



**Testimony presented by St. Vincent's Medical Center
before the Human Services Committee
Thursday, January 18, 2007**

On the adequacy of hospital reimbursement from private managed care organizations serving Husky and Medicaid clients.

Dear Members of the Human Services Committee,

My name is Ron Bianchi, and I am Corporate Senior Vice President of St. Vincent's Health Services. For the past ten years, I also have had a volunteer responsibility which included the founding and chairing of the Family Health Association of Connecticut. The FHA was made up of 28 hospitals, which partnered with Anthem Blue Cross in creating the state's largest Medicaid Managed Care plan. I would like to direct my comments to the function of this entity, why it initially succeeded and why it eventually failed.

When the Medicaid Managed Care program was initiated, we pondered on how Managed Care Organizations could add administrative overhead of 20% to the cost of Medicaid and still enable the plan to work. Our expectations were that Managed Care companies, as well as providers, would have to accept less payment and we all would also have to be creative in working together to make the plan work. We were very grateful and proud to work with an organization like Anthem Blue Cross, which accepted the responsibility of contributing back to this plan. They agreed to accept an administrative rate of less than 10%, which was far less than any other Managed Care plan we approached.

Anthem proved to be a very good partner, as did DSS. On many occasions, we met with DSS and worked in a collaborative way to do something, which had never been done before, namely; put the insurance company, the providers and the plan authority in the same room, looking for solutions. During the first several years of FHA's existence, this relationship was a resounding success. We built the largest Medicaid Managed Care plan in Connecticut, with over 130,000 enrollees. We had the largest number of physician and specialty providers of any plan in the state by far. The BlueCare Family Plan, which was the name of the product that was created, was by far the most highly rated plan by enrollees in Connecticut. Anyone who carried the membership card for this plan believed that this was the best plan they could have.

FHA hospitals were willing to accept creative models for reinsurance. Many hospitals assumed risk. They also assumed responsibility for developing data by which they could manage the plan; there was a commitment to create an outreach effort to deal with enrollees who were at highest risk. There was a shared commitment to treating the poor and we all recognized the need to work together.

It has only been in the past few years that this plan began to flounder seriously, and the reasons for this change related to compensation approved for services. The plan was always under-funded, but there was at least enough room in the under-funded model to find creative solutions. The plan continued to be funded without adjustments for inflation. In fact, the base rate has never been adjusted for inflation in 25 years. I can't imagine any company or industry being able to survive where the base rate, by which it is compensated, is 25 years old. That is, however, what is happening with Connecticut's funding of Medicaid health plans.

Initially, providers were receiving increases provided through the annual state budget. In recent years, those increases have not been passed through by the Managed Care Organizations to providers, so the operating shortfall for providers has expanded to the breaking point.

For several years, the FHA plan could recruit and retain physicians due to the hospital influence. Eventually, physicians were losing so much money while assuming enormous liability, that more and more doctors, especially specialists, began to tell us that they could no longer care for patients, as the model that we originally created began to unravel. Medicaid patients were forced to use higher cost services; such as emergency departments, as their only resource, and this obviously compounds the problem.

There are ways to fix this problem. One needs to look at the financing methodology and needs to challenge a 25-year old model, which has never been updated for inflation. If there is income given to the Managed Care companies by DSS, those increases have to filter down to the providers. The reality is that hospitals in Connecticut contribute \$334 million a year to cover the uncompensated cost of Medicaid, SAGA, and the uninsured. This is the amount of money that is not covered under the current reimbursement model. By default, hospitals have become the ultimate safety net of care, and the reality is that this system will break if it is not corrected. Hospitals need to cover their costs, and whatever plan is used for Medicaid Managed Care needs to be able to accomplish that goal so Medicaid will work in the future.

I thank you for your consideration and for the opportunity to speak before you.
