Health Committee
JOINT FAVORABLE REPORT

Bill No.: HB-5488
Title: AN ACT CONCERNING VARIOUS REVISIONS TO THE PUBLIC HEALTH STATUTES.
Vote Date: 3/22/2024
Vote Action: Joint Favorable Substitute
PH Date: 3/18/2024
File No.: 423

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SPONSORS OF BILL:

The Public Health Committee

REASONS FOR BILL:

The bill makes various revisions to the public-health related statutes and programs and includes the following:

- Adds to the list of organizations from which a clinical medical assistant may be certified for administering vaccines.
- Allows DPH to impose disciplinary action on a health care facility that fails to report an adverse event.
- Requires ambulances to be equipped with glucagon nasal powders and allows EMS personal to administer it.
- Increases from 12 to 24 months the duration for which postgraduate experience is required for initial licensure for marital and family therapists (LMFTs).
- Reinstates a provision that makes it an unfair practice for a facility to collect facility fees in certain situations.
- Adds EMS organizations to an existing law that makes it an unfair trade practice for a provider to request payments for certain covered facility fees, emergency services by out-of-network providers, surprise bills, or report to a credit reporting agency if the patient fails to pay.
- Adds injection, infusion, and drug administration codes to the list of procedures for which hospitals and health systems are prohibited from charging facility fees.

- Allows the governor to enter into an agreement with the state's federally recognized tribes to allow birth and death certificates to be issued and filed by the tribe instead of a municipality.

- Allows master social work licensure candidates to receive a degree from a program that is in the process of getting accredited.
- Requires the DPH commissioner to notify hairdresser and cosmetician license applicants that they may be eligible for certain testing accommodations.
- Allows APRNs to perform fluoroscopy.
- Makes technical changes to various statues.
- Requires DPH to conduct a scope of practice review for naturopathic physicians.

RESPONSE FROM ADMINISTRATION/AGENCY:

Martin Looney, Senator (11th District), Connecticut General Assembly:
Sen. Looney agrees with the addition of infusion and injection services to the list of outpatient procedures for which hospitals cannot charge facility fees. Infusions at hospitals cost approximately twice as much as the same infusion at a non-hospital owned infusion center. Prohibiting this fee will lessen the disparity. He also agrees with the restoration of the penalty regarding facility fees that was inadvertently removed in a bill last year, as well as the increased patient protections against balance billing.

William Tong, Attorney General, Office of the Attorney General (OAG):
The OAG supports Section 5 which makes it an unfair trade practice to charge a facility fee making it consistent with the illegal billing statute. The OAG supports Section 6 which adds Emergency Medical Services (EMS) organizations to an existing law that makes it an unfair trade practice for a provider to request payments for certain covered facility fees. Complaints regarding balance billing by emergency medical providers and hospital systems account for a significant portion of the illegal billing complaints received by the OAG. The OAG notes that although the bill adds to the list of unfair billing practices a health care provider's collection of facility fees that are covered by a health plan, it did not expand the definition of health care provider to include institutional providers who are the only type of providers that charge facility fees. The OAG also supports Section 11 which adds infusion and administration of injection services to the type of services which would trigger an advance notice that both a professional and facility fee may be charged. This provides patients a better understanding of their medical and financial options.

NATURE AND SOURCES OF SUPPORT:

Laura Prior, APRN, CT APRN Society, Health Policy Co-Chair:
The Society is in support of Section 10 of this bill which creates an educational and testing pathway preparing APRN's to safely use fluoroscopy equipment for certain procedures. By allowing APRNs to perform this procedure reduces unnecessary exposure to radiation to themselves, patients, and staff. Physician Assistants (PAs) have had the ability to perform fluoroscopy since 2012 with no known adverse patient outcomes or compromises to patient safety. As APRN's, we are asking for the same opportunity to extend our knowledge and continue to improve outcomes for our patients.

12 additional APRNs submitted testimony expressing similar comments in support of this Section of the bill.

Jaime Rodriquez, Advocacy Chair, Ct Association of Marriage, and Family Therapists (CTAMFT):
The CTAMFT supports Section 4 of this bill. For Many years, MFT's were not eligible to be Medicare providers and were often denied employment by agencies that served Medicare individuals. Last year, Congress passed legislation allowing MFTs to be enrolled in Medicare as of January 1, 2024. However, MFTs in Connecticut are still experiencing roadblocks to enrolling as Medicare providers due to our state's licensure requirements regarding the work experience requirement. To serve patients, Medicare requires that a LMFT must have at least 2-years' experience or 3000 hours of clinical supervised experience. Changing Connecticut statute to two years versus the current one year will place Connecticut in line with other states. However, this change may create a potential hardship for LMFTs who have completed their required 1,000 hours of direct care before the proposed two-year period. To ensure their protection, CTMFT submitted with their testimony, additional language to grandfather those eligible LMFTs to continue to work, and respectfully requests the committee to include it in the bill. They also request that the Section 4 make the change effective upon passage.

25 additional LMFTs submitted testimony in support of Section 4 expressing the reasons above.

NATURE AND SOURCES OF OPPOSITION:

The Connecticut Hospital Association (CHA):
CHA has concerns with the following sections in the bill:

- **Section 2** which penalizes providers who fail to report adverse events. Unreported adverse events occur infrequently, however, when they do occur, the issue is usually related to honest differences in interpretation of regulations. There are already effective processes in place to align reporting with the adverse event program requirements. Currently, CHA and DPH have an existing structure which allows for discussions that ensure the reporting of adverse events is resolved, providers obtain clarity, and the system collects accurate reports. Punitive measures might cause over-reporting which muddles the system and detracts from the purpose of this reporting. CHA suggests that DPH could instead increase real time feedback opportunities so that events that meet criteria are captured.
- **Section 5** as it seeks to remedy a problem that doesn't exist. Current law allows the collection of prohibited facility fees if the fees were already included in a contract between a hospital and a commercial health insurance payer when the fee was enacted. Once the contract expires the prohibited fees may not be collected. Section 5 makes the fees an unfair trade practice. When certain facility fees were prohibited in 2016, the prohibition enacted was without any punitive enforcement requirement thus, CHA sees this section as unnecessary.
- **Section 6** is unclear as CHA supports prohibiting the reporting of medical debt to a credit rating agency as well as ensuring accurate and clear billing. However, CHA opposes the attachment of this as an unfair trade practice violation.

- **Section 11 and 12** are about the injection and infusion services provided by hospitals in off-campus settings. Most of this care supports cancer treatment and section 12 would institute an outright prohibition on commercial reimbursement for these services in off-campus settings. Hospitals and staff who support this treatment would receive no commercial payment for these services, other than for the cost of the drug. This would result in the immediate cessation of such services and the loss of access across the state. This would also result in the needless loss of tens of millions in hospital revenue at a time when hospitals are experiencing financial challenges. Low-income patients rely on access provided by hospitals that they may not otherwise have in community practice settings. Hospitals often serve patients with more severe or complex conditions and are better served than in non-hospital settings. There is no public health rationale for making it illegal for hospitals to collect commercial reimbursement and would result in the elimination of these care settings.

Stacey Yarbrough, Town Clerk, CT Town Clerks Association (CTCA):
The CTCA is opposed to Section 7 as town clerks have been responsible for the processing and permanent retention of birth and death records that occur in town for centuries. Towns are heavily invested in the protection of these documents. The CTCA, in collaboration with DPH, developed training materials and a module dedicated to storing vital records. They are concerned with the loosening of the production and retention of birth and death records to anyone other than certified town clerks.

Antoinette Spinelli, Waterbury Town Clerk and
Mark Bernacki, New Britain Town Clerk:
Submitted joint testimony in opposition as expressed above.

Michael Loiz, Director of Emergency Medical Services (EMS), Town of Stratford:
CTAMFT opposes section 3 of this bill which requires EMS providers to supply and administer glucagon nasal powder. The current protocol for patients experiencing low blood sugar is for EMS providers to administer glucagon through intramuscular injection and for basic EMTs to provide patients with oral glucose gel. This bill would require EMS personnel to administer glucagon nasal powder when deemed necessary, and that all licensed or certified ambulances be equipped with the glucagon nasal powder. This bill will burden the EMS system with significant increases in cost without first obtaining input from those stakeholders who implement EMS protocols. This section short-circuits the deliberate and thoughtful review provided by the CT EMS Medical Advisory Council (CEMSMAC) upon whose medical expertise the legislature has decided the interventions included in the State's EMS protocols, and how such intervention shall be executed. The State's EMS protocols are normally implemented with medical expertise and much deliberation among the many stakeholders involved in the protocol process. This mandate will create a substantive change to the current protocol which has been established as the best practice to treat low blood sugar. Another major concern for EMS providers is how they would absorb the staggering costs of the glucagon nasal powder as this would be an unfunded mandate. The current protocol costs between $150-300 per dose while the nasal powder costs $388 for a single dose.

The Following individuals submitted testimony expressing similar opposition:
- Greg Allard, Association of CT Ambulance Providers

- EMS Medical Directors'. Katherine Couturier, Dr. Kyle McClaine, Dr. Richard Kamin and Charles Johndro,

Diane Kosenko, CT Society of Radiologic Technologists (CSRT):

(CSRT) opposes Section 10 which allows APRNS to do fluoroscopy. The CSRT is concerned that a scope of practice determination was not conducted and, of note, is that most other states do not allow APRNs to do fluoroscopy. Ms. Kosennko cited an Iowa Supreme Court decision that allowed fluoroscopy by an APRN only under the supervision of a radiologic technologist. APRNs and RNs have no radiology components in their curriculum and are not trained in this area. If any APRNs in this state are doing procedures using fluoroscopy, there is a radiographer in the room, operating the fluoroscope. The radiographer is the most qualified person to operate the machine. Even though APRNs and Physician Assistants (PAs) are included in a host of other legislation, in this instance it would not be in the best interest of the patients. APRNs may practice independently after 3 years. Current educational requirements for APRN's include 40 hours educational, 40 hours clinical and passing the Fluoroscopy Exam from the American Registry of Radiologic Technologists. Compare that to an Interventional Radiologist who goes through medical school, internship, residency, and a fellowship and then takes a different exam from the American Registry of Radiologic Technologists. CSRT would like to see documentation language updated on the DPH website so that everyone would be able to compare if the APRN or PA has the right credentials to perform a procedure as is the case for every other licensed professional on the website.

Others in Opposition to Section 10 expressing the same concerns as in the above testimony:

- Connecticut State Medical Society (CSMS)
- CT Orthopedic Society
- 18 licensed and registered radiologic technologists

Reported by: Kathleen Panazza **Date: April 2, 2024**