2023

Recommendations of The 2022 Physician Practice Workgroup

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Executive Director, Connecticut Office of Health Strategy

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EXECUTIVE SUMMARY

Public Act No. 21-129 is an act concerning hospital billing and collection efforts by hospitals and collection agencies that was approved and signed into law on July 7, 2021, by Governor Ned Lamont. Section 5 of the Public Act requires the Office of Health Strategy ("OHS") to study physician practices within Connecticut (CT). To accomplish this, OHS formed the Physician Practice Workgroup (PPW or the Workgroup) by assembling a wide range of volunteers. Members consisted of some nominated by legislators, some from physicians in private practice or those employed by health care systems, hospital executives, and members of local communities.

The Workgroup's mission was threefold:

- To improve the oversight and regulation of mergers and acquisitions of physician practices to improve health care quality and choice in CT;
- To study methods to ensure the viability of physician practices; and
- To develop legislative recommendations to improve reporting and oversight of physician practice mergers and acquisitions, including possible changes to the CT general statutes.

The executive director of OHS must report on the outcome of the study and provide recommendations for legislative action as a result of the study, not later than February 1, 2023. The following report represents the recommendations of the Workgroup to the OHS Executive Director.

STATUTORY FRAMEWORK

AN ACT CONCERNING HOSPITAL BILLING AND COLLECTION EFFORTS BY HOSPITALS AND COLLECTION AGENCIES was the official title for Substitute for Senate Bill 683. Soon after the bill was signed into law on July 7, 2021, it became Public Act 21-129 and its fifth and last section described the requirements and makeup of the study and its members, Section 5 of Public Act 21-129, was drafted as follows:

(a) The Office of Health Strategy shall, within available appropriations:

(1) Study methods to improve oversight and regulation of mergers and acquisitions of physician practices to improve health care quality and choice in Connecticut, including, but not limited to, a review of sections 19a-486i, 19a-639 and 19a-630 of the general statutes;

(2) Study methods to ensure the viability of physician practices; and

(3) Develop legislative recommendations to improve reporting and oversight of physician practice mergers and acquisitions, including, but not limited to, the necessity for any amendments to section 19a-486i, 19a-639 or 19a-630 of the general statutes.

(b) Not later than February 1, 2023, the executive director of the Office of Health Strategy shall report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health regarding the outcome of the study and any recommendations for legislative action as a result of such study.

Once the members were appointed, the Workgroup held its first meeting via Zoom in November 2021. They continued to meet on a monthly basis throughout 2022 to gather ideas in response to their legislative mandate and develop recommendations to the OHS Executive Director for submission to the General Assembly's Committee on Public Health.

This report provides detailed information about how the Workgroup was formed, shares the presentations and discussions from the meetings, as well as provides background and context as to how the Workgroup distilled the data into priority categories to provide recommendations to the OHS Executive Director.

OHS Recommendations on Physician Group Practices

The Workgroup's findings contained numerous proposals to address its statutory charge. OHS carefully analyzed these proposals for fiscal and implementation feasibility as well as crafted its own proposals for potential inclusion. The following list includes OHS' final recommendations culminating from this review process.

1. **Expand the number of group practices required to report data to both OHS and OAG.**

   Within the general statutes, there exist different thresholds for group practice size for reporting purposes. In §19a-486i(h), the current reporting threshold requires only group practices of 30 or more physicians to file certain information about their practices to both the Attorney General and OHS. OHS recommends exploring lowering the threshold to apply to group practices of two or more (2+) physicians. A lower threshold will provide clarity on the number of physician practices operating in the state with between two to twenty-nine (2 - 29) members. Reducing this threshold reflects the spirit of Workgroup's recommendation.[1]

   In addition, OHS recommends including personal service agreements under the group practice definition contained in §19a-486i(a)(10)[2]. This change addresses the Workgroup's concern that group practices may not be accurately reflecting their true size by hiring physicians under Professional Service Agreements (PSAs). A physician working under a PSA is an employee and not a member of a group practice, and thus is not counted for purposes of reporting or CON review.

2. **Expand CON oversight of group practice acquisitions.**[3]

   The Workgroup strongly recommends that all entities that acquire group practices be subject to the same level of regulatory oversight. OHS concurs with this finding and recommends that CON statutes be amended to explicitly apply to group practice transfers of ownership involving private equity firms which includes hedge funds as well as payer/provider organizations, also known as "payviders". OHS further recommends specifying that transfers of ownership at any level of corporate governance of any parental companies be explicitly included. To accomplish this, OHS proposes the following statutory changes:

   - In §19a-638(a)(3), delete "*other than a (A) physician, or (B) group of two or more physicians, legally organized in a partnership, professional corporation or limited liability company formed to render professional services and not employed by or an affiliate of any hospital, medical foundation, insurance company or other similar entity*"

[1] Workgroup Vote: 8 Agree, 4 Disagree, 3 No Opinion, 5 Absent
[2] Workgroup Vote: 13 Agree, 2 No Opinion, 5 Absent
[3] Workgroup Vote: 12 Agree, 3 No Opinion, 5 Absent

- In §19a-630(13) add Private Equity Firms (including hedge funds) and Payer-Provider/Payvider to definition of "person"
- In §19a-630(15), add to definition of Transfer of Ownership "AT ANY LEVEL OF GOVERNANCE"

3. **Remove "presumed approved" language from CON statutes governing the transfer of ownership of group practices.**

Section 19a-639(b) confers a presumption in favor of approval on transfers of ownership of a large group practice. Although not a Workgroup recommendation, OHS suggests that this section be removed so that group practices will be treated in the same manner as hospitals, health care facilities and providers and will be subject to the same level of scrutiny. Removing this subsection is completely in alignment with the spirit of the Workgroup's other recommendations.

In § 19a-639 delete "*(b) In deliberations as described in subsection (a) of this section, there shall be a presumption in favor of approving the certificate of need application for a transfer of ownership of a large group practice, as described in subdivision (3) of subsection (a) of section 19a-638, when an offer was made in response to a request for proposal or similar voluntary offer for sale.*"

4. **Assess penalties for non-compliance for group practices.**[4]

Continuing the theme of including transfers of ownership of group practices under all pertinent CON statutes, OHS recommends that group practices be specifically added to the list of entities subject to civil penalty for non-compliance with enumerated statutory provisions.

In §19a-653, add Group Practices throughout as appropriate.

5. **Develop annual report to track additional group practices.**[5]

If the above measures are enacted, OHS will be collecting a large amount of data from the expanded list of governed entities. OHS agrees with the Workgroups recommendation for the Health Systems Planning unit of OHS to develop an annual report on group practices (like the Financial Stability Report produced for hospitals) within existing resources.

6. **Conduct study on Corporate Practice of Medicine.** [6]

The Workgroup's yearlong investigation into transfers of ownership among group practices revealed a concern regarding the Corporate Practice of Medicine (CPOM). In brief, the CPOM holds that only licensed health care providers may practice medicine and corporate entities may

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[4] (Workgroup Vote: 11 Agree, 1 Disagree, 3 No Opinion, 5 Absent)
[5] Workgroup Vote: 14 Agree, 1 No Opinion, 5 Absent
[6] Workgroup Vote: 9 Agree, 2 Disagree, 4 No Opinion, 5 Absent

not. The CPOM doctrine is the basis of an increasing amount of litigation in the U.S. due to private equity's relatively recent targeting of health care entities for acquisition. Connecticut law (§ 20-9(a)) states *"No person shall, for compensation, gain or reward, received or expected, diagnose, treat, operate for or prescribe for any injury, deformity, ailment or disease, actual or imaginary, of another person, nor practice surgery, until he has obtained such a license as provided in § 20-10, and then only in the kind or branch of practice stated in such license*." There are several statutory references relating to CPOM as well as case law in CT that have not been thoroughly researched. OHS would like more comprehensive guidance on CPOM provided by an outside expert.

7. **Restrict the use of restrictive covenants.**[7]

A restrictive covenant is a condition that restricts, limits, prohibits, or prevents the actions of someone named in an enforceable agreement. Restrictive covenants are sometimes included in contracts for the transfer of ownership of group practices that limit the geographical location or medical specialty a physician will be allowed to choose once the transaction is completed. The Workgroup and OHS support restrictions on the use of restrictive covenants in these types of contracts and are actively watching bills already introduced on this topic this legislative session.

[7] Workgroup Vote: 11 Agree, 2 Disagree, 2 No Opinion, 5 Absent

APPENDIX A: MEMBERS

A list of Physician Practice Workgroup members is provided below.

Member	Organization
Rod Acosta, MD	Stamford Health
Jean Ahn	Nuvance Health
Rich Almada	ProHealth Physicians
Marjorie J. Breen	Connecticut Insurance Department
Ronald Ciesones	Office of Health Strategy
Jeff Cohen, MD	Hartford HealthCare
Alan Coker	Consumer Representative
Rachel Davis*	Office of Attorney General
Lou Fiorillo	CIGNA Insurance Company
Khuram R. Ghumman, MD	East Granby Family Practice, LLC
Richard Goldstein, MD	Northeast Medical Group
Chris Hyers	UCONN Health
Dinesh Kapur, MD**	Eastern CT Hematology/Oncology Associates
Alan Kaye, MD	Retired Radiology Physician
Steven Lazarus**	Office of Health Strategy
Leland McKenna	Middlesex Hospital
Atique A. Mirza, MD	Central CT Cardiologists, LLC
Robin Gail Oshman, MD, PhD	Private Practice Physician
Theresa Riordan	Anthem Insurance Company
Robert D. Russo, MD	Russo Radiology
Michael Steinmetz	Generations Family Health Center
Lisa Trumble	Southern New England Healthcare Organization

**Rachel Davis retired at the end of March 2022 and was replaced by Nicole Demers who took a new position at the Office of the Attorney General in October 2022 and was then replaced by Cara Passaro.*

***Steven Lazarus and Dinesh Kapur, MD, were co-chairs of the workgroup.*

APPENDIX B: MEETING DATES AND TIMES

Physician Practice Workgroup meetings were held on the second (2nd) Thursday of each month. In accordance with Public Act 22-3, OHS intends to hold all meetings solely by means of electronic equipment (remotely).

Meeting Location: Zoom Conference
Dial In: +1 646 876 9923 US (New York)
Meeting ID: 816 3245 3588
Passcode: 752431

Date	Time (EST)
November 8, 2021	5:00-6:30 pm
December 9, 2021	5:00-6:30 pm
January 13, 2022	5:00-6:30 pm
February 10, 2022	5:00-6:30 pm
March 10, 2022	5:00-6:30 pm
May 12, 2022	5:00-6:30 pm
June 9, 2022	5:00-6:30 pm
July 14, 2022	5:00-6:30 pm
August 11, 2022	5:00-6:30 pm
September 15, 2022	5:00-6:30 pm
October 13, 2022	5:00-6:30 pm
November 3, 2022	5:00-6:30 pm
November 10, 2022	5:00-6:30 pm
December 8, 2022	5:00-6:30 pm
December 21, 2022	5:00-6:30 pm
January 12, 2022	5:00-6:30 pm

Agendas, materials, and updated meeting information can be found on the Office of Health Strategy website: PPW Related Materials

Pursuant to Public Act 22-3, OHS will provide accommodations for members of the public who need access to electronic equipment. Please contact OHS@ct.gov no later than 24 hours in advance of the meeting to make a request.

APPENDIX C: PRESENTATIONS

Date	Title/Topic	Presenter
November 8, 2021	First meeting of the workgroup	n/a
December 9, 2021	Presentation on OHS Statutes related to group practices and the CON process. Group practice data collected by OHS.	Steven Lazarus (OHS) Olga Armah (OHS)
January 13, 2022	Presentation entitled "Antitrust Enforcement in Healthcare Markets Physician Practices and Hospitals."	Fiona Scott Morton (Yale School of Management)
February 10, 2022	Presentation entitled "Consolidation of Healthcare Providers."	Katherine Gudikson (The Source)
March 10, 2022	Presentation on how Material Change of Ownership transactions are reviewed by the Office of the Attorney General.	Attorney Rachel Davis (Office of the Attorney General)
May 12, 2022	Presentation entitled "Recruitment and Retention of Physicians in Connecticut and the Disappearing Independent Practice of Medicine." Comments on life experiences with getting proper healthcare.	Robert D. Russo (Russo Radiology) Alan Coker (Public / Consumer)
June 9, 2022	Comments on Stamford Health Medical and his personal experiences on group practices.	Rod Acosta (Stamford Health)
July 14, 2022	Presentation on Yale Medicine. Comments on Middlesex Hospital/Health and group practices.	Margaret McGovern (Yale Medicine) Leland McKenna (Middlesex Hospital)
August 11, 2022	Presentation on the Yale New Haven Health Services entity Northeast Medical Group. Presentation on ProHealth / Optum.	Richard Goldstein and Aimee Derry (Northeast Medical Group) Rich Almada (ProHealth Physicians and Optum Care Network of CT)
September 15, 2022	Presentation entitled "Physician Practice Workgroup Considerations."	Jean Ahn (Nuvance Health)
October 13, 2022	Presentation entitled "The Corporate Practice of Medicine."	Andrew Keller, MD (OHS)

	Presentation of Financial data collected by OHS on medical groups.	Ron Ciesones (OHS)
November 3, 2022	No Presentation	n/a
November 10, 2022	No Presentation	n/a
December 8, 2022	No Presentation	n/a
December 21, 2022	No Presentation	n/a
January 12, 2022	No Presentation	n/a

Appendix D: Process

To form the Workgroup, OHS actively recruited volunteers to complete and submit a short application. After receiving over 30 applications, OHS staff grouped the applicants by the type of business they represented in the first step of the review process. Next, an independent group of OHS staff reviewed the applications and strategically selected twenty-two (22) diverse members for appointment to the PPW. OHS aimed to have representation from a cross-section of Connecticut's constituents on the Workgroup. The expertise and experiences of these nominees spanned the following sectors: insurance carriers, hospitals and health systems, specialty physician groups, small physician groups, large physician groups, local health centers, related state agencies, and consumers. Appendix A contains the full list of members and the organizations that they represent.

The Workgroup members participated in an inaugural meeting in November 2021 and met monthly thereafter via Zoom video conference calls until January 2023. Appendix B contains a table with the dates and times of workgroup meetings. The meetings contained presentations from Workgroup members and subject matter experts from various State agencies and non-governmental agencies covering an array of topics related to the operations and daily issues facing physician group practices. Appendix C tabulates the date, topic, and presenters at the monthly meetings. After the presentations, members discussed the topics and provided opinions and insight based on their unique qualifications.

After many months of presentations and discussions, members of the group narrowed down the issues and decided to focus on a core group of five topics. A structured process allowed Workgroup members to participate in topic selection. OHS staff analyzed, then condensed this data into a final list of twenty-one (21) recommendations which the Workgroup then voted on.

The following sections summarize OHS's conclusions on physician practices, highlight the five (5) core topics as determined by the Workgroup, present the Workgroup's recommendations on possible solutions to the issues to the OHS Executive Director, and details the activities at each monthly meeting (Appendix D). Additional information on the Workgroup meetings along with videos of the meetings can be found on the OHS website by clicking OHS PPW webpage.

APPENDIX E: WORKGROUP TOPICS & RECOMMENDATIONS

After several weeks of deliberations, a majority of the Workgroup members decided that the following five (5) topics related to physician practices merited the most attention and should be reframed as recommendations to the Executive Director.

The Workgroups 5 topics are:

1. Reconcile internal inconsistencies among OHS' data reporting requirements for group practices;
2. Align OHS and the Office of the Attorney General (OAG) reporting standards to streamline enforcement for non-compliance;
3. Improve recruitment of new physicians for group practices of all sizes & increase healthy competition among group practices;
4. Develop methods to assist small-to-medium sized independent group practices in remaining independent; and
5. Improve transparency and oversight of the acquisition of physician practices.

After the Workgroup members defined the five (5) main topics to focus on, they collaboratively developed an array of recommendations to address each topic. The PPW members provided a total of twenty-one (21) recommendations across the main topics. Prior to the conclusion of the workgroup, a majority of the Workgroup members voted on each of the recommendations. The recommendations that received a majority of the votes are provided below. Please note that the recommendations of the PPW are not necessarily those of the OHS.

Recommendations Approved for Topic 1:

Reconcile data reporting requirements for group practices in different statutory sections.

1. Two different chapters of the Connecticut General Statutes (C.G.S.) require group practices to report data to the state. Chapter 368z includes C.G.S. §§ 19a-638(a)(3), 19a-630(9), and 19a-639(b) and considers group practices that have eight (8) or more full time equivalent (FTE) physicians and only to OHS. In contrast, Chapter 368v includes C.G.S. §§ 19a-486i(h) and requires filing of data concurrently with OHS and the Office of the Attorney General when there are thirty (30) or more FTE physicians. Reconcile these different thresholds for reporting.
2. Develop and publish an annual report summarizing physician practices in CT based on data collected.

Recommendations Approved for Topic 2:

Align reporting standards of OHS and the Office of the Attorney General (OAG) to streamline enforcement for non-compliance.

1. Assess standardized penalties for all entities for any non-compliance issues using OHS existing civil penalty statute §19a-653.

Recommendations Approved for Topic 3:

Improve recruitment of new physicians for group practices of all sizes & increase healthy competition among group practices.

1. Offer incentives such as student loan forgiveness, home buying for new physicians, etc., to encourage physicians to work in underserved areas, community-based practices, or in needed specialties (primary care, behavioral health, etc.), for a fixed period.
2. Expand programs for foreign medical graduates to establish clinical practices in CT.
3. Explore tort reform and put maximum caps on malpractice awards to lower the number of lawsuits and the cost of malpractice insurance.
4. Standardize insurance prior authorization policies and procedures for medical procedures and prescription medicines so that they are only required for certain procedures or medicines.

Recommendations Approved for Topic 4:

Develop methods to assist small-to-medium-sized independent group practices in remaining independent.

1. Provide assistance such as tax credits for upgrading IT networks so they are secure.
2. Establish programs to help small and medium-sized independent physician practices recruit and retain physicians and other medical personnel, in addition to providing funding for malpractice costs, acquiring or updating EHR systems, and reducing the burden of prior authorizations for prescriptions and imaging procedures.

Recommendations Approved for Topic 5:
Improve transparency and oversight of the acquisition of physician practices.

1. Change restrictive covenants for physicians when physician practices are acquired particularly when there's been a change in governance structure or control of a practice or when a physician is terminated without cause.
2. Conduct a study on the corporate practice of medicine (CPM) to assess current statutes and regulations governing the CPM.
3. Apply Certificate of Need (CON) regulations for physician practice acquisitions equally to private equity entities.

APPENDIX F: OTHER WORKGROUP RECOMMENDATIONS

The Workgroup members disagreed on the recommendations for Topic # 4 which dealt with strategies to enable small to medium-sized independent group practices to remain independent. The recommendations that were not approved by the majority of the Workgroup members are provided below.

1. Eliminate high deductible insurance plans, where possible, especially for individuals and small groups.
2. Eliminate co-pays or require insurance companies to collect co-pays.
3. Assign an insurance company representative to certain private practices to resolve patient and financial issues to ensure they are resolved in a timely manner.
4. Reduce consolidation of health insurance companies which reduces competition which increases costs.
5. Ask AG to do a review to prevent narrow and in-network referrals and steerage in medical groups affiliated with hospital systems.
6. Require insurance carriers to offer access to out-of-network providers at a small fee and to have access to the carrier system for prior authorization and submitting claims electronically.
7. Support an “Any Willing Provider” law requiring insurance companies to accept any qualified provider who wishes to join their panel of physicians as long as they meet training requirements.
8. Require state-mandated continuing medical education classes to be taken one time only and lower licensing fees.

A majority of Workgroup members approved all the recommendations for topics 1-3 and topic 5 as discussed in Section 2.

Appendix G: Monthly Meeting Summaries

Meeting November 8, 2021

Vicki Veltri, the former executive director of OHS, welcomed everyone to this November meeting which was the initial meeting of the PPW. She thanked everyone for taking valuable time away from their day to be a part of this group. She indicated that the tasks the Workgroup have been given were pressing issues of the legislature in the last legislative session as they wanted to maintain cost and quality of services for CT residents. Furthermore, Ms. Veltri indicated that she was pleased the Workgroup's members represented a broad spectrum of groups including hospitals, small and large medical practices, state agencies, and insurance companies.

Everyone proceeded to introduce themselves to the group by sharing their employment history, relevant highlights from their careers, and their reasons for joining the Workgroup. Next, members of the PPW approved Dr. Dinesh Kapur to be co-chair along with Steven Lazarus, a member of the OHS staff. The group decided to meet on the second Thursday of each month at 5pm. After further discussion, members agreed that meetings would attempt to begin with at least one presentation by a group members or other subject matter experts followed by a general discussion for the remainder of the meetings. OHS staff provided a draft of the Workgroup's charter for review ahead of a vote at the next meeting.

Meeting December 9, 2021

Steven Lazarus, a co-chair of the PPW and has the title of Principal Health Care Analyst at OHS opened this meeting by providing background on the OHS statutes that apply to the filing of data for physician group practices and the Certificate of Need (CON) process. Section 19a-638(3) defines the OHS CON authority over large group practices. Section 19a-630(9) defines large group practice as eight (8) or more full-time equivalent physicians that are legally organized. Section 19a-639(b) implies there shall be a presumption in favor of approving a CON application for the transfer of ownership of a large group practice. Additionally, over the previous five (5) years, OHS and its predecessor agency, Office of Health Care Access (OHCA), received four (4) CON determinations regarding group practices which lead to two (2) actual CONs.

Olga Armah, Research Analyst Supervisor at OHS, presented the data OHS collects each year under Section 19a-486i (g) and (h) which requires group practices of thirty (30) or more physicians to report data to both OHS and the Office of the Attorney General (OAG). The data included the name of the group and affiliation to the hospital, a list of the physicians and their specialties, the practice location, primary service area and zip codes, and the specialties provided at the location. Olga indicated there are limitations on the data collected as it's not provided by all group practices, not all specialties are at all locations, and most large group practices are part of large health systems, provide multispecialty services, and acquire smaller practices to grow further. She also described Material Change of Ownership data which occur when a group practice is acquired.

The group commended on the sufficiency of the data collected by OHS and whether additional data points should be collected in the future. The Workgroup noted that such changes would require laws to be changed first. Most members felt the data collected currently by OHS is filed in good faith by those

doing the filings. Several members spoke about suggestions for future presentations and discussed best ways to circulate related news articles around to group members.

Meeting January 13, 2022
Professor Fiona Scott Morton from the Yale School of Management provided a presentation entitled "Antitrust Enforcement in Healthcare Markets Physician practices and hospitals". Fiona presented a demand curve to show the correlation between price and quantity within any given industry and how the curve changes based on price and supply. The demand curve graph was contrasted against a monopoly. When the monopoly price is set higher than the competitive price, consumer surplus shrinks because the price is higher and the lower quantity of the goods, increase the price even more.

The affect a monopoly has on a market dramatically increases the amount of profit. The consumers want competitive pricing vs businesses wanting monopoly pricing. There are three tactics a business can use to achieve monopoly pricing: 1) collude; competitors agree that each one will charge the monopoly price 2) merge: competing businesses merge and in that way can change a monopoly price; and 3) monopolize; a large business uses its existing power to drive out/down competitors, slowing it to charge a monopoly price.

Since the late 1990s, a majority of hospitals have merged with other hospitals. Most urban areas are now dominated by 1 or 2 large hospital systems. Physician practices have been merging at a very rapid rate. Most physician practices are merging due to hospital acquisitions. The number of physicians at a practice are also declining. Hospital mergers hurt consumers since there are fewer alternate hospitals to go to. COPA (Certificate of Public Advantage) is a strategy to fight monopolies created by mergers by allowing the state to oversee the merger.

The state can use existing and enact new antitrust enforcement laws to reduce monopoly pricing. Federal regulations also exist. Other tools include, corporations providing advance notification confirming the makeup of the corporation, a Health Policy Commission body, review state laws to ensure they are sufficient and consider ways to insulate the state from political influence.

February 10, 2022
Katherine Gudiksen from The Source on Healthcare Price and Competition provided a presentation entitled "Consolidation of Healthcare Providers". Since the end of World War II, Healthcare prices have seen a dramatic increase in price. The same service at the same hospital, can have a dramatic change in price all based on the consumers insurance plan. Most consumers in the US, will spend more money on care and receive lower quality when compared to competing countries. This problem was mostly caused by healthcare mergers.

From 1991 to 2011, the FTC did not win a single case to prevent a hospital merger. Because of this, the FTC focused their efforts in other areas, and this created a period of rapid consolidation. There are three types of mergers, horizontal, vertical and cross-market. All the healthcare mergers have contributed to dramatically increasing price for the last three decades.

States can limit the impact of consolidation by limiting future anticompetitive consolidations and enhance existing competition. In the last few years, Attorney Generals from various states have been introducing litigation to limit anticompetitive consolidations. These litigations are helping to pave the way for future legislation. Some additional tools for states to consider in order to constrain provider pricing power are cost growth benchmarks, caps on out-of-network rates, affordability standards, public option, flexible global budgets, direct rate setting.

Meeting March 10, 2022

Rachel Davis, the Assistant Attorney General at the State of Connecticut Office of the Attorney General (OAG), presented information regarding Notices of Material Change (NOMC) and her presentation included references, statutory citations, OAG's quasi-regulatory process, and additional commentary. The Connecticut Antitrust Act enables the OAG to review material changes (e.g., mergers, asset change, affiliation changes, and acquisitions) that may have adverse impact on competition. The OAG requires advanced notices of these material changes by these physician practice groups and hospital affiliated physician as of 2014. The review process consists of an initial review for completeness, a substantive review that incorporates geographical and service market(s) data, and for a NOMC that appears likely to have an adverse impact on competition, the OAG will investigate these alleged violations as authorized by the Antitrust Act during the antitrust investigation phase of the process. Attorney Davis then shared the NOMC forms which need updating to support the reporting and review requirements.
After the presentation, the workgroup asked Attorney Davis questions regarding the details of NOMCs. Such questions included potential improvements to existing statutes and data sources that would help both sides of the process, examples of different types of material change, related entities, interlocking directorates, clinically integrated networks, and practice ownership models. The discussion also covered some upcoming topics such as the healthcare workforce, comparing traditional vs modern private practice structures, and the impact of restrictive covenants on practicing physicians.

Meeting May 12, 2022

Robert Russo, a representative for specialty practices, prepared a slide presentation entitled "Recruitment and Retention of Physicians in Connecticut and the Disappearing Independent Practice of Medicine." Doctor Russo provided the current Connecticut recruitment and retention landscape which trends towards exporting physicians trained in CT. He shared some barriers to recruitment and retention are an aging medical population, lack of loan forgiveness, administrative burdens, and a hostile medical liability climate. In addition to a dwindling workforce, administrative burdens such as prior authorizations and difficulty in negotiating with insurers, increase in hospital owned physicians over the last three years, lack of loan forgiveness, and changing the medical liability landscape all contribute to the disappearance of private practices. Dr. Russo suggested fixing prior authorization issues and changing the ways physicians and insurers negotiate to encourage private practices.

The second presenter was Alan Coker, a representative for consumers, who shared his life experiences with dealing with physicians. He recalled when his physician came to his home to provide care and indicated that it's difficult to find a physician these days as there are urgent care centers and walk in

medical centers at local pharmacies such as CVS and Walgreens. He shared that he likes having an independent physician so he can shop around for a specialist if he needs one and lamented patients and physicians are getting lost in the paperwork shuffling. He feels there are issues with treating Medicare and Medicaid patients differently from than other patients. Future, he believes some (not all) physicians just worry about the bottom line, but is glad to be part of a workgroup that gives him hope that issues facing society may in some way be corrected.

A discussion related to the presentations took place between members of the workgroup related to doctor and patient relationships, along with smaller physician groups affiliating with larger hospital owned groups or private equity groups. There were some comments by members on if there was any data on the cost of care or price transparency. There was also discussion regarding if there was an overview of services and providers in CT and where those services and providers are located.

Meeting June 9, 2022

Rod Acosta, President and Chief Executive Officer of Stamford Health Medical Group (SHMG) and Chief Executive Officer of Stamford Health, Inc., provided some background on his 35-year career in healthcare. He began treating patients as a practicing physician with a solo practice that gradually grew to have a half dozen physicians. Over time it became more difficult to run a practice due to issues related to human resources, the ability to negotiate with insurance companies, rising supply costs and service denials from insurance companies.

After years of struggling with the issues of running a practice, he and his colleagues agreed that it would be in their best interests to become part of a larger medical group. The members spoke with groups of all sizes and eventually decided to join SHMG which was in its infancy. Over time, the group gradually expanded and now has over 200 physicians and related staff members. Many of the physicians that join the SHMG are independent physicians experiencing the same challenges he went through prior to joining a group.

Mr. Acosta indicated that SHMG strives to provide quality care to patients and has a committee that meets monthly to review quality measures. His mission is to support the needs of the community. He is concerned with physician groups being acquired by private equity firms and feels they don’t have a community’s best interests at heart. Another member indicated that when a private equity firm purchases a physician’s group, the new owner only wants to buy it, leverage it, and sell it to another company for a profit.

SHMG tends to refer patients to specialists that are part of SHMG, but the priority is to refer a patient to a physician based on their condition, personality, or preference. If the patient is self-pay or has a high deductible insurance plan, the physicians will try to send that person to a lower cost outpatient setting for care. Mr. Acosta stated he feels that decisions need to be based on quality of care and patient preference and not to profit insurance companies. He mentioned State legislators should do whatever is necessary to support independent physician groups.

Some group members commented that the consolidation of physician practices into a few large corporations would lead to lack of quality of care to patients and no patient choice when seeking medical care. Members from smaller physician groups mentioned that it is difficult to maintain their business model due to the reasons Mr. Acosta mentioned at the beginning of his presentation. A prime example

is the extreme cost for a new Electronic Medical Records system (EMR) for small to midsize medial groups that do not have one-hundred thousand or more (100,000+) patient visits a year which is required for an EPIC medical records system. Physician groups sometimes join a large system to overcome this EMR issue.

Meeting July 14, 2022

Margaret McGovern, MD, PhD and Deputy Dean for Clinical Affairs and Chief Executive Officer of Yale Medicine, provided a presentation on Yale Medicine which is the faculty practice of the Yale School of Medicine. Dr. McGovern indicated that there are challenges facing academic medical centers such as high costs of research, maintaining clinical sites and accreditation, investments in technology and societal changes. She informed the group that a physician practice may be acquired to support recruitment of patient volunteers to clinical trials, support population health initiatives and equitable care, provide essential community-based settings for medical education and to meet patient expectations for access and convenience.

Dr. McGovern and her staff indicated that since 2018, Yale Medicine has made eight (8) physician practice acquisitions. These purchases were mostly acquisitions of solo practitioners and the highest number of physicians that were part of any of the acquisitions were four (4) physicians. Her assistant, Yolanda London, indicated that when a physician practice is purchased, they are typically purchasing the hard assets and investing capital into the practice for items such as an EPIC system.

Much of the dialogue between PPW members and Ms. McGovern involved providing care at Yale-New Haven Health affiliated hospitals and how profits of the health system hospitals get reinvested. Unfortunately, Yale Medicine and Yale New Haven Health operate separately so she only had knowledge of the operations of Yale Medicine.

Leland McKenna, Director of Business and Strategy for Middlesex Hospital (MH), spoke to the group on recent physician practice acquisitions by MH. He indicated that as a small independent community hospital which primarily services the Middletown area, their market has not changed in ten (10) years and approximately half of the medical staff is employed by MH and the other half are independent. Over the last five to eight (5-8) years there were five (5) physician practices that joined the MH employee group and there are not many independent physician practices left in the primary service area. The practices that have joined MH have done so for a variety of reasons including: 1) physicians want to retire so they are looking for a transition plan for their patients; 2) the business and financial pressures of running a practice are too much; and 3) the physicians themselves often want to try being in a different health system.

While many people focus on the negatives of affiliations, there are many benefits to physician practices being acquired by a health system. One of the benefits is that it is easier to recruit new physicians to a larger network. Another benefit is keeping the services in the area because if the practice is not acquired, the group may move out of the area and the services they provide may no longer be available. An added benefit to a small physician practice is that the acquiring hospital or health system usually makes needed capital improvements and adds employee resources to the group. Lastly, an EHR such as EPIC, which is a large expense for a small practice, is typically already used by the acquiring entity. Paper records can usually be stored or scanned into the EHR so patient records will be available for continuity of care.

Mr. McKenna suggested to that the State should create a database to keep track of corporate structures which would allow everyone to understand affiliations between physicians and hospitals. He also feels that practices currently in place work efficiently. Therefore, he does not think the Workgroup should create new processes that would require more paperwork from filers if the acquisition does not impact competitive advantage.

In response to Mr. McKenna's presentation, some members commented that surgical practices are key to maintaining services and filling operating rooms at hospitals so hospitals should do whatever they can to keep surgical practices from leaving. Other PPW member s commented that oncology is another high margin business that hospitals want to control. Members were also concerned with out of state private equity firms acquiring physician practices due to changes that occur within the practice, and the revenue enhancement mechanisms private equity firms employ which do not usually benefit patients. Several members felt that the AGO should review the corporate practice of medicine laws. Some members felt that patient access is important, and electronic health records sometimes block patients from seeing physicians not affiliated with the hospital.

Meeting August 11, 2022

At the meeting, there were two presentations, one from Yale-New Haven Health System's (YNHS) North East Medical Group (NEMG) and the second by ProHealth/Optum Care Network of CT.

Richard Goldstein, Chief Medical Officer of NEMG and Vice President of YNHS, is also a PPW member presented with Aimee Derry, the Vice President of Business Development for NEMG. Their presentation highlighted that NEMG is a non-profit medical foundation founded in 2010 and is a member of the Yale-New Haven Health System and began with approximately 200 clinicians. The CEO/President is a physician, and so is the majority of the Board of Directors (currently 7 out of 11 directors.). There are over 700 physicians (MD/DO) and almost 500 advanced practice clinicians (APCs such as APRN and PA's). NEMG has contracts with over 126,000 Medicare and Commercial patients. Average quality scores for the group continues to rate high on a yearly basis for various savings metrics, quality, and enrollment size. Physicians find value in NEMG due to the support they are given including such things as electronic health records, mentoring, providing malpractice insurance, and best practices for safety practices. NEMG also provides opportunities for teaching, research, and on-going education especially with the group's association with Yale School of Medicine. Over the last 5 years they have hired 750 clinicians (MDs and Advanced Practice Clinicians (APCs)). Each year about 60% of hiring is succession planning and normal attrition and 40% is for newly created roles. Of the 40% that are hired for new roles, 60% are MD's and remaining 40% are APCs. 23 physicians have come from acquisition (15 Primary care and 8 specialists). They recruit many of the physicians from across the country as new graduates who are interested in being part of a large system to continue careers in a clinical setting or a teaching setting. About 30-35% of physicians and APCs are at or above a normal retirement age so the focus will be on replacing the workforce. Following the PowerPoint presentation by NEMG, the Workgroup discussed how NEMG operates with respect to treating patients, how they treat physicians, and how they might evolve over time in a changing healthcare environment.

Rich Almada, Senior VP of payer strategy specialty network management at ProHealth and Chief Operating Officer at Optum Care Network of CT, shared via oral presentation Optum's operation of ProHealth Physician Groups and its view of the healthcare landscape. Optum (which is owned by United

Healthcare) acquired ProHealth Physicians (PH) in 2015 in a move to provide value-based care. Optum Care Network of CT is the independent physician association. PH is an independent medical group that operates throughout CT with 440k patients and had one million patient encounters in 2021. The group has over sixty (60) practice locations including family practices, a free-standing lab, and express walk-in centers and they continually upgrade the facilities. PH is a practice that wants to continue growing but is very selective in choosing physicians that want to be involved in value-based care initiatives. The group is attempting to enhance patient access with having call centers, developing online schedulers, updating facilities as well as centralized service for billing, medications renewals, referrals and prior authorizations from a centralized referring team, record requests, and on-call services. They help providers manage quality and see real time productivity with dashboards. Optum Care Network of CT is an independent physician association (IPA). Started as a risk bearing organization to holds the risk from payers for Medicare advantage and dual needs plans. They are a "pay-vider" as they are a provider that pays the claims assumed delegation of claims payment and oversees medical management. In 2018 they started their first global risk arrangement assumed from payers and they do delegation of services, medical management, credentialing, and network management. The PPW members discussed the unique nature of ProHealth, patient access to appointments, and referrals to specialists after the second presentation.
Lastly, the Co-Chair of the Workgroup outlined the plan for the coming months which includes soliciting additional input from workgroup members that represent the various types of healthcare entities in Connecticut and to provide a list of topics for PPW member to consider as the group works towards possible recommendations.

Meeting September 15, 2022

Jean Ahn, Chief Strategy Officer for Nuvance Health provided a presentation entitled Physician Practice Workgroup Considerations. Ms. Ahn stated that Nuvance Health (NH) is a multi-hospital healthcare system with seven (7) hospitals in Connecticut and New York. The mission of NH is to improve the lives of everyone even though some services lose money such as emergency services and trauma care, research and teaching, and some of the specialty clinic operations. She indicated that many hospitals nationally are experiencing negative margins due to higher labor costs and lower outpatient activity while many insurance companies are profitable.

Ms. Ahn indicated that private equity or investor capital played a role in approximately 75% of provider purchases in 2021. Pay-Vider companies such as Optum which is owned by United Healthcare and owns physician practices as well as insurance operations, is changing how healthcare is delivered. Unfortunately, private equity purchases of health care entities such as physician practices usually leads to increased spending and utilization of services which goes against some of the principals in the Workgroup's charter.

After the presentation there was a discussion from members on reducing restrictive covenants when physician practices are purchased to allow physicians who aren't pleased with the new arrangement of the practice, to stay in an area and serve patients. A few members spoke about helping young physicians with their loans if they practiced in underserved areas. There was some debate on if physicians with their own practice needed help to retire but if they sell their practice there is usually favorable tax treatment on the purchase price. Members also felt that there should be a presentation on the corporate practice

of medicine. As a group everyone thought that they needed to solve the issue of maintaining patient care and quality and getting physicians into the State to practice medicine in a quality way.

There was some discussion on preparations for the final report. The chairman of the group indicated that OHS was already beginning to prepare a report for the group. A document would be created for members to put the issues they feel are the most important issues to focus on in the final report. This document will likely be a shared file and sent around to all members the following week. Due to the report needing to be finalized by late December, it was noted that the group may have to have some extra meetings to finish all tasks on time.

Meeting October 13, 2022

The presentation entitled “The Corporate Practice of Medicine” by Andrew Keller, MD was postponed until a special meeting held on November 3rd.

Steven Lazarus stated a report on the workgroup’s findings should be completed by the group in the next several months. The goal is to have a final report by December 1st and have several members speak on the findings at the December Health Care Cabinet meeting. The workgroup may be required to meet in between meetings to discuss topics and finalize the report.

Steve and Ron Ciesones provided a list of topics from the workgroup’s past meetings with the intention of summarizing the main issues discussed by the group over the last year. During the meeting, some additional items were added to this list. Some of these items were combined and a link to the updated list was provided so that workgroup members can access the updated list and provide comments. and That document will be used to begin drafting the workgroup’s report.

Meeting November 3, 2022

This meeting focused on the topic of Corporate Practice of Medicine (CPOM). The Workgroup requested to discuss this topic and requested additional research from OHS. Based on that recommendation, OHS tasked Andrew Keller, M.D., a legal intern at OHS, to research and present on this topic.

Dr. Keller shared his presentation titled “The Corporate Practice of Medicine in Connecticut.” The presentation explained that the CPOM doctrine specifies that a corporation may not be licensed to practice medicine, members in a corporation to practice medicine must be licensed, and for-profit corporations cannot form or own any part of a professional corporation. In CT, several state agencies deal with the CPOM including the Department of Public Health, Office of Health Strategy, and Office of the Attorney General. The statutes related to the CPOM include C.G.S. § 20-9(a) and C.G.S. §19a-19. Additionally, statutes defining the incorporation of physicians are C.G.S. §33-182a and C.G.S. §34-243 and statutes defining medical foundations are C.G.S. § 33-182a and C.G.S. § 34-243. CPOM laws vary in states neighboring Connecticut (CT) such as Massachusetts, New Jersey, New York and Rhode Island. In CT the CPOM is monitored through Medical Foundations based on certain legislative statutes. A discussion related to the CPOM took place, specifically on how it relates to the major topics the group will focus on in the final report.

Meeting November 10, 2022

This meeting focused OHS data related to physician group practices. Ronald Ciesones, an OHS Supervisor, shared with the group some financial data reports and provided the limitations of OHS data.

Ron Ciesones, member of the OHS staff, provided financial data to the workgroup that OHS collects each year, this includes medical group statement of operation amounts from health system audited financial statements which show yearly losses from medical groups. Stand-alone audited financial statements are not put together for the medical groups. Financial data Hospital Reporting System report 6 which shows transfers between affiliated hospitals and medical groups. The data in Report 6 can't be traced back to the audited financial statements.

A general discussion related to the data in the presentation took place between members of the workgroup related to medical group finances and restrictive covenants. Ron Ciesones answered the workgroup members questions on the data collected.

After the presentation, the group decided that the preliminary list of topics provided to the group are the topics that Steven Lazarus and Ron Ciesones would focus on when drafting the report on behalf of the workgroup They would provide a document for group members to complete with suggestions in the coming days. Steven Lazarus indicated that he and Ron Ciesones have begun drafting the workgroup's report based on feedback received from the workgroup members and the hope is that a final draft will be provided to everyone prior to the next meeting. If need be, the group may have a special meeting on December 15, 2022, to accomplish the goal of finishing the report on time. We are still seeking volunteers to speak on the findings at the January Health Care Cabinet meeting.

Meeting December 8, 2022

OHS staff presented a draft version of the Workgroup's report and went through the various sections of the report which include the objectives for the group from Public Act 21-129, a description of how the workgroup meetings were structured, a table with member names, a table with a list of presentations, the main areas of focus the group decided to address and a short narrative on each major topic along with a list of recommendations to address these issues.

Discussions from the group were concentrated on how to resolve issues related to larger health system referral patterns and if the physicians at large health system owned groups were steering patients to health system physicians. Members on the panel felt patients should have a choice to go to any physician. Several members commented that sometimes electronic health record systems such as EPIC only refer to physicians within the health system.

Members then talked about next steps for the Workgroup. After some discussion, it was decided that members would continue to add comments in the topics file. In a few days, OHS staff would review the document and include any additional recommendations in the Workgroup's draft report. OHS will send out a Doodle poll to arrange another meeting in several weeks to discuss the updated version of the report. At that meeting, the hope is that the group will find a mechanism to vote on the recommendations suggested by PPW members**.**

Meeting December 21, 2022

OHS staff reviewed a file with members that contained the draft recommendations from group members organized by topic. Some of the members that provided comments, expanded on their thoughts so the group would better understand their recommendations. One member explained that taking the group practice filings and synthesizing the data into a report would be beneficial. There was also some discussion from members on having physician practices of two (2) or more complete the group practice

filing documents and members felt that as long as the forms weren't too onerous to complete, the additional data would help in getting a better picture of the physician landscape in CT.

Several members remarked on the group trying to pass legislation to make CT more appealing for young physicians as a place to practice medicine. Ideas such as having young physicians work in an undeserved area, providing loan forgiveness or tax advantages, along with some form of tort reform were all mentioned. Another member noted that changing any willing provider laws would help get more physicians approved by insurance companies.

Discussions then turned to the recommendations in the report and the steps needed to finalize the report. After some comments by members, it was decided that OHS staff would update the recommendations section and send the report to members to review. OHS staff would also devise a strategy for members with respect to voting on each of the recommendations to determine if there is a consensus amongst group members.

Meeting January 12, 2023

OHS shared an updated version of the PPW Report to Workgroup members. It was noted that the first week of January 2023, OHS sent out a draft version of the report to members and asked everyone to provide their edits, vote on each of the recommendations, and forward their version of the document to all members of the Workgroup. OHS staff then proceeded to tally votes from members and make some of the suggested edits. Revisions were not made to the document if OHS staff felt the context of an edit would change the meaning of a recommendation.

During the meeting, members provided their opinions on the voting process and how the recommendations were grouped. After some discussion, minor edits were made to the report, and a motion for the group to accept the document allowing for minor grammatical changes was approved. OHS staff indicated that in the coming days they would review the report again for grammatical errors and then pass it along to Dr. Gifford. Members then indicated they would like a meeting with Dr. Gifford to discuss the recommendations and OHS staff stated they would pass along the group's request.