Connecticut Children's Medical Center

Connecticut Children's Medical Center (Connecticut Children's) in Hartford, Connecticut is a freestanding children's hospital that uses Medicaid disproportionate share hospital (DSH) payments to help offset the hospital's Medicaid shortfall. The hospital's DSH payments are specified as a line item in the state budget and fluctuate from year to year based on state budget constraints.

Hospital and Market Characteristics

Connecticut Children's is a 187-bed non-profit children's hospital; it is the primary pediatric teaching hospital for the University of Connecticut School of Medicine. It is the only freestanding children's hospital in Connecticut and includes a Level 4 neonatal intensive care unit (NICU), an ambulatory surgery center, and five specialty care centers. Connecticut Children's received $10 million in Medicaid DSH payments in 2012, which represented 10 percent of its total Medicaid revenue ($103 million) and 4 percent of its total operating revenue ($266 billion).

Role in the safety net

Connecticut Children's serves a much higher share of Medicaid and low-income patients than other hospitals in its hospital referral region (HRR) and in Connecticut on average (Table 1). Hospital executives reported that Connecticut Children's is the main care provider for the Medicaid pediatric population in Hartford County and estimated that their hospital served about half of the state's Medicaid-enrolled children in need of hospital services. About 5 percent of Connecticut Children's patients come from outside of the state (e.g., from Massachusetts and Rhode Island).

Connecticut Children's Medicaid caseload has increased in recent years, which executives attributed more to Connecticut's slow economic recovery from the recession than to implementation of the ACA. One executive explained, "About 10 years ago, before the recession, we were about 45 percent Medicaid and 55 percent commercial, and that has flip-flopped."

Types of services provided

Connecticut Children's has 103 beds at its main facility in Hartford, and 187 licensed beds overall. Connecticut Children's leases space in other hospitals—operating 42 NICU beds at Hartford Hospital, 12 NICU beds at the University of Connecticut Health Center in Farmington, and 12 pediatric beds at St. Mary's Hospital in Waterbury. Across all beds, the hospital averages 6,000 inpatient admissions annually,

with about 45,000 patient days. In addition, it provides about 150,000 outpatient encounters per year. Connecticut Children's runs a number of specialty centers, the largest being the Connecticut Children's Specialty Group with 165 physicians (some employed and others under contract), most of whom are pediatric specialists.

TABLE 1. Medicaid and Low-Income Utilization Statistics for Connecticut Children's Medical Center and Other Hospitals, 2014

Comparison region	Medicaid inpatient utilization rate	Low-income utilization rate
Connecticut Children's Medical Center (Hartford, CT)	56%	37%[1]
Hartford, CT, hospital referral region average	21	13
Connecticut average	20	10
National average	18	13

Notes: The Medicaid inpatient utilization rate is the percentage of hospital inpatient days that are attributable to patients who are eligible for Medicaid. The low-income utilization rate is a measure of Medicaid and charity care utilization.
[1] The low-income utilization rate provided for Connecticut Children's Medical Center comes from the hospital's 2012 DSH audit because complete data necessary to calculate the low-income utilization rate for 2014 were not available on the hospital's Medicare cost report.
Source: MACPAC, 2017 analysis of 2014 Medicare cost reports and 2012 DSH audits.

Market characteristics

Connecticut Children's is one of two freestanding children's hospitals in the Northeast. (The other is Boston Children's Hospital.)One hospital executive described Connecticut Children's relationship with hospitals in Hartford County and the surrounding area as collaborative, noting, "We have good relationships with adult hospitals in the state and they will typically send pediatric patients to us via our transport team when the acuity level gets high enough that our special expertise is required." The hospital is working to build relationships with other medical centers and promote its pediatric specialty services, and has reportedly seen some increase in its neurosurgery and pulmonology care as a result.

On the other hand, some competition with Yale-New Haven Children's Hospital was reported. Connecticut Children's executives estimated that about half of the state pediatric patients are cared for by Yale-New Haven Children's Hospital. In addition, it was estimated that every year about 1,000 Connecticut patients receive care from Boston Children's Hospital, some likely due to services not available at Connecticut Children's or Yale-New Haven.

State Context

Connecticut was an early adopter of the Medicaid expansion under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), and the state expanded Medicaid coverage to adults under age 65 with incomes at or below 138 percent of the federal poverty level in 2010. In 2014, 6.9 percent of its population was uninsured.

Connecticut switched its Medicaid delivery system from managed care to managed fee for service (FFS) in 2010. In 2014, supplemental payments accounted for about 6 percent of its Medicaid benefit spending.

Effects of the Affordable Care Act

According to one hospital executive, passage of the ACA had only a small effect on Connecticut Children's payer mix because the state already had a high rate of insurance coverage for children before health reform. Connecticut's Medicaid rate cuts, enacted during the early days of the ACA, put financial pressure on Connecticut Children's because Medicaid enrollees accounted for such a high share of its patient load. According to one executive, before this reduction in Medicaid payment, Connecticut Children's was losing between $8 million and $10 million per year treating Medicaid-enrolled patients, but with the cutback the loss jumped to $30 million to $50 million. During this period, Connecticut Children's went through a major overhaul in an effort to reduce its cost structure and the way it did business. As one executive said, "We looked at everything we do, including differential payments; literally everything was on the table. During that process we saved $25–$30 million. . . . We are doing everything we can to sustain that."

In 2015, the system showed a small profit for the first time in many years, due to an additional $10 million Medicaid DSH payment from the state and other changes in Connecticut's Medicaid payments as a result of the move to FFS, and a shift to payments based on patient acuity. Connecticut Children's projected the possibility of a 2 percent to 3 percent profit margin for 2016, mainly because of efforts to secure the best rates possible from commercial payers. One executive said, "You really need to be able to make a profit of 3 percent or more to keep current with other facilities and put money into growth. I hope we're in the first step of hopefully an upward trend and that puts us in a position where we can do a better job of offsetting Medicaid losses." In addition, executives at Connecticut Children's reported continuing to examine ways to cut operational costs even further, including lean management, supply chain, revenue cycle, and staffing models.

State policy changes affecting Medicaid supplemental payments

Executives said that unlike other hospitals in the state, Connecticut Children's DSH payment has long been a separate line item in the state's budget, with the level of payment tied to how the state's finances are faring. As one executive explained, "It really hinges on how we do with lobbying, how other folks do with their lobbying, and where the budget ends up falling is really going to determine what we get for DSH payments." Because of this, Connecticut Children's reported experiencing fluctuation in its DSH payments in recent years, ranging from a low of $10 million in 2012 to a high of $20 million in 2015, which was due to a one-time bump in DSH payments to help offset a cut in base Medicaid payments (see below). In 2016, Connecticut Children's was expecting to receive $12.5 million in DSH payments. One executive expressed

particular concern about payment in the upcoming fiscal year 2018 because Connecticut is facing a $1.5 billion deficit. This same executive shared that Connecticut Children's is "thinking very hard about what we might need to do to charge or to absorb $12 million [in DSH payments]. We expect to lose that in 2018." As a pediatric hospital, Connecticut Children's is exempt from the provider tax used to finance the state share of DSH payments, so the full amounts paid to Connecticut Children's are realized by the hospital.

Some state policy changes have affected Connecticut Children's base Medicaid payments. Most notably, in 2012 Connecticut moved away from the use of private managed care organizations (MCOs) and began managing all of its Medicaid-enrolled patients directly through an administrative services organization. This change reportedly had a negative financial effect on Connecticut Children's, and according to one executive, "For us that was a big hit. We had been able to negotiate some preferential rates [with the MCOs] that had helped us." In addition, Connecticut reduced Medicaid rates in the early days of the ACA. Medicaid expansion put a slight downward pressure on Connecticut's Medicaid payment rates as the overall number of Medicaid beneficiaries (particularly adults) increased, and the state, facing tough fiscal times, struggled to contain the subsequent growth in program spending. As one executive reported, "they [the state] were absolutely cutting dollars out of both the adults and the pediatric hospitals."

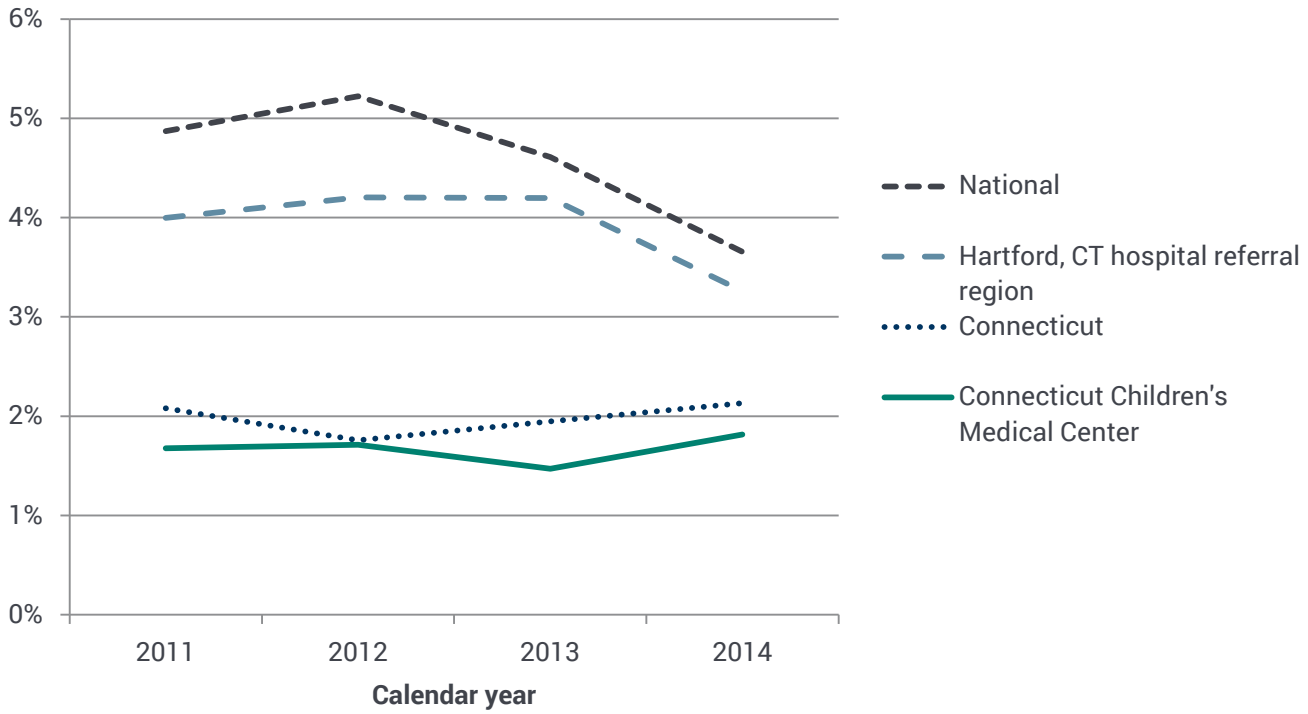
Connecticut Children's actively lobbied the Connecticut Department of Social Services, the state legislature, and the governor's office to push back against the Medicaid rate cuts and ultimately was successful. In January 2015, Connecticut switched from a per diem rate system for hospital inpatient stays to All Patient Refined, Diagnosis-Related Group (APR-DRG) payments based on patient acuity (Connecticut Department of Social Services 2015). Because Connecticut Children's treats highly medically complicated Medicaid-enrolled patients, the hospital has fared much better under the new APR-DRG system, according to one executive.

Hospital Financial Information

Uncompensated care

In 2014, bad debt and charity care represented less than 2 percent of Connecticut Children's operating costs, a proportion slightly lower than that of other hospitals in the HRR and in the state and half that of the national average (Figure 1). Medicare cost report data suggest that charity care and bad debt remained relatively stable between 2011 and 2014. One Connecticut Children's executive, however, reported that the share of bad debt declined between 2012 and 2014 due to targeted efforts by the hospital to better communicate with patients about their financial obligations and to offer financial counseling. Charity care, by contrast, remained unchanged and relatively low over the period, concentrated mostly around financial assistance to families with high deductible plans and an increase in international charity care. Connecticut Children's receives a relatively small number of patients needing charity care from outside the state, but they are often highly complex cases that require a lot of resources from the hospital.

FIGURE 1. Uncompensated Care as a Share of Hospital Operating Expenses, Connecticut Children's Medical Center versus Other Hospitals, 2011–2014



Note: Medicare cost reports define uncompensated care as charity care and bad debt.
Source: MACPAC, 2017 analysis of Medicare cost reports.

Medicaid payment shortfall

Data from Connecticut's 2012 DSH audit show that Medicaid payments for inpatient and outpatient care before Medicaid supplemental payments covered approximately 77 percent of Connecticut Children's costs of caring for Medicaid-enrolled patients. Executives explained that since that time, Connecticut Children's Medicaid shortfall has increased—in part due to the state's move away from Medicaid MCOs and in part due to previous Medicaid rate cuts as described above. Connecticut Children's estimated that Medicaid, including supplemental payments, covered about 65 percent of patient costs in 2015. One executive felt that Connecticut Children's was shouldering a larger Medicaid shortfall than children's hospitals in other states due to lower Medicaid payment rates in Connecticut, saying, "The children's hospital[s do] an annual survey, and we have seen that we are similar to everyone else in the percentage of Medicaid patients we see, but I think the loss we see is a little bit higher than in other states."

Medicaid DSH payments

Data from the 2012 Connecticut DSH audit shows that 90 percent of Connecticut Children's Medicaid revenues were from regular base payments and 10 percent were from DSH payments. It was expected that in 2016, Connecticut Children's would receive about $12.5 million in DSH payments and, given the overall

increase in Medicaid-enrolled patients, executives believed that DSH payments would represent a slightly smaller percentage of their overall Medicaid payments in 2016 than in 2012.

Other Medicaid supplemental payments

Unlike other hospitals in Connecticut, Connecticut Children's does not receive upper payment limit (UPL) payments (OLR 2016).[1] In 2012, Connecticut Children's did not receive any non-DSH supplemental payments.

Role of DSH Funding

A Connecticut Children's executive reported that the hospital used its Medicaid DSH payments to help cover the payment shortfall for treating Medicaid-enrolled patients, explaining, "We are not making a profit on Medicaid, and even with the DSH we're losing significant amounts of money, so it's really just used to stem the losses." The executive reported that because the majority (55 percent) of Connecticut Children's patients are Medicaid beneficiaries, the hospital relies heavily on Medicaid payments and continuously appeals to the state for additional support to help reduce losses from serving Medicaid-enrolled patients. Using DSH payments to cover uncompensated care costs is less of an issue for the hospital because it has few charity care patients. Consistent with patterns observed nationally in children's hospitals, uninsured patients account for a low share (less than half of 1 percent) of Connecticut Children's patient population, according to hospital executives.

One Connecticut Children's executive said that without DSH payments, the hospital system would likely be forced to cut some services and perhaps partner with another children's hospital to stay in business. Another executive described what might happen if DSH payments were reduced: "Every children's hospital wants to be all things for all people, but that is just really not a viable scenario. So we have to figure out a way to survive. . . . Right now, we want to keep kids in Connecticut. But if we lost that [DSH payment], would we have to go to Boston Children's and say 'let's talk.' We couldn't be by ourselves anymore, and that is absolutely part of the conversation."

One Connecticut Children's executive commented on the importance of DSH funding with regard to the unique patient composition of pediatric hospitals. Compared to adult-focused facilities, pediatric hospitals have higher Medicaid patient loads and lower commercial and Medicare loads, and they are therefore less able to shift the unreimbursed costs of providing care to Medicaid-enrolled patients to their better paying patients who have commercial insurance and Medicare coverage. This executive said, "If you look at some of the larger hospitals at the adult side of acute care, they have a higher commercial population than we do. . . . [Also,] Medicare is a better payer than Medicaid is, so [the Medicaid shortfall] is a little bit less of a burden to the adult hospitals."

Data and Methods

The information in this profile comes from interviews with hospital executives during the summer and fall of 2016 and MACPAC's analysis of Medicare cost reports, DSH audits, and other publicly available data.

For a summary of the findings from all seven DSH hospitals that we profiled and more information about our methods, please see MACPAC's issue brief, *Profiles of Disproportionate Share Hospitals*.

MACPAC would like to thank Teresa Coughlin and Christal Ramos at Urban Institute for designing and conducting the interview with Connecticut Children's Medical Center that was the basis for this profile. The interview was one of seven interviews with executives from safety-net hospitals across the country that occurred between June and October of 2016.

Endnote

[1] An upper payment limit (UPL) is the maximum aggregate amount of Medicaid fee-for-service payments that a state may make to a class of institutional providers. A UPL payment is a supplemental payment to a Medicaid provider based on the difference between the amount paid in standard payment rates and the UPL.

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