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**TESTIMONY OF  
PETER J. KARL  
PRESIDENT & CEO  
EASTERN CONNECTICUT HEALTH NETWORK  
BEFORE THE  
APPROPRIATIONS COMMITTEE  
Thursday, February 11, 2010**

**HB 5018, AN ACT MAKING ADJUSTMENTS TO STATE EXPENDITURES  
AND REVENUES FOR THE STATE FISCAL YEAR ENDING JUNE 30, 2011**

My name is Peter Karl. I am the President and CEO of Eastern Connecticut Health Network. I am testifying today in opposition to **HB 5018, An Act Making Adjustments To State Expenditures And Revenues For The State Fiscal Year Ending June 30, 2011.**

For the past two years, Connecticut's hospitals lost more than \$300 million per year due to under-reimbursement for Medicaid and SAGA patients. In addition, non-operating (investment) income fell short of what was expected by over \$620 million. These investments traditionally helped nonprofit hospitals to continue providing quality care to all who walk through our doors, regardless of ability to pay, 24 hours a day, seven days a week year round. The magnitude of these losses is unprecedented. Hospitals have been especially hit hard considering that we face the same ongoing economic hurdles the State must deal with, such as the funding of employee pensions and lost income because of lost jobs. However, unlike the State, we have no way of generating additional revenues. Our estimate is that it will take well over a decade to recover what has been lost.

Finally, since the start of the recession, about 100,000 Connecticut residents have lost jobs and employer-paid health insurance coverage, and the Medicaid and SAGA populations have increased by 75,000; combined enrollment in those programs now stands at about 500,000 – a little more than 14 percent of the state population. Where do you think people without insurance will seek health care? There is a strong correlation between the health of our communities and the health of their local hospitals. Unfortunately, the economic crisis is ravaging the health of our hospitals.

My comments today will be limited to one change in the proposed budget adjustments: cutting the dollars appropriated to raise hospital payments in the SAGA program up to Medicaid payment levels. By doing so, you place an unnecessary economic burden on hospitals. To put it more clearly in dollars, the impact of cutting hospital funding for SAGA from January 1, 2010, through June 30, 2011, will be a loss of almost \$3 million

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to Eastern Connecticut Health Network's two hospitals, Manchester Memorial and Rockville General. **Therefore, we strongly oppose that reduction and urge you to pay Connecticut's hospitals the Medicaid rate for services under the SAGA program as provided for in the budget.**

Currently, SAGA non-hospital providers are paid 100 percent of the Medicaid rate, while hospitals are paid about 43 percent of the Medicaid rate. As of today, the DSS has not taken the administrative steps needed to implement a 1115 waiver for the SAGA program as directed by the legislature and does not plan to do so until July 1, 2011 – a full seven and a half years after first directed by the legislature to do so. In a letter dated January 20, 2010, DSS stated that the further delay is due to the uncertainty created by federal healthcare reform.

The biennial budget passed in September 2009 provided the funding needed to raise hospital SAGA rates up to Medicaid effective January 1, 2010. This new budget makes it clear that DSS will not be implementing existing law in the time frame required. **The funds necessary to raise hospital SAGA rates to Medicaid have been appropriated and will be matched with or without a waiver.** So, let's just start paying hospitals in accordance with the biennium budget at the Medicaid rate for SAGA and finally put hospitals on par with all other providers to the SAGA program. This change can be accomplished by modifying section 17b-192(f) to read:

(f) The Commissioner of Social Services shall [,within available appropriations,] make payments to hospitals for inpatient and outpatient services at the Medicaid rate.[based on their pro rata share of the costs of services provided or the number of clients served, or both.] The Commissioner of Social Services shall, within available appropriations, make payments for any non-hospital ancillary or specialty services provided to state-administered general assistance recipients under this section based on a methodology determined by the commissioner.

Thank you for your consideration of our position.

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