



General Assembly

February Session, 2012

Raised Bill No. 5321

LCO No. 1423

01423_____PH_

Referred to Committee on Public Health

Introduced by:
(PH)

**AN ACT CONCERNING THE OFFICE OF HEALTH CARE ACCESS
AND THE CERTIFICATE OF NEED PROCESS.**

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Subsection (a) of section 19a-639 of the general statutes is
2 repealed and the following is substituted in lieu thereof (*Effective*
3 *October 1, 2012*):

4 (a) In any deliberations involving a certificate of need application
5 filed pursuant to section 19a-638, the office shall take into
6 consideration and make written findings concerning each of the
7 following guidelines and principles:

8 (1) Whether the proposed project is consistent with any applicable
9 policies and standards adopted in regulations by the office;

10 (2) The relationship of the proposed project to the state-wide health
11 care facilities and services plan;

12 (3) Whether there is a clear public need for the health care facility or
13 services proposed by the applicant;

14 (4) Whether the applicant has satisfactorily demonstrated [how the
15 proposal will impact the financial strength of the health care system in
16 the state] that the proposal is financially feasible for the applicant;

17 (5) Whether the applicant has satisfactorily demonstrated how the
18 proposal will improve quality, accessibility and cost effectiveness of
19 health care delivery in the region;

20 (6) The applicant's past and proposed provision of health care
21 services to relevant patient populations and payer mix;

22 (7) Whether the applicant has satisfactorily identified the population
23 to be served by the proposed project and satisfactorily demonstrated
24 that the identified population has a need for the proposed services;

25 (8) The utilization of existing health care facilities and health care
26 services in the service area of the applicant; and

27 (9) Whether the applicant has satisfactorily demonstrated that the
28 proposed project shall not result in an unnecessary duplication of
29 existing or approved health care services or facilities.

30 Sec. 2. Subsection (d) of section 19a-639a of the 2012 supplement to
31 the general statutes is repealed and the following is substituted in lieu
32 thereof (*Effective October 1, 2012*):

33 (d) Upon determining that an application is complete, the office
34 shall provide notice of this determination to the applicant and to the
35 public in accordance with regulations adopted by the office. In
36 addition, the office shall post such notice on its web site. The date on
37 which the office posts such notice on its web site shall begin the review
38 period. Except as provided in this subsection, (1) the review period for
39 a completed application shall be ninety days from the date on which
40 the office posts such notice on its web site; and (2) the office shall issue
41 a decision on a completed application prior to the expiration of the
42 ninety-day review period. Upon request or for good cause shown, the
43 office may extend the review period for a period of time not to exceed

44 sixty days. If the review period is extended, the office shall issue a
45 decision on the completed application prior to the expiration of the
46 extended review period. If the office holds a public hearing concerning
47 a completed application in accordance with subsection (e) or (f) of this
48 section, the office shall issue a decision on the completed application
49 not later than sixty days after the date [of] the office closes the public
50 hearing.

51 Sec. 3. Section 19a-644 of the general statutes is amended by adding
52 subsection (e) as follows (*Effective October 1, 2012*):

53 (NEW) (e) Each short-term acute care general or children's hospital
54 shall report to the office with respect to operational and utilization
55 data on a quarterly basis, in such form as the office may by regulation
56 require. Reports that include such data from the prior quarter shall be
57 submitted to the office on or before: (1) January thirty-first; (2) April
58 thirtieth; (3) July thirty-first; and (4) October thirty-first.

59 Sec. 4. Subsection (a) of section 19a-649 of the 2012 supplement to
60 the general statutes is repealed and the following is substituted in lieu
61 thereof (*Effective October 1, 2012*):

62 (a) The office shall review annually the level of uncompensated care
63 provided by each hospital to the indigent. Each hospital shall file
64 annually with the office its policies regarding the provision of charity
65 care and reduced cost services to the indigent, excluding medical
66 assistance recipients, and its debt collection practices. A hospital shall
67 file its audited financial statements [by] not later than February
68 twenty-eighth of each year. [The filing shall include] Not later than
69 March thirty-first of each year, the hospital shall file a verification of
70 the hospital's net revenue for the most recently completed fiscal year in
71 a format prescribed by the office.

72 Sec. 5. Section 19a-7e of the general statutes is repealed and the
73 following is substituted in lieu thereof (*Effective October 1, 2012*):

74 The Department of Public Health, in consultation with the
75 Department of Social Services, shall establish a three-year
76 demonstration program to improve access to health care for uninsured
77 pregnant women under two hundred fifty per cent of the poverty
78 level. Services to be covered by the program shall include, but not be
79 limited to, the professional services of obstetricians, dental care
80 providers, physician assistants or midwives on the staff of the
81 sponsoring hospital and community-based providers; services of
82 pediatricians for purposes of assistance in delivery and postnatal care;
83 dietary counseling; dental care; substance abuse counseling, and other
84 ancillary services which may include substance abuse treatment and
85 mental health services, as required by the patient's condition, history
86 or circumstances; necessary pharmaceutical and other durable medical
87 equipment during the prenatal period; and postnatal care, as well as
88 preventative and primary care for children up to age six in families in
89 the eligible income level. The program shall encourage the acquisition,
90 sponsorship and extension of existing outreach activities and the
91 activities of mobile, satellite and other outreach units. The
92 Commissioner of Public Health shall issue a request for proposals to
93 Connecticut hospitals. Such request shall require: (1) An interactive
94 relationship between the hospital, community health centers,
95 community-based providers and the healthy start program; (2)
96 provisions for case management; (3) provisions for financial eligibility
97 screening, referrals and enrollment assistance where appropriate to the
98 medical assistance program, the healthy start program or private
99 insurance; and (4) provisions for a formal liaison function between
100 hospitals, community health centers and other health care providers.
101 [The Office of Health Care Access is authorized, through the hospital
102 rate setting process, to fund specific additions to fiscal years 1992 to
103 1994, inclusive, budgets for hospitals chosen for participation in the
104 program. In requesting additions to their budgets, each hospital shall
105 address specific program elements including adjustments to the
106 hospital's expense base, as well as adjustments to its revenues, in a
107 manner which will produce income sufficient to offset the adjustment

108 in expenses. The office shall insure that the network of hospital
109 providers will serve the greatest number of people, while not
110 exceeding a state-wide cost increase of three million dollars per year.]
111 Hospitals participating in the program shall report monthly to the
112 Departments of Public Health and Social Services or their designees
113 and annually to the joint standing committees of the General Assembly
114 having cognizance of matters relating to public health and human
115 services such information as the departments and the committees
116 deem necessary.

117 Sec. 6. Subsections (a) and (b) of section 19a-634 of the 2012
118 supplement to the general statutes are repealed and the following is
119 substituted in lieu thereof (*Effective October 1, 2012*):

120 (a) The Office of Health Care Access shall conduct, on [an annual] a
121 biannual basis, a state-wide health care facility utilization study. Such
122 study [shall] may include [, but not be limited to,] an assessment of: (1)
123 Current availability and utilization of acute hospital care, hospital
124 emergency care, specialty hospital care, outpatient surgical care,
125 primary care and clinic care; (2) geographic areas and subpopulations
126 that may be underserved or have reduced access to specific types of
127 health care services; and (3) other factors that the office deems
128 pertinent to health care facility utilization. Not later than June thirtieth
129 of [each] the year in which the biannual study is conducted, the
130 Commissioner of Public Health shall report, in accordance with section
131 11-4a, to the Governor and the joint standing committees of the
132 General Assembly having cognizance of matters relating to public
133 health and human services on the findings of the study. Such report
134 may also include the office's recommendations for addressing
135 identified gaps in the provision of health care services and
136 recommendations concerning a lack of access to health care services.

137 (b) The office, in consultation with such other state agencies as the
138 Commissioner of Public Health deems appropriate, shall establish and
139 maintain a state-wide health care facilities and services plan. Such plan

140 may include, but not be limited to: (1) An assessment of the availability
141 of acute hospital care, hospital emergency care, specialty hospital care,
142 outpatient surgical care, primary care and clinic care; (2) an evaluation
143 of the unmet needs of persons at risk and vulnerable populations as
144 determined by the commissioner; (3) a projection of future demand for
145 health care services and the impact that technology may have on the
146 demand, capacity or need for such services; and (4) recommendations
147 for the expansion, reduction or modification of health care facilities or
148 services. In the development of the plan, the office shall consider the
149 recommendations of any advisory bodies which may be established by
150 the commissioner. The commissioner may also incorporate the
151 recommendations of authoritative organizations whose mission is to
152 promote policies based on best practices or evidence-based research.
153 The commissioner, in consultation with hospital representatives, shall
154 develop a process that encourages hospitals to incorporate the state-
155 wide health care facilities and services plan into hospital long-range
156 planning and shall facilitate communication between appropriate state
157 agencies concerning innovations or changes that may affect future
158 health planning. The office shall update the state-wide health care
159 facilities and services plan [on or before July 1, 2012, and every five
160 years thereafter] not less than once every two years.

161 Sec. 7. Subsections (a) to (g), inclusive, of section 19a-646 of the
162 general statutes are repealed and the following is substituted in lieu
163 thereof (*Effective October 1, 2012*):

164 (a) As used in this section:

165 (1) "Office" means the Office of Health Care Access division of the
166 Department of Public Health;

167 (2) "Fiscal year" means the hospital fiscal year, as used for purposes
168 of this chapter, consisting of a twelve-month period commencing on
169 October first and ending the following September thirtieth;

170 (3) "Hospital" means any short-term acute care general or children's

171 hospital licensed by the Department of Public Health, including the
172 John Dempsey Hospital of The University of Connecticut Health
173 Center;

174 (4) "Payer" means any person, legal entity, governmental body or
175 eligible organization that meets the definition of an eligible
176 organization under 42 USC Section 1395mm (b) of the Social Security
177 Act, or any combination thereof, except for Medicare and Medicaid
178 which is or may become legally responsible, in whole or in part for the
179 payment of services rendered to or on behalf of a patient by a hospital.
180 Payer also includes any legal entity whose membership includes one
181 or more payers and any third-party payer; and

182 (5) "Prompt payment" means payment made for services to a
183 hospital by mail or other means on or before the tenth business day
184 after receipt of the bill by the payer.

185 (b) No hospital shall provide a discount or different rate or method
186 of reimbursement from the filed rates or charges to any payer except as
187 provided in this section.

188 [(c) (1) From April 1, 1994, to June 30, 2002, any payer may directly
189 negotiate for a different rate and method of reimbursement with a
190 hospital provided the charges and payments for the payer are reported
191 in accordance with this subsection. No discount agreement or
192 agreement for a different rate or method of reimbursement shall be
193 effective until filed with the office.]

194 [(2) On and after July 1, 2002, any] (c) (1) Any payer may directly
195 negotiate with a hospital for a different rate or method of
196 reimbursement, or both, provided the charges and payments for the
197 payer are on file at the hospital business office in accordance with this
198 subsection. No discount agreement or agreement for a different rate or
199 method of reimbursement, or both, shall be effective until a complete
200 written agreement between the hospital and the payer is on file at the
201 hospital. Each such agreement shall be available to the office for

202 inspection or submission to the office upon request, for at least three
203 years after the close of the applicable fiscal year.

204 [(3) On and after April 1, 1994, the] (2) The charges and payments
205 for each payer receiving a discount shall be accumulated by the
206 hospital for each payer and reported as required by the office. [The
207 office may require a review by the hospital's independent auditor, at
208 the hospital's expense, to determine compliance with this subsection.

209 (4) From October 2, 1991, to June 30, 2002, a full written copy of each
210 agreement executed pursuant to this subsection shall be filed with the
211 Office of Health Care Access by each hospital executing such an
212 agreement, no later than ten business days after such agreement is
213 executed. On and after July 1, 2002, a]

214 (3) A full written copy of each agreement executed pursuant to this
215 subsection shall be on file in the hospital business office within twenty-
216 four hours of execution. [Each agreement filed shall specify on its face
217 that it was executed and filed pursuant to this subsection. Agreements
218 filed at the Office of Health Care Access, in accordance with this
219 subsection, shall be considered trade secrets pursuant to subdivision
220 (5) of subsection (b) of section 1-210, except that the office may utilize
221 and distribute data derived from such agreements, including the
222 names of the parties to the agreement, the duration and dates of the
223 agreement and the estimated value of any discount or alternate rate of
224 payment.]

225 (d) A payer may negotiate with a hospital to obtain a discount on
226 rates or charges for prompt payment.

227 (e) A payer may also negotiate for and may receive a discount for
228 the provision of the following administrative services: (1) A system
229 which permits the hospital to bill the payer through either a computer-
230 processed or machine-readable or similar billing procedure; (2) a
231 system which enables the hospital to verify coverage of a patient by
232 the payer at the time the service is provided; and (3) a guarantee of

233 payment within the scope of the agreement between the patient and
234 the third-party payer for service to the patient prior to the provision of
235 that service.

236 (f) No hospital may require a payer to negotiate for another element
237 or any combination of the above elements of a discount, as established
238 in subsections (d) and (e) of this section, in order to negotiate for or
239 obtain a discount for any single element. No hospital may require a
240 payer to negotiate a discount for all patients covered by such payer in
241 order to negotiate a discount for any patient or group of patients
242 covered by such payer.

243 (g) Any hospital which agrees to provide a discount to a payer
244 under subsection (d) or (e) of this section shall file a copy of the
245 agreement in the hospital's business office and shall provide the same
246 discount to any other payer who agrees to make prompt payment or
247 provide administrative services similar to that contained in the
248 agreement. Each agreement filed shall specify on its face that it was
249 executed and filed pursuant to this subsection. [The office shall
250 disallow any agreement which gives a discount pursuant to the terms
251 of subsections (d) and (e) of this section which is in excess of the
252 maximum amount set forth in said subsections. No such agreement
253 shall be contingent on volume or drafted in such a manner as to limit
254 the discount to one or more payers by establishing criteria unique to
255 such payers. Any payer aggrieved under this subsection may petition
256 the office for an order directing the hospital to provide a similar
257 discount. The Department of Public Health shall adopt regulations in
258 accordance with the provisions of chapter 54 to carry out the
259 provisions of this subsection.]

260 Sec. 8. Section 19a-676 of the general statutes is repealed and the
261 following is substituted in lieu thereof (*Effective October 1, 2012*):

262 On or before March thirty-first of each year, for the preceding fiscal
263 year, each hospital shall submit to the office, in the form and manner
264 prescribed by the office, the data specified in regulations adopted by

265 the commissioner in accordance with chapter 54, the [independent
266 audit] hospital's verification of net revenue required under section 19a-
267 649, as amended by this act, and any other data required by the office,
268 including hospital budget system data for the hospital's twelve
269 months' actual filing requirements.

270 Sec. 9. Subsection (d) of section 19a-654 of the 2012 supplement to
271 the general statutes is repealed and the following is substituted in lieu
272 thereof (*Effective October 1, 2012*):

273 (d) Except as [otherwise] provided in this subsection, patient-
274 identifiable data received by the office shall be kept confidential and
275 shall not be considered public records or files subject to disclosure
276 under the Freedom of Information Act, as defined in section 1-200. The
277 office may release de-identified patient data or aggregate patient data
278 to the public in a manner consistent with the provisions of 45 CFR
279 164.514. Any de-identified patient data released by the office shall
280 exclude provider, physician and payer organization names or codes
281 and shall be kept confidential by the recipient. The office may [not]
282 release patient-identifiable data [except] (1) as provided for in section
283 19a-25 and regulations adopted pursuant to [said] section 19a-25, and
284 (2) to a municipality or state agency, as defined in section 4-230,
285 another state, or a federal agency upon receipt of a request from such
286 municipality or agency relating to such municipality's or agency's
287 oversight or investigation of a health care facility, provided, prior to
288 the release of such patient-identifiable data, such municipality or
289 agency enters into a written agreement with the office pursuant to
290 which such municipality or agency agrees to protect the confidentiality
291 of such patient-identifiable data and not to use such patient-
292 identifiable data as a basis for any decision concerning a patient. No
293 individual or entity receiving patient-identifiable data may release
294 such data in any manner that may result in an individual patient,
295 physician, provider or payer being identified. The office shall impose a
296 reasonable, cost-based fee for any patient data provided to a
297 nongovernmental entity.

298 Sec. 10. Subsection (a) of section 19a-639e of the 2012 supplement to
 299 the general statutes is repealed and the following is substituted in lieu
 300 thereof (*Effective October 1, 2012*):

301 (a) Unless otherwise required to file a certificate of need application
 302 pursuant to the provisions of subsection (a) of section 19a-638, any
 303 health care facility that proposes to terminate a service or enter into a
 304 contract for another entity to provide a service that was authorized
 305 pursuant to a certificate of need issued under this chapter shall file a
 306 modification request with the office not later than sixty days prior to
 307 the proposed date of the termination of the service. The office may
 308 request additional information from the health care facility as
 309 necessary to process the modification request. In addition, the office
 310 shall hold a public hearing on any request from a health care facility to
 311 terminate a service or enter into a contract for another entity to provide
 312 a service pursuant to this section if three or more individuals or an
 313 individual representing an entity with five or more people submits a
 314 request, in writing, that a public hearing be held on the health care
 315 facility's proposal to terminate a service or enter into a contract for
 316 another entity to provide a service.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>October 1, 2012</i>	19a-639(a)
Sec. 2	<i>October 1, 2012</i>	19a-639a(d)
Sec. 3	<i>October 1, 2012</i>	19a-644
Sec. 4	<i>October 1, 2012</i>	19a-649(a)
Sec. 5	<i>October 1, 2012</i>	19a-7e
Sec. 6	<i>October 1, 2012</i>	19a-634(a) and (b)
Sec. 7	<i>October 1, 2012</i>	19a-646(a) to (g)
Sec. 8	<i>October 1, 2012</i>	19a-676
Sec. 9	<i>October 1, 2012</i>	19a-654(d)
Sec. 10	<i>October 1, 2012</i>	19a-639e(a)

Statement of Purpose:

To make changes to various public health statutes involving the Office of Health Care Access.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]