News from:

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LEMBO TESTIFIES AT BI-PARTISAN ROUNDTABLE ON HEALTH-CARE PROVIDER CONSOLIDATIONS, FACILITY FEES AND EMERGENCY ROOM CHARGES

Comptroller Kevin Lembo today testified before the legislative Bi-Partisan Roundtable on Hospitals and Healthcare to discuss ongoing investigations into facility fees and emergency room (ER) charges resulting from health-care provider consolidations.

As the administrator of the state employee health plan, Lembo is conducting ongoing investigations into the consequences of the changing landscape of Connecticut's health-care delivery system as hospitals and provider networks merge.

"In recent years we have seen significant and rapid changes in the state's health-care delivery system, moving from a system that was dominated by small independent practices to one now dominated by large integrated hospital systems," Lembo said. "The landscape of health-care delivery is changing dramatically – so it's important that we identify these changes, and establish appropriate policies to manage these changes to deliver the best possible care to Connecticut consumers, while ensuring the stability of our health care delivery systems."

Lembo has separate, but related, ongoing investigations involving Connecticut's health-care delivery system. Public Act 14-217 requires that his office study the impact of facility fees and total costs to the state employee plan resulting from the consolidation of provider groups and independent facilities into hospital systems.

Facility fees are submitted by a provider facility to cover the overhead costs and materials associated with providing care. However, facility fee charges are *in addition* to professional fees, which cover the cost of the professional services provided. Independent physician offices generally do not charge facility fees, receiving only one professional fee for the total cost of the

visit for overhead, materials and professional services. Lembo's ongoing review of facility fees will determine if these fees are resulting in higher costs to the state.

Lembo is also investigating hospital emergency room (ER) claims to determine whether the state plan is being appropriately charged for services. This ongoing review was initiated after several complaints by plan participants who were charged ER co-pays for what they believed to be urgent care visits, Lembo said.

"The audit has so far revealed several concerning practices related to hospital billing and claims oversight by Anthem and United on behalf of the state employee plan," Lembo said.

The ongoing review has already found that claims were coded differently than expected, based on diagnosis, in more than 50 percent of cases. Virtually all encounters at free-standing or in-hospital ERs are billed at ER rates rather than lower urgent care rates, regardless of whether a patient saw an ER doctor for a real emergency or an APRN or PA for a non-emergent condition.

While the investigation is ongoing, Lembo's office is addressing these early findings by requesting that the state's carriers negotiate stricter standards for ER billing and updating urgent care directories to remove ER locations that do not use urgent care revenue codes.

"Moving forward we will expand our investigation into ER billing practices to identify other services areas where similar revenue maximization practices may be in place due to lax standards and oversight by the insurance carriers," Lembo said.

To address some concerns related to provider consolidations, Lembo offered possible legislative options, including:

- Requiring each individually licensed hospital in a system to negotiate contracts with insurance carriers independently.
- Requiring a 30-day period of mandatory mediation after a contract expires to balance the financial needs of the hospital with the consumer interest of keeping health care affordable and accessible.
- Requiring an extended period of time that hospitals must continue to accept patients and receive reimbursement at previously contracted rates after a contract expires and negotiations break down. This will provide patients – particularly those who are in the middle of a treatment plan -- with time to find new providers and ensure continuity of their care, making the prospect of a hospital going out of network less daunting.

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