University of Connecticut

I am Dr. Anne R. Bavier, dean of the School of Nursing at the University of Connecticut. As the State's flagship School, the nursing educational programs at UConn are sensitive and committed to improving the preparation of nurses for practice in the State's Hospital Systems. With this written testimony, I am addressing the draft recommendations relating to nurses developed by Governor Rell's Hospital System Strategic Task Force.

A. Expand current loan repayment and forgiveness programs for nursing students.

Connecticut's Registered Nurse Workforce

In 2005, Connecticut faced a 20% shortage of RNs and currently the shortage is 25%, or 8,000 nurses. By 2010, this shortage is projected to increase to 33% or a shortage of 11,000, and by 2020, the shortage is expected to reach 57%, or 22,400 nurses according to Federal predictions. Of all states, Connecticut is projected to have the 2nd greatest decline in the supply of nurses, if schools continue to produce the current number of graduates.

The negative effect these dramatic shortages will have on other healthcare professions and healthcare delivery cannot be overstated. A vibrant, healthy pipeline of qualified nurses graduating from programs in Connecticut can have a significant impact on our workforce and economy. Greater than 80% of students who enroll in Connecticut baccalaureate and higher degree nursing programs graduate with nursing degrees and, on average, approximately 85% who graduate from the public university nursing programs work in Connecticut in professional nursing positions, according to the Council of Deans and Directors of Connecticut League of Nurses (CLN).

Expansion of UConn's Prelicensure Programs

The University Of Connecticut School of Nursing provides a comprehensive program of nursing education offering students quality, professional healthcare education at the undergraduate, master's and doctoral levels. UConn significantly increased enrollment in the undergraduate nursing program, going from 360 students in 2000 to 571 in 2006. We created and established the Master's Entry into Nursing (MbEIN) program at our Storrs campus to attract individuals with non-nursing bachelor's degrees into nursing. Students enrolled in this program are eligible to take the RN licensure examination after one year of study and can earn their master's in three years. Our retention rate for this

program is greater than 99% and, to date, 90% remain in the state for employment post-graduation. With both private dollars and $200,000 received in state surplus appropriations in FY 08, the University will expand this successful program at our Waterbury campus in January 2008 and next year at our Stamford campus.

Yet, our efforts are not nearly enough. The recently published report of the *Council of Physician and Nurse Supply*, an independent group based at the University of Pennsylvania and co-chaired by the pre-eminent nurse researcher on workforce issues, Dr. Linda Aiken, recommends that more financial support be provided to baccalaureate and higher degree programs. Her data indicate that few associate degree graduates advance to master's level or doctoral level preparation—the levels necessary to become faculty and prepare nurses needed in the future.

I fully support the implementation of the recommendation, "expand current loan repayment and forgiveness programs for nursing students." However, the **program expansion should be aimed primarily at baccalaureate and post-baccalaureate nursing students who will become educators.**

C. Provide funding to the University of Connecticut (? elsewhere) for Masters level programs to prepare baccalaureate nurses to serve as educators.

Nurse Faculty

It is difficult to graduate additional nurses on an annual basis due to the current and growing faculty shortage. In Connecticut, it is anticipated that 23% of nurse-faculty will retire over the next five years. Specifically, 50% of UConn's nursing faculty will be eligible for retirement within the next five years. State-wide, Connecticut's nursing programs denied more than 2000 qualified nursing applicants entrance into its education programs in 2005, the last year for which there is accurate data. The main reason for denial was lack of qualified faculty.

Appropriately, faculty teaching basic nursing must have a minimum of a master's degree in nursing and faculty teaching at the master's and doctoral level are required to have a doctoral degree. A 2005 report issued by the CLN's Deans and Directors Council states that an additional 33 full-time faculty are needed to combat the current shortage and more may be needed, as we move forward. These positions are in addition to the existing 26 faculty vacancies.

UConn's Contributions

UConn, as a public research university, is responsible for knowledge development and dissemination. Therefore, a major function is preparing tomorrow's leaders at the master's and doctoral levels. We need more faculty to meet the demand for doctoral education as we are the only public university in the state authorized to offer a PhD in nursing (the credential for the majority of nursing faculty, at this time). Additionally, we

are pursuing approval for offering a Doctorate in Nursing Practice (DNP) for nurses who do not need a research credential in their institutions.

UConn needs additional faculty to expand enrollment in its master's and doctoral nursing education programs to assist in addressing the nursing faculty shortage. Currently, the university is only able to admit 60% of the qualified students who desire doctoral study. This situation could worsen since it is projected that at least 50% of the faculty in our School of Nursing are eligible for retirement within the next five years.

Investing in the university's established, successful master's and doctoral programs by hiring additional faculty makes a great deal of sense. The university's nursing master's program has had an attrition rate of less than 1% and degree completion averages 3 years. In the 13 years UConn has been offering a nursing PhD, there has been less than a 5% attrition rate and average degree completion is in 5 years. These figures are significantly lower than national norms and reflect the benefit of our low faculty to student ratio. If funding were available to expand our successful PhD program to other parts of the state (through new faculty positions, enhanced technology for video/TV delivery and/or online course development), faculty numbers could be enhanced as well.

The recommendation, "provide funding to the University of Connecticut for master's level programs to prepare baccalaureate nurses to serve as educators" can be accomplished by **hiring additional doctorally prepared faculty in our current programs**. It is important to note that master's in nursing programs need a lot of clinical content in order for the future educator to organize content that captures the latest scientific evidence on diseases, disorders and conditions that affect human health. Master's students also can gain experience in the art and science of education through focused courses on such topics as adult learners and curriculum design and testing. **The programs for master's students cannot be solely programs on teaching/learning.**

Faculty Compensation

While the Task Force makes no mention of faculty salaries, it is another significant barrier to the recruitment of clinically competent, front-line faculty members. Typically, a qualified master's prepared clinical faculty earns $25,000 less than the counterpart in health care systems. An immediate inducement for qualified nurses to become faculty would be to follow the example of the State of Virginia. That state **raised all clinical faculty salaries by 10%.**

A concern among health care providers is that their most talented master's or doctorally prepared clinicians will leave to become faculty members, taking away the institution's investment in the employee and sophisticated care providers. Dual appointments are a win-win situation in which the agency and the educational facility dually hire a qualified individual. Making **funds available to schools of nursing** to support these arrangements (as the educational institutions pay less than the agencies) would encourage the development of more such appointments.

d. Provide funding for a pilot program at XXXXX to teach nursing management skills to nurses in clinical practice.

Nurse Management

The final draft recommendation is, "provide funding for a pilot program to teach nursing management skills to nurses in clinical practice." At UConn, we already have this program—the Clinical Nurse Leader (CNL). The national development of CNL programs and curricula evolved from an independently funded national pilot partnership of schools of nursing and health care agencies. CNL, both as a role and a curriculum, is based on the explicit needs of nursing service administration to retain clinically adept nurses in positions where their own provision of care is a model of excellence and educates other nurses. Through structured courses in organizational design, management theory and financial planning, students gain knowledge to lead large segments of health care agencies in which they also model excellent practice. A significant feature of the CNL is the residency during the final semesters. Students actually implement the CNL role in an agency, with the guidance and advice of both agency leaders and university faculty members. Graduates are eligible to take the national certifying examination as a CNL—which documents learning of the critical information for leadership roles.

While UConn has a strong CNL curriculum, enrollment is low because there is a paucity of apparent jobs for graduates in Connecticut. The existence of this recommendation suggests that some hospitals would welcome CNLs, but are unaware of the clearly defined and rigorous pathway that already exists for nursing management preparation of nurses in clinical practice. **Funding students in our program** and aligning them for return to their originating agencies will address the needs suggested in this draft recommendation.

I commend the members of the Task Force and Governor Rell for considering the challenges of our health care systems and workforce. If I can provide additional information, please contact me: anne.bavier@uconn.edu; 860-486-0537.

Saint Raphael Healthcare System

1450 Chapel Street • New Haven, Connecticut 06511 • www.srhs.org

David W. Benfer, FACHE
President and Chief Executive Officer
Saint Raphael Healthcare System
and Hospital of Saint Raphael

203.789.3020
203.867.5235 Fax

WRITTEN TESTIMONY OF
DAVID W. BENFER, FACHE
PRESIDENT AND CEO
SAINT RAPHAEL HEALTHCARE SYSTEM

GOVERNOR RELL'S HOSPITAL SYSTEM STRATEGIC TASK FORCE
Tuesday, November 13, 2007

RE: TASK FORCE RECOMMENDATIONS

The Saint Raphael Healthcare System is pleased to provide testimony concerning Governor Rell's Hospital System Strategic Task Force recommendations and would like to commend Office of Health Care Access (OHCA) Commissioner Vogel, Office of Policy and Management (OPM) Secretary Genuario, and the Task Force members for researching, debating, and developing recommendations to improve the financial stability of Connecticut's hospitals.

As outlined below, we support most of the subcommittee recommendations and have also offered a few additional ideas to consider. We have also provided specific information as to how the Hospital of Saint Raphael has been impacted in the past by various policy decisions and how the Task Force recommendations might positively impact our Hospital in the near future.

Financial Structure Subcommittee:

- We fully support the recommendation to increase Medicaid and State-Administered General Assistance (SAGA) reimbursement. In fiscal year 2007, the Hospital of Saint Raphael received inpatient reimbursement at approximately 58 percent of what it ***cost*** us to provide care to Medicaid and SAGA patients. The shortfall of reimbursement we received from the State versus the cost to deliver that service is largely responsible for significant operating losses the Hospital has experienced the past two years.

  We are grateful that the Governor and the legislature appropriated $118 million in fiscal years 2008 and 2009 to decrease the Medicaid funding gap. Although the specific distribution formula has not yet been finalized with each hospital, the additional funding will help the Hospital of Saint Raphael continue to fulfill its mission of caring for the underserved, poor, and the elderly.

Unfortunately, the under-funding of the Medicaid and SAGA programs has accumulated over the years and despite the large allocation of Medicaid funding in the recently-passed state budget, a large gap still remains. Due to this shortfall, the Hospital of Saint Raphael has had to reallocate funds earmarked for capital projects, including building a freestanding Family Health Center that would have allowed easier and expanded access to Medicaid, SAGA, and uninsured patients. We have also been unable to expand our community outreach programs to meet the demands of our community and are even considering decreasing or eliminating specific services and programs. We support the Task Force's recommendation to pay the full cost of caring for Medicaid and SAGA patients. This additional funding will allow the Hospital of Saint Raphael to renovate our operating rooms, invest in new technology, make infrastructure improvements, and continue to meet the needs of the underserved and poor in our community.

- We also support the recommendation to financially support a study of the reimbursement systems available for Medicaid and SAGA to determine the most appropriate and equitable system. Further, we would hope that this study will include consideration of a proposal made on October 29, 2007 by Saint Raphael's Chief Financial Officer Paul Storiale. He presented a reimbursement methodology to the Task Force and the Department of Social Services (DSS) that is based upon parity among Connecticut's hospitals. This methodology would update the 1982 formula that is currently being used by DSS as its base and, instead, would reimburse for Medicaid services based on a flat per case rate with occupational-mix adjusted labor rates for urban, suburban, and rural hospitals. Another possible option that would result in parity is to reimburse each hospital based upon a DRG-based rate formula, similar to the Medicare program, and also similar to 35 other states across the country. We support the study of equitable Medicaid reimbursement systems, including the proposals we have brought before the Task Force. An updated and equitable system for Medicaid reimbursement is long-overdue -- it will reward hospitals that are efficient and will fairly reimburse hospitals that provide the same high-quality care to Medicaid and SAGA patients throughout our state.

- Saint Raphael's fully supports the Task Force recommendation that would require the Connecticut Health and Education Facilities Authority (CHEFA) to issue revenue bonds backed by the State with the debt service paid by the State of Connecticut. The proceeds from these bonds would be in the form of grants, forgivable loans and low-interest rate loans and would help hospitals address important capital needs, including the purchase of medical equipment and information technology as well as addressing facility needs and other financial challenges. The Connecticut Hospital Association (CHA) reports that Connecticut hospitals have deferred $1.1 billion in capital investments. At the Hospital of Saint Raphael, our three-year capital needs total in excess of $100 million. Due to the under-reimbursement of the Medicaid and SAGA programs

and less than full-cost reimbursement from the Medicare program, the Hospital of Saint Raphael ended fiscal year 2006 with a $5.4 million loss and expects to end fiscal year 2007 with a $6.5 million loss. As a result, we do not have the capacity to borrow funds to meet all of our capital needs, including long overdue facility improvements. The creation of an approximately $650 million pool by the State would significantly help Connecticut's hospitals to provide high-quality and efficient care to our patients.

- Saint Raphael's also supports the remaining Financial Structure Subcommittee recommendations to: financially support system changes that promote cost-effective service delivery and maintain or improve quality of care; pursue an application to CMS to permit the inclusion of SAGA in Medicaid to receive Medicare DSH funds as well as other initiatives to obtain adequate funding from the Medicare program, and additional support to expand access through the federally-qualified health centers.

Workforce Issues Subcommittee:

- Saint Raphael's supports the recommendations of the Workforce Issues Subcommittee, and wholeheartedly endorses the grants to distressed hospitals to purchase patient-lifting equipment and additional funding to hospitals and universities to increase the numbers of nurse faculty, staff nurses, physicians, and allied health personnel. We also encourage the Task Force to pursue the recommendation to create a loan forgiveness program that links loan forgiveness to the number of years that a physician takes "on-call coverage" at hospitals. Providing adequate "specialty" on-call coverage in emergency departments across the state is both challenging and expensive. Creative solutions, such as the loan forgiveness program, are needed to assure that specialty care is available to meet our patients' needs.

System-wide Utilization and Planning Subcommittee:

- Planning Recommendations: We endorse the updating of the State Health Plan, the development of a state-wide plan for mental health services, and a State-Wide Health Care Facilities Plan. We encourage the Department of Public Health (DPH), the Department of Mental Health and Addiction Services (DMHAS), and the Office of Health Care Access (OHCA) to collaboratively work together so that the plans support each other. These plans will be useful to our hospital's planning department and to our Board's Strategic and Financial Planning Committee to better understand the state's priorities and to assure that our hospital's strategic plan fits into the overall State Health Plan. These state plans should also simplify the certificate-of-need process and will allow for better integration and coordination of health services in our communities.

- Emergency Department (ED) Overuse Recommendations: We are interested in learning more about "Behavioral Health High Demand ED Areas" -- it is not yet clear as to how this designation may impact access, funding, and quality of care. It is clear, however, that current behavioral health rates have resulted in a lack of access and the inability for patients to be discharged from hospitals and/or emergency departments in a timely manner. Behavioral provider rates must be increased, and state incentives must be offered to expand inpatient facilities and outpatient programs to meet the growing mental health needs in our communities.

- Regarding the recommendation to move to appropriate units to wait for an available bed, it is extremely important that if this measure is considered that factors such as the need for specific monitoring equipment and appropriately-trained staff be taken into account. Many times, the delay for transferring a patient to an inpatient bed is due to the need for the patient to be placed in an intensive care unit, or on a patient unit with specific equipment such as heart monitors, or on a patient floor with staff trained to care for that patient's needs. Decreasing the time spent in emergency departments while waiting for an inpatient bed is an extremely important goal for all of us, however, patient safety and providing the best quality of care are the most important priorities.

- Saint Raphael's supports efforts to reduce the inappropriate use of emergency departments for primary care services. The Task Force's recommendation to implement programs to expand primary care hours during the evening and weekends should help to alleviate some of the overcrowding in our emergency departments across the state. It is important, however, that premium differentials that providers must pay to staff to work during these hours are taken into account when establishing the reimbursement mechanisms for these programs.

We applaud Secretary Genuario, Commissioner Vogel, and all the Task Force members for raising these issues, researching possible solutions, and developing these recommendations to help stabilize Connecticut's hospitals. We look forward to working with Task Force members as you finalize your report. Thank you for the opportunity to comment.

TESTIMONY OF MARJORIE A. BERRY
CHIEF EXECUTIVE OFFICER
EAST HARTFORD COMMUNITY HEALTHCARE
Before
THE HOSPITAL SYSTEM STRATEGIC TASK FORCE
November 13, 2007

I am responding to the System Wide Utilization and Planning Subcommittee's recommendation to reduce inappropriate use of the emergency Department for primary health services.

Federally Qualified Community Health Centers are part of the solution.

- Our patients are the sickest of the sick and the poorest of the poor.
- East Hartford Community HealthCare (EHCHC) opened its doors in June, 1996 with a small grant from the State of Connecticut Department of Public Health. In 2000 we were designated as a FQHC Look Alike and in June, 2002 we successfully completed the competitive process to receive federal 330 grant funds. We are a member of the Connecticut Primary Care Association (CPCA), an alliance of 12 of the 13 FQHCs in the state and I currently serve as President of the CPCA Board.
- East Hartford Community HealthCare provides both medical and dental services including obstetrics and high risk gynecology. We provide mental health services through an arrangement with Intercommunity Mental Health in East Hartford and Genesis Center in Manchester.
- Our annual visits went from **1500 at the end of 1997** to **33,000 by the end of 2006.**
- Besides East Hartford we have a site in Manchester and most recently opened a site in Vernon. We are expanding our East Hartford site to add 10 exam rooms for our new Women and Children's Center, so we anticipate our visit volume will continue to grow as we expand our facilities.
- Our Hours of operation are:
    - East Hartford - Monday – Thursday 7 am –7 pm and Friday 7 am –5
    - Manchester Dental - Monday –Thursday 7 am – 7 pm and Friday 8 – 4:30
      Manchester Medical site is open 8 – 4:30 pm Monday – Friday
      Vernon - Monday, Wednesday and Friday- 8 am – 4:30 pm.
- We have 7 Physicians and 3 Nurse Practitioners in the fields of Family Practice, Internal Medicine, Pediatrics and 1 Obstetrics and Gynecology. In Dental we have 6 Dentists and 6 Dental Hygienists and 1 Pediatric Dentist contracted 1 day per week from UCONN and 3 Dental Residents two days per week.
- In 1996 we had 4 employees, today we have 75 employees.
- We provide **Dental Hygiene services to the elementary schools in both East Hartford and Manchester** using portable dental equipment.
- We provide **Dental screenings for the Head Start Programs in both Manchester and Vernon.**
- Each year we participate in **Give Kids a Smile Day.** On **2/2/2007 our staff and volunteer community Dentists provided dental care to 77 children.**

- **Pharmacy Services** include a 340B program with Walgreens. This has saved our patients as much as $300 for a 3 month prescription. We also offer the Pharmaceutical Assistance Program and have approximately 413 individual patients enrolled and fill 1080 prescriptions for free medications each month.
- **Obstetrics and Gynecology**: With the hiring of a full time Ob/Gyn Physician in July, 2007 we have already enrolled 40 prenatal patients, and its only November, and 21 gynecology procedures in the O.R. such as hysterectomy, cone biopsy, tubal ligations, laparoscopies.
- We also provide **Lactation Counseling** to our new Mothers and babies.
- We have many patients with chronic diseases such as Diabetes, Hypertension, High Cholesterol, Obesity and Asthma, to whom we provide services using the Chronic Care Model developed by the Institute for Healthcare Improvement and implemented in health centers across the country.
- **We go the extra mile:**
    - Friday afternoon, Mother calls for refill for 6 y.o. child's medication, must be pre-authorized by insurer, cannot get pre-authorization, if the child doesn't get his medication, mom will miss work on Saturday and Monday, no pay. We called the Pharmacy and guaranteed the payment of the medication ($100) if the insurance did not pay. Child received medication, Mom went to work.
    - Middle-aged man arrives for the first time at Center with Congestive Heart Failure, sent by ambulance to hospital, a life saved.
    - We have a patient fund that will pay for transportation to specialists, prescriptions and diagnostic testing.
- Patient Support Services provides help with housing, transportation, medication, HUSKY enrollment and many other life support systems.
- We are just one small Health Center; there are 12 others in the state providing the same services, some on an even bigger scale.

Community Health Centers are READY, WILLING AND ABLE to be part of the solution to some of the issues/challenges this Task Force seeks to address.

- We can and will expand hours to keep primary care services out of the emergency room.
- We are willing to develop systems in terms of scheduling and patient care with hospitals and other providers.
- We are willing to develop a system with the Department of Corrections to provide a "Medical Home" to persons being released from prisons. This can be done through health fairs at the prisons and/or our social workers working with social workers at the Dept. of Corrections.

In order to do so the FQHCs need your support in two ways:

- We **NEED** specialists at our centers or at the least in the community to take our uninsured patients. Presently our patients wait 3 to 5 months for appointments with specialists.
- We will **NEED** the additional resources to expand our hours and be assured that the increased costs of additional overhead, security, support staff and providers including specialists will be covered.

Testimony of Yale-New Haven Hospital
Before the Hospital Task Force
November 13, 2007

Hospital Task Force Recommendations to Governor Jodi Rell

Good afternoon Commissioner Vogel, Secretary Genuario and members of the Hospital Task Force. My name is Marna Borgstrom, and I am President and CEO of Yale-New Haven Hospital and Yale New Haven Health System which includes Yale-New Haven, Bridgeport and Greenwich Hospitals. Thank you for the opportunity to appear before you and testify on this critical matter.

I would also like to thank Governor Rell for creating this Task Force. Charged with proposing strategies to stabilize the healthcare system and ensure access to necessary and quality health care, this Task Force along with its three subcommittees, is undoubtedly finding its work very challenging; not unlike the many challenges Connecticut's hospitals face on a daily basis in caring for their patients.

Yale-New Haven Hospital (YNHH) is a 944-bed tertiary referral center which includes the 201-bed Yale-New Haven Children's Hospital and the 76-bed Yale-New Haven Psychiatric Hospital. The Yale-New Haven Cancer Hospital is currently under construction and is scheduled to open in late 2009/early 2010 to help meet the increasing demand for oncology services. As the primary teaching hospital for Yale University School of Medicine (YSM), Yale-New Haven's medical staff is enhanced by 618 supervised residents who add around-the-clock coverage, making YNHH the largest teaching hospital in Connecticut. Yale-New Haven Hospital operates three emergency departments (adult, children's and a Shoreline emergency department in Guilford). And, with over 120,000 emergency visits in FY 2007, YNHH remains the State's largest emergency service provider and the only Level One trauma service provider for children and adults. Yale-New Haven Hospital's full range of health care services is available 24 hours a day, 365 days a year.

Yale-New Haven also services by far, the most Medicaid patients in the State of Connecticut. Based on data in the most recent Program Review and Investigations Committee report on Hospital Funding, in Fiscal Year ~~2005~~, Yale-New Haven had 11,599 Medicaid discharges, and that number grew to 12,839 in FY 2007. The second largest provider was Hartford Hospital with 6,986 Medicaid discharges. In 2005, YNHH also had the largest number of Medicaid discharges as a percentage of its total discharges at 24%. This has grown to 25% using more recent 2007 data. Additionally, like the Connecticut Children's Medical Center, more than 50% of the children admitted at Yale-New Haven Children's Hospital are insured by the Medicaid program. As a result of Medicaid underpayments, Yale-New Haven had an $80 million Medicaid shortfall during FY 2006 and that jumped to nearly $92 million in FY 2007. YNHH covers these losses by managing expenses and negotiating higher managed care rates with commercial payors. As a result, independent businesses pay far more for employee and dependent health insurance and as

this continues, employees themselves are shouldering this burden with higher co-pays and deductibles, or by opting out of coverage altogether. This then increases our free care and bad debt expense.

Bridgeport Hospital also serves a significant number of Medicaid patients, and in FY 2007, the hospital had nearly 5,200 Medicaid and Medicaid Managed Care discharges, which represents 26 percent of their total discharges for the year. Additionally, Bridgeport Hospital receives only 70 cents for every dollar spent on providing care to its patients who are enrolled in Medicaid. In FY 2007, the hospital's shortfall for all Medicaid programs was approximately $19.5 million. Bridgeport Hospital serves as the health care safety net for many residents from the City of Bridgeport and the surrounding towns. Overall, Yale-New Haven and Bridgeport Hospitals provide a disproportionate amount of care to Connecticut Medicaid patients.

As I said earlier, this Task Force's work is very challenging, particularly because the panel was given only six months to examine not only the financial health of Connecticut's hospitals, but also access to affordable care, emergency room utilization, and the delivery of primary care. Although there are numerous recommendations that have been suggested by the subcommittees, all worthy of review, in the interest of time, I will highlight a few that we believe are essential to consider.

We applaud the Hospital Task Force for acknowledging, through its Financial Structure Subcommittee, that rates for hospitals and other providers in State and Federal health programs do not reflect the costs incurred, and that the shortfall is shifted to businesses and those insured through the workplace. The cost shift is a barrier to affordable employer-based health insurance and is not sustainable. It is critically important that rates paid to hospitals cover the costs incurred for patients insured through governmental programs like Medicaid and SAGA. In addition,

- the rates paid in these programs must be issued in a timely and predictable manner so that required, significant investments in infrastructure and technology can be undertaken,
- SAGA reimbursement rates should be reset to equal Medicaid rates,
- and, DSS should file a waiver to permit the inclusion of SAGA in Medicaid so that hospitals can receive all available Medicare DSH dollars.

Additionally, we generally support the recommendations of the Task Force's System Wide Utilization and Planning Subcommittee for the creation of a State Health Plan that would address public health priorities, leading causes of mortality and morbidity, and needed health care delivery systems. We also support the creation of a State-Wide Health Care Facilities Plan. More specifically however, we agree that it is critical for the State to reduce the inappropriate use of hospital Emergency Departments (ED) for mental health services by implementing programs to assure access to and use of outpatient services to reduce the instances of crises that would escalate to a need for emergency room care. Furthermore, we also agree that the State should reduce the inappropriate use of hospital EDs for primary health services by implementing programs that create improved access to care. This would help to alleviate the burden on hospitals that are already overburdened.

We cannot adequately address the opportunities to stabilize Connecticut's healthcare system without discussing workforce planning and development. Over the last several years, it has become more difficult for hospitals to recruit and retain qualified healthcare professionals. Increasingly, this has become a major cost driver since healthcare staff and resources must be redirected to cover shortfalls. It is therefore imperative for the Hospital Task Force, through its Workforce subcommittee, to examine and identify opportunities to maintain a healthy workforce. This can be accomplished by increasing the capacity (faculty and classroom space) of training programs in the state so we can produce the nurses, pharmacists, physical therapists and other clinical staff the state will need to care for its citizens.

We strive to be both a provider and employer of choice, and YNHH regularly ranks among the best hospitals in the United States. However, as patient demands increase and government reimbursement continues to lag well behind our costs, our ability to meet these demands will be increasingly challenged. We hope that the recommendations of the overall hospital taskforce will provide adequate guidelines that will aide the State in stabilizing Connecticut's hospitals.

Thank you for your consideration on this important matter.

TESTIMONY
GOVERNOR'S HOSPITAL SYSTEM
STRATEGIC TASK FORCE

Good afternoon Secretary Genuario and Commissioner Vogel and distinguished members of the Governor's Task Force. My name is Dick Brvenik, and I am President and Chief Executive Officer at Windham Community Memorial Hospital in Willimantic. Our hospital is a 130 bed licensed acute care facility serving a 19 town service area with an annual budget of $80 million. Windham Hospital has a 75 year history of service to the community and is deeply devoted to Family Centered Care.

I am grateful for the opportunity to speak before you today and appreciate that Governor Rell and her administration has taken this leadership role to help focus on the important needs of Connecticut's hospitals.

Windham Hospital has been designated by Medicare as a rural hospital and serves many rural communities yet due to its location in Willimantic, we face many challenges similar to those of larger urban communities. We serve significant percentages of uninsured including undocumented persons, and in the most recent fiscal year nearly 17% of our volume was for Medicaid beneficiaries. Our hospital has been among the lowest cost hospitals on a case mix adjusted basis. We continue to pursue efficiency of operation and attempt to achieve value for all our patients and families through aggressive labor productivity programs and benchmarking against best practice institutions across the country. We are also very proud of our plans for affiliation with Hartford Health Care Corporation and the systems benefits which that affiliation will bring.

Unfortunately, when our full costs are not covered through the Medicaid program, there is a diminished ability to produce the necessary income to reinvest in technology, plant and equipment. Indeed, hospital financial analysts indicate that hospitals need to achieve a 5% annual operating margin to fulfill their mission and ensure financial success. Unfortunately, there are very few acute care hospitals in Connecticut which have consistently met that operating margin level of performance over multiple years.

The constraints in operating income brought on by Medicaid payments that do not cover the cost of care have impacted us in several ways. While we are very proud of our Jeffrey P. Ossen

Emergency Center which opened in August, 2006, this was a project which was delayed for over 10 years. This project was completed largely as a result of community philanthropy.

Additionally, basic physical facility upgrades ranging from roof repair and brick repointing to investments in information technology have been delayed due to inadequate Medicaid reimbursement. Our organization also needs more private inpatient rooms, particularly patient isolation rooms. We routinely postpone the purchase of clinical and non-clinical equipment as well as programs for our medically underserved, such as asthma management programs, which affect the health of our Latino population in Willimantic.

The limitations which Windham Hospital experiences are not unique. Hospitals across our state face unique demands in recruiting new physicians in primary care and key specialties. While shortages of nurses have been well documented, there is also significant need in other allied health professions. The directors of undergraduate and graduate health care management programs at Connecticut universities routinely report that while the majority of their students 20 years ago were interested in careers in acute care hospitals, the overwhelming majority of students – 90% or greater –now seek career opportunities outside hospitals. All of these have serious long-term implications for the future success of hospitals.

One area which is particularly important to Windham Hospital is the need to assure appropriate access to primary care. With adequate rates for physicians and other providers, access to care will be improved and correspondingly more expensive emergent and acute care can be avoided.

The challenge which the Task Force faces is daunting but this work is of vital importance to all the citizenry of Connecticut. In recent years, Connecticut's leadership has wisely invested in its university system, educating Connecticut's best and brightest young minds, and providing corresponding benefits for our work force. I am convinced that the important work of the Governor's Task Force can identify investments that will yield similar improvements. By pursuing a structured and orderly plan to address the urgent needs of hospitals and health care systems, advances will be made that can enhance healthcare delivery and improve the overall health of Connecticut residents.

Thank you.

MIDDLESEX
HOSPITAL

TESTIMONY OF
VINCENT CAPECE
SENIOR VICE PRESIDENT, FINANCE & OPERATIONS
MIDDLESEX HOSPITAL
ON BEHALF OF
MIDDLESEX HOSPITAL
BEFORE
GOVERNOR RELL'S HOSPITAL STRATEGIC TASK FORCE
Tuesday, November 13, 2007

Response to Task Force Draft Recommendations

My name is Vincent Capece and I am the Senior Vice President, Finance & Operations at Middlesex Hospital. I am also a member of the Connecticut Hospital Association's (CHA) Committee on Finance, and I am a member of The Health Care Financial Managers Association and the American College of Health Care Executives. I appreciate the opportunity to testify on behalf of Middlesex Hospital on the draft recommendations of Governor Rell's Hospital Strategic Task Force (The Task Force).

Middlesex Hospital supports all of the recommendations developed by the three subcommittees of The Task Force. We also concur with the premise put forth in this report that "our hospitals are the safety-net for the communities they serve and their ability to remain financially viable ensures continuous access to necessary services" and that "hospitals are one part of the health care delivery system and that for strategies to be successful it will take a combined effort to make changes that will be measurable, attainable, and sustainable…"

It is our opinion that the proposed recommendations seek to provide appropriate assistance that is essential in helping Connecticut's system of health care providers not only maintain but enhance their ability to serve the ever increasing health care needs of the communities they serve.

With respect to the specific recommendations put forth by the three subcommittees we believe that one of the most important recommendations was put forth by the Financial Structure subcommittee which has proposed that all of the state's health care programs (Medicaid-fee-for-service, Husky and SAGA) reimburse providers at a level that at least covers the cost of providing services. The current level of reimbursement for the services provided under these programs has created a burden for all participating providers. This burden is significant and it's growing each year. Middlesex Hospital had an estimated "shortfall" from the services it provided to patients enrolled in these state-sponsored programs of almost $10 million in our 2007 fiscal year. This amount is larger than the operating income generated by the hospital in 2007. In 2006 this "shortfall" was over $7 million.

28 Crescent Street
Middletown, Connecticut 06457-3650

Tel 860 344-6000
www.middlesexhealth.org

One comment that we would like to provide The Task Force and its subcommittees, as a suggestion, is to explore the concept of recommending that the state's health care programs reimburse providers for the provision of disease management services. We currently support several of these programs without any formal reimbursement source and we've have found them to be extremely successful in terms of improving each patient's quality of life and in reducing the overall cost of care. As an additional benefit, we believe these types of programs will also help to reduce emergency department utilization.

In conclusion, I would like to reiterate Middlesex Hospital's support for the recommendations put forth by The Task Force subcommittees. We believe these recommendations appropriately focus on the major issues facing the state's system of health care providers.

Thank you for your consideration.

28 Crescent Street
Middletown, Connecticut 06457-3650

Tel 860 344-6000
www.middlesexhealth.org

Testimony of
Patrick A. Charmel
Chief Executive Officer
Griffin Hospital
before the
Governor's Hospital System Strategic Task Force
November 13, 2007

Secretary Genuario, Commissioner Vogel, and members of the Task Force, my name is Patrick A. Charmel. I am Chief Executive Officer of Griffin Hospital, located in Derby, Connecticut; I am also Chairman of the Board of Trustees of the Connecticut Hospital Association and am serving as a member of the Financial Structure Subcommittee of this Task Force.

The draft recommendations issued last week by the Task Force reflect a substantial amount of work on the part of the Task Force and subcommittee members, and I am pleased to have the opportunity to comment on them today.

Connecticut hospitals strongly support the draft recommendation of the Financial Structure Subcommittee to increase hospital reimbursement to cover the cost of providing care to patients in the Medicaid For-Service, HUSKY, and SAGA programs to ensure continued access to health care services. Providing funding to cover the cost incurred in delivering care to the beneficiaries of those programs is the single most important step the State can take to stabilize Connecticut hospitals financially. The Subcommittee heard that message repeatedly from hospitals, from the business community, and from industry experts.

We also strongly endorse the Subcommittee's recommendation that the Connecticut Health and Educational Facilities Authority (CHEFA) should issue revenue bonds backed by contract assistance of the state that would cover at least 60% of the $1.1 billion in needed investment – this much-needed access to capital would go a long way toward addressing the results of the past underfunding.

We are also pleased that the Subcommittee draft recommendations include initiatives to ensure that Connecticut hospitals obtain adequate funding from the Medicare program and all available Medicare DSH dollars.

Regarding the recommendations of the System-wide Utilization and Planning Subcommittee, we support the development of a state health plan, statewide health

care facilities plan, and mental health and substance abuse plans, with specific goals, progress reports, regular updates, effective communication with hospitals, and advisory bodies for oversight.

We also generally support the initiatives recommended to decrease the inappropriate use of hospital emergency departments for mental health and/or substance abuse services and to increase the capacity and continuum of effective and efficient care to meet the needs of patients with such illnesses presenting at the ED. We also support the recommendations to reduce inappropriate use of the ED for routine primary care

Regarding the recommendations of the Workforce Issues Subcommittee, hospitals support initiatives to address nursing and allied health faculty shortages, to increase effective workforce planning, provide support to hospitals for best practice studies and much-needed patient lifting equipment, to increase physician emergency on call coverage in the state, and to address the high cost of medical malpractice insurance in Connecticut.

In summary, we are pleased that the draft recommendations include a broad array of initiatives critical to the long term stability of Connecticut Hospitals. I will stress again, however, that the largest obstacle to hospital financial stability is government underfunding. As we have heard throughout our meetings this fall, the communities we serve are shortchanged as hospital funds are diverted from investment in facilities, technology, and patient care services to cover this funding gap.

I join my hospital colleagues in thanking the Governor for making the long-term financial stability of hospitals a priority. We are committed to working with the key state agencies that have participated in this important process to ensure that Connecticut residents have access to the level of quality hospital care they have come to expect and deserve.

I'd be pleased to answer any questions.

GOVERNOR'S HOSPITAL SYSTEM

TASK FORCE

PUBLIC HEARING

NOVEMBER 13, 2007

SUSAN L. DAVIS RN, Ed. D

ST. VINCENT'S MEDICAL CENTER

The State of Connecticut Health Care System is fragile at best and I applaud the Governor, the Office of Health Care Access and the Department of Public Health for your efforts to explore options and solutions to help stabilize our Health Care System. I also appreciate the opportunity to speak to you today.

Any proposal for health care reform must clearly state that it aims to provide coverage for all persons and a reimbursement system that covers the cost of care. These aims are vital to insuring a delivery system that is safe, improves the quality & safety of health care, and does so in a cost effective manner.

In order to accomplish these Aims we need a Health Care System that provides:

1. **Equitable Benefits:** The Benefit structure must provide benefits equal to others in our communities and encourage disease prevention, health promotion and timely access to needed services.

2. **Attention to Vulnerable Populations and Coverage Gaps:** Any restructuring of the Health System must address the most vulnerable populations, particularly our children, and cannot leave gaps for individuals in our community in essential services such as mental health, dental services and prescription drugs.

3. **Insurance Reform:** The regulatory environment in which private insurance operates is complex, involving laws and regulations at the state and federal level. To achieve the broadest possible pooling of risk reforming the private insurance market at the state level must include addressing issues of solvency, market conduct, consumer protections, and underwriting and ratings. For the statewide public programs such as Medicaid, SAGA and HUSKY, the answer is less complex; it requires full funding to cover the cost of care to providers and must include benefits that are equal to other private plans so that a two tiered health system does not continue to exist in our State.

4. **Economic Viability and Sustainability:** As providers we live in a highly regulated environment and do believe that the State of Connecticut has worked diligently to create a safe environment for patients through their oversight process. As providers we share the State's priority of insuring quality outcomes and safety for our patients. However the reality is that we must do this in an under funded Health System that does not come close to covering provider costs. Patients need access to Primary Care physicians to provide continuity in care. Unfortunately, the uninsured and underinsured to not have this access and as a result our Emergency Departments have become the safety net for our community. This system results in a lack of continuity of care, expensive duplication of testing and services, a limited access to sub specialists, and long waits for those in need of true emergency services.

   The current system does not include any incentives for prevention or early diagnosis and treatment. People in our communities who cannot afford the cost of care often delay care until the cost of treatment far exceeds what it would have been if treated at an early stage in the disease process and results in higher mortality rates for our most vulnerable.

   The final point that must be noted is the impact that our current funding system has on economic development in our communities and the State of Connecticut. The Business Community and Insurers have clearly documented how the under financing of state health plans has resulted in cost shifting to private insurers thus increasing the premiums paid by private business. As the cost of doing business in Connecticut increases private business looks to other states where costs are lower.

SUMMARY:

In summary, by establishing this task force the Governor has indicated that she recognized the need for change and reform in the State Health Care System in the State. However, it is vital this reform must include:

- Full reimbursement to hospitals for the cost of care of patients covered by HUSKY, Medicaid Fee for Service and SAGA programs in order to help stabilize hospital finances, improve access by participants, reduce cost shifting to employers providing coverage to all and ultimately improve the quality and safety for our patients.
- Market rates for physicians that care for patients covered by state programs
- Removing the cap on SAGA payments
- SAGA reimbursement rates must be reset to equal Medicaid rates
- DSS must pursue an application to CMS to include SAGA in Medicaid so that hospitals receive all Medicare DSH funds.

- Provide incentives to providers that have demonstrated effective cost control initiatives.

The results of Health Care reform and financing of our State Payment Systems must enable our most vulnerable citizens to have confidence that:

- The system will be easy to navigate.
- They will get the best care they need to stay healthy or recover when they are sick.
- They will have health insurance; can they keep it, can they afford it, and it will be there when they need it
- The coverage is similar to others in their community and
- They have continuity in care and access to sub specialists when needed.

We believe that these financing steps along with the development of a State Health Plan that addresses Public Health priorities will in fact achieve the stated goals for the people in our communities who lack access, are uninsured or underinsured.

Thank you for your consideration.

Connecticut Children's
MEDICAL CENTER

Testimony of Martin J. Gavin, President and CEO
of the Connecticut Children's Medical Center
to the Governor's Hospital System Strategic Task Force
regarding the Draft Recommendations
November 13, 2007

The Connecticut Children's Medical Center (CCMC) is pleased to have the opportunity to submit testimony regarding the draft recommendations of the Governor's Task Force. CCMC is grateful for Governor Rell's leadership in establishing the Task Force and for the commitment and dedication of its Co-Chairs, Secretary Robert Genuario and Commissioner Cristine Vogel. CCMC supports the overall recommendations of the Task Force as a major step forward in improving access to and quality of health care services for all of Connecticut's citizens.

Specifically, we would like to comment on three of the draft recommendations:

1. Medicaid
2. Workforce planning
3. Behavioral health care in hospital emergency departments

Medicaid

All children should have the health care they need to grow and learn. The children of Connecticut deserve a health care system that both provides them with coverage and enables them to access high quality health care services. It is critically important for the State to provide coverage for uninsured children, but the coverage will not help them if providers cannot afford to treat them. The State must pay safety net providers like CCMC adequately in order to ensure access to care.

CCMC offers the full spectrum of pediatric care to children from each of Connecticut's 169 cities and towns. Each year, CCMC provides:

- 30,000 primary care visits (78% for HUSKY kids)
- 43,000 emergency care visits (60% for HUSKY kids)
- 92,000 physician specialty care visits (40% for HUSKY kids)
- 33,000 inpatient hospital days (49% for HUSKY kids)
- 8,500 surgical procedures (35% for HUSKY kids)

CCMC is a vital resource for children and families across the state. As the Pediatric Department for the University of Connecticut School of Medicine, CCMC has trained over 150 new pediatricians in the past 10 years and 66 of these are currently practicing in

Connecticut. We develop pioneering treatment programs for asthma, diabetes, cancer, pain management and other major concerns of childhood. Our 10 hospital affiliation agreements and 13 satellite clinics are improving the quality of pediatric care throughout the state for all of Connecticut's children.

CCMC is successfully fulfilling its mission to provide specialized pediatric care for children throughout Connecticut. However, the HUSKY Program, which covers nearly half of the children we care for, is seriously flawed, if not broken. Without significant changes to HUSKY's reimbursement rates, CCMC will not be able to sustain its efforts.

The Task Force draft recommendations on Access to Capital accurately reflect one of the long-term consequences of poor reimbursement from HUSKY. CCMC's current and growing HUSKY shortfall reduces our ability to make needed capital investments and impairs our ability to recruit and retain exemplary staff.

Workforce planning

CCMC also supports the draft recommendations related to workforce issues, and in particular we would like to comment on those related to medical liability insurance and the nursing shortage. The medical liability insurance crisis is not just a problem for physicians. It is a critical problem for hospitals and ultimately for our entire system for delivering healthcare in this state. CCMC agrees with the Task Force regarding the need to further address this issue in order to promote predictability, efficiency, and fairness for all parties in medical malpractice litigation.

The average hospitalized child requires 31% more nursing care than the average adult. At CCMC, 70% of our inpatient care is devoted to children less than 6 years of age. Young children are not developmentally able to care for themselves, remain unattended, explain their pains, or lie still for procedures. For these reasons, the nursing shortage has particular implications for CCMC. We concur with the recommendations to recruit and retain nurses and nursing faculty. In keeping with our ongoing efforts to recruit and train highly qualified pediatric nurses, CCMC would be interested in competing for a grant to establish a pilot nursing residency program.

Behavioral health care in hospital emergency departments

CCMC agrees with the recommendations regarding the need to reduce inappropriate utilization of hospital emergency departments for mental health and behavioral health services. For many years, CCMC's Emergency Department (ED) has been a prime example of the problems facing children in behavioral health crisis. Thanks to the commitment of the Connecticut General Assembly and the Rell Administration, the Child and Adolescent Rapid Emergency Stabilization Service (CARES) opened at the Institute of Living in October. In only a few weeks of operation, the CARES unit has had a significant positive impact on the children who come to CCMC in behavioral health crisis, the children with medical emergencies that our ED is intended to serve and the working environment of our dedicated staff. We look forward to additional system

improvements for the statewide system of behavioral health services as a result of the draft recommendations of this Task Force.

Once again, CCMC appreciates the opportunity to submit comments to the Governor's Hospital System Strategic Task Force. We would welcome opportunities to stay engaged in these efforts as the recommendations move forward.

TESTIMONY
Hospital System Strategic Task Force
Public Hearing
November 13, 2007

Secretary Genuario, Commissioner Vogel, members of the Task Force, I am Michael Hogan, President of the University of Connecticut, and I thank you for the opportunity to speak on behalf of the UConn Health Center. I commend you for the time and effort you are committing to charting the future course of hospitals and access to quality health care in Connecticut.

By way of background, I came to UConn from the University of Iowa, where I served as Executive Vice President and Provost. As Provost, I was responsible for oversight of all of the Health Science Colleges, including the College of Medicine, and in which capacity I also collaborated with the University President in overseeing Iowa's academic hospital, which has roughly 750 beds. I would not claim to be an expert in hospital administration or academic medicine, but at the same time the many issues you're discussing today are not altogether new to me.

As health care providers, we are increasingly challenged by low reimbursements, fierce competition, and workforce shortages. I know you'll be hearing from many hospitals about those issues. I am here because, while the University provides health care services, we do so because it's a necessary compliment to our primary mission, which is education and research. Naturally, I believe that this mission gives the UConn Health Center a special place in any plan for the future.

We know that our state faces significant growth in demand for healthcare. According to the 2000 US Census, Connecticut placed 10th among the states in terms of population aged 65 years and older. It is projected that we will move up to 9th place by 2010. While the Census Bureau projects that overall population growth in the State will increase a modest 5.3% percent by 2030, it projects a staggering growth of 65% in the 65- and- over population. In raw numbers, from 2005 to 2030 the states elderly population will grow by 315,000.

As we all know, this population accesses healthcare services at a more frequent rate, and is hospitalized at a much higher rate, than any other age group. We also know there are people of all ages in Connecticut who are underserved, and that many of our children face growing health challenges. Our future well-being demands sound planning today.

UConn's business is all about the future. We prepare the future healthcare workforce and discover the treatments of tomorrow. Our doctors train new doctors, dentists and scientists (nurses, pharmacists and physical therapists are educated at the Storrs campus) and a significant percentage of them go

on to practice in the state. Indeed, approximately 35% of our medical school graduates remain here, as do 46% of our dental school graduates. In addition, with more than $90 million in bio-medical research, we are advancing the frontiers of medical science and technology. Through the tremendous investment in stem cell research, to give one notable example, this state and its University are pioneers in a field that is destined to change the future of healthcare.

As the 16th largest employer in the state, our research activities, not to mention the commercialization of our intellectual property, contribute substantially to the states economic growth and well being. In short, we are a generator of new jobs, gross state product, and additional state tax revenues. As home to more than 600 doctors-in-training, we also provide the house staff to area hospitals, and these interns and residents contribute to a higher quality of patient care in the region.

As you know, UConn's John Dempsey Hospital is the state's only public acute care hospital. Our ability to provide that care contributes directly to the quality of the Medical and Dental Schools. It helps us to recruit and retain high quality faculty and students and to integrate our research and clinical efforts. It is also a training site for our students in nursing, pharmacy, biomedical engineering, and physical therapy, not to mention dental hygienists and dental assistants.

Finally, our public service mission means that we are the direct providers for many populations who would otherwise not receive services, such as dental services to Medicaid recipients and persons with developmental disabilities. Indeed, as part of our educational mission, we teach our students the value of service to the community through programs like the migrant worker clinics and homeless shelter clinics.

As the state's only public academic medical center, we produce the doctors and dentists who will treat this changing demographic, and the scientists who will create innovations in care and prevention strategies. The University of Connecticut will help prevent disease, will help treat disease, and will help cure disease, and we will accomplish this through education and research.

The development of a state health plan and state-wide health care facilities plan are critical to assisting all of us in mapping how together we will meet this growing demand for health care services. We play a special role in meeting those needs and ask that your recommendations include us as part of the solution. Thank you for your attention and consideration. I am happy to entertain any questions you may have.

TESTIMONY OF PETER J. KARL, PRESIDENT & CEO OF EASTERN CONNECTICUT HEALTH NETWORK (ECHN) BEFORE THE GOVERNOR'S HOSPTIAL SYSTEM STRATEGIC TASK FORCE
NOVEMBER 13, 2007

Secretary Genaurio, Commissioner Vogel, and members of the Governor's Strategic Task Force, my name is Peter Karl and I am the President & CEO of Eastern Connecticut Health Network, the non-profit parent corporation of both Manchester Memorial and Rockville General Hospitals.

I appreciate this opportunity to speak before the Task Force and to comment on some of your recommendations. ECHN is the single major provider of health care services as well as the largest employer in our communities. As a result, I feel a special responsibility to help assure that ECHN's two hospitals remain financially viable organizations in order to meet the growing patient needs in eastern Hartford and Tolland counties.

I urge the Task Force to recommend an increase in Medicaid, HUSKY and SAGA funding that reflects the current costs that we experience to provide high quality care to patients covered by such programs. I also encourage the Task Force to recommend a state-wide initiative involving the business, insurance and governmental communities designed to assure that Connecticut's hospitals receive adequate funding from the Medicare program.

Both of ECHN's hospitals need significant physical plant improvements as well as access to new technology. ECHN has recorded only very small operating margins over the past two years, insufficient for the type of investment necessary to update our facilities and replace aging equipment. As a result, patient access is compromised on both fronts. I would recommend that the Task Force support efforts to improve access to needed capital through innovative but sound financial mechanisms proposed by CHEFA.

Access will be further jeopardized in the future by the growing shortage of nurses, allied health professionals, and physicians. I support efforts aimed at increasing the number of nursing educators available to train the next generation of nursing professionals, as well as incentives designed to not only encourage this next generation of nurses, but to also assure their success once in the field. We must develop programs to attract physician specialists to Connecticut and incentives for those willing to practice in medically-underserved areas.

Finally, since ECHN operates one of the most comprehensive behavioral health services in a community hospital setting, I believe that the Task Force's recommendations must include adequate funding for our inpatient and outpatient adult and adolescent programs, which help meet the crisis needs and serve as the safety net for community-based programs.

Thank you.

Danbury Hospital

Testimony of Frank J. Kelly

President and CEO of Danbury Hospital

as presented to the Hospital System Strategic Task Force, Tuesday, November 13, 2007

Good afternoon Commissioner Vogel, Secretary Genuario and ladies and gentlemen of the Hospital System Strategic Task Force. My name is Frank Kelly and I'm the President and CEO of Danbury Hospital in Danbury, CT. I believe the draft recommendations of the individual subcommittees are quite valuable, on the whole. I'd like to speak specifically to two issues; the Financial Structure Sub-Committee recommendations that support increases in Medicaid and other government reimbursements to cover the cost of care and the System-wide Utilization and Planning Subcommittee's recommendations that address statewide planning for the delivery of behavioral health and substance abuse treatment.

Regarding the Financial Structure Sub-Committee recommendations that support increases in Medicaid and other government reimbursements to cover the cost of care, Danbury Hospital just closed out its FY07 in the black and has been in that position for the last several years. We have been repeatedly recognized by Cleverly and Associates studies for providing a high Community Value Index (Top 20% in the U.S.) based on the ratio of costs to charges. So you may wonder why I'm here today to talk about these recommendations and hospital underfunding. Our posted operating margins were largely funded by shifting costs from government-sponsored payers to commercial payers. We increased our revenue by 2.5% the last fiscal year in order to have funds enough to cover Medicaid and other government reimbursement shortfalls. In 2007, Danbury Hospital provided services to 13,427 CT Medicaid and SAGA patients at a cost of $16.2 million, receiving only $9.6 million in payment against those provided services. If Medicaid weren't underfunded, we wouldn't need to shift costs to private payers who then pass on these costs to employers and ultimately all citizens. We continue to see the number of Medicaid and Medicare patients climbing, including patients from other regions in Connecticut, and the need for this cost-shifting is an unsustainable and inappropriate practice.

Our Hospital and others are good stewards of the limited resources available. We hear the constant demands of our patients and community to have the best care and service using the latest procedures and technologies in a safe and modern environment and we struggle with how to manage those expectations based on the reimbursement shortfalls we face. Each of us has hard choices to make between hiring staff to provide needed direct care, fulfilling pension promises to employees, adding technology that will reduce medical errors and the constant challenge of maintain aging facilities.

I was particularly encouraged to read Recommendation 4, of the System-wide Utilization and Planning Subcommittee, that addresses statewide planning for the delivery of behavioral health and substance abuse treatment, particularly the acknowledgement of the escalating crisis of inappropriate use of emergency departments for those in crisis. As a Region V institution, we have faced significant challenges, as many of our sister institutions have, in terms of our ED utilization because of the lack of appropriate referral options. We look forward to partnering with the Department of Mental Health and Addiction Services ("DMHAS") and the Office of Health Care Access ("OHCA") to develop solutions to respond to the needs of those in our community. It is my belief that this set of recommendations is the most critical of those advanced by the task force and I hope that it receives priority consideration once the implementation phase of your deliberations commences. Our patients and their families can no longer afford status quo. Here again, the solution must include appropriate funding.

Thank you for allowing me some of your time today to speak on these recommendations. I'd be pleased to answer any questions you have today and also to be a part of any ongoing discussions.

Testimony of J. Kevin Kinsella, Vice President
Hartford Hospital
Draft Recommendation of the Governor
Strategic Hospital Task Force
11/13/07

Thank you for the opportunity to comment on the draft recommendations of the Governor's Strategic Task Force. My comments will be brief, focusing on the three major areas of the report.

Finance:

Connecticut Hospitals have continued to struggle under the burden of inadequate Medicaid reimbursement. Hartford Hospital, the second largest hospital in the state, lost $3.2 million in fiscal year 2006 -2007. This lost was on a total operating budget of $650 million. The lost was in large part attributable to the large number of Medicaid and SAGA patients treated on both our inpatient units and in our ambulatory clinics.

Workforce:

Loan forgiveness programs that now apply to Federally Qualified Health Centers (FQHCs) for physicians should apply to hospital clinics located only hundred of yards away with the same patient population.

The state should fully fund programs at our Connecticut State Universities and Community Colleges to support BSN programs.

System Utilization:

Item 4.3 suggests increases for behavioral health services in emergency rooms. I would recommend that one or two pilot programs be funded this year. These pilots would be similar to the CARES unit established for adults by the legislature and DSS last year.

Proposed recommendation 5.2 regarding boarding of patients in emergency rooms was not discussed in the task force meetings. This is a clinical/regulatory issue which needs to be vetted in a different arena rather than be part of the Governor's report and as written may be in conflict with regulations of the Connecticut State Department of Public Health.

The release of inmates from the Department of Corrections directly to emergency rooms at the end of their sentence is not good patient care but unfortunately is common practice. These issues regarding patient placement are currently be adjudicated by OPM on a case by case basis, which I believe is also not good practice. The contract that UConn Health Center has with the state to provide care for inmates should include care for inmates upon their release.

In the area of primary care the Department of Social Services should consider equalizing clinic visit rates between FQHCs and hospital clinics. This would help reduce the use of emergency rooms by patients for primary care.

Thank you for the opportunity to comment on the draft document.

CONNECTICUT TRIAL LAWYERS ASSOCIATION

CTLA . 100 Wells Street, Suite 2H. Hartford, CT 06103
Phone: (860) 522-4345 . Fax: (860) 522-1027
www.cttriallawyers.org

Office of Policy & Management:
Hospital System Strategic Task Force Public Hearing
Tuesday, November 12, 2007 – 12:45 p.m. Room 1E LOB

In its draft recommendations the Task Force suggested that, based on ***"much anecdotal evidence,"*** both new and experienced doctors no longer find Connecticut an attractive place to practice medicine.

The report continues, by suggesting that this trend, coupled with the high cost of living in Connecticut and, the high cost of medical malpractice insurance along with the burdensome "call requirements" for doctors, "Connecticut is experiencing a shortage of doctors in many specialty areas."

Therefore, the Hospital Task Force recommends based on this anecdotal evidence, that a Working Group consisting of physicians, insurance industry representatives and others be formed to develop a comprehensive tort reform proposal.

Is such a proposal duplicative? **YES.**

- Public Act 05-275 requires *Not earlier than October 1, 2008, the Insurance Commissioner shall review professional liability insurance rates in this state for physicians and surgeons, hospitals, advanced practice registered nurses and physicians assistants to determine whether (1) the amount or frequency of insured awards and settlements against physicians and surgeons, hospitals, advanced practice registered nurses and physicians assistance have decreased since October 1, 2005, (2) such rates reflect any such decrease, and (3) such rates bear a reasonable relationship to the costs of writing such insurance in this state. In conducting the review, the commissioner shall examine the rates for such insurance under policies issued by (A) captive insurers and risk retention groups, to the extent such information is available to the commissioner, and (B) insurers licensed in this state.*

  If after such review the ***commissioner determines that such insurance rates have not decreased,*** *and such insurance rates are not reasonably related to the costs of writing such insurance in this state, the commissioner shall convene a working group in accordance with subsection (c) of this section.* ***The working group shall consider, among other things, the amounts of awards and settlements during the prior ten years and shall recommend appropriate revisions, if any, to the general statutes in order to decrease rates or establish reasonable rates. Such revisions may include, but need not be limited to, reasonable limitations on noneconomic damages awards,*** *revisions to procedures used by insurers to establish rates, and regulation of reimbursement rates paid by health insurers and health care centers to health care providers in this state. The working group shall*

submit its recommendations to the General Assembly and the Governor in accordance with section 11-4a of the general statutes.

Has there been recent substantial legislation addressing malpractice insurance rates? **YES**

In 2005 the Connecticut General Assembly passed Public Act 05-275 (the "Act"). This act makes numerous changes in the laws dealing with civil litigation, primarily relating to medical malpractice; medical malpractice insurance regulation and oversight; and the regulation, oversight, and disciplining of doctors.

This comprehensive legislation enacted numerous alternatives to caps which have led, along with other market trends, to steady or lower premiums in Connecticut. In addition to the closed claim reporting outlined above the act also:

- requires, as a condition of filing a medical malpractice lawsuit, a signed opinion from a similar health care provider indicating that malpractice has occurred
- reduces the interest rate the court may award with respect to an offer of compromise for cases that accrue after September 30, 2005, from 12% to 8%, and establishes some additional requirements for such cases (In general, a cause of action accrues when the right to bring suit on a claim is complete.)
- makes expressions of sympathy by health care providers inadmissible in lawsuits by victims of unanticipated outcomes of medical care
- requires the court to review the evidence in medical malpractice cases where $1 million or more in noneconomic damages is awarded to determine if the award is excessive as a matter of law
- requires prior rate approval when an insurer wants to increase medical malpractice insurance rates by 7. 5% or more for physicians, hospitals, and certain other health care providers and requires an insurer to give insureds at least 60 days notice of (a) the proposed rate increase and (b) their right to request a hearing before the insurance commissioner
- amends the physician profile law to require more information about adverse licensure actions in other states, professional liability insurance, and active involvement in patient care and requires physicians to report any changes or updates in mandatory reporting information
- requires each hospital to contract with a patient safety organization to gather medical- or health care-related data and make recommendations to the hospital on ways to improve patient care and safety

Are there **Facts** not **Anecdotes** that have significant bearing on this matter? **YES**

- **The number of Doctors:** As reported by the Department of Public Health, the number of doctors who are licensed in the State Connecticut has increased every year from 2000 thru 2007. Specifically, the practice fields of Anesthesiology, Emergency Medicine, Family Practice, Internal

Medicine, Obstetrics and Gynecology, Orthopedic Surgery and General Surgery have all experienced increases in numbers respectively.

- **Economic Impact of Medical Malpractice awards on Connecticut Economy:** A January 2005 Economic Research Study ***"Malpractice Payments, Premiums and Physicians in Connecticut"*** conducted by Dartmouth (now both Harvard) Economists Dr's Katherine Baicker and Amitabh Chandra, demonstrated that the Connecticut "Total malpractice payments (verdicts and settlements) continue to represent only a small fraction of health care expenditures – ***less than one half of one percent."***

- **This same study also found:** "there is little evidence of decline in the current physician workforce (including obstetricians) accompanying increases in malpractice payments or premiums." **"Connecticut continues to have the third highest number of doctors, including obstetricians and gynecologists in the United States."**

- **Regarding Doctors Medical Malpractice Premiums:** During the last three years, from data collected from the Connecticut Department of Insurance, medical malpractices premiums have stabilized with no dependent premiums increases for Connecticut physicians. **In fact, one company (ProSelect) the leading writer of medical malpractice insurance in Connecticut has decreased its premiums by as much as 24% and, this line of insurance continues to reward companies with increased profits.**

- **Insurance Company Profits continue to increase:** According to the latest data available from the CT Department of Insurance, CMIC, the largest state mutual and the second largest CT medical malpractice insurer, reported net income from January 1, 2004 through June 2007 of $51 million after taxes. These profits were over 40% of the net premium CMIC earned from doctors. Since 2004 CT physicians have continued to fund CMIC profits with the following results -- **$7.6 million in 2004, $10.9 million in 2005 and $24 million in 2006.**

- **CT Medical Malpractice Insurance Market:** The CT Department of Insurance in its Close Claim Report dated April 2007 (page 8,) reports that; *"The market is concentrated with 87% of the premium written by the* ***top 10 insurers*** *and 50% by the top 2, Connecticut Mutual Insurance Company and ProSelect Insurance Company. The third leading writer, MCIC Vermont, is a hospital risk retention group and has almost 20% of the written premium. Non-admitted carriers (i.e., surplus lines [captives] and risk retention groups) are writing approximately 36% of the business."* The total number of insurers writing business in Connecticut, appearing in **Appendix 5** of the Closed Claim Report, indicates that 5 companies are writing annual premium of $10 million and above with a significant number of lesser companies writing premium of $3 million or less annually. The leading writer of Connecticut medical malpractice insurance, ProSelect, reports Direct Premium Earned (paid) of **$58 million for 2006. (See Attached – Appendix 5)**

- **Defensive Medicine:** In his 2005 richly researched book "The Medical Malpractice Myth," Professor Tom Baker, Connecticut Mutual Professor of Law and director of the Insurance Law Center at the UCONN School of Law writes, *"The best research shows that the price tag for medical malpractice insurance, medical malpractice lawsuits, and the **associated expenses** is somewhere between 1 and 2 percent of health care expenses, so malpractice lawsuits in fact are not an important factor in the high cost of health care. (Some readers surely are wondering about **defensive medicine** at this point. The short answer is that there is a lot of talk about defensive medicine, **but little proof**.)"[Page 46]*

- **Defensive Medicine II:** In **"The Effect of Malpractice Liability on the Delivery of Health Care"** a 2004 report for the National Bureau of Economic Research, Dartmouth Professors Baicker and Chandra address both the issues of physician exodus and defensive medicine. In their closing comments they state, *"The fact that we see very little evidence of widespread physician exodus or dramatic increases in the use of defensive medicine in response to increases of state malpractice premiums places the more dire prediction of malpractice alarmists in doubt. The arguments that state tort reforms will avert local physician shortages or lead to greater efficiencies in care are not supported by our findings."*

ACTIVE PHYSICIANS AND SURGEONS IN CONNECTICUT AS OF THE REPORT DATE **

Report Date:	10/4/2000	11/13/2001	7/26/2002	1/7/2003	1/8/2004	1/19/2005	1/4/2006	3/30/2007
Total CT Doctors	10,829	11,039	11,227	11,248	11,460	11,688	11,893	12,068
Total Doctors (Incl. Out of State)	13,875	14,124	14,448	14,535	15,016	15,344	15,662	15,970
Selected Specialties (IN STATE)								
Anesthesiology	481	500	500	495	501	509	513	523
Emergency Medicine	337	373	378	383	394	407	415	424
Family Practice	515	561	568	562	567	587	594	596
Internal Medicine	2,993	3,175	3,229	3,260	3,360	3,423	3,480	3,561
Obstetrics & Gynecology	627	650	652	356	665	674	669	671
Orthopaedic Surgery	345	359	360	362	367	373	378	382
General Surgery	475	485	483	489	490	477	469	483

** Source: CT Department of Public Health License and Renewal Master Analysis

AIS RISK CONSULTANTS, INC.

Consulting Actuaries • Insurance Advisors

4400 Route 9 South • Suite 1200 • Freehold, NJ 07728 • (732) 780-0330 • Fax (732) 780-2706

CONNECTICUT MEDICAL INSURANCE COMPANY EXPERIENCE

Based upon our analysis, Connecticut Medical Insurance Company (CMIC) has in recent years had: (i) excessive profits, (ii) a high level of surplus growth, (iii) a level of surplus disproportionately high in relation to premium and (iv) a pattern of reporting excessive reserves which would tend to lower the reported profit and surplus values below the real levels. This is discussed in the following items (all values are given in millions of dollars)

➢ The profits of CMIC have been extremely high in recent years, as shown in the following table.

Connecticut Mutual Insurance Company -- Net Premium and Income
(Amounts in Millions)

Time Period	Net Earned Premium	Net Income After Tax	Net Income as % of Premium
01/01/2004 - 12/31/2004	$37.3	$7.6	20.4%
01/01/2005 - 12/31/2005	$23.0	$10.9	47.4%
01/01/2006 - 12/31/2006	$42.0	$24.5	58.3%
01/01/2007 - 06/30/2007	$20.8	$8.4	40.4%
Combined	$123.1	$51.4	41.8%

An after tax net income of more than 40% of premium is highly excessive and indicates that rates can be substantially decreased.

➢ The large profits of CMIC have resulted in the surplus (i.e., net worth) of CMIC growing at a very large rate, as shown in the following table.

AIS RISK CONSULTANTS, INC.

Consulting Actuaries • Insurance Advisors

4400 Route 9 South • Suite 1200 • Freehold, NJ 07728 • (732) 780-0330 • Fax (732) 780-2706

CONNECTICUT MEDICAL INSURANCE COMPANY EXPERIENCE

Connecticut Mutual Insurance Company -- Annual Change in Surplus
(Amounts in Millions)

Time Period	Surplus Start of Year	Surplus End of Year	Annual Percent Change in Surplus
01/01/2004 - 12/31/2004	$67.7	$75.4	11.4%
01/01/2005 - 12/31/2005	$75.4	$83.5	10.7%
01/01/2006 - 12/31/2006	$83.5	$111.9	34.0%
01/01/2007 - 06/30/2007	$111.9	$125.3	25.4%
Average			20.4%

➢ The excessive profits of CMIC, along with the commensurate high increase in surplus, has resulted in the surplus of CMIC being disproportionately high in relation to the exposure to loss as measured by the premium, as shown in the following table.

Connecticut Mutual Insurance Company -- Surplus in Relation to Premium
(Amounts in Millions)

Time Period	Surplus End of Year	Annualized Net Earned Premium	Surplus in Relation to Premium
01/01/2004 - 12/31/2004	$75.4	$37.3	202%
01/01/2005 - 12/31/2005	$83.5	$23.0	363%
01/01/2006 - 12/31/2006	$111.9	$42.0	266%
01/01/2007 - 06/30/2007	$125.3	$41.6	301%
Average			283%

A surplus level of 2 or more times higher than the premium indicates a very large amount of surplus in relation to the exposure to loss.

AIS RISK CONSULTANTS, INC.

Consulting Actuaries • Insurance Advisors

4400 Route 9 South • Suite 1200 • Freehold, NJ 07728 • (732) 780-0330 • Fax (732) 780-2706

CONNECTICUT MEDICAL INSURANCE COMPANY EXPERIENCE

➢ The reserves established by CMIC have been consistently excessive.

CMIC has displayed a consistent pattern of using excessive reserve values in the financial statements submitted to the Connecticut Department of Insurance (CTDOI).

The reserves values published by CMIC and submitted to the CTDOI as of 12/31/2006 have turned out within just six months (through 6/30/2007) to be excessive by $8.0 million. This continues a pattern which has existed over the years for CMIC to set excessive reserves.

The consistent pattern of over reserving by CMIC has tended to depress the values reported by CMIC for both profits and surplus. Hence, the values discussed in the prior items are if anything too low, and the real CMIC profits and surplus are higher than those reported by CMIC, which makes the situation of the excessive rates being charged by CMIC even more egregious.

BRIDGEPORT HOSPITAL
YALE NEW HAVEN HEALTH

Testimony of Bridgeport Hospital
Before the Hospital Task Force
November 13, 2007

Hospital Task Force Recommendations to Governor Jodi Rell

Good afternoon Commissioner Vogel, Secretary Genuario and members of the Hospital Task Force. My name is Patrick McCabe, and I am the Chief Financial Officer of Bridgeport Hospital. Thank you for the opportunity to comment on this critical matter.

Bridgeport Hospital strives to be both a provider and employer of choice that delivers safe, high quality care. Last year, we provided more than 200,000 outpatient and emergency room visits and 19,600 inpatient stays. We offer services from primary care in our clinics to leading edge specialty inpatient services. We train hundreds physicians and nurses, have the only burn service for the State of Connecticut, are a recognized leader in cardiac care, and have the only Pediatric Intensive Care Unit in Fairfield County. Our full range of health care services is available 24 hours a day, 365 days a year. We take our mission seriously and are proud to be the safety net provider for the community. Additionally, with 2,200 employees, Bridgeport Hospital is one of the largest employers in the greater Bridgeport area.

A member of Yale New Haven Health System, Bridgeport Hospital serves a significant number of Medicaid patients. In FY 2007, Bridgeport Hospital had nearly 5,200 Medicaid and Medicaid Managed Care discharges, which represents 26 percent of total discharges for the year. We are the hospital with the second highest proportion of Medicaid discharges in the state (highest proportion is Connecticut Children's Medical Center.) However, we are not paid what it costs us to care for these patients.

Today, Bridgeport Hospital receives only 70 cents for every dollar spent on providing care to its Medicaid patients. In FY 2007, the hospital's shortfall for all Medicaid programs was approximately $19.5 million. Bridgeport Hospital subsidizes this underpayment by negotiating higher managed care rates with commercial payors. However, this cost is passed through by health plans to businesses, causing the citizens of Connecticut to shoulder more of their healthcare costs (through higher deductibles and co-pays) or forego health insurance altogether, which then leads to more people without health insurance. In addition, because virtually all the funds in excess of cost received from the managed care companies must go to cover the Medicaid shortfall, there is little left over to keep up with the constant capital needs of the hospital. Important projects that would enhance patient safety, such as installing a Computerized Physician Order Entry system, have been implemented over the course of multiple years, as we have had the funding available.

I applaud this Task Force for its hard work to examine the financial health of Connecticut's hospitals, access to affordable care, emergency room utilization, and the delivery of primary care. Although there are numerous recommendations that were suggested by the subcommittees, there are a few on which I would like to comment.

267 Grant Street
P.O. Box 5000
Bridgeport, CT 06610-0120
203.384.3000

I applaud the Hospital Task Force for acknowledging, through its Financial Structure Subcommittee, that rates for hospitals and other providers in State and Federal health programs are not equal to the cost to provide that care, and that the shortfall is transferred to business and those insured through the workplace in the form of cost shifting. The cost shift is a barrier to affordable employer-based health insurance and is not sustainable. It is critically important that rates paid to hospitals cover the cost incurred in the Medicare, Medicaid Fee-For-Service, Medicaid Managed Care, and SAGA programs. In addition,

- the rates paid in these programs must be issued in a timely and predictable manner so that required major long-term investment in infrastructure and technology can be undertaken,
- SAGA reimbursement rates should be reset to equal Medicaid rates,
- and, DSS should file a waiver to permit the inclusion of SAGA in Medicaid so that hospitals can receive all available Medicare DSH dollars.

Additionally, Bridgeport Hospital generally supports the recommendations of the Task Force's System Wide Utilization and Planning Subcommittee for the creation of a State Health Plan that would address public health priorities, leading causes of mortality and morbidity and needed health care delivery systems, and also the creation of a State-Wide Health Care Facilities Plan. More specifically however, Bridgeport Hospital agrees that it is critical for the State to reduce the inappropriate use of hospital Emergency Departments (ED) for Mental Health services by implementing programs to assure access to and use of outpatient services and reducing the inappropriate use of hospital EDs for primary health services. This would help to alleviate the burden on hospital emergency departments that need to be available for patients who need emergent as opposed to urgent care.

I would also like to comment on the Workforce Planning and Development Task Force's recommendations. Over the last several years, it has become more difficult for hospitals to recruit and retain qualified healthcare professionals. Increasingly, this has become a major cost driver from Bridgeport Hospital, as we have had to continually increase clinical salaries to stay competitive in a tight market and have had to hire expensive, temporary staff to cover vacant positions. Bridgeport Hospital has a nursing school and accepts 150 students a year into our program. We receive over 500 applications for those 150 slots. Based on our experience, and also discussions we have had with other nursing schools in Fairfield County, a key issue is one of capacity in the schools. Thus, I strongly recommend the State determine a way to increase the capacity (faculty and classroom space) of training programs in the state so we can produce the nurses, pharmacists, physical therapists, and other clinical staff that our state will need to care for its citizens over the next 20 years.

Bridgeport Hospital is a valuable resource for the Bridgeport Region and the State. However, as patient demands increase and state reimbursement continues to lag well behind cost, our ability to meet these demands will be increasingly challenged. We hope that the recommendations of the overall hospital taskforce will provide adequate guidelines that will aide the State in stabilizing Connecticut's hospitals.

Thank you for your consideration on this important matter.

- DANIEL J. McINTYRE, PRESIDENT
  THE CHARLOTTE HUNGERFORD HOSPITAL IN TORRINGTON, CT.

- AN ACUTE CARE NON-FOR-PROFIT HOSPITAL LICENSED FOR 109 BEDS

- SERVING TOWNS OF TORRINGTON, WINSTED, LITCHFIELD, GOSHEN, HARWINTON, NEW HARTFORD, BARKHAMSTED, COLEBROOK, CORNWALL, MORRIS, NORFOLK, THOMASTON, AND CANTON

- MEDICAID COSTS AND REIMBURSEMENTS:

Hospitals	Medicaid FFS Total	Managed Medicaid Total	SAGA/ OMA Total	Total Med. Ass't Total
Total Cost	3,348,455	4,529,376	3,079,625	10,957,455
Total Payment	1,628,772	2,991,342	777,527	5,397,641
Patient Services Gain/Loss	(1,719,683)	(1,538,034)	(2,302,098)	(5,559,814)
Patient Services Margin	-105.6%	-51.4%	-296.1%	-103.0%

- RECOGNIZE THE COMPLEXITY OF EACH OF OUR SETS OF ISSUES (HOSPITALS, INSURERS, PHYSICIANS, STATE AND FEDERAL PROGRAM ADMINISTRATORS, SOCIAL SERVICE AGENCIES, PATIENTS, AND TAX PAYERS).

- RECOGNIZE THAT EACH OF US IN THESE HEALTH SERVICE AND HEALTH CONSUMER SECTORS REALLY BELIEVE THAT WE'RE DOING THE BEST WE CAN WITHIN OUR RESPECTIVE SCOPES OF RESPONSIBILITY AND GIVEN OUR VERY LIMITED RESOURCES.

- SPEAKING ONLY ON BEHALF OF CHH, OUR FRUSTRATIONS AND CHALLENGES HAVE BEEN THESE:

    - STATE, FEDERAL AND PRIVATE COMMERCIAL INSURANCE PLANS, AS WELL AS STATE AND FEDERAL GOVERNMENTAL AGENCIES HAVE ALLOWED OUR HOSPITAL'S BEST PAYING SERVICE LINES TO BE TAKEN AWAY FROM OUR HOSPITAL (ORTHO/G.I.)

    - I RECOGNIZE THAT THE C.O.N. LAWS WERE FINALLY CHANGED, BUT SOME 30 DEALS WERE MADE IN ORDER TO GET THE C.O.N. LAWS CHANGED. THIS MOVED 1,000 OUTPATIENT SURGICAL CASES OUT OF OUR COMMUNITY HOSPITAL.

    - THIS EVENT, ADDED TO THE HISTORICAL MEDICAID UNDER PAYMENT, NOW CALCULATED AT ABOUT 5.6 MILLION DOLLARS PER YEAR DID NOT AND DOES NOT HELP US.

    - I BELIEVE WE HAVE WONDERFUL PLANS TO IMPROVE OUR QUALITY OF CARE AND OUR LEVELS OF SERVICE TO PATIENTS AND FAMILIES, BUT MY FEAR IS THAT OUR ABILITY TO MAKE GOOD PROGRESS IS ALWAYS COMPROMISED BY PROGRAMS NOT PAYING US WHAT WE DESERVE AND BY THE DEAL-MAKING THAT SEEM TO BE A NECESSARY PART OF WHAT WE CALL "PROGRESS".

- SOCIETY HAS ENTRUSTED US TO CARE FOR OUR ILL AND OUR INJURED. WE'RE CERTAINLY NOT PERFECT, BUT WE TRY VERY HARD TO PERFECT OUR CARE AS EACH HOUR OF OUR 24 HOUR DAY PASSES.

- IT IS NOT HELPFUL TO US WHEN WE ARE CONSTANTLY UNDER PAID WHILE WE SIMULTANEOUSLY FACE SOCIETY'S AND GOVERNMENT'S EVER-GROWING EXPECTATIONS.

- IF YOU EXPECT US TO CARE FOR OUR SICK, PLEASE GIVE US THE FUNDING WE NEED, AND ALLOW US TO DO OUR JOB. THANK YOU.

Governor's Hospital Task Force
Public Hearing
Tuesday, November 13, 2007

Testimony of: *William E. Purcell, President*
Greater Valley Chamber of Commerce
900 Bridgeport Avenue
Shelton, CT 06484

Good afternoon to the Chairs and to all of the distinguished members of Governor Rell's Hospital System Strategic Task Force.

My name is Bill Purcell, President of the Greater Valley Chamber of Commerce, a voluntary business association serving over 750 member businesses in the All-America City Naugatuck River Valley here in the great State of Connecticut.

Let me begin by congratulating Governor Rell for her leadership and foresight in establishing a high-level Task Force to examine the financial condition of Connecticut's hospitals and to propose strategies to stabilize the system so as to ensure access to necessary and quality healthcare services for all of the state's residents and businesses.

And thanks to all of you; leaders and experts in your respective fields, for dialoging, debating and laboring over the critical issues that face the state's 30 acute care hospitals, and by extension, both the physical and, I will argue, the economic health of our citizens and our communities.

I am pleased to join with so many of my colleagues in representing the state's businesses and business associations who recognize the critical role that our hospitals play in providing us with a vital healthcare safety net, while serving as economic engines for our local communities and the statewide economy.

I believe that the Task Force was prudent and wise to organize itself into three subcommittees, centered on the Financial Structure, Workforce Issues, and System-wide Strategizing and Planning. I would like to provide a brief comment on some of the subcommittee's recommendations; and thought it best to do so in the context of my experience and observations of the Valley's leading community Hospital.

First, let me provide you with a few facts… Griffin Hospital is a not-for profit tax-exempt subsidiary of the Griffin Health Services Corporation. A 160-bed acute care community hospital located in

the City of Derby, the very heart of the lower Naugatuck Valley, Griffin has over 200 active and courtesy physicians who have admitting privileges.

Griffin has received national recognition for creating a facility and an approach to patient care that is responsive to the needs of the community.

In fact, just last month, Griffin was honored with the 2007 Premiere/Care Science Select Practice National Quality Award for superior patient outcomes in both quality and efficiency; one of only 49 hospitals nationally, or the top 1% of acute in-patient facilities to be recognized with this Award.

Each year, Griffin Hospital provides care for over 7,500 people admitted to its facility, treats more than 36,000 people in its emergency department, and welcomes over 700 babies into the world.

As a leading contributor to the Valley's economy, Griffin employs over 1,300 people, 80% of whom are the Valley residents, contributes over $158 million annually to the Valley's economy, and provides the City of Derby with $900,000 annually through the State's PILOT Program.

Presently, the hospital is in the midst of a major capital expansion with the construction of a 49,000 square foot Ambulatory Care Pavilion and Community Cancer Center to be combined with the expansion of the hospital's ER Department to accommodate its 37,000 annual patient visits.

Together, these projects represent a $33 million investment in the Valley economy, are providing hundreds of construction jobs at a time when they are sorely needed, and will provide our residents with vital healthcare services "closer to home".

With this as a backdrop, it is clear why the Chamber and all Chambers across the state are concerned about the current and long-term financial health and condition of our acute care hospitals and why the work of this Task Force is so important.

Today, Griffin, like most of the state's acute care hospitals, is struggling to maintain the viability of its fragile infrastructure in the face of inadequate government reimbursement rates and uncompensated care.

In 2005, for instance, Griffin treated 3,448 persons without health insurance. In the same year, Griffin provided care for 9,298 Medicaid recipients and 9,273 Medicare recipients. Half of all patients treated at Griffin are uninsured or covered by under funded government programs.

Sadly, the cost of care far exceeds reimbursement. For every $1 that Griffin spends on providing care, Medicare reimburses only 97 cents, Medicaid only 86 cents and SAGA only 52 cents.

In total, the state's under funding shortchanges the hospital by nearly $2 million annually, which could have leveraged $1 million in federal matching dollars and another $1 million in local economic activity.

The Chamber is in full support of the subcommittee's recommendations to increase the Medicaid reimbursement for services to reflect current costs to provide care to patients in the Medicaid-Fee-For-Service, HUSKY and SAGA programs.

The Greater Valley Chamber would also be willing to join a coalition with the Administration, the Connecticut hospitals, Insurance Companies and other Business Associations in advocating for adequate funding from the Medicare Program.

We believe that these programs will help to eliminate the "hidden tax" on Connecticut businesses that results from inadequate Medicaid reimbursement which forces hospitals to shift cost to commercial payers/managed care companies who in turn raise the premiums they charge employers that purchase health insurance for their employees. The resulting inflated premiums and higher operating costs put Connecticut businesses at a disadvantage versus competitors operating in other states. Rising premiums have forced some companies to drop employee health coverage or dramatically raise co-pays and deductibles which may restrict access to care which in the long run will have an impact on worker productivity.

Finally, the Chamber supports the subcommittees recommendation to authorize CHEFA to provide a bonding mechanism that will provide our hospitals with access to the capital necessary to invest in physical plant, equipment and advanced technology.

Such a state-backed mechanism can help to lower the cost of capital and position our hospitals to leverage additional private dollars through philanthropy.

This is illustrated in the Capital structure of Griffin's Ambulatory Care Project, which is comprised of a Bond issue of $27.5 million and a Private Capital campaign of $5.5 million.

With regard to the Workforce subcommittee recommendations, the Chamber is in full support of establishing a comprehensive database of licensed healthcare professionals, to encourage and support our hospitals to share best practices in human resources training and providing a supportive and professional work environment, and to provide scholarships to clinical providers who are willing to practice in under-served areas across our state.

Saint Mary's
HEALTH SYSTEM

Office of the President
Robert P. Ritz, C.H.E.

Hospital System Strategic Task Force
Testimony of Robert P. Ritz
November 13, 2007

Good afternoon and thank you very much for the opportunity to provide comments on the State's Hospital System Strategic Task Force preliminary recommendations

Before I begin, I would like to offer our sincere appreciation to Governor Rell, the Administration, Secretary Genuario, Commissioner Vogel, and members of the Hospital System Strategic Task Force. We appreciate the investment in time and resources that the Governor has allocated to this very important process. We also appreciate the leadership provided by Secretary Genaurio and Commissioner Vogel to co-chair this process.

It is a very critical time for our State's healthcare delivery system and it is extremely appropriate for the State to critically analyze the status of our healthcare delivery system and its performance.

- At a time when the nation's hospital industry has reported five years of successive improvements in operating performance and profitability, our State hospital industry, as confirmed by the 2006 Annual Report published by the Office of Health Care Access, has declined in financial status and performance. As a result, our hospitals are challenged to fulfill our missions and to ensure access to needed healthcare services.
- The review by the Governor's Task Force is sound healthcare and economic policy. The quality of living in our communities, and certainly in the State as a whole, is directly related to the wellbeing of the State's healthcare delivery system. It is also sound economic policy to ensure the State's healthcare delivery system is financially stable and able to sustain itself for the long term. Our hospitals are typically the largest employers in their respective communities and a weakening healthcare delivery system will clearly weaken local economies. Studies have shown an investment in healthcare has a multiplier effect of approximately four to six times. Hospitals are typically the greatest contributor to their local economy from an investment standpoint. Therefore, from a policy standpoint, we need to understand our healthcare delivery system and, specifically, we need to take decisive action to improve its long-term outlook to strengthen our economies and to ensure access to healthcare services.
- Looking at the nation as a whole, the hospital industry has returned to profit levels that were common prior to the passage of the Balanced Budget Act of 1997. Economically, we know a corporation needs to generate a 3-5% operating margin to sustain itself and to fund its future. Yet, at a time when our nation's hospital industry appears to gaining strength after 10 years of impact from the Balanced Budget Act, the hospital industry in the State of Connecticut shows opposite trends. Specifically, the 2006 Annual Report published by the Office of Healthcare Access, recently confirmed the operating

56 Franklin Street
Waterbury, CT 06706

performance of our State hospitals is declining, with a 0.62% operating margin. This level of performance is truly a cause for concern.

- The two hospitals in Waterbury have also shown similar trends in performance. Over the last 10 years, the two hospitals in Waterbury have sustained significant operating losses totaling approximately $180 million. This clearly strains our local economy and impacts the ability of our healthcare delivery system to meet its fiduciary, clinical, and economic responsibilities to our community. Our two hospitals have sustained themselves by delaying investment in facilities, technologies, development of new programs and services, and expansion of existing programs and services.
- At a time when the demand for healthcare is increasing as indicated by inpatient, outpatient, and emergency department statistics, we find ourselves struggling to survive. When analyzing the reasons for this financial pressure, which ultimately transfers to the quality, efficiency, and performance of our delivery system, it appears the level of reimbursement for Medicaid and other state payers is placing hospitals in a financially challenging position.
- While hospitals are not-for-profit organizations and typically organized under section 501c(3) of the Internal Revenue Service Code, it goes without saying hospitals, too, need to generate an operating profit to reinvest in the community, jobs, and future services.
- Saint Mary's, specifically, is in a "Catch-22" situation. The hospital continues to grow as a result of increasing demand for services, yet the socioeconomic and demographic characteristics of our marketplace put the hospital in a unique situation. Our inpatient occupancy is one of the highest in the State at approximately 92%. Demand for emergency department services has grown by approximately 5% annually for the last five years, and the increase in demand for outpatient and primary care clinic services continues to grow at approximately 5% per year. As a result, Saint Mary's needs to expand facilities and services yet, due to the financial pressures of past performance, the hospital has a difficult time accessing capital to fund these very important and needed investments. Therefore, efficiency is challenged, patients are boarded in the emergency department awaiting inpatient beds, and outpatient and emergency department services suffer tremendous inefficiencies.
- This year alone, based on the projected reimbursement for Medicaid and other State payers, Saint Mary's forecasts a $16.8 million loss at the beginning of the fiscal year 2008. This loss must be made up by increasing profits from Medicare and third-party commercial insurers. It is impossible to negotiate a better rate from Medicare and it is equally challenging to negotiate commercial rates at the level required to subsidize this loss. Therefore, Saint Mary's must do everything possible to break even from providing patient care services. After years of sustaining operating losses, the hospital's ability to access capital and invest in improving quality, technology, efficiency, and facilities is a significant challenge.
- On average, it appears Saint Mary's receives approximately 70 cents on the dollar of actual cost for providing services to the Medicaid and other State-payer populations. After 99 years of mission effectiveness, our ability to sustain our safety net of services is questionable. In addition, due to the challenging reimbursement environment, coupled with the increasing demand for our services, we find it extremely difficult to get physicians who are willing to provide emergency call for support of the emergency department. This year alone, our emergency department will see approximately 70,000 patient visits, of which 44% are Medicaid and other state payers. This is one of the highest in the state. In order for Saint Mary's to address the healthcare needs of these patients presenting to our emergency department, the hospital has to compensate physicians to take call due to their losses, risk of malpractice, and disruption in their private practice settings, where paying patients are scheduled for their services.

Needless to say, this has become a significant challenge and one that will only get worse. Perhaps should pay a premium rate of reimbursement for physicians who see patients in the emergency department.

- Saint Mary's is one of the largest providers of Medicaid-reimbursable services in the State. Even though the hospital is one of the lowest-cost hospitals in the State, due to the low reimbursement rate, the Hospital continues to forecast substantial operating losses from taking care of Medicaid and other State-payers. We applaud the State, the legislature, and the Governor for passage of this year's bi-annual budget in which reimbursement rates for Medicaid services are being increased. However, we forecast an improvement of approximately $2.4 million over the next two years versus the annual operating loss on these patient services of approximately $30 million during this same timeframe.
- Saint Mary's is committed to fulfill its Mission to provide excellent healthcare services in a spiritually enriched environment. Our Hospital runs at an extremely high occupancy rate, perhaps with a law of diminishing return on efficiency due to the "bottle-neck" in the emergency department. Pressure for delivering outpatient and inpatient behavioral health services, primary care services, and growing inpatient demand will continue to weigh heavily on the Hospital's ability to fund its Mission at its current level. Therefore, without substantial reform in payment and access to capital, the balance in the financing and delivery of our healthcare delivery system and, specifically, at Saint Mary's, could prove detrimental to the access to healthcare services.
- We appreciate the Governor's Hospital System Strategic Task Force recommendations to make improvements in the financing and delivery of healthcare that will not only sustain our current healthcare delivery system but also to assist hospitals to improve quality, investment in expansion of facilities and programs, and upgrading clinical and information technology. In addition, workforce-related issues are paramount with our local and state healthcare delivery system. The State of Connecticut is forecasted to have one of the greatest deficits in the availability of registered nurses over the next twenty years. This, too, will place an increasing financial burden on the ability of hospitals to provide services and to sustain their long-term outlook. Without reform of our State healthcare policy and, specifically, reimbursement for Medicaid and other state-payers, our healthcare delivery system and will continue to perform significantly below the national level.
- In this great state of Connecticut, one of the most advanced states economically and educationally, we cannot afford to let this negative trend in our state's healthcare delivery system continue.
- As policy-makers and key decision-makers, we applaud your efforts to improve the outlook of our healthcare delivery system and we stand ready to help implement changes that will improve the long-term outlook for our State's healthcare delivery system.

Thank you very much for this wonderful opportunity to comment on the Task Force's preliminary findings and recommendations.

56 Franklin Street
Waterbury, CT 06706

Innovative Hospice Care®
VITAS®

Governor's Hospital Task Force
Public Hearing
November 13, 2007

Testimony of Pat Tadel, RN, MSN, CHPN
Hospice Director, VITAS Innovative Hospice Care of Middlebury

Good afternoon Secretary Genuario, Commissioner Vogel and members of the Governor's Hospital System Task Force. My name is Pat Tadel, Hospice Director for VITAS Innovative Hospice Care, which operates two Medicare certified hospice programs in the Greater Waterbury, Hartford and Bridgeport areas of Connecticut. I am an advanced practice registered nurse, certified in hospice and palliative care, and I have been working in hospice and palliative care for over 16 years. I am a thanatologist and hold a post-doctoral certificate in clinical ethics. My clinical experience includes 2 years working in the Chicago Cook County hospital system. During this time the Medicaid hospice benefit was rescinded and the dramatic increased use of Emergency department and financial burden on hospital systems was personally experienced by me and others supporting those with life-limiting illnesses. I am here this afternoon to raise awareness amongst policy makers and suggest your task force recommend encouraging more hospice utilization by Connecticut's hospitals and to recommend adding a Medicaid hospice benefit.

VITAS Innovative Hospice Care®, a pioneer and leader in the hospice movement since 1978, is the nation's largest provider of end-of-life care. VITAS employs 8,640 professionals who care for terminally ill patients daily, primarily in the patients' homes, but also in the company's 25 inpatient hospice units as well as in hospitals, nursing homes and assisted living communities/residential care facilities for the elderly. VITAS cares for approximately 11,500 patients and families each day.

VITAS has been providing hospice services in Connecticut since 2004. In the few years in which we have been serving patients here in Connecticut, we have provided hospice care to over 1,800 patients and families.

VITAS is committed to expanding access for traditionally underserved populations, particularly communities of color, the economically disadvantaged and those with non-cancer diagnoses including AIDS. We have been advocating for a Medicaid hospice benefit for the past two years and are please to speak before you on this important issue to Connecticut's Medicaid population.

I have listed out some important considerations which impact the overcrowding of emergency rooms and pull at hospital resources.

- Team approach to care
  Four hospitals in CT have engaged in a partnership which assures effective and timely management of patients with life-limited illness. Rapid response for patients in crisis avoids hospital admissions and decreases time in the ED by the hospice interdisciplinary team. Consultation related to prognosis and goals of care for disease trajectory demonstrates best practice with hospice as part of the continuum of care, not an endpoint. Safe discharge home with assurance of staying home, limited return to ED over the next week and ongoing support with no exacerbation of symptoms which warrants return to ED. Hospice pharmacy services are available 24 hours a day. Nurses and psychosocial team can be reached anytime day or night to respond to the suffering of patients and their families, going to where they live, whether alone, in a nursing home, or assisted living community to assure their needs are addressed rapidly.
  Use of continuous care and aggressive patient/family teaching helps with acute management so that patient's symptoms controlled in home setting
  Aggressive crisis intervention in the home setting can support patient's advance directives while managing symptoms and keeping the patient out of the ED
  Patient is supported so that independence is maintained for as long as possible so that the developmental tasks at end of life can be accomplished without restrictions such as being home-bound.
- Tipping point related to decline for non-cancer and cancer patients alike is related to activities of daily living such as getting in and out of bed and anxiety related to this can exacerbate other symptoms such as shortness of breath and physical pain. End of life patients with life-limiting illness, whether cancer or non-cancer should be supported with hospice services. For instance, the ACC/AHA Practice Guidelines (2005) recommend that for Stage D refractory heart failure compassionate end of life care/hospice should be part of the plan of care for all patients. Per Dr. Mariell Jessop, "There is a failure to recognize that end-stage heart failure patients frequently come in and out of the hospital over and over again and suffer a lot with really no impact on their ultimate survival" (2005).
- Cost savings for home hospice patients
  In the last month of life alone, savings from 31 - 64% Tamir et al (2007)
  In the last two months patient supported outside of the hospital setting by hospice services go up to a median of 80% regardless of disease
  Labs and radiology use, as well as ICU and other hospital unit stays are significantly high the last 48 hours of life for the seriously ill. This patient population also has a markedly higher use of ED in the 12 months prior to death (Rice & Betcher, 2007)
  Shorter quicker initial interventions for patients in the ED when hospice support is identified can not only move patient quickly through the process, but conversations with the patient and family can help clarify goals for care for the end of life patient caught up in the revolving door of crisis management. "Making an impact earlier not only markedly improves care quality, but also contributes to the hospital's overall efficiency" (Meier & Beresford, 2007).
- Lengthy inpatient stays over the last 12 months of life
  Center to Advance Palliative Care (CAPC) developed process of estimating total reimbursements for providing care for patients who died inpatient and projecting a reduction in service costs associated with providing evidence-based care to the terminally

ill. Inappropriate or ineffective care results in negative clinical outcomes, which includes longer length of stay and frequent use of healthcare services, including ED and outpatient clinics (Morrison, Ransey, and Snyder, 2000).
Weighing the benefit against the potential harm of life-prolonging care should be part of ongoing treatment discussions and this is eased by earlier access to hospice services.
Over one third of hospice referrals are made in the last two weeks of life.

- Death attendance
  Although 9:10 patients say they would prefer to die at home numerous studies show that unless supported by hospice services, death occurs in hospital in upwards of 80% for patients with life limited illness. (Tamir, et al, 2007 and Rice & Betcher, 2007).
- Limited access and no funding for Medicaid patients with life-limited illness.
  Three times more access to ED than the privately insured, 5 x more for non-urgent care.
  Medicaid FFS patients access the ED 14 x higher than privately insured
  Mentally ill patients may have co-existing illness which may be life-limiting and contributing factors to crisis which brings the patient to the ED
  Evidence exists which demonstrates appropriate alternative services should include hospice funding for this patient population
  The aging population and lack of support for Medicare patients with life-limiting illness will continue to tax emergent care services

These issues should unsettle all of us because they do not only tap our limited resources, but are not in alignment with best practice for care of the seriously ill. Evidence-based practice is the "conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients." Sackett et al (1996). Gibbs (2003) also clarifies this as looking at patient benefits first, asking questions with "direct practical importance to clients" which "involves continually posing specific questions of practical importance to clients, searching objectively and efficiently for the current best evidence relative to each question and taking appropriate action guided by evidence." Interventions which take into consideration the trajectory of illness, continually asking the question, does this intervention offer the best impact for optimum benefit for this patient. Best practice demands that goals of care include "doing the right thing at the right time" to assure outcomes which include the individual patient's goal of care, quality of life and developmental tasks. When what we are doing isn't doing enough, hospice adds clinical expertise to assure symptoms are managed and holistic care of the patient occurs as aggressive palliation of symptoms. As one patient said, "If you can't fix me, cure me, make it go away, can you at least see me for who I am, and try to stand beside me, so that I don't have to work so hard just to be here". When the diagnosis-therapy-cure model can no longer offer the patient support, patient perspective becomes paramount (Michiels, et al. 2007)

In an article titled "What do we owe the dying? Strategies to strengthen end-of-life care" by Imhof and Kaskie (2005) the authors remind us "the aging of the US population in the next 20 years will result in the significant increase in the number of deaths and the rise in end of life service reimbursements". As well, lack of evidence-based practice results not just in intensive life-sustaining medical interventions and lengthy inpatient stays, but also leaves pain and other symptoms unrelieved. In a statement released by the Center for Medicare and Medicaid Services (CMS, 2003) is noted, "Much of the pain and sense of hopelessness that may accompany terminal illness can be eased by services specifically designed to address these needs".

Increasing involvement of hospice at the point of access, in the Emergency department, can assure supportive services are brought forward which follow clinical guidelines and support patient/family preferences, take into consideration benefit and burden of care options, and enhance quality of life.

In closing, I would like to encourage the task force to make two recommendations regarding better utilization of hospice programs in Connecticut.

1. The task force should encourage Connecticut hospitals to partner with hospice programs to assure effective and timely management of patients with life-limited.

2. The task force should recommend the addition of a Medicaid hospice benefit in its state plan to allow more hospice programs to care for terminally-ill patients at home as opposed to a hospital.

I appreciate your time, and I am happy to answer any questions you might have.

Testimony of
Laurence A. Tanner, President and CEO
The Hospital of Central Connecticut
Before the Hospital System Strategic Task Force
Tuesday, November 13, 2007

Secretary Genuario, Commissioner Vogel, and members of the Task Force, my name is Larry Tanner and I am President and CEO of The Hospital of Central Connecticut. I am grateful for the opportunity to address you today in support of the critical work being done by this committee on hospital stabilization and in particular the set of draft recommendations that have recently been developed. Last year's legislative session brought with it a much needed focus on the fragility of our hospital system. It is apparent to me that Governor Rell and the leaders of our state legislature do recognize the urgency of these issues. I believe there is also a growing recognition of the interrelationship between hospital financial stabilization and both the optimization of the larger health delivery system in Connecticut and the state's overall level of economic competitiveness.

Let me start by stating the following: The absolute key to the long term financial viability of Connecticut's acute care hospitals is an effective response to the chronic under-funding of hospital service by state and federal government agencies. At The Hospital of Central Connecticut, government programs account for more than 61% of our revenue stream. Based on the latest OCHA findings, we are paid 16% below our cost for both these government programs. In absolute dollar terms, we lost $24.5 million dollars providing services to Medicaid and Medicare beneficiaries last year ($6.5 million for Medicaid, $18 million for Medicare). Despite whatever I or any CEO can do in terms of improved efficiency of hospital services, this level of under-funding is simply not sustainable.

The Hospital of Central Connecticut provides a substantial and disproportionate level of care to the underinsured in Hartford County. Through a recent analysis we did using Connecticut Hospital Association (CHIME) data, our proportion of inpatient Medicaid discharges to total discharges was the 4th highest in the state and the largest in the county. In our emergency room, we had over 24,000 Medicaid visits in 2006 which accounted for 42% of the total visits; the second highest percentage in the state. What is even more troubling is that between 2006 and 2007, we have noted a 17% growth in the volume of Medicaid discharges. At the current of under-funding, our continued financial viability is seriously challenged by these trends.

I do want to deal straight on with at least one issue which I would expect members of the Committee to inquire about. That is the question of what impact the additional funding approved by the legislature for the current biennial budget will have on the level of under-funding. Did it help? Absolutely. Did we appreciate it? Absolutely. Did it erase 25

years of rate freezes and reductions? Unfortunately the answer to that is no. Our costs continue to rise for employee salaries and for many components of our cost structure such as energy, blood products, pharmaceuticals and supplies, etc. Secondly, despite the very substantial amount of new funding that was approved, it unfortunately represented about a third of the current shortfall of over $300 million. Working our way out of this funding deficit will take more than 2 years.

It is true that some hospitals in Connecticut, including The Hospital of Central Connecticut have recently managed to somehow achieve a modest margin despite government under-funding. However, where hospitals have achieved positive margins, they have largely been achieved by substantially shifting government under-funding to commercial payers and patients. The current level of cost shift and price acceleration for hospital services on to employers and the privately insured population is simply not sustainable. Without question, it is also seriously undermining the economic competitiveness of our state.

In Connecticut during 2006, the median hospital operating margin was only 1.36%, far less than is necessary to invest effectively in technology and infrastructure improvement. Under normal conditions, an ongoing margin of at least 3 % is considered necessary for sustained financial viability. However, here in Connecticut, our physical plants are older and more outdated than is typical nationwide, making it necessary to achieve greater margins than might be otherwise necessary. At our facility for instance, to upgrade our patient rooms to single occupancy (which is optimal for patient care and fast becoming the standard) will cost $120 million. Additional operating margins are also necessary to produce the quality data and clinical outcomes reporting that hospitals are increasingly being held accountable for. Finally in terms of our margins, the demands of our workforce, in particular the acute and growing shortage of nurses, physicians, and other health care workers, is requiring a financial investment that goes well beyond the typical needs of a non-profit organization.

The last point I would make is about our role as employers and economic engines in our community. At approximately 2200 employees, we are the largest employer in New Britain. In fact, our financial well-being is critical to the economic stability of the greater New Britain community. This is unfortunately an inter-relationship that is often overlooked.

Despite all the financial challenges mentioned above, we see much to be optimistic about in reviewing the draft recommendations before you. We desperately need to fund hospital rates at cost. An overhaul of the current payment methodology used by DSS to pay hospitals is long overdue. The other recommendations addressing workforce and planning/utilization are very much needed. It all comes down to renewed focus on investment and planning. We, as hospitals, welcome the opportunity to work collaboratively with the Governor, the state legislature, the business community, and our community at large to address these issues. I thank you again for this opportunity to speak to you.

Testimony of Bridgeport Hospital
Before the Hospital Task Force
November 13, 2007

Provided by: Paul S. Timpanelli, President & CEO, the Bridgeport Regional Business Council

Hospital Task Force Recommendations to Governor Jodi Rell

Good afternoon Commissioner Vogel, Secretary Genuario and members of the Hospital Task Force. My name is Paul Timpanelli, and I am the President and Chief Executive Officer of the Bridgeport Regional Business Council. Thank you for the opportunity to comment on this critical matter.

The Bridgeport Regional Business Council (BRBC) is the regional Chamber of Commerce of the Bridgeport Region. We manage the Chambers in Bridgeport, Trumbull and Stratford; and we represent over 1,000 businesses. The mission of the BRBC is to increase the economic opportunities for the people of the Bridgeport Region by acting to create an environment for business expansion, retention, and recruitment that will result in jobs and tax base growth.

The legislative agenda for the BRBC this year had four key policy priorities, one of which was to improve the state of health care access, affordability, and quality. Specifically, the BRBC supports a health system where coverage is universal, continuous, and affordable to individuals and society and enhances well-being. We also support efforts to reduce the cost shift from government payers to business by fully funding the Medicaid program for providers.

Clearly, having a high quality, affordable and accessible health system is a key factor that influences whether existing businesses can expand or new businesses can move into the Bridgeport Region. For the businesses in our Region, the cost of health care insurance has increased dramatically over the last five years; and it is difficult for smaller employers, in particular, to continue to offer affordable health care to their employees. When an employer can't offer health care benefits, they

10 Middle Street • Bridgeport, CT 06604-4229
Tel. 203 335 5800 • Fax. 203 366 0105
E-Mail: info@brbc.org
www.brbc.org

Bridgeport Regional Business Council

have a more difficult time recruiting staff and may experience a higher rate of employee sick time. This affects their competitiveness in the market as well as their productivity, and, therefore, clearly increases the cost of doing business.

The Bridgeport Region has two excellent hospitals: Bridgeport Hospital and St. Vincent's Medical Center. The Bridgeport Region is a desirable region for businesses to move due to the existence of these two facilities that offer high quality, comprehensive health care for our citizens. These hospitals are also two of the largest employers in the Region and provide over 4,000 jobs for our citizens. It is vital that we support these two hospitals and critical to the economic well-being of our Region and our State that these hospitals receive adequate and fair compensation and reimbursement for the services that they provide.

I am glad that the Hospital Task Force acknowledged that rates for hospitals and other providers in State and Federal health programs are not equal to the cost to provide that care, and that a cost shift to businesses occurs. The cost shift is a barrier to affordable employer-based health insurance and is not sustainable. Paying the providers adequately will help businesses in Connecticut to be more competitive in the world-wide market.

I would also like to comment on the Workforce Planning and Development Task Force's recommendations. Based on a report developed by the One Coast Initiative, of which I was a member, I know that it has become more difficult for hospitals to recruit and retain qualified healthcare professionals. The issue raised by the various schools involved in that study was that there was a need for more faculty and classroom space for the nursing and allied health schools – many schools had to turn away hundreds of interested students due to capacity constraints. Thus, I strongly recommend the State determine a way to increase the capacity (faculty and classroom space) of training programs in the state so we can produce the nurses, pharmacists, physical therapists, and other clinical staff that our State will need to care for its citizens over the next 20 years.

Thank you for your consideration on this important matter.

10 Middle Street • Bridgeport, CT 06604-4229
Tel: 203.335.3860 • Fax: 203.366.0805
E-Mail: info@brbc.org
www.brbc.org

Hospital System Strategic Task Force – Testimony
Waterbury Hospital
John H. Tobin, DMan, MPH

As President and CEO of Waterbury Hospital, I applaud the efforts by our state's leadership to explore the challenges faced by the health care industry and to bring together a group of interested parties to identify solutions.

Waterbury Hospital is financially challenged and is in need of **immediate financial assistance**. We have lost money on operations for the last several years and are projected to lose money in the new fiscal year that just started on October 1. This fact puts us in a category of one of several hospitals in the state considered financially distressed. The community we serve lags behind the State in every measured demographic statistic, based on the 2000 Census. Waterbury has a higher proportion of 20 – 24 year olds (most likely to be uninsured) and a higher percentage of residents over 75 years old (requiring more intensive & costly health care) as well as a higher unemployment rate than the state average. Consequently, we serve a higher percentage of Medicaid and SAGA patients that the state average. The chronic under funding of these programs over many years have resulted in a hospital which cannot generate operating profits or support the reinvestment required to keep our physical plant and equipment up to date. Continued under funding could jeopardize the quality of care or scope of services offered. Our Medicaid under funding shortfall approximates $14 million each year. These facts are well documented in both the Office of Health Care Access's Report of Investigative Proceedings issued on May 23, 2007 (DN # 06-30760-VST) and the Funding of Hospital Care report issued by the Legislative Program Review & Investigations Committee issued on December 18, 2006.

When faced with declining profits, hospitals are forced to make difficult decisions in allocating their limited resources. They can continue to make all their debt payments, including pension payments and pay vendors timely or they can chose to redirect those payments to physical plant improvements, marketing and other discretionary expenditures.

At Waterbury Hospital, over the years, we have continued to place a high priority on keeping current with our debt and pension obligations and have allowed the capital needs of the organization take a lower priority.

Marketing and other discretionary expenses are at minimal levels. The result of these decisions is that the average age of our physical plant is 18 years old compared to the hospital state average of 12 years old – a 50% differential. Now we are faced with some significant physical plant needs, and because of operating performance, we are unable to access the debt markets to provide the necessary resources.

Therefore, we support the increases in Medicaid funding proposed in the committee's recommendations. We agree with the position to recognize SAGA patients as Medicare DSH eligible. We strongly support the recommendations on access to capital whereby CHEFA would issues revenue bonds and the state would support the debt service on those bonds. As our regions largest Behavioral Health provider, we agree that a new model of care for that vulnerable population needs to be developed and established with appropriate reimbursement levels.

We have spent considerable time and effort to long range financial planning in the past year and have concluded with our expert financial advisors, Kaufman Hall that Waterbury Hospital will survive only if the state funds the Medicaid & SAGA populations that we serve at approximately cost. Based on publicly available data and our financial analysis, the outlook for the only other hospital provider in our community is precarious and considered financially distressed. Without intervention, the communities that we collectively serve may find that access to health care for them can no longer be met in Waterbury. This will be a crisis of unprecedented proportions for our state.

Waterbury Hospital recognizes that the state cannot and should not abandon its responsibility to hold providers accountable for rising health care costs. The provider community – especially hospitals, who must treat everyone that comes through their doors – cannot continue to subsidize the care of the Medicaid and SAGA populations. We ask the state to appropriately fund this care NOW, while the planning and studies continue to develop a better model of care for our state. Waterbury Hospital has proudly served its community for over 110 years and needs a thoughtful state health plan that is appropriately funded to continue to meet the challenges that we will face over the next 100 years. We understand that such deliberations and planning will likely unfold over a period of years. We also appreciate the funding commitments that have been made by the legislature for this year. But for Waterbury Hospital, those additional funds still fall far short of covering the

cost of care for this population. The challenge for Waterbury Hospital will be to survive in the interim period as the planning evolves and to continue to provide quality care and the breath of services our community needs and expects. Our needs for funding solutions are urgent and must be of a predictable nature, not dependant on an allocation of 'hardship' funds that are determined annually. I urge you to consider the consequences I've outlined above and imagine a community of 300,000 residents without local access to health care. We are committed to work together with the state to find solutions on an urgent basis to save health care for the Greater Waterbury community.