relatively limited portion of hospital revenues. (All inpatient Medicaid FFS and SAGA revenues are about 5 percent of all hospital payments.)

A very small number of states are moving to the all-patient refined (APR-DRG) system for payment structures. Maryland currently uses the system, but that state sets hospital rates for all payers. The Agency for Healthcare Research and Quality (AHRQ), a section of the federal Health and Human Services Department, uses the APR-DRG system to evaluate and measure quality and outcomes of many aspects of nation's health care system. The committee understands that the Centers for Medicare and Medicaid Services is considering moving to an APR-DRG system to set Medicare rates. If and when CMS does that, because Medicare is such a large payer, its payment system will drive the change to an APR-DRG system, and Connecticut could then adopt that system for Medicaid as well.

The committee also examined a simple rebasing system where all estimated inpatient expenses divided by all discharges yielded a current inpatient expense per discharge for each hospital. The same case mix adjustment was applied to yield an adjusted per stay rate for Medicaid, and the weight- adjusted rate was multiplied by the number of Medicaid discharges for FY 05, with a resulting increase in inpatient Medicaid costs of $228 million. With a 50 percent match from the federal government, the net increase in costs to the state under a rebasing would be about $114 million, an added expense that would certainly bump up against the state's spending cap, and would perpetuate a system of rewarding higher-cost hospitals.

Medicaid Managed Care Rates

Department of Social Services negotiates rate increases with Medicaid managed care organizations (MCOs) annually. The Balanced Budget Act (1997) and federal CMS regulations

(2002) require that state Medicaid rates paid to managed care organizations be "actuarially sound." Prior to that, the state, through the MCOs, could not pay more for a particular service than the state would have paid if it were reimbursing the provider directly.

However, a recent report [6] by the Lewin Group, a nationally recognized health consulting firm, under contract with the Association of Community Affiliated Plans to conduct an assessment of the "actuarial soundness", noted two major problems with these requirements:

1) "the exact meaning of the phrase 'actuarially sound' as it applies to health plans is not yet defined and is still being debated within the actuarial profession – with the likely outcome that different definitions will be considered appropriate for different situations";

2) in theory while this ["actuarial soundness"] is the way Medicaid managed care rates are supposed to be established, the report states Medicaid payments in practice often are affected by the availability of funds, (just as they are in Medicaid FFS) and sometimes [budget considerations] override actuarial principles.

DSS has contracted with Mercer Health Care Consulting to perform the actuarial analysis to establish Medicaid MCO rates. The firm also collects and maintains the encounter data from the MCOs on which the rates are based. Encounter data are also used by DSS to monitor utilization levels and access to care. The contract with Mercer was begun in 1997 and has been extended a number of times; the annualized cost of the contract over the 10-year period is $2 million.

The committee believes that, in addition to the problems with the MCO rate-setting process noted in the Lewin report, there is another complication with the Medicaid managed care rate process that directly impacts hospitals. While managed care plans negotiate with DSS on what rate increases they will accept (or lose the Medicaid business), the MCOs then negotiate with medical providers, including hospitals, on how much the MCOs will reimburse them for care. Many private community providers may not accept the Medicaid rates offered and therefore opt not to treat Medicaid patients. Hospitals, however, are required by federal law to treat all patients who come to an emergency room, regardless of type or lack of insurance.

Aggregate financial data for the Medicaid MCOs were presented in Table II-6 in Chapter II. The data indicate that revenues to the MCOs from the state have increased about 70 percent from 2000 to 2005. Because MCOs negotiated rates for providers are considered proprietary, PRI did not have access to those rates for hospitals (or other providers). The committee also did not have hospital payments from Medicaid for the entire 2000-2005 period. However, analysis of available MCO financial data from 2003 to 2005 show:

- overall revenues to MCOs increased from about $647 million to almost $745 million, or about 17 percent;

[6] The Lewin Group. *Rate Setting and Actuarial Soundness in Medicaid Managed Care*, January 2006

- total MCO payments to hospitals rose from $242 million to $277 million or about 14.5 percent;

- MCO per member per month (PMPM) rates increased about 10 percent over the two-year period -- from $174.18 to $191.27 per month; and

- the average inpatient payment per discharge to hospitals for an MCO inpatient stay increased only 1.8 percent, as shown in Table IV-12.

Table IV-12. Inpatient Stays and Payments for Medicaid Managed Care: FY 03 – FY 05

	FY 03	FY 04	FY 05	% inc
Total MMC Inpatient Stays	33,853	35,273	36,635	8.2%
ALOS*	3.9 days	4.0 days	4.0 days	2.5%
Total MCO inpatient hospital payments	$242m	$266m	$277m	14.5%
Average Discharge Payment	$3,853	$3,963	$3,925	1.8%
Average Per Diem MMC	$976	$983	$845	-13.4%

Source of Data: PRI Analysis of Hospital Schedules Filed with OHCA.
*ALOS- average length of stay

Further, even though the average hospital length of stay for this population increased slightly from 3.9 days to 4.0 days, the average hospital per diem payment actually went down from $976 to $845 over the two-year period. In order to fully determine the reasons for the increases in state payments to MCOs, trends in other Medicaid managed care expenses, like pharmaceuticals, would need to be analyzed.

For the same FY 03 to FY 05 time period, Medicaid MCOs medical expenses increased about $90 million (or about 15.6 percent), while their administrative expenses increased $20.2 million, or 33 percent. *It appears that much of the rate increases to Medicaid MCOs has gone to increased MCO administrative expenses and have not been passed on to providers, at least not to hospitals.*

The committee recommends the Department of Social Services require as part of the contracts with Medicaid managed care organizations that rates to providers increase by at least the same percentage as the per member per month increase and limit the increase in administrative expenses to the same ratio as the increase in the per member per month rate.

Emergency room visits. One of the foundations of managed care is that a MCO take the financial risk of insuring appropriate medical care for enrollees for a given rate. A plausible benefit of ensuring access to appropriate care is to reduce the number of inappropriate visits to the emergency room. However, in the case of Medicaid managed care, there may not be enough financial incentive for MCOs (or their clients) to make sure their enrollees have access to and are receiving preventive, primary care in the most appropriate setting.

Until July 2006, the Medicaid outpatient fee-for-service rates for hospitals had not increased since 2001. The payment rate ER visit prior to July 2006 was $124.87 (increased to $198.63 as of July 1). But, if the ER visit was deemed (i.e., coded) not an emergency, then the rate the hospital received was a clinic rate. Prior to July 1, 2006, the clinic rate was $34.80 and increased to $69.70 after that date. However, even the increased rate is lower than the federally qualified health center (FQHC) rate of $122 to $144 (as of October 1, 2006) for a medical clinic visit.

Hospital representatives indicate that MCOs still use the Medicaid fee-for-service rates as the standard for their payment. The committee asked DSS for MCO outpatient encounter and claims data, similar to the data the department provided for its Medicaid fee-for-service clients. The committee had hoped to determine from the requested data where Medicaid MCO clients were receiving their medical services. However, because of computer system problems and other issues around retrieving the data, DSS was not able to get the information to the committee for this report. It is clear from other hospital emergency room data however, that the use of the ER has not gone down for the Medicaid managed care population. In fact it has increased almost 10 percent over the past two years -- from 70.5 to 76 visits per 100 enrollees.

The committee believes there should be a stronger financial incentive for Medicaid MCOs to ensure their clients have access to, and use, preventive care in the most appropriate setting. Therefore, the committee recommends that the **Department of Social Services, in its contracts with Medicaid managed care organizations place a cap on the number of emergency room visits per MCO client. The MCO would incur a financial penalty -- $100 a visit – for a client who uses the emergency room more than twice in a year when the visit is coded as a non-emergency. DSS should use the encounter and claims data to determine when this occurs and adjust its payments to the MCOs. The penalty adjustments would be pooled and used to supplement funding to hospitals that served those clients.**

Other states have experienced inappropriate use of the emergency room by Medicaid clients, and are trying to deal with it in different ways. New Hampshire, for example, recently imposed a $6 co-pay for Medicaid clients who use the emergency room inappropriately. However, hospitals must collect the co-pay at the time of service, and cannot refuse treatment to anyone who states he or she cannot pay. Thus, the burden is still on the hospital for treatment and payment collection. The committee believes making the MCOs bear more financial responsibility for appropriate medical care for their clients is a better approach because it encourages MCOs to make sure their clients have access to appropriate preventive and routine health care.

Outpatient revenues. Altogether state medical assistance program payments to Connecticut hospitals totaled $574 million, about $276 million from managed care $298 from FFS. Medicaid managed care pays about 48 percent of its hospital payments for outpatient services, while outpatient payments for Medicaid fee-for-service account for only about 35 percent of its hospital payments. However, there are no comprehensive utilization data to assess per- patient outpatient costs for either of the Medicaid populations.

For the vast majority of providers, outpatient rates are not based on hospital or provider costs -- FQHCs are the exception. DSS establishes the rates -- either on a set fee schedule, or on an overall ratio of cost to charges for a given service. DMHAS has its own rates for SAGA clients' behavioral health. Even though the DSS rates are low, they are the same for all hospitals (SAGA rates vary slightly by hospital), so higher-cost hospitals are not getting paid a higher amount for the same service, and hospitals know ahead of time what rates they will be paid.

Until July 2006, the fee-for-service rates for most outpatient care had not been increased in five years. In the FY 07 budget, the legislature authorized an increase of $7 million to increase outpatient rates to hospitals, including: lab fees; emergency room visits; and clinics. The rate increases will help hospitals, especially those with a high percentage of outpatient Medicaid volume. Historically, fee schedules have been thought to raise costs by increasing utilization. That is difficult to assess for this study, because no utilization data exist for all Medicaid clients.

Medicare, the largest single-source payer, for the most part uses a prospective payment system (adjusted by wages), known as the ambulatory payment classification (APC) to set outpatient rates. Massachusetts uses a prospective payment amount per episode (PAPE), which is an all-inclusive rate that covers all outpatient services for persons when they are treated. The PAPE rates vary considerably by hospital from $125 to $350 at general hospitals to more than $500 at several specialty hospitals. However, the committee believes that to recommend adopting an outpatient payment structure based on different hospital costs -- while moving away from such a system for inpatient care -- would contradict the purpose of promoting fairness in reimbursement to hospitals.

Therefore, the committee recommends maintaining the current outpatient reimbursement structure, but believes the rates should be increased annually. The committee recommends that DSS adjust the outpatient rates by increases in the Consumer Price Index (urban).

The committee believes that some annual adjustment should be made to outpatient rates to reflect inflation, and provide some assurance that Medicaid clients have access to those services. Not updating the payment schedules for years at a time limits access to outpatient services and ultimately could drive up more costly inpatient care. On the other hand, containing costs is an overriding concern in the state Medicaid program. The committee considered applying an adjustment factor based on medical inflation, or using the same annual increases as Medicare outpatient, but determined using either of those will likely lead to unsustainable increases. Therefore, the recommendation proposes annual increases, but limits those to inflationary changes in the overall economy, which have typically been lower than increases in health care. With this proposal, more moderate, but frequent, adjustments will be applied, ensuring a closer connection between outpatient service costs and payments, and assuring better Medicaid client access to those services.

The committee recommends, however, that, while maintaining the per-service fee schedule, DSS through its payment contractor – Electronic Data Systems – ensure that hospitals (or any other provider) are not over-utilizing certain services per episode to increase outpatient payments. DSS and DMHAS, as payers, should also increase

monitoring of payment of inpatient care for its clients to ensure that such care is necessary and appropriate, and could not have been provided on an outpatient basis.

Chapter V

Additional Financial Assistance

In addition to the various rate reimbursement systems and rate exceptions discussed in Chapter II, there is a number of other financial assistance opportunities available to hospitals. Among these are the hospital hardship grants appropriated in 2006, the rate adjustments for hospitals serving a disproportionate share (DSH) of low-income individuals, as well as additional payments for under-insured and uninsured clients. However, some of the assistance (i.e., hardship grants) are considered one-time opportunities. *The level and availability of the other forms of financial assistance is unpredictable and not open to all hospitals.*

Hardship Grants

Recognizing the need for financial stability, the legislature in the 2006 session authorized DSS to distribute $11 million for hardship grants to Connecticut hospitals (P.A. 06-186). The grants were to help hospitals: avoid substantial financial deterioration that may adversely affect patient care, and assist in their continued operation. Hospitals were notified in August 2006 of the availability of funds and the application process.

DSS determined grant recipients in consultation with the Department of Public Health, the Office of Health Care Access, and the Connecticut Health and Educational Facilities Authority. Pursuant to the public act, consideration was to be given to the number of clients on state assistance that a hospital serves; the hospital's licensure and compliance history; and the reasonableness of its actual and projected revenues and expenses. Table V-1 lists the hospitals that applied for the hardship funds.

Table V-1. Hospital Hardship Fund Request
Bradley/New Britain
Bridgeport
Bristol
New Milford
Rockville
St. Mary's
St. Raphael
Waterbury
Windham
Source: DSS

To qualify, a hospital was required to submit a plan describing how the hospital would achieve operating savings and increase nongovernmental revenues. Quarterly reports on plan implementation are required for continued grant payments. DSS must submit quarterly reports to the Appropriations and Human Services committees identifying the hospitals asking for grants, the grant amounts, and the commissioner's action on each request.

The program review committee examined the application submissions received by DSS for the hardship funds. In general, each hospital applicant was judged in three main categories. The categories and specific application requirements were as follows:

I. Financial Condition

Each hospital applicant was required to submit audited financial statements and Internal Revenue Service 990 filings for FY 2004 and 2005. The submissions were to include a

description of the hospital's financial condition and projections for the next two fiscal years including key revenue and/or cost factors affecting the hospital's financial performance.

In addition, a review was made of the applicant's total amount of outstanding debt, the payment schedule on the debt, and the probability of the applicant violating covenants in any loan agreements as well as information pertaining to hospital credit lines.

II. Utilization Statistics

Pursuant to the public act, each hospital was required to submit selected utilization statistics with the application. Specifically, each hospital was to report volume for low-income inpatient, clinic, and emergency services for 2004 and 2005.

III. Planned Use and Projected Operating Savings

Each hospital was to explain its planned use of grant funds and expected results as well as to project savings and non-governmental revenue enhancements planned between October 1, 2006 and June 30, 2007. Each applicant was also to identify if any such activities would be a one-time or an ongoing/long-term initiative.

Each applicant's plan was evaluated on the basis of the benefit to state-assisted and uninsured individuals and the feasibility of the plan in light of the hospital's financial condition. In addition, each applicant's projected savings and enhancements were reviewed for reasonableness.

Summary of applicant submissions. Table V-2 provides a limited profile of the nine hospital applicants. As the table shows, five of the applicants are teaching hospitals. Three hospitals had fewer than 90 staffed beds, two had between 150 and 170 staffed beds, and four had more than 280. Three hospitals were in New Haven county, two in Hartford county, and one each from Fairfield, Litchfield, Tolland, and Windham counties. In addition, six of the nine hospitals had negative operating margins in 2005 including Bradley, which is now merged with New Britain.

Table V-2. Profile of Hardship Grant Applicants

Hospital	County	Teaching	FY 2005	
			Staffed Beds	Operating Margin
Bradley/New Britain	Hartford	No/Yes	46/290	-2.55 / 4.94
Bridgeport	Fairfield	Yes	335	2.72
Bristol	Hartford		154	-4.19
New Milford	Litchfield		72	1.05
St. Mary's	New Haven	Yes	169	-10.02
St. Raphael	New Haven	Yes	474	-1.20
Waterbury	New Haven	Yes	288	-1.17
Windham	Windham		87	0.06
Rockville	Tolland		66	-4.48

Source: LPR&IC Analysis

With respect to their financial conditions, almost all the hospitals noted their financial conditions were impacted by losses from operations and low government rate reimbursement. Some cited a growing number of uninsured and underinsured patients creating financial shortfalls. A few voiced concern over their debt service. Two specifically mentioned losses due to changes in the Medicare wage index areas.

Utilization rates. Table V-3 presents the utilization statistics selected by DSS to be submitted as part of the hardship grant applications. Of the three statistical areas under review, the highest utilization was seen in clinic and emergency room use among the low-income population. Bridgeport reported the highest percentage of utilization of low-income populations in all three areas of inpatient, clinic, and emergency room. St. Raphael and St. Mary's reported large percentages of low-income and uncompensated care populations in their clinics and emergency rooms. Finally, Windham Hospital also had high utilization rates for inpatient and emergency room use by low-income individuals.

Planned use of grant funds. Each hospital applicant discussed its planned use of hardship funds. The plans varied in purpose and level of detail. Table V-4 lists each hospital's primary planned use as reported in the application. Each hospital also noted that although these plans were identified as priorities, several other critical needs were still pending.

Table V-4. Applicant Reported Planned Use for Hardship Grants

Hospital/Applicant	Planned Use
St. Raphael	Meet current liabilities as they become due, fund pension expenses, and address capital investments
New Milford	Offset loss due to reclassification of the hospital's Medicare wage index area and to prevent or reduce the need for layoffs of personnel due to increases in various costs including utilities, pensions, wages, and malpractice insurance
Windham	Provide strategic capital to fund projects related to medical imaging services
Rockville	Offset the start-up costs related to building up operating room inventory to support the restoration of certain inpatient services and help fund the capital budget for renovations and/or equipment
St. Mary's	Reduce and meet debt service obligations as well as funds for employee pensions, information infrastructure, and a number of physical plant projects
Bristol	Support registered nurse investment strategies, emergency department improvement initiatives, and the cancer program
(New Britain/Bradley) Hospital for Central Connecticut	Streamline administrative and management systems due to merger
Waterbury	Update the hospital's imaging technology and increase available bed capacity for inpatient care
Bridgeport	Support medical staff recruitment to address physician retirements in the areas of general surgery, psychiatry, and geriatrics

Source: DSS Hardship Applications

Table V-3. Selected 2004 and 2005 Utilization Statistics Submitted as Part of Hospital Hardship Grant Application													
		Inpatient				Clinic				Emergency Room			
Hospital	FY	Total	Low Income %	UCC %	All Other %	Total	Low Income %	UCC %	ALL Other %	Total	Low Income %	UCC %	All Other %
St. Raphael	04	142,977	14	6	79	68,306	62	20	18	39,210	31	28	42
	05	131,347	15	5	80	69,489	62	18	20	41,303	34	21	45
New Milford	04	14,352	6	11	83	76,223	5	3	92	19,049	8	18	73
	05	14,747	6	9	85	78,465	5	3	92	19,533	4	18	78
St. Mary's	04	54,200	11	1	88	69,512	71	5	24	52,044	23	10	67
	05	55,099	11	1	88	75,913	73	5	22	55,165	17	9	74
Rockville	04	16,097	14	5	81	68,744	6	2	92	18781	19	2	78
	05	15,620	15	8	77	69,367	6	2	92	19,034	21	2	76
Windham	04	20,958	20	6	74	825	13	63	23	21,258	30	18	52
	05	20,261	18	15	67	669	13	67	20	22,401	33	27	40
Bridgeport	04	107,646	24	10	66	31,753	72	17	11	52,136	43	26	32
	05	107,947	23	14	62	34,186	70	17	13	53,567	43	24	33
Bristol	04	36,826	13	16	71	134,621	9	10	81	31,007	30	32	38
	05	36,810	14	17	70	127,405	9	9	82	32,084	31	30	39
Waterbury	04	79,072	17	12	72	131,582	15	0	85	44,581	32	0	68
	05	81,131	18	11	71	123,399	14	0	86	45,506	33	0	67
Bradley	04	2,323	3	1	96	62,340	5	3	93	14,970	12	8	80
	05	2,338	3	1	96	67,676	5	2	93	14,970	15	7	79
New Britain	04	17,617	20	2	78	306,995	21	4	75	63,585	21	9	70
	05*	N/A	-	-	-	N/A	-	-	-	N/A	-	-	-

Low income includes Medicaid Fee-for-Service, Husky A/B, and SAGA
UCC includes free care and uncompensated care
* FY 05 utilization data was not included in application

Source: DSS Hospital Hardship Grant Applications

Operating savings and revenue enhancement. The hospitals each discussed a variety of savings initiatives and non-governmental revenue enhancements. Among the initiatives considered were:

- more favorable negotiations with managed care contracts;
- expense reductions related to salary, pension, and benefits;
- implementation of energy management plan and conservation improvements;
- better use of new information system to bill and collect for services rendered;
- improvements in emergency room and surgical services operations such as scheduling, staffing, and supply costs;
- conversion of employee group health insurance benefit from fully-insured plan to self-insured plan;
- consolidation of certain support services; and
- introduction of information technology to reduce redundancy in testing and other clinical diagnostic procedures.

Distribution of grants. Grant determination notices were mailed to all applicants on November 28, 2006. The notice stated DSS considered awards based upon the severity of financial difficulties and the volume/proportion of hospital services provided to state-assisted and uninsured patients. According to the notice, the grant funding was "neither intended nor sufficient to meet losses projected by all hospitals for 2007 or shortfalls between government health program payment levels and standard charges." The notice further stated the hardship funds were better suited for one-time projects such as capital improvements. Grantees were reminded grant funds were a limited appropriation and grantees should not rely on any future additional grant funds. Table V-5 lists the distribution of hardship funds as of February 12, 2007.

Table V-5. Distribution of the Hospital Hardship Grants

Hospital Applicant	Grant Amount	Outcome/DSS Intended Purpose
Bridgeport	$1.7 million	Facility upgrades (operating room, switchgear/generator and air handler)
Bristol	$1.2 million	Emergency department expansion
Hospital of Central Connecticut (New Britain/Bradley)	$0	Based on reported profits hardship was not determined
Rockville	$0	Based on projected profits and lower utilization rates than other applicants no grant award
New Milford	$0	Based on lower utilization rates than other applicants no grant award
St. Mary's	$5.5 million	Address operating shortfalls and bond covenants
Waterbury	$1 million	Applied toward CT scan
St. Raphael	$0.6 million	Applied toward equipment replacements (CT scan, EKG, ER monitors)
Windham	$1 million	Applied toward CT scan
Total Awarded	**$11 million**	

Source: DSS Determination Notices of Hardship Grants

Medicaid Disproportionate Share (DSH) Program

The Medicaid DSH program allows states to consider special payment needs for hospitals that serve a large portion of Medicaid and uninsured patients. The rationale behind the additional payments is that hospitals with high volumes of low-income individuals often lose money as a result of low Medicaid reimbursement rates. They also lose money because these same hospitals generally provide high volumes of care to indigent patients resulting in high levels of uncompensated care. In addition, many hospitals with large caseloads of low-income patients frequently have low private caseloads. Therefore, they are less able to shift the cost of uncompensated care to privately insured patients.

Federal requirements. The Omnibus Budget Reconciliation Act of 1981 established the DSH program, which is codified in section 1923 of the Social Security Act. The section requires state Medicaid agencies to make additional payments to hospitals that serve disproportionate numbers of low-income patients.

States have considerable flexibility in defining their DSH programs under the act. States receive allotments of DSH funds as set forth by section 1923. The federal government shares in the cost of Medicaid DSH expenditures based on the federal medical assistance percentage for each state. In Connecticut, the federal government share is 50 percent.

DSH Payments and Adjustments

Connecticut acute care hospitals receive DSH monies under both Medicare and Medicaid. As noted above, states have wide discretion in how they administer Medicaid DSH funds. Table V-6 distinguishes the various types of DSH monies received by Connecticut acute care hospitals as well as who administers them.

Table V-6. Disproportionate Share (DSH) Programs for Connecticut Acute Care Hospitals

Program Name	Type of DSH	Administered by
Medicare		
Mandatory	Mandatory rate *adjustment* pursuant to federal regulation	Federal Center for Medicare and Medicaid Services (CMS)
Medicaid		
"Mandatory"	"Mandatory" rate *adjustment* pursuant to federal regulation as adopted in Medicaid State Plan	DSS
Uncompensated Care	*Payment* formula pursuant to state statute as adopted in Medicaid State Plan	DSS with OHCA
Urban	*Payment* formula pursuant to state statute as adopted in Medicaid State Plan	DSS

Source: LPR&IC

As the table shows, there are three major DSH funds administered by the Department of Social Services. Uncompensated care and urban DSH *payments* are made by DSS and paid from general fund revenues with matching funds from the federal government. Medicaid DSH *adjustments* are built into the Medicaid target rate for a few hospitals that qualify. These adjustments, also calculated by DSS, are separate from DSH payments. Hospitals also receive DSH adjustments for Medicare rates but these adjustments are handled by the federal government.

Medicare DSH adjustment. Enacted in 1983, the Medicare disproportionate share adjustment is an add-on to the diagnosis-related group rate under the Medicare prospective payment system to acknowledge the special needs of public or other hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under Part A of the Medicare hospital program. The primary method for a hospital to qualify for a Medicare DSH adjustment is based on a complex federal formula that results in a DSH patient percentage. To qualify for Medicare DSH, a hospital's share of low-income patients must equal or exceed 15 percent.[13]

Table V-7 provides the 2006 Medicare DSH percentage for qualifying hospitals along with their 2005 and 2006 adjustments. Thirteen acute care hospitals in Connecticut have a Medicare DSH percentage over 15 percent allowing them to receive Medicare DSH adjustments. Yale-New Haven has the largest Medicare DSH percentage (30%) with a rate adjustment of 0.1399; that percentage is then added to the hospital's basic Medicare rate.

Table V-7. Distribution of Medicare Disproportionate Share Adjustments FYs 05-06.

HOSPITAL	DSH %	05 Medicare DSH Adjustment	06 Medicare DSH Adjustment
Backus	20.0	0.0576	0.0576
Bridgeport	23.1	0.0825	0.0825
Day Kimball	15.7	0.0294	0.0294
Dempsey	24.7	0.0962	0.0962
Hartford	17.2	0.0394	0.0394
New Britain General	21.0	0.0650	0.0650
St. Francis	20.8	0.0641	0.0641
St. Mary's	20.6	0.0618	0.0618
St. Vincent's	21.4	0.0688	0.0688
Stamford	18.6	0.0484	0.0484
Waterbury	19.1	0.0517	0.0517
Windham	23.4	0.0851	0.0851
Yale-New Haven	30.0	0.1399	0.1399
Source: Connecticut Hospital Association Report			

[13] The low-income share is determined by summing: a) the number of Medicare inpatient days provided to Supplemental Security Income (SSI) recipients divided by total Medicare patient days, and b) the number of inpatient days provided to Medicaid beneficiaries (non-Medicare) divided by total inpatient days.

Medicaid DSH adjustment. Under the Medicaid program, states are allowed to designate certain hospitals as disproportionate share facilities under their Medicaid plans and make additional payments to those DSH hospitals by adjusting their Medicaid rates. Pursuant to federal law, DSS may provide a disproportionate share adjustment to hospitals that have a Medicaid inpatient utilization rate that is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state.[14] The hospital must also have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under the state Medicaid plan.

DSS determines which hospitals meet the standard deviation criteria from information contained in the Medicaid cost reports annually filed by the hospitals. The utilization rate is calculated by dividing the total number of Medicaid inpatient days for both Medicaid managed care and fee-for-service clients by the total number of inpatient days. DSS must then calculate the mean and standard deviation for the entire group to determine the qualifying hospitals. (The DSS calculation for the 2006 Medicaid DSH adjustment is presented in Appendix E.)

To qualify for the 2006 mandatory DSH adjustment, hospitals must have a utilization rate that is at a minimum one standard deviation over the mean (17.4107). As Table V-8 shows, three hospitals (Bridgeport, John Dempsey, and Yale-New Haven) qualified for the 2006 Medicaid DSH adjustment.

Each qualifying hospital's base rate then receives a DSH adjustment add-on based on a federally prescribed formula. The DSH adjustment add-on formula is similar to the formula used for the Medicare DSH adjustment.

A comparison of the three hospitals that qualify for the 2006 federal DSH adjustment is provided in the table below. As the table shows, the addition of the DSH adjustment results in rates that are up to $800 higher than the base rate. As a result, *the Medicaid DSH rate adjustment creates a "cliff effect" whereby the few hospitals that qualify receive significant increases in their rates.*

Table V-8. Comparison of Adjusted and Non-adjusted Rates for Qualifying Medicaid DSH Hospitals

Hospital	FY 06 Base Rate w/o DSH Adjustment	DSH Adjustment	DSH Adjusted Base Rate	Difference b/w adjusted and non-adjusted base rates	FY 05 Medicaid FFS Discharges	Total Difference due to DSH
Bridgeport	$5,350	0.10697	$5,922	$572	1,964	$1,123,408
Dempsey	$7,797	0.10054	$8,581	$784	621	$486,864
Yale-New Haven	$5,151	0.15543	$5,951	$800	4,289	$3,431,200
Source: LPR&IC Analysis						

[14] The standard deviation is a statistical measure of the dispersion of hospitals' utilization rates around the average; the use of this measure identifies hospitals whose Medicaid utilization is unusually high.

Since FY 99, a total of six hospitals have qualified for Medicaid DSH adjustments. Three of the six (Bridgeport, John Dempsey, and Yale-New Haven) have qualified every year. St. Francis Hospital had qualified every year until 2006. Waterbury and St. Mary's qualified in 2001 and 2004 respectively.

The impact the Medicaid DSH adjustment has on hospital rates is substantial. As noted above, St. Francis Hospital qualified every year since 1999 until 2006. In FY 05, St. Francis Hospital met the qualifying utilization rate and received a DSH adjusted base rate of $3,821. In FY 06, St. Francis's total Medicaid patient days decreased and the hospital did not meet the qualifying utilization rate for the DSH adjustment. As a result, the hospital went from a DSH adjusted rate of $3,821 in FY 05 to a base rate of $3,438 in FY 06, a reduction of $383 per discharge.[15]

The impact of the Medicaid DSH adjustment is also visible when comparing hospitals located in the same town presumably serving the same population. In FY 06, two of the three hospitals receiving a DSH rate adjustment (Bridgeport and Yale-New Haven) were located in cities that each had another acute care hospital. Both St. Vincent's, which is located in Bridgeport, and St. Raphael, located in New Haven, did not qualify for a Medicaid DSH adjustment. Table V-9 illustrates the difference in adjusted and non-adjusted base rates for these hospitals in FY 06.

Table V-9. Comparison of Adjusted and Non-adjusted Rates for Co-located Hospitals: FY 06

Hospital	Utilization Rate	Base Rate	Base Rate w/ Adjustment	Rate Difference b/w Co-located Hospitals
Yale-New Haven	24.7718*****	$5,151	$5,951	$2,167
St. Raphael	13.4322	$3,784	Not Qualify	
Bridgeport	20.1005*****	$5,350	$5,922	$2,018
St. Vincent's	12.2281	$3,904	Not Qualify	
Standard Deviation	5.4216			
Mean/Average	11.9891			
Qualifying Rate	**17.4107***			
Source: LPR&IC Analysis				

As the table shows, the Medicaid utilization rates for St. Raphael and St. Vincent's exceeded the statewide average in FY 06. However, neither hospital met the qualifying rate set by the standard deviation requirement. Consequently, both St. Raphael and St. Vincent's received the base rates while Yale-New Haven and Bridgeport had the DSH rate adjustment added on to their base rates. This translates into a difference of over $2,000 per discharge for the hospitals. Interestingly, *other hospitals also serving large urban populations (e.g., Hartford and New Britain) have not qualified for the Medicaid DSH adjustment despite growing Medicaid numbers.*

[15] The impact of this was lessened because a number of hospital rates including St. Francis increased to $4,000 in FY 07 as a result of the state raising the statutory minimum base rate during the last legislative session.

In addition to the volatility and unfairness created by DSH adjustments to rates, the formula only considers Medicaid *inpatient* volume. This may create a perverse incentive for certain hospitals to treat Medicaid clients on an inpatient basis and to increase the inpatient days.

Therefore, program review recommends **DSS terminate the application of the Medicaid DSH rate adjustment.** There is no federal requirement that the state continue this practice. The Medicaid DSH rate adjustment benefits few and creates a significant "cliff effect" in the rates of a small number of hospitals. Discontinuation of the Medicaid DSH adjustment would also avoid the potential incentive of treating clients on an inpatient basis.

It is important to note that eliminating the Medicaid DSH adjustment would not mean Connecticut would lose federal funds or in effect "leave federal DSH money on the table." The proposed new Medicaid inpatient reimbursement rate would increase the state's Medicaid budget by approximately $30 million, half of which is matched by the federal government. Therefore, the state would not "lose" Medicaid money but rather redistribute the funds more fairly through the proposed Medicaid rate structure.

Calculation of DSH payments. Disproportionate share *payments*, as opposed to rate *adjustments*, refer to additional payments by the state to compensate hospitals for a portion of the services they provide to under-insured and uninsured patients. Under the Medicaid program, DSS may claim DSH payments made to acute care hospitals under certain categories defined within the state's Medicaid plan to receive federal matching funds. As noted earlier, Connecticut receives federal matching funds at a 50 percent rate.

Uncompensated Care (UCC) program. The largest DSH payment category is through the Uncompensated Care program, which is statutorily made available to all acute care hospitals except children's hospitals and John Dempsey.

DSS determines the amount of UCC disproportionate share payments to be made to each eligible hospital based on information provided by the Office of Health Care Access. In general, DSS makes payments to qualified disproportionate share hospitals based upon: 1) the costs they incurred for uncompensated services; 2) the federal upper limit on aggregate state disproportionate share payments that are eligible for federal matching payments; and 3) the amount determined to be available under state law.

An approach known as a baseline methodology is used to determine how much each hospital is to receive in UCC DSH payments. OHCA calculates each hospital's baseline underpayment, which equals the cost of uncompensated care (bad debt and free care) and the cost of Medical Assistance underpayment (for state Medicaid FFS and Managed Care as well as SAGA).

UCC calculation. OHCA bases its calculation on information submitted in financial schedules filed by each hospital. To bring the hospital "charge" level down to a "cost" level, OHCA calculates a cost ratio using the total net revenue from all hospital payers divided by the total charges from all payers. The resulting statewide cost ratio is used to determine the total cost of uncompensated care and medical assistance underpayments.

The uncompensated care total is multiplied by the cost ratio to produce the cost of uncompensated care. The hospital's medical assistance charges that include all Medicaid and SAGA charges are also multiplied by the cost ratio to determine the cost of medical assistance. The total payments made to a hospital for Medicaid and SAGA are then subtracted from the cost of medical assistance to identify the medical assistance underpayment. Adding the cost of uncompensated care with the medical assistance underpayment produces the total cost of uncompensated care and medical assistance underpayment.

In addition to calculating and reporting each hospital's baseline underpayment to DSS, OHCA must also calculate the federal DSH upper payment limit (UPL). With the passage of the Federal Omnibus Budget Reconciliation Act of 1993, states must demonstrate to CMS that the DSH amount each hospital would receive would not exceed each hospital's specific upper payment limit. This federal restriction prohibits states from making Medicaid DSH payments that are higher than reasonable estimates of the amounts the Medicare program would pay for the same services.

To comply with this provision, OHCA determines and reports each hospital's UPL to DSS for its calculation of DSH payments. According to OHCA and DSS, this calculation usually has little relevance as Connecticut hospitals have rarely exceeded their limit. The calculation for UPL is complex; however, in general terms OHCA adds the underpayment totals for uninsured, outpatient Medicaid, and other medical assistance (SAGA) to yield the total projected underpayment according to Medicare reimbursement principles.

All hospitals with a baseline DSH payment that exceeds their UPL have their DSH payment amount reduced to the UPL. The total amount of these reductions is then redistributed to all hospitals with room under their upper limit.

The baseline underpayments and upper payment limits are provided by OHCA; DSS proceeds to determine DSH payments available to hospitals under the UCC program. Each hospital's baseline percentage of the appropriation is calculated by dividing the hospital's baseline underpayment by the statewide baseline underpayment. The hospital's percentage is then multiplied by the state DSH appropriation to calculate each hospital's DSH payment for the year. Table V-10 on the next page illustrates the 2007 distribution of the $53,725,000 state appropriation for UCC DSH payments.

As the table shows, there is a total of almost $54 million in uncompensated care DSH payments in FY 07. One hospital (Bradley) did not receive any uncompensated care DSH monies. The portion of DSH funds that Bradley would have been eligible for was redistributed among the remaining hospitals.

Table V-10. Distribution of DSH Funds Under the Uncompensated Care Program (UCP) – FY 07							
HOSPITAL	Upper Limit	Total Cost of UC & MedAss Underpayment	Baseline %	Baseline Method Payment	Room under Limit	Additional DSH	Total UCP DSH
Backus	$7,945,183	$15,053,971	3.392657	$1,822,705	$6,122,478	$1,155	$1,823,860
Bradley	$0	$485,626	0.109444	$58,799	$0	$0	$0
Bridgeport	$28,117,664	$32,366,407	7.294295	$3,918,860	$24,198,804	$4,566	$3,923,426
Bristol	$5,872,805	$5,748,416	1.295499	$696,007	$5,176,798	$977	$696,984
Danbury	$14,706,920	$23,269,814	5.244230	$2,817,463	$11,889,457	$2,243	$2,819,706
Day Kimball	$8,284,307	$7,124,218	1.605558	$862,586	$7,421,721	$1,400	$863,986
Essent/Sharon	$1,307,441	$2,230,536	0.502688	$270,069	$1,037,372	$196	$270,265
Greenwich	$6,035,826	$8,802,124	1.983702	$1,065,744	$4,970,082	$938	$1,066,682
Griffin	$3,839,752	$5,298,548	1.194114	$641,538	$3,198,214	$603	$642,141
Hartford	$45,753,146	$48,491,299	10.928301	$5,871,230	$39,881,916	$7,525	$5,878,755
Hungerford	$9,189,393	$5,326,895	1.200502	$644,970	$8,544,423	$1,612	$646,582
Johnson Memorial	$2,021,519	$1,378,305	0.310623	$166,882	$1,854,637	$350	$167,232
Lawrence Memorial	$10,629,653	$16,493,418	3.717060	$1,996,990	$8,632,663	$1,629	$1,998,619
Manchester	$3,967,450	$5,011,950	1.129524	$606,837	$3,360,613	$634	$607,471
Mid State	$9,465,282	$9,864,689	2.223168	$1,194,397	$8,270,885	$1,561	$1,195,958
Middlesex	$8,573,927	$13,160,244	2.964875	$1,593,416	$6,980,511	$1,317	$1,594,733
Milford	$1,854,305	$2,415,176	0.544299	$292,425	$1,561,880	$295	$292,720
New Britain General	$9,096,326	$12,505,438	2.818303	$1,514,134	$7,582,192	$1,431	$1,515,565
New Milford	$1,008,902	$2,208,888	0.497809	$267,448	$741,454	$140	$267,588
Norwalk	$14,807,764	$17,687,107	3.960770	$2,141,520	$12,666,244	$2,390	$2,143,910
Rockville	$1,683,921	$2,596,713	0.585212	$314,405	$1,369,516	$258	$314,663
St. Francis	$29,433,216	$33,429,786	7.533945	$4,047,612	$25,385,604	$4,790	$4,052,402
St. Mary's	$25,313,285	$15,137,383	3.411455	$1,832,804	$23,480,481	$4,430	$1,837,234
St. Raphael	$24,354,681	$22,534,451	5.078504	$2,728,426	$21,626,255	$4,081	$2,732,507
St. Vincent's	$16,247,218	$18,534,220	4.176987	$2,244,086	$14,003,132	$2,642	$2,246,728
Stamford	$17,374,940	$23,996,250	5.407944	$2,905,418	$14,469,522	$2,730	$2,908,148
Waterbury	$11,020,265	$12,963,059	2.921436	$1,569,541	$9,450,724	$1,783	$1,571,324
Windham	$3,867,719	$3,611,060	0.813811	$437,220	$3,430,499	$647	$437,867
Yale-New Haven	$43,519,937	$75,996,203	17.126978	$9,201,469	$34,318,468	$6,475	$9,207,944
TOTAL	**$365,292,748**	**$443,722,195**	**100%**	**$53,725,000**	**$311,625,546**	**$58,799**	**$53,725,000**
Source: Department of Social Services							

Urban/distressed DSH program. A third DSH program targets hospitals located in distressed communities. In 2001, the legislature established a DSH program aimed at helping hospitals in distressed municipalities with populations over 70,000. In 2003, the legislature also allowed DSH payments to hospitals located in targeted investment communities with enterprise zones and populations over 100,000. In 2006, nine hospitals were located in five distressed municipalities with populations over 70,000 (Bridgeport, Hartford, New Britain, New Haven, and Waterbury). One additional hospital is found in a targeted investment community with a population of 100,000 (Stamford). No payments can be made to a children's hospital under this program.

The payment amount for each hospital is based on the ratio of inpatient discharges paid on a Medicaid fee-for-service basis to the total number of such inpatient hospital discharges for all hospitals as reported in the most recently filed cost reports. Table V-11 provides the 2006 distribution of the $31.5 million appropriation for urban DSH payments. As the table shows, *more than half (59 percent) of the 2006 urban DSH funds are provided to four hospitals (Bridgeport, Hartford, St. Francis, and Yale-New Haven).*

Table V-11. Distribution of Urban DSH Funds (FY 06).

Qualifying Hospital	04 Medicaid FFS Discharges	Percent of Total	Appropriation DSH Distribution
Bridgeport	1,836	10.49	$3,312,696
Hartford	2,612	14.93	$4,712,833
New Britain	1,036	5.92	$1,869,255
St. Francis	2,210	12.63	$3,987,504
St. Mary's	866	4.95	$1,562,524
St. Raphael	1,349	7.71	$2,434,001
St. Vincent's	1,469	8.40	$2,650,518
Stamford	1,409	8.05	$2,542,260
Waterbury	990	5.66	$1,786,258
Yale-New Haven	3,709	21.21	$6,692,151
TOTAL	**17,486**	**100%**	**$31,550,000**
Source: Department of Social Services			

While the state's urban/distressed DSH program recognizes the need for additional DSH monies, the existing program definition excludes some hospitals serving similar populations. The program review committee examined the ratio of Medicaid fee-for-service discharges to total discharges for all individual hospitals in FY 05. The analysis, seen in Table V-12, shows that the Medicaid fee-for-service discharges for the hospitals that currently receive urban DSH range between six and ten percent of their total discharges. The committee found five other hospitals that had percentages within the same range -- Norwalk (8 percent), Danbury (7 percent), Mid State (6 percent), Dempsey (6 percent), and Windham (6 percent).

Based on population alone, Danbury (74,848) and Norwalk (82,951) hospitals would satisfy the population requirement for urban DSH. Both Danbury and Norwalk also have comparable Medicaid fee-for-service discharges to the hospitals receiving urban DSH payments. However, neither town is classified as a distressed municipality.

Table V-12. Comparison of Urban DSH Hospitals and Hospitals Serving Similar Populations					
Urban DSH Hospitals	**Population**	**Distressed Municipality**	**FY 05 FFS Discharges**	**FY 05 Discharges**	**Percent of Discharges**
Bridgeport	139,529	Y	1,964	20,109	10
Hartford	121,578	Y	3,085	39,045	8
New Britain	71,538	Y	1,134	17,610	6
St. Francis	121,578	Y	2,239	32,175	7
St. Mary's	107,271	Y	872	12,268	7
St. Vincent's	139,529	Y	1,513	19,375	8
St. Raphael	123,626	Y	1,359	24,841	6
Stamford	117,083	Y	1,491	17,464	9
Waterbury	107,271	Y	1,023	15,535	7
Yale-New Haven	123,626	Y	4,289	48,616	9
Hospitals Not Qualifying					
Danbury	74,848	N	1,331	19,907	7
Dempsey	23,641	N	621	9,799	6
Mid State	58,244	Y	605	9,866	6
Norwalk	82,951	N	1,170	15,523	8
Windham	22,857	Y	325	5,207	6
Source: LPR&IC Analysis					

Both Mid State and Windham, which also had percentages within the same range as hospitals receiving urban DSH, are located in distressed municipalities but do not meet the population criteria. There are an additional six hospitals located within distressed municipalities that also do not meet the population criteria. Together, these hospitals have populations ranging from 9,000 to slightly over 60,000. They also have Medicaid fee-for-service discharges between 245 and 672 which are between three to six percent of their total discharges. (It also bears repeating that Norwalk and Windham have twice requested and received rate exceptions.)

Therefore, the program review committee recommends **the urban DSH funds should be made available to hospitals with greater percentages of Medicaid discharges rather than limiting funds to hospitals in municipalities with a combination of certain population and economic aspects. At a minimum, four hospitals (Norwalk, Danbury, Mid State and Windham) should be considered for the urban/distressed DSH funds.**

Even if the program parameters for urban DSH remain the same, program review recommends **the distribution formula for urban DSH should be re-configured.** Currently, the urban DSH formula only reflects the Medicaid fee-for-service population; for payment the SAGA population is not taken into consideration. Table V-13 re-calculates the payment distribution of the urban DSH appropriation for FY 06 when the

SAGA discharges are also taken into account. As the table shows, the percentages among the hospitals currently receiving urban DSH shifts when the SAGA volume is considered.

Table V-13. Re-distribution of FY 06 DSH Funds When Considering SAGA Population.

Hospital	04 FFS Discharges	04 Discharges (w/SAGA)	New Percent of Discharge Total	New Distribution	Difference
Bridgeport	1,836	2,356	10.0481	$3,170,205	(142,491)
Hartford	2,612	3,558	15.1746	$4,787,602	74,769
New Britain	1,036	1,422	6.0647	$1,913,426	44,171
St. Francis	2,210	3,411	14.5477	$4,589,800	602,296
St. Mary's	866	1,243	5.3013	$1,672,566	110,042
St. Raphael	1,349	1,843	7.8602	$2,479,919	45,918
St. Vincent's	1,469	1,732	7.3868	$2,330,558	(319,960)
Stamford	1,409	1,669	7.1181	$2,245,786	(296,474)
Waterbury	990	1,342	5.7235	$1,805,779	19,521
Yale-New Haven	3,709	4,871	20.7745	$6,554,359	(137,792)
TOTAL	**17,486**	**23,447**	100	**$31,550,000**	

Source: LPRIC Analysis

As noted earlier, DSS is authorized within Connecticut's state Medicaid plan to receive federal matching funds under the DSH Medicaid program for payments made to hospitals for various low-income populations. DSS also receives matching funds for payments made to hospitals providing treatment services to low-income persons determined eligible for assistance under SAGA.[16] (Table V-14 reflects Connecticut's annual DSH report for 2005.)

Given that DSS receives matching federal funds for payments made for SAGA clients and that the payment to cost ratio for SAGA patients is extremely low supports the conclusion that the DSH distribution formula should be reconfigured to further assist hospitals that serve a disproportionate share of SAGA clients.

Outpatient services. As mentioned earlier, hospitals receive a substantial amount of revenue from outpatient services. Medicaid paid hospitals approximately $238 million for outpatient services in FY 05. This reflects about 48 percent of the Medicaid managed care hospital payments and one-third of the fee-for-service payments.

A closer examination reveals that outpatient services constitute more than 60 percent of total payments at five hospitals. Comparing populations, Medicaid managed care provides more than 60 percent of payments for outpatient services at 12 hospitals while three hospitals receive more than 65 percent of outpatient payments for Medicaid fee-for-service.

[16] DSS also receives matching federal funds for DSH monies made to the Connecticut Children's Medical Center (CCMC) and uninsured or underinsured children under the jurisdiction of the Commissioner of the Department of Children and Families (DCF).

Table V-14. Department of Social Services FY 05 DSH Annual Report							
HOSPITAL	**SAGA & DCF**	**UCC Program**	**DMHAS SAGA**	**CHN Hosp O/P & Ancillaries**	**URBAN**	**CCMC**	**TOTAL DSH**
Backus	$1,078,985	$2,400,051	$596,622	$6,533			$4,082,191
Bradley	$0	$0	$0	$0			$0
Bridgeport	$3,388,612	$4,334,767	$494,108	$51,962	$3,218,952		$11,488,401
Bristol	$863,670	$909,539	$353,153	$965			$2,127,328
CCMC	$99,924	$0	$0	$0		$6,750,000	$6,849,924
Danbury	$1,802,634	$3,119,747	$490,181	$69,250			$5,481,811
Day Kimball	$594,327	$1,086,733	$128,486	$0			$1,809,545
Dempsey	$1,374,215	$0	$285,858	$0			$1,660,073
Essent/Sharon	$122,057	$237,402	$0	$2,780			$362,239
Greenwich	$149,955	$1,349,888	$10,557	$9,272			$1,519,672
Griffin	$11,394	$634,696	$0	$0			$646,090
Hartford	$4,854,609	$7,215,639	$1,767,586	$198,324	$4,641,049		$18,677,207
Hungerford	$539,877	$907,863	$593,652	$31,737			$2,073,129
Johnson Memorial	$418,165	$414,228	$415,558	$0			$1,247,951
Lawrence Memorial	$1,291,277	$2,490,216	$183,119	$8,830			$3,973,442
Manchester	$874,125	$1,015,020	$639,639	$28			$2,528,812
Mid State	$1,222,191	$1,449,168	$144,665	$308			$2,816,332
Middlesex	$1,197,304	$1,911,608	$513,229	$168			$3,622,308
Milford	$416,983	$248,135	$0	$0			$665,118
New Britain General	$2,342,237	$1,855,117	$647,213	$93,395	$1,876,978		$6,814,939
New Milford	$345,526	$333,621	$8,946	$737			$688,830
Norwalk	$1,705,231	$2,518,880	$377,730	$4,164			$4,606,004
Rockville	$419,566	$417,097	$0	$0			$836,663
St. Francis	$3,513,196	$4,742,209	$1,204,132	$163,497	$3,989,826		$13,612,859
St. Mary's	$2,054,675	$1,025,124	$422,757	$0	$1,639,072		$5,141,627
St. Raphael	$2,783,022	$2,873,242	$331,813	$118,570	$2,318,560		$8,425,206
St. Vincent's	$2,278,105	$2,870,692	$47,815	$24,281	$2,321,704		$7,542,597
Stamford	$1,458,854	$3,629,579	$413,797	$36,590	$2,586,771		$8,125,590
Waterbury	$1,751,561	$2,033,757	$615,036	$19	$1,670,202		$6,070,575
Windham	$1,185,457	$530,066	$17,515	$184			$1,733,222
Yale-New Haven	$7,707,888	$9,920,920	$1,106,818	$66,272	$7,286,886		$26,088,785
TOTAL	**$47,845,623**	**$62,475,000**	**$11,809,983**	**$887,866**	**$31,550,000**	**$6,750,000**	**$161,318,472**
Source: Department of Social Services							

The correlation between the amount of outpatient payments and outpatient services is unknown because comprehensive utilization data is not collected Nevertheless, it is clear that *certain hospitals rely heavily on outpatient revenue and presumably provide a great deal of outpatient services to their communities*. Earlier, program review recommended Medicaid outpatient rates be adjusted annually noting that increases would especially help hospitals that receive much of their revenue from outpatient services. In addition, the program review committee recommends **the state establish a disproportionate share fund available to hospitals serving large percentages of Medicaid clients on an outpatient basis.**

Outpatient services at a hospital often supplement medical services in the community or in some cases may be the only access available in a community. As such, program review believes financial recognition of this hospital service should be established. Without utilization data, the exact level of outpatient services is unknown. However, the enhanced monitoring of utilization by DSS and DHMAS recommended earlier should provide information as the potential basis for distribution of funds.

Federal DSH reporting requirements. The Medicare Prescription Drug, Improvement, and Modernization Act of 2004 (MMA) implemented new reporting and audit requirements for the DSH program. For fiscal years beginning in 2004, each state is required to submit to CMS an annual report that identifies each hospital that received DSH payments for the preceding fiscal year and the amount of DSH payments made to the hospital. CMS may also obtain other information deemed necessary to ensure the appropriateness of DSH payments for the preceding year.

For fiscal years beginning in 2004, each state is also required to submit to CMS an annual independently certified audit that verifies the amount by which hospitals have reduced their uncompensated care costs as a result of claimed DSH expenditures. This comprehensive audit is to include verification of payments to hospitals, uncompensated care costs, hospital-specific limits, and adherence to documentation requirements.

Uncompensated Care

Connecticut hospitals must, pursuant to federal law, serve any person who presents with an emergency medical condition, regardless of insurance status or ability to pay.[17] As a result, hospitals typically end up providing a substantial amount of free or discounted care. To fund uncompensated care, hospitals must either be able to charge paying patients more (that is, shift costs) or assume the loss.

The discussion below focuses on the two components of uncompensated care – free care and bad debt. In addition, the use of free bed funds available at some Connecticut hospitals is also discussed.

[17] The Emergency Medical Treatment and Active Labor Act was passed as part of the Consolidated Omnibus Budget Reconciliation Act of 1986.

Free care and bad debt. Each Connecticut hospital must file a copy of its current policies relating to free care and bad debt with OHCA. Free care is the provision of service by a hospital knowing in advance there will be no payment by the patient.[18] (Courtesy discounts, contractual allowances, and charges for health care services provided to employees are not included under the definition of free care.)

Bad debt is the cost of providing care for which the hospital expects to obtain reimbursement but learns after the fact that it will not receive payment. Bad debt is considered a deduction from revenues if, after reasonable collection efforts, it is determined that the accounts are uncollectible.

Each hospital must annually file information with OHCA regarding the amount of free care given as well as the total amount of bad debts written off during the previous year. OHCA may annually review each hospital's level of uncompensated care, which includes free care and bad debts, to assure that an appropriate level of care is provided to the indigent and the uninsured, but when appropriate, collection efforts have taken place.

Table V-15 shows the total amount of uncompensated care for each hospital reported in FY 05. As the table shows, the total uncompensated care charges for all hospitals in FY 05 was over $388 million ranging from slightly over $900,000 at Bradley to close to $42 million at Hartford Hospital. The statewide hospital median for uncompensated care at the charge level was $9.8 million.

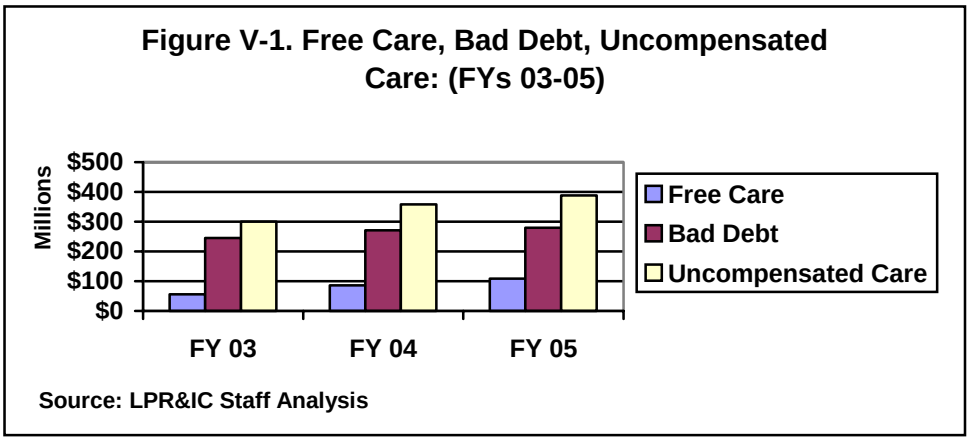
Table V-15 also breaks down each hospital's total uncompensated care into its two components of: 1) free care; and 2) bad debt. As the table illustrates, bad debt accounted for 72 percent of total statewide uncompensated care. For FY 05, the percent of bad debt at each hospital ranged from 28 percent at Greenwich to 97 percent at New Britain. *With the exception of Greenwich Hospital, every acute care hospital's overall bad debt outweighed free care.* Statewide, the median percentage for bad debt was 76 percent of the hospitals'uncompensated care expenses, with a median bad debt total of $7 million.

The total amount of free care ranged from approximately $32,000 at Bradley to $17 million at Hartford Hospital. The percentage of free care ranged from 3 percent at New Britain to 72 percent at Greenwich. The statewide median percentage of free care was 24 percent and the median amount of free care was $1.6 million.

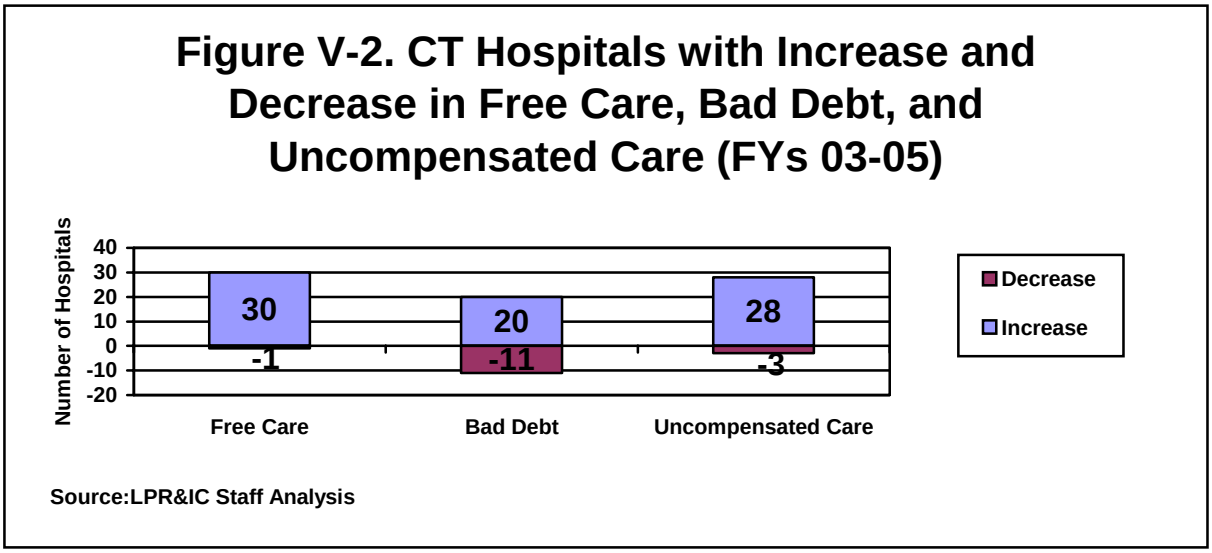
[18] Specifically, OHCA regulations define free care as "the difference between the amount of expected reimbursement from charity patients, as defined by a hospital board approved free care policy approved by OHCA, for hospital services rendered, and the amounts of the hospital's published charges for such services." Bad debt is defined as "the uncollectible accounts receivable of the hospital relating to patients from whom reimbursement was expected."

Table V-15. Distribution of Free Care, Bad Debt, and Total Uncompensated Care in FY 05.					
HOSPITAL	FY 05 Free Care	% of Hospital Total	FY 05 Bad Debt	% of Hospital Total	FY 05 Total Hospital Uncompensated Care
Backus	$2,535,009	25	$7,476,665	75	$10,011,674
Bradley	$32,174	4	$878,461	96	$910,635
Bridgeport	$8,920,434	33	$18,489,055	67	$27,409,489
Bristol	$688,672	9	$6,896,262	91	$7,584,934
CCMC	$420,544	17	$2,025,390	83	$2,445,934
Danbury	$8,121,149	42	$11,347,701	58	$19,468,850
Day Kimball	$759,601	17	$3,663,413	83	$4,423,014
Dempsey	$752,944	22	$2,723,435	78	$3,476,379
Essent/Sharon	$600,122	25	$1,819,158	75	$2,419,280
Greenwich	$11,932,073	72	$4,621,730	28	$16,553,803
Griffin	$2,094,321	25	$6,415,560	75	$8,509,881
Hartford	$17,123,304	41	$24,861,932	59	$41,985,236
Hungerford	$566,431	29	$1,381,066	71	$1,947,497
Johnson Memorial	$431,525	9	$4,416,509	91	$4,848,034
Lawrence Memorial	$1,898,766	14	$11,496,698	86	$13,395,464
Manchester	$1,281,564	24	$4,169,968	76	$5,451,532
Mid State	$917,479	11	$7,080,686	89	$7,998,165
Middlesex	$2,253,481	18	$10,361,301	82	$12,614,782
Milford	$371,489	11	$2,869,952	89	$3,241,441
New Britain General	$327,997	3	$12,034,382	97	$12,362,379
New Milford	$1,173,949	36	$2,095,138	64	$3,269,087
Norwalk	$5,122,306	32	$10,641,421	68	$15,763,727
Rockville	$715,770	24	$2,298,807	76	$3,014,577
St. Francis	$7,030,166	36	$12,624,331	64	$19,654,497
St. Mary's	$1,175,197	12	$8,670,440	88	$9,845,637
St. Raphael	$3,901,407	21	$14,297,995	79	$18,199,402
St. Vincent's	$5,231,883	26	$14,634,541	74	$19,866,424
Stamford	$6,566,676	19	$28,875,611	81	$35,442,287
Waterbury	$1,620,443	12	$12,447,806	88	$14,068,249
Windham	$1,625,369	33	$3,365,153	67	$4,990,522
Yale-New Haven	$12,560,367	34	$24,404,596	66	$36,964,963
TOTAL	**$108,752,612**	28%	**$279,385,163**	72%	**$388,137,775**
Median	**$1,620,443**		**$7,080,686**		**$9,845,637**
Source: LPR&IC Analysis					

Reported bad debt and free care and total uncompensated care since FY 03 are depicted in Figure V-1. As the figure shows, total uncompensated care has grown since FY 03 with considerable growth in both free care and bad debt. *Overall, there has been a 29 percent increase in total uncompensated care between FYs 03 and 05, with bad debt increasing 14 percent and free care almost doubling (96 percent) during the same time period.*



An examination of the increase/decrease percentage change in the total amount of free care, bad debt, and uncompensated care between FY 03 and FY 05 is presented in Figure V-2. Uncompensated care at three hospitals has decreased since FY 03, with a 33 percent decrease at Connecticut Children's Medical Center. During this same time period, 28 hospitals witnessed an increase in uncompensated care including 21 hospitals with increases ranging from slightly less than one percent up to 50 percent. Seven additional hospitals experienced an increase of uncompensated care of more than 50 percent with two hospitals (Bradley and New Milford) seeing an increase of their total uncompensated care exceed 100 percent.



The amount of free care increased in all but one hospital (Bristol) between FYs 03-05. Almost all the hospitals experienced significant growth in the level of free care. Sixteen of the 30 hospitals had free care levels that more than doubled. Between FYs 03 and 05, 20 hospitals also saw an increase in bad debt. However, 11 hospitals experienced a decline in reported bad debt. (The total amount of free care, bad debt, and uncompensated care for each individual hospital since FY 03 is detailed in Appendices F, G, and H.)

Cost of uncompensated care. As noted earlier, charges for uncompensated care in FY 05 totaled $388 million. However, the actual cost to hospitals is calculated by multiplying uncompensated care charges by the ratio of cost to charges for all payers. In FY 05, Connecticut's statewide uncompensated care costs among acute care hospitals totaled more than $173 million. This represented 2.8 percent of total hospital expenses. *A large portion (47 percent) of the total cost of uncompensated care for the state was borne by the nine urban hospitals in Hartford, New Haven, Bridgeport, and Waterbury.*

Table V-16 shows the uncompensated care costs as a percent of total operating expenses statewide since FY 03. As the table shows, both uncompensated care costs and total operating expenses have increased since FY 03. However, *uncompensated care costs as a percentage of total expenses have remained relatively the same.*

Table V-16. Uncompensated Care Costs as Percentage of Total Expenses.

STATEWIDE	FY 03	FY 04	FY 05
Uncompensated Care Costs	$148,827,480	$164,312,115	$173,340,070
Total Operating Expenses	$5,308,480,106	$5,682,065,439	$6,050,276,212
Uncompensated Care % of Total Expenses	2.80	2.89	2.86

Source: LPR&IC Analysis

Summary. For almost every hospital in the state, bad debt far outweighs free care as a percentage of uncompensated care. However, free care has significantly increased (96 percent) since FY 03. A large portion of uncompensated care is seen in the state's major cities. To put these figures in context, it may be reasonable to assume that during strong economic times higher levels of employment would translate into lower levels of free care. However, increasingly higher co-pays and deductibles imposed by many employers may actually increase bad debt and/or the need for reduced cost care.

The program review committee asked the Connecticut Hospital Association if it would be possible to identify how much of a hospital's bad debt is the result of insured individuals unable to meet deductibles. However, currently this type of information is not routinely captured or reported by hospitals.

Free Care and Reduced-Cost Reporting Requirement

Since 2003, state law requires hospitals to file more detailed information on their free care and reduced care with the Office of Health Care Access. Specifically, state law requires that hospitals file annually their policies on free or reduced-cost services to the indigent and their debt collection practices with OHCA. State law also requires hospitals to report: 1) the number of applicants for free care and reduced-cost care, 2) the number of approved applicants, and 3) the total and average values of free and reduced-cost care provided. The following is a discussion of the program review analysis of this information.

Hospital financial assistance policies. State law prohibits hospitals that provide services to an uninsured patient from collecting from the patient more than the cost of providing the

services. State law defines an uninsured patient as a person with income at or below 250 percent of the federal poverty level who: 1) has been denied eligibility for health care coverage under Medicaid or the state administered general assistance program for failure to satisfy income or other eligibility requirements; and 2) was not eligible for hospital service coverage under Medicare, Champus, Medicaid, or any health insurance program of another nation, state, or U.S. territory or commonwealth, or any other government, or private health, accident insurance, or benefit program.

In 2006, that income threshold -- 250 percent of the federal poverty level -- is $24,500 annually or $2,042 monthly for an individual. Some hospitals hoping to assist uninsured individuals obtain coverage may hire or designate an employee to assist patients with the various application processes or in some cases even compensate the state to have a DSS Medicaid eligibility worker on location.

The process of identifying patients who may be eligible for a government program or who otherwise may need some level of free or reduced cost care is not simple. To qualify for financial assistance from a hospital, patients are often asked to complete and return forms, submit proof of income, and provide a variety of other documentation. This process can be long and cumbersome, and patients, sometimes indigent, may forget, give up, or get lost in the process. Consequently, some services that could have been classified as charity care are categorized as bad debt when the hospital receives no payments.

The program review committee examined the most recent free bed and charity care policies filed at OHCA. A review of hospital policies filed with OHCA found that eligibility and application requirements vary but all hospitals utilize a percentage of the federal poverty level to determine patient eligibility for hospital financial assistance.

All hospitals expect all third party resources to be exhausted before considering patients for financial assistance or free bed funds. Full charity care is available at all hospitals to patients with household incomes at 100 percent of the federal poverty level. Almost all the hospitals have developed a sliding-fee scale that specifies different percentage discounts from charges depending on a patient's household income; for example, free care for patients is provided at a specified percentage of FPL with lesser discounts for patients with progressively greater means.

In general, hospital financial assistance and availability of free bed funds start at 250 percent of the federal poverty guidelines, which is the basis for the statutory definition of an uninsured individual. As Table V-17 shows, Connecticut acute care hospitals offer financial assistance to patients with household incomes that fall in ranges up to 500 percent of the federal poverty level. A few hospitals (St. Raphael, Stamford, and Yale-New Haven) also extend discounts to patients whose income may be relatively high, but whose hospital bills exceed a certain proportion of their annual household income or assets. One hospital (Norwalk) provides a 15 percent reduction to patients at any income level if they express difficulty paying bills. However, the reduction is not available for co-pays, deductibles, or government programs. Nine hospitals specifically mention the reduction of charges to cost for uninsured individuals pursuant to state law.

Table V-17. Summary of Current Hospital Policies on Financial Assistance.	
Policy	**Number of Hospitals**
Eligible for financial assistance, including free beds, if family income is at or below 250% of federal poverty guideline	31
Eligible for sliding scale discount if income is above 250%	9
Eligible for sliding scale discount if income is at or below 300%	1
Eligible for sliding scale discount if income is at or below 350%	3
Eligible for sliding scale discount if income is at or below 400%	4
Eligible for sliding scale discount if income is at or below 500%	1
Specifically mentions reduction of charges to cost for uninsured individuals pursuant to state law	9
Source: LPR&IC Analysis	

Free care applicants. Table V-18 provides a summary of the number of free care applicants, the number and percentage approved for free care, as well as the total free care charges and costs reported by hospitals in FY 05. As the table shows, there were more than 67,000 applicants statewide for free care in FY 05. Of this number, 86 percent were approved for free care.

The free care applicant pool ranged from 60 at Bradley to over 14,000 at St. Francis. The approval rates ranged from 18 percent at New Britain to 100 percent at three hospitals (Greenwich, Waterbury, and St. Mary's). Overall, 17 hospitals approved 90 or more percent of free care applicants. Six hospitals had approval ratings of less than 40 percent.

Table V-18. Number and Approval Rates of Free Care Applicants in FY 05					
STATEWIDE	**Free Care Applicants**	**Approved Applicants**	**% Approved**	**Total Free Care Charges**	**Total Free Care Costs**
TOTAL	**67,678**	**58,500**	**86%**	**$108,752,614**	**$50,377,094**
Range					
Low	60	23	18%	$32,173	$14,700
High	14,442	14,233	100%	$17,123,304	$8,849,324
Median	924	553	91%	$1,622,906	$579,146
Source: LPR&IC Analysis					

As discussed earlier, the free care *charges* reported in FY 05 ranged from slightly over $32,000 to approximately $17 million. However, total free care *costs* ranged from about $15,000 to close to $9 million. Statewide, the cost of free care totaled $50.3 million with a median cost per hospital of $579,146.

Charity care applicants. As noted previously, courtesy discounts, contractual allowances, and charges for health care services provided to employees are not included under the definition of free care and not included in the calculation of disproportionate share payments. These items are typically reported under the broader term of charity care. The program review committee examined OHCA reports collected under the provisions of P.A. 03-266 and found that 16 hospitals did not treat or report any items as charity care in FY 05.

According to OHCA, some of the smaller hospitals may, in fact, not have charity care items beyond free care. However, certain hospitals that do not report some of these items (e.g. employee discounts) as charity care do report them as allowances in their audited financial statements which OHCA reconciles. OHCA states that this does not affect any calculations or provide any incentive or benefit. Charity care items as defined by OHCA are not detailed in the reported allowances. Therefore, further analysis for these hospitals was not possible.

Table V-19 lists the hospitals that did report charity care to OHCA in FY 05. As the table presents, 15 hospitals reported providing charity care beyond the OHCA definition of free care. This charity care totaled $40.8 million in hospital charges and $17.7 in hospital costs. Based on these reports, 29,000 additional individuals received charity care. *The vast majority of the charity care was reported by three hospitals (Bridgeport, Hartford, and Yale-New Haven).*

Table V-19. Charity Care Charges and Costs Among Hospitals in FY 05

HOSPITAL	Charity Care Charges	Charity Care Costs
Backus	$384,351	$208,164
Bridgeport	$15,234,566	$5,934,435
Bristol	$56,637	$56,891
CCMC	$803,893	$490,867
Greenwich	$678,925	$306,060
Hartford	$5,379,192	$2,779,966
Lawrence Memorial	$311,064	$160,301
New Britain General	$286,752	$116,684
New Milford	$660,907	$300,779
Rockville	$27	$12
St. Mary's	$443,803	$193,720
Stamford	$12,324	$5,600
Waterbury	$539,919	$192,967
Windham	$21,393	$406,988
Yale-New Haven	$15,995,038	$6,623,545
Total	**$40,808,791**	**$17,776,979**

Source: LPR&IC Analysis

Bed funds. In addition to free or charity care, many hospitals have bed funds available to certain qualified patients. By OHCA regulation, hospital bed funds refer to "gifts of money, stock, other financial instruments, or other property made to establish a fund to provide medical care to patients at a hospital. A fund may be established by gift, bequest, subscription, solicitation, dedication, or any other means."

State law requires information on available bed funds to be posted conspicuously in public places of hospitals where patients are admitted. This includes the admissions office, emergency room, social services department, and patient accounts or billing office. The information must be in plain language and statutorily required to be in 48 to 72 point type. The information must include notification that bed funds exist and the contact person for fund applications. The notice must be in English and Spanish. As with free care, hospitals with bed funds must maintain and annually compile information on applications for the funds.

Table V-20 lists information regarding hospital bed funds in FY 05. Nineteen hospitals reported bed fund activity in FY 05. The hospitals had a total applicant pool of approximately 12,900 individuals with 34 percent approved.

Table V-20. Bed Fund Activity Reported Among Hospitals in FY 05.

HOSPITAL	Bed Fund Applicants	Applicants Approved	% Approved	Total Bed Fund Charges	Total Bed Fund Cost	FY 05 Ending Balance of Available Bed Funds
Stamford	997	9	1	$436,257	$198,210	$557,531
St. Francis	2,183	27	1	$227,498	$118,049	$781,337
Lawrence Memorial	1,242	48	4	$50,831	$26,239	$1,054,234
Middlesex	3,310	446	13	$150,840	$68,975	$1,742,023
Mid State	197	37	19	$119,283	$60,620	$125,000
New Britain General	459	116	25	$286,752	$116,683	$732,973
Backus	423	147	35	$440,434	$238,539	$125,000
Manchester	597	244	41	$775,000	$356,500	$618,392
Bristol	35	25	71	$11,928	$5,437	$1,410,387
Hartford	614	465	76	$2,151,583	$1,111,938	$60,205,406
Greenwich	291	238	82	$1,341,387	$604,697	$1,123,000
Waterbury	804	803	100	$541,661	$193,590	$13,924,016
Bridgeport	295	295	100	$178,124	$69,379	$12,066,320
CCMC	1	1	100	$2,008	$1,226	$75,211
Griffin	6	6	100	$8,384	$2,971	$231,897
Hungerford	43	43	100	$28,375	$16,136	$265,004
St. Mary's	4	4	100	$21,755	$9,496	$0
St. Raphael	31	31	100	$111,176	$42,592	$716,635
Yale-New Haven	1,373	1,373	100	$4,721,870	$1,955,326	$25,533,147
TOTAL	**12,905**	**4,358**	**34**	**$11,605,146**	**$5,196,603**	**$121,287,513**
RANGE Low	1	1	1%	$2,008	$1,226	$0
High	3,310	1,373	100%	$4,721,870	$1,955,326	$60,205,406
Median	423	48	76%	$178,124	$69,379	$732,973

Source: LP&RIC Analysis

The statewide median number of bed fund applicants was 423. The approval rate ranged from one to 100 percent with a median approval rate of 76 percent. Eight hospitals approved all applicants for their bed funds. Charges for bed funds totaled $11.6 million while costs were closer to $5.2 million.

Table V-20 also provides each hospital's reported ending balance of donations and funds restricted for indigent care/free beds for FY 05. As the table shows, the statewide ending balance for these funds in FY 05 was over $121 million and the FY 05 expenditures based on charges from these funds were $11.6 million. (Three additional hospitals - St. Vincent's, Rockville, and Windham - reported available ending balances in FY 05 but had no corresponding expenditures or applicants.)

Based on the analysis, *there appears to be a number of hospitals with a substantial balance in bed funds. However, the restrictions placed on many of the bed funds are sometimes a condition of the gift or donation (e.g. available to members of certain groups). As a result, the use of bed funds for several hospitals is limited.*

Further review of the free bed expenditures revealed that almost all of the hospitals providing free care funds receive their compensation on charges. According to OHCA, there is no rule or policy regarding this practice. The committee questioned whether hospitals should compensate themselves on a charge level for individuals who are determined to be in need. However, given the limited access to bed funds for most hospitals, it seems prudent for hospitals to follow this practice if so desired.

Summary. A review of the information that is currently collected by OHCA reveals the need for further comprehensive analysis. According to OHCA, *the information submitted by hospitals on the levels of free and reduced cost care pursuant to P.A. 03-266 is collected for the sole purpose of satisfying the statutory reporting requirements.* The information submitted by each hospital is reviewed by the OHCA analyst assigned to examine the individual hospital's finances. However, *OHCA does not conduct a statewide overview or comparison of this particular hospital reporting requirement nor make any determinations about the implementation of hospital policies or other mandated activities.*

Through its examination of this information, the committee found at least one example of a hospital reporting erroneous information (i.e., number of applications as opposed to applicants), which was subsequently corrected. Discussions with OHCA staff revealed that the mistake was due in part to the newness of the reporting requirement and a misunderstanding by the hospital of what information was required. The committee acknowledges the recent implementation of this reporting requirement and the need for time to remedy any learning curve. However, it is not clear to the committee that a process is in place that would have otherwise detected the misreporting for this item since no analysis of this particular information is performed and it is collected solely to satisfy the statutory reporting requirement. The program review committee believes *if the information collected pursuant to Public Act 03-266 is to remain a mandatory reporting requirement, then the data should be used towards some purpose or measure. Furthermore, all hospital data filed with OHCA should be routinely verified for accuracy and consistent reporting among hospitals.*

Program review researched the legislative history for this statutory reporting requirement and found no stated legislative intent. The changes appear to have evolved from concerns regarding aggressive billing and collection practices at certain hospitals. OHCA is reporting, as mandated, on the number of applicants and approvals for free and reduced cost charges and care. However, the committee believes *OHCA should be more than central repository for health care data.*

As part of its mission, OHCA gathers, verifies, analyzes, and reports on a wide range of hospital financial data for use by health care policy decision-makers. Currently, OHCA produces a number of publications regarding various aspects of health care policy. Information in these publications includes hospital expenses and revenues, uncompensated care volumes, and other

financial data. OHCA also reports on data related to hospital and health care utilization. This published information is the result of OHCA analyzing audited financial statements, hospital forms, schedules, and attachments submitted by the individual hospitals. However, the committee believes *OHCA should extend its analysis to a more comprehensive level.*

For example, one of OHCA's existing publications is an annual report on the financial status of Connecticut's acute care hospitals. The report provides a profile of each hospital on a number of financial and utilization measures. There is a broad statewide overview provided in the beginning of the report and a number of appendices containing graphics and tables. However, any comparisons among hospitals or conclusions regarding individual hospitals are left to the reader to determine. The committee believes *OHCA should assume a more advisory role to policy makers on health care issues.*

Therefore, the program review committee recommends **OHCA prepare a supplemental report that summarizes all information currently filed by hospitals. At a minimum, OHCA should conduct analysis that compares hospitals on the basis of size and/or geographical location that leads to conclusions and potential recommendations for policy makers. In particular, OHCA's review for the supplemental report should include, but not be limited to:**

- **the general provisions of each hospital's policies regarding free and charitable care including bed funds;**
- **the number and approval rates of free and reduced care applicants;**
- **access, use, and available level of bed funds; and**
- **analysis of charges and costs for free and reduced care.**

As part of this expanded review, OHCA may want to consider requesting further detailed information from hospitals. For example, OHCA may wish to explore whether additional information may gauge the impact of high deductibles or premiums on a hospital's bad debt. However, OHCA reports should contain more than a compilation of data. Further data analysis would allow OHCA to fully carry out its mission of monitoring the state's health care delivery system, identifying areas of potential need, and formulating appropriate solutions. This analysis should lead to better coordination of state policy and actions to control cost and increase quality. Finally, in addition to informing policymakers, this supplemental report may educate consumers and assist them in making their health care decisions.

Chapter VI

Hospital Utilization in Connecticut

Emergency Room Utilization

Connecticut residents' use of the emergency room is high and the increase in usage has been substantial. Program review committee members had expressed concern over the rising ER use, and asked staff to examine this area.

According to the latest overall emergency room data maintained at the Office of Health Care Access, in FY 03 there were a 1.38 million ER visits statewide, and in FY 06, almost 1.46 million – more than 75,000 additional visits in two years, about a 5.5 percent increase. There were about 38.3 ER visits per 100 residents nationwide and about 40.6 ER visits per 100 in Connecticut, about 5 percent higher.

The Connecticut Hospital Association maintains emergency room data by payer source. The latest FY 06 ER utilization data by payer group, expressed in visits per 100 persons, are shown in Table VI-1 below.

Table VI-1. Connecticut Emergency Room Use by Payer Group FY 06

Payer Group	ER Visits per 100
Private Payer	25.4
Medicare	57.6
Medicaid FFS	105.3
Medicaid Managed Care	76.1
SAGA	165.6
Uninsured	41.9
Overall ER Visits per 100	40.4

Source: Connecticut Hospital Association Data

As noted in the table, all government payers had considerably higher emergency room utilization than the private payer group, the uninsured, or the overall average. These numbers mimic data from national studies showing that emergency room use is growing and that those insured by government payers have substantially higher use. A couple of major reasons appear to contribute to the trend. The payment structure of government payers, especially Medicaid and SAGA, limits access to other care, with private providers unwilling to take Medicaid clients because of low reimbursement. Under the SAGA program, no private medical community access is provided. Community Health Network (CHN-CT), a managed care organization, works through the federally qualified health centers, which are under contract to provide SAGA clients' community medical services. With limited access to other providers, these clients go to the emergency room.

There also is no financial deterrent to the client and, as discussed in the Chapter IV, a limited financial drawback to the Medicaid MCOs for their enrollees seeking emergency room

care. Many privately insured persons have better access to other care – private physicians, pediatric groups, and the like. These privately insured clients often incur substantial co-pays for ER visits; the Connecticut Insurance Department allowable maximum co-pay for an ER visit is $150. With no financial deterrent on the individual Medicaid client or on the Medicaid managed care plan against using the ER for primary care, and limited or no access to care in other settings, it is not surprising that SAGA and Medicaid client use of the ER is high.

A recent analysis by the Office of Health Care Access shows the rise in the use of the ER by payer group, and, as Table VI-2 indicates, for each payer category, the percentage of inpatient discharges that began in the ER has grown. In fact, in FY 05 more than half of inpatient stays begin in the emergency room (if newborns were taken out of the denominator, the percentage would be even higher).

Table VI-2: Connecticut Emergency Room Use – FY 01 and FY 05

	Fiscal Year 2001			Fiscal Year 2005		
	Percent of all stays billed to each payer	Percent of stays beginning in the ER billed to each payer	Percent of each payer's hospital stay that begin in the ER	Percent of all stays billed to each payer	Percent of stays beginning in the ER billed to each payer	Percent of each payer's hospital stay that begin in the ER
Medicare	39%	54%	62%	40%	54%	68%
Medicaid	15%	14%	41%	17%	15%	44%
Other Public	1%	1%	25%	1%	1%	31%
Commercial	42%	28%	30%	39%	27%	34%
Uninsured	3%	3%	49%	3%	3%	63%
	100%	100%	44%	100%	100%	54%

Source: Office of Health Care Access

Emergency room volume impact by hospital. Program review examined each hospital's volume of ER visits as a percent of all ER visits statewide and found that four hospitals handle about one-quarter of all ER visits in the state. This is shown in Table VI-3.

Table VI-3. Emergency Room Use—Top Hospitals

Hospital	Percent of total
Yale-New Haven	7.37%
Lawrence and Memorial	5.82%
Middlesex	5.77%
Hartford	5.52%
Total %	24.48%

Source: LPR&IC Analysis

Because some of the largest hospitals (e.g., St. Francis, St. Raphael, Bridgeport) were not among the top hospitals for ER volume, the committee examined the distribution of ER volume further. The committee used the ratio of a hospital's ER volume to the total ER volume and compared that to the ratio of staffed beds that a hospital has of all hospital beds statewide (as a proxy for capacity). The results showed that there is a correlation (+.71) between the two

measures, but there are also some imbalances. Program review subtracted the percentage of staffed beds from the percentage of total ER visits for each hospital and found gaps on either side -- those with a greater percentage of beds than their ER visits of the total, and those with a greater percentage of ER visits than beds of total beds. Table VI-4 shows the five hospitals with the greatest gaps on either side.

Table VI-4. Comparison of the Gap in Distribution of Beds and ER Visits Among Hospitals

Hospitals with a Greater Percentage of ER Visits than Staffed Beds		**Hospitals with a Greater Percentage of Staffed Beds than ER Visits**	
Hospital	Gap -- % More ER visits	Hospital	Gap-- % More Beds
Middlesex	3.34	Hartford	5.19
Mid State	2.73	Yale New Haven	4.62
Lawrence and Memorial	2.37	St Francis	3.65
St. Mary's	2.01	St. Raphael	2.91
Danbury	1.28	Stamford	1.45
Source: LPR&IC Analysis			

While certainly the larger urban hospitals are handling a greater percentage of ER visits of the total number as shown in Table VI-3, it is worth noting that the smaller urban hospitals see a greater percentage of the volume than their bed size would indicate. The high volume of ER visits to these smaller urban hospitals may indicate they are the only hospitals for a wide service area so that in an emergency local residents go to the closest hospital, whereas for a planned hospital procedure, a patient would travel to one of the larger urban hospitals.

Admit rates. On average, only about 15 percent of patients who go to the ER are admitted for inpatient care. Program review examined the percentage of patients who come to the ER who are admitted by hospital and the top seven hospitals (above 19 percent are admitted) and bottom (below 10 percent are admitted) are reported in Table VI-5.

Table VI-5. Comparison of Emergency Room Admit Rates

Highest Percentage Admit of ER Visits		**Lowest Percentage Admit of ER Visits**	
St. Raphael	27.5%	Mid State	8.8%
Yale-New Haven	21%	CCMC	9.2%
St. Francis	20.8%	Middlesex	9.3%
Stamford	20%	Lawrence & Memorial	9.3%
Norwalk	19.7%	New Milford	9.5%
Day Kimball	19.6%		
St. Vincent	19.6%		
Statewide Average	**15.3%**	**Statewide Median**	**14.5%**
Source: LPR&IC Analysis of Office of Health Care Access Data			

It is interesting to note that three of the five hospitals – MidState, Middlesex, and Lawrence and Memorial -- with the greatest gap between the percentage of ER visits over bed ratio (Table VI-4) also had the lowest admits through the ER. *This may suggest there is a dearth of access to other care in those areas and that people are seeking treatment at the ER because of that gap.*

Further, while large city hospitals do have the highest admit rates from the emergency room, it is unclear why New Haven's two hospitals have the highest admit rates, while neither Hartford or Bridgeport have more than one hospital on the list. This is especially noteworthy since Hartford Hospital, which is not among the highest admit-rate hospitals, is a level one trauma center as is Yale-New Haven.

Program review is aware the legislature's Public Health Committee has created a study group, comprised of a broad panel of experts, to examine the issue of over-crowding in the emergency room. The analysis above raises further questions that might be examined by that panel. Those areas, which conceivably contribute to overcrowding, include:

- *a trend of most hospital inpatient stays beginning in the emergency room. One factor might be that for scheduled procedures, Medicare and private pay patients are increasingly getting care elsewhere, and thus only using a hospital when in medical crisis;*
- *significant use of the emergency room by Medicaid and SAGA clients, suggesting that efforts to provide other access to care may not be working;*
- *a gap between where hospital beds are and where emergency room visits are occurring, placing a higher demand on emergency rooms at some smaller hospitals;*
- *lower admit rates at some of those hospitals with high ER volume, further suggesting that there might be a lack of access to other care in the region, and the population is seeking care at the ER inappropriately; and*
- *emergency room admit rates that vary tremendously by hospital, and even among hospitals in similar environments, with similar levels of ER certification.*

The program review committee believes the Medicaid MCO financial penalty for inappropriate use of the ER, as recommended in the previous section, may provide an incentive for MCOs to develop better preventive and primary care networks for their clients.

Medicaid Inpatient Utilization

There were approximately 420,000 total inpatient hospital stays in Connecticut in FY 05, a rate for the overall population of 12 stays per 100 residents. Medicaid clients accounted for about 70,000 hospital stays, or about 16.7 percent of all stays. The breakdown in inpatient stays by segments of the Medicaid population is shown in Table VI-6 below.

Table VI-6. Medicaid Inpatient Stays by Population – FY 05

Medicaid Inpatient Utilization By Population	Stays per 100 Enrollees
Medicaid Managed Care	12
Medicaid Fee for Service	35.4
SAGA	30.8
Source: LPR&IC Analysis	

Childbirth-related inpatient services. During the study, the program review committee asked staff to further examine Medicaid inpatient utilization by illness or treatment category to determine what hospital treatments were being furnished. FY 05 CHA discharge data maintained by diagnostic related groups were examined and the committee found the most prevalent Medicaid categories were for labor and delivery and newborns, just as they are for the overall population. Table VI-7 below shows the overall inpatient numbers as well as the number and percent of Medicaid clients categorized in those DRGs. As the table shows, inpatient stays around childbirth account for about one-third of the 70,000 Medicaid inpatient stays, and about 18 percent of all stays in the general population.

Table VI-7. Utilization – Overall and Medicaid – by Prevalent Childbirth DRG Codes

Category and DRG #	Total Number	Medicaid Number	% Medicaid
Normal Newborn (DRG 391)	30,685	9,409	30.6%
Newborn with significant problems (DRG 390)	5,032	1,641	32.6%
Total newborns	**35,717**	**11,050**	**30.9%**
Labor and Delivery Categories	**Total Number**	**Medicaid Number**	**% Medicaid**
Normal Labor and Delivery without complications (DRG 373)	22,950	7,075	30.8%
Labor and Delivery with Complicating diagnosis (DRG 372)	3,568	1,175	32.9%
C-Section with complications (DRG 370)	2,741	977	35.6%
C-Section without complications (DRG 371)	10,851	3,148	29%
Total Childbirth-related DRGs	75,827	23,425	30.9%
Percent of these DRGS of all discharges and all Medicaid discharges	18%		33.5%
Source: LPR&IC Analysis			

For the most part, the childbirth-related discharges should be included in the Medicaid Managed Care population, and inpatient services paid for by Medicaid MCOs. However, program review asked DSS to provide data on the labor and delivery charges paid by the department under fee-for-service Medicaid. This would occur for two primary reasons: 1) when a pregnant woman was otherwise eligible for Medicaid but did not establish that eligibility (or seek care) before the third trimester; or 2) the pregnant woman could not establish eligibility for lack of some type of required documentation, including legal status. In the latter case, Medicaid FFS pays for emergency services, which would include labor and delivery, but the person is taken off the eligibility rolls the following month. Medicaid FFS also pays for medical services for the newborn for a period of time until Medicaid eligibility is granted to the child. The DSS data indicated there were about 2,350 cases where DSS made payments for such services during the most recent federal fiscal year, ending September 30, 2006.

While the data in Table VI-7 on all newborns under Medicaid are for FY 05, and DSS payment data are for FY 06, there is no reason the total number of Medicaid births should vary dramatically from year to year. Thus, the data indicate more than 20 percent of Medicaid labor and deliveries and newborn services are paid for under fee for service and not Medicaid managed

care. Further, it is likely that a high percentage of the 2,350 cases are because the pregnant woman was unable to document her legal status.

Other prevalent inpatient services. The next most prevalent DRG codes (after childbirth) for Medicaid and total inpatient utilization are shown in Table VI-8 below. The most prevalent code for both the general and Medicaid populations is psychoses; in fact about 4 percent of all discharges and 8.5 percent of Medicaid discharges are in that one DRG.

Table VI-8. Prevalent Utilization Codes – Overall and Medicaid

Behavioral Health Categories -- by DRG Number	**Total Number**	**Medicaid Number**	**% Medicaid**
Psychoses (430)	16,947	5,978	35.3%
Depressive Neurosis (426)	1,845	962	52.1%
Neurosis except depressive (427)	722	374	51.8%
Childhood mental disorders (431)	473	263	49.9%
Total Psychiatric DRGs	**19,987**	**7577**	**37.9%**
Other Prevalent DRG Codes	**Total Number**	**Medicaid Number**	**% Medicaid**
Pneumonia (DRG 89)	10,931	768	7%
Chronic Obstructive Pulmonary Disease COPD (DRG 88)	6,423	606	9.4%
Chest Pain (DRG 143)	7,932	979	12.3%
Heart failure and Shock (DRG 127)	10,389	549	5.3%
Surgery – lower extremity reattachment (DRG 209)	9,363	180	1.9%
Total Prevalent Psychiatric and Medical Codes	64,568	10,643	
Percent of these DRGS of all discharges and all Medicaid discharges	15.4%	15.2%	

Source: LPR&IC Analysis

As Table VI-8 shows, the Medicaid population makes up a high percentage of the discharges in the behavioral health categories but a much smaller portion of the prevalent medical DRGs. It is probably not surprising that the Medicaid population comprises a large percentage of the behavioral health discharges – DRGs 426, 427, 430, and 431. A large segment of the Medicaid FFS population is eligible for Medicaid by virtue of a disability, including mental illness, and SAGA clients (also included in the Medicaid numbers) may be awaiting Medicaid eligibility based on a disability, also including mental illness. If the behavioral health inpatient stays are taken as a percentage of the 34,931 FY 05 Medicaid FFS and SAGA hospital stays, those DRGs would account for about 22 percent of the stays.

The study also examined which hospitals are treating Medicaid patients with behavioral health issues (using DRG 430). Table VI-9 lists the top and bottom hospitals by percentage of all Medicaid DRG 430 stays. (CCMC is not on the list since DRG 430 is an adult code.)

Table VI-9. Comparison of Medicaid DRG 430 Stays by Hospital –FY 05

Highest %		**Lowest %**	
Hartford	17%	Greenwich	0%
Yale-New Haven	12.7%	Windham	0%
St. Francis	9.0%	Griffin	1.3%
Bridgeport	6.3%	Day Kimball	1.4%
Waterbury	5.0%	Mid State	1.4%
Manchester	4.9%	Johnson Memorial	2.2%

Source of Data: Office of Health Care Access

The state's two largest hospitals accounted for almost 30 percent of all Medicaid stays for psychoses, while Greenwich and Windham Hospitals accounted for no inpatient psychiatric care for Medicaid clients. Greenwich has no inpatient psychiatric unit, and Windham had no patients in that DRG for FY 05. It may be that because of the close proximity of Natchaug, a solely psychiatric hospital located in Mansfield, Windham Hospital does not receive patients needing that service.

However, also noteworthy is that Manchester and Johnson Memorial hospitals treat a higher percentage of Medicaid psychiatric patients than either hospital's total staffed bed number or overall stays would indicate. Committee staff contacted both DSS and DMHAS (which pays for SAGA inpatient stays) to determine if either agency had agreements with those hospitals to provide inpatient psychiatric care for their clients, and both agencies indicated they were unaware of any arrangement.

Overall Medicaid fee-for-service and SAGA inpatient hospital costs totaled slightly more than $192 million in FY 05, or almost $5,500 per inpatient discharge. The committee could not determine what total payments are for inpatient psychiatric care or any of the most prevalent services used by Medicaid clients, as the data by DRGs lists charges only and not payments or costs. The committee believes such payment information would be very useful to DSS and DMHAS as the major payers of psychiatric care for Medicaid clients.

While the committee recognizes that Medicaid fee-for-service clients are not in managed care, state agency payers should collect and analyze payment and client utilization data for a number of reasons:

- **determine where Medicaid clients are receiving treatment, and for what conditions;**
- **determine whether inpatient care is disproportionately used by a small number of clients;**
- **ensure that other state agencies, or those under contract to serve these clients in the community, are providing needed services;**
- **conduct a cost-benefit analysis to determine if increasing rates for providers in the community, especially in the psychiatric area, may lessen the need for more intensive and expensive inpatient psychiatric care; and**
- **analyze the use of Medicaid inpatient stays for psychiatric care by hospital to determine whether outcomes (e.g., longer periods between episodes requiring hospitalization) are better at certain hospitals, especially when examined in connection with hospital costs.**

The Department of Social Services should also examine the payments being made under fee-for-service that would generally be paid for under Medicaid managed care, for example for inpatient newborn and labor and delivery services. If fee-for-service rather than Medicaid managed care is reimbursing for an increasing percentage of the costs of providing care to the Medicaid population, that information should be used when renewing contracts with the Medicaid MCOs and determining any rate increases.

Chapter VII

Connecticut's Health Care Market and Cost Containment

Connecticut's hospitals for the most part are in worse financial condition than hospitals in the rest of the nation. As discussed in Chapter I, Connecticut had a greater percentage of hospitals with negative operating margins than nationally. In six of the last seven years, at least 10 (more than 30 percent) Connecticut hospitals have had negative operating margins. Analysis provided in Chapter III indicates that six Connecticut hospitals are in serious financial condition, with negative margins for all of the past three years, or a large negative margin for the last year. Further, the average operating margins in this state are lower than those in the rest of the country.

Many factors contribute to the poor financial health of Connecticut hospitals. Connecticut hospitals face higher than average energy costs and medical malpractice insurance costs are high in Connecticut. State hospitals are older than most hospitals in the rest of the country, but some Connecticut hospitals do not have adequate cash reserves and are unable to access the necessary capital to upgrade facilities.

Connecticut has a slightly higher Medicare population; fifteen percent of state residents are Medicare enrollees compared to 14 percent nationally. Medicare reimburses hospitals in Connecticut for 97 percent of costs overall, but because Medicare pays teaching hospitals substantially more, a few hospitals are paid above their costs, while 22 hospitals in the state are not fully paid their costs.

Connecticut has a lower uninsured population than the rest of the country; but a growing percentage of residents are covered by government insurance (i.e., Medicare and Medicaid). Twenty-five percent of state residents are now insured through a government program, up from 22.8 percent just four years ago. Government insurers typically reimburse hospitals at lower levels than private payers.

The state expends a lower percentage of health care dollars on hospital care (30.8 percent) compared to the national average (36.6 percent). However, a much larger portion of state health expenditures fund long-term care (12.5 percent) compared to the national average of 7.5 percent. This funding, primarily on nursing home care for the elderly, means fewer dollars are being spent on acute and primary care.

Long-term care is mostly funded with Medicaid dollars; about $1.3 billion, or one-third of the state's Medicaid budget, is spent on nursing home care. All FY 05 state medical assistance payments for both Medicaid and SAGA populations, and disproportionate share payments totaled almost $675 million, about half the amount of long-term care payments. Because such a large percentage of the state's Medicaid dollars go to long-term care, less funding remains available for other providers, including hospitals. Further, since Medicaid payments account for about 68 percent of nursing home revenues, there is little opportunity for those facilities to shift costs to other patients.

Medical assistance payments to hospitals statewide cover an average of 73 percent of the costs of treating Medicaid and SAGA clients. Only Bradley Memorial Hospital (which is no longer a separate hospital) is funded fully for its Medicaid costs. State Medicaid payments account for about 10 percent of all hospital revenues, and historically hospitals were able to shift the gap from government underpayments onto private payers. But Medicaid clients make up about 17 percent of all inpatient discharges, and for some hospitals, with shrinking private paying populations, there is nowhere to shift costs.

Over the past decade, federal provisions to balance the nation's budget have also had a negative impact on most hospitals in Connecticut and the Northeast. For example, the Balanced Budget Act of 1997 required Medicare to readjust its rate structure to pay more to hospitals in rural areas of the country while remaining budget neutral.

Connecticut's Health Insurance and Hospital Market

In addition to these elements, there has been a convergence of other factors that have shaken the financial footing of some state hospitals. A major component is an imbalanced health care insurance and hospital industry, with market share heavily concentrated in a few insurers and hospitals.

There has been considerable consolidation in the health insurance industry in Connecticut. In 1995, there were 12 licensed health maintenance organizations (HMOs), and five of them were non-profits. Currently there are six licensed HMOs and all are for-profit. While there are also approximately 20 other health insurers, the health care insurance market is dominated by a few insurers. In fact, one company has 43 percent of individuals covered by private health insurance in Connecticut.

These private health insurers negotiate with individual hospitals on what the insurance companies will pay them for services. Connecticut had an all-payer rate-setting system for hospitals until 1994. Under that structure, all hospitals were almost assured their costs would be covered by the various government and private payers. Since hospital rate deregulation, there has been a competitive market for private payers, while government programs like Medicare and Medicaid set rates that hospitals must accept.

After hospital rate deregulation, there were four hospital closings in Connecticut – St. Joseph's in Stamford, Mt. Sinai in Hartford, Park City in Bridgeport, and Winsted Hospital in Winsted. In FY 92, before these closings, Connecticut had 9,437 hospital beds[25]; in FY 05 there were 7,223 hospital beds, a reduction of 23 percent. However, the occupancy rate of the staffed beds has not changed significantly – it was 73.3 percent in FY 92 and 77.3 percent in FY 05 reflecting an increasing shift from inpatient stays to outpatient treatment and services, as well as decreasing length of inpatient stays over the 1990s and early half of this decade.

Competition among hospitals. Since the hospital closings and bed reductions, it appears that Connecticut does not have excess hospital capacity. As indicated in Chapter I, Connecticut has a lower number of hospitals and hospital beds per capita than most other states. But because

[25] LPR&IC, *Health Care Cost Containment in Connecticut*, February 1994

the state is small and densely populated, Connecticut residents have a hospital located closer to them than residents have in almost any other state. However, not all hospitals provide the same services or have the same type of staffed beds. Residents may seek treatment at their local community hospital in an emergency, or if they have pneumonia, because it is close and convenient. However, for a more complicated procedure, residents have the option of obtaining services at a larger urban hospital not that far away.

The committee staff met with representatives of Connecticut health maintenance organizations to discuss the study and hospital funding issues. HMO representatives indicate that Connecticut consumers want to have their local hospital covered in the health care plan their employer chooses. But that means one of the tenets of managed care – to limit the providers in a network to those willing to accept the insurer's price, in exchange for assured volume – has not been implemented successfully. Conversely, because of the consolidation in the health insurance market, smaller hospitals have to be included in the remaining large health plans to be assured any private pay patients, but do not have much bargaining leverage on price, and have little guarantee of patient volume from the insurer.

The hospital market in Connecticut is also highly concentrated. Four hospitals have more than one-third of the staffed bed capacity in the state:

Yale-New Haven – 10.2 percent	**Hartford – 9.4 percent**
St Francis – 7.4 percent	**St. Raphael – 5.8 percent**

The same four hospitals accounted for 37 percent of all inpatient days and 35 percent of all equivalent patient days (a calculation that accounts for both inpatient and outpatient services) for FY 05. The next four hospitals – Danbury, Bridgeport, Lawrence and Memorial, and St. Vincent's -- account for another 20 percent of volume, which means that eight hospitals (25.8 percent of the 31 hospitals) account for 55 percent of the hospital business in Connecticut. On the other end of the spectrum, five hospitals – Bradley, Johnson, New Milford, Rockville and Sharon – each accounted for less than one percent of all inpatient discharges.

The measure for outpatient days (equivalent patient days minus inpatient days) is somewhat more evenly distributed. The top six hospitals account for almost 38 percent of outpatient days. Three of the four hospitals – Yale-New Haven, Hartford, and St. Francis -- that have a greater market share of beds and inpatient days also account for the highest percentage of outpatient days. St. Raphael is not among the top six hospitals, and accounts for less than 4 percent of outpatient days.

Thus, health care is considered to be a "competitive" market in that prices are not set by the state for private payers. But consolidation of health plans and the dominance of the hospital market in Connecticut by several larger hospitals create an uncompetitive health care system.

While health care prices and costs are not regulated by the state, the services a hospital offers are, to some extent, controlled through the certificate of need (CON) process. The CON is

a regulatory provision that attempts to hold down costs by limiting the number of health care facilities in the state that can provide a new, upgraded, or expanded service. Thus, many of the larger hospitals have services (and physicians to perform them) approved through the CON process, that smaller community hospitals do not.

The certificate of need process for medical services largely applied to hospitals, and until July of this year, included capital expenditures or expansions of more than $1 million dollars, and major medical equipment that would have cost more than $400,000. Legislation passed during 2006 increased the CON thresholds for both capital expansions and major medical equipment to $3 million. However, CON rules on imaging equipment were tightened so that most types have to be approved by CON no matter how they are acquired, or how little the cost.

Connecticut average hospital costs are still higher than in most states. As discussed in Chapter I, FY 04 hospital inpatient expenses were about 15 percent higher in Connecticut than nationally. However, there is wide variation among hospital costs in Connecticut. Analysis of the expense per case mix adjusted equivalent discharge (CMAED) by hospital was discussed in Chapter III. Using this broad efficiency measure, which accounts for expenses for both inpatient and outpatient hospital services, program review found that the average CMAED expense was $7,054. However, the standard deviation (distance from the average) was $1,572 and the range was a low of $3,904 at Johnson Memorial, to a high of $11,867 at CCMC. Much of the variation in costs can be attributed to location, especially for those hospitals in Fairfield County where wages are especially high, and to the added expense in teaching hospitals.

Historically, most consumers have not paid for health care directly, but through an insurer or other third party. Therefore, insured individuals have not been that concerned about costs, and so hospitals and other providers have not had to compete on price. This is changing, as consumers are increasingly asked to shoulder a greater share of their health care premiums, and also incur higher deductibles and co-pays.

The current federal administration and the Congress have promoted this paradigm shift to greater individual responsibility for financing health care, by enacting tax incentives for health savings accounts and other consumer-directed ways to pay for health care. The belief is that only if consumers have "skin in the game" will they care about health care costs. However, the ultimate success of increased consumer involvement and its impact on health care providers and hospitals is difficult to predict.

Other Competitive Pressures

Fixed costs. Because hospitals are typically large institutions operating 24 hours a day, seven days a week, their fixed costs are high. Hospitals must pay for round-the-clock staffing, and compete with each other as well as with other health care providers for nurses, nursing assistants, and other medical personnel. Hospitals also face increasing energy costs and high medical malpractice insurance premiums.

Hours of operation. Hospital emergency rooms are always open, and there is a growing trend in emergency room use as shown in Chapter VI. Whether the visit is prompted by a true emergency, limited access to other primary care, the time of day that care is needed, or physician

advice to go to the ER, the reasons are secondary to the fact there is a community expectation to receive medical treatment at a hospital any time. Twenty-four hour emergency room care is a costly and unpredictable service that only hospitals are providing. Even the FQHCs, which receive much of their funding from Medicaid and other government sources, and whose major purpose is to provide primary and preventive care to Medicaid and other low-income residents, operate on a much more limited schedule.

Other health care facilities. Hospitals have been subject to the CON process since the late 1970s. However, since 2004 outpatient or ambulatory surgical centers (ASCs) are also subject to the CON process, with certain exceptions, including if the facility was in operation prior to July 1, 2003. As of June 2006, there were 33 outpatient surgical centers licensed by the state Department of Public Health. By March 30, 2007, all surgical centers will have to be licensed by DPH, but will not have to meet accreditation requirements, such as the Joint Commission on Accreditation of Hospitals (JCAHO) standards.

Ambulatory surgical centers now perform many of the procedures that used to be carried out in hospitals. According to hospital administrators, that has taken many of the private pay patients away, and left the sicker and/or Medicaid or Medicare patients for the hospitals to serve. This also contributes to the poor financial condition of some hospitals.

Currently, the state does not collect data to assess what type of procedures or how many are being conducted in ambulatory surgical centers. A recent American Hospital Association issue brief indicates that most are in the areas of ophthalmology, orthopedics, gastroenterology, and gynecology, and that the volume of these procedures for Medicare beneficiaries rose 145 percent between 1997 and 2004.

Many of the ASCs have some or all physician ownership, so there is a financial incentive for doctors to refer and perform more procedures at these locations. While initially it was projected these ASCs would lower health care costs by dropping the expense per procedure, Medicare and other major payers are now concerned that, because of increased volume of procedures at these facilities, it has contributed greatly to increasing costs overall.

Another aspect of the regulatory imbalance is that hospitals must report their financial and utilization data to the Office of Health Care Access, while other health care providers currently do not. Since 1998, OHCA statutorily has had the option to collect "patient level" outpatient data from ambulatory surgical centers and other health care providers (as defined in C.G.S. Sec. 19a-630). However, although the agency is developing regulations for this reporting, it does not appear that financial data will be required. The lack of system-wide health care data makes it difficult to evaluate consumer access, financial impact, and outcomes for many health care services.

Hospitals are required to report a great deal of financial and expense data to the Office of Health Care Access. Not required to be reported, however, is the expense for marketing a hospital or a particular service a hospital provides. While the actual dollars spent on marketing may not be that great, many policymakers believe that marketing in health care – whether for prescription drugs or elective medical procedures – create demand, which further increases costs.

Summary of Findings:

Connecticut hospitals are not all similar or equal entities. Hospitals vary by location populations they serve, as well as by size and services offered. They are not all structured similarly, nor do they have equal bargaining power to negotiate with health insurers or compete for privately insured patients. A combination of these historical, regulatory, and market forces have shaken the financial foundation of many.

There is a community expectation that local hospitals will be there for emergency care and basic medical treatment 24 hours a day, but it is clear that for elective procedures or more specialized medical services, patients are going elsewhere. In many cases, the smaller urban and community hospitals have the lowest expenses, but state government cannot mandate where people should go to receive their medical service, and increasingly it is apparent that managed care has not been successful in that either.

Without private paying patients obtaining services at hospitals, it is likely that not all hospitals will survive as currently structured. Recent developments that have indicated that include:

- *Essent Healthcare Corporation, a private for-profit company, purchased Sharon Hospital in 2002. Essent/Sharon, which was previously a non-profit facility, now operates as a for-profit hospital. That hospital has also received Medicare designation as a sole community provider hospital, which gives it a higher Medicare rate, and has helped improve the hospital's condition dramatically.*

- *Since October 1, 2006, Bradley Memorial and New Britain General Hospitals consolidated, although both campuses are still operating.*

Although recommendations are made to change the Medicaid fee-for-service payment structure, and increase accountability of Medicaid managed care organizations, Medicaid payments are not a large source of most hospitals' revenue stream. For the smallest hospitals, serving less than 1 percent of all patients statewide, and a very small portion of Medicaid clients, the payment changes from Medicaid will not help their financial situation.

Market forces - whether inability to compete for scarce nursing and other medical personnel to staff hospitals, or failure to attract enough paying patients to cover hospital expenses - may result in further consolidations or closures. Hospital consolidations or closures may not bring about lower hospital costs, but may further shift utilization to the remaining higher cost hospitals. It is difficult to predict what factors individual consumers will consider when making more of their own health care decisions and what impact that will have on individual hospitals.

While steps have been taken to level the regulatory playing field between hospitals and other health care facilities, further efforts are needed. In addition, consumers will need better information on all aspects of their health care, if they are expected to shoulder more of the cost burden and make informed choices. To advance these areas, the committee recommends the following:

The Office of Health Care Access should broaden its oversight perspective to include requiring reporting of outpatient data from health care facilities as outlined in statute. OHCA should analyze and report on outpatient data as they do inpatient hospital data. The office should also phase-in a reporting requirement of aggregate financial data from health care facilities other than hospitals.

The Office of Health Care Access shall report on indicators of hospital expenses as part of its *Annual Report on the Financial Status of Connecticut's Hospitals.* Those indicators for each hospital should include but not be limited to:

- **the expense per case mix adjusted discharge and equivalent discharge,**
- **salary and fringe benefit expenses for the top 10 positions as reported on Attachment 25 from hospitals; and**
- **administrative expenses related to marketing.**

Statutorily, the Office of Health Care Access may establish a consumer education unit "to provide information to residents of the state concerning the availability of public and private health care coverage", but OHCA indicates the unit is not currently operational. **The committee recommends that OHCA, within available staffing resources, develop and disseminate through its website, information that will assist consumers in making more informed health care decisions. Such information should be developed in concert with the Department of Insurance, where appropriate, and should include, but not be limited to:**

- **managed care report card results reported by the insurance department;**
- **information on average, median, and range of premiums charged by Connecticut-licensed health insurers;**
- **medical loss ratios of health insurers, and to the extent possible, their profit margins;**
- **the hospital expense data reported on an individual basis (as recommended above);**
- **hospital performance ratings as measured in the National Healthcare Quality Report, which includes hospital grades based on a series of measures used by CMS under Medicare as well as other quality indicators;**
- **rating outcomes for Connecticut hospitals based on about two dozen common hospital procedures currently evaluated by Health Grades, Inc. (see rationale below); and**
- **OHCA's estimates of what the hospital's charges and costs for the procedure would be, using patient data OHCA obtains from hospitals and CHIME data, matched with outcome ratings.**

OHCA should begin to develop and report similar information for other health care facilities and providers as the data are obtained.

Rationale

The recommendation to expand OHCA's collection and reporting of data from health care facilities, in addition to hospitals, recognizes that much current medical care is provided outside a hospital setting. Connecticut's reporting requirements should not apply to only one area of the health care system.

In addition to the cost data currently included in OHCA's annual hospital report, the committee believes that an expense factor per patient should be included. If a hospital's expenses are reported on an individual patient level, it makes financial data more understandable, easier to compare, and ultimately more usable by both policymakers and consumers.

The hospital expense reporting requirement should be a first step in providing comparable data consumers can understand and use. But as consumers need both evaluative and financial information to make health care decisions, OHCA and CID will have to assist. The recommendation is a starting point for offering information in one place regarding health insurance, and hospital evaluations and outcomes.

The CMS and the National Healthcare Quality Report data are readily available. They can be used to compare grades among hospitals within a state, and to compare a state's overall hospital performance with that in other states. The use of the Health Grades information on hospital procedures is currently publicly available at no charge. Health Grades is a publicly traded health care ratings company. The company uses Medicare data available through CMS and uses the APR-DRG grouper (discussed in Chapter IV) to evaluate and assign one of three ratings to a hospital based on actual outcomes -- either based on short and long-term survival, or complications, depending on the procedure -- versus what might be predicted given the patient characteristics having the procedure. The committee recommends that OHCA supplement the information with relevant hospital financial data, starting with the same specific procedures, which would give the consumer a more complete picture on which to make decisions.

OHCA should also explore obtaining access to additional evaluative information for other procedures, and in other settings, either through Health Grades or other health care evaluation organizations. OHCA could also begin developing its own evaluation information -- for additional procedures and conditions, using hospital inpatient data it already obtains, and through use of new grouper systems available -- and produce and report on comparative outcomes results, together with financial information.

Containing Health Care Costs

Improving the Medicaid payment system to hospitals and strengthening hospital reporting and state agency oversight on their financial condition may help some hospitals in the short term. But as this report discusses, hospital care is only one part of the fragmented, partly regulated, partly competitive, multi-payer, costly health care system. Increasingly, economists and health

care policy experts indicate that recent growth in health care costs is unsustainable, and that unless actions are taken to curb that growth, they predict dire consequences.

As evidence of the unsustainable growth, the literature points to the rise in health care costs as measured against several important economic indicators like growth in the gross state product, rises in personal income, and growth in health insurance premiums compared to wages. Program review examined many of these measures as they pertain to Connecticut's health care system and presents them in this section.

Health Care Spending Outpacing Other Economic Growth

Gross state product. As discussed in Chapter I, national health care expenditures[26] now consume approximately 16 percent of the gross domestic product (GDP), and personal health care expenditures nationwide account for about 14 percent of the GDP. In Connecticut, personal health care spending for 2004 was about 11.7 percent of gross state product, less than the national average. However, if the trends in growth are measured, Connecticut's health expenditures are growing faster than gross state product:

- From 1993 to 2004 gross state product increased by 60.3 percent while personal health care expenditures grew by 66 percent.
- The average annual increase in gross state product was 5.02 while health care expenditures grew at annual rate of 5.5 percent.

Health care spending increases of 5.5 percent also have exceeded yearly increases in Connecticut's state budget, which have averaged 4.8 percent since 1993. Further, 20 percent of the state's budget is Medicaid; if Medicaid were excluded from the budget, state expenditure growth would be less. Connecticut health care costs are far outpacing inflation. Annual increases in the consumer price index since 2005 have been about 2.6 percent, or about half of the annual increases in health care expenditures.

On a more individual level, Connecticut has a high per capita income – measured at $47,819 in 2005, which is about 38 percent higher than the national average. But the annual growth rate in the state's per capita income over the past 10 years was 4.3 percent, lagging behind the 5.5 percent yearly increases in health care costs.

Recognizing that health care costs in the state are rising at an alarming rate is important in terms of the state's overall economy, because business decisions on whether to locate or expand in the state or not are impacted, as is a business's decision to continue to provide health insurance to its employees. Out-of-control health care costs stifle growth in other areas of the economy, leaving employers with less money to expand a company or increase wages. Individuals also feel the impact, with fewer dollars to spend on housing, utilities, education, or entertainment.

[26] National health care expenditures include personal health care expenses as well as spending on research and other grants made by government agencies such as National Institute of Health and Centers for Disease Control. Personal health expenditures exclude these costs.

Private health insurance. **B**ased on 2004 census data Connecticut has a higher percentage of state residents who are covered by employer-based health insurance and a lower percentage of uninsured than the rest of the country. However, the trends in Connecticut coverage are negative:

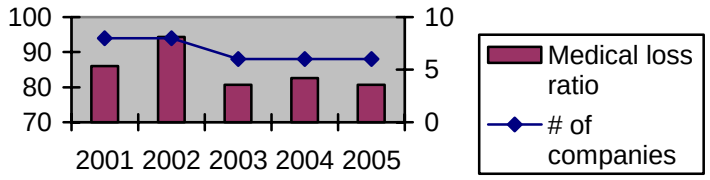
- The 2004 census data indicate that Connecticut's percentage of population covered by employer insurance has shrunk from 72.5 percent in 1999 to 67.2 percent in 2004.

- The 2004 census data showed that 407,000 people were uninsured, an increase of 50,000 people without insurance from 2003.

- The committee obtained 2006 health insurance coverage statistics from CID, which show a further net decline of privately insured people (73,200) since 2005. Further, the decline (79,282) is in the HMO coverage area, with more comprehensive benefits, while the indemnity plans (typically with high deductibles) showed an increase in coverage of almost 6,100.

The CID also provided the annual medical loss ratios (percent of revenue spent on medical expenses) for health insurers licensed in Connecticut from 2001 through 2005. The committee used the loss ratios for the licensed HMOs, and the average annual medical loss ratios (not weighted by size of premiums), and the results are shown in Figure VII-2. (This analysis did not use the loss ratios of the indemnity health insurance companies; if those were included the average medical loss ratios would be less.)

Figure VII-2. Average Annual Medical Loss Ratios of CT HMOs -- 2001- 2005



Source: LPR&IC Staff Analysis

As the figure shows, except for 2002, when the average medical loss ratio was 94.3 percent, loss ratios have been well below 90 percent, and as the health insurance industry has consolidated, the ratios have been trending down towards 80 percent. The committee could not determine profit margins, but insurance department financial data show all Connecticut licensed health insurers had positive net income for each of the past three years.

A report released in October 2006 by Families USA, a national non-profit health care consumer group, indicates that "over the past six years (2000 to 2006), family health insurance premiums for Connecticut workers rose 5.8 times more quickly than median earnings. On

average, family health care premiums rose by 77 percent [over the period] while median earnings rose only 13.2 percent."

- The average health insurance premium for family coverage in 2006 was $12,904 -- the employer share is $10,246 and the employee's share is $2,658.

- The most recent state comparative data for 2004 showed Connecticut's health insurance premiums were the fourth highest in the nation (including D.C., with the highest), and 10 percent more than the national average.

- A recent survey conducted by the Connecticut Business and Industry Association (CBIA) of its members (released in September 2006) indicates that, for the fifth straight year, respondents stated that high health care costs are the major financial concern of businesses in Connecticut. Further, almost 60 percent of CBIA survey respondents said they had experienced increases of 10 percent or more in health care costs in the past year.

- Some of the higher health insurance premiums in Connecticut may be to cover the cost shift in hospital care for the uninsured and Medicaid and Medicare population, but it does not appear to be reflected in health insurers' medical loss ratios, which are declining.

The program review committee believes that the recent growth in health care costs is unsustainable and that it is beginning to affect private insurance coverage, both in the actual decline in numbers and the shift to less coverage. However, covering the uninsured in a government-insured program does not seem to be either an affordable, or a long-term, solution. Government insurance, especially Medicaid, with lower reimbursement rates and limited community access, appears to increase hospital utilization. As this report has discussed, hospital emergency room use is highest among government payers, and inpatient care is also higher among the Medicaid and SAGA populations.

Coupling lower government reimbursement rates with increasing the numbers of a high-utilization population will only further worsen some hospitals' financial condition. Further increasing the amounts of underpayments will likely add to the portion private insurers are expected to pay, driving premiums higher while insuring fewer people. Instead, the committee believes the state must take steps to make private health insurance more affordable and improve access to primary and preventive care.

The factors contributing to higher health care costs in Connecticut that need closer examination are numerous, interconnected, and complicated. While this report has discussed many elements -- from Connecticut's high portion of costs for nursing home care to the added costs of teaching hospitals -- many are beyond the scope and resources of this study.

The Office of Health Care Access already has statutory responsibility to "oversee and coordinate health system planning; and monitor health care costs" (C.G.S. Sec. 19a-613 (3)(b). but the committee believes the responsibility for containing health care costs is beyond the scope of one state agency.

Recognizing the breadth and severity of the problem, the committee recommends that a panel should be established and convened by March 1, 2007, to examine health care costs, make private health insurance more affordable, and improve access to primary and preventive health care.

The panel should consist of the following 40 members:

Six members of whom one each shall be appointed by the speaker of the House of Representatives, the president pro tempore of the Senate, the majority leader of the House of Representatives, the majority leader of the Senate, the minority leader of the House of Representatives, and the minority leader of the Senate;

The chairpersons and ranking members of the committees on: public health; insurance; human services; commerce; appropriations; finance, revenue and bonding;

Ten members appointed by the Governor, who shall include representatives from the Connecticut Hospital Association, the Connecticut Business and Industry Association, Connecticut Medical Society, the Connecticut Nurses' Association, Connecticut Primary Care Association, the state association representing health care plans, and the Connecticut Association of Health Care Facilities; and

The commissioners, or their designees, of the Office of Policy and Management, the Office of Health Care Access, Connecticut Insurance Department, Department of Public Health, Department of Social Services, Department of Mental Health and Addiction Services;

The panel shall be convened by the chairs of the legislature's public health and insurance committees and the panel shall elect its co-chairs from among its members.

Areas for the panel's consideration should include but not be limited to:

- ***The state's current nursing shortage*** **and developing strategies for enhancing the education and supply of nurses. The panel should consult the report issued in October 2005 by the Council of Deans and Directors of Nursing Programs.**

- ***Strategies to promote increased access to primary and preventive care, especially for Medicaid populations, which should include expanding hours of federally qualified health care clinics.*** *(In October 2006, approximately $14 million in state bonding money was approved to expand and improve the facilities of several FQHCs)*

- ***Encouraging development and approval of health insurance products*** **that lower costs to consumers if they maintain healthy lifestyles. For example, new policies provide discounts for persons who maintain a body mass index below a certain level. Also, current health care policies seem to emphasize high consumer deductibles and co-pays at the front end, but once the**

deductible level is reached, the consumer has no financial incentive to consider cost in the health care decision. Perhaps policies could combine lower initial deductibles, with a percentage of overall costs - for a consultation, procedure, or diagnostic test - to be borne by the consumer. The consumer would then have a financial interest in knowing and comparing costs.

- ***The adequacy of the current level of regulation by the Insurance Department over health insurers and premium rate increases.***

- ***Current statutory health insurance mandates*** **and analysis of whether they add to health care costs in Connecticut.**

- ***Strategies to assist lower-wage individuals and small businesses pay health insurance premiums.***

- ***The current distribution of state Medicaid dollars*** **-- specifically the high proportion to nursing homes.**

The panel should report its findings and recommendations to the Governor and Legislative leadership by January 1, 2008.

The committee is aware of the great interest by state lawmakers to address health care cost and access issues, both in terms of funding and service delivery, as soon as possible. Indeed, in the context of hospitals as they currently exist now in Connecticut, and in terms of cost areas over which the state currently has some control, the proposed recommendations contained in this report are intended to promote access and cost accountabilities. There may be other recommendations affecting other parts of the health care system that could be implemented in the near future also. However, longer-term solutions to the access and cost problems might well require fundamental change. While some might say more study at this point is avoiding the issues, the committee thinks that the situation may be serious enough now, and recognized as such, that a time-limited, well-focused, purposeful, and inclusive system-wide review would be beneficial.