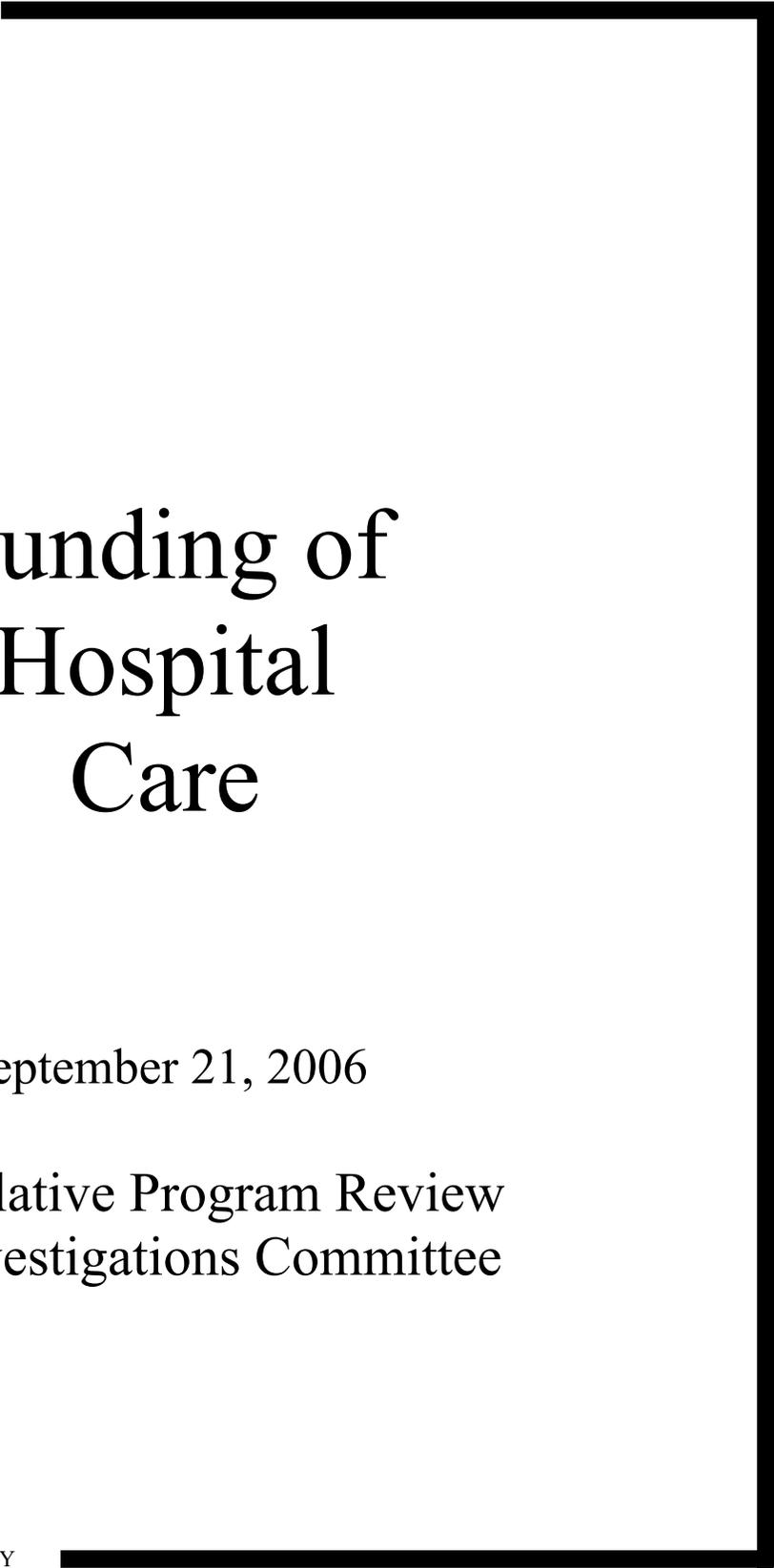


Staff Briefing



Funding of Hospital Care

September 21, 2006

Legislative Program Review
& Investigations Committee

Introduction

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 is 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 31 acute care hospitals in Connecticut, and all except one are non-profits. 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 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. A recent study issued by the American Hospital Association reported that the average median age of hospital physical plant nationwide is 9.8 years. Most of Connecticut hospitals are considerably older than that, but some Connecticut hospitals here do not have adequate cash reserves, and are not able to borrow the capital necessary to upgrade their facilities.¹

¹ The Connecticut Education and Health Facilities Authority is a quasi-public agency established to issue tax exempt bonds to non-profits, including schools and hospitals. CHEFA has not done any transactions with Milford Hospital, and both St. Mary's and Windham Hospitals were given negative outlooks for future borrowing by Moody's

Connecticut appears to receive high Medicare payments compared to the rest of the country --\$3,086 for an average inpatient stay in Connecticut compared to \$2,706 nationally. Overall, Medicare payments in Connecticut cover a similar percentage of hospital costs as in the rest of the country, but staff will be examining this issue further for the final report.

This briefing report also examines Connecticut's Medicaid payments to hospitals and finds that all -- whether for managed care, fee-for-service, or SAGA clients -- are substantially below those paid by both non-government payers and Medicare. Also, medical assistance underpayments to hospitals account for a higher percentage of total costs for uncompensated care than those without insurance and other "uncompensated" care. Staff is developing comparative Medicaid payments and the ratio of costs covered with other states for the final report.

While inadequate revenues can cause weakened financial conditions, hospitals may not be run as efficiently as they might be. Section III determines that some hospitals in financial distress (i.e., experiencing negative margins over three consecutive years or a high negative margin in FY 05) also have high expenses per discharge, even when adjusted for severity of illness. Some financially weak hospitals have held the line or even cut costs, while a few others experienced high percentage increases in expenses. Committee staff is not clear whether these financially distressed hospitals with high increased expenses are attempting to strengthen their ability to compete and offer improved services with additional hiring, or whether it indicates management deficiencies.

Methods. To prepare the briefing report, staff relied heavily on the financial reports and accompanying schedules that hospitals must file with the Office of Health Care Access (OHCA). The fiscal year for hospitals is identical to the federal fiscal year -- October 1 through September 30, and references to FYs in the report are for that period, unless otherwise noted. Staff reviewed the FY 03 through FY 05 financial reports and the results of the analysis are presented in Sections II and III. Determining the current financial condition of hospitals in Connecticut is somewhat difficult because there is a lag time between the end of the hospital fiscal year and the filing of financial reports with OHCA, and when those financial reports are reviewed and made available by OHCA.

Staff also obtained information from the Department of Social Services, the Department of Mental Health and Addiction Services, the Connecticut Health and Educational Facilities Authority (CHEFA), Connecticut Insurance Department, the Connecticut Hospital Association (CHIME data), and the Centers for Medicare and Medicaid Services (CMS). In addition to meeting with personnel from the state agencies listed, committee staff also met with representatives of the Connecticut Hospital Association, the Connecticut Association of Health Maintenance Organizations, and administrators from several individual hospitals.

Report organization. The briefing report contains three sections. The first section gives a brief chronology of hospital funding, listing milestone legislation nationally and in Connecticut. This section also lays out Connecticut's health care and hospital system --

Investors Services. Up until 2005, John Dempsey was excluded as a state facility, but P.A. 05-255 authorized the University of Connecticut Health Center to access CHEFA financing.

including hospital capacity in the state, state spending on hospital care and other health care expenditures, and comparative information on hospitals financial condition – compared to the nation as a whole.

Section II describes the operating revenue stream to hospitals by patient payer group. Included is a description of the populations covered by: Medicare; Medicaid, both fee-for-service and managed care programs; the State Administered General Assistance program, and non-government payers. The way each payer sets rates and pays hospitals is also described. This section also provides hospital utilization statistics by each of the payer groups.

Section III provides a statewide profile of Connecticut acute care hospitals on three aspects – their administrative structure, utilization measures, and basic financial and efficiency measures. Appendix A includes a profile of each hospital using several of these measures.

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% 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

Table I - 1. Hospital Funding – A Chronological Synopsis

competitive 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% 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 section 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 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.

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	

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.

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.

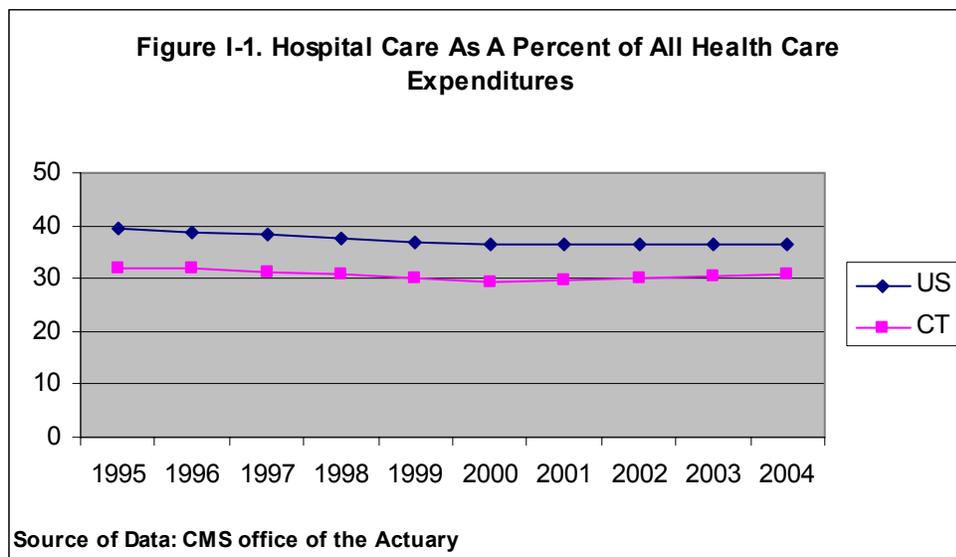
Table 1-4. Comparison of Hospitals by Population and Square Mile				
State	Pop Per Sq. Mile	State Rank	Sq. Miles Per Hospital (The range is + and - 100 Sq. Miles)	State Rank
New Jersey	1,175	1	96	1
Rhode Island	1,030	2	95	2
Massachusetts	816	3	109	3
Connecticut	725	4	151	4
Maryland	573	5	208	5
Delaware	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 state using this measure, and indicates that Connecticut ranks 5th. (The District of Columbia is not included because of distortions in spending and population)

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.

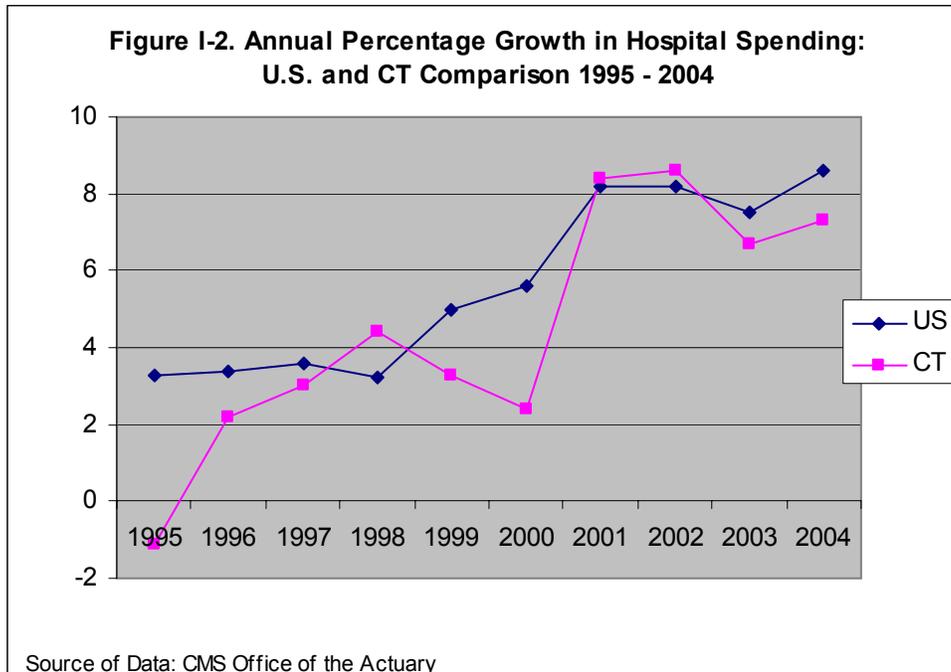


Further, for the last two decades, Connecticut has spent less than the national average in terms of the percentage of health care spending on hospital care. As Figure 1-1 shows, Connecticut's percentage spent on hospital care has hovered around 30 percent, while the national average has been at least 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% less) than the national average, and significantly more (69% 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.

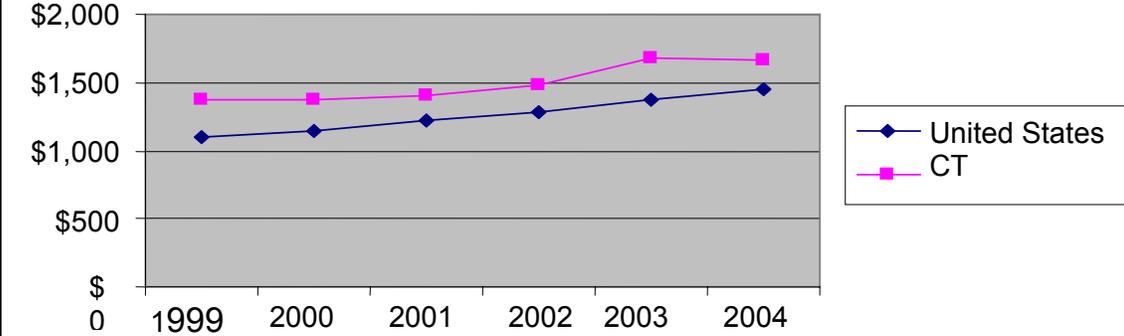
Trends in overall hospital spending. Connecticut has also lagged behind the rest of the country in terms of the percentage increases in hospital spending for all payers. Nationally the average annual long-term growth (1980-2004) has been 7.5 percent, while in Connecticut that growth rate has been 6.8 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.



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 Sections II and III.

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



Source of Data: Kaiser Family Foundation, State Health Facts

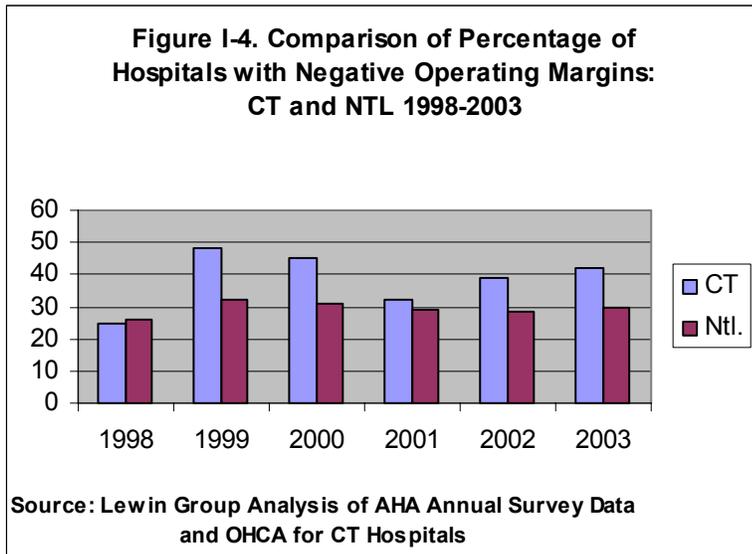
Comparison of hospital operating margins. Table I-8 shows that Connecticut hospital operating margins are less than the average nationally. (This is the percent of surplus or loss of operating revenues). Reasons contributing to this are that hospital expenses are higher in Connecticut, as shown in Figure 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. Section III analyzes in greater detail some of the aspects that appear to impact the financial viability of Connecticut hospitals.

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. Section III discusses the impact of these various factors on individual hospitals.

This section 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.

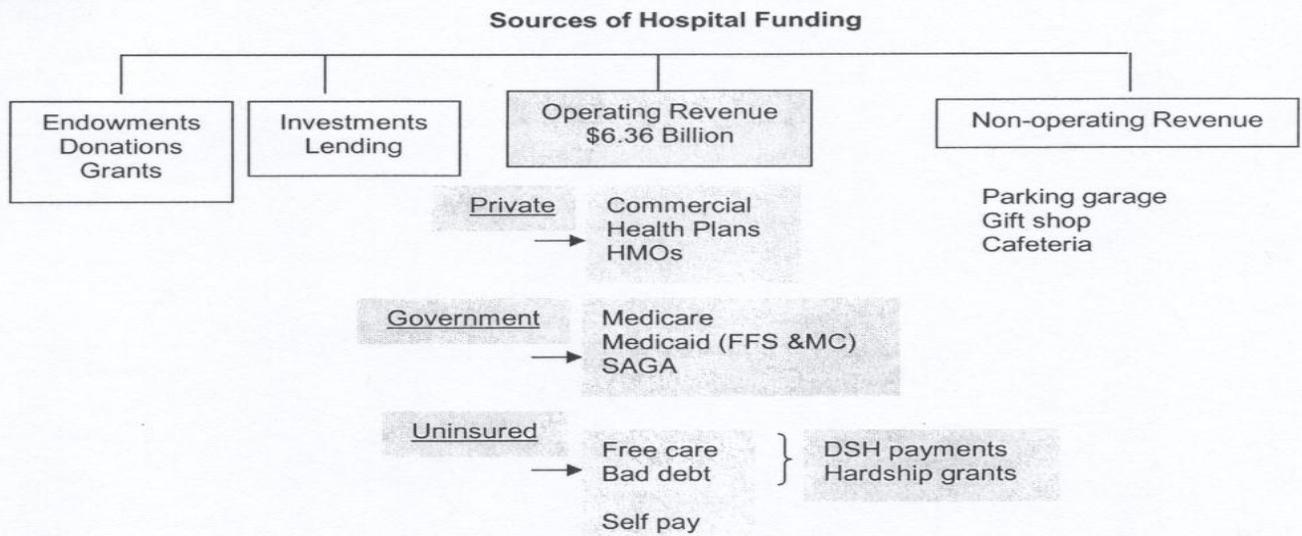
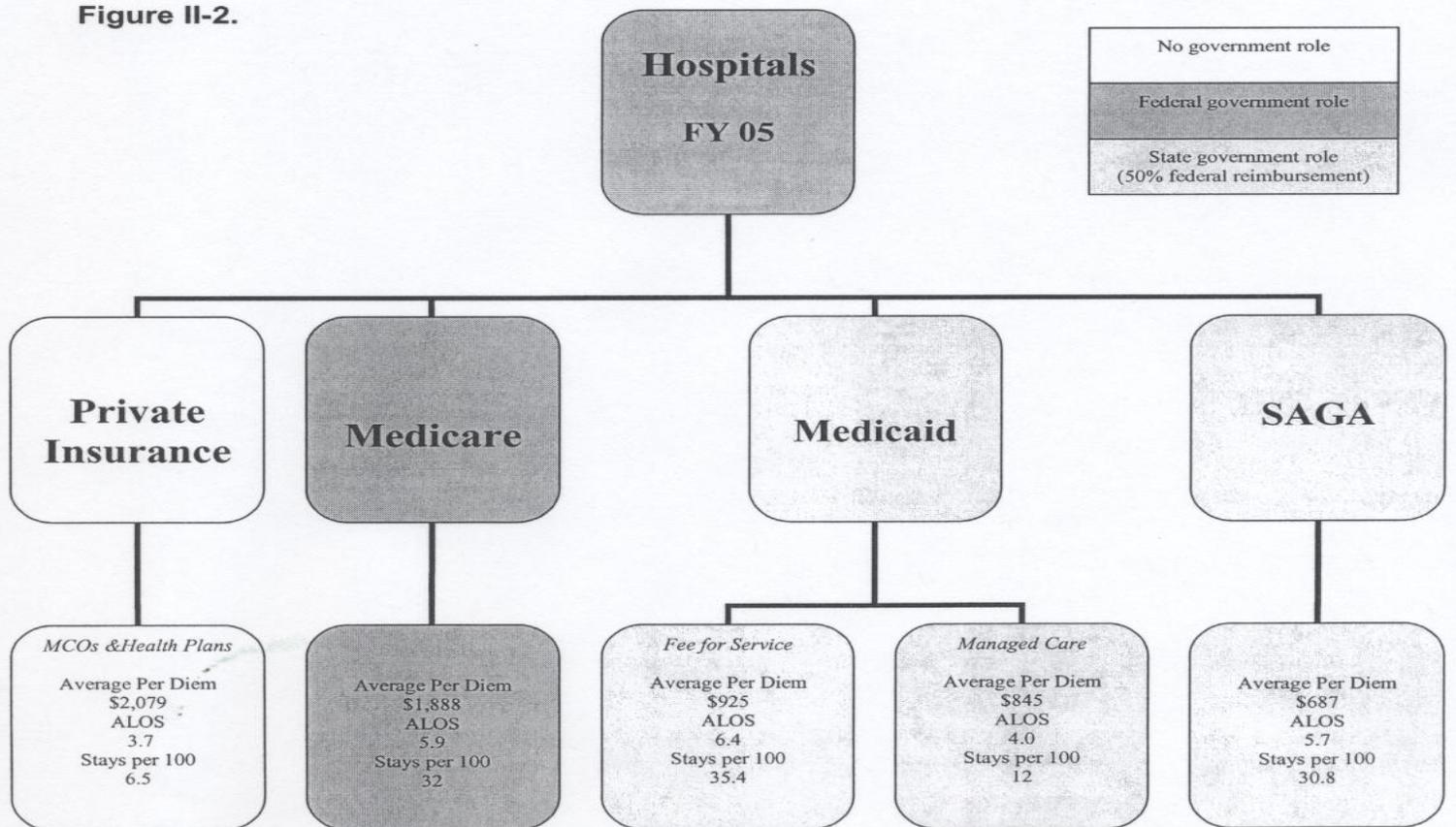


Figure II-2.



- 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 the Office of Health Care Access (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 staff 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.

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.

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: <i>Kaiser Family Foundation Health Facts</i> website; based on data from Census Bureau, Urban Institute and Kaiser Commission on Medicaid and the Uninsured		

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.²

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		

² 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.

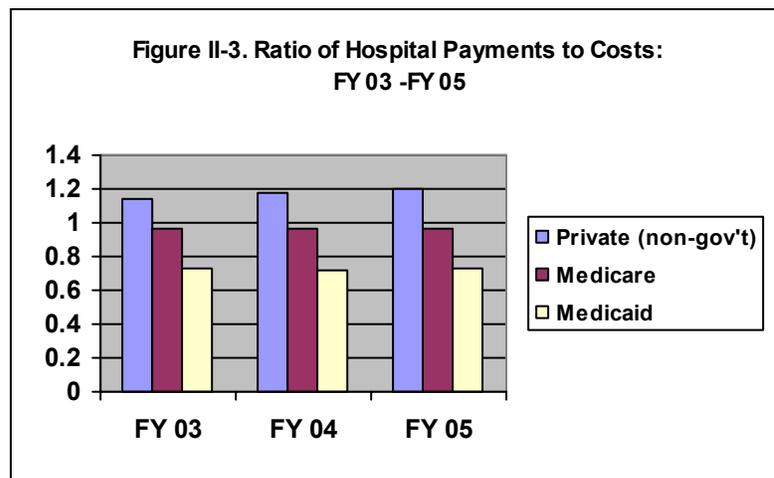
Rates and Payments

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 the full 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 the 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).



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
- End-stage renal disease; no matter the age
- A percentage of the Medicare population are 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
- There are approximately 524,000 Medicare enrollees in CT. This is about 15 percent of the state's population, and the national average 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 (CMS) 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).

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.³

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.

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:

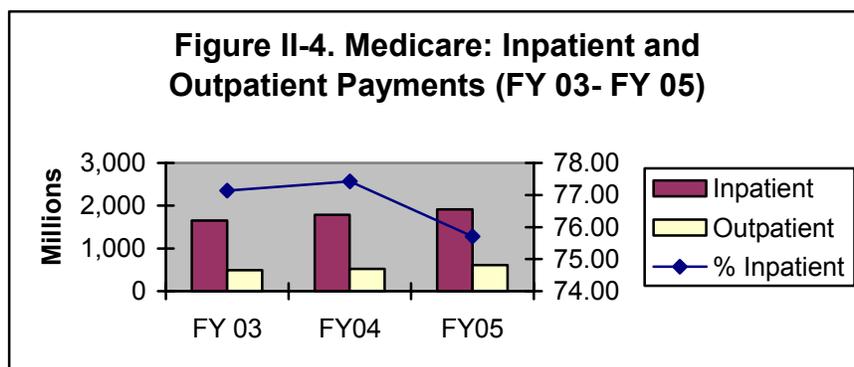
Graduate Medical Education Payments		
Type	Includes Payment for:	Based on:
Direct Medical Education (DME)	Salaries for residents, teaching physicians and class space	Ratio of use by Medicare patients by all utilization
Indirect Medical Education (IME)	Higher costs assumed at teaching hospitals, such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

³ 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.

Payments and Rates

- Medicare has typically paid for about 41 percent of all hospital payments in Connecticut.
- Total Medicare payments to hospitals for FY 05 were about \$2.53 billion.
- 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 to about 75.5 percent of Medicare hospital funding.



- 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. 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 staff 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). The average per diem for all payers has increased about 9.5 percent.

- The average Medicare per diem is somewhat higher than the average overall per diem, for each of the three years.
- The range in per diems among hospitals is great with both Medicare and all payers -- 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 Staff 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. The 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.
- 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.
- 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.
- Medicaid Managed Care covers primarily children and their families.

Coverage

- Medicaid Managed Care plans cover all health care services except behavioral health which has been “carved out” of the managed care plan recently.
- The Department of Social Services (DSS) is the state administrative agency for all Medicaid services.
- DSS contracts with four Managed Care Organizations (MCOs)
 - Anthem,
 - CHN-CT
 - Health Net and
 - Well Care/Preferred One.
- All MCOs must offer statewide network coverage.
- 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).

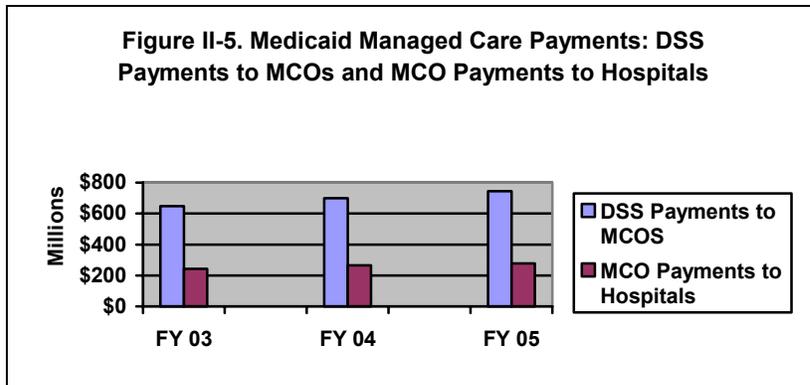
Table II-6 shows payments and per-member per month rates for Medicaid Managed Care (all plans), and expenses – medical and administrative -- from 2000 to 2005. Overall the plan enrollment has increased by 38 percent but revenue to the plans has increased by 70 percent over the period. This translates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

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							

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.

Trends in Medicaid Managed Care

While PRI staff 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.



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 PRI staff did not have the actual rates negotiated by the MCOs and the hospitals, committee staff 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%) 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 Staff 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.
- The ALOS has also increased slightly, from a statewide average of 3.9 to 4.0 days.

- The average ALOS for MMC inpatients for FY 05 was 4.0 while the overall average is 4.8 days.
- 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 were removed from the Medicaid index.

Outpatient and Emergency Room Utilization:

- Almost half of all hospital payments for Medicaid Managed Care is for outpatient services -- 46.2% in FY 03, 47.5% in FY 04, and 48.2% 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	232,006
% of All ER Visits	16%	16.5%	17%
Rate per 100 Enrollees	70.5	74	77.0
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 FFS primarily serves aged, blind, and disabled individuals. There are also some adults and children not enrolled with a managed care health plan.
- There were 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.

Coverage

- Medicaid services include remedial, preventive, and long-term medical care, as well as acute hospital inpatient and outpatient care.

Rates and Payments

- The Department of Social Services is responsible for Medicaid rate setting.
- Connecticut's Medicaid FFS program uses a TEFRA rate setting methodology.
- Connecticut's Medicaid program receives a 50 percent federal match.
- 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.

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. 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 rate, or "rebased", 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, sixteen of the 30 hospitals were rebased in 2001 at a new target rate of 62.5 percent of their 1999 costs per discharge.

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	

- 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 two most recent adjustment requests approved in 2006 were for Norwalk and Windham, which had received a previous exception request in 2004.

- 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	
Fiscal Year Ending 9/30/06	Number of Hospitals
Minimum rate of \$3,750 or less	13
\$3,751 to \$3,999	4
\$4,000 to \$4,999	9
Over \$5,000 to \$7,797	4
Total	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 have the minimum rate while four hospitals are very close to the minimum. Thirteen hospitals have target rates exceeding \$4,000 including four hospitals exceeding \$5,000 (Bradley, Bridgeport, Dempsey, and Yale). As the table shows, the range

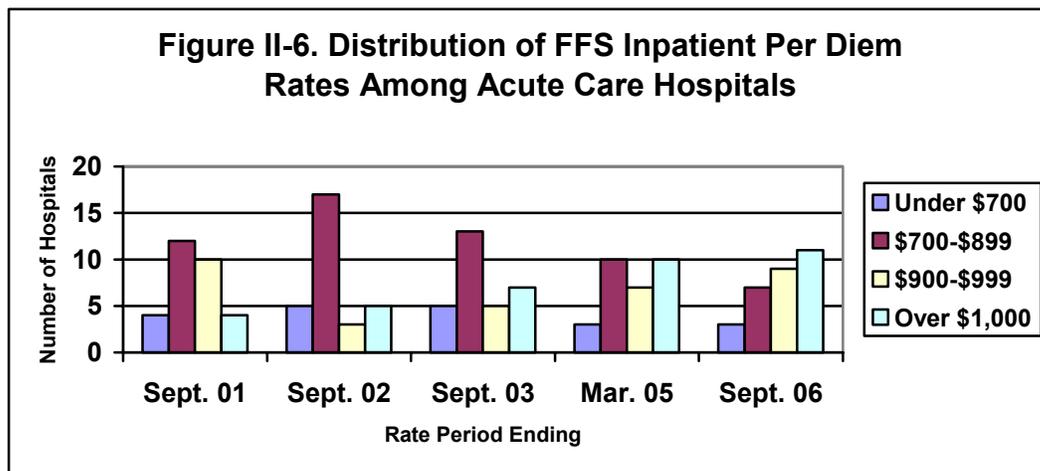
among hospitals' Medicaid target rate is extremely broad, with John Dempsey Hospital at \$7,797 receiving more than double the minimum target amount.

- 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. DSS anticipates 17 hospitals will increase to the new \$4,000 minimum floor.
- 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.⁴ 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 section.)
- 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. (A listing of each hospital's FFS per diem payment is provided in Appendix A.)

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



⁴ Federal law requires states to 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.

- 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.

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 Staff Analysis of Hospital Schedules Filed with OHCA			

- 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.
- 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 outpatient hospital services. The fee schedule is adjusted periodically, within available appropriations, to reflect necessary increases in the cost of services.
- Certain Medicaid payments for outpatient hospital services are individually priced as a ratio of cost for the service to hospital charges. These 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. (According to DSS, 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	101,598
% of All ER Visits	7.1%	7.1%	7.4%
Rate per 100 Enrollees	92.8	101.8	99.6
Source of Data: CT Hospital Association			

STATE ADMINISTERED GENERAL ASSISTANCE (SAGA) MEDICAL ASSISTANCE

Population

- The average monthly enrollment for the SAGA medical assistance program is approximately 35,000. 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.
- 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 (FQHC). 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

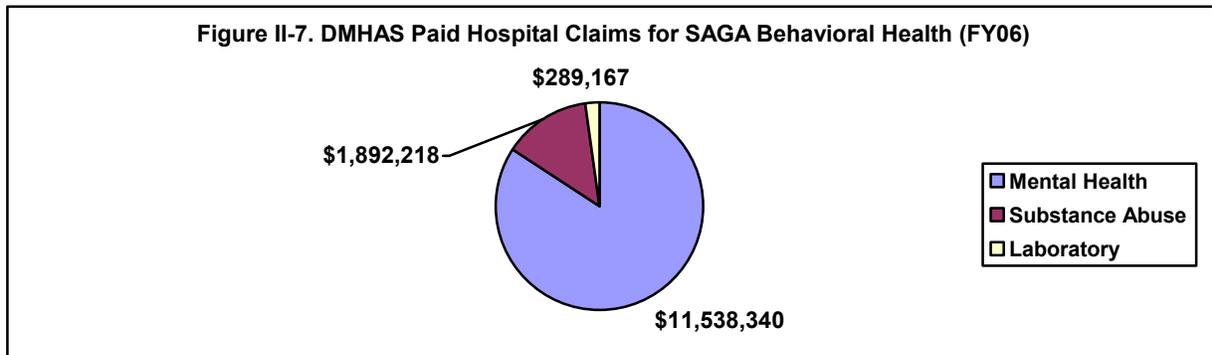
- Total DSS payments for SAGA inpatient medical care was \$42,394,933 in FY 05.
- As of 2003, DSS pays health care providers in the SAGA network, including hospitals, prospectively based on their pro rata share of the cost of services provided.
- Hospitals bill DSS at their Medicaid fee-for-service rate. 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.
- Table II-16 shows the total inpatient days, average length of stay (ALOS), and average payments for SAGA clients.

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 Staff Analysis of Hospital Schedules Filed with OHCA.			

- As the table shows, there has been an increase in SAGA discharges (12.2%) and inpatient days (7.1%) over the three-year period.
- 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’s 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	45,250
% of All ER Visits	2.6%	3%	3.3%
Rate per 100 Enrollees	122.4	145.2	155.5
Source of Data: CT. Hospital Association			

DISPROPORTIONATE SHARE PROGRAM (DSH)

Program

- 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

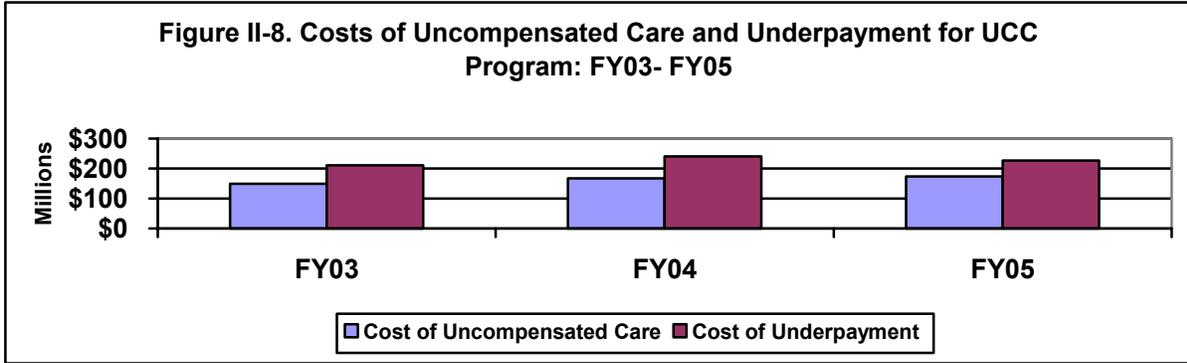
- The Department of Social Services administers the majority of Connecticut's DSH programs.
- In FY 05, DSH payments for Connecticut's acute care hospitals totaled \$161,318,472, which is a 0.2 percent increase over DSH payments made in FY 04.

Uncompensated Care (UCC)

- 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.
- 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.
- The UCC program is funded by the state through General Fund appropriations.⁵ It is federally reimbursable under Medicaid at 50 percent.
- 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 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.

⁵ 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 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.

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	\$ 1,639,072
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.
- 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.

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 (Public Act 06-186). The grants are to help hospitals: avoid substantial financial deterioration that may adversely affect patient care; and assist in their continued operation.
- DSS will determine 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 must be given to the number of clients on state assistance that the hospital serves; a hospital’s licensure and compliance history; and the reasonableness of its actual and projected revenues and expenses. Table II-19 lists the hospitals that have applied for the hardship funds.
- To qualify, a hospital must submit a plan describing operating savings and increases in 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 an increase, the increase amount, and the commissioner’s action on each request. DSS anticipates a decision on the hardship awards will be made in October 2006.

Table II-19. Hospital Hardship Fund Request
Bradley/New Britain
Bridgeport
Bristol
New Milford
St. Mary’s
St. Raphael’s
Waterbury
Windham
Source: DSS

Hospital Profile

This section profiles Connecticut's acute care hospitals on three aspects -- their administrative structure, basic financial indicators, and utilization measures. The discussion in this section focuses on generalized statewide data. However, additional information on individual hospitals is provided in Appendix A.

Administrative Structures

Connecticut has 31 acute care hospitals including one children's hospital. All are not-for-profit except for Essent-Sharon. Eighteen are teaching hospitals including John Dempsey Hospital, which is state-owned. Four of the 31 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 staff 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.⁶

All 31 acute care 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 31 hospitals have inpatient medical surgical beds. Although all provide emergency services, only two are certified 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 31 hospitals provide maternity and newborn care. (Bradley and CCMC do not.) Only 15 hospitals, including CCMC, have neonatal intensive care units.

⁶ 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.

Of the possible 57 services or types of care certified by JCAHO, the commission reports eleven Connecticut acute care hospitals offer 45 or more available services. Sixteen hospitals provide between 25 to 44 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 C.)

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			

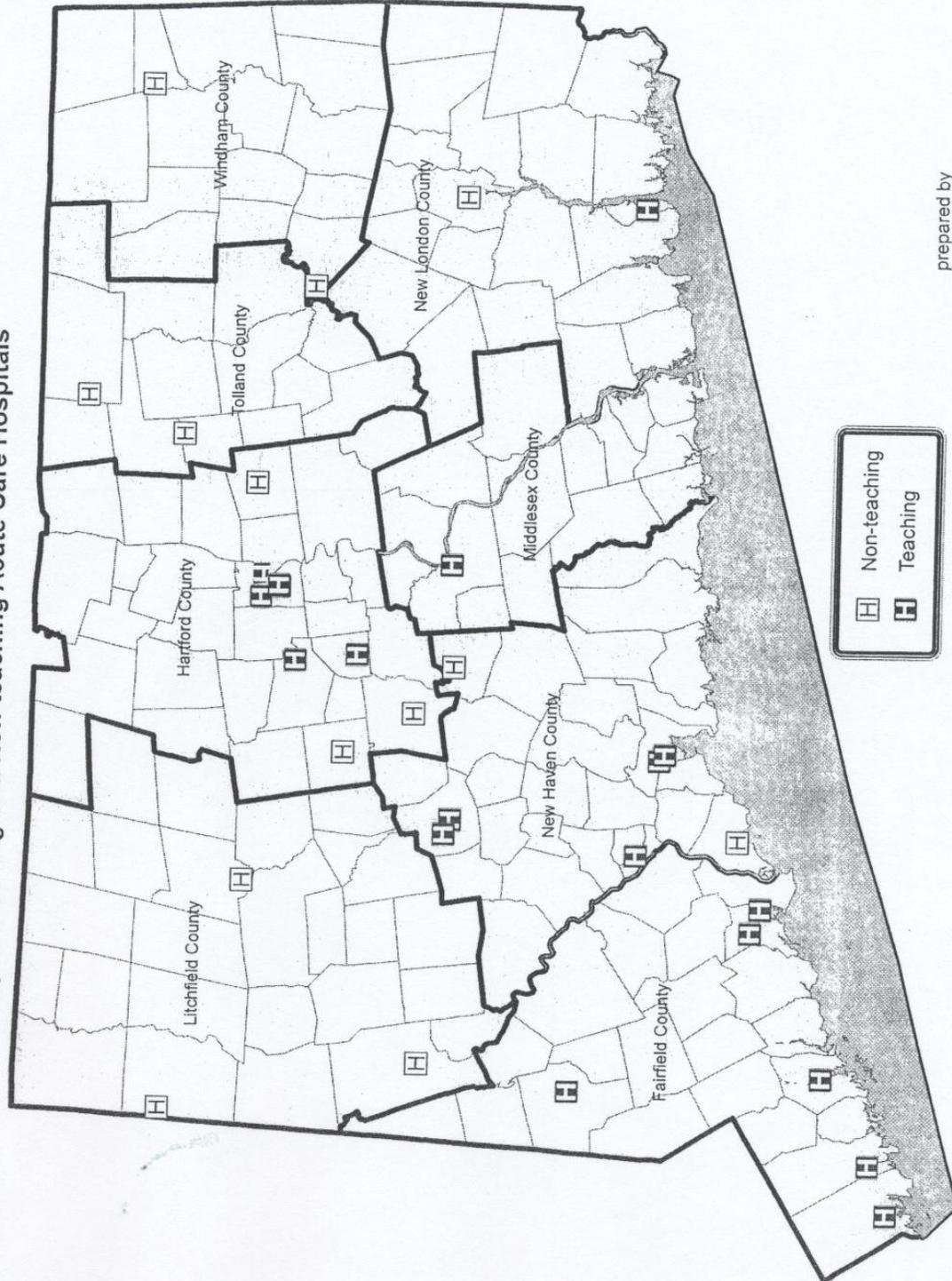
As the table shows, Connecticut has 9,247 licensed hospital beds but just over 7,200 are reported as staffed beds. The smallest hospital has 84 licensed beds (Bradley) and the largest has over 900 (Yale New Haven). Nine of the 31 acute care hospitals have fewer than 100 staffed beds. The occupancy rate 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 the Appendix A.)

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 FY 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

Map I. Teaching and Non-teaching Acute Care Hospitals



prepared by
Office of Legislative Research
September, 2006

work in a hospital and are not considered employees. Employee figures for each hospital are provided in Appendix A.

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

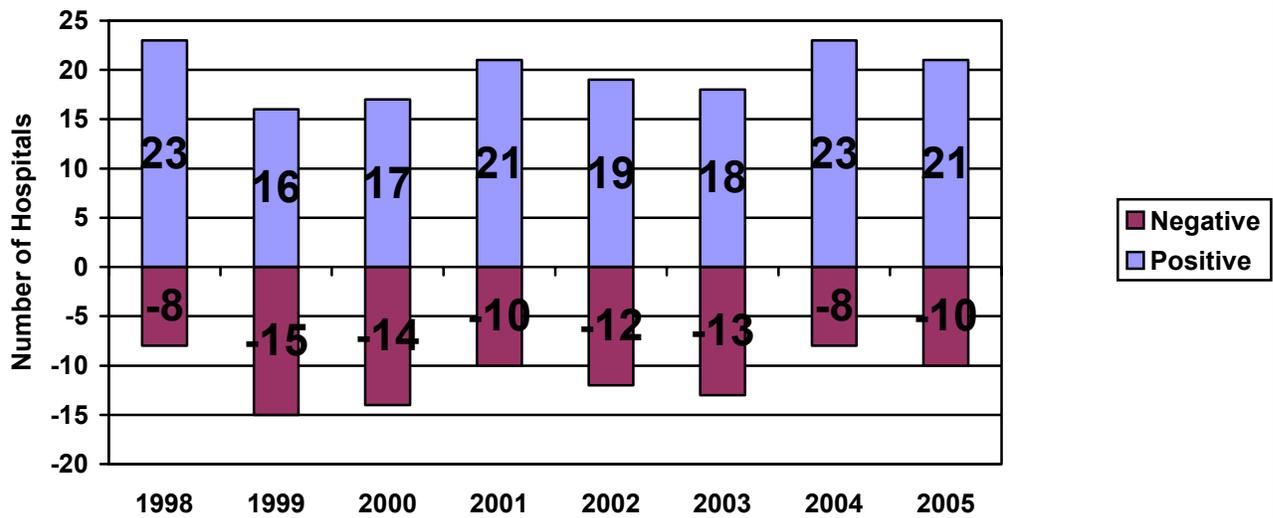
In FY 05, Connecticut's acute care hospitals reported a net adjusted revenue total of approximately \$6.36 billion. Hospitals generate both patient service revenue and non-operating revenue. Revenues generated from patient services are known as operating revenue. Revenues generated from other services 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 A.)

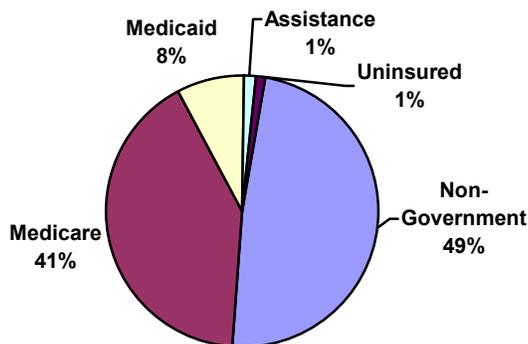
Figure III-1 shows the number of hospitals with either positive or negative operating revenue for each year from 1998 through 2005. The distribution of positive or negative operating margins among acute care hospitals has fluctuated slightly over the last eight years. In 1999, Connecticut had almost 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. However, this number increased to 10 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%) 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. This percentage for each hospital is displayed in Appendix A.

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 two 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.

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 know 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, 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 section. (A breakdown of each hospital's discharges and ALOS for both government and non-government programs is provided in the Appendix A.)

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 Section II, emergency room use has increased across the government programs. Table III-4 provides a summary comparison for FY 06.

	Private Insured	Medicare	Medicaid Managed Care	Medicaid FFS	SAGA	Uninsured	TOTAL
Total Visits	536,268	296,028	232,006	101,598	45,250	150,770	1,361,920
% of All ER Visits	39.3%	21.7%	17%	7.4%	3.3%	11%	100%
Rate per 100 Enrollees	24.2	56.3	77.0	99.6	155.5	39.6	39.0
Source of Data: Connecticut Hospital Association							

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 PRI staff 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 1000 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 Section 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 Section 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 they treat 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 based on negotiated rates and discounts, while DSS pays for the fee-for-service clients based on predetermined rates. 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 section, 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.

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 staff 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.

Lowest Operating Expense per CMAED		Highest Operating Expense per CMAED	
Johnson Memorial	\$3,904	CCMC	\$11,867
New Britain	\$5,263	Norwalk	\$9,575
Windham	\$5,306	Greenwich	\$8,875
Bridgeport	\$5,557	John Dempsey	\$8,415
Bristol	\$5,781	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. There appears to be a growing trend of doctors, especially emergency room physicians who are employed by the hospital however. 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.

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 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 % Salary and Fringe 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

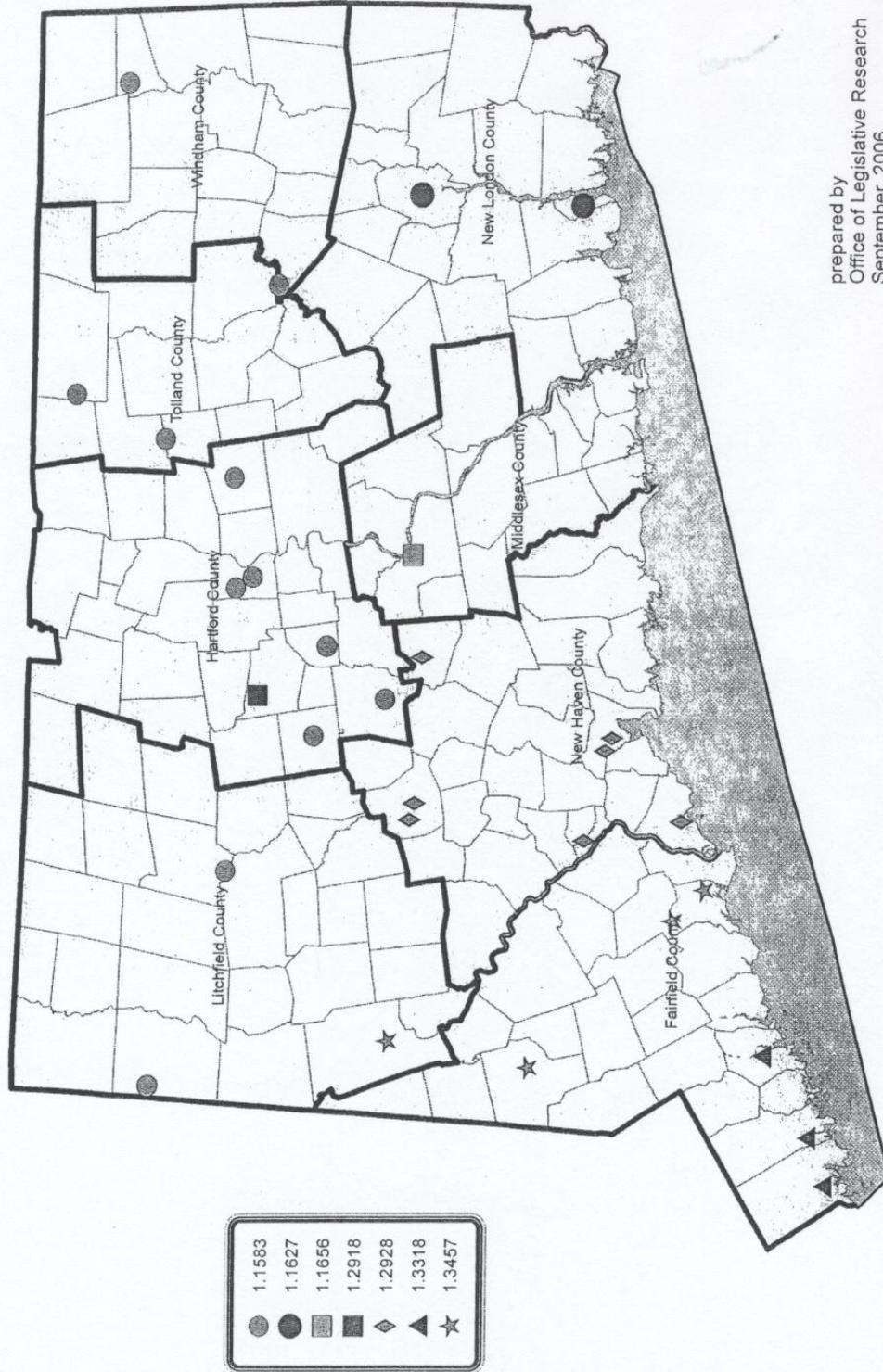
As discussed in Section II, Medicare adjusts its Prospective Payment System (PPS) to consider differences in wages across the country. While all hospitals in Connecticut are given a higher than standard wage index (with 1=standard), there is still considerable variation among Connecticut hospitals in 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 (FY 02-05)		Highest Cumulative % Increase (FY 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



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, PRI staff outlines in the table below 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 1000 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.