Physician Group Practice Workgroup Discussion Topics

Topic 1: Reconcile Office of Health Strategy's (OHS) reporting of group practice data between the various group practice regulations.	**Initial**
Hospital Systems, Independent Medical groups, Private Equity, Insurance Companies should all have the same reporting requirements for physician/ practice acquisitions and professional services agreements.	RA
Develop and Publish an annual report summarizing large physician practices in Connecticut. The data for this report would come from the annual group filing requirement.	LM
We would suggest that the 30-physician threshold for the OHS annual group filing requirement at C.G.S. §19a-486i(g) be aligned with the 2-physician threshold for the OAG Notice of Material Change filings at §19a-486i(a)(10) to require that group practices that consist of 2 to 29 physicians be required to now file the annual group practice form. This expand public data collection and would allow OHS, the AG's office and policymakers to better understand the independent practice landscape and how it is evolving as they consider policy changes. It would also provide a data source for reviews undertaken by our office when we review group practice combinations that would result in a material change under 19a-486i.	OAG/ Cara Passaro
"apply provisions to **insurance companies, private equity firms, and business affiliations—** including circumstances where any entity does not purchase the assets of the practice **but controls the practice." (JA) from Topic 6 but relevant here too.**	LM

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Topic 2: Enhance Office of Health Strategy and Office of Attorney General's enforcement for non compliance.	**Initial**
Penalties should also be the same for all parties	RA
Hospitals need to report on pricing structure for Hospital Outpatient services. Penalties should be enforced for non-compliance	DK

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Topic 3: Improve recruitment of new physicians for group practices of all sizes especially in underserved areas to replace physicians moving out of state or retiring.	**Initial**
Incentives for COMMUNITY BASED private practice primary care and behavioral health physicians. Consider financial incentives such as student loan assistance, tax abatements, etc. Look into expanding our definition of "underserved areas" to attract more of above and enhanced foreign medical grads/visa candidates.	AK
Compare CT with other states in # of physicians per capita and assess if there are other specialties in short supply.	AK
FOCUSED tort reform. I am not an expert on this topic but CT is not viewed as a friendly state.	AK
This is often cited by physicians as a reason for practicing in other states – many states have caps on malpractice awards and the number of lawsuits is much lower in these states	RA
Agree with RA Comment above	MB
Agree with RA Comment above	MS
New physicians have a huge financial burden amounting to hundreds of thousands of dollars in student loan debt accruing interest at rates as high as 8.5%. If the state bought up the loans and offered repayment based on income with a 0% or low percent interest rate the state could require service in an underserved area for a period of 10 years in return.	RO
Agree with RO comment above	MB
Student loan forgiveness is a powerful enticement for young physicians who owe upwards of $250,000 when finishing training. Coupled with incentives for buying a house or stipends to join a practice forgivable over a number of years can be equally beneficial. And If we are looking at a goal of bringing more physicians to CT, then adding further incentives for working in underserved areas or needed specialties (primary care, behavioral health) would also be worthwhile.	JC
NHSC Loan / Public Service Loan Forgiveness (PSLF) Repayment Program(s) are great options for loan repayment. Unfortunately, they are less than a guarantee. They do support service delivery sites in underserved areas in the specialties of Dental / Behavioral Health, and Primary Care. More programs that offer a higher degree and fulfillment of loan repayment is attractive to recruitment.	MS
Make a prior authorization list that is the only items all carriers can require prior authorization on to limit excess use of prior auth and all carriers and members know that all carriers use the same list	MB
Prior authorization policies by the insurance companies are onerous and they are affecting all medical offices. This is compounded by the lack of available staff that is required to perform these requirements. Some states have already started looking at this "delay tactic" that affects not just physicians but also the patients. One of the proposed solutions has been to review the physician's prior authorization rate and if it is above a certain threshold these physicians no longer require prior authorizations for the year.	RA NEW
Incentivizing independent and Private Practices will send a positive message for new Physicians looking to join or establish a Practice in CT.	DK
CON regulations with regard to physician practice acquisitions should be equally applied to private equity entities	RG

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Topic 4: Develop methods to assist small to medium size independent group practices to be capable of sustaining their practices and remain independent.	**Initial**
Would like to see some examples of this.	AK
Some suggestions would be to mandate Insurance companies to: • Negotiate or offer similar rates to independent physicians as the rates that have been negotiated by local hospital systems • Decrease all the red tape including prior authorizations for medications, radiology tests, and continuous glucose monitors (just to name some examples) • Provide student loan forgiveness plans especially to physicians joining OR STARTING independent practices in underserved areas	RA
I agree with the above suggestions and would add the following: 1. End high deductible insurance policies. 2. End copays or require insurance companies to collect them rather than physicians. 3. Assign an insurance company representative to each private practice so that patient and financial issues can be resolved in a timely manner through direct communication. 4. Prevent further consolidation of insurance companies in Connecticut. With fewer companies offering health insurance to the public, competition among insurance companies is reduced and doctors are forced to join the few companies that exist or risk losing their patients. 5. There is a concern of not having secure networks in the practice for patient communication. The cost of maintaining the level of security is burdensome for the practice. Providing assistance in this area would help. Due to HIPAA regulations, doctors are concerned about having their systems hacked and being responsible for stolen data. 6. Do not allow narrow referrals and forced steerage within hospitals and large group practices. 7. The topic specific CME credits, required by the state of Connecticut, should be a one-time requirement for our licensed physicians rather than have them repeated every six years.	RO
Have each carrier have both their in-network providers & offer access to non-network providers, at a small fee, to have access to the carrier system for prior auth and submitting claims electronically. The carrier would be the one handling the confidentiality and safety issues with the system.	MB
Recommend that AG's office look into the arrangements of Healthcare Networks with Hospital Medical Groups/Foundations that are getting subsidized by the Networks to refer patients to "High Cost Settings" that are Hospital based. This is leading to " Closed Referral Networks" and are eliminating patient choice, raising cost of care and in turn are eliminating Independent Practices.	DK
EPIC EHR is being used to direct/divert patients to Hospital Employed Groups who in turn are directing patients to Hospital System for High Cost Procedures, Infusions, Chemotherapy, etc.	DK

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Non Employed Physicians are listed as External in the EHR thereby diverting referrals to Hospital Network Physicians. These are anti-business and ant-competitive practices!	
The state of Connecticut should have an “Any Willing Provider” law which would have all medical insurance companies active in our state accept any provider practicing in the state who applies to join their panel of physicians. Some companies can take over a year to accept physicians as providers on their plans which makes it difficult for new physicians to get started in practice.	RO
The Department of Public Health shall establish a program to support small and medium-sized independent physician practices. The support may be used to recruit or retain physicians, recruit and retain other medical professionals within the practice, offset some medical malpractice costs, and/or fund the acquisition of or update to electronic health record (EHR) systems and expand EHR technologies.	RG
The Department of Public Health shall develop for all physician offices programs and processes designed to significantly decrease the burden of prior authorizations for prescription medications and imaging procedures.	RG
Prior Authorization: The Problem Prior authorization is an administrative hurdle created by the health insurance industry to commonly delay access to care for patients and serve as an imposition into the patient-physician relationship and decision-making process. Prior authorization processes can harm patient outcomes and create a tremendous obstacle to treatment decisions deemed most appropriate by physicians. The concept of prior authorization originated from the use of utilization reviews in the 1960s. Utilization review started at the beginning of Medicare and Medicaid legislation and the primary use was to verify an admission to a hospital in an attempt to limit unnecessary hospital stays and cut costs. As managed care took hold throughout the 1990s, health insurers used prior authorization, but rather sparingly and only when it came to high-cost pharmaceuticals and high-cost services. In the last three decades, however, the use of prior authorization has snowballed, and we have reached a point where health plans require prior authorization for a multitude of procedures, tests, surgeries, and pharmaceuticals. Where prior authorization began as a reason to look at hospital admissions, we now see it being used as a blunt edged tool designed to reduce reimbursement for medical care. Ultimately, **almost all** services requiring prior authorization are approved. Thus, these prior authorization requirements are unnecessary, detrimental to patient health, and wasteful of the physician's time and resources. Prior authorization requirements (even for services that are ultimately approved) invariably delay care and keep physicians on the phone with health plans, detracting from time that could be spent on patient care. Additionally, before a health plan can issue an adverse determination on a prior authorization request, the health plan is supposed to provide the physician whose service is being reviewed a reasonable opportunity to discuss the proposed care with the reviewing physician. This is sometimes informally referred to as a "peer-to-peer" call. Often the reviewing "peer" physician	RR

is not of the same specialty as the treating physician. For example, an oncologist's recommended course of treatment could be reviewed by an orthopedic surgeon working for the health plan. Due to the difference in specialty areas, the "peer" physician may not be as familiar with the course of treatment being reviewed. This specialty difference can lead to unnecessary initial denials of prior authorization requests and delays in medically necessary care.

Aside from the delays in patient care and the burdens faced by physicians, health plans commonly use medical necessity criteria and other clinical guidelines for prior authorization processes, guidelines that are often deemed proprietary and not shared with physicians. In addition, each health plan has a different and ever-changing list of what services that require prior authorization. There is no uniformity between the commercial health plans, as well as Medicare and Medicaid. This makes it nearly impossible for physicians to keep track of what services require prior authorization as well as how to anticipate what the health plan may request as evidence of medical necessity. As a result of this lack of transparency, there is often extensive back and forth between physicians and health plans in response to insurer requests for documentation. It is crucial for patient safety that payers are transparent so that physicians can resubmit for approval as quickly as possible to avoid any delays in care or treatment for patients.

In addition, health plans have multiple departments internally that deal with prior authorizations. Physicians may encounter one department or representative of the plan who will state that prior authorization is not needed and then after the service is provided to the patient, another department of that same health plan will now deny the service saying that prior authorization was in fact needed. This results in both the patient and/or the physician being responsible for the financial cost of the service not through any fault of their own, but solely due to the failure of the health plan to coordinate its own internal departments. This logic is backwards, counterproductive, and destructive to the patient-physician relationship. Errors and inefficiencies of health plans should not be used to punish either patients or physicians. Health plans should be held responsible for their initial determinations.
In a 2021 survey of physicians conducted by the American Medical Association (AMA), 93% of respondents reported that prior authorization requirements created delays in accessing necessary care. In that survey, 82% of physicians reported that prior authorization can lead to patients abandoning a recommended course of treatment. In addition, 34% of respondents reported that prior authorization requirements have led to a serious adverse medical event for a patient with nearly one quarter reporting that prior authorization delays have led to a patient's hospitalization.

Prior authorization requirements delay patients' timely access to health care. Every physician has a story about a patient that was harmed by a prior authorization delay; some with very tragic endings. In the orthopedic setting, it is not uncommon for a health plan to deny a patient a needed MRI, instead requiring several sessions of physical therapy be done first before the MRI is approved. The physician knows the physical therapy will not help the patient and the patient is forced to spend time and money on an often-futile exercise simply to "check the box" that is required by the health plan to get the MRI.

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Prior Authorization: Solutions

Gold Card:

Two years ago, the Texas legislature passed the Gold Card Law which allows physicians who have a 90 percent prior authorization approval rate over a six-month period on certain services to be exempt, or "gold carded", from prior authorization requirements for those services. The idea behind gold card legislation is that physicians who routinely receive prior authorization approvals for services will be able to bypass the prior authorization approval process, allowing patients more timely access to needed medical care and eliminating a significant administrative burden for the physician.

Gold carding is included in a set of prior authorization reform principles put forth by the AMA and 16 other physician, patient, and health care organizations. Specifically, these principles state that health plans should restrict utilization management programs to outlier providers whose prescribing or ordering patterns differ significantly from their peers after adjusting for patient mix and other relevant factors. The principles further elaborate that health plans should offer a physician-driven, clinically based alternative to prior authorization, such as gold card programs.

Uniform Standards:

A uniform set of standards must be used by all commercial health plans. As noted above, it is nearly impossible for a physician office to keep track of the myriad of requirements, methodologies, and documentation necessities when each of the commercial health plans, as well as Medicaid and Medicare, has a different set of standards.

Weekend and Night Hours:

Healthcare services are not needed only Monday to Friday, 9am to 5pm. Yet the health insurers do not have staff available after 5pm or on weekends to handle prior authorization requests. Patients do not only get sick during the week and during the daytime. Physicians provide medical care on a 24/7 basis, and it should be expected and required that health insurers have representatives available to deal with prior authorization requirements after 5pm and on weekends.

Technology Modernization:

In a world dominated by technology, it seems incredibly obsolete that prior authorization is still done primarily by telephone and facsimile. Physicians can spend hours on the phone trying to get a representative of the health plan on the phone to discuss a prior authorization request. Follow-up information is often required to be sent via facsimile and often necessitates further phone calls to ensure information was received. It is astounding that the prior authorization process is not automated or done through electronic means.

Prior Authorization: The Impact on Connecticut

It is no secret that the independent practice of medicine is disappearing. Administrative burdens, such as prior authorization, created by the health insurers, are a big factor in driving consolidation and ultimately the demise of the independent practice of medicine. The time to do something about prior authorizations is now. The reality is that Connecticut physicians and patients cannot wait even one more year for relief. Connecticut does not need a study; we need a solution. The time has come to fix prior authorization in Connecticut and help preserve what is left of the independent practice of medicine. Our patients need help. Our physicians need help.

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Additional study: https://www.medscape.com/viewarticle/985396	

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Topic 5: Increase healthy competition (to increase cost savings, promote market/population coverage, increase recruitment (via higher profile, etc.).	**Initial**
Topic 3 has a number of items which would be an incentive to increase recruitment	MB

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Topic 6: Improve regulations on the purchasing of physician practices (i.e. private equity, insurance companies, restrictive covenants, and stealth consolidations).	**Initial**
Amend CON statutes relating to ownership, affiliates, and management control [i.e., 19a-630(15); 19a-630a; 19a-638(a)(3)] to specifically apply provisions to **insurance companies, private equity firms, and business affiliations—**including circumstances where any entity does not purchase the assets of the practice **but controls the practice.** (I agree with this LM)	JA & LM
Re-look at the corporate practice of medicine in CT. Assess current statutes, regulations and the loopholes and workarounds that have circumvented the intent of the prohibition.	AK
Consider changes in non-compete legislation for physicians, particularly in situations where there has been a change of governance structure or control of the practices. (More to follow.)	AK
Non-compete regulations protect individual practices as well as hospitals and most states enforce non-compete agreements. Removing non-compete agreements will not improve recruitment by small independent groups or practices; removing non-compete agreements will allow larger health systems to continue their expansion in the state by now focusing on the ambulatory setting and continue to acquire physicians, even physicians who are presently employed by other health systems and independent practices.	RA
Agree. There are situations, however, where restrictive covenants are counterproductive. I will present these shortly.	AK
It is now a national phenomenon that recruitment of physicians is very difficult. While we are all aware of Connecticut's positive qualities as a place to live, the highly competitive landscape or physician recruitment speaks to the need to mitigate factors that diminish attractiveness to young physicians. Some of the negatives are out of our control, e.g., business climate, housing costs, etc. Our Workgroup should look at factors that affect the private practice of medicine, in general, and focus laser-like on those at the minds of young physicians. In the general private practice category, we might consider tort reform, leveling the playing field on reimbursement, supporting the costs of compliance with state mandates (e.g., participation in Health Information Exchange, tax credits for acquisition of electronic medical records, lower license fees for private practice physicians…). With respect to young physicians, we might consider benefits that would accrue directly to the young physicians, such as student loan abatement and more favorable environment for foreign medical graduates. Expanding the definition of Underserved Areas" might factor into both the above benefit programs. Another thing on the minds of new physicians, particularly those that want to enter private practice, is how they might be affected by practice consolidation. While consolidation is a prominent topic in discussions in this Workgroup and in OHS and even nationally, it is beyond the scope of my comments on this item. The issue above is a by-product of a subset of consolidation – i.e., the buyouts of private practices by non-physician controlled/owned entities. Physician trainees are acutely aware and highly concerned about their futures in this aspect of practice consolidation, whereby private practices are "acquired" by hospitals, insurance companies, and financial entities (e.g., private equity companies). Many inquire about potential	AK

acquisition in the process of visitation, interviews, and contract negotiations. Practices are very circumspect (or even deceptive) in answering these questions, partly because they are bound by non-disclosure agreements. And, of course, these acquisitions commonly include significant payments to the private practice PARTNERS, with no obligations or plans to include new physicians in the buyout proceeds. To add insult to injury, these new physicians are frequently bound by restrictive covenants whereby a new recruit who has relocated to Connecticut (and maybe bought a home with a mortgage) may not like the new practice environment. If they choose to stay, they will find themselves in a practice that is very different from that which they joined – compensation, employer, prospective "ownership" and control – I.e., everything. The ultimate "bait and switch." **I propose that we take at least one concern off the shoulders of new physicians considering joining a private practice in Connecticut and pass legislation that would nullify contractual restrictive covenants in the in the event of a substantial change in or control of ownership or structure of the practice.** This recommendation became policy for the American College of Radiology at its 2022 Annual Meeting: *The ACR recommends transparency and professionalism in the hiring process, that partnership track associates should receive at least some proportional monetary compensation and should be included in discussions related to substantial changes in practice structure or ownership as legally permissible and that in the event of a substantial change in or control of ownership or structure of the practice, any restrictive covenant in an associate's current employment contract should be waived. The ACR will contribute legal and government relations resources to suggest model language for state legislative initiatives to effectuate the above statutory changes to restrictive covenants and its delegation to the American Medical Association (AMA) will submit a similar resolution for consideration by the AMA House of Delegates.*	
An additional provision might be to disallow restrictive covenants when physicians are terminated by their practices without cause (as opposed to with cause).	
In this Workgroup, consolidation of physician practices under a hospital umbrella has received a lot of attention. Indeed, many physicians are very concerned about this. https://opmed.doximity.com/articles/most-doctors-are-very-concerned-about-health-care-consolidation I would like to highlight another type of consolidation that is common and growing, Early in the last century, the AMA spearheaded a national campaign to prevent the corporate practice of medicine (CPM): *The corporate practice of medicine doctrine prohibits corporations from practicing medicine or employing a physician to provide professional medical services. This doctrine arises from state medical practice acts and is based on a number of public policy concerns, such as (1) allowing corporations to practice medicine or employ physicians will result in the commercialization of the practice of medicine, (2) a corporation's obligation to its shareholders may not align with a physician's obligation to his patients, and (3) employment of a physician by a corporation may interfere with the physician's independent medical judgment. While most states prohibit the corporate practice of medicine, almost every state has broad exceptions, such as for professional corporations and employment of physicians by certain health care entities.*	AK

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Over the century since the AMA raised concerns and states enacted laws to combat CPM, the laws and other regulations have been undermined through loopholes such that "Private equity has poured nearly $1 trillion into nearly 8,000 health care transactions during the past decade, according to PitchBook." Indeed, a week does not pass that does not include a news story related to the CPM, most commonly related to private equity. Usually, these include examples of business practices extracting revenues or reducing costs, which may be considered unorthodox, abusive, aggressive, etc., and frequently prey on unsuspecting patients, underserved demographic groups and the safety net of our insurance products meant to shield us from insolvency. A study in JAMA Health Forum "found that private equity-acquired medical practices charged 20 percent more, on average, per insurance claim, and saw a nearly 40% increase in new patients compared to independently owned practices." Below is a sample of recent articles from just one news publication, Kaiser Health News, over the time span of May to September, 2022. I have submitted several additional articles to this workgroup previously. The purview of this Workgroup is to suggest ways to enhance private practices. While these private-equity owned entities call themselves private practices, they are anything but the kind of practices we want to foster. Indeed, judging from the frequent news stories about them, the only physicians who benefit from these acquisitions are the few partners who garner financial windfalls from the purchases and their favorable tax treatment. Patients, payers, and young physicians, on the other hand, do not appear to fare as well.

I recommend that the legislature conduct or commission a study of the concept, history, and consequences of CPM with an eye toward addressing what is, effectively, meaningless regulation and an absence of oversight.

Sick Profit: Investigating Private Equity's Stealthy Takeover of Health Care Across Cities and Specialties

By Fred Schulte NOVEMBER 14, 2022 KHN ORIGINAL

Private equity firms have shelled out almost $1 trillion to acquire nearly 8,000 health care businesses, in deals almost always hidden from federal regulators. The result: higher prices, lawsuits, and complaints about care.

How Private Equity Is Investing in Health Care: A Video Primer

By Hannah Norman and Oona Tempest OCTOBER 26, 2022 KHN ORIGINAL

Investors are putting money into everything from emergency room obstetrics units and dermatology practices to nursing homes and hospice care — from cradle to grave.

'An Arm and a Leg': Private Equity Is Everywhere in Health Care. Really.

By Dan Weissmann MAY 27, 2022 KHN ORIGINAL

Private equity companies are the house-flippers of the investment world, and they've found their way into many areas of our lives — including your local gastroenterologist's office.

Private Equity Sees the Billions in Eye Care as Firms Target High-Profit Procedures

By Lauren Weber SEPTEMBER 19, 2022 KHN ORIGINAL

As private equity groups are swarming into aging America's eye care, the consolidation is costing the U.S. health care system and patients more money.

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Baby, That Bill Is High: Private Equity 'Gambit' Squeezes Excessive ER Charges From Routine Births By Rae Ellen Bichell OCTOBER 13, 2022 KHN ORIGINAL Hospitals, boosted by private equity-backed staffing companies, have embraced a new idea: the obstetrics emergency department. Often, it is just a triage room in the labor-and-delivery area, but it bills like the main emergency department. **Betting on 'Golden Age' of Colonoscopies, Private Equity Invests in Gastro Docs** By Emily Pisacreta and Emmarie Huetteman MAY 27, 2022 KHN ORIGINAL An aging population in need of regular cancer screenings has driven private equity companies, seeking profits, to invest in many gastroenterology practices and set up aggressive billing practices. Steep prices on routine tests are one consequence for patients. **How Banks and Private Equity Cash In When Patients Can't Pay Their Medical Bills** By Noam N. Levey and Aneri Pattani NOVEMBER 17, 2022 KHN ORIGINAL Hospitals strike deals with financing companies, generating profits for lenders, and more debt for patients.	
Newly practicing physicians find it very attractive to practice in states which do not allow restrictive covenants. Maine, California and Massachusetts are three examples. **Connecticut should in the very least protect employed physicians by disallowing the enforcement of restrictive covenants if the physician is let go by their employer without just cause.**	RO
I would point out that by CT statute should an employer terminate a physician without cause, the restrictive covenant is non enforceable .	
Some excellent points regarding the role that private equity is increasingly playing in the acquisition of private practices. Given the goal of attracting and retaining young physicians in CT, this model could be a significant deterrent as it generally only benefits the senior partners and not the younger employed physicians. The younger physicians often find themselves in a practice model that they didn't sign up for. While some contracts have a provision eliminating the restrictive covenant when there is a change of control, many do not and this would be an area to explore further.	