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| **Meeting Date** | **Meeting Time** | **Location** |
| March 9, 2021 | 9:00 a.m. - 11:00 a.m. | Webinar and Conference Call |

**Participant Name and Attendance**

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| **Healthcare Cabinet Members** |
| Victoria Veltri  | X | Kate McEvoy | X | Valencia Bagby Young | X |
| Ellen Andrews | X | Alan Kaye | X |  |  |
| Rev. Robyn Anderson | X | Paul Lombardo | X |  |  |
| Patricia Baker | X | Judy Dowd | X |  |  |
| Nicole Taylor | X | Nichelle Mullins | X |  |  |
| Shelly Sweatt | X | Danielle Morgan | X |  |  |
| Nancy Navarretta  | X | Cassandra Murphy | X |  |  |
| Ted Doolittle | X | Frances Padilla | X |  |  |
| **Others Present** |
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|  | Kim Martone, OHS |  |
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| **Members Absent** |
| Susan Adams | Joshua Wojcik | David Whitehead |
| James Michel | Margherita Giuliano | Kurt Barwis |
| William Handelman | Hussam Saada | Heather Aaron |

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|  | **Agenda** | **Responsible Person(s)** |
| **1.** | **Call to order and Introductions** | **Victoria Veltri** |
|  | The regularly scheduled meeting of the Healthcare Cabinet was held on Tuesday, March 9, 2020 via Zoom. The meeting convened at 9:00 a.m. Victoria Veltri presiding. Attendance taken by roll call. |
| **2.** | **Public Comment** | **Victoria Veltri** |
|  | There was no public comment. |
| **3.** | **Approval of the February 9, 2021 Meeting Minutes** | **Victoria Veltri** |
|  | The motion was made by Pat Baker and seconded by Danielle Morgan to approve the February 09, 2021 Healthcare Cabinet meeting minutes. Vote by roll call. Motion carried. |
| **4.** | **Trauma Fee Activation Policies & Charges** | **Alla Veyberman, OHS** |
|  | Director Veltri introduced Alla Veyberman who presented Trauma Fee Activation Policies and Changes. To give an understanding of the presentation Ms. Veyberman shared a story about an eight-month-old baby who fell three feet and hit his head on the floor. By the time the child arrived at the hospital, their trauma team was dispatched. Upon arrival, the child was evaluated and after a few hours in the hospital, he was discharged. A few months later the parents received a bill from the hospital which included a trauma fee activation charge in the amount of $15,600. The second story she shared was about a young man who got injured in a motorcycle crash. He suffered a cut on his head and had a few stitches. He received some IV fluids and ibuprofen, no x rays, no scans, and no blood work was done. A few weeks later, he also received a bill, which included the trauma fee activation charge in the amount of $22,500. Ms. Veyberman stated that these examples demonstrate how controversial this topic is. For these reasons OHS (Office of Health Strategy) is authorized by C.G.S. §19a-644 to collect trauma activation fee policies and charge data from short term acute care general and children’s hospitals. Hospitals are required to file the information as a part of their annual financial report filing and annual disclosure began in February 2020. Trauma Activation Fee is the reimbursement associated with deployment of a hospital’s specialized trauma response team for a patient. Reimbursement is based on special codes and related fee payment system. The primary purpose of the fee is to help trauma centers remain financially viable, given the significant cost burden associated with professional and administrative resources needed to achieve and maintain the advanced level of readiness and capability of their critical care services. Ms. Veyberman gave some statics from FY2019. Approximately 7100 patients were billed a trauma activation fee and $32 million were charged or billed for trauma activation fee charges; 2% of emergency department patients admitted to inpatient care had the trauma team activated and were send a fee bill; 4% emergency department patients treated and discharged without an overnight stay, were billed trauma activation fee. It was noted that the two examples given at the beginning were a part of this group of patients who are treated and discharged without an overnight stay.It was noted that there is no standardization of policy among hospitals. It is not only in Connecticut, but also nationwide. Even though all hospitals policy included the composition of their teams, they did not include the team members roles within the trauma response team. And there is no uniformity in the billing, some hospitals bill in blocks of time while some have fixed charges.Pat Baker noted that she was not aware about this and it is important. Pat asked if we had the information by payer because it would be really interesting to know how much of this is falling on commercial versus Medicare versus Medicaid? Pat also asked if we had patient demographics. Ms. Veyberman noted that we do have the data but it has not been analyzed. If we had the IDC codes, we would be able to extract it from the APCD database. It is something to investigate. It was noted the hospital calls for the trauma team when the patient meets certain criteria. For example, the blood pressure should be less than 90, or the respiratory rate should be less than 10 or higher than 29. The injury should be penetrating injury to the head, neck or torso, if it is a fall, it should be from like more than 20 feet.Ms. Veltri thanked Ms. Veyberman for the presentation. For more information and to view the presentation please see the link below. [March 9 2021 (ct.gov)](https://portal.ct.gov/OHS/Content/Health-Care-Cabinet/Meeting-Agendas/March-9-2021) |
| **5.** | **State Efforts to Address Health Care Consolidation & Costs**  | **Katherine L. Gudiksen, Ph.D., M.S.** |
|  | Ms. Veltri introduced Katherine Gudiksen, she is with The Source for Healthcare Pricing Competition at University of California Hastings. Ms. Gudiksen has graciously accepted to present to the healthcare cabinet, on state efforts to address healthcare consolidation of costs.Ms. Gudiksen gave a quick introduction of the source, which is grant funded and is essentially a think tank that sits inside UC Hastings College of the Law. It was also noted that today’s presentation is about some of their recent projects, including giving you some more information about what's been happening across the country at the state level to address healthcare consolidation, essentially, mergers and costs and competition.Some highlights from the presentation are below:* Why prices for Health care have increased much faster than inflation.
	+ Failure to protect a free market – lack of transparency.
	+ Failure to protect competition and rigorously enforce antitrust laws.
	+ Failure of policymakers to act when competition no longer exists.
* Health care Horizontal mergers.
	+ **Increased Prices:** Post-merger hospital prices increased 20-44%
	+ **Increased Premiums:** Higher hospital concentration associated with higher ACA premiums
	+ **Reduced Wage Growth:** Hospital mergers reduced wage growth by 6.3% for nurses and pharmacists
	+ **Mixed to Negative on Quality:** Hospital acquisition associated with modestly worse patient experiences, reduced quality, or no effect.
* Health care Vertical Mergers
	+ **Higher Physician Prices**: Physician prices increase post-merger by an average of 14%
		- Cardiologist prices increased by 33.5%
		- Orthopedist prices increased by 12-20%
	+ **Higher Clinic Prices:** Hospital-acquired clinic prices increased 32–47% within four years
	+ **Higher Hospital Prices**
	+ **Little to no quality improvements**
* Cross-Market Mergers
	+ **Increased Prices at Acquired Hospital:** 7-17% increases in prices for hospitals purchased by out-of-market systems
	+ **Increased Prices at Acquiring Hospital:** 7-9% increase after merging with a hospital in a different market in same state
	+ **Increased Prices at Other Hospitals**: Price increases by 7.8% in nearby rival hospitals
* Physician Consolidation also likely leads to price increases.
	+ Generalist and specialist prices are higher when in integrated practices. (Baker 2020)
	+ FTC announced a retrospective study about physician group and facility mergers
	+ House Energy and Commerce Committee launched an investigation into acquisitions of hospital-based physician groups by private equity firms and their billing practices
* What can states do to Protect remaining competition?
	+ Antitrust enforcers should consider unwinding problematic mergers, but “unscrambling the egg” is very difficult
	+ Improved merger review is critical to prevent additional consolidation
	+ AG unable to challenge mergers they don’t know about

Other areas discussed at the meeting were:* Failure to Act when competition becomes insufficient;
* Anticompetitive Contracting Practices;
* Anti-Tiering and Anti-steering Clauses;
* Use of Litigation to Address Anticompetitive Contracting;
* Use of Legislation to Support Competitive Markets;
* Use of Legislation to Address Anticompetitive Contracting;
* Regulatory Oversight.

Ms. Veltri gave two comment on behalf of our agency. Noting one item that Ms. Gudiksen pointed out, on the regulation slide is financial resources. It is certainly an issue in Connecticut, Ms. Veltri noted that you must have the resources if you want to regulate. It is a challenge here in the state. Ms. Veltri would like this group to understand the group practice side of the equation. The group practice acquisitions are happening at a rapid rate and Connecticut’s statutes regulate practice acquisitions for eight or more physicians. Currently anything below 8 physicians is not addressed. There is a question whether to address that because you want some competition. But also, our statute approved, deems approved, group practice acquisitions over eight, which makes it very difficult to challenge them. Ms. Veltri pointed out that we are missing a fair share of the good practices that exist in Connecticut under existing law, because only physician practices that have 30 or more report to us every year, unless there's a change in ownership. It is difficult to track it under current law.Several discussions ensued for more information please see the link below. <https://ctvideo.ct.gov/ohs/GMT20210309-133848_HCC-_1920x1080_Trim.mp4>Ms. Veltri thanked Ms. Gudiksen for a very comprehensive presentation.  |
|  | **Next Steps – Cabinet Discussion** |  |
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| **6.** | **Adjourn** | **Victoria Veltri** |
|  | The motion to adjourn the meeting was made by Pat Baker and seconded by Francis Padilla. The motion passed. The meeting adjourned at 11:05 a.m. |
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