



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

TESTIMONY PRESENTED BEFORE THE COMMITTEE ON PUBLIC HEALTH March 23, 2011

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Senate Bill 1184 - An Act Concerning Health Care Facilities

The Department of Public Health supports Senate Bill 1184

The Department of Public Health thanks the committee for choosing to take up the department's proposal. Below is information on the provisions contained in the bill.

Section 1

This section makes a technical correction to clarify the definition of "institution" under the statutes.

Section 2

This section grants the Department the authority to impose civil money penalties not to exceed \$25,000 for hospitals and \$3,000 for institutions other than hospitals, residential care homes, nursing homes and rest homes for each violation in any provision of the CGS or any regulation of the Public Health Code or the State Fire Code.

- Factors to assist in determining the amount of civil penalty and hearing rights are specified.
- Currently CGS sections 19a-524, 19a-525, 19a-526, 19a-527 and 19a-528 provide the Department the authority to impose citations and civil penalties when a nursing home facility (defined in 19a-521) has violated specific sections of CGS. Class A violations which present an immediate danger of death or serious harm may be imposed a civil penalty of not more than \$5,000 and Class B violations which present a probability of serious harm in the reasonably foreseeable future may be imposed a civil penalty of not more than \$3,000 as directed in CGS section 19a-527. This Section extends that authority to other licensed providers, including hospitals, allowing the Department consistency in enforcement remedies.

Section 3

This section enhances disciplinary remedies that could be taken when substantial noncompliance with state laws and regulations have been identified, and includes:

- Directed Plan of Correction (DPOC): This is a very valuable tool that the Department's Facilities Licensing and Inspection Section (FLIS) has utilized successfully when imposing federal remedies related to deficiencies with Medicare Regulations, which FLIS would like to extend to its state remedy actions. In calendar year 2010, a DPOC was utilized as an interim remedy rather than a consent order with two hospitals when a singular significant failure was identified that resulted in a significant outcome. FLIS engages in a deliberative discussion regarding a DPOC versus a consent order as it relates to the substantial failure identified, utilizing the Consent Order for system failures and hospital-wide issues.
- Imposition of a civil penalty enhances the current list of disciplinary remedies available.

Section 4

This section speaks to licensure and inspection fees associated with health care institutions. In an effort to be consistent with all other institutions, FLIS has proposed licensure fees for Home Health Care Agencies, Homemaker-Home Health Aide Agencies and Assisted Living Services Agencies. This proposal is a revenue enhancement. There are currently 98 licensed home health care agencies, 6 homemaker-home health aide agencies and 84 assisted living services agencies. This has the potential for new revenue of \$36,600 annually.

Section 5

This section addresses the fees associated with the technical assistance provided for the design, review and development of an institution's construction, sale or change in ownership. The current fee (\$565.00) associated with the technical assistance is not consistent with the scope and complexity of the review and assistance provided for a large number of the projects. In calendar year 2009, the Department reviewed twenty-two plans which included four hospital projects. One such hospital project, which was a multimillion dollar project requiring several reviews and inspections by multiple inspectors for several days, and was assessed a fee of \$450.00. In calendar year 2009, the Department collected \$10,245.00 for these twenty-two plan reviews. In calendar year 2010,

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the Department has reviewed thirty projects inclusive of five hospital projects (multimillion dollar projects) with \$16,950.00 collected in fees to date. Review of the fee schedule in several other states identified in part, that fees were assessed based on a percentage of the total project cost and/or the number of reviews and on-site inspections required for approvals of project completion and/or whether the project was an existing renovation or new construction.

Sections 6-10

This section provides a graduated late fee for assessment payments made to the Office of Health Care Access (OHCA) after the due date and Section 7 incorporates the late fees into the civil penalty section of OHCA's statutes. Section 8 makes a technical change which defines hospital for the new sections proposed under sections 9 and 10 of the Bill. Section 9 will allow hospitals to pay OHCA Funding assessments via electronic funds transfer (EFT). Finally, Section 10 requires hospitals to file a statement of operations and certain utilization statistics with OHCA on a quarterly basis.

The proposed graduated late fee for assessment payments made after the due date should provide hospitals the incentive to pay the assessment in a timely manner. These proposed percentage increases mirror late payment penalties which DRS imposes pursuant to General Statutes § 12-687. The current late fee structure imposes a \$10 late fee per quarterly assessment period and one and a quarter percent interest per-month for each month the payment is late. Therefore, if a hospital makes payment two days late, ten days late or twenty-two days late, there is currently no difference in the penalty and no incentive to pay the assessment in a timely manner. Under the proposed language in Section 6, however, if an assessment payment is two days late, the hospital is charged a late fee of 2% of the assessment, if the payment is made ten days late the hospital is charged a late fee of 5% of the assessment and if payment is made twenty-two days late, the hospital would be charged a late fee of 10% of the assessment. OHCA anticipates that the graduated late fee will ensure greater compliance with statutory deadlines and result in expediting the revenue collection process for OHCA funding.

The proposal to allow hospitals to make assessment payments via EFT would streamline and modernize OHCA's administrative efforts in the collection of these funds and would be more convenient for hospitals. Payment of hospital assessments via EFT would convert the deposits of these payments to a paperless system and improve the timeliness of these payments, especially by avoiding delays from having the assessment payment checks being mailed to the wrong address, for example. This process will also expedite the deposits of payments to the general fund.

Section 10 of the Bill would require hospitals to file a statement of operations and utilization statistics on a quarterly basis, which will provide OHCA with a small number of performance indicators or measures in order to see more immediate financial and utilization performance results, and allow OHCA to publish a dashboard of financial indicators quarterly. This change will allow OHCA to provide the public and policy makers with the most current information on the financial performance of Connecticut's hospitals.

OHCA currently receives substantial financial data and information on an annual basis from Connecticut's acute care general hospitals and children's hospital pursuant to state statute and regulation. OHCA utilizes this data to publish an annual acute care hospital financial stability report, to publish various briefs or fact sheets, to calculate and recommend to DSS the allocation of DSH payments among the hospitals, to calculate the allocation of the OHCA Funding Assessment amounts among the hospitals as OHCA is an industry-funded division, to support the Certificate of Need process, and also to support Facility Planning efforts which OHCA is undertaking. However, OHCA receives this annual data, by law, five to six months after the end of the hospital fiscal year.

Given the rather dynamic and fluid nature of hospital finances, OHCA wants to enhance data reporting efforts and collect some information on a quarterly basis. Currently, OHCA is unable to know, and therefore not able to inform policy makers of early indications of trends in performance, on a hospital-specific, regional or statewide basis. The data elements which OHCA will request will be limited and will include amounts for operating and non-operating revenue; various expenses such as interest expense and depreciation; current assets and liabilities; discharges; patient days; staffed beds; average daily census and case mix index. This information measures profitability, liquidity, solvency and hospital utilization.

Other states currently collect quarterly data from hospitals. For example, the Division of Health Care Finance and Policy, a division of the Massachusetts Office of Health and Human Services, collects and publishes quarterly financial performance indicators or measures for Massachusetts hospitals. That division publishes quarterly results on their website but makes it clear to the reader that the filings are based on the hospitals' unaudited internal financial statements. The state of Washington also collects quarterly data in conjunction with that state's hospital association via a memorandum of understanding. In Washington, the collection of quarterly data is a cooperative effort between the state and the hospital association and both have administrative rights on the system and can configure reports. OHCA's reporting of the quarterly data would be similar to that of Massachusetts and it would be clear that the information is based upon unaudited financial statements.

Thank you for your consideration of the Department's views on this bill.

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