CONNECTICUT HOSPITAL ASSOCIATION

TESTIMONY OF
CONNECTICUT HOSPITAL ASSOCIATION
SUBMITTED TO THE
PUBLIC HEALTH COMMITTEE
Monday, March 13, 2023

HB 6669, An Act Protecting Patients And Prohibiting Unnecessary Health Care Costs

The Connecticut Hospital Association (CHA) appreciates this opportunity to submit testimony concerning **HB 6669, An Act Protecting Patients And Prohibiting Unnecessary Health Care Costs. CHA opposes sections 11 to 15 and section 19.**

Connecticut hospitals continue to meet the challenges posed by the COVID-19 pandemic and are now facing new challenges of treating sicker patients than they saw before the pandemic, with a dedicated but smaller workforce who are exemplary but exhausted. They are also experiencing significant financial hardships brought on by record inflation. Through it all, hospitals have been steadfast, providing high-quality care for everyone who walks through their doors, regardless of ability to pay.

HB 6669 among other things: limits the billing for facility fees (section 11), makes changes to the Certificate of Need program (CON)(sections 12 to 15), and for hospitals participating in the 340B program, requires annual reporting on the difference between the acquisition costs for 340B drugs and the reimbursements received for the same drugs, as well as a summary of how the net revenue was applied to the benefit of the community (section 19).

Facility Fees (Section 11)

By way of background, facility fees came about because the Medicare and Medicaid programs require facilities to bill the cost of using the facility separately from the cost of the professional medical services rendered. Historically, patients have received separate bills for their stay in the hospital and additional bills from the physicians who took care of them while they were in the hospital. Today, hospitals are involved in the provision of outpatient physician services as a substantial part of their mission to serve the community. The Medicare program has set forth specific criteria to determine when the provision of that service is hospital-based and when it is simply a physician office service. When it meets the tests to be hospital-based, the service is entitled to a higher level of Medicare funding, which is set in recognition of the fact that the hospital is a more expensive place to deliver care and is held to a number of higher standards. Below is chart that outlines those higher standards.

Regulatory Requirements/Roles	Hospital Outpatient Department	Ambulatory Surgery Center	Physician Office
24/7 Standby Capacity for ED Services	✔		
Back up for Complications Occurring in Other Settings	✔		
Disaster Preparedness and Response	✔		
EMTALA Requirements	✔		
Uncompensated Care/Safety Net	✔		
Teaching/Graduate Medical Education	✔		
Special Capabilities (burn, trauma, neonatal, psychiatric services, etc.)	✔		
Required Government Cost Reports	✔		
Equipment Redundancy Requirements	✔		
Stringent Building Codes (ventilation systems, hallway widths, ceiling heights, etc.)	✔		
Infection Control Program	✔	✔	
Quality Assurance Program	✔	✔	
Joint Commission Accreditation	✔	✔	
Life and Fire Safety Codes	✔	✔	✔
Malpractice Insurance	✔	✔	✔
Admin Staff/Billing	✔	✔	✔
Medical Supplies	✔	✔	✔
Nurses	✔	✔	✔
Space and Utilities	✔	✔	✔

Over the years, Connecticut has passed several laws impacting facility fees, from requiring detailed notices, to prohibiting a facility fee from being collected for outpatient healthcare services using a CPT evaluation and management code at a hospital-based facility off-site from the hospital campus. HB 6669 extends that prohibition to any outpatient off-campus facility.

The fact sheet created for HB 6669 by the Administration indicates that the impact of the proposed facility fee restrictions on hospital outpatient revenue is approximately $410 million. Using more current FY 2021 data, we anticipate that the impact of the proposal could be more than $435 million for the off-campus prohibition alone.

As drafted, HB 6669 also prohibits facility fees from being charged, regardless of setting (on-campus or off-campus), for evaluation and management and assessment and management services. What this means is that a hospital will be prohibited from billing for any evaluation and management service for patients in an emergency department.

Also, HB 6669 allows the Executive Director of the Office of Health Strategy (OHS), without notice, any administrative process, or legislative review, to prohibit facility fees for any outpatient diagnostic and imaging services the Executive Director decides may reliably be provided safely and effectively in a setting other than a hospital.

The consequences of adopting section 11 would be financially devastating to Connecticut's hospitals and health systems. This must be viewed along with the $1.12 billion in Medicare losses and $993 million in Medicaid losses Connecticut hospitals experienced in 2021 and the nearly $250 million in charity care and bad debt absorbed in the same year.

The math doesn't work.

Connecticut hospitals lost $164 million in fiscal year 2022. Hospitals and health systems cannot sustain the robust healthcare delivery system that Connecticut residents enjoy if they cannot cover their costs.. The legislation would make our state less prepared to respond to another pandemic — a response that for the last three years has been dominated by a reliance on Connecticut's hospitals and health systems — as well as unable to invest in new technologies and provide access to care in settings preferred by patients.

This legislation is an unfortunate departure from the spirit of collaboration and cooperation that has been the hallmark of statewide discussions on how to address healthcare affordability. We support the cost growth benchmark as a means to examine and address cost growth across multiple sectors of the healthcare system. It was only last year that the legislature codified the benchmark and this will be the first year of publicly reported data — we should let that process work.

We also support recent federal legislation that requires a level of price transparency among providers and payers to ensure that consumers have the information they need to make decisions about where to seek care.

<u>Certificate of Need (Sections 12 to 15)</u>

Sections 12 to 15 of HB 6669 propose to make several changes to the CON program that increase the regulatory burden on hospitals and health systems and providers and add to the ability to punish providers.

CHA agrees that changes to the CON program are desperately needed, however the changes that are needed are ones that remedy the deficiencies with the current process. Legislative attention should be focused on efforts to improve and speed up the process, remove unnecessary costs, and reduce the regulatory burden on hospitals and healthcare systems.

As such, CHA urges the Committee to delete sections 12 to 15 and replace them with sections that will:

- Tighten the timelines and deadlines applicable to OHS processes (and activities of the Office's CON unit) throughout the CON process to improve usefulness and effectiveness of CON oversight
- Expand the imaging modalities that may be replaced without going through the full CON process
- Prohibit OHS from applying the cost growth benchmarks to CON
- Ensure all entities providing services or conducting activities governed by the CON process are held to the same standards

- Require OHS to provide technical assistance about the CON process and requirements as a way to reduce adding unnecessary healthcare costs to the system

340B Program (Section 19)

CHA opposes Section 19 of the legislation, which requires extensive reporting to the state on the federal 340B Drug Pricing Program.

The assistance made possible by the 340B program is felt by communities across our state, but is especially important to some of our largest urban centers like Bridgeport, Hartford, New Haven, Stamford, and Waterbury. The health inequity across our country, laid bare by the uneven impact COVID-19 has had on our communities, reinforces the ongoing need for the investments 340B savings allow.

The 340B program was established 30 years ago to allow hospitals and other covered entities to stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services. Access to drug discounts provided through the program assists hospitals in meeting the needs of their patients in vulnerable communities. In many instances, the availability of 340B pricing is what allows a hospital to provide certain services at all. Without the program, many patients would need to seek care elsewhere.

Unfortunately, this legislation seeks costly and impractical reporting on a federally regulated program to the state government by covered entities. This reporting is unnecessary and unworkable. It creates a significant risk that hospitals will use the program less because the administrative burdens will outweigh the benefits of participation.

As an example of the reporting's unworkability, reporting requirement (C) misunderstands how services are provided and reimbursed. In many instances, outpatient services include and are billed with the drug costs as part of the overall service. Segregating the payment for the drug component of the overall outpatient payment is out-of-step with how these services are packaged and paid for.

The savings derived from the 340B program — meaning the difference between the discounted price at which covered entities are able to purchase 340B drugs rather than the non-discounted price they would otherwise be required to pay — supports the nearly $1 billion in unreimbursed care for low-income Medicaid beneficiaries provided each year, the nearly $250 million in uncompensated care (charity care/bad debt) provided each year, and the millions in community investments provided each year by hospitals across the state.

The purpose of the 340B program is for covered entities to use the program broadly to reach more eligible patients and offer more comprehensive services. Hospitals are able to support their critical financial assistance policies, which provide free and reduced cost care, in part due to 340B program savings. Connecticut hospitals strive to ensure that inability to pay for services does not deter anyone from seeking needed medical care, and 340B program participation helps support the ability of hospitals to offer financial assistance policies beyond statutory requirements, helping to ensure more patients are able to afford their medical care.

A well-functioning 340B program is essential to hospitals that serve vulnerable communities and, as the statute describes, stretch scarce federal resources as far as possible to support essential services for their communities. Unfortunately, this section of the legislation adds unnecessary burden to 340B covered entities with no benefit to patients.

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