

Executive Summary

Funding Hospital Care in Connecticut

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

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

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

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

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

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

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

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

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

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

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

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

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

RECOMMENDATIONS

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

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

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

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

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

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

The Department of Social Services, in its contracts with Medicaid managed care organizations, shall place a cap on the number of emergency room visits per MCO client. The MCO would incur a financial penalty -- \$100 a visit -- for a client who uses the emergency room more than twice in a year when the visit is coded as a non-emergency. DSS should use the encounter and claims data to determine when this occurs and adjust its payments to the MCOs. The penalty adjustments would be pooled and used to supplement funding to hospitals that served those clients.

- 3) The committee recommends maintaining the current outpatient reimbursement structure, but believes the rates should be increased annually. DSS shall adjust the outpatient rates by increases in the Consumer Price Index (urban).
- 4) The committee recommends, however, that, while maintaining the per-service fee schedule, DSS through its payment contractor -- Electronic Data Systems -- ensure that

hospitals (or any other provider) are not over-utilizing certain services per episode to increase outpatient payments. DSS and DMHAS, as payers, should also increase monitoring of payment of inpatient care for their clients to ensure that such care is necessary and appropriate, and could not have been provided on an outpatient basis.

- 5) DSS shall terminate the application of the Medicaid DSH rate adjustment.
- 6) The urban DSH funds should be made available to hospitals with greater percentages of Medicaid discharges rather than limiting funds to hospitals in municipalities with a combination of certain population and economic aspects. At a minimum, four hospitals (Norwalk, Danbury, Mid State and Windham) should be considered for the urban/distressed DSH funds.
- 7) The distribution formula for urban DSH should be re-configured.
- 8) The state should establish a disproportionate share fund available to hospitals serving large percentages of Medicaid clients on an outpatient basis.
- 9) OHCA should prepare a supplemental report that summarizes all information currently filed by hospitals related to provision of service for the uninsured and underinsured. At a minimum, OHCA should conduct analysis that compares hospitals on the basis of size and/or geographical location that leads to conclusions and potential recommendations for policy makers. In particular, OHCA's review for the supplemental report should include, but not be limited to:
 - the general provisions of each hospital's policies regarding free and charitable care including bed funds;
 - the number and approval rates of free and reduced care applicants;
 - access, use, and available level of bed funds; and
 - analysis of charges and costs for free and reduced care.
- 10) While the committee recognizes that Medicaid fee-for-service clients are not in managed care, state agency payers should collect and analyze payment and client utilization data for a number of reasons:
 - determine where Medicaid clients are receiving treatment, and for what conditions;
 - determine whether inpatient care is disproportionately used by a small number of clients;
 - ensure that other state agencies, or those under contract to serve these clients in the community, are providing needed services;
 - conduct a cost-benefit analysis to determine if increasing rates for providers in the community, especially in the psychiatric area, may lessen the need for more intensive and expensive inpatient psychiatric care; and
 - analyze the use of Medicaid inpatient stays for psychiatric care by hospital to determine whether outcomes (e.g., longer periods between episodes requiring

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

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

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

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

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

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

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

- rating outcomes for Connecticut hospitals based on about two dozen common hospital procedures currently evaluated by Health Grades, Inc. (see rationale below); and
- OHCA's estimates of what the hospital's charges and costs for the procedure would be, using patient data OHCA obtains from hospitals and CHIME data, matched with outcome ratings.

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

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

The panel should consist of the following 40 members:

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

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

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

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

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

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

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

- *Strategies to promote increased access to primary and preventive care, especially for Medicaid populations, which should include expanding hours of federally qualified health care clinics.* (In October 2006, approximately \$14 million in state bonding money was approved to expand and improve the facilities of several FQHCs)
- *Encouraging development and approval of health insurance products that lower costs to consumers if they maintain healthy lifestyles.* For example, new policies provide discounts for persons who maintain a body mass index below a certain level. Also, current health care policies seem to emphasize high consumer deductibles and co-pays at the front end, but once the deductible level is reached, the consumer has no financial incentive to consider cost in the health care decision. Perhaps policies could combine lower initial deductibles, with a percentage of overall costs for a consultation, procedure, or diagnostic test borne by the consumer. The consumer would then have a financial interest in knowing and comparing costs.
- *The adequacy of the current level of regulation by the Insurance Department over health insurers and premium rate increases.*
- *Current statutory health insurance mandates and analysis of whether they add to health care costs in Connecticut.*
- *Strategies to assist lower-wage individuals and small businesses pay health insurance premiums.*
- *The current distribution of state Medicaid dollars -- specifically the high proportion to nursing homes.*

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