



## The Economic Impact of SAGA Medical Changes on Connecticut's Hospitals and FQHCs

The State Administered General Assistance (SAGA) Medical program covers medical treatment for low-income Connecticut adults who do not qualify for Medicaid or any other health care assistance. In 2003, Connecticut restructured the medical component of the SAGA program from a fee-for-service to a managed care system, in an effort to reduce costs. The state has also eliminated services and capped provider expenditures. Total savings estimates range from \$34.8 to \$43.8 million in 2005.

During the 2005 session, the General Assembly increased funding under the SAGA program, for hospitals and Federally Qualified Health Centers (FQHCs) by 5%. While these increases are important, additional provider reimbursements and restoration of services will be needed in order to reverse the significant reductions made during the 2003 session.

This report examines the impact of those changes on hospitals and FQHCs in the context of a managed care environment.

### MAJOR FINDINGS

- Hospitals will receive between \$16.2 and \$24.3 million less each year, depending upon utilization, as SAGA will pay only 41% of the costs of care in FY2005.
- Since the SAGA changes were implemented, hospital inpatient expenditures increased 24% and hospital outpatient expenditures increased 21% per member, per month between FY2003 and FY2004.
- Hospitals are charging private insurers more than the costs of care to recoup some of their losses from the SAGA changes. On average, private insurers paid 18% more than the cost of care in Connecticut in FY2003. These costs are passed to employers and employees alike through higher premiums and co-payments.
- FQHCs will receive between \$2.8 and \$3.7 million less in revenues annually under the new SAGA structure.
- FQHCs were a medical home for 17,059 enrollees in Oct 31, 2004 compared to 6,960 in June 30, 2003. This represents 145% more enrollees. The new SAGA payment levels however, reduce reimbursements from a cost-based reimbursement to as little as 65% of the cost of care.

## THE SAGA PROGRAM

Connecticut's SAGA Program offers medical assistance to very low-income adults who do not qualify for Medicaid. To qualify for SAGA, individuals must have incomes less than 75% of the Federal Poverty Level (below \$476.19 to \$574.86 per month) and eligible assets worth less than \$1,000. In March 2005, 30,491 individuals received SAGA medical assistance, up from 26,669 in December 2003.<sup>1</sup>

Connecticut's SAGA enrollees tend to have above average medical needs. For example, at least 70% of SAGA enrollees received some behavioral health services in 2004 (see first report in this series at [www.LARCC.org](http://www.LARCC.org), Hot Topics/Recent Publications). SAGA clients need more enabling services such as transportation, and language translation to access appropriate care. This is consistent with other findings that show high rates of disability in similar populations.<sup>2</sup>

### CHANGES TO SAGA

#### AUGUST 2001

Coverage eliminated for most non-emergency transportation.

#### JANUARY 1, 2003

Implementation of coverage elimination for home health services, vision care, physical and occupational therapy, durable medical equipment, speech therapy and audiology, chiropractic care, podiatry and naturopath services.

#### JANUARY 1, 2004

Upper limit set on hospital reimbursement.

#### OCTOBER 1, 2004

Upper limit set on clinic and physician services, reimbursement rates reduced, drug formulary adopted and managed care implemented.

## ECONOMIC IMPACT OF SAGA CHANGES ON HOSPITALS

Under the old system, SAGA reimbursed hospitals on the same basis as Medicaid. In FY2003, this resulted in 60% of the costs of care being reimbursed. Under the new system, in FY2005, SAGA would pay only 41% of the costs of care (Source: CT Hospital Association [CHA]). Based on this data, SAGA reimbursement is substantially below the old rate. In the aggregate, hospitals will therefore receive between \$16.2 and \$24.3 million less each year, depending upon utilization (CT Center for Economic Analysis [CCEA], 2005).

This shortfall is particularly egregious for hospitals which will receive roughly the same cost-to-reimbursement rate from SAGA as they do from patients without any health insurance. Although the state recovers SAGA expenditures from the Federal government by claim-

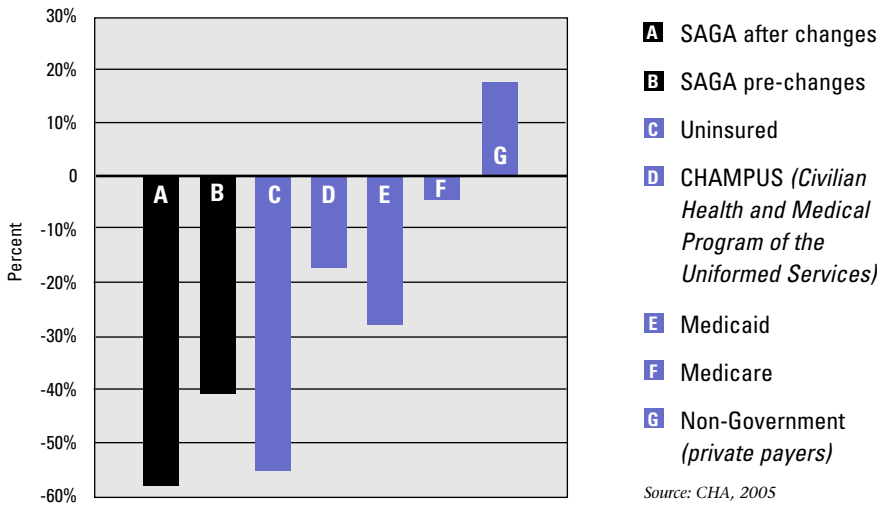
ing Medicaid Disproportionate Share (DSH) funds, these funds are used to pay for existing services rather than to increase hospital funding. Because SAGA care is neither Medicaid nor wholly uncompensated, the potential to recover losses through DSH is also limited.<sup>3</sup>

Some of these costs to hospitals are recouped through cost shifting by charging private insurers more than the costs of care. On average, private insurers paid 18% more than the cost of care in Connecticut in FY2003 (Office of Health Care Access [OHCA] and CHA data, 2005). These costs are passed on to employers and employees alike through higher premiums and co-payments. Figure One illustrates the fact that reimbursements from non-governmental sources, or private payers, represent gains to hospital cash flow while SAGA reimbursements now comprise even greater losses than in the past.

In addition to the lower rates of reimbursement, elimination of services under SAGA may play a role in rising hospital costs. From FY2003 to 2004, hospital inpatient expenditures increased 24% and hospital outpatient expenditures increased 21% on a per member per month basis for SAGA participants.<sup>4</sup> This increase in hospital inpatient expenditures is particularly noticeable as it is 16% above its previous peak in FY2001. In contrast, pharmacy expenditures increased 3% and other expenditures, including clinic, physician and ancillary services declined 2% from FY2003 to 2004.<sup>5</sup> While declines in aggregate expenditures may result from price or utilization decreases, these findings are consistent with the notion that the eliminated services formerly provided by SAGA may play a role in increasing hospital costs.

Figure 1

**Hospital Costs After Reimbursement by Payer**



**ECONOMIC IMPACT OF SAGA CHANGES ON FEDERALLY QUALIFIED HEALTH CENTERS**

In 2003, SAGA enrollees had an estimated 59,814 FQHC visits. Under the new SAGA payment structure, centers are reimbursed between 72% and 65% of the cost of care depending on total expenditures (see Figure 2, Bar A).<sup>6</sup> Where centers once received between \$105 to \$150 per patient visit, they now receive \$80 per visit up front with \$8 withheld. The withheld funds are distributed at the end of the fiscal year if the total SAGA spending on primary, specialist and ancillary care falls below a total annualized cap of \$18 million.<sup>7</sup>

In addition to reductions in the per unit reimbursement, the number of SAGA enrollees assigned to receive primary care at FQHCs has increased an estimated 145% compared to where they habitually received their care in 2003.

Overall, FQHCs will receive between \$2.8 and \$3.7 million less in revenues annually depending on utilization (CCEA, 2005). Although more patients mean additional revenue, each SAGA patient is treated at a greater loss than before.

**CONCLUSION**

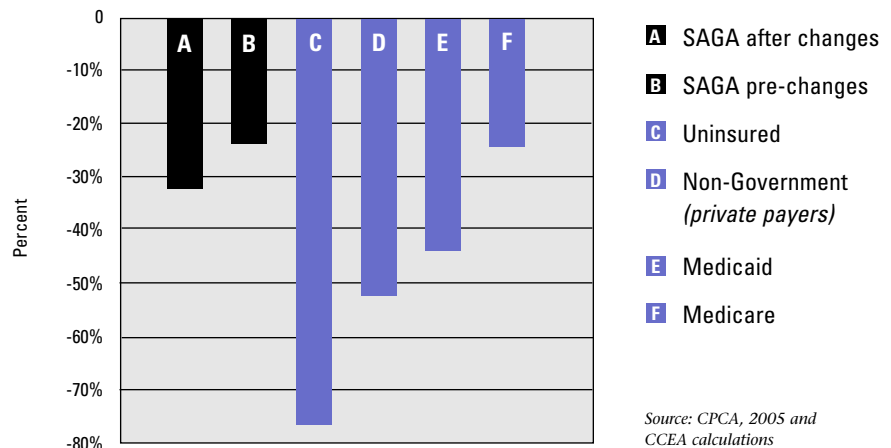
**Hospitals and FQHCs are facing increased financial pressure when caring for SAGA enrollees. Hospital reimbursements have fallen below the previous Medicaid level, covering only 41% of the cost of care while per person hospital expenditures are increasing. Despite an increasing patient population, FQHCs are now reimbursed a maximum of 72% of the cost of care.**

**These reimbursement reductions may generate savings to the health care system in the short run, but over time, payment levels below market norms contract the network of participating providers and result in shortages of care.**

**Evidence indicates that increased financial pressures on providers reduces access and levels of health care for individuals without insurance in the surrounding communities.<sup>8</sup> Additionally, some of these costs to hospitals are recouped through cost shifting by charging private insurers more than the costs of care.**

Figure 2

**Health Center Costs After Reimbursement by Payer**



## THE CONTEXT OF MANAGED CARE

In October 2004, Connecticut contracted with the Community Health Network of Connecticut (CHNCT) to manage care for the SAGA population at a cost of \$2 million per year.

In theory, managed care reduces costs and improves health outcomes by:

- encouraging use of appropriate care including preventive and routine services
- assigning primary care physicians
- creating cost-saving provider incentives
- instituting price controls/discounts
- using utilization review.

In practice, however, these cost savings and outcomes are not always realized. The design, implementation, population characteristics and adequacy of the provider network play important roles in determining the degree to which cost savings can be realized. For example, to avoid costly hospitalizations, managed care programs need sufficient in-network primary and specialist health care providers as well as other services such as home care and transportation.

If not implemented properly, managed care can result in constant or increased costs due to covering a population with higher medical needs, high administrative costs due to transitory enrollment, or having an inadequate provider network.



For additional data and full background report, contact LARCC at 860.278.5688 or [www.larcc.org](http://www.larcc.org).

## NOTES

1 Office of Legislative Research. State-Administered General Assistance (SAGA) Recent History. <http://www.cga.ct.gov/2005/rpt/2005-R-0187.htm>

2 See for instance, Minnesota's analysis of disability in a similar population (Sacks and Dorn, 2004).

3 Based on personal communication by CCEA with the Connecticut Hospital Association.

4 Inflation adjusted expenditures based on DSS Monthly Expenditure Reports as reported in Year End Comprehensive Finance Report.

5 Inflation-adjusted expenditures from DSS Monthly Expenditure Reports as reported for Year End Comprehensive Finance Report.

6 Cost-to-reimbursement estimates based on average 2003 ratio of charges to reimbursable costs from Bureau of Primary Health Care (2003) Uniform Data System.

7 Rate information supplied through personal communication between CCEA and John Steimer at Connecticut Primary Care Association (CPCA).

8 Cunningham, P., 1999. This result is consistent with the Institute of Medicine's (2003) conclusion that high levels of uncompensated care reduce access and quality of care for all users of the medical care system.

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