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Chairpersons: Representative Cristin McCarthy Vahey, Senator Saud Anwar

Senators: Gordon, Marx, Rahman, Slap, Somers

Representatives: Belton, Berger-Girvalo, Carpino, Cook, Dauphinais, DeCaprio, Demicco, Denning, Genga, Gilchrest, Kavros, DeGraw, Keitt, Kennedy, Klarides-Ditria, Linehan, Marra, McCarty, Palm, Parker, Perillo, Rader, Reddington-Hughes, Ryan, Steinberg, Tercyak, Welander, Zupkus

Rep. McCarthy-Vahey (133rd): Good morning. I'd like to call our Public Health Committee hearing to order. It's 11:01. We have a full agenda today. We have had in a wonderful way 98 people sign up to testify today. So a few notes before we begin. The first hour of our hearing is reserved for public officials. After that hour, we will alternate between our public officials and members of the public.

We have, for this hearing, made some special accommodations for a group of people from the disability community. They will be testifying at approximately 2:00 to 3:00 p.m. So I wanted to make sure that folks were aware of that as well. If you are on Zoom, a reminder to please accept your promotion, and you will be removed from the platform at the completion of your testimony and can continue watching the hearing on CTN.

For our wonderful fellow members of the committee, again with 98 folks coming to testify, I'd ask that
you make sure that you're asking your questions succinctly and with brevity so that we can make sure that we hear from all of those 98 people who have come before us today. With that, I will offer this to Senator Anwar for some opening remarks.

SENATOR ANWAR (3RD): Let's start.

REP. MCCARTHY-VAHEY (133RD): Oh, I love that brevity. And I am not quite logged on. Senator Somers, I believe is online. Senator Somers.

SENATOR SOMERS (18TH): Yes. I'm just looking forward to hearing what everyone has to say today and I'm ready to get started. Thank you.

REP. MCCARTHY-VAHEY (133RD): Thank you so much, Senator Summers. Representative Klarides-Ditria.

REP. KLARIDES-DITRIA (105TH): Thank you. Let's get started, everybody.

REP. MCCARTHY-VAHEY (133RD): Wonderful. Thank you so much. I believe that the first person on our list, who is in the room -- we have Senator Looney, Comptroller Scanlon, Commissioner Juthani. Oh, Commissioner Juthani, she is here. Welcome. You will be first up for us today and we'll go back to those who are not quite here yet.

So, thank you so much, Commissioner, for joining us and we look forward to kicking off with you. Welcome. Actually, one more thing, I should remind everyone, we do have a three-minute limit. There will be questions for you, I'm sure, but just a reminder to all those testifying. Thank you, Commissioner. Welcome.

CMMR. MANISHA JUTHANI: Thank you so much. Good morning, Senator Anwar, Representative McCarthy
Vahey, Senator Somers, Representative Klarides-Ditria, and esteemed members of the Public Health Committee. Thank you for the opportunity to testify today in strong support of House Bill 5058, AN ACT ADOPTING THE NURSE LICENSURE COMPACT.

Connecticut has some of the strongest hospitals and healthcare professionals and programs throughout the nation, and yet, we still suffer from the same nationwide shortage of providers that many other states are experiencing as well, and we are feeling this very acutely in the nursing workforce. So why do we support this compact? Because it will provide relief to the ongoing nurse workforce shortage that we are experiencing.

Secondly, it'll allow more people to be licensed in the state, which could expand our nurse education resources through a larger pool of eligible nurse educators and preceptors. We know that many of our surrounding states including Rhode Island, New York, and New Jersey are already due this and Massachusetts is considering joining the compact as well.

We know that some of our greatest challenges in our nursing schools has been to have educators available who can train the next generation of nurses. So, joining the nurse compact will provide not only workforce additional personnel, but will provide those educators that can help train our newest nurses.

This bill sunsets the compact after three years. At which point, the Committee and Executive branch will have a chance to examine the impact it's had over those years to determine if it should be continued. So, we look forward to being part of this conversation and I'm available for any questions you may have.
REP. MCCARTHY-VAHEY (133RD): Thank you very much and thank you for getting right to the point with that. The nursing compact is an important conversation here today. Are there questions from members of the committee? Well, thank you, Commissioner. I know we will, as has been the case, remain in conversation about this and I thank you very much for being here with us today.

CMMR. MANISHA JUTHANI: Thank you.

REP. MCCARTHY-VAHEY (133RD): Next on our list is -- I don't believe Senator Looney -- Oh, Senator Looney. Wow, that timing was impeccable. Welcome to Public Health, Senator Looney.

SENATOR MARTIN LOONEY: Good morning.

REP. MCCARTHY-VAHEY (133RD): We're happy to have you here.

SENATOR MARTIN LOONEY: Happy to be here too.

REP. MCCARTHY-VAHEY (133RD): Senator before you begin, I'm just going to remind you to turn the microphone on if you would. Thank you.

SENATOR MARTIN LOONEY: Very good. Thank you so much. Good morning, Representative McCarthy Vahey and Senator Anwar, and members of the Public Health Committee. I'm Martin Looney, State Senator of the 11th district, representing parts of New Haven and Hamden and would like to comment on three bills on today's agenda; House Bill 5319, AN ACT REQUIRING A PLAN CONCERNING PRIVATE EQUITY FIRMS ACQUIRING OR HOLDING AN OWNERSHIP INTEREST IN HEALTH CARE FACILITIES, House Bill 5320, AN ACT CONCERNING HOSPITAL FINANCIAL ASSISTANCE, and Senate Bill No. 9, AN ACT PROMOTING HOSPITAL FINANCIAL STABILITY.
House Bill 5320 would increase Connecticut's protections from predatory hospital debt collection practices. I was one of the co-sponsors of the 2003 legislation with then State Senator Chris Murphy, who was our Senate Chair of Public Health at the time, which was the original legislation that prohibited some of these predatory debt collection practices by hospitals and our follow-up legislation. Then in 2021, which updated our statutes to address hospital-affiliated entities, and I support the changes and that this bill would make and would like to suggest some additional protections.

I was recently contacted by Chuck Bell, program director for the Consumer Reports Advocacy, that's a formerly Consumer Union, and he suggested that Connecticut consider banning the reporting of medical debt to credit bureaus. Currently, we don't allow it for one year, and clearly, no one acquires medical debt voluntarily. It's always when people are in extremis and have to get the care that they often can't afford. And we should realize that New York and Colorado have already done this. And he also indicated a link to an advisory opinion from the Consumer Financial Protection Bureau that indicates that states do have the power to do this. I would urge the committee to add that to this bill.

House Bill 5319 would require the Office of Health Strategy to create a plan with legislative recommendations to improve the oversight of private equity ownership in healthcare. Our state must address this current trend regarding not only hospitals but also other healthcare providers. I've been in contact with Attorney General Tong language to beef up oversight of acquisitions and mergers, including those involving private equity, and look
forward to working with the committee on this important issue.

And finally, Senate Bill 9 addresses several issues regarding hospital regulation, but in reviewing it, I find that one section somewhat of concern and that is Section 4F, lines 323 to 330 which appear to grant automatic approval to all practice acquisitions made by any entity until December 31st, 2025. That I think is an alarming relinquishing of oversight, and I would look forward to working with the committee and updating our statute on practice acquisition, but believe that automatic approvals are not the appropriate way to go.

In fact, would also encourage the committee to shift the presumption of approval, that the presumption of approval be removed from the current statute, and that the size of the practice that triggers a review be lowered. And I want to thank the committee for hearing these important bills in dealing with so many issues of great importance to our people every year. Thank you so much.

REP. MCCARTHY-VAHEY (133RD): Thank you, Senator Looney, and thank you for being such a long-time champion for healthcare access and affordability in our state. Are there questions? Senator Anwar.

SENATOR ANWAR (3RD): Thank you, Madam Chair. Thank you, Senator Looney, for your recommendations and then also the work that you've been doing. So, looking forward to listening to each and every one of your comments and moving forward with them. Thank you.

SENATOR MARTIN LOONEY: Thank you, Mr. Chairman.

REP. MCCARTHY-VAHEY (133RD): Thank you very much, Senator Looney. Have a wonderful day.
SENATOR MARTIN LOONEY: Thank you. And again, every blessing on the great work that this committee does year in and year out.

REP. MCCARTHY-VAHEY (133RD): Thank you. We appreciate that. Next on our list is Representative Jennifer Leeper. Welcome.

STATE REPRESENTATIVE JENNIFER LEEPER: Thank you. And I think the microphone is still on. Good morning, Chairs McCarthy Vahey and Senator Anwar, ranking members, Representative Klarides-Ditria and Senator Somers, and all the good members of the Public Health Committee. I'm Jennifer Leeper, state representative from Fairfield and I'm very happy to be back before you today to testify in support of HB 5318, AN ACT REQUIRING THE LICENSURE OF LACTATION CONSULTANTS.

In '22, I was shocked to learn that the clinical lactation services are not available for Medicaid reimbursement because of their lack of licensure, and therefore women on Medicaid are often locked out of clinical lactation support after they leave the hospital. I have not come across any other area in healthcare where we provide durable medical equipment, in this case, breast pumps, and no professional support to accompany it.

Having experienced my own mismanaged care in the hospital by another licensed healthcare professional, I was extremely grateful to several IBCLCs who identified what was happening and got me and my baby the proper care, and salvaged my ability to breastfeed. After last session, I along with my MAPOC subcommittee on Women and Children's Co-Chair organized a working group of public health experts across the public health spectrum from pediatricians to OBs, researchers, IBCLCs, and a peer counselor.
We held six meetings over four months, all of which are recorded on CTN and available in link too in our final recommendations. Our unanimous recommendation was to license the International Board Certified Lactation Consultants or IBCLCs to both protect patients and also to create a pathway for Medicaid reimbursement so that low-income mothers and babies can access this care.

This recommendation is consistent with the US Surgeon General's Recommendations from 2011 from the Surgeon General's call to action to support breastfeeding. Quoting the Surgeon General, International Board Certified Lactation Consultants are healthcare professionals who specialize in the clinical management of breastfeeding. The only healthcare professionals certified in lactation management. They carry certification by the International Board of Lactation Consultant Examiners. Like all other US certification boards for healthcare professionals, the IBCLE operates under the direction of the US National Commission for certifying agencies and maintains a rigorous professional standard. IBCLC candidates must demonstrate sufficient academic preparation as well as experience and supervised direct consultation on breastfeeding to be eligible to take the certification exam.

Low-income mothers and mothers of color have lower initiation rates and also shorter breastfeeding duration than their non-low-income and non-Hispanic white peers. It has been well documented through many studies that lactation support and clinical management increase the rates of breastfeeding for all groups.

Increased breastfeeding is a piece of the puzzle in closing our maternal health outcome gaps. We are
recommending licensing only IBCLCs because we want to ensure that there are not two tiers of care and that women on Medicaid can access clinical care and not only peer support. I have a lot more to say, but I'm sure I'm brushing up against my three minutes, and so I have submitted longer testimony and I'm grateful for your attention and happy to answer any questions.

REP. MCCARTHY-VAHEY (133RD): Thank you, Representative Leeper, and thanks to you and your co-chair, who I believe we'll hear from later today, and the MAPOC Working Group for providing such a thorough analysis and background information for all of us to review as well as your written testimony. Are there questions? Senator Anwar.

SENATOR ANWAR (3RD): Thank you, Madam Co-Chair. Representative Leeper, thank you for the work that you've done as a co-chair of MAPOC. I'm privy to the hard work that has gone on behind the scenes. Even though we look at this bill, there are hundreds of hours of work that have gone on behind the scenes to make it right for everyone in our state, so I wanted to thank you for that and each and everyone who participated in the process. And I'm sorry that the last time around this bill did not go through. Hopefully, we'll take it across the finish line this time and we'll be able to make sure we help each and every one of our families who do need support for this. So thank you for that.

REP. MCCARTHY-VAHEY (133RD): Thank you, Senator Anwar. Representative Parker.

REP. PARKER (101ST): Thank you, Madam Chair. Thank you, Representative Leeper, for all your really hard work on this over the last many months. We're grateful for that. I have two quick questions. My first one is, if you've been to our other meetings,
you know we like to talk about data collection and how that informs the policy we're making. So you reference this, but can you speak a little bit more to the specific data that demonstrates why supportive breastfeeding is important for health equity?

STATE REPRESENTATIVE JENNIFER LEEPER: Thank you so much for that question. And most folks know, I also really love data. So the data is very clear on the health benefits to both mothers and babies and just to put some statistics to this impact, per the American Academy of Pediatrics, a nationally representative sample found that breastfeeding was associated with a 21% reduced risk in postneonatal death for all infants and a 31% reduced risk for black infants.

A recent analysis linking birth and death certificates for all us births in 2017 found that any breastfeeding of non-Hispanic black infants is associated with a 17% reduction in infant mortality and a 29% reduction in neonatal mortality. And lastly, and I think to highlight the impact on closing our maternal health outcome gaps, mothers who breastfeed experience lower risk of Type 2 diabetes, breast-ovarian, and endometrial cancer, but also specifically hypertension, which is the leading cause of maternal deaths. So I hope that's helpful.

REP. PARKER (101ST): Thanks, Rep. Leeper. That's seems really compelling to me and something that we really want to work towards supporting. My other quick question is, I know you referenced this in your testimony, but if you could just give us the highlights of -- I believe you proposed some changes to the legislation as it's currently written, so we love to know what those are.
STATE REPRESENTATIVE JENNIFER LEEPER: Yeah. Thank you. There were a couple of components to the bill before you that were not consistent with the recommendations put forward by the working group. Specifically, we would like to add a definition of perinatal health worker so that we can ensure we are not excluding any of our perinatal health workers, which are doulas, community health workers, peer counselors, WIC peer counselors, peer supporters, breastfeeding and lactation educators or counselors, childbirth educator, social worker, home visitor, and any other perinatal educator from practicing within their scope of practice. These professionals are really important in the entire spectrum of caring for the mother-baby diet, and we would not want to pass anything that would exclude them from that practice.

And then the second primary concern with the language in this bill is Section 3 part B in which we would strike that in its entirety. We don't believe it's consistent with the recommendations because our recommendations are quite specific to license clinical lactation management, and we believe this section actually opens the door for almost anyone else, but thank you for the question.

REP. PARKER (101ST): Got it. Thanks for explaining that. We're always thinking about workforce, so wanting to lift up those professions seems really important. Thank you for all your work, Rep. Leeper. Thanks for your time, Madam Chair.

REP. MCCARTHY-VAHEY (133RD): Thank you, Representative Parker. Representative Klarides-Ditria.

REP. KLARIDES-DITRIA (105TH): Thank you, Madam Chair. Thank you, Representative, for all your hard work. I know you've been working on this for quite
some time. What is the licensure fee that will be [crosstalk]

STATE REPRESENTATIVE JENNIFER LEEPER: I'm really grateful you asked that because I did include that in my written comments and we would not support the really high fee that's currently proposed. And we think a one-time $200 initiation fee and then every other year, $100 renewal fee would be a much more reasonable expenditure for IBCLCs. This is not a high-paying profession, as I'm sure you can imagine, and we don't want to inadvertently discourage people from getting into this practice because it's too expensive.

REP. KLARIDES-DITRIA (105TH): What's the proposed fee in the bill?

STATE REPRESENTATIVE JENNIFER LEEPER: The bill has the initial fee of -- give me one moment. The initial fee at $350 and then an annual fee at $190, and I just want to reiterate we're not in support of those really high fees.

REP. KLARIDES-DITRIA (105TH): Thank you. And do you know how those fees compared to neighboring states or any state for that matter?

STATE REPRESENTATIVE JENNIFER LEEPER: So I actually looked at our nursing fees and I made the suggestion I did to be more in line with the nursing fees. There's actually not that many states that have licensed IBCLCs, so we don't have a lot of good comparative models for fee structure. So I looked at our other clinical providers.

REP. KLARIDES-DITRIA (105TH): Thank you for your testimony today. Thank you, Madam Chair.
REP. MCCARTHY-VAHEY (133RD): Thank you, Representative Klarides-Ditria. Seeing no other questions, thank you for being with us today, Representative Leeper, and again, for all your work on this important issue. Next, we have Dr. Deidre Gifford. Dr. Gifford, welcome.

EXECUTIVE DIRECTOR DEIDRE GIFFORD: Thank you, Representative. Good morning, Representative McCarthy Vahey, Senator Anwar, Representative Klarides-Ditria, Senator Somers and distinguished members of the Public Health Committee. Very happy to be here this morning. My name is Deidre Gifford and I'm the Executive Director of the Office of Health Strategy.

I'm pleased to be able to offer testimony on three bills this morning; SB 9, the Governor's Act promoting hospital financial stability, HB 5319, AN ACT REQUIRING A PLAN CONCERNING PRIVATE EQUITY FIRMS ACQUIRING, and HB 5320, AN ACT CONCERNING HOSPITAL FINANCIAL ASSISTANCE.

First of all, in strong support of the Governor's Bill SB 9. I will start by saying something that I think we all agree on, which is that a well-functioning, efficient hospital system that serves the needs of Connecticut residents is an essential part of our public health system. And as such, the state has a critical role in understanding the financial condition of hospitals and the financial practices of hospital ownership to ensure that they are not having negative impact on the health and safety of patients and communities.

We've seen a lot of changes in the last 10 to 15 years impacting our hospital systems. Consolidation and other transformations in the hospital sector have raised some concerns about hospital financial stability. And in the past year, we have seen
several hospitals either seeking financial assistance from the state or facing challenges in meeting their financial obligations for a variety of reasons.

So the Governor's Bill SB 9 proposes important new initiatives that will provide an early warning system of hospital financial instability and give the state additional opportunities to protect the interests of patients and communities. Sections 3 and 4 of this bill would close a loophole in the transfer of ownership and would require state review and approval of certain types of transactions that currently do not require review. For example, the sale of a hospital parent company from one entity to another or the sale by a hospital of its real estate assets do not currently undergo review, and the Governor's Bill would close that loophole.

It would allow OHS to identify potential negative impacts of these transactions on the hospital's financial stability, quality, or access, and allow the opportunity to impose safeguards or remedies as part of the approval process.

Second, Section 5 of the bill would make important and significant modifications to the CON approval criteria found in our statute. The Governor believes that the CON process should be transparent, efficient, and effective. To that end, these modifications clarify and improve the approval criteria to make it easier for applicants to provide the information they need when they make a CON application and to avoid a time-consuming back and forth between the agency and the applicant to get the information that's required. Lastly --

CLERK HANNAH: Excuse me, Dr. Gifford, but your time is up. Thank you.
EXECUTIVE DIRECTOR DEIDRE GIFFORD: Thank you.

REP. MCCARTHY-VAHEY (133RD): If you could finish that lastly and then I'll have some questions for you on the other bills as well.

EXECUTIVE DIRECTOR DEIDRE GIFFORD: Happy to.
Section 6 of the bill requires additional reporting by hospitals to OHS of some key financial metrics on a more frequent basis. This is a small number of data elements that would be reported on a quarterly basis that would give the office an opportunity to have an early warning when hospitals were facing financial challenges. So the Governor's Bill provides a comprehensive approach to some of the significant challenges in our healthcare delivery system and I respectfully encourage support of the committee.

REP. MCCARTHY-VAHEY (133RD): Thank you, Dr. Gifford. Dr. Gifford, you mentioned that you had thoughts about 5319 and 5320. And 5319, just to speak about private equity, I know you referenced a few moments ago just the different methods of funding and trying to close some loopholes in the Governor's Bill. Can you speak to 5319 and your thoughts about that?

EXECUTIVE DIRECTOR DEIDRE GIFFORD: Happy to. So that bill would require OHS to develop a plan to address private equity acquisition of healthcare entities. We believe that we agree and support that this is something that is an important consideration. We believe that the Governor's Bill would include reviews of purchases or transfers of ownership involving a number of different types of entities, but that would include private equity. Similarly, transfers of a large group practices or other types of healthcare institutions, transfers of
ownership involving private equity would also be covered under the Governor's Bill.

REP. MCCARTHY-VAHEY (133RD): Okay. Thank you.

EXECUTIVE DIRECTOR DEIDRE GIFFORD: Welcome.

REP. MCCARTHY-VAHEY (133RD): And then finally before I go to Senator Anwar, 5320, I'm also interested in hearing just a summary of your thoughts about that bill as well.

EXECUTIVE DIRECTOR DEIDRE GIFFORD: Thank you, Representative. OHS supports the intent of this bill which is to improve the availability of hospital financial assistance. We can't support the bill in its current form because it requires some responsibilities for OHS that are not currently contemplated in the Governor's budget, but we'd be happy to discuss further with members of the committee.

REP. MCCARTHY-VAHEY (133RD): Thank you very much, Dr. Gifford. Senator Anwar.

SENATOR ANWAR (3RD): Thank you so much. Dr. Gifford, thank you for your testimony and the work that you and your team are doing. With respect to the private equity, of course, the idea is that the Office of Health Strategies would be involved if there's any change of ownership with the healthcare systems or practices. What are the ways potentially that Office of Health Strategy can help protect us from what we have seen nationally, not necessarily in Connecticut, but nationally to make sure that the citizens of the state can be protected if that happens?

EXECUTIVE DIRECTOR DEIDRE GIFFORD: Thank you, Senator. The statutory criteria that are in
The overarching statutes for CON now, only require a certificate of need when there is a change in control at the immediate ownership level of a facility. What the Governor's Bill does is that it requires review at any level of control of the facility, parent grandparent, or any entity with a 20% or more controlling interest.

That review, Senator to respond specifically to your question, would allow us, first of all, to evaluate where there is any risk to the institution that's being acquired, and if there's no risk, then the evidence would be developed through the CON process. But it would allow OHS to seek remedies through an agreed settlement or if it's a hospital through imposed conditions, seek remedies such as we've seen in other states that might prevent some of the adverse impacts on the healthcare system from financial practices that are not in the best interest of the patients or the communities.

SENATOR ANWAR (3RD): So for example, that there have been information that some of these entities would sell parts of the hospital which are not making enough money or are providing care to the most indigenous communities or they may sell the building to a real estate investment trust or something. So, with this bill, we would require some of those transactions to go through the State Office of Health Strategies to assess the pros and cons of all those options. Is that --

EXECUTIVE DIRECTOR DEIDRE GIFFORD: That's correct, Senator.

SENATOR ANWAR (3RD): Okay. Thank you so much for clarification. Thank you. Thank you, Madam Chair.

REP. MCCARTHY-VAHEY (133RD): Senator Somers to be followed by Representative Klarides-Ditria.
SENATOR SOMERS (18TH): Yes, good morning. And thank you for your testimony. I have a question specifically on SB 9, which has to do with Section 4, lines 323 through 330. It speaks -- and I don't need to read it if the Commissioner has it in front of her. What I'm trying to find out is what is this language mean, who is it for, and why was it put in the bill.

EXECUTIVE DIRECTOR DEIDRE GIFFORD: I want to make sure I have the -- could you read, Senator, the specific language that you talked about?

SENATOR SOMERS (18TH): I can read you the language too if that is helpful.

EXECUTIVE DIRECTOR DEIDRE GIFFORD: Yes.

SENATOR SOMERS (18TH): It says withstanding the provisions of this section -- hold on, I'm sorry. And Section 19A-639 as amended by this act and 19A-639A on or before December 31st, 2025, the unit shall automatically issue a certificate of need to any large group practice or healthcare facility except a hospital license pursuant to Chapter 368 for transfer of ownership as defined in Subparagraph C and Subdivision 16 of Section 193-630 as amended by this act upon such practice or facility submission of a certificate of need request determination by the unit. So I'm trying to figure out who is that put in for, what is this specifically addressing, and why is this language in the bill.

EXECUTIVE DIRECTOR DEIDRE GIFFORD: Senator, I do very much appreciate the question because Senator Looney also raised this issue. So let us clarify. So the Governor's Bill would require OHS to review transfers of ownership, not only for hospitals but
for large group practices and other types of healthcare institutions and facilities that are not currently subject to CON.

So it adds a new body of work to OHS, including large group practices, other types of institutions, and other facilities. Certain of those transfers are not subject to CON right now under existing law. We would be adding those under the Governor's Bill, but because we do not know the volume of those transactions that we need to anticipate and we don't want to slow down the certificate of need process by having an onslaught of new applications that we are not staffed or resourced to review, the way we have proposed in the legislation is that those transactions would come to us as a notification or determination, but they would not be assessed like a typical certificate of need until a further date. That would allow us to know how many of these do we see in 2025. And is it 100? Is it five? Is it 300? And we would need to be staffed appropriately depending on the volume.

Let me make one thing super clear because I think there's a little bit of a clarification required. Transfers of ownership of group practices and other facilities and institutions that are currently subject to CON under the existing law would continue to be subject to CON. What this delay pertains to is only those new reviews that we don't have an ability to understand how many are out there happening. So would give us a year to sort of count how many are out there, what are the resources needed, and then it would be put into practice in 2026. Does that clarify it for you, Senator?

SENATOR SOMERS (18TH): It does clarify a little bit. I feel like the Office of Health Strategy though is just continuing to get bigger and bigger and bigger as far as all the things that we're
looking at for CON. And there's some of us that -- if you do the analysis in some other states that the price of healthcare without CON is no more than with CON.

So I think that there are and there's been a lot of issues with larger hospital systems trying to buy failing hospitals and through the CON process, how it is taking forever to get through that process. So this particular language, to me, it appeared like it was opening up the floodgate to let institutions go around the CON process, but I must have been reading it incorrectly.

So thank you for that clarification. I may have more. I think one of the things that might help this committee is for us to get a clear and definite list of the types of practices that you just described that are not part of the CON and what would be part of the CON going forward. I think that would be helpful for us so we could decide if this is the direction we want to go, but thank you for your testimony.

EXECUTIVE DIRECTOR DEIDRE GIFFORD: You're welcome and happy to provide that clarifying information, Senator.

REP. MCCARTHY-VAHEY (133RD): Thank you, Senator Somers. And in fact, Representative Klarides-Ditria had a similar question and I will note we will have additional CON bills before us at a future hearing date just so that members are aware of that as well. We have Representative Cook followed by Senator Gordon.

REP. COOK (65TH): Nice to see you. Thank you for being here. I just want to touch base briefly and I think it's just for public clarification. So HB 5319 when we talk about private equity firms and
it's one of our favorite subjects as you know, and nursing homes. So obviously with this, under the definition of healthcare facility, that would also encompass nursing homes, correct?

EXECUTIVE DIRECTOR DEIDRE GIFFORD: Actually, no, Representative. The CON process by statute for nursing homes is housed at the Department of Social Services and OHS does not review transactions pertaining to nursing homes.

REP. COOK (65TH): Thank you for that clarification. I greatly appreciate that. Maybe it's something we need to also look at. Thank you.

REP. MCCARTHY-VAHEY (133RD): Thank you very much, Representative Cook. I think there will be ongoing continued conversations about certificates of need in this committee and have been in others. We have Senator Gordon.

SENATOR GORDON (35TH): Thank you very much, Madam Chairwoman, and it's nice to see you again. Thank you for being here. Quick note about HB 5319. I think it is extremely important we are looking at what those firms do. As you know, we're dealing with that now, with a firm that has been dealing with Rockville Hospital, which is in my district, and others, and I think that we can see the problems that can be created.

And I think there's some things we should be doing more than what's in SB 9 to not only protect the people of Connecticut, but those whose jobs are dependent upon the hospitals and especially if it's going to go to a private equity firm. So I'll reserve any of my questions about that to another public hearing.
I just have two quick questions. One is when we're talking about in Bill 9 and those are the lines that Senator Somers had raised 323 to 330. If it's going to be an automatic issue over a certificate of need for somebody or a group that falls within this new wording, is OHS going to be charging a fee for whatever is going to be submitted? Because it does create time and effort and money and resources to submit these things. So, one of the things I have a question about, if it's an automatic CON, are you going to be charging them a fee just to submit something that's going to be automatically approved anyway?

EXECUTIVE DIRECTOR DEIDRE GIFFORD: Thank you for that question, Senator. It's a good question. So, we would not be requiring an entire CON application. It's more of a notification. And I don't believe we charge, I'm checking with my team, we don't charge for a determination. So the answer is no, there would be no charge to the applicant. They would fill out a standardized form that lets us know that this transaction is happening. We'd be able to count them before it goes into law that we would need to review them so that we would understand the resources that would be required.

SENATOR GORDON (35TH): And thank you and I appreciate that. And I would hope that if we were to accept this wording, we make it very clear, there's no fee, so in the future, suddenly there was a surprise billing that's going on. And my last question at least for right now is, and you may not know this right now and you can get back to me in the committee, is Lines 323 to 330 in Bill 9, does it at all conflict with the provisions of 19a 638(a) 3, which is existing law? And I don't want to put you on the spot, but it is an important thing to note and that's why I flagged it.
And certainly, if you need to get back to us with the answer, I'm happy to know, but there have been some concerns by some that there might be a potential conflict. Maybe there isn't, but that's why I'm asking at the public hearing.

REP. MCCARTHY-VAHEY (133RD): Dr. Gifford, if you could turn your mic on [crosstalk]

EXECUTIVE DIRECTOR DEIDRE GIFFORD: Sorry. Senator, would you mind restating? I see the lines you're referring to, which are the same lines that others had questions about, but what is the statute that you want us to compare it to?

SENATOR GORDON (35TH): Sure. It's statute 19a 638(a) 3.

EXECUTIVE DIRECTOR DEIDRE GIFFORD: Okay. Not having had that statutory language committed to memory. I won't attempt to answer it. Now, I will only say that this language is not intended to modify anything in existing statute. It only changes the future applications and puts them off for a year. So with that sort of blanket, we'll be happy to get back to you with specifics about those lines in the statute.

SENATOR GORDON (35TH): And I would appreciate that just because some people have raised a concern that there is a conflict in what you're proposing with existing law and maybe there isn't just want to make certain we're clear on that because it's an important point. It might not be actually a minor issue if there's a conflict.

EXECUTIVE DIRECTOR DEIDRE GIFFORD: Thanks, Senator.

REP. MCCARTHY-VAHEY (133RD): Thank you, Senator Gordon. I think that's a question also well-
directed to our LCO and OLR attorneys, which we will do as well. Seeing no other questions, Dr. Gifford, I know we will be in conversation with you again. Thank you for your time with us today and for all the good work you do at the Office of Health Strategy.

EXECUTIVE DIRECTOR DEIDRE GIFFORD: You're welcome, and I will look forward to further conversations. Thanks.

REP. MCCARTHY-VAHEY (133RD): Thank you. Next on our list is our Comptroller Sean Scanlon. Welcome.

STATE COMPTROLLER SEAN SCANLON: Good morning, Madam Chair Senator Anwar, members of the committee. It is good to be back in a different way. But I'm here this morning. I know you have a very long agenda to testify in favor of House Bill 5322, which is an act concerning the distribution of educational materials regarding intimate partner violence.

In addition to being married to the CEO and President of the Connecticut Coalition Against Domestic Violence and working with her to combat domestic violence and intimate partner violence across our state, I as Comptroller upon being elected, formed a healthcare cabinet given my interest in this issue. Those of you who have served on this committee for a while know that healthcare was the thing I cared the most about when I served both on this committee and as chair of the Insurance Committee prior to being Comptroller, and we brought together the best and the brightest from across our state on eight different subcommittees to look at ways that we can make healthcare better in the state of Connecticut.

The women's subcommittee was one of the subcommittees that looked at domestic violence and
intimate partner violence and one of the recommendations of that task force and that subcommittee was to do this very bill that's in front of you. And the reason for that is because we unfortunately know all too well that intimate partner violence is a particular threat to women and birthing people during and right after a birth of a child. And from 2015 to 2021, one in three of the maternal mortalities that occurred in this state happened because of intimate partner violence.

And so a few months ago, I think some of you were there, I convened a round table over in another room here of stakeholders looking at maternal mortality in the state. Connecticut has made so many great strides when it comes to trying to combat it, but Connecticut is still woefully lagging in our national rankings and we actually have much more prevalence of maternal mortality and infant mortality in our state than I think anyone would ever want.

So one way that we can combat that is to make sure that anybody who has a child is given materials upon leaving that hospital. I've had two kids. We get home -- Yale gave us packets of information, but not included in that information was anything to do with intimate partner violence at a time when we know from statistically that that is the greatest threat to that mother and to that child. We can fix that by passing this bill, and I would encourage all of you to take a look at this and hopefully to pass it and help the task force that we put together and the cabinet advance one of the most important recommendations that they made to this body and to me. So, thank you so much.

REP. MCCARTHY-VAHEY (133RD): Thank you so much to you and also to your wife, Megan, for her incredible advocacy on this issue. We have seen crime in so
many ways decrease, but when it comes to intimate partner violence, the numbers are going in the wrong direction. So thank you for being an advocate. Representative Berger-Girvalo to be followed by Representative Welander.

REP. BERGER-GIRVALO (111TH): Thank you so much for being here today and for sharing this really important point of view. The only thing it's really more of a comment is I would really like for everyone who is watching this and hearing your support for this to look more closely at their own districts and see that they may be surprised and shocked to see how many are affected by intimate partner violence within their own district. So thank you so much for doing this.

STATE COMPTROLLER SEAN SCANLON: Thank you, Representative.

REP. BERGER-GIRVALO (111TH): Appreciate it tremendously.

REP. MCCARTHY-VAHEY (133RD): Thank you, Representative. Representative Welander.

REP. WELANDER (114TH): Thank you, Madam Chair. I also agree this is a fantastic proposal. And you referenced it very quickly, but my one concern is to make sure that any information that is provided is along with all of the other information that is provided so we don't inadvertently put anyone at risk by handing out something that is this topic specific.

STATE COMPTROLLER SEAN SCANLON: My understanding, Representative, the goal of this is to make sure that that's included in that postpartum packet of information that is given out by all the hospitals in the state. I know there's everything in there
from Chet to how to install a car seat to so many other things that we've mandated over the years. This would just be a part of that overall packet.

REP. WELANDER (114TH): Thank you. And one final thing, when you mentioned hospital, I believe it is in the testimony that it is any like birthing center.

STATE COMPTROLLER SEAN SCANLON: Absolutely.

REP. WELANDER (114TH): Anywhere that --

STATE COMPTROLLER SEAN SCANLON: I keep saying hospital but yes, anywhere.

REP. WELANDER (114TH): Just double-check. All right. Thank you so much. I appreciate it. Thank you, Madam Chair.

REP. MCCARTHY-VAHEY (133RD): Thank you, Rep. Welander, for that inclusion. Representative Klarides-Ditria to be followed by Representative Reddington-Hughes and then Senator Gordon.

REP. KLARIDES-DITRIA (105TH): Thank you, Madam Chair. Thank you for being here today. Do you know how many pages this will entail for it to be added to the packet?

STATE COMPTROLLER SEAN SCANLON: I do not know that that's been determined yet. I think what this bill would do is just require that it be distributed, but it would be up to the people to determine what that looked like and the size and all those other characteristics.

REP. MCCARTHY-VAHEY (133RD): Thank you, Representative. Representative Reddington-Hughes to be followed by Senator Gordon.

REP. REDDINGTON-HUGHES (66TH): Thank you, Madam Chair. My question has to do with folks that have home births. Is there any information that is sent to them? Because they obviously would not have been at a hospital. So I just didn't know if there was anything that was ever sent to them.

STATE COMPTROLLER SEAN SCANLON: It's a good question. I believe that they would receive some information. I don't know the manner in which that happens, but certainly can look into that and get back to your, Representative.

REP. REDDINGTON-HUGHES (66TH): Thank you.


SENATOR GORDON (35TH): Thank you, Madam Chair. Mr. Comptroller, it's good to see you again.

STATE COMPTROLLER SEAN SCANLON: Likewise, Senator.

SENATOR GORDON (35TH): I did track as best as I could, the work that your health cabinet was doing and I'm glad to see that when it comes to rural health, you guys propose things that I've been advocating for years and even some that I've submitted this session on before your report. One question I have, it's more mechanics, who actually or what committee will be working on what will now be added to the packet? I'm not opposed to the bill, I just want to better understand who actually will be creating the additional paperwork and what, so I can have an idea to track that
STATE COMPTROLLER SEAN SCANLON: My understanding would be that it would be probably a collaboration between the Department of Public Health who I think is in charge of that dissemination of that and working with Connecticut Hospital Association. My wife's organization CCADV to come up with what form and manner that is and then have it be distributed throughout the different birthing centers in the state.

SENATOR GORDON (35TH): Thank you.


REP. PARKER (101ST): Thank you, Madam Chair. Thank you, Mr. Comptroller. It's lovely to see Megan Scanlon's husband, spending time with us today. I just wanted to share that the Maternal Mortality Review Committee is a group that's working on this information has actually created something and so what we're getting into in this bill is about making sure that's distributed, not just digitally including to doulas, so folks that may be involved in home birth, but then also some potential printing or hopefully printing to get out actually to the hospitals and birthing centers. So we get out in person. We appreciate your advocacy, Sean, and happy to talk to folks that are interested in this as we keep going forward. Thanks for your time, Madam Chair.

REP. MCCARTHY-VAHEY (133RD): Thank you, Representative Parker. Seeing no further questions, Comptroller Scanlon, we are grateful for your advocacy and partnership with your amazing wife and CCADV and all who have been working on this issue to help provide safety for our moms and babies and birthing people. Thank you.
STATE COMPTROLLER SEAN SCANLON: Thank you all. Have a great day today.

REP. MCCARTHY-VAHEY (133RD): Next on our list is Mairead Painter. Welcome.

MS. MAIREAD PAINTER: Good morning. Good morning, Senator Anwar, Representative McCarthy Vahey, Senator Somers, Representative Klarides-Ditria, and distinguished members of the Public Health Committee. I'm Mairead Painter, the State Long Term Care Ombudsman and I'm happy to testify before you today Hb 5319, an act requiring a plan for nursing homes and their ownership related to private equity firms and their acquisitions.

As a State Long Term Care Ombudsman, I support this bill and I'm committed to safeguarding the rights, well-being, and overall care for residents and skilled nursing facilities. I believe that this legislation will improve transparency, accountability, and quality and care. The bill seeks to address a growing concern related to private equity firms acquiring or holding ownership interests in skilled nursing facilities.

Study after study report when private equity firms are involved in the ownership or investors in skilled nursing facilities, there are significant implications related to the delivery of care and services to residents. The compelling evidence presented in recent studies underscores the urgent need for this legislative action.

Research featured in the JAMA Health Forum and the National Bureau of Economic Research provides a stark description of the consequences associated with private equity ownership and nursing facilities. These studies highlight increased rates of preventable hospitalizations, higher mortality
rates and escalated prescriptions of antipsychotic drugs, decreased front-line nurse staffing hours, and elevated taxpayer dollars spent per resident in private equity-owned nursing homes versus their competitors.

Furthermore, the devastating impact of private equity ownership during COVID-19 as observed in New Jersey and the case study in 2020 cannot be overlooked. This study revealed a 30% higher infection rate and a 40% higher death rate in homes backed by private equity compared to the others and the statewide average.

It is essential that we gain an understanding regarding how this is impacting the residents in our state. The development of a comprehensive plan to help policymakers address whether the certificate of need should be required for private equity acquisitions, what other limitations on private equity involvement might be needed, and the further disclosure requirements for health facilities is recommended. I believe this would only strengthen the protections and improve outcomes for residents. I've seen firsthand the impact of ownership structures on the quality of care provided to residents.

Private equity involvement cannot be introduced without challenges, including potential conflicts of interest and prioritizing profits over the well-being of the residents. The proposed legislation provides an opportunity for Connecticut to proactively address these issues and ensure that residents receive the highest standard of care regardless of the ownership structure. By addressing private equity in their unique challenges, Connecticut can set a precedent for other states in safeguarding our residents. Included in my written testimony are references to
research articles that highlight the impact and further discuss this issue underscoring the importance of this study. Thank you.

REP. MCCARTHY-VAHEY (133RD): Ms. Painter, thank you. I'd like to say thank you, but some of the information you've presented is actually very disturbing. So thank you for bringing it to light, but also, I believe Senator Anwar has a question and we may have others.

SENATOR ANWAR (3RD): Thank you so much for your testimony. Those numbers are quite scary. Can you speak them again if you could? And then also, do you have a written testimony because I did not see that associated with the bill yet?

MS. MAIREAD PAINTER: I do and I'll be submitting it right after this.

SENATOR ANWAR (3RD): Okay.

MS. MAIREAD PAINTER: There is a lot of information included. However --

SENATOR ANWAR (3RD): The mortality rate was 30% higher.

MS. MAIREAD PAINTER: Yes. During COVID --

SENATOR ANWAR (3RD): 30.

MS. MAIREAD PAINTER: -- in New Jersey, there was a study in 2020, it showed that there was a 30% higher infection rate and a 40% higher death rate in private equity-backed nursing homes compared to other homes statewide.

SENATOR ANWAR (3RD): Wow. Thank you so much. I hope people are listening to this fact that the
private equity who come as a savior for healthcare are resulting in more infections and more deaths of our most vulnerable and precious citizens in any of the states. Thank you so much.

REP. MCCARTHY-VAHEY (133RD): Thank you. Senator Marx will be followed by Representative Cook.

SENATOR MARX (20TH): Thank you, Chair. Through you. Thanks, Ms. Painter. It's great to see you. Again, I just want to thank you that it's because of your advocacy and because of your leadership as the ombudsman, I don't think you have to be doing this, but I think because you take such great pride in your work and the people that you serve are so important to you and that you've seen this unbelievable inequity and the poor care that our seniors are getting, that you have opened all of our eyes to the private equity dilemma. The private equity, I'm not sure what the word is, rip off in the seniors in nursing homes. And I am forever grateful for you for what you have done, for everybody sitting at this table, and for the seniors in Connecticut.

MS. MAIREAD PAINTER: Thank you very much.


REP. COOK (65TH): Hi, Mairead. And I want to echo the sentiments on the gratitude. I think it's so vitally important that the work that you're doing is being done. It's sad that it has to be. I want to clarify something that Deidre Gifford stated when we talk about 5319 and they were talking about it that this piece of legislation does not cover nursing homes. So you discuss skilled living facilities. I just want to bring that to your attention and then ask you as we know that there's a variety of
different pieces of legislation that are all over the place, but OHS apparently does not cover the nursing home component. It comes under human services, which you and I spend a lot of time there. But I think that the conversation remains the same.

So my question for you is, as we look at 5319 and the private equity that you are referring to, I think it warrants that conversation to our chairs about how we look to add those two together because as much as we might recognize that something doesn't fall under one department or the other, this is still a public health issue, and I want to ensure that we don't silo this conversation out.

So my question for you would be how do you see us blending that together? If we recognize where we are. As we know that a significant amount of loss is happening. We know that there are truly good actors and bad actors in this business, and we know that over the last several weeks, the newspapers have been diligent about reporting this conversation to ensure that the money that is hidden from those private owners has many, many legs and then tentacles off of those legs and following the dollars is beyond frustrating and back taxes that are owed and a variety of other things that are happening to where folks could, in essence, be put in harm's way if a facility closes, if we take no action. So would you like to speak to that just a little bit?

MS. MAIREAD PAINTER: Yes. Thank you for asking that. I think that any CON process where you have an entity that impacts individuals care and services and that they could potentially financially gain from how they control what's delivered and how those services are delivered to individuals, especially if it's tied to taxpayer dollars, that we should have a clear understanding of any investors ownership. And
it would allow us really -- what we're trying to work on a level is to see what is the impact in how they're providing care across the country. And so if they're going to come into our state and buy a facility or invest in a healthcare entity, that we have a good understanding of who is coming in, who's investing in care and services in our state, and are these investors that we should be allowing to come in and purchase healthcare companies in our state?

REP. COOK (65TH): Thank you for that. And I think that we should go one step further when folks are in bad standing, they're not allowed to take new patients. So I'm just leaving you with that. Thank you, Madam Chairman. Thank you, Mr. Chairman. Thank you Mairead for everything.

REP. MCCARTHY-VAHEY (133RD): Thank you, Representative Cook. And indeed, the conversations related to the certificate of need and private equity are intimately linked. Private equity's sole goal and focus is to make money. That is not the sole goal and focus of healthcare. However, we know that there is cost and budgeting that is required.

That's the balance that we seek to have as we look at our certificate of need process, it's about access, quality, and cost all of those things, but ultimately, that is in service of a mission of caring for patients. So thank you for this conversation. Again, as I said to Dr. Gifford and will to many others, these will be ongoing conversations as we seek to balance the issues of cost and the ability to provide equitable care. So, thank you for being with us today. We are grateful for your work every day.

MS. MAIREAD PAINTER: Thank you very much.
REP. MCCARTHY-VAHEY (133RD): Next on our list is Representative Mitch Bolinsky. Welcome, Representative.

STATE REPRESENTATIVE MITCH BOLINSKY: Thank you so much, Madam Chair. Allow me to just organize my papers here very quickly. It's an honor to be before this committee. So, aside from the formality of saying good morning to the Co-Chairs and to the ranking members, and to all the members of this committee, I want to acknowledge the serious conversations that come before, the access to care, the private equity questions that nobody seems to want to talk about.

And this is not part of my testimony, this is my personal perspective on the conversation that just happened, and the information that comes through the sharing of questioning from people like Representative Cook. She and I experienced some pretty eye-opening, tragic family circumstances at the beginning of the pandemic, and a lot of it was related to the conversations that just took place, so forgive my distraction. But I am here today with good news. So I'm here to uplift you.

I want to thank this Committee with all of my heart for raising Bill Number 5323, which is An Act Developing a Plan for Licensure of Dance/Movement Therapists, or what they call themselves, DMTs.

I'm also here to commit to the Department of Public Health and to this Committee, the full support of people that have been waiting for the opportunity to be licensed for over six years. And you know how we got to where we are is, is much less consequential to, you know, than to where we need to be, because DMT, Dance Movement Therapy, is a complementary therapy for mental health patients and what it does is amazing. And you might be wondering what's a big
guy like me doing sitting in the front of the room talking about dance therapy because I'm not going to be dancing with any stars anytime soon. The fact of the matter is circumstances sometimes put you in funny places.

And I don't mean funny, ha-ha. I mean just ironic places. I represent Newtown. And my first exposures to expressive creative therapies came very early in my service to the State of Connecticut and to the town of Newtown and to my neighbors and to my friends. And the trauma, a pure trauma of living through or seeing, or even reading about something that no human being should ever have to even put into their consciousness, is crippling. So for a moment, and I'm very careful with how I use my words here because I don't have the privilege of exploiting these words...

CLERK: Excuse me, Representative Bolinsky, but your time is up. Thank you.

REP. MCCARTHY VAHEY (133RD): Thank you, Representative. I know it goes quickly but there's at least one question for you. So you will have an ability to share a little bit more.

STATE REPRESENTATIVE MITCH BOLINSKY: Thank you very much.

REP. MCCARTHY VAHEY (133RD): Representative Klarides-Ditria.

REP. KLARIDES-DITRIA (105TH): Thank you, Madam Chair. Thank you, Representative, for being here today on this very important issue. A couple of questions. How many other states license their Dance Movement Therapists?
STATE REPRESENTATIVE MITCH BOLINSKY: I believe it's over 40. There's a full association that is involved with this. And we don't have a single state in the region in New England that is not licensing these. As a matter of fact, the DMTs that are certified to practice that live in the State of Connecticut have to practice outside of the State. They came to me and they asked if they could bring their art home. And the healing powers of this particular therapy are so profound that the journey for these creative art therapies actually began long ago with the passage in 2019 of the Art Therapy Bill followed by the music therapists last year.

And this year, we're looking to, you know, put an exclamation point on the DMT as well as a complementary therapy. So the reason I'm here is because this works. This is a way to reach people that can't be reached through talk therapy. And because there's no licensure in this state, there's an inability to practice. There's an inability to provide, you know, the access to a therapy that works on very, very difficult-to-reach individuals. But it's not covered by insurance. It's not covered by Medicaid. And it doesn't even have title protection in the State of Connecticut.

Whereas, you know, my primary contact in this business has been a DMT who travels to Brooklyn, New York, every day to practice her art. And she and I have been talking for many years and she wishes nothing more in the world than to be able to work in her home state without that 3.5 hour daily trudge back and forth. But it's not about her, it's about the people that she helps.

REP. KLARIDES-DITRIA (105TH): Yes, thank you.

STATE REPRESENTATIVE MITCH BOLINSKY: So she is so immersed in this and has seen such dramatic changes
in people that range from children to people that are traumatized in family violence, children of divorced people, veterans with PTSD that can't be reached, with dance and movement therapy. And you'll hear from this particular individual. Dr. Naomi, later in the testimony, she'll be testifying remote. But you know, she tells stories of people that have been able to express themselves with movement, and have that training of theirs, which includes the, you know, the clinical interpretation of it.

It's not dance classes. It's therapy that is drawn out through a different part of your brain, and it works. And I'm just here asking for the opportunity to get it licensed so that it can be practiced in our state so that people of Connecticut that do live here, can practice it here. And so that the people of my community and yours can benefit from it. If they can't be reached by talk therapy.

REP. KLARIDES-DITRIA (105TH): Thank you. That's a perfect explanation. And just quickly, can you tell us what education they need to become certified?

STATE REPRESENTATIVE MITCH BOLINSKY: Absolutely. Well first of all, the implementation of this from an educational standpoint, there is a full educational complement and the credentialing board that comes with this. So if I may, the American Dance Therapy Association is the credentialing body. The educational and continuing education requirements involved in certification are pretty rigorous, as well as the practicum. This is something that requires a great deal of education. The exact hours are something that I will defer to the therapist that will be testifying in positions 43 and 44, I believe. But from a perspective of the Committee and the perspective of the State of Connecticut's Department of Public Health, we have
submitted scoping and language around this bill on a half a dozen other occasion.

And the ADTA and their credentialing board are fully able to assist us in making sure that this thing is written out in a way that requires almost no work on the part of the DPH. Essentially, they'll be the ones issuing licenses and collecting the money. This whole exercise would be revenue positive for the State of Connecticut. It has no fiscal note and it has practically no work involved in it. So it's sort of a no-brainer. And it follows very closely along the scoping and the licensure that we've already accomplished twice, once with art therapy and once with music therapy.

REP. KLARIDES-DITRIA (105TH): That's perfect. Thank you, Representative, for your answers. Thank you, Madam Chair.

REP. MCCARTHY VAHEY (133RD): Thank you, Representative Klarides-Ditria. Representative Parker.

REP. PARKER (101ST): Thank you, Madam Chair, and thank you, Rep Bolinsky, for your advocacy. My wife is an expressive arts therapist. And so I will lift up the incredible value of this related field of therapy. My question is, expressive arts therapists are also not licensed in the State of Connecticut. I know that she practices as a licensed professional counselor and can do work in Connecticut.

Similarly, people that are social workers or LMFTs can do this kind of therapy in Connecticut. So Rep. Bolinsky, I'm just wondering, have you heard from anyone? Is there any worry that people that are practicing DMT in Connecticut under a com---, you know, appropriate similar license that there be any negative impacts on folks like that? I haven't heard
that myself. I just want to know if that came up in your conversations.

STATE REPRESENTATIVE MITCH BOLINSKY: It has not come up where there's any restriction in people that are practicing other licenses. Because most of them are practicing in situations where they're working for a larger facility or a larger health care network. That would be the only circumstance under which currently somebody who is a DMT can practice in the State of Connecticut. So for them, it's not a full-time job. It's not the ability to, you know, to have a practice.

And it still is not something that can be claimed necessarily under a private health insurance plan, Medicaid or anything. So we're restricting access by not having this available. And Representative, as an individual who has a wife that practices the creative art therapies, you know that we're dealing with the ability to reach people that are otherwise unreachable and provide an incredible human benefit to thousands of people in the State of Connecticut, while still being able to allow our DMTs to come home and work.

REP. PARKER (101ST): Yeah, thanks for saying. That seems like very well put. Thanks for your advocacy, Rep. Bolinsky. Thanks for your time, Madam Chair.

REP. MCCARTHY VAHEY (133RD): Thank you, Representative Parker. Representative Bolinsky, thank you so much for your advocacy here and your time with us today.

STATE REPRESENTATIVE MITCH BOLINSKY: Thank you very much.

REP. MCCARTHY VAHEY (133RD): Since we have exceeded the first hour, we are going to begin rotating. We
are actually going to go to Luisa Gasco-Soboleski, who is Number 23 on our list. She will be next, to be followed by Sarah Eagan. Luisa, welcome.

MS. LUISA GASCO-SOBOLESKI: [inaudible] Senator...

REP. MCCARTHY VAHEY (133RD): Oh, excuse me, if I may. If you can turn on the microphone for us, press the button. Thank you so much.

MS. LUISA GASCO-SOBOLESKI: Apologize. Well, good late morning, early afternoon, Senator Saud Anwar, Representative McCarthy, Representative Demicco and the Public Health Committee. My name is Luisa Gasco-Soboleski and I am here to testify in support of Raised House Bill 5200.

I am here representing the deaf, deaf-blind and hard-of-hearing community as president of Connecticut Association of the Deaf. I am also a board member on Disability Rights Connecticut. And I am a Co-chair of the Governor's State Advisory Board for persons who are deaf, deaf-blind, and hard-of-hearing. I'm a retired principal of the American School for the Deaf. And I live in Southington. I am a third-generation deaf individual. I wanna thank you for giving us the opportunity to come and speak on behalf of this Bill 5200.

It is important that we work together to better serve our community, especially in this area of health care for persons with disabilities. We do have disabled, deaf, deaf-blind, and hard of hearing members who need the same type of access, whether that be a wheelchair mobility, visual access, along with the communication access for this population. And that accessibility is often lacking.
We are asking to have what's called a universal design for every individual, meaning equitable access for everyone, regardless of the population they identify in. Every individual with disability having equitable access. So for example, universal design means that a ramp being there for ADA mobility access is also beneficial for parents that are using strollers or large loads that needed to be rested -- needing to be arriving.

Another example is if you're in a loud environment at a restaurant and the TV is there. Captioning, which is mainly for the deaf, deaf-blind, hard-of-hearing population is beneficial for those in a loud environment, watching the news, trying to find out what's being said, they are then able to use closed-captioning.

Now in your Raised Bill 5200 at Line 34, after 'assistive device', we would like to see added, 'to stating communication aid, built-in internet access space for sign language or ASL interpreter and visual/light arrangements.' Oftentimes we have issues with wi-fi. Especially as we're using the video remote interpreting, or VRI, wi-fi may not be strong enough to handle that accommodation which causes pixelation or picture freezing during the interpretation.

Also, we do need good lighting when it comes to watching the sign language or ASL interpreter and space for the interpreter to stand or sit so that the deaf person has a better view. It's important that we have that equitable access. I do want to let you know that sometimes the interpreters have to stand away from windows because of backlighting or reflection issues. The issues have been repeatedly consistent for the deaf, deaf-blind and hard-of-hearing communities. This is frustrating for all of us.
I personally have been getting several calls from the community expressing their concerns with language accessibility in the health care settings. So we need to be heard and this needs to be improved. We do support this bill, Raised House Bill 5200, and would appreciate that we add the communication accessibility. Thank you for your time.

REP. MCCARTHY VAHEY (133RD): Thank you very much. Are there, if you hang on one moment if you don't mind, just to make sure we may have some questions or comments. And first, we will begin with Senator Anwar, and then we will be followed by Representative Demicco. Senator Anwar.

SENATOR ANWAR (3RD): You have to look at me for the comment.

MS. LUISA GASCO-SOBOLESKI: [laughs] Oh my gosh. Oh, I adore you. Oh my gosh. That's something I taught you two weeks ago. Yes. [laughter]

REP. MCCARTHY VAHEY (133RD): Thank you. And if you would share the interpretation with us, that would be wonderful, Senator Anwar.

SENATOR ANWAR (3RD): Love you and thank you.

MS. LUISA GASCO-SOBOLESKI: Thank you and I love you back. Yes.

REP. MCCARTHY VAHEY (133RD): Thank you. Representative Demicco.

REP. DEMICCO (21ST): Thank you very much, Madam Chair. Thank you, Ms. Gasco-Soboleski, for coming and testifying today. I appreciate your suggestions as to how we can improve House Bill 5200 to make it
stronger and better for members of the deaf and hard-of-hearing community. Since you are involved much more so with that community than I, I just want to ask you just one or two questions. Has your have you or the people that you work with made these complaints and/or suggestions known to members of the medical community? And if so, what kind of a response have you received?

MS. LUISA GASCO-SOBOLESKI: Thank you, Representative Demicco, for asking that question. So typically the members of the deaf community call me for support in contacting the Department of Justice, or the DoJ, when any issues within the medical settings do come up. So I join as their advocate, helping them connect with a formal complaint process. Right now there is a case where we're in the midst of just collecting information and data. I think right now individuals in the community that are experiencing the frustrations are fearful of going through the process. Because again, English is not their first language.

And 90% of deaf individuals are born into families and parents that are hearing. Only about 10% such as myself are born into a deaf family. And I had communication access and acquisition from birth throughout my childhood. So I was a fortunate child in experiencing that. But 90% of the population do not experience that. They don't have that language access from day one. Parents are hearing, baby is deaf, they're not acquiring that language. They're not getting that exposure until later in childhood such as age three or four, potentially.

And so a lot of the individuals within our community are fearful in trying to go through that process because it does heavily rely on English skills. So we are seeing more and more with advocacy efforts, more and more deaf individuals that are stepping
forward with bravery and making their complaints known. But I would say over 12 times, we've experienced willingness to work with us and that is good news. It's about time. We are wanting to see more and more of that. Especially targeting the communication access across the setting, not just in hospitals but in all medical or health care settings. Does that answer your question?

REP. DEMICCO (21ST): Yes, it does. I appreciate that and I appreciate your advocacy on behalf of the deaf and hard-of-hearing community. And I especially appreciate your efforts and your suggestions to try and make this bill even better. Because after all, that's why we have these public hearings, is to review the bills and hopefully make them better, and I'm confident that we will. So thank you. And thank you, Madam Chair.

REP. MCCARTHY VAHEY (133RD): Thank you, Representative Demicco.

MS. LUISA GASCO-SOBOLESKI: Thank you for just taking the time to listen and really taking these words into thought because this is coming from our community into yours. So this is not just a benefit for us. We hope it's for everyone.

REP. MCCARTHY VAHEY (133RD): We do have another question for you.

MS. LUISA GASCO-SOBOLESKI: Oh, all right.


REP. REDDINGTON-HUGHES (66TH): Thank you, Madam Chair. Thank you for being here today, and also for bringing these issues to light for us. My question has to do with other states, and if you have another
state that would be a great example of a place that is doing this right?

MS. LUISA GASCO-SOBOLESKI: That is a very good question. And if you wouldn't mind giving me some time to research a little bit more into that. But I was at a conference last week. It was where 28 different states were represented. Maine recently had a horrible, violent shooting occur where four deaf individuals were part of the casualty list. And so Maine decided to have communication access language put in to more of their work, just for the entire population.

So if you wouldn't mind, I can reach out to Maine and those that have worked on all of the language additions. I know that Massachusetts also has a few things that they have done recently. Connecticut is one of the first states that had a commission for the deaf and hard-of-hearing. And unfortunately, we did lose that. Tomorrow there is a public hearing for House Bill 5241, which will address hopefully getting some of that service back from the commission-type work. So let me reach out and then we'll work on that.

REP. REDDINGTON-HUGHES (66TH): Thank you very much.

REP. MCCARTHY VAHEY (133RD): Thank you, Representative Reddington-Hughes. And again, thank you for being here with us today, Ms. Gasco-Soboleski. We so appreciate the time that you have taken to educate us and inform us and for your many, many years of advocacy. We appreciate you. Next on our list...

MS. LUISA GASCO-SOBOLESKI: And please, ladies and gentlemen, please feel free to contact me if you have any further questions. Just to make sure,
clarify. It's important that we have a very collaborative working experience. So, thank you.

REP. MCCARTHY VAHEY (133RD): Thank you. And we will take you up on that.

MS. LUISA GASCO-SOBOLESKI: Please do anytime.

REP. MCCARTHY VAHEY (133RD): Thank you. Next on our list is Sarah Eagan, to be followed online by Jennifer Tow. Ms. Eagan, it's nice to see you. Welcome.

MS. SARAH EAGAN (OCC): Good afternoon to the Committee. My name is Sarah Eagan. I run the State's Office of the Child Advocate. Get my glasses here. We're here to testify in strong, very strong, all caps, underlying support of Bill 274. And thanks to the Committee for raising this bill, which we think directly addresses the State's multigenerational opioid crisis and the impact of opioids on the health and safety of children.

I think many of you know, but maybe not all that, the obligations of the Office of the Child Advocate are to review, investigate and make recommendations regarding the publicly-funded state and local systems and how they meet the needs of vulnerable children. We are specifically directed, among other responsibilities, to conduct child fatality, review and make annual reports and investigative reports to the legislature. I want to quote the National Center for Fatality Review and Prevention when I tell you that the statutory purpose of fatality and critical incident review, is to inform statewide child injury prevention efforts.

According to the National Center, every child fatality must be understood as a sentinel event that should catalyze action. Since 2021, almost 50
children under the age of five have suffered an ingestion injury from opioids. Twelve of these children have died as recently as a couple of months ago and an ingestion injury as recently as last week. Every single one of these injuries is a near-fatal event for a child under the age of five. The majority of these 50 children were saved by the administration of naloxone by first responders.

Based on OCA's tracking of ingestion injuries reported to DCF and coded as critical incidents by DCF which are then copied to OCA, there has not been a reduction in the number of critical ingestion reports between 2021 and the end of 2023. Notably, while Connecticut has thankfully seen some reduction in adult overdose fatalities over the last two years, Connecticut has persistently remained in the top 10 of all states for adult opioid overdoses per 100,000 adults. It is imperative that we have a structure for developing, coordinating, strengthening public health responses that respond to the multigenerational aspects of the fentanyl crisis, including specific attention to the needs of caregivers with opioid use disorder and their children.

Only a few weeks ago, the OCA issued a fatality report following the death by homicide of 10-month-old Marcello from fentanyl, xylazine and cocaine intoxication. Marcello who died last summer, was the 11th young child in Connecticut to die from opioid ingestion. His family had an open child abuse neglect case with DCF until weeks prior to his death. And his mother had outstanding warrants for violation of probation issued by the criminal court shortly after his birth, which were served at the time of his death.

OCA found that though agencies involved with the family provided supervision and referrals to
community-based services, they did not comply with all their respective policies and procedures regarding risk and safety management. OCA found that agencies policies and processes for regarding risk and safety need improvement. OCA also...

CLERK: Excuse me, Ms. Eagan, but your time is up. Thank you.

MS. SARAH EAGAN (OCC): Thank you.

REP. MCCARTHY VAHEY (133RD): If you can just summarize, that would be wonderful. And then we'll have some questions.

MS. SARAH EAGAN (OCC): Yes. OCA found that treatment for the family was poorly coordinated and that providers working with the family had varying protocols for fentanyl testing, did not share results with each other and did not effectively safety plan for Marcello's family. Bill 274 creates a subcommittee of the State's alcohol Drug and Policy Council to bring folks together.

Advocates like the OCA providers, state agencies, these issues cut across state agencies. DCF, DMHAS, the Department of Correction, the Judicial Branch, all which are part of the ADPC is an opportunity for coordinate planful strategic discussion. Rolling up our sleeves to talk very specifically about what are the treatment opportunities. What are the safety planning discussions? What is the availability of naloxone to caregivers? And while I appreciate that both DCF and DMHAS are going to oppose this bill today and provide testimony that it is not needed, I want to respectfully and strongly tell you that I disagree with that. If I didn't think we need it, we would not keep recommending it in the reports that we put out.
If all the work was getting done that needed to get done, we would not keep making this recommendation. It is not an indictment of the effort that people at state agencies and members of the ADPC, which includes the OCA are making. It is a recognition that after 50 deaths or near deaths of children under the age of five from opioid intoxication that this needs more attention and it needs it now. And I know I'm strong and heated today, but frankly, I feel strong and heated today. And so I'm not going to hide that from the Committee. We're always willing to work with folks to get these things over the finish line, but we need to do more.

REP. MCCARTHY VAHEY (133RD): Thank you, Ms. Eagan.

MS. SARAH EAGAN (OCC): And I'm looking forward to the opportunity to work with the agencies to get that done. Thank you.

REP. MCCARTHY VAHEY (133RD): I wanna acknowledge your passion. I don't think there's anyone in this room who wouldn't share that passion when it comes to protecting children in that way and from this type of harm, which we know that opioids are an epidemic for both our adult population. And now we're seeing more of our children who are suffering and struggling.

I think it's just kind of taking a step away from that passion and emotion and just looking at the mechanics and the specifics of the bill itself. Some of the things in your testimony are with respect to DCF policies and procedures. And I recognize that that is the purview of the Children's Committee and you spend a lot of time talking with them there. So this bill in particular is a part of the alcohol and drug policy counseling. You're a member of that, correct?
MS. SARAH EAGAN (OCC): Yes.

REP. MCCARTHY VAHEY (133RD): Yes. So part of my question is, logistically speaking... and I sit in on those meetings as well. I have not been there as much as many of the other people in this room or who are really diligently doing that work. There are a number of subcommittees already and I think the struggle and balance that we have is, as we do that work, and I found that group to be a pretty serious group, right? Co-chaired by leaders of our commissions, our commissioners and then with providers who are in the trenches and people who are facing the issues such as yourself.

The struggle is being specific. And I think what you're talking about is specifically focusing on an issue that we're seeing that is more and more of a problem before us today. And balancing that with not siloing. And I think we're saying the same things. But my question is, given the current makeup of the subcommittees of the Alcohol and Drug Policy Council, you feel like it's important to have a separate group as opposed to having some of the existing groups take on this particular mission. Is that right?

MS. SARAH EAGAN (OCC): Yes, and I appreciate the question. I think there has to be a structure to support the work that we're recommending be done, which is more than itemizing the services that we have for children and families. But looking at, where are the services available? What is the capacity of those programs to meet the needs of the population in those catchment areas? What are the outcomes for those programs? What do we need more of? Maybe what do we need less of? How are agencies coordinating with each other and with providers to develop protocols to respond to the kind emergencies and safety issues that we see. And I don't have all...
the answers at the Office of the Child Advocate. And I need and rely every day on the input from agency personnel, community providers, family advocates, to do that. And I think our bill proposal and we're not wedded to every particular word in it. And I invited the Department of Mental Health and Addiction Services to provide me with substitute language. If they had a proposal they thought could work better. So I'm open to seeing that. Right. But what our proposal is really about, we don't think that we're having enough of this conversation. I don't think we're having enough of it at ADPC. I don't think we're having enough of it at the OSAC.

We're not looking at it structurally enough in an open coordinated fashion between the providers and the agencies. And that is continuously, frankly, the feedback I get from the providers and family advocates. They want more of this discussion. They supported this initiative. So is this the only structure for doing it? No. Could it possibly fit under the auspices of another subcommittee? Possibly. But it has to come, it should come, with a specific mandate for, this is what we want you to look at; and this is what we need reported back. Because we've been missing this on these young children. We've been missing it. So I'm looking for something different.

And with all due respect, you know, SB 9 last year required that the agencies coordinate and respond on, what is the service array for caregivers with opioid use disorder, substance use disorder in their children? And where are the gaps? Well, I read that report for the first time today because it was attached to the agency's testimony and there are helpful things in it. And I read it quickly. It's like 30 pages. And what I see in there is an itemization of, these are the services that we have
and for most but not all of the services, this is the utilization.

What I don't see in there is the barriers and gaps analysis, right? So for example, just one more example, when it lists like where are the parent and pregnant women residential treatment programs and it lists the places that there are and the 150-plus admissions over fiscal year 2023, you can see that there are regions of the State that don't have that program. So this morning after reviewing it, I called up a human service specialist in one of the regions that doesn't have that program.

And I said, Is this a program that you need? And this person says back to me, Sarah, we need everything. We need everything. Another provider I talked to this morning who runs a program for children and families said that they have a program that's not allowed to run a waitlist, which some programs are just operated that way, can't have waitlists. But communicated that they turn away two to three families a week that they can't serve.

So our vision for what SB-9 was requiring was that analysis. What do we have? We have a lot of stuff that's good. We have a lot of things that are working. But what do we not have and what do we need? And what is that going to cost? And what do we need to do about reimbursement rates? Because without that analysis, the legislature can't act and that's the work that we want done. Whether it's in a subcommittee, whether it's a working group, whether it's time-limited, I'm open to all of that. But it's got to be something more than what we've been doing.

REP. MCCARTHY VAHEY (133RD): Thank you for that answer. I think one of the conundrums based on some of our other conversations that you've had with
Senator Anwar and I, is the challenge between assuring that our parents who need treatment and seek treatment are able to do so without facing, you know, punitive consequences. And frankly, I'll put that on all of us at the legislature as well. Right? We're a part of that equation. Because when an incident occurs and the child is in danger or tragically dies, we look to... and that's, you know, obviously your office's job to where are those gaps and how do we get there?

And then we sometimes we become a little more strict in terms of, you know, what we're doing in order to protect children's safety. And then on the other side of that, as a parent who may be in need of treatment. Now how do they go forward and how do they... not only do they access services but do so in a way that provides the support. And frankly, I see the whole spectrum there. Whether it's the folks at DCF who are charged with assuring that those children in care and custody are safe. And then those of you who are looking at these tragic incidents after the fact.

So I think this is, it's a really complex situation. That's why I went back to the specifics of the bill, which is to say, is this particular mechanism the best way for us to get at what is a very critical and necessary conversation. Because we know that when it comes to opioids and the people of our state, adults and children dying, we all have more to do. And we know that we need to continue to learn. We had conversations in this Committee last year with some ideas and thoughts on that. We know that many of our nonprofit and agency partners are doing the same. But I'm going to turn it over to Senator Anwar and we will continue this conversation.
SENATOR ANWAR (3RD): Thank you so much, Madam Co-chair, Thank you, Ms. Eagan for your testimony and your passion. I just wanna make a quick little statement. I know this for a fact that every single person in DMHAS, every single person in DCF, they're committed to make sure that they are able to fulfill their requirements with the resources that they have. And be able to do the difficult job that's expected and necessary. This epidemic is growing at a rate that we may not have been able to put the resources around it.

And now what we are seeing is with the increase in the number of families and individuals who are exposed to the substances. They are two-generation families and then we are seeing the anticipated, unfortunately, anticipated changes and deaths of our children, or near-deaths of our children in our state. And when it comes to children, it becomes even a far more critical issue for everyone.

And I think that's where you have looked at some 49 cases or 11 deaths and near-deaths, and the challenges. And there's a pattern that is emerging and collectively, we do not have a full handle on it because the existing challenge and its ongoing increase is still something that is overwhelming the existing agencies as well.

The way I see this is that the more conversations that we have and more organized structures that we create to help the legislative body and the administration put resources to protect the citizens who are going through these high-risk situations, and especially our children, is a necessary thing. So I know that because of the bandwidth limitations at times, the agencies would say maybe we should not have another group amongst 20 others that we are part of. To have the conversation because it's taking us away from what needs to be done. But when
it comes to children and where we are with the numbers, this is a necessary thing so that we can actually literally get all hands on deck.

So I hear where you're coming from and I respect the agency's perspective as well. And I think, end of the day, we do need more resources. This is the time when our children start to die and come to near-death experiences from opioids because of their parents, this should be a call for another, yet another crisis. So hear you, support you, and I will be conversing with our amazing group of people from the DMHAS, as well as DCF, to share what are the areas of opportunity that they also feel is at issue? Back to my question, the 49 near-deaths, what are the patterns that we can actually look at that is going to give us a glimpse into better policymaking, perhaps even in this session as well?

MS. SARAH EAGAN (OCC): So it's for clarity, it's 37 ingestion injuries that were reported and coded as criticals by DCF that did not result in a fatality. The number of fatalities over and above that is 12 as of now, without updated information from the Medical Examiner on children whose deaths are pending further studies. So what can we do right now? Well, our recommendation is, is what is proposed in 274, which looks at a structure for what Representative McCarthy Vahey, I think, you know, taking the words out of my mouth, says it is a very challenging conversation.

Like that's what I mean when I say I don't have all the answers, right? As to how do you support the safety of children, very young children, in the context of a treatment approach which we all support, right? And that's I think what we have to really dig into with our providers, with our adult probation folks who come into contact with lots and lots of folks, right, just like Marcello's family
with the other agencies, to talk about what are best practices going to look like for sharing information? For coordinating treatment, for frequency of testing, for interpretation of test results, for access to naloxone? There are so many things and creating and having a table that is dedicated to that discussion. I think it's not a lot to ask.

And then there are other provisions within the bill that speak to having a plan for Medicaid and insurance reimbursement so that health care facilities can distribute naloxone as applicable where appropriate to individuals upon discharge, which is based on work, legislative work, that's happened in Colorado under their naloxone project and Mom's Project. So that's something that I think is a short session, right. That's something we could do now, right. To talk about, and I have been strong this morning. I know that this afternoon or whatever time it is.

So please don't, you know, my colleagues are sitting here in the room. Everybody is working hard. I understand that. And it's our job from our office to offer you an independent lens on these issues. And sometimes it's hard just being honest. It's hard to get a gaps analysis that we need when the state agencies operate under budget constraints and structural constraints that I think sometimes limit the conversation that we're having about what we really need to invest in and how much investment that costs, right. Because nobody is a free agent here with a blank check and I understand that. So it has to be advocates and providers who say we need more, right?

I think there's other questions that, you know, DMHAS testimony today in the report that they're providing raised, that need to be looked at, around
the utilization of the services that we do have. We only have a few intensive, for example, intensive in-home services for caregivers with substance use disorder in children under the age of six. Utilization is down in those programs a lot. Why? I mean the need isn't down so why is the contract utilization down? Is that because referrals aren't made or is that because the workforce isn't there? I don't know. Right.

But these are actually the kind of granular questions that need to be looked at and there has to be a setting for that. And I spoke to one of the providers on "[our end]" with this. One of the providers I spoke to this morning about, you know, what is it that you need? And the person said, "We need more opportunity for interagency coordination and a dialogue for providers and agencies on these subjects." So we can coordinate on again, what Representative McCarthy Vahey said, are these really challenging scenarios. That's what we're asking for, a table where that happens. Thank you.

SENATOR ANWAR (3RD): Thank you so much. We appreciate your testimony and we appreciate your thoughts. We hear you. Thank you.

REP. MCCARTHY VAHEY (133RD): Representative Dauphinais.

REP. DAUPHINAIS (44TH): Thank you so much for being here. It's almost like Deja Vu from yesterday with the story of Liam. And so we're grateful to have you on-board. I think you give us the bird's eye view and it doesn't sound like you're picking on any one person. It just seems like we need to pull these things together and better coordinate in a case management-type setting where, you know, you see it done in the nursing homes. You see it done everywhere else where the client is kind of the
center and all the entities are working together to make sure everything's coordinated. Is that correct? I mean, it sounds like there's missing pieces and that's what we need to do, some sort of that thing.

MS. SARAH EAGAN (OCC): Represent Dauphinais, I think that's probably where we want to get to, right. And so if we know the goal is family-centered treatment. We know we wanna preserve families whenever safely possible. What is it going to take to do that, right? In the context of what we know is by necessity, harm-reduction model. And I don't, sitting here today, I don't know 100% what that looks like when we're talking about a parent that is new to recovery or not yet rooted in a program of recovery. Who wants to be in recovery, who has very young children and we're trying to keep that family together. Ad it's not that we again, we have services that are geared to support that. Right? But that's what we need to look really closely at. What's working the best? What happens when a parent leaves the parent child program? What does DCF have on the table? What do other, you know, what are we offering? How do we better coordinate that? Right?

REP. DAUPHINAIS (44TH): The coordination seems key. I mean, it seems like yesterday one wasn't talking to the other and things just kind of fell apart, you know. There are many parts, moving parts, to these issues and they all need to kind of talk. So anyway, thank you so much for what you do, and I'm very supportive of your efforts and really appreciate your passion.

MS. SARAH EAGAN (OCC): Thank you.

REP. MCCARTHY VAHEY (133RD): Thank you, Representative Dauphinais. One thing that I had
hoped to do before the hearing, but I'll confess I did not, was to reach out and talk to some members of the Alcohol and Drug Policy Council, aside from the leaders of that, to just get their take on this. And I will ask you the same question I'm going to ask of the commissioners, which is, have you talked to anyone else on Alcohol and Drug Policy Council, particularly leaders of some of those subcommittees, about this?

MS. SARAH EAGAN (OCC): No. That's a fair question. I primarily have talked to providers in the course of our work, I never come here in a vacuum, right. I'm a lawyer. Not a social worker. Not a substance uses treatment provider. I'm a lawyer for kids and an advocate. So everything I give you, I have discussed endlessly with people doing the work. But they can't always come up here and talk about the things that I talk about, right, for a lot of reasons. And so the recommendations that we make in our reports and our legislation are discussed, vetted, amended by stakeholders throughout the state. Some overlap with the ADPC. But it's a fair question and I'm happy to do more footwork on my end on that.

REP. MCCARTHY VAHEY (133RD): Thank you. As will I. And as I said, I will be asking the commissioners the same. But I do think that it's something we should talk about because that is an important group as is the Opioid Settlement Advisory Group, as well Committee. You referenced them. So I think bridging those conversations will be helpful. Thank you so much. I don't see any other questions, but I know we'll be continuing the conversation with you and appreciate your testimony and your passion and your work every day. Thank you.

Next, we actually have, I believe, both of our commissioners, Commissioner Navarretta, and our
Commissioner Designate Hill-Lilly, are coming before us and I would remind you that you have three minutes even though there are two of you. And we're so glad to have you here. Oh, you know what? I apologize. I'm going to apologize to Jennifer Tow. That was my mistake. And if you would, since there, if you don't mind, commissioners, I'm going to ask you just -- you can just wait there if you don't mind. Jennifer Tow is online. If Jennifer, you are able to testify, I got distracted and I know we were going down the... Jennifer, are you with us online?

MS. JENNIFER TOW: I am. Yes, I am.

REP. MCCARTHY VAHEY (133RD): Thank you, Commissioners. Thank you for your indulgence. I appreciate it, Jennifer, welcome and please proceed.

MS. JENNIFER TOW, CMMR.: Good afternoon. My name is Jennifer Tow. I'm a mother of three, resident of Glastonbury in IBCLC of 28 years. I oppose HB 5318, An Act Requiring the Licensure of IBCLCs. I began my career in the early 90s, developing the first- peer counseling program in Connecticut to support an underserved population. And financial hardship and health consequences resulting when parents are denied insurance coverage for skilled lactation care isn't lost on anyone. The working group that proposed this bill excluded IBCLC who raised concerns last year in direct contradiction to the request of this Committee.

Among its 16 members, only three are Connecticut IBCLCs. Their key selling point is that licensure will allow access to Medicaid reimbursement. IBCLCs have not attained Medicaid coverage in their three licensed states. IBCLCs in private practice, most likely to be adversely affected by this bill cannot sustainably accept Medicaid coverage. OBs, pediatricians and clinics can already bill Medicaid
for IVCLCs under their own licenses. Several states are addressing the Medicaid issue without licensure, including Colorado and New Jersey. In Connecticut, unlicensed doulas will be able to bill Medicaid.

So it seems the Medicaid issue can be addressed in a separate legislative or procedural act, avoiding the perceived need for licensure. The lactation field's a quagmire of 20-plus certifications that are misleading to the public as well as policymakers. Parents cannot differentiate between breastfeeding specialists, lactation counselor, educator or other title. Nor will licensing change that fact. A tired parent isn't going to Google licensed when seeking breastfeeding support.

The second selling point that licensure would elevate the profession is contradicted by the language of the bill itself. Originally, language limited clinical practice to IBCLCs, the only credential qualified to provide such care. Now, all 20-plus other certificates may practice freely based on the "scope of practice of the person's license, permit or certification and training". Which means that so long as their certificate claims they can provide clinical care, no matter how limited their education, they may do so. No fees, no license, no restrictions, no risk for misinterpretation of scope of practice by DPH, as IBCLCs now face. Concerns raised but to the working group as to these potential consequences were met with tacit dismissal, yet all have come to pass with this bill.

HB 5318 deters candidates from seeking the credential and actually encourages them not to. If I am able to practice because my certificate claims I am equal to an IBCLC, why become an IBC LC? Why pay for the education fees and recertification on top of fees to the State of Connecticut when I can pay a nominal fee and practice at will with no
repercussion, no matter how I practice? In contrast, IBCLCs will be penalized financially and professionally. And if as lactation counselors now demand others are equally licensed, licensure is a "moot point.

And summary, HB 5318 establishes a system of punitive action toward the highest credential, obstructing our ability to practice, deterring candidates from pursuit of the IBCLCs and actually encodes a system of disparity of care into statute. Thank you for listening to my testimony. If anyone has any questions, I'm happy to answer them.

REP. MCCARTHY VAHEY (133RD): Thank you, Ms. Tow, and I appreciate you getting in under that three minutes. That's impressive and you got a lot in there. Seeing no questions from the Committee, I appreciate your time and testimony and hope you have a wonderful day.

MS. JENNIFER TOW, CMMR.: Thank you.

REP. MCCARTHY VAHEY (133RD): Next on our list... Thank you for your patience. Commissioners. Please proceed and welcome.

CMMR. NANCY NAVARRETTA Good afternoon, Senator Anwar, Representative McCarthy Vahey, Senator Summers, Representative Klarides-Ditria and Distinguished Members of the Public Health Committee. Thank you for the opportunity to provide testimony on SB 274, An Act Concerning Opioids. I'm Nancy Navarretta, the Commissioner of the Department of Mental Health and Addiction Services and I'm here with Commissioner Hill-Lily from DCF. We're testifying together as we co-chair the ADPC.

So as you've heard, the Alcohol and Drug Policy Council, or ADPC, is legislatively-mandated. It's a
body comprised of a wide range of stakeholders including some of you that I am before today. So many state agencies, providers of adult and child services, experts in the field of prevention, harm reduction, treatment and recovery, individuals and family members with lived experience, Co-chairs and Ranking Members of the General Assembly's Public Health, Criminal Justice and Appropriations Committees, as well as the Child Advocate.

So we are charged, as we've been talking about, to have this coordinated discussion and developing recommendations and implementing interventions which address substance use related priorities on behalf of all Connecticut citizens across the lifespan and from all regions of the State.

Some of you have seats there and you've seen the enthusiasm of the group and their commitment to reducing opioid deaths across the life span. And you've also seen the participation of the subcommittees and the work that they do between council meetings. So the structure was set up in a very thoughtful and deliberative process and there are four domains, Prevention and Screening and Early Intervention is one sub-committee. Treatment is another. Recovery and Criminal Justice are the other two.

Through their missions and charters, each group has successfully recommended policy changes, many of which have been implemented relating to specific impacts of alcohol, tobacco, opioids and other substances across the lifespan. And this includes special populations such as caregivers and children. This bill would require the ADPC to establish a standing sub-committee to examine programs and services for parents and caregivers impacted by substance use disorder and their children and make recommendations.
DMHAS and DCF thank the Committee for how vital it is to have family-centered approaches and the treatment of substance use disorder. We cannot overstate how serious both of our agencies take the responsibility of collaborating to support the safety and wellbeing of children. We thoroughly support and currently engage in the delivery of substance use treatment programs and prevention services to families, safety planning and supports for children and targeted distribution of naloxone to parents and caregivers. The comprehensive reports that we recently submitted, Public Act 23-97, were attached.

In fact, another development is we're meeting on Monday with CHA, Connecticut Hospital Association, to develop a distribution plan for naloxone to labor and delivery, as well as EDs. I know this is something that the OCA was looking for. And in listening to the OCA and to the legislators speak today, I think we are all in agreement that the conversation is necessary and we are just saying that we think it can be accommodated within the current structure. So as Co-chairs, we have the express authority to establish subcommittees and working groups. The subcommittee structure itself is not codified, but instead is fluid. So it allows us to be responsive to current trends and substance use. So we...

CLERK: Excuse me, Commissioner, but your time is up. Thank you.

CMMR. NANCY NAVARRETTA Thank you.

REP. MCCARTHY VAHEY (133RD): If you don't mind completing that thought, I would like to hear that.
CMMR. NANCY NAVARRETTA: Sure. So for example, when we were reconstituted as the opioid crisis was amping up, we took an express desire to address the opioid crisis and we were reconstituted yo do that even within appropriated funds. And we did and we have continued to do that over the past 10 years.

If you look back, historically, the group was focused on alcohol and tobacco before this past decade because that was happened to be more of a concern at the time. So we're able to be fluid and to adjust within the prevention subcommittee, for example.

Almost 70% of the recommendations that have been put forward through prevention include expressly mentioned children and families. So in preparation for today, I went back and looked at all of the recommendations that were made over the past several years and I think that says a lot that 70% expressly mention children and families and in the rest of the recommendation, it's implied we take a two-gen approach and address lifespan issues.

REP. MCCARTHY VAHEY (133RD): Thank you, Commissioner. I know -- I'm sure there are going to be a few questions.

CMMR. NANCY NAVARRETTA: Sure.

REP. MCCARTHY VAHEY (133RD): And as you heard during earlier testimony, I have a couple of questions. I appreciate you sharing that the subcommittee structure is not codified. And I should add to -- it's nice to have you Commissioner Designate here. We don't usually see you here, and so it's nice to have you both here together. And as Senator Amar said earlier, we are grateful for the work that you all do in your agencies as well. And with that, some of those questions, the bill before
us would require that standing subcommittee. And what you're saying -- what I'm hearing you say is that prevention, screening and I forget the rest of the category --

CMMR. NANCY NAVARRETTA: Early intervention.

REP. MCCARTHY VAHEY (133RD): -- can you repeat that?

CMMR. NANCY NAVARRETTA: Early intervention.

REP. MCCARTHY VAHEY (133RD): Early intervention? Okay. So that subcommittee is set up and you've heard they quantified the 70% of the recommendations included children and families. But this proposal is really geared towards something a little more specific in that we're seeing ingestion now. And we're seeing this more because we're seeing this substance -- more -- the substances in question more ubiquitously in our society in general.

So two questions to start. 1, is, has the subcommittee really looked at that kind of specificity of the issue? Is one and then 2. The question that you heard me to ask earlier, which was have you been able to speak with anyone at the alcohol -- others members of the Alcohol and Drug Policy Council about this knowing that I too will be reaching out directly to speak with them as well.

CMMR. NANCY NAVARRETTA: So -- excuse me. So I would say that this is not a new conversation to especially the prevention subcommittee. There already have been recommendations that have come out of the OCAS report and concerns. So we were asked, for example, you know, as it was being played out in the media in these very unfortunate deaths of children. We did things like amplified our prevention messaging around safe storage.
And the fact that naloxone is safe for everyone we're going to continue amplifying that message in some of our media campaigns. We have a collaborative project where DMHAS will be training all of DCF's social workers in the state of Connecticut and commissioner can speak to that a little bit as well, but we're taking our staff, we're purchasing naloxone, we're going to distribute it across the state through the social workers that work in DCF and are actually in the homes and can talk to the parents and do some of that education. All of this is a result of these conversations around the opioid poisonings.

CMMR. JODI HILL-LILLY: So good afternoon. I can say, well, I'm at Week 5, so -- in this role, so give me a little bit of grace that we have some subject matter experts here if need be, but I'm not new to DCF. 35 years and five years as Deputy commissioner. And I have what I would consider to be a significant amount of national experience understanding what's happening in Child Protective Services across the country.

And I can say hands down that if you're looking for a partnership, what a partnership should look like on the continuum of adults and children. It's this through the ADPC. We have people who come to our office routinely and one person who I won't name specifically, she's in the room, but the guards know her well, because she's there all the time. This partnership is second to none and we are just in mourning quite frankly of what's happening in our society and to our children.

And I appreciated the testimony that or the comments that were made about us needing to all just be on the same page because I feel like we're in a war zone and we need to be together to try to be
solution focused, to figure out how we get our arms around this horrible situation that we're all grappling with and learning at the same time. DMHAS has been wonderful teachers to us. We are learning, we are evolving, we are doing the best we can and quite frankly, I appreciate the passion from the child advocate, I welcome it, I welcome the criticism. I welcome the challenge.

We need it to keep us hold us accountable. And I invite -- we met just as recently as yesterday, just talking through things. I will be at the table and those things don't -- I appreciate any comments that are made that are going to push the -- push the envelope to make sure that we do something to address this crisis. I will say as we're doing this, it -- we need to be cognizant of the fact that it doesn't make much sense to involve ourselves in duplicative efforts. Why not use the structure that we have to push that agenda as deemed necessary and appropriate?

So I don't disagree with the urgency to any of this. I don't disagree that we need to do more in terms of, you know, adding to, you know, incorporating some of these suggestions, it's the how that we're talking about and the procedures and why not use the same infrastructure. One of the things where grappling with is time and resources and the more meetings you hold, the less time we have actually doing the work. We do have a workforce shortage in DCF and among our providers. And I too spoke to a provider just yesterday who was very grateful of the work that we're doing together regarding naloxone and making it available.

And actually said to me himself, this is a national standard. I mean, in terms of the way that we've been collaborating and together. So I believe that we have the right passion, we have the right
infrastructure. I just would hope that we would consider not engaging in duplicative sort of efforts and that we would take the content of what we feel is missing, whatever that is, we're open to hearing from it, but we don't want to create another committee to create -- to address duplicative issues.

CMMR. NANCY NAVARRETTA: And I would add, there is a piece also about data and so if there are suggestions about data that we're not reporting in the triennial report. So every three years, we do a comprehensive report that covers all substance use services across the lifespan and across departments. If there's something in that report that's missing, we -- and we're responsible for that happy to have that conversation to add that data as well.

REP. MCCARTHY VAHEY (133RD): Thank you, Commissioner and I appreciate your comments about being in a war zone and the war zone is against opioids and we're all together in that. And I do think as in my earlier conversation, I'm interested in the practical realities of how we are going to most effectively address this. We're all on the same page with this. So I'm interested in us kind of drilling down to make sure that as we look at the structures, we're really getting to the roots of what we're talking about.

And I think as I listen to this conversation, I think I'm interested in talking together with you and our child advocate about how we're defining the problems in order to understand how to address them. Because of course, there are a million things that we need to do when it comes to prevent opioids, naloxone distribution and availability is one of them. Obviously, our prevention in terms of law enforcement is a piece there are so many pieces of this conversation. So I appreciate that
perspective. Senator Anwar has a question to be followed by Representative Reddington-Hughes, hold on one second to be followed by Rep. Dauphinais.

SENATOR ANWAR (3RD): Good. Thank you so much for your testimony. Thank you, Commissioner, Commissioner designate. We appreciate the work that you do. I have been part of those meetings and I see the work that goes on and I appreciate the challenges -- and then the challenging work that you are doing. And I'm also obviously privy to the work outside of that committee that you are doing and your entire team is doing. Here's the dilemma that I have right now. Children in our state are dying for a variety of reasons, but specific to the opioid crisis, they are dying, the trajectory has not changed. And if the trajectory has not changed, and that means the status quo is not good enough in my mind.

So we should not necessarily continue to do what we have been doing in anticipating that things will suddenly change. And also the bill Child Advocates Office who have the responsibility from this body and then the entire legislative body to look at every death in our community of child -- children and look at what can be done to prevent it. And they have a passionate clear view that this is the step to take. So for a disaster, that's happening every day asking us to stay the course and not even have a subcommittee to focus on that conversation. It's not sitting well with me comfortably yet.

I hear you, I hear the challenges that you have if something was going wrong and we said stay the course, I can't live with that and especially the children on the other end. So if you can help me and then perhaps this committee could be for three year duration or some duration and not be forever. Hopefully, it will not be needed in three years or a
few years from now. But I wanted to put that out there. I can't accept the status quo at all.

CMMR. NANCY NAVARRETTA: And we agree with you 150%. And I think what I heard Ms. Egan say is that she isn't wedded to codifying the subcommittee structure and she's willing to talk with us and we're willing to talk with her about time, limited work groups or depending on what areas she and the subject matter experts think are most important? Do they fall in early intervention prevention? Do they fall within treatment? Do they fall within recovery supports? We can amplify that message and, you know, look at what is happening across the nation and what are evidence based practices.

What do we want to try in Connecticut that perhaps has not been tried elsewhere? I mean, the fact that we're going to be doing education, prevention and distributing naloxone in labor and delivery. It’s both impressive and scary that this is the place that we're at. But thinking about things like that to reach the most people to make the most difference.

CMMR. JODI HILL-LILLY: I would completely agree with everything that you're saying and I agree with you, Senator Anwar. We don't want to keep doing the same thing. I don't -- we're not suggesting that we do the same thing we're saying. We use the same structure but change the content to address the issues. Sarah Egan, the child advocate is on the subcommittee. We need to leverage that voice in the structure that we have to make the changes that are deemed necessary and appropriate.

I've attended one meeting so far, and so in my capacity and I'm, I've taken the time to read up on all the policies and certainly I've been involved in certain subcommittees and some of the work and have
been really, really impressed. I have yet, even though I spent an hour over an hour with Sarah yesterday, we talked for a long time. We didn't get to this specific agenda item, but what I will tell you in talking with and dealing with my co-chair, even when I was Deputy Commissioner, we spoke often.

We need to be in a place of listening and hearing and responding and that we are committed to do. And we're just hoping that we are able to do it within the existing robust infrastructure that we already have. And the fact that Sarah is on the child advocate is on that actual subcommittee gives us the perfect opportunity to make sure that we leverage that voice and address the concerns that are on the table now.

SENATOR ANWAR (3RD): Thank you, Commissioner and Commissioner Designate. I'll just add, I read about a couple of the deaths and I was looking at it from how could have this been prevented? There are so many opportunities for prevention. I will like to see the 37 near deaths and the 12 deaths total and see what patterns there are and what can be done to have a prevention strategy and then perhaps see if that amount of work and a prevention strategy and implementation strategy would require the existing subcommittees to be able to do it or not or should we have a specific group targeting that work, even if it's for a short term to be able to look at the pattern that we're seeing and then have a prevention, comprehensive integrated prevention strategy between the two agencies and the workforce. I think that's how I'm seeing the bill work and I'll probably have to do more homework to see how the existing framework can do this. So, but I hear you and understand where you're coming from. Thank you.

CMMR. JODI HILL-LILLY: Thank you -- Thank you for that. I would be remiss if I didn't say we have
many other structures internal to the agency and external to the agency that are reviewing each one of these fatalities coming up with recommendations. So this isn't the only body that is used to make recommendations.

And I'll also add that we at DCF sit with this death as well. Looking into these deaths, looking into the workers' eyes, knowing that we're in this war zone and we're all trying to learn. We are mourning this. We have each -- we have the passion that everyone has here and yet we have to intervene with the resources that we have the knowledge that we have. And as I said, the partnership here is second to none and we are learning. We have grown as a result of this partnership just learning how best to respond to the emerging needs of our kids and our families.

SENATOR ANWAR (3RD): And Commissioner Designate, I just want to make one comment. I'm so glad the governor has chosen you to be our Commissioner. So thank you for your work that you've done all these years and anticipated work going forward. And thank you both Commissioners. Thank you.

REP. MCCARTHY VAHEY (133R): Thank you, Senator Anwar. We have Rep. Reddington-Hughes, to be followed by Rep. Dauphinais, to be followed by Representative Zupkus.

REP. REDDINGTON-HUGHES (66TH): Thank you, Madam Chair. My question has to do with the circle back to the data. With the data, is this going to be used to create a better paradigm so that you would be able to identify when a child is perhaps no longer safe in their present environment. Even though there is that desire to keep the family together?
CMMR. NANCY NAVARRETTA: There's a -- there's an outstanding question, I think as to what that data would be. So we're open to having that conversation with the Office of the Child Advocate. If there's something she thinks is missing. Right now, we do a report every three years that looks across all of the state agencies. So we're flexible in terms of, if there's a piece of data that could be helpful, we would include that.

REP. REDDINGTON-HUGHES (66TH): Great. Thank you.

REP. MCCARTHY VAHEY (133RD): Thank you, Representative. Representative Dauphinais to be followed by Representative Zupkus.

REP. DAUPHINAIS (44TH): Thank you. And thank you both for being here and I certainly can appreciate and recognize your passion, both of you. I, you know, the war zone your passion, the bill -- the work that you're doing. I really think you do want to do a good job and are working at doing that. I think what I heard Sarah Eagan talk about though was not per se you so much as is the work that's being done in these silos and the silos that need some kind of coordination’s.

So, when you talked about the structure and feeling like it didn't need to change. I would challenge that and say that that structure does need to change to include coordinating better with, you know, the other agencies, the other moving parts to this. And I think that's really what she was asking for is like we have to look at this from a bird's eye view and say, where are the gaps where in the missing pieces? Not specific to DCF, but maybe perhaps bringing all of them together. I've got to believe that you guys are all doing this job because you're passionate about it.
So I don't really question that. I question the fact that we need more of a case management style, overlook bird's eye view at all of the moving parts to come together because if deaths are occurring something missing, right? And so that's all I would say to that I didn't really have a question. I just wanted to comment on that. So thank you for being here today.

CMMR. JODI HILL-LILLY: I'm happy to just respond. Thank you for that. One of the things that the child advocate mentioned was the inclusion of the perspective of the providers, which I think is really key and we've been doing a whole lot of that. Some -- and so I do think that there is a lot of misinformation that is -- has not really been articulated here and we are more than willing and maybe this might be a solution if we were to have an opportunity to present to you all, you know what the work of the ADPC is and what we're already doing and then we can make an informed decision about whether or not this is duplicative or whether or not we need to do something different. But I would hate for us to make a decision without knowing what is in detail, what is already being done.

REP. DAUPHINAIS (44TH): Yeah, I can appreciate that. I didn't hear her saying or talking about making a decision as much as I mean, she was very open to language come in and give us your input and she was -- she was saying, I don't have all the answers. Let's come together and pull together and identify these gaps and make this a better process. So that's what I heard her say.

CMMR. NANCY NAVARRETTA: Yeah. I would just like to mention that there's actually is a strategic plan where all of the stakeholders have come together. And so there was one that covered 2016 through '21 and there's a new one that goes from '22 to '27 and
that addresses substance exposed infants statewide. So there are other forums, I won't go through all of them, but there's like a plan of safe -- safe care, stakeholder work group. And I think those kinds of meetings do exactly what you're asking for and also the fatality review committees, all those folks are in the room, DMHAS, DCF, DPH. I don't know if you --

CMMR. JODI HILL-LILLY: Hospitals, yeah.

CMMR. NANCY NAVARRETTA: -- yes, hospitals.

CMMR. JODI HILL-LILLY: Yeah. That, I mean, I think that's what I was saying is that there's a lot of work that's being done and there's a lot of different entities that are doing a lot of this work and maybe we could core with the child advocate to say, okay, here's where -- what we're doing and here are some of the gaps. I don't know if we can do that. I'm not sure what the rules are, but we're happy to present outside of this meeting so that we can make an informed decision about how best to go forward.

REP. DAUPHINAIS (44TH): Thank you. I appreciate that. I mean, obviously, the structure that is in place isn't working if children are dying. And so there has to be some evaluation of that. Where are the holes? Where are the pitfalls? How can we make this better? Thank you.

REP. MCCARTHY VAHEY (133RD): Thank you, Representative. Before I go to Reps Zupkus because I would just comment that I think we all agree that there's a gap. The question is the structure the cause of the gap or there are other causes? And that's when I talked earlier about the idea of the problem definition. And I think it's very multifactorial Representative Zupkus.
REP. ZUPKUS (89TH): Thank you, Madam Chair. And I agree with what's being said. I have always said when I served on children's, I would never want to be the Commissioner of DCF, it is brutal [laughs] but I understand what [laughs]. No, but understanding it's a difficult and even DMHAS, we all know that and your passion does show through it just happened yesterday. One of my best friends is burying their daughter, she died of opioids yesterday.

So I get it and they weren't in the DCF system. I mean, this good family, the whole thing. So it's not just one group, it's something that we need to address overall. And I am not going to reiterate the gaps. We've got to figure it out because what's happening, it's not working, what we're doing. And so I would love to hear and this is the perfect opportunity. What are those gaps? And let's put it into place and fix it because it's not working.

And my other issue is the Marijuana Bill, it passed. That's a gateway. People can argue it or not, but it's -- I'm not going to rehash, but that is we're legalizing something that is a drug and impairs people, all of those things. And so to me, I just see and now they're talking about mushrooms and all these things and we're headed down a road. People are dying from these things and the bills come out of this building. Thank you.

CMMR. JODI HILL-LILLY: I just wanted to respond by saying so sorry for your loss. And I appreciate your words that hits home because as I said earlier, this is a war zone and we're all trying to get our arms around it and believe it or not, there are different variants that are emerging. I don't want to step in my Commissioners [laughs]. It's a field there, but I cannot stress to you.
I joked a little bit about being the Commissioner of DCF I'm -- I feel like it's an honor and a humbling experience. I feel like I signed up to serve and that's what I've done because I have to speak on behalf of the staff who are feeling the pain that you're feeling. I look into the eyes of the staff every day when we -- when we lose a child, it is heartbreaking. This is gut wrenching work and there's -- we need to be together in this to try to be solution focused.

There's no other way to do this because we have a workforce shortage. We don't want to create an environment where we exacerbate the problem with people wanting -- not wanting to do this work. We got to support our workforce. And so the way we do that is to work collaboratively together to address this horrible situation.

REP. MCCARTHY VAHEY (133RD): Thank you, Commissioner, and thank you Representative Zupkus. And I would add my sincere condolences. Too many of our children and our fellow community members are being lost. And so that's what we're here to do is to do more. Thank you for your testimony today and your time, as I say often to those before us. But certainly in this case, we will be talking together about the best way forward for this. So I, we appreciate you. Next on our list is Claudio Capone followed by Carolina Bortolletto. Mr. Capone. Welcome, please unmute yourself and proceed.

MR. CLAUDIO CAPONE: Good afternoon, Madam Chair and Mr. chair and members of the Public Health Committee. I'm Claudio Capone and I serve as the Regional Vice President of Strategy and Business Development for Trinity Health, New England. And I appreciate the opportunity to submit testimony in opposition to Senate Bill 9 and act promoting
hospital financial stability. Trinity Health, New England opposes SB-9 which increases regulatory oversight and control over our hospitals without providing any assistance to address the many issues impacting our hospitals. Imposing penalties and adding more regulatory burden will help more patients get care, won't support access to care across the state and won't help the health care workforce.

These actions will however, add unnecessary costs more red tape and interfere in the care related decisions of health care providers in emergency situations. We are experiencing significant financial challenges brought on by these workforce and supply chain cost increases and that are exasperated by continued Medicaid underpayment and burdensome commercial insurance practices including restrictive prior authorization protocols. The resulting financial performance is unsustainable for us. Adding to the administrative burden of the hospitals through the con program financial reporting requirements and diversion policies under the current framework will only worsen in already fragile health care system.

We appreciate the Office of Health Care Strategy is under resourced and it's challenged to appropriately and timely carry out its current regulatory responsibilities. Our experience with OHS has always been productive but the under-resourced realities impacted us in the ability to implement CON regulated services. As an example, one of our CNS for an inter operative CAT Scanners for cranial and spine procedures in the operating room took a year to receive a decision.

This well-established technology allows for improved accuracy of implants and screw, resulting in fewer realignments and revision surgeries that May
increase the cost of care. This year long CON process should have been quicker and easier allowing for patients to receive a higher standard of clear air quicker. Therefore, we support updating the CON program to streamline the process to help improve access and reduce the total cost of care. But feel that some of the proposed changes will do more harm than good.

Focus should be on making the programs more collaborative, efficient, timely and removing unnecessary costs, reducing the regulatory burden on hospitals and healthcare systems and creating a more competitive healthcare system. We urge you to oppose Senate Bill 9 and look for ways to provide help to hospitals to support patient care and access. Thank you.

REP. MCCARTHY VAHEY (133RD): Thank you very much for your testimony, Mr. Capone seeing no -- oh Senator Anwar.

SENATOR ANWAR (3RD): Thank you, Mr. Capone for your testimony. Can you help us solve the challenge that when private equity is going to come to this, any health care system and invest with their primary goal is to make money from the bill illness of individuals. How can we as a state, protect our citizens if we do not have CON and if we do not have a bill which states what it does in Senate Bill 9?

MR. CLAUDIO CAPONE: So it's not so much that we aren't opposed to having CON on Senator Anwar, it's really revolving around ensuring that it's not too onerous for those that are already in the state, like nonprofits like ourselves. We understand that yes, we agree that some private equities should have further regulation, but the regulation should not impose hardships on the current organizations like
the not for profit health care systems already in
the state.

SENATOR ANWAR (3RD): Thank you for clarifying that.
Thank you. Thank you, Madam Chair.

REP. MCCARTHY VAHEY (133RD): Thank you, Senator
Anwar -- thank you, Senator Anwar, Senator Gordon.

SENATOR GORDON (35TH): Thank you, Madam Chairwoman,
I'll be real quick. Mr. Capone, thank you for
testifying. I also want to say thank you to Trinity
Health for the work it does up at Johnson Memorial
Hospital in my district in Stafford. If I can just
ask you a question, I know I've been working with
people to see what we can do in a common sense and
meaningful way with regards to certificate of need.
I know that Trinity Health did do a big expansion is
continuing to do expansion of some of the outpatient
facilities and services in that part of the state.

Can you just say real quickly what you feel has been
the burden to have to go through a process for
something that is expanding upon existing outpatient
services and trying to provide even more outpatient
services in communities that need it and otherwise
have to travel quite some distances or even hop the
border to another state to get those services as an
example about some of the burden you've noticed with
certificate of need.

MR. CLAUDIO CAPONE: Yeah, I appreciate that
question, Senator Gordon. I think if we harken back
to when -- ohs was well resourced. The process was
shorter for us, I think in the past couple of years,
we've seen it increase and over time which is
causing us to delay services or delay some of the
movements we want to make to expand ambulatory care
like the project you're mentioning, for example, is
one of them. So for us, it's -- it would be to
streamline the process, you know, really to go back to a process that makes more sense that asks the right questions up front and then we're not prolonging it so that we can do these expansions to provide the care in those communities and continue to expand.

SENATOR GORDON (35TH): Thank you, Madam Chairwoman.

REP. MCCARTHY VAHEY (133RD): Thank you, Senator Gordon. Mr. Capone. Thank you for your answers and your time with us today. Appreciate it. Next on our list is Carolina Bortolleto, I believe is with us online.

MS. CAROLINA BORTOLLETO: Hi. Hello. Yes, I'm here.

REP. MCCARTHY VAHEY (133RD): Hello, welcome. If you are able to turn on your camera, that would be great. If not, please proceed.

MS. CAROLINA BORTOLLETO: I can because I'm on -- I'm on my phone. Right. Hi, my name is Carolina Bortolleto. I'm a resident of Brookfield and I've been a resident of [inaudible] in Brookfield for over 26 years. I'm also undocumented. I'm a Co-founder and board member of Connecticut Students for a Dream, which is an organization that fights for the rights of undocumented youth and also lead in a Husky for immigrant coalition, fighting to expand health care for the undocumented communities. I'm here today testifying strong support of HB-5320, which is an act concerning hospital financial assistance.

I have substantial personal experience with medical data and charity care as a 26 years old -- 26 year old. Six months after I was kicked off my parents health insurance plan. I suffered a severe and
further medical emergency. I had a gastric obstruction and a rupture and I got sent to the emergency room. I woke up two weeks later from a coma to learn what had happened. And then I spent eight months in various hospitals in Connecticut. Black and Latino people reported being less likely to receive information about charity care programs and less likely to have insurance, higher rates of uninsurance means that the bullying of medical debt. So that falls disproportionately on Black, Latino and other communities of color and immigrants.

I'm not a personal color, but I am undocumented. And I saw this first hand, I'm not sure if I was ever offered financial assistance or charity here during the first hospital, I was impatient at which is why I'm glad that this bill will require hospitals to provide financial assistance to those who qualify. Well, I do you remember is the bills that my parents kept receiving in the mail while I was in the hospital. This is because 45% of nonprofit hospitals routinely send medical bills to patients whose incomes are low enough to qualify for financial assistance.

My parents tried to keep the information from me but in between my medical procedures in a moment where I wasn't in constant pain, I remember my parents whispering, what were they going to do about all these bills that wouldn't stop coming. Halfway through my eight months, I was transferred to a different hospital in Connecticut by ambulance.

And it was then the first time that I heard about hospital, financial assistance or charity care. My parents were very happy but the process was not easy. I don't remember much, but I remember working on a new application than I had at my previous hospitals. I remember long conversations with the admin from my hospital trying to explain to my
parents in English what bad funds were and asking if I could find a donor for bad funds.

Certainly a common application would have helped me when I was healing from the nine surgeries that I had in those eight months. What I clearly remember is after I was discharged from the hospital, I had ongoing care needs, I could not eat or drink anything for three years and I was dependent on the feeding tube. This required equipment formula PPN, among other things, I had to apply for charity care again.

But first I had to apply and be rejected by Husky. As an undocumented person, I did not qualify for Husky, and I clearly remember the few my parents had that I had to apply and be rejected. They thought we were going to get in trouble and I had to explain to them that this is what I had to do. I remember being bad bound in my house with a pile of papers around me trying to figure out what to do. How do I apply to Husky? Where do I mail this? Do I call the office? I had never applied for any government benefit or been on the website.

I was thinking, what do I say over the phone? How long will this denial take? If this denial doesn't get approved fast enough? How am I going to get my feeding tube formula. That's why I believe that implementing measures such as creating a common application for financial assistance, ensuring language accessibility and automatically qualify certain patients for assistance based on income level of vital steps toward making financial assistance more accessible and reducing the barriers faced by marginalized communities. And so I urged the committee to favorably pass this Bill HB-5320 and that concerning possible financial assistance policies. Thank you.
REP. MCCARTHY VAHEY (133RD): Thank you so much for your testimony and for sharing your story with us. You have been through a lot and to come here and share that with us today so that we can better understand why this work is important, we are very grateful, seeing and hearing no questions. Thank you for taking the time to be with us today and for being such a tremendous advocate. Next on the list, we have Craig Miller, Mr. Miller. Welcome. Please on mute and proceed, welcome.

MR. CRAIG MILLER: Hi, thank you, Representative McCarthy Vahey, and also thank you for your support and my nomination to the Rare Disease Advisory Council. My name is Craig Miller. I'm the Director of Immunology and Respiratory Disease Research at Boehringer Ingelheim Pharmaceuticals and a member of the Rare Disease Advisory Council. Representative McCarthy Vahey, Senator Anwar, Representative Klarides-Ditria and Senator Somers and esteemed members of the Public Health Committee.

I submit this testimony today in support of Committee Bill 175 to provide funding for the Rare Disease Advisory Council, Boehringer Ingelheim is working on breakthrough therapies that transform the lives of patients today and for generations to come. As leading research driven biopharmaceutical company. We create value through innovation in areas of high unmet medical need including rare diseases. Founded in 1885 and family owned ever since Boehringer Ingelheim takes a long term sustainable perspective to our research.

Our US headquarters are in Richfield, Connecticut and home to our North American research hub with more than 2100 employees. Today. I stand not only as a member of the Connecticut Rare Disease Council, but also as a dedicated researcher at Boehringer Ingelheim, focusing on rare disease treatments.
Throughout my 20 year career in discovering new therapeutics with a focus on rare diseases.

I have witnessed firsthand the challenging nature of these diseases and the burden they place on patients, their families and communities. First, I want to thank the committee for your support in forming the Connecticut Rare Disease Advisory Council. As a proud member, I value the opportunity to bring more awareness to the needs of those patients living with rare disease and their caregivers. I stand here today because the council lacks the necessary funding to carry out its vital work.

This bill will provide essential funding for key functions such as staff support and the creation of a dedicated website to reach out to patients. Just last week, Rare Disease Day was commemorated at the legislative office building in Hartford. I was honored to speak at this event, and more importantly to hear from patients caregivers, researchers and physicians about the challenges they face and the hurdles they have to overcome. It is evident that our continued work on the council can make a significant difference, but it requires this funding to turn that potential into reality. I thank you for your time and for your consideration for this bill and I am happy to answer any questions you may have.

REP. MCCARTHY VAHEY (133RD): Ms. Miller, thank you for your time here with us today and for your work on behalf of all those with rare diseases in our state for serving as a member of the council. Thank you for your advocacy and seeing no questions we will go on to next on our list, Cody Cuni. Cody, are you able -- there you are, welcome.
MR. CODY CUNI: Hello, good afternoon, distinguished chair member and members of the Public Health Committee. My name is Cody Cuni and I am speaking today as a resident of Hartford County, Connecticut and as an International Board Certified Lactation consultant IBCLC. I am in opposition to HB-5318 an act requiring licensure of lactation consultant. I support families in both my private practice in OBGYN office and in the hospital setting. I have a background in public health and for years was a community health worker supporting the most at risk families meet their breastfeeding goals. Licensing IBCLCs does nothing to support families in our state. It places undue burden upon the highest skilled providers while less allowing lesser credentials to practice without oversight. Sleep deprived parents will not understand the nuance between a licensed lactation consultant and someone calling themselves a breastfeeding or lactation specialist. This bill would hurt families as the language takes away any incentive for people to achieve the IBCLC credential, given that they could practice without licensure if they had a lesser credential. This bill has been proposed as a pathway to allow IBCLCs to take Medicaid.

However, this is far from certain in most states where IBCLCs have been licensed, they still do not receive Medicaid reimbursement. Even if Medicaid coverage was achieved, the reimbursement rates would not be sustainable for most private practice LC. OBGYN and pediatric offices already have options for providing IBCLC support for Medicaid recipients. If they hire IBCLCs and bill for those services, it is possible to change Medicaid requirements without the need of licensure. There is precedent for unlicensed providers to be reimbursed.

The field of lactation location is quickly evolving. The language of this bill would give oversight an
interpretation of an IBCLC scope of practice to the Commission of Public Health. This commission would not be qualified to make decisions regarding lactation support. They do not possess the education or clinical experience to do so. Nurses and physicians are overseen by a board of their peers well versed in the nuances of our profession.

We deserve to be reviewed by a board of our peers which is already in place through the International Board of Lactation Examiners, IBCLE. There’s already an avenue in place to lodge complaints and censure IBCLCs if needed. We already have continuing education and recertification requirements for -- I from IBCLE reporting to an additional board is redundant.

We need more access to care by not limiting or discouraging people from becoming IBCLC, which this bill would do. Vulnerable families, especially those low income families do not need less quality support. This bill would threaten the profession that I love and limit my ability to provide the highest quality care to family for these reasons. I urge you to vote no to this bill. Thank you for your time.

REP. MCCARTHY VAHEY (133RD): Thank you for your testimony today and for being here with us and for your work supporting new parents seeking to breastfeed. Seeing no questions from the group. I am going to just pause for a moment if you recall at the beginning of our meeting. We talked about having a group coming this afternoon testifying between approximately 2:00 and 3:00.

We're -- we're a little bit before 2 o'clock, but I am wondering if Ruth and others are ready for us to go ahead and move to the group with my thanks to those of you who are just ahead of them, we will
come back to you once we get through our speakers, Number 26 through 36. So we will have Numbers 26 through 36 speak next and then we will go back to the next folks on our list. So Ruth, welcome and thank you for being here today. Ruth. If you could press the button right in front of you -- wonderful. And would you like a chair? We move the chairs over -- there you go so you can sit.

MS. RUTH GROBE: Thank you.

REP. MCCARTHY VAHEY (133RD): Yes. Thank you.

MS. RUTH GROBE: Representative McCarthy Vahey and Senator Anwar and members of the Public Health Committee. My -- my name is Ruth Grobe and I live in Farmington where I serve as the Secretary of the Citizens Coalition for Equal Access, a grassroots disability advocacy organization comprised mostly of volunteers with physical disabilities. In my work, I have learned how many physical attitudinal and institutional barriers they face in a country that espouses equality for all. This is particularly true in the critical area of health care.

A problem that our advocates have been asking the General Assembly to address since 2017. People with disabilities lives are at risk because most medical diagnostic equipment is not accessible. House Bill 5200 shows promise but to make it stronger, our advocates are urging you to adopt revisions and additions to the language of the bill. I have submitted suggested amendments as an attachment to my written testimony and today I will try to briefly explain what we are requesting, but first, a little background.

In 2017, the US Architectural and Transportation Barriers Compliance Board published standards for accessible medical diagnostic equipment. And the
Citizens Coalition has been advocating for change since that date. However, opponents of state regulation have routinely argued that we need to wait for the relevant federal agencies to promulgate regulations based on the compliance board standards because we wouldn't be sure otherwise which standards they would accept.

Just recently, both the Department of Health and Human Services and the Department of Justice began the process of doing just that by issuing notices of rulemaking that adopt the compliance board standards in their entirety and apply them to all health care providers accepting federal funds. There is no longer any question that the standards will be when ultimately imposed nationally and therefore no longer any need to wait.

HB-5200 just moves Connecticut along to implement those uniform federal standards a little earlier. However, we do think it is important for HB-5200 to more closely track the proposed federal regulations for two reasons. First, the federal government has reasonably proposed to apply three broad exceptions to compliance. For example, the claim of undue burden.

The Citizens Coalition recommends that these exceptions be included in HB-5200 in order to reduce the hardship on medical providers. Second, the federal language includes an affirmative obligation to acquire within a designated time frame. The two most fundamental and least expensive pieces of MDE exam tables and weight scales. As presently written HB-5200 allows a medical facil -- facility to wait on any purchases until it is adding to its supply of medical diagnostic equipment or replacing a worn out piece of equipment.
Now, I would like to also call your attention to the additional health care accessibility issues that are covered in HB-5200 but not addressed in the proposed federal regulations. The -- first, the provision of adequate space in the medical exam room for a wheelchair to maneuver and second the provision of lifts to help with transferring patients with disabilities. Both of these provisions are extremely important aspects of providing health care equity. Our proposed amendment expands on the language regarding lifts to make it more specific and more relevant to the most pressing needs.

And then finally, I turn to our proposed amended language that is totally new to the bill. We proposed three additions to HB-5200. First, the creation of a fund to help with the costs associated with the health care facilities, implementation of the new requirements. Second, the adequate training of medical personnel and third, enforcement procedures.

So to summarize, I would submit to you that the suggested amended language simultaneously makes the bill stronger and yet less onerous for our state's medical facilities. In closing, I want to say what an extraordinary effort it has taken for the citizens coalition volunteers with disabilities to engage in legislative advocacy. And I want to thank the many people who have made it here to testify today.

Many of them need to expend extraordinary amounts of energy, just managing the basic tasks of daily life. And many are struggling with additional problems of wheelchair repair, delays, and scarcity of reliable caregivers. I know how weary they are. I would strongly urge you to act now. Please don't make them wait additional years for what is rightfully theirs equal treatment under the law. Thank you for
the opportunity to testify and please read the alternative bill language attached to my written testimony. Thank you so much.

REP. MCCARTHY VAHEY (133RD): Oh, thank you. But please stay with us if you would because we know we're going to have a few questions for you, Ms. Grobe, could -- there you go. Thank you. I'd like to begin by saying, thank you. What a tremendous advocate you have been and you've got a great partner in Rep. Demicco, of course. But truly, thank you.

Your written testimony is wonderful you went through a few things that were related to the compliance board standards. And then you have a few additions to that and then some new language which I appreciate the way you frame that. That it would be the ability to strengthen the bill while at the same time making it less onerous, which is just an example of how you've been willing to work together. So I thank you. I have a feeling we may have a few questions or comments starting with Senator Anwar.

SENATOR ANWAR (3RD): Thank you, Madam Chair. Ruth, thank you for being here and thank you for being a force of nature on -- on all of these important issues. How would we respond to somebody who would say that, let's wait for the federal government to give us a very specific black and white regulation and we should continue to wait. How would we respond to that?

MS. RUTH GROBE: The -- the bill standards in the -- in the rule making that has been published by both the Department of Justice and the Department of Health and Human Services. There is no question that the compliance board standards are the standards that would be used. There are some
questions about how long it should take for facilities to acquire equipment.

There are some questions about the -- I think it's called scoping, the percentage of equipment that a facility would be required to provide that is accessible. But all of those are -- could be incorporated into Connecticut Law. And as long as there was nothing that contradicted the eventual rulemaking by the federal government, the bill two could stand -- the two -- the state law and the federal laws could stand together and there would be required compliance with both.

SENATOR ANWAR (3RD): Thank you for that. And how would you respond if we were to say that there is a small group of three or four physicians or clinicians who have a practice and -- an -- and we want to change the structure and then they are barely surviving. They can't even make their payroll. How would they make those changes?

MS. RUTH GROBE: And this is why we are recommending changes to the language in HB-5200, because the federal exceptions that are in the federal rule making include that one of the exceptions would be a medical facility with a staff of 15 people or under, they would be exempted from the requirements.

SENATOR ANWAR (3RD): Thank you. Do -- do you foresee having a conversation with the DSS on the Medicaid role in helping out in some of those components or patients with the special needs.

MS. RUTH GROBE: I'm not sure how that -- I'm -- I'm not familiar enough with Medicaid. I mean, I'd be more than willing to, but somebody would have to educate me a little bit about how Medicaid works and what we could do.
SENATOR ANWAR (3RD): Okay. And when the last question again is you -- you've suggested a fund and I think the fund is going to be something that we are hoping that various private, as well as public entities would be able to help with to implement this.

MS. RUTH GROBE: Yes, I will say that we are sort of secretly hoping that if we included in the language of the bill, the exceptions, for example, undue burden is one of those exceptions that perhaps a fund might not even be needed, but that would be something that, of course, I would, you know, defer to the Public Health Committee's decision about.

SENATOR ANWAR (3RD): Thank you so much for your testimony and thank you for your advocacy.

MS. RUTH GROBE: Thank you.

SENATOR ANWAR (3RD): Thank you, Madam Chair.

REP. MCCARTHY VAHEY (133RD): Thank you, Senator Anwar Representative Demicco to be followed by Senator Gordon.

REP. DEMICCO (21ST): Thank you Madam Chair and Mr. Chair. Thank you, Ruth for coming to testify. And I just want to echo the comments of the chairs. You have been a champion for the -- for the disability community for -- for many, many years and these efforts would -- would not -- would not be even close to fruition if it weren't for what you have done. So, you -- you are to be commended and I wanted to publicly commend you for that.

MS. RUTH GROBE: Thank you.

REP. DEMICCO (21ST): So, and my contribution, it pales in comparison to yours. So, anyhow, so I just
wanted to just to clarify the bill -- the suggestion has been made in past years and it is being made again this year that we can't -- and this follows Senator Anwar's question that we -- we have to wait until we get more specific guidance from the -- from the feds. And as I understand your testimony, you -- you're telling me that there are at least two federal agencies that have already adopted these federal standards that have been -- would you want to expand on that a little bit?

MS. RUTH GROBE: Yes. Well, in the bill rule making that they have published and -- and they asked for public comment and that public comment period has closed. But in the public comment, they asked all kinds of questions about different aspects of the rule making. But the one thing they didn't ask questions about were the standards they are -- they are a given in this rule making, and so that they will not change.

And recently the bill compliance board finalized -- there was one standard that been left unfinalized in 2017. And they finally -- and they did more research and they interviewed many more people and got more public comment and then finalized the bill last standard, the bill minimum height of an exam table. They -- they finished that this year. So those standards are complete the way they are and that's the way it will stay in federal regulations.

REP. DEMICCO (21ST): Thank you for that and madam chair, if I can ask one or two more questions, I would appreciate it. So -- so -- so the other thing I wanted to ask you about Ruth has to do with the availability of medical diagnostic equipment that's accessible to people with disabilities. It has been suggested in past years, and I think it's been suggested in some testimony again this year that -- that equipment just isn't going to be available
through — the through the manufacturers. Is that accurate? And would you like to — would you like to comment on that?

MS. RUTH GROBE: Thank you. Yeah, I would say that first of all, several health care — large health care facilities have already started to acquire medical diagnostic equipment that meets the standards that Sutter Health in California, which is a very large health care provider in the state just went through a whole process of becoming more accessible in a voluntarily and then the Department of Veterans Affairs in their facilities, they have adopted accessible medical diagnostic equipment as a requirement to be provided in their facilities.

And so there must be some accessible equipment available. But again, in the exceptions that are in the federal rule making and that we would recommend for HB-5200 in the exceptions, if you can't find a piece of equipment that may, you know, if it's not for sale or it's unavailable, that would count as an exception. So there — and I just went online and put in accessible exam table and immediately one popped up. That was a combination exam table and weight scale and it was only $8500. So, I think it's available.

REP. DEMICCO (21ST): Thank you. I appreciate that. And then the other question I would have for you has to do with again, there was — there was some discussion I believe in testimony that will be presented later. That the expense of reworking the building spaces that you propose in order to accommodate larger wheelchairs and so forth, would you like to comment on how that expense can be ameliorated?

MS. RUTH GROBE: Well, clearly, that is a big issue here. And what I would say to that is that I would
at least like to have that provision as a preventative measure. Our advocates have been telling us for years that even when big medical facilities go through rehab or open new facilities, they often aren't any more accessible than the old facility was.

In fact that no attention was paid to physical accessibility. So it would be very helpful to have a statute in Connecticut that would make, when new facilities were built or when facilities were rehabilitated, something that made the planners pay attention to physical accessibility as part of the planning and building process.

REP. DEMICCO (21ST): Thank you. And I wanted just to reiterate for the benefit of my colleagues as well as the Chairs, that some of the testimony or the proposal that you submitted that amends House Bill 5200, would actually rather than hinder it, would actually help medical facilities to be able to meet these guidelines because it does provide for exceptions and it does provide for financial assistance, if that's necessary.

So I just wanted to thank you. Thank you for that contribution. As I said to a previous person testifying on a previous bill, we are here to listen to the public and to try to make these bills better. And I think that your contribution and the contribution of the Citizens Coalition for Equal Access actually does make this bill better. And I hope that this Committee will consider it. Thank you, Ruth.

MS. RUTH GROBE: Thank you. Thank you so much.

REP. DEMICCO (21ST): Thank you, Madam Chair.
REP. MCCARTHY VAHEY (133RD): Ruth, we have one more question from Senator Gordon. Senator Gordon.

SENATOR GORDON (35TH): Thank you, Madam Chairwoman. Thank you for your advocacy. As a doctor, I've been well aware of folks with all sorts of disabilities. And it's just not physical but also intellectual as far as getting in the test they need. And I know a couple of years ago we spent a lot of money in my office to get new exam tables. I think it cost around $100,000 overall, which is a lot of money to get, good exam tables that actually would meet the federal provisions. Because we knew that there was a need.

So the equipment is, you know, certainly there. And I think it's very important as was discussed. And one of my questions to you is you are looking to have in to this bill, the provisions that's in the federal rules as far as the exceptions, because there are private practices that are struggling. I've heard from a lot of those doctors, my colleagues, where they're just not able to either afford that right away and they might have to do it in piecemeal. They buy one and then they can budget for another, you know, given some of the expenses.

But also they may not have an exam room large enough, for example, and they can't change their layout easily. But it sounds like my question to you is, you're looking to have some of those exceptions put in for people who would want to in good faith, try to do it, but they either can't do it right away or they just might have to phase it in depending upon, you know, some of those aspects. Is that correct?

MS. RUTH GROBE: Yes, that's absolutely right. Undue burden. Fundamental alteration is another
exception. So there, yes. We really want to work together with the medical community, not be at odds.

SENATOR GORDON (35TH): And the last question I have real quick is who would be making the determination here in the State? Would that be DPH would review and say yes, you meet the exception? Is that how, if we're gonna put this in the bill, would that be what you're envisioning? Is that the agency?

MS. RUTH GROBE: I'm not a lawyer, I'm a social worker, so I'm not sure how the enforcement would work. But presumably the same way. My understanding, and this might be wrong, on the federal level is you submit that the undue burden request or whatever as usually honored unless there's some kind of litigation associated with it. But that could be wrong. I'm sorry, I don't know. I'm not sure.

SENATOR GORDON (35TH): I appreciate that. I just want to make certain that, you know, it's clear in the process. I think having the exceptions would be important. Especially again, those who in good faith want to make the effort, but they can't do it in one fell swoop, especially for small practices. But I do very much appreciate your advocacy and the advocacy of others on this. Because it is still an unmet need even though I know the profession has made a lot of strides in general. But there's certainly more to see what we could do and we just want to balance those different interests. So overall we could see what to do together. So thank you for advocating for it.

MS. RUTH GROBE: Thank you so much.

REP. MCCARTHY VAHEY (133RD): Thank you, Senator. Ruth, thank you so much for being here with us today. [inaudible background voice] [laughter]
That's wonderful. That's a good thing. [laughter] Well, Rep. Demicco, I'm gonna ask you to do me a favor and move that chair back over, if you don't mind. Next on our list is Suzanne Garraffa. Suzanne, you are... All right. We're so happy that you are coming up.

So Suzanne, so I'll read the list off so that everyone knows. You may know your order already. But Suzanne is followed by Charles Hutchings. And then by Jennifer Kane, and after Jennifer is Carmen Myers. So speaking of needing space to maneuver the legislative office building is not necessarily the most user friendly, is it? Yes, we had a bill in Planning and Development on that to have a task force. Not sure that task force ever was seated, but...

MS. SUZANNE GARRAFFA: Hi, my name is Suzanne Garraffa. I'm with the Equal Access Group. I also have [inaudible]. I'm gonna ask Ruth Grobe to read my testimony because I'm unable to. Okay?

REP. MCCARTHY VAHEY (133RD): Yes, Suzanne, thank you. And Ruth, you are more than welcome to sit and see where you were or wherever you're more comfortable.

MS. RUTH GROBE: No, no, you're fine. Good afternoon. I am testifying in favor of what will hopefully be a modified version of HB 5200, An Act Concerning Health Care Accessibility for Persons with a Disability. Two and a half years ago, I was referred to the Citizens Coalition for Equal Access by my advocate at Independence Unlimited. Because I wasn't able to find an accessible weight scale at Hartford Hospital.

I had drafted a petition and gotten 100 signatures but I never heard anything from the Hartford Health
Leadership in response to the petition. My primary care physician has been concerned about my weight and diet for approximately three years. Even though my doctor is part of Hartford Health and his office is in a building with many doctors offices, there is no accessible weight scale in the building. And I am never weighed when I go for a checkup. I currently do not know what my weight is.

When my doctor referred me to a dietician, there was no accessible scale in her office either and she scolded me for coming to her without knowing my weight. My doctor told me to go to the emergency room to get weighed. But did not give me any help in how to make an appointment or what to do. When I called on my own, I was told by the ER that this is not possible. This is not the only accessibility issue that I have had.

In fact, because I cannot stand and pivot on my own. I have been refused for X-ray service by Jefferson Radiology. I have gotten so desperate that I filed an ADA complaint. Because I have severe dyslexia doing this was very hard on me. And I don't think that my fellow advocates with disabilities should have to go through this process when many of them already have to struggle with the basic tasks of daily living.

Inaccessible medical diagnostic equipment is a problem with the health care system. And the Citizens Coalition for Equal Access has been working for years to get legislative remedies including in the present session when we are advocating for some different language for HB 5200. Please consider our recommendations and please support HB 5200. Thank you.
REP. MCCARTHY VAHEY (133RD): Thank you. Thank you both and Ruth I love that we're hearing from you and Suzanne. Did you want to add anything else?

MS. SUZANNE GARAFFA: No, I just need you to really, really support this so we can make a difference in our [inaudible].

REP. MCCARTHY VAHEY (133RD): Thank you.

MS. SUZANNE GARAFFA: If you don't support it, we're gonna have really big trouble because we can't get around at our doctor's appointments or doctor's places. Okay. So please think of us when you're doing this. Please support this.

REP. MCCARTHY VAHEY (133RD): Thank you so much for taking the time and making the effort to be here with us today. We're so grateful.

MS. SUZANNE GARAFFA: I hope it works. I didn't mean to get that bad.

REP. MCCARTHY VAHEY (133RD): No, you're good. So next, we have Charles Hutchings. And again, Charles will be followed by Jennifer Kane. Is Charles here? Oh, hi, Charles. Okay. We'll just wait just a moment. Hello, Mr. Hutchings, welcome.

MR. CHARLES HUTCHINGS: [inaudible]

UNNAMED SPEAKER FOR MR. HUTCHINGS: Want me to read it for you?

REP. MCCARTHY VAHEY (133RD): Okay. You would like your friend to be able to read your testimony? Okay. Hang on one second. Senator Anwar is going to help make sure that the microphone is able to pick you up and pick up what you're saying so that everyone can
hear it as well as those who are watching. Thank you.

UNNAMED SPEAKER FOR MR. HUTCHINGS: Hello. My name is Charles Hutchings, testimony on HB 5200. Good afternoon, Members of the Public Health Committee. My name is Charles Hutchings and I live in Unionville. I have had cerebral palsy all my life. I have a speech disability and use a wheelchair. In addition, over the past few years, I've had multiple health issues including developing lupus, aspirating, being catheters, using a feeding tube and experiencing two broken lumbar vertebrae. Recently, a third one showed up. All these health conditions have resulted in my having multiple X-rays and MRIs.

Recently, I went to the outpatient pavillion at UConn for an X-ray of my back. In order to try to take the X-ray with me in my wheelchair. The medical technician kept telling me that I should keep moving forward in my chair even though I tried to warn him several times that my chair was too big to fit. My speech disability makes it difficult for them to understand. So I had asked to bring my friend, Carmen, into the X-ray room so that she could help. But my request had been refused. Afterwards, we called Carmen and after I ran my wheelchair into the X-ray, then they called me in. The machine and made a dent in it. After he made a dent in it while following the attendant's instructions.

This story is an example of two issues that are included in HB 5200. The need for lifts to transfer a patient to the X-ray table and the need for medical personnel to be trained to listen to what a person with a disability has to say about his accessibility needs. Even in medical facilities where there is a lift present, it doesn't always
work for me because my legs don't bend. I need a Hoyer Lift, not a Sara.

When I try to tell medical personnel what my needs are and what doesn't work, they do not take the time to listen. One time, some medical attendant tried to force my legs into the Sara Lift and turned my heels in the process. Medical facilities need to be prepared for the diverse needs of people with disabilities and the staff needs to be trained to listen and respect what the patient tells them.

I am glad that HB 5200 addresses the issue of space in doctors' offices. I am a live tall man and my motorized wheelchair is large as well. When I go to the dentist, I stay in my wheelchair because it reclines. But the staff has to move everything out of the room in order to accommodate me. I also have to go to the pulmonologist for checkups on a regular basis and his office is not set up to accommodate a wheelchair.

The doorways are very narrow and the examining room is so small that I have to back my wheelchair into it. There are obstacles such as chairs, stools, so I frequently steer my chair at the exam table by mistake. I would argue that not only the medical diagnostic equipment needs to be accessible, the office space does as well. Thank you very much for your considering my testimony.

REP. MCCARTHY VAHEY (133RD): Thank you very much. Is there anything else you would like to add?

UNNAMED SPEAKER FOR MR. HUTCHINGS: Do you want to add anything else, Charles?

MR. CHARLES HUTCHINGS: Yeah, only [inaudible] plan.
UNNAMED SPEAKER FOR MR. HUTCHINGS: Only that they need to come up with a better plan.

REP. MCCARTHY VAHEY (133RD): Yes, we need to come up with a better plan. And we hear you loud and clear that we should be listening to you about what you need and that our providers should as well. So thank you so much for sharing your testimony with us and for being here today. So next on our list is Jennifer Kane, to be followed by Carmen Myers.

MS. JENNIFER KANE: I'm going to use [inaudible]

REP. MCCARTHY VAHEY (133RD): You want me to read it?

MS. JENNIFER KANE: Please.

REP. MCCARTHY VAHEY (133RD): Ms. [inaudible], may I ask, are you going to read the testimony for Jennifer?

UNNAMED SPEAKER FOR MS. JENNIFER KANE: Yes.

REP. MCCARTHY VAHEY (133RD): Would you...? That's fine. That's absolutely fine. Do you mind if you... are you able to be at the chair just so that people watching can see you? It's not necessary. Whatever is easiest for you, honestly, for both of you.

UNNAMED SPEAKER FOR MS. JENNIFER KANE: I'm coming over here, [inaudible]. Okay. Good afternoon, Members of the Public Health Committee. My name is Jennifer Kane and I live in Unionville. I suffered a brain injury at the age of 24 and it has affected my mobility so that I have to use a wheelchair. I have been submitting testimony for several years about the issue of inaccessible medical diagnostic equipment. And I'm here today to ask you to support
HB 5200, especially if you adopt some of the language submitted by the Citizens Coalition for equal access. A patient with a disability should be responsible to request any special accommodations in advance of their medical appointment. But by the same token, a doctor's office should be responsible to provide the accommodation, and frequently at the moment, this is not the case. I already have a brain injury. I need to stop banging my head against a legislative brick wall. Please support HB 5200 and language that would make it stronger and easier to pass. Did you want to say anything?

MS. JENNIFER KANE: No.

UNNAMED SPEAKER FOR MS. JENNIFER KANE: No, you sure?

MS. JENNIFER KANE: Yeah.

REP. MCCARTHY VAHEY (133RD): Well, that was very well done. Thank you for that. We have a couple questions or comments. So if you can stay there where you are, that would be great. Senator Anwar.

SENATOR ANWAR (3RD): If I can ask you for a favor. Would you be able to just speak in the mic and speak about the legislative brick wall sentence again, please. [laughter]

REP. MCCARTHY VAHEY (133RD): Good.

UNNAMED SPEAKER FOR MS. JENNIFER KANE: No, you say at this time. You said it to me. [laughs]

MS. JENNIFER KANE: I don't know where it is though.

UNNAMED SPEAKER FOR MS. JENNIFER KANE: What? Oh, here you go. I already have a brain injury.
MS. JENNIFER KANE: I have a brain injury. Please stop. I need to stop banging my head against a legislative brick wall. Please support HB 5200 in language that would make it easier to pass, stronger and easier to pass.

REP. MCCARTHY VAHEY (133RD): Thank you so very much. We appreciate you and all of the effort and time that you took to get here today. Thank you. So next up, we have Carmen Myers, to be followed by Alexandria Bode, and forgive me if I'm mispronouncing your name. You will correct me. Welcome, Carmen. Okay.

MS. CARMEN MYERS: Good afternoon, Members of the Public Health Committee. My name is Carmen Myers. I live in Farmington. Today, I want to tell you why I support HB 5200, An Act Concerning Healthcare Accessibility for Persons with Disabilities. I have COPD, it means chronic obstructive pulmonary disease and congestive heart failure. And arthrogryposis, which is a congenital muscles and joints disease from birth. And I use a wheelchair.

I have had a lot of health issues in recent years and I have had some bad experiences because I cannot count on the availability of accessible diagnostic equipment. Even if I call ahead and warn of my disability. At one point, my doctor wanted me to have a stress test, but I couldn't do it because there was no way for me to get on the machine. You got to literally climb up high. At another time when I had an MRI, the technicians had to force my neck and head into a cage and it was very stressful and a little painful.

Because of my health issues, it is critical for me to watch my weight. My primary chiropractor does not have an accessible scale in her office. So I have to find alternatives. Let alone I have to go
in through the back door to get into the bottom level because there's no accessibility upstairs. But I'm grateful that at least she has a room and actually a table that's a little low, which I was very amazed by. But there is no way to get weighed when I have an appointment at hospital for special care, I can weigh myself.

But even there, I have to go to a different department in order to find an accessible scale. But at least I found one. Please help people with disabilities to access the care we need by supporting HB 5200 and by considering the alternative language that has been suggested by the Citizens Coalition for Equal Access. Thank you very much,

REP. MCCARTHY VAHEY (133RD): Carmen. Thank you so much for being here today for your testimony and sharing the specifics of your story which are very compelling. So we appreciate,

MS. CARMEN MYERS: I appreciate you taking the time with me. Thank you.

REP. MCCARTHY VAHEY (133RD): Thank you. Next on our list, we have Alexandria Bode. I'm not sure if I'm saying that correctly. And then followed by Valerie Rumpf. Hello.

UNNAMED SPEAKER FOR MS. ALEXANDRIA BODE: I'm going up to the table right now. I'm just gonna grab a chair to sit next to you.


MS. ALEXANDRIA BODE: How are you?

REP. MCCARTHY VAHEY (133RD): I'm good. How are you today?
MS. ALEXANDRIA BODE: Very well.

REP. MCCARTHY VAHEY (133RD): We are very happy to have you here. And it looks like you have someone with you.

MS. ALEXANDRIA BODE: Yeah. Isn't that [inaudible]? I know [inaudible]

REP. MCCARTHY VAHEY (133RD): And someone who will read your testimony? Oh, I'm sorry to interrupt you. Go ahead.

MS. ALEXANDRIA BODE: Yeah, [inaudible].

UNNAMED SPEAKER FOR MS. ALEXANDRIA BODE: I'm the Executive Director of a nonprofit called Peace Love Accessibility and it focuses on access for all.

REP. MCCARTHY VAHEY (133RD): So if I can ask you, if you don't mind moving the microphone. There you go. Thank you. And if you would also just share your name, please, that would be wonderful.

UNNAMED SPEAKER FOR MS. ALEXANDRIA BODE: Is this on?

REP. MCCARTHY VAHEY (133RD): Yes, it is.

MS. OLIVIA DELVAS FOR ALEX BODE: Okay. My name is Olivia Delvas. So I'm one of Alex's many PCAs.

REP. MCCARTHY VAHEY (133RD): Welcome.

MS. OLIVIA DELVAS FOR ALEX BODE: And I'm going to read her testimony on behalf of Alex.

REP. DEMICCO (21ST): Madam Chair, can I suggest just for ease of hearing that maybe you could move
over to a different microphone just so we'll all be able to hear you more clearly.

REP. MCCARTHY VAHEY (133RD): Yes. Thank you, Representative Demicco. That would be wonderful. Alexandria, we're just going to have and...

MS. OLIVIA DELVAS FOR ALEX BODE: Al, I'm just moving over to a chair, a different mic over here.

MS. ALEXANDRIA BODE: [inaudible]

MS. OLIVIA DELVAS FOR ALEX BODE: All right.

REP. MCCARTHY VAHEY (133RD): Thank you.

MS. OLIVIA DELVAS FOR ALEX BODE: My name is Alex Bode. I'm writing to passionately advocate for passage of HB 5200, An Act Concerning Health Care Accessibility for Persons with Disabilities. My experience during a recent medical sleep study underscores the urgent need for this legislation. Despite assurances of accommodations, my disability was met with disregard and discrimination.

Upon arrival, instead of including me in any decision, staff unilaterally decided to physically move me by picking me up, although a patient lift was available and in the room. This was done ignoring any of my needs or preferences. When I required access to the bathroom during the night, I was informed that it wasn't reachable via their patient lift, which meant I did not have access to any bathroom. The solution to their inaccessible bathroom presented to me was humiliating and degrading.

Regrettably, this experience isn't an isolated incident but rather a common occurrence of disrespectful treatment endured by individuals with
disabilities within health care settings. The passage of this bill is long overdue. It would bring about essential changes to ensure that individuals with disabilities are treated with the dignity and respect they deserve in health care settings. I ask you to please support this bill and consider the stronger language proposed by CC Equals A. Please work towards a health care system where everyone, regardless of ability, can access care with dignity and equality.

In closing, Alex would like to recite a quote from her favorite disability advocate, Judith Heumann. Disability only becomes a tragedy when society fails to provide the things we need to lead our lives." Thank you.

REP. MCCARTHY VAHEY (133RD): Thank you so much for that powerful testimony and for sharing your experience with us. What's clear and a theme that we're hearing today is that your voice and your wishes are not being heard and we're here today to help address that. It looks like we have a question for you or a comment from Representative Welander.

REP. WELANDER (114TH): Thank you, Madam Chair. It's probably more of a comment. And I just wanted to... I was listening out of the room to everyone testifying and I just wanted to acknowledge the indignity that you've all been treated with. And the lack of respect that you have been treated with in sharing your stories, in your experiences. It's been hard to listen to.

And I just appreciate you all taking the time to be here today to explain what you've been going through and how you are advocating, not only for your own personal health, but for the betterment of everyone. So, I'm sorry that these situations happen to you and Alexandria specifically, I'm sorry about that
situation at the sleep study. And I do hope we can make things much better moving forward.

MS. ALEXANDRIA BODE: Thank you.

REP. WELANDER (114TH): Thank you. Thank you, Madam Chair.

REP. MCCARTHY VAHEY (133RD): Thank you, Representative Welander. Thank you for being here with us today, Alex. Next on our list is Valerie Rumpf, to be followed by Maureen Amirault.

REP. MCCARTHY VAHEY (133RD):

MS. VALERIE RUMPF: Hello.

REP. MCCARTHY VAHEY (133RD): Welcome.

MS. VALERIE RUMPF: Hello, ladies and gentlemen. My name is Valerie N. Rumpf and I'm with the Citizens Coalition for Equal Access. I'm here to support House Bill 5200 regarding accessible medical equipment. I do have some personal stories that I've had with the health care system in the past year, especially dealing with diagnostic medical equipment. I recently had to go for an MRI of my lower back because I have cerebral palsy and I have all the "wonderful orthopedic issues" that go along with it.

And one of them was, I did have to go for an MRI on my lower back. And for me, trying to transfer out of my power wheelchair and into the manual wheelchair that they had at the MRI facility over at UConn, that that was a pain in the butt because first of all, the chair that they had me transfer into was extremely heavy and clunky. But I do understand why I couldn't take my own chair into the MRI room because of, you know, because of obvious
safety reasons. But it got me thinking what, you know, what if a patient with a disability couldn't transfer into a manual chair by themselves, you know? Is there a lift or anything available?

Also I've had to have X-rays done too. And for me, trying to get on the X-ray table, that was a pain in the you-know-what, too. Oh boy. And also, I've had a couple of other and, you know, diagnostic images done and also tests. Just trying to actually physically get on the equipment, especially when it's not adjustable, it's not a good situation.

I've also had to go for an eye exam at one of my doctor's offices and just trying to get into the room with and with my power wheelchair, that's, I felt like I had to Tetris my way into the room because the room was so small. I'm just hoping that this bill passes so that people with disabilities don't have to go through all of this rigmarole just to get, you know, just to get the proper health care that we deserve. Thank you.

REP. MCCARTHY VAHEY (133RD): Oh my goodness. Thank you. Thank you again for sharing your story and explaining the difficulties that you face in trying to access care. And we're grateful that you took the time to get here and made the effort to get here today. Thank you so much. Next on our list is Maureen l and Amirault. And Maureen will be followed by Gary Gross. Hello, Maureen. Welcome.

MS. MAUREEN AMIRAULT: Yeah, thank you, Representative McCarthy Vahey and Senator Anwar and Members of the Committee. My name is Maureen Amirault. I am a resident of Weathersfield and I have muscular dystrophy. Before I make a new appointment with a new medical appointment, I have to call ahead to ask about the accessibility of the office. Does the equipment raise and lower? Will
the exam room be large enough to accommodate my wheelchair? Will I be able to transfer safely to an exam table or chair? I traveled to a dentist's office this past summer, they assured me they were accessible, but when I got there, my chair could not fit into the exam room or into the hallway. And while the dental chair was adjustable, the stationary armrest prevented me from a safe transfer. I went through a total of three dentists and five eye doctors in a period of six months before finding offices that were accessible to me. I was actually lucky in this case because despite the hassle, I was able to find locations that met my needs.

But with other medical appointments, it hasn't been as easy. When a facility is not fully accessible, the solution I'm given time and again is that we'll just do the best that we can. And I've learned that sometimes that means we can't do anything at all. And there have been many tests and cancer screenings that I have not been able to do because of inaccessibility. And here are a few examples of other issues.

I had a few years ago, I had a Melanoma, but the best that we can do to monitor my skin is a less than thorough skin check. I have lymphoedema and I need ultrasounds to check for blood clots. But because I cannot get onto the exam table or turn over, the best we can do is get images of just the tops of my legs. I went to the lymphoedema specialist, I could not get onto the table. So the best that we could do is just get a few measurements of my legs and just eyeball the rest.

I had an urgent endoscopy and colonoscopy scheduled. Not for a routine test, but because I had symptoms, they scheduled to admit me the night before to help with the prep. This was not something I could do on
my own. But they're supposed to call me when they were ready for me to come in, but they never did and they did not return my phone calls. When I finally talked to them a couple of days later, they said they explained that they no longer help with the prep. And when I followed up with my specialist, he said, 'Well, we'll just assume that the stool test was a false positive and we'll just closely monitor your situation.' But how do you closely monitor a situation when you don't have accessible testing options? And the answer seems to be, you don't.

I haven't had an endoscopy or any further tests. And we're just gonna wait and see what happens with this GI issue. We're not monitoring for my lymphoedema and blood clots even though my lymphoedema is getting worse. And there are no alternative forms of testing, monitoring or treatment that have been offered to me at the end of the day. The best we can do is nothing at all. And that's not good enough. In fact, it's pretty terrible. Without the intervention and the basic standards, or the revised standards outlined in HB 5200, it will only get worse. It will get worse for me and the tens of thousands of disabled residents in Connecticut. Please remember us and our stories and support this important bill. Thank you.

REP. MCCARTHY VAHEY (133RD): Thank you for that powerful testimony. The best we can do is nothing else, is not an answer that any of us should ever hear. And it's concerning to hear what you're sharing as it has been to hear all the stories today. Thank you very much for being here and I apologize for mispronouncing your last name. I was way off. Our next guest here today or visitor—testifier... I always want to say 'witness'. It's I think being raised by a lawyer. Gary Gross, to be followed by Andrew Bate.
MS. RUTH GROBE: Let me get you as close to the mic as I can hang on. Okay, go for it.

REP. MCCARTHY VAHEY (133RD): Thank you, Mr. Gross. Welcome.

MR. GARY GROSS: Welcome. Thank you for having me. I wanna say a couple of things and then I'm gonna have Ruth read my testimony because I like what I wrote better than what I'm gonna say. It seems like we've been here a lot of times talking about the same thing. We need to have 5200 pass so all the people in Connecticut who have physical disabilities, you know, can have exam tables and lifts that really work. Now I'm gonna have Ruth read my testimony.

MS. RUTH GROBE: Thanks, Gary. Almost every CC Equals A member has a story to tell about inaccessible health care. But many of us are also very discouraged, isolated and dealing with many problems. Many people with multiple disabilities like myself face tons of problems, including delays in wheelchair repair and difficulty finding caregivers. I want to thank my fellow advocates who are here today because it is stressful and difficult.

Now, let me share my personal experience about medical diagnostic equipment. Every few months, I used to go for a Botox shot to help alleviate spasms in my inner thighs and tightness in my knees from my cerebral palsy. I brought my aide who had to lift me onto my doctor's exam table because it was not accessible. This is dangerous for both her and me. When I lost my aide and had to hire somebody else, the new person was not willing to transfer me manually.
So I had to give up on the shots. I like my doctor and have a long standing relationship, but I don't think that he will get an accessible table or lift without some kind of incentive. As I age, transferring becomes increasingly difficult because my body has started to break down even more. This makes me aware that HB 5200 could be as important for seniors as it is for people with disabilities. Thank you for considering my testimony.

MR. GARY GROSS: And I just want to say one more thing. I wanna thank Ruth Grobe very much, and Representative Mike Demicco very much. So thank you, Ruth and Mike.

REP. MCCARTHY VAHEY (133RD): Thank you for that Mr. Gross and thank you for talking about and acknowledging the difficulty of getting here and sharing this message. And we hear your message, and we're very grateful for you being here in person with us today. Next, we have Andrew Bate and then finally, will be Mary-Ann Langton.

MR. ANDREW BATE: That should work. Thank you, Senator.

REP. MCCARTHY VAHEY (133RD): Welcome.

MR. ANDREW BATE: Thank you, Senator Anwar, Representative McCarthy Vahey and all Members of the Public Health Committee for the opportunity to speak in strong support of HB 5200, An Act Concerning Accessibility for Persons with Disabilities. In my personal experience, I now recognize that I have not had a comprehensive physical exam since my adulthood because I have been unable to get up on an examination table since about my mid twenties. In my professional experience as a social worker, I can see that while I'm not aware of any deaths, I am aware of several close calls where treatment was
delayed and there was a longer treatment course for recovery time. Let's see. My apologies. One second, please.

REP. Mccarthy Vahey (133rd): No need to apologize. Take your time.

Mr. Andrew Bate: There we go. Due to the access to -- due to lack of access to accessible medical equipment, and that would be such as, in these instances that I'm aware of, they involve the breast, pelvic and prostate cancer screening. And we all know how important that is, or at least people with disabilities are told all the time. They are told all the time to get those through the media.

I would ask you, please pay particular attention to the proposed amendment attached to the testimony of Ruth Grobe, the Secretary of the Citizens Coalition4Equal Access. The proposed amendment provides for additional protections for small private practices and undue [inaudible] exception for those practices or hospitals that cannot demonstrate -- that can demonstrate that they not financially comply and establish. And then with HB 5200 and establishes a fund in order to help practices comply with of this legislation.

Some or all of you may be aware of the federal regulations written by the United States Office of Health and Human Services to address these issues. And some of you may be asking, Why not wait for the federal government? In my opinion is that if the Connecticut State legislature takes no action on this issue, it may already be too late for some people in this room. And I just want to add that, I think it was Maureen that mentioned that she didn't have access to the proper medical equipment to get a
colonoscopy. Well, that's what I mean by a close call because that delay is gonna cause a problem.

I attached to my testimony, a report that in 2021 the National Council and Disability entitles enforceable, accessible medical equipment standards and it's necessary to access the opportunities of persons with disabilities. I wanna say that in that "[table]", it indicates that various federal agencies have been working on this issue since 1991. Thank you.

REP. MCCARTHY VAHEY (133RD): Thank you so much for your testimony today. And you and your fellow testifiers have raised so many very powerful and important points to us here. Senator Anwar.

SENATOR ANWAR (3RD): Thank you so much, Madam Co-chair. I just wanted to make a few comments for the Connecticut Coalition for Equal Access. It takes a lot of effort to come here, look at the logistics and the work. And I'm sorry, you had to come here to ask for what is your right. I'm so sorry that you had to come here to ask for what is your right. What should have been your right. And you should have been taking care of your average daily activities rather than being here to say, How long are we going to wait for this?

And also all the advocates, all the people who have spoken about how long we're going to wait for this, our hope is that we should be able to address this as a body. We should be able to address this as a Public Health Committee. You are equal partners, equal citizens. And more equal citizens than others at times because you need our help. We need to work together and then your asks are very simple.

You're asking that you just get the care that you deserve. You get to be able to be weighed, to be
examined, just like anybody else is. If you get an examination, a radiologic test, you should be able to get that. You should have equipment that should be able to address your needs according to your needs. And all the health care workforce should have the empathy, kindness and willingness to work and recognize what your experience is and to be able to help you through that process.

So your testimonies, your efforts, it is something that we have all heard. We will... I'm touched. I know my colleagues are touched. We are here for this purpose and we are hoping that we will do the right thing going forward, and listen to the very fair suggested new language that you've talked about and then get this out of the Committee. Then after that, hopefully advocate to the rest of this body to do the right thing. And then then also ask the state government to be able to put resources so that the fund would have money so that we can create a mechanism to address this. So thank you. Thank you and thank you, and we appreciate you being here. Thank you, Madam Chair.

REP. MCCARTHY VAHEY (133RD): Thank you, Senator Anwar. Representative Welander.

REP. WELANDER (114TH): Thank you, Madam Chair. Andrew, may I ask a question?

MR. ANDREW BATE: Yes.

REP. WELANDER (114TH): Is it safe to assume that you and your colleagues who are here today, and those who are not able to be here today, have all had to skip routine health care over the years?

MR. ANDREW BATE: Yeah, I think that would be accurate. Yes.
REP. WELANDER (114TH): So the regular testing that we are all encouraged to do and sort of sometimes chided by our physicians because we recognize through decades of scientific research that early detection is key, those exams and those tests you have not been able to attend to?

MR. ANDREW BATE: No.

REP. WELANDER (114TH): Okay.

MR. ANDREW BATE: In my professional experience when I was at the [inaudible] Hospital as an intern, it was known that if you lose a certain percentage of your body weight that over a three-month period, you have to get re-evaluated. You have to be evaluated for a change of position. And you know, I haven't been weighed since my mid-twenties. So while it may seems like a great idea for somebody that wants to hide their weight, [laughter] it's not a good idea if you want to stay healthy.

REP. WELANDER (114TH): I appreciate your sense of humor in this, very much, but I think it's important to note, not only for people who may be wondering how, what kind of burden are we going to be asking medical facilities to take on, what are the long-term costs?

If we have to take something that is a very human issue and break it down to a fiscal issue, what are the long-term costs of a large group of people unable to attend to early-screening and early-diagnostic medical procedures that can not only improve their own quality of life but also save money for the insurance companies and individuals and different providers in the long run. Like this seems to be a bit of a no-brainer across the board.
And I think Gary, I believe, made the very smart point that this is also for people who are just senior citizens who have mobility issues and this is a growing population. So thank you very much for your time today, Andrew, and your testimony and I appreciate it. Thank you, Madam Chair.

REP. MCCARTHY VAHEY (133RD): Thank you. Thank you very much, Gary, and to everyone from the Citizens Coalition for Equal Access Group for being here with us today. We do have another, actually one other person. I'm sorry. Mary-Ann Langton. Welcome.

MS. MARY-ANN LANGTON: Hello, Co-chairs Anwar and McCarthy and Members of the Public Health Committee. My name is Mary-Ann Langton and Jill Bantevenko, who is my assistant will be reading my statement that I have written for today's hearing. I am extremely supportive and excited about HB 5200, An Act concerning Health Care Accessibility for Persons with Disabilities.

But I would also urge you to adopt the alternative language that will be proposed to you by the Citizens Coalition4EqualAccess. There are 55,000 folks with mobility disabilities in Connecticut that are not getting adequate medical exams and so forth due to inaccessibility of medical machines and/or equipment. In addition, people who are obese and the elderly would find these accessible features useful, too.

The State of Connecticut is failing in their responsibility of requiring that medical facilities be accessible for people with disabilities. According to the American with Disabilities Law, this federal law requires full and equal access to health care facilities. Not only is accessibility legally required, but also medically imperative, so that minor issues can be addressed before turning
into life-threatening problems. Imagine being a person in a power wheelchair and not feeling well.

Your head is throbbing and your doctor has ordered you to have a cat scan test to see if you might have a sinus infection. You roll into the testing room with your power wheelchair and there is a gasp from the medical assistant because he or she does not know what to do with you. Then you see medical assistants huddled together trying to figure out how to assist you on the high table. This is a true story that has happened to me many times when I go for various medical tests. Thank you.

REP. MCCARTHY VAHEY (133RD): Thank you for being here with us today. Thank you both. And again, really on behalf of the entire Public Health Committee, thanks to all who have testified today to give voice to the support for 5200. And in particular, for the work that's been done with the language that will be something that we can really move forward with, as Senator Anwar said, and continue to remain in discussion that will make the bill stronger and also more practical in many ways. So thank you Ruth and all who came to testify today. With that, we are going to go back into our regular order and... oh, I am sorry, Representative Rader, I missed you. I am remiss. Representative Rader.

REP. RADER (98TH): Thank you, Madam Chair. I want to take just one minute. I've been sitting listening to all these incredible people here with Citizens Coalition4Equal Access. And as someone who had a dear uncle in my life with cerebral palsy, it is quite shocking to me that unfortunately, you are all dealing with these challenges every day in terms of what should be just your right as Senator Anwar spoke to. So I just want to thank you.
I know it's not easy for you to physically get there to here to testify and please know that, I'm glad Madam Chair just said this, but the entire Committee is so thankful for your testimony. And we will do everything we can to strengthen this bill and to make sure that this is not something that you continue to have to deal with. So thank you for indulging me for just a minute, Madam Chair.

REP. MCCARTHY VAHEY (133RD): Thank you, Representative Rader. Next we have Jim Iacobelis up here in person. Welcome.

MR. JAMES IACOBELIS (CHA): Thank you. First, I'd like to say it's humbling and inspiring to follow the advocacy I just followed and I just think that that's important to say at the outset. My name is Jim Iacobelis. I'm the Senior Vice-President of Government and Regulatory Affairs at the Connecticut Hospital Association. I'm pleased to be here to testify on Senate Bill 9, An Act Promoting Hospital Financial Stability.

We are aware this is a bill proposed by the Governor in our working relationship with the Governor. We also know that he has always been one throughout the pandemic who is interested in making things work and work well and is interested in partnership. And it's with that spirit that I testify on Senate Bill 9.

When I first read the bill and the title, an Act Promoting Hospital Financial Stability, I was kind of thrilled and hoped to see a bill that would actually help hospitals ensure their financial stability and deal with what is a fragile hospital community. How could it not? In September of 2023, the Office of Health Strategy published an annual report on the stability of hospitals. And I quote: The growth in operating expenses far exceeded the
growth in operating revenue. 29% increase in contract labor, 26 in growth in salaries and wages, 17% growth in drugs and supplies and statewide margins down. But Senate Bill 9 doesn't do anything to assist and address those issues.

Given that I have three minutes, I will not go through our concerns line by line. I'm happy to if someone wants me to, but I expect that will be for further conversations. But let's talk about some themes in this bill. Senate Bill 9, out of its six sections, adds three new civil penalties for hospitals and institutions.

Senate Bill 9 substitutes the judgment of clinicians on clinical matters and health care experts with that judgment of the State. It dramatically increases the financial data submitted to the Office of Health Strategy even given the fact that in September of 2023, and as long as I can remember, every year, we see 123-page report, which looks at hospital finances and goes back five years.

And it doesn't do anything to address what are the foundational broken parts of the CON process. In fact, it expands regulatory oversight. So we're hoping this Committee will be that bridge to not simply identifying problems but solving them with respect to hospital diversion.

Simply having the state decide when a hospital can and is allowed to divert a patient to work with us to add provisions about prior authorization about the needs for community resources, pre and post hospitalization, especially in the area of behavioral health, to look at Medicaid rates for community providers so we can ensure that patients are treated in the most appropriate setting.
No assistance for those hospitals that are in financial distress that we're going to provide information on, no grants, no loans, no assistance, no increase in Medicaid rates and no assistance to look at the workforce struggles. And finally, no solution to, as I said before, the broken CON process.

I would like to highlight language that we've talked about. The Committee has talked about before lines 323 to 330. We read them the way Senator Looney reads them. We read them the way Senator Somers reads them in the way, Senator Gordon reads them as well. What they will do, let's be clear, is between now and December 31st of 2025. It will say anyone but a hospital, whether you're a private equity, whether you are a billionaire in Idaho, whether you're a physician practice in Texas or whether you're a corporation, you can come in and acquire a physician practice without going through CON.

So those hospitals that have been in this state for over 200 years are the ones that will be going through CON, but it allows all of those entities to come in during that time frame. I was here and listened to doctor Gifford talk about the need to understand the process, and how many applications are coming in. But let's be clear on what that's going to do, and all the talk about private equity. We are opening the door and we put notice for all those individuals that between now and December 31st come into the state of Connecticut without regulatory oversight. Thank you. And I'm happy to answer any questions.

REP. MCCARTHY VAHEY (133RD): Thank you very much. There's a lot to talk about there, isn't there? I know we have a few questions. I'll begin with Senator Anwar to be followed by Rep. Klarides-Ditria.
SENATOR ANWAR (3RD): Thank you, Madam co-Chair. Thank you Jim for your testimony and then speaking, I thought all the billionaires from Idaho had moved to Connecticut but not quite. We appreciate your testimony and appreciate your thoughts even in the past when there have been Bills where we’re trying to find common ground. This Committee has been part of that conversation to, I think we are all trying to solve similar problems, and we may have a different way of approaching them. So we hear you, we hear the challenges the hospitals are experiencing as well. And there may be opportunities to address some of that.

I think from what I heard, Doctor Gifford says that as of right now, there is no law having an impact on practices. And that's part of the weakness that they have. And putting that language, their intention, what I heard was to start to collect the data but not have any intervention yet because there is a workforce issue that they are having, which CHA understands better than probably any other body, that the Office of Health Strategies need more personnel or more processes improvement.

So adding another burden or responsibility, sorry, may require more workforce, and they're trying to gather data to say what workforce needs they may have. And I think that's the rationale for it. But I hear that there's an opportunity to fix that. If we change the language, the workforce issues will get even more complex. And then that's the part I'm worried about. Do you want to reflect on that aspect?

MR. JAMES IACOBELIS (CHA): I understand that, but I don't think I or we understand and are perplexed by, if we need to understand what the workforce impact will be, why they decided to focus on Connecticut
hospitals versus new out of state players and allowing them to go through the process without going through CON versus Connecticut hospitals. If we're looking to understand what the workflow is, I'm not sure how that does it.

Believe me, we submitted testimony in support of 5319 AN ACT CONCERNING PRIVATE EQUITY, in the help. It is important, we need to understand it. If we look around it, what our neighbors are doing and neighboring states, they are all trying to get their arms around it. But that provision will have the absolute opposite effect. It could have the absolute opposite effect. So we are really concerned about that.

And in relation to the certificate of need process, and I know we're going to have at least two other Bills to talk about. That provision is in the Office of House Strategy Bill as well. So it will come up again. But until we fix the foundational problems of the Office of Health Strategy, you heard about the year it took to acquire a CAT scan. We want to just hearken back to the conversation we just had in order to acquire a piece of diagnostic equipment to take a year to get through CON is problematic, and that's simply acquiring a CAT scan.

We can't simply not add into the fact that--we can't simply keep adding things to the CON process and expect the timeline in the process to get better when we're not making any efficiencies in the process. One of the things that we'll hear is we think there are things that should go from the Office of Health Strategy to the office of the Attorney General. Yes, we're saying things should better off in the office of the Attorney General. That's rare that we say that. But we think in order to make suggestions on how to make the process work better, we have to come up with some solutions. So
that's a little tease for next week or the week after.

And I understand the issue about we need an early warning signal, if hospitals are in distress. We think there is enough information that is any of the hospitals that were part of the conversation about providing financial assistance. If you look back on those reports to the Office of Health Strategy, that information is there. Granted, there is a lag. I think it can be done in an easier and more simplistic way as opposed to a complete, a significant amount of data being given to the health strategy by every hospital, whether you're financially secure or not, as opposed to really digging down and figuring out what is the trigger that means you're in distress and putting that onus on somebody who is hitting that trigger as opposed to every single hospital, every single quarter, providing every single invoice that is past 90 days due. There are ways to get at this, but we think it can be improved and we don't think we need to have civil penalties in every step of the way.

SENATOR ANWAR (3RD): We hear you loud and clear. And I'll just say that there have been some hospitals who have functioned in a manner that has probably triggered parts of the Bill. I say this many times that bad actors make great Bills. And unfortunately, that's part of the reason that the Governor has put some of the provisions because end of the day, when things fall apart, the state has to intervene and we have to figure out in our budgets, how do you make the health care system survive? But these are very valid conversations and I think it's a beginning of-- because this is just one Bill and there are about five other similar Bills that are floating around and we'll probably put them all together and start to have some real conversations
with rolling up our sleeves and looking at multi-pronged aspects to this.

MR. JAMES IACOBELIS (CHA): And I don't want to leave the impression at all that we would not and could not support provisions related to some of the issues that you're talking about. But we simply can't keep adding that to the plates already bending one year to get a CAT scan approved.

SENATOR ANWAR (3RD): With you 100 percent. Thank you so much, Madam Chair.

REP. MCCARTHY VAHEY (133RD): Thank you, Senator Anwar. Representative Klarides-Ditria, to be followed by Representative Demicco.

REP. KLARIDES-DITRIA (105TH): Thank you, Madam Chair. Thank you for being here today. I just want to know if you can discuss or comment on that Section two, lines 24 through 43, in regards to hospitals going on diversion. Are we having an issue with how hospitals go on diversion now? And how would this change it? And especially my concern is that it says in the language that hospitals, before they go on diversion, they have to notify DPH, they're going on diversion. I just don't understand how that would be possible.

MR. JAMES IACOBELIS (CHA): I have not had any conversations with the administration of the Office of Health Strategy or DPH on specifically why that is in there. However, we know and we read articles about the cyclical increase in behavioral health patients going to Connecticut Children's Hospital, and what that means, and how they handle those patients. And if your ED is overcrowding. Where do those patients go? So, I would guess that part of that conversation is what may have sparked this.
However, you're absolutely right. If you are a hospital and something happens, I think an easier, way, easier way to talk about it is if you're a hospital and your CAT scan goes down. So those individuals that are coming in, they're needing stroke care. You want them to go, you don't want them to come into the hospital and then find out the CAT scans going on. You want to divert them quickly. So simply by making the decision that it's better to get that hospital to go from Derby to Bridgeport because it's better for the patient and you haven't called DPH and told them or provided them notice on the form 25,000 dollars penalty,

The system can be improved, right. There are issues and it's sort of what I was talking about. We need to get to the underlying issues. If we have issues related to significant number of behavioral health patients, the answer isn't to simply move them around as the state decides they should be moved around. It's, let's make sure we have the services in the community that prevent someone from going into crisis and helps them after going into crisis.

So it's sort of-- This Bill does a great job if you will of identifying issues, but it doesn't do anything to help solve them. More information, whether it's last week's 340 B, this week's financial information and these new diversions are all sort of more state oversight and control and taking judgment away from the physicians that can do it better every single day.

REP. KLARIDES-DITRIA (105TH): Thank you for that explanation. And I don't know if you've mentioned that at all, but have you heard of any hospitals having issues with how they're diverting?

MR. JAMES IACOBELIS (CHA): I think frequent basis, we know that sometimes the CAT scan example does
happen. And we know that Connecticut children's is having continuing problems on behavioral health and the hospitals in Connecticut have jumped in. But outside of those sort of examples, I have not.

REP. Klarides-Ditria (105TH): Okay. Thank you so much for your testimony today. Thank you, Madam Chair.

MR. James Iacobelis (CHA): But we did have a whole conversation about ED overcrowding, right? These two things are not unconnected.

REP. McCarthy Vahey (133RD): Thank you, Representative Klarides-Ditria. Indeed, they are connected for certain. Representative Demicco.

REP. Demicco (21ST): Thank you, Madam chair. Thanks Jim for coming to testify. I'm going to turn your attention to a different Bill if I may, my favorite Bill, House Bill 5200. The Hospital Association submitted testimony on this. So I presume you're familiar with the testimony. You may have even written the testimony.

MR. James Iacobelis (CHA): I will say that my colleague, Karen has been the point person in that and she apologizes for being here. She's taking care of a very sick family member who has mobility issues. So she understands all of this, but I'm happy to try to answer your question.

REP. Demicco (21ST): Fair enough. All right. Thank you. And, I appreciate that. I appreciate Karen's diligence. So, I'm looking at the testimony from the Connecticut Hospital Association and with regards to House Bill 5200, and I'm just looking at some of the, a couple of the paragraphs. I won't read it back to you, obviously, but it talked about the fact, the testimony talks about the fact that
the federal rules are not final. There are many open questions that remain.

Federal rules need to be finalized, questioning the availability of medical equipment. And I just wanted to, just point out to you, I don't know if you were around for the discussion that we had earlier. I know you were in and out of the room but in discussing these issues with the Secretary of the Citizens Coalition for Equal Access, she said, and it's also, I believe in her testimony that the Federal government has accepted the technical standards that have come down from the U.S. access board, which have been around for seven years by the way.

And, to go a little further, just to put a little finer point on it. My understanding is that the U.S. Department of Health and Human Services has adopted in their entirety, all of these technical standards from the access board as well as the U.S. Department of Justice. So I guess my question for you is if the Department of Justice has accepted these technical standards and the Department of Health and Human Services has accepted these technical standards, why in the world can't little old state of Connecticut accept these technical standards from the U.S. access board?

MR. JAMES IACOBELIS (CHA): My understanding, again, I'm not the expert. My understanding is you're correct. They have accepted this-- what are the standards. What they haven't yet decided is to whom it applies and when it will apply, right? So the standards for the diagnostic equipment, our understanding is have been accepted, but to whom that will apply to, when it will apply?

And what are the exceptions that that's part of the conversation that is going forward? I think it's
important to note that we absolutely support and understand and appreciate the need to make sure everybody gets the appropriate care, whether it's a physician's office, an eye doctor's office or a hospital. We need to do this together. I haven't seen it. I know my colleague hasn't seen the changes that were going to be applied to this Bill, and that may remove some of our concerns. And my guess is it does, when we talk about state support.

However, we know of a hospital that spent 600,000 dollars and waited eight months in order to reconfigure in office space for four inches for a piece of imaging equipment. So we need to at the same time as we're dealing with the standards, be able to deal with some of the other regulatory issues, the certificate of need requirements for acquisition of certain diagnostic equipment. The Department of Public Health's requirement to come in and look at the building to make sure it complies with the building code and building safety 600,000 dollars, eight months, four inches for a piece of radiology equipment.

So, it's a long way of saying we need to look at what the proposed amendments are. It may take care of some of our concerns but in and of itself the Bill if passed, even with the money does not solve the red tape, which is a significant issue.

REP. DEMICCO (21ST): But not to be argumentative, Jim. But, if these standards have been around for seven years, and I think it's fair to say that no one is questioning whether or not these will be the final standards. These are going to be the standards from as far as I know. So why can't we take those standards and apply them to Connecticut? I don't understand the reticence. I really don't.
MR. JAMES IACOBELIS (CHA): No, I apologize. I probably wasn't clear enough. What I had said was we agreed that the standards were there and we agreed that your characterization and the previous characterizations about the standards is accurate. However, the comments in the conversation that's still going on at the federal level, it's my understanding. Again, I'm not the expert here.

And my understanding is that to whom they apply, I mean, do they apply to Doctor Jim or Doctor Demicco, hasn't been decided. When will Doctor Jim or Doctor Demicco have to comply with these standards, which we all agree on? And what are the exceptions that those are the items? I'm not arguing about the standards themselves. It's those things that I think are still up for discussion.

REP. DEMICCO (21ST): But would it not be possible for Connecticut to decide on its own that these standards apply to Doctor Jim and Doctor Demicco and all the other doctors and just put them into effect, and without any harm in suing there from?

MR. JAMES IACOBELIS (CHA): I do not doubt that the state has the absolute ability to do this. The question becomes if we put these requirements on Doctor Demicco, and he goes through and makes all of these changes and we find out that for whatever reasons they don't apply to Doctor Demicco. Is that going to be a problem?

REP. DEMICCO (21ST): Why would they not apply to Doctor Demicco?

MR. JAMES IACOBELIS (CHA): Because that's the conversation I understand that's happening at the federal level because they're going to make a distinction between who it can apply to. That's my
understanding is what they're out for comment, but I'm happy to have to have--

REP. DEMICCO (21ST): Would you not agree? Would you not agree that the state of Connecticut can forego waiting for the feds who can't get out of their own way and just make its own decisions as to whom those standards would apply and just go from there?

MR. JAMES IACOBELIS (CHA): I apologize. I was probably not clear enough. I do not doubt or question the authority of the state of Connecticut to apply those standards and any standards. However, we need to be cognizant of what that will mean in terms of our state agencies coming in and making sure that they can work and they have the ability to do that, right?

If you say everyone needs to by January 1st, 2025 have an accessible piece of imaging equipment. Under our current CON program that will not happen, because it takes a year to go through that process and it takes eight months for the reconfiguration of the Department of Public Health. So there are other things that need to be added in there. I did not question, and say it again, the state's authority to put these on. We're questioning sort of the appropriateness of how and when we do it.

REP. MCCARTHY VAHEY (133RD): Representative Demicco, do you like to conclude your question?

REP. DEMICCO (21ST): Yes, Madam Chair, I apologize. I know we're not supposed to debate, but I was really curious to get the perspective of the hospital association on this. So, thank you for your forbearance. I appreciate it. Thank you, Jim. Thank you, Madam Chair.
REP. MCCARTHY VAHEY (133RD): Thank you, Representative. And certainly when Miss Buckley is available, we will have additional conversations with her directly as well. Seeing no other questions. Thank you for being here with us today and for waiting earlier. We appreciate that tremendously.

MR. JAMES IACOBELIS (CHA): Happy to. Thank you.

REP. MCCARTHY VAHEY (133RD): Next, we have Mira Cohen who's here in person with us, to be followed by MaryEllen Conway online, who we also thank for waiting for us today. Welcome, Miss Cohen. Before you proceed, if you could press the button right in front of you, so we can hear you. Thank you.

MIRA COHEN: Thank you. This is my first time doing this. So, good afternoon, Senator Anwar, Representative McCarthy Vahey and esteemed Members of the Public Health Committee. My name is Mira Cohen. I'm a resident of West Hartford and a student in the MSW program at the University of Connecticut. I'm here today to speak in support of House Bill 5320 AN ACT CONCERNING HOSPITAL FINANCIAL ASSISTANCE.

Medical debt is a major and growing contributor to the cycle of economic and health inequity. Racial inequities in income, wealth, and insurance coverage play a role in the prevalence and burden of medical debt. Financial Assistance policies also known as Charity Care can help reduce how often patients incur medical debt and ensure that people eligible for assistance do not end up in collections.

Medical debt is incredibly widespread and can impact anyone in this room. As many as 40 percent of U.S. adults or about 100 million people are currently in debt because of medical or dental bills. In
Connecticut, roughly 280,000 people have medical debt. A study in 2023 found that people's incomes below 200 percent of the federal poverty level are particularly vulnerable, often lacking insurance coverage and having to delay or forgo medical care due to cost.

However, people with health insurance still struggle to pay medical bills. The same study found that middle class families with incomes between 50,000 and 100,000 are hit the hardest. As an emerging social worker, I see the complexities in navigating the health care system without adding medical debt. This is why I support the measures outlined in House Bill 5320.

The Committee should also consider mandating hospitals offer a reasonable payment plan for anyone not qualifying for assistance. This ensures that patients do not have to cut back on basic living necessities to pay their bills and can decrease hospitals bad debt. Thank you so much for the opportunity to testify in support of House Bill 5320, AN ACT CONCERNING HOSPITAL FINANCIAL ASSISTANCE POLICIES. I urge the Committee to favorably pass this Bill.

REP. MCCARTHY VAHEY (133RD): Thank you so much, Miss Cohen. As a fellow social worker, I hope that while it's your first time testifying, I hope it is not your last and I hope that you will have this experience and share your advocacy many, many more times. Seeing no questions. Thank you for being here with us today. We appreciate it. Next online, we have MaryEllen Conway, forgive me, to be followed by Christopher Arnold. Miss Conway, welcome. Please proceed.

MS. MARYELLEN CONWAY: Good afternoon, Madam Chair, Senator Anwar and esteemed Members of the Public
Health Committee. My name is MaryEllen Conway and I'm a social worker, speaking testimony in favor of House Bill 5320 AN ACT CONCERNING HOSPITAL FINANCIAL ASSISTANCE. I currently work within the health sector directly assisting the HIV AIDS community, a community which has been consistently failed by the medical community as a whole. Early in the AIDS epidemic, their fight for survival was in their own hands. They were untouched by those with the medical experience to save them and countless died because of it.

Now I watch clients be ignored yet again because the financial cost of treatment exceeds any possible fee they can afford. They have to choose between housing and medical appointments, between food and the medication they need to survive. Their lives are tied to necessary medical care that is not only bankrupting them but creating a generational debt that their families are left to pay. More clients are scared to leave their families with mountains of medical debt than they are of death itself.

To speak to the resiliency of the community would take more words than I'm allowed. The stories that I have heard from clients show loving family members, creative spirits and activists who have given more back to the communities than we can ever thank them for. This Bill would allow us to show some gratitude to the HIV AIDS community by reducing the financial trade for treatment they fight so hard. Let us do what we can to help them and their families for the consistent battles they face every day by allowing better access to hospital financial assistance. Thank you for the opportunity to speak today.

REP. MCCARTHY VAHEY (133RD): Miss Conway, I'm sure you heard what I said to your fellow social worker student. It's wonderful to have you here and thank
you for your advocacy on this very important issue. The numbers that you all are sharing with us as well as the stories are very compelling. Seeing and hearing no questions. We will move on to number 25, Christopher Arnold, who is with us online. And Mr. Arnold will be followed by Marcus Palumbo. Welcome, Mr. Arnold.

MR. CHRISTOPHER ARNOLD: Thank you, Madam Chair. Christopher Arnold, United States Department of Defense State Liaison Office here on behalf of my colleague, Melissa Willett, your New England region liaison who is on maternity leave. In a time when military families face constant relocations and unique health challenges, interstate compacts such as House Bill 5058 offer a beacon of stability and excellence in health care reinforcing Connecticut's unwavering commitment to those who serve our nation including Connecticut residents currently stationed in other states.

On January 5th, 2023 the President signed the Veterans Auto and Education Improvement Act which allows for recognition of out of state licenses. The law specifically states that interstate occupational licensure compacts are preferred. Additionally, while Connecticut's licensing agencies are now required to recognize out of state licenses as valid for the duration of a military spouse's residency due to military orders, Connecticut's employers and insurers are not.

Congress required DOD to enter into a co-operative agreement with the council of state governments to support the development and passage of interstate compacts. Congress also required us to consider membership in the nurse licensure compact as a factor considered in the military department's strategic basing scorecard.
I'll explain why. Frequent moves associated with military service disproportionately affect service members and families who are covered by state specific credentialing requirements. These cause delays and gaps in in employment. House Bill 5058 will have a substantial positive impact which not only benefits military spouses but all eligible professionals who call Connecticut home when seeking employment as a nurse in a compact member state.

In addition to supporting the drafting of model compact laws for professions, federal law requires DOD to support professions with developing database systems to make the compacts more efficient and operational, which allows states to share information about practitioners using compact provisions to work in member states.

House Bill 5058 advances an important policy to support the economic security of Connecticut's military families stationed around the country while simultaneously providing qualified individuals to address the broader issue of the nationwide nursing shortage. As always as liaison to the mid-Atlantic region, I stand ready to answer any questions you may have.

REP. MCCARTHY VAHEY (133RD): Mr. Arnold, I am grateful for your testimony. As the spouse of a 21-year navy veteran, I am so thankful for the work that you do. And in fact, I often took issue with the term that the military used, which was dependent. And this Bill actually will help those military spouses to be able to continue to further their careers and continue to be able to support their families as well. So I appreciate your testimony today. There is one question for you. Representative Marra.
REP. MARRA (141ST): Thank you so much, Madam Chair. Thank you so much for your testimony today. Just curious from a military perspective, you know, really appreciate you speaking on this. But are there any other professions that you foresee a compact would be useful for in the future from a military perspective? Thank you.

MR. CHRISTOPHER ARNOLD: Thank you, Representative for that excellent question. And in 2022, I've quoted extensively in the DPH report to the General Assembly on this subject. But the cooperative agreement we have with CSG has led to the development of seven compacts so far. We have another grant out right now for number eight and we can fund up to 10. In total there are 15 compacts which we support. And there's not a compact for every occupation nor is each state a member of every compact, which is why the department pursues a variety of approaches to reciprocity simultaneously.

Regardless of the military spouse's years of experience in an occupation, boards often look to test scores and academic records to assess competency and military spouses who have maintained a successful career in an occupation in a variety of locations and circumstances expressed frustration over having to justify their credibility and competence in the same manner as first time applicants.

But other than the compact, there's no law that Connecticut can pass to help the thousands of other Connecticut residents stationed around the country to obtain a license in another state. So our current effort to develop the compact through the cooperative agreement is a collaboration between the federal government, state governments and non-governmental organizations representing professional associations, unions, state licensing boards so that
all practitioners of the occupation have greater mobility while sustaining that focus on assuring public safety through licensure. So the Secretary of Defense has three priorities, and one of them is succeeding through teamwork. And the federal government looks forward to continued collaboration with the General Assembly to do just that.

REP. MARRA (141ST): Okay. Thank you.

REP. MCCARTHY VAHEY (133RD): Thank you, Representative Marra. And Mr. Arnold, you may have seen me in the Zoom taking a picture of this wonderful new sticker that we just have. I'm sure you can see it. For those who can't, it's a picture of a submarine, it says run silent, run deep, submariners saying. So I just had to share that with you, Mr. Arnold. I thought you'd appreciate it.

MR. CHRISTOPHER ARNOLD: Roger that, Ma'am. And my regards to Senator Mark, representing the sub base on the Committee. I no longer cover New England states. My new region is New York on down to Virginia, but as a combat veteran of a Connecticut army unit, 'Go Army,' I do love the patch and I will have to pick one up the next time I'm in Hartford covering for my colleagues. So thank you so much, Madam Chair.

REP. MCCARTHY VAHEY (133RD): Thank you. One other question for you. I like how you got that 'Go Army' in there. I'll just say "Go Navy." So one thing that you mentioned was that the compact was part of the base scoring process. Can you just elaborate on that a little bit so that we can be really clear about what you mean when you say that?

MR. CHRISTOPHER ARNOLD: Absolutely. And I'll endeavor not to belabor much of what I submitted in
my written testimony where I sort of expound upon that at length, but the best evidence that we have about the quality benefits of licensure relate to occupations which tend to have more harmonized standards across states where we do not have any strong evidence is to suggest that the type of licensure such as multi-states before you today are associated with worse quality or worse care outcomes. It's a type of well-designed licensure regime that enhances public safety while expanding health care access in historically underserved communities.

So in 2018, the secretaries of the military departments through the National Governors Association sent a letter to the States saying that they were going to consider certain factors whenever they're making a basing stationing or home boarding decision. And that is basically Pentagon speak for either assigning personnel and equipment to a location or removing personnel or equipment from a location.

And in the fiscal year 2020 National Defense Authorization Act, Congress codified that consideration. And whenever there's a basing action, the secretary's concerns shall consider the availability of license reciprocity, housing, health care and then other factors which the Secretary shall designate, which as of this time includes education.

So, Connecticut's Office of Military Affairs is charged with making sure that the state scores well on that scorecard and the office of the Secretary of Defense does a qualitative evaluation where we're looking at, you know, whether the state has or has not enacted a policy, and then the military departments each have their own quantitative evaluation where they turn that into a score.
So. for example, the Air Force looks at 36 occupations, one of which is nursing. And as I said, you still need a good state specific law for folks that don't want to avail themselves of the multi-state license or the compact privilege, which fortunately Connecticut has and passed in 2022. But then we also look at the compact as our optimum end state for license reciprocity in so far as our bottom line effort is getting that license out the door within 30 days, right? So we know we're going to be changing station to the sub base in the fall in October. I got six months to start looking for a job. I can get to Connecticut in one October, get my license by November 1st, and then start applying for work.

Whereas if I'm transitioning from a compact state to a compact state and Connecticut is a member of the compact, there's nothing I need to do. I can begin working immediately because I know my multi-state license is going to work there.

REP. MCCARTHY VAHEY (133RD): Thank you.

MR. CHRISTOPHER ARNOLD: So, that is why it is such an important factor. I think probably 50 percent of the licensing scorecard and that's articulated in title 10 as well. I can send you that Section of the law if you'd like.

REP. MCCARTHY VAHEY (133RD): No. I thank you very much for that answer and for your testimony here today. And again, for all the work that you do. Next on our list. Hold on one second, is Marcus Palumbo. Is Mr. Palumbo here with us? No. Constanza Segovia? Okay. I think we're going on to Nicole Livanos. Nicole, welcome. Please proceed.
MS. NICOLE LIVANOS: Thank you so much co-Chairs, Anwar and McCarthy Vahey, vice Chairs and Members of the Joint Committee. Thank you for the opportunity to testify in support of House Bill 5058, the Nurse Licensure Compact or NLC. My name is Nicole Livanos. I'm the Director of State Affairs for the National Council of State Boards of Nursing. NCSBN's members are nursing regulatory bodies across the country. And the NLC is an initiative drafted by boards of nursing whose mandate is to protect the public. That's why we know that if House Bill 5058 is enacted, Connecticut would be joining a safe and tested compact that has been operational for almost 25 years.

Under the compact, a nurse who elects to obtain a multi-state license would first have to meet their home state requirements and then meet 11 uniform licensure requirements outlined in the compact. With that one license, the nurse can practice in all 41 compact states both in person and electronically. While the functions of licensing, regulation, and enforcement of the practice laws in Connecticut remain with Connecticut. The NLC is part of the conversation as States continue to look for short and long term solutions for the nursing shortage, and data should guide decision making.

NCSBN conducts a national nursing workforce study, and the 2022 survey found that over 100,000 RNs left the workforce between 2020 and 2022. And 800,000 RNs have indicated an intent to leave the workforce by 2027. The NLC is a nurse supported solution for the crisis, and in their 2023 nurse staffing task force, imperatives recommendations and actions, the American Nurses Association recommended exploring the NLC in its expansion.

And during COVID, Ohio, Pennsylvania and Vermont joined the NLC recognizing the need for a permanent
solution for licensure mobility and aiding disaster response. And in 2023 neighboring Rhode Island became the NLC's 41st member following a commission report that found the compact would broaden Rhode Island's available nursing workforce in a more timely and accessible manner. The commission inclusive of union voices and the Rhode Island Nurses Association recommended the legislature consider enactment. And the support from nursing makes sense. For nurses who hold multiple licenses, there's an immediate cost and time saving to not have to obtain and maintain multiple licenses. And for employers who recruit a nurse, that nurse can get to work immediately, alleviating pressures on existing staff and increasing access to care for patients. And for nursing education, the NLC facilitates the hiring of faculty, decreases barriers for distance education and increases access to clinical sites.

The NLC has strong and diverse support across the country from nurses to military families, patients and providers, and the diversity is a testament to the impact the NLC has. Thank you for your time and for exploring this evidence based and nurse supportive solution. Thank you.

REP. MCCARTHY VAHEY (133RD): Thank you so much for bringing your perspective here today. We appreciate your time and your advocacy. Seeing no questions. We are actually going to go back to Constanza Segovia who I believe has stepped back in the room. Welcome.

MS. CONSTANZA SEGOVIA: Thank you. Thank you, Members of the Committee. My name is Constanza Segovia. I live in Hartford and I'm the organizing director and co-founder of Hartford Deportation Defense, an organization representing 300 immigrant
families in the Greater Hartford area and we are part of the Connecticut for all coalition.

I am here to express my strong support of HB 5320, AN ACT CONCERNING HOSPITAL FINANCIAL ASSISTANCE. So our work in the HUSKY For Immigrants Coalition, we have now spent three years hearing our members' stories of lack of access to health care. Listening, we have learned that it's not only the lack of insurance that becomes a barrier. Even when we know funds are available for people to get financial support to pay their medical bills, the barriers to that support are many and often don't make any sense.

For example, sometimes people do have insurance but have a high deductible and they are not offered the funds that are actually available to them. This leads to Connecticut residents drowning in avoidable medical debt. Importantly, knowledge of financial assistance also increases health care utilization. Regardless of these facts, non-profit hospitals continue to build patients who are eligible for assistance. We urgently need oversight of this process.

Another barrier for our members in getting access to financial assistance is the fact that many speak English as a second language. This makes the convoluted application process harder to navigate, especially as you have to figure out each time you go to a different health care facility. There is no good reason for these processes to not be standardized. For immigrant members, it would be helpful for folks to be able to provide alternative documents to prove their income other than just a pay stub, and that should be across the board.

As an advocate for equitable access to health care, I firmly believe that this Bill is a necessary and
just measure that will positively impact countless of lives in our community. I urge the Committee to pass it and stand with us in the fight against medical debt and health care inequities. Thank you.

REP. MCCARTHY VAHEY (133RD): Thank you so much for your advocacy work on this issue and on so many others impacting so many vulnerable members of our community. We're grateful. Seeing no questions before us. We are going to go to, I believe Doctor Lynda Naimoli. Hold on one second if you would, I just want to make sure. Yes. Doctor Naimoli, go ahead. Please proceed.

MS. LYNDYNA NAIMOLI: Can you hear me?

REP. MCCARTHY VAHEY (133RD): Yes, we can now.

MS. LYNDYNA NAIMOLI: Okay. Good afternoon, co-Chairs McCarthy Vahey and Anwar, tanking Members, Klarides-Ditria and Somers, and distinguished Members of the Public Health Committee. I'm Dr. Lynda Naimoli, a resident of Stratford, Connecticut. I've raised my children here. This is our home. m I had to study outside the state and also practice my field outside the state. I am a board certified Dance Movement therapist with a Master's in science in dance movement therapy, and a PhD in expressive therapies.

I am here today in strong support of HB 5323, and the licensing of Clinical Dance Movement Therapists. Dance movement therapy is an embodied practice through a therapeutic lens to connect with individuals that supports a path of healing, cognitively, emotionally, socially and physically. It's especially complementary to traditional therapies and to other creative arts therapies like art therapy and music therapy. Both of which have been licensed for practice in Connecticut by this Committee.
DMTs are not currently able to practice or earn a living in our home state without a license, instead having to commute to neighboring states. And in my case, I travel daily to Brooklyn, New York. University masters curriculum in Connecticut for art and music therapy fall under the LPC curriculum with an emphasis in their modality. There is not a DMT Masters level program in Connecticut. And so we study in other states.

DMT study a full Master's level program as rigorous as an LPC program, plus a rigorous dance movement psychotherapy curriculum. In my case, I furthered my education in this field with a PhD in another state. I am making a statement supporting a clinical DMT license so that we do not have to apply for licensure outside our state and practice outside our state.

Title and Consumer Protection is needed for those of us who want to come home and work home. I focus on an individual's movement through a therapeutic lens. I begin to understand their experiences through an embodied and aesthetic response which gives me an opportunity to embody the overarching themes and patterns that emerge furthering and understanding of someone's experience. Expressive communicative and adaptive behaviors are all considered and addressed throughout the process. Verbal and nonverbal interaction simultaneously provides the means of assessment and the mode of intervention.

I would like to share a quick story of a father whose 13-year-old son was diagnosed with autism spectrum disorder, physically stiff and rigid, including facial muscles and did not make eye contact. The nonverbal young boy gestured for the large stretchy band which I use, which we both stepped into and placed around our waist, and we
began to move, swaying and turning, using the band to guide us as if swing dancing. The boy was not as stiff, he was not as rigid. His body was somewhat relaxed and flexible. While stretching band out from one end to the other, the boy lifted his arms up and made a verbal sound as he continued to sway and turn. The boy made eye contact with me and he continued to dance until we both had to catch our breath. And then--

CLERK: Doctor Naimoli. Excuse me, but your time is up. Thank you.

REP. MCCARTHY VAHEY (133RD): You could just summarize that last thought, that would be great. Briefly. If you wanted to summarize that last thought and finish your sentence.

MS. LYNDA NAIMOLI: Yes. Out of the corner of my eye, I saw the father weeping, who had been peering through the window of the studio. He had witnessed his son move a completely different way. And after the session, the father said to me, it was as if his son morphed into a butterfly flying in the air. Thank you.

REP. MCCARTHY VAHEY (133RD): Thank you. Thank you very much for the work that you do to help people to be able to heal. We appreciate that and thank you for coming to testify before us today.

MS. LYNDA NAIMOLI: Thanks for having me.

REP. MCCARTHY VAHEY (133RD): Next, we're going back to Marcus Palumbo, who has stepped back into the room. And then I did Mr. Isaac Tait. If Mr. Tait is here with us, then he'll be next. Welcome.

MR. MARCUS PALUMBO: Can everyone hear me okay? Excellent. Good afternoon, honorable Members of the
Public Health Committee. My name is Marcus Palumbo and I'm here testifying in support of H B 5200 AN ACT CONCERNING HEALTH CARE ACCESSIBILITY FOR PERSONS WITH DISABILITIES. And I want to start by doing something that I don't normally do or don't do that often, which is actually to quote from the founding documents, in particular, the phrase life, liberty and the pursuit of happiness. I mean, those are the opening lines in the declaration, the self-evident rights.

But I want to point out here that there is something that is a prerequisite for all of those. In order to have to be able to pursue life, liberty and happiness, you have to have your health first. That is the most important thing. So, in order to do those things, you have to have access to health care that is able to provide you with health. And that is crucial to meet a basic standard of living. And yet currently, we don't ensure as a matter of law that health care is accessible to the disabled folks who live in Connecticut. And so this Bill takes an important step in rectifying that. And it does this in a few ways.

Firstly, by requiring medical equipment to be purchased to meet accessibility standards. This just is across the board going to ensure that there is more distribution and incentive for demand for equipment that meets standards of accessibility, for all rooms, for all rooms in a hospital. But then secondly, and very crucially also would require that health care facilities have at least one exam room that is fully compliant and accessible for folks with an assistive device such as a wheelchair. And that means having enough space and having access to a lift, which as we've heard from people today is crucial and very important, and for meeting those care needs.
Now, briefly I also want to touch on some criticism that people may level at the Bill and say--people may criticize it and say, "Oh, how are hospitals going to pay for this?" They're going to say it's an unfunded mandate. You know, how can we regulate this to be a thing without providing help? And I'm not saying we shouldn't provide help, but I want to just clarify for people here.

I think we have to apply the same standard that we do to this that we do for all the other requirements that we ask of hospitals, right? You know, sure, it's more expensive to require hospitals to buy actual defibrillators instead of just using like a car battery with spoons. But we require them to do that because it's in the interest of the people receiving care and it's crucial to have that standard of care. And it's the same thing here.

All we are saying is that we need to mandate this standard of care and accessibility for all of our people in Connecticut to have access to. Because ultimately, that's the kind of state we want to live in is one where those options for health are accessible to everyone. So, thank you.

REP. MCCARTHY VAHEY (133RD): Thank you so much for taking the time to be here and for lending your voice to this very important conversation. Senator Anwar.

SENATOR ANWAR (3RD): Thank you. I love this car battery with spoons idea. Did you come up with yourself?

MR. MARCUS PALUMBO: Yeah, I did. Thank you.

MR. MARCUS PALUMBO: Thank you.

REP. MCCARTHY VAHEY (133RD): Thank you. Next is Isaac Tait.

MR. ISAAC TAIT: Distinguished Members of the Public Health Committee, my name is Isaac Tait, and I live in Oakdale. I'm a volunteer with the Connecticut Chapter of Moms Demand Action. I am a United States marine who has been deployed to combat several times. I am also a gun violence survivor. From firearm suicides to violence in my community, I have seen too much. My home here in Connecticut has even been struck by gunfire. It is because of my experiences with guns and the violence they wreak on our communities that I am testifying to voice my support of the Sustainable Funding Initiative in H B 5317.

It is imperative that the life-saving work of community violence intervention programs be continued and sustained. The problem of gun violence in our communities and countries is solvable. And one of the solutions is community violence prevention. If I did not believe this, I would not be volunteering my time to address the epidemic of violence gripping our country.

Ensuring the public health and safety of our communities is and always should be one of the primary functions of the state government. My heart breaks for those of our neighbors living in chronically underserved communities that are disproportionately impacted by gun violence each and every day because I know what they are suffering. And furthermore, I know that their voices have been marginalized and silenced.

I am speaking for everyone who has to live with gun violence every day, the uncertainty, the fear, the
anger that not enough is being done and the hopelessness that those who can act often don't seem to care enough to do so. Please show that you care by sustaining funding for community violence intervention so that community violence intervention programs which are working directly within the communities most impacted by gun violence, receive the resources they need to continue. Thank you, Members of the Public Health Committee for the opportunity to share with you why I am in full support of the Sustainable Funding Initiative brought forth in H B 5317.

REP. MCCARTHY VAHEY (133RD): Mr. Tait, thank you so much and I recognize that marine cap right away. And so thank you for serving our country in that way and serving in this way by being an advocate and lending your voice to this important conversation. We appreciate you being here and thank you. And you have a comment or a question representative.

Representative Welander.

REP. WELANDER (114TH): Probably more of a [CROSSTALK 00:56:02] at this point. Good afternoon. Thank you for being here. As the older sister of a marine, I wanted just to say thank you. I'm not going to try to do the call because that would look silly on my part. But, I just also wanted to thank you for taking the time to use your experience, which is a very unique experience.

My brothers, I have three younger brothers, all are combat veterans. And they have a very different approach to firearms and gun violence than I do personally. So I appreciate you taking the time to be here and using your voice in that way. And also, I was wondering if there was anything that you thought we could do better on this end from your experience and perspective.
MR. ISAAC TAIT: I've just stepped into this volunteer role in the last few months, due to what's going on in my community. It's a rural community but it's disturbing, and I'm just getting my feet on the ground and figuring out what's going on. I really appreciate the question, and you taking the time to listen to my testimony. I think that is really important to understand what is going on in our communities as a way to move forward and to address this problem. So--

REP. WELANDER (114TH): Thank you. I appreciate that response. And I think I agree that the bottom up type of response from within the community is often more effective than a top down dictation. So, all right. Thank you so much for your time today. Thank you, Madam Chair.

REP. MCCARTHY VAHEY (133RD): Thank you, Representative Welander. Thank you, Mr. Tait. Next, we will hear from Melissa Kane, who's with us online. Welcome.

MS. MELISSA KANE: Thank you so much. Good afternoon, Senator Anwar, Representative McCarthy Vahey, Senator Somers, Representative Klarides-Ditria and distinguished Members of the Public Health Committee. My name is Melissa Kane. I live in Westport and I am the Board Chair and Interim Executive Director of Connecticut against gun violence. I am testifying today regarding H B 5317, which Isaac referred to, AN ACT REQUIRING A STUDY CONCERNING THE FUNDING FOR AND EFFECTIVENESS OF THE COMMUNITY GUN VIOLENCE INTERVENTION AND PREVENTION PROGRAM.

In my role with CAGV, I am a new member of the Commission on Community Gun Violence Intervention and Prevention, which was established in 2022 by the Connecticut General Assembly to guide the Department
of Public Health Office of Injury Prevention on awarding grants to community-based anti-violence programs and to work to identify resources to stem the flow of community gun violence.

Last week, I testified at the appropriation sub-committee on health in support of protecting the combined 3.9 million dollars included in the Governor's budget for DPH for fiscal year 2025 for gun violence prevention grants and personnel. It is essential that this funding remain intact. We are grateful to the Governor and the CGA for the much needed funding that has been appropriated and that has already been put to work to fund evidence based violence prevention and intervention programs within the hardest hit communities across the state.

Next session, we look forward to being able to share the successes of the second round of grants currently being sought. In 2021, the CGA passed SB one with the support of many of you here which declared racism a public health crisis and established this commission within the Department of Public Health because the structural racism that drives health disparities is also a root cause of community gun violence.

As such, it is clear that the existing commission is the appropriate body to oversee any study on possible future funding sources for community gun violence, as well as provide recommendations on the long term sustainability of the grant program. My understanding is that the sustainability sub-committee of the commission is well positioned to do so.

And while reviewing outcomes of grants is and should continue to be part of the DPH grant administration process, it's truly unnecessary to conduct a general study of the efficacy of community violence.
intervention programs, they've already been proven through years of copious research to be effective. CAGV supports exploring all avenues to raise revenue and find additional consistent funding for community based programs to reduce gun violence, particularly ones that have been shown to be effective in other states.

However, we urge that the exploration not jeopardize current appropriated funding. At current funding levels, we're just beginning to meet the very great need that exists. It's essential to maintain the continuity of care that these programs and communities need to be successful.

I urge you to recommend that the commission on community gun violence intervention and prevention oversee any study to evaluate potential funding sources to increase funding for the reduction of community gun violence. Thank you so much for listening to my testimony.

REP. MCCARTHY VAHEY (133RD): Thank you very much, Melissa, for your ongoing work with CAGV and advocating for gun violence prevention and for your work on the commission, and specifically the focus with the public health lens. And I appreciate your comment to ask that that group really direct any conversation related to what we're trying to do with the bill. Are there questions, comments? Seeing none, thank you so much.

MS. MELISSA KANE: Okay.

REP. MCCARTHY VAHEY (133RD): And we will go on to Ellen Andrews who's also joining us online. Miss Andrews, welcome.

MS. ELLEN ANDREWS: Hi. Thank you for having me. I'm Ellen Andrews, I'm Executive Director of the
Connecticut Health Policy Project. And I want to thank you for the opportunity to express the support of the Connecticut Health Policy project for SB 9 and the governor's plans to stabilize Connecticut's hospital finances. There are growing concerns you've heard about today about the spread of private equity ownership of hospitals and other healthcare entities across the nation.

One recent study found that when private equity funds purchase hospitals, the quality of care suffers, another found that cost to patients and payers increase. We're not immune from this in Connecticut, you've heard about prospect medical holdings when they acquired three Connecticut hospitals in our state, vendors, providers and municipal taxes have not been paid, cutbacks led to a serious cyber-attack that jeopardized patient care, and fund owners borrowed over a billion dollars against the hospital's assets to pay investors and executives hundreds of millions of dollars.

State taxpayers have been asked to fix this mess. Unfortunately, this mess is not unique to Connecticut, nor was it unexpected. In September 2021, a little under two years ago, the Insurance Committee held a forum outlining this problem and highlighting promising protections. Assistant Attorney General from Rhode Island was there and was able to describe the protections that they've passed to preserve their hospitals' assets from prospect medical holdings, ownership and protective patients access to vital care.

I'm happy to share the link, it's on CTN or the slides, with anyone who's interested. The governor's current proposals in SB 9 are an important start to strengthening the state's CON process to protect Connecticut residents from
private equity harms. I go through that in my testimony, my written testimony. I will only talk about one small change that could further improve it. The proposal to trigger a CON requirement if issuing dividends of 20% of the hospital's net worth over three years is entirely too high. Taking 19% of the assets out of a hospital within three years is reckless.

Most hospitals are looking at private equity when they're fragile and in trouble, and there should be investments. Taking out 20% is just unreasonable. I was listening to the hospital's concerns about transparency and reporting, and I don't disagree that there are reports there that maybe aren't necessary anymore. But I've spent a lot of time in those hospital reports and there are just a lot of things that are not clear and not understood.

I don't understand why adding liabilities and unpaid bills, and profit margins, is a huge burden on them. I would hope that they offer those, that they provide that to their board members at every board meeting. These should be reports that they're providing all the time. So I just don't see, I guess the burden of those particular reports. And I think we should be looking at even more granular. If we'd known how much, that cybersecurity, for instance, investments have been um going down at prospect, we might have been able to prevent that cyber-attack that was very devastating to care.

CLERK: Thank you Miss Andrews, but your time is up. Thank you.

MS. ELLEN ANDREWS: Okay. Thank you for your time and your commitment to Connecticut's health and hospitals, and I'm happy to answer any questions.
REP. MCCARTHY VAHEY (133RD): Thank you very much for your testimony, for your work, your advocacy. And as you heard earlier in the discussion, the issue of private equity investments in health care is going to be an ongoing conversation, not just here in Connecticut, nationally.

I think there was a Wall Street Journal article just this morning about some of the work that's being done on the federal level, and we will continue these conversations here in Connecticut. Thank you for being with us today. Next, I believe we have Dawn Holcombe. Dawn, welcome. If you can unmute yourself.

MS. DAWN HOLCOMBE: Okay. How am I now?

REP. MCCARTHY VAHEY (133RD): You're great. We can hear you.

MS. DAWN HOLCOMBE: Okay, wonderful. Thank you so much. I appreciate the time from the honorable members of the Public Health Committee. My name is Dawn Holcombe, I'm riding as the Executive Director of the Connecticut Oncology Association. We support the Connecticut physicians and the cancer centers who treat patients who have cancer all through the state. We have, or I'm expressing strong concern that our position to the bill as it is currently written regarding raised Bill 5319, the act concerning private equity firms and health care facilities.

I am a resident of South Windsor, Connecticut. I fully understand the concern that the governor and the members of the Connecticut General Assembly have about the impact of private equity firms. We have all read the news about prospect medical holdings. I know the presentation of this bill is extremely well intended but there are actual consequences of
implementation as it is currently written, that could well have the opposite effect for patients and for those who deliver care in the state of Connecticut.

The definition of private equity firms is those that raise capital and look at the margins, sell companies for a profit. And the definition of health care facilities that include over 16 different kinds of possible facilities going from hospitals to outpatient clinic. They are so broad and they catch in those broad statements, situations that are so helpful and do not need the insertion of digital oversight control. This is my concern, is that we're going to miss an opportunity if we enact the bill as it is written, to support and protect very critical alternative sites of cost effective care.

Cost of care for Connecticut residents is a huge driver, it's a big concern, but we also want to support access to quality care. We have a number of very strong health systems in Connecticut, but we still also have a number of strong private practice providers. So I'm here talking about preserving community practice as a much needed balance for cost effective quality health care. Larger systems have a huge role to play, they're very important, but if we lose our private community practices, that we will have forever lost the central component of an affordable Connecticut healthcare environment.

Private practices are critical for access to cost effective care. In November 2018, publication from the Oncology Primary journal, the American Society of Clinical Oncology Journal of Oncology, looked at over 6600 patients seen in either a community based cancer clinic or a hospital based cancer clinic. And the mean total per patient per month cost was significantly of 38% lower for a patient treated in
the community based setting than in the hospital setting. And the mean per patient per month cost was also significant and lower 41% in the community setting.

So both chemotherapy and overall treatment were significantly lower. And we're talking 12,500 versus 20,000. We're talking 4900 versus 8500. See, the lower costs of the community practice is irrespective of the chemotherapy regimen of the type. We have seen a huge number of private practices in Connecticut absorbed by Connecticut hospital based systems. There are a few that remain strong and they remain strong in part because they haven't aligned with predatory private equity firms, but they have aligned with other almost-- Okay, I'll go with physical based networks, medical networks. They're medically aligned partnerships of like-minded other private practices. That is a distinct difference.

And so what I'm doing is I would respectfully request that this bill not be passed in any way as it is currently written, that we would consider the need to recognize those alignments as different from a private equity firm that is like a prospect medical. That we do want a grandfather existing alignments that have already happened. And if any study or panel that looks at private equity activities in the state should include representation by patients and the community providers so we don't lose them. Thank you.

REP. MCCARTHY VAHEY (133RD): Thank you. And I think you give voice to some of the conundrum that is faced because the cost of health care is so significant and it falls on patients, it falls on us here in government. And I think the market is looking at different ways to address this. And so we will, as I have said many times today, be
continuing this conversation and I appreciate your perspective today.

MS. DAWN HOLCOMBE: Thank you.

REP. MCCARTHY VAHEY (133RD): Seeing no questions, next is Erin Barthel. Welcome.

MS. ERIN BARTHEL: Dear chairs and distinguished members of the Public Health Committee, Can you hear me okay?

REP. MCCARTHY VAHEY (133RD): Yes, we can.

MS. ERIN BARTHEL: Thank you. My name is Erin Barthel, and I'm a resident of Avon, mother of three children, and a pediatric oncologist at Connecticut Children's Medical Center. I'm here today to testify in support of Bill No. 5317, on behalf of the Connecticut Chapter of Moms Demand Action for Gun Sense in America, and on behalf of all children in Connecticut. As a pediatric oncologist, I treat children with cancer and other serious blood diseases.

Cancer is tied for the fourth leading cause of death among children and teens, ages one to 19 in the state of Connecticut. While 85% of children with cancer survive five years or more, there are still too many children dying from this disease. There is no one specific cure for cancer, each pediatric cancer is treated with specific therapies that attack unique targets.

Doctors and researchers continuously work to find new therapies before this disease takes another child's life. Unfortunately, outside the hospital, firearms are still killing our healthy children. In the United States, firearms are the leading cause of death among children and teens. In Connecticut,
it's the second leading cause of death among children and teens. This is unacceptable, children are dying of preventable death.

Like cancer, there is no one cure for this problem, we must treat this problem with specific therapies from every angle. In 2022 the state passed an act addressing gun violence which contained comprehensive laws to reduce the number of firearms reaching the hands of children and young adults in homes and on the streets. For years, community violence intervention programs have been doing both preventative work and dealing with the traumatic aftermath of gun violence, however, they cannot continue to do this without funding.

The study proposed by 5317 ensures that there will be an answer to the question of how the state will provide sustainable funding. One solution is to tax the gun industry which makes billions of dollars in profits each year while our state and communities pay the physical, economic and emotional cost of this epidemic. California recently passed this legislation in 2023.

The American Academy of Pediatrics supports a comprehensive approach to preventing gun violence and supports measures such as community violence intervention programs, a background check on every gun sale, increasing purchase age limits, purchase waiting periods, the list goes on and on. Connecticut is a national leader on gun safety laws, we need to continue to support our community leaders that know the problem, have created creative ideas to address the problem, and are fighting every day to ensure that gun violence does not take another child's life. For all our children in Connecticut, I urge you to pass 5317. You too can do something to decrease childhood deaths. Thank you for your consideration.
REP. MCCARTHY VAHEY (133RD): Thank you for that powerful testimony and for the work that you do at the hospital every day, and you raise very valid and very important points. We were talking earlier today about opioids and the epidemic that they are and how they are impacting the lives of our vulnerable children.

And in this committee, we have not spoken quite as much since I've been here about gun violence, the work is often done in our Judiciary Committee, but I appreciate you and others who have been here today speaking to this issue and why this is a public health issue. So thank you so much. Seeing no questions, we will go on to Michael Loughlin who is with us online. Dr. Laughlin, welcome.

MR. MICHAEL LOUGHLIN: Can you see me?

REP. MCCARTHY VAHEY (133RD): Yes, we can and we can hear you as well.

MR. MICHAEL LOUGHLIN: Thank you. Thank you, good afternoon. My name is Michael Loughlin, I'm a clinical radiologist as well as the director of MRI and CT for Jefferson Radiology. Jefferson Radiology is based out of East Hartford, Connecticut, we employ over 400 staff members. Our radiologists are medical doctors with at least four years of specialized training in the performance, supervision and interpretation of imaging for medical diagnosis and treatment.

This includes dead training for understanding the physics of x-rays, and in particular CT scanners and ways to utilize these for the optimum safety and benefits for our patients. Our radiologists work in variety of settings from hospital radiology departments to private practice outpatient offices.
in communities throughout the state. I would like to offer public comment on the SB 9, the raised, which is the act of concerning a certificate of need with special attention to the CON provisions for acquisition of advanced imaging equipment.

I support the goal of a review of the existing CON process to identify areas of improvement in efficiency, effectiveness and alignment with the state and federal health care reform efforts. At the same time, as the subspecialized physician in medical imaging, I strongly support maintaining the CON process for advanced imaging equipment acquisition including specifically CT scanners. This would continue the existing benefits of the CON process for all of our patients in Connecticut. The existing CON process for imaging ensures safeguards for quality and safety controlling imaging costs, serving the public needs that would be maintained regardless of any modifications.

The existing CON process ensures quality in patient safety, and through years of work, the existing CON process mandates patient protections and ensure medical personnel will be prepared in the event of medical emergency or adverse reaction during a scan, and to ensure the safest use of radiation and radiation materials. The citizens in the state of Connecticut benefit from these requirements and deserve to [inaudible 00:16:57].

From a financial perspective, the existing CON process serves to control overall health care costs in the state. Elimination of the CON requirements will lead to increasing costs, one of the most specific ways to the existing CON process limits health care costs from advanced imaging is by limiting self-referral, and this is the practice of health care providers referring patients to imaging facilities in which they have an ownership interest.
In 2012, the United States General Accounting Office released a mandated report showing that self-referral advanced imaging results in markedly increased volumes of scans and the cost to Medicare and Medicaid programs for billions of dollars. Even when seemingly unintentional, the self-referral incentives for health care providers to expand services exist regardless of the demand.

The existing CON process limits this for increasing health care costs. For these reasons, as a radiologist, I strongly oppose elimination of the CON process for CT scanners and strongly advocate that any change to the CON process for advanced imaging equipment strengthen protection against self-referral and maintain existing guarantees for quality and safety for our patients in Connecticut. And that's it.

REP. MCCARTHY VAHEY (133RD): Thank you, Dr. Loughlin, and I'm sorry, we missed your [inaudible 00:18:08] earlier.

MR. MICHAEL LOUGHLIN: That's okay.

REP. MCCARTHY VAHEY (133RD): But thank you for being here today, spending time and for your advocacy. Seeing no questions, we are going to go back to the folks I had missed. Madhavi Raghu is here, and then will be followed by Norma Martinez-HoSang. And please correct me if I mispronounced your names.

MS. MADHAVI RAGHU: Hi. Can you hear me? Can you see me?

REP. MCCARTHY VAHEY (133RD): Yes, we can.
MS. MADHAVI RAGHU: Okay. Well, good afternoon members of the committee. My name is Madhavi Raghu, I am a physician and a radiologist practicing in Western Connecticut at Danbury Radiology Associates. My specialty is breast imaging where I direct our facilities program in that area. Previously, I was the fellowship director of breast imaging at Yale. I am offering brief comments to you today on Senate Bill 9, an Act promoting hospital financial stability.

I would like to confine my comments to line 175 in section four. What this does is exempt any computed axial tomography scanner known as CT scan from the certificate of need process. In my experience, I believe this would be a mistake. Right now, receipt of a CON for this type of equipment requires the applicant to show that they will have a commitment to serving low income underserved communities. We do that as a matter of practice in our office. That requirement is critical if we are to solve what we all know is a significant inequity in the delivery of health care services in this state.

Yet, untethering CT scanners from CON will mean that the new owner now has absolutely no obligation to serve patients in distressed areas. You will see an avalanche of CT scanners flood the market, but they will be cited in wealthier areas that cater to self-pay and well insured. Unfortunately, another reality is the increasing number of private equity companies entering Connecticut. They will all want a CT scanner to add revenue for their investors, and at what cost to the patients or our health care system. The inequity will worsen and distressed areas will be left out in the cold. I fear that women in low income areas will find it much more difficult to get their breast cancer screenings.
The proposed exemption will take a well regulated market for CT scanners and turn into the Wild West. Anything goes, you'll see offices cropping up offering cheap breast cancer screenings, but the patient won't know that the machines are old and lack today's technology, which are much better in detecting the presence of cancer, or even if the images are read by qualified or subspecialized radiologists. As a radiologist, I do not order a patient's breast imaging study, that is done by the patient's primary care doctor.

We perform the exam, I read it, and then summarize the results in a written report. That boundary will be lost if section four becomes law. Also, offices will be free to order an imaging exam with no guarantee that the interpreting radiologist is qualified to read the study. This is self-referral, which results in unnecessary additional testing, increasing health care costs. That is not the kind of care I want for my patients. For the reasons I outlined in my testimony, please retain the CON requirement for the acquisition of CT scanners. Please strike section four from the bill. Thank you so much.

REP. MCCARTHY VAHEY (133RD): Thank you, Dr. Raghu, for your testimony today and for your work every day caring for patients. Very much appreciated. Seeing no questions-- Oh my goodness, yes, I forgot. Representative Klarides-Ditria, who had told me before that she had a question for you. So, Representative Klarides-Ditria.

REP. KLARIDES-DITRIA [105TH]: Thank you madam chair. Thank you for being here today and providing testimony. I read through your testimony, I just have a couple questions. So with regards to the breast cancer screenings, can you just elaborate a
little on why this proposal can cause delays or hardships for women?

MS. MADHAVI RAGHU: So, at present right now, we know that women are under screened for breast cancer screening, for breast cancer in general. And that this can be attributed to numerous reasons, and this includes insurance, it includes access, but also, patients have to take time and they have to look for quality places to actually get quality care.

So even though access may be limited for some of these patients, we want them to go to offices where they're going to be provided high level superb care. And when we start opening offices where just the imaging is free for all, it's going to diminish the quality of care, and it may have adverse outcomes for patients in general.

REP. KLARIDES-DITRIA [105TH]: Thank you for that explanation. And then also in your testimony, you mentioned, "Wild Wild West." So if Connecticut scanners are deregulated, what's going to be the outcome? Can you elaborate on that?

MS. MADHAVI RAGHU: I'm going to tell you everything for me is about quality, quality, quality, quality. We want to make sure that every patient that enters an office is entering an office that is well regulated with great protocols. For something like a CT scan, for example, these are studies that are fairly complicated and involve multiple sequences, and they should be crafted very carefully and protocolled appropriately so that additional radiation is not being performed, and the patient has a correct study for the correct amount of time that they're actually there.

And this also extends to breast imaging, because people think breast imaging is just a screening
mammogram, but really, it's not just the screening, it's a screening, it's a diagnosis, it's a treatment. We want to make sure that we're providing quality level care for every aspect of breast health.

REP. KLARIDES-DITRIA [105TH]: Thank you for that. And madam chair, just one final question. We've heard a lot about the process of CON, of Certificate of Need, what has been your experience with this? And is the issue that most people say, that the process takes too long?

REP. MCCARTHY VAHEY (133RD): Dr. Raghu, you may have frozen. Oh, are you there? Were you able to hear the representative's question?

MS. MADHAVI RAGHU: Oh, so sorry. I didn't realize that was meant for me. Yes. Were you asking me if the process was taking too long? I thought it was directed at somebody else.

REP. KLARIDES-DITRIA [105TH]: It was directed at you.

MS. MADHAVI RAGHU: Oh, my apologies. Yes, I know that it does take a long time. But again, I think that we really have to be very mindful and thoughtful about the quality of care that we deliver to these patients. The worst thing that can happen is, an inadequate study, a poorly performed study, that essentially misses a critical finding. That may have a detrimental effect on a patient's health.

And breast cancer is, whether it's a delayed diagnosis or misdiagnosis, is a perfect example of that. The doubling time for most breast cancers is about two years, but we know that we're seeing younger and younger patients with cancers and sometimes with fairly locally advanced cancers. And
so if some of these patients go in for imaging studies where it was not appropriately done, then I think that there is a risk that they may attain poor care, and therefore poor outcomes in the long run.

REP. KLARIDES-DITRIA [105TH]: Okay. Thank you for answering my questions. And just a simple yes or no on this last one. So you want to see section four stricken from this legislation, is that correct?

MS. MADHAVI RAGHU: Correct. Yes.

REP. KLARIDES-DITRIA [105TH]: Thank you very much for your testimony. Thank you madam chair.

MS. MADHAVI RAGHU: Thank you. Thank you so much.

REP. MCCARTHY VAHEY (133RD): Thank you, Representative Klarides-Ditria, and thank you also Dr. Raghu. Next up we have Norma Martinez-HoSang, who is with us online, to be followed by, give me one, Cindy Miller.

MS. NORMA MARTINEZ-HOSANG: Well, great. Thank you, um dear Senator Anwar, Representative McCarthy Vahey, and esteemed members of the Public Health Committee. My name is Norma Martinez-HoSang, and I live in Hampden, and I'm the director of Connecticut For All. We're a coalition of about 60 labor community and faith organizations fighting to end extreme inequalities in our state.

One of our primary goals of our coalition is to win real equity for all residents in Connecticut, and that spans from strong public K-12, public higher education, and of course health care. All these are essential services for our communities to live a full life with dignity. So I'm here today to express my strong support for HB 5320, an act concerning hospital financial assistance. A
nationally medical debt is one of the reasons families declared bankruptcy here in Connecticut. Roughly 280,000 people have medical debt.

Financial assistance policies also known as charity care can, excuse me, can help reduce how often patients incur medical debt and ensure that people eligible for assistance do not end up in collections. This bill will help communities who need it the most. Access in charity care by, one, creating a common application for financial assistance, that all Connecticut hospitals will access and therefore making it easier for patients to navigate the application process. This bill would also automatically qualify some patients who are enrolled in SNAP and WIC with household income at or below 250% of the federal poverty level.

And lastly, I want to just highlight that it would also make sure that people know about the financial assistance options since they often, people who otherwise qualify don't often know that this is available. This bill would cost little or nothing to implement, but it would make a big difference for some of the families between going into debt or getting lifesaving health care services.

The people who would qualify for charity care are part of families that already are living paycheck to paycheck and struggling to make ends meet day to day. Organizations in our coalition focus on different issues, but one of the things that we all really care about is health care and good health system for all of the people in Connecticut. We believe in equitable access to health care and therefore we're firmly supporting HB 5320, as a necessary measure that will positively impact countless of lives in our community.
I urge you all to consider this bill and stand with us in the fight against medical debt and health care inequalities. Thank you for the opportunity to testify on this. Excuse me.

REP. MCCARTHY VAHEY (133RD): Thank you. Thank you for your advocacy here today on this and on so many other issues that, again, are facing some of our most vulnerable community members. We appreciate you being here with us today. Seeing no questions, we will go next to Cindy Miller.

MS. CINDY MILLER: Good afternoon, Senator Anwar, Representative McCarthy Vahey, and members of the Public Health Committee. I'm really pleased to have been given the chance to testify along with other members of the Citizens Coalition for Equal Access. We want very badly that there be passage of HB 5200 with amendments as has been described earlier today in some detail by the Secretary of CC Equals A, Ruth Grobe.

I will not be focusing on the specifics of our proposed modifications of the HB 5200, but will instead describe a little about myself and how that has informed my participation in these efforts. Since birth, it was known that I had moderate bilaterally symmetric muscle weakness for which an all-encompassing diagnosis was not rendered until further investigation was prompted following the development of seizures when I was 27 years old. It wasn't until I was 39, that a final diagnosis of congenital muscular dystrophy with merosin deficiency was confirmed.

I had been encouraged by my family and by my mentors to pursue my dreams, and so despite increasing weakness, I became a physician. I chose to train as a diagnostic radiologist in order that my physical limitations would not hinder my ability to perform a
complete medical examination of any patient. During my years as an attending physician at Yale New Haven Hospital, my own internist asked if I'd be interested in participating in a class for second year medical students on the concept of disability.

I have done this for at least 10 years now, and have noted each time that the class has served as an introduction to disability to students who have already been in school for a year and a half. But along with the increased awareness of the types of disabilities they might encounter in their future practices, there are numerous students who begin to think about ways in which they could fashion their own practices to accommodate patients with all types of disabilities.

The reality is, that at the present time, I have not had a complete physical examination for at least 20 years due to my inability to move independently from my wheelchair to an examination table as it is difficult, next to impossible, for me to disrobe independently, no physician has put his or her eyes on my skin surface in its entirety. I know that I have a pressure ulcer because I felt discomfort related to it.

But apart from a cursory inspection of it, no attempt has ever been made to inspect the rest of my skin's surface. I have a progressive muscle disorder, but I cannot remember the last time my muscles were palpated, nor my feet examined so as to reveal the discoloration that accompanies the dependent edema that I have. When my internist reported to me that no physician was allowed to lift a patient, he had his assistant utilize a lift, and that went relatively smoothly.

At this past year's appointment, when I demonstrated the capability of my wheelchair to enable me to lie
in a supine position, he was satisfied to just
examine the front of my lungs through a twin sweater
set through which it would be nearly impossible to
discern an abnormality if one were present. Before
I finish my remarks, I must include a description of
the process of my being weighed.

It used to be that I would arrive in clinic and
would be asked by a nurse's assistant as I rode in,
in my motorized scooter, if I were able to stand up
on the scale. As I shook my head in disbelief, we
arrived at the realization that I would need to know
the weight of my scooter or my chair in order that I
could be weighed in it and then the weight of the
chair would be subtracted to derive my own weight.

This works if I know precisely the weight of the
chair and if the entire chair is actually on the
scale, otherwise my weight would be underestimated.
I am just one individual, but I am one who based on
her medical education, is able to state
unequivocally that everyone is entitled to a
complete physical exam.

In order for that to happen, there needs to be at
the minimum, an accessible weight scale, an
accessible examining table, and appropriate lifts to
be utilized to assist in moving disabled patients
with dignity, and staff trained to do so. HB 5200,
with the modifications proposed and other testimony,
will be instrumental in achieving that desired
results. Thank you.

REP. MCCARTHY VAHEY (133RD): Dr Miller, thank you
so much For your testimony. What occurred to me as
you were talking is that it's just the opposite of
how it should be, that folks who need more
monitoring or more support aren't getting even the
basics of what you need. So I thank you for taking
the time to testify before us today and to be an
advocate and care for others. I see that Rep Demicco would like to speak. Representative Demicco.

REP. DEMICCO (21ST): Thank you very much madam chair. I will be brief. Thank you, Dr. Miller, for coming to testify. Unfortunately, your testimony is not also all that different from several of the testimonies that we heard earlier today, earlier this afternoon. Did I hear you say that you have not had a complete physical examination in 20 years? Did I catch that correctly?

MS. CINDY MILLER: That's correct. That is absolutely correct. Because part of the time people I think are sort of dancing around, how are we going to ask her to do these things? But the reality is, my own physician who I've seen for this whole period of time, still doesn't recognize the fact that I cannot lift my arms above my head in order to take off a top that I'm wearing, nor can I disrobe from the bottom half of my body. So it's important that physicians recognize the limitations of their patients and do what they can do around those limitations in order that they receive complete care.

REP. DEMICCO (21ST): If I May madam chair. So, Dr. Miller, thank you. That's a good segue into my final question, which has to do with what you referenced earlier in your testimony about medical students and their training and their understanding of the needs of people with disabilities. Could you just expand on that a little bit?

MS. CINDY MILLER: I'd be happy to. I mentioned that the talk that I give are part of during the middle half of their second year of school, is their first true exposure to the concept of disability. So when I became involved with Citizens Coalition
for Equal Access, and I became aware of the
disability interest group at [inaudible 00:38:41], I
was quite thrilled to recognize that such a group
exists. And I think if medical education should
include similar groups at every medical school.

REP. DEMICCO (21ST): Maybe that'll be next year's
bill. But thank you Dr. Miller. Something for us
to think about. Thank you, Dr. Miller, and thank
you for your work with the Citizens Coalition for
Equal Access. Thank you madam chair.

REP. MCCARTHY VAHEY (133RD): Thank you,
Representative Demicco. I love how you're thinking
ahead. That's wonderful. Seeing no other. Oh,
Senator Anwar. Excuse me.

SENATOR ANWAR (3RD): Thank you madam chair. Thank
you, Dr. Miller. This is, we've had multiple
conversations, we appreciate your advocacy and the
amazing work that you've been doing on behalf of all
the people who would need some help. And then your
points are well taken, and we're just having the
conversation that empathy is something that it
should be part of all health care workers,
education, and training.

So, clearly the medical schools can do far better,
and then also we're talking about, in this bill, or
the proposed language, to have effort on education
as well. So we're going to start this process
should this bill pass, and then move forward. Thank
you.

REP. MCCARTHY VAHEY (133RD): We're the committee
with the squeaky mic. Thank you, Dr. Miller. And
next we will hear from Dr. Weigert.

MS. JEAN WEIGERT: Thank you very much. I hope you
can hear me.
REP. MCCARTHY VAHEY (133RD): Yes, we can.

MS. JEAN WEIGERT: I know I'm speaking to another topic, but I just want to comment to Dr. Miller, that I so heartily feel for what you've been going through, and I do hope there are facilities that are available for you to get, as a breast imager that I am, your mammograms. And if not, that we could perhaps help that happen. Anyway, I'm going to move on to my topic now.

Dear Senator Anwar, Representative McCarthy Vahey, Senator Somers, Representative Klarides-Ditia, and members of the Public Health Committee, my name is Jean Weigert. I am a clinical radiologist with a specialty training in women's imaging, in particular, breast imaging. I am past president of the Radiological Society of Connecticut and a member of the executive board. I am past chair and still a member of the Committee for the American College of Radiology, Mammography Accreditation, which is an FDA certification process.

I'd like to offer public comment on SB 9, act concerning certificates of need with specific attention to the CON provisions for acquisition of advanced medical imaging equipment including CT scanners, which is involved with section four. As several of my colleagues have already spoken today, I want to join them and underscore the importance of a review of the existing CON process, to identify areas of improvement in efficiency, effectiveness and alignment with state and federal health care reform efforts.

But I strongly support maintaining the CON process for advanced medical imaging equipment including CT scanners and continuing this process for all our patients in Connecticut. It ensures safeguards for
quality and safety controls, imaging costs, and serving the public needs that should be maintained regarding any modifications. As an imager devoted to the care of women with gynecological malignancies, particularly breast cancer, I want to underscore the need for high quality imaging which does include CT scanning in the evaluation and follow up of treatment of these cancers.

We use CT scanning as a way of finding metastatic disease, and then of course following their treatment to see if it is remitting or increasing. Through my years involved in the ACR accreditation process, I understand the need for assessment of quality, both the technical aspect and in the physician interpretation of these important imaging studies.

Yes, the process of acquiring a CON and applying for it can be difficult, there is lots to do, a lot of paperwork, but it is the same kind of process that we have for accreditation of all our modalities, whether it's mammography down the line at the American College of Radiology.

It can be difficult but it maintains superb technological quality of both the scanning equipment and of the physicians who interpret that equipment. And this, again, protects our patients, and that it allows them to have high quality care. The other aspect of cost, obviously, I'm sorry, is the fact that without a CON, we will be increasing costs to the state and increasing costs to our patients.

CLERK: Excuse me, Dr. Weigert, but your time is up. Thank you.

MS. JEAN WEIGERT: Thank you.
REP. MCCARTHY VAHEY (133RD): Thank you doctor. A question from Senator Anwar, to be followed by Representative Cook.

SENATOR ANWAR (3RD): Dr. Weigert, thank you so much for your testimony. I wanted to clarify something. So if I heard you correctly, you are suggesting that a same CT scan that your organization would have and somebody else got the same CT scan for the imaging, the other company would have bad results or inaccurate results? Can you clarify that?

MS. JEAN WEIGERT: I think what I'm saying is that the fact that one must follow certain protocols, one must maintain certain quality controls on a routine basis. We know that we do that in our imaging centers and in hospitals that have CONs. What our concern is, that these sites may not follow those specific criteria, because they would not feel obliged to.

SENATOR ANWAR (3RD): Do you have evidence to that or it's just an assumption that anybody else who is going to get some of these imaging modalities, they would not follow the protocols even though they are required to.

MS. JEAN WEIGERT: Well, they may not be required to if there's no specific formats for them to maintain. These CONs require a significant amount of effort, and again, we don't know, we just don't know if they will do that. We also don't know if they will be maintaining a certification under the American College of Radiology Accreditation for these imaging modalities.

Right now, mammography is FDA mandated, but it is the purpose of our offices, the ones that fulfill these criteria, that we all do have these ACR certifications. It's just another aspect of the
fact that what all of us who have testified today are saying, is that we are underscoring the importance of quality, and that we feel that these other sites may not, I'm not saying that they won't, but they may not.

SENATOR ANWAR (3RD): So if we were to make policies about may not, then we will probably not be able to make too many policies. But I'm just going to just share with you some of the other things that we have heard. We heard a number of individuals who have disabilities and they are not getting access to many of the sites, and somebody actually even mentioned one of your sites, to be able to get their care.

And let's say one of the other hospitals, the hospital, CHA came and they said that it takes them a year to get CT scanner. And that's where the CON system is somewhat failing, because we have a number of our citizens who cannot get the care that they need and they should get. And you're saying that keep the CON because they may not provide, even though they will be radiologists, reading those same procedures, the machine will probably be from the same company.

It's tricky because the access is being impacted right now, and my fear is that if we continue to restrict access, the individuals who are hurting to get the care, they will not get the care. So that's just my perspective. So I was not fully convinced from your argument yet. I thought I just share that with you.

MS. JEAN WEIGERT: Okay.

REP. MCCARTHY VAHEY (133RD): My apologies, Senator Anwar. I wanted you to know doctor, Senator Anwar said thank you, and I had turned off the microphone too quickly. Representative Cook.
REP. COOK (65TH): Thank you madam chairman. Doctor, are you still with us.

MS. JEAN WEIGERT: I am.

REP. COOK (65TH): Okay, perfect. So two questions. One, can you discuss briefly what the safety impact would be by the provisions that you're testifying on? Would there be--

MS. JEAN WEIGERT: I think that it is that when we go through the existing CON process, it mandates patient protections and ensures that there are medical personnel that are trained appropriately on all levels to take care of patients if there is a problem.

Again, I am not saying that that might not happen if a site does not have a CON to have their operation. I just know from the experiences that I have had, that there's a lot of education mandated through our offices because of maintaining these protocols that we know we have to maintain. I can't address whether or not sites that don't have a CON would not, of course, maintain safety protocols. I would hope they do, but again, this is from my years of experience. So thank you.

REP. COOK (65TH): Thank you. And then my last part of that question would be section four when we talk about the certificate of need, you would support the bill, but you would support it without section four. Correct?

MS. JEAN WEIGERT: Yes, ma'am.

REP. COOK (65TH): Thank you. Thank you so much.
REP. MCCRTHY VAHEY (133RD): Thank you, Representative Cook and thank you doctor for being here with us today and for the work that you do in the community as well. Next, we are going back to Kayla Holland, we missed, and she's here with us online. Miss Holland, welcome.

MS. KAYLA HOLLAND: Well, thank you. Good afternoon, Co-chair McCarthy Vahey and Anwar, vice chairs, Parker, Kushner and Marx, ranking members, Klarides-Ditria and Somers, and distinguished members of the Public Health Committee. I'm Kayla Holland, the Food and Nutrition Program manager at the Center for Black Health and Equity, and the Center for Black Health and Equity is also referred to as the Center. It's a national nonprofit committed to addressing the social and economic injustices that have led to deep health disparities for marginalized communities.

The center's mission is to facilitate programs and services to benefit communities and people of African descent by building community capacity, developing community infrastructure and advocating for equity center policies. I am a nutritionist and registered lactation consultant with over five years of experience in the field serving as an expert resource on nutrition, food justice, food systems and health equity.

I'm uniquely equipped to address the benefits of licensure for IBCLCs that this bill offers as well as its potential impact on increasing the numbers of BPOC IBCLCs. The center strongly supports House Bill 5318, an act requiring the licensure of lactation consultants, and we would like to extend our deepest gratitude for the committee's contributions towards the advancement of breastfeeding and breastfeeding support for Connecticut's families reflected with this bill.
We applaud house bill 5318 as a testament to your intentional efforts in addressing the current disparities in maternal and infant health outcomes, and for the opportunity to provide testimony here today. We are in support of household 5318 because we firmly believe that licensure of the IBCLC will promote equitable access to clinical lactation care, and we believe this bill will improve maternal and infant health outcomes and move us forward closer to pregnancy and birth injustice. We also believe that licensing the IBCLC will open opportunities for community colleges to streamline the education and clinical training required for this credential making a career in this field more accessible, economical and attainable for those in underrepresented communities.

The significance of license share for lactation consultants is rooted in the fact that Medicaid mandates reimbursable services to be conducted by licensed professionals. We respect that mandate and want clinicians to be licensed so that the state is able to monitor their work. There is risk of harm with this care. Unfortunately, many birthing families in marginalized communities are covered by Medicaid, and as a result, do not currently have access to clinical lactation services.

It is imperative that we work towards changing this reality, and this bill represents an important step toward achieving health equity in maternal and infant health spaces. We respectfully urge you to consider modifying this bill language to make IBCLC licensure affordable in Connecticut to ensure every aspect of this bill is written through an equity centered lens.

Specifically, we recommend a reduction in the application fee to $200, and a reduction in the
renewal fee to $100. Furthermore, we express our support for the elimination of section three subsection B and we thank you for your time and consideration of making amendments to house bill 5318 and addressing these concerns.

REP. MCCARTHY VAHEY (133RD): Miss Holland, thank you very much for being here. And it sounds like you are concurrent with the suggestions made here earlier today in terms of the fees and the change in the language. I just have a question for you. You said in your testimony, there is a risk of harm with some of this care. Can you just briefly elaborate on what you mean and say why you're sharing that with us?

MS. KAYLA HOLLAND: Of course, I will be happy to. The importance of acknowledging the risk of harm in providing clinical lactation care is critical because anyone can, unfortunately at this time, go up to a breastfeeding mother and call themselves a specialist. They can call themselves a lactation consultant, and licensure will allow us to do a number of things including distinguish the marked differences between clinical practitioners that are able to provide quality lactation care. And the risk of harm is that without specific language in this bill and equitable access to lactation care, we are putting mothers and babies at risk of not getting the help that they desperately need.

REP. MCCARTHY VAHEY (133RD): Thank you for that. I appreciate that. Often times, I think when people think of breastfeeding, they think it just happens. So it's wonderful that we have folks in the community who are able to provide that support and I appreciate very much you bringing up the issues of equity and access and speaking to the Medicaid issues to assure that, as we heard earlier today from Rep Leeper, that there is a safe and equitable
access. So seeing no other questions, we will go on to Mary Caruso, who I believe is here with us in the room. Is Mary here? Okay. If not, I believe that Vicki Lucas is next.

DR. VICKI LUCAS: Hello.


DR. VICKI LUCAS: Thank you. Hello and thank you so much. And I appreciate the opportunity to sit before this distinguished committee. I'm Dr. Vicki Lucas, and I'm a senior advisor to Nest Collaborative, which is the number one teletelactation company in the United States. We served over 41,000 families last year and over 2000 families in Connecticut.

And we are in support of— and our headquarters, by the way, is in Farmington, Connecticut. And so we have a unique place in that we serve people that don't have access to personal care going into the home. We use telemedicine technology to zoom in, and we have all IBCLCs. And so we are in support of Health Bill 5318 with the specific language of IBCLCs being licensed.

The reason we are in support of that is there is the number one, the golden standard across the United States in the world, it is standardized, they have very specific curriculum with academic classes, with anatomy and physiology, specific testing, very rigorous clinical activities. So there's that standardization of care. We believe that standardization care is the safest thing for our most vulnerable population, which is our mothers and babies. It's the only credential that allows for clinical lactation consultation.
All the others have variability in education, variability in skills. So again, we believe that our most vulnerable population truly needs to have licensure of IBCLCs. We also believe that IBCLCs will increase access to care, that it will draw more IBCLCs into Connecticut, it will allow for reimbursement for those services. Right now, women that have IBCLCs out of the hospital are paying cash for that, our most vulnerable population.

And those that have disparate outcomes and disparate access, are not served because of that. If we are licensed, then we'll have the ability for reimbursement and can have all IBCLCs in the state serve that population. We also believe that licensure will allow a venue for citizens to file complaints and have due process, certification does not allow for that.

So in summary, we believe that the passage of the House Bill 5318, but with the language of IBCLCs only due to the standardization of credentialing and the standardization of outcomes, we believe that will increase the access, decrease the disparity of care for lactation consultation services throughout Connecticut and will truly improve morbidity and mortality as well as decrease the cost of public funding. I'm available for questions. Thank you.

SENATOR ANWAR (3RD): Thank you so much, Miss Lucas, for your testimony. Seeing no questions or comments, we will move to the next person on our list which is in person over here, number 60.

DR. VICKI LUCAS: Thank you.

SENATOR ANWAR (3RD): You're welcome. Thank you. Ashley Starr Frechette, welcome.
MS. ASHLEY STARR FRECHETTE: Good afternoon. Thanks so much for having me. Senator Anwar, Representative McCarthy Vahey, Senator Somers and Representative Klarides-Ditria, and members of the Public Health Committee. My name is Ashley Starr Frichette, I am the Director of Health Professional Outreach at the Connecticut Coalition Against Domestic Violence. Our 18 member organizations serve nearly 40,000 victims of intimate partner violence each year.

I'm here today to strongly urge your support of House Bill 5322. The proposed bill seeks to provide potentially lifesaving resources about intimate partner violence to every birthing person in Connecticut through birthing hospitals and obstetric providers.

Part of my role at CCADV is overseeing our maternal mortality due to intimate partner violence grant project. Last spring, we released a report which looked at all maternal mortalities from the year of 2015 to 2021 in the state of Connecticut. Of the 102 individuals who lost their life while being a birthing person, during that time, 32% experienced intimate partner violence at some point in their life.

And of those individuals, 67% of those individuals experienced IPV during pregnancy or within that one year of postpartum care. ACOG says that 1 in 6 abused woman is first abused during pregnancy. With that all being said, we still rarely see or hear any resources on healthy relationships or where we can look for supports when we are pregnant.

IPV during pregnancy increases the risk for preeclampsia, preterm birth, postpartum depression, and countless other negative health consequences. If we want to truly prevent this maternal mortality and
support birthing people in Connecticut, we need to include IPV in all conversations around what a healthy pregnancy can look like.

Existing statutory language focuses on developing crucial education materials for mental health, substance use and IPV, preventing maternal mortality as a direct result of the state's MMRC Committee. Bill 5322 would ensure that education on IPV is not only distributed to providers but also to the patients that are being served.

The research is clear that there's countless missed opportunities with screening and people not being comfortable to disclose. Educational materials given to every birthing person would ensure that everyone is leaving with a resource and educational material that they can go home with.

CCADV's pregnancy-related resources are validated, developed and ready to distribute. CCADV's health professional outreach advocacy team is ready and willing to ensure free trainings and supports to any provider that is outlined in this proposal. This bill will provide IPV resources at a crucial point of intervention.

IPV is amongst the top contributors to maternal mortality and morbidity and it needs to be recognized as such. Connecticut simply can't sit by and afford to continue to miss these opportunities. Thank you very much for your time in consideration of this very important bill. CCADV always appreciates the committee's longstanding commitment to protecting victims and survivors. Thank you.

SENATOR ANWAR (3RD): Thank you Ms. Starr Frechette for your testimony. And thank you for the work CCADV do every single day. You've been lifesaver for a lot
of our constituents and individuals. I see a question or a comment from Representative Parker.

REP. PARKER (101ST): Thank you, Dr. Anwar. Thanks, Ashley, for being here with us and for the work that you folks do. I just want to see if you can help us understand a little bit about the work of the Maternal Mortality Review Committee and CCADV's role on that, and specifically in terms of creating this resource. As we continue conversations with folks at DPH, we just want to understand the commitment of CCADV to doing some of the heavy lifting, because we know how resource constrained they and so many others are. So, can you just help us understand what you folks, I think you referenced maybe, have already done a lot of these materials. But in terms of seeing that through, we'd love to know more. Thank you.

ASHLEY STARR FRECHETTE: Thank you. Of course. So, I serve as a member on the Maternal Mortality Review Committee and I work very closely with DPH on many different projects, and we are ready and willing to do all of the work. These are resources that we use every single day already to help providers.

So, CCADV is ready and willing to provide all these resources, work directly with DPH on everything that has to do with this. And then, like I said, we have 10 health professional outreach advocates that serve across the state to help support any providers that might want education. It's all free and we do provide credits for that as well. So, thank you for the question.

REP. PARKER (101ST): Thank you so much.

SENATOR ANWAR (3RD): Thank you. Representative Parker, we would encourage you to ask more questions because you look good on the screen with a baby.
[Laughs] Seeing no other questions or comments, thank you so much.

ASHLEY STARR FRECHETTE: Thank you.

SENATOR ANWAR (3RD): Thank you. Next on our list is number 62, Jennifer Handt. Remotely. Welcome. I hope I pronounced your name correctly.

JENNIFER HANDT: Hi. Thank you. I'm Jennifer Handt from Darien, Connecticut. I'm here to support House Bill 5321, as a parent of a six-year-old child, Charlie, who lives with Duchenne muscular dystrophy. In 2020, Charlie was diagnosed with Duchenne, a relentless fatal neuromuscular condition that impacts 1 in 3,500 boys.

Without the protein dystrophin, muscles impacted by Duchenne waste away every day, leaving boys in a wheelchair by early teens and dying from heart failure in young adulthood. It's a diagnosis that changes life as you know it forever. Before diagnosis, we worried about Charlie's development, wondering why he wasn't crawling or walking or pulling himself up.

Our pediatrician told us it was likely nothing. So, we did things we now regret, including receiving physical therapy for Charlie through Connecticut Birth to Three. Without a diagnosis, that therapy pushed our baby's unprotected muscles too hard. Our baby, who couldn't tell us how difficult or even painful those exercises must have felt. It's heartbreaking to think about that now.

Our parental intuition finally led us to diagnosis at Yale. So, why am I here today when we've already had that heartbreak? First, the delay in diagnosis takes a toll. The average age of Duchenne diagnosis at five costs over $200,000 in medical expenses and
productivity loss per family, and hundreds of thousands in insurance claims.

Without awareness of the condition, families may take counterproductive action like we did enrolling our son in PT, or having more children without knowing they're carriers of the condition. Duchenne also impacts behavior and learning, and children may enroll in school without special supports that they need in place.

Second, we're at a turning point with treatment for Duchenne. For us, once we finally got diagnosed, we got lucky. Charlie turned four just in time to qualify for a phase three trial of a gene therapy Elevidys, which is now approved for four and five year old patients only. Elevidys has significantly improved Charlie's stamina and strength.

Last month, he was able to walk thousands of steps with us while on school break. That simple family experience would not have been possible without treatment. Families should not need luck to access the seven FDA approved therapies now available for Duchenne. They need early diagnosis.

Third, high quality care alone has improved outcomes. Numerous studies show that coordinated care for DMD has resulted in a full 10% increase in life expectancy. The sooner patients can begin this care, the better.

Finally, if we routinely screen babies, we put every patient on an even playing field with access to early stage clinical trials and treatment, to better care and to supports like the Katie Beckett Medicaid waiver. And we can immediately recognize the impact of all those things on patients from day one.
It's a virtuous cycle that will add up to further progress against this terrible disease. Time is muscle. Every day we wait for diagnosis, patients are declining. Science has solutions. But first we need the diagnosis, and we have a simple, affordable way to start doing that now. Connecticut has a huge opportunity to lead the way toward better outcomes in Duchenne newborn screening. Thank you. And I'd be happy to take any questions.

SENATOR ANWAR (3RD): Thank you so much for your testimony. I wanted to ask you, the bill is talking about the early diagnosis, but what are the screening tests that you're aware of that can help us? Yeah.

JENNIFER HANDT: Sure. So, the first screening test is called CKMM. It's looking for a biomarker of muscle breakdown basically. And they do that when they suspect Duchenne. If they do that in newborns, basically, the process will be able, just like other rare diseases like cystic fibrosis where they do a secondary, they do a repeat test and then patients from there would be recommended for DNA sequencing to confirm a diagnosis.

SENATOR ANWAR (3RD): Okay. So, a blood test will give us insight into muscle breakdown. And then you have a suspicion and then you go further to confirm the diagnosis with the tissue diagnosis?

JENNIFER HANDT: No tissue is necessary. It's just a DNA sequencing of another blood test.

SENATOR ANWAR (3RD): Okay. This is very helpful. Thank you so much. Rep, you have a question? No. You do? Yeah, Cook has a question.

REP. COOK (65TH): Thank you. Thank you, Senator. And I just wanted to make sure that everybody knows
too. We have packets that are in front of you that really give a lot of great information. I want to thank you for being here. I understand that as a mom with family members, it makes it difficult to come in-person, and I'm happy that you could be here to join us and tell your story. Is there anything else that you think is relevant that we need to know while we're making this decision?

JENNIFER HANDT: I mean, I think it's important to remember that this test is already routinely given to newborns, and adding Duchenne is not a huge lift. I mean, it's basically, like I said, it's using a simple blood test to sort of identify a suspicion. And then from there, there are steps that you can take and different states are approaching it differently. So, there's different ways that we can do it in Connecticut.

But just identifying that this might be happening is going to reduce the sort of diagnostic Odyssey that a lot of our family -- my story, I guess I would just say my story is not unique. My story is actually very common. Everyone from we had no idea until he was six that, you know, anything was wrong, to we knew something was wrong, but then they thought it was a liver issue.

They thought it was this and that. And that just adds up on so many levels cost and also, you know, psychological distress and all the things that you would think. So, yeah. So, I just think this is a low lift in terms of really impacting outcomes for the better.

REP. COOK (65TH): Thank you, and thank you again for being here and sharing your story. Best of luck to all of you.

JENNIFER HANDT: Thank you.
SENATOR ANWAR (3RD): Thank you so much.
Representative Marra has a question or a comment.

REP. MARRA (141ST): Thank you so much, Jennifer. I really appreciate you coming here, and I've enjoyed our discussions and hearing so much about Charlie along the way. [Clearing throat] Excuse me, I understand that it's Lobby Day this week in DC. And maybe some of the folks that could be talking with us here today aren't able to make it, but there's certainly testimony for them.

But I just, I know you talked about kind of the psychological distress and some of the money that you've had to spend along the way between that age of birth and four, but maybe can you just touch on if you did have a newborn screening and if you found out Charlie's illness very early on, what kind of therapy could be done since we know that something like gene therapy couldn't be done until when he was older. Is there anything else that can be done at that young age?

JENNIFER HANDT: Yeah. So, I mean, first of all, treatments are emerging all the time and we're learning more about early intervention. For us, it would have been, we certainly wouldn't have pushed him in BT which actually broke down his muscles more and was really detrimental. We would have gotten in with a care center earlier, we would have had more information, we would have gotten him into that comprehensive care that's so critical.

I think it's also important to remember right now, the treatment that Charlie got, which was so completely transformational, is only approved for kids four and five years old. So, if you look at the average age of diagnosis at five, that's giving no time to -- and let me tell you, like getting, you
know, getting into care and like agreeing that this
treatment is the right step and then getting
insurance approval, like there is very little time.

So, if you have a kid who's diagnosed, you know, as
a baby, then you've got that time to plan like what
his care will look like, you know, what treatments
look like, what clinical trials look like. It's
just, you don't want to rely on luck in terms of
like timing your child to like make critical
decisions about a really serious disease. It just,
it makes no sense.

We have the science right now. I mean, it's not even
revolutionary science. It's part of the, you know,
heel prick that babies get, and it costs like $8 per
child to add this on. And it's, actually in terms of
being a rare disease, it's a pretty prevalent one.
So, I just think all the, you know, everything winds
up that it makes so much sense and it's really going
to have a tremendous impact on outcomes.

REP. COOK (65TH): Thank you so much, and thank you
for your advocacy.

JENNIFER HANDT: And thank you for your support.

REP. COOK (65TH): For sure. Any time.

SENATOR ANWAR (3RD): Thank you. Seeing no other
questions or comments, we want to thank you for your
testimony, and we will move to the next person on
our list, which is Luis Luna. Welcome. 61.

LUIS LUNA: Thank you, Senator Anwar, Representative
McCarthy Vahey and esteemed members of the Public
Health Committee. My name is Luis Luna. I serve as
the coalition manager for Husky for Immigrants, and
I'm here today to express my strong support of HB
5320.
So, medical debt is not just a financial burden. It is a barrier to equitable health care access and perpetuates cycles of economic and health inequities. As someone deeply involved in advocating for immigrant communities, I have seen firsthand the devastating impact of medical debt. Over the years, countless individuals we worked with, including my own father, have found themselves drowning in medical debt after receiving necessary healthcare services.

Three years ago, my father, who is undocumented, suffered a heart attack. He had an emergency procedure and made it through. After returning home, he was sent a bill of over $15,000. He applied for financial assistance but he was denied. They told him that the best thing that they could do is put him on a payment plan.

This story is not unique. This is the reality for many people in our community. For example, Sandra, who is a member of one of our organizations owes over $30,000. She's undocumented and a homeowner. She also has applied. She has sent documents. She has also begged for some type of financial assistance and has not found relief.

Of course, her example also highlights a larger systemic issue. She does not qualify for Medicaid because of her immigration status, which could also be a pathway to address her medical debt. In Connecticut, approximately 59% of undocumented immigrants are uninsured, compared to just 5.9 of residents with citizenship or a social security number.

This staggering disparity highlights the urgent need for legislative action to address the issue of medical debt and to ensure access to health care for
all residents regardless of their immigration status. Passing HB 5320 would be a crucial step towards providing relief to individuals who are disproportionately affected by medical debt and lack of access to essential healthcare services.

Moreover, implementing measures such as creating a common application for financial assistance, ensuring language accessibility and automatically qualifying certain patients for assistance based on income level or enrollment in programs like SNAP or WIC are vital steps towards making financial assistance more accessible and reducing the barriers faced by marginalized communities.

As an advocate for equitable access to health care, I firmly believe that HB 5320 is a necessary and just measure that will positively impact countless lives in our community. I urge the committee to favorably pass this bill and stand with us in the fight against medical debt and health care inequities. Thank you for the opportunity to testify today.

SENATOR ANWAR (3RD): Thank you so much, Luis, for your testimonies. There is a question. Representative Zupkus has a question for you. Wait.

REP. ZUPKUS (89TH): Thank you, Mr. Chair. Hi, thank you for coming today. I'm just trying to understand what you're asking for. Are you asking for a payment plan to pay off the debt?

LUIS LUNA: Yeah. So, what I'm asking for is some type of relief for families who don't have insurance, but also like for the larger community. I think like what we see is that folks who don't have insurance in our perspective as, you know, fighting for folks who don't have access to insurance is that folks need to see the doctor. And when they return
home, either for emergency or any type of specialized care or any type of encounters that they have with medical providers, that they are burdened with debt.

So, then this causes a really big issue because folks then have to choose, and sometimes they think, should I see the doctor or should I ignore what I'm feeling or the things that I need in terms of seeing a doctor? I mean, with my father, for instance, after he had the heart attack, yeah, he came home, he had a stent placed in his heart and he made it through.

But then after he came from the hospital, he was questioning on whether like he should see and follow up with a cardiologist because he received a large bill. So, this is the reality that we see with a lot of folks. So, if we are able to -- you know, this is a larger systemic issue.

But if we're able to find some relief where folks are able to apply for financial assistance in their language, creating a common application where hospitals across the region can use the same so then they can, so then patients can apply for this assistance in a more equitable way and in an easier way, I think this will go a long way. So, what I'm advocating is to make sure that we try to find relief with this bill for many of our community members.

REP. ZUPKUS (89TH): Okay. Thank you, because I think there's a lot of people that need relief, maybe more than even in just your community, because I think you said that it's a bigger systemic issue than just that. But I'm glad to hear it's more of a payment plan and to help with payments because medical expenses are extremely high for everybody.
So, thank you. I just wanted to clarify what you were asking.

LUIS LUNA: Yeah. Yeah. No, absolutely. And I agree with that. I think like there's a lot of work to do to make health care --

SENATOR ANWAR (3RD): Thank you so much. I think this is good. We have no more questions or comments, we appreciate your testimonies, Luis. We move to the next person on the list is number 63, Laila McGeorge. Welcome.

LAILA MCGEORGE: Hello. Can you hear me?

SENATOR ANWAR (3RD): Very well.

LAILA MCGEORGE: Okay, great. Hi, everyone. My name is Laila McGeorge. Senator Anwar, Representative McCarthy Vahey and esteemed members of the Public Health Committee. I am a resident of Trumbull and I am currently pursuing my Master's in Social Work and Master's in Public Health at the University of Connecticut. And I stand in support of HB 5320, an act concerning hospital financial assistance.

So, in 2020, hospital and physician visits together comprised more than half of an individual's average annual health care spending in Connecticut. The cost of health care in Connecticut has increased within the past few decades, disproportionately impacting low income adults, adults ages 18 to 64, immigrants, and Black and Latino residents.

Those experiencing medical debt are forced to delay or forgo needed medical care which can lead to worse health outcomes. Hospital financial assistance for medical costs can alleviate the heavy burden of medical debt for many vulnerable Connecticut
residents. So, medical expenses have touched all of our lives, I'm sure, and mine included.

In 2018, my mother was diagnosed with stage two breast cancer, and this really shook the foundations of our family and was a time of uncertainty and fear. So, after an intense bout of surgeries, chemotherapy and radiation, my mom is now proudly a breast cancer survivor. Throughout her journey, the thought of medical expenses was not on the forefront of our minds at all. We just wanted my mother to heal and survive.

However, my mother was shocked to learn that after all of her surgeries and various treatments for her cancer, the total cost was over half a million dollars. Thankfully, my family has insurance that covered most of those expenses. However, even after the coverage, we were left having to pay a significant remainder insurance would not cover.

Without the surgeries, chemotherapy and radiation, my mother may have not survived or would have prolonged going to the doctors until she had stage three or four breast cancer. We are so, so lucky to have insurance that covers most medical expenses.

However, having insurance with decent coverage is hard to come by, let alone having insurance at all. Imagine we did not have insurance. Imagine we had no way to even begin to pay off the medical expenses she incurred. That is a stark reality for roughly 280,000 Connecticut residents who have medical debt.

The key provisions of this bill will help the most disenfranchised residents by making financial assistance more accessible. So, like creating a common application for financial assistance that all Connecticut hospitals would accept would make it more accessible, as well as automatic qualification...
for assistance for certain patients who are enrolled in SNAP and WIC or with a household income at or below 250% of the federal poverty line.

Thank you for the opportunity to testify in support of HB 5320, an act concerning hospital financial assistance policies. I urge the committee to favorably pass this bill. Thank you.

SENATOR ANWAR (3RD): Thank you so much for your testimony, and just wanted to comment that MPH and MSW is a very interesting combination. You're going to do good work.

LAILA MCGEORGE: Thank you.

SENATOR ANWAR (3RD): No questions or comments. We'll move to the next person on our list, which is Ellie Mulpeter. Welcome.

EUGENE CURRY: Thank you. As I think everybody can figure out, I am not Ellie Mulpeter. Ellie had to step away from the conference call. My name is Eugene Curry and I'm testifying in her place. I'm speaking on behalf of the Academy of Lactation Policy and Practice, which certifies qualified lactation support professionals known as certified lactation counselors, otherwise known as CLCs.

We support the overall goal -- I'm testifying on behalf of HB 5318, and we support the overall goal of increasing access to breastfeeding and access to breastfeeding care professionals. However, we have some concerns about the bill as drafted.

First of all, as a general proposition, we would like to see both CLCs and IBCLCs be reimbursed based upon their certification. And based on testimony today that I heard, it's my understanding that at
least some health care professionals in Connecticut are being reimbursed by Medicaid without licensure.

In New York, legislation was passed that specifically allowed for reimbursement, Medicaid reimbursement for both IBCLCs and CLCs based on certification. To the extent that licensure is necessary, we would want both IBCLCs and CLCs to be licensed, and we would also recommend that that licensure be voluntary. There are a wealth of economic evidence suggesting that mandatory licensure restricts access to care and raises prices for care.

There's a bill that was passed in New Mexico that provides for voluntary licensure for IBCLCs and CLCs. And we suggest that might be a useful model to consider. I want to respond to some of the comments that have been made about the relevant qualifications of IBCLCs and CLCs, particularly the comment that IBCLCs are clinical and somehow CLCs are not.

There was a case decided last year in Georgia where those very issues were at stake, and the Georgia Supreme Court concluded a couple of things that I think are relevant to this committee's deliberations. First of all, it concluded that, it rejected the argument that IBCLCs and CLCs were not, IBCLCs were clinical and CLCs were not. It declared that both were clinical.

It further concluded that the record before the court supported the conclusion that CLCs are trained to provide safe and competent lactation care and services within the scope of their practice, which is similar, by the way, to the scope of practice of IBCLCs.
And my last point is that Rhode Island, which is a voluntary licensure state, has been pointed out as a model to be followed in connection with this legislation. And I thought it might interest the committee to know that there are amendments to the Rhode Island licensure bill pending before the state legislature that would include CLCs in their licensure scheme. I'm available to answer any questions that the committee may have.

SENATOR ANWAR (3RD): Thank you so much for your testimony. We have noted your concerns. Seeing no questions or comments, we'll move to the next person on our list. Thank you for being there. Next person is Mark Schaefer. Welcome, Mr. Schaefer. Mark, you there?

MARK SCHAEFER: Yes.

SENATOR ANWAR (3RD): Hi. Go ahead.

MARK SCHAEFER: I am. I'm sorry. I thought you all had the control over muting and unmuting. So, I've learned that now, and we'll begin.

SENATOR ANWAR (3RD): We do have the control, but we don't want to let you know that. Welcome.

MARK SCHAEFER: Thank you. So, good evening, Senator Anwar, Senator Vahey McCarthy, Representative Klarides-Ditria, Representative Somers, members of the committee. My name is Mark Schaefer, Vice President, System Innovation and Financing at Connecticut Hospital Association. We appreciate this opportunity to -- I appreciate this opportunity to testify concerning House Bill 5320, an act concerning hospital financial assistance. CHA opposes this bill.
Connecticut hospitals strive to ensure that the inability to pay for services is not a barrier to seeking medical care, and it's why they work hard to ensure their financial assistance policies are applied to all those who are eligible and to connect eligible uninsured patients with a regular source of health insurance coverage.

CHA's primary objection to this bill is that it's largely duplicative. Section one of this bill focuses on financial assistance for individuals enrolled in SNAP and WIC regardless of immigration status. All Connecticut hospitals already provide free care, financial assistance to uninsured individuals who fall within the income requirements of these programs regardless of immigration steps.

Section one also requires that hospitals use a uniform application for financial assistance. In addition to offering free care for low income individuals, hospitals may offer a range of financial assistance programs to help patients cover their medical expenses. And these programs vary from hospital to hospital based on the kinds of donations they may receive to cover such services or programs, and typically have specific requirements regarding who qualifies and the criteria for eligibility, and these may vary from year to year.

So, an application that took into consideration all such requirements for all hospitals would be difficult to maintain because the programs change, and it could also require the patient to complete a much longer and more burdensome form than they do for an individual hospital today.

The bill also imposes unnecessary and burdensome reporting requirements that add to hospitals' administrative expenses and ultimately the costs of care we all bear. Finally, the bill authorizes the
attorney general to investigate the application of hospital financial assistance policies, when these policies are already subject to the oversight of the Office of Health Strategy.

CHA will continue to focus on hospitals' efforts to make their financial assistance programs as easy to access and navigate as possible, raise awareness about these programs with patients, and ensure that hospital staff remain well prepared and trained to articulate these policies to patients. Thank you for your consideration of our position.

SENATOR ANWAR (3RD): Thank you so much for your testimony. So, can I clarify? So, the CHA's position is even the universal form is not acceptable?

MARK SCHAEFER: Yes. In discussing and talking with our members, there are beyond simply the free care that they all offer for uninsured individuals below 200% of federal poverty level, or in some cases 250%. There may be special unrestricted donor funds that are restricted donor funds, for example, that might support a particular medical assistance opportunity or financial assistance opportunity. And so, the application forms are designed to help identify folks who might be eligible for more than just the basic free care or financial assistance that they would otherwise be entitled to.

SENATOR ANWAR (3RD): So, Mark, what are the things you guys like about this bill?

MARK SCHAEFER: I think there isn't a provision in this bill that we're voicing support for because we believe that the hospital's free care and financial assistance policies are actually some of the best in the nation. And that's also in part because the statutes in Connecticut are much more protective of individuals around things like liens, for example.
So, in Connecticut, we think we're in pretty good shape even despite the fact that without question, medical debt is an issue. But that's a different set of problems requiring a different set of solutions.

SENATOR ANWAR (3RD): Thank you so much. This is very helpful. I would just say that the issues are real and the people who have come and spoken, they do have very valid issues that they are trying to bring to the table. And the hospitals do have a role in the picture. We just have to look at what is the way to find a way to move forward and address some of these issues that we can.

The idea is also not to make it too burdensome from logistic point of view for the hospitals, but at least we should have a mechanism to address the medical debt and some of the other challenges. That was more of a comment. So, if there is no other questions or comments, we'll move to the next person on our list. Thank you so much for your testimony. We appreciate you being here.

MARK SCHAEFER: Thank you.

SENATOR ANWAR (3RD): Next on our list is Elizabeth Ryan. Welcome.

ELIZABETH RYAN: Hi, thank you so much. I want to thank the chairs and all members of the committee for hearing me out this evening. My name is Elizabeth Ryan. I am policy counsel with Everytown for Gun Safety. I am testifying in support of HB 5317, an act requiring a study concerning the funding for and effectiveness of community gun violence intervention and prevention programs.

I want to echo the notion that we heard earlier that we have plenty of data. The community violence intervention programs work, and I would like to
encourage that this study focus on sustainable funding for those programs. So, as you go into this study, I would like, we are asking that you go into it with substantive ideas for sustainable funding specifically.

Well, Connecticut communities continue to suffer from the devastating impacts of gun violence. The firearms industry continues to reap record profits as their products fuel a public health epidemic. Connecticut has already established itself as a nationwide leader in gun safety, and that includes the establishment of the expert driven Commission on Community Gun Violence Intervention and Prevention.

But the commission cannot continue to distribute grants to support life saving community-based violence intervention programs or perform its other vital functions without a sustained source of funding. Community violence intervention programs far too often have to rely on changing yearly budget allocations or one-time federal funding that can fluctuate wildly and prevent them from being able to adequately staff, plan and sustain their work.

What they need is a source of funding that they can rely on. And to create this steady funding, Connecticut should look to California and impose a modest excise tax on businesses selling firearms and ammunition. A rate of 11% on gross revenue for such sales would mirror the existing federal excise tax that has been in place since 1919. That tax, which generated $1.1 billion nationwide in 2022, supports wildlife conservation and hunter education programs.

That year, Connecticut was in the top 10 states in terms of contributions per capita through that federal tax. If Connecticut instituted its own excise tax on these sales, the funds it would generate could substantially and sustainably benefit
evidence-based community violence intervention programs.

The Commission on Community Gun Violence Intervention and Prevention has the unique experience to vet, evaluate and monitor these programs, but it needs sustainable funds like the money that an excise tax would generate. An excise tax would ensure that the firearm industry pays its fair share of the costs of gun violence without placing the burden directly on consumers. Thank you.

SENATOR ANWAR (3RD): Thank you so much for your testimony. We appreciate you being here and sharing your concerns. Can you speak a little bit more about the data of the interventions and how that's helping some of the communities from the current studies, if you have them?

ELIZABETH RYAN: Sure. So, we have evidence. I can get you specific data studies after the hearing. But there are plenty of studies that show that a lot of these programs make a huge impact directly in the community. The commission last year funded some programs that do things like place care workers into hospitals, directly supporting victims of gun violence, programs that help specifically young mothers and children who are at particular risk for gun violence.

And even things like safe passage programs which helps young people get to and from school and other activities safely without being exposed to gun violence. Those were all things that Connecticut funded last year, unfortunately, with some federal funds that are only one time. But we have, a lot of these programs have been in place for decades, but that lack of funding is really potentially holding them back a lot. And we're encouraging that these proven programs be funded sustainably.
SENATOR ANWAR (3RD): So, the ROI is quite significant from the investments that have been made in the communities through the existing programs?

ELIZABETH RYAN: Yes.

SENATOR ANWAR (3RD): Okay. And what you're saying is that the sustainability of this is going to be critical, going forward?

ELIZABETH RYAN: Correct.

SENATOR ANWAR (3RD): Okay. All right. Thank you so much for your testimony. Seeing no questions or comments, we'll move to the next person on our list. We appreciate you being here.

ELIZABETH RYAN: Thank you.

SENATOR ANWAR (3RD): Next is number 68, Nick McLaughlin, followed by James Lawrence. Mr. McLaughlin.

NICK MCLAUGHLIN: All right. Thank you so much for having me today. Chairperson Anwar and McCarthy Vahey, Ranking Members Somers and Klarides-Ditria, members of the Public Health Committee, thank you for this opportunity to speak today. My name is Nick McLaughlin. I am the President of Breez Health. And please consider this to be my public testimony in support of Raised Bill number 5320.

At Breez Health, we are experts in hospital financial assistance programs. We partner with hospitals. Our mission is to make these programs easy for both hospital administrators as well as their patients. And a description of our financial assistance solutions is available on our website, breezhealth.com.
We can help hospitals, or what we do is help hospitals make it easy for their patients to see if they qualify and apply for free or discounted care under the hospital's financial assistance program. If I could use one word to describe hospital financial assistance programs, it's underutilized. So many patients that qualify for these programs are not accessing these resources and this free or discounted care that qualify for.

And I know this because I spent nearly 15 years in the hospital debt collections industry. I started Breez because the status quo for hospital financial assistance programs nationwide is cumbersome and complicated and often involves application forms that request more information than is needed to determine eligibility, and documentation requirements that are overly burdensome as well.

We act as a trusted partner to our hospital clients taking a collaborative approach to simplify and streamline their financial assistance programs to help them fulfill their missions as organizations serving their community. Now, I mentioned I'm in support of 5320, especially with the mandate of developing a uniform application for financial assistance. Standardizing this often complex application form for patients will go a long way to helping residents of Connecticut.

So, a couple of thoughts to add. Medical debt is wreaking havoc on families. Hospital financial assistance programs are woefully underutilized, as I mentioned, and we applaud the state for committing COVID relief funds to pay off old medical debt for Connecticut residents. However, we need to implement sustainable solutions to prevent medical debt in the future as well.
Simplifying and streamlining the patient experience with hospital financial assistance programs would be tremendously beneficial. And a patient-friendly state uniform financial assistance application would be a great step towards that. A few states that have implemented one previously mandated are Washington and Oregon and Maryland. Ohio has one that the state developed in partnership with the Ohio Hospital Association, and it's not mandatory. However, every hospital in the state has voluntarily adopted it and it's only a single page application template.

A few things that I would recommend adding to the bill is, one would be creating a statewide centralized online hospital financial assistance portal where Connecticut residents could apply online for financial assistance at any hospital in the state. A portal like that alongside promotional efforts to drive awareness of hospital financial assistance programs will drastically increase engagement and access to these resources for patients that struggle with medical debt.

I would also encourage ensuring that underinsured patients, people who have insurance but cannot afford their out-of-pocket costs are not excluded from financial assistance policies, and also create minimum financial assistance program income eligibility criteria that is to be utilized by all hospitals in Connecticut. Washington, Oregon, Illinois, California, New York are already leveraging policies like these, and a good minimum benchmark would be 100% discount for patients up to 250.

THE CLERK: Excuse me, Mr. McLaughlin, but your time is up. Thank you.

NICK MCLAUGHLIN: Thank you.
SENATOR ANWAR (3RD): Mr. McLaughlin, I just wanted to clarify. Is your company giving loans?

NICK MCLAUGHLIN: No, not at all. We help facilitate these financial assistance programs that exist at hospitals. So, it's not facilitating payment, it's facilitating the patient experience and connecting the lower income patients that cannot afford their care to receive these discounts on their care.

SENATOR ANWAR (3RD): How are you able to sustain yourself, if I may ask?

NICK MCLAUGHLIN: So, our fee structure is in partnership with hospitals, they pay us a license fee for setting up our software to make it available to their patients. So, our clients spend some money to make financial assistance programs where they are largely not receiving money available to their patients. It's patient advocacy is at the heart of these efforts.

SENATOR ANWAR (3RD): Okay. So, in other words, the universal application form, you're trying to centralize it and that's how you're connecting with the people in the community who need the help, and you're working with the hospitals to be able to help provide it to them?

NICK MCLAUGHLIN: Say that one more time, please.

SENATOR ANWAR (3RD): So, you have a universal application form that's online that your group has created and that's allowing the services to be provided to the patients who need help, and then you collaborate with the hospitals to do that?

NICK MCLAUGHLIN: Not exactly. We facilitate the financial assistance applications of our client hospitals. A uniform, a universal application form
would make that simpler for the residents in Connecticut and simpler to execute a state centralized financial assistance portal.

SENATOR ANWAR (3RD): Okay. This is helpful. Thank you so much for your testimony. Seeing no other questions or comments, we'll move to the next person on the list, which is --

NICK MCLAUGHLIN: Thank you so much.

SENATOR ANWAR (3RD): Thank you. Mr. James Lawrence. Welcome, Mr. Lawrence.

JAMES LAWRENCE: Hi. Hello. I hope you can hear me all right.

SENATOR ANWAR (3RD): Yes, we can.

JAMES LAWRENCE: Thank you. I'm sorry, I couldn't be there in person. I had a class today. Good evening, esteemed members of the Public Health Committee. Thank you for the opportunity to speak today. My name is James Lawrence. I'm a current candidate for Master of Public Health and Health Policy at the Yale School of Public Health, an incoming medical student, and the son of two disabled parents. Today, I'm before you virtually in support of HB 5200.

Over the last few years, my work has taken me from Connecticut to California and Connecticut again, a place I've come to call home. I've had the pleasure of working with health equity experts from Gallaudet University who championed disability rights within the healthcare sector and have been involved at the ground level in both outpatient care and emergency department services since my undergraduate studies.

From the perspective of someone who spent the better part of my childhood helping to make up for the
shortcomings of an ill-fitting healthcare system, this bill is an opportunity to implement equitable healthcare practices that foster the well being of not just those who are most convenient to care for, but all who seek it.

In caring for patients during vulnerable moments where they may be awaiting a diagnosis that could change their life forever or in seeking compassionate continued care from health care providers they have placed their trust in, cost and access should not preclude provision, regardless of perceived difficulty of implementation.

Illustrating this need, I wanted to point out that in Connecticut alone, a striking 613,853 adults have a disability. These patients account for nearly 37% of the state's health care spending, which amounts to $21,000 per person annually with a disability.

As I'm sure you all are aware, in 2017, the U.S. Access Board issued new standards for the utilization of medical diagnostic equipment. These are minimum guidelines but not hard and fast rules as stated by those who testified before me.

To ensure that these important suggestions are implemented, I urge the committee to consider including language in HB 5200 that more closely affirms these recommendations by explicitly including accessible exam tables, scales and lists, an avenue for enforcement of the statute through the office of the State Attorney General, a requirement to train health care staffs on the need of disabled population.

And regarding Senator Gordon's earlier questions, a safety belt for smaller practices that may experience a greater cost burden, referred to in these guidelines as an undue burden, and a highlight
of the tax credits that can be claimed for retrofitting facilities to ensure that every patient has the opportunity to receive the care they deserve.

At our academic program, we're educated on how resources are allocated, how medical practices may help but also harm, and that sometimes profit comes before patients. 1 in 4 20-year-olds will become disabled before they retire. This could be your friend, your spouse, your coworker or your child.

Today, I'd like you to place yourself in their shoes and imagine coming into an exam room for a mammogram, afraid for what the results might show, and being turned away because you entered the room in a wheelchair and forced to seek care elsewhere because a decision was made to cut marginal costs and accessible diagnostic imaging equipment was not provided.

Today, we have the opportunity to ensure that health care in this state is characterized by being more than just a commodity but serves as an example for the rest of the country for how you, your neighbor and your loved ones should be treated. Thank you for your time.

SENATOR ANWAR (3RD): Thank you so much for your testimony, Mr. Lawrence. Could you tell us a little bit about some of the models that we have spoken of in the past about retrofitting health care facilities, in California, perhaps. You talked about that.

JAMES LAWRENCE: Yeah, absolutely. There have been a couple of different examples, especially within, you know, comparable healthcare facilities. We can look to Sutter Health in Northern California who voluntarily retrofit their entire facility following
a change to the California building code I think in the early 2020s, and they did this voluntarily and with relative haste. And this was in compliance with the building code.

There is also a couple of other examples where, especially with regards to enforcement in New York, there were partnerships with the State Attorney General and nonprofits that facilitated enforcement to ensure that standards were met. They built these capacities through community-based organizational partnerships that already served and built trust with these communities that had physical disabilities.

And as noted in previous housing cases, using programs like proactive rental inspection worked really best with the compliance-based system. So, in terms of enforcement and in terms of looking at other states for precedent, California and New York could serve as good examples for how we might be able to implement this here in the state of Connecticut.

SENATOR ANWAR (3RD): And you're aware of the recommendations from the coalition, and are they similar to what some of the other states have done or are we at a different pathway?

JAMES LAWRENCE: No, they're very similar. And especially with regards to how they're taking this conversation, really, you know, after listening to what the coalition has testified on earlier today, really, they're only asking for compliance with the Access Board. You know, we're seeing that despite these being federal regulations, they aren't actually being adhered to, they're not being enforced, they're not being encouraged.
So, at the state level, it makes sense to sort of get ahead of the federal level and ensure that these folks get the care that they deserve. You know, that's been recommended, you know, that's stated before by the DOJ, by the HHS, but hasn't been adopted yet. So, at the state level, it does make a lot of sense. There's precedent in states like Texas and Minnesota that have passed similar legislation or are planning to pass it in this legislative session. So, there's absolutely precedent in other states.

SENATOR ANWAR (3RD): Sure. And my last question is you probably heard one of the testimony to change the language to be inclusive of individuals who have experiencing, who are deaf or hard of hearing. What were your thoughts on that?

JAMES LAWRENCE: Yeah. I am somewhat biased. Both of my parents are deaf and/or hard of hearing. My mother was hard of hearing but progressed into deafness later in her life. And, you know, language and accessibility on that front is a huge burden as well. Personally, I served as their interpreter for most of my childhood.

You know, despite having the availability of interpreting services, most of the time it was quite difficult for, you know, for my parents to coordinate care. Often it was on them to have to provide those services for themselves, to coordinate interpreters to come to their medical visits. And as a result, frequently they would just have me tag along instead of having a qualified medical interpreter there to explain to them.

And I think, you know, if this is another provision that's being considered, I would like to highlight the importance of having disability education or at least that lens within medical education training
because quite frequently, and surprisingly, despite being a 16-year-old or 17-year-old, often the providers would look at me instead of my parents when they were speaking to me as the interpreter. They wouldn't look directly at them despite them being the patient.

So, I think, you know, if those language provisions were included, if there was a sort of requirement to at least coordinate interpreting services or make sure that those needs were noted and that healthcare professionals were required to understand what it was like to be treated as another despite the care being about you, I think that would make quite a big difference.

SENATOR ANWAR (3RD): Thank you, James. And I can tell you that earlier, we were having a conversation about some of the physicians and other health care workers not having the empathy. Listening to you gives me a lot of hope. So, thank you for your testimony and thank you for being here.

JAMES LAWRENCE: Thank you for your time.

SENATOR ANWAR (3RD): Next person on our list is Siyan Zhou. Welcome.

SIYAN ZHOU: Hi. Senator Anwar, Representative McCarthy Vahey, and the distinguished members of the Public Health Committee, my name is Siyan Zhou. I am also a Master of Public Health candidate at Yale. My study focuses on maternal health. I'm here to express my support for House Bill 5318, an act requiring the licensure of lactation consultants.

So, breastfeeding reduce the risks of many health conditions for infants and mothers. However, many mothers discontinue it prematurely. Data from the CDC indicate that in Connecticut, only 1 in 5
infants is exclusive breastfeed through six months as recommended by WHO, which is 20% below the national average.

The low breastfeeding rates impose additional $3 billion medical costs to mothers and babies annually in the United States. So, therefore, there must be effort to support breastfeeding. The IBCLC certification which requires coursework, 95 hours of lactation education and at least 300 clinical hours ensures quality services provided to families in need.

And I also want to stress that this is not only a health issue but also an active issue. Also from the CDC, breastfeeding rates are not fully lower among Hispanic and Black communities. Low income, single and the high school graduate mothers are 30% less likely to breastfeed their children to the recommended time compared to their counterparts respectively.

So, enhancing access to lactation support helps address these disparities. Currently, it can be exhausting and frustrating for families to search for reliable lactation support since there are many programs award credentials after only a short didactic education. And for those who lack the sufficient time and resources, it can be difficult to understand and differentiate different certifications. And licensure also provides the foundation for service access and financial reimbursement.

Many physicians will not refer patients for lactation care and many insurers will not reimburse for such services rendered if they are not able to qualify qualification. So, with this action and with this change, our mothers may enjoy lactation services more easily and at a lower cost. And also
for the profession, lactation consultants can potentially be benefited as well by being reimbursed for their services and potentially receive more job opportunities. And thank you for the privilege of testifying today.

SENATOR ANWAR (3RD): Thank you so much. Siyan Zhou for your testimony. My co-chair has a question or comment.

REP. MCCARTHY VAHEY (133RD): Just a quick comment and a word of thanks for your amazing work and your advocacy today. I appreciate you and appreciate you being here.

SIYAN ZHOU: Yeah. Thank you.

SENATOR ANWAR (3RD): And seeing no other questions or comments, we will move on to the next person on our list, which is Johanna Schubert. Welcome.

MS. JOHANNA SCHUBERT: Good evening. Good evening, distinguished members of the Public Health Committee. My name is Johanna Schubert, and I'm the Director of the Connecticut Hospital Violence Intervention Program Collaborative or CT HVIP at Hartford Communities that Care. I'm also a member of the DPH Commission on Community Violence Intervention and Prevention. Our agency, Hartford Communities that Care is joining other advocates here today in support of HB 5317, an act requiring a study concerning the funding for effectiveness of the community gun violence intervention and prevention programs.

Hartford Communities that Care was founded in 1998 with the youth program at Fox Middle School called Stump The violence. Our CEO, Andrew Woods, and others recognized that tensions that began during the school day were spilling out and leading to
violence in the streets. We understood then that early intervention, mentoring and supporting the whole family would be key to stopping this violence. One of our youth leaders like to say that youth development is violence prevention, and we couldn't agree more.

Over the last 25 years, we've worked hard towards that goal. And today, HCTC supports four complementary programs that focus on our mission of creating a drug free and violence free environment. Our work has helped shape national best practice models and is a contributor to making Connecticut a nationwide leader in violence prevention.

According to Giffords Law Center, effective CVI programs are associated with an up to 40% reduction in gun violence. When we measure this in human cost, it means more birthdays, more gainfully employed citizens, more small businesses and communities and less trauma overall. Less violence also has a monetary value.

According to data from Hartford's three level-one trauma centers, up to 85% of victims of community violence are eligible for or already on Medicaid. In fact, according to Everytown for Gun Safety, gun deaths and injuries cost Connecticut $2.6 billion each year, of which $57.1 million is paid by taxpayers. That's a staggering $742 per person.

The evidence-based and community centered violence prevention programs here in Connecticut can go a long way to shrinking that number. But to be most effective, community violence reduction programs rely on sustainable funding to provide the quality and continuity of care that communities deserve.

Thanks to leadership from the governor's office and the legislature, including many of you around this
table, we now have the infrastructure to support a consistent funding stream. In 2021, with the leadership of Senator Moore and others, SB 1 established a Commission on Community Violence Intervention and Prevention that would make recommendations to the legislature on best ways to attain and focus resources to stem the flow of community violence.

That report was submitted to the legislature at the end of 2021 calendar year, and chief recommendation among them was the establishment of a permanent commission, one that would continue to advise the legislature and help maintain healthy and sustainable sources of funds for community violence work.

Such a commission was formed in 2022, and the Connecticut Commission on Community Gun Violence Intervention and Prevention sits at the Department of Public Health. The DPH commission is made up of experts in the field of violence prevention who have been appointed by the legislature. Its subcommittees are the right vehicle in the right place to receive and allocate funds from a consistent source of state funding.

In its first year, as you heard previously, the DPH Commission considered proposals for a first round of grants and awarded eight agencies multiyear funding, that will have a major impact on the communities they serve. It's a great start, but it's not enough.

CLERK: Excuse me, Ms. Schumer, but your time is up. Thank you.

MS. JOHANNA SCHUBERT: Thank you.

SENATOR ANWAR (3RD): Thank you. Can I just ask you if you --
MS. JOHANNA SCHUBERT: Yes, sir.

SENATOR ANWAR (3RD): -- can summarize your last couple of sentences?

MS. JOHANNA SCHUBERT: Absolutely. So the money that was awarded and allocated through the DPH Commission is a great start, but it's not enough. And we're fast approaching the ARPA fiscal cliff that many others are approaching as well. It's time for the state of Connecticut to step up and provide consistent sustainable funding to keep the CBI programs going.

SENATOR ANWAR (3RD): Thank you. Ms. Schubert, from complete Public Health lens, why are these programs necessary? And can you tell us because you've been part of this for over a year now, what are the things happening in Hartford or parts of Hartford?

MS. JOHANNA SCHUBERT: Yeah. So the DPH Commission has been established for over a year now. My membership is relatively new. But I've been observing and part of the meetings and contributing, since its inception and I've been part of the CBI field for about 10 years now. So, community violence, we recognize as a public health issue because we see it as a reaction to other forces that are happening around people.

When people don't have enough to eat, when people are facing poverty, when people are facing powerlessness, they turn to violence, it becomes a reactionary and systemic symptom of a larger problem. And so as we address issues of Public Health; things like making sure people have safe and secure housing, that they have enough to eat, and that their basic needs are being met, we find that trends in violence come down radically.
SENATOR ANWAR (3RD): Okay. We have one-year program. Is there any experience outside which has been much longer where it shows that it's -- with data to show that it works?

MS. JOHANNA SCHUBERT: Yeah. So I can speak specifically to our agency, Hartford Communities that Care has put an emphasis on data. We were founded by an MSWA social worker, and we really understand the value of tracking data and understanding that adapting to trends over time is going to help serve the community the best way possible. It's also going to help us use our limited resources in the best way possible.

So, Giffords Law Center tells us that up to 20% of those who are victims of violent crime can become shooters themselves, because of the trauma that they experience. And so we tracked over 200 clients that we served in 2020, and of those 200 only three either became justice involved or were reinjured. And so we know that that's far smaller than the national average. And it's the intensive intervention prevention treatment and recovery continuum that CBI programs like ours follow that allows for these better outcomes.

SENATOR ANWAR (3RD): So, I'm going to ask you a question and I know the answer to this, but I'm just going to ask so that it gets clear. This is not about taking anybody's rights away for having guns, it's about taking care of the individuals who are suffering and being hurt from violence in the communities.

MS. JOHANNA SCHUBERT: That's correct. There's no provision that talks about legislating guns, taking guns away, restricting access to guns. All we want to do is to continue providing the services we know,
make a difference, and an impact in the communities that are already vulnerable.

SENATOR ANWAR (3RD): Okay. Just wanted to clarify that. Thank you for that. Seeing no other questions or comments from anybody, thank you for your testimony and thank you for being with us this morning, afternoon, and evening.

MS. JOHANNA SCHUBERT: Thank you and thank you for listening so kindly and intentionally.

SENATOR ANWAR (3RD): Thank you. All right, moving to the next person on our list is Ms. Lori Atkins online. And I love --

MS. LORI ATKINS: Hello, can you hear me?

SENATOR ANWAR (3RD): I can hear you and I love the name of your organization. You may want to share that too.

MS. LORI ATKINS: Oh, Baby! Lactation Care. So I am here this evening. Thank you for listening. Thank you for all the esteemed members of the committee. I am here in support of House Bill 5318, AN ACT REQUIRING THE LICENSURE OF LACTATION CONSULTANTS. I'm Lori Atkins. I'm a nurse and I'm an RN and IBCLC here in Connecticut. I have a private practice in Glastonbury in Old Lyme and also a member of the MAPOC Committee on IBCLC licensure.

In my practice, we take care of hundreds of Connecticut families a year and we offer everything from prenatal education to expert troubleshooting for postpartum breastfeeding families. We screen for postpartum depression. We discuss maternal care recovery, compliance with the six-week postpartum visit, and contraception.
I employ one contractor IBCLC and we are a full-time in this woman-owned business. Despite our expertise in caring for the most complicated of babies, I cannot Bill Husky for this care. Medicaid and other private insurers as well, some do not cover clinical breastfeeding care, because we are not licensed health care providers in the state of Connecticut and it should not be this way.

I know how painful it is to turn families away because they have to pay out-of-pocket, especially a Medicaid population. And is this healthcare equity? I don't think so. I received a referral from CCMC for a newly discharged mom and baby which was last year, the baby was born at 27 weeks, dangerously close to not surviving. This was a young mother of color that was reaching out for help for feeding her baby breast milk and I could not give her the care that I wanted to and it broke my heart.

The IBCLC is the highest level of clinical breastfeeding certification in the field. There's nothing close, requiring many hours of mentoring college-level study, a rigorous exam, and recertification every five years. This preparation is far above what other breastfeeding helper certificates require. We need everyone at the table but the IBCLC is far and away, more clinically competent, and prepared and ready for licensure.

Licensor elevates the credential we currently have and equals us to the other licensed healthcare providers that we work with every day. There are many professional licenses required for Connecticut workers, taxidermists, HVAC professionals. Nail technicians require licensing for Public Health and Safety. Shouldn't we at least expect the same for healthcare professionals that manage tiny newborn babies? We carry an important and impactful role and
we are vitally important to maternal and child health.

I do object to the present Bill language concerning fees. This has been raised before me. I know that the $315 application fee is cost-prohibitive and not at all equitable. Again, I echo many people ahead of me with a $200 initial application fee and $100 a year. I think that that would be fair. Rhode Island requires a $50 fee for application and covers two years of an IBCLC license. So that's what our sister state is doing. There will be opposition to this Bill for a myriad of reasons, but I asked you to continue to put Connecticut families and babies first and at the center of any decisions you make, that's what ultimately matters. And I thank you for your time tonight.

SENATOR ANWAR (3RD): Thank you so much for your testimony and thank you for speaking and about this important Bill, but also being part of the work for the working group for MAPOC. So thank you so much.

MS. LORI ATKINS: You're welcome. It was an honor.

SENATOR ANWAR (3RD): And seeing no questions or comments, we'll move to the next person on our list, which is Amy Gagliardi. Welcome.

MS. AMY GAGLIARDI: Thank you. Good evening Public Health Chairs, Representative McCarthy Vahey and Senator Anwar, and esteemed members of the Public Health Committee. Thank you for the opportunity to testify today. For the record, my name is Amy D. Gagliardi. I'm an international board-certified lactation consultant and I'm employed by Community Health Center INC, a federally qualified health center. I'm here in support of House Bill 5318, AN ACT REQUIRING THE LICENSURE OF LACTATION CONSULTANTS.
As an allied healthcare professional, I have worked as an IBCLC with underserved families at an FQHC for almost 30 years. As you all know FQHCs primarily serve under-insured, uninsured, and Medicaid-insured people. When I received my board certification, I chose to work in an FQHC in order to render clinical lactation services to underserve populations. At that time, there was a large gap between who breastfed and who didn't and it was based on race, income, and payer type with Medicaid having the lowest rates of women who breastfeed their babies.

Unfortunately, this gap still exists. People with private insurance coverage and those who can afford to pay out-of-pocket are the ones most likely receiving clinical lactation care. With licensure, I believe this highest IBCLC standard of care can be received for by more people who don't currently have access to the service. We do not want a two-tiered system of care in Connecticut.

Prior to becoming an IBCLC, I volunteered as a mother support group leader. I have also trained in supervised breastfeeding peer counselors. I provide trainings for community health workers and health care professionals. I am very aware of the ecosystem of breastfeeding support services and of the over 20 certifications, most of which require anything from a one-day to one-week training with no clinical component.

The IBCLC is considered the gold standard in lactation care and this is endorsed by HSA, the CDC, the surgeon general and I can go on and on, but I only have three minutes. So I support House Bill 5318 with some provisions that I would like to say that I think Rep. Leper has already recommended around language. And what is important is that we create equity and access to clinical lactation
services as breastfeeding renders both short-term and long-term health benefits for both the mother and the baby.

Most importantly, though licensure will help protect the public as they access IBCLC services and license is required in our health care system for all independent health care practitioners. Additionally, licensure will open the door for Medicaid coverage which will help close the important health care gap in maternal child outcomes based on the research connecting maternal child outcomes and breastfeeding. So vulnerable population they really have a right to this gold standard of care and also have a right with further assurance of public safety.

SENATOR ANWAR (3RD): Thank you so much for your testimony. We appreciate your work. I just wanted to ask a few questions just to clarify things. One is that the best quality of training is for the IBCLCs?

MS. AMY GAGLIARDI: Yes, sir.

SENATOR ANWAR (3RD): And this Bill is going to expand the best quality trained individuals to the most vulnerable in our state?

MS. AMY GAGLIARDI: Well, we hope that licensure would open the door for expanded coverage, particularly with Medicaid coverage. So that we can reach the most vulnerable people who can't pay for this out-of-pocket.

SENATOR ANWAR (3RD): And I'm aware of the patient population that you're seeing at the FQHC. Would it be fair to say that your presence and your expertise is truly helping the first few critical times of our infants who are low birth weight infants and then subsequently helping them get healthier?
MS. AMY GAGLIARI DI: So I think, you know, me as part of a team of health care that has values that support maternity, maternal health, and maternal outcomes and infant health. I will say that we have very high rates of breastfeeding, which are equitable. So we don't have higher rates among one group over the other. So we have been successful, but again, it's been a long-term goal that we continue to expand and you know, they tell us 99 cents -- 99% is not 100 and we're trying to get to 100%.

SENATOR ANWAR (3RD): Amen. Thank you so much. And I have Representative Gilchrest who has a question or comment.

REP. GILCHREST (18TH): Thank you, Mr. Chair. Good. Amy just wanted to say, thank you so much for your continued advocacy for this important policy. Thank you.

MS. AMY GAGLIARI DI: Thank you, Representative Gilchrest.

SENATOR ANWAR (3RD): And my esteem Co-chair has a comment or question?

REP. MCCARTHY-VAHEY (133RD): Thank you, Senator Anwar. And Amy, thank you. It is a comment just to say, thank you so much for your ongoing work in this area and for co-chairing the working group with Representative Leper and continuing to bring this forward to provide equity and access. I think that there's been a lot of great conversation today. I will offer you the opportunity if there's anything else that you heard today that you thought we need to particularly hear a differing viewpoint on.
MS. AMY GAGLIARDI: So, I mean, there are several things that, you know, people have perceptions vary as Queen had said. Perceptions vary and people practice differently and people practice with different populations. My perception is through the eye of equity and vulnerable populations because that's what I've been doing for 30 years.

And so I think what somebody in private practice who is accustomed to working independently. It's really a paradigm shift to look at something like licensure and having, you know, fees that you would pay for your license and being accountable, having somebody have the ability to file a complaint. I mean, all these are a paradigm shift for a profession that's worked pretty much under the radar.

And so I'm very sensitive to their comments and to their needs and their perceptions. But again, my lens is through a lens of equity and I know the good work that can be done. And I think all mothers and fathers and families and babies are created equal and they have a right to equal services.

REP. MCCARTHY-VAHEY (133RD): Thank you so much for that. Thank you, Senator Anwar.

SENATOR ANWAR (3RD): Thank you so much. Seeing no other questions or comments, we want to thank you for your testimony and your work. And the next person on our list is number 74, Paul Kidwell. Welcome. Thank you for being here in person with us.

MR. PAUL KIDWELL: Thank you, Senator. I always enjoy being here in person because I leave the room much more well-informed than I walked in and so it's always fascinating experience. So thank you very much for having me. My name is Paul Kidwell. I'm the senior vice president for policy at the Connecticut Hospital Association and I'm here to support
Governor's Bill HB 5058, AN ACT ADOPTING THE NURSE LICENSURE COMPACT.

Connecticut is an exceptional healthcare workforce, you've heard that already today that is committed to serving patients every day. A robust and growing healthcare workforce is required to support healthcare delivery throughout our state. Unfortunately, the current system is not training or attracting enough individuals interested in healthcare careers that are in demand. And we all have a role obviously to play in supporting that infrastructure, certainly hospitals do. And we are working individually together and with partners across the state to support the current workforce and create new ways to improve and enhance retention, recruitment, education, and training.

Together, we can build on the investments already made to expand educational opportunities, ease the path to careers in healthcare, support retention, and enhance the safety of our current and future healthcare workers. Joining the nurse licensure compact is required by 5058 and is an important part of maintaining the momentum we've built to grow and support our workforce. As we consider the best ways to build the nursing workforce of the future, joining the other 41 states and jurisdictions that are already part of the compact will help make Connecticut more competitive as we work to attract nurses into the state while embracing new ways to provide care such as through telehealth.

As the legislation advances, CHA looks forward to continuing to work with committed parties to ensure that nurses in Connecticut continue to have access to and the confidentiality of the Haven program. And if you're not familiar with the Haven program, it's a really important program for healthcare professionals in Connecticut used many times as an
alternate to discipline for individuals who need assistance with substance use disorder treatment, et cetera. And we want to make sure that that confidentiality is maintained and we do think there's an opportunity to do that to both maintain the confidentiality of the program and join the compact.

So in final and conclusion, participation in the licensure compact is an important tool to address workforce shortage issues, and CHA looks forward to working with the committee to couple this action with other steps to improve the education pipeline, support retention, as I noted, and improve opportunities for career advancement. And I appreciate the time this evening and happy to take any of your questions.

SENATOR ANWAR (3RD): Thank you so much and I do have one. So this Bill is an important Bill from the workforce perspective. It almost has a few issues with it. One of them being that we have looked at multiple other compacts and for most of the other compacts that the Public Health Committee has looked at, you have some limited component to change them.

MR. PAUL KIDWELL: Yes.

SENATOR ANWAR (3RD): They have been confidentialities protected. But this one for the nurses has the least protections for the nurses. And that's part of the challenge is that their confidential information related to Haven would not necessarily be protected the way the others are. So, can you speak to that?

MR. PAUL KIDWELL: Thank you for bringing it up because it's really important. So our understanding is that a nurse in Connecticut would then hold two licenses, right? One would be the Connecticut
license and one would be the compact license. And so all the rules related to the nurse's Connecticut license remain in place, and the nurse then can obtain the compact license and work in Connecticut work in adjoining states; to the extent the nurse would want to avail themselves of an alternate to discipline program.

They could basically turn off the interstate Compact license, retain their Connecticut license, go into the program, complete the program, come out of the program and the license would be turned back on. It's our understanding that no information is shared related to why the compact license was turned off. And so, certainly would be happy to speak with you about that and go further. But we do think there's a way to maintain the confidentiality within this compact while also getting the benefits of the compact.

SENATOR ANWAR (3RD): Okay. So, I'm not sure if all of that language is in the Bill right now, but we definitely are very interested to get insight into how do we make sure those protections are in place because that's a very big hurdle. It's not something that everybody wants to have a protection. That's your right.

MR. PAUL KIDWELL: Yeah, and we're very interested in working with Haven, with the Governor's office to find a solution here. We think there's one, where we can join the compact, we can make sure Connecticut Law, is clear around this confidentiality, and basically protect what we think is really important while also getting this added benefit of the compact.

SENATOR ANWAR (3RD): I ask for a request, when you're having those conversations, I would love for the Connecticut Nurses Association Representative to
be there in that gathering and when you're looking at the solution, but also have the labor representative representing the nurses in the state to be in the room as well. Because this Bill's actual success when passed is going to be dependent on that aspect.

MR. PAUL KIDWELL: I'll defer to you members of the committee and the Governor's office related to negotiations, but certainly CHA would like to be at the table and be productive in those conversations.

SENATOR ANWAR (3RD): Okay. Thank you so much for your testimony. Seeing no other questions or comments, we'll move to the next person. Thank you for being here in person. Next person on our list is Ranya Alboslani. Welcome.

MS. RANYA ALBOSLANI: Hi, can you hear me?

SENATOR ANWAR (3RD): Very well.

MS. RANYA ALBOSLANI: Hello. Thank you so much for having me. Dear Senator Anwar, Representative McCarthy Vahey and esteemed members of the Public Health Committee. I am Ranya Alboslani, a resident of Glastonbury, a student at the University of Connecticut, pursuing a master of Social work degree and the public policy intern at Universal Healthcare Foundation of Connecticut. At Universal our mission is to accelerate the movement for health justice for everybody because health is a human right in core to social justice and equity.

We are here today to stand in support of HB 5320, AN ACT CONCERNING HOSPITAL FINANCIAL ASSISTANCE. Medical debt is a major and growing contributor to the cycle of economic and health inequality. Racial inequities in income, wealth, and insurance coverage play a
role in the prevalence and burden of medical debt; disproportionately impacting people of color.

Financial assistance policies also known as charity care can help reduce how often patients incur medical debt and ensure that people eligible for assistance do not end up in collections. My mother still has medical debt that is owed to a hospital for a small but necessary procedure. She fell a couple years ago and had a piece of glass stuck in her palm. At that time, my mother was laid off from her full-time job and was ineligible for private insurance. She had qualified for Medicaid, but the process was taking a while for her approval that resulted in her not having insurance for a few weeks. She was in a lot of pain and refused to go to the hospital at first.

After urging her to go multiple times, she listened and went to New Britain General, which is a nonprofit institution under Harford Health Care. When we arrived, the surgeon used an ultrasound to see how deep the glass was. We realized it was right next to a nerve and that it was dangerous. The procedure was needed to remove that small piece of glass that was embedded deep in her palm and required a surgeon. If she had waited any longer, that glass could have cut a nerve in her palm. She waited because she knew she did not have insurance and could not pay out-of-pocket. She feared it would end up in collection and she was right.

That day, she acquired over $1,000 in medical debts. She was never offered any financial assistance by the hospital nor did they even acknowledge that it was an option. Instead, my mother was billed the full amount. Despite me speaking with the staff and explaining she could not pay the bill at the hospital, the staff said that Husky would cover the bill if she was qualified, that they would send the
bill to them first. However, that never happened. I tried for a few weeks to correct this wrong with both the hospital and DSS but neither were held accountable.

If hospitals were held accountable, my mother would not be in medical debt and struggling to find a way to pay. This is a health inequity, people should not have to postpone care or fear seeking medical treatment because of financial aspects that they have no control over. I hope you consider my testimony and my mother's story. It is just one of many examples of why we urge you to pass this Bill. Thank you for the opportunity to testify in support of HB 5320, AN ACT CONCERNING HOSPITAL FINANCIAL ASSISTANCE policies.

SENATOR ANWAR (3RD): Thank you so much, Ranya, for your testimony and thank you for sharing your personal experience. And that gives a lot of more credibility and value to us. So we appreciate your insight. Seeing no questions or comments, we'll move to the next person on the list, which is number 76, John Brady. Welcome.

MR. JOHN BRADY: Good evening, Senator Anwar, Rep. McCarthy Vahey, and members of the committee. I wish I could be with you tonight, but I'm traveling for work. My name is John Brady, I'm the vice president of AFT Connecticut. We are a union that represents healthcare workers among others and we represent about 4,500 registered nurses in the state of Connecticut. I've submitted written testimony on three bills, but I'd like to comment on 5058, the nurse compacts which we opposed.

Many of our concerns were spelled out in the DPH report to the General Assembly two years ago. That report was based on a task force comprised of a wide spectrum of stakeholders from unions, hospitals,
professional associations like the Connecticut Nurses Association, and the Hospital Association. I've included a link in my testimony.

The recommendations from two years ago were to move forward with the physicians and the psychologist compacts, but not the nurse's compact. And the reason is simple, not all compacts are created equal. For example, the physician's compact provides an expedited process for a physician to obtain licenses in other states. This is what Connecticut did for military spouses including nurses in 2021 and we supported that action.

However, the nurse compact is unlike the physician's compact, the nurse compact is a single license for multiple states, with Connecticut giving up some of his autonomy over the regulation of nursing in the process. One big issue with the nurse compact is how nurses would be treated when they're undergoing treatment through the Haven program.

Haven is an alternative discipline program. It's vital in helping all Connecticut healthcare professionals who need support due to chemical dependency, emotional or behavioral disorders or physical or mental illnesses. Its success depends on the promise of confidentiality which was deemed so important that it is codified in public act Public Act 7-103.

Unlike the physician's compact, which allows continued confidential treatment, the nurse compact does not. The nurse compact requires disclosure of such treatment including self-disclosure by the nurse and relinquishing of the rights to practice under the compact license. Our fear is that this will discourage nurses from seeking treatment, endangering the nurse and their patients.
Another issue is a loss of revenue. The 2022 report estimates the yearly loss of $177,000 yearly for Haven and just over $5.2 million a year for the state. This is because when a nurse switches to a compact license. The license fees are lost to the state and to Haven. In some compact states that loss has been passed on to nurses through increased licensing fees.

I've included a link to a report from Vermont, which entered the compact two years ago which shows a similar loss of revenue. Lastly, we recognize the desire to make Connecticut is a place for nurses to move to and to work in. We believe that there are other ways to achieve this which do not carry the same downsides as the nurse compact, as we have done recently with military spouses and with telemedicine loss.

CLERK: Excuse me, Mr. Brady, but your time is up. Thank you.

MR. JOHN BRADY: Thank you. And if I can answer any questions, I'd be glad to try.

SENATOR ANWAR (3RD): John, if you want to summarize the last couple of sentences.

MR. JOHN BRADY: I was at the end anyway, Senator.

SENATOR ANWAR (3RD): Okay. So, John, I wanted to clarify a couple of thoughts. So if the confidentiality is protected and the cost to the financial cost to the nurses is minimized, would you be on board with the Bill?

MR. JOHN BRADY: Yeah, and I've heard that people are working on a workaround for the confidentiality. The devil's in the details. We haven't seen the language, we've been promised language, but we
haven't seen it. The language we have is what's before this committee today and language before is this committee today is not acceptable.

If there is a workaround and if the state could come up with, you know, $5.2 million a year, I have a few other uses for it too and not pass that along to the nurses and increase fees, then that helps a lot. We're not opposed to solutions, but I do want to caution that I have reservations that this is a fix for the workforce, both the nursing workforce and the nursing-educated workforce.

I tried to find statistics from other states that have the compact that showed that there was an improvement on anything and I could not find anything. The only statistic I could find was that about 30% of the nurses who get a compact license end up using it to be a travel nurse, which I'm not sure is something we really want to encourage. We have to remember that compact license is a door that swings both ways is just, it's easy for a nurse that lives in Connecticut to go work in another state if they have a compact license as it is for a nurse from another state to come work in Connecticut.

The reason we have a shortage of nurse educators is because they don't make enough money, they make more money at the bedside. That's just the fact. You really have to love being a nurse educator to give up the money, to go work in the university. And the reason we have a shortage of nurses at the bedside is what we tried to address last year with our staffing bills and what we're going to try to address this year with workplace violence bills. The compact isn't the solution to that. So I just want to caution people not to get their hopes up that it is.
SENATOR ANWAR (3RD): And can I just say that, are you around the table where there's a workaround being figured out or being addressed? Are you guys involved in that process with Connecticut Nurses Association and your group?

MR. JOHN BRADY: No, we had one meeting with the Governor's office, the Connecticut Nurses Association, ours, and several stakeholders who have spoken today. AARP was there, the Nursing Home Groups were there, there were a lot of people there, we had one meeting with them and we spelled out what our concerns were and they were basically the concerns that are spelled out in the DPH report two years ago and on that DPH report, Connecticut Nurses Association was a part of that, Connecticut Hospital Association was a part of that and so were many other groups in producing that, including us.

SENATOR ANWAR (3RD): Thank you. And I think Representative Kennedy has a question. No, you don't. He answered that on. Okay, you answered that already. So again, I think this will be a conversation that will continue on John. This is well helpful because you're right, confidentiality is critical and we want our nurses to be protected and we want the compact to be there and how that's going to play out, is a different story. But with respect to the confidentiality, that's probably a critical part of that entire effort.

MR. JOHN BRADY: Yes.

SENATOR ANWAR (3RD): Thank you.

MR. JOHN BRADY: It is the one.

SENATOR ANWAR (3RD): Thank you so much. Seeing no other questions or comments, we will move to the
next person on our list, which is, Joe Pandolfo. Welcome Mr. Pandolfo.

MR. JOE PANDOLFO: Thank you. Good evening, Senator Anwar, Representative McCarthy Vahey, Senator Somers, Representative

MR. JOE PANDOLFO: Klarides-Ditria and distinguished members of the Public Health Committee. Thank you for your service on the committee and also for this opportunity to provide testimony on Senate Bill 274, AN ACT CONCERNING OPIOIDS.

Our organization, we fully support and applaud the sub-committee that you've proposed to establish with this Bill. We feel that the attention and the efforts of this type of sub-committee would surely benefit families in the state that are affected by the opioid epidemic as well as the providers and agencies and organizations that they work with.

We would also offer our expertise and experience to this effort to serve as participants or advisor to the sub-committee that's established. Credentialed acupuncturists have a long history of providing evidence-based, effective, and sought after paying treatment, which has proven in various studies to reduce the use of opioids. A number of our members also have recent experience serving patients in the Medicaid program and report that their patients express profound gratitude for an alternative to costly and risky opioid prescriptions.

The treatments that we provide are used extensively by the VA and are now approved as Medicare services and can play a part in a comprehensive system of opioid alternatives here at the state level. And this part we could play has been recognized in earlier legislation related to this Bill, the Governor's Opioid Bill from a few years ago. We'd
welcome the opportunity to share materials with the committee and to assist with the goals of this good Bill in any way that we can. And again, thank you for the opportunity to speak.

SENATOR ANWAR (3RD): Thank you so much for your testimony, Mr. Pandolfo, and we will take you up on that. If you can send us any of the data and information that you are talking about, that would be very helpful.

MR. JOE PANDOLFO: Great.

SENATOR ANWAR (3RD): Thank you.

MR. JOE PANDOLFO: Thank you.

SENATOR ANWAR (3RD): Seeing no questions or comments, we'll move to the next person on our list which is Mr. Sheldon Toubman. Welcome.

MR. SHELDON TOUBMAN: Thank you. Good evening, Senator Anwar, Representative McCarthy Vahey, and members of the Public Health Committee. My name is Sheldon Taubman. I'm the litigation attorney at Disability Rights Connecticut. We are the Protection and Advocacy System for Connecticut, serving individuals with a full range of disabilities. I'm here to testify about the impact of HB 5200 on people with mobility disabilities.

The hospital industry has for years deflected any mandate to require the essential, accessible medical diagnostic equipment per the 2017 access board standards, arguing that states can't regulate in this area, absent federal regulations because we just don't know what the standards would be that they would adopt. Well, finally proposed federal regulations are out and they adopt the access board standards in whole. The only thing of substance that
the proposed regulations add is a timeline for implementation and scoping rules. Scoping rules refers to -- if it's not going to be that 100% of the devices have to be accessible, what percentage have to be.

Besides that, the only thing that federal rights really added was incorporation of long-standing exceptions to compliance with these new standards under the ADA and the Rehab Act. So now the federal agency has had agencies have confirmed they intend to apply all the access support standards. No one disputes that these are the right standards. So there's nothing standing in the way of passing HB 5200 which just adopts those standards.

But the hospital association wants to continue to delay any mandates stating in their written testimony today, "because these federal rules are not final and there are many open questions that the federal government is working through on topics as diverse as scoping and thresholds, timelines, and applicability of the rules, it would be premature to adopt a state law to proposed federal rules before they are finalized". And they also say we need to again "wait for the federal rules to be finalized before moving ahead. It is unrealistic and will be extremely costly to do otherwise". Well, not exactly.

It's possible that HHS while firmly adopting the access courts long-standing standards may in its final regulations change the scope a little bit and may change the compliance timeline. However, this will not present any problems for regulated entities in Connecticut if the bill as drafted is adopted, because any entity always has the obligation to apply with both state and federal regulations if it can do so without a conflict.
In this situation, it can readily do that by acquiring the amount of equipment which meets the most rigid standard under either the state or federal regulations in terms of scoping and similarly by acquiring accessible scales and exam tables at the earliest date under either of the rules. No conflict, as there would be if there were actually varying standards, but we don't have to worry about that.

Finally, the amendments to the bill as drafted, which are attached to Ruth Grobe's testimony for the CCEqual's 4 Group, particularly tracking the proposed federal regulations resolves the hospital remaining concerns. One, it will provide --

CLERK: Excuse me, Mr. Toubman, but your time is up. Thank you.

MR. SHELDON TOUBMAN: Okay. If I could just wrap up, please.

SENATOR ANWAR (3RD): Yes, please. I think you came to the most critical part and then --

MR. SHELDON TOUBMAN: Right. One big thing that the amendments do is they just single out two equipment which are referenced in the federal rights as well for a duty to affirmatively purchase them scales exam tables, but do not require affirmative purchasing of anything outside of that area. But most importantly, these amendments directly address.

The CHA claimed that compliance with the access board standards and HB 5200 adopting it those standards would be extremely costly because their amendments would incorporate the three significant exceptions to compliance with the new mandates which are already included in the proposed federal regulations.
There's three of them on [inaudible 00:40:01] or fundamental operation. You heard about small practices under 15 and where a reasonable percentage of a given type of diagnostic equipment has already been obtained in accessible versions and the amendment suggests 20%. With the amendments proposed by CCEquals A. HB 5200 will be right in the mainstream of state regulation working effectively in tandem with federal regulation and without unduly burdening any regulated entity. Thank you for letting me go over. I'm sorry about that.

SENATOR ANWAR (3RD): It's okay. I'm just going in ask you a theoretical question. So let's say we move forward with this bill and let's say hospital A invest into something and the federal regulations theoretically come in 2026 and they say that you are seven inches short on some goal. The implementation of the law is going to be through DPH in Connecticut. Is there language that we can place in to have some opportunity to grandfather people in the States? Should there be a future regulation that may have a negative impact on them? I'm just talking in hypotheticals to try and get by-in from people who are concerned.

MR. SHELDON TOUBMAN: I understand. I think that when you say inches, and that's where we really don't have to worry. And the reason we don't have to worry is the access board has detailed that they spent years and in 2017, after much discussion and debate, they came up with the technical specs for all this equipment. So there's no dispute what those standards are. The only issues are, how soon do we have to do this?

Do we have to do it affirmatively or can we just do it when we're replacing anyway? And lastly, what percent of our devices have to be like that? The
hypothetical I think you're talking about doesn't exist because there's not going to be any kind of disagreement about the number of inches. It's already been decided what all of these technical specs will be. It's just a question of when you buy it, how many you get to spot.

SENATOR ANWAR (3RD): That's very helpful. I think we had heard a testimony that made me ask that question, but I appreciate your insight and I want to thank you for your advocacy and the work that you have been doing with the community. So truly you're a leader in your work, so thank you for all that you do.

MR. SHELDON TOUBMAN: Thank you very much.

SENATOR ANWAR (3RD): Seeing no other questions or comments, we'll move to the next person on -- sorry. Representative Demicco has a question.

REP. DEMICCO (21ST): Thank you, Mr. Chair. Sorry about the last-minute nature. So Sheldon, thank you very much for your testimony, and thank you for your good advice. If you could and maybe you did it already and I missed it. Could you just clarify a couple of things that were spoken about earlier this afternoon in the public hearing?

Who would be the entity that would decide what constitutes a fundamental alteration if we do decide to go forward with this Bill? And fundamental alteration also, who would decide if it's an undue burden on a medical facility?

MR. SHELDON TOUBMAN: The amended, it wasn't in the original 5200 as it's drafted, but in the amendment from CCEquals Four, they have a detail. If you look at it, I think it's Subsection E and it's a detailed laying out of fundamental alteration under burns and
what the process is. And that is taken verbatim. I think verbatim from the proposed federal regs 84.92 Section 504 rights from HHS.

And what it's laid out very clearly is that the burden is on the recipient. In that case, recipient of federal funds are under this bill, the provider. The burden is on them to establish that fundamental alteration or undue burden is met, but it specifies that it must be that basically the head of the entity, not a lower level person has to be making the call after looking at all the resources and after making the decision, it has to be documented.

So the decision really is with the entity and by itself. If it's not then contested, that's where it stands. If there were a contest, then of course, it would be all documented. And then if there were a complaint filed under the federal regs with the Office of Civil Rights of HHS where we can talk about in Connecticut, where the enforcement would likely be such as CHRO, then they would look at, okay, what was the documentation?

The bill if you adopt amendments, says there's going to be that same kind of documentation, that same person, the higher level person makes a decision and then put it in writing and then we'll have that review in the event of any context. So I think that that's really what your answer is. I also think that if you adopt these provisions, we should assume good faith and I think we should assume that there's going to be compliance.

And if an entity thinks that it's a fundamental alteration or undue burden, they will go through the process and they will document it and that will, in most cases, be accepted. Of course, if it's under 15 employees, that's pretty straightforward, but I think that's the answer.
As far as enforcement, which I just talked about in Connecticut, I think right now, any kind of non-compliance with the civil rights statute goes to the CHRO or can go to the CHRO and that includes disability discrimination, failure to make reasonable accommodations. So, if this bill were to be passed and there was a conflict on fundamental alteration or just non-compliance, I would presume it could go to CHRO now and if you wanted to make that absolutely crystal clear, you could clarify that right now. The law with a sentence just saying that non-compliance with this provision shall be deemed to be a non-compliance with disability discrimination laws and that jurisdiction shall lie with the CHRO with any complaints.

REP. DEMICCO (21ST): One more question, Mr. Chair, if I could.

SENATOR ANWAR (3RD): Please go ahead.

REP. DEMICCO (21ST): All right. Thank you, sir. Just one more, Sheldon, just because again, it came up earlier this afternoon. So the federal regulations as you said, it's taken him years to finally come up with these regs, the access board regs. To whom do these regs apply? And the reason that I ask is because a previous testifier was questioning whether Connecticut should even go forward because we don't have any clarity as to which entities that these regs would apply to. Could you shed some light on that?

MR. SHELDON TOUBMAN: I wasn't there for that testimony, so I'm not sure exactly. If they're talking that the proposed federal regs are not clear, I think they're quite clear. Those apply to any recipient of federal funds, that's Medicare or Medicaid. If you're a recipient of federal funds and
you're a healthcare provider, then the standards apply to you subject to the three big exceptions.

And this statute of this bill that you have before you, 5200 is also very clear. There's a definition right at the beginning, healthcare provider, healthcare facility, I should say, and it also says you have to have two or more exam groups. I don't agree that there's anything ambiguous in the proposed federal regs, but this is even more direct. I don't think there's any ambiguity as to who this would be applied to.

REP. DEMICCO (21ST): All right. Thank you. I appreciate that.

MR. SHELDON TOUBMAN: Thank you.

REP. DEMICCO (21ST): Thank you, Mr. Chair.

SENATOR ANWAR (3RD): Thank you so much. Thank you, Mr. Toubman. And we'll move on to the next person on our list, which is Matt Pagano. Welcome.


I testified today on behalf of the Association wishing to comment on Senate Bill 274, AN ACT CONCERNING OPIOIDS. As the General Assembly is revising the Alcohol and Drug Policy Council within the Department of Mental Health and Addiction Services, the Connecticut Chiropractic Association urges members to include chiropractors in their deliberations. Noting that the intended purpose of
this proposed legislation is to reduce the number of accidental opioid overdoses.

We feel that it's important to also acknowledge that for many individuals addicted to opioids, their addiction started subsequent to an appropriate prescription given to mitigate a pain complaint. Our belief is that if the public were made more aware of the variety of non-pharmacological strategies for pain management, perhaps some who ultimately end up being addicted to opiates might not have started down that path in the first place.

We note that the language of the bill specifies the composition of this proposed standing sub-committee, and we note that the language also specifies such individuals that also might be added to subcommittees or other working groups under the council. Therefore, I come before you today to state our suggestion that chiropractors should be specified in the language as one of the providers who could help people suffering from addiction in the state of Connecticut.

Since the late 1800s, the chiropractic profession has, by definition, been a pharmacological-free type of healthcare, especially in the last several decades. There is a considerable and growing body of research which substantiates the efficacy of our interventions in the realm of musculoskeletal injuries and pain complaints.

Consequently, it seems appropriate to include us as part of the discussion. I urge you to consider that you have hundreds of willing providers in the state who wish to be part of the solution by which we as a society decrease the incidence of opioid addiction and deaths caused by opioids. Specifically, including us in the proposed language in this Bill and acknowledging our important potential
contribution to society in this regard would be appropriate and timely. I'm happy to answer any questions you may have.

SENATOR ANWAR (3RD): Yes. Thank you so much for your testimony. Representative Cook has a question or comment.

REP. COOK (65TH): Hi, Matt. It's great to see you.

MR. MATT PAGANO: Absolutely. You too.

REP. COOK (65TH): Thank you for being here and taking time out of your day and for everything that you all do. So being part of the solution and recognizing that you're saying that you all definitely do help with pain management, do you have suggested language change or just adding you all to the table?

MR. MATT PAGANO: In this Bill, they do get in. I don't have it in front of me presently, but they do get into some specificity with respect to certain types of providers who might be implemented in this regard. And so I'd like to see us perhaps listed explicitly there. We appreciate the fact that your committees recognize the utility of chiropractic and providing these non-pharmacological treatments to reduce patients' pain.

In 2019 when passing the provision that's now in statute that prescribers of an opioid greater than 12 weeks get counseling and discussion with patients of the availability of treatments that can reduce pain without drugs. So that statute specifically references chiropractic, which is wonderful and a similar recognition of our ability to help in this regard in this proposed language would be definitely what we would like to see happen.
REP. COOK (65TH): Okay, I appreciate that. So if you have anything further, if you want to send it over, you know where to find me. I'd be happy to continue the conversation and we'll continue to make this a hot topic for our committee. Thanks, Matt. Take care.

MR. MATT PAGANO: Yeah. Thank you. You too.

SENATOR ANWAR (3RD): Seeing no comments or questions, we'll move to the next person on our list. Thank you for your testimony. Next person is Dean. Houle. Welcome, Mr. Houle.

CEO DEAN HOULE: good evening, distinguished members of the Public Health Committee. My name is Dean Houle and I live in Vernon, Connecticut. I want to encourage the Public Health Committee's support to support SB Number 175. I understand and believe in the work the Rare Disease Advisory Council does and strongly feel they need to have proper funding to accomplish their mission.

I am the president of the MoyaMoya Foundation which is a nonprofit charitable foundation located in Connecticut focused on rare disease called MoyaMoya. I am also the father of a child living with this rare disease. My daughter has had seven strokes and three brain surgeries over the past 10 years because of this disease.

Today she's doing well, post-surgery. MoyaMoya disease causes the main internal arteries and intracranial branches, supplying the brain with blood to narrow reducing the blood flow to the brain. There is no cure for this disease and patients with MoyaMoya are at increased risk for stroke. Our foundation's primary mission is to promote awareness of this disease and to raise funds for research and to help find cures. MoyaMoya
disease is only one of over 10,000 rare diseases affecting 25 to 30 million Americans. Again, I urge your support for SB 175 and appreciate your efforts in raising attention for rare diseases like my daughter's, and thank you for your time.

SENATOR ANWAR (3RD): Thank you so much for your testimony. Sorry for mispronouncing your name earlier. Mister Houle, this is more for my knowledge. Where do you send the patients for surgery for this, who have the surgical technique for re-vascularization intracranially? That's pretty complex.

CEO DEAN HOULE: It is and there's several locations around the country. But most recently, we've learned of the procedure being performed at Harford Hospital in Connecticut. There is a surgeon there now who trained by one of the best out in California who has brought it to Hartford. Unfortunately, when my daughter was first diagnosed and had her surgeries, he was not in Connecticut and we had to go out of state to get the surgery.

SENATOR ANWAR (3RD): Is that Dr. Qureshi?

CEO DEAN HOULE: It's Dr. Sussman.

SENATOR ANWAR (3RD): Sussman. Okay, perfect. Thank you so much. Thank you for your testimony. Seeing no questions or comments, we move to the next person on our list, which is John Filchak if you're here. He's not. We'll move to the next person who is Laura Kabel.

MS. LAURA KABEL: Kabel. Good try. Good afternoon. Not good afternoon. Good evening chairs and distinguished members of the Connecticut Public Health Committee. My name is Laura Kabel and I was born and raised in Bridgeport, Connecticut where I
currently live with my husband and our four children.

In my professional life -- I'm an educator and have spent over 20 years serving families in city schools across the country as a teacher administrator and district curriculum leader, including Bridgeport Hartford and New Haven. In my volunteer life, I have worked as a gun violence prevention advocate with Moms Demand Action for Gun Sense in America for the past six years working with a variety of incredible and impactful community gun violence prevention groups.

I am here today in support of 5317 to study the sustainability of funding for Connecticut's Community Gun Violence Intervention and Prevention Program. I started my career in urban education over 20 years ago because when I was a child, a member of my family involved as a teenager with street groups was responsible for a gun homicide in Bridgeport.

The differences between our lives in terms of the choices that seem possible and available to each of us struck me deeply and ultimately led me into the classroom with a resolve to help my students find a way or make one to build the lives they wanted. Well, I love my education work as I continued to watch the number of students who lost loved ones to gun violence increase.

Year after year, it became clear to me that I needed to get involved much more directly in the fight to end gun violence. Each year in Connecticut, an average of 211 people die from gun violence and 308 are wounded. In America at large, we see 120 people die from gun violence and 200 wounded by guns daily with a person being killed every 12 minutes with a gun.
While our Connecticut numbers are considerably lower, the picture is quite different when we consider race. In Connecticut, black people are 27 times more likely to die by gun homicide than white people compared to 12 times more likely nationally. We know that the majority of gun homicides across the country are happening in our cities, which is why consistent and adequate funding for this program is so critical.

This program ensures that local grassroots groups like Yana, Project Longevity, Street Safe Bridgeport, Compass Youth Collaborative and Mothers United against violence have the support they need including increasing their staff and building their capacity. They do street outreach, group violence intervention, hospital-based violence intervention, and cognitive behavioral therapy.

I firmly believe that given the billions of dollars in profits that the gun industry makes each year, placing a small excise tax on the sale of guns and ammunition is appropriate in order to ensure reliable funding for the life-saving work being done by these groups. Over the past six years, I have found works of organizations such as the used to be life-saving, inspiring, under-celebrated, and inconsistently funded.

I employ you to pass 5317 so that we can address the critical funding piece and so that these groups can go about their work of saving lives, particularly those of black people living in our cities. Thank you for your time and consideration.

REP. MCCARTHY-VAHEY (133RD): Laura, thank you so much for your testimony. It's great to see our Bridgeport crew here and I know Marc is right after you, Marc Donald, as you probably know. Laura, I want to thank you in particular for highlighting the
racial disparities in the fatality rates and the death rates. It's something so important and I appreciate you bringing that up in such a specific way.

I also appreciate you calling out our local grassroots groups, particularly in our urban centers, and for your commitment and work is tremendous. So, thank you for being here today to testify before us.

MS. LAURA KABEL: Absolutely. Thank you so much.

REP. MCCARTHY VAHEY (133RD): We have one question. Representative Reddington-Hughes.

REP. REDDINGTON-HUGHES (66TH): Thank you, Madam Chair, and thank you for being here so late. I just have one question. The funding that you get right now. Where does that come from? I know that you're referencing, you know, different ways of acquiring new funding. But where are you getting your funding presently from?

MS. LAURA KABEL: So, my understanding is that the funding that is there currently is not sustainable over the long haul. Marc might be able to speak more specifically than me, Marc Don, who's coming up next. I could see him smiling at me in the Zoom to give you the specifics on where that's coming from currently. But I do know that this Bill proposes to study sustainable funding over the long term. And that my understanding is what is there currently is not going to be sustainable year after year, and we're going to need the work of these organizations year after year.

REP. REDDINGTON-HUGHES (66TH): Sure. I just, you know, with nonprofits, you know, they do
fundraising, they, you know, will have benefactors that was kind of where I was trying to go with this.

MS. LAURA KABEL: Yeah. No, I hear that. I think that what I've found is, like, you know, it's a case of, like, competing causes always. Right. Like, where's the funds going to go? And, like, as somebody who works in charter schools, and like spends a lot of time thinking about where the funding is coming from, philanthropy. It's just not consistent, and it's not reliable. And we need consistent, reliable funding if we're going to change that 27 times more likely number in terms of black people dying in Connecticut compared to their white peers.

REP. REDDINGTON-HUGHES (66TH): Thank you.

MS. LAURA KABEL: Of course.

REP. MCCARTHY VAHEY (133RD): Thank you, Representative. We do have ARPA dollar issues in terms of the funding. So, that is part of the issue that we face. Thank you, Laura, so much for being here with us today. Next up, we welcome Marc Donald. Nice to see you, Marc. Marc, we for some reason cannot hear you. Is your microphone turned on because you are unmuted?

MR. MARC DONALD: How about now? Do you hear my sound?

REP. MCCARTHY VAHEY (133RD): Yes, we can hear you now.

MR. MARC DONALD: Great. Apologies for that. My name is Marc Donald, and I'm the executive director of RYASAP, which is the parent organization of Street Safe Bridgeport, which Laura Kabel just mentioned. And it's great to follow her, because
Laura was part of our youth gun violence task and received state funding up until 2022. And then back in 2022, I actually, excuse me, I'm speaking in support of Bill 5317, AN ACT REQUIRING A STUDY CONCERNING THE

MR. MARC DONALD: FUNDING FOR AND EFFECTIVENESS OF THE COMMUNITY GUN VIOLENCE INTERVENTION AND PREVENTION PROGRAM. So, as I was saying, we had a youth gun violence task force composed of members of the police department, members of the community grassroots organizations, as well as members of our Street Safe Bridgeport program.

In 22, Bridgeport was one of six cities across the country where youth gun violence went down. I actually wrote an op-ed asking why and advocating for public funding to study why. And speaking to Representative Reddington-Hughes's questions, part of our programming is publicly funded, and part of it is privately funding. And over the last year, our public funding has actually declined.

And we haven't been funded by the Gun Violence Commission at this point. So, the competition for funding in my role, is super important, and paramount. However, regardless of the funding source, we need to study what we're doing if it's working or not, and what are the factors that go in?

And certainly, in Bridgeport, there are a lot of factors involved in terms of proactive policing, in terms of the intervention efforts of our out gang outreach and got intervention program at Street Safe. But there's other factors involved including the schools and the social-emotional learning efforts that led to a 10-year decline in suspension and expulsions.
And young people who are in school are less likely to fall far off track. But you know, the question is why, and what can we point to best practices from a true public health perspective? which is what makes me excited that this lives in public health because it is a public health issue. I had a conversation with a mother one time in one of the public housing units who lives about two miles away from me, who said that she asked for a move from one side of the projects as she used the term to the other because there's less shooting, and she wouldn't let her 13-year-old son go outside.

Now, if that's not a summary of a public health issue and its impact on gun violence within the community, I don't know what is. So, studying these efforts, I think gives us an idea of what the best practices are, how we can improve. And that's why I think this legislation is so key as we seek to address it. Happy to answer any questions.

REP. MCCARTHY VAHEY (133RD): Thank you, Marc. Thank you so much. And you know, I've long been a supporter of the work at RYASAP, and I know that you've done a lot of prevention work and you do work in prevention of all sorts. I'm thinking about opioids right now. We talked earlier today about opioids and Connecticut is going to receive hundreds of millions of dollars to address the opioid epidemic.

We're not seeing that in the same way when it comes to the gun violence epidemic. So, I wondered if you could talk just a little bit briefly because it's late. And I know we do have a question from Rep Reddington-Hughes. In terms of public and private dollars and the kind of volume, just your organization has seen and on balance, who's providing more funding to you at this point?
MR. MARC DONALD: Right? And thank you, I only had three minutes on the first jump. So, I couldn't speak about the Hub or RBHAO, which works across the public health spectrum, and opioid cannabis, other addiction services as well. So, you know, that program is mostly publicly funded. And we do to use that those funds in terms of education and capacity building in regards to that.

And I think that, you know, for me, that's where this lives in the public health arena. Because so often we think of these issues as separate when they're so interrelated. And when you have opioid deaths in urban environments, they tend to look a little bit differently, particularly along racial lines. That Laura so eloquently outlined overall, but our opioid efforts are entirely publicly funded.

REP. MCCARTHY VAHEY (133RD): Your gun violence prevention efforts. In contrast, if you could just specifically.

MR. MARC DONALD: So, we have $100,000 in that, that funding is expiring. And other than that, we're about 30% publicly funded. 70% privately funded, including funds from the Dalio Foundation Connecticut Opportunity Project. Which I don't know if that's been spoken about the unspoken crisis report, which also in my estimation is also very much a public health report aimed at opportunity, youth, or disengaged in disconnected youth.

REP. MCCARTHY VAHEY (133RD): Thank you for that. I highlight that in part because as we understand gun violence as the second leading cause of death for children in Connecticut, the first leading in the country, this is an epidemic for our young people. Yet, we are not investing in the same way that we are and we need to invest when it comes to, for example, the opioid crisis.
So, I'm hoping that we can look at how we fund this going forward. I think it's, it'll be a difficult question, but it's a conversation worth having. Representative Reddington-Hughes, followed by Rep Zupkus.

REP. REDDINGTON-HUGHES (66TH): Thank you, Madam Chair. Going back to the gun violence program and the monies that are allocated only to that. What percentage of those funds go to administration costs versus the programs?

MR. MARC DONALD: Very little, probably about 10% at the end of the day. Most of that administrative time would be for back office support. All of my time and all of the kind of Senior Management time is allocated to private funding.

REP. REDDINGTON-HUGHES (66TH): Thank you.

REP. MCCARTHY VAHEY (133RD): Thank you, Representative. Representative Zupkus.

REP. ZUPKUS (89TH): Thank you, Madam Chair. Thank you for coming. I'm very glad to hear about the work you're doing in the inner cities because I know you're right. That's where a lot of the gun violence happens. And I live next to Waterbury, and I pick up the paper every single day and it's always gun violence. And people are still out on the streets and they're being arrested with guns in their cars and drugs, and it is terrible.

It's a terrible situation. But does your group, or these groups, I always seem, when I see gun violence, it's always drugs involved. And so, is part of your work, include drugs and you know, arrest and juvenile, the crime, all of that really is compacted up together. In every article that I
read in the Waterbury paper, it's all of that combined. And I'm wondering, are y'all just focused on the guns, or do you look at the whole picture? Because I do believe it's the whole picture.

MR. MARC DONALD: So, I think that that's a great question in regards to how it really is a public health issue. And certainly, there is a component of drugs and what we see generally it's kind, it's more territorial, which can include some of the drugs and the sales. But, you know, for us in Bridgeport, a lot of it's generational.

And you actually just jog something in my mind that I think speaks to Representative McCarthy Vahey. Under RYASAP, we also run the regional Suicide Advisory Board, which very much is a gun violence issue and that is entirely publicly funded, right? And then, if we talk about the demographics, the demographics of suicide while they're changing a little bit, the people impacted by that tend to look like me, not like the victims of youth gun violence who tend to be black and brown young men.

So, I think that's one thing we need to, I think lift up. And then, you know, especially when you're talking about urban gun violence, youth gun violence, some of it is impacted or does involve drugs. A lot of times with the older gentlemen, one thing we're still seeing in the trends in Bridgeport, is the victims of homicide and the perpetrators of homicide tend to be between the ages of 28 and 49. And those instances tend to be later at night and often involve alcohol as the number one. But certainly, other drugs as well.

REP. ZUPKUS (89TH): Well, thank you. So, I guess drugs and alcohol. Right. All of it.

MR. MARC DONALD: Alcohol is the biggest factor.
REP. ZUPKUS (89TH): Yes. So, I do appreciate it because it's horrible is what's going on. And most of it, I do believe you're right happens in the inner cities. And we want to protect those kids. There was, you know, I read three articles in a row from the Hartford Current that a three-year-old was shot at drive-by, and that's unacceptable. And so, there has to be something done. And I believe it does consist of, you know, not law-abiding citizens with guns, but most of those guns are probably illegal from what I've read, and the drugs and the alcohol all of that.

So, it's a big task to undertake, but it does need attention, and I won't go into it now because I know it's getting late. But I would like to know, for example, when your organization started and the progress that has taken place. So, at some point, if you could send that along or in all these agencies, it would be great to see. You're being funded and what really has taken place with those funds? Thank you.

MR. MARC DONALD: Yeah, thank you.

REP. MCCARTHY VAHEY (133RD): Thank you, Representative Zupkus. And that is exactly why we're doing this Bill is to be able to take a look at some of the efforts that have occurred. And what kind of effectiveness? And the one thing that is so wonderful about RYASAP and the Hub is they use data to inform their decisions. And I'm so glad Marc, that you referenced alcohol as the number one factor because we see over and over again in the data that is alcohol far exceeds any substances, other substances in terms of these issues, the data that we see in our region, which obviously we share our region supports that.
In addition, the framing of gun violence in terms of suicide is so important, and I appreciate that. And as you said, Marc, people who look like you namely your age and your race. And we had a very sad and unfortunate incident in Fairfield just this week. So, when we talk about gun violence prevention, I think it's important that we understand the full spectrum of issues when it comes to gun violence. And I appreciate you speaking to those issues. Thank you. I'm going to turn it back over to Senator Anwar.

SENATOR ANWAR (3RD): Thank you. I see Representative McCarty has unmuted herself. Is that because you had a question and you get there?

REP. MCCARTY (38TH): He reads my mind very well. I just wanted to make a quick comment. And thank you so much for coming in and stressing the importance of continuing to study gun violence and prevention. And what programs work. I think it's such an important issue today. And I'd like to just thank you for mentioning the relevance and the importance in our schools of looking at social-emotional learning. I know Representative McCarthy Vahey a supporter as well. And you mentioned the word interrelatedness. We need to all collaborate and work together to end this scourge that we have. So, I just wanted to take the moment to thank you very much for your work.

MR. MARC DONALD: Thank you.

SENATOR ANWAR (3RD): Thank you so much, Representative McCarthy, and thank you so much, Mr. Donald. Seeing no other questions or comments, we'll move to the next person on our list, which is number 84, TJ Clark. You're welcome. Come, welcome.
MR. TJ CLARK II: Good evening, Senator Anwar, Representative McCarthy Vahey, and esteemed Members of the Public Health Committee. My name is TJ Clark the second. I'm a resident of Hartford, and I serve as the executive director at Connecticut Oral Health Initiative, formerly known as COHI located in Hartford, Connecticut. Our mission is to strengthen and safeguard access to quality, affordable Oral health services for all Connecticut residents.

Our goal is for all residents to have equal opportunity to obtain services needed to maintain good oral health. COHI is the only nonprofit organization in Connecticut that solely dedicates his time to advocating for equitable oral health policies.

Thank you for allowing me to testify in favor regarding House Bill 5320 AN ACT CONCERNING HOSPITAL FINANCIAL ASSISTANCE. Medical debt is a major growing contributor to the cycle of economic and health inequity. Ratio, inequities and income, wealth and insurance coverage play a role in the prevalence and burden of medical debt. Financial assistance policies known as a charity care, can help reduce how often patients incur medical debt and ensure that people eligible for assistance do not end up in collections.

Black and Latino people in Connecticut are more likely to lack insurance, or have a high deductible health plan due to a combination of factors resulting from systemic racism such as disparities in employment and education. Inequities and wealth mean black and Latino people are also less likely to have cash on hand to pay large unexpected bills. Higher rates of insurance mean the burden of medical debt falls disproportionately on black, Latino, other communities of color, and immigrants.
In Connecticut, roughly 280,000 people have medical debt. And currently, 72% of people attribute their medical debt to bills from acute care such as a single hospital stay or treatment from an accident. Medical debt can have a significant impact on oral health in several ways. Deferred dental care, limited access to dental services, neglect of preventative measures, impact on mental health, limited resources for dental insurance, interconnected health.

In conclusion, medical debt provides a wide range of financial hardships and can create barriers to accessing dental care and maintaining good oral health hygiene practices. Addressing both medical and dental care affordability is crucial for ensuring comprehensive health and well-being.

Thank you for the opportunity to provide testimony before you in the Committee, and I hope that you take my comments into consideration. Thank you very much.

SENATOR ANWAR (3RD): Thank you so much, Mr. Clark for your testimony. And yes, we will take your remarks into consideration. Seeing no questions or comments. We'll move to the next person on our list, which is Doctor Michael Crain number 85. Welcome.

DR. MICHAEL CRAIN: Thank you, Senator Anwar, Representative McCarthy Vahey, Senator Somers, and the Members of the Committee. My name is Doctor Michael Crane. I've been a radiologist in Connecticut for the past 35 years working out of Middlesex Hospital and our private offices, which currently is just one Guildford Radiology. I was also the past president of the Radiological Society of Connecticut. And also, I'm the executive director of the nonprofit charity to promote
compassionate health care in Connecticut called the Patient Is You.

I'm offering brief comments to you today on Senate Bill 9 on AN ACT PROMOTING HOSPITAL FINANCIAL STABILITY. I would like to confine my comments to section four, specifically the line exempting CT Scanners from the CON process. Otherwise, I surely support Senate Bill Nine. From what I understand, Doctor Gifford had suggested that since all the CTCON applications in the past three years were approved that the CON is not needed anymore for them.

And I would suggest that this precisely is why we need CON. I've been through the CON process various times from when I brought the third MRI scanner to Connecticut in 1989 to our recent CT and MRI scanners at Guilford. That the CON process very wise people are on the CON committees. And I think that they have wise advice.

I think without the CTCON, CT Scanners will increase in Connecticut, and new scanners will bring more scans. And whether this is in private equity or entrepreneurs, I think that the number of scans will be done. And maybe unnecessary. I look at my private office in Guilford as an example about 10 years ago, all of the CTS and MRI were going to the hospital systems. Guilford Radiology was going to close because we couldn't do everything else we wanted to do and having unused CT scanners and MRI scanner in our office.

We've always considered ourselves to be a high-quality, low-cost office. And later, maybe about in 2017, 2018, the insurance companies realized that we were a better place to send their patients. And so, we started to get the business again. And now, we're doing fine, but we're no means at capacity.
We do about ten CAT scans a day, 10 MRIs a day. And if a CT scan little office opened up across the street, it would truly make our office unstable. And there's no need for it, because we can provide plenty of scanning for anybody who needs it. And which gives me another point is that we service all our patients, you know, whether no matter what kind of insurance they have HUSKY Medicaid. And even if they have no insurance, we work out payment plans with them. And we're a full-service organization and I think --

CLERK: Excuse me, Doctor Crain, your time is up. Thank you.

DR. MICHAEL CRAIN: Okay, thank you very much. If you have any questions, let me know.

SENATOR ANWAR (3RD): Thank you so much, Doctor Crain, for your testimony. Can I just clarify, you talked about in the absence of CON for CT scans, private equity will come to the state of Connecticut. What's the official position of the Radiologic Society of Connecticut about private equity and radiologists working for private equity?

DR. MICHAEL CRAIN: I'm not an expert. You know, I don't know what the recommendations are. I think that our main concern as radiologists is to provide the best care, the safest care to our patients. So, I think that, you know, for a private equity firm owns a practice, you know, hopefully, the radiologist will work to ensure that the patient care is provided at the highest level.

And particularly, the safety issues, you know, most of these scanners that are less expensive, generally have more radiation. It's all the fancier scanners that have the technology that we don't need to use the higher doses of radiation that we used to use.
And also, one thing I think is so important is that the sharing of exams, I know that with Connie, we're going to be sharing exams a lot more.

But you know, at Guilford Radiology, for instance, we always share our CAT scans, and we get their CAT scans with Yale, Middlesex, and other centers, which also improves care and decreases costs. You know, by not just doing our cat scans in one little office, but providing full services for our patients.

SENATOR ANWAR (3RD): So, one of the reasons I think the Office of Health Strategies has requested this is that they don't have enough workforce and they are making decisions, which have an impact on half a million population directly. And 5 to 7000 people will lose their jobs based on decisions or keep their jobs based on decisions. And there are hundreds of CAT scanners across the state, they need to be upgraded, there needs to be a change.

So, if their limited workforce is going to start to look at the CAT scanners to give some security to some companies, there is a big picture that they are going to lose out on, and there's not enough bandwidth in the department to do it. I think that's a rationale. Do you want to reflect on that?

DR. MICHAEL CRAIN: Yeah, I guess I'm not clear. For instance, at Guilford Radiology, we could do 20 CAT scans a day. So, there's plenty of opportunity for patients to come to us. I mean, I know at Middlesex, we have various scanners and they could do a lot more at the hospital. But again, you know, that I don't do the scheduling there. But you know, if scanners need to be upgraded, if anything, you know, that should be a something that the government should promote that if they're old scanners. But to
add more scanners, is going to put the current scanners out of business.

And I think that's sort of what my concern is that I know that that's the case in Guilford. Because if somebody put let's say a mobile CAT scanner across the street, they would make plenty of money. But we would go back to doing three cases a day, and then all of our mammography, all of the low reimbursement items that were, you know, studies that we do like lung cancer screening, mammography, breast ultrasound, those are very time-consuming and low in revenue.

SENATOR ANWAR (3RD): Doctor Crain, I want to ask more questions if you don't mind. I just keep you short. I just want to clarify a few things. One of the Radiologists earlier made a comment that the new cat scanners if they are brought in the mammograms would not be as good a quality. And I'm trying to understand is the new technology or new CAT scans not good for that purpose, or it was just?

DR. MICHAEL CRAIN: Yeah. No, no. It's an interesting point. The CAT scans and the MRI scans help to support the office. It's very hard to have an office with just mammography, X-ray, and ultrasound. I don't think that you know, the office would survive. So, by having a CAT scanner brings in the revenue that we need, and we sort of offset, you know, I mean, for instance, we offset the one-quarter of the payment from HUSKY, you know. And we do those because we can offset the cost to CAT scans, which are paying by the insurers. So, I don't think the [Inaudible] and CAT scanning have anything to do with each other. It's just how an office can stay profitable.

SENATOR ANWAR (3RD): I think that makes a little bit more sense to me because what was said earlier
was that cancers are going to be missed because of the CON allowing CAT scanners to be there. So the quality of care is going to decrease. And I could not make that connection, but I think there's a financial rationale for this that I can understand. But it was a clear rationale, I could not understand. So, you've helped clarify that for me. Thank you for that. And then, I think Representative Klarides-Ditria has a question.

REP. KLARIDES-DITIRA (105TH): Thank you, Mr. Chair. Thank you for being here today and clarifying some of our questions. One more is, are most of the radiologists in your society are they hospital-based?

DR. MICHAEL CRAIN: I would say that most are, they often have private practices too. Like my group of 13 radiologists, we used to have four or three different offices now we just have one. But it's kind of a nice like you know, experience for a radiologist like myself to have both the hospital-based where there's obviously a lot more severe sick patients. And then also, do things like screening mammography and screening CTS, and in the private practice of radiology. And as you all know, the private practice of radiology and private offices is a lot cheaper than the hospital exams.

REP. KLARIDES-DITIRA (105TH): Thank you. Thank you for that answer. And is there a difference in and if you have a workforce shortage in the hospitals versus offices, or private practices?

DR. MICHAEL CRAIN: I'm sorry, what's that?

REP. KLARIDES-DITIRA (105TH): Is there a workforce, do you see a workforce shortage in your hospitals versus private practices?
DR. MICHAEL CRAIN: No, I think that the workforce is stable. You know, it's not ideal and you know, we surely do everything we can to bring in the best radiologists into the state. And you know, obviously, everything that the state does to make Connecticut friendlier to doctors is great and we surely appreciate that. But as far as you know, the workforce, I think it's the same. And you know, we surely could do for a few more radiologists coming our way. But so far, you know, I think we're getting the work done.

REP. KLARIDES-DITIRA (105TH): Thank you very much for your testimony. Thank you, Mr. Chair.

DR. MICHAEL CRAIN: You're welcome.

SENATOR ANWAR (3RD): Thank you, Representative Carpino.

REP. CARPINO (32ND): Hi, Doctor Crane. It's nice to see you again. You said something earlier that I may have misheard. So, I was just hoping that you could clarify when you're answering Senator Anwar's questions. You made a reference that your practices share scans. I may have misunderstood, but were you indicating that there are some practices that don't share their patient scans?

DR. MICHAEL CRAIN: Well, you know, I can only speak for my group, but I think that it's the way that all groups in Connecticut work and all the radiologists that I know of. Is that we believe in not repeating studies that don't need to be repeated, and to share exams with other institutions. I mean, you know, and for a while, you know, years where, you know, for instance, well, a certain hospital wouldn't share with guilt for radiology. And, we worked hard to promote that and we now share freely.
We send them exams, they send us exams and it's within the half an hour, it's really, it's remarkable. What I would suggest is that if one wanted to make a lot of money, they could put a CAT scanner across some radiology and just read them out, and that's not what we do. You know, if the CAT scan is done, we might look at the other studies that the patient has had. We might look on to see if, you know, other institutions in Connecticut have it.

Soon we'll be using Connie to do that. But, you know, that's just the philosophy that we have is we're a full-service center. And I think most radiologists feel this way too and that we're proud of what we do. We're not just a company trying to make money. So, I think that that's what I'm afraid of without this CTCON is that people are going to come from anywhere, and just open up a CT scanner and dictate out the cases.

REP. CARPINO (32ND): No, and I appreciate that. I wanted to be clear if you were saying that there were still groups who were not sharing what I believe are documents and scans that actually belong to the patient as opposed to the provider. I would have taken it offline and discussed with you. I will, I know how to find you, Dr Crain. I will reach out to you at a more reasonable hour.

DR. MICHAEL CRAIN: Can I just make one point? And yeah, I mean, it's how quickly the scans are shared. And the way we do it now it's within an hour, it's not a matter of putting in snail mail and getting it next week. So, I think that's where the sharing is very important. Thank you.

REP. CARPINO (32ND): I appreciate that we're a long way from having to show up at an office and pick up a CD and hand-carry it. So, thank you, sir.
SENATOR ANWAR (3RD): Thank you. Seeing no other questions or comments. We appreciate your testimony and staying with us for this evening. Next on our list is number 86, Merrilee Gober. Welcome.

MS. MERRILEE GOBER: Thank you. Good evening, Members of the Public Health Committee. I am Merrilee Gober. I'm a registered nurse with obstetrical expertise, and an attorney with expertise in health care law. But disclaimer, I'm not licensed for either in Connecticut. I am here today as a board member of the National Lactation Consultant Alliance, where I volunteer my time and effort to improve patient access to the clinical care that Lactation Consultants are qualified to provide.

I offer testimony today in support of HB 5318. But more importantly, I want to highlight that over 600 of your Connecticut physicians support this Bill. As stated in a published letter from Dr Carbonari, your pediatricians recognize the need for this legislation. Thank you for raising this Bill.

I have no financial interest in lactation care for mothers and babies. My only interest is in wanting mothers and babies to be able to access competent clinical lactation care when they have breastfeeding difficulty. Because professionally, I have seen unmet needs and personally, I even experienced difficulty myself as an OB nurse needing help that I did not get.

In the field of medicine and health care, licensure is the norm for independent clinical care. Physicians and insurance companies want to know that the allied health care providers to whom they are referring have been vetted by the state, and possess the minimum level of education, training, and
verified competency established by the state. To provide the care allowed within a state scope of practice. Licensure of lactation consultants would give physicians and insurance companies a measure of protection from claims of negligent referral should harm result from care rendered by the lactation consultant.

Without a license referral from a physician brings the risk of liability to that physician for the care rendered. Without licensure, lactation consultants are off the grid. They are not part of the healthcare team, and many physicians will not refer patients to them. We want our mothers and babies to be successful with their breastfeeding efforts. With regard to harm and injury, mothers who fail at breastfeeding are at much higher risk of postpartum depression.

They have a higher risk of health issues later in life such as diabetes, breast cancer, and stroke. And their babies are at higher risk for many illnesses too, ear infections, respiratory infections, even SIDS just to name a few.

Without human milk, preemie babies have much higher risk of neck, which is gangrene of the intestines, which can be deadly, and which in fact does kill babies every year. Those guts cannot digest infant formula. Furthermore, misguided advice can cause infant dehydration, jaundice, and brain damage to full-term healthy babies.

CLERK: Excuse me, Miss Gober, but your time is up. Thank you.

SENATOR ANWAR (3RD): Thank you, Miss Gober. If you want to just finish your thought.
MS. MERRILEE GOBER: Yes, I'm going to say that mothers too can suffer permanent and disfiguring breast damage from abscesses that are not timely recognized and treated, and that we really support the licensing of lactation consultants to be able to bring this care to mothers and babies. Thank you very much.

SENATOR ANWAR (3RD): Thank you.

MS. MERRILEE GOBER: And I will say too that that lack teaching consultants are the highest trained, lowest cost clinicians who can do this work competently.

SENATOR ANWAR (3RD): Thank you. You're a very passionate advocate, and I so much appreciate you. Thank you for the work that you do voluntarily, and making sure that our next generation is healthy and well.

MS. MERRILEE GOBER: Thank you.

MS. MERRILEE GOBER:

SENATOR ANWAR (3RD): Seeing no questions or comments. We'll move to the next person on our list, which is Dr Adam Kaye. Welcome. Thank you for joining us.

DR. ADAM KAYE: Thank you, Senator Anwar, Representative McCarthy Vahey, Senator Somers, Representative Klarides, and Members of the Public Health Committee. Thanks again for allowing me to speak the second week in a row. My name is Dr Adam Kaye. I'm a Partner at Advanced Radiology Consultants based out of Shelton, Connecticut. And currently, the Chair of Radiology at ST Vincent's Medical Center in Bridgeport. You've heard from a
bunch of several of my colleagues from the Radiology Society of Connecticut already.

And I'm also like them here to comment on the Governor's Bill number nine, specifically section four related to the removal of certificate of need for CT scanners. You've heard a bunch about us already, but radiologists and the practices we run in the hospitals, and the hospital departments we work for, and the thousands of employees we have across the state, are the gatekeepers in medical imaging. Connecticut has enjoyed many years of a CON process that protects patient access to high-quality and highly available imaging.

And if the need is there, it's worth our time and our money to bring a CON to be approved and open up even more access to this vital and life-changing technology. The effect of removing CON can be devastating, not just to patient access to other modalities as Dr Crain just eloquently outlined, but can also drastically alter imaging patterns for the worse. Next door, in Rhode Island, they removed the CON for MRI. And sure enough, every practice orthopedist, neurologist, everyone wanted their own MRI scanner. They're profitable machines when they're used appropriately, but utilization also skyrocketed.

And as you can imagine if you have an MRI scanner, even if you're not, you know, on the fence, if a patient needs it or not sure a patient needs it, it's very easy to send the patient right around to the other side of the building to get their MRI. And not always the same day as a lot of them would like to have you believe in this utopia of patient, easy and timely patient access. Most times, you still have to make an appointment for another time another day, just like you would with a radiologist's office.
We will see the same thing with CAT scanners here. If the CON process is removed. It isn't just the growth of imaging either one can imagine say, you know, an ENT surgeon has access to their own CT scanner, and all of a sudden more CTS are being done of the sinuses, which means more surgeries of the sinuses might be done. And you know, they are the gatekeepers of who needs as sign of surgery, but they need the input from a radiologist to make that decision about what patients need sign of surgery. And when they do.

So, this doesn't just increase the cost of health. So, this increases the cost of health care for all of us. Not just in utilization of imaging services, but really in the utilization of all services across the board. So, we're asking your consideration in allowing us to hold on to this gatekeeper role, so that we can ensure that our important services make it not just to as many Connecticut residents as possible, but most importantly to the right residents and at the right time. Thank you.

SENATOR ANWAR (3RD): Thank you so much for your testimony. We appreciate your input. Seeing no questions or comments. We'll move to the next person on our list. Thank you, Doctor Kaye. The next person is in person, Katia Ruesta-Daley. Welcome. Thank you for being with us. I hope I pronounce your name accurately, Katia.

MS. KATIA RUESTA-DALEY: Yeah. Okay, good evening, Senator Anwar, Representative McCarthy Vahey, and Esteemed Members of the Public Health Committee. My name is Katia Ruesta-Daley, and I am a resident of Vernon Connecticut. And I am also a graduate student at the UConn Social Work Program. I stand
in support of HB 5320 AN ACT CONCERNING HOSPITAL FINANCIAL ASSISTANCE.

Medical debt is significantly contributes to the perpetuating perpetuation of economic and health disparities with racial inequality and income, wealth, and insurance coverage. [Inaudible] is prevalence and impact policies offering financial assistance such as charity care can be the frequency of medical debt occurrences and prevent eligible individuals from falling into collections. Since 2020, I've actively participated in the HUSKY for Immigrants campaign mobilizing community members to share their impactful and often dramatic stories around health care access.

A prevailing concern among them is the burden of an affordable hospital bills and medical debt. Half of immigrant adults potentially undocumented, lack insurance, heightening their in susceptibility to medical debt. Immigrants and limited English proficient residents here in Connecticut encounter hurdles in navigating financial aid applications. Additionally, emergency and hospital services remain the primary resource for undocumented individuals. Yet, many face barriers to access it.

It is imperative to enhance hospital financial assistance policies, ensuring affordability and alleviating additional stress and financial strain on community members seeking health care. There are about 280,000 city residents with medical debt. And nationally, there's 72% of Americans attributed their medical debt to bills from acute care such as a single hospital stay or treatment for an accident.

Six out of every ten individuals facing challenges in paying medical bills, possess health insurance coverage yet remain unable to afford payments. Implementing eligibility screenings for insured
patients can mitigate the frequencies of patients accumulating medical debt. This Bill will ensure that patients can receive hospital financial assistance through more accessible and equitable avenues, and prevent patients seeking care from getting into medical debt and putting them at risk of economic instability.

I also request the Committee's support to incorporate language in the Bill around hospitals offering a fair payment arrangement for individuals ineligible for assistance. This measure aims to prevent patients from sacrificing essential needs to settle their bills, and can reduce hospital incur debt. Additionally, granting applicants the option to submit alternative documentation to verify their income and assess eligibility for hospital financial assistance is vital.

Lastly, enhance accountability by mandating hospitals to disclose race, ethnicity, and language data concerning their financial assistance allocations. This data should include details such as the recipient's assistance, the number of patients referred to collection, and those facing legal actions all categorized by the race, ethnicity, and language data, demographics. Such transparency can foster equitable access to financial support. Thank you for the opportunity in testifying in support of HP 5320, and I urge the Committee to pass this Bill favorably. Thank you.

SENATOR ANWAR (3RD): Very good. No questions, no comments. I appreciate you being here. Thank you. Next person on our list is, Himani Pattisam. Welcome.

MS. HIMANI PATTISAM: Thank you, dear Senator Anwar, Representative McCarthy Vahey, and Esteemed Members of the Public Health Committee. My name is Himani
Pattisam, and I'm a student from New Haven, Connecticut. I served as director of the medical debt and insurance counseling department at the HAVEN Free Clinic, which is a student-run free clinic affiliated with Yale University School of Medicine that serves primarily Spanish-speaking patients without health insurance in the Greater New Haven area.

I also intern at the health department of the Serving Undocumented Neighbors division of IRIS Integrated refugee and Immigrant Services, which is a refugee resettlement agency with offices in New Haven and Hartford. IRIS strives to provide support to immigrants and refugees from diverse backgrounds and immigration experiences. Both IRIS and the HAVEN Free Clinic are members of the HUSKY for Immigrants Coalition.

I stand in support of HB 5320 AN ACT CONCERNING HOSPITAL FINANCIAL ASSISTANCE. This Bill is really important to me because I have seen firsthand the impact of Charity Care Programs such as the financial assistance program at Yale New Haven Hospital. At HAVEN Free Clinic and at IRIS, I have served patients and clients who lacked health insurance and could not afford to pay the high cost of their medical bills. Many of the people I have worked with have had incredibly difficult decisions to make. Often they were working multiple jobs just to avoid having to choose between putting food on the table for their children, paying their rent, affording necessary medications for chronic illness, or paying their medical bills.

These people would qualify for financial assistance, but they are often instead overwhelmed by the lengthy application process and lack of transparency. I have worked with patients who are fearful of seeking care in the future because they
had received letters and calls from debt collectors. Many patients do not know that they qualify for financial assistance or even that these programs exist to help people just like them. At HAVEN Free Clinic.

And IRIS, I have seen firsthand the struggles patients and clients face when trying to apply for financial assistance programs at other healthcare institutions. And sometimes patients cannot complete the application process despite the fact that their income would qualify because the process requires that they provide documentation showing that they have been denied health insurance coverage. Many patients are aware that they do not qualify for health insurance coverage and this application requirement dissuades patients who would otherwise qualify from financial assistance from even submitting their application.

This Bill would ensure that our patients and clients can go through a transparent and centralized process, that would make financial assistance programs at hospitals more accessible so that patients are not afraid to seek the care that they need. Some of our patients and clients are repeatedly denied despite qualifying for financial assistance on the basis of their income because of the lack of transparency and accountability through this process. Creating an oversight entity would greatly help to ensure that these programs are accessible to the people who need them.

Thank you so much for the opportunity to testify in support of HB 5320 AN ACT CONCERNING HOSPITAL FINANCIAL ASSISTANCE policies. I strongly urge the Committee to favorably pass this Bill. Thank you so much for your time.
SENATOR ANWAR (3RD): Thank you, Himani. Very, very well said, we appreciate your testimony. Seeing no questions or comments. We will move to the next person on our list, which is Ellen Crafts. Welcome.

MS. ELLEN CRAFTS: Thank you, Senator Anwar, Representative McCarthy Vahey, vice-chairs, and distinguished members of the Public Health Committee. My name is Ellen Scherer Crafts, and I have been a volunteer with Moms Demand Action for Gun Sense in America for over six years. I'm before you today to ask to pass HB 5317 to require a study concerning funding for an effectiveness of the community gun violence intervention and prevention program.

The issue of gun violence prevention in all its forms, is extremely important to my family. I lost my father to suicide by gun. My dad's access to a firearm on one very bad day ensured that that day would be his last. I'm an advocate for gun safety, for my family, for my daughter, in memory of my dad. And also, because everyone deserves a life to live safe from gun violence.

My family moved to Western Connecticut in 2021 from California, and my husband and I are so happy to be raising our daughter here. We frankly chose Connecticut as it had strong gun safety laws. But I know personally that laws alone can't and won't keep citizens safe. In Connecticut in an average year, 211 people died by guns and another 308 are wounded.

And in the volunteer work, I do, I personally see time and time again the gap between gun violence intervention work and legislation. A gap that you can help close in part with authorizing the study, and giving a commitment to sustain sufficient funding for the community gun violence intervention
and prevention program that the legislature created in 2022.

We know that CVI programs are evidence-based backed and critical tools that can reduce gun violence across our state. But most importantly, in our cities of New Haven, Hartford, and my neighbors in Bridgeport, these cities are disproportionately impacted by everyday gun violence. And the data shows us that in Connecticut, black people are 27 times as likely to die by gun homicide as white people. And that's compared to 12 times Nationwide. This is a public health crisis on so many levels.

And in addition to the immeasurable human suffering, gun violence is costing Connecticut taxpayers millions of dollars every single year in health care, law enforcement, and other expenses. A current estimate has that cost at 51.7 million paid by taxpayers, which is part of a total cost to Connecticut of 2.6 billion each year. So, this is something for us to consider.

The gun industry makes billions of dollars in profits each year, while our state and communities quite literally pay the price in physical, emotional, and economic costs. I would suggest when the study is conducted that we also look to the gun industry as a source of funding. As it was recently done in California, Connecticut could impose a small excise tax on the sale of guns and ammunition in Connecticut, and direct this revenue to support CVI work in the state. You could thus ensure reliable funding for community violence, gun violence intervention, and prevention programs.

And to note Colorado, Vermont, New York, Massachusetts, Washington, and New Mexico are among the states where lawmakers are currently considering similar Bills. The time for more study on this in
Connecticut is now. Data from a now around the Nation shows us that when adequately resourced and properly implemented community gun violence intervention strategies can produce the most important goal. So

CLERK: Excuse me, Miss Craft, your time is up. Thank you.

MS. ELLEN CRAFTS: Thank you.

SENATOR ANWAR (3RD): Thank you, Miss Crafts. Do you have a written testimony as well with some of the data that you are sharing?

MS. ELLEN CRAFTS: I do, I submitted that as well.

SENATOR ANWAR (3RD): Okay. Thank you. This is very helpful. Representative Klarides-Ditria, has a question or a comment.

REP. KLARIDES-DITIRA (105TH): Thank you, Mr. Chair. Thank you for being here today. Can you clarify? You just mentioned that you named a few other states. I don't know if you said California, Colorado, and Vermont are doing similar legislation. Are you talking about the study, or are you talking about taxing ammunition?

MS. ELLEN CRAFTS: I'm talking about taxing ammunition, the excise tax. It's currently passed in California and those other states are currently considering some of low legislation.

REP. KLARIDES-DITIRA (105TH): Do you know what percent of the excise on ammo was in California?

MS. ELLEN CRAFTS: I do not. I have that data, I can send that over to you though. I can't quota it at this call.
REP. KLARIDES-DITIRA (105TH): Thank you for your testimony today.

MS. ELLEN CRAFTS: Thank you.

SENATOR ANWAR (3RD): Yes. we have the question from Representative Kavros DeGraw.

REP. KAVROS DEGRAW (17TH): I admit it's more of a comment, but I will be brief. First of all, I just wanted to say, I'm very sorry for the loss of your father that had to be incredibly difficult. And second of all, I don't know if you're aware, but we are actually looking at an ammunition tax in the Finance Committee. It's HB 51. I'm sorry, I have to put my glasses on 5114. So, that may be something that you would be interested in testifying on as well. Thank you so much for being here.

MS. ELLEN CRAFTS: Thank you. Thank you so much for the time and for your questions.

SENATOR ANWAR (3RD): Thank you. So, I don't see any other questions or comments. We appreciate your insight, and I'm so sorry for your loss as well. Next person on our list is number 91, Mariella LaRosa. Welcome.

MS. MARIELLA LAROSA: Thank you. Thank you. Good evening. Senator Anwar, and Representative McCarthy Vahey, and other distinguished Members of the Public Health Committee. My name is Mariella LaRosa, and I am the executive director of the Health Assistance Intervention Education Network, also known as HAVEN, which is Connecticut's Health and Monitoring program for our state's licensed healthcare professionals. Thank you for allowing me to testify this evening regarding House Bill 5058 AN ACT ADOPTING THE NURSE LICENSURE COMPACT. HAVEN's position regarding this
compact is set out in the written testimony previously submitted to this Committee, and I would like to adopt that written testimony in full. What I would emphasize this evening is that HAVEN can support House Bill 5058 with two important caveats. First, it is very important that we have some assurance that nurses practicing in Connecticut can continue to access HAVEN services, and to do so confidentially as allowed under existing Connecticut Law.

A pathway to allow this seems to have been identified, though it does require some additional language be added to the compact legislation. That a nurse can deactivate the multi-state compact license and revert to a single-state license at any time for any reason or for no reason, and without disclosing the reason for the deactivation. This would then allow the nurse to engage with HAVEN confidentially under existing Connecticut law, without the need to self-disclose the engagement with HAVEN to the licensing board or to the compact commission and the data-based system that it has.

The other major concern for HAVEN, and the other condition here is that the projected revenue loss to HAVEN resulting from this compact needs to be addressed, preferably in a manner that's statutorily mandated and that is sustainable. The projected loss to HAVEN from this compact is in the range of 175,000 to $200,000 per year. That's a loss from the licensure fee revenues that HAVEN currently receives. And this is about 18%. sorry, it's actually about 15% of HAVEN's operating budget. This is especially important right now because, over the last year to two years, we have seen an approximate 20% increase in referrals to HAVEN.

So, we're actually looking at having to increase our staffing and our resources, and we really could not
absorb such a large hit to our operating budget. I just would like to conclude by thanking two individuals who worked very hard to try to find solutions to these issues. So, Thank you to Claire Botnick and Claudio Galtieri, for working diligently with us in coming up with some solutions to these issues. So, thank you for your thoughtful consideration, and I'm happy to entertain any questions. So, I know the hour is late.

SENATOR ANWAR (3RD): Thank you so much for your testimony. Actually, many of us were waiting to have a conversation with you. So, I'm so glad you're here. First and foremost, you are doing some very amazing work. The entire team of people at HAVEN, you have kept healthcare alive in the state in many ways from individuals who are going through some tough times.

And you've been able to confidentially protecting the patients taking care of those health care workers. So, I cannot thank you enough. We collectively cannot thank you enough for what you do every single day. You are not only a leader in the state, but you are a national leader. So, I wanted you to hear that from us first.

MS. MARIELLA LAROSA: Thank you, Senator.

SENATOR ANWAR (3RD): Now, when you get so much good stuff done, then there comes a problem. The problem is how do we create protection? And I think you've touched on this, but I wanted to clarify a few things. One, for the number of other compacts that we have passed, we have been able to figure out a way to protect the confidentiality of those healthcare workers. Is that accurate?

MS. MARIELLA LAROSA: That is, yes.
SENATOR ANWAR (3RD): So, why are we treating the nurses so differently in our state?

MS. MARIELLA LAROSA: Yes. So, thank you for that question, Senator. Actually, it's the compact itself that treats the nurses differently. So, this issue regarding access to HAVEN and access to our services in a confidential way is rather unique to the nurse compact. The other compacts that have passed and been enacted in Connecticut do not contain the same language that we see in the nurse compact.

In the nurse compact, there are specific language that precludes a nurse who holds a compact from engaging in a confidential alternative to a discipline program. And if the nurse does need to engage with that program, the nurse is required to disclose this to the Licensing Board and the Licensing Board is then required to deactivate the Compact and report the deactivation and the reason for it to the Compact Commission and the database, which I understand is accessible to all other states in the Nurse Compact.

And so, this is unique to the nurse compact statute or legislation. We don't see that language, for example, in the physician's compact, it's actually not an issue at all.

And so, this is why this compact is being treated differently because it does create an issue for the nurses and the language in the compact seems to be in direct conflict with the existing Connecticut law. Our HAVEN statutes require in fact mandate strict confidentiality. So, this is the difference that we're having here and why we're needing to be creative in coming up with a solution.
SENATOR ANWAR (3RD): And have you been part of those conversations with the governor's office and the people who are looking at this?

MS. MARIELLA LAROSA: Absolutely. Yes.

SENATOR ANWAR (3RD): And is it possible to make sure that the nurses are at that table too, please, to make sure that they feel comfortable going forward? Because this is going to be the lifeline for this compact if we fix this aspect.

MS. MARIELLA LAROSA: Yes, of course. And the nurses have been part of the conversation. So, of course, I will continue to do what I can to make sure that they are at the table. There's a critical part of this discussion.

SENATOR ANWAR (3RD): I'm sure we're going to have more conversation around the compact and the confidentiality. It's confidentiality is mentioned 20 plus times or something in the bill where there are quite a few current weaknesses in the way the bill is written right now.

So, we will definitely need a solution and if your testimony wanted to modify things or send this to the committee, we would love to share it with the entire committee to see if there's an opportunity to find the way and solution for this issue. The second big challenge is that your sustainability is critical to the wellbeing of health care workers in our state.

Should this Public Health Committees look at how we can create plans for your HAVEN to get stronger and be able to also provide more care because the number of challenges in health care world with the trauma that the health care workers, the nurses are experiencing, the problems are increasing. And so,
we need your sustainability as a very critical part. Can you speak to that and how can we help you there?

MS. MARIELLA LAROSA: Yes, thank you, Senator. So, yes. So, absolutely. I am respectfully requesting that this committee consider the funding aspect that is the result of this Nurse Compact. So, as I mentioned, we are looking at between 175,000 to $200,000 per year of a cut in our funding from the licensing fee. And so, this would not be doable for HAVEN.

So, HAVEN cannot absorb this large of a cut in its revenue. So, we are actually meeting tomorrow with the interested parties to attempt to delineate a more specific plan on how to address this loss and how to keep HAVEN whole. So, one idea that has been discussed is the idea that Connecticut can, I believe charge a fee to a nurse who is working in this state pursuant to the Compact privilege.

And so, if there is going to be that fee charge, then perhaps $5 from that fee can be set aside to behave and fund the way the current $5 fee is set from the license. So, this may be an option. I am not sure because I haven't seen the specific numbers. I don't know what the state is planning to charge for that compact fee and whether this could work. But it is something that we are flushing out and we are having, as I say, a meeting tomorrow for more specific discussion. So, the funding is an issue and it does need to be addressed before HAVEN can definitively support this bill.

SENATOR ANWAR (3RD): Okay. This is very helpful. I think many of the moving parts if we can get clarity, that's going to help us not having to have the LCOs change the bill too many times in this short session.
MS. MARIELLA LAROSA: Yes.

SENATOR ANWAR (3RD): So, this would be important to keep us in the loop on some of these things. We appreciate your testimony. I think many of my colleagues may have had questions but I probably asked some of them and it's late at night, so we'll probably have more questions later. So, I appreciate you being here and thank you for the work you do.

MS. MARIELLA LAROSA: Absolutely. Thank you.

SENATOR ANWAR (3RD): Thank you. With that, we'll move to the next person on our list, which is number 92, Katherine Villeda. Welcome.

MS. KATHERINE VILLED A: Hi, everyone. Good evening, dear Senator Anwar, Representative McCarthy Vahey, Senator Somers and Representative Klarides-Ditria and esteemed members of the Public Health Committee. My name is Katherine Villeda and I am the Director of Policy at Health Equity Solutions. Health Equity Solutions is a nonprofit organization with a statewide focus on advancing health equity through anti-racist policies and practices.

Our mission is for every Connecticut resident to attain optimal health, regardless of race, ethnicity or socioeconomic status. Thank you for the opportunity to testify in support of HB 5320, an Act concerning hospital financial assistance.

Unlike planned debts such as mortgages, medical debts often result from unforeseen or emergency medical needs. No one should discover in the days or months after a hospital visit that the bill far exceeds their savings and be unaware or too overwhelmed to apply for financial assistance.
programs that also needed to help, as we've heard many stories today.

72% of people attributed their medical debt to bills from one time or short term medical expenses associated with acute care such as a single hospital stay or treatment for an accident at a hospital. Furthermore, medical debt, not only perpetuates economic disparities, but also contributes to the cycle of health inequity and serious economic consequences such as access to credit and increased likelihood of bankruptcy.

Individuals burdened by medical, that experience heightened stress levels, poor health outcomes and often are compelled to delay or forgo needed medical care which is particularly concerning for individuals with chronic conditions. Nonprofit hospitals are mandated to offer financial assistance to eligible patients yet barriers persist. Connecticut hospitals have been progressively spending less on financial assistance leading to a 339 million deficit in financial assistance and community investment compared to the value of their tax exemptions. This deficit amount could have wiped out medical debt for 69% of the roughly 280 Connecticut residents with medical debt if hospitals had just spent their fair share on hospital financial assistance policies.

Nationally, 45% of nonprofit hospitals send bills to patients eligible for assistance contributing to over 2.7 billion in uncollected bills. This proposed bill would keep more Connecticut residents from incurring medical debt by setting standards for these policies, increasing awareness and access to financial assistance and ensure compliance with hospital financial assistance policy requirements.
I know you all have heard a lot about what this bill already requires, I'm going to jump to explain a few recommendations and amendments that we would like to see in the bill to make sure that it is more effective and comprehensive, including providing flexibility for applicants to submit alternative documents to verify their income for eligibility determination as in Illinois and Colorado. Flexibility is especially important for individuals who do not get paid with pay stubs, who may be a survivor of intimate partner violence or may be experiencing homelessness.

Additionally, we recommend that hospital should be required to direct patients to the Office of the Health Care Advocate long before they are ever sent to a collections agency. And furthermore, we also asked to enhance the requirements for hospitals to report the data that they would be reporting on financial assistance to be broken down by race, ethnicity and language data as it relates to how much financial assistance they offer. This is already done in Colorado and in Maryland.

CLERK: Excuse me, Miss Villeda, but your time is up. Thank you.

MS. KATHERINE VILLED: Okay. I will wrap up. The last thing I will add is that we also recommend that hospitals should be allowed to submit corrective plans with the Attorney General's office to make sure that there are ongoing conversations if corrective action ever needs to be taken. So, with that, thank you for the opportunity to submit this testimony in strong support of HB 5320. Thank you.

SENATOR ANWAR (3RD): Thank you, Kattie for your testimony. We appreciate you staying with us and still having the smile that you had this morning. So, that's miraculous.
MS. KATHERINE VILLED: Thank you. I appreciate the full room.

SENATOR ANWAR (3RD): A Representative has a question for you. Go ahead, please.

REP. CARPINO (32ND): Thank you, Mr. Chairman. Thank you for being here. Thank you for staying with us. I just had a question. I was hoping that you could answer. You were not the first one who suggested alternative income verification. And I'm just curious what you think that would look like so that we can offer patients the benefit of the doubt and yet still maintaining fairness amongst individuals who would be submitting income verification. So, what do you envision?

MS. KATHERINE VILLED: So, we elaborate briefly on this in our written testimony. One of the examples that we provide is that they can ask their employer for a letter attesting to the fact that the patient is employed and the their rate of payments. So, this might be for somebody who might be getting paid in cash, for example. So, a lot like a notarized letter might be a way for someone to attest and confirm their income.

REP. CARPINO (32ND): Sure. And any other suggestions?

MS. KATHERINE VILLED: Yes, I am drawing a blank at the moment. We can ask for tax return documents that is for people who might have W-2's, but also people who will have item numbers, so like a tax ID number. So, that might be like a 1099 form, for example, versus a W-2. And then, we have also recommended--I can send more information. My apologies. I'm just drawing a blank at this point.
REP. CARPINO (32ND): I realize it's late.

MS. KATHERINE VILLEDA: It's late, yes.

REP. CARPINO (32ND): If you could send that to--

MS. KATHERINE VILLEDA: Yes, I'm happy to send over more examples.

REP. CARPINO (32ND): To either myself or the Committee administrator. That would be--

MS. KATHERINE VILLEDA: Yes.

REP. CARPINO (32ND): Great. Thank you. Thank you, Mr. Chairman.

SENATOR ANWAR (3RD): Thank you, Representative Carpino. Thank you, Kattie, for your testimony. Thank you for the work you're doing.

MS. KATHERINE VILLEDA: Thank you.

SENATOR ANWAR (3RD): And with that, we'll move to the next person on our list, which is Kim Sandor. Welcome, Kim and thank you for being here in person. I know you were here all day in person, but then you had to attend to something at home or outside. Thank you.

MS. KATHERINE VILLEDA: Thank you.

MS. KATHERINE VILLEDA: Thank you. And hello everybody, Senator Anwar, Representative McCarthy Vahey and esteemed members of the Public Health Committee, it was great to see some of you up there today. I did run home so I could watch my son's first college Lacrosse game tonight, which was a W so it was very exciting and appreciate being able to connect with you via Zoom. We're here tonight to provide some testimony in opposition to HB 5058, an act adopting the Nurse License Compact as written. And I am very
appreciative of Mariella LaRosa, the Executive Director of HAVEN and John Brady with AFT who have recently testified and provided a lot of background on this. So, I will try and hit the high notes.

As stated, all compacts aren't created equal. I think you've heard that the RN/LPN compact is a little bit tricky. It has some restrictions on it in the actual standard language that needs to get dumped into every state law. And it's that language that's really causing some issues for us. And these issues aren't new. We've been exploring the contact since 2018 when it was finally updated. After about 18 years, we worked with NCSBN, state partners, people across the country have had the compact for 20 years and two years to figure out how is it going and how are you handling some of these issues? We participated in the 2022 Advisory on Compacts, same issues. No real solution. No real ideas for how to make any changes in it.

While we support the concept of interstate health care licenses, each compact really needs to be considered individually and the implications of adopting them understood. We have two major issues and then a handful of smaller issues. And the two major issues are really why we say tonight that we are in opposition of the compact is written.

While Mariella, alluded to hearing about some fixes and addressing the funding, we have yet to see it and we do not feel that we can offer support for it when for so long, we've been looking for some sort of a solution and haven't been able to see it. So, we really need to see what is being offered and see how it works with the NCSBN Compact and what that looks like getting implemented in the state.

So, the two major issues, I'm going to start with, first, I'll go into the other little ones. They are
required about the confidentiality and the funding
to HAVEN. And really these tweaks are so that
Connecticut cannot go backwards. This is all
supposed to be about moving forward and adopting the
compact as is really moves things backwards for the
nursing healthcare workforce in the state. The loss
of confidentiality is, Senator Anwar, so
appreciative you've read our stuff. 24 times, HAVEN
was established for confidentiality.

The word confidential is included 24 times. That's
how important it is to the healthcare workforce that
when people have a need to get help, they can get
confidential services just like anyone else. Why
does it have to go on the public record and be there
for other people? Let them get their services and
get the help they need. And so, that is not okay
for nurses to not be treated like any other
healthcare professional and loses confidentiality,
it really needs to be maintained.

The second is the piece on funding. So right now, I
think it's a little confusing but we have to over
26,000 nurses that Connecticut licenses that live
out of state and they live in states that have a
compact. So, if Connecticut implements the compact,
if those 26 nurses that live in those compact states
could get a compact license, no longer need to
purchase a Connecticut license.

So, Connecticut loses the 26,000 nurses that are
buying all the money from those 26,000 nurses buying
a Connecticut license. Plus HAVEN's losing the $5
on those, whatever percentage of those nurses leave.
So, it's a huge consideration and it needs to get
figured out as Mariella said. It is critical to
HAVEN funding because the state has never paid for
HAVEN funding.
The only reason HAVEN gets that money is 'cause the health care professionals agreed to an increase in their licensure fee so that the state could collect money to give to HAVEN. So, it was always something from the health professional side. The little issues I say are more related to things that we've heard from across the country.

CLERK: Excuse me, Miss Sandor, but your time is up. Thank you.

MS. KIM SANDOR: Thank you, Kathleen. I tried to talk fast.

SENATOR ANWAR (3RD): Well, Kim, tell me about these minor issues.

MS. KIM SANDOR: Well, one of them is just a loss in revenue to the state. We don't want to see the licensure fees for nurses in the state to go up extraordinarily, so the state can recover the money they're losing. We don't want to see that happen. Data; people look up to Connecticut with such admiration because we have wonderful data about our nursing workforce. These 39 states in two territories that are collecting data, wish they had the data we have.

And what happens is that when someone goes into the compact, they're no longer buying that Connecticut license. So, we have no data about who's coming into our state to work on the compact. So, we're just recommending that employers actually register nurses that come into the state working on the compact, so the state has data on who's coming in under the compact and knowing who's actually working there.

The other pieces around scope of practice, nurses, their scope of practice, RNS and LPNs vary across
the country and the compact puts a responsibility on the individual nurse to know the scope of practice of the state that they're working in. Scope of practice is this thing that's thrown around. But, let me give you a hard example. In some states, LPNs do dialysis.

So, if LPN comes here and they think they can do dialysis or an RN is working with an RN, they do dialysis and they delegate that, they're working outside the scope of practice in Connecticut. So, that puts our patients at risk and it puts our nurses at risk. So, we think that as nurses coming into the state to work with their Compact License that they're employed here, it tells them they have to take a module so that they can learn about the nurse Practice Act in the state of Connecticut.

And we're totally happy to help with that, but we think that's a huge protection for the nurse as well, it is for the patients in the state. And fingerprinting is the last thing which I know, you guys know, is an issue in the state. But we don't have FBI fingerprinting which a lot of other states have it already.

And so, the system is really well worked out. FBI fingerprinting for that tens of thousands of nurses, I don't know the state's capacity for that and I think the state should be really well prepared if they're going to implement the compact to have a plan to make sure that how that's going to happen. So, it happens. So, those are the other things.

SENATOR ANWAR (3RD): Thank you so much. Representative Cook has a question for you.

REP. COOK (65TH): Hi, Kim. Thank you. And I'm going to be brief and you answered part of my question, but my other question would be this, so
the thoughts on the compact solving the problem on our shortages in the health care industry. What are your thoughts? And before anybody around this desk gives me more dirty looks, make that answer quick. Thank you.

MS. KIM SANDOR: I'll make it quick. Yeah, does it? Who knows? As John said, the door swings both ways. We did a quick survey of our members, 75% were excited to say, oh, we could get the compact and they had nothing that they wanted to do with it, they just thought it would be cool to have.

But when we educated them that the compact could bring with it, the loss of confidentiality with HAVEN, they were like, whoa, that's got to be solved. And so, I think that travelers have always come into our state. I mean, back a long time ago, I've been nursing now and we've always had travelers in our state and you guys have done a tremendous job to make it easy for nurses coming into the state to get their license within two weeks.

So, people coming into the state, I don't think it's that big of a deal. Thinking about telehealth and where the future of nursing is going, I think we do need to find a solution. I think we need to take the time to get the right solution. I think we all need to see the right solution. I think we need to vet it and think about it and make sure that all the issues are being addressed so that we're moving forward and we're not creating new problems, but we're really being smart.

We're learning from other people's problems and issues that they've had in implementing this and we are getting on top of it before we start having problems in our state, which sets us up for continued excellence.
REPRESENTATIVE COOK (65TH): Thank you. I appreciate that, your dedication to the cause and congratulations to that first victory tonight. Thanks Senator.

MS. KIM SANDOR: Thank you.

SENATOR ANWAR (3RD): Thank you. Kim, if you feel that you're not part of the conversations, please reach out to us. We really want--

MS. KIM SANDOR: Thank you.

SENATOR ANWAR (3RD): Things to move in the way the nurses are protected. Thank you.

MS. KIM SANDOR: Thank you very much. Thanks everybody.

SENATOR ANWAR (3RD): Thank you. Next, person on that list is Kerrie Raissian. Thank you so much for being with us this morning, afternoon, evening and now night.

MS. KERRIE RAISSIAN: All the time. [inaudible] I usually teach at night, so this is perfectly fine.

SENATOR ANWAR (3RD): Thank you. We'll be your class tonight.

MS. KERRIE RAISSIAN: Oh--

MS. KERRIE RAISSIAN: Oh, gosh. Okay. Well, that's wonderful. Well, good evening, morning, whatever time it is, distinguished members of the Public Health Committee. My name is Dr. Kerrie Raissian and I'm pleased to submit testimony supporting HB 5317, an act requiring a study concerning the funding for an effectiveness of the Community Gun Violence Intervention and Prevention program.
I'm an Associate professor of Public Policy at the University of Connecticut and the Director of UConn Center for Advancing Research Methods and Scholarship and Gun Injury Prevention or ARMS. My expertise is Causal Program Evaluation. I'm also a member of Connecticut's Commission on Gun Violence Prevention and Intervention and I co-chair the commission subcommittee on Data and Evaluation.

I'd like to thank Senator Moore, each of you, the full assembly, the governor and his staff and the Department of Public Health for all their efforts in building and sustaining the commission and its work. ARMS supports this bill and indeed believes it's critical to creating the infrastructure that is necessary to ensure the continued and effective prevention and intervention of community gun violence here in our state. UConn is further committed to having ARMS work with DPH and anyone at the commission and community programs to develop, implement and evaluate strategies intended to help reduce gun violence in Connecticut.

I think we can all appreciate how important community violence programs are. But I'd like to use my time to talk about the importance of evaluation of these programs. Programs should carefully consider how they're going to intervene, what that intervention would do and why it's expected to work and how they're going to measure it. Programs must also define evaluation which can be categorized broadly as either a process or outcome evaluation. A process evaluation measures how well another program is followed based on a particular design.

An outcome evaluation is what tells you if something is effective. And it's hard. And it requires funding. Did the program actually reduce gun injury and violence? Being able to answer that question is
really important if we want to know if a program is working.

Ideally, these two kinds of evaluations work together. And it's important to know if the program is being offered as intended and if it works. Funders, political officials and citizens want to know the answers to these questions but so do providers. But knowing requires an evaluation which requires sustained investment. I've had the privilege to work with many of these programs in Connecticut and I can confidently say providers want to know if what they're doing is effective and they want to know what they should do more or less of because they have scarce resources.

In my um expertise though, evaluation is hard, it's program design, data measurement, data collection and data analysis. And a study like the one proposed in HB 5317 would help programs engage in community violence interruption work, measure their effects and understand how to improve their already good work.

But many of them would need outside evaluation support. Many of them don't have evaluators on their staff. One potential model is for ARMS to work like a National Institute of Health or NIH Data Coordinating Center. In the NIH model, ARMS would work with DPH to identify evidence-based programs, work with programs to create that data evaluation plan, ensure evaluation data is properly collected and consistently collected across programs and help programs demonstrate their success for future and sustainable funding.

CLERK: Excuse me, Doctor, but your time is up. Thank you.
MS. KERRIE RAISSIAN: Thank you. I would just end by saying that ARMS seeks to be a resource in the state and I'm happy to answer any questions and I do have some answers to other questions that were asked. I'm happy to share that or submit it in an email later knowing the hour of the night.

SENATOR ANWAR (3RD): I do have a few questions and it will be very fast.

MS. KERRIE RAISSIAN: Of course.

SENATOR ANWAR (3RD): How are you funded?

MS. KERRIE RAISSIAN: So, ARMS is funded largely through internal investment at UConn as infrastructure. It's very difficult to get infrastructure dollars from external sources, especially at an R1 University. R1 universities usually fund particular research tasks. And so, currently our funding comes from the indirect from those research grants and then internal investment from our OVPR's office.

SENATOR ANWAR (3RD): And do you have NIH grants?

MS. KERRIE RAISSIAN: I'm sorry, what?

SENATOR ANWAR (3RD): Do you have NIH grants?

MS. KERRIE RAISSIAN: We do not currently have NIH grants. You may know that only recently did federal funding become available for gun violence prevention work. And the NIH has released very few calls for this kind of work and the University of Michigan received the Coordinating Center Grant that was recently administered or given out through NIH. So, no, we do not have one of those, but we know the model quite well.
SENATOR ANWAR (3RD): And the funding that we are talking about is not going to impact you, but your work helps us identify where it would be very effective. Is that fair?

MS. KERRIE RAISSIAN: Yeah. So, we don't really stand to gain anything here except if--evaluations do cost money and whoever does that would need funding to do that evaluation. Currently, I serve on the commission as a volunteer and as a part of my Yukon ARMS dues and would be happy to continue to do that. But the evaluation itself would require sustained investment.

SENATOR ANWAR (3RD): I heard a lot about the work that you've been doing. So, I wanted to just thank you for the work you're doing. If you can take one minute to answer some of the questions that you feel that we should have that we had asked.

MS. KERRIE RAISSIAN: Sure. The main question I wanted to answer was about the tax in the California data which came from this side of the room. So, I was faced behind you. It's an 11% tax which is similar to the federal tax, which is between 10 to 11% based on the type of ammunition. California's is 11% and it's estimated to raise $160 million every year. That is from Johanna Schubert. She had that in her notes.

SENATOR ANWAR (3RD): Perfect. Representative Kennedy has a question.

REP. KENNEDY (119TH): Just a comment. Did you submit your testimony in writing as well?

MS. KERRIE RAISSIAN: The government relations submitted on my behalf, yes.
REP. KENNEDY (119TH): Okay, great. Thank you so much. And as Senator Anwar, suggested, could you put what you just gave us in writing as well? [crosstalk]

MS. KERRIE RAISSIAN: It's in Johanna's testimony, but I'm happy--

REP. KENNEDY (119TH): Okay.

MS. KERRIE RAISSIAN: To follow up with an email.

REP. KENNEDY (119TH): All right. Perfect then.

MS. KERRIE RAISSIAN: But it is in her written testimony. She just didn't have time in her three minutes.

REP. KENNEDY (119TH): All right. Thank you so much. Thank you, Mr. Chair.

JOHANNA SCHUBERT: Hi, I'm Johanna [inaudible] I should have the written testimony [inaudible]

SENATOR ANWAR (3RD): Nope. So, that's separate. Okay, good. And you're done with your question, Representative Kennedy? Okay. And my Co-chair has a question and then Representative Welander. We have a squeaky mic because we heard the squeaky mics get the money.

REP. MACCARTHY VAHEY (133RD): Squeak away. The squeaky Mike gets the funds. Thank you, Senator Anwar and thank you for being here with us, for staying all day. So, just in terms of how we structure this group and this body, we heard earlier conversation about having the commission direct the conversation. There's you, there's creating another group.
I don't really like to duplicate efforts, but I just wondered if you wanted to share your thoughts about that in terms of, for example, you said you co-share the subcommittee on data and evaluation. So, when I hear that, I think, well, maybe the subcommittee on data and evaluation is a good place to have some of this conversation because we're looking at sustainability of funding and the ability to evaluate which, these things go together. But if you could just comment a little bit about that.

MS. KERRIE RAISSIAN: Yeah, happy to. So, the subcommittee on Data and Evaluation right now is making recommendations on what evaluation would look like. It doesn't itself have the capacity to carry out an evaluation independent without funding or without infrastructure. Which I think DPH would be well positioned to help secure and to not duplicate services.

I do think that this kind of study would be well placed in a place like DPH, I think the kinds of programs that are currently funded through the commission really vary a lot in terms of how they seek to move the needle on this issue. And I think it requires an interdisciplinary suite of expertise and tools. But they all seem to comport with the public health prevention model. And so, I think it's well placed in DPH.

I think it does need to be thoughtful about how those pieces work together. But I think the basic tools are already there. It would be a matter of how you actually execute the study in a way to ensure that the question is answered. Not only that the state wants to know is our investment working, but as I alluded to in my remarks to answer what the providers want to know, which is, am I doing my job?
Every community violence interrupter program that I've ever met and I'm a formal social worker, we feel a calling to this work, it's really important to know if it is working? And without this kind of investment and an evaluation, we don't know, you don't know, citizens don't know and we all deserve to know.

MR. MIKE WATERBURY: It's not going to work. I just thought.

MS. KERRIE RAISSIAN: Oh, okay. Someone believes it's not going to work. I think evaluation is powerful. I think research design is powerful. I think it's important to have an objective party conducting that evaluation though. And having DPH overseeing that is important.

REP. MACCARTHY VAHEY (133RD): Oh, thank you. Thanks, Senator Anwar. Thank you for that answer. Essentially what you're saying is we, in order to be able to do this properly, what we're looking to do in this bill, we need resources to accomplish that?

MS. KERRIE RAISSIAN: You do.

REP. MACCARTHY VAHEY (133RD): We're going to need funding to actually be able to do this evaluation, which by the way, as a local prevention council with a small tiny grant from the state and we have a drug free communities grant which is from the CDC. We pay an evaluator locally to assure that we are achieving results in terms of lowering the number of children who are increasing age of onset for alcohol use. I'm saying, I'm hearing clearly in a different way, what you're telling us is we've got to invest, seed money essentially in order to be able to know how we can have that sustainable funding and if what we're doing is effective.
MS. KERRIE RAISSIAN: I think it's also important to--so there are eight mini grants that were funded through the RPH dollars. There are a lot of other programs that were not funded through the RPH dollars that may wish to apply for future funding. And then, there are some for whom this call may not be well suited for. And the evaluation of all of those programs in a holistic way is something that's really missing in this infrastructure.

And I think there's a lot of economies of scale of having that evaluation in a centralized place as opposed to having an evaluator for each of these programs where that data is not culled together and thought about. What are the measures that we are collectively interested in measuring? And if you have a different evaluator for each program, you're simply not going to have that. Which is the NIH coordinating center model, which is to pull this and pull it together so that you can have one training.

So, ARMS system trainings for the programs, for example. So, that there's one training, we do it one time, we have follow up questions, we try to answer individual questions as well, understand all programs are different, but there are some things that all programs can hear and benefit from at one time. And that kind of economies of scale is really what's important in a scarce resource environment.

REP. MACCARTHY VAHEY (133RD): Very quickly. Is there a plan to evaluate those aid programs at this point?

MS. KERRIE RAISSIAN: There is an RFP for the evaluator, it is in legal land somewhere being reviewed. The RFP for the evaluator for those programs has not yet been released, which is going to be problematic. And I don't think that was anyone's preference. It's just how this happened
and the need to get those RPH dollars out by a certain date. Ideally, you want an evaluation to happen before a program starts. So, you have data measurements in place and you have a plan for measuring things in place. You also want baseline measures. Did it change something? I don't know, where do we start? And so, if you're not collecting that from the outset, it's going to be problematic.

REP. MACCARTHY VAHEY (133RD): Thank you.

SENATOR ANWAR (3RD): Representative Welander, followed by Representative Zupkus.

REP. WELANDER (114TH): Thank you, Mr. Chair. Based on your research experience, if this proposal goes through, will the data and information that we gain, be helpful in securing additional funding--outside funding such as the NIH or CDC or anything else?

MS. KERRIE RAISSIAN: Yeah. So, that's a great question. So, one of the reasons I think that the evaluation is so important is to be able to tap into sustainable funding from probably not the sources that you've mentioned. I think there are funding sources that are more philanthropic and based in foundations that have been interested in funding this work, the federal government's dollars are pretty restrictive and well defined based on just new historic data driven practices.

But I think there are a lot of opportunities for outside funding. But the programs need a plan to--I view the migrants as pilot programs. It's not a lot of money, it's about $88,000 per program, per year. In the scope of providing social services when we're talking about something as entrenched as gun violence, $88,000 can transform a program, but can it transform a problem? That a different question.
And so, those dollars are a real opportunity for these programs to be able to think like, how can I measure this and demonstrate my effect and take it to a funder and then really scale this up in a way that's much more effective? So, yes.

REP. WELANDER (114TH): Okay. So, simply put, a small investment on our end now could potentially open us up to outside funding that would come in and it saved up money for the state in the long run.

MS. KERRIE RAISSIAN: I think so. I mean, I do think a lot of philanthropies would want to see the state match those dollars. Most of them have a scale up model. Philanthropy dollars are not invented either, but there are state dollars, there is a new initiative at the White House looking to make these programs more sustainable federally. So, there's a little bit of a wait and see in this space as you can imagine.

REP. WELANDER (114TH): Thank you, Mr. Chair. Thank you for your answers.

SENATOR ANWAR (3RD): Representative Zupkus.

REP. ZUPKUS (89TH): Thank you, Mr. Chair. I'll be quick. Thank you for coming. I do agree with you that data is important and you can't measure it. You can't manage it if you can't measure it. A lot of these programs have been around already. And so, I'm interested in knowing what they're doing now. What are the measurements now that they're going for? And that doesn't take any money. Since they've been in formation, where were they and where have they come from now? And what is the data?

MS. KERRIE RAISSIAN: Yeah.
REP. ZUPKUS (89TH): That's what I'm interested in for now.

MS. KERRIE RAISSIAN: So, I would categorize that under a process evaluation. What is their process? What are they doing? What are their outputs and what are their outcomes? You can't infer from that necessarily that the program caused a change in those numbers. We may all recall from introductory stats class that correlation is not causation. And when you look at those numbers and you're like, where did I go? And where did I stop? That's really correlation and it can be informative and it's really hard to have causation without a correlation that's in the direction you hope it to be. But without a research design, you cannot fully attribute that change to the program itself.

REP. ZUPKUS (89TH): Okay. But they--

MS. KERRIE RAISSIAN: And so, that's why those larger evaluations are important.

REP. ZUPKUS (89TH): But they should be evaluating themselves as they go. [crosstalk]

MS. KERRIE RAISSIAN: Should they have that expertise? There was another question about what amount of funding goes to administration and a lot of times we don't like to see funding go to administration, but that's precisely what evaluation is. And so, this is a really hard tension.

REP. ZUPKUS (89TH): And I understand. I know all about nonprofits.

MS. KERRIE RAISSIAN: Yes, I know you do.

REP. ZUPKUS (89TH): I know funding comes and I get it all.
MS. KERRIE RAISSIAN: 100%.

REP. ZUPKUS (89TH): But, we are constantly in the nonprofit that I'm working with. We're constantly evaluating. We can always get better. But every year we're evaluating what are our benchmarks? Are we meeting our goals and how do we move forward? And where's that funding coming from? So, I'm interested in, okay, they've been funded all these years, what's happening?

MS. KERRIE RAISSIAN: Yeah, I know.

REP. ZUPKUS (89TH): What are the improvements on? And that doesn't cost us any money.

MS. KERRIE RAISSIAN: I'm not sure that that's 100% true. It might not call you an additional money, but it should be captured in your investments that you've already made. So, I grant you, it's not additional or marginal dollars. That said, I don't know. I'm not evaluating those programs per se. I will say that the mini grant programs are required to provide a report to DPH, I believe once a quarter or every six months. They recently had a showcase where they're starting on that. So, those will be available to both DPH and then the assembly to know the change in those metrics.

REP. ZUPKUS (89TH): Right. Thank you. And I'll end with that because I'm a believer that we should fund things that work and don't throw money after things that don't work. And we can't do that if we don't know if it's working or not. So, thank you.

MS. KERRIE RAISSIAN: Full agreement.

SENATOR ANWAR (3RD): Professor, this was a good class for us and--
MS. KERRIE RAIISSIAN: You were a very attentive group. Much more so than some of my students and what time are we at? 8:11 on a--what even day is it? I don't even know. Oh, my gosh. Thanks.

SENATOR ANWAR (3RD): As long as there's no quiz, but thank you for your testimony and this was very helpful. We appreciate you staying here all day and then appreciate your testimony as you obviously figured out how attentive we all have been.

MS. KERRIE RAIISSIAN: My pleasure and I'm around tomorrow as well.

SENATOR ANWAR (3RD): Thank you. All right with that, your wait is over, Mr. Mike Waterbury. Thank you for being here all day. I know you had to go to a wake and you're outside that place in the car right now. So, welcome, you're on.

MR. MIKE WATERBURY: Thank you, Public Health Committee, not only for the opportunity to speak but also your endurance. It's been an impressive day and a great experience. So, I am the Chairman and CEO of [inaudible] which is a community of companies working to reinvent healthcare, one system at a time. I'm going to cut to the chase and spare you all the statistics 'cause a lot of people spoke very eloquently about it all day.

Medical debt in this country is a public health crisis and financial assistance plans, programs are not working. So, we applaud what you've proposed in House Bill 5320, uniform application will help, for sure. Reporting and accountability will help, for sure. I think the one thing and maybe you heard it from one of my colleagues earlier today that we think is important to add to the bill is a uniform online application process for everybody in the
state of Connecticut for all the nonprofit hospitals in the state of Connecticut.

We think that would significantly improve the access and really the effectiveness of financial assistance plan. So, other than that, the bill is going to help. So, we support it. But if you could consider adding that we think that would significantly improve really the health and wellbeing of the residents of Connecticut.

So, that's really all I wanted to add and I appreciate the opportunity to speak to you all tonight.

SENATOR ANWAR (3RD): Thank you. So, help us understand this a little bit. How does your model work and how is it going to help the citizens who are impacted under the medical debt?

MR. MIKE WATERBURY: Yeah. I mean, I think financial assistance plans and programs are in place today that should help people who can't afford to pay for care where they don't have insurance. The challenge is that they're not easy to have access and they're not uniform. They're usually buried in a hospital website through a link that leads you to a paper application.

So, we believe that one single place to go that could be promoted in a lot of different ways that gave residents a very easy way to understand if they qualify and then a very simple way to upload documents and complete the application will significantly improve the accessibility and the effectiveness of financial assistance plan.

So, that's really what we've seen across the country, if we work with hospitals, if you make it available online, you promote it and you support
people through the process, they'll apply, they'll be aware and when appropriate, they'll get approved and they won't go into medical debt.

SENATOR ANWAR (3RD): Okay. So, I think that your testimony is helpful, it tells us there's more than one way to assess and manage this situation. I think at some point it would be worthy to sit down with some stakeholders, including yourself to get a better understanding of how we can create some model that may be effective and organized.

MR. MIKE WATERBURY: Yeah. No, we'd welcome that opportunity. And I think we're doing this across the country today and feel like we could support the residents of Connecticut through just a very simple-to-use online portal that feeds into every one of the nonprofit hospitals in the State of Connecticut. So, happy to do that. And again, I applaud what the state is doing with House Bill 5320 and financial assistance is not the complete answer, we have a lot of problems but it will help lower income families and patients in the state of Connecticut avoid medical debt.

SENATOR ANWAR (3RD): Okay. Thank you so much. My Co-chair has a question.

REP. MACCARTHY VAHEY (133RD): Thank you, Mr. Waterbury. Thank you to my good Co-chair. You referenced that if this was online and promoted that more people would actually make the application and that you're doing this in other places around the country. Do you have any data that you can share with us to help make the case with the data?

MR. MIKE WATERBURY: Yeah. In our testimony, we've done a number of surveys around this. Part of the challenge ultimately is that people are unaware of financial assistance and it impacts people not only
are uninsured, but also are insured. I mean, one of the biggest trends is that it's high deductible [inaudible] where that not only the [inaudible] and old.

REP. MACCARTHY VAHEY (133RD): Mr. Waterbury, you're cutting in and out a little bit.

MR. MIKE WATERBURY: Oh, I'm sorry.

REP. MACCARTHY VAHEY (133RD): Yeah, I think we--

MR. MIKE WATERBURY: Hopefully, you'll find that information and that you asked to my testimony. We put a lot of statistics in there.

REP. MACCARTHY VAHEY (133RD): Okay, great. Thank you very much.

MR. MIKE WATERBURY: You're welcome.

SENATOR ANWAR (3RD): Thank you so much for your testimony. Seeing no other questions or comments, we will try and follow up. Thank you for your time. Next on our list is Mr. Paul Pescatello. Thank you for your patience with us and thank you for spending the afternoon and evening and now night with us.

MR. PAUL PESCATELLO: Yes. Thank you so much for this opportunity to speak before you. Thank you for your endurance. Again, Paul Pescatello, I'm senior counsel at the CBIA and I chair its Bioscience Growth Council. I'm also chair of We Work for Health Connecticut. Both groups bring together biopharma companies, merging biotech companies, research organizations and patient groups. I'll be as quick as I possibly can.

I'm here today in support of SB 175, an act concerning funds for the Rare Disease Advisory
Council. As you know, all the groups that I represent, we were very enthusiastic supporters of establishing the Rare Disease Advisory Council. In my written testimony that you have before you, we all know how important rare disease research is, how many rare diseases there are. I always say every individual rare disease is in fact rare but rare diseases are not rare depending on how you count them.

There are 5 to 7000 rare diseases. So, many of us suffer from them or in some ways are connected to somebody who does. The work of the Rare Disease Advisory Council is so important. It's there to convene patient groups and industry and research institutions.

And it also, some very practical charges like setting up a website to make what's available out there for rare disease sufferers, what resources are available out there more accessible to them. And so, to do those very practical things, it needs some money. And so, this bill solves that problem with a request for $50,000 and/or the ability to legally go raise money from other public sources or private sources. And so with that, I'd be happy to answer any questions, but I hope you will support this bill and get some funding for the Rare Disease Advisory Council.

SENATOR ANWAR (3RD): My Co-chair has a question.

REP. MCCARTHY VAHEY (133RD): Thank you. There's that squeaky mic again back with the funds. Thank you for being here. I commented to Senator Anwar that we don't have people from CBIA here very often at the Public Health Committee. And it's wonderful that you're here because this just demonstrates that there are multiple levels of impact and I appreciate
you advocating alongside us for these funds because indeed those administrative costs are real costs.

And though the Rare Disease Advisory Council has a number of just incredibly committed professionals and people who are volunteering their time being able to do these things will take that. So, I just wanted to say thank you, especially for staying all the way through, so that you could share that message with us in person. Very much appreciate it.

MR. PAUL PESCATELLO: Well, again, thank you.

SENATOR ANWAR (3RD): Thank you. I don't have anything to add except that I hope you enjoyed our life for a little while.

MR. PAUL PESCATELLO: I'm going to go to the gym to get some exercise.

SENATOR ANWAR (3RD): Can you do the exercise for us too? We've been sitting all day. The next person on our list is Ichchha Pradhan, welcome. After that, we have Dr. Audrey Merriam and then we also have Dr. Farquhar after that. Go ahead please.

MS. ICHCHHA PRADHAN: Dear Senator Anwar, Representative McCarthy Vahey and esteemed members of the Public Health Committee. My name is Ichchha Pradhan and I'm a Policy and Advocacy Specialist at Health Equity Solutions, but I'm here testifying on my own behalf as a resident of Hartford, Connecticut and not my employers today. I would like to thank you for the opportunity to testify in support of House Bill 5320, an act concerning hospital financial assistance.

During my time as an international student here, we had a spoken and implicit understanding among us
international students that if any of us ever needed medical help for whatever reason, do not call an ambulance, call me an Uber. Even though we were all required to purchase student health insurance through the university, we were wary of getting any medical help due to horror stories we had heard about others who had racked up tens of thousands in medical debt. This was due to the unpredictability of hospital costs and how even when prices are publicly available, patients often face unexpected out of pocket expenses.

After all, even among insured individuals, healthcare costs remain a significant barrier with 42% of those insured from Access Health Connecticut struggling to afford rising healthcare costs. All of this set the stage for me and other international students to start delaying or foregoing medical care. Unpaid medical bills create a great deal of anxiety for anyone and especially when you are not familiar with the medical system in a foreign country.

So, the easiest thing to do was just avoid getting medical care altogether. Not one of us were aware of hospital financial assistance programs and that we could have qualified for them. This lack of knowledge is being driven and worsened by the inaccessibility of onerous financial assistance policy and application processes as well as inadequate notification from hospitals on the availability of such assistance.

In fact, the first time I learned about hospital financial assistance was not during the very few times that I visited a hospital or doctor here, but when I engaged in health policy research at Health Equity Solutions. Had I known about hospital financial assistance, I would not have struggled to
pay my medical bills as a student or delayed care for as long as I did.

Therefore, I strongly support House Bill 5320 as it would simplify the application and screening process by creating a uniform application and setting higher standards for notification to patients of available financial assistance option. Furthermore, the IRS has not revoked any hospitals nonprofit status for noncompliance in the past decade, which means states have a crucial role to play in closing these regulatory gaps and ensuring that Connecticut residents are not forced into unnecessary medical debt.

I also urge the committee to incorporate language in the bill around one, hospitals offering a reasonable payment plan for individuals ineligible for assistance. If I can be offered payment plans to purchase a phone, laptop, jacket, then why not for something more essential and unavoidable such as a medical expense.

And two, enhance accountability, mandating hospitals to disclose race, ethnicity and language data and their financial assistance and medical debt reporting. Thank you for the opportunity to testify in support of House Bill 5320, an act concerning hospital financial assistance policies. I urge the committee to pass the bill favorably. Thank you.

SENATOR ANWAR (3RD): Ichchha.

MS. ICHCHHA PRADHAN: Yes.

SENATOR ANWAR (3RD): Dhanyavaad.

MS. ICHCHHA PRADHAN: Thank you.

SENATOR ANWAR (3RD): You did a very good job.
MS. ICHCHHA PRADHAN: Thank you.

SENATOR ANWAR (3RD): And I think this is very helpful. I'm so glad you stayed and you were very focused and succinct and this was very helpful.

MS. ICHCHHA PRADHAN: Thank you, Senator Anwar.

SENATOR ANWAR (3RD): You have a written testimony as well?

MS. ICHCHHA PRADHAN: Not personally, it's on behalf of Health Equity Solutions.

SENATOR ANWAR (3RD): Okay. So, whatever you said, if you want to send them in written format, you're welcome to do so then.

MS. ICHCHHA PRADHAN: Okay. Thank you so much.

SENATOR ANWAR (3RD): Okay.

MS. ICHCHHA PRADHAN: I will do so.

SENATOR ANWAR (3RD): All right, you stay well. Next person on our list is Dr. Audrey Merriam.

DR. AUDREY MERRIAM: Thank you, Senator Anwar, Representative McCarthy Vahey and distinguished members of the Public Health Committee. My name is Dr. Audrey Merriam and I am an Associate Professor of Maternal Fetal Medicine at the Yale School of Medicine, the Co-chair of Connecticut's Maternal Mortality Review Committee and the Chair of the Perinatal Quality and Safety Initiative for ACOG's District one.

I'm here today representing the Maternal Mortality Review Committee and ACOG to testify on House Bill
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I am opposed to this bill and here is why. First, the Maternal Mortality Committee in Connecticut has a mission to identify pregnancy associated deaths, review those deaths caused by pregnancy complications and other associated causes and identify the factors contributing to these deaths and recommend public health and clinical interventions that may reduce these deaths and improve systems of care.

The goals of the committee are to perform a multidisciplinary review of cases, determine the annual number of maternal deaths related to pregnancy, identify trends and risk factors among pregnancy related deaths, recommend improvements to care at the provider and system levels with the potential for reducing or preventing future events, prioritize findings and recommendations and recommend actionable strategies for prevention and intervention. Additionally, the Public Act that establishes committee states that our task is to review maternal deaths and make recommendations. There is nothing in our mission statement or in our charge from the state that pertains to us creating and distributing educational materials to hospitals and providers.

Secondly, the healthcare systems and physician offices already use electronic medical records with evidence-based screening tools for IPV and depression in the programming. The maternal mortality committee does not claim to know what is best for each provider in terms of screening tools and has on past occasions, stressed the importance of screening by providers for both mood disorders and IPV. The larger issues that we have seen are that despite screening, there are not adequate resources to deal with the problem and would urge the committee to focus its time and attention on
ways to increase funding for IPV and mental health resources.

Third, well, the Maternal Mortality Review Committee recognizes that IPV and mood disorders play a significant role in maternal mortality in the state. This bill does not align with any of the committee's recent recommendations about how to help curtail maternal mortality in the state. I would urge the committee to look at those recommendations and draft legislation that is in line with the recommendations our committee has taken the care and time to propose based on our review of the deaths in the state.

Finally, the Maternal Mortality Review Committee is a purely voluntary committee with no funding from the state. We dedicate our personal time to reviewing traumatic cases and make recommendations at these meetings. We do not have the manpower nor the expertise to draft and distribute screening tools and educational materials for IPV and mood disorders. We have not previously met with any state senators or representatives regarding our ability or our scope to perform the work asked of us in this bill.

In summary, well, I wholeheartedly agree that we should be doing more to screen for IPV and mood disorders and provide interventions to prevent maternal mortality related to these issues. However, this still misses the mark. We need to move beyond screening and provide resources that will impact more than just birthing persons during pregnancy in the one year postpartum.

We need more mental health care providers to see and treat these [inaudible] combination with obstetric providers. We need education for the potential perpetrators of IPV to teach healthy relationship skills and prevent IPV across all stages of life.
So, I oppose House Bill 5322 but would gladly work with any member of this committee to draft meaningful legislation in line with our committee recommendations to combat maternal mortality in Connecticut.

SENATOR ANWAR (3RD): Thank you so much for your testimony. You were just like within the exact three minute timeline and you covered all aspects. So, very helpful and I appreciate your testimony. Representative Parker has a question or comment.

REP. PARKER (101TH): Thank you, Mr. Chair. Thank you, Dr. Merriam for being here and for your work on the committee for your leadership. And it has been a long day. We heard testimony earlier from CCADV, they said that they, if I understand as a member of the committee and said that they would be happy to do the heavy lifting of developing and helping distribute. And I can just speak for experience I've had so far of folks that have been great in working behind the scenes to try to move this through. So, I'm wondering, does that seem to be your experience with them on that committee? And does that seem to be an appropriate role for them to play in this context?

DR. AUDREY MERRIAM: Well, I think if CCADV wants to take the lead, then it should be listed as CCADV's charter in this bill and not the Maternal Mortality Review committees. So, I think if they have the manpower and the staff to do that for IPV, then we will support them in that. That is in line with our recommendations. But I think that, that should be their task then and not the Maternal Mortality Review Committees.

REP. PARKER (101TH): I appreciate you sharing that. I'm no LCO attorney. I don't know that we could name a group like CCADV and statutes. So, maybe
that's why going through the Maternal Mortality Review committee is what makes most sense or has been the path we've been pursuing.

And my other quick question is, and I really appreciate you noting that there are recommendations that, I'll speak for myself, I should do a better job, paying attention to and we look forward to working with you to lift some of those up. In the meantime, if this were to move forward, do you see that there's any downside to this presuming that the lift is there from CCADV that TPH is able to get it out? Is there some negative consequence we're not seeing here?

DR. AUDREY MERRIAM: I don't think that there's a negative consequence. I just think that this is not in line with what this committee is tasked with doing. And I think that, again, there are screening tools that already exist, providers know them, hospitals know them.

The committee in the past has distributed materials electronically informing people of our work and recommending screening tools if they did not already know about them. But again, I don't think as a committee, we are not specialists in creating educational materials for providers and for hospitals and would rather than be on CCADV or other committees who do have expertise and have that manpower, as we are already all volunteering our time to review these cases and make these recommendations.

REP. PARKER (101ST): Thank you for those answers. And again, thank you so much for your work. Thanks for being with us today.

DR. AUDREY MERRIAM: Of course.
REP. PARKER (101ST): Thank you, Mr. Chair.

SENATOR ANWAR (3RD): Thank you. Seeing no other questions. It's our bandwidth issue. We do have a lot of questions, but we don't have any capacity anymore. So, we will reach out for--

DR. AUDREY MERRIAM: That's quite all right. Thank you so much, everyone.

SENATOR ANWAR (3RD): With that, we'll move to the next person on our list, which is Dr. Farquhar. Thank you, Dr. Farquhar for, your patience, and welcome.

DR. THOMAS FARQUHAR: Hi. Thank you. Sorry to be going so late. Dear Senator Anwar, Representative McCarthy Vahey, Senator Somers, Representative Klarides-Ditria, and Members of the Public Health Committee. My name is Thomas Farquhar, and I am the President of the Radiological Society of Connecticut. I know I've met and spoken to many of you previously, and thank you for your support of the CON Law directly for advanced medical imaging. I've submitted my testimony, and I know you've spoken to a number of my colleagues. So, I just kind of wanted to-- it's been a long day for me. When my number was called, I was in the middle of fluoro.

So I just wanted to clarify a few things that I've heard brought up, just to make sure that we had them straight. There was a question about, we have 300 radiologists in the State. There was a question about whether or not they were hospital-based. Yes, most of us work in hospitals, not necessarily employed by hospitals, but work there, with the other fraction of us in office settings. There was another question about a workforce shortage, and I don't know that they were talking about there is a national shortage of radiologists. But in terms of
staff, we have a tremendous workforce shortage. So for stenographers, CT techs, mammographer, x-ray techs.

I've been in the office setting where folks are leaving to go work for the hospital because they'll get better pay and benefits. And then in the hospitals, they leave to go back into an office setting because they don't want to work weekends or evenings or call. And there is definitely a workforce shortage in all of the specialized trained staff that we need to do radiology. But the main focus for our comments was about Governor's Bill No. 9, AN ACT PROMOTING HOSPITAL FINANCIAL STABILITY, particularly Section 4, which wanted to exempt CT scanners from the CON process.

Let me be clear. We're fine with apples to apples replacement of scanners. That should be a very rapid process. But what we're concerned about is adding new CT scanners without any barriers. And I know that when Dr. Gifford spoke, she said that in the last three years, they have approved all of the applications for CT scanners. But I know if she looked back four years ago, it seems like it was even longer than this, but it was the very beginning of COVID back then four years ago. I was gathering the current radiology and pulmonology literature on CT scans for COVID because there was a physician in Fairfield County who wanted to get three mobile CT scanners to scan asymptomatic patients as a test for COVID.

And if you want to read more about them, you can just Google, "Connecticut physician took advantage of pandemic," and you will hear all about the over testing that he did for these unnecessary CT scans. And that's the type of thing that we're worried about if you exempt the CON for CT scanners would be over utilization that drives up costs. So my
testimony includes a study from the Federal GAO, showing that self-referral can drive up costs in healthcare. But you'll also see a rise of for-profit out-of-State entities bringing CT scanners to the State. And that's the real type of thing that we don't want to see.

So replacing a CT scanner that a practice or a hospital already has, they're usually doing that to get better technology, which is actually good for patients. But to simply allow the Wild West where anyone can bring in a CT scanner, it's definitely going to have deleterious consequences. I just don't understand her logic that in the last three years, she hasn't declined an application. It basically means that the providers know what it takes to get a CON, and what is actually needed, and so you're not getting unnecessary requests. I don't think that that means that there's not people who would be placing unnecessary requests if there was no process for it. But I'm happy to answer any other questions if anybody had any. I do realize it's late.

SENATOR ANWAR (3RD): Thank you so much for your testimony, and thank you for clarifying a number of things, because I was having difficulty with some components, but you've helped me understand them better.

DR. THOMAS FARQUHAR: Thank you.

SENATOR ANWAR (3RD): I don't see any questions at this time, but we appreciate your testimony. And thank you for staying with us this evening.

DR. THOMAS FARQUHAR: My pleasure. Nice to see you. Take care. Good evening.

SENATOR ANWAR (3RD): And Dr. Farquhar was the last person on the list, so we do not have anybody else
to testify. So please get some rest. The ones who are at home, rest more, and the ones who have to head home, drive carefully. And we are adjourning this public hearing. Thank you.

REP. PARKER (101ST): Drive safe, Capital folks.