NEW MEDICAID UNDERFUNDING FORMULA HIDES ONGOING PROBLEMS HARMING HEALTHCARE ACCESS

The state's Office of Health Strategy (OHS) is changing how it calculates hospitals' payment-to-cost ratio, which measures Medicaid underfunding. This new creative accounting disregards the totality of the role that hospital taxes play in supporting the Medicaid program and, as a result, shows false improvements in Medicaid reimbursement and undercounts the uncompensated costs that hospitals incur in providing essential access to Medicaid patients. For years, OHS has calculated a Medicaid payment-to-cost ratio that shows that hospitals are reimbursed about 60 to 65 cents for every dollar of care provided by hospitals to Medicaid patients. The new calculation instead estimates that hospitals get about *93 cents for every dollar of care provided*.

The fact is hospital operating shortfall resulting from Connecticut's Medicaid payment and tax policy was $1.23 billion in FY 2022. No matter how you account for those dollars, this is a loss felt across the state. **Changing the math may hide the problem, but it does not change the burden on hospitals, which in turn is borne by the employers and employees who cover these uncompensated costs in their annual premiums.**

WHAT'S CHANGED?

Despite the dramatic increase in the payment-cost-ratio, **nothing** about hospital Medicaid reimbursement has changed. Instead, the state has decided to count the hospital tax financed supplemental payments as Medicaid payments, *without counting the full value of the taxes these payments are intended to offset*. As a result, Medicaid hospital reimbursement appears to be much better than it is. If instead the calculation were to recognize the full value of the tax, the result would be about 58 cents on the dollar, much closer to the figure OHS has used for more than a decade.

OHS argues they should only look at what they call the "Medicaid attributable share" of the tax, but the reality is the whole tax is tied to Medicaid. In Connecticut, the hospital tax, in its entirety, has been recognized as part of the Medicaid program, and was spelled out as such in the hospital tax settlement.

Settlement Agreement

> over the Term of the Agreement; (iv) continue significant financial benefit to the State by allowing it to access federal funds to fund the state's Medicaid program and provide significant benefit to the Hospitals by enabling the use of federal funds for the State to pay, and the Hospitals to receive, the Medicaid supplemental payments and rate increases described in the Agreement; and (v) enable a collaborative working relationship between the Hospitals and the

The settlement clearly states the purpose of the tax, which is to allow the state to "*access federal funds to fund the state's Medicaid program*" and enable "*the use of federal funds for the State to pay, and the Hospitals to receive, the Medicaid supplemental payments and rate increases described in the Agreement*." The hospital tax is a cost to Medicaid. ***If it's not considered a cost to Medicaid, then it is a tax on every employer and employee in the state with private health insurance.***

CHANGING THE MATH DOES NOT CHANGE THE BURDEN ON HEALTHCARE

- **The new ratio uses new math that does not reflect reality**
  The new payment-to-cost ratio calculation omits key factors to make Medicaid funding on paper appear better than reality. The new calculation directly contradicts the Medicaid shortfall figures contained in OHS's Hospitals' Community Benefit Summary and Analysis Report 2022, which reports a Medicaid shortfall percentage that is 79% higher than the national average. If the intent is to reflect the reality of Medicaid payments accurately, this misses the mark entirely.

- **The new calculation only looks at one part of the equation**
  The new ratio only looks at how much hospitals get back from the hospital tax, but does not look at all that hospitals are paying for the tax. After a long history of hospitals paying far more than they received back from the tax, with the state coming out far ahead, it is startling that the full impact of the tax would be excluded from any calculation.

- **Hiding problems does not fix them**
  Medicaid rates are woefully insufficient, and the effect on healthcare is evident across the state. Modifying the way Medicaid underpayment is measured does not resolve ongoing underpayment issues, it distracts from the problem we need to focus on solving. Medicaid rates are unsustainable at current levels. Medicaid underfunding not only leads to cost shifts that increase costs for families with private insurance, but it also deprives people who are medically underserved of access to needed care and social supports. ***Hiding the problem means worse access for all patients.***

BACKGROUND

What is the hospital tax?

Hospitals are one of the state's largest sources of tax revenue. Since 2012, they have been taxed on their patient revenue. Over the years, the tax has grown to $850 million per year. *Unlike other businesses, hospitals pay this tax, every year, even when they have negative operating margins.*

The state uses the tax revenue to cover the state share of the Medicaid program. A portion of the tax is used to fund Medicaid payments to hospitals in an effort to offset the burden of the tax. Under the 2020 state/hospital Settlement Agreement, *the state is required to fund enough extra Medicaid payments to cover the cost of the tax in full. Most of these extra payments come in the form of lump sum payments, called supplemental payments.*

What is payment-to-cost ratio?

The payment-to-cost ratio is a calculation that shows whether a payer is covering the cost of services provided. For years, OHS has calculated a Medicaid payment-to-cost ratio that shows that hospitals are reimbursed about 60 to 65 cents for every dollar of care provided by hospitals to Medicaid patients. The new calculation instead estimates that hospitals get about *93 cents for every dollar of care provided*.