

FUNDING OF HOSPITAL CARE

- Nationally, Medicaid pays a greater percentage of hospital costs than the program pays in Connecticut. Nationwide, Medicaid paid about 87 percent of hospital costs, while in Connecticut, the Medicaid program reimbursed hospitals for about 73 percent of their costs.
- Nationally, the private payment to cost ratio is 130 percent while in Connecticut it is 120 percent. The fact that the gap in lower government payments (especially Medicaid) has not been shifted to private payers in Connecticut to the extent it has nationally has most likely been a contributing factor to the tenuous financial condition of some Connecticut hospitals.
- The medical assistance underpayments exact varying burdens on hospitals in Connecticut, depending on: the percentage of Medicaid and SAGA populations the hospital serves; whether the services provided are inpatient or outpatient; the hospital's payer mix; and the percentage of costs Medicaid is paying of the hospital's costs.
- For most hospitals -- 22 of the 31 -- the financial impact of medical assistance underpayments was greater than the costs of uncompensated care (free care and bad debt).
- Connecticut's Medicaid Fee-for-Service program reimburses hospitals for inpatient care using target discharge rates that were based initially on 1982 cost reports, and adjusted for inflation in some years, depending on the state budget. Thus, hospitals with lower costs in that initial year have been disadvantaged, because over time the gap between payments and costs has widened.
- Connecticut is one of only six states that continue to set inpatient Medicaid payments to hospitals based on costs. The system favors higher-cost hospitals, and further favors inpatient treatment at those high cost hospitals; does not consider acuity of Medicaid patients, even in a general way; contributes to the poor financial condition of some hospitals; and has prompted a parallel informal "rate exception" process to develop.
- Prior to July 2006, most outpatient fee schedules had not been increased since 2001.
- Emergency room visits have increased about 10 percent for the Medicaid managed care population -- from 70.5 to 77 visits per 100 enrollees -- over the past two years. There may not be a financial disincentive for MCOs to discourage their clients' use of the emergency room and to establish better access to more appropriate care.
- The Medicaid DSH rate adjustment creates a "cliff effect" whereby the few hospitals

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that qualify receive significant increases in their rates. Other hospitals also serving large urban populations (e.g., Hartford and New Britain) have not qualified for the Medicaid DSH adjustment despite growing Medicaid numbers.

- More than half (59%) of the 2006 urban DSH funds are provided to four hospitals (Bridgeport, Hartford, St. Francis, and Yale-New Haven). The existing urban/distressed DSH program definition excludes some hospitals serving similar populations.
- Certain hospitals rely heavily on outpatient revenue and presumably provide a great deal of outpatient services to their communities.
- Overall, there has been a 29 percent increase in total uncompensated care between FYs 03 and 05 with bad debt increasing 14 percent and free care almost doubling (96%) during the same time period.
- A large portion (47%) of the total cost of uncompensated care for the state was borne by the nine urban hospitals in Hartford, New Haven, Bridgeport, and Waterbury.
- There appears to be a number of hospitals with a substantial balance in free bed funds. However, the use of free bed funds for several hospitals is limited because of the restrictions sometimes as a condition of the gift or donation (e.g. available to members of certain groups).
- The information submitted by hospitals on the levels of free and reduced cost care pursuant to P. A. 03-266 is collected for the sole purpose of satisfying the statutory reporting requirements. OHCA does not conduct a statewide overview or comparison of this particular hospital reporting requirement nor make any determinations about the implementation of hospital policies or other mandated activities.
- OHCA should be more than a central repository for health care data. OHCA should extend its analysis to a more comprehensive level and assume a more advisory role to policy makers on health care issues.
- There is significant use of the emergency room by Medicaid and SAGA clients, suggesting that efforts to provide other access to care may not be working.
- There is a gap between where hospital beds are and where emergency room visits are occurring, placing a higher demand on emergency rooms at some smaller hospitals. There is also significant variation in emergency room admit rates, even among hospitals in similar environments, and with similar levels of ER certification.
- The most prevalent inpatient utilization for both the general and Medicaid populations is in for childbirth and labor and delivery services. The second most prevalent inpatient utilization area, both for the general and Medicaid populations, is

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for psychiatric services.

- Connecticut has had a greater percentage of hospitals with negative operating margins than nationally. In six of the last seven years, at least 10 Connecticut hospitals have had negative operating margins.
- Connecticut hospitals are not all similar or equal entities. Hospitals vary by location populations they serve, as well as by size and services offered. They are not all structured similarly, nor do they have equal bargaining power to negotiate with health insurers or compete for privately insured patients. A combination of historical, regulatory, and market forces have shaken the financial foundation of many.
- There is a community expectation that local hospitals will be there for emergency care and basic medical treatment 24 hours a day, but it is clear that for elective procedures or more specialized medical services, patients are going elsewhere. In many cases, the smaller urban and community hospitals have the lowest expenses, but state government cannot mandate where people should go to receive their medical service, and increasingly it is apparent that managed care has not been successful in that either.
- Market forces -- whether inability to compete for scarce nursing and other medical personnel to staff hospitals, or failure to attract enough paying patients to cover hospital expenses -- may result in further consolidations or closures. Hospital consolidation or closure may not bring about lower hospital costs, but only shift utilization to the remaining higher cost hospitals.
- Consumers will need more comprehensive information on health care outcomes and costs if they are expected to shoulder a greater share of the costs, and make informed decisions on where to receive their medical services.
- Some information on health care quality, outcomes and costs is available, but in various locations. State agencies like the Connecticut Insurance Department and the Office of Health Care Access will have to assist in consolidating and reporting the information.
- Hospitals must report their financial and utilization (inpatient) data to the Office of Health Care Access, while other health care providers currently do not. OHCA has had statutory authority to collect outpatient data from other facilities since 1998, but the agency is currently developing regulations to carry this out.
- Health care costs and health insurance premiums are rising much faster than other economic indicators like: gross state product; per capita income; or median worker earnings.

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- Private insurance coverage is decreasing in Connecticut both in terms of persons covered and reduced benefits.
- Factors contributing to higher health care costs in Connecticut that need closer examination are numerous, interconnected, and complicated, and many are beyond the scope and resources of this study.

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 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.**

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

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- 3) **The committee recommends maintaining the current outpatient reimbursement structure, but believes the rates should be increased annually. The committee recommends that DSS adjust the outpatient rates by increases in the Consumer Price Index (urban).**
- 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 its clients to ensure that such care is necessary and appropriate, and could not have been provided on an outpatient basis.**
- 5) **DSS 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:**

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- 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 ten 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:

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- 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

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Association, the state association representing health care plans, and the Connecticut Association of Health Care Facilities; and

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

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

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

- *The state's current nursing shortage* and developing strategies for enhancing the education and supply of nurses. The panel should consult the report issued in October 2005 by the Council of Deans and Directors of Nursing Programs.
- *Strategies to promote increased access to primary and preventive care, especially for Medicaid populations, which should include expanding hours of federally qualified health care clinics.* (In October 2006, approximately \$14 million in state bonding money was approved to expand and improve the facilities of several FQHCs)
- *Encouraging development and approval of health insurance products that lower costs to consumers if they maintain healthy lifestyles.* For example, new policies provide discounts for persons who maintain a body mass index below a certain level. Also, current health care policies seem to emphasize high consumer deductibles and co-pays at the front end, but once the deductible level is reached, the consumer has no financial incentive to consider cost in the health care decision. Perhaps policies could combine lower initial deductibles, with a percentage of overall costs for a consultation, procedure, or diagnostic test 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.*

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