CONNECTICUT HOSPITAL ASSOCIATION

TESTIMONY OF
CONNECTICUT HOSPITAL ASSOCIATION
SUBMITTED TO THE
PUBLIC HEALTH COMMITTEE
Monday, March 18, 2024

HB 5488, An Act Concerning Various Revisions To The Public Health Statutes

The Connecticut Hospital Association (CHA) appreciates this opportunity to submit testimony concerning **HB 5488, An Act Concerning Various Revisions To The Public Health Statutes.** CHA opposes Sections 2, 5, 6, 11, and 12 of this bill.

Connecticut hospitals are critical to their communities. They are confronting the challenges posed by a post-pandemic healthcare system with an exemplary healthcare workforce that continues to provide outstanding care. But challenges remain. Hospitals are treating sicker patients, it continues to be challenging to hire and retain staff, and the financial headwinds are grave. Through it all, hospitals are steadfast, providing high-quality 24-hour care for everyone who walks through their doors, focusing on making Connecticut's healthcare system more equitable, and driving world-class innovation right here in Connecticut.

CHA has concerns with **Section 2**, which seeks to penalize providers who fail to report adverse events under 19a-127n. Unreported adverse events occur infrequently. When they do occur, the issue is usually related to honest differences in the interpretation of reporting criteria and regulations. We are puzzled by the need for more punitive measures when there are already effective processes in place to align reporting with the adverse event program requirements. CHA and the Department of Public Health (DPH) have an existing structure that allows for open and collaborative discussions to ensure discrepancies in the reporting of adverse events are resolved and providers obtain clarity so that the system collects accurate reports. To positively affect safety, there must be accurate and consistent reporting across facilities. Punitive measures don't achieve that, but they might cause over-reporting, which muddles the system and detracts from the purpose of making care safer. Instead of punitive measures, DPH could increase real-time feedback opportunities so that events that meet reporting criteria are accurately captured.

Section 5 seeks to remedy a problem where none exists. Current law allows the collection of prohibited facility fees if those fees were already included in a contract between a hospital and a commercial health insurance payer when the prohibition on the facility fees was enacted. Once the contract reaches its expiration, those prohibited facility fees may not then be collected. Section 5 makes a violation of current law an unfair trade practice. When certain

facility fees were prohibited in 2016, the current law allowance for existing commercial contracts was put into place without any punitive enforcement requirement. CHA is not aware of evidence that current law is not being followed and question why such an enforcement requirement is being proposed given the prior eight years of experience. We oppose this new language as unnecessary.

The intent of **Section 6** is unclear and CHA is interested in better understanding the intent of the amendments. CHA supports prohibiting the reporting of medical debt to a credit rating agency and supports ensuring accurate and clear billing but opposes the attachment of an unfair trade practice violation as outlined in the statute. As with Section 5, it is unclear what evidence exists to support the need to impose this type of enforcement mechanism on hospitals and so we oppose this section.

Sections 11 and 12 of this bill focus on the injection and infusion services provided by hospitals in off-campus settings. The majority of this care supports cancer treatment, which typically involves frequent infusion of chemotherapy or other drugs by nurses or other hospital staff pursuant to a physician order and plan of care. Section 12 of the bill would introduce an outright prohibition on commercial reimbursement for these services in off-campus settings. Stated another way, hospitals and the clinical staff who support these services would receive no commercial payment whatsoever for providing these services, other than for the cost of the drug. This would likely result in an immediate cessation of such services and loss of access in clinics across the state. It would also introduce the needless loss of tens of millions in hospital revenue at a time when hospitals across the state are experiencing extraordinary financial challenges.

Low-income patients on Medicaid rely on the access provided by hospitals—access which they may not otherwise be afforded in community practice settings. In addition, hospitals often serve patients with more severe or complex conditions than can be effectively managed in non-hospital settings. There is no public health rationale for making it illegal for hospitals to collect commercial reimbursement for these services, which would result in the elimination of these care settings entirely and access for all patients who rely on this care, regardless of payer.

We strongly encourage the Committee to strike these provisions from this bill.

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