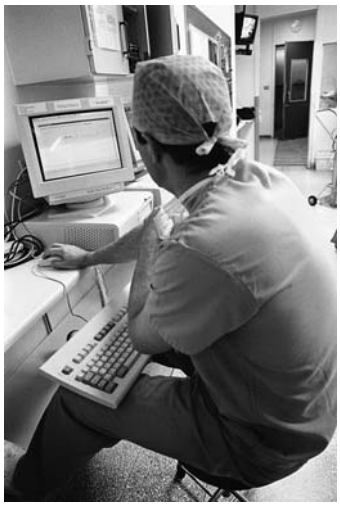
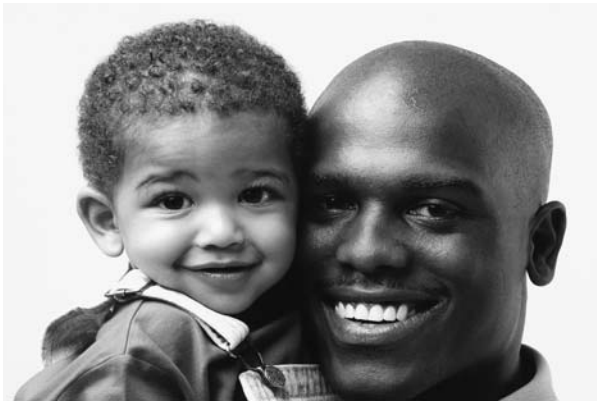
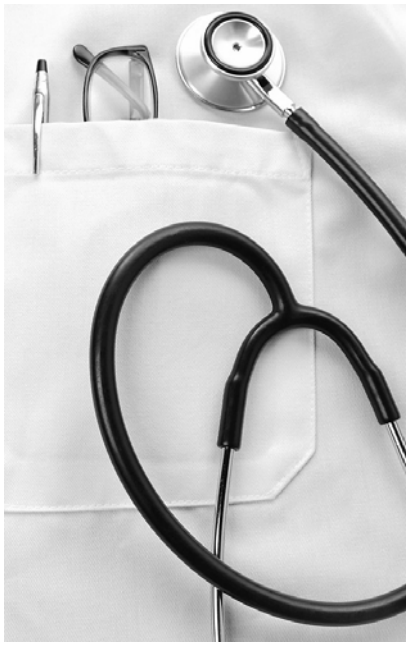
The Office of Health Care Access

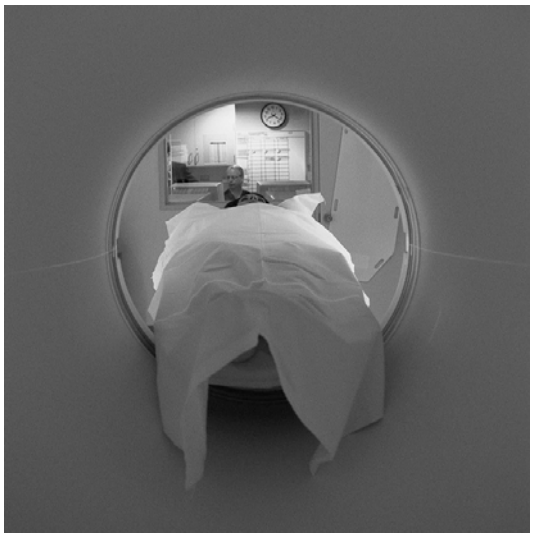
Annual Report

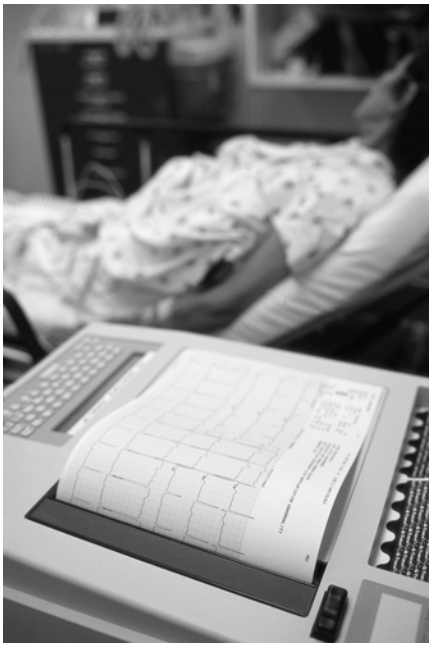
To the Governor and Legislature











April 2008

Commissioner's Message

In 2007, the Office of Health Care Access (OHCA) continued its ongoing efforts to examine and improve the state's health care system. Whether through the agency's participation on the Governor's Hospital System Strategic Task Force, conducting its numerous Certificate of Need activities, improving and updating the agency's hospital financial reporting system or expanding data collection to facilitate data-driven policy making, OHCA is committed to ensuring access to a quality health care system for all of Connecticut's citizens.

Among OHCA's 2007 activities were:

- *Co-chairing Governor Rell's Hospital System Strategic Task Force, charged with developing strategies to stabilize and chart the future course of hospitals in Connecticut. In a report submitted to the Governor, the task force examined the current financial health of Connecticut's hospitals, access to care, emergency room utilization, affordability, alternative delivery of primary care and the Certificate of Need process. The task force provided recommendations that would stabilize the health care delivery system in Connecticut with respect to workforce challenges, access limitations and fundamental financial structural issues*

- *Administering the Certificate of Need (CON) program -- issuing 62 decisions, 41, determinations, 27 modifications and 19 waivers. Many CON actions reflected several major trends: hospitals and physician offices acquiring new and replacement imaging equipment, hospitals seeking to establish and operate freestanding services, providers moving services from town to town or changing ownership, and hospitals undertaking major building or renovation project. CON action also involved addressing emergency department crowding by children requiring mental health evaluations.*

- *Contracting to develop and implement a new Hospital Reporting System database application to replace the agency's existing Hospital Budget System database. The new reporting system will facilitate more efficient data entry by the hospitals and give OHCA the ability to create more useful reports for financial and statistical analysis.*

- *Convening an Outpatient Data Advisory Committee, consisting of representatives from hospitals, free-standing ambulatory surgical centers, psychiatric hospitals and community health centers to begin informal discussions regarding the industry's perspective on outpatient data collection and reporting. The collection of outpatient data will give OHCA the ability to identify any gaps or other access issues that exist in the outpatient delivery of care system.*

This annual report presents an overview of many of the agency's Certificate of Need, Financial Analysis and Research and Planning activities in 2007.

Health Care Access

Certificate of Need (CON) Program

Through the administration of the CON program for hospitals, surgical facilities and other health care facilities, OHCA ensures service accessibility for citizens while regulating duplication or excess capacity of services. In 2007, OHCA issued **62** CON decisions, **41** CON determinations, **27** CON modifications, and **19** CON waivers. Figures 1 and 2 below illustrate 2007 CONs by type.

Figure 1: CONs and Waivers by Category (%)

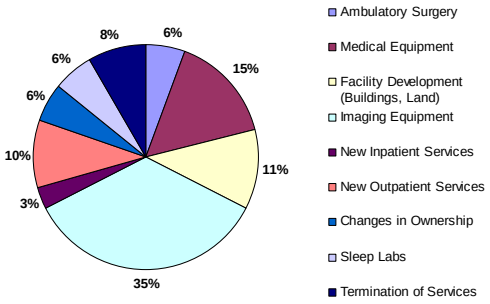
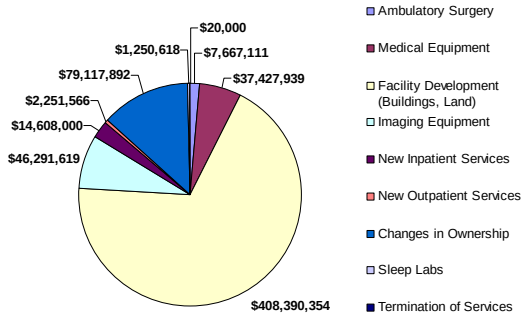


Figure 2: CONs and Waivers by Category ($)



Four major trends are reflected in OHCA's 2007 CON actions: (1) hospitals and doctors' offices continuing to acquire new and replacement imaging equipment; (2) hospitals seeking to establish and operate freestanding services and/or develop collaborative relationships in their communities; (3) providers seeking to improve access by moving services from one town to another or changing ownership from one provider to another; and (4) providers, particularly hospitals, undertaking major building or renovation projects. An additional item of interest in 2007 was the issuance of a Declaratory Ruling regarding the i-CAT Cone Beam Dental Imaging System.

In 2007, Connecticut hospitals and physicians continued to acquire and upgrade imaging and other major medical equipment. As in 2006, the number of imaging proposals received by OHCA was driven by the statutory change requiring that any provider acquiring a CT scanner, PET scanner, PET/CT scanner, MRI scanner, cineangiography equipment, a linear accelerator or other similar equipment, regardless of the cost, requires CON authorization. In 2007, OHCA authorized the replacement of one CT scanner and one MRI, along with the acquisition of three MRIs and five CT scanners/simulators, in order to improve diagnostic capability and quality of care, and/or because they were operating at equipment capacity. OHCA denied the acquisition of four MRIs, one CT scanner, and a mobile PET-CT scanner, due to a lack of supporting documentation and insufficient evidence substantiating the need for the proposed acquisitions.

Hospitals also continued to purchase advanced technology to meet demand and improve quality for their cancer, cardiac, and other patients, and the number of proposals was noteworthy considering that the threshold for acquisition of major medical equipment is $3 million. Among the proposals approved by OHCA, The Stamford Hospital and the Hospital of Saint Raphael were each authorized to acquire and operate a Cyberknife system, and the Hospital of Central Connecticut was authorized to acquire and operate a Stereotactic Radiosurgery System.

The trend of hospitals seeking to establish and operate freestanding services and/or develop collaborative relationships with physician groups and other providers continued in 2007. For example, four Connecticut hospitals--Johnson Memorial Hospital, Manchester Memorial Hospital, Rockville General Hospital, and Windham Community Memorial Hospital--proposed a joint venture to establish a comprehensive freestanding imaging center in Tolland. Although finding that the proposal would improve the accessibility and quality of imaging services, OHCA was concerned about the impact of conservative CT and MRI volumes on the center's financial viability, and therefore conditionally authorized the center as a three year demonstration project.

Another significant collaborative relationship in 2007, the Child and Adolescent Rapid Emergency Stabilization (CARES) Program, was proposed jointly by Hartford Hospital and Connecticut Children's Medical Center. OHCA authorized this program in order to improve access and alleviate emergency department backlogs by providing an alternative level of care to children in a psychiatric crisis who can be rapidly stabilized.

In 2007, Hospitals worked collaboratively with physicians to develop endoscopy centers designed to alleviate capacity issues at existing facilities. Greenwich Hospital was authorized to terminate its services at The Endoscopy Center of Greenwich Hospital and establish a joint venture freestanding gastroenterology center with physicians at the same location. OHCA authorized the following new freestanding endoscopy centers:

- Evergreen Endoscopy Center, LLC, a partnership between the Eastern Connecticut Health Network and physicians, established a center in South Windsor;
- Glastonbury Endoscopy Center, LLC, a partnership between Hartford Hospital and physicians, established a center in Glastonbury; and
- Saint Francis GI Endoscopy, LLC, a partnership between Saint Francis Hospital and Medical Center and physicians, established a center in Windsor.

Not all proposals demonstrated need for additional freestanding and/or collaborative services, however. The William W. Backus Hospital and Constitution Eye Surgery Center East LLC were denied the establishment of an outpatient surgical facility in Waterford due to lack of sufficient documentation of public need and the existing capacity for outpatient surgical procedures in the area. The Hospital of Saint Raphael was denied the establishment and operation of an emergency service satellite in North Haven due to lack of sufficient evidence demonstrating the cost-effectiveness of the proposal for the consumers of the service.

The termination and establishment of health care services also continued to be prevalent in 2007, as providers sought approval to move services from one town to another, change ownership from one provider to another, or terminate services altogether. In order to improve access to the community served, two hospitals were authorized, under four CON decisions, to terminate sleep laboratory services in one town and establish the same services with additional beds in another service area town. These were Johnson Memorial Hospital, which was authorized to terminate sleep laboratory services in Stafford Springs and establish the same services in Enfield with two additional beds, and Gaylord Hospital, which was authorized to terminate sleep laboratory services in Fairfield, New Haven, Wallingford, and West Hartford, and establish the same services in Glastonbury, North Haven, and Trumbull. Gaylord was not authorized for the full complement of requested beds at the Glastonbury site, due to lack of documentation of need.

The termination and establishment of health care services also continued to be prevalent in 2007, as providers sought approval to move services from one town to another, change ownership from one provider to another, or terminate services altogether.

The accessibility of health care services was maintained or improved in 2007 with the change in ownership or termination and transfer of services to entities with expertise in a particular industry or with a particular patient population:

- HEALTHSOUTH Corporation was authorized to terminate its ambulatory surgery division in Connecticut and transfer the centers to ASC Acquisition LLC;
- HEALTHSOUTH Corporation was authorized to terminate 32 outpatient rehabilitation centers and transfer the centers to Select Medical Corporation;
- The Stamford Hospital was authorized to terminate four ambulatory care clinics and transfer them to Optimus Health Care, Inc.;

- Stamford Health System, Inc. was authorized to terminate long-term care services in Stamford and transfer the service to Mill River Foundation, Inc.; and
- Rushford Center, Inc. was authorized to terminate its Shoreline Child & Adolescent Mental Health Partial Hospital Program and Intensive Outpatient Program in Branford and transfer the programs to the Hospital of Saint Raphael.

These projects were authorized in order to improve access to services for additional populations, expand service offerings, improve efficiencies, and/or improve geographic access to services. Four providers were also authorized to terminate mental health/substance abuse services due to lack of referrals and/or funding. For some of these providers, the impact on patient access could not be determined due to the closure of these services prior to CON authorization.

OHCA authorized eight projects in 2007 that involved facilities development, building and renovations, and increased licensed bed capacity. Gaylord Hospital was authorized to increase its licensed bed capacity from 109 to 137 licensed beds to improve access for its medically complex patients. Three Hospitals—Saint Vincent's Medical Center, Saint Francis Hospital and Medical Center, and Griffin Hospital—were authorized to undertake significant facility development projects. Each of these projects included an expansion and/or redesign of the emergency department, and both Saint Vincent's and Griffin Hospital also created expanded and better integrated cancer centers. Other highlights included the replacement of the surgical department, an increase of 53 staffed medical-surgical beds at Saint Francis, and the reactivation of 14 staffed-bed medical-surgical unit at Griffin Hospital.

A Declaratory Ruling was conducted to answer the following question: "Whether dental providers in Connecticut may acquire and operate an i-CAT Cone Beam 3D Dental Imaging System without prior certificate of need approval?" OHCA found that dentists are providers or persons as used in Section 19a-639 (c) C.G.S. and that, to the extent that they acquire any of the equipment enumerated in that section, they are required to apply for a CON prior to such acquisition. Although the Petitioner testified that the i-CAT is different from a "conventional" CT scanner, OHCA concluded that the i-CAT is still a CT scanner within the meaning of Section 19a-639 (c) C.G.S. Therefore, OHCA concluded that CON approval is required in order for dental providers in Connecticut to acquire and operate an i-CAT Cone Beam 3D Dental Imaging System.

The 2007 CON Decisions and Determinations can be found at http://www.ct.gov/ohca.

Investigative Proceedings

In November 2006, OHCA initiated an investigation into the acquisition of a PET scanner and/or PET-CT scanner and related costs and the acquisition of a CT scanner for the 2660 Main Street Bridgeport practice location of Robert D. Russo, M.D. & Associates Radiology, P.C., pursuant to Section 19a-633 of the Connecticut General Statutes. After a December 2006 hearing in this matter was held, OHCA released a Report of Investigative Proceeding under Docket Number 06-30865-VST in April 2007. OHCA concluded that this provider practice had acquired a PET/CT unit in violation of CON laws in this State. OHCA further concluded that this medical practice may continue to operate the CT scanner, which was previously authorized by OHCA, as a stand alone unit but may not combine or integrate it with the unauthorized PET technology.

Financial Analysis

Financial Status of Connecticut's Hospitals

Faced with significant and ongoing challenges, Connecticut hospitals lost ground in FY 2006 (the most recent year for which data is available), with the number of hospitals experiencing operating losses growing from eleven in FY 2005 to fourteen in FY 2006. Moreover, FY 2006's weakest performing hospital had a negative operating margin of -17%, as compared to FY 2005's poorest performing hospital's negative operating margin

of -10.2%. These losses directly affect the hospitals' ability to reinvest in their facilities and expand services. A hospital must earn sufficient income to improve facilities and replace equipment as they become worn out or obsolete, to keep pace with technological changes, and to meet the changing health care needs of the community.

The statewide average total margin slipped from 3.34% in FY 2005 to 2.51% in FY 2006. This decline can be attributed to a significant decrease in average operating margin, which was accompanied by an increase in average non-operating margin. The 64% drop in average operating margin was partially offset by a 17% increase in average non-operating margin. No hospital achieved an operating margin greater than 6%.

Figure 3: Statewide Average Hospital Margins

Fiscal Year	2002	2003	2004	2005	2006	Change' 05-'06
Operating Margin	0.35%	0.44%	1.47%	1.72%	0.62%	-64%
Non-Operating Margin	0.50%	0.70%	1.59%	1.62%	1.89%	17%
Total Margin*	0.85%	1.14%	3.06%	3.34%	2.51%	-25%

Source: Connecticut Acute Care Hospital Annual Reporting
*Average calculated using dollar amounts. (Excess of Revenues over Expenses/Total Revenues)*100.

Indicators reflective of the overall statewide decrease from FY 2005 to FY 2006 include:

- Patient days dropped by 14,439;
- Number of days in patient accounts receivable increased to 50 days;
- Number of days cash on hand dropped to 42 days;
- Cash flow to total debt ratio declined (indicating potential future debt repayment problems);
- Equity financing ratio declined (indicating a slight increase in the use of debt financing in asset acquisitions);
- FTEs (full time equivalents) increased by 695 (increasing hospital expenses for salaries and fringe benefits);
- Uncompensated care costs rose by 12% to more than $190 million; and
- Increased energy costs.

During FY 2006, the number of hospitals with a negative total margin dropped from seven in FY 2005 to six in FY 2006. However, while FY 2005 saw six hospitals with a total margin exceeding 6%, that number dropped by half in FY 2006 to three hospitals. In addition to the decline in overall financial performance, only 11 of Connecticut's hospitals saw improvements in their total margin in FY 2006 as compared to 18 in FY 2005. On the positive side, there were 15 acute care hospitals that had total margins exceeding 2%. Also, the statewide median total margin was higher than the statewide median operating margin for the third consecutive year.

In FY 2006, total statewide hospital net patient revenue increased by 6% over the previous year to more than $6.7 billion. Hospitals received the largest share of their net revenue, 50%, from non-government "commercial" payers, followed by major government payers at 48%. The remaining net revenue came from medical assistance and the uninsured, which includes self-pay patients. Overall, Connecticut's acute care hospitals' total net revenue payer mix remained relatively unchanged from the prior fiscal year.

Statewide, total hospital operating expenses increased in FY 2006 by 7.6% to nearly $7.1 billion from the prior year. The major categories of expenses include salaries, supplies, depreciation and amortization, interest and bad debts expenses. Non-physician salaries and fringes made up the largest portion, 53%, of hospital expenses in FY 2006. Hospitals are competing for limited health care workers and the expenses associated with recruitment are substantial.

Uncompensated Care

By law, all emergent, non-elective patients at Connecticut's hospitals must be treated, regardless of their ability to pay. Uncompensated care, the level of charges for which hospitals do not receive reimbursement, consists of two components: charity care and bad debts. Charity care is that which a hospital provides knowing in advance that it will not be reimbursed; and bad debts are incurred when a hospital learns after providing care that it will not be reimbursed fully for its services. Uncompensated care (UCC) represents the charges for which hospitals do not receive reimbursement. UCC costs increased by 12% to approximately $191 million over the year, and uncompensated care comprised a slightly larger portion of total expenses in FY 2006 as compared to FY 2005 (2.9% versus 2.8%).

Disproportionate Share Hospital (DSH) Program

The Disproportionate Share Hospital (DSH) Program is a joint federal/state program established to financially assist hospitals that provide care to a relatively high number of uninsured and Medicaid patients, as the reimbursement from these populations is less than the costs incurred in treating these patients. By providing this supplemental reimbursement, the DSH Program has enhanced the hospitals' ability to continue to function as a safety net for those patients without any other access to health care. Using the financial and statistical data filed annually by hospitals, OHCA performs the calculations for the DSH Program. In FY 2006, DSH Program payments totaled over $81 million.

New Hospital Reporting System Database

During 2007, the Office of Health Care Access contracted with PCC Technology Group, Inc. to formulate and implement a new Hospital Reporting System (HRS) database application. The new HRS database application will replace OHCA's outdated Hospital Budget System database and will be used by hospitals to file the necessary data associated with their Annual Reporting, Twelve Months Actual and Hospital Budget filings. The new HRS will eliminate some existing reports that are obsolete, include new reports, and assist OHCA with financial and statistical report data queries and the analysis of hospital filings. The new reporting system will facilitate more efficient data entry by the hospitals and give OHCA the ability to create useful reports.

Research and Planning

OHCA's data collection, analysis and public release of health care utilization information is a cornerstone of the agency, and allows the agency to function as both policy advisor and information resource to a variety of organizations and individuals. OHCA regularly provides legislators, health care policy makers, the health care industry and members of the general public with detailed analyses of health care trends and health care topics relevant to public policy and public interest.

OHCA's Outpatient Data Advisory Committee

In 2007, OHCA convened an Outpatient Data Advisory Committee, consisting of representatives from hospitals, free-standing ambulatory surgical centers, psychiatric hospitals and community health centers to begin informal discussions regarding the industry's perspective on issues related to outpatient data collection and reporting. OHCA has statutory authority to collect outpatient data and wants to begin data collection in a manner that recognizes the financial and human resource impact on the reporting facilities. The advisory committee, which held four meetings in 2007, provided valuable feedback to OHCA on the possible administrative and technical challenges facilities may

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face in providing the agency with outpatient data. In addition, the work group offered many suggestions regarding what information should be collected, from whom and how it may be used by the health care industry and policymakers.

Among the issues discussed by the advisory group were: limiting collection largely to those data elements routinely collected as part of the standard billing process, agreeing upon standard definitions across providers and services, phasing in data collection over time and collecting aggregate data as an interim step to full-scale, record-level data collection. The advisory group will have the opportunity to review and comment on a draft data collection instrument in 2008, prior to the commencement of outpatient data collection by OHCA.

Efforts to Improve Access to Health Insurance Coverage

In March 2007, OHCA concluded six years of research supported by State Planning Grants (SPGs) competitively awarded by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA). The SPG program helped states design policies to expand access to affordable health insurance coverage and funded the collection of data on health insurance coverage and the development of health coverage options.

Agency Activities and Reports

Hospital System Strategic Task Force

Concerned about the condition of Connecticut hospitals and Connecticut residents' access to health care, Governor Rell convened a task force co-chaired by OPM Secretary Robert Genuario and OHCA Commissioner Vogel in April to develop strategies to stabilize and chart the future course of hospitals in Connecticut. Task Force members included state agency commissioners, legislators, and individuals representing hospitals, the business community, community health clinics, consumer advocates, primary care providers, physicians, emergency department physicians, nurses, and insurance industry executives.

The Governor requested that the Task Force examine the current financial health of Connecticut's hospitals, access to care, emergency room utilization, affordability, alternative delivery of primary care and the Certificate of Need process. Due to the complexity of the subject, three task force subcommittees were formed to focus on specific areas of concern: system-wide utilization and planning, workforce issues, and financial structure. A public hearing was also held to elicit feedback in response to preliminary recommendations. The Task Force report submitted to the Governor provided 29 recommendations that would further stabilize the health care delivery system in Connecticut with respect to workforce challenges, access limitations and some fundamental financial structural issues.

The Hospital System Strategic Task Force Report can be found at http://www.ct.gov/ohca

The Connecticut Health Information Network (CHIN)

During the 2007 special legislative session, the state passed a law allowing the development of a plan to integrate state health and social services data, consistent with state and federal privacy laws, within and across several state agencies. The Connecticut Health Information Network (CHIN) is a collaborative partnership between the Center for Public Health and Health Policy at the University of Connecticut and state agencies (the Office of Health Care Access, along with the University of Connecticut Health Center and the Departments of Public Health, Developmental Services and Children and Families) for the purpose of developing a computer network. The network would offer the opportunity to integrate and analyze public health data from diverse agency databases to inform program development and policy decisions.

As envisioned, CHIN will work with agencies' current data systems, and not require additional agency resources to restructure existing data. Additionally, it will allow agencies to maintain control over access to their data, and will have an oversight body to ensure the network will be used strictly for research purposes related to policy development/program evaluation.

In the coming year, OHCA will work with its partners and provide an inventory of current databases and platforms, along with data dictionaries, descriptions of data sharing protocols and review boards/committees so that an assessment of existing data systems can be completed.

2007 OHCA Publications

Annual Report on the Financial Status of Connecticut's Short Term Acute Care Hospitals for Fiscal Year 2006 (October 2007)

Connecticut Hospitals Lost Ground in FY 2006 (June 2007)

OHCA 2006 Annual Report to the Governor and Legislature (April 2007)

Summary Results from OHCA's Hispanic Adults Survey (March 2007)

Long Term Acute Care Hospital Demonstration Projects Report to Public Health Committee (March 2007)

Overview of OHCA's 2006 Young Adults Survey (March 2007)

Child Health Coverage in Connecticut 2006 (March 2007)

Databook: Health Insurance Coverage in Connecticut Results of Office of Health Care Access 2006 Household Health Insurance Survey (Jan 2007)

Copies of all reports are available on the agency's website at http://www.ct.gov/ohca

Statewide Health Information Technology Plan

In 2007, the Connecticut General Assembly passed Public Act No. 07-2, authorizing the Department of Public Health (DPH), in consultation with the Office of Health Care Access (OHCA) to contract, through a competitive bidding process, for the development of a state-wide health information technology plan. An advisory committee consisting of members from state agencies, primary care providers and community health clinics released a request for proposal (RFP) in December for the development of a state-wide health information technology plan (CT Health IT Plan). The selected organization will be designated as the lead health information exchange (HIE) organization for the state of Connecticut from the contract start date until June 30, 2009. Beginning in December 2008 and annually thereafter, DPH, in conjunction with OHCA, will report to the legislature on the status of the state-wide health information technology plan.

Legislative Update

Public Acts

In 2007, the legislature enacted Public Act No. 07-149, which redefined several terms utilized by OHCA in calculating uncompensated care for the disproportionate share hospital payment system. The act also made minor and technical changes and deleted obsolete references.

The effective date of sections 1, 2, 6, 7, and 8 was July 1, 2007, while sections 3, 4, 5 and 9 had an effective date of October 1, 2007.

The act substitutes the term "charity care" for free care and redefines "primary payer" to conform to the definition of primary payer as it is used in the UCC/DSH calculations by dropping the requirement that the payer be responsible for 50% or more of the charges.

Public Act 07-149 also redefined: (1) "Medical assistance" to include HUSKY Plans, Parts A and B; (2) "Medical assistance underpayment" to reflect the method by which OHCA currently calculates this figure; (3) "Contractual allowances" to clarify how the figure is calculated; (4) "Uncompensated Care" to exclude emergency assistance to families and to specify that it is based on the hospitals' published and filed charges and the charity care provided and bad debts that are written off, rather than the actual costs of free care and bad debt; and (5) "Hospital" to include any hospital licensed as a children's hospital. The act also made minor or technical changes to several other definitions.

Regulations

Following the passage of Public Act 07-149, the legislature approved OHCA's new Hospital Financial Review Regulations, effective November 1, 2007. The regulations repeal all references concerning the previous Commission on Hospitals and Health Care's and OHCA's detailed, partial and exempt budget review process, the statutory basis for which was previously repealed by the legislature, and updates and clarifies OHCA's annual review of hospital financial information and statistical data. The regulations also establish new reporting definitions and reporting items, and annual filing submission dates that were recently established or updated in state statutes. New definitions include definitions for Charity Care, Parent Corporation and Self-Pay Discount, and new reporting items include Debt Collection Policies and Procedures, Hospital Bed Funds and Hospital Budgets.

The Office of Health Care Access

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