

**TESTIMONY OF  
STEPHEN FRAYNE  
SENIOR VICE PRESIDENT, HEALTH POLICY  
CONNECTICUT HOSPITAL ASSOCIATION  
BEFORE THE  
HUMAN SERVICES COMMITTEE  
Thursday, March 15, 2007**

**SB 3, An Act Concerning Increased Access To Health Care Through The Husky Program**

My name is Stephen Frayne and I am Senior Vice President, Health Policy of the Connecticut Hospital Association (CHA). I appreciate the opportunity to testify on behalf of CHA and its members on **SB 3, An Act Concerning Increased Access To Health Care Through The Husky Program**.

As drafted, SB 3 contains many needed provisions that expand access to healthcare by: raising eligibility limits, increasing outreach, making it easier to enroll, and providing continuous and presumptive eligibility. My testimony will focus on two other aspects of the bill: first, the requirement that SAGA be moved into the Medicaid program; and second, the level of reimbursement proposed.

Current law obligates the Department of Social Services to seek a waiver to permit the movement of SAGA into Medicaid. The waiver request was supposed to have been submitted by March 2004. The proposed bill changes the date from March 2004 to January 2008. We believe this section needs to be a priority. The immediate benefits of such a move are two. First, the state would be able to claim a match for all SAGA expenditures, thereby decreasing for the state the cost of operating the program. Second, it will eliminate Connecticut's current disadvantage in being able to attract federal Medicare DSH dollars into the state.

Many other states have moved their general assistance populations into Medicaid. In so doing, they have helped their state's economy by bringing back more of the state's federal tax dollars in the form of Medicare DSH dollars. By not characterizing SAGA as Medicaid, Connecticut is unable to maximize this source of federal Medicare funding for hospitals, as many other states have done. This is an opportunity we believe Connecticut and hospitals can ill afford to continue to forfeit.

The bill as drafted would require that Medicare rates of payment be adopted for use in the Medicaid program. Adopting Medicare rates would go a long way to bringing the level of payment for those services closer to cost than it has been in a quite awhile, but would still fall short of covering the full cost of the Medicaid program. A Medicare basis of payment is a complicated undertaking and, as such, unlikely to be implemented by October 1, 2007. Paying based on Medicare requires paying based on Diagnosis Related Groups (DRGs) for inpatient services and Ambulatory Patient Classifications (APCs) for outpatients. Annually, Medicare promulgates over a thousand pages of proposed rules regarding these systems.

When setting rates, one has to be constantly mindful of how those rates relate to the underlying cost of service. The last time we calibrated our Medicaid and SAGA rates equal to cost was over twenty-five years ago. Such a calibration is long overdue and is the logical first step in hospital rate reform.

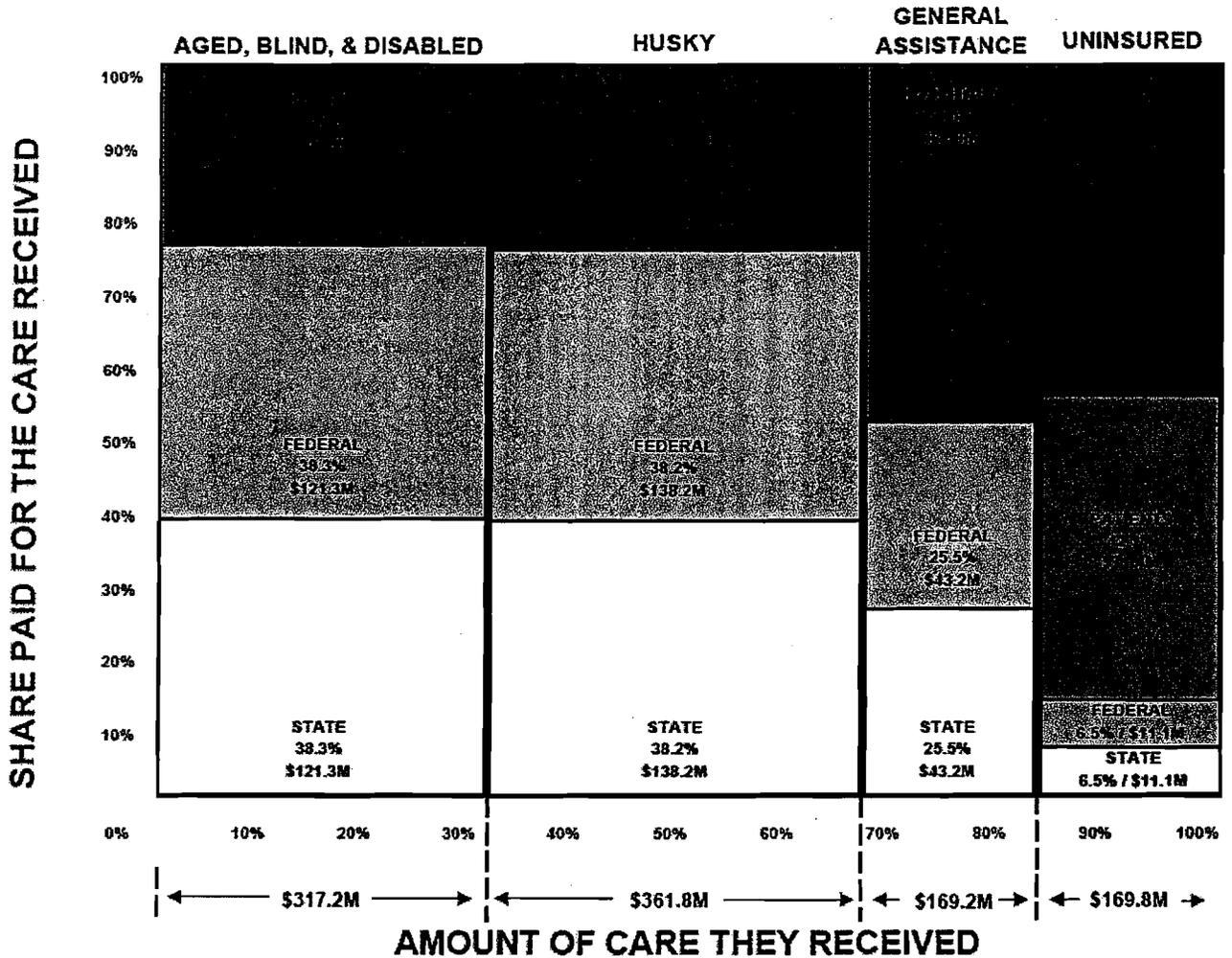
The best independent work available that outlines why hospital rate setting in the Medicaid and SAGA programs needs an overhaul can be found in the Legislative Program Review and Investigations Committee December 18, 2006 report, *Concerning the Funding of Hospital Care*. The Program Review Committee and its staff should be commended for the extraordinary quality and thoroughness of the December 18, 2006 report. The committee documented the mix of revenue sources hospitals rely on to fund services, the adequacy and equity of Medicaid and SAGA rate setting processes, and how those programs impact negatively the financial viability of Connecticut hospitals. The independence of that report lends both credibility and urgency to the need for rate relief for Connecticut hospitals.

While the Program Review Committee report is chock full of detail and analysis, the key takeaways relative to Medicaid and SAGA hospital rate setting are: the current system is broken, the current level of funding is inadequate and needs to be dramatically increased, and rates need to be maintained and updated with annual increases. The importance of this last point can't be understated. In fact, it has been the past failure to maintain and annually increase the rates that has largely put us in the current mess.

For your convenience, I have attached a synopsis of the last twenty-five years of hospital Medicaid rate setting. At the beginning of the time line, hospitals were paid cost. However, during those twenty-five years, the combination of freezes, cuts, and repeals of future promises brought us to the point where today we are losing \$250 million per year.

As the chart below clearly indicates, every year before a hospital plans a new program, hires another nurse, or invests in a quality initiative, it must first figure out how to cover the annual \$250 million dollar deficit caused by state underfunding of its existing insurance programs. Under current law, this is a never-ending and ever growing deficit. Current law freezes existing rates forever.

# WHO PAYS FOR THE COST OF CARE FOR THE UNINSURED AND INDIVIDUALS ELIGIBLE FOR STATE ASSISTANCE



## What should be done?

Hospitals need the legislature to recognize that its fiscal policies dramatically affect the ability of hospitals to succeed in caring for the people of Connecticut.

Hospitals need you to decide that investing in their ability to care for Connecticut is a priority.

Paying hospitals what it costs to serve individuals enrolled in state programs is an investment that makes sense and is long overdue.

For additional information, contact CHA Government Relations at (203) 294-7310.

## Synopsis of 25 Years of Cuts and Freezes

Year	Change	Comment
1982	Paid actual cost for inpatient and emergency room care.....	No loss providing services
	Clinic care was paid at actual cost capped at 150% of the cost for a physician office visit. ....	No loss providing services
1984	PA 84-367: Changed payment from actual to reasonable cost of an efficient provider. ....	Cut
	Added payments for Inpatient Administrative days .....	Increase not implemented
1985	PA 85-482: Reduced the amount allowable for clinic from reasonable cost capped at 150% of the physician fee schedule to 116% of the physician fee schedule. ....	Cut
1987	PA 87-27: Removed from allowable cost expenses related to supporting or opposing unionization. ....	Cut
	PA 87-516: Permitted the Commissioner to pay more for clinic to DSH hospitals up to 175% of physician fee. ....	Increase not implemented
1988	PA 88-156: Permitted the Commissioner to pay more than reasonable cost for DSH hospitals. ....	Increase not implemented
1989	PA 89-297: Reduced Emergency room payment for non-emergency use of the emergency room to the clinic rate. ....	Cut
1991	PA 91-8: Capped the increase in the clinic rate to no more than CPI changes, froze current ED rates except those that decreased. ....	Cut and Freeze
	Reduced by the most recent Medical CPI payments for those outpatient services paid on a cost basis. ....	Cut
1992	PA 92-16: Froze the ED rates for another year except those that decreased..	Freeze
1994	PA 94-5: Reduced by the most recent Medical CPI payments for those outpatient services paid on a cost basis. ....	Cut
	Froze the ED rates for another year except those that decreased. ....	Freeze
	Required a fee schedule to be developed for all outpatient services effective 1/1/1995, froze the fee schedule for 18 months, then required it to be increased to reflect the cost of services. ....	Cut and Freeze
1995	PA 95-306: Limited the application of AND enhanced payments to instances when the patient is not eligible for Medicare.....	Cut
1998	PA 98-131: Beginning 10/1/1998, stopped pegging the annual inpatient inflation increase to Medicare and set it at 3% per annum thereafter.....	Cut

## Synopsis of 25 Years of Cuts and Freezes

1999	PA 99-279: Repealed the 3% inpatient adjustment for all years after 10/1/1998 - granting no increase thereafter.....	Cut
	Repealed outpatient fee schedule updates for 1999 and 2000. ....	Cut
2001	Repealed taxes.....	Increase
	PA 01-3: Increased outpatient fees by 10.5%.....	No new dollars; funded by Reduction to Uncompensated Care Pool
	Increased inpatient to a minimum of 62.5% of cost. If above the minimum no increase. Froze the rates for 2002 and 2003.....	No new dollars; funded by Reduction to Uncompensated Care Pool
2003	PA 03-3: Extended outpatient rate freeze through 2005. ....	Freeze
	Extended inpatient rate freeze to 2004 and 2005. ....	Freeze
2004	PA 04-258: Set minimum inpatient target for 4/1/05 at 3,750, 4/1/06 at \$4,000, 4/1/07 at \$4,250; inpatient rates remain frozen if above minimum. ...	Increase
	Cut SAGA by \$20 million per year.....	Cut
2005	PA 05-280: Delayed increasing the 2006 and 2007 minimum inpatient target for six months. ....	Freeze
	Cut DSH by \$10 million per year.....	Cut
2006	PA 06-188: Repealed the 2007 \$4,250 minimum inpatient target. ....	Cut
	Permitted an inpatient increase for 2006 for institutions not eligible for minimum. ....	Increase not implemented
	Permitted an increase for outpatient clinic rates.....	Increase
	Permitted an increase for outpatient MRI rates. ....	Increase not implemented
	Permitted an increase for outpatient CT SCAN rates.....	Increase not implemented
	Permitted an increase for outpatient ED rates. ....	Increase
2007	<b>Rates frozen in perpetuity. ....</b>	<b>Loss providing service \$250 Million</b>
		<b>Loss grows by more than \$30 Million per year</b>