CONNECTICUT HOSPITAL ASSOCIATION

TESTIMONY OF
CONNECTICUT HOSPITAL ASSOCIATION
SUBMITTED TO THE
HUMAN SERVICES COMMITTEE
Tuesday, February 28, 2023

SB 1110, An Act Concerning Various Revisions To The Department Of Social Services Statutes

The Connecticut Hospital Association (CHA) appreciates this opportunity to submit testimony concerning **SB 1110, An Act Concerning Various Revisions To The Department Of Social Services.** CHA opposes Section 6 of this bill.

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.

CHA supports efforts to address disparities of access, utilization, and outcomes for pregnant people, with an emphasis on birthing people of color and the proposed expansion of services available to birthing persons, such as doulas, care navigators, and breastfeeding support. We recognize that an alternative payment model (APM) focused on maternity care can be a means to achieve progress toward the promotion of maternal health and we support granting the Department of Social Services (DSS) the authority to implement a maternity bundled payment program. However, we believe that DSS should be required to issue regulations describing important details involved in the administration of this program prior to implementation.

CHA appreciates DSS's informal involvement of stakeholders in the development of the model through its Maternity Bundle Stakeholder Advisory Council. We have been active participants in planning for the maternity bundle and believe the proposed program promises to advance maternal health and address associated disparities. For that reason, we support granting DSS authority to implement a maternity APM. However, DSS's informal process is not a substitute for formal issuance of proposed regulations through the notice and comment process. Failure to do so provides DSS with far too much discretion to modify the program in a manner that could jeopardize access to maternity care services and the quality of those services.

We believe this bill should provide DSS with direction on key program parameters including the following:

- Voluntary participation
- New covered services such as doulas, care navigators, and breastfeeding support
- Exclusion of facility-based services from the proposed prospective payment model
- Adjustments for clinical risk, social risk, and facility price in setting benchmark price and assessing performance against the benchmark
- The maximum amount of any discount that may be established by DSS to the benchmark price, the minimum shared savings percentage, and the entities entitled to share in the savings

Regarding the sharing of savings, we believe the savings percentage should be set at or above 75% to support investments in quality improvement in this essential area of care delivery. In addition, it is notable that the most heavily weighted quality-related performance measures in this program are Maternal Adverse Events and proportion of cesarean deliveries among nulliparous, term, singleton, vertex (NTSV) deliveries. These and several other measures such as breastfeeding during the hospitalization depend on hospital labor and delivery care processes. **For this reason, we further recommend that birthing hospitals receive no less than 25% of the savings in the form of base rate increases or payment rewards.**

Performance on the Maternal Adverse Events measure, which includes 21 maternal morbidities plus maternal mortality occurring during the delivery, is heavily dependent on the hospital-based clinical teams that support labor and delivery. Improvement on this measure depends on hospital-led efforts to drive care improvements, such as through the Alliance for Innovation in Maternal Health (AIM). AIM is a national data-driven maternal safety and quality improvement initiative based on interdisciplinary consensus-based practices to improve maternal safety and outcomes. In Connecticut, all birthing hospitals are implementing the AIM Severe Maternal Hypertension Bundle, which includes the identification of severe hypertension cases including real-time care flags, reporting, and case reviews, and the tracking of patient health outcomes such as time to treat stratified by race and ethnicity.

In contrast to reimbursement for obstetrical care in the community, **Medicaid reimbursement for hospital services is approximately 68% of the cost of care.** Any APM that seeks to effect improvements in clinical care outcomes should promote adequacy of reimbursement for the essential provider participants in the care process. As should be evident from the above, hospitals will play a critical role in achieving the goals of a maternity bundled payment program and should receive a portion of any savings that result to support continued improvement.

Finally, **SB 1110 authorization should be limited to a maternity bundled payment program**. In most areas of service delivery, the Medicaid program markedly underpays its providers — payments are generally well below cost and also well below Medicare — and as such, does not lend itself to payment models that impose additional administrative burden and financial risk. **Each APM opportunity is unique and should be authorized by statute with details set out in proposed regulations providing opportunity for notice and comment.** The language in Section 6 is overly broad and would allow the Commissioner to impose any

alternative payment methodology or combination of methodologies at the Commissioner's discretion and through the use of policies and procedures, rather than formal rulemaking. Changes to Medicaid payment policies, especially those as potentially dramatic as imposed through alternative methodologies, should be crafted with input from the legislature and stakeholders. The language in Section 6 would skirt any requirement for outside input.

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