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Current Health Care Environment

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CHAPTER 1. CURRENT HEALTH CARE ENVIRONMENT

With the 2010 passage of the Patient Protection and Affordable Care Act, health care providers must now deliver more effective care while being held accountable for patient outcomes. In response to health care reform mandates and other forces, Connecticut's health care system landscape continues to transform. The transformation can be seen in the regulatory arena via Certificate of Need (CON) applications received by OHCA, as providers focus on creating new models of care that bring higher quality at a lower cost, thus delivering greater value in health care.

OHCA, which administers the CON Program in accordance with Sections 19a-638 (see Appendix D) and 19a-639 (see Appendix E) of the Connecticut General Statutes, has recently seen considerable activity among health care providers it regulates in anticipation of or in response to health care reform mandates. Change in ownership, termination of service, merger of general hospitals and for-profit conversion applications received by OHCA in the past two years have specifically mentioned the PPACA as a reason, in part, for the proposed action. For example, recent CON applications have cited the need to consolidate and remove excess costs to keep pace with decreasing reimbursements; emphasized the importance of reducing fragmentation, collaborative care and patient centered medical homes and stressed the need to comply with federal "meaningful use" requirements and adopt technology that promotes coordinated care as reasons for applying for such CONs.

Table 1 below notes the type and number of applications received over the past two years.

Table 1. Certificate of Need Applications, Connecticut, 2012 and 2013

CON Type	Number of CON Applications 2012	Number of CON Applications 2013
Change in ownership	4	7
Medical equipment (e.g., MRI, CT, PET-CT, CT simulator)	10	6
Termination of services	6	5
New facilities (e.g., behavioral health, outpatient surgical facilities)	2	4
Cardiac Services – elective angioplasty	4	0
Behavioral health – new outpatient services	4	4
486 joint venture (profit/non-profit)	1	2
Affiliation of general hospital with a health care system	1	1
Relocation of services	0	1
Merger of two general hospitals	0	1
Additional acute care beds	1	0

Source: Connecticut Department of Public Health. *Summary of Application Received by OHCA in Calendar Year 2012, 2013*. Office of Health Care Access, Connecticut Department of Public Health.

MERGERS AND ACQUISITIONS

Increasingly, Connecticut's hospitals are applying for regulatory approval to become members of larger umbrella corporate health care systems, and in some cases, out-of-state hospital systems.[8] **Table 2** identifies the parent corporations for those Connecticut hospitals that are, at the time of publication, affiliated with other hospitals and **Table 3** identifies the parent corporations of those health systems that do not include more than one hospital. Although corporate systems that hold hospitals as well as other medical and non-medical entities dates back to before the managed care trends in the 1990s, there has been a significant increase in affiliations between hospitals under the same umbrella organization. These affiliations or mergers may be attributed to several factors, including the economic downturn that began in 2008, health care market competition, anticipation of health systems changes under the PPACA, payer contract negotiations and improving efficiencies in health care administration and delivery.[9]

To illustrate this trend, in the past year alone the following has occurred: in December 2013, OHCA authorized a Certificate of Need (CON) for the affiliation of Norwalk Health Service Corporation, the parent corporation of Norwalk Hospital, and Western Connecticut Health Network, Inc. (the parent corporation of Danbury Hospital and New Milford Hospital, Inc.). On January 1, 2014, these parties became formally affiliated and Norwalk Hospital now operates within the Western Connecticut Health Network system. In June 2014, a CON was issued to New Milford Hospital Inc., Danbury Hospital, and Western Connecticut Health Network, Inc., approving a consolidation of the operations of Danbury Hospital and New Milford Hospital under a single general hospital license. With this licensure change on October 1, 2014, this combined hospital now operates with one license and two hospital campuses, similar to the change that occurred in September 2012 when Yale acquired the Hospital of Saint Raphael.

In contrast, some Connecticut hospitals are pursuing strategies to remain financially viable and independent of large health care systems. In September 2014, five Connecticut health care systems announced the formation of the "Value Care Alliance."[10] The hospitals that are part of these systems include Danbury Hospital, Griffin Hospital, Lawrence + Memorial Hospital, Middlesex Hospital, Norwalk Hospital and St. Vincent's Medical Center. The alliance was formed to extend the economies of scale enjoyed by large health care systems, while preserving and supporting each hospital's independence. The benefits sought include enhanced purchasing power in a tight financial environment, the sharing of best practices and strategies to adapt to the evolving health care environment.

Table 2. Hospitals and Parent Companies for Affiliated Hospitals, Connecticut, FY 2013

CORPORATE AFFILIATIONS BETWEEN HOSPITALS (Affiliated Hospitals) (ordered by higher level parent name)			
Hospital (Full Legal Name)	**Parent Corporation (Full Legal Name)**	**Higher Level Parent Corporation (Full Legal Name)**	**Other acute care hospitals currently under the same parent corporation**
St. Vincent's Medical Center	St. Vincent's Health Services Corporation	Ascension Health, Inc.	Multiple hospitals across the U.S. under larger parent, Ascension Health Alliance. No others within Connecticut.
Manchester Memorial Hospital	Eastern Connecticut Health Network, Inc. (ECHN)	N/A	Manchester Memorial Hospital Rockville General Hospital
Rockville General Hospital		N/A	
Essent Healthcare of Connecticut, Inc. d/b/a Sharon Hospital	Sharon Hospital Holding Company	Essent HealthCare, Inc.	Multiple across the U.S. under larger parent, RegionalCare Hospital Partners, Inc. No others within Connecticut
Hartford Hospital	Hartford Healthcare Corporation	N/A	Hartford Hospital Hospital of Central Connecticut MidState Medical Center William W. Backus Hospital Windham Community Memorial Hospital
MidState Medical Center	Hartford Healthcare Corporation	N/A	
Hospital of Central Connecticut	Central Connecticut Health Alliance, Inc.	Hartford Healthcare Corporation	
William W. Backus Hospital	Backus Corporation	Hartford Healthcare Corporation	
Windham Community Memorial Hospital, Inc.	Hartford Healthcare Corporation	N/A	
Lawrence+Memorial Hospital, Inc.	Lawrence + Memorial Corporation	N/A	LMW Healthcare, Inc. d/b/a Westerly Hospital (in Westerly, RI)

Danbury Hospital,[a] The	Western Connecticut Health Network, Inc.	N/A	Danbury Hospital Norwalk Hospital
Norwalk Hospital Association, The	Norwalk Health Services Corporation	Western Connecticut Health Network, Inc.	
Bridgeport Hospital	Yale-New Haven Network Corporation, Inc.[b]	N/A	Bridgeport Hospital Greenwich Hospital Yale-New Haven Hospital
Greenwich Hospital	Greenwich Healthcare Services, Inc.	Yale-New Haven Health Services Corporation	
Yale-New Haven Hospital	Yale-New Haven Health Services Corporation[c]	N/A	

[a] On October 1, 2014, Danbury and New Milford Hospitals began operating under a single license.
[b] On May 15, 2014, the former parent corporation of Bridgeport Hospital, called Bridgeport Hospital & Healthcare Services, Inc., merged into Bridgeport Hospital. The Hospital is now a direct subsidiary of the larger parent corporation, Yale-New Haven Health Services Corporation.
[c] On May 15, 2014, the former parent corporation of Yale-New Haven Hospital, called YNH Network Corporation, merged into Yale-New Haven Hospital. The Hospital is now a direct subsidiary of the larger parent corporation, Yale-New Haven Health Services Corporation.

Information current though publication of FY 2013 Financial Stability Report

Table 3. Hospitals and Parent Companies for Non-Affiliated Hospitals, Connecticut, FY 2013

HEALTH SYSTEMS THAT DO NOT INCLUDE MORE THAN ONE HOSPITAL (Non Affiliated Hospitals) (ordered by higher level parent name)				
Hospital (Full Legal Name)	**Parent Corporation (Full Legal Name)**	**Higher Level Parent Corporation (Full Legal Name)**	**Other acute care hospitals currently under the same parent corporation**	**Town Hospital Service Area**
Bristol Hospital, Inc.	Bristol Hospital & Healthcare Group	N/A	N/A	Bristol, Plymouth, Plainville
Charlotte Hungerford Hospital	N/A	N/A	N/A	Litchfield, Torrington, Winchester
Day Kimball Healthcare, Inc. d/b/a Day Kimball Hospital	Day Kimball Healthcare, Inc.	N/A	N/A	Killingly, Putnam, Plainfield, Brooklyn, Thompson
Connecticut Children's Medical Center	CCMC Corporation, Inc.	N/A	N/A	Avon, Bloomfield, Bristol, Canton, Colchester, Danbury, East Hartford, Enfield, Farmington, Glastonbury, Hartford, Manchester, Meriden, Middletown, Naugatuck, New Britain, Newington, Norwich, Plainfield, Plainville, Rocky Hill, Simsbury, South Windsor, Southington, Tolland, Torrington, Vernon, Waterbury, West Hartford, Wethersfield, Windham, Windsor
Waterbury Hospital	Greater Waterbury Health Network, Inc.	N/A	N/A	Waterbury, Naugatuck, Watertown, Southbury, Wolcott
Griffin Hospital	Griffin Health Services Corporation	N/A	N/A	Shelton, Ansonia, Seymour, Derby, Oxford, Naugatuck
Johnson Memorial Medical Center	Johnson Memorial Medical Center, Inc.	N/A	N/A	Enfield, Stafford+Union, Somers, Suffield
Middlesex Hospital	Middlesex Health System, Inc.	N/A	N/A	Middletown, Cromwell, East Hampton, Old Saybrook, Portland, Clinton, Haddam, East Haddam, Colchester, Westbrook, Essex, Durham, Chester, Old Lyme+Lyme
Milford Hospital	Milford Health & Medical, Inc.	N/A	N/A	Milford, West Haven, Orange

St. Francis Hospital and Medical Center	Saint Francis Care, Inc.	N/A	N/A	Hartford, East Hartford, West Hartford, Bloomfield, Enfield, Manchester, Windsor, South Windsor, Windsor Locks, Vernon, Wethersfield, Glastonbury, Simsbury, Bristol, Newington, Rocky Hill, Suffield, New Britain, East Windsor
St. Mary's Hospital	Saint Mary's Health System, Inc.	N/A	N/A	Waterbury, Naugatuck, Wolcott, Watertown
Stamford Hospital	Stamford Health System	N/A	N/A	Stamford, Norwalk
John Dempsey Hospital	University of Connecticut Health Center	N/A	N/A	Farmington, West Hartford, New Britain, Hartford, Bristol, Avon, Simsbury, Canton, East Hartford, Newington, Bloomfield, Plainville, Southington, Manchester, Torrington, Rocky Hill

INSURANCE COVERAGE

Connecticut is one of 28 states that expanded Medicaid coverage to childless adults through an option within the Affordable Care Act. In 2010, the State launched Husky D, which transitioned very low income adults from State Administered General Assistance (SAGA) into Medicaid. In 2014, it further expanded coverage for childless adults by raising the income limit to 138 percent of FPL. In January 2014, an estimated 286,000 Connecticut residents were uninsured. According to Access Health CT (the quasi-public insurance marketplace) an estimated 147,000 residents remained uninsured in October 2014.[11]

Data available for this Plan does not reflect increases in Medicaid or commercial coverage resulting from the 2014 Medicaid expansion or Access Health CT open enrollment, which runs through February 15, 2015.

CURRENT INITIATIVES

Two key activities related to the current health care environment have emerged since the publication of the 2012 Plan. Both the State Innovation Model (SIM) Grant and the Round Table on Hospitals and Health Care have implications for the future of the state's health care delivery system.

State Innovation Model (SIM) Grant from the Center for Medicare and Medicaid Innovation

In 2013, Connecticut received a $2.8 million planning grant from the Center for Medicaid and Medicare Innovation (CMMI) to develop a health care innovation plan to achieve three goals: (1) improve the health of Connecticut's residents while reducing health inequities; (2) improve health care quality; and (3) slow the growth of health care costs in Connecticut. After engaging stakeholders across sectors in efforts to prioritize and evaluate health care innovation strategies, Connecticut's Program Management Office submitted a State Innovation Model (SIM) grant to the CMMI. This plan, known as the *CT Health Care Innovation Plan*, seeks to support the development of innovative strategies to improve health care and health care delivery by enhancing primary care and improving community health.[12] The Innovation Plan identified the following impediments to improving health and health care in Connecticut: access barriers, fragmented delivery, lack of transparency with respect to cost and performance and payment methods based on the quantity of health care services versus the quality of service.

The Innovation Plan proposes the development of a "whole-person-centered care" model that integrates a "social determinants of health" framework into strategies to improve medical, oral and behavioral health. This is achieved through three strategies: incorporating an advanced medical home model into primary care practice; improving community health by coordinating prevention strategies among community-based organizations, health care providers, consumers, and public health agencies; and empowering consumers by strengthening opportunities to solicit consumer feedback, incentivizing a positive health care experience and sharing health information with consumers to enable them to make informed health care decisions.

Connecticut was one of eleven states awarded State Innovation Model Test Grant funding in December 2014. Connecticut will receive up to $45 million to implement a number of initiatives designed to improve population health, strengthen primary care, promote value-based payment and insurance design, and obtain multi-payer alignment on quality, health equity and care experience measures. Connecticut's plan includes more than $6 million to measure and improve community health and health equity, address increasing rates of obesity and diabetes and strengthen primary care. The state also plans to implement a Medicaid Quality Improvement Shared Savings Program that will reward providers that invest in delivering better care (i.e., improved quality, equity and patient experience) for Medicaid beneficiaries.[13] Further information on this plan can be found at http://www.healthreform.ct.gov/.

Round Table on Hospitals and Health Care

In October 2014, the legislature announced the formation of a bi-partisan Round Table on Hospitals and Health Care, with the goal of monitoring the implementation of recent legislation, discussing the rapid changes in the market and developing policy recommendations to help ensure continued access to affordable quality care in Connecticut. Discussions focused on what is occurring in the current environment, especially as it relates to the consolidation of hospitals into large networks, the conversion of non-profit hospitals to for-profit entities and the purchase of medical practices by hospitals. Further information on the Round Table's activities can be found at http://www.cga.ct.gov/ph/taskforce.asp?TF=20141015_Bipartisan%20Roundtable%20on%20Hospitals%20and%20Healthcare.

RECENT LEGISLATION

Since publication of the 2012 Plan, several public acts related to Connecticut's health care system have been signed into law or implemented. This section provides a brief summary of relevant public acts passed or implemented in 2013 or 2014.

Certificate of Need (CON)

A recent law mandates greater regulatory oversight and strict new financial reporting requirements on the sale or conversion of non-profit hospitals. Public Act 14-168 bolsters existing laws that mandate the approval of the Attorney General and DPH Commissioner for the sale of a non-profit hospital or conversion of the non-profit hospital's legal status to a for-profit entity.[14] The law requires any new for-profit hospital to provide continued access to high quality affordable care and authorizes both the DPH and Attorney General to impose conditions upon any new hospital owner to guarantee those commitments. Furthermore, it requires that, prior to the CON application, a public hearing is held in the municipality where the hospital is located. The act also ensures greater oversight of large physician practice acquisitions by hospitals and other entities by requiring CON approval.

Under Connecticut General Statutes (Conn. Gen Stat.) § 19a-639, when reviewing Certificate of Need (CON) applications, OHCA must consider the implications of the proposed action on vulnerable populations. Under the act, OHCA must consider the current provision of services to Medicaid recipients and indigent populations and the implications of the requests in the CON application for these populations.[15]

In addition, OHCA is currently in the process of drafting CON regulations pertaining to the acquisition of imaging equipment, criteria for determining bed need, outpatient surgical facilities, and cardiac services.

Medical Foundations

Public Act 14-168, passed in the spring of 2014, allows for-profit hospitals and health systems to create or join a medical foundation, which was previously only available to non-profit entities.[16] The initial Medical Foundation law passed in 2009 allowed hospitals or health systems to create these types of legal entities in order to employ physicians or other practitioners directly. A medical foundation is a separate legal entity from the hospital or its parent corporation and is governed by its own board of directors, but operates under the same corporate umbrella as the hospital and health system.

There are currently 12 entities structured as medical foundations in the State:[17]

1. Alliance Medical Group, Inc. (part of Waterbury Hospital)
2. Bristol Hospital Multispecialty Group, Inc. (part of Bristol Hospital and Health Care Group, Inc.)
3. Community Medical Partners, Inc. (part of Backus Corporation)
4. Connecticut Geriatric Specialty Group, Inc. (part of Hebrew Health Care, Inc.)
5. Day Kimball Medical Group, Inc. (part of Day Kimball Healthcare, Inc.)
6. Eastern Connecticut Medical Professionals Foundation, Inc. (part of ECHN)
7. HHC PhysiciansCare, Inc. (part of Hartford HealthCare Corporation)
8. L&M Physician Association, Inc. (part of Lawrence & Memorial Corporation)
9. MHS Primary Care, Inc. (part of Middlesex Health System, Inc.)
10. Northeast Medical Group, Inc. (part of Yale-New Haven Health Services Corporation)
11. St. Vincent's Multispecialty Group, Inc. (part of Saint Vincent's Medical Center)
12. Western Connecticut Medical Group, Inc. (part of Western Connecticut Health Network, Inc.)

Physician Reimbursement and Intensive Case Management (ICM) for Medicaid Recipients

Several recently-passed acts affect the health care of and reimbursements for Medicaid recipients. PA 14-160 allows for emergency department (ED) physicians who meet particular requirements to enroll separately as a Medicaid provider and to become eligible for direct reimbursement for emergency services provided in the ED to the Medicaid recipient.[18] Further, PA 14-62 mandates intensive case management for Medicaid patients by identifying EDs where a large number of Medicaid patients frequent, creating ICM teams to work with ED physicians, and assessing and encouraging Medicaid patients to use primary care and behavioral health providers.[19]

Under PA 14-217, the Medicaid state plan is extended to provide coverage for behavioral health services to Medicaid recipients age 21 or older.[20] The Act also provides that acute care and children's hospitals will be reimbursed for care to Medicaid recipients based on diagnostic related groups.[21] Further, this act requires a Medicaid rate increase for private psychiatric residential treatment facilities.

Patient-Centered Medical Homes

Patient-centered medical homes (PCMHs) are medical bases where patients receive ongoing care from primary care physicians and where primary care physicians coordinate patient care.[22] The SHIP and SIM identify PCMHs as critical to improving the delivery and integration of health care. Medical homes are associated with improvements in health outcomes and health equity and with reductions in health care costs, which are attributed to the coordination and continuity of care.[23] Characteristics of PCMHs that may contribute to the reduction of health disparities include: developing an individualized care plan for each patient, tracking and coordinating care, ensuring language access throughout the health care experience, using multiple forms of communication between the primary care team and patient, creating medical homes for racial and ethnic minorities and measuring and improving health care performance.[24]

In 2011, the Medicaid PCMH was established and was informed by the Joint Commission and National Committee for Quality Assurance (NCQA) medical home models. In January 2012, Connecticut implemented a PCMH initiative as part of the HUSKY Health program, which has also expanded eligibility to persons with disabilities and low-income residents.[25] Under this model, practices and clinics that meet PCMH standards receive new payment incentives through Medicaid. Connecticut is also offering the Glide Path Program to support practices incrementally transitioning into PCMHs and becoming eligible for enhanced incentives.[26] The majority of federally qualified health centers in Connecticut participated in Glide and many are now recognized as PCMHs.

Through the SIM grant, and with support from Medicare, Medicaid, and commercial payers, Connecticut is implementing an initiative to support the transformation of primary care practices to advanced medical homes, with a goal of at least 90% of practices achieving advanced medical home status by 2020.

Behavioral Health Determinants and Services

As discussed in the SHIP, SIM and numerous hospital community health needs assessments (CHNAs), improving access to treatment for mental health and substance abuse is a priority for the State as a whole and each of the communities in Connecticut. In response to recent gun violence and subsequent discussions of the influence of mental health on mass tragedies and trauma recovery, several acts were implemented in 2013 to promote care for mental health and substance abuse. Public Act 13-3 established a 20-member task force to investigate behavioral health care services in Connecticut, particularly for persons aged 16 to 25 years.[27] Under this act, the task force must assess and provide recommendations to improve behavioral health screening, early intervention and treatment, improve the number of behavioral health providers and the use of involuntary outpatient commitment. Findings and recommendations based on this study were due February 1, 2014. The report can be accessed at http://www.cga.ct.gov/ph/tfs/20130701_Task%20Force%20to%20Study%20The%20Provisions%20of%20Behavioral%20Health%20Services%20For%20Young%20Adults/Final%20Report%20for%20the%20Task%20Force%20to%20Study%20the%20Provision%20of%20Behavioral%20Health%20Services%20for%20Young%20Adults.pdf.

This act also mandated the implementation of a person-centered, recovery-based mental health program for persons diagnosed with severe mental illness in communities that had not yet implemented this program.

Also in 2013, PA 13-178 created a task force to investigate the influence of nutrition, genetics, complementary and alternative treatments, and psychotropic drugs on children's mental, emotional, and behavioral health.[28] This task force is mandated to submit a report to the Department of Children and Family Services by September 30, 2014.

The Act also required DCF and the Office of Early Childhood to collaborate with other agencies to develop a comprehensive plan to address children's mental, emotional and behavioral health needs including coordinating home visitation programs for vulnerable families with young children and creating a public information and education campaign. The report can be accessed at http://www.plan4children.org/final-plan/.

Two acts passed in the 2014 legislative session are intended to improve access to behavioral health services. PA 14-138 codified practices that allow DMHAS clients to receive behavioral health services outside of the mental health region in which they reside.[29] PA 14-115 mandated that the Office of the Healthcare Advocate establish a behavioral health provider referral service by January 1, 2015 and thereafter report any gaps in services and resources to improve care.[30]

Chronic Disease Care Coordination

PA 14-148 requires the DPH Commissioner to develop and implement a strategic plan to reduce the incidence of chronic disease, improve care coordination, and improve outcomes for conditions associated with chronic diseases.[31]

All Payer Claims Database

With the passage of Public Act 13-247, the Connecticut General Assembly authorized Access Health CT (Connecticut's health insurance exchange) to oversee the planning, implementation and administration of an all-payer claims database program for the purpose of collecting, assessing and reporting health care information relating to safety, quality, cost-effectiveness, access and efficiency for all levels of health care. The requirements of the APCD are being implemented in phases, with full implementation targeted in January 2016.

Once established, the all-payer claims database will provide information about how and where health care dollars are being spent and will help answer important questions for consumers, business owners and policy makers. The APCD will include medical, pharmacy, dental, provider, and eligibility data files that will be used to report on health care utilization costs and quality of services for health care consumers and public and private entities conducting health assessments.[32,33,34]

Consistent with the initiatives proposed in the SIM grant, the APCD is intended to facilitate health system measurement and improvement strategies. Information regarding disease incidence, treatment costs, and health outcomes, and geographic or demographic variations therein, may inform the development and evaluation of policies and programs.[35] Payers and providers will be able to utilize APCD data to compare payment rates, assess clinical quality and evaluate performance.[36] Health care quality and cost information that is easily accessible may also be of use for consumers.[37] Finally, it is hoped that the collection and integration of comprehensive claims information will help the State understand the evolving needs of the health care system.

Outpatient Surgery Data

Connecticut General Statute Sections 19a-634 and 19a-654 require outpatient surgical facilities, short-term acute care general and children's hospital and any facility that provides outpatient surgical services as part of the outpatient surgery department of a short-term acute care hospital to report patient data to DPH OHCA. Reporting will begin in July 1, 2015. With the support of the Outpatient Data Workgroup, the Connecticut Hospital Association and the Connecticut Association for Ambulatory Surgery Centers, OHCA piloted data collection with 12 hospital based or affiliated surgery department/centers, four free standing outpatient surgical facilities. The pilot was initiated to assess the data collection and submission ability of a representative sample of facilities, the data submission requirements and process, ease of use of the submission web portal and quality of the data submitted. Results from the pilot are expected to facilitate cost effective and efficient data submission and collection. The mandates also required short-term acute care general and children's hospital to provide patient identifiable emergency department data to OHCA.