

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

SB 986, An Act Protecting Maternal Health

The Connecticut Hospital Association (CHA) appreciates this opportunity to submit testimony concerning **SB 986, An Act Protecting Maternal Health**. CHA supports portions of the bill but opposes the sections pertaining to birthing centers as written.

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.

SB 986 proposes to license birthing centers, proposes a certification pathway for doulas, a work group to recommend certification pathways for midwives, an Infant Mortality Review Program at the Department of Public Health (DPH) to study infant deaths, and directs state agencies to design a statewide program for Universal Home Visiting (UHV), building on a pilot program in the greater Bridgeport area.

The Connecticut Hospital Association supports doula services as an important strategy to improve equity in maternal health outcomes and supports the certification process described in SB 986.

The Connecticut Hospital Association supports the:

- Expansion of universal home visiting services as a strategy to advance maternal and child health. Home visiting provides connections and supportive relationships and services to pregnant and postpartum populations, and infants and young children. Hospitals have partnered in the home visiting pilot in Bridgeport and serve as essential partners in any expansion of home visiting on a statewide level. We respectfully request that a representative from the Connecticut Hospital Association be involved in the state agency planning process for universal home visiting.

- Creation of an Infant Mortality Review Committee. CHA, however, notes that there is a missed opportunity in not including fetal deaths in any infant mortality review process. In addition to the burden of infant mortality, an almost equal number of pregnancies in the United States end in a stillbirth or fetal death, an infant born without signs of life, generally after 20 weeks of gestation. Profound and persistent disparities exist for both fetal and infant deaths. According to the U.S. fetal death report, non-Hispanic Black women have more than twice the fetal mortality rate compared with non-Hispanic white and Hispanic women.¹ Infants born to non-Hispanic Black women die at a rate 2.3 times greater than infants born to non-Hispanic white women.² In the 27 states that have infant mortality review committees, all include “fetal” in the name of their committee and the scope of the death reviews.³ To ensure the purpose of the infant death review includes preventing a wide range of social, economic, and environmental factors that contribute to the tragedy of infant loss, an examination of fetal deaths must also be included, as this is an area of large health inequities. The Connecticut Hospital Association requests that section 8 be expanded to include a representative of the Connecticut Hospital Association representing an acute-care hospital as a vast majority of Connecticut’s births occur at acute care hospitals.

While CHA and its member health systems and hospitals support the broadening of patient choice in all areas of reproductive health, including creating better infrastructure for home and out-of-hospital planned births, we have significant concerns about the language in the bill relating to birthing centers for two main reasons:

- First, there is not enough structure, regulation, or clinical and administrative guidance in place yet to oversee birthing centers as a new type of facility. Before any birthing center is approved, clinical thresholds and protocols, mandatory clinical guidelines, stakeholder review, public oversight, and transparency must be in place – and accomplished in a way that would meet typical standards of administrative procedure. The bill mentions that DPH *may* create regulations for birthing centers. That regulatory step should not be optional, it must be made a condition precedent to the licensing of any birthing center.

Our three border states have had years of experience in oversight of birthing centers. We have the advantage of learning from their experiences. Massachusetts has over 25 pages of regulatory requirements for birthing centers. New York has several different levels of birthing centers and is undergoing a review of how to fine-tune oversight for access, quality, and safety. Rhode Island has meaningful and clear regulation, including clinical thresholds relating to transfers, in place for birthing centers. Connecticut has a

¹ Pruit, S. et al. Racial and Ethnic Disparities in Fetal Deaths — United States, 2015-2017. Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report/Vol.69/No.37.

² Ely DM, Driscoll AK. Infant mortality in the United States, 2018: Data from the period linked birth/ infant death file. National Vital Statistics Reports, vol 69 no 7. Hyattsville, MD: National Center for Health Statistics. 2020.

³ National Center for Fatality Review and Prevention, December 2021. <https://ncfrp.org/wp-content/uploads/NCRPCD-Docs/FIMRManual.pdf> Accessed February 20, 2023.

blank canvas that needs a more fully formed picture with appropriate oversight, regulations, protocols, and transparency to earn the trust of patients and families.

SB 986, as drafted, leaves open many basic questions, including but not limited to:

- How will newborns be screened for health conditions?
 - What licensed professionals and practitioners should birthing centers need to engage?
 - Who can own a birthing center?
 - Who can work at birthing centers (e.g., licensed, certified, midwives, doulas, other)?
 - Should birthing centers be subject to CON?
 - What data will be collected from birthing centers by DPH?
 - What quality and safety standards and benchmarks will apply to birthing centers?
 - Does HIPAA apply to birthing centers?
 - What other privacy and security rules apply?
 - Should mandatory insurance coverage apply to birthing centers?
- Second, the bill mandates that hospitals “contract” with birthing centers, essentially relegating hospitals to be birthing centers’ safety backstop. The bill states that hospitals cannot refuse to accept a birthing center contract and once contracted, the hospital may not end the contract without DPH approval.

This statutory command is not a contract. It is entirely an unfunded mandate, with the weight of regulatory oversight despite the lack of the necessary regulatory rulemaking steps. That statutory approach lacks sufficient due process or legal procedure and should be rejected by the legislature. Hospitals are going to treat patients that come from birthing centers. However, patients are not served by a broad mandate that requires hospitals to become the backstop for birthing centers but does not have sufficient developed structures or the necessary features in place to monitor, oversee, and track birthing centers’ operations.

Beyond the obvious legal failure to meet basic due process requirements, mandating that hospitals be the backstop for birthing centers is a misplaced approach. A regulatory approach should be first adopted to ensure that the care provided at a birthing center does not need a mandatory requirement on hospitals to serve as the back stop. It should be incumbent on birthing centers to follow protocols and clinical guidelines, established by DPH, to ensure safe care and transfers; arrange for and provide for medically appropriate, staffed transfers (following federal and state EMS protocols); as well as to provide data that allows quality and safety to be measured in real time. It is incumbent upon DPH to set those standards, with appropriate regulatory review, with the entire care continuum in mind. Expecting hospitals to act broadly as the safety net for an emerging care setting is not a reasonable approach.

We can reasonably anticipate that transfers to hospitals from birthing centers will not be a rare situation and may result in more than a fifth of patients who opted for a birthing center experience (including prenatal care) eventually needing a hospital-based delivery or other maternal or pediatric care. A 2018 report funded by CMS⁴, which included a study of 46,000 women’s experiences, found that in 47 freestanding birth centers across 22 states, 16-20% of the deliveries on average needed to be performed at hospitals because the women “risky out” – meaning they ended up being too high risk to deliver at a birthing center.

Connecticut needs a fully developed, cogent plan for birthing centers before the facilities engage patients, and an equally robust way to measure, assess, and ensure their safe operations over time.

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