



**TESTIMONY OF
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BEFORE THE
HUMAN SERVICES COMMITTEE
Tuesday, March 15, 2011**

**SB 1013, An Act Implementing The Governor's Budget Recommendations
Concerning Human Services**

My name is Stephen Frayne. I am the Senior Vice President, Health Policy of the Connecticut Hospital Association (CHA). I am testifying today in opposition to **SB 1013, An Act Implementing The Governor's Budget Recommendations Concerning Human Services**.

Before outlining our concerns and reasons for opposing this proposed bill, I'd like to talk about the members of the Connecticut Hospital Association—Connecticut's not-for-profit hospitals—and the critical role they play in the health and quality of life of our communities. Our state's hospitals are more than facts and figures, and dollars and cents—hospitals, at their core, are all about people. All of our lives have, in some way, been touched by a hospital: the birth of a child... a life saved by prompt action in an emergency room... the compassionate end-of-life care for someone we love. Or, perhaps, our son, daughter, husband, wife, or friend works for, or is a volunteer at, a Connecticut hospital.

Hospitals are essentially people taking care of people. Each year, the 52,300 people employed in Connecticut's hospitals care for more than 430,000 people admitted to their facilities, treat nearly 1.6 million people in their emergency rooms, and welcome more than 38,000 babies into the world. We provide care to all people regardless of their ability to pay—in fact, every three minutes someone without health insurance comes to a Connecticut hospital in need of inpatient, emergency, or outpatient surgical services. And, we do this 24 hours a day, seven days a week, 365 days a year.

Every day, we see the consequences and health implications for individuals and families who lack access to care and coverage. Our emergency rooms are filled with individuals who cannot find a physician to care for them because they are uninsured or underinsured – or they are Medicaid beneficiaries and few physicians will accept the low rates paid by Medicaid. Our emergency rooms are treating both those who have delayed seeking treatment because of inadequate or no coverage and those who have no other place to go—our hospitals are their healthcare safety net.

Thus, as front line caregivers, Connecticut hospitals are absolutely committed to initiatives that improve access to high quality care and expand health insurance coverage. We stand ready to be partners in solutions to create a system of healthcare coverage that ensures access to care for all residents. Such a system must ensure seamless care that is affordable to individuals and families and is sufficiently financed. The ultimate goal is a healthier Connecticut—this can be accomplished by establishing a healthcare system through which coverage is affordable and sustainable, and access to care is guaranteed.

SB 1013 imposes a hospital tax of 5.5 percent, which increases to the maximum allowable under federal law after September 30, 2011. Let's be clear that this tax is a cut to hospitals—it takes \$267 million from hospitals and, as the administration asserts, “in the aggregate return all the money.” However, this assertion misses the obvious – hospital care for patients occurs locally, not in the aggregate – and when funding for services at the local level is cut, that cut hurts the ability to provide hospital care in that community. Unfortunately, our analysis (attached) shows that the combination of eliminating uncompensated care funds and imposing a hospital tax results in every single hospital in Connecticut experiencing a financial loss—and let's not forget that the ones who lose the most are our communities, our patients, and those who rely on hospitals as their safety net.

Unfortunately the proposed state budget cuts \$83 million in funding from the Uncompensated Care and DSH pools, in addition to the imposition of a 5.5 percent tax on hospitals, and makes a number of other reductions and changes to the Medicaid program that will negatively affect hospitals and the people they serve. In fact, these budget actions threaten hospitals' significant role as today's safety net and seriously jeopardize our ability to invest in tomorrow. Therefore, we would ask that you oppose this bill as it relates to the imposition of the hospital tax and the reduction in hospital funding.

I'm sure, by now, many of you are uncertain what to believe regarding the impact SB 1013 and the state budget would have on hospitals. On the one side, you have the administration suggesting that hospitals will be more than fine because of the increased funding they are receiving from the conversion of State Administered General Assistance (SAGA) to Medicaid for Low Income Adults (MLIA). On the other side, you have hospitals saying no way, not even close—a cut of existing uncompensated funding, plus a tax, will be devastating.

What I would like to do in the time allotted is to provide some clarity on the question about hospitals' financial condition vis à vis SAGA and MLIA and offer more details about the effect that the proposed budget package will have on hospitals.

As many of you may know, for several decades prior to January 1, 2004, the state reimbursed hospitals for services delivered to SAGA patients at the Medicaid rate. In 2003, in response to budget pressures, the legislature enacted some changes to SAGA funding. In brief, the legislature reduced funding for the SAGA program by about 20 percent and capped expenditures for the program but not enrollment. Three caps were established: one for hospital services, another for pharmacy, and another for all other providers, such as Federally Qualified Health Centers, physicians, etc. When the legislature imposed the 20 percent cut and cap on expenditures, the SAGA program covered about 27,500 people.

In the time between January 1, 2004, and March 31, 2010, several things happened. First, the number of individuals enrolled in SAGA grew by 61 percent to 44,200. Second, the caps on pharmacy and all non-hospital providers were effectively removed, resulting in those providers being paid the Medicaid rate without reduction. Third, the cap on hospital services remained in force and didn't grow to keep pace with the increase in enrollment—as a consequence, the hospital payment reduction for SAGA patients grew from 20 percent of Medicaid to nearly 60 percent of Medicaid in 2010. By 2009, hospital losses on care they provided for SAGA patients were nearly \$150 million per year.

Last year, the legislature and the Rell administration converted SAGA patients to MLIA primarily to address the state deficit—this action led to nearly \$40 million per year in federal funding being leveraged to help address the state budget gap. However, to obtain the \$40 million in federal funds, the state could no longer pay hospitals and other providers less than the Medicaid rate for services. Thus, the budget anticipated an increase in funding for hospital services of about \$66 million per year to bring payment for SAGA hospital medical services up to the amount required by Medicaid. The previous administration and the legislature were willing to make that investment and expand Medicaid entitlement—in particular, because, even **after** accounting for the increased expenditures for hospitals and others totaling about \$91 million per year, the state deficit would be reduced by about \$40 million per year.

There were and are three key benefits to moving SAGA into Medicaid: patients were helped because access to needed medical care for this population improved; the state benefited because making all state expenditures for SAGA eligible for a federal match helped reduce the state deficit; and hospitals were helped because their losses for serving SAGA patients were moderated slightly.

To help put hospital losses in context, below is a table that shows Medicaid enrollment and hospital losses serving Medicaid patients. As can be seen from the table, enrollment in Medicaid and SAGA and their related hospital losses have been growing exponentially, and will continue to do so. By 2014, the low-end estimate is that hospital losses will more than double to \$749 million per year. The high-end estimate is that hospital losses will nearly triple to \$924 million per year. The low-end estimate assumes enrollment in Medicaid stays right about where it is today – those leaving the program as they regain jobs with employer-sponsored insurance are replaced with those who join because of expanded eligibility. The high-end estimate assumes enrollment around 664,000 – no reduction in current enrollment due to a jobless recovery and an addition due to expanded eligibility. Neither result is sustainable.

	Enrollment				Hospital Losses		
	SAGA	FFS	MCO	Total	FFS + MCO	SAGA	Total
2004	27,509	93,699	298,328	419,536	\$(130,638,000)	\$(74,309,000)	\$(204,947,000)
2009	37,288	104,610	331,213	473,111	\$(211,538,000)	\$145,726,000	\$(357,264,000)
1/2011	59,652	106,947	391,054	557,653			
2014				538,000 to 664,000			\$(749,000,000) to \$(924,451,000)

It is not appropriate or fair to suggest that paying hospitals the Medicaid rate for MLIA patients should be counted as an increase or that hospitals can well afford to absorb cuts – particularly when one considers that paying the Medicaid rate for MLIA patients was done primarily as way to help reduce the state deficit.

We are grateful that the losses we were experiencing in the SAGA program have shrunk somewhat and proud to have been part of an effort to help reduce the state deficit. However, we don't believe either of these can or should be used as justification for the proposed budget package of cuts and taxes that will negatively impact hospitals. These budget cuts include:

- eliminating \$83 million in funds for the Uncompensated Care and Disproportionate Share pools.
- cutting \$1.1 million in funding for certain hospital outpatient services.
- reducing non-emergency dental services for adults under Medicaid. This \$9.8 million will impact hospitals that may be the community's only dental provider that accepts Medicaid patients.
- imposing cost sharing requirements for certain individuals receiving Medicaid services. The accompanying \$8.3 million reduction in state funding will also negatively impact hospitals.
- reducing grants from the Department of Mental Health and Addition Services for uncompensated care in FQHCs.
- eliminating funding for the LifeStar program.

In our opinion, we can and should do better. We have outlined in the [\(attached\)](#) Medicaid Modernization brief an alternative approach that improves the care and value for patients, reduces the state deficit, materially reduces the cost shift to Connecticut businesses and workers, and makes it possible for Connecticut hospitals to remain strong and viable in their role as Connecticut's healthcare safety net.

Thank you for considering our position.

CHA Analysis of the Impact of Cutting \$83.275 Million in Existing DSH Funding and Imposing a Redistributive Provider Tax

	A	B	C	D	E
	Projected Tax FY 2012	DSH Allotment Based on a Pool of 266.6 Million	DSH Allotment Less Provider Tax	Less Current DSH Funding	Impact of Cuts to DSH and a Provider Tax
			(B - A)		(B - A - D)
WILLIAM W. BACKUS HOSPITAL	9,864,284	10,476,055	611,771	(2,032,535)	(1,420,764)
BRIDGEPORT HOSPITAL	11,484,454	16,847,560	5,363,107	(6,742,809)	(1,379,703)
BRISTOL HOSPITAL	4,100,856	3,319,301	(781,556)	(644,002)	(1,425,557)
HOSPITAL OF CENTRAL CONNECTICUT	12,013,548	8,949,930	(3,063,618)	(3,816,261)	(6,879,879)
CONNECTICUT CHILDREN'S*		-	0	0	0
DANBURY HOSPITAL	16,709,098	12,603,494	(4,105,604)	(2,445,295)	(6,550,899)
DAY KIMBALL HOSPITAL	3,276,258	2,372,391	(903,867)	(460,285)	(1,364,152)
JOHN DEMPSEY HOSPITAL*		-	0	0	0
GREENWICH HOSPITAL	10,790,613	5,069,828	(5,720,785)	(983,634)	(6,704,419)
GRIFFIN HOSPITAL	3,529,597	2,763,458	(766,139)	(536,159)	(1,302,298)
HARTFORD HOSPITAL	22,927,516	20,900,552	(2,026,964)	(8,829,048)	(10,856,011)
CHARLOTTE HUNGERFORD HOSPITAL	2,621,645	2,774,128	152,483	(538,229)	(385,746)
JOHNSON MEMORIAL HOSPITAL	2,352,039	-	(2,352,039)	0	(2,352,039)
LAWRENCE & MEMORIAL HOSPITAL	9,941,487	8,811,245	(1,130,242)	(1,709,533)	(2,839,776)
MANCHESTER HOSPITAL (ECHN)	5,544,493	2,664,312	(2,880,180)	(516,923)	(3,397,103)
MIDDLESEX HOSPITAL	10,736,832	9,097,512	(1,639,321)	(1,765,074)	(3,404,395)
MIDSTATE MEDICAL CENTER	5,848,165	5,588,275	(259,890)	(1,084,222)	(1,344,112)
MILFORD HOSPITAL	2,363,912	2,007,893	(356,019)	(389,566)	(745,585)
NEW MILFORD HOSPITAL	3,340,361	1,238,584	(2,101,777)	(240,307)	(2,342,084)
NORWALK HOSPITAL	11,027,618	12,966,773	1,939,155	(2,515,778)	(576,622)
ROCKVILLE HOSPITAL (ECHN)	2,114,082	1,592,994	(521,088)	(309,068)	(830,156)
ST. FRANCIS HOSPITAL	17,063,918	20,827,834	3,763,916	(7,490,215)	(3,726,299)
SAINT MARY'S HOSPITAL	5,300,530	6,448,142	1,147,612	(2,936,763)	(1,789,151)
HOSPITAL OF ST. RAPHAEL	12,404,828	10,598,659	(1,806,169)	(4,164,291)	(5,970,460)
ST. VINCENT'S MEDICAL CENTER	9,855,474	11,346,739	1,491,265	(4,645,583)	(3,154,319)
STAMFORD HOSPITAL	16,138,843	17,490,442	1,351,600	(5,671,976)	(4,320,376)
WATERBURY HOSPITAL	6,690,563	7,217,342	526,778	(3,047,917)	(2,521,138)
WINDHAM HOSPITAL	2,566,357	2,567,009	651	(498,044)	(497,393)
YALE-NEW HAVEN HOSPITAL**	44,445,481	58,929,341	14,483,860	(19,042,205)	(18,997,522)
ESSENT-SHARON HOSPITAL	1,547,150	1,130,208	(416,942)	(219,280)	(636,222)
TOTAL	266,600,001	266,600,000	(14,439,179)	(83,275,000)	(97,714,179)

* The tax does not apply to these providers

** Gain / (Loss) impacted because UPL currently does not recognize inpatient Medicaid losses.

Modernizing Medicaid: SOLUTIONS FOR BUILDING A BETTER, HEALTHIER CONNECTICUT

Connecticut faces an *unprecedented state budget crisis*, but Connecticut hospitals have developed a package of *workable, practical solutions for modernizing Medicaid* – turning this crisis into an opportunity for improving access to care, creating a Medicaid system that better focuses on quality and efficiency, while reducing the state deficit.

A combination of short- and longer-term structural changes to modernize Connecticut's Medicaid program will build a better, healthier Connecticut. We urge the Governor and legislature to include the following elements in the 2012-13 budget:

Improve access to physicians and primary care for Medicaid patients

- **Raise Medicaid physician rates to Medicare levels and allow hospitals to bill for physician services provided. Effective January 1, 2013.** This can be done with no cost to the state by taking advantage of increased federal matching funds for primary care physicians and by converting some current Disproportionate Share Hospital payments into Medicaid rate increases for physicians. Raising payment rates and attracting more physicians to participate in Medicaid will ensure that patients have access to more consistent, coordinated care, resulting in better health outcomes – and also help to ensure that hospital Emergency Departments are focused on providing critical emergency care, not congested by patients without other options in a system that doesn't work properly.

Cost to the state budget: \$0

Combining short- and longer-term structural changes to modernize Connecticut's Medicaid program will:

- Improve access to care for Medicaid patients;
- Create an up-to-date Medicaid payment system that better focuses on quality, efficiency, and safety; and
- Reduce the state deficit.

Reduce the state deficit

- **Implement existing Medicaid law** (to move from current managed care contracts, a change that was passed in 2010 and included in current budget planning, but not implemented), and apply medical management to all Medicaid populations. **Effective July 1, 2011.** Estimated savings include \$60 million from medical management and \$60 million in administrative savings. Savings to the state budget: \$60 million annually
- **After using \$60 million in savings to help the state budget, reinvest the remaining \$60 million of savings, plus \$35 million from current Disproportionate Share Hospital payments, to begin to modernize the hospital payment system** by raising physician rates and beginning the transition process to a DRG system (discussed below). **Effective July 1, 2011.** Cost to the state budget: \$0
- **Introduce a gain-sharing element that encourages effective, coordinated patient care management.** This puts a portion of new hospital funding "at risk" and ensures that hospital and state incentives are aligned. **Effective July 1, 2011.** Cost to the state budget: \$0
- **Align the state's Medicaid program with health reform guidelines** by enrolling in private insurance those Medicaid patients with incomes eligible for federal subsidies in the new Health Insurance Exchange. **Effective January 1, 2014.** The shift of patients from Medicaid to private insurance will result in significant savings: even assuming the state pays all out-of-pocket costs to keep beneficiaries whole and invests an additional \$250 million in hospital rates and modernization, the state would still see an enormous return. Savings to the state budget: \$229 million annually

Create an up-to-date Medicaid hospital payment system that better focuses on quality, efficiency, and safety

- **Converting to a Diagnosis Related Group (DRG) system**, such as that used by Medicare (and nearly all other states for their Medicaid programs), **creates the foundation for a system that can also reliably measure quality, efficiency, and safety. Implementation to begin in 2011.**

Replacing Connecticut's outdated TEFRA target system (which does not connect payment to specific care provided), with a DRG system would provide a manageable, appropriate way to relate the resources needed by specific patients with the payments hospitals receive for caring for those patients.

Cost to the state budget: \$0

These are actionable solutions that will enable Connecticut hospitals to continue providing top quality care to patients across the state. They don't require legislation or a federal waiver. They are solutions that improve the care and value for patients, dramatically reduce the state deficit, materially reduce the cost shift to Connecticut businesses and workers, and make it possible for Connecticut hospitals to remain strong and viable in their role as Connecticut's healthcare safety net.

An effective Medicaid program must:

- Offer quality options for patients
- Provide high value and collaboration between providers
- Fully leverage available federal dollars
- Align provider incentives with program goals
- Provide adequate payment to providers through a modern reimbursement system

Connecticut hospitals stand ready to be actively engaged partners in building a financially sound Connecticut, supported by a dynamic, job-generating economy, and an innovative, compassionate healthcare system that meets the needs of all Connecticut residents.



Contact **CHA**
for more information

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