



**TESTIMONY OF
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CONNECTICUT HOSPITAL ASSOCIATION
BEFORE THE
APPROPRIATIONS COMMITTEE
Friday, February 14, 2014**

**HB 5030, An Act Making Adjustments To State Expenditures For The
Fiscal Year Ending June 30, 2015**

My name is Stephen Frayne. I am the Senior Vice President of Health Policy at the Connecticut Hospital Association (CHA). I am testifying today concerning **HB 5030, *An Act Making Adjustments To State Expenditures For The Fiscal Year Ending June 30, 2015***. Since the passage of the biennium budget this past May, CHA and its members have been working with the Office of Policy and Management (OPM) and the Department of Social Services (DSS) to develop a new payment framework for acute care hospitals that provides stable and predictable resources to hospitals while improving care and controlling costs. Our mutual goal has been to develop and implement that framework by July 1, 2014.

Before outlining our concerns, it's important to detail the critical role hospitals play in the health and quality of life of our communities. All of our lives have, in some way, been touched by a hospital: through the birth of a child, a life saved by prompt action in an emergency room, or the compassionate end-of-life care for someone we love. Or perhaps our son, daughter, husband, wife, or friend works for, or is a volunteer at, a Connecticut hospital.

Hospitals treat everyone who comes through their doors 24 hours a day, regardless of ability to pay. In 2012, Connecticut hospitals provided nearly \$225 million in free services for those who could not afford to pay.

Connecticut hospitals are committed to initiatives that improve access to safe, high-quality care. They are ensuring that safety is reinforced as the most important focus—the foundation on which all hospital work is done.

Connecticut hospitals launched the first statewide initiative in the country to become high reliability organizations, creating cultures with a relentless focus on safety and a goal to eliminate all preventable harm. This program is saving lives.

Providing culturally competent care, eliminating disparities, and achieving health equity are also priorities of Connecticut hospitals. The CHA Diversity Collaborative, a first-in-the-nation program to achieve these goals, has been recognized as a national model.

The benefits of hospitals extend well beyond their walls, as they strive to improve the health of our communities and play a vital role in our economy. Connecticut hospitals provide great jobs to more than 55,000 people who make sure we have access to the very best care whenever we need it. Every hospital job creates another job in our community. In total, Connecticut hospitals generate more than 110,000 jobs in our communities and contribute more than \$20 billion to the state and local economies.

We are working to improve the quality of care by redesigning the Medicaid program, with a keen focus on patients and improving the care they count on.

Attached to my testimony is an outline of our proposal as well as draft legislative language to implement the proposal. In brief, the proposal is modeled on the Medicare Value-Based Purchasing program and incorporates those concepts into the Medicaid hospital payment system. The proposal aligns with the state's health reform agenda; builds upon the existing Medicaid FFS payment system; focuses on programs to improve access to appropriate care, thereby reducing disparities and improving population health; uses quality metrics to track and reward change; and invests in hospitals that achieve the shared vision.

The program has two key elements.

The first is the Member Priority Program (MPP). In the MPP, hospitals will need to develop the systems to provide real-time notification to the Community Health Network (CHN) of Medicaid individuals in the emergency department as well as those who have been admitted to the hospital. These notifications have already been identified by CHN and DSS as major priorities for this current year. The value of these real-time notifications is enormous – there is no better time to connect people to programs and resources that can improve their health – such as making sure they have access to primary care and support managing chronic conditions – than when they are already seeking care. These notifications will progress in sophistication over a two-year period. Hospitals would commit to starting with an Automated Data Transfer (ADT) and then eventually migrating to full Continuity of Care Documents (CCD) generated from their electronic health records. The ADT information would provide notification that an individual is being seen, while the CCD would provide more robust clinical information that can assist in connecting the member to the right programs offered by CHN.

The second is the Hospital Community Connections Program (HCCP). In the HCCP, hospitals would integrate and embed CHN staff into the hospital discharge planning process. In so doing, hospitals would streamline uptake into the CHN Inpatient Discharge Care Management (ICDM) and the Intensive Care Management Programs (ICM). In addition, hospitals would also agree to add resources to help achieve a stabilization/reduction in All-Cause Readmission Rates as well as reductions in Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), and Adult Asthma admissions – all these areas have been identified by CHN and DSS as priorities for improved care.

While new for Medicaid, the proposals outlined here are not pie in the sky, “maybe someday” ideas. These proposals are well established processes and priorities for hospitals in the Medicare program. We believe now is the time to take the experience and success hospitals have had in improving care and outcomes for Medicare patients and extend them to the Medicaid program. Unfortunately, the systems, clinical staffing, and patient navigators needed to make these things happen are not possible within the current Medicaid resources available to hospitals. Making this change happen will require additional and ongoing investments by hospitals. We are proposing, as a way to fund those investments, a series of incentives that are tied to producing results – exactly as is expected in the State Innovation Model (SIM). The incentives would be sourced by a \$30 million appropriation of state funds, which would be matched by \$70 million in federal funds. Payout from the incentive pool would be conditioned on achieving the desired results.

Connecticut's acute care hospitals are willing to be leaders in driving the change that OPM and DSS are seeking in the Medicaid program. Hopefully you will agree from the material provided and the information shared today that much has been done to develop a consensus around the approach and design of these initiatives. These ideas are actionable, and we are ready to put them in place effective July 1, 2014. Please vote to modify the budget to include the investment dollars necessary to make it happen.

Thank you for your consideration of our position. For additional information, contact CHA Government Relations at (203) 294-7310.

A Proposal to Implement a Medicaid Value-Based Hospital Payment System and Phase Out the Hospital Tax Over Five Years

November 26, 2013

Principles for a Medicaid Hospital Value-Based Payment System

- Our efforts should:
 - Align with the state’s health reform agenda.
 - Build upon the existing Medicaid FFS payment system.
 - Focus on programs to improve access to appropriate care thereby reducing disparities and improving population health.
 - Use quality metrics to track and reward change.
 - Implement new payment methods to incentivize hospital change.
 - To the extent practical, use the methods and processes developed for Medicare.

Initial Areas of Focus for Hospital-Value Based Payments

- DSS/CHN identified priorities:
 - ✓ Reduce avoidable ED visits
 - ✓ Reduce readmissions
 - ✓ Intensive care management (ICM)
 - Asthma, Diabetes, Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD)
 - ✓ Inpatient discharge care management programs (ICDM)

Hospital Value-Based Concept to Action

How to Convert Hospital Value-Based Principles and Priorities to Incentives

Medicaid Hospital Value-Base Payment Structure

- **Member Priority Program (MPP)**
 - The MPP has two elements: Intensive Care Management Referral (ICMR) and Quality Reporting and Measurement (QRM); the Medicare analog is Pay-for-Reporting.
- **Hospital-Community Connection Program (HCCP)**
 - The HCCP has two elements: Participation in CHN's Inpatient Discharge Care Management Program (ICDM) and Intensive Care Management Program (ICM), and performance measurement; the Medicare analog is Pay-for-Performance.
- **Hospital Reporting Program (HRP)**
 - DSS/CHN will provide hospitals access to summary and member baseline and ongoing performance reports, predictive modeling analytics, and other data analytics.

Member Priority Program (MPP)

- MPP Essentials
 - Hospital payment rates are annually updated by the Medicare Market Basket update beginning July 1, 2014.
 - To be eligible for the full update, hospitals must provide timely ED and inpatient admission notification as well as HEDIS reporting data; method and frequency to be determined.
 - Hospitals not providing timely ED and inpatient admission notification as well as HEDIS reporting data will have their payments updated by the Medicare Market Basket less 2 percentage points.

Hospital-Community Connections Program (HCCP)

- HCCP Essentials
 - The HCCP is dynamic with incentives and program structure changing over time as the program and experience matures.
 - Beginning July 1, 2014 hospitals are annually eligible for a share of a supplemental Pay-For-Performance payment pool equal to 3% of forecasted total hospital expenditures for the succeeding year.
 - A hospital's share of the funds shall be calculated as its attainment score x share of expenditures x the supplemental pool.
 - An attainment score is the share of the 3% a hospital is eligible to receive – e.g., if a hospital earns 2% of the 3% maximum, its attainment score would be 66%.

Hospital-Community Connections Program (HCCP)

- HCCP (continued)
 - Year 1, July 1, 2014 - June 30, 2015, hospitals will earn 1% each for: participation in the CHN Inpatient Discharge Care Management Program (ICDM), Intensive Care Management Program (ICM), and a stabilization/reduction in statewide Plan All-Cause Readmission rates.
 - Year 2 and 3, July 1, 2015 - June 30, 2017, hospitals will earn .5% each for: participation in ICDM and ICM; and .5% each for stabilization/reduction in statewide rates for: Plan All-Cause Readmission, COPD Admission, CHF Admission, and Adult Asthma Admission.

Hospital Reporting Program (HRP)

- HRP Essentials
 - By December 31, 2013 DSS/CHN/CHA will agree on the content and frequency of performance reporting.
 - By March 1, 2014 DSS/CHN will provide hospitals access to summary and member baseline and ongoing performance reports, predictive modeling analytics, and other data analytics.
 - By July 1, 2014 DSS/CHN/CHA will agree on the form and frequency of meetings to discuss and share Best Practices on implementing the requirements of the MPP and HCCP.

Phasing Out the Hospital Tax: Concept to Action

How to Phase Out the Hospital Tax Over Five Years

Phase Out of the Hospital Tax 2015 to 2019

(in Millions)

	Hospital Payments	Hospital Taxes	Net Benefit to Hospitals	Net Benefit to State
2011	83	0	83	(42)
2012	400	350	50	150
2013	323	350	(27)	189
2014	249	350	(102)	275
2015*	99	350	(251)	320
2015**	79	300	(221)	276
2016**	53	220	(167)	204
2017**	27	140	(113)	132
2018**	14	60	(46)	56
2019**	0			
			(794)	1,561

* Current law **Proposed

An Act Concerning Implementation Of a Medicaid Value-Based Hospital Payment System

Whereas the State has identified a number of priorities in order to improve care to patients and reduce costs to taxpayers; and

Whereas these priorities include (a) reducing the number of avoidable emergency department visits; (b) reducing the number of hospital readmissions; (c) better management of chronic conditions such as asthma, diabetes, congestive heart failure and chronic obstructive pulmonary disease; and (d) better management of patients following discharge from the hospital; and

Whereas the State has determined that the best means of accomplishing these priorities is to establish certain hospital value-based reimbursement principles;

Therefore, we are enacting the following provisions to assist in the achievement of these priorities.

Section 1. Definitions.

- (a) Member Priority Program (MPP). The MPP consists of two elements: Intensive Care Management Referral (ICMR) and Quality Reporting and Measurement (QRM).
- (b) Hospital-Community Connection Program (HCCP). The HCCP consists of two elements: Participation in the Department of Social Service's Inpatient Discharge Care Management Program IDCM and Intensive Care Management Program (ICM), and performance measurement.
- (c) Hospital Reporting Program (HRP). The HRP is data DSS shall provide to hospitals which will include but not be limited to Continuity of Care Document (CCD), summary and member baseline and ongoing performance reports, predictive modeling analytics, and other data analytics.
- (d) Department of Social Services (DSS). DSS shall mean the department, its commissioner or designated agents.

Section 2. The MPP

- (a) Hospital payment rates shall be annually updated beginning October 1, 2014, by the inpatient Prospective Payment System (IPPS) Hospital Market Basket as published annually by CMS in the Federal Register. To be eligible for the full amount of the update, hospitals must provide timely Emergency Department (ED) and inpatient admission notification as well

as HEDIS reporting data, in a manner and frequency as determined jointly by DSS and The Connecticut Hospital Association.

- (b) Payments to hospitals not providing timely ED and inpatient admission notification as well as HEDIS reporting data shall be updated by the Medicare Market Basket less 2 percentage points.

Section 2. HCCP.

- (a) Effective July 1, 2014, hospitals shall be annually eligible for a share of a supplemental HCCP payment pool equal to 3% of forecasted total hospital expenditures for the succeeding year.
- (b) An attainment score is defined as the share of the 3% a hospital is eligible to receive – e.g., if a hospital earns 2% of the 3% maximum, its attainment score would be 67%.
- (c) A hospital's share of the funds shall be calculated by multiplying its attainment score times its share of expenditures times the amount in the supplemental pool.
- (d) Effective July 1, 2014 through June 30, 2015, hospitals shall earn 1% each for: participation in (1) the Inpatient Discharge Care Management Program (IDCM), (2) the Intensive Care Management Program (ICM), and (3) a program to stabilize and reduce statewide Plan All-Cause Readmission rates.
- (e) Effective July 1, 2015 through June 30, 2017, hospitals shall earn (1) a potential one percent of the pool as follows: one half of one (.5%) percent each for: participation in IDCM and ICM; and (2) a potential two percent for the pool as follows: one half of one (.5%) percent each for stabilization/reduction in statewide rates for (i) Plan All-Cause Readmission, (ii) COPD Admission, (iii) CHF Admission, and (iv) Adult Asthma Admission.

Section 3. HRP.

- (a) By June 1, 2014 DSS and CHA will agree on the content and frequency of performance reporting; and
- (b) DSS shall provide hospitals access to summary and member baseline and ongoing performance reports, predictive modeling analytics, and other data analytics.

- (c) By July 1, 2014 DSS and CHA will agree on the form and frequency of meetings to discuss and share Best Practices on implementing the requirements of the MPP and HCCP.