Bipartisan Proposals on Hospitals and Healthcare

March 11, 2015

Senate President Pro Tempore Martin Looney
Senate Minority Leader Len Fasano

BIPARTISAN ROUND TABLE ON HOSPITALS AND HEALTH CARE

- 7 Informational Hearings Over 4 Months
- Input From Policy Makers And Public Officials Including the Attorney General, State Comptroller, Health Care Advocate, Dept. of Insurance, and Dept. of Public Health
- Stakeholders Including Connecticut Hospitals (large and small), the Connecticut State Medical Society, Independent Providers, and Employee Representatives
- Out of State Experts Including the Massachusetts Health Policy Commission and Rhode Island Quality Institute

KEY FINDINGS

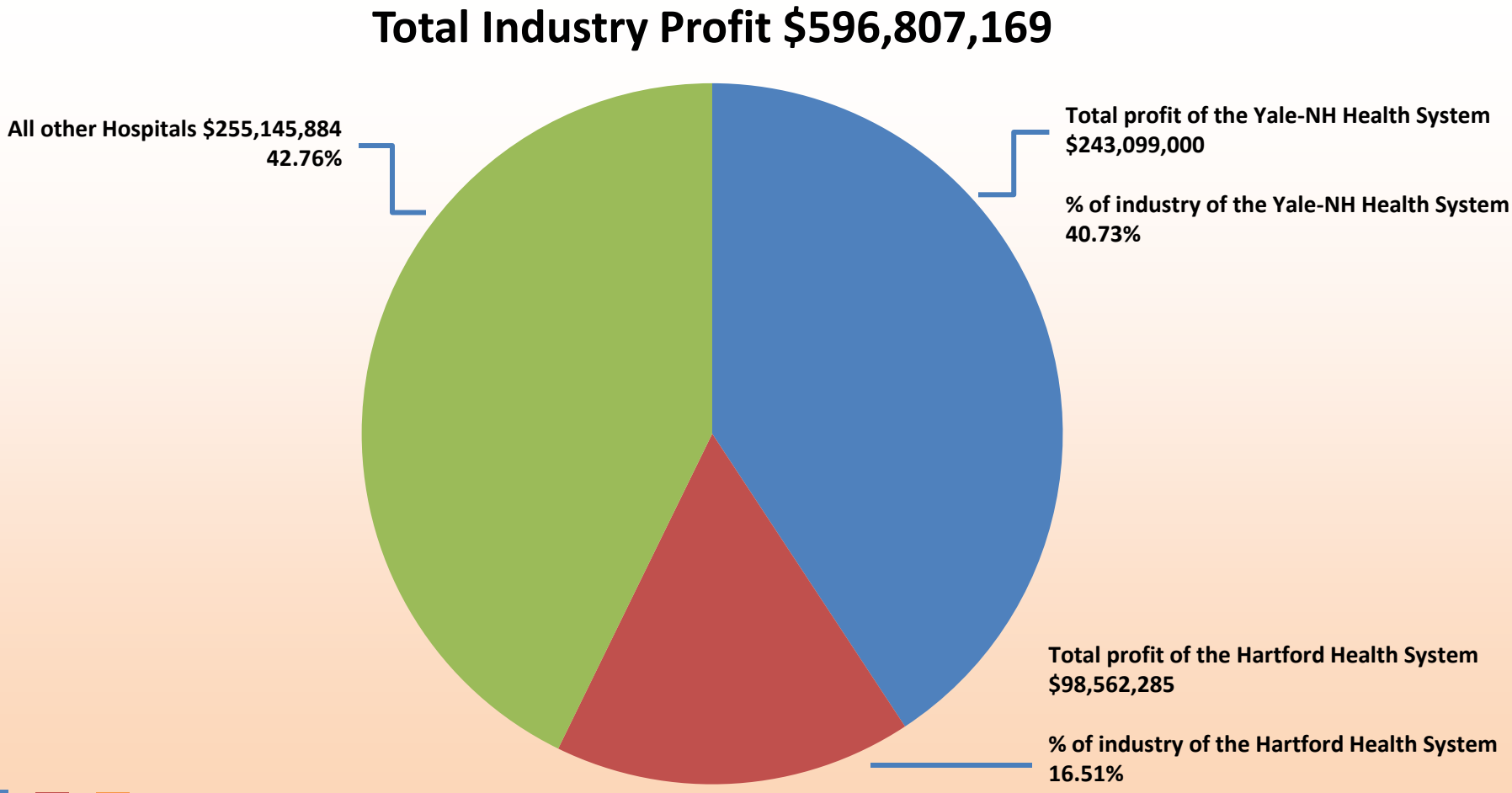
- Rapid Change – Hospitals Are Consolidating And Purchasing Physician Practices Resulting In ***Large Health Systems*** With Increasing Market Power
- Lower Cost Independent Providers, Including Our Low Cost/High Quality Community Hospitals, Are Being Squeezed Out Of The Market
- Market Consolidation Is Resulting In Higher Costs For Payers and Consumers and Greater Price Disparity Between Providers
- Connecticut Lacks Critical Information Regarding Health Care Market Changes, Costs, Quality And Access
- Connecticut Is Far Behind In Providing Meaningful Price And Quality Transparency That Enables Payers And Consumers To Make Value Based Decisions
- The State's Failure To Implement A Statewide Health Information Exchange (HIE) Has Resulted in a Fragmented System That Leaves Out Many Patients and Providers

THE GROWTH OF "HEALTH SYSTEMS"

Hospital Consolidation

- Hospital Consolidations and Physician Practice Acquisitions are Occurring at a Rapid Pace Nationally and in Connecticut
- There Were Twice As Many Hospital Mergers Nationally Between 2012 And 2014 Than Previously Recorded (100 A Year Versus 50)
- Half of Our State's Hospitals Are Part Of Large In-State Or National Health Systems And We Know More Are Looking To Be Acquired
- Two Health Systems Account For Half of All Hospital Revenue in the State
- One System Alone Receives Nearly One-Third of All Hospital Revenue and Almost 40% of All Industry Profits

"Hospital Excess Revenue Over Expenses (i.e. Profit) For 2013"



Source: OHCA - Annual Report on the Financial Status of Connecticut's Short Term Acute Care Hospitals 2013

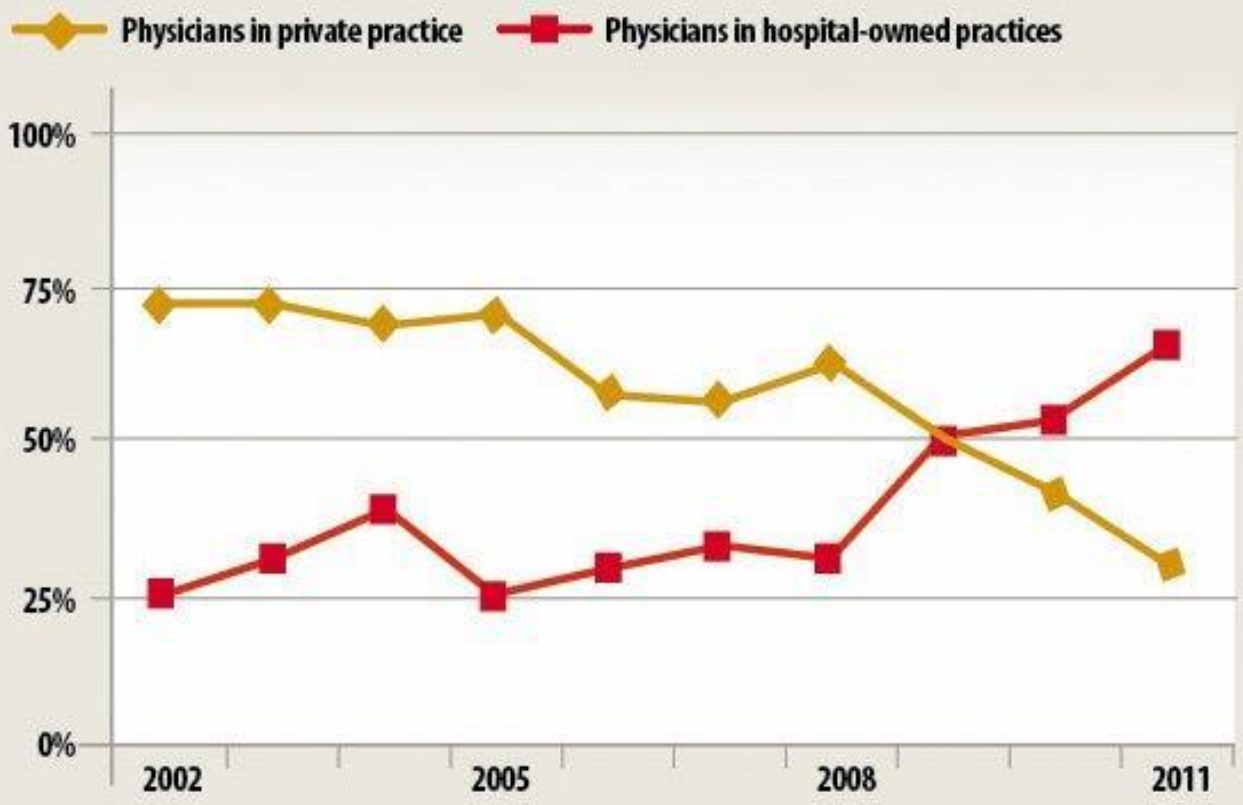
THE GROWTH OF "HEALTH SYSTEMS"

Hospitals Buying Physician Practices

- Hospitals Have Also Been Purchasing Physician Practices
  - Hospital Employment Of Physicians Grew By More Than 50% In The Last Decade
  - 60% Of Primary Care Doctors And 50% Of Surgeons Are Now "Employees"
  - Between 2007 and 2012, The Number of Cardiologists Employed By Hospitals Tripled
  - The Share of Medical Spending Attributed To Hospital Owned Physicians Increased 57% Between 2007 and 2013
- While Concrete Data Is Lacking, Since The 2009 Passage of Our Medical Foundation Law Allowing Hospitals to Employ Physicians, Hospital Employment of Physicians Appears to have Skyrocketed In Connecticut
- For Example, Northeast Medical Group, Which Is Affiliated With Yale And Formed in 2010, Now Employs Over 600 Physicians and Recently Acquired Fairfield County Based PriMed, A Group Of 120 Physicians With 31 Locations

Changing employment dynamics:

Private versus hospital-owned practices, 2002-2011



Source: Physician Compensation and Production Survey, Medical Group Management Association, 2011 Survey

CAUSES OF CONSOLIDATION AND EXPANSION

It's NOT The ACA

- Claims That The Affordable Care Act (*ACA*) Requires Or Even Promotes Market Consolidation Are Misplaced - Independent Providers Can Collaborate, Form Accountable Care Organizations (*ACOs*) And Provide Integrated Care Without Consolidating
- The Federal Trade Commission Has Warned That Efforts To Justify Health Care Mergers By Pointing To The ACA And Its Promotion Of Integrated Care and ACOs Are:
  - ***"creative, but misguided … the ACA neither requires nor encourages providers to merge or otherwise consolidate … ACOs may be formed through contractual arrangements that are well short of a merger"***
    (Julie Brill, FTC Commissioner)

CAUSES OF CONSOLIDATION AND EXPANSION

- In Rejecting A Bid By St Luke's Health Care System of Idaho To Acquire A Large Physician Practice, The FTC Argued, and the Court Agreed That:
  - ***there was no persuasive evidence that a merger was needed to generate those efficiencies … employing physicians is not necessary to achieving integrated care … integrated care and the greater use of electronic medical records can be achieved in ways other than the acquisition of a physician practice group which created a substantial risk of higher prices.(Deborah L. Feinstein, Director Bureau of Competition, FTC)***

- In Other Words, We Can Get The Benefits of Collaboration and Integration Without the Negative Effects of Consolidation - This Is What The ACA Promotes, and This is What State Policy Should Support.

CAUSES OF CONSOLIDATION AND EXPANSION

It Is The Money

- Evidence Suggests That The Primary Motivation For Hospital Consolidations and Physician Practice Acquisitions Is Monetary - Driven By Reimbursement Policies and a Desire to Enhance Bargaining Power
- Medicare Has Historically Paid Hospitals More Than Independent Providers For The Same Service – This Payment Differential Has Two Components (1) ***Facility Fees*** and (2) Significantly ***Higher Reimbursement Rates***
  - For Example, in Addition to Paying a Separate Hospital "Facility Fee", Medicare Pays 70% More for an Office Consultation With A Hospital Based Provider Than An Independent Physician and Twice As Much for An Echocardiogram Or Colonoscopy
- Private Insurers Model Their Reimbursement Policies On Medicare And Also Pay Hospital Based Providers At A Higher Rate

Office vs. hospital payments

Medicare fee-for-service payments for non-emergency evaluation and management (E&M) patient visits differs between office-based physicians and hospitals. In its 2013 report, MedPAC called for "site neutral" payments for E&M visits between physician offices and hospital outpatient departments.

CPT Code	Office-based physician payment	Hospital Payment*
99201	$41.11	$78.18
99202	$71.01	$124.06
99203	$102.95	$174.46
99204	$158.33	$254.87
99205	$197.06	$331.33
99211	$19.71	$61.53
99212	$41.45	$100.27
99213	$68.97	$124.40
99214	$102.27	$175.48
99215	$137.60	$235.51

SOURCE: Centers for Medicare and Medicaid Services, 2011

*Hospital payments include payment to physician and payment to hospital.

CAUSES OF CONSOLIDATION AND EXPANSION

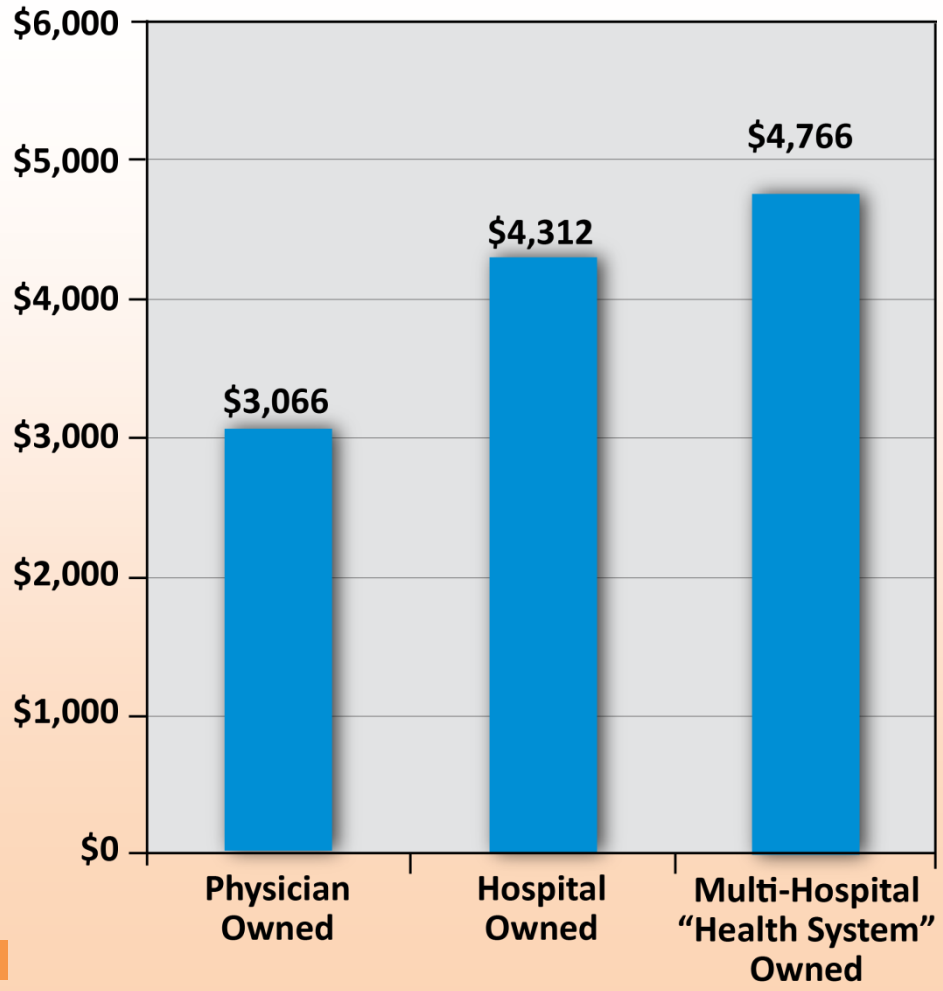
- Between Facility Fees And Higher Reimbursement Rates, When A Physician Practice Is Acquired By A Hospital, Costs For The Very Same Care Provided In The Same Location Go Up Dramatically
- A 2013 Report By The Medicare Payment Advisory Commission (MedPAC) Warned That These Perverse Financial Incentives Were Inducing Hospitals To Buy Up Physician Practices In Order to Generate Revenue Through Facility Fees and Higher Reimbursement Rates
- A St. Luke's Hospital Board Member Perhaps Said It Best In An Internal Document Discovered By The FTC -

"Employing physicians is not achieving better cost, it's achieving better profit."

HOSPITAL CONSOLIDATION AND EXPANSION LEADS TO HIGHER COSTS

- A 2012 Robert Wood Johnson Report Found that (1) Hospital Consolidation Results In Higher Prices With Increases Often Exceeding 20% and (2) Hospital Physician Practice Acquisitions Have Not Led To Improved Quality Or Reduced Costs
- A California Study Published Last Year In JAMA Found That Per Patient Expenditures By Hospital Employed Physicians Were Almost 20% Greater Than Independent Physicians
- A Recent Study By The Institute For Policy Research At Northwestern University Found:
  - Hospital Employment Of Physicians Was Associated With ***Significant Price Increases***, More Than 30% for Some Specialties Such As Cardiology
  - When The Acquiring Hospital Has A Virtual Monopoly In Its Local Market, Price Increases Are An Additional ***20% Higher***
  - Facility Fees Represent One Quarter of The Overall Increase In Prices
  - There Was No Evidence That Physician Practice Acquisitions Led To Reduced Spending
  - The Most Efficient Practice Model Appeared To Be A ***Small Group of 7-10 Physicians***

Per Patient Expenditures

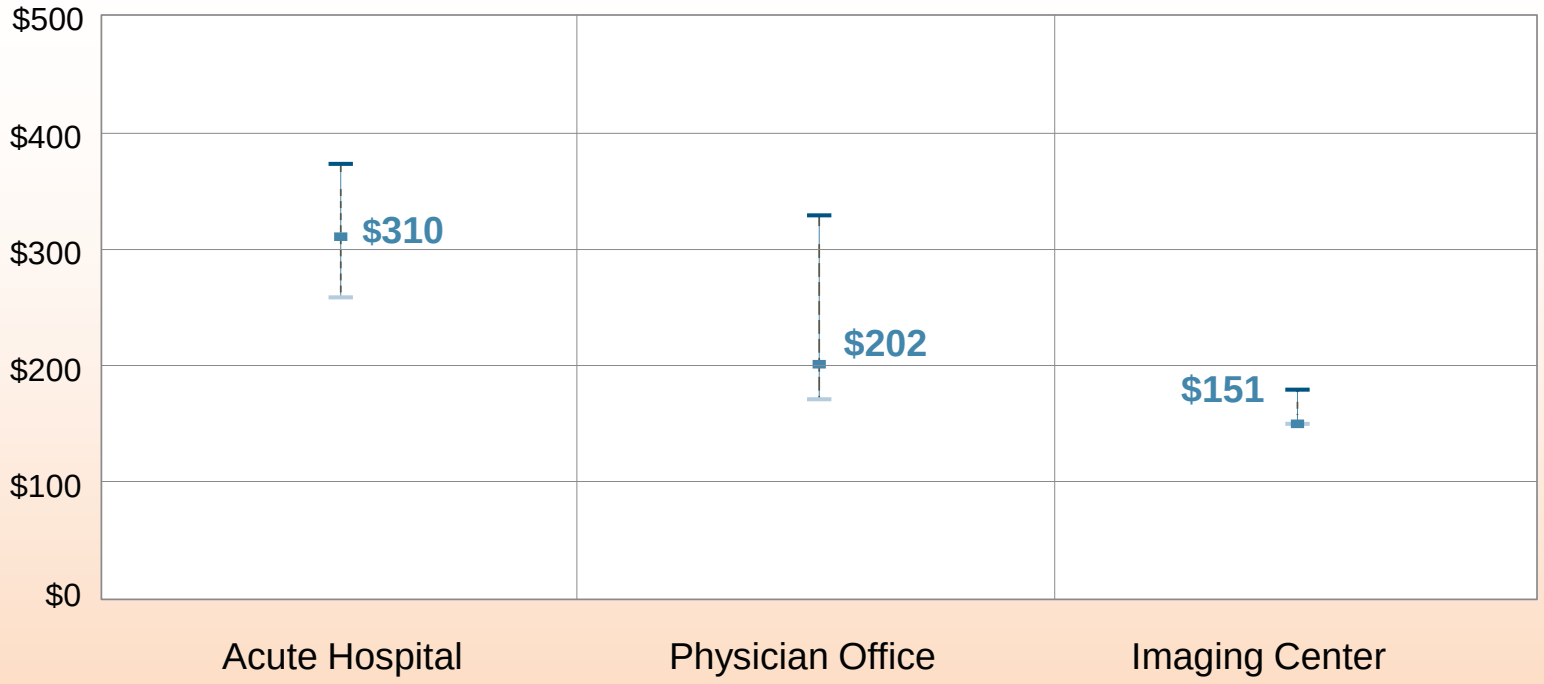


From: "Total Expenditures Per Patient In Hospital Owned and Physician-Owned Physician Organizations in California", JAMA 2014

HOSPITAL CONSOLIDATION AND EXPANSION LEADS TO HIGHER COSTS

- As MedPAC and the Mass. Health Policy Commission Have Found:
  - Hospital Physician Practice Acquisitions Have a Compounding Effect on Costs Because They Implicate All of the Major Contributors to Rising Costs – *Utilization*, *Unit Cost* and *Provider Mix*
  - More Providers Bill At The Higher Hospital Rate and They Refer More Patients For More Services to Fellow Hospital Employed Physicians
- By Expanding Their Physician Practice Network Hospitals Guarantee Themselves a Steady Supply of Referrals and Expand the Sites of Service at Which They Can Charge Facility Fees and Higher Rates.

Price Variation for Screening Mammography by Provider Type, 2012



25th Percentile Median Price 75th Percentile

Massachusetts Center for Health Information and Analysis

CONSUMERS ARE PAYING THE PRICE

- While Connecticut Lacks System Wide Data Regarding the Impact of Hospital Consolidation and Expansion, Anecdotal Evidence Suggests The Costs Are Staggering
- The Health Care Advocate Testified That:
  - A consumer undergoing chemotherapy saw the charge for a routine injection go from ***$2,500 to almost $12,000*** after the practice was purchased by a hospital, with a corresponding increase in his out of pocket costs.
  - Another Consumer Received A Bill From A Hospital Of ***Over $5,000*** For An Echocardiogram When The Average Cost For Such Procedure Is Just $1,100
- An Independent Radiologist Testified That:
  - The Hospital Rates For Routine Diagnostic Imaging Tests Are Often ***2 to 3 Times Higher*** Than At An Independent Facility
  - When Norwalk Hospital Acquired The Norwalk Radiology Center, A CT Scan That Might Have Previously Cost *$550* Suddenly Cost Over *$3,000*

Adjusted Chemotherapy Episode Costs, by Length of Episode

Length of episode in months	Office-managed episodes		HOPD-managed episodes		
	Number of episodes	Average episode cost	Number of episodes	Average episode cost	Percent difference
1	4,601	$10,764	1,784	$13,828	28.5%
2	3,679	$17,431	1,240	$23,917	37.2%
3	2,502	$26,893	1,091	$32,541	21.0%
4	2,518	$33,192	859	$42,628	28.4%
5	1,601	$39,220	481	$53,538	36.5%
6	1,151	$49,062	332	$61,661	25.7%
7	1,091	$39,888	268	$55,216	38.4%
8	635	$47,709	165	$74,066	55.2%
9	734	$42,838	127	$75,645	76.6%
10	445	$48,683	105	$67,003	37.6%
11	302	$67,068	69	$86,938	29.6%
12	303	$66,826	85	$102,395	53.2%

Source: Avalere Health analysis of NAMCP member data
Cost estimates adjusted for age, sex, and prior history of cancer
Costs include all care received by patient during chemotherapy episode, including some care unrelated to the provision of chemotherapy

CONSUMERS ARE PAYING THE PRICE

- Our State Comptroller, As Administrator For The State's $1.4 Billion a Year Employee and Retiree Health Plan, Warned That:
  - ***"provider consolidation with hospitals may result in increased health care prices and total costs. The impact is measurable both in hospital prices and in per-patient expenditures of hospital-owned physician practices."***
- MedPAC Has Warned That The Migration Of Previously Independent Practices To Hospitals Is Costing Medicare Billions Of Dollars For The Same Care
  - MedPAC has Recommended Eliminating Medicare Reimbursement For Facility Fees And Equalizing Reimbursement Rates For Those Procedure That Can Be Safely Performed In Non-Hospital Outpatient Settings – This Proposal Could Save Medicare ***$30 Billion Over 10 Years – More Than Raising The Eligibility Age to 67!***
- Thus, Facility Fees and Increased Hospital Based Reimbursement Rates Are Putting Strain On Government Funded Programs, Employers and Consumers

THE WAY FORWARD

- Whatever One's Position Is On The ACA, We Cannot Let Its Promise of Expanded Coverage, Improved Outcomes and Increased Efficiency Be Squandered
- To Ensure That Consumers Realize the Benefits of These Policies We Must Mitigate The Anticompetitive Effects of Market Consolidation Through:
  - Greater Market Scrutiny and Oversight
  - Policies That Promote Collaboration Over Consolidation and Support Our Low Cost/High Quality Providers and Hospitals
  - Increased Price and Quality Transparency To Empower Payers and Consumers to Make Value Based Decisions About Their Care
  - Robust Electronic Health Information Systems That Allow Health Records To Follow The Patient And Promote Efficient Integrated Care Regardless of Provider Setting

S.B. 815 AN ACT CONCERNING HEALTH CARE POLICY AND COST CONTAINMENT.

- Establish a ***Connecticut Health Policy Commission*** To:
  1. monitor and report on health care cost, delivery and payment trends,
  2. recommend policy changes to reduce health care costs and improve quality,
  3. establish benchmarks for health care cost growth,
  4. identify providers that exceed the benchmarks and work with them to implement a performance improvement plan,
  5. analyze provider mergers and acquisitions , identify those likely to significantly impact health care competition or costs, and provide a cost and market impact analysis to the Attorney General and the Office of Health Care Access.

- Based on Mass Health Policy Commission - A Single Independent State Agency Responsible for Monitoring and Reporting on Health Care Costs and Market Trends

S.B. 815 AN ACT CONCERNING HEALTH CARE POLICY AND COST CONTAINMENT.

- The Mass Health Policy Commission Played An Instrumental Role In Analyzing The Potential Impact of a Hospital Merger Saving Massachusetts Consumers Millions:
- Blocking a Proposal by Partners HealthCare, a Large Non-Profit Health System, to Buy Three Community Hospitals in Eastern Mass, the Court Relied Upon the Commission's Analysis Showing:
  - Massachusetts spends more on health care than any other state
  - 21% to 39% of Massachusetts health care spending is "wasteful"
  - Massachusetts is dominated by a few large health systems that use their market leverage to increase prices
  - Partners' Hospitals and Physicians Were - ***"consistently the highest priced"*** and their ***"high costs do not translate into higher quality care."***
  - Partner's Purchase of Just These Three Hospitals Would Increase Health Care Costs by *$38 to* ***$49 Million a Year***.
- Connecticut Lacks this Kind of Detailed Economic Data and Analysis. Massive Changes Have Occurred in our Health Care Market with Little Analysis or Understanding of the Impact on the State, Our Economy or Individual Consumers

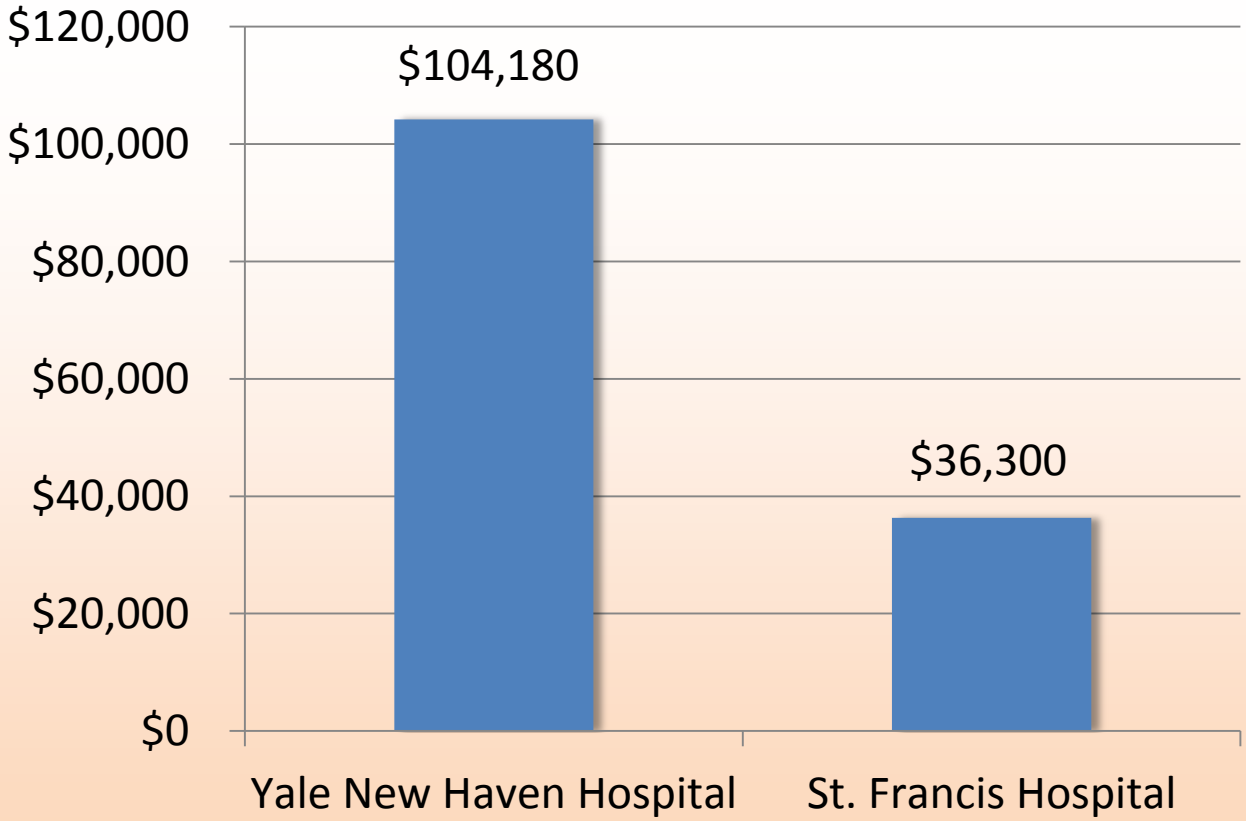
S.B. 810 AN ACT ESTABLISHING A SPECIAL COMMISSION ON PROVIDER PRICE VARIATION AND REFORM.

- Establish a Special Commission to Study Provider Price Variation - (i.e. the difference in the prices charged by various providers for the same services, such as hospitals vs. independent providers, large versus small hospitals, etc,)
- Commission to include Attorney General, Health Care Advocate, Insurance Commissioner and Representatives of Payers, Providers and Patients
- Report in 2016 on Extent of Price Variation, Causes and Recommendations to Reduce Variations that are not Justified by Actual Differences in Costs or Quality.

We Know Price Variation Exists and Can be Dramatic. However, We Lack Connecticut Specific Statewide Data on the Extent of Such Variation and its Impact on Total Medical Costs as well as Consumers' Out of Pocket Costs.

A Massachusetts' study found significant unjustified price variation among providers with large hospitals and hospital systems charging significantly more than smaller hospitals and independent providers – ***often a 3 to 7 times factor***. It also found that simply narrowing the range of variation to within the current 20th to 80th percentile would save payers, including the state, ***over $250 million a year.***

Cost of Implanting a Permanent Cardiac Pacemaker



Source: "Hospital Mergers Raise Concerns Over Patient Costs", Conn. Health Investigative Team, March 23, 2014.

P.B. 813 AN ACT CONCERNING HEALTH CARE PRICE, COST AND QUALITY TRANSPARENCY.

- Conn Receives an "F" for Price and Quality Transparency in National Surveys
- To Promote Low Cost/High Quality Care, Consumers and Payers Must Have Timely, Accurate and Understandable Price and Quality Information
- S.B 813 Would Move Us Closer To This Goal By:
  1) Developing a ***consumer health information website*** that allows consumers to compare cost and quality data across all payers and providers and enables them to make informed choices regarding their care;
  2) Requiring providers to give consumers ***timely information regarding the price*** of scheduled procedures and services and to disclose business relationships with any providers to which they are referring a patient;
  3) Requiring insurers to establish ***toll free numbers and websites*** allowing insureds to obtain real time information regarding charges for services and the amount the insured will be responsible to pay including any facility fee, copay, deductible, coinsurance or other out of pocket cost;
  4) Require hospitals to participate in a ***nationally recognized cost and quality rating system*** and provide consumers with information regarding their performance and ratings.

P.B. 813 AN ACT CONCERNING HEALTH CARE PRICE, COST AND QUALITY TRANSPARENCY.

- Price Transparency is a Powerful Tool for Cost Containment - A Recent Report by the West Health Policy Center Found that Providing Patients, Physicians, Employers and Policy Makers with Price Information Could Save ***$100 Billion Over 10 Years***, Including ***$15 to $20 Billion in Out of Pocket Costs*** for Consumers;
- New Hampshire Found that Simply Publicizing and Exposing the Price Disparity Among Providers had a Significant Impact on the Market - ***Price Variation Decreased Substantially*** as Higher Priced Providers Reduced their Rates to Meet the Demands of Consumers, Payers and Policy Makers;

S.B. 812 AN ACT CONCERNING ELECTRONIC HEALTH RECORDS AND HEALTH INFORMATION EXCHANGE

- The Seamless Exchange of Patient Health Information Across All Provider Settings is Essential to Achieve the Triple Aim of Improving the Quality of Patient Care, Improving Population Health, and Containing Costs
- ***Health Records Must Follow The Patient***. The State Must Affirm as a Matter of Policy That Health Records Belong to the Patient, Not the Provider. Patient Medical Records Are Not Proprietary and Should Not be Used for Competitive Advantage.
- Without the Sharing of Patient Information, the Promise of Electronic Health Records to Improve Accurate and Timely Diagnosis, Eliminate Duplicative Testing, Reduce Medical Errors and Improve the Overall Efficiency of Health Care Delivery Cannot be Achieved

S.B. 812 AN ACT CONCERNING ELECTRONIC HEALTH RECORDS AND HEALTH INFORMATION EXCHANGE

- Recognizing the Inconsistent Implementation of HIE at the State Level, the Federal Office of the National Coordinator for Health IT Recently Issued a 10 Year Health IT Roadmap that Recommends the Following:
  - A ***Public-Private Partnership*** and Governance Framework
  - A Focus on Systems that ***Maximize Information Sharing*** with the Least Amount of Effort and Cost
  - ***Sustainable Funding*** Mechanisms
  - Increased ***Public and Private Incentives*** for Providers to Implement Interoperable Electronic Health Records Systems
- SB 812 Seeks to Put Connecticut on this Road Map By:
  - Committing the State to the Implementation of a Statewide HIE
  - Creating a Sustainable Funding Mechanism to Support the Statewide HIE that Includes Public and Private Support
- Providing Support and Incentives for Providers to Adopt Interoperable Electronic Health Records Systems that can Share Information Through the HIE

S.B. 812 AN ACT CONCERNING ELECTRONIC HEALTH RECORDS AND HEALTH INFORMATION EXCHANGE

- Commitments From Stakeholders :
  - Everyone- the State, Employers, Commercial Payers, Providers and Patients - Stands to Benefit From a Fully Functioning State HIE. ***Everyone Should Contribute to its Success***.
  - SB 812 Does This by Requiring (1) Hospitals to Ensure the Interoperability of their Own Systems and to Support Community Providers in Adopting Electronic Health Records Systems, (2) Payers to Contribute to Funding the State HIE and to Provide Enhanced Reimbursement to Providers with Certified Electronic Health Records Systems, and (3) the State to Provide Seed Funding for the HIE as well as Loans, Grants and Tax credits for Providers.
  - These Joint Investments and Contributions are Critical to the Long Term Success of this Effort and Have Been Shown to Work in Other States.

S.B. 812 AN ACT CONCERNING ELECTRONIC HEALTH RECORDS AND HEALTH INFORMATION EXCHANGE

- Numerous Studies Have Shown the Value of HIE in Terms of Patient Care, Quality and Costs;
  - A 2014 Study by Weill Cornell Medical College Showed a ***30% Reduction in Hospital Admissions*** Through HIE Use
  - Research from the American College of Emergency Physicians Showed that HIE use Resulted in Average ***Savings of $2,000 Per Patient*** by Reducing Tests and Hospital Admissions. ER Physicians also Reported that Quality of Patient Care Improved.
  - Rhode Island, Which has a Successfully Operating Statewide HIE, Found a Statistically Significant Reduction in Hospital Readmissions Resulting in ***Savings of $24 Million*** in 2013

S.B. 809 AN ACT CONCERNING FACILITY FEES

- According to a 2014 Conn Attorney General Report, ***22 of 29 Conn hospitals charge facility fees*** and they can range from ***$100 to more than $1,000*** - Although the State Health Care Advocate Reports of Facility Fees as High as $5,000
- A federal study found that, by 2021, facility fees for routine doctor visits and cardiac imaging tests alone will ***cost Medicare an extra $2.3 billion*** and patients an extra $590 million in out-of-pocket expenses each year.
- MedPAC has recommended ***eliminating Medicare reimbursement for facility fees*** related to outpatient services that have historically been provided in physician offices or non-hospital outpatient settings and can safely be provided in such settings.
- SB 809 Would Crack Down on the Inappropriate Use of Facility Fees By:
    1) Prohibiting facility fees for procedures in group 1 of the Medicare ambulatory payment classifications (i.e. those MedPAC has determined can be safely performed in an outpatient setting)
    2) Capping all other facility fees at $100
    3) Requiring insurance coverage of such fees

S.B. 814 AN ACT PROMOTING ACCOUNTABLE CARE COLLABORATIVES.

- Accountable Care Organizations (ACOs) are a Voluntary Network of Providers (Hospitals, Primary Care Physicians, Specialists, etc.) Who Agree to Coordinate Care for a Group of Patients
- The Center for Medicare and Medicaid Services (CMS) Certifies ACOs to Participate in the Medicare Shared Savings Program. Providers Manage and Coordinate Care for Medicare Patients and are Eligible to Share in any Savings Generated.
- Because Federal Antitrust Laws Generally Prohibit Independent Market Participants Joining Together to Negotiate Prices, the Federal Government has Carved out an Antitrust "Safe Harbor" for Providers Participating in a Medicare ACO that Allows Those Providers to Jointly Negotiate Payment Terms.
- While ACOs are Being Developed in the Private Market Outside of Medicare, There is No State Regulatory Framework for Such Entities. A Number of States, Including New York, Are Developing A Certification Process for State ACO Like Entities and Granting State Certified ACOs the same Antitrust Safe Harbor.

S.B. 814 AN ACT PROMOTING ACCOUNTABLE CARE COLLABORATIVES.

SB 814 Would Promote the Development of State Accountable Care Collaboratives By:

1. Providing ***state certification for Accountable Care Collaboratives (ACC)*** - a group of clinically integrated health care providers that work together to provide, manage and coordinate care for a defined group of patients and share accountability for the quality and cost of such care;
2. Giving providers in a state certified ACC a ***"safe harbor"*** under state antitrust laws allowing them to negotiate rates and payment terms.

- The Goal is to (1) Promote the Development of State ACO like Models of Care, which Promise to Improve Patient Outcomes and Reduce Costs through Better Coordination and Integration of Care, and (2) Encourage the Participation of Small Independent Providers, Who are Often the Low Cost/High Quality Providers, in these Care Models.

S.B. 811 AN ACT CONCERNING PARITY IN HOSPITAL SALES OVERSIGHT

- Apply Our State's Hospital Conversion Process to Sales Between Non-profit Entities
- As the Partners Healthcare Case in Massachusetts Demonstrates, Non-profit Health Systems Can Engage in Anticompetitive Behavior and the Expansion of Non-profit Health Systems Can Have a Significant Impact on Health Care Costs for the State and for Consumers
- Regardless of the Tax Status of the Purchaser, There Needs to be a Thorough and Thoughtful Review of Any Hospital Sale to Determine its Impact on Health Care Costs and Access to Care
- S.B. 811 Would Also Require OHCA to Consider the Potential Negative Impact on the Community and Access to Care if a Proposed Sale is not Approved and Weigh these Potential Negative Effects Against the Benefits of the Conditions it Seeks to Impose.

OTHER PROPOSALS – SUPPORTING COMMUNITY HOPITALS AND PROVIDERS

While Large Well Capitalized Health Systems Are Thriving, Many of Our Smaller Community Hospitals and Providers Struggle. They Cannot Afford to Buy Physician Practices Nor do they Have the Bargaining Power to Negotiate Higher Rates. Yet They Often Provide the Kind of Value Based Care the ACA Seeks to Promote.

To Support These Hospitals and Providers We Should Consider:

1. ***Maintain Funding For Small Low Cost/High Quality Hospital Pool***
   State hospitals receive hundreds of millions a year in state and federal reimbursement through the Medicare and Medicaid programs. To promote the efficient delivery of high quality care in low cost settings, a portion of that state support should be set aside to support our small community hospitals who provide such care. Despite difficult state budget constraints, every effort should be made to maintain the $15 million set aside to support our small low cost hospitals.
2. ***A Community Hospital Investment and Transformation Program***
   Establish a Competitive Process For State Loans and Assistance With an Emphasis on Proposals that Promote Efficient Integrated Care Delivery, Coordination of Resources, the Ability to Participate in ACOs and the Adoption of Electronic Health Records. (Based on Massachusetts CHART Program)

OTHER PROPOSALS – SUPPORTING COMMUNITY HOPITALS AND PROVIDERS

3. State Assisted Purchasing

State Statutes Allow DAS to Enter into Cooperative Purchasing Agreements With Nonprofit Organizations and Allow Certain Government Funded Entities to Purchase Through DAS. However, the State Has No Specific Purchasing Program for Community Hospitals or Providers. We Should Consider Implementing Such a Program to Assist Community Hospitals and Providers in Achieving Savings in Their Purchasing of Supplies, Services and Equipment.

4. A Model ACO Program

Establish a Model ACO Program That Gives Preference to State Certified ACOs that Meet Certain Metrics, Such as the Inclusion of Low Cost/High Quality Hospitals and Independent Providers, and Support Such ACOs Through the State Employee and Retiree Health Plan, Medicaid and Other State Administered Programs.

OTHER PROPOSALS – SUPPORTING COMMUNITY HOPITALS AND PROVIDERS

5. Community Health Teams

Support the Development of Community Health Teams to Provide Practice Management and Care Coordination Services to Small Independent Providers to Help Facilitate Their Participation in ACOs and Modern Care and Payment Models. Small Practices, While Often High Quality and Low Cost, Do Not Have the Internal Staffing or Financial Resources to Support the Infrastructure Required to Participate in ACOs and Integrated Care Models. Yet, They Are Often the Providers who Can have the Greatest Impact on Patient Health, Utilization and Costs.

OTHER PENDING LEGISLATION

In addition to these bills, we have two bills pending in the Insurance Committee:

P.B. 807 - AN ACT CONCERNING FAIRNESS AND EFFICIENCY IN INSURANCE CONTRACTING is intended to mitigate the unequal bargaining power of large health systems and reduce payment disparity by, among other things, requiring (1) hospitals to negotiate separately even if commonly owned, and (2) insurers to include site neutral payment policies that provide equal reimbursement to all providers for common outpatient services.

P.B. 808 AN ACT CONCERNING SURPRISE BILLING is intended to prevent out of network providers from billing consumers for services when the consumer had no notice of the providers out of network status.

CONCLUSION

Together all of these bills are designed to:

1) protect consumers from unjustified price increases and facility fees;
2) empower consumers through greater price transparency,
3) mitigate the anticompetitive effects of hospital and provider consolidation and reduce price disparity among providers,
4) increase the state's oversight of the health care market,
5) support independent low cost/high quality providers, and
6) promote efficient patient centered care through the adoption of electronic health records and a state health information exchange.

We look forward to working with the committee and stakeholders to further develop these proposals. The status quo of a system based on secrecy, market power and resource control cannot stand. The costs of such a system threaten to overwhelm the progress made in expanding coverage and are unsustainable.

Source Material

"Monopolizing medicine: Why hospital consolidation may increase healthcare costs" Medical Economics, Feb. 24, 2014

"When Hospitals Buy Doctor's Offices, and Patient Fees Soar", New York Times, Feb 6, 2015

"The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending", Institute for Policy Research, Northwestern University, Feb. 2015.

"A Common Sense Medicare Solution: Site-Neutral Payment Reform", Barry Brooks, Roll Call, Feb. 25, 2015

"Hospital Mergers Raise Concerns Over Patient Costs", Conn. Health Investigative Team, March 23, 2014.

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