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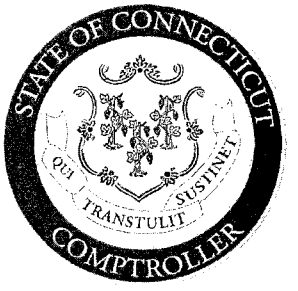

STATE OF CONNECTICUT
OFFICE *of the* STATE COMPTROLLER
55 Elm Street
Hartford, CT 06106

WRITTEN TESTIMONY
Kevin Lembo
State Comptroller

Concerning
S.B. 809 An Act Concerning Facility Fees
S.B. 993 An Act Concerning Facility Fees
S.B. 810 an Act Establishing a Special Commission on Provider Price Variation and Reform
S.B. 813 An Act Concerning Health Care Price, Cost and Quality Transparency

March 11, 2015

Senator Gerratana, Representative Ritter, Senator Markley, Representative Srinivasan and Members of the Committee:

For the record, I am Kevin Lembo, Connecticut State Comptroller.

Thank you for raising this legislation and giving me an opportunity to express my support.

I would also like to thank Senate President ProTempore Martin Looney and Senate Minority Leader Leonard Fasano for the leadership they have shown in working to tackle the incredibly complex issues surrounding the state's health care delivery system.

Our state has seen unprecedented change in our health care system. Once dominated by independent non-profit hospitals and small independent provider practices, the state has seen the emergence of large hospital systems and provider groups through hospital mergers and provider consolidations happening over the last several years. In addition, new payment models are emerging, moving away from the historic fee for service reimbursement model toward payment models that incent quality and care coordination.

The changing landscape calls for an in-depth evaluation of the state's oversight, regulation and infrastructure that oversees and supports our health care system to ensure the best quality and value care for Connecticut residents.

Senators Looney and Fasano have taken this issue head on by establishing the Bi-partisan Roundtable on Hospitals and Health Care. In a show of true bi-partisanship the roundtable has invited a diverse set of speakers from physician groups, hospitals, insurers and regulatory

agencies in other states to speak and share their perspectives on a variety of topics. The work of the roundtable is the genesis for many of the bills the Public Health Committee is hearing today and I applaud the continued spirit of bi-partisanship being shown on this very important issue.

On the bills before you today, I would like to provide comment on the Acts concerning facility fees, cost and quality transparency and An Act Establishing a Special Commission on Provider Price Variation and Reform.

Senate Bills 809 and 993 An Act Concerning Facility Fees

Last legislative session my office was charged with studying the impact the expansion of facility fees are having on the State Employee Plan. Facility fees are charges submitted by a facility to cover the overhead costs and materials associated with providing care. They are in addition to professional fees which cover the cost of professional services provided. In general facility fees provide a mechanism for hospitals and certain outpatient facilities to be reimbursed for the overhead costs they incur for procedures performed at the facilities they maintain. An issue has developed when facility fee charges are applied to professional services that do not require special facilities and have historically not been subject to such fees.

In 2012 several complaints were filed with the Office of the Attorney General, and Office of the Healthcare Advocate charging that new facility fee charges had been instituted at hospital-owned practices that had previously not charged facility fees. The new fees came as a surprise to patients who saw drastic increases in their out-of-pocket costs from one visit to the next for the same services at the same provider locations.

Over the last six months my office, in conjunction with our health care consultants and third party administrators, has sought to detangle a web of complex claims data to determine where new facility fees may have been implemented, when and how much the new fees are costing the state plan.

While we are still awaiting some additional data from our health care consultant, our preliminary findings indicate that the practice of implementing new facility fee charges at provider offices that historically only billed professional fees is not widespread. Our initial analysis, which covers the time period between 2010 and 2013, found two health care systems that clearly instituted new facility fees in certain service categories: Yale-New Haven – Cardiology and John Dempsey Hospital – Dermatology. The increase in cost to the state associated with the new application of facility fees over this time period was relatively small in terms of total spend for the state plan, but significant in terms of growth in spending at each facility. Over the analysis period, spending by the state employee plan in the identified service areas at Yale-New Haven and John Dempsey increased by approximately 400% due to a change in billing practice. Yale-New Haven – Cardiology spending increased from a base of $310,000

to $1.2 million; and similarly at John Dempsey Hospital – Dermatology, state spending increased from a base of $40,000 to $445,000.

It's important to note that the analysis performed to determine the locations that began to charge facility fees for the first time over the analysis period was complex, requiring a multi-step process. It is possible that not all locations that instituted facility fees for the first time were detected as the analysis depended on identifying spikes in the data. New facility fees may have appeared to have had a minimal impact on the state employee plan and thus not identified.

Overall, the analysis indicates that the application of new facility fees may not be as widespread as initially thought. Generally, professional practices affiliated with hospitals are not using provider based billing, which is used to charge both professional and facility fees. Instead they depend on traditional professional fee reimbursements.

Anthem, one of the state's third party administrators, is instituting new policies to limit the use of provider based billing in an office setting. Anthem recently released new policies that establishes criteria and defines a professional provider office location, stipulating that facility fees charged in professional provider office location are not eligible for reimbursement. Anthem's claims processing also rejects any claims with facility fees that are billed with office visit evaluation and management codes.

Anthem's criteria and definition of a professional provider office location are attached. The committee may want to consider utilizing similar language to prohibit the inappropriate charging of facility fees in the future for all patients regardless of insurance status or carrier.

On a related note, this fall when my office began to analyze facility fee charges and their impact on the state plan, I invited comment from the general public. We received some correspondence indicating that some locations are not consistently notifying patients of potential facility fee charges prior to providing service as required by law. The provision requiring online notification as required by SB 993 may help to alleviate the confusion that can occur when current notices are either untimely or vaguely written.

Finally, I would like to note that while the vertical consolidation of our health care system may not be resulting in significant proliferation of new locations charging facility fees, my office remains concerned that market concentration will drive health care costs higher. There is significant evidence that suggests hospital mergers lead to higher prices.[1] More recent studies have also found that per patient

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[1] Matthew S. Lewis & Kevin E. Pflum, Hospital Systems and Bargaining Power: Evidence from Out-of-Market Acquisitions (Working Paper, 2013); Robert A. Berenson et al., "The Growing Power of Some Providers to Win Steep Payment Increases Insurers Suggests Policy Remedies May Be Needed", 31 Health Affairs. 973, 976 (2012)

[1] Statement of John Lynch, Executive Director, Pro-Health Physicians, Comptroller's Informational Forum on Facility Fees, December 3, 2014.

expenditures at physician practices owned by large hospital systems were higher than those of independent practices.[2] My office is working on an analysis of the Connecticut market to determine if similar disparities in per patient expenditures exist here in our state. Many of the proposals being heard today and other initiatives being discussed this legislative session would help us to better understand and respond to some of the cost issues related to hospital and provider consolidation.

SB 810 AA Establishing a Special Commission on Provider Price Variation

I would like to express my support for SB 810 AA Establishing a Special Commission on Provider Price Variation. Through review of the claims data for the state employee plan, my office has identified significant price variation across providers. Price variation has a significant impact on costs, especially in the context of a fee for service system in which there is little incentive for providers to consider costs when making referrals. It is hoped that as the reimbursement system continues to move toward shared savings and global payment models that the incentives will shift and patients will be referred to high value providers – high quality, low cost – thereby improving the efficiency of our health care system. In the meantime, the existing price variation results in increased costs to the health care system as a whole resulting in higher costs for employers and individuals alike.

I would appreciate your consideration of including my office as part of the Commission. As the administrator of the state employee plan, the State Comptroller's office is the only agency in state government with direct access to a large database of commercial claims. This data is essential to performing the required analysis, and could serve as a great resource for the Commission.

S.B. 813 An Act Concerning Health Care Price, Cost and Quality Transparency

I would like to express my support for improving health care price, cost and quality transparency in the state. Adequate cost and quality information is essential in a world where we are asking patients to be directly involved in their care and providers to take on risk based upon the total cost of care for their attributed patients. However, just because price and quality transparency tools are available, that does not mean they are effective. Research shows that consumers want cost and quality information that is specific to their circumstances and easy for them to understand. This means quality measures on clinical and patient experience outcomes for the procedure they are considering and cost measures that show differences in out of pocket costs. Consumers also value knowing the source of any cost and quality measures preferring information provided by sources that are viewed as independent and objective.[3]

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[2] Baker LC, Bundorf MK, Kessler DP. "Vertical integration: hospital ownership of physician practices is associated with higher prices and spending." Health Affairs (Millwood). 2014;33(5):756-763;
James C. Robinson and Kelly Miller. "Total Expenditures per Patient in Hospital-Owned and Physician-Owned Physician Organizations in California", JAMA October 22/29, 2014 Volume 312, Number 16

[3] Government Accountability Office. "Health Care Transparency: Actions Needed to Improve Cost and Quality Information to Consumers", October 2014. http://www.gao.gov/assets/670/666572.pdf

Connecticut is behind other states in the availability of cost and quality data. The state's All-Payer Claims Database is still in development and provider specific cost and quality data may not be available until well into 2016, possibly later. However, it's more important that as a state we ensure consumers receive useful and actionable cost and quality transparency data, because it is what helps patients make the best decisions about the care they receive. When done right it allows patients to get the most value out of their health care dollars, improving outcome and reducing costs.[4]

Closing

In closing, thank you for the opportunity to testify before the Public Health Committee today. I applaud the work the committee is undertaking. The landscape of health-care delivery is changing dramatically so it's important that we identify the necessary changes, and establish appropriate policies to manage them enabling the delivery of the best possible care to Connecticut consumers, while also ensuring the stability of our health care delivery systems.

I urge your support and thank you for your consideration.

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[4] J. H. Hibbard, J. Greene, S. Sofaer et al., "An Experiment Shows That a Well-Designed Report on Costs and Quality Can Help Consumers Choose High-Value Health Care," *Health Affairs*, March 2012 31(3):560–68. http://content.healthaffairs.org/content/31/3/560.full

Anthem BlueCross BlueShield

Anthem Blue Cross and Blue Shield Professional Reimbursement Policy

Subject: Office Place of Service	
CT Policy: 0042	**Effective: 06/01/2015**

Coverage is subject to the terms, conditions, and limitations of an individual member's programs or products and policy criteria listed below.

Description

Current Procedural Terminology (CPT®') describes the office place of service (POS code 11) as a "Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis."[1]

This policy documents how the Health Plan defines an office place of service (POS) and our requirements for services provided by a professional provider or private practice group in an office setting and reported on a Form CMS-1500.

Policy

1. The Health Plan follows CPT's definition of an office POS as described above. The Health Plan further defines an office POS as a location outside of a hospital or facility wherein the professional provider/private practice may or may not own equipment, compensate staff, or hold responsibility for all overhead expenses. Additionally, the physical site location **does not** include state licensed inpatient beds, a state licensed emergency room or emergency department, nor provide 24 hour per day seven days a week on site continuous physician and nursing services for diagnosis and treatment of patients. The physical site location also **does not** have licensure and accreditation (either Joint Commission or Accreditation Association for Ambulatory Health Care (AAAHC) certification) as an Ambulatory Surgery Center.

2. In addition, the Health Plan defines an office setting as one that is located within a hospital or facility, a professional building attached to and owned by a hospital or facility, or an offsite professional building owned by a hospital or facility when one or more of the following conditions is present:

   a) Office space is rented by or there is some agreement between the professional provider/private practice that operates under a separate National Provider Identifier (NPI), and the hospital or facility.

   b) The location is in a separately identifiable part of the hospital or facility and used solely as the professional provider's/private practice's office regardless of the state's licensing or certification of certain areas within the hospital or facility as a department of the hospital (e.g., orthopedic clinic, pediatric clinic).

Anthem Blue Cross and Blue Shield
Professional Reimbursement Policy

c) When equipment is located in rented space within the hospital or facility's "four walls" then the services (e.g., radiology services, electrocardiograms) are considered to be provided in an office setting regardless of who owns the equipment.

d) A free standing or off campus location owned by a hospital, facility, or health system that allows for separate offices is considered an office place of service and services provided in this type of setting are considered to be provided in an office.

3. The Health Plan does not recognize Provider Based Clinics (PBCs), as defined by the Centers for Medicare & Medicaid Services (CMS), as an extension of the hospital. Therefore, when the location's focus is seeing patients from the community on a daily basis, the Health Plan considers the services provided in the PBC to be provided in an office.

4. The Health plan does not recognize ownership of a professional provider/private practice by a hospital or facility, or use of a hospital or facility's tax identification number for claims submission on behalf of the provider/private practice, as a hospital or facility provider, when the setting is office based. Therefore, when this type of relationship exists, the place of service where services are provided is **not** considered by the Health Plan to be a hospital or facility.

5. The Health Plan does not reimburse for separate facility fees billed in conjunction with services rendered by professional providers/private practices in an office place of service as defined in this policy. A facility fee is defined as a separate bill submitted by a facility for facility services provided as part of a professional provider's/private practice's service in an office place of service as defined in this policy. Reimbursement for such facility fees is considered included in the reimbursement to the professional provider/private practice

All procedures and/or services performed by a private professional provider/private practice group in an office POS as defined in this policy will only be eligible for reimbursement when reported on a Form CMS-1500 with an office place of service (POS code 11).

Use of Reimbursement Policy:
This policy is subject to federal and state laws, to the extent applicable, as well as the terms, conditions, and limitations of a member's benefits on the date of service. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.