



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

TESTIMONY PRESENTED BEFORE THE COMMITTEE ON PUBLIC HEALTH

March 7, 2012

Kimberly Martone, Director of Operations, Office of Health Care Access, 860-418-7029

*House Bill – Bill 5321 - An Act Concerning the Office of Health Care Access
and the Certificate of Need Process*

The Department of Public Health would like to provide the following information in favor of House Bill 5321. We thank the Committee for choosing to take up the Department's proposal. Below is information on the provisions contained in the bill.

Section 1

The Department's Office of Health Care Access (OHCA) is proposing to replace the phrase "how the proposal will impact the financial strength of the health care system in the state" within §19a-639(a)(4) of the General Statutes with "that the proposal is financially feasible for the applicant." In evaluating Certificate of Need (CON) applications, OHCA can verify and measure the effect a CON proposal has on the applicant by reviewing the financial status of the applicant; however, OHCA does not have the data to properly evaluate the financial impact of the CON proposal on the state's health care system. Moreover, CON applicants struggle to produce evidence demonstrating the impact of the proposal on the state's health care system. It is also worth noting that the majority of the CON proposals received and reviewed by OHCA over the past year involve the acquisition of imaging equipment, the establishment of substance abuse/mental health services, and transfer of ownership of a health care facility. Such proposals do not lend themselves to an easy demonstration of their impact on the financial strength of the health care system statewide.

Prior to the changes implemented under Public Act 10-179, OHCA evaluated the financial feasibility of the proposal rather than looking at the impact on the entire state. This financial feasibility evaluation is a more realistic guideline and most applicants are able to produce financial documents and analysis demonstrating that a particular proposal is financially feasible.

Section 2

OHCA proposes to amend the proposed language in this section by deleting "after the date the office closes the public hearing" in line 49 and substituting "following the close of the hearing record." This is to clarify the closing of the hearing record as opposed to the actual public hearing. At the public hearing, OHCA often orders additional evidence be provided after the public hearing has ended. Once the information is received by OHCA, it then *closes* the hearing record through a letter. Therefore, the proposed language clarifies when the hearing record is legally closed as well as the day on which the 60 day review period for OHCA to render a decision begins.

*Phone: (860) 509-7269, Fax: (860) 509-7100
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Section 3

This section would require hospitals to file a statement of operations and utilization statistics on a quarterly basis, which will provide OHCA with a small number of performance indicators or measures in order to see more immediate financial and utilization performance results, and allow OHCA to publish a dashboard of financial indicators quarterly. This change will allow OHCA to provide the public and policy makers with the most current information on the financial performance of Connecticut's hospitals.

OHCA currently receives substantial financial data and information on an annual basis from Connecticut's acute care general hospitals and children's hospital pursuant to state statute and regulation. OHCA utilizes this data to publish an annual acute care hospital financial stability report, to publish various fact sheets, to verify hospital net revenues, to calculate the allocation of the OHCA funding assessment amounts among the hospitals (OHCA is an industry-funded division), to support the Certificate of Need process, and also to support facility planning efforts which OHCA is undertaking. However, OHCA receives this annual data, by law, five to six months after the end of the hospital fiscal year.

Given the rather dynamic and fluid nature of hospital finances, OHCA wants to enhance data reporting efforts and collect certain information on a quarterly basis. Currently, OHCA cannot determine and is therefore not able to inform policy makers of early indications of trends in performance, on a hospital-specific, regional or statewide basis. The data elements which OHCA will request will be limited and will include: amounts for operating and non-operating revenue; various expenses such as interest expense and depreciation; current assets and liabilities; discharges; patient days; staffed beds; average daily census; and case mix index. This information measures profitability, liquidity, solvency and hospital utilization.

Other states currently collect quarterly data from hospitals. For example, the Division of Health Care Finance and Policy, a division of the Massachusetts Office of Health and Human Services, collects and publishes quarterly financial performance indicators or measures for Massachusetts hospitals. That division publishes quarterly results on their website but makes it clear to the reader that the filings are based on the hospitals' unaudited internal financial statements. The state of Washington also collects quarterly data in conjunction with that state's hospital association via a memorandum of understanding. In Washington, the collection of quarterly data is a cooperative effort between the state and the hospital association and both have administrative rights on the system and can configure reports. OHCA's collecting and reporting of the quarterly data would be similar to that of Massachusetts and it would be clear that the information is based upon unaudited financial statements.

Section 4

This section revises the date of receipt of net revenue verification from February 28 to March 31 of each year. The rationale is to make the filing date of the new verification of net revenue document the same as the Twelve-Month Actual Filing, which is March 31st. This reduces the possibility of the hospitals filing numbers on the Hospital Reporting System (HRS) that may differ from those contained within the verification of net revenue document.

Section 5

This section revises statute to omit an obsolete reference to a hospital rate setting process that was in place during 1992 to 1994, when the Commission on Hospitals and Health Care ("CHHC", OHCA's predecessor agency) was authorized to set acute care hospital rates. The statutory rate setting program sunset on March 31, 1994. Prior to that date, CHHC allowed for incremental expenses in the rates of acute care hospitals participating in the *Maternal and Child Health Program* as a funding mechanism.

Section 6

OHCA respectfully requests amending the language in line 121 from "The Office of Health Care Access shall conduct, on a biannual basis" to "The Office of Health Care Access shall conduct, on a biennial

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basis” and the proposed language in line 129 “in which the biannual study is conducted” to “in which the biennial study is conducted.” This is a technical revision to remove ambiguity and make clear that the study will be done every two years and not twice a year.

The proposal changes language in §19a-634(a) from “Such study shall include” to “Such study may include” to make the language for the statewide health care facility utilization study consistent with subsection (b) which states that the health care facility plan “may include.” Additionally, this change allows OHCA to exclude from the study utilization data from facilities such as outpatient surgical facilities until OHCA has access to complete useable data in June 2015, as stipulated in §19a-654. OHCA also proposes to carry out the utilization study biennially rather than annually. Since the inventory of health care facilities is completed biennially, it makes sense to prepare a utilization study in alternate years, biennially. Additionally, OHCA is proposing to update the statewide health care facility plan every two years and will need to devote a significant amount of time and resources to the plan during those years. In subsection (b), OHCA proposes to change the time frame by which the state health care facility plan is updated because it will allow for more frequent updates that may be necessary due to health care reform, technological advances and billing changes. Also, it will provide health facilities and providers, covered under the statute, with the ability to initiate the updates based upon their experiences.

Section 7

Statute is being revised for the following reasons:

- The Office has not regulated discounts (contractual allowances) since hospital rate-setting ended, March 31, 1994. Almost all of the nongovernmental (commercial) contracts are negotiated;
- The dates referenced in the statute have long expired;
- The main purpose for the agreements being filed was due to two hospital tax programs, the Gross Earnings (“GET”) and sales taxes, which ended in 1998 and 2001, respectively;
- Discount agreements or contracts negotiated for a different rate or method of reimbursement have not been filed or reviewed at OHCA since 2002;
- The agreements no longer need to be submitted to OHCA. They are required to be filed within 24 hours of their execution at a hospital’s business office and available for viewing upon request; and,
- The Office no longer holds public hearings for aggrieved payers that have not been awarded a discount by a hospital if the hospital had awarded a discount(s) to other payer(s).

Section 8

The wording in this statute is requested to be revised to “verification of net revenue” in order to be consistent with the new wording on subsection (a) of §19a-649.

Section 9

OHCA respectfully requests amending the proposed language in lines 284-287 from “...to a municipality or state agency, as defined in §4-230, another state, or a federal agency...” to “a state agency for the purpose of health care services delivery improvement or oversight; a federal agency or the state of Connecticut Office of the Attorney General for the investigation of hospital mergers and acquisitions; or another state’s patient-level data collection agency with which the office, for the purposes of certificate of need review or state-wide health care facilities and services planning, enters into a reciprocal data-sharing agreement.” This revision clarifies which entities may receive patient-level (a record of the patient’s information which includes demographics, diagnoses, procedures but not patient name, SSN or address) and for what purposes.

The proposal adds language to §19a-654 that would allow for the release of patient level data to certain governmental entities for specific purposes. Any such entity receiving the data shall sign a data use agreement which will require the entity to protect the confidentiality of the personal health data, not to re-

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transfer or re-distribute the original data, and not to identify or contact individuals in the data for any reason.

OHCA receives requests from other state agencies (e.g., DCF, DMHAS, DSS, OHR&I) for patient-level data that is not releasable under §19a-25 but is needed for service delivery improvements, cost analyses and program innovation.

OHCA has also received requests for inpatient hospital data from the Federal Trade Commission and the Attorney General's Office in the course of investigating potential mergers between hospitals and other health care facilities to determine whether the proposed merger would violate antitrust laws. In the past, OHCA was able to release the requested information, but in light of changes made to §19a-654 under Public Act 11-61, OHCA is only able to release patient-identifiable data pursuant to §19a-25, which does not allow for the release to the federal or state government for investigation into antitrust matters.

In addition, current statute prohibits reciprocal sharing of patient-level data with health care services-related agencies in states bordering Connecticut, especially in markets where there is a great deal of cross-border migration. This prohibits the office from conducting comprehensive utilization analyses required for adequate health care facilities and services planning.

Section 10

OHCA is requesting to eliminate the proposed language "or enter into a contract for another entity to provide a service" as it is too broad and may extend beyond OHCA's authority pursuant to §19a-638. Additionally, OHCA only regulates health care facilities as defined under §19a-630 and this language appears to extend OHCA's authority beyond its statutory authority pursuant to §§ 19a-630, 19a-638, and 19a-639. Furthermore, OHCA no longer regulates any establishment or addition of service and this language expands OHCA's authority into regulating the types of services and entities beyond health care facilities, as defined pursuant to §19a-630, that it currently does not have authority to review. Therefore, OHCA requests to eliminate/delete the proposed new language and maintain Section 10 as originally drafted. Due to the fact that the Department does not currently require Certificate of Need authorization for contractual arrangements, additional staff would be needed to meet this requirement.

Thank you for your consideration of the Department's views on this bill.

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