Senate

General Assembly

File No. 697

January Session, 2015

Substitute Senate Bill No. 812

Senate, April 16, 2015

The Committee on Public Health reported through SEN. GERRATANA of the 6th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING ELECTRONIC HEALTH RECORDS AND HEALTH INFORMATION EXCHANGE.

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

Section 1. (NEW) (*Effective from passage*) All patient health records, including electronic health records, belong to the patient who is the subject of the records and shall, to the fullest extent practicable, be accessible to the patient and any authorized representative or health care provider of the patient's choice regardless of such health care provider's location or affiliation.

Sec. 2. (NEW) (*Effective from passage*) (a) For purposes of this section:

(1) "Health care provider" means any individual, corporation, facility or institution licensed by this state to provide health care services; and

(2) "Certified electronic health record system" means a health care provider's health records system that meets the criteria for certification

by the federal Office of the National Coordinator for Health Information Technology.

(b) There is established a State-wide Health Information Exchange to empower health care consumers in making decisions relating to their health care, promote patient-centered care, improve the quality, safety and value of health care, reduce waste and duplication of services and support clinical decision-making.

(c) The State-wide Health Information Exchange shall: (1) Allow real-time, secure access to patient health information across all health care provider settings; (2) provide patients with secure electronic access to their health information; (3) allow voluntary participation by patients at no cost to them; (4) meet all state and federal privacy and security requirements; and (5) support public health reporting and academic research.

(d) (1) The Commissioner of Public Health shall issue a request for proposals to eligible nonprofit organizations for the development, management and operation of the State-wide Health Information Exchange.

(2) An eligible nonprofit organization responding to the request for proposal shall: (A) Have experience in not less than one other state in operating a state-wide health information exchange as an official state-designated entity that (i) enables the seamless exchange of patient health information among health care providers, health plans and other authorized users without regard to geographic region, source of payment or technology, (ii) includes, with proper consent, behavioral health and substance abuse treatment information, (iii) supports transitions of care and care coordination through real-time health care provider alerts and access to clinical information, (iv) allows health information to follow each patient, (v) allows patients to access and manage their health data, and (vi) has demonstrated success in reducing costs associated with preventable readmissions, duplicative testing and medical errors; (B) be committed to, and demonstrate, a high level of transparency in its governance, decision-making and

operations; and (C) have sufficient staff and appropriate expertise and experience to carry out the administrative, operational and financial responsibilities of the State-wide Health Information Exchange.

(e) Such request shall require: (1) Broad local governance that (A) includes all stakeholders, including, but not limited to, hospitals, physicians, behavioral health providers, long-term care providers, health insurers, employers, patients and state officials, and (B) is committed to the successful development and implementation of the State-wide Health Information Exchange; (2) provision of a health information exchange plan that (A) builds upon existing infrastructure and is coordinated with existing programs, (B) ensures the privacy and security of patient information at all levels and, at a minimum, complies with all applicable state and federal privacy and security laws, (C) focuses on efforts to maximize utility with minimal cost and burden on stakeholders, (D) promotes the highest level of interoperability and utilization of national information technology standards, and (E) is consistent with the statewide health information technology plan developed pursuant to section 19a-25d of the general statutes; and (3) provision of a business plan that includes (A) a collaborative process engaging all stakeholders in the development of recommended funding streams sufficient to support the annual operating expenses of the State-wide Health Information Exchange, and (B) the development of services and products to support the long-term sustainability of the State-wide Health Information Exchange.

(f) (1) Not later than six months after commencement of the operation of the State-wide Health Information Exchange, each health care provider with a certified electronic health record system shall connect to, and participate in, the State-wide Health Information Exchange.

(2) Not later than three years after commencement of the operation of the State-wide Health Information Exchange, each health care provider shall maintain a certified electronic health records system and connect to, and participate in, the State-wide Health Information

Exchange.

Sec. 3. (*Effective July 1, 2015*) (a) For the purposes described in subsection (b) of this section, the State Bond Commission shall have the power from time to time to authorize the issuance of bonds of the state in one or more series and in principal amounts not exceeding in the aggregate fifty million dollars, provided fifteen million dollars of said authorization shall be effective July 1, 2016, ten million dollars of said authorization shall be effective July 1, 2017, and ten million dollars shall be effective July 1, 2018.

(b) The proceeds of the sale of such bonds, to the extent of the amount stated in subsection (a) of this section, shall be used by the Department of Public Health for the development and maintenance of the State-wide Health Information Exchange, established pursuant to section 2 of this act, including the purchase of software and related equipment.

(c) All provisions of section 3-20 of the general statutes, or the exercise of any right or power granted thereby, that are not inconsistent with the provisions of this section are hereby adopted and shall apply to all bonds authorized by the State Bond Commission pursuant to this section. Temporary notes in anticipation of the money to be derived from the sale of any such bonds so authorized may be issued in accordance with section 3-20 of the general statutes and from time to time renewed. Such bonds shall mature at such time or times not exceeding twenty years from their respective dates as may be provided in or pursuant to the resolution or resolutions of the State Bond Commission authorizing such bonds. None of such bonds shall be authorized except upon a finding by the State Bond Commission that there has been filed with it a request for such authorization that is signed by or on behalf of the Secretary of the Office of Policy and Management and states such terms and conditions as said commission, in its discretion, may require. Such bonds issued pursuant to this section shall be general obligations of the state and the full faith and credit of the state of Connecticut are pledged for the payment of the

principal of and interest on such bonds as the same become due, and accordingly and as part of the contract of the state with the holders of such bonds, appropriation of all amounts necessary for punctual payment of such principal and interest is hereby made, and the State Treasurer shall pay such principal and interest as the same become due.

Sec. 4. (NEW) (*Effective from passage*) There is established an account to be known as the "State-wide Health Information Exchange account" which shall be a separate, nonlapsing account within the General Fund. The account shall contain any moneys required by law to be deposited in the account. Moneys in the account shall be expended by the Commissioner of Public Health for the purposes of the development and maintenance of the State-wide Health Information Exchange, established pursuant to section 2 of this act.

Sec. 5. (NEW) (*Effective from passage*) (a) For the purposes of this section: (1) "Certified electronic health record system" means a health care provider's health records system that meets the criteria for certification by the federal Office of the National Coordinator for Health Information Technology, (2) "hospital" has the same meaning as provided in section 19a-490 of the general statutes, and (3) "health care provider" means any individual, corporation, facility or institution licensed by this state to provide health care services.

(b) Each hospital shall, as a condition of its license, (1) maintain a certified electronic health records system, and (2) enable bidirectional connectivity for the secure exchange of patient health records between the hospital and other licensed health care providers that maintain a certified electronic health records system that is technologically capable of accepting such records, including at least the following: (A) Laboratory and diagnostic tests; (B) radiological and other diagnostic imaging; (C) continuity of care documents; (D) discharge notifications and documents; and (E) patient care referrals.

(c) Each hospital shall implement the use of any hardware, software or other functionality or program settings existing and available within

its electronic health records system that would support the exchange of information as described in subsection (b) of this section.

(d) Except as required by federal law, no hospital shall (1) require any health care provider to pay for any hardware, software or other internal cost associated with the hospital's implementation or maintenance of the hospital's electronic health records system, or (2) charge any fee to connect to, or exchange information through, the hospital's electronic health records system.

(e) To the extent the exchange of patient health records, as described in subsection (b) of this section, requires the installation of an interface or the purchase of additional software, information technology, services or equipment, a hospital may donate such items, to the extent authorized by federal law, to a health care provider. Such health care provider may make a request for such donation in writing to the hospital. The hospital shall respond, in writing, to such request not later than thirty days after receipt of the request and submit a copy of the health care provider's request and the hospital's response to the request, not later than fifteen days after the date of such response, to the Commissioner of Public Health and the Commissioner of Consumer Protection. Any such donation shall be eligible for a tax credit equal to the actual cost to the hospital of the donated items against the tax imposed pursuant to chapter 211a of the general statutes, as provided in section 6 of this act.

(f) It shall be an unfair trade practice pursuant to section 42-110b of the general statutes for any hospital to (1) fail to take all reasonable actions necessary to comply with subsections (b) and (c) of this section or to otherwise unreasonably fail to facilitate the timely electronic exchange of patient health information, or (2) take any action in violation of subsection (d) of this section.

(g) If the Commissioner of Consumer Protection finds that a hospital has intentionally violated the provisions of this section, the commissioner shall forward such findings, to the Attorney General. The Attorney General may investigate such complaint to determine

whether any action on the part of the hospital constitutes a violation of the provisions of chapter 624 of the general statutes, to the extent such action constitutes a restraint of trade or an attempt to monopolize or otherwise result in a lessening of competition by dividing patients among health care providers, inducing patients to refuse to obtain services from certain health care providers or lessening competition among health care providers.

Sec. 6. (NEW) (*Effective July 1, 2015, and applicable to income years commencing on or after January 1, 2015*) (a) For the income years commencing January 1, 2015, and ending December 31, 2020, there shall be allowed as a credit against the tax imposed by section 12-263b of the general statutes for items donated by a hospital to a health care provider. The amount of credit allowed shall be equal to the actual cost to a hospital of items donated to a health care provider, as described in subsection (e) of section 5 of this act.

(b) The amount of credit allowed any taxpayer under this section for any income year may not exceed the amount of tax due from such taxpayer under section 12-263b of the general statutes with respect to such income year.

Sec. 7. (NEW) (*Effective from passage and applicable to taxable or income years, as appropriate, commencing on or after January 1, 2015*) (a) There shall be allowed as a credit against the tax imposed by chapter 208, 211a or 229 of the general statutes for health care providers implementing or upgrading an electronic health records system. The amount of credit allowed shall be equal to the actual cost to health care providers of the implementation of a certified electronic health records system or upgrade of an existing health records system to a certified electronic health records system. As used in this subsection, "certified electronic health records system" means a health care provider's health records system that meets the criteria for certification by the federal Office of the National Coordinator for Health Information Technology.

(b) The amount of credit allowed any taxpayer under this section for any income or taxable year, as appropriate, may not exceed the

amount of tax due from such taxpayer under chapter 208, 211a or 229 of the general statutes with respect to such income or taxable year, as appropriate.

(c) No credit shall be allowed pursuant to this section for income or taxable years, as appropriate, commencing on and after January 1, 2021.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	New section
Sec. 2	*from passage*	New section
Sec. 3	*July 1, 2015*	New section
Sec. 4	*from passage*	New section
Sec. 5	*from passage*	New section
Sec. 6	*July 1, 2015, and applicable to income years commencing on or after January 1, 2015*	New section
Sec. 7	*from passage and applicable to taxable or income years, as appropriate, commencing on or after January 1, 2015*	New section

Statement of Legislative Commissioners:
In Section 2(b), "shall be established" was changed to "is established", for conformity with statutory format; in Section 2(c), a colon was placed before "(1)" and "Allow" was capitalized, for conformity with statutory format; and in Section 5(e), "as provided in section 6 of this act" was added for clarity.

PH *Joint Favorable Subst. -LCO*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 16 $	FY 17 $
Public Health, Dept.	GF - Cost	400,020	831,428
UConn Health Ctr.	SF - Cost	See Below	See Below
Department of Revenue Services	GF - Cost	174,000	119,000
Comptroller Misc. Accounts (Fringe Benefits)[1]	GF - Cost	158,900	311,514
Treasurer, Debt Serv.	GF - Cost	None	1.5 million
Department of Revenue Services	GF - Revenue Loss	Potential Significant	Potential Significant

Note: GF=General Fund; SF=Special Fund (Non-appropriated)

Municipal Impact: None

Explanation

The bill establishes a State-wide Health Information Exchange (the Exchange) and requires the Department of Public Health (DPH) to issue a request for proposal (RFP) to eligible nonprofits for the development, management and operation of the Exchange. The bill authorizes a total of $50 million in General Obligation (GO) bonds over four years for the development and maintenance of the Exchange. The sections of the bill with fiscal impact are described below.

Section 2 requires DPH to issue an RFP to eligible nonprofits for the development, management and operation of the Exchange. The department does not currently have the staff or expertise to develop an RFP for the Exchange and provide managerial oversight of the selected

[1]The fringe benefit costs for most state employees are budgeted centrally in accounts administered by the Comptroller. The estimated active employee fringe benefit cost associated with most personnel changes is 38.65% of payroll in FY 16 and FY 17.

vendor. DPH will require an IT Project Manager Consultant to work with state agency personnel to define technical requirements across a broad portfolio of public health applications and to work with the Department of Administrative Services' Bureau of Enterprise Systems and Technology technical staff. The agency requires four positions and one durational staff attorney, effective 10/1/2015, related to the development of the RFP. An additional three positions are required in FY 17 to review data standards and integration processes developed by the vendor. The following table details the necessary positions and the DPH and State Comptroller- Fringe Benefit costs.

DPH Staffing Requirements

Personal Services - Title	**Effective**	**FY 16 $**	**FY 17 $**
Administrative Assistant	10/1/2015	45,258	65,304
Epidemiologist	10/1/2015	64,196	92,628
Accountant	10/1/2015	56,268	81,118
Grants and Contract Specialists	10/1/2015	64,673	93,317
Durational Staff Attorney (2yrs)	10/1/2015	61,728	89,067
IT Analyst 3	7/1/2016	-	96,735
IT Analyst 2	7/1/2016	-	91,242
Quality Assurance Coordinator	7/1/2016	-	77,575
TOTAL		**292,123**	**686,986**
Other Expenses			
Consultant - IT Project Manager	10/1/2015	102,970	141,412
Equipment		5,050	3,030
TOTAL		**108,020**	**144,442**
TOTAL DPH COST		**400,143**	**831,428**
State Comptroller- Fringe Benefits		**112,906**	**265,520**

Section 3 authorizes a total of $50 million in General Obligation (GO) bonds for the development and maintenance of a state-wide health information exchange. The table below summarizes the authorization schedule for the bonds between FY 16 and FY 19, and the debt service cost for each year. Assuming that the initial $15.0 million is allocated through the State Bond Commission during FY 16 and the

Office of the State Treasurer issues the bonds before the end of FY 16, the debt service cost in FY 17 will be $1.5 million.

New GO Bond Authorizations and Estimated Debt Service Cost (in millions)

Fiscal Year	Authorization Amount $	Total Debt Service Cost[1] $	Interest $	Principal $
2016	15.0	22.9	7.9	15.0
2017	15.0	22.9	7.9	15.0
2018	10.0	15.3	5.3	10.0
2019	10.0	15.3	5.3	10.0
TOTAL	**50.0**	**76.4**	**26.4**	**50.0**

[1]Figures assume that bonds are issued at 5.0% over a 20 year term.

Section 4 establishes a separate nonlapsing "State-wide Health Information Exchange account" to be used by DPH for the development and maintenance of the Exchange. However, it should be noted that the bill does not specify a funding source for the account so it is unclear how DPH will support the costs detailed in Section 3.

Section 5 will result in significant increased costs for the John Dempsey Hospital (JDH) at the University of Connecticut Health Center (UCHC). First, the bill requires, as a condition of licensure, hospitals to maintain a certified electronic health record (EHR) system. UCHC has recently explored the purchase of such a system for JDH. Based on a request-for-information from that process, the one-time cost to purchase and fully implement a new EHR system would be approximately $85 million.

Second, the bill requires hospitals to enable bidirectional connectivity between themselves and other providers with EHR systems. In addition to the costs to purchase an EHR system with this capability, noted above, it is estimated that at least four additional information technology positions will be necessary to develop, test and maintain the interoperability of the system with the various providers. These positions would have annual salary and fringe benefit costs of approximately $550,000.

Third, the bill prohibits hospitals from requiring providers to pay for items related to the hospital's EHR system or charging fees to access the system. It also allows hospitals to donate items necessary to interface with the new EHR system. The impact of these requirements is uncertain, as it is unknown what additional costs providers might incur to connect with the new system nor what JDH's ultimate responsibility to pay for these costs is under the language of the bill.

Section 6 results in a potential revenue loss by allowing a tax credit for hospitals that donate equipment to providers. The actual revenue loss will vary based upon the value of the donation and the number of hospitals providing donations.

For illustrative purposes, the initial start-up cost for hardware per provider at a small practice can range from $12,500 to $23,500. Ongoing costs related to hardware replacements can be up to $3,000.[2]

Section 7 results in a potentially significant revenue loss by authorizing tax credits for health care providers implementing and upgrading EHR systems. The credit may be taken against the corporate business tax, hospital tax, or the income tax. The actual revenue loss will depend upon the number of health care providers that implement or upgrade an EHR system.

For illustrative purposes, the total initial costs per provider at a small practice for all components of a system (e.g. software installation, hardware, and training) can range from $44,000 to $63,000.[3]

As mentioned above, the one-time cost to purchase and fully implement a new EHR system at John Dempsey Hospital would be approximately $85 million.

As an illustration of a large EHR system, the Yale-New Haven

[2] "The Value of Electronic Records in Solo or Small Group Practices," *Health Affairs* – Volume 24, Number 5, September 2005.
[3] "The Value of Electronic Records in Solo or Small Group Practices," *Health Affairs* – Volume 24, Number 5, September 2005.

Hospital System, which includes Bridgeport Hospital, Greenwich Hospital, Yale-New Haven Hospital, Northeast Medical Group, Yale Medical Group, and various community physicians, initiated an EHR system at a cost of $290 million.[4]

Department of Revenue Services Costs

To administer the tax credits established under the bill, the Department of Revenue Services (DRS) would require one Tax Correction Examiner ($55,000 for salary and $21,258 for fringe) and one Revenue Examiner ($64,000 for salary and $24,736 for fringe costs) for initial review and on-going compliance, resulting in a total annualized cost of $164,994.

The DRS would also incur a one-time cost of approximately $55,000 to administer the new tax credits, including changes to the online Taxpayer Service Center, form alteration, printing costs, and programming changes to the Department's Integrated Tax Administration System.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation, except as identified as durational. The General Fund debt service impact identified above would continue over the 20 year term of issuance for the bonds.

[4] Yale New Haven Health 2013 Annual Report

OLR Bill Analysis

sSB 812

AN ACT CONCERNING ELECTRONIC HEALTH RECORDS AND HEALTH INFORMATION EXCHANGE.

SUMMARY:

This bill establishes a statewide health information exchange to, among other things, allow real-time, secure access to patient health information across all provider settings. The bill requires the public health (DPH) commissioner to issue a request for proposals (RFP) for nonprofit organizations to develop and operate the exchange. It specifies eligibility criteria for these organizations and required features of the exchange. It authorizes up to $50 million in bonding over four years for DPH to develop and maintain the exchange. It also establishes a nonlapsing General Fund account to be used for the exchange.

The bill sets deadlines for all licensed health care providers in the state to (1) connect to the exchange and (2) maintain electronic health record (EHR) systems that meet federal certification standards.

Among other things, the bill also:

1. requires hospitals, as a condition of licensure, to (a) maintain a certified EHR system and (b) enable bidirectional connectivity for the exchange of patient records with other providers;

2. generally restricts hospitals from charging fees to a provider to connect to their EHR systems;

3. provides a tax credit for hospitals who donate EHR-related equipment to providers;

4. provides a tax credit for providers implementing or upgrading

their EHR systems to meet federal certification standards; and

5. specifies that all patient health records (electronic or otherwise) belong to the patient, and to the fullest extent practicable must be accessible to the patient and any authorized representatives or providers the patient chooses, regardless of the provider's location or affiliation (§ 1).

EFFECTIVE DATE: Upon passage, except the (1) provider tax credit is effective upon passage and applies to taxable or income years beginning on or after January 1, 2015; (2) hospital tax credit is effective July 1, 2015 and applies to income years beginning on or after January 1, 2015; and (3) bonding authorization is effective July 1, 2015.

§§ 2 - 4 – STATEWIDE HEALTH INFORMATION EXCHANGE

The bill establishes a Statewide Health Information Exchange. Its purposes include (1) empowering consumers to make health care decisions; (2) promoting patient-centered care; (3) improving health care quality, safety and value; (4) reducing waste and duplication of services; and (5) supporting clinical decision-making.

The exchange must:

1. allow real-time, secure access to patient health information across all provider settings;

2. provide patients with secure electronic access to their health information, and allow voluntary patient participation free of charge;

3. meet all state and federal privacy and security requirements; and

4. support public health reporting and academic research.

§ 2 – RFP

The bill requires the DPH commissioner to issue an RFP to eligible nonprofit organizations to develop, manage, and operate the exchange.

To be eligible, a nonprofit organization must have experience operating a similar exchange in at least one other state as the official state-designated entity to do so. That other exchange must:

1. enable the seamless exchange of patient health information among providers, health plans, and other authorized users regardless of geographic region, payment source, or technology;

2. include behavioral health and substance abuse treatment information, with proper consent;

3. support transitions of care and care coordination through real-time provider alerts and access to clinical information;

4. allow health information to follow each patient and patients to access and manage their health data; and

5. have successfully reduced costs associated with preventable readmissions, duplicative testing, and medical errors.

To be eligible, an organization also must (1) have a high level of transparency in its governance, decision-making, and operations and (2) have enough staff and appropriate expertise and experience to carry out the exchange's administrative, operational, and financial responsibilities.

The RFP must require broad local governance committed to the exchange's successful development and implementation. That governance must include all stakeholders, including hospitals, physicians, behavioral health providers, long-term care providers, health insurers, employers, patients, and state officials.

The RFP must require the organization to complete a health information exchange plan and business plan. The health information exchange plan must:

1. build upon existing infrastructure and coordinate with existing programs,

2. ensure patient information privacy and security at all levels and at least comply with all applicable state and federal privacy and security laws,

3. focus on maximizing utility with minimal cost and burden on stakeholders,

4. promote the highest level of interoperability and use of national information technology standards, and

5. be consistent with the existing statewide health information technology plan (see BACKGROUND).

The business plan must include a collaborative process that engages all stakeholders in developing recommended funding streams to support the exchange's annual operating expenses. It also must include the development of services and products to support the exchange's long-term sustainability.

§ 2 – Required Provider Participation

Under the bill, within six months after the exchange's launch, each health care provider with a certified EHR system must connect to and participate in the exchange. The bill defines a certified EHR system as one that meets the criteria for certification by the federal Office of the National Coordinator for Health Information Technology.

Within three years after the exchange's launch, each provider must (1) maintain a certified EHR system and (2) connect to and participate in the exchange.

(See section 5 for specific requirements for hospitals to maintain certified EHR systems.)

§ 3 – Bonding Authorization

The bill authorizes up to $50 million in general obligation bonding for DPH to develop and maintain the exchange, including the purchase of software and related equipment. The authorization is for up to $15 million per year in FYs 16 and 17 and up to $10 million per

year the next two years.

§ 4 – Separate General Fund Account

The bill establishes the Statewide Health Information Exchange Account as a separate, nonlapsing General Fund account. DPH must use the account's funds to develop and maintain the exchange. The account must contain any funds the law requires to be deposited in it. (The bill does not specify a funding source for the account.)

§ 5 – HOSPITAL EHR SYSTEMS

The bill requires all hospitals, as a condition of licensure, to maintain a certified EHR system.

It also requires them, as a condition of licensure, to enable bidirectional connectivity for the secure exchange of patient health records between the hospital and other licensed providers with certified EHR systems that can accept these records, including laboratory and diagnostic tests, radiological and other diagnostic imaging, continuity of care documents, discharge notifications and documents, and patient care referrals. Hospitals must use any hardware, software, or other functionality or program settings existing and available within their EHR systems that would support this information exchange.

Under the bill, it is an unfair trade practice (see BACKGROUND) for a hospital to fail to take all reasonable actions needed to comply with these provisions or to otherwise unreasonably fail to facilitate the timely electronic exchange of patient health information.

The bill prohibits hospitals, unless required by federal law, from:

1. requiring providers to pay for any hardware, software, or other internal cost associated with the hospital's implementation or maintenance of its EHR system or

2. charging fees to connect to or exchange information through that system.

A violation is an unfair trade practice.

Equipment Donation

Under the bill, to the extent the exchange of patient health records between hospitals and providers, as described above, requires providers to install an interface or purchase additional software, information technology, services, or equipment, hospitals may donate these items to providers. They may do so only as allowed by federal law. (Federal regulations specify circumstances under which hospitals may donate certain EHR equipment to physicians without violating self-referral and anti-kickback laws.)

The bill allows providers to make written requests to hospitals for these donations. It requires the hospital to respond in writing within 30 days. Within 15 days after responding, the hospital must submit the request and its response to the DPH and consumer protection (DCP) commissioners.

The bill also authorizes a tax credit for hospitals that make these donations (see below).

Antitrust Enforcement

Under the bill, if the DCP commissioner finds that a hospital has intentionally violated these provisions, he must forward his findings to the attorney general. The attorney general may investigate the complaint to determine whether the hospital violated the antitrust laws, to the extent the hospital's action constitutes a restraint of trade or an attempt to monopolize or otherwise reduces competition by dividing patients among providers, inducing patients to refuse to obtain services from certain providers, or reducing competition among providers.

§ 6 – HOSPITAL EQUIPMENT DONATION TAX CREDIT

The bill authorizes a tax credit for hospitals that donate EHR equipment to providers as specified above. The credit is against the tax on hospital net patient revenue ("hospital tax"). The credit is equal to the hospital's actual costs for the donated items, up to the amount of

the hospital's tax liability for that year. The credit sunsets on January 1, 2021.

§ 7 – PROVIDER TAX CREDIT

The bill also authorizes tax credits for health care providers implementing or upgrading EHR systems. The credit is against the corporate business tax, hospital tax, or income tax.

The credit is for the provider's actual cost to implement a certified EHR system or upgrade an existing health records system to a certified system, up to the amount of the provider's liability under the applicable tax for that year. The credit sunsets on January 1, 2021.

BACKGROUND

Statewide Health Information Technology Plan

By law, the statewide health information technology plan must include (1) general standards and protocols for health information exchange, (2) electronic data standards to facilitate the development of a statewide, integrated electronic health information system for state-funded providers and institutions, and (3) pilot programs for health information exchange and the projected costs and sources of funding for these programs (CGS § 19a-25d).

PA 14-217 transferred to the social services commissioner the responsibility to implement and periodically revise the plan. He must do so in consultation with the DPH and mental health and addiction services commissioners.

Previously, this responsibility was vested in the Health Information Technology Exchange of Connecticut (HITE-CT), which the act eliminated. HITE-CT was a quasi-public agency that was also responsible for, among other things, developing a statewide health information exchange.

Connecticut Unfair Trade Practices Act (CUTPA)

This law prohibits businesses from engaging in unfair and deceptive acts or practices. CUTPA allows the DCP commissioner to issue

regulations defining unfair trade practices, investigate complaints, issue cease and desist orders, order restitution in cases involving less than $5,000, enter into consent agreements, ask the attorney general to seek injunctive relief, and accept voluntary statements of compliance. It also allows individuals to sue. Courts may issue restraining orders; award actual and punitive damages, costs, and reasonable attorney's fees; and impose civil penalties of up to $5,000 for willful violations and $25,000 for violation of a restraining order.

COMMITTEE ACTION

Public Health Committee

Joint Favorable
Yea 25 Nay 0 (03/30/2015)