General Assembly

Raised Bill No. 5290

February Session, 2018

LCO No. **1386**

Referred to Committee on PUBLIC HEALTH

Introduced by:
(PH)

AN ACT CONCERNING THE OFFICE OF HEALTH STRATEGY.

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

1 Section 1. Section 19a-754a of the 2018 supplement to the general
2 statutes is repealed and the following is substituted in lieu thereof
3 (*Effective from passage*):

4 (a) There is established an Office of Health Strategy, which shall be
5 within the Department of Public Health for administrative purposes
6 only. The department head of said office shall be the executive director
7 of the Office of Health Strategy, who shall be appointed by the
8 Governor in accordance with the provisions of sections 4-5 to 4-8,
9 inclusive, as amended by this act, with the powers and duties therein
10 prescribed.

11 (b) **[**On or before July 1, 2018, the**]** The Office of Health Strategy
12 shall be responsible for the following:

13 (1) Developing and implementing a comprehensive and cohesive

14 health care vision for the state, including, but not limited to, a
15 coordinated state health care cost containment strategy;

16 (2) Promoting effective health planning and the provision of quality
17 health care in the state in a manner that ensures access for all state
18 residents to cost-effective health care services, avoids the duplication
19 of such services and improves the availability and financial stability of
20 such services throughout the state;

21 **[**(2)**]** (3) Directing and overseeing **[**(A) the all-payers claims database
22 program established pursuant to section 19a-755a, and (B)**]** the State
23 Innovation Model Initiative and related successor initiatives;

24 **[**(3)**]** (4) (A) Coordinating the state's health information technology
25 initiatives, (B) seeking funding for and overseeing the planning,
26 implementation and development of policies and procedures for the
27 administration of the all-payer claims database program established
28 under section 19a-775a, as amended by this act, (C) establishing and
29 maintaining a consumer health information Internet web site under
30 19a-755b, as amended by this act, and (D) designating an unclassified
31 individual from the office to perform the duties of a health information
32 technology officer as set forth in sections 17b-59f and 17b-59g, as
33 amended by this act;

34 **[**(4)**]** (5) Directing and overseeing the **[**Office of Health Care Access**]**
35 Health Systems Planning Unit established under section 19a-612, as
36 amended by this act, and all of its duties and responsibilities as set
37 forth in chapter 368z; and

38 **[**(5)**]** (6) Convening forums and meetings with state government and
39 external stakeholders, including, but not limited to, the Connecticut
40 Health Insurance Exchange, to discuss health care issues designed to
41 develop effective health care cost and quality strategies.

42 (c) The Office of Health Strategy shall constitute a successor, in
43 accordance with the provisions of sections 4-38d, 4-38e and 4-39, to the
44 functions, powers and duties of the following:

45 (1) The Connecticut Health Insurance Exchange, established
46 pursuant to section 38a-1081, relating to the administration of the all-
47 payer claims database pursuant to section 19a-755a, as amended by
48 this act; and

49 (2) The Office of the Lieutenant Governor, relating to the (A)
50 development of a chronic disease plan pursuant to section 19a-6q, as
51 amended by this act, (B) housing, chairing and staffing of the Health
52 Care Cabinet pursuant to section 19a-725, as amended by this act, and
53 (C) (i) appointment of the health information technology officer,
54 [pursuant to section 19a-755,] and (ii) oversight of the duties of such
55 health information technology officer as set forth in sections [17b-59,
56 17b-59a and] 17b-59f, as amended by this act, and 17b-59g, as amended
57 by this act.

58 (d) Any order or regulation of the entities listed in subdivisions (1)
59 and (2) of subsection (c) of this section that is in force on July 1, 2018,
60 shall continue in force and effect as an order or regulation until
61 amended, repealed or superseded pursuant to law.

62 Sec. 2. Section 4-5 of the 2018 supplement to the general statutes is
63 repealed and the following is substituted in lieu thereof (*Effective from*
64 *passage*):

65 As used in sections 4-6, 4-7 and 4-8, the term "department head"
66 means Secretary of the Office of Policy and Management,
67 Commissioner of Administrative Services, Commissioner of Revenue
68 Services, Banking Commissioner, Commissioner of Children and
69 Families, Commissioner of Consumer Protection, Commissioner of
70 Correction, Commissioner of Economic and Community Development,
71 State Board of Education, Commissioner of Emergency Services and
72 Public Protection, Commissioner of Energy and Environmental
73 Protection, Commissioner of Agriculture, Commissioner of Public
74 Health, Insurance Commissioner, Labor Commissioner, Commissioner
75 of Mental Health and Addiction Services, Commissioner of Social
76 Services, Commissioner of Developmental Services, Commissioner of

77 Motor Vehicles, Commissioner of Transportation, Commissioner of
78 Veterans Affairs, Commissioner of Housing, Commissioner of
79 Rehabilitation Services, the Commissioner of Early Childhood, [and]
80 the executive director of the Office of Military Affairs and the
81 executive director of the Office of Health Strategy. As used in sections
82 4-6 and 4-7, "department head" also means the Commissioner of
83 Education.

84 Sec. 3. Section 4-5 of the 2018 supplement to the general statutes, as
85 amended by section 6 of public act 17-237 and section 279 of public act
86 17-2 of the June special session, is repealed and the following is
87 substituted in lieu thereof (*Effective July 1, 2019*):

88 As used in sections 4-6, 4-7 and 4-8, the term "department head"
89 means Secretary of the Office of Policy and Management,
90 Commissioner of Administrative Services, Commissioner of Revenue
91 Services, Banking Commissioner, Commissioner of Children and
92 Families, Commissioner of Consumer Protection, Commissioner of
93 Correction, Commissioner of Economic and Community Development,
94 State Board of Education, Commissioner of Emergency Services and
95 Public Protection, Commissioner of Energy and Environmental
96 Protection, Commissioner of Agriculture, Commissioner of Public
97 Health, Insurance Commissioner, Labor Commissioner, Commissioner
98 of Mental Health and Addiction Services, Commissioner of Social
99 Services, Commissioner of Developmental Services, Commissioner of
100 Motor Vehicles, Commissioner of Transportation, Commissioner of
101 Veterans Affairs, Commissioner of Housing, Commissioner of
102 Rehabilitation Services, the Commissioner of Early Childhood, the
103 executive director of the Office of Military Affairs, [and] the executive
104 director of the Technical Education and Career System and the
105 executive director of the Office of Health Strategy. As used in sections
106 4-6 and 4-7, "department head" also means the Commissioner of
107 Education.

108 Sec. 4. Section 19a-755a of the 2018 supplement to the general
109 statutes is repealed and the following is substituted in lieu thereof

110 (*Effective from passage*):

111 (a) As used in this section:

112 (1) "All-payer claims database" means a database that receives and
113 stores data from a reporting entity relating to medical insurance
114 claims, dental insurance claims, pharmacy claims and other insurance
115 claims information from enrollment and eligibility files.

116 (2) (A) "Reporting entity" means:

117 (i) An insurer, as described in section 38a-1, licensed to do health
118 insurance business in this state;

119 (ii) A health care center, as defined in section 38a-175;

120 (iii) An insurer or health care center that provides coverage under
121 Part C or Part D of Title XVIII of the Social Security Act, as amended
122 from time to time, to residents of this state;

123 (iv) A third-party administrator, as defined in section 38a-720;

124 (v) A pharmacy benefits manager, as defined in section 38a-479aaa;

125 (vi) A hospital service corporation, as defined in section 38a-199;

126 (vii) A nonprofit medical service corporation, as defined in section
127 38a-214;

128 (viii) A fraternal benefit society, as described in section 38a-595, that
129 transacts health insurance business in this state;

130 (ix) A dental plan organization, as defined in section 38a-577;

131 (x) A preferred provider network, as defined in section 38a-479aa;
132 and

133 (xi) Any other person that administers health care claims and
134 payments pursuant to a contract or agreement or is required by statute
135 to administer such claims and payments.

136 (B) "Reporting entity" does not include an employee welfare benefit
137 plan, as defined in the federal Employee Retirement Income Security
138 Act of 1974, as amended from time to time, that is also a trust
139 established pursuant to collective bargaining subject to the federal
140 Labor Management Relations Act.

141 (3) "Medicaid data" means the Medicaid provider registry, health
142 claims data and Medicaid recipient data maintained by the
143 Department of Social Services.

144 (b) (1) There is established an all-payer claims database program.
145 The **[**Health Information Technology Officer, designated under section
146 19a-755,**]** Office of Health Strategy shall: (A) Oversee the planning,
147 implementation and administration of the all-payer claims database
148 program for the purpose of collecting, assessing and reporting health
149 care information relating to safety, quality, cost-effectiveness, access
150 and efficiency for all levels of health care; (B) ensure that data received
151 is securely collected, compiled and stored in accordance with state and
152 federal law; **[**and**]** (C) conduct audits of data submitted by reporting
153 entities in order to verify its accuracy; and (D) in consultation with the
154 Health Information Technology Advisory Council established under
155 section 17b-59f, as amended by this act, maintain written procedures
156 for the administration of such all-payer claims database. Any such
157 written procedures shall include (i) reporting requirements for
158 reporting entities, and (ii) requirements for providing notice to a
159 reporting entity regarding any alleged failure on the part of such
160 reporting entity to comply with such reporting requirements.

161 (2) The **[**Health Information Technology Officer**]** executive director
162 of the Office of Health Strategy shall seek funding from the federal
163 government, other public sources and other private sources to cover
164 costs associated with the planning, implementation and administration
165 of the all-payer claims database program.

166 (3) (A) Upon the adoption of reporting requirements as set forth in
167 subsection (b) of **[**section 19a-755**]** this section, a reporting entity shall

168 report health care information for inclusion in the all-payer claims
169 database in a form and manner prescribed by the [Health Information
170 Technology Officer] executive director of the Office of Health Strategy.
171 The [Health Information Technology Officer] executive director may,
172 after notice and hearing, impose a civil penalty on any reporting entity
173 that fails to report health care information as prescribed. Such civil
174 penalty shall not exceed one thousand dollars per day for each day of
175 violation and shall not be imposed as a cost for the purpose of rate
176 determination or reimbursement by a third-party payer.

177 (B) The [Health Information Technology Officer] executive director
178 of the Office of Health Strategy may provide the name of any reporting
179 entity on which such penalty has been imposed to the Insurance
180 Commissioner. After consultation with said [officer] executive director,
181 the commissioner may request the Attorney General to bring an action
182 in the superior court for the judicial district of Hartford to recover any
183 penalty imposed pursuant to subparagraph (A) of this subdivision.

184 (4) The Commissioner of Social Services shall submit Medicaid data
185 to the [Health Information Technology Officer] executive director of
186 the Office of Health Strategy for inclusion in the all-payer claims
187 database only for purposes related to administration of the State
188 Medicaid Plan, in accordance with 42 CFR 431.301 to 42 CFR 431.306,
189 inclusive.

190 (5) The [Health Information Technology Officer] executive director
191 of the Office of Health Strategy shall: (A) Utilize data in the all-payer
192 claims database to provide health care consumers in the state with
193 information concerning the cost and quality of health care services for
194 the purpose of allowing such consumers to make economically sound
195 and medically appropriate health care decisions; and (B) make data in
196 the all-payer claims database available to any state agency, insurer,
197 employer, health care provider, consumer of health care services or
198 researcher for the purpose of allowing such person or entity to review
199 such data as it relates to health care utilization, costs or quality of
200 health care services. If health information, as defined in 45 CFR

201 160.103, as amended from time to time, is permitted to be disclosed
202 under the Health Insurance Portability and Accountability Act of 1996,
203 P.L. 104-191, as amended from time to time, or regulations adopted
204 thereunder, any disclosure thereof made pursuant to this subdivision
205 shall have identifiers removed, as set forth in 45 CFR 164.514, as
206 amended from time to time. Any disclosure made pursuant to this
207 subdivision of information other than health information shall be
208 made in a manner to protect the confidentiality of such other
209 information as required by state and federal law. The **[**Health
210 Information Technology Officer**]** <u>executive director of the Office of</u>
211 <u>Health Strategy</u> may set a fee to be charged to each person or entity
212 requesting access to data stored in the all-payer claims database.

213 (6) The **[**Health Information Technology Officer**]** <u>executive director</u>
214 <u>of the Office of Health Strategy</u> may (A) in consultation with the All-
215 Payer Claims Database Advisory Group set forth in section 17b-59f, <u>as</u>
216 <u>amended by this act,</u> enter into a contract with a person or entity to
217 plan, implement or administer the all-payer claims database program,
218 (B) enter into a contract or take any action that is necessary to obtain
219 data that is the same data required to be submitted by reporting
220 entities under Medicare Part A or Part B, (C) enter into a contract for
221 the collection, management or analysis of data received from reporting
222 entities, and (D) in accordance with subdivision (4) of this subsection,
223 enter into a contract or take any action that is necessary to obtain
224 Medicaid data. Any such contract for the collection, management or
225 analysis of such data shall expressly prohibit the disclosure of such
226 data for purposes other than the purposes described in this subsection.

227 <u>(c) Unless otherwise specified, nothing in this section and no action</u>
228 <u>taken by the executive director of the Office of Health Strategy</u>
229 <u>pursuant to this section or section 19a-755b, as amended by this act,</u>
230 <u>shall be construed to preempt, supersede or affect the authority of the</u>
231 <u>Insurance Commissioner to regulate the business of insurance in the</u>
232 <u>state.</u>

233 Sec. 5. Section 19a-755b of the 2018 supplement to the general

234 statutes is repealed and the following is substituted in lieu thereof
235 (*Effective from passage*):

236 (a) For purposes of this section and sections 19a-904a, 19a-904b and
237 38a-477d to 38a-477f, inclusive:

238 (1) "Allowed amount" means the maximum reimbursement dollar
239 amount that an insured's health insurance policy allows for a specific
240 procedure or service;

241 (2) "Consumer health information Internet web site" means an
242 Internet web site developed and operated by the **[**Health Information
243 Technology Officer**]** Office of Health Strategy to assist consumers in
244 making informed decisions concerning their health care and informed
245 choices among health care providers;

246 (3) "Episode of care" means all health care services related to the
247 treatment of a condition or a service category for such treatment and,
248 for acute conditions, includes health care services and treatment
249 provided from the onset of the condition to its resolution or a service
250 category for such treatment and, for chronic conditions, includes
251 health care services and treatment provided over a given period of
252 time or a service category for such treatment;

253 (4) "Executive director" means the executive director of the Office of
254 Health Strategy;

255 **[**(4)**]** (5) "Health care provider" means any individual, corporation,
256 facility or institution licensed by this state to provide health care
257 services;

258 **[**(5)**]** (6) "Health carrier" means any insurer, health care center,
259 hospital service corporation, medical service corporation, fraternal
260 benefit society or other entity delivering, issuing for delivery,
261 renewing, amending or continuing any individual or group health
262 insurance policy in this state providing coverage of the type specified
263 in subdivisions (1), (2), (4), (11) and (12) of section 38a-469;

264 [(6) "Health Information Technology Officer" means the individual
265 designated pursuant to section 19a-755;]

266 (7) "Hospital" has the same meaning as provided in section 19a-490;

267 (8) "Out-of-pocket costs" means costs that are not reimbursed by a
268 health insurance policy and includes deductibles, coinsurance and
269 copayments for covered services and other costs to the consumer
270 associated with a procedure or service;

271 (9) "Outpatient surgical facility" has the same meaning as provided
272 in section 19a-493b, as amended by this act; and

273 (10) "Public or private third party" means the state, the federal
274 government, employers, a health carrier, third-party administrator, as
275 defined in section 38a-720, or managed care organization.

276 (b) (1) Within available resources, the consumer health information
277 Internet web site shall: (A) Contain information comparing the quality,
278 price and cost of health care services, including, to the extent
279 practicable, (i) comparative price and cost information for the health
280 care services and procedures reported pursuant to subsection (c) of
281 this section categorized by payer or listed by health care provider, (ii)
282 links to Internet web sites and consumer tools where consumers may
283 obtain comparative cost and quality information, including The Joint
284 Commission and Medicare hospital compare tool, (iii) definitions of
285 common health insurance and medical terms so consumers may
286 compare health coverage and understand the terms of their coverage,
287 and (iv) factors consumers should consider when choosing an
288 insurance product or provider group, including provider network,
289 premium, cost sharing, covered services and tier information; (B) be
290 designed to assist consumers and institutional purchasers in making
291 informed decisions regarding their health care and informed choices
292 among health care providers and, to the extent practicable, provide
293 reference pricing for services paid by various health carriers to health
294 care providers; (C) present information in language and a format that
295 is understandable to the average consumer; and (D) be publicized to

296 the general public. All information outlined in this section shall be
297 posted on an Internet web site established, or to be established, by the
298 [Health Information Technology Officer] executive director of the
299 Office of Health Strategy in a manner and time frame as may be
300 organizationally and financially reasonable in his or her sole
301 discretion.

302 (2) Information collected, stored and published by the exchange
303 pursuant to this section is subject to the federal Health Insurance
304 Portability and Accountability Act of 1996, P.L. 104-191, as amended
305 from time to time.

306 (3) The [Health Information Technology Officer] executive director
307 of the Office of Health Strategy may consider adding quality measures
308 to the consumer health information Internet web site. [as
309 recommended by the State Innovation Model Initiative program
310 management office.]

311 (c) Not later than January 1, 2018, and annually thereafter, the
312 [Health Information Technology Officer] executive director of the
313 Office of Health Strategy shall, to the extent the information is
314 available, make available to the public on the consumer health
315 information Internet web site a list of: (1) The fifty most frequently
316 occurring inpatient services or procedures in the state; (2) the fifty
317 most frequently provided outpatient services or procedures in the
318 state; (3) the twenty-five most frequent surgical services or procedures
319 in the state; (4) the twenty-five most frequent imaging services or
320 procedures in the state; and (5) the twenty-five most frequently used
321 pharmaceutical products and medical devices in the state. Such lists
322 may (A) be expanded to include additional admissions and
323 procedures, (B) be based upon those services and procedures that are
324 most commonly performed by volume or that represent the greatest
325 percentage of related health care expenditures, or (C) be designed to
326 include those services and procedures most likely to result in out-of-
327 pocket costs to consumers or include bundled episodes of care.

328 (d) Not later than January 1, 2018, and annually thereafter, to the
329 extent practicable, the **[**Health Information Technology Officer**]**
330 executive director of the Office of Health Strategy shall issue a report,
331 in a manner to be decided by the **[**officer**]** executive director, that
332 includes the (1) billed and allowed amounts paid to health care
333 providers in each health carrier's network for each service and
334 procedure service included pursuant to subsection (c) of this section,
335 and (2) out-of-pocket costs for each such service and procedure.

336 (e) (1) On and after January 1, 2018, each hospital shall, at the time
337 of scheduling a service or procedure for nonemergency care that is
338 included in the report prepared by the **[**Health Information
339 Technology Officer**]** executive director of the Office of Health Strategy
340 pursuant to subsection (c) of this section, regardless of the location or
341 setting where such services are delivered, notify the patient of the
342 patient's right to make a request for cost and quality information.
343 Upon the request of a patient for a diagnosis or procedure included in
344 such report, the hospital shall, not later than three business days after
345 scheduling such service or procedure, provide written notice,
346 electronically or by mail, to the patient who is the subject of the service
347 or procedure concerning: (A) If the patient is uninsured, the amount to
348 be charged for the service or procedure if all charges are paid in full
349 without a public or private third party paying any portion of the
350 charges, including the amount of any facility fee, or, if the hospital is
351 not able to provide a specific amount due to an inability to predict the
352 specific treatment or diagnostic code, the estimated maximum allowed
353 amount or charge for the service or procedure, including the amount
354 of any facility fee; (B) the corresponding Medicare reimbursement
355 amount or, if there is no corresponding Medicare reimbursement
356 amount for such diagnosis or procedure, (i) the approximate amount
357 Medicare would have paid the hospital for the services on the billing
358 statement, or (ii) the percentage of the hospital's charges that Medicare
359 would have paid the hospital for the services; (C) if the patient is
360 insured, the allowed amount, the toll-free telephone number and the
361 Internet web site address of the patient's health carrier where the

362 patient can obtain information concerning charges and out-of-pocket
363 costs; (D) The Joint Commission's composite accountability rating and
364 the Medicare hospital compare star rating for the hospital, as
365 applicable; and (E) the Internet web site addresses for The Joint
366 Commission and the Medicare hospital compare tool where the patient
367 may obtain information concerning the hospital.

368 (2) If the patient is insured and the hospital is out-of-network under
369 the patient's health insurance policy, such written notice shall include
370 a statement that the service or procedure will likely be deemed out-of-
371 network and that any out-of-network applicable rates under such
372 policy may apply.

373 Sec. 6. Subsection (a) of section 38a-477e of the 2018 supplement to
374 the general statutes is repealed and the following is substituted in lieu
375 thereof (*Effective from passage*):

376 (a) On and after January 1, 2017, each health carrier, as defined in
377 section 19a-755b, as amended by this act, shall maintain an Internet
378 web site and toll-free telephone number that enables consumers to
379 request and obtain: (1) Information on in-network costs for inpatient
380 admissions, health care procedures and services, including (A) the
381 allowed amount for, at a minimum, admissions and procedures
382 reported to the **[**exchange**]** executive director of the Office of Health
383 Strategy pursuant to section 19a-755b, as amended by this act, for each
384 health care provider in the state; (B) the estimated out-of-pocket costs
385 that a consumer would be responsible for paying for any such
386 admission or procedure that is medically necessary, including any
387 facility fee, coinsurance, copayment, deductible or other out-of-pocket
388 expense; and (C) data or other information concerning (i) quality
389 measures for the health care provider, (ii) patient satisfaction, to the
390 extent such information is available, (iii) a directory of participating
391 providers, as defined in section 38a-472f, in accordance with the
392 provisions of section 38a-477h; and (2) information on out-of-network
393 costs for inpatient admissions, health care procedures and services.

394 Sec. 7. Section 17b-59a of the general statutes is repealed and the
395 following is substituted in lieu thereof (*Effective from passage*):

396 (a) As used in this section:

397 (1) "Electronic health information system" means an information
398 processing system, involving both computer hardware and software
399 that deals with the storage, retrieval, sharing and use of health care
400 information, data and knowledge for communication and decision
401 making, and includes: (A) An electronic health record that provides
402 access in real time to a patient's complete medical record; (B) a
403 personal health record through which an individual, and anyone
404 authorized by such individual, can maintain and manage such
405 individual's health information; (C) computerized order entry
406 technology that permits a health care provider to order diagnostic and
407 treatment services, including prescription drugs electronically; (D)
408 electronic alerts and reminders to health care providers to improve
409 compliance with best practices, promote regular screenings and other
410 preventive practices, and facilitate diagnoses and treatments; (E) error
411 notification procedures that generate a warning if an order is entered
412 that is likely to lead to a significant adverse outcome for a patient; and
413 (F) tools to allow for the collection, analysis and reporting of data on
414 adverse events, near misses, the quality and efficiency of care, patient
415 satisfaction and other healthcare-related performance measures.

416 (2) "Interoperability" means the ability of two or more systems or
417 components to exchange information and to use the information that
418 has been exchanged and includes: (A) The capacity to physically
419 connect to a network for the purpose of exchanging data with other
420 users; and (B) the capacity of a connected user to access, transmit,
421 receive and exchange usable information with other users.

422 (3) "Standard electronic format" means a format using open
423 electronic standards that: (A) Enable health information technology to
424 be used for the collection of clinically specific data; (B) promote the
425 interoperability of health care information across health care settings,

426 including reporting to local, state and federal agencies; and (C)
427 facilitate clinical decision support.

428 (b) The Commissioner of Social Services, in consultation with the
429 [Health Information Technology Officer] executive director of the
430 Office of Health Strategy, established under section 19a-754a, as
431 amended by this act, shall (1) develop, throughout the Departments of
432 Developmental Services, Public Health, Correction, Children and
433 Families, Veterans Affairs and Mental Health and Addiction Services,
434 uniform management information, uniform statistical information,
435 uniform terminology for similar facilities, uniform electronic health
436 information technology standards and uniform regulations for the
437 licensing of human services facilities, (2) plan for increased
438 participation of the private sector in the delivery of human services, (3)
439 provide direction and coordination to federally funded programs in
440 the human services agencies and recommend uniform system
441 improvements and reallocation of physical resources and designation
442 of a single responsibility across human services agencies lines to
443 facilitate shared services and eliminate duplication.

444 (c) The [Health Information Technology Officer, designated in
445 accordance with section 19a-755,] executive director of the Office of
446 Health Strategy shall, in consultation with the Commissioner of Social
447 Services and the Health Information Technology Advisory Council,
448 established pursuant to section 17b-59f, as amended by this act,
449 implement and periodically revise the state-wide health information
450 technology plan established pursuant to this section and shall establish
451 electronic data standards to facilitate the development of integrated
452 electronic health information systems for use by health care providers
453 and institutions that receive state funding. Such electronic data
454 standards shall: (1) Include provisions relating to security, privacy,
455 data content, structures and format, vocabulary and transmission
456 protocols; (2) limit the use and dissemination of an individual's Social
457 Security number and require the encryption of any Social Security
458 number provided by an individual; (3) require privacy standards no
459 less stringent than the "Standards for Privacy of Individually

460 Identifiable Health Information" established under the Health
461 Insurance Portability and Accountability Act of 1996, P.L. 104-191, as
462 amended from time to time, and contained in 45 CFR 160, 164; (4)
463 require that individually identifiable health information be secure and
464 that access to such information be traceable by an electronic audit trail;
465 (5) be compatible with any national data standards in order to allow
466 for interstate interoperability; (6) permit the collection of health
467 information in a standard electronic format; and (7) be compatible with
468 the requirements for an electronic health information system.

469 (d) The [Health Information Technology Officer] executive director
470 of the Office of Health Strategy shall, within existing resources and in
471 consultation with the State Health Information Technology Advisory
472 Council: (1) Oversee the development and implementation of the State-
473 wide Health Information Exchange in conformance with section 17b-
474 59d, as amended by this act; (2) coordinate the state's health
475 information technology and health information exchange efforts to
476 ensure consistent and collaborative cross-agency planning and
477 implementation; and (3) serve as the state liaison to, and work
478 collaboratively with, the State-wide Health Information Exchange
479 established pursuant to section 17b-59d, as amended by this act, to
480 ensure consistency between the state-wide health information
481 technology plan and the State-wide Health Information Exchange and
482 to support the state's health information technology and exchange
483 goals.

484 (e) The state-wide health information technology plan, implemented
485 and periodically revised pursuant to subsection (c) of this section, shall
486 enhance interoperability to support optimal health outcomes and
487 include, but not be limited to (1) general standards and protocols for
488 health information exchange, and (2) national data standards to
489 support secure data exchange data standards to facilitate the
490 development of a state-wide, integrated electronic health information
491 system for use by health care providers and institutions that are
492 licensed by the state. Such electronic data standards shall (A) include
493 provisions relating to security, privacy, data content, structures and

494 format, vocabulary and transmission protocols, (B) be compatible with
495 any national data standards in order to allow for interstate
496 interoperability, (C) permit the collection of health information in a
497 standard electronic format, and (D) be compatible with the
498 requirements for an electronic health information system.

499 (f) Not later than February 1, 2017, and annually thereafter, the
500 [Health Information Technology Officer] executive director of the
501 Office of Health Strategy, in consultation with the State Health
502 Information Technology Advisory Council, shall report in accordance
503 with the provisions of section 11-4a to the joint standing committees of
504 the General Assembly having cognizance of matters relating to human
505 services and public health concerning: (1) The development and
506 implementation of the state-wide health information technology plan
507 and data standards, established and implemented by the [Health
508 Information Technology Officer] executive director of the Office of
509 Health Strategy pursuant to this section; (2) the establishment of the
510 State-wide Health Information Exchange; and (3) recommendations for
511 policy, regulatory and legislative changes and other initiatives to
512 promote the state's health information technology and exchange goals.

513 Sec. 8. Section 17b-59c of the general statutes is repealed and the
514 following is substituted in lieu thereof (*Effective from passage*):

515 (a) Matters of policy related to subsection (b) of section 17b-59a, as
516 amended by this act, involving more than one of the agencies
517 designated in [section 17b-59a] said subsection shall be presented to
518 the Commissioner of Social Services for his or her approval prior to
519 implementation.

520 (b) Matters of program development related to subsection (b) of
521 section 17b-59a, as amended by this act, involving more than one of the
522 agencies designated in [section 17b-59a] said subsection, as amended
523 by this act, shall be presented to the commissioner for his or her
524 approval prior to implementation.

525 (c) Any plan of any agency designated in subsection (b) of section

526 17b-59a<u>, as amended by this act,</u> for the future use or development of
527 property or other resources <u>for the purposes of said subsection, as</u>
528 <u>amended by this act,</u> shall be submitted to the commissioner for his or
529 her approval prior to implementation.

530 **[**(d) Any plan of any agency designated in section 17b-59a for
531 revision of the health information technology plan shall be submitted
532 to the commissioner for his or her approval prior to implementation. If
533 such approval requires funding, after the commissioner has granted
534 approval, the commissioner shall submit such revisions to the
535 Secretary of the Office of Policy and Management.

536 (e) On or before January 1, 2015, and annually thereafter, the
537 commissioner shall submit, in accordance with the provisions of
538 section 11-4a, the state-wide health information technology plan, as
539 revised in accordance with section 17b-59a, to the joint standing
540 committees of the General Assembly having cognizance of matters
541 relating to human services, public health and appropriations and the
542 budgets of state agencies.**]**

543 Sec. 9. Subdivision (1) of subsection (d) of section 17b-59d of the
544 2018 supplement to the general statutes is repealed and the following
545 is substituted in lieu thereof (*Effective from passage*):

546 (d) (1) The **[**Health Information Technology Officer, designated in
547 accordance with section 19a-755**]** <u>executive director of the Office of</u>
548 <u>Health Strategy</u>, in consultation with the Secretary of the Office of
549 Policy and Management and the State Health Information Technology
550 Advisory Council, established pursuant to section 17b-59f, <u>as amended</u>
551 <u>by this act,</u> shall, upon the approval by the State Bond Commission of
552 bond funds authorized by the General Assembly for the purposes of
553 establishing a State-wide Health Information Exchange, develop and
554 issue a request for proposals for the development, management and
555 operation of the State-wide Health Information Exchange. Such
556 request shall promote the reuse of any and all enterprise health
557 information technology assets, such as the existing Provider Directory,

558 Enterprise Master Person Index, Direct Secure Messaging Health
559 Information Service provider infrastructure, analytic capabilities and
560 tools that exist in the state or are in the process of being deployed. Any
561 enterprise health information exchange technology assets purchased
562 after June 2, 2016, and prior to the implementation of the State-wide
563 Health Information Exchange shall be capable of interoperability with
564 a State-wide Health Information Exchange.

565 Sec. 10. Subsection (f) of section 17b-59d of the 2018 supplement to
566 the general statutes is repealed and the following is substituted in lieu
567 thereof (*Effective from passage*):

568 (f) The **[**Health Information Technology Officer**]** executive director
569 of the Office of Health Strategy shall have administrative authority
570 over the State-wide Health Information Exchange. The **[**Health
571 Information Technology Officer**]** executive director shall be
572 responsible for designating, and posting on its Internet web site, the
573 list of systems, technologies, entities and programs that shall constitute
574 the State-wide Health Information Exchange. Systems, technologies,
575 entities, and programs that have not been so designated shall not be
576 considered part of said exchange.

577 Sec. 11. Section 17b-59f of the 2018 supplement to the general
578 statutes is repealed and the following is substituted in lieu thereof
579 (*Effective from passage*):

580 (a) There shall be a State Health Information Technology Advisory
581 Council to advise the **[**Health Information Technology Officer**]**
582 executive director of the Office of Health Strategy and the health
583 information technology officer, designated in accordance with section
584 **[**19a-755**]** 19a-754a, as amended by this act, in developing priorities
585 and policy recommendations for advancing the state's health
586 information technology and health information exchange efforts and
587 goals and to advise the **[**Health Information Technology Officer**]**
588 executive director and officer in the development and implementation
589 of the state-wide health information technology plan and standards

590 and the State-wide Health Information Exchange, established pursuant
591 to section 17b-59d, as amended by this act. The advisory council shall
592 also advise the [Health Information Technology Officer] executive
593 director and officer regarding the development of appropriate
594 governance, oversight and accountability measures to ensure success
595 in achieving the state's health information technology and exchange
596 goals.

597 (b) The council shall consist of the following members:

598 (1) [The Health Information Technology Officer, appointed in
599 accordance with section 19a-755, or the Health Information
600 Technology Officer's designee] One member appointed by the
601 executive director of the Office of Health Strategy, who shall be an
602 expert in state health care reform initiatives;

603 (2) The health information technology officer, designated in
604 accordance with section 19a-754a, as amended by this act, or the health
605 information technology officer's designee;

606 [(2)] (3) The Commissioners of Social Services, Mental Health and
607 Addiction Services, Children and Families, Correction, Public Health
608 and Developmental Services, or the commissioners' designees;

609 [(3)] (4) The Chief Information Officer of the state, or the Chief
610 Information Officer's designee;

611 [(4)] (5) The chief executive officer of the Connecticut Health
612 Insurance Exchange, or the chief executive officer's designee;

613 [(5) The director of the state innovation model initiative program
614 management office, or the director's designee;]

615 (6) The chief information officer of The University of Connecticut
616 Health Center, or [said] the chief information officer's designee;

617 (7) The Healthcare Advocate, or the Healthcare Advocate's
618 designee;

619 (8) The Comptroller, or the Comptroller's designee;

620 (9) Five members appointed by the Governor, one each [of whom]
621 who shall be (A) a representative of a health system that includes more
622 than one hospital, (B) a representative of the health insurance industry,
623 (C) an expert in health information technology, (D) a health care
624 consumer or consumer advocate, and (E) a current or former employee
625 or trustee of a plan established pursuant to subdivision (5) of
626 subsection (c) of 29 USC 186;

627 (10) Three members appointed by the president pro tempore of the
628 Senate, one each who shall be (A) a representative of a federally
629 qualified health center, (B) a provider of behavioral health services,
630 and (C) a [representative of the Connecticut State Medical Society]
631 physician licensed under chapter 370;

632 (11) Three members appointed by the speaker of the House of
633 Representatives, one each who shall be (A) a technology expert who
634 represents a hospital system, as defined in section 19a-486i, as
635 amended by this act, (B) a provider of home health care services, and
636 (C) a health care consumer or a health care consumer advocate;

637 (12) One member appointed by the majority leader of the Senate,
638 who shall be a representative of an independent community hospital;

639 (13) One member appointed by the majority leader of the House of
640 Representatives, who shall be a physician who provides services in a
641 multispecialty group and who is not employed by a hospital;

642 (14) One member appointed by the minority leader of the Senate,
643 who shall be a primary care physician who provides services in a small
644 independent practice;

645 (15) One member appointed by the minority leader of the House of
646 Representatives, who shall be an expert in health care analytics and
647 quality analysis;

648 (16) The president pro tempore of the Senate, or the president's

649 designee;

650 (17) The speaker of the House of Representatives, or the speaker's
651 designee;

652 (18) The minority leader of the Senate, or the minority leader's
653 designee; and

654 (19) The minority leader of the House of Representatives, or the
655 minority leader's designee.

656 (c) Any member appointed or designated under subdivisions (10) to
657 (19), inclusive, of subsection (b) of this section may be a member of the
658 General Assembly.

659 (d) (1) The **[**Health Information Technology Officer, appointed in
660 accordance with section 19a-755**]** health information technology officer,
661 designated in accordance with section 19a-754a, as amended by this
662 act, shall serve as a chairperson of the council. The council shall elect a
663 second chairperson from among its members, who shall not be a state
664 official. The chairpersons of the council may establish subcommittees
665 and working groups and may appoint individuals other than members
666 of the council to serve as members of the subcommittees or working
667 groups. The terms of the members shall be coterminous with the terms
668 of the appointing authority for each member and subject to the
669 provisions of section 4-1a. If any vacancy occurs on the council, the
670 appointing authority having the power to make the appointment
671 under the provisions of this section shall appoint a person in
672 accordance with the provisions of this section. A majority of the
673 members of the council shall constitute a quorum. Members of the
674 council shall serve without compensation, but shall be reimbursed for
675 all reasonable expenses incurred in the performance of their duties.

676 (2) The chairpersons of the council may appoint up to four
677 additional members to the council, who shall serve at the pleasure of
678 the chairpersons.

(e) (1) The council shall establish a working group to be known as the All-Payer Claims Database Advisory Group. Said group shall include, but need not be limited to, (A) the Secretary of the Office of Policy and Management, the Comptroller, the Commissioners of Public Health, Social Services and Mental Health and Addiction Services, the Insurance Commissioner, the Healthcare Advocate and the Chief Information Officer, or their designees; (B) a representative of the Connecticut State Medical Society; and (C) representatives of health insurance companies, health insurance purchasers, hospitals, consumer advocates and health care providers. The [Health Information Technology Officer] health information technology officer may appoint additional members to said group.

(2) The All-Payer Claims Database Advisory Group shall develop a plan to implement a state-wide multipayer data initiative to enhance the state's use of heath care data from multiple sources to increase efficiency, enhance outcomes and improve the understanding of health care expenditures in the public and private sectors.

(f) Prior to submitting any application, proposal, planning document or other request seeking federal grants, matching funds or other federal support for health information technology or health information exchange, the [Health Information Technology Officer] executive director of the Office of Health Strategy or the Commissioner of Social Services shall present such application, proposal, document or other request to the council for review and comment.

Sec. 12. Section 17b-59g of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The state, acting by and through the Secretary of the Office of Policy and Management, in collaboration with the [Health Information Technology Officer designated under section 19a-755, and the Lieutenant Governor] executive director of the Office of Health Strategy, shall establish a program to expedite the development of the

711 State-wide Health Information Exchange, established under section
712 17b-59d, as amended by this act, to assist the state, health care
713 providers, insurance carriers, physicians and all stakeholders in
714 empowering consumers to make effective health care decisions,
715 promote patient-centered care, improve the quality, safety and value of
716 health care, reduce waste and duplication of services, support clinical
717 decision-making, keep confidential health information secure and
718 make progress toward the state's public health goals. The purposes of
719 the program shall be to (1) assist the State-wide Health Information
720 Exchange in establishing and maintaining itself as a neutral and
721 trusted entity that serves the public good for the benefit of all
722 Connecticut residents, including, but not limited to, Connecticut health
723 care consumers and Connecticut health care providers and carriers, (2)
724 perform, on behalf of the state, the role of intermediary between public
725 and private stakeholders and customers of the State-wide Health
726 Information Exchange, and (3) fulfill the responsibilities of the Office
727 of Health Strategy, as described in section 19a-754a, as amended by
728 this act.

729 (b) The [Health Information Technology Officer] executive director
730 of the Office of Health Strategy, in consultation with the health
731 information technology officer, designated in accordance with section
732 19a-754, as amended by this act, shall design, and the Secretary of the
733 Office of Policy and Management, in collaboration with said [officer]
734 executive director, may establish or incorporate an entity to implement
735 the program established under subsection (a) of this section. Such
736 entity shall, without limitation, be owned and governed, in whole or in
737 part, by a party or parties other than the state and may be organized as
738 a nonprofit entity.

739 (c) Any entity established or incorporated pursuant to subsection (b)
740 of this section shall have its powers vested in and exercised by a board
741 of directors. The board of directors shall be comprised of the following
742 members who shall each serve for a term of two years:

743 (1) One member who shall have expertise as an advocate for

744 consumers of health care, appointed by the Governor;

745 (2) One member who shall have expertise as a clinical medical
746 doctor, appointed by the president pro tempore of the Senate;

747 (3) One member who shall have expertise in the area of hospital
748 administration, appointed by the speaker of the House of
749 Representatives;

750 (4) One member who shall have expertise in the area of corporate
751 law or finance, appointed by the minority leader of the Senate;

752 (5) One member who shall have expertise in group health insurance
753 coverage, appointed by the minority leader of the House of
754 Representatives;

755 (6) The Chief Information Officer **[**,**]** and the Secretary of the Office
756 of Policy and Management, **[**and the Health Information Technology
757 Officer,**]** or their designees, who shall serve as ex-officio, voting
758 members of the board; and

759 (7) The **[**Health Information Technology Officer, or his or her
760 designee**]** health information technology officer, designated in
761 accordance with section 19a-754a, as amended by this act, who shall
762 serve as chairperson of the board.

763 (d) **[**All initial appointments shall be made not later than February 1,
764 2018.**]** Any vacancy shall be filled by the appointing authority for the
765 balance of the unexpired term. If an appointing authority fails to make
766 an initial appointment on or before sixty days after the establishment
767 of such entity, or to fill a vacancy in an appointment on or before sixty
768 days after the date of such vacancy, the Governor shall make such
769 appointment or fill such vacancy.

770 (e) **[**The**]** Any entity established or incorporated under subsection
771 **[**(c)**]** (b) of this section may (1) employ a staff and fix their duties,
772 qualifications and compensation; (2) solicit, receive and accept aid or
773 contributions, including money, property, labor and other things of

774 value from any source; (3) receive, and manage on behalf of the state,
775 funding from the federal government, other public sources or private
776 sources to cover costs associated with the planning, implementation
777 and administration of the State-wide Health Information Exchange; (4)
778 collect and remit fees set by the Health Information Technology Officer
779 charged to persons or entities for access to or interaction with said
780 exchange; (5) retain outside consultants and technical experts; (6)
781 maintain an office in the state at such place or places as such entity
782 may designate; (7) procure insurance against loss in connection with
783 such entity's property and other assets in such amounts and from such
784 insurers as such entity deems desirable; (8) sue and be sued and plead
785 and be impleaded; (9) borrow money for the purpose of obtaining
786 working capital; and (10) subject to the powers, purposes and
787 restrictions of sections 17b-59a, as amended by this act, 17b-59d, as
788 amended by this act, 17b-59f, as amended by this act, **[**and 19a-755,**]** do
789 all acts and things necessary and convenient to carry out the purposes
790 of this section and section 19a-754a, as amended by this act.

791 Sec. 13. Subsection (b) of section 2-124a of the 2018 supplement to
792 the general statutes is repealed and the following is substituted in lieu
793 thereof (*Effective from passage*):

794 (b) Appointments to the working group pursuant to subsection (a)
795 of this section shall include, but need not be limited to, the **[**Health
796 Information Technology Officer, designated in accordance with section
797 19a-755**]** executive director of the Office of Health Strategy, or such
798 executive director's designee, and representatives from the insurance
799 industry, the health care industry, the Connecticut Education Network,
800 broadband Internet service providers, the Connecticut Technology
801 Council, the bioscience industry and public or private universities and
802 research institutions. The working group shall also include the
803 Consumer Counsel, or the Consumer Counsel's designee. All
804 appointments to the working group shall be made not later than thirty
805 days after June 30, 2017. Any member of the working group
806 established pursuant to this section may be a member of the working
807 group established pursuant to special act 16-20 or a member of the

808 General Assembly or the Commission on Economic Competitiveness.

809 Sec. 14. Section 19a-612 of the general statutes is repealed and the
810 following is substituted in lieu thereof (*Effective from passage*):

811 (a) There is established, within the **[**Department of Public Health, a
812 division**]** Office of Health Strategy, established under section 19a-754a,
813 as amended by this act, a unit to be known as the **[**Office of Health
814 Care Access**]** Health Systems Planning Unit. The **[**division**]** unit, under
815 the direction of the **[**Commissioner of Public Health**]** executive director
816 of the Office of Health Strategy, shall constitute a successor to the
817 former Office of Health Care Access, in accordance with the provisions
818 of sections 4-38d and 4-39.

819 (b) Any order, decision, agreed settlement **[**,**]** or regulation of the
820 former Office of Health Care Access which is in force on **[**October 6,
821 2009**]** July 1, 2018, shall continue in force and effect as an order or
822 regulation of the **[**Department of Public Health**]** Office of Health
823 Strategy until amended, repealed or superseded pursuant to law.

824 (c) If the words "Office of Health Care Access" are used or referred
825 to in any public or special act of 2009 or in any section of the general
826 statutes which is amended in 2009, such words shall be deemed to
827 mean or refer to the Office of Health Care Access division within the
828 Department of Public Health. If the words "Office of Health Care
829 Access" are used or referred to in any public or special act of 2018 or in
830 any section of the general statutes which is amended in 2018, such
831 words shall be deemed to mean or refer to the Health Systems
832 Planning Unit within the Office of Health Strategy.

833 Sec. 15. Section 19a-612d of the general statutes is repealed and the
834 following is substituted in lieu thereof (*Effective from passage*):

835 (a) **[**Notwithstanding any provision of the general statutes, there
836 shall be a Deputy Commissioner of Public Health who**]** The executive
837 director of the Office of Health Strategy shall oversee the **[**Office of
838 Health Care Access division of the Department of Public Health and

839 who] Health Systems Planning Unit and shall exercise independent
840 decision-making authority over all certificate of need decisions.

841 (b) Notwithstanding the provisions of subsection (a) of this section,
842 the Deputy Commissioner of Public Health shall retain independent
843 decision-making authority over only the certificate of need
844 applications that are pending before the Office of Health Care Access
845 and have been deemed completed by said office on or before the
846 effective date of this section. Following the issuance by the Deputy
847 Commissioner of Public Health of a final decision on any such
848 certificate of need application, the executive director of the Office of
849 Health Strategy shall exercise independent authority on any further
850 action required on such certificate of need application or the certificate
851 of need issued pursuant to such application.

852 Sec. 16. Section 19a-613 of the general statutes is repealed and the
853 following is substituted in lieu thereof (*Effective from passage*):

854 (a) The [Office of Health Care Access] Health Systems Planning Unit
855 may employ the most effective and practical means necessary to fulfill
856 the purposes of this chapter, which may include, but need not be
857 limited to:

858 (1) Collecting patient-level outpatient data from health care facilities
859 or institutions, as defined in section 19a-630, as amended by this act;

860 (2) Establishing a cooperative data collection effort, across public
861 and private sectors, to assure that adequate health care personnel
862 demographics are readily available; and

863 (3) Performing the duties and functions as enumerated in subsection
864 (b) of this section.

865 (b) The [office] unit shall: (1) Authorize and oversee the collection of
866 data required to carry out the provisions of this chapter; (2) oversee
867 and coordinate health system planning for the state; (3) monitor health
868 care costs; and (4) implement and oversee health care reform as

869 enacted by the General Assembly.

870 (c) The [Commissioner of Public Health] executive director of the
871 Office of Health Strategy, or any person the [commissioner] executive
872 director designates, may conduct a hearing and render a final decision
873 in any case when a hearing is required or authorized under the
874 provisions of any statute dealing with the [Office of Health Care
875 Access] Health Systems Planning Unit.

876 Sec. 17. Section 19a-614 of the general statutes is repealed and the
877 following is substituted in lieu thereof (*Effective from passage*):

878 [(a)] The [Commissioner of Public Health] executive director of the
879 Office of Health Strategy may employ and pay professional and
880 support staff subject to the provisions of chapter 67 and contract with
881 and engage consultants and other independent professionals as may
882 be necessary or desirable to carry out the functions of the [office]
883 Health Systems Planning Unit.

884 [(b) The commissioner may establish a consumer education unit
885 within the office to provide information to residents of the state
886 concerning the availability of public and private health care coverage.]

887 Sec. 18. Section 19a-630 of the general statutes is repealed and the
888 following is substituted in lieu thereof (*Effective from passage*):

889 As used in this chapter, unless the context otherwise requires:

890 (1) "Affiliate" means a person, entity or organization controlling,
891 controlled by or under common control with another person, entity or
892 organization. Affiliate does not include a medical foundation
893 organized under chapter 594b.

894 (2) "Applicant" means any person or health care facility that applies
895 for a certificate of need pursuant to section 19a-639a, as amended by
896 this act.

897 (3) "Bed capacity" means the total number of inpatient beds in a

898 facility licensed by the Department of Public Health under sections
899 19a-490 to 19a-503, inclusive.

900 (4) "Capital expenditure" means an expenditure that under
901 generally accepted accounting principles consistently applied is not
902 properly chargeable as an expense of operation or maintenance and
903 includes acquisition by purchase, transfer, lease or comparable
904 arrangement, or through donation, if the expenditure would have been
905 considered a capital expenditure had the acquisition been by purchase.

906 (5) "Certificate of need" means a certificate issued by the **[**office**]**
907 unit.

908 (6) "Days" means calendar days.

909 **[**(7) "Deputy commissioner" means the deputy commissioner of
910 Public Health who oversees the Office of Health Care Access division
911 of the Department of Public Health.

912 (8) "Commissioner" means the Commissioner of Public Health.**]**

913 (7) "Executive director" means the executive director of the Office of
914 Health Strategy.

915 **[**(9)**]** (8) "Free clinic" means a private, nonprofit community-based
916 organization that provides medical, dental, pharmaceutical or mental
917 health services at reduced cost or no cost to low-income, uninsured
918 and underinsured individuals.

919 **[**(10)**]** (9) "Large group practice" means eight or more full-time
920 equivalent physicians, legally organized in a partnership, professional
921 corporation, limited liability company formed to render professional
922 services, medical foundation, not-for-profit corporation, faculty
923 practice plan or other similar entity (A) in which each physician who is
924 a member of the group provides substantially the full range of services
925 that the physician routinely provides, including, but not limited to,
926 medical care, consultation, diagnosis or treatment, through the joint
927 use of shared office space, facilities, equipment or personnel; (B) for

928 which substantially all of the services of the physicians who are
929 members of the group are provided through the group and are billed
930 in the name of the group practice and amounts so received are treated
931 as receipts of the group; or (C) in which the overhead expenses of, and
932 the income from, the group are distributed in accordance with
933 methods previously determined by members of the group. An entity
934 that otherwise meets the definition of group practice under this section
935 shall be considered a group practice although its shareholders,
936 partners or owners of the group practice include single-physician
937 professional corporations, limited liability companies formed to render
938 professional services or other entities in which beneficial owners are
939 individual physicians.

940 **[**(11)**]** (10) "Health care facility" means (A) hospitals licensed by the
941 Department of Public Health under chapter 368v; (B) specialty
942 hospitals; (C) freestanding emergency departments; (D) outpatient
943 surgical facilities, as defined in section 19a-493b, as amended by this
944 act, and licensed under chapter 368v; (E) a hospital or other facility or
945 institution operated by the state that provides services that are eligible
946 for reimbursement under Title XVIII or XIX of the federal Social
947 Security Act, 42 USC 301, as amended; (F) a central service facility; (G)
948 mental health facilities; (H) substance abuse treatment facilities; and (I)
949 any other facility requiring certificate of need review pursuant to
950 subsection (a) of section 19a-638, as amended by this act. "Health care
951 facility" includes any parent company, subsidiary, affiliate or joint
952 venture, or any combination thereof, of any such facility.

953 **[**(12)**]** (11) "Nonhospital based" means located at a site other than the
954 main campus of the hospital.

955 **[**(13)**]** (12) "Office" means the Office of Health **[**Care Access division
956 within the Department of Public Health**]** Strategy.

957 **[**(14)**]** (13) "Person" means any individual, partnership, corporation,
958 limited liability company, association, governmental subdivision,
959 agency or public or private organization of any character, but does not

960 include the agency conducting the proceeding.

961 [(15)] (14) "Physician" has the same meaning as provided in section
962 20-13a.

963 [(16)] (15) "Transfer of ownership" means a transfer that impacts or
964 changes the governance or controlling body of a health care facility,
965 institution or large group practice, including, but not limited to, all
966 affiliations, mergers or any sale or transfer of net assets of a health care
967 facility.

968 (16) "Unit" means the Health Systems Planning Unit.

969 Sec. 19. Subsection (b) of section 19a-631 of the general statutes is
970 repealed and the following is substituted in lieu thereof (*Effective from*
971 *passage*):

972 (b) Each hospital shall annually pay to the [Commissioner of Public
973 Health] executive director of the Office of Health Strategy, for deposit
974 in the General Fund, an amount equal to its share of the actual
975 expenditures made by the [office] unit during each fiscal year
976 including the cost of fringe benefits for [office] unit personnel as
977 estimated by the Comptroller, the amount of expenses for central state
978 services attributable to the [office] unit for the fiscal year as estimated
979 by the Comptroller, plus the expenditures made on behalf of the
980 [office] unit from the Capital Equipment Purchase Fund pursuant to
981 section 4a-9 for such year. Payments shall be made by assessment of all
982 hospitals of the costs calculated and collected in accordance with the
983 provisions of this section and section 19a-632, as amended by this act.
984 If for any reason a hospital ceases operation, any unpaid assessment
985 for the operations of the [office] unit shall be reapportioned among the
986 remaining hospitals to be paid in addition to any other assessment.

987 Sec. 20. Section 19a-632 of the general statutes is repealed and the
988 following is substituted in lieu thereof (*Effective from passage*):

989 (a) On or before September first, annually, the [Office of Health Care

990 Access] Health Systems Planning Unit shall determine (1) the total net
991 revenue of each hospital for the most recently completed hospital fiscal
992 year beginning October first; and (2) the proposed assessment on the
993 hospital for the state fiscal year. The assessment on each hospital shall
994 be calculated by multiplying the hospital's percentage share of the total
995 net revenue specified in subdivision (1) of this subsection times the
996 costs of the [office] unit, as determined in subsection (b) of this section.

997 (b) The costs of the [office] unit shall be the total of (1) the amount
998 appropriated for expenses for the operation of the [office] unit for the
999 fiscal year, as estimated by the Comptroller, (2) the cost of fringe
1000 benefits for [office] unit personnel for such year, as estimated by the
1001 Comptroller, (3) the amount of expenses for central state services
1002 attributable to the [office] unit for the fiscal year as estimated by the
1003 Comptroller, and (4) the estimated expenditures on behalf of the
1004 [office] unit from the Capital Equipment Purchase Fund pursuant to
1005 section 4a-9 for such year, provided for purposes of this calculation the
1006 amount of expenses for the operation of the [office] unit for the fiscal
1007 year as estimated by the Comptroller, plus the cost of fringe benefits
1008 for personnel, the amount of expenses for said central state services for
1009 the fiscal year as estimated by the Comptroller, and said estimated
1010 expenditures from the Capital Equipment Purchase Fund pursuant to
1011 section 4a-9 shall be deemed to be the actual expenditures of the
1012 [office] unit.

1013 (c) On or before December thirty-first, annually, for each fiscal year,
1014 each hospital shall pay the [office] unit twenty-five per cent of its
1015 proposed assessment, adjusted to reflect any credit or amount due
1016 under the recalculated assessment for the preceding state fiscal year as
1017 determined pursuant to subsection (d) of this section or any
1018 reapportioned assessment pursuant to subsection (b) of section 19a-
1019 631, as amended by this act. The hospital shall pay the remaining
1020 seventy-five per cent of its assessment to the [office] unit in three equal
1021 installments on or before the following March thirty-first, June thirtieth
1022 and September thirtieth, annually.

1023 (d) Immediately following the close of each state fiscal year the
1024 [commissioner] executive director shall recalculate the proposed
1025 assessment for each hospital based on the costs of the [office] unit in
1026 accordance with subsection (b) of this section using the actual
1027 expenditures made by the [office] unit during that fiscal year and the
1028 actual expenditures made on behalf of the [office] unit from the Capital
1029 Equipment Purchase Fund pursuant to section 4a-9. On or before
1030 August thirty-first, annually, the [office] unit shall render to each
1031 hospital a statement showing the difference between the respective
1032 recalculated assessment and the amount previously paid. On or before
1033 September thirtieth, the [commissioner] executive director, after
1034 receiving any objections to such statements, shall make such
1035 adjustments which in said [commissioner's] executive director's
1036 opinion may be indicated and shall render an adjusted assessment, if
1037 any, to the affected hospitals. Adjustments to reflect any credit or
1038 amount due under the recalculated assessment for the previous state
1039 fiscal year shall be made to the proposed assessment due on or before
1040 December thirty-first of the following state fiscal year.

1041 (e) If any assessment is not paid when due, the [commissioner]
1042 executive director shall impose a fee equal to (1) two per cent of the
1043 assessment if such failure to pay is for not more than five days, (2) five
1044 per cent of the assessment if such failure to pay is for more than five
1045 days but not more than fifteen days, or (3) ten per cent of the
1046 assessment if such failure to pay is for more than fifteen days. If a
1047 hospital fails to pay any assessment for more than thirty days after the
1048 date when due, the [commissioner] executive director may, in addition
1049 to the fees imposed pursuant to this subsection, impose a civil penalty
1050 of up to one thousand dollars per day for each day past the initial
1051 thirty days that the assessment is not paid. Any civil penalty
1052 authorized by this subsection shall be imposed by the [commissioner]
1053 executive director in accordance with subsections (b) to (e), inclusive,
1054 of section 19a-653, as amended by this act.

1055 (f) The [office] unit shall deposit all payments received pursuant to
1056 this section with the State Treasurer. The moneys so deposited shall be

1057 credited to the General Fund and shall be accounted for as expenses
1058 recovered from hospitals.

1059 Sec. 21. Subsection (b) of section 19a-632a of the general statutes is
1060 repealed and the following is substituted in lieu thereof (*Effective from*
1061 *passage*):

1062 (b) The [Department of Public Health] Office of Health Strategy may
1063 require a hospital to pay an assessment levied pursuant to section 19a-
1064 632, as amended by this act, by way of an approved method of
1065 electronic funds transfer.

1066 Sec. 22. Subsection (f) of section 19a-632a of the general statutes is
1067 repealed and the following is substituted in lieu thereof (*Effective from*
1068 *passage*):

1069 (f) The [department] office shall deposit all payments received
1070 pursuant to this section with the State Treasurer. The moneys so
1071 deposited shall be credited to the General Fund and shall be accounted
1072 for as expenses recovered from hospitals.

1073 Sec. 23. Section 19a-633 of the general statutes is repealed and the
1074 following is substituted in lieu thereof (*Effective from passage*):

1075 The [commissioner] executive director, or any agent authorized by
1076 [him] such executive director to conduct any inquiry, investigation or
1077 hearing under the provisions of this chapter, shall have power to
1078 administer oaths and take testimony under oath relative to the matter
1079 of inquiry or investigation. At any hearing ordered by the office, the
1080 [commissioner] executive director or such agent having authority by
1081 law to issue such process may subpoena witnesses and require the
1082 production of records, papers and documents pertinent to such
1083 inquiry. If any person disobeys such process or, having appeared in
1084 obedience thereto, refuses to answer any pertinent question put to
1085 [him] such person by the [commissioner] executive director or [his]
1086 such executive director's authorized agent or to produce any records
1087 and papers pursuant thereto, the [commissioner] executive director or

1088 [his] such executive director's agent may apply to the superior court
1089 for the judicial district of Hartford or for the judicial district wherein
1090 the person resides or wherein the business has been conducted, or to
1091 any judge of said court if the same is not in session, setting forth such
1092 disobedience to process or refusal to answer, and said court or such
1093 judge shall cite such person to appear before said court or such judge
1094 to answer such question or to produce such records and papers.

1095 Sec. 24. Section 19a-634 of the general statutes is repealed and the
1096 following is substituted in lieu thereof (*Effective from passage*):

1097 (a) The [Office of Health Care Access] Health Systems Planning Unit
1098 shall conduct, on a biennial basis, a state-wide health care facility
1099 utilization study. Such study may include an assessment of: (1)
1100 Current availability and utilization of acute hospital care, hospital
1101 emergency care, specialty hospital care, outpatient surgical care,
1102 primary care and clinic care; (2) geographic areas and subpopulations
1103 that may be underserved or have reduced access to specific types of
1104 health care services; and (3) other factors that the [office] unit deems
1105 pertinent to health care facility utilization. Not later than June thirtieth
1106 of the year in which the biennial study is conducted, the
1107 [Commissioner of Public Health] executive director of the Office of
1108 Health Strategy shall report, in accordance with section 11-4a, to the
1109 Governor and the joint standing committees of the General Assembly
1110 having cognizance of matters relating to public health and human
1111 services on the findings of the study. Such report may also include the
1112 [office's] unit's recommendations for addressing identified gaps in the
1113 provision of health care services and recommendations concerning a
1114 lack of access to health care services.

1115 (b) The [office] unit, in consultation with such other state agencies as
1116 the [Commissioner of Public Health] executive director deems
1117 appropriate, shall establish and maintain a state-wide health care
1118 facilities and services plan. Such plan may include, but not be limited
1119 to: (1) An assessment of the availability of acute hospital care, hospital
1120 emergency care, specialty hospital care, outpatient surgical care,

1121 primary care and clinic care; (2) an evaluation of the unmet needs of
1122 persons at risk and vulnerable populations as determined by the
1123 [commissioner] executive director; (3) a projection of future demand
1124 for health care services and the impact that technology may have on
1125 the demand, capacity or need for such services; and (4)
1126 recommendations for the expansion, reduction or modification of
1127 health care facilities or services. In the development of the plan, the
1128 [office] unit shall consider the recommendations of any advisory
1129 bodies which may be established by the [commissioner] executive
1130 director. The [commissioner] executive director may also incorporate
1131 the recommendations of authoritative organizations whose mission is
1132 to promote policies based on best practices or evidence-based research.
1133 The [commissioner] executive director, in consultation with hospital
1134 representatives, shall develop a process that encourages hospitals to
1135 incorporate the state-wide health care facilities and services plan into
1136 hospital long-range planning and shall facilitate communication
1137 between appropriate state agencies concerning innovations or changes
1138 that may affect future health planning. The [office] unit shall update
1139 the state-wide health care facilities and services plan not less than once
1140 every two years.

1141 (c) For purposes of conducting the state-wide health care facility
1142 utilization study and preparing the state-wide health care facilities and
1143 services plan, the [office] unit shall establish and maintain an
1144 inventory of all health care facilities, the equipment identified in
1145 subdivisions (9) and (10) of subsection (a) of section 19a-638, as
1146 amended by this act, and services in the state, including health care
1147 facilities that are exempt from certificate of need requirements under
1148 subsection (b) of section 19a-638, as amended by this act. The [office]
1149 unit shall develop an inventory questionnaire to obtain the following
1150 information: (1) The name and location of the facility; (2) the type of
1151 facility; (3) the hours of operation; (4) the type of services provided at
1152 that location; and (5) the total number of clients, treatments, patient
1153 visits, procedures performed or scans performed in a calendar year.
1154 The inventory shall be completed biennially by health care facilities

1155 and providers and such health care facilities and providers shall not be
1156 required to provide patient specific or financial data.

1157 Sec. 25. Section 19a-638 of the general statutes is repealed and the
1158 following is substituted in lieu thereof (*Effective from passage*):

1159 (a) A certificate of need issued by the **[**office**]** unit shall be required
1160 for:

1161 (1) The establishment of a new health care facility;

1162 (2) A transfer of ownership of a health care facility;

1163 (3) A transfer of ownership of a large group practice to any entity
1164 other than a (A) physician, or (B) group of two or more physicians,
1165 legally organized in a partnership, professional corporation or limited
1166 liability company formed to render professional services and not
1167 employed by or an affiliate of any hospital, medical foundation,
1168 insurance company or other similar entity;

1169 (4) The establishment of a freestanding emergency department;

1170 (5) The termination of inpatient or outpatient services offered by a
1171 hospital, including, but not limited to, the termination by a short-term
1172 acute care general hospital or children's hospital of inpatient and
1173 outpatient mental health and substance abuse services;

1174 (6) The establishment of an outpatient surgical facility, as defined in
1175 section 19a-493b, as amended by this act, or as established by a short-
1176 term acute care general hospital;

1177 (7) The termination of surgical services by an outpatient surgical
1178 facility, as defined in section 19a-493b, as amended by this act, or a
1179 facility that provides outpatient surgical services as part of the
1180 outpatient surgery department of a short-term acute care general
1181 hospital, provided termination of outpatient surgical services due to
1182 (A) insufficient patient volume, or (B) the termination of any
1183 subspecialty surgical service, shall not require certificate of need

1184 approval;

1185 (8) The termination of an emergency department by a short-term
1186 acute care general hospital;

1187 (9) The establishment of cardiac services, including inpatient and
1188 outpatient cardiac catheterization, interventional cardiology and
1189 cardiovascular surgery;

1190 (10) The acquisition of computed tomography scanners, magnetic
1191 resonance imaging scanners, positron emission tomography scanners
1192 or positron emission tomography-computed tomography scanners, by
1193 any person, physician, provider, short-term acute care general hospital
1194 or children's hospital, except (A) as provided for in subdivision (22) of
1195 subsection (b) of this section, and (B) a certificate of need issued by the
1196 [office] unit shall not be required where such scanner is a replacement
1197 for a scanner that was previously acquired through certificate of need
1198 approval or a certificate of need determination;

1199 (11) The acquisition of nonhospital based linear accelerators;

1200 (12) An increase in the licensed bed capacity of a health care facility;

1201 (13) The acquisition of equipment utilizing technology that has not
1202 previously been utilized in the state;

1203 (14) An increase of two or more operating rooms within any three-
1204 year period, commencing on and after October 1, 2010, by an
1205 outpatient surgical facility, as defined in section 19a-493b, as amended
1206 by this act, or by a short-term acute care general hospital; and

1207 (15) The termination of inpatient or outpatient services offered by a
1208 hospital or other facility or institution operated by the state that
1209 provides services that are eligible for reimbursement under Title XVIII
1210 or XIX of the federal Social Security Act, 42 USC 301, as amended.

1211 (b) A certificate of need shall not be required for:

1212 (1) Health care facilities owned and operated by the federal
1213 government;

1214 (2) The establishment of offices by a licensed private practitioner,
1215 whether for individual or group practice, except when a certificate of
1216 need is required in accordance with the requirements of section 19a-
1217 493b, as amended by this act, or subdivision (3), (10) or (11) of
1218 subsection (a) of this section;

1219 (3) A health care facility operated by a religious group that
1220 exclusively relies upon spiritual means through prayer for healing;

1221 (4) Residential care homes, nursing homes and rest homes, as
1222 defined in subsection (c) of section 19a-490;

1223 (5) An assisted living services agency, as defined in section 19a-490;

1224 (6) Home health agencies, as defined in section 19a-490;

1225 (7) Hospice services, as described in section 19a-122b;

1226 (8) Outpatient rehabilitation facilities;

1227 (9) Outpatient chronic dialysis services;

1228 (10) Transplant services;

1229 (11) Free clinics, as defined in section 19a-630, as amended by this
1230 act;

1231 (12) School-based health centers and expanded school health sites,
1232 as such terms are defined in section 19a-6r, community health centers,
1233 as defined in section 19a-490a, not-for-profit outpatient clinics licensed
1234 in accordance with the provisions of chapter 368v and federally
1235 qualified health centers;

1236 (13) A program licensed or funded by the Department of Children
1237 and Families, provided such program is not a psychiatric residential
1238 treatment facility;

1239 (14) Any nonprofit facility, institution or provider that has a contract
1240 with, or is certified or licensed to provide a service for, a state agency
1241 or department for a service that would otherwise require a certificate
1242 of need. The provisions of this subdivision shall not apply to a short-
1243 term acute care general hospital or children's hospital, or a hospital or
1244 other facility or institution operated by the state that provides services
1245 that are eligible for reimbursement under Title XVIII or XIX of the
1246 federal Social Security Act, 42 USC 301, as amended;

1247 (15) A health care facility operated by a nonprofit educational
1248 institution exclusively for students, faculty and staff of such institution
1249 and their dependents;

1250 (16) An outpatient clinic or program operated exclusively by or
1251 contracted to be operated exclusively by a municipality, municipal
1252 agency, municipal board of education or a health district, as described
1253 in section 19a-241;

1254 (17) A residential facility for persons with intellectual disability
1255 licensed pursuant to section 17a-227 and certified to participate in the
1256 Title XIX Medicaid program as an intermediate care facility for
1257 individuals with intellectual disabilities;

1258 (18) Replacement of existing imaging equipment if such equipment
1259 was acquired through certificate of need approval or a certificate of
1260 need determination, provided a health care facility, provider,
1261 physician or person notifies the **[**office**]** unit of the date on which the
1262 equipment is replaced and the disposition of the replaced equipment;

1263 (19) Acquisition of cone-beam dental imaging equipment that is to
1264 be used exclusively by a dentist licensed pursuant to chapter 379;

1265 (20) The partial or total elimination of services provided by an
1266 outpatient surgical facility, as defined in section 19a-493b, as amended
1267 by this act, except as provided in subdivision (6) of subsection (a) of
1268 this section and section 19a-639e, as amended by this act;

1269 (21) The termination of services for which the Department of Public
1270 Health has requested the facility to relinquish its license; or

1271 (22) Acquisition of any equipment by any person that is to be used
1272 exclusively for scientific research that is not conducted on humans.

1273 (c) (1) Any person, health care facility or institution that is unsure
1274 whether a certificate of need is required under this section, or (2) any
1275 health care facility that proposes to relocate pursuant to section 19a-
1276 639c, as amended by this act, shall send a letter to the [office] unit that
1277 describes the project and requests that the [office] unit make a
1278 determination as to whether a certificate of need is required. In the
1279 case of a relocation of a health care facility, the letter shall include
1280 information described in section 19a-639c, as amended by this act. A
1281 person, health care facility or institution making such request shall
1282 provide the [office] unit with any information the [office] unit requests
1283 as part of its determination process.

1284 (d) The [Commissioner of Public Health] executive director of the
1285 Office of Health Strategy may implement policies and procedures
1286 necessary to administer the provisions of this section while in the
1287 process of adopting such policies and procedures as regulation,
1288 provided the [commissioner] executive director holds a public hearing
1289 prior to implementing the policies and procedures and [prints] posts
1290 notice of intent to adopt regulations [in the Connecticut Law Journal]
1291 on the office's Internet website and the eRegulations System not later
1292 than twenty days after the date of implementation. Policies and
1293 procedures implemented pursuant to this section shall be valid until
1294 the time final regulations are adopted. [Final regulations shall be
1295 adopted by December 31, 2011.]

1296 Sec. 26. Section 19a-639 of the general statutes is repealed and the
1297 following is substituted in lieu thereof (*Effective from passage*):

1298 (a) In any deliberations involving a certificate of need application
1299 filed pursuant to section 19a-638, as amended by this act, the [office]
1300 unit shall take into consideration and make written findings

1301 concerning each of the following guidelines and principles:

1302 (1) Whether the proposed project is consistent with any applicable
1303 policies and standards adopted in regulations by the [Department of
1304 Public Health] Office of Health Strategy;

1305 (2) The relationship of the proposed project to the state-wide health
1306 care facilities and services plan;

1307 (3) Whether there is a clear public need for the health care facility or
1308 services proposed by the applicant;

1309 (4) Whether the applicant has satisfactorily demonstrated how the
1310 proposal will impact the financial strength of the health care system in
1311 the state or that the proposal is financially feasible for the applicant;

1312 (5) Whether the applicant has satisfactorily demonstrated how the
1313 proposal will improve quality, accessibility and cost effectiveness of
1314 health care delivery in the region, including, but not limited to,
1315 provision of or any change in the access to services for Medicaid
1316 recipients and indigent persons;

1317 (6) The applicant's past and proposed provision of health care
1318 services to relevant patient populations and payer mix, including, but
1319 not limited to, access to services by Medicaid recipients and indigent
1320 persons;

1321 (7) Whether the applicant has satisfactorily identified the population
1322 to be served by the proposed project and satisfactorily demonstrated
1323 that the identified population has a need for the proposed services;

1324 (8) The utilization of existing health care facilities and health care
1325 services in the service area of the applicant;

1326 (9) Whether the applicant has satisfactorily demonstrated that the
1327 proposed project shall not result in an unnecessary duplication of
1328 existing or approved health care services or facilities;

1329 (10) Whether an applicant, who has failed to provide or reduced
1330 access to services by Medicaid recipients or indigent persons, has
1331 demonstrated good cause for doing so, which shall not be
1332 demonstrated solely on the basis of differences in reimbursement rates
1333 between Medicaid and other health care payers;

1334 (11) Whether the applicant has satisfactorily demonstrated that the
1335 proposal will not negatively impact the diversity of health care
1336 providers and patient choice in the geographic region; and

1337 (12) Whether the applicant has satisfactorily demonstrated that any
1338 consolidation resulting from the proposal will not adversely affect
1339 health care costs or accessibility to care.

1340 (b) In deliberations as described in subsection (a) of this section,
1341 there shall be a presumption in favor of approving the certificate of
1342 need application for a transfer of ownership of a large group practice,
1343 as described in subdivision (3) of subsection (a) of section 19a-638, as
1344 amended by this act, when an offer was made in response to a request
1345 for proposal or similar voluntary offer for sale.

1346 (c) The **[**office**]** unit, as it deems necessary, may revise or
1347 supplement the guidelines and principles, **[**through regulation
1348 prescribed in subsection (a) of this section**]** set forth in subsection (a) of
1349 this section, through regulation.

1350 (d) (1) For purposes of this subsection and subsection (e) of this
1351 section:

1352 (A) "Affected community" means a municipality where a hospital is
1353 physically located or a municipality whose inhabitants are regularly
1354 served by a hospital;

1355 (B) "Hospital" has the same meaning as provided in section 19a-490;

1356 (C) "New hospital" means a hospital as it exists after the approval of
1357 an agreement pursuant to section 19a-486b, as amended by this act, or
1358 a certificate of need application for a transfer of ownership of a

1359 hospital;

1360 (D) "Purchaser" means a person who is acquiring, or has acquired,
1361 any assets of a hospital through a transfer of ownership of a hospital;

1362 (E) "Transacting party" means a purchaser and any person who is a
1363 party to a proposed agreement for transfer of ownership of a hospital;

1364 (F) "Transfer" means to sell, transfer, lease, exchange, option,
1365 convey, give or otherwise dispose of or transfer control over,
1366 including, but not limited to, transfer by way of merger or joint
1367 venture not in the ordinary course of business; and

1368 (G) "Transfer of ownership of a hospital" means a transfer that
1369 impacts or changes the governance or controlling body of a hospital,
1370 including, but not limited to, all affiliations, mergers or any sale or
1371 transfer of net assets of a hospital and for which a certificate of need
1372 application or a certificate of need determination letter is filed on or
1373 after December 1, 2015.

1374 (2) In any deliberations involving a certificate of need application
1375 filed pursuant to section 19a-638, as amended by this act, that involves
1376 the transfer of ownership of a hospital, the [office] unit shall, in
1377 addition to the guidelines and principles set forth in subsection (a) of
1378 this section and those prescribed through regulation pursuant to
1379 subsection (c) of this section, take into consideration and make written
1380 findings concerning each of the following guidelines and principles:

1381 (A) Whether the applicant fairly considered alternative proposals or
1382 offers in light of the purpose of maintaining health care provider
1383 diversity and consumer choice in the health care market and access to
1384 affordable quality health care for the affected community; and

1385 (B) Whether the plan submitted pursuant to section 19a-639a, as
1386 amended by this act, demonstrates, in a manner consistent with this
1387 chapter, how health care services will be provided by the new hospital
1388 for the first three years following the transfer of ownership of the

1389 hospital, including any consolidation, reduction, elimination or
1390 expansion of existing services or introduction of new services.

1391 (3) The [office] unit shall deny any certificate of need application
1392 involving a transfer of ownership of a hospital unless the
1393 [commissioner] executive director finds that the affected community
1394 will be assured of continued access to high quality and affordable
1395 health care after accounting for any proposed change impacting
1396 hospital staffing.

1397 (4) The [office] unit may deny any certificate of need application
1398 involving a transfer of ownership of a hospital subject to a cost and
1399 market impact review pursuant to section 19a-639f, as amended by this
1400 act, if the [commissioner] executive director finds that (A) the affected
1401 community will not be assured of continued access to high quality and
1402 affordable health care after accounting for any consolidation in the
1403 hospital and health care market that may lessen health care provider
1404 diversity, consumer choice and access to care, and (B) any likely
1405 increases in the prices for health care services or total health care
1406 spending in the state may negatively impact the affordability of care.

1407 (5) The [office] unit may place any conditions on the approval of a
1408 certificate of need application involving a transfer of ownership of a
1409 hospital consistent with the provisions of this chapter. Before placing
1410 any such conditions, the [office] unit shall weigh the value of such
1411 conditions in promoting the purposes of this chapter against the
1412 individual and cumulative burden of such conditions on the
1413 transacting parties and the new hospital. For each condition imposed,
1414 the [office] unit shall include a concise statement of the legal and
1415 factual basis for such condition and the provision or provisions of this
1416 chapter that it is intended to promote. Each condition shall be
1417 reasonably tailored in time and scope. The transacting parties or the
1418 new hospital shall have the right to make a request to the [office] unit
1419 for an amendment to, or relief from, any condition based on changed
1420 circumstances, hardship or for other good cause.

1421 (e) (1) If the certificate of need application (A) involves the transfer
1422 of ownership of a hospital, (B) the purchaser is a hospital, as defined in
1423 section 19a-490, whether located within or outside the state, that had
1424 net patient revenue for fiscal year 2013 in an amount greater than one
1425 billion five hundred million dollars or a hospital system, as defined in
1426 section 19a-486i, as amended by this act, whether located within or
1427 outside the state, that had net patient revenue for fiscal year 2013 in an
1428 amount greater than one billion five hundred million dollars, or any
1429 person that is organized or operated for profit, and (C) such
1430 application is approved, the [office] unit shall hire an independent
1431 consultant to serve as a post-transfer compliance reporter for a period
1432 of three years after completion of the transfer of ownership of the
1433 hospital. Such reporter shall, at a minimum: (i) Meet with
1434 representatives of the purchaser, the new hospital and members of the
1435 affected community served by the new hospital not less than quarterly;
1436 and (ii) report to the [office] unit not less than quarterly concerning (I)
1437 efforts the purchaser and representatives of the new hospital have
1438 taken to comply with any conditions the [office] unit placed on the
1439 approval of the certificate of need application and plans for future
1440 compliance, and (II) community benefits and uncompensated care
1441 provided by the new hospital. The purchaser shall give the reporter
1442 access to its records and facilities for the purposes of carrying out the
1443 reporter's duties. The purchaser shall hold a public hearing in the
1444 municipality in which the new hospital is located not less than
1445 annually during the reporting period to provide for public review and
1446 comment on the reporter's reports and findings.

1447 (2) If the reporter finds that the purchaser has breached a condition
1448 of the approval of the certificate of need application, the [office] unit
1449 may, in consultation with the purchaser, the reporter and any other
1450 interested parties it deems appropriate, implement a performance
1451 improvement plan designed to remedy the conditions identified by the
1452 reporter and continue the reporting period for up to one year
1453 following a determination by the [office] unit that such conditions
1454 have been resolved.

1455 (3) The purchaser shall provide funds, in an amount determined by
1456 the [office] unit not to exceed two hundred thousand dollars annually,
1457 for the hiring of the post-transfer compliance reporter.

1458 (f) Nothing in subsection (d) or (e) of this section shall apply to a
1459 transfer of ownership of a hospital in which either a certificate of need
1460 application is filed on or before December 1, 2015, or where a
1461 certificate of need determination letter is filed on or before December 1,
1462 2015.

1463 Sec. 27. Section 19a-639a of the general statutes is repealed and the
1464 following is substituted in lieu thereof (*Effective from passage*):

1465 (a) An application for a certificate of need shall be filed with the
1466 [office] unit in accordance with the provisions of this section and any
1467 regulations adopted by the [Department of Public Health] Office of
1468 Health Strategy. The application shall address the guidelines and
1469 principles set forth in (1) subsection (a) of section 19a-639, as amended
1470 by this act, and (2) regulations adopted by the department. The
1471 applicant shall include with the application a nonrefundable
1472 application fee of five hundred dollars.

1473 (b) Prior to the filing of a certificate of need application, the
1474 applicant shall publish notice that an application is to be submitted to
1475 the [office] unit in a newspaper having a substantial circulation in the
1476 area where the project is to be located. Such notice shall (1) be
1477 published (A) not later than twenty days prior to the date of filing of
1478 the certificate of need application, and (B) for not less than three
1479 consecutive days, and (2) contain a brief description of the nature of
1480 the project and the street address where the project is to be located. An
1481 applicant shall file the certificate of need application with the [office]
1482 unit not later than ninety days after publishing notice of the
1483 application in accordance with the provisions of this subsection. The
1484 [office] unit shall not accept the applicant's certificate of need
1485 application for filing unless the application is accompanied by the
1486 application fee prescribed in subsection (a) of this section and proof of

1487 compliance with the publication requirements prescribed in this
1488 subsection.

1489 (c) (1) Not later than five business days after receipt of a properly
1490 filed certificate of need application, the **[**office**]** unit shall publish notice
1491 of the application on its Internet web site. Not later than thirty days
1492 after the date of filing of the application, the office may request such
1493 additional information as the **[**office**]** unit determines necessary to
1494 complete the application. In addition to any information requested by
1495 the **[**office**]** unit, if the application involves the transfer of ownership of
1496 a hospital, as defined in section 19a-639, as amended by this act, the
1497 applicant shall submit to the **[**office**]** unit (A) a plan demonstrating
1498 how health care services will be provided by the new hospital for the
1499 first three years following the transfer of ownership of the hospital,
1500 including any consolidation, reduction, elimination or expansion of
1501 existing services or introduction of new services, and (B) the names of
1502 persons currently holding a position with the hospital to be purchased
1503 or the purchaser, as defined in section 19a-639, as amended by this act,
1504 as an officer, director, board member or senior manager, whether or
1505 not such person is expected to hold a position with the hospital after
1506 completion of the transfer of ownership of the hospital and any salary,
1507 severance, stock offering or any financial gain, current or deferred,
1508 such person is expected to receive as a result of, or in relation to, the
1509 transfer of ownership of the hospital.

1510 (2) The applicant shall, not later than sixty days after the date of the
1511 **[**office's**]** unit's request, submit any requested information and any
1512 information required under this subsection to the **[**office**]** unit. If an
1513 applicant fails to submit such information to the **[**office**]** unit within the
1514 sixty-day period, the **[**office**]** unit shall consider the application to have
1515 been withdrawn.

1516 (d) Upon determining that an application is complete, the **[**office**]**
1517 unit shall provide notice of this determination to the applicant and to
1518 the public in accordance with regulations adopted by the department.
1519 In addition, the **[**office**]** unit shall post such notice on its Internet web

1520 site. The date on which the [office] unit posts such notice on its Internet
1521 web site shall begin the review period. Except as provided in this
1522 subsection, (1) the review period for a completed application shall be
1523 ninety days from the date on which the [office] unit posts such notice
1524 on its Internet web site; and (2) the [office] unit shall issue a decision
1525 on a completed application prior to the expiration of the ninety-day
1526 review period. The review period for a completed application that
1527 involves a transfer of a large group practice, as described in
1528 subdivision (3) of subsection (a) of section 19a-638, as amended by this
1529 act, when the offer was made in response to a request for proposal or
1530 similar voluntary offer for sale, shall be sixty days from the date on
1531 which the [office] unit posts notice on its Internet web site. Upon
1532 request or for good cause shown, the [office] unit may extend the
1533 review period for a period of time not to exceed sixty days. If the
1534 review period is extended, the [office] unit shall issue a decision on the
1535 completed application prior to the expiration of the extended review
1536 period. If the [office] unit holds a public hearing concerning a
1537 completed application in accordance with subsection (e) or (f) of this
1538 section, the [office] unit shall issue a decision on the completed
1539 application not later than sixty days after the date the [office] unit
1540 closes the public hearing record.

1541 (e) Except as provided in this subsection, the [office] unit shall hold
1542 a public hearing on a properly filed and completed certificate of need
1543 application if three or more individuals or an individual representing
1544 an entity with five or more people submits a request, in writing, that a
1545 public hearing be held on the application. For a properly filed and
1546 completed certificate of need application involving a transfer of
1547 ownership of a large group practice, as described in subdivision (3) of
1548 subsection (a) of section 19a-638, as amended by this act, when an offer
1549 was made in response to a request for proposal or similar voluntary
1550 offer for sale, a public hearing shall be held if twenty-five or more
1551 individuals or an individual representing twenty-five or more people
1552 submits a request, in writing, that a public hearing be held on the
1553 application. Any request for a public hearing shall be made to the

1554 [office] unit not later than thirty days after the date the [office] unit
1555 determines the application to be complete.

1556 (f) (1) The [office] unit shall hold a public hearing with respect to
1557 each certificate of need application filed pursuant to section 19a-638, as
1558 amended by this act, after December 1, 2015, that concerns any transfer
1559 of ownership involving a hospital. Such hearing shall be held in the
1560 municipality in which the hospital that is the subject of the application
1561 is located.

1562 (2) The [office] unit may hold a public hearing with respect to any
1563 certificate of need application submitted under this chapter. The
1564 [office] unit shall provide not less than two weeks' advance notice to
1565 the applicant, in writing, and to the public by publication in a
1566 newspaper having a substantial circulation in the area served by the
1567 health care facility or provider. In conducting its activities under this
1568 chapter, the [office] unit may hold hearing on applications of a similar
1569 nature at the same time.

1570 (g) The [Commissioner of Public Health] executive director of the
1571 Office of Health Strategy may implement policies and procedures
1572 necessary to administer the provisions of this section while in the
1573 process of adopting such policies and procedures as regulation,
1574 provided the [commissioner] executive director holds a public hearing
1575 prior to implementing the policies and procedures and [prints] posts
1576 notice of intent to adopt regulations on the [department's] office's
1577 Internet web site and the eRegulations System not later than twenty
1578 days after the date of implementation. Policies and procedures
1579 implemented pursuant to this section shall be valid until the time final
1580 regulations are adopted.

1581 Sec. 28. Section 19a-639b of the general statutes is repealed and the
1582 following is substituted in lieu thereof (*Effective from passage*):

1583 (a) A certificate of need shall be valid only for the project described
1584 in the application. A certificate of need shall be valid for two years
1585 from the date of issuance by the [office] unit. During the period of time

1586 that such certificate is valid and the thirty-day period following the
1587 expiration of the certificate, the holder of the certificate shall provide
1588 the [office] unit with such information as the [office] unit may request
1589 on the development of the project covered by the certificate.

1590 (b) Upon request from a certificate holder, the [office] unit may
1591 extend the duration of a certificate of need for such additional period
1592 of time as the [office] unit determines is reasonably necessary to
1593 expeditiously complete the project. Not later than five business days
1594 after receiving a request to extend the duration of a certificate of need,
1595 the [office] unit shall post such request on its web site. Any person
1596 who wishes to comment on extending the duration of the certificate of
1597 need shall provide written comments to the [office] unit on the
1598 requested extension not later than thirty days after the date the [office]
1599 unit posts notice of the request for an extension of time on its web site.
1600 The [office] unit shall hold a public hearing on any request to extend
1601 the duration of a certificate of need if three or more individuals or an
1602 individual representing an entity with five or more people submits a
1603 request, in writing, that a public hearing be held on the request to
1604 extend the duration of a certificate of need.

1605 (c) In the event that the [office] unit determines that: (1)
1606 Commencement, construction or other preparation has not been
1607 substantially undertaken during a valid certificate of need period; or
1608 (2) the certificate holder has not made a good-faith effort to complete
1609 the project as approved, the [office] unit may withdraw, revoke or
1610 rescind the certificate of need.

1611 (d) A certificate of need shall not be transferable or assignable nor
1612 shall a project be transferred from a certificate holder to another
1613 person.

1614 (e) The [Commissioner of Public Health] executive director of the
1615 Office of Health Strategy may implement policies and procedures
1616 necessary to administer the provisions of this section while in the
1617 process of adopting such policies and procedures as regulation,

1618 provided the [commissioner] executive director holds a public hearing
1619 prior to implementing the policies and procedures and [prints] posts
1620 notice of intent to adopt regulations [in the Connecticut Law Journal]
1621 on the office's Internet web site and the eRegulations System not later
1622 than twenty days after the date of implementation. Policies and
1623 procedures implemented pursuant to this section shall be valid until
1624 the time final regulations are adopted. Final regulations shall be
1625 adopted by December 31, 2011.

1626 Sec. 29. Section 19a-639c of the general statutes is repealed and the
1627 following is substituted in lieu thereof (*Effective from passage*):

1628 (a) Any health care facility that proposes to relocate a facility shall
1629 submit a letter to the [office] unit, as described in subsection (c) of
1630 section 19a-638, as amended by this act. In addition to the
1631 requirements prescribed in said subsection (c), in such letter the health
1632 care facility shall demonstrate to the satisfaction of the [office] unit that
1633 the population served by the health care facility and the payer mix will
1634 not substantially change as a result of the facility's proposed relocation.
1635 If the facility is unable to demonstrate to the satisfaction of the [office]
1636 unit that the population served and the payer mix will not
1637 substantially change as a result of the proposed relocation, the health
1638 care facility shall apply for certificate of need approval pursuant to
1639 subdivision (1) of subsection (a) of section 19a-638, as amended by this
1640 act, in order to effectuate the proposed relocation.

1641 (b) The [Commissioner of Public Health] executive director of the
1642 Office of Health Strategy may implement policies and procedures
1643 necessary to administer the provisions of this section while in the
1644 process of adopting such policies and procedures as regulation,
1645 provided the [commissioner] executive director holds a public hearing
1646 prior to implementing the policies and procedures and [prints] posts
1647 notice of intent to adopt regulations [in the Connecticut Law Journal]
1648 on the office's Internet web site and the eRegulations System not later
1649 than twenty days after the date of implementation. Policies and
1650 procedures implemented pursuant to this section shall be valid until

1651 the time final regulations are adopted. **[**Final regulations shall be
1652 adopted by December 31, 2011.**]**

1653 Sec. 30. Section 19a-639e of the general statutes is repealed and the
1654 following is substituted in lieu thereof (*Effective from passage*):

1655 (a) Unless otherwise required to file a certificate of need application
1656 pursuant to the provisions of subsection (a) of section 19a-638, as
1657 amended by this act, any health care facility that proposes to terminate
1658 a service that was authorized pursuant to a certificate of need issued
1659 under this chapter shall file a modification request with the **[**office**]**
1660 unit not later than sixty days prior to the proposed date of the
1661 termination of the service. The **[**office**]** unit may request additional
1662 information from the health care facility as necessary to process the
1663 modification request. In addition, the **[**office**]** unit shall hold a public
1664 hearing on any request from a health care facility to terminate a service
1665 pursuant to this section if three or more individuals or an individual
1666 representing an entity with five or more people submits a request, in
1667 writing, that a public hearing be held on the health care facility's
1668 proposal to terminate a service.

1669 (b) Unless otherwise required to file a certificate of need application
1670 pursuant to the provisions of subsection (a) of section 19a-638, as
1671 amended by this act, any health care facility that proposes to terminate
1672 all services offered by such facility, that were authorized pursuant to
1673 one or more certificates of need issued under this chapter, shall
1674 provide notification to the **[**office**]** unit not later than sixty days prior to
1675 the termination of services and such facility shall surrender its
1676 certificate of need not later than thirty days prior to the termination of
1677 services.

1678 (c) Unless otherwise required to file a certificate of need application
1679 pursuant to the provisions of subsection (a) of section 19a-638, as
1680 amended by this act, any health care facility that proposes to terminate
1681 the operation of a facility or service for which a certificate of need was
1682 not obtained shall notify the **[**office**]** unit not later than sixty days prior

1683 to terminating the operation of the facility or service.

1684 (d) The [Commissioner of Public Health] executive director of the
1685 Office of Health Strategy may implement policies and procedures
1686 necessary to administer the provisions of this section while in the
1687 process of adopting such policies and procedures as regulation,
1688 provided the [commissioner] executive director holds a public hearing
1689 prior to implementing the policies and procedures and [prints] posts
1690 notice of intent to adopt regulations [in the Connecticut Law Journal]
1691 on the office's Internet web site and the eRegulations System not later
1692 than twenty days after the date of implementation. Policies and
1693 procedures implemented pursuant to this section shall be valid until
1694 the time final regulations are adopted. Final regulations shall be
1695 adopted by December 31, 2015.

1696 Sec. 31. Section 19a-639f of the general statutes is repealed and the
1697 following is substituted in lieu thereof (*Effective from passage*):

1698 (a) The [Office of Healthcare Access division within the Department
1699 of Public Health] Health Systems Planning Unit of the Office of Health
1700 Strategy shall conduct a cost and market impact review in each case
1701 where (1) an application for a certificate of need filed pursuant to
1702 section 19a-638, as amended by this act, involves the transfer of
1703 ownership of a hospital, as defined in section 19a-639, as amended by
1704 this act, and (2) the purchaser is a hospital, as defined in section 19a-
1705 490, whether located within or outside the state, that had net patient
1706 revenue for fiscal year 2013 in an amount greater than one billion five
1707 hundred million dollars, or a hospital system, as defined in section
1708 19a-486i, as amended by this act, whether located within or outside the
1709 state, that had net patient revenue for fiscal year 2013 in an amount
1710 greater than one billion five hundred million dollars or any person that
1711 is organized or operated for profit.

1712 (b) Not later than twenty-one days after receipt of a properly filed
1713 certificate of need application involving the transfer of ownership of a
1714 hospital filed on or after December 1, 2015, as described in subsection

1715 (a) of this section, the [office] unit shall initiate such cost and market
1716 impact review by sending the transacting parties a written notice that
1717 shall contain a description of the basis for the cost and market impact
1718 review as well as a request for information and documents. Not later
1719 than thirty days after receipt of such notice, the transacting parties
1720 shall submit to the [office] unit a written response. Such response shall
1721 include, but need not be limited to, any information or documents
1722 requested by the [office] unit concerning the transfer of ownership of
1723 the hospital. The [office] unit shall have the powers with respect to the
1724 cost and market impact review as provided in section 19a-633, as
1725 amended by this act.

1726 (c) The [office] unit shall keep confidential all nonpublic information
1727 and documents obtained pursuant to this section and shall not disclose
1728 the information or documents to any person without the consent of the
1729 person that produced the information or documents, except in a
1730 preliminary report or final report issued in accordance with this
1731 section if the [office] unit believes that such disclosure should be made
1732 in the public interest after taking into account any privacy, trade secret
1733 or anti-competitive considerations. Such information and documents
1734 shall not be deemed a public record, under section 1-210, and shall be
1735 exempt from disclosure.

1736 (d) The cost and market impact review conducted pursuant to this
1737 section shall examine factors relating to the businesses and relative
1738 market positions of the transacting parties as defined in subsection (d)
1739 of section 19a-639, as amended by this act, and may include, but need
1740 not be limited to: (1) The transacting parties' size and market share
1741 within its primary service area, by major service category and within
1742 its dispersed service areas; (2) the transacting parties' prices for
1743 services, including the transacting parties' relative prices compared to
1744 other health care providers for the same services in the same market;
1745 (3) the transacting parties' health status adjusted total medical expense,
1746 including the transacting parties' health status adjusted total medical
1747 expense compared to that of similar health care providers; (4) the
1748 quality of the services provided by the transacting parties, including

1749 patient experience; (5) the transacting parties' cost and cost trends in
1750 comparison to total health care expenditures state wide; (6) the
1751 availability and accessibility of services similar to those provided by
1752 each transacting party, or proposed to be provided as a result of the
1753 transfer of ownership of a hospital within each transacting party's
1754 primary service areas and dispersed service areas; (7) the impact of the
1755 proposed transfer of ownership of the hospital on competing options
1756 for the delivery of health care services within each transacting party's
1757 primary service area and dispersed service area including the impact
1758 on existing service providers; (8) the methods used by the transacting
1759 parties to attract patient volume and to recruit or acquire health care
1760 professionals or facilities; (9) the role of each transacting party in
1761 serving at-risk, underserved and government payer patient
1762 populations, including those with behavioral, substance use disorder
1763 and mental health conditions, within each transacting party's primary
1764 service area and dispersed service area; (10) the role of each transacting
1765 party in providing low margin or negative margin services within each
1766 transacting party's primary service area and dispersed service area;
1767 (11) consumer concerns, including, but not limited to, complaints or
1768 other allegations that a transacting party has engaged in any unfair
1769 method of competition or any unfair or deceptive act or practice; and
1770 (12) any other factors that the **[**office**]** unit determines to be in the
1771 public interest.

1772 (e) Not later than ninety days after the **[**office**]** unit determines that
1773 there is substantial compliance with any request for documents or
1774 information issued by the **[**office**]** unit in accordance with this section,
1775 or a later date set by mutual agreement of the **[**office**]** unit and the
1776 transacting parties, the **[**office**]** unit shall make factual findings and
1777 issue a preliminary report on the cost and market impact review. Such
1778 preliminary report shall include, but shall not be limited to, an
1779 indication as to whether a transacting party meets the following
1780 criteria: (1) Currently has or, following the proposed transfer of
1781 operations of the hospital, is likely to have a dominant market share
1782 for the services the transacting party provides; and (2) (A) currently

1783 charges or, following the proposed transfer of operations of the
1784 hospital, is likely to charge prices for services that are materially higher
1785 than the median prices charged by all other health care providers for
1786 the same services in the same market, or (B) currently has or, following
1787 the proposed transfer of operations of a hospital, is likely to have a
1788 health status adjusted total medical expense that is materially higher
1789 than the median total medical expense for all other health care
1790 providers for the same service in the same market.

1791 (f) The transacting parties that are the subject of the cost and market
1792 impact review may respond in writing to the findings in the
1793 preliminary report issued in accordance with subsection (e) of this
1794 section not later than thirty days after the issuance of the preliminary
1795 report. Not later than sixty days after the issuance of the preliminary
1796 report, the [office] unit shall issue a final report of the cost and market
1797 impact review. The [office] unit shall refer to the Attorney General any
1798 final report on any proposed transfer of ownership that meets the
1799 criteria described in subsection (e) of this section.

1800 (g) Nothing in this section shall prohibit a transfer of ownership of a
1801 hospital, provided any such proposed transfer shall not be completed
1802 (1) less than thirty days after the [office] unit has issued a final report
1803 on a cost and market impact review, if such review is required, or (2)
1804 while any action brought by the Attorney General pursuant to
1805 subsection (h) of this section is pending and before a final judgment on
1806 such action is issued by a court of competent jurisdiction.

1807 (h) After the [office] unit refers a final report on a transfer of
1808 ownership of a hospital to the Attorney General under subsection (f) of
1809 this section, the Attorney General may: (1) Conduct an investigation to
1810 determine whether the transacting parties engaged, or, as a result of
1811 completing the transfer of ownership of the hospital, are expected to
1812 engage in unfair methods of competition, anti-competitive behavior or
1813 other conduct in violation of chapter 624 or 735a or any other state or
1814 federal law; and (2) if appropriate, take action under chapter 624 or
1815 735a or any other state law to protect consumers in the health care

1816 market. The [office's] unit's final report may be evidence in any such
1817 action.

1818 (i) For the purposes of this section, the provisions of chapter 735a
1819 may be directly enforced by the Attorney General. Nothing in this
1820 section shall be construed to modify, impair or supersede the
1821 operation of any state antitrust law or otherwise limit the authority of
1822 the Attorney General to (1) take any action against a transacting party
1823 as authorized by any law, or (2) protect consumers in the health care
1824 market under any law. Notwithstanding subdivision (1) of subsection
1825 (a) of section 42-110c, the transacting parties shall be subject to chapter
1826 735a.

1827 (j) The [office] unit shall retain an independent consultant with
1828 expertise on the economic analysis of the health care market and health
1829 care costs and prices to conduct each cost and market impact review,
1830 as described in this section. The [office] unit shall submit bills for such
1831 services to the purchaser, as defined in subsection (d) of section 19a-
1832 639, as amended by this act. Such purchaser shall pay such bills not
1833 later than thirty days after receipt. Such bills shall not exceed two
1834 hundred thousand dollars per application. The provisions of chapter
1835 57, sections 4-212 to 4-219, inclusive, and section 4e-19 shall not apply
1836 to any agreement executed pursuant to this subsection.

1837 (k) Any employee of the [office] unit who directly oversees or assists
1838 in conducting a cost and market impact review shall not take part in
1839 factual deliberations or the issuance of a preliminary or final decision
1840 on the certificate of need application concerning the transfer of
1841 ownership of a hospital that is the subject of such cost and market
1842 impact review.

1843 (l) The [Commissioner of Public Health] executive director of the
1844 Office of Health Strategy shall adopt regulations, in accordance with
1845 the provisions of chapter 54, concerning cost and market impact
1846 reviews and to administer the provisions of this section. Such
1847 regulations shall include definitions of the following terms: "Dispersed

1848 service area", "health status adjusted total medical expense", "major
1849 service category", "relative prices", "total health care spending" and
1850 "health care services". The **[**commissioner**]** executive director may
1851 implement policies and procedures necessary to administer the
1852 provisions of this section while in the process of adopting such policies
1853 and procedures in regulation form, provided the **[**commissioner**]**
1854 executive director publishes notice of intention to adopt the
1855 regulations on the **[**Department of Public Health's**]** office's Internet
1856 web site and the eRegulations System not later than twenty days after
1857 implementing such policies and procedures. Policies and procedures
1858 implemented pursuant to this subsection shall be valid until the time
1859 such regulations are effective.

1860 Sec. 32. Section 19a-641 of the general statutes is repealed and the
1861 following is substituted in lieu thereof (*Effective from passage*):

1862 Any health care facility or institution and any state health care
1863 facility or institution aggrieved by any final decision of said **[**office**]**
1864 unit under the provisions of sections 19a-630 to 19a-639e, inclusive, as
1865 amended by this act, may appeal from such decision in accordance
1866 with the provisions of section 4-183, except venue shall be in the
1867 judicial district in which it is located. Such appeal shall have
1868 precedence in respect to order of trial over all other cases except writs
1869 of habeas corpus, actions brought by or on behalf of the state,
1870 including **[**informations**]** information on the relation of private
1871 individuals, and appeals from awards or decisions of workers'
1872 compensation commissioners.

1873 Sec. 33. Section 19a-642 of the general statutes is repealed and the
1874 following is substituted in lieu thereof (*Effective from passage*):

1875 The Superior Court on application of the **[**office**]** unit or the
1876 Attorney General, may enforce, by appropriate decree or process, any
1877 provision of this chapter or any act or any order of the **[**office**]** unit
1878 rendered in pursuance of any statutory provision.

1879 Sec. 34. Section 19a-643 of the general statutes is repealed and the

1880 following is substituted in lieu thereof (*Effective from passage*):

1881 (a) The [Department of Public Health] Office of Health Strategy
1882 shall adopt regulations, in accordance with the provisions of chapter
1883 54, to carry out the provisions of sections 19a-630 to 19a-639e,
1884 inclusive, as amended by this act, and sections 19a-644 and 19a-645, as
1885 amended by this act, concerning the submission of data by health care
1886 facilities and institutions, including data on dealings between health
1887 care facilities and institutions and their affiliates, and, with regard to
1888 requests or proposals pursuant to sections 19a-638 to 19a-639e,
1889 inclusive, as amended by this act, by state health care facilities and
1890 institutions, the ongoing inspections by the [office] unit of operating
1891 budgets that have been approved by the health care facilities and
1892 institutions, standard reporting forms and standard accounting
1893 procedures to be utilized by health care facilities and institutions and
1894 the transferability of line items in the approved operating budgets of
1895 the health care facilities and institutions, except that any health care
1896 facility or institution may transfer any amounts among items in its
1897 operating budget. All such transfers shall be reported to the [office]
1898 unit [within] not later than thirty days [of] after the transfer or
1899 transfers.

1900 (b) The [Department of Public Health] Office of Health Strategy may
1901 adopt such regulations, in accordance with the provisions of chapter
1902 54, as are necessary to implement this chapter.

1903 Sec. 35. Section 19a-644 of the general statutes is repealed and the
1904 following is substituted in lieu thereof (*Effective from passage*):

1905 (a) On or before February twenty-eighth annually, for the fiscal year
1906 ending on September thirtieth of the immediately preceding year, each
1907 short-term acute care general or children's hospital shall report to the
1908 [office] unit with respect to its operations in such fiscal year, in such
1909 form as the [office] unit may by regulation require. Such report shall
1910 include: (1) Salaries and fringe benefits for the ten highest paid
1911 hospital and health system employees; (2) the name of each joint

1912 venture, partnership, subsidiary and corporation related to the
1913 hospital; and (3) the salaries paid to hospital and health system
1914 employees by each such joint venture, partnership, subsidiary and
1915 related corporation and by the hospital to the employees of related
1916 corporations. For purposes of this subsection, "health system" has the
1917 same meaning as provided in section 33-182aa.

1918 (b) The [Department of Public Health] Office of Health Strategy
1919 shall adopt regulations in accordance with chapter 54 to provide for
1920 the collection of data and information in addition to the annual report
1921 required in subsection (a) of this section. Such regulations shall
1922 provide for the submission of information about the operations of the
1923 following entities: Persons or parent corporations that own or control
1924 the health care facility, institution or provider; corporations, including
1925 limited liability corporations, in which the health care facility,
1926 institution, provider, its parent, any type of affiliate or any
1927 combination thereof, owns more than an aggregate of fifty per cent of
1928 the stock or, in the case of nonstock corporations, is the sole member;
1929 and any partnerships in which the person, health care facility,
1930 institution, provider, its parent or an affiliate or any combination
1931 thereof, or any combination of health care providers or related persons,
1932 owns a greater than fifty per cent interest. For purposes of this
1933 [section] subsection, "affiliate" means any person that directly or
1934 indirectly through one or more intermediaries, controls or is controlled
1935 by or is under common control with any health care facility,
1936 institution, provider or person that is regulated in any way under this
1937 chapter. A person is deemed controlled by another person if the other
1938 person, or one of that other person's affiliates, officers, agents or
1939 management employees, acts as a general partner or manager of the
1940 person in question.

1941 (c) Each nonprofit short-term acute care general or children's
1942 hospital shall include in the annual report required pursuant to
1943 subsection (a) of this section a report of all transfers of assets, transfers
1944 of operations or changes of control involving its clinical or nonclinical
1945 services or functions from such hospital to a person or entity organized

1946 or operated for profit.

1947 (d) Each hospital that is a party to a transfer of ownership involving
1948 a hospital for which a certificate of need application was filed and
1949 approved pursuant to this chapter shall, during the fiscal year ending
1950 on September thirtieth of the immediately preceding year, include in
1951 the annual report required pursuant to subsection (a) of this section
1952 any salary, severance payment, stock offering or other financial gain
1953 realized by each officer, director, board member or senior manager of
1954 the hospital as a result of such transaction.

1955 (e) The [office] unit shall require each hospital licensed by the
1956 Department of Public Health, that is not subject to the provisions of
1957 subsection (a) of this section, to report to said [office] unit on its
1958 operations in the preceding fiscal year by filing copies of the hospital's
1959 audited financial statements, except a health system, as defined in
1960 section 19a-508c, as amended by this act, may submit to the [office]
1961 unit one such report that includes the audited financial statements for
1962 each of its hospitals. Such report shall be due at the [office] unit on or
1963 before the close of business on the last business day of the fifth month
1964 following the month in which a hospital's fiscal year ends.

1965 Sec. 36. Section 19a-645 of the general statutes is repealed and the
1966 following is substituted in lieu thereof (*Effective from passage*):

1967 A nonprofit hospital, licensed by the Department of Public Health,
1968 which provides lodging, care and treatment to members of the public,
1969 and which wishes to enlarge its public facilities by adding contiguous
1970 land and buildings thereon, if any, the title to which it cannot
1971 otherwise acquire, may prefer a complaint for the right to take such
1972 land to the superior court for the judicial district in which such land is
1973 located, provided such hospital shall have received the approval of the
1974 [Office of Health Care Access division] Health Systems Planning Unit
1975 of the [Department of Public Health] Office of Health Strategy in
1976 accordance with the provisions of this chapter. Said court shall appoint
1977 a committee of three disinterested persons, who, after examining the

1978 premises and hearing the parties, shall report to the court as to the
1979 necessity and propriety of such enlargement and as to the quantity,
1980 boundaries and value of the land and buildings thereon, if any, which
1981 they deem proper to be taken for such purpose and the damages
1982 resulting from such taking. If such committee reports that such
1983 enlargement is necessary and proper and the court accepts such report,
1984 the decision of said court thereon shall have the effect of a judgment
1985 and execution may be issued thereon accordingly, in favor of the
1986 person to whom damages may be assessed, for the amount thereof;
1987 and, on payment thereof, the title to the land and buildings thereon, if
1988 any, for such purpose shall be vested in the complainant, but such land
1989 and buildings thereon, if any, shall not be taken until such damages
1990 are paid to such owner or deposited with said court, for such owner's
1991 use, within thirty days after such report is accepted. If such application
1992 is denied, the owner of the land shall recover costs of the applicant, to
1993 be taxed by said court, which may issue execution therefor. Land so
1994 taken shall be held by such hospital and used only for the public
1995 purpose stated in its complaint to the superior court. No land
1996 dedicated or otherwise reserved as open space or park land or for
1997 other recreational purposes and no land belonging to any town, city or
1998 borough shall be taken under the provisions of this section.

1999 Sec. 37. Section 19a-646 of the general statutes is repealed and the
2000 following is substituted in lieu thereof (*Effective from passage*):

2001 (a) As used in this section:

2002 **[**(1) "Office" means the Office of Health Care Access division of the
2003 Department of Public Health;**]**

2004 <u>(1) "Unit" means the Health Systems Planning Unit within the Office</u>
2005 <u>of Health Strategy, established under section 19a-612, as amended by</u>
2006 <u>this act;</u>

2007 (2) "Fiscal year" means the hospital fiscal year, as used for purposes
2008 of this chapter, consisting of a twelve-month period commencing on
2009 October first and ending the following September thirtieth;

2010 (3) "Hospital" means any short-term acute care general or children's
2011 hospital licensed by the Department of Public Health, including the
2012 John Dempsey Hospital of The University of Connecticut Health
2013 Center;

2014 (4) "Payer" means any person, legal entity, governmental body or
2015 eligible organization that meets the definition of an eligible
2016 organization under 42 USC Section 1395mm (b) of the Social Security
2017 Act, or any combination thereof, except for Medicare and Medicaid
2018 which is or may become legally responsible, in whole or in part for the
2019 payment of services rendered to or on behalf of a patient by a hospital.
2020 Payer also includes any legal entity whose membership includes one
2021 or more payers and any third-party payer; and

2022 (5) "Prompt payment" means payment made for services to a
2023 hospital by mail or other means on or before the tenth business day
2024 after receipt of the bill by the payer.

2025 (b) No hospital shall provide a discount or different rate or method
2026 of reimbursement from the filed rates or charges to any payer except as
2027 provided in this section.

2028 (c) (1) Any payer may directly negotiate with a hospital for a
2029 different rate or method of reimbursement, or both, provided the
2030 charges and payments for the payer are on file at the hospital business
2031 office in accordance with this subsection. No discount agreement or
2032 agreement for a different rate or method of reimbursement, or both,
2033 shall be effective until a complete written agreement between the
2034 hospital and the payer is on file at the hospital. Each such agreement
2035 shall be available to the **[**office**]** unit for inspection or submission to the
2036 **[**office**]** unit upon request, for at least three years after the close of the
2037 applicable fiscal year.

2038 (2) The charges and payments for each payer receiving a discount
2039 shall be accumulated by the hospital for each payer and reported as
2040 required by the **[**office**]** unit.

2041 (3) A full written copy of each agreement executed pursuant to this
2042 subsection shall be on file in the hospital business office within twenty-
2043 four hours of execution.

2044 (d) A payer may negotiate with a hospital to obtain a discount on
2045 rates or charges for prompt payment.

2046 (e) A payer may also negotiate for and may receive a discount for
2047 the provision of the following administrative services: (1) A system
2048 which permits the hospital to bill the payer through either a computer-
2049 processed or machine-readable or similar billing procedure; (2) a
2050 system which enables the hospital to verify coverage of a patient by
2051 the payer at the time the service is provided; and (3) a guarantee of
2052 payment within the scope of the agreement between the patient and
2053 the third-party payer for service to the patient prior to the provision of
2054 that service.

2055 (f) No hospital may require a payer to negotiate for another element
2056 or any combination of the above elements of a discount, as established
2057 in subsections (d) and (e) of this section, in order to negotiate for or
2058 obtain a discount for any single element. No hospital may require a
2059 payer to negotiate a discount for all patients covered by such payer in
2060 order to negotiate a discount for any patient or group of patients
2061 covered by such payer.

2062 (g) Any hospital which agrees to provide a discount to a payer
2063 under subsection (d) or (e) of this section shall file a copy of the
2064 agreement in the hospital's business office and shall provide the same
2065 discount to any other payer who agrees to make prompt payment or
2066 provide administrative services similar to that contained in the
2067 agreement. Each agreement filed shall specify on its face that it was
2068 executed and filed pursuant to this subsection.

2069 (h) (1) Nothing in this section shall be construed to require payment
2070 by any payer or purchaser, under any program or contract for
2071 payment or reimbursement of expenses for health care services, for:
2072 (A) Services not covered under such program or contract; or (B) that

2073 portion of any charge for services furnished by a hospital that exceeds
2074 the amount covered by such program or contract.

2075 (2) Nothing in this section shall be construed to supersede or modify
2076 any provision of such program or contract that requires payment of a
2077 copayment, deductible or enrollment fee or that imposes any similar
2078 requirement.

2079 (i) A hospital which has established a program approved by the
2080 **[**office**]** unit with one or more banks for the purpose of reducing the
2081 hospital's bad debt load, may reduce its published charges for that
2082 portion of a patient's bill for services which a payer who is a private
2083 individual is or may become legally responsible for, after all other
2084 insurers or third-party payers have been assessed their full charges
2085 provided (1) prior to the rendering of such services, the hospital and
2086 the individual payer or parent or guardian or custodian have agreed in
2087 writing that after receipt of any insurer or third-party payment paid in
2088 accordance with the full hospital charges the remaining payment due
2089 from the private individual for such reduced charges shall be made in
2090 whole or in part from the balance on deposit in a bank account which
2091 has been established by or on behalf of such individual patient, and (2)
2092 such payment is made from such account. Nothing in this section shall
2093 relieve a patient or legally liable person from being responsible for the
2094 full amount of any underpayment of the hospital's authorized charges
2095 excluding any discount under this section, by a patient's insurer or any
2096 other third-party payer for that insurer's or third-party payer's portion
2097 of the bill. Any reduction in charges granted to an individual or parent
2098 or guardian or custodian under this subsection shall be reported to the
2099 **[**office**]** unit as a contractual allowance. For purposes of this **[**section**]**
2100 subsection "private individual" shall include a patient's parent, legal
2101 guardian or legal custodian but shall not include an insurer or third-
2102 party payer.

2103 Sec. 38. Section 19a-649 of the general statutes is repealed and the
2104 following is substituted in lieu thereof (*Effective from passage*):

2105 (a) The [office] unit shall review annually the level of
2106 uncompensated care provided by each hospital to the indigent. Each
2107 hospital shall file annually with the [office] unit its policies regarding
2108 the provision of charity care and reduced cost services to the indigent,
2109 excluding medical assistance recipients, and its debt collection
2110 practices. A hospital shall file its audited financial statements not later
2111 than February twenty-eighth of each year, except a health system, as
2112 defined in section 19a-508c, as amended by this act, may file one such
2113 statement that includes the audited financial statements for each
2114 hospital within the health system. Not later than March thirty-first of
2115 each year, the hospital shall file a verification of the hospital's net
2116 revenue for the most recently completed fiscal year in a format
2117 prescribed by the [office] unit.

2118 (b) Each hospital shall annually report, along with data submitted
2119 pursuant to subsection (a) of this section, (1) the number of applicants
2120 for charity care and reduced cost services, (2) the number of approved
2121 applicants, and (3) the total and average charges and costs of the
2122 amount of charity care and reduced cost services provided.

2123 (c) Each hospital recognized as a nonprofit organization under
2124 Section 501(c)(3) of the Internal Revenue Code of 1986, or any
2125 subsequent corresponding internal revenue code of the United States,
2126 as amended from time to time, shall, along with data submitted
2127 annually pursuant to subsection (a) of this section, submit to the
2128 [office] unit (1) a complete copy of such hospital's most-recently
2129 completed Internal Revenue Service form 990, including all parts and
2130 schedules; and (2) in the form and manner prescribed by the [office]
2131 unit, data compiled to prepare such hospital's community health needs
2132 assessment, as required pursuant to Section 501(r) of the Internal
2133 Revenue Code of 1986, or any subsequent corresponding internal
2134 revenue code of the United States, as amended from time to time,
2135 provided such copy and data submitted pursuant to this subsection
2136 shall not include: (A) Individual patient information, including, but
2137 not limited to, patient-identifiable information; (B) information that is
2138 not owned or controlled by such hospital; (C) information that such

2139 hospital is contractually required to keep confidential or that is
2140 prohibited from disclosure by a data use agreement; or (D) information
2141 concerning research on human subjects as described in section 45 CFR
2142 46.101 et seq., as amended from time to time.

2143 Sec. 39. Section 19a-653 of the general statutes is repealed and the
2144 following is substituted in lieu thereof (*Effective from passage*):

2145 (a) Any person or health care facility or institution that is required
2146 to file a certificate of need for any of the activities described in section
2147 19a-638, as amended by this act, and any person or health care facility
2148 or institution that is required to file data or information under any
2149 public or special act or under this chapter or sections 19a-486 to 19a-
2150 486h, inclusive, as amended by this act, or any regulation adopted or
2151 order issued under this chapter or said sections, which wilfully fails to
2152 seek certificate of need approval for any of the activities described in
2153 section 19a-638, as amended by this act, or to so file within prescribed
2154 time periods, shall be subject to a civil penalty of up to one thousand
2155 dollars a day for each day such person or health care facility or
2156 institution conducts any of the described activities without certificate
2157 of need approval as required by section 19a-638, as amended by this
2158 act, or for each day such information is missing, incomplete or
2159 inaccurate. Any civil penalty authorized by this section shall be
2160 imposed by the **[**Department of Public Health**]** Office of Health
2161 Strategy in accordance with subsections (b) to (e), inclusive, of this
2162 section.

2163 (b) If the **[**Department of Public Health**]** Office of Health Strategy
2164 has reason to believe that a violation has occurred for which a civil
2165 penalty is authorized by subsection (a) of this section or subsection (e)
2166 of section 19a-632, as amended by this act, it shall notify the person or
2167 health care facility or institution by first-class mail or personal service.
2168 The notice shall include: (1) A reference to the sections of the statute or
2169 regulation involved; (2) a short and plain statement of the matters
2170 asserted or charged; (3) a statement of the amount of the civil penalty
2171 or penalties to be imposed; (4) the initial date of the imposition of the

2172 penalty; and (5) a statement of the party's right to a hearing.

2173 (c) The person or health care facility or institution to whom the
2174 notice is addressed shall have fifteen business days from the date of
2175 mailing of the notice to make written application to the **[**office**]** <u>unit</u> to
2176 request (1) a hearing to contest the imposition of the penalty, or (2) an
2177 extension of time to file the required data. A failure to make a timely
2178 request for a hearing or an extension of time to file the required data or
2179 a denial of a request for an extension of time shall result in a final order
2180 for the imposition of the penalty. All hearings under this section shall
2181 be conducted pursuant to sections 4-176e to 4-184, inclusive. The
2182 **[**Department of Public Health**]** <u>Office of Health Strategy</u> may grant an
2183 extension of time for filing the required data or mitigate or waive the
2184 penalty upon such terms and conditions as, in its discretion, it deems
2185 proper or necessary upon consideration of any extenuating factors or
2186 circumstances.

2187 (d) A final order of the **[**Department of Public Health**]** <u>Office of</u>
2188 <u>Health Strategy</u> assessing a civil penalty shall be subject to appeal as
2189 set forth in section 4-183 after a hearing before the **[**office**]** <u>unit</u>
2190 pursuant to subsection (c) of this section, except that any such appeal
2191 shall be taken to the superior court for the judicial district of New
2192 Britain. Such final order shall not be subject to appeal under any other
2193 provision of the general statutes. No challenge to any such final order
2194 shall be allowed as to any issue which could have been raised by an
2195 appeal of an earlier order, denial or other final decision by the
2196 **[**Department of Public Health**]** <u>office</u>.

2197 (e) If any person or health care facility or institution fails to pay any
2198 civil penalty under this section, after the assessment of such penalty
2199 has become final the amount of such penalty may be deducted from
2200 payments to such person or health care facility or institution from the
2201 Medicaid account.

2202 Sec. 40. Section 19a-654 of the general statutes is repealed and the
2203 following is substituted in lieu thereof (*Effective from passage*):

2204 (a) As used in this section:

2205 (1) "Patient-identifiable data" means any information that identifies
2206 or may reasonably be used as a basis to identify an individual patient;
2207 and

2208 (2) "De-identified patient data" means any information that meets
2209 the requirements for de-identification of protected health information
2210 as set forth in 45 CFR 164.514.

2211 (b) Each short-term acute care general or children's hospital shall
2212 submit patient-identifiable inpatient discharge data and emergency
2213 department data to the **[**Office of Health Care Access division**]** <u>Health</u>
2214 <u>Systems Planning Unit</u> of the **[**Department of Public Health**]** <u>Office of</u>
2215 <u>Health Strategy</u> to fulfill the responsibilities of the **[**office**]** <u>unit</u>. Such
2216 data shall include data taken from patient medical record abstracts and
2217 bills. The **[**office**]** <u>unit</u> shall specify the timing and format of such
2218 submissions. Data submitted pursuant to this section may be
2219 submitted through a contractual arrangement with an intermediary
2220 and such contractual arrangement shall (1) comply with the provisions
2221 of the Health Insurance Portability and Accountability Act of 1996 P.L.
2222 104-191 (HIPAA), and (2) ensure that such submission of data is timely
2223 and accurate. The **[**office**]** <u>unit</u> may conduct an audit of the data
2224 submitted through such intermediary in order to verify its accuracy.

2225 (c) An outpatient surgical facility, as defined in section 19a-493b, <u>as</u>
2226 <u>amended by this act,</u> a short-term acute care general or children's
2227 hospital, or a facility that provides outpatient surgical services as part
2228 of the outpatient surgery department of a short-term acute care
2229 hospital shall submit to the **[**office**]** <u>unit</u> the data identified in
2230 subsection (c) of section 19a-634<u>, as amended by this act</u>. The **[**office**]**
2231 <u>unit</u> shall convene a working group consisting of representatives of
2232 outpatient surgical facilities, hospitals and other individuals necessary
2233 to develop recommendations that address current obstacles to, and
2234 proposed requirements for, patient-identifiable data reporting in the
2235 outpatient setting. On or before February 1, 2012, the working group

2236 shall report, in accordance with the provisions of section 11-4a, on its
2237 findings and recommendations to the joint standing committees of the
2238 General Assembly having cognizance of matters relating to public
2239 health and insurance and real estate. Additional reporting of
2240 outpatient data as the [office] unit deems necessary shall begin not
2241 later than July 1, 2015. On or before July 1, [2012] 2018, and annually
2242 thereafter, the Connecticut Association of Ambulatory Surgery Centers
2243 shall provide a progress report to the [Department of Public Health]
2244 Office of Health Strategy, until such time as all ambulatory surgery
2245 centers are in full compliance with the implementation of systems that
2246 allow for the reporting of outpatient data as required by the
2247 [commissioner] executive director. Until such additional reporting
2248 requirements take effect on July 1, 2015, the department may work
2249 with the Connecticut Association of Ambulatory Surgery Centers and
2250 the Connecticut Hospital Association on specific data reporting
2251 initiatives provided that no penalties shall be assessed under this
2252 chapter or any other provision of law with respect to the failure to
2253 submit such data.

2254 (d) Except as provided in this subsection, patient-identifiable data
2255 received by the [office] unit shall be kept confidential and shall not be
2256 considered public records or files subject to disclosure under the
2257 Freedom of Information Act, as defined in section 1-200. The [office]
2258 unit may release de-identified patient data or aggregate patient data to
2259 the public in a manner consistent with the provisions of 45 CFR
2260 164.514. Any de-identified patient data released by the [office] unit
2261 shall exclude provider, physician and payer organization names or
2262 codes and shall be kept confidential by the recipient. The [office] unit
2263 may release patient-identifiable data (1) for medical and scientific
2264 research as provided for in section 19a-25-3 of the regulations of
2265 Connecticut state agencies, and (2) to (A) a state agency for the
2266 purpose of improving health care service delivery, (B) a federal agency
2267 or the office of the Attorney General for the purpose of investigating
2268 hospital mergers and acquisitions, or (C) another state's health data
2269 collection agency with which the [office] unit has entered into a

2270 reciprocal data-sharing agreement for the purpose of certificate of need
2271 review or evaluation of health care services, upon receipt of a request
2272 from such agency, provided, prior to the release of such patient-
2273 identifiable data, such agency enters into a written agreement with the
2274 [office] unit pursuant to which such agency agrees to protect the
2275 confidentiality of such patient-identifiable data and not to use such
2276 patient-identifiable data as a basis for any decision concerning a
2277 patient. No individual or entity receiving patient-identifiable data may
2278 release such data in any manner that may result in an individual
2279 patient, physician, provider or payer being identified. The [office] unit
2280 shall impose a reasonable, cost-based fee for any patient data provided
2281 to a nongovernmental entity.

2282 (e) Not later than October 1, [2011] 2018, the [Office of Health Care
2283 Access] Health Systems Planning Unit shall enter into a memorandum
2284 of understanding with the Comptroller that shall permit the
2285 Comptroller to access the data set forth in subsections (b) and (c) of
2286 this section, provided the Comptroller agrees, in writing, to keep
2287 individual patient and provider data identified by proper name or
2288 personal identification code and submitted pursuant to this section
2289 confidential.

2290 (f) The [Commissioner of Public Health] executive director of the
2291 Office of Health Strategy shall adopt regulations, in accordance with
2292 the provisions of chapter 54, to carry out the provisions of this section.

2293 (g) The duties assigned to the [Department of Public Health] Office
2294 of Health Strategy under the provisions of this section shall be
2295 implemented within available appropriations.

2296 Sec. 41. Section 19a-659 of the general statutes is repealed and the
2297 following is substituted in lieu thereof (*Effective from passage*):

2298 As used in [this chapter] sections 19a-644, as amended by this act,
2299 19a-649, as amended by this act, 19a-670, as amended by this act, and
2300 19a-676, as amended by this act, unless the context otherwise requires:

2301 [(1) "Office" means the Office of Health Care Access division of the
2302 Department of Public Health;]

2303 (1) "Unit" means the Health Systems Planning Unit within the Office
2304 of Health Strategy, established under section 19a-612, as amended by
2305 this act;

2306 (2) "Hospital" means any hospital licensed as a short-term acute care
2307 general or children's hospital by the Department of Public Health,
2308 including John Dempsey Hospital of The University of Connecticut
2309 Health Center;

2310 (3) "Fiscal year" means the hospital fiscal year consisting of a twelve-
2311 month period commencing on October first and ending the following
2312 September thirtieth;

2313 (4) "Affiliate" means a person, entity or organization controlling,
2314 controlled by, or under common control with another person, entity or
2315 organization;

2316 (5) "Uncompensated care" means the total amount of charity care
2317 and bad debts determined by using the hospital's published charges
2318 and consistent with the hospital's policies regarding charity care and
2319 bad debts which are on file at the [office] unit;

2320 (6) "Medical assistance" means (A) the programs for medical
2321 assistance provided under the Medicaid program, including HUSKY
2322 A, or (B) any other state-funded medical assistance program, including
2323 HUSKY B;

2324 (7) "CHAMPUS" or "TriCare" means the federal Civilian Health and
2325 Medical Program of the Uniformed Services, as defined in 10 USC
2326 1072(4), as from time to time amended;

2327 (8) "Primary payer" means the payer responsible for the highest
2328 percentage of the charges for a patient's inpatient or outpatient
2329 hospital services;

2330 (9) "Case mix index" means the arithmetic mean of the Medicare
2331 diagnosis related group case weights assigned to each inpatient
2332 discharge for a specific hospital during a given fiscal year. The case
2333 mix index shall be calculated by dividing the hospital's total case mix
2334 adjusted discharges by the hospital's actual number of discharges for
2335 the fiscal year. The total case mix adjusted discharges shall be
2336 calculated by (A) multiplying the number of discharges in each
2337 diagnosis-related group by the Medicare weights in effect for that
2338 same diagnosis-related group and fiscal year, and (B) then totaling the
2339 resulting products for all diagnosis-related groups;

2340 (10) "Contractual allowances" means the difference between hospital
2341 published charges and payments generated by negotiated agreements
2342 for a different or discounted rate or method of payment;

2343 (11) "Medical assistance underpayment" means the amount
2344 calculated by dividing the total net revenue by the total gross revenue,
2345 and then multiplying the quotient by the total medical assistance
2346 charges, and then subtracting medical assistance payments from the
2347 product;

2348 (12) "Other allowances" means the amount of any difference
2349 between charges for employee self-insurance and related expenses
2350 determined using the hospital's overall relationship of costs to charges;

2351 (13) "Gross revenue" means the total gross patient charges for all
2352 patient services provided by a hospital; and

2353 (14) "Net revenue" means total gross revenue less contractual
2354 allowance, less the difference between government charges and
2355 government payments, less uncompensated care and other allowances.

2356 Sec. 42. Section 19a-670 of the general statutes is repealed and the
2357 following is substituted in lieu thereof (*Effective from passage*):

2358 The [office] unit shall, by September first of each year, report the
2359 results of the [office's] unit's review of the hospitals' annual and

2360 twelve-month filings under sections 19a-644, as amended by this act,
2361 19a-649, as amended by this act, and 19a-676, as amended by this act,
2362 for the previous hospital fiscal year to the joint standing committee of
2363 the General Assembly having cognizance of matters relating to public
2364 health. The report shall include information concerning the financial
2365 stability of hospitals in a competitive market.

2366 Sec. 43. Subdivision (1) of subsection (a) of section 19a-673 of the
2367 general statutes is repealed and the following is substituted in lieu
2368 thereof (*Effective from passage*):

2369 (1) "Cost of providing services" means a hospital's published
2370 charges at the time of billing, multiplied by the hospital's most recent
2371 relationship of costs to charges as taken from the hospital's most
2372 recently available annual financial filing with the **[**office**]** unit.

2373 Sec. 44. Section 19a-673a of the general statutes is repealed and the
2374 following is substituted in lieu thereof (*Effective from passage*):

2375 The **[**Commissioner of Public Health**]** executive director of the
2376 Office of Health Strategy shall adopt regulations, in accordance with
2377 chapter 54, to establish uniform debt collection standards for hospitals.

2378 Sec. 45. Section 19a-673c of the general statutes is repealed and the
2379 following is substituted in lieu thereof (*Effective from passage*):

2380 On or before March 1, 2004, and annually thereafter, each hospital
2381 shall file with the **[**office**]** unit a debt collection report that includes (1)
2382 whether the hospital uses a collection agent, as defined in section 19a-
2383 509b, as amended by this act, to assist with debt collection, (2) the
2384 name of any collection agent used, (3) the hospital's processes and
2385 policies for assigning a debt to a collection agent and for compensating
2386 such collection agent for services rendered, and (4) the recovery rate on
2387 accounts assigned to collection agents, exclusive of Medicare accounts,
2388 in the most recent hospital fiscal year.

2389 Sec. 46. Section 19a-676 of the general statutes is repealed and the

2390 following is substituted in lieu thereof (*Effective from passage*):

2391 On or before March thirty-first of each year, for the preceding fiscal
2392 year, each hospital shall submit to the [office] unit, in the form and
2393 manner prescribed by the [office] unit, the data specified in regulations
2394 adopted by the [commissioner] executive director in accordance with
2395 chapter 54, the hospital's verification of net revenue required under
2396 section 19a-649, as amended by this act, and any other data required
2397 by the [office] unit, including hospital budget system data for the
2398 hospital's twelve months' actual filing requirements.

2399 Sec. 47. Section 19a-681 of the general statutes is repealed and the
2400 following is substituted in lieu thereof (*Effective from passage*):

2401 (a) For purposes of this section: (1) "Detailed patient bill" means a
2402 patient billing statement that includes, in each line item, the hospital's
2403 current pricemaster code, a description of the charge and the billed
2404 amount; and (2) "pricemaster" means a detailed schedule of hospital
2405 charges.

2406 (b) Each hospital shall file with the [office] unit its current
2407 pricemaster which shall include each charge in its detailed schedule of
2408 charges.

2409 (c) Upon the request of the [Department of Public Health] Office of
2410 Health Strategy, established under section 19a-754a, as amended by
2411 this act, or a patient, a hospital shall provide to the [department] office
2412 or the patient a detailed patient bill. If the billing detail by line item on
2413 a detailed patient bill does not agree with the detailed schedule of
2414 charges on file with the [office] unit for the date of service specified on
2415 the bill, the hospital shall be subject to a civil penalty of five hundred
2416 dollars per occurrence payable to the state not later than fourteen days
2417 after the date of notification. The penalty shall be imposed in
2418 accordance with section 19a-653, as amended by this act. The [office]
2419 unit may issue an order requiring such hospital, not later than fourteen
2420 days after the date of notification of an overcharge to a patient, to
2421 adjust the bill to be consistent with the detailed schedule of charges on

2422 file with the [office] unit for the date of service specified on the
2423 detailed patient bill.

2424 Sec. 48. Section 19a-486 of the general statutes is repealed and the
2425 following is substituted in lieu thereof (*Effective from passage*):

2426 For purposes of sections 19a-486 to 19a-486h, inclusive, as amended
2427 by this act:

2428 (1) "Nonprofit hospital" means a nonprofit entity licensed as a
2429 hospital pursuant to this chapter and any entity affiliated with such a
2430 hospital through governance or membership, including, but not
2431 limited to, a holding company or subsidiary.

2432 (2) "Purchaser" means a person acquiring any assets of a nonprofit
2433 hospital through a transfer.

2434 (3) "Person" means any individual, firm, partnership, corporation,
2435 limited liability company, association or other entity.

2436 (4) "Transfer" means to sell, transfer, lease, exchange, option,
2437 convey, give or otherwise dispose of or transfer control over,
2438 including, but not limited to, transfer by way of merger or joint
2439 venture not in the ordinary course of business.

2440 (5) "Control" has the meaning assigned to it in section 36b-41.

2441 (6) ["Commissioner" means the Commissioner of Public Health or
2442 the commissioner's designee.] "Executive director" means the executive
2443 director of the Office of Health Strategy, established under section 19a-
2444 754a, as amended by this act, or the executive director's designee.

2445 Sec. 49. Section 19a-486a of the general statutes is repealed and the
2446 following is substituted in lieu thereof (*Effective from passage*):

2447 (a) No nonprofit hospital shall enter into an agreement to transfer a
2448 material amount of its assets or operations or a change in control of
2449 operations to a person that is organized or operated for profit without

2450 first having received approval of the agreement by the [commissioner]
2451 executive director and the Attorney General pursuant to sections 19a-
2452 486 to 19a-486h, inclusive, as amended by this act, and pursuant to the
2453 Attorney General's authority under section 3-125. Any such agreement
2454 without the approval required by sections 19a-486 to 19a-486h,
2455 inclusive, as amended by this act, shall be void.

2456 (b) Prior to any transaction described in subsection (a) of this
2457 section, the nonprofit hospital and the purchaser shall concurrently
2458 submit a certificate of need determination letter as described in
2459 subsection (c) of section 19a-638, as amended by this act, to the
2460 [commissioner] executive director and the Attorney General by serving
2461 it on them by certified mail, return receipt requested, or delivering it
2462 by hand to each office. The certificate of need determination letter shall
2463 contain: (1) The name and address of the nonprofit hospital; (2) the
2464 name and address of the purchaser; (3) a brief description of the terms
2465 of the proposed agreement; and (4) the estimated capital expenditure,
2466 cost or value associated with the proposed agreement. The certificate
2467 of need determination letter shall be subject to disclosure pursuant to
2468 section 1-210.

2469 (c) Not later than thirty days after receipt of the certificate of need
2470 determination letter by the [commissioner] executive director and the
2471 Attorney General, the purchaser and the nonprofit hospital shall hold a
2472 hearing on the contents of the certificate of need determination letter in
2473 the municipality in which the new hospital is proposed to be located.
2474 The nonprofit hospital shall provide not less than two weeks' advance
2475 notice of the hearing to the public by publication in a newspaper
2476 having a substantial circulation in the affected community for not less
2477 than three consecutive days. Such notice shall contain substantially the
2478 same information as in the certificate of need determination letter. The
2479 purchaser and the nonprofit hospital shall record and transcribe the
2480 hearing and make such recording or transcription available to the
2481 [commissioner] executive director, the Attorney General or members
2482 of the public upon request. A public hearing held in accordance with
2483 the provisions of section 19a-639a, as amended by this act, shall satisfy

2484 the requirements of this subsection.

2485 (d) The [commissioner] executive director and the Attorney General
2486 shall review the certificate of need determination letter. The Attorney
2487 General shall determine whether the agreement requires approval
2488 pursuant to this chapter. If such approval is required, the
2489 [commissioner] executive director and the Attorney General shall
2490 transmit to the purchaser and the nonprofit hospital an application
2491 form for approval pursuant to this chapter, unless the [commissioner]
2492 executive director refuses to accept a filed or submitted certificate of
2493 need determination letter. Such application form shall require the
2494 following information: (1) The name and address of the nonprofit
2495 hospital; (2) the name and address of the purchaser; (3) a description of
2496 the terms of the proposed agreement; (4) copies of all contracts,
2497 agreements and memoranda of understanding relating to the proposed
2498 agreement; (5) a fairness evaluation by an independent person who is
2499 an expert in such agreements, that includes an analysis of each of the
2500 criteria set forth in section 19a-486c; (6) documentation that the
2501 nonprofit hospital exercised the due diligence required by subdivision
2502 (2) of subsection (a) of section 19a-486c, including disclosure of the
2503 terms of any other offers to transfer assets or operations or change
2504 control of operations received by the nonprofit hospital and the reason
2505 for rejection of such offers; and (7) such other information as the
2506 [commissioner] executive director or the Attorney General deem
2507 necessary to their review pursuant to the provisions of sections 19a-486
2508 to 19a-486f, inclusive, as amended by this act, and chapter 368z. The
2509 application shall be subject to disclosure pursuant to section 1-210.

2510 (e) No later than sixty days after the date of mailing of the
2511 application form, the nonprofit hospital and the purchaser shall
2512 concurrently file an application with the [commissioner] executive
2513 director and the Attorney General containing all the required
2514 information. The [commissioner] executive director and the Attorney
2515 General shall review the application and determine whether the
2516 application is complete. The [commissioner] executive director and the
2517 Attorney General shall, no later than twenty days after the date of their

2518 receipt of the application, provide written notice to the nonprofit
2519 hospital and the purchaser of any deficiencies in the application. Such
2520 application shall not be deemed complete until such deficiencies are
2521 corrected.

2522 (f) No later than twenty-five days after the date of their receipt of
2523 the completed application under this section, the [commissioner]
2524 executive director and the Attorney General shall jointly publish a
2525 summary of such agreement in a newspaper of general circulation
2526 where the nonprofit hospital is located.

2527 (g) Any person may seek to intervene in the proceedings under
2528 section 19a-486e, as amended by this act, in the same manner as
2529 provided in section 4-177a.

2530 Sec. 50. Section 19a-486b of the general statutes is repealed and the
2531 following is substituted in lieu thereof (*Effective from passage*):

2532 (a) Not later than one hundred twenty days after the date of receipt
2533 of the completed application pursuant to subsection (e) of section 19a-
2534 486a, as amended by this act, the Attorney General and the
2535 [commissioner] executive director shall approve the application, with
2536 or without modification, or deny the application. The [commissioner]
2537 executive director shall also determine, in accordance with the
2538 provisions of chapter 368z, whether to approve, with or without
2539 modification, or deny the application for a certificate of need that is
2540 part of the completed application. Notwithstanding the provisions of
2541 section 19a-639a, as amended by this act, the [commissioner] executive
2542 director shall complete the decision on the application for a certificate
2543 of need within the same time period as the completed application.
2544 Such one-hundred-twenty-day period may be extended by (1)
2545 agreement of the Attorney General, the [commissioner] executive
2546 director, the nonprofit hospital and the purchaser, or (2) the
2547 [commissioner] executive director for an additional one hundred
2548 twenty days pending completion of a cost and market impact review
2549 conducted pursuant to section 19a-639f, as amended by this act. If the

2550 Attorney General initiates a proceeding to enforce a subpoena
2551 pursuant to section 19a-486c or 19a-486d, as amended by this act, the
2552 one-hundred-twenty-day period shall be tolled until the final court
2553 decision on the last pending enforcement proceeding, including any
2554 appeal or time for the filing of such appeal. Unless the one-hundred-
2555 twenty-day period is extended pursuant to this section, if the
2556 [commissioner] executive director and Attorney General fail to take
2557 action on an agreement prior to the one hundred twenty-first day after
2558 the date of the filing of the completed application, the application shall
2559 be deemed approved.

2560 (b) The [commissioner] executive director and the Attorney General
2561 may place any conditions on the approval of an application that relate
2562 to the purposes of sections 19a-486a to 19a-486h, inclusive, as amended
2563 by this act. In placing any such conditions the [commissioner]
2564 executive director shall follow the guidelines and criteria described in
2565 subdivision (4) of subsection (d) of section 19a-639, as amended by this
2566 act. Any such conditions may be in addition to any conditions placed
2567 by the [commissioner] executive director pursuant to subdivision (4) of
2568 subsection (d) of section 19a-639, as amended by this act.

2569 Sec. 51. Section 19a-486d of the general statutes is repealed and the
2570 following is substituted in lieu thereof (*Effective from passage*):

2571 (a) The [commissioner] executive director shall deny an application
2572 filed pursuant to subsection (d) of section 19a-486a, as amended by this
2573 act, unless the [commissioner] executive director finds that: (1) In a
2574 situation where the asset or operation to be transferred provides or has
2575 provided health care services to the uninsured or underinsured, the
2576 purchaser has made a commitment to provide health care to the
2577 uninsured and the underinsured; (2) in a situation where health care
2578 providers or insurers will be offered the opportunity to invest or own
2579 an interest in the purchaser or an entity related to the purchaser
2580 safeguard procedures are in place to avoid a conflict of interest in
2581 patient referral; and (3) certificate of need authorization is justified in
2582 accordance with chapter 368z. The [commissioner] executive director

2583 may contract with any person, including, but not limited to, financial
2584 or actuarial experts or consultants, or legal experts with the approval
2585 of the Attorney General, to assist in reviewing the completed
2586 application. The [commissioner] executive director shall submit any
2587 bills for such contracts to the purchaser. Such bills shall not exceed one
2588 hundred fifty thousand dollars. The purchaser shall pay such bills no
2589 later than thirty days after the date of receipt of such bills.

2590 (b) The [commissioner] executive director may, during the course of
2591 a review required by this section: (1) Issue in writing and cause to be
2592 served upon any person, by subpoena, a demand that such person
2593 appear before the [commissioner] executive director and give
2594 testimony or produce documents as to any matters relevant to the
2595 scope of the review; and (2) issue written interrogatories, to be
2596 answered under oath, as to any matters relevant to the scope of the
2597 review and prescribing a return date that would allow a reasonable
2598 time to respond. If any person fails to comply with the provisions of
2599 this subsection, the [commissioner] executive director, through the
2600 Attorney General, may apply to the superior court for the judicial
2601 district of Hartford seeking enforcement of such subpoena. The
2602 superior court may, upon notice to such person, issue and cause to be
2603 served an order requiring compliance. Service of subpoenas ad
2604 testificandum, subpoenas duces tecum, notices of deposition and
2605 written interrogatories as provided in this subsection may be made by
2606 personal service at the usual place of abode or by certified mail, return
2607 receipt requested, addressed to the person to be served at such
2608 person's principal place of business within or without this state or such
2609 person's residence.

2610 Sec. 52. Section 19a-486e of the general statutes is repealed and the
2611 following is substituted in lieu thereof (*Effective from passage*):

2612 Prior to making any decision to approve, with or without
2613 modification, or deny any application filed pursuant to subsection (d)
2614 of section 19a-486a, as amended by this act, the Attorney General and
2615 the [commissioner] executive director shall jointly conduct one or more

2616 public hearings, one of which shall be in the primary service area of
2617 the nonprofit hospital. At least fourteen days before conducting the
2618 public hearing, the Attorney General and the [commissioner] executive
2619 director shall provide notice of the time and place of the hearing
2620 through publication in one or more newspapers of general circulation
2621 in the affected community.

2622 Sec. 53. Section 19a-486f of the general statutes is repealed and the
2623 following is substituted in lieu thereof (*Effective from passage*):

2624 If the [commissioner] executive director or the Attorney General
2625 denies an application filed pursuant to subsection (d) of section 19a-
2626 486a, as amended by this act, or approves it with modification, the
2627 nonprofit hospital or the purchaser may appeal such decision in the
2628 same manner as provided in section 4-183, provided that nothing in
2629 sections 19a-486 to 19a-486f, inclusive, as amended by this act, shall be
2630 construed to apply the provisions of chapter 54 to the proceedings of
2631 the Attorney General.

2632 Sec. 54. Section 19a-486g of the general statutes is repealed and the
2633 following is substituted in lieu thereof (*Effective from passage*):

2634 The Commissioner of Public Health shall refuse to issue a license to,
2635 or if issued shall suspend or revoke the license of, a hospital if the
2636 commissioner finds, after a hearing and opportunity to be heard, that:

2637 (1) There was a transaction described in section 19a-486a, as
2638 amended by this act, that occurred without the approval of the
2639 [commissioner] executive director, if such approval was required by
2640 sections 19a-486 to 19a-486h, inclusive, as amended by this act;

2641 (2) There was a transaction described in section 19a-486a, as
2642 amended by this act, without the approval of the Attorney General, if
2643 such approval was required by sections 19a-486 to 19a-486h, inclusive,
2644 as amended by this act, and the Attorney General certifies to the
2645 [Commissioner of Public Health] executive director that such
2646 transaction involved a material amount of the nonprofit hospital's

2647 assets or operations or a change in control of operations; or

2648 (3) The hospital is not complying with the terms of an agreement
2649 approved by the Attorney General and [commissioner] executive
2650 director pursuant to sections 19a-486 to 19a-486h, inclusive, as
2651 amended by this act.

2652 Sec. 55. Section 19a-486h of the general statutes is repealed and the
2653 following is substituted in lieu thereof (*Effective from passage*):

2654 Nothing in sections 19a-486 to 19a-486h, inclusive, as amended by
2655 this act, shall be construed to limit: (1) The common law or statutory
2656 authority of the Attorney General; (2) the statutory authority of the
2657 Commissioner of Public Health including, but not limited to, licensing;
2658 [and] (3) the statutory authority of the executive director of the Office
2659 of Health Strategy, including, but not limited to, certificate of need
2660 authority; or [(3)] (4) the application of the doctrine of cy pres or
2661 approximation.

2662 Sec. 56. Subsections (d) to (i), inclusive, of section 19a-486i of the
2663 2018 supplement to the general statutes are repealed and the following
2664 is substituted in lieu thereof (*Effective from passage*):

2665 (d) (1) The written notice required under subsection (c) of this
2666 section shall identify each party to the transaction and describe the
2667 material change as of the date of such notice to the business or
2668 corporate structure of the group practice, including: (A) A description
2669 of the nature of the proposed relationship among the parties to the
2670 proposed transaction; (B) the names and specialties of each physician
2671 that is a member of the group practice that is the subject of the
2672 proposed transaction and who will practice medicine with the
2673 resulting group practice, hospital, hospital system, captive professional
2674 entity, medical foundation or other entity organized by, controlled by,
2675 or otherwise affiliated with such hospital or hospital system following
2676 the effective date of the transaction; (C) the names of the business
2677 entities that are to provide services following the effective date of the
2678 transaction; (D) the address for each location where such services are

2679 to be provided; (E) a description of the services to be provided at each
2680 such location; and (F) the primary service area to be served by each
2681 such location.

2682 (2) Not later than thirty days after the effective date of any
2683 transaction described in subsection (c) of this section, the parties to the
2684 transaction shall submit written notice to the [Commissioner of Public
2685 Health] executive director of the Office of Health Strategy. Such
2686 written notice shall include, but need not be limited to, the same
2687 information described in subdivision (1) of this subsection. The
2688 [commissioner] executive director shall post a link to such notice on
2689 the [Department of Public Health's] Office of Health Strategy's Internet
2690 web site.

2691 (e) Not less than thirty days prior to the effective date of any
2692 transaction that results in an affiliation between one hospital or
2693 hospital system and another hospital or hospital system, the parties to
2694 the affiliation shall submit written notice to the Attorney General of
2695 such affiliation. Such written notice shall identify each party to the
2696 affiliation and describe the affiliation as of the date of such notice,
2697 including: (1) A description of the nature of the proposed relationship
2698 among the parties to the affiliation; (2) the names of the business
2699 entities that are to provide services following the effective date of the
2700 affiliation; (3) the address for each location where such services are to
2701 be provided; (4) a description of the services to be provided at each
2702 such location; and (5) the primary service area to be served by each
2703 such location.

2704 (f) Written information submitted to the Attorney General pursuant
2705 to subsections (b) to (e), inclusive, of this section shall be maintained
2706 and used by the Attorney General in the same manner as provided in
2707 section 35-42.

2708 (g) Not later than January 15, 2018, and annually thereafter, each
2709 hospital and hospital system shall file with the Attorney General and
2710 the [Commissioner of Public Health] executive director of the Office of

2711 Health Strategy a written report describing the activities of the group
2712 practices owned or affiliated with such hospital or hospital system.
2713 Such report shall include, for each such group practice: (1) A
2714 description of the nature of the relationship between the hospital or
2715 hospital system and the group practice; (2) the names and specialties of
2716 each physician practicing medicine with the group practice; (3) the
2717 names of the business entities that provide services as part of the
2718 group practice and the address for each location where such services
2719 are provided; (4) a description of the services provided at each such
2720 location; and (5) the primary service area served by each such location.

2721 (h) Not later than January 15, 2018, and annually thereafter, each
2722 group practice comprised of thirty or more physicians that is not the
2723 subject of a report filed under subsection (g) of this section shall file
2724 with the Attorney General and the [Commissioner of Public Health]
2725 executive director of the Office of Health Strategy a written report
2726 concerning the group practice. Such report shall include, for each such
2727 group practice: (1) The names and specialties of each physician
2728 practicing medicine with the group practice; (2) the names of the
2729 business entities that provide services as part of the group practice and
2730 the address for each location where such services are provided; (3) a
2731 description of the services provided at each such location; and (4) the
2732 primary service area served by each such location.

2733 (i) Not later than January 15, 2018, and annually thereafter, each
2734 hospital and hospital system shall file with the Attorney General and
2735 the [Commissioner of Public Health] executive director of the Office of
2736 Health Strategy a written report describing each affiliation with
2737 another hospital or hospital system. Such report shall include: (1) The
2738 name and address of each party to the affiliation; (2) a description of
2739 the nature of the relationship among the parties to the affiliation; (3)
2740 the names of the business entities that provide services as part of the
2741 affiliation and the address for each location where such services are
2742 provided; (4) a description of the services provided at each such
2743 location; and (5) the primary service area served by each such location.

2744 Sec. 57. Subsections (j) to (m), inclusive, of section 19a-508c of the
2745 2018 supplement to the general statutes are repealed and the following
2746 is substituted in lieu thereof (*Effective from passage*):

2747 (j) A hospital-based facility shall, when scheduling services for
2748 which a facility fee may be charged, inform the patient (1) that the
2749 hospital-based facility is part of a hospital or health system, (2) of the
2750 name of the hospital or health system, (3) that the hospital or health
2751 system may charge a facility fee in addition to and separate from the
2752 professional fee charged by the provider, and (4) of the telephone
2753 number the patient may call for additional information regarding such
2754 patient's potential financial liability.

2755 (k) (1) On and after January 1, 2016, if any transaction, as described
2756 in subsection (c) of section 19a-486i, <u>as amended by this act,</u> results in
2757 the establishment of a hospital-based facility at which facility fees will
2758 likely be billed, the hospital or health system, that is the purchaser in
2759 such transaction shall, not later than thirty days after such transaction,
2760 provide written notice, by first class mail, of the transaction to each
2761 patient served within the previous three years by the health care
2762 facility that has been purchased as part of such transaction.

2763 (2) Such notice shall include the following information:

2764 (A) A statement that the health care facility is now a hospital-based
2765 facility and is part of a hospital or health system;

2766 (B) The name, business address and phone number of the hospital
2767 or health system that is the purchaser of the health care facility;

2768 (C) A statement that the hospital-based facility bills, or is likely to
2769 bill, patients a facility fee that may be in addition to, and separate
2770 from, any professional fee billed by a health care provider at the
2771 hospital-based facility;

2772 (D) (i) A statement that the patient's actual financial liability will
2773 depend on the professional medical services actually provided to the

2774 patient, and (ii) an explanation that the patient may incur financial
2775 liability that is greater than the patient would incur if the hospital-
2776 based facility were not a hospital-based facility;

2777 (E) The estimated amount or range of amounts the hospital-based
2778 facility may bill for a facility fee or an example of the average facility
2779 fee billed at such hospital-based facility for the most common services
2780 provided at such hospital-based facility; and

2781 (F) A statement that, prior to seeking services at such hospital-based
2782 facility, a patient covered by a health insurance policy should contact
2783 the patient's health insurer for additional information regarding the
2784 hospital-based facility fees, including the patient's potential financial
2785 liability, if any, for such fees.

2786 (3) A copy of the written notice provided to patients in accordance
2787 with this subsection shall be filed with the [Office of Health Care
2788 Access] Health Systems Planning Unit of the Office of Health Strategy,
2789 established under section 19a-612, as amended by this act. Said [office]
2790 unit shall post a link to such notice on its Internet web site.

2791 (4) A hospital, health system or hospital-based facility shall not
2792 collect a facility fee for services provided at a hospital-based facility
2793 that is subject to the provisions of this subsection from the date of the
2794 transaction until at least thirty days after the written notice required
2795 pursuant to this subsection is mailed to the patient or a copy of such
2796 notice is filed with the [Office of Health Care Access] Health Systems
2797 Planning Unit, whichever is later. A violation of this subsection shall
2798 be considered an unfair trade practice pursuant to section 42-110b.

2799 (l) Notwithstanding the provisions of this section, on and after
2800 January 1, 2017, no hospital, health system or hospital-based facility
2801 shall collect a facility fee for (1) outpatient health care services that use
2802 a current procedural terminology evaluation and management code
2803 and are provided at a hospital-based facility, other than a hospital
2804 emergency department, located off-site from a hospital campus, or (2)
2805 outpatient health care services, other than those provided in an

2806 emergency department located off-site from a hospital campus,
2807 received by a patient who is uninsured of more than the Medicare rate.
2808 Notwithstanding the provisions of this subsection, in circumstances
2809 when an insurance contract that is in effect on July 1, 2016, provides
2810 reimbursement for facility fees prohibited under the provisions of this
2811 section, a hospital or health system may continue to collect
2812 reimbursement from the health insurer for such facility fees until the
2813 date of expiration of such contract. A violation of this subsection shall
2814 be considered an unfair trade practice pursuant to chapter 735a.

2815 (m) (1) Each hospital and health system shall report not later than
2816 July 1, 2016, and annually thereafter to the [Commissioner of Public
2817 Health] executive director of the Office of Health Strategy concerning
2818 facility fees charged or billed during the preceding calendar year. Such
2819 report shall include (A) the name and location of each facility owned
2820 or operated by the hospital or health system that provides services for
2821 which a facility fee is charged or billed, (B) the number of patient visits
2822 at each such facility for which a facility fee was charged or billed, (C)
2823 the number, total amount and range of allowable facility fees paid at
2824 each such facility by Medicare, Medicaid or under private insurance
2825 policies, (D) for each facility, the total amount of revenue received by
2826 the hospital or health system derived from facility fees, (E) the total
2827 amount of revenue received by the hospital or health system from all
2828 facilities derived from facility fees, (F) a description of the ten
2829 procedures or services that generated the greatest amount of facility
2830 fee revenue and, for each such procedure or service, the total amount
2831 of revenue received by the hospital or health system derived from
2832 facility fees, and (G) the top ten procedures for which facility fees are
2833 charged based on patient volume. For purposes of this subsection,
2834 "facility" means a hospital-based facility that is located outside a
2835 hospital campus.

2836 (2) The [commissioner] executive director shall publish the
2837 information reported pursuant to subdivision (1) of this subsection, or
2838 post a link to such information, on the Internet web site of the Office of
2839 Health [Care Access] Strategy.

2840 Sec. 58. Subsections (c) to (f), inclusive, of section 19a-509b of the
2841 general statutes are repealed and the following is substituted in lieu
2842 thereof (*Effective from passage*):

2843 (c) Each hospital that holds or administers one or more hospital bed
2844 funds shall make available in a place and manner allowing individual
2845 members of the public to easily obtain it, a one-page summary in
2846 English and Spanish describing hospital bed funds and how to apply
2847 for them. The summary shall also describe any other policies regarding
2848 the provision of charity care and reduced cost services for the indigent
2849 as reported by the hospital to the **[**Office of Health Care Access
2850 division of the Department of Public Health**]** Health Systems Planning
2851 Unit of the Office of Health Strategy pursuant to section 19a-649, as
2852 amended by this act, and shall clearly distinguish hospital bed funds
2853 from other sources of financial assistance. The summary shall include
2854 notification that the patient is entitled to reapply upon rejection, and
2855 that additional funds may become available on an annual basis. The
2856 summary shall be available in the patient admissions office, emergency
2857 room, social services department and patient accounts or billing office,
2858 and from any collection agent. If during the admission process or
2859 during its review of the financial resources of the patient, the hospital
2860 reasonably believes the patient will have limited funds to pay for any
2861 portion of the patient's hospitalization not covered by insurance, the
2862 hospital shall provide the summary to each such patient.

2863 (d) Each hospital which holds or administers one or more hospital
2864 bed funds shall require its collection agents to include a summary as
2865 provided in subsection (c) of this section in all bills and collection
2866 notices sent by such collection agents.

2867 (e) Applicants for assistance from hospital bed funds shall be
2868 notified in writing of any award or any rejection and the reason for
2869 such rejection. Patients who cannot pay any outstanding medical bill at
2870 the hospital shall be allowed to apply or reapply for hospital bed
2871 funds.

2872 (f) Each hospital which holds or administers one or more hospital
2873 bed funds shall maintain and annually compile, at the end of the fiscal
2874 year of the hospital, the following information: (1) The number of
2875 applications for hospital bed funds; (2) the number of patients
2876 receiving hospital bed fund grants and the actual dollar amounts
2877 provided to each patient from such fund; (3) the fair market value of
2878 the principal of each individual hospital bed fund, or the principal
2879 attributable to each bed fund if held in a pooled investment; (4) the
2880 total earnings for each hospital bed fund or the earnings attributable to
2881 each hospital bed fund; (5) the dollar amount of earnings reinvested as
2882 principal if any; and (6) the dollar amount of earnings available for
2883 patient care. The information compiled pursuant to this subsection
2884 shall be permanently retained by the hospital and made available to
2885 the [Office of Health Care Access] Health Systems Planning Unit upon
2886 request.

2887 Sec. 59. Subsections (e) to (g), inclusive, of section 33-182bb of the
2888 general statutes are repealed and the following is substituted in lieu
2889 thereof (*Effective from passage*):

2890 (e) Any medical foundation organized on or after July 1, 2009, shall
2891 file a copy of its certificate of incorporation and any amendments to its
2892 certificate of incorporation with the [Office of Health Care Access
2893 division of the Department of Public Health] Health Systems Planning
2894 Unit of the Office of Health Strategy not later than ten business days
2895 after the medical foundation files such certificate of incorporation or
2896 amendment with the Secretary of the State pursuant to chapter 602.

2897 (f) Any medical group clinic corporation formed under chapter 594
2898 of the general statutes, revision of 1958, revised to 1995, which amends
2899 its certificate of incorporation pursuant to subsection (a) of section 33-
2900 182cc, shall file with the [Office of Health Care Access division of the
2901 Department of Public Health] Health Systems Planning Unit of the
2902 Office of Health Strategy a copy of its certificate of incorporation and
2903 any amendments to its certificate of incorporation, including any
2904 amendment to its certificate of incorporation that complies with the

2905 requirements of subsection (a) of section 33-182cc, not later than ten
2906 business days after the medical foundation files its certificate of
2907 incorporation or any amendments to its certificate of incorporation
2908 with the Secretary of the State.

2909 (g) Any medical foundation, regardless of when organized, shall file
2910 notice with the [Office of Health Care Access division of the
2911 Department of Public Health] Health Systems Planning Unit of the
2912 Office of Health Strategy and the Secretary of the State of its
2913 liquidation, termination, dissolution or cessation of operations not later
2914 than ten business days after a vote by its board of directors or
2915 members to take such action. A medical foundation shall, annually,
2916 provide the office with (1) a statement of its mission, (2) the name and
2917 address of the organizing members, (3) the name and specialty of each
2918 physician employed by or acting as an agent of the medical
2919 foundation, (4) the location or locations where each such physician
2920 practices, (5) a description of the services provided at each such
2921 location, (6) a description of any significant change in its services
2922 during the preceding year, (7) a copy of the medical foundation's
2923 governing documents and bylaws, (8) the name and employer of each
2924 member of the board of directors, and (9) other financial information
2925 as reported on the medical foundation's most recently filed Internal
2926 Revenue Service return of organization exempt from income tax form,
2927 or any replacement form adopted by the Internal Revenue Service, or,
2928 if such medical foundation is not required to file such form,
2929 information substantially similar to that required by such form. The
2930 [Office of Health Care Access] Health Systems Planning Unit shall
2931 make such forms and information available to members of the public
2932 and accessible on said [office's] unit's Internet web site.

2933 Sec. 60. Subsections (b) and (c) of section 19a-493b of the general
2934 statutes are repealed and the following is substituted in lieu thereof
2935 (*Effective from passage*):

2936 (b) No entity, individual, firm, partnership, corporation, limited
2937 liability company or association, other than a hospital, shall

2938 individually or jointly establish or operate an outpatient surgical
2939 facility in this state without complying with chapter 368z, except as
2940 otherwise provided by this section, and obtaining a license within the
2941 time specified in this subsection from the Department of Public Health
2942 for such facility pursuant to the provisions of this chapter, unless such
2943 entity, individual, firm, partnership, corporation, limited liability
2944 company or association: (1) Provides to the [Office of Health Care
2945 Access division of the Department of Public Health] Health Systems
2946 Planning Unit of the Office of Health Strategy satisfactory evidence
2947 that it was in operation on or before July 1, 2003, or (2) obtained, on or
2948 before July 1, 2003, from the Office of Health Care Access, a
2949 determination that a certificate of need is not required. An entity,
2950 individual, firm, partnership, corporation, limited liability company or
2951 association otherwise in compliance with this section may operate an
2952 outpatient surgical facility without a license through March 30, 2007,
2953 and shall have until March 30, 2007, to obtain a license from the
2954 Department of Public Health.

2955 (c) Notwithstanding the provisions of this section, no outpatient
2956 surgical facility shall be required to comply with section 19a-631, as
2957 amended by this act, 19a-632, as amended by this act, 19a-644, as
2958 amended by this act, 19a-645, as amended by this act, 19a-646, as
2959 amended by this act, 19a-649, as amended by this act, 19a-664 to 19a-
2960 666, inclusive, 19a-673 to 19a-676, inclusive, as amended by this act,
2961 19a-678, 19a-681, as amended by this act, or 19a-683. Each outpatient
2962 surgical facility shall continue to be subject to the obligations and
2963 requirements applicable to such facility, including, but not limited to,
2964 any applicable provision of this chapter and those provisions of
2965 chapter 368z not specified in this subsection, except that a request for
2966 permission to undertake a transfer or change of ownership or control
2967 shall not be required pursuant to subsection (a) of section 19a-638, as
2968 amended by this act, if the [Office of Health Care Access division of the
2969 Department of Public Health] Health Systems Planning Unit of the
2970 Office of Health Strategy determines that the following conditions are
2971 satisfied: (1) Prior to any such transfer or change of ownership or

2972 control, the outpatient surgical facility shall be owned and controlled
2973 exclusively by persons licensed pursuant to section 20-13 or chapter
2974 375, either directly or through a limited liability company, formed
2975 pursuant to chapter 613, a corporation, formed pursuant to chapters
2976 601 and 602, or a limited liability partnership, formed pursuant to
2977 chapter 614, that is exclusively owned by persons licensed pursuant to
2978 section 20-13 or chapter 375, or is under the interim control of an estate
2979 executor or conservator pending transfer of an ownership interest or
2980 control to a person licensed under section 20-13 or chapter 375, and (2)
2981 after any such transfer or change of ownership or control, persons
2982 licensed pursuant to section 20-13 or chapter 375, a limited liability
2983 company, formed pursuant to chapter 613, a corporation, formed
2984 pursuant to chapters 601 and 602, or a limited liability partnership,
2985 formed pursuant to chapter 614, that is exclusively owned by persons
2986 licensed pursuant to section 20-13 or chapter 375, shall own and
2987 control no less than a sixty per cent interest in the outpatient surgical
2988 facility.

2989 Sec. 61. Section 19a-6q of the general statutes is repealed and the
2990 following is substituted in lieu thereof (*Effective from passage*):

2991 (a) The Commissioner of Public Health, in consultation with the
2992 **[**Lieutenant Governor, or the Lieutenant Governor's designee,**]**
2993 executive director of the Office of Health Strategy, established under
2994 section 19a-754a, as amended by this act, and local and regional health
2995 departments, shall, within available resources, develop a plan that is
2996 consistent with the Department of Public Health's Healthy Connecticut
2997 2020 health improvement plan and the state healthcare innovation
2998 plan developed pursuant to the State Innovation Model Initiative by
2999 the Centers for Medicare and Medicaid Services Innovation Center.
3000 The commissioner shall develop and implement such plan to: (1)
3001 Reduce the incidence of chronic disease, including, but not limited to,
3002 chronic cardiovascular disease, cancer, lupus, stroke, chronic lung
3003 disease, diabetes, arthritis or another chronic metabolic disease and the
3004 effects of behavioral health disorders; (2) improve chronic disease care
3005 coordination in the state; and (3) reduce the incidence and effects of

3006 chronic disease and improve outcomes for conditions associated with
3007 chronic disease in the state.

3008 (b) The commissioner shall, on or before January 15, 2015, and
3009 biennially thereafter, submit a report, in consultation with the
3010 [Lieutenant Governor or the Lieutenant Governor's designee]
3011 executive director of the Office of Health Strategy, in accordance with
3012 the provisions of section 11-4a to the joint standing committee of the
3013 General Assembly having cognizance of matters relating to public
3014 health concerning chronic disease and implementation of the plan
3015 described in subsection (a) of this section. The commissioner shall post
3016 each report on the Department of Public Health's Internet web site not
3017 later than thirty days after submitting such report. Each report shall
3018 include, but need not be limited to: (1) A description of the chronic
3019 diseases that are most likely to cause a person's death or disability, the
3020 approximate number of persons affected by such chronic diseases and
3021 an assessment of the financial effects of each such disease on the state
3022 and on hospitals and health care facilities; (2) a description and
3023 assessment of programs and actions that have been implemented by
3024 the department and health care providers to improve chronic disease
3025 care coordination and prevent chronic disease; (3) the sources and
3026 amounts of funding received by the department to treat persons with
3027 multiple chronic diseases and to treat or reduce the most prevalent
3028 chronic diseases in the state; (4) a description of chronic disease care
3029 coordination between the department and health care providers, to
3030 prevent and treat chronic disease; and (5) recommendations
3031 concerning actions that health care providers and persons with chronic
3032 disease may take to reduce the incidence and effects of chronic disease.

3033 Sec. 62. Section 19a-725 of the 2018 supplement to the general
3034 statutes is repealed and the following is substituted in lieu thereof
3035 (*Effective from passage*):

3036 (a) There is established within the [office of the Lieutenant
3037 Governor] Office of Health Strategy, established under section 19a-
3038 754a, as amended by this act, the Health Care Cabinet for the purpose

3039 of advising the Governor on the matters set forth in subsection (c) of
3040 this section.

3041 (b) (1) The Health Care Cabinet shall consist of the following
3042 members who shall be appointed on or before August 1, 2011: (A) Five
3043 appointed by the Governor, two of whom may represent the health
3044 care industry and shall serve for terms of four years, one of whom
3045 shall represent community health centers and shall serve for a term of
3046 three years, one of whom shall represent insurance producers and
3047 shall serve for a term of three years and one of whom shall be an at-
3048 large appointment and shall serve for a term of three years; (B) one
3049 appointed by the president pro tempore of the Senate, who shall be an
3050 oral health specialist engaged in active practice and shall serve for a
3051 term of four years; (C) one appointed by the majority leader of the
3052 Senate, who shall represent labor and shall serve for a term of three
3053 years; (D) one appointed by the minority leader of the Senate, who
3054 shall be an advanced practice registered nurse engaged in active
3055 practice and shall serve for a term of two years; (E) one appointed by
3056 the speaker of the House of Representatives, who shall be a consumer
3057 advocate and shall serve for a term of four years; (F) one appointed by
3058 the majority leader of the House of Representatives, who shall be a
3059 primary care physician engaged in active practice and shall serve for a
3060 term of four years; (G) one appointed by the minority leader of the
3061 House of Representatives, who shall represent the health information
3062 technology industry and shall serve for a term of three years; (H) five
3063 appointed jointly by the chairpersons of the SustiNet Health
3064 Partnership board of directors, one of whom shall represent faith
3065 communities, one of whom shall represent small businesses, one of
3066 whom shall represent the home health care industry, one of whom
3067 shall represent hospitals, and one of whom shall be an at-large
3068 appointment, all of whom shall serve for terms of five years; (I) the
3069 [Lieutenant Governor] executive director of the Office of Health
3070 Strategy, or the executive director's designee; (J) the Secretary of the
3071 Office of Policy and Management, or the secretary's designee; the
3072 Comptroller, or the Comptroller's designee; the chief executive officer

3073 of the Connecticut Health Insurance Exchange, or said officer's
3074 designee; the Commissioners of Social Services and Public Health, or
3075 their designees; and the Healthcare Advocate, or the Healthcare
3076 Advocate's designee, all of whom shall serve as ex-officio voting
3077 members; and (K) the Commissioners of Children and Families,
3078 Developmental Services and Mental Health and Addiction Services,
3079 and the Insurance Commissioner, or their designees, and the nonprofit
3080 liaison to the Governor, or the nonprofit liaison's designee, all of whom
3081 shall serve as ex-officio nonvoting members.

3082 (2) Following the expiration of initial cabinet member terms,
3083 subsequent cabinet terms shall be for four years, commencing on
3084 August first of the year of the appointment. If an appointing authority
3085 fails to make an initial appointment to the cabinet or an appointment
3086 to fill a cabinet vacancy within ninety days of the date of such vacancy,
3087 the appointed cabinet members shall, by majority vote, make such
3088 appointment to the cabinet.

3089 (3) Upon the expiration of the initial terms of the five cabinet
3090 members appointed by SustiNet Health Partnership board of directors,
3091 five successor cabinet members shall be appointed as follows: (A) One
3092 appointed by the Governor; (B) one appointed by the president pro
3093 tempore of the Senate; (C) one appointed by the speaker of the House
3094 of Representatives; and (D) two appointed by majority vote of the
3095 appointed board members. Successor board members appointed
3096 pursuant to this subdivision shall be at-large appointments.

3097 (4) The **[**Lieutenant Governor**]** <u>executive director of the Office of</u>
3098 <u>Health Strategy, or the executive director's designee,</u> shall serve as the
3099 chairperson of the Health Care Cabinet.

3100 (c) The Health Care Cabinet shall advise the Governor regarding the
3101 development of an integrated health care system for Connecticut and
3102 shall:

3103 (1) Evaluate the means of ensuring an adequate health care
3104 workforce in the state;

3105 (2) Jointly evaluate, with the chief executive officer of the
3106 Connecticut Health Insurance Exchange, the feasibility of
3107 implementing a basic health program option as set forth in Section
3108 1331 of the Affordable Care Act;

3109 (3) Identify short and long-range opportunities, issues and gaps
3110 created by the enactment of federal health care reform;

3111 (4) Review the effectiveness of delivery system reforms and other
3112 efforts to control health care costs, including, but not limited to,
3113 reforms and efforts implemented by state agencies; and

3114 (5) Advise the Governor on matters relating to: (A) The design,
3115 implementation, actionable objectives and evaluation of state and
3116 federal health care policies, priorities and objectives relating to the
3117 state's efforts to improve access to health care, (B) the quality of such
3118 care and the affordability and sustainability of the state's health care
3119 system, and (C) total state-wide health care spending, including
3120 methods to collect, analyze and report health care spending data.

3121 (d) The Health Care Cabinet may convene working groups, which
3122 include volunteer health care experts, to make recommendations
3123 concerning the development and implementation of service delivery
3124 and health care provider payment reforms, including multipayer
3125 initiatives, medical homes, electronic health records and evidenced-
3126 based health care quality improvement.

3127 (e) The **[**office of the Lieutenant Governor and the Office of the
3128 Healthcare Advocate**]** <u>Office of Health Strategy</u> shall provide support
3129 staff to the Health Care Cabinet.

3130 Sec. 63. Section 20-195sss of the 2018 supplement to the general
3131 statutes is repealed and the following is substituted in lieu thereof
3132 (*Effective from passage*):

3133 (a) As used in this section, "community health worker" means a
3134 public health outreach professional with an in-depth understanding of

3135 the experience, language, culture and socioeconomic needs of the
3136 community who (1) serves as a liaison between individuals within the
3137 community and health care and social services providers to facilitate
3138 access to such services and health-related resources, improve the
3139 quality and cultural competence of the delivery of such services and
3140 address social determinants of health with a goal toward reducing
3141 racial, ethnic, gender and socioeconomic health disparities, and (2)
3142 increases health knowledge and self-sufficiency through a range of
3143 services including outreach, engagement, education, coaching,
3144 informal counseling, social support, advocacy, care coordination,
3145 research related to social determinants of health and basic screenings
3146 and assessments of any risks associated with social determinants of
3147 health.

3148 (b) The executive director of the [state innovation model initiative
3149 program management office] Office of Health Strategy, established
3150 under section 19a-754a, as amended by this act, shall, within available
3151 resources and in consultation with the Community Health Worker
3152 Advisory Committee established by [such] said office and the
3153 Commissioner of Public Health, study the feasibility of creating a
3154 certification program for community health workers. Such study shall
3155 examine the fiscal impact of implementing such a certification program
3156 and include recommendations for (1) requirements for certification
3157 and renewal of certification of community health workers, including
3158 any training, experience or continuing education requirements, (2)
3159 methods for administering a certification program, including a
3160 certification application, a standardized assessment of experience,
3161 knowledge and skills, and an electronic registry, and (3) requirements
3162 for recognizing training program curricula that are sufficient to satisfy
3163 the requirements of certification.

3164 (c) Not later than October 1, 2018, the executive director of the [state
3165 innovation model initiative program management office] Office of
3166 Health Strategy shall report, in accordance with the provisions of
3167 section 11-4a, on the results of such study and recommendations to the
3168 joint standing committees of the General Assembly having cognizance

3169 of matters relating to public health and human services.

3170 Sec. 64. Section 38a-47 of the 2018 supplement to the general statutes
3171 is repealed and the following is substituted in lieu thereof (*Effective*
3172 *from passage*):

3173 (a) All domestic insurance companies and other domestic entities
3174 subject to taxation under chapter 207 shall, in accordance with section
3175 38a-48, as amended by this act, annually pay to the Insurance
3176 Commissioner, for deposit in the Insurance Fund established under
3177 section 38a-52a, an amount equal to: **[**the**]**

3178 (1) The actual expenditures made by the Insurance Department
3179 during each fiscal year, and the actual expenditures made by the Office
3180 of the Healthcare Advocate, including the cost of fringe benefits for
3181 department and office personnel as estimated by the Comptroller; **[**,
3182 plus (1) the**]**

3183 (2) The amount appropriated to the Office of Health Strategy from
3184 the Insurance Fund for the fiscal year, including the cost of fringe
3185 benefits for office personnel as estimated by the Comptroller;

3186 (3) The expenditures made on behalf of the department and **[**the
3187 office**]** said offices from the Capital Equipment Purchase Fund
3188 pursuant to section 4a-9 for such year, **[**and (2) the**]** but excluding such
3189 estimated expenditures made on behalf of the Health Systems
3190 Planning Unit of the Office of Health Strategy; and

3191 (4) The amount appropriated to the Department of Social Services
3192 for the fall prevention program established in section 17a-303a from
3193 the Insurance Fund for the fiscal year. **[**, but excluding**]**

3194 (b) The expenditures and amounts specified in subdivisions (1) to
3195 (4), inclusive, of subsection (a) of this section shall exclude
3196 expenditures paid for by fraternal benefit societies, foreign and alien
3197 insurance companies and other foreign and alien entities under
3198 sections 38a-49 and 38a-50.

3199 (c) Payments shall be made by assessment of all such domestic
3200 insurance companies and other domestic entities calculated and
3201 collected in accordance with the provisions of section 38a-48, as
3202 amended by this act. Any such domestic insurance company or other
3203 domestic entity aggrieved because of any assessment levied under this
3204 section may appeal therefrom in accordance with the provisions of
3205 section 38a-52.

3206 Sec. 65. Section 38a-48 of the 2018 supplement to the general statutes
3207 is repealed and the following is substituted in lieu thereof (*Effective*
3208 *from passage*):

3209 (a) On or before June thirtieth, annually, the Commissioner of
3210 Revenue Services shall render to the Insurance Commissioner a
3211 statement certifying the amount of taxes or charges imposed on each
3212 domestic insurance company or other domestic entity under chapter
3213 207 on business done in this state during the preceding calendar year.
3214 The statement for local domestic insurance companies shall set forth
3215 the amount of taxes and charges before any tax credits allowed as
3216 provided in subsection (a) of section 12-202.

3217 (b) On or before July thirty-first, annually, the Insurance
3218 Commissioner and the Office of the Healthcare Advocate shall render
3219 to each domestic insurance company or other domestic entity liable for
3220 payment under section 38a-47, as amended by this act: (1) A statement
3221 that includes (A) the amount appropriated to the Insurance
3222 Department, [and] the Office of the Healthcare Advocate and the
3223 Office of Health Strategy from the Insurance Fund established under
3224 section 38a-52a for the fiscal year beginning July first of the same year,
3225 (B) the cost of fringe benefits for department and office personnel for
3226 such year, as estimated by the Comptroller, (C) the estimated
3227 expenditures on behalf of the department and the [office] offices from
3228 the Capital Equipment Purchase Fund pursuant to section 4a-9 for
3229 such year, not including such estimated expenditures made on behalf
3230 of the Health Systems Planning Unit of the Office of Health Strategy,
3231 and (D) the amount appropriated to the Department of Social Services

3232 for the fall prevention program established in section 17a-303a from
3233 the Insurance Fund for the fiscal year; (2) a statement of the total taxes
3234 imposed on all domestic insurance companies and domestic insurance
3235 entities under chapter 207 on business done in this state during the
3236 preceding calendar year; and (3) the proposed assessment against that
3237 company or entity, calculated in accordance with the provisions of
3238 subsection (c) of this section, provided for the purposes of this
3239 calculation the amount appropriated to the Insurance Department,
3240 [and] the Office of the Healthcare Advocate and the Office of Health
3241 Strategy from the Insurance Fund plus the cost of fringe benefits for
3242 department and office personnel and the estimated expenditures on
3243 behalf of the department and the office from the Capital Equipment
3244 Purchase Fund pursuant to section 4a-9, not including such
3245 expenditures made on behalf of the Health Systems Planning Unit of
3246 the Office of Health Strategy shall be deemed to be the actual
3247 expenditures of the department and the office, and the amount
3248 appropriated to the Department of Social Services from the Insurance
3249 Fund for the fiscal year for the fall prevention program established in
3250 section 17a-303a shall be deemed to be the actual expenditures for the
3251 program.

3252 (c) (1) The proposed assessments for each domestic insurance
3253 company or other domestic entity shall be calculated by (A) allocating
3254 twenty per cent of the amount to be paid under section 38a-47, as
3255 amended by this act, among the domestic entities organized under
3256 sections 38a-199 to 38a-209, inclusive, and 38a-214 to 38a-225, inclusive,
3257 in proportion to their respective shares of the total taxes and charges
3258 imposed under chapter 207 on such entities on business done in this
3259 state during the preceding calendar year, and (B) allocating eighty per
3260 cent of the amount to be paid under section 38a-47, as amended by this
3261 act, among all domestic insurance companies and domestic entities
3262 other than those organized under sections 38a-199 to 38a-209,
3263 inclusive, and 38a-214 to 38a-225, inclusive, in proportion to their
3264 respective shares of the total taxes and charges imposed under chapter
3265 207 on such domestic insurance companies and domestic entities on

3266 business done in this state during the preceding calendar year,
3267 provided if there are no domestic entities organized under sections
3268 38a-199 to 38a-209, inclusive, and 38a-214 to 38a-225, inclusive, at the
3269 time of assessment, one hundred per cent of the amount to be paid
3270 under section 38a-47, as amended by this act, shall be allocated among
3271 such domestic insurance companies and domestic entities.

3272 (2) When the amount any such company or entity is assessed
3273 pursuant to this section exceeds twenty-five per cent of the actual
3274 expenditures of the Insurance Department, [and] the Office of the
3275 Healthcare Advocate and the Office of Health Strategy from the
3276 Insurance Fund, such excess amount shall not be paid by such
3277 company or entity but rather shall be assessed against and paid by all
3278 other such companies and entities in proportion to their respective
3279 shares of the total taxes and charges imposed under chapter 207 on
3280 business done in this state during the preceding calendar year, except
3281 that for purposes of any assessment made to fund payments to the
3282 Department of Public Health to purchase vaccines, such company or
3283 entity shall be responsible for its share of the costs, notwithstanding
3284 whether its assessment exceeds twenty-five per cent of the actual
3285 expenditures of the Insurance Department, [and] the Office of the
3286 Healthcare Advocate and the Office of Health Strategy from the
3287 Insurance Fund. The provisions of this subdivision shall not be
3288 applicable to any corporation which has converted to a domestic
3289 mutual insurance company pursuant to section 38a-155 upon the
3290 effective date of any public act which amends said section to modify or
3291 remove any restriction on the business such a company may engage in,
3292 for purposes of any assessment due from such company on and after
3293 such effective date.

3294 (d) For purposes of calculating the amount of payment under
3295 section 38a-47, as amended by this act, as well as the amount of the
3296 assessments under this section, the "total taxes imposed on all
3297 domestic insurance companies and other domestic entities under
3298 chapter 207" shall be based upon the amounts shown as payable to the
3299 state for the calendar year on the returns filed with the Commissioner

3300 of Revenue Services pursuant to chapter 207; with respect to
3301 calculating the amount of payment and assessment for local domestic
3302 insurance companies, the amount used shall be the taxes and charges
3303 imposed before any tax credits allowed as provided in subsection (a) of
3304 section 12-202.

3305 (e) On or before September thirtieth, annually, for each fiscal year
3306 ending prior to July 1, 1990, the Insurance Commissioner and the
3307 Healthcare Advocate, after receiving any objections to the proposed
3308 assessments and making such adjustments as in their opinion may be
3309 indicated, shall assess each such domestic insurance company or other
3310 domestic entity an amount equal to its proposed assessment as so
3311 adjusted. Each domestic insurance company or other domestic entity
3312 shall pay to the Insurance Commissioner on or before October thirty-
3313 first an amount equal to fifty per cent of its assessment adjusted to
3314 reflect any credit or amount due from the preceding fiscal year as
3315 determined by the commissioner under subsection (g) of this section.
3316 Each domestic insurance company or other domestic entity shall pay
3317 to the Insurance Commissioner on or before the following April
3318 thirtieth, the remaining fifty per cent of its assessment.

3319 (f) On or before September first, annually, for each fiscal year
3320 ending after July 1, 1990, the Insurance Commissioner and the
3321 Healthcare Advocate, after receiving any objections to the proposed
3322 assessments and making such adjustments as in their opinion may be
3323 indicated, shall assess each such domestic insurance company or other
3324 domestic entity an amount equal to its proposed assessment as so
3325 adjusted. Each domestic insurance company or other domestic entity
3326 shall pay to the Insurance Commissioner (1) on or before June 30, 1990,
3327 and on or before June thirtieth annually thereafter, an estimated
3328 payment against its assessment for the following year equal to twenty-
3329 five per cent of its assessment for the fiscal year ending such June
3330 thirtieth, (2) on or before September thirtieth, annually, twenty-five per
3331 cent of its assessment adjusted to reflect any credit or amount due
3332 from the preceding fiscal year as determined by the commissioner
3333 under subsection (g) of this section, and (3) on or before the following

3334 December thirty-first and March thirty-first, annually, each domestic
3335 insurance company or other domestic entity shall pay to the Insurance
3336 Commissioner the remaining fifty per cent of its proposed assessment
3337 to the department in two equal installments.

3338 (g) If the actual expenditures for the fall prevention program
3339 established in section 17a-303a are less than the amount allocated, the
3340 Commissioner of Social Services shall notify the Insurance
3341 Commissioner and the Healthcare Advocate. Immediately following
3342 the close of the fiscal year, the Insurance Commissioner and the
3343 Healthcare Advocate shall recalculate the proposed assessment for
3344 each domestic insurance company or other domestic entity in
3345 accordance with subsection (c) of this section using the actual
3346 expenditures made during the fiscal year by the Insurance
3347 Department, [and] the Office of the Healthcare Advocate [during that
3348 fiscal year] and the Office of Health Strategy from the Insurance Fund,
3349 the actual expenditures made on behalf of the department and the
3350 [office] offices from the Capital Equipment Purchase Fund pursuant to
3351 section 4a-9, not including such expenditures made on behalf of the
3352 Health Systems Planning Unit of the Office of Health Strategy, and the
3353 actual expenditures for the fall prevention program. On or before July
3354 thirty-first, the Insurance Commissioner and the Healthcare Advocate
3355 shall render to each such domestic insurance company and other
3356 domestic entity a statement showing the difference between their
3357 respective recalculated assessments and the amount they have
3358 previously paid. On or before August thirty-first, the Insurance
3359 Commissioner and the Healthcare Advocate, after receiving any
3360 objections to such statements, shall make such adjustments which in
3361 their opinion may be indicated, and shall render an adjusted
3362 assessment, if any, to the affected companies.

3363 (h) If any assessment is not paid when due, a penalty of twenty-five
3364 dollars shall be added thereto, and interest at the rate of six per cent
3365 per annum shall be paid thereafter on such assessment and penalty.

3366 (i) The commissioner shall deposit all payments made under this

3367 section with the State Treasurer. On and after June 6, 1991, the moneys
3368 so deposited shall be credited to the Insurance Fund established under
3369 section 38a-52a and shall be accounted for as expenses recovered from
3370 insurance companies.

3371 Sec. 66. Subsection (c) of section 1-84b of the general statutes is
3372 repealed and the following is substituted in lieu thereof (*Effective from*
3373 *passage*):

3374 (c) The provisions of this subsection apply to present or former
3375 executive branch public officials or state employees who hold or
3376 formerly held positions which involve significant decision-making or
3377 supervisory responsibility and are designated as such by the Office of
3378 State Ethics in consultation with the agency concerned except that such
3379 provisions shall not apply to members or former members of the
3380 boards or commissions who serve ex officio, who are required by
3381 statute to represent the regulated industry or who are permitted by
3382 statute to have a past or present affiliation with the regulated industry.
3383 Designation of positions subject to the provisions of this subsection
3384 shall be by regulations adopted by the Citizen's Ethics Advisory Board
3385 in accordance with chapter 54. As used in this subsection, "agency"
3386 means the [Office of Health Care Access division within the
3387 Department of Public Health] Health Systems Planning Unit of the
3388 Office of Health Strategy, the Connecticut Siting Council, the
3389 Department of Banking, the Insurance Department, the Department of
3390 Emergency Services and Public Protection, the office within the
3391 Department of Consumer Protection that carries out the duties and
3392 responsibilities of sections 30-2 to 30-68m, inclusive, the Public Utilities
3393 Regulatory Authority, including the Office of Consumer Counsel, and
3394 the Department of Consumer Protection and the term "employment"
3395 means professional services or other services rendered as an employee
3396 or as an independent contractor.

3397 (1) No public official or state employee in an executive branch
3398 position designated by the Office of State Ethics shall negotiate for,
3399 seek or accept employment with any business subject to regulation by

3400 his agency.

3401 (2) No former public official or state employee who held such a
3402 position in the executive branch shall within one year after leaving an
3403 agency, accept employment with a business subject to regulation by
3404 that agency.

3405 (3) No business shall employ a present or former public official or
3406 state employee in violation of this subsection.

3407 Sec. 67. Section 3-123i of the general statutes is repealed and the
3408 following is substituted in lieu thereof (*Effective from passage*):

3409 For the fiscal year ending June 30, 2014, and for each fiscal year
3410 thereafter, the Comptroller shall fund the fringe benefit cost
3411 differential between the average rate for fringe benefits for employees
3412 of private hospitals in the state and the fringe benefit rate for
3413 employees of The University of Connecticut Health Center from the
3414 resources appropriated for State Comptroller-Fringe Benefits in an
3415 amount not to exceed $13,500,000. For purposes of this section, the
3416 "fringe benefit cost differential" means the difference between the state
3417 fringe benefit rate calculated on The University of Connecticut Health
3418 Center payroll and the average member fringe benefit rate of all
3419 Connecticut acute care hospitals as contained in the annual reports
3420 submitted to the **[**Office of Health Care Access**]** Health Systems
3421 Planning Unit of the Office of Health Strategy pursuant to section 19a-
3422 644.

3423 Sec. 68. Subsection (b) of section 4-101a of the general statutes is
3424 repealed and the following is substituted in lieu thereof (*Effective from*
3425 *passage*):

3426 (b) Grants, technical assistance or consultation services, or any
3427 combination thereof, provided under this section may be made to
3428 assist a nongovernmental acute care general hospital to develop and
3429 implement a plan to achieve financial stability and assure the delivery
3430 of appropriate health care services in the service area of such hospital,

3431 or to assist a nongovernmental acute care general hospital in
3432 determining strategies, goals and plans to ensure its financial viability
3433 or stability. Any such hospital seeking such grants, technical assistance
3434 or consultation services shall prepare and submit to the Office of Policy
3435 and Management and the [Office of Health Care Access division of the
3436 Department of Public Health] Health Systems Planning Unit of the
3437 Office of Health Strategy a plan that includes at least the following: (1)
3438 A statement of the hospital's current projections of its finances for the
3439 current and the next three fiscal years; (2) identification of the major
3440 financial issues which effect the financial stability of the hospital; (3)
3441 the steps proposed to study or improve the financial status of the
3442 hospital and eliminate ongoing operating losses; (4) plans to study or
3443 change the mix of services provided by the hospital, which may
3444 include transition to an alternative licensure category; and (5) other
3445 related elements as determined by the Office of Policy and
3446 Management. Such plan shall clearly identify the amount, value or
3447 type of the grant, technical assistance or consultation services, or
3448 combination thereof, requested. Any grants, technical assistance or
3449 consultation services, or any combination thereof, provided under this
3450 section shall be determined by the Secretary of the Office of Policy and
3451 Management not to jeopardize the federal matching payments under
3452 the medical assistance program and the emergency assistance to
3453 families program as determined by the [Office of Health Care Access
3454 division of the Department of Public Health] Health Systems Planning
3455 Unit of the Office of Health Strategy or the Department of Social
3456 Services in consultation with the Office of Policy and Management.

3457 Sec. 69. Subsection (c) of section 17b-337 of the 2018 supplement to
3458 the general statutes is repealed and the following is substituted in lieu
3459 thereof (*Effective from passage*):

3460 (c) The Long-Term Care Planning Committee shall consist of: (1)
3461 The chairpersons and ranking members of the joint standing
3462 committees of the General Assembly having cognizance of matters
3463 relating to human services, public health, elderly services and long-
3464 term care; (2) the Commissioner of Social Services, or the

3465 commissioner's designee; (3) one member of the Office of Policy and
3466 Management appointed by the Secretary of the Office of Policy and
3467 Management; (4) [two members] one member from the Department of
3468 Public Health appointed by the Commissioner of Public Health; [, one
3469 of whom is from the Office of Health Care Access division of the
3470 department;] (5) one member from the Department of Housing
3471 appointed by the Commissioner of Housing; (6) one member from the
3472 Department of Developmental Services appointed by the
3473 Commissioner of Developmental Services; (7) one member from the
3474 Department of Mental Health and Addiction Services appointed by the
3475 Commissioner of Mental Health and Addiction Services; (8) one
3476 member from the Department of Transportation appointed by the
3477 Commissioner of Transportation; [and] (9) one member from the
3478 Department of Children and Families appointed by the Commissioner
3479 of Children and Families; and (10) one member from the Health
3480 Systems Planning Unit of the Office of Health Strategy appointed by
3481 the executive director of the Office of Health Strategy. The committee
3482 shall convene no later than ninety days after June 4, 1998. Any vacancy
3483 shall be filled by the appointing authority. The chairperson shall be
3484 elected from among the members of the committee. The committee
3485 shall seek the advice and participation of any person, organization or
3486 state or federal agency it deems necessary to carry out the provisions
3487 of this section.

3488 Sec. 70. Subsection (g) of section 17b-352 of the 2018 supplement to
3489 the general statutes is repealed and the following is substituted in lieu
3490 thereof (*Effective from passage*):

3491 (g) The Commissioner of Social Services shall adopt regulations, in
3492 accordance with chapter 54, to implement the provisions of this
3493 section. [The commissioner shall implement the standards and
3494 procedures of the Office of Health Care Access division of the
3495 Department of Public Health concerning certificates of need
3496 established pursuant to section 19a-643, as appropriate for the
3497 purposes of this section, until the time final regulations are adopted in
3498 accordance with said chapter 54.]

3499 Sec. 71. Subsection (e) of section 17b-353 of the 2018 supplement to
3500 the general statutes is repealed and the following is substituted in lieu
3501 thereof (*Effective from passage*):

3502 (e) The Commissioner of Social Services shall adopt regulations, in
3503 accordance with chapter 54, to implement the provisions of this
3504 section. **[**The commissioner shall implement the standards and
3505 procedures of the Office of Health Care Access division of the
3506 Department of Public Health concerning certificates of need
3507 established pursuant to section 19a-643, as appropriate for the
3508 purposes of this section, until the time final regulations are adopted in
3509 accordance with said chapter 54.**]**

3510 Sec. 72. Subsection (f) of section 17b-354 of the 2018 supplement to
3511 the general statutes is repealed and the following is substituted in lieu
3512 thereof (*Effective from passage*):

3513 (f) The Commissioner of Social Services may adopt regulations, in
3514 accordance with chapter 54, to implement the provisions of this
3515 section. **[**The commissioner shall implement the standards and
3516 procedures of the Office of Health Care Access division of the
3517 Department of Public Health concerning certificates of need
3518 established pursuant to section 19a-643, as appropriate for the
3519 purposes of this section, until the time final regulations are adopted in
3520 accordance with said chapter 54.**]**

3521 Sec. 73. Section 17b-356 of the general statutes is repealed and the
3522 following is substituted in lieu thereof (*Effective from passage*):

3523 Any health care facility or institution, as defined in subsection (a) of
3524 section 19a-490, except a nursing home, rest home, residential care
3525 home or residential facility for persons with intellectual disability
3526 licensed pursuant to section 17a-227 and certified to participate in the
3527 Title XIX Medicaid program as an intermediate care facility for
3528 individuals with intellectual disabilities, proposing to expand its
3529 services by adding nursing home beds shall obtain the approval of the
3530 Commissioner of Social Services in accordance with the procedures

3531 established pursuant to sections 17b-352, 17b-353 and 17b-354 for a
3532 facility, as defined in section 17b-352, prior to obtaining the approval
3533 of the [Office of Health Care Access division of the Department of
3534 Public Health] Health Systems Planning Unit of the Office of Health
3535 Strategy pursuant to section 19a-639, as amended by this act.

3536 Sec. 74. Subsection (b) of section 19a-7 of the general statutes is
3537 repealed and the following is substituted in lieu thereof (*Effective from*
3538 *passage*):

3539 (b) For the purposes of establishing a state health plan as required
3540 by subsection (a) of this section and consistent with state and federal
3541 law on patient records, the department is entitled to access hospital
3542 discharge data, emergency room and ambulatory surgery encounter
3543 data, data on home health care agency client encounters and services,
3544 data from community health centers on client encounters and services
3545 and all data collected or compiled by the [Office of Health Care Access
3546 division of the Department of Public Health] Health Systems Planning
3547 unit of the Office of Health Strategy pursuant to section 19a-613, as
3548 amended by this act.

3549 Sec. 75. Subsection (a) of section 19a-507 of the general statutes is
3550 repealed and the following is substituted in lieu thereof (*Effective from*
3551 *passage*):

3552 (a) Notwithstanding the provisions of chapter 368z, New Horizons,
3553 Inc., a nonprofit, nonsectarian organization, or a subsidiary
3554 organization controlled by New Horizons, Inc., is authorized to
3555 construct and operate an independent living facility for severely
3556 physically disabled adults, in the town of Farmington, provided such
3557 facility shall be constructed in accordance with applicable building
3558 codes. The Farmington Housing Authority, or any issuer acting on
3559 behalf of said authority, subject to the provisions of this section, may
3560 issue tax-exempt revenue bonds on a competitive or negotiated basis
3561 for the purpose of providing construction and permanent mortgage
3562 financing for the facility in accordance with Section 103 of the Internal

3563 Revenue Code. Prior to the issuance of such bonds, plans for the
3564 construction of the facility shall be submitted to and approved by the
3565 [Office of Health Care Access] Health Systems Planning Unit of the
3566 Office of Health Strategy. The [office] unit shall approve or disapprove
3567 such plans within thirty days of receipt thereof. If the plans are
3568 disapproved they may be resubmitted. Failure of the [office] unit to act
3569 on the plans within such thirty-day period shall be deemed approval
3570 thereof. The payments to residents of the facility who are eligible for
3571 assistance under the state supplement program for room and board
3572 and necessary services, shall be determined annually to be effective
3573 July first of each year. Such payments shall be determined on a basis of
3574 a reasonable payment for necessary services, which basis shall take
3575 into account as a factor the costs of providing those services and such
3576 other factors as the commissioner deems reasonable, including
3577 anticipated fluctuations in the cost of providing services. Such
3578 payments shall be calculated in accordance with the manner in which
3579 rates are calculated pursuant to subsection (h) of section 17b-340 and
3580 the cost-related reimbursement system pursuant to said section except
3581 that efficiency incentives shall not be granted. The commissioner may
3582 adjust such rates to account for the availability of personal care
3583 services for residents under the Medicaid program. The commissioner
3584 shall, upon submission of a request, allow actual debt service,
3585 comprised of principal and interest, in excess of property costs allowed
3586 pursuant to section 17-313b-5 of the regulations of Connecticut state
3587 agencies, provided such debt service terms and amounts are
3588 reasonable in relation to the useful life and the base value of the
3589 property. The cost basis for such payment shall be subject to audit, and
3590 a recomputation of the rate shall be made based upon such audit. The
3591 facility shall report on a fiscal year ending on the thirtieth day of
3592 September on forms provided by the commissioner. The required
3593 report shall be received by the commissioner no later than December
3594 thirty-first of each year. The Department of Social Services may use its
3595 existing utilization review procedures to monitor utilization of the
3596 facility. If the facility is aggrieved by any decision of the commissioner,
3597 the facility may, within ten days, after written notice thereof from the

3598 commissioner, obtain by written request to the commissioner, a
3599 hearing on all items of aggrievement. If the facility is aggrieved by the
3600 decision of the commissioner after such hearing, the facility may
3601 appeal to the Superior Court in accordance with the provisions of
3602 section 4-183.

3603 Sec. 76. Subsection (c) of section 12-263q of the 2018 supplement to
3604 the general statutes is repealed and the following is substituted in lieu
3605 thereof (*Effective from passage*):

3606 (c) Prior to January 1, 2018, and every three years thereafter, the
3607 Commissioner of Social Services shall seek approval from the Centers
3608 for Medicare and Medicaid Services to exempt financially distressed
3609 hospitals from the net revenue tax imposed on outpatient hospital
3610 services. Any such hospital for which the Centers for Medicare and
3611 Medicaid Services grants an exemption shall be exempt from the net
3612 revenue tax imposed on outpatient hospital services under subsection
3613 (a) of this section. Any hospital for which the Centers for Medicare and
3614 Medicaid Services denies an exemption shall be required to pay the net
3615 revenue tax imposed on outpatient hospital services under subsection
3616 (a) of this section. For purposes of this subsection, "financially
3617 distressed hospital" means a hospital that has experienced over a five-
3618 year period an average net loss of more than five per cent of aggregate
3619 revenue. A hospital has an average net loss of more than five per cent
3620 of aggregate revenue if such a loss is reflected in the five most recent
3621 years of financial reporting that have been made available by the
3622 **[**Office of Health Care Access**]** Health Systems Planning Unit of the
3623 Office of Health Strategy for such hospital in accordance with section
3624 19a-670 as of the effective date of the request for approval which
3625 effective date shall be July first of the year in which the request is
3626 made.

3627 Sec. 77. Subsection (b) of section 13 of public act 17-4 of the June
3628 special session is repealed and the following is substituted in lieu
3629 thereof (*Effective from passage*):

3630 (b) The commissioner may impose such conditions as the
3631 commissioner determines to be necessary in making any advance in
3632 accordance with this section, including, but not limited to, financial
3633 reporting, schedule of recoupment of advance payments and
3634 adjustments to any future payments to such hospital. For purposes of
3635 this section, "distressed hospital" means a short-term general acute care
3636 hospital licensed by the Department of Public Health that (1) the
3637 Commissioner of Social Services determines is financially distressed in
3638 accordance with financial criteria selected or developed by the
3639 commissioner, and (2) is independent and is not affiliated with any
3640 other hospital or hospital-based system that includes two or more
3641 hospitals, as documented through the certificate of need process
3642 administered by the **[**Department of Public Health, Office of Health
3643 Care Access**]** <u>Health Systems Planning Unit of the Office of Health</u>
3644 <u>Strategy</u>.

3645 Sec. 78. Subsection (b) of section 10a-109gg of the general statutes is
3646 repealed and the following is substituted in lieu thereof (*Effective from*
3647 *passage*):

3648 (b) The proceeds of the sale of the bond issuance described in
3649 subsection (a) of this section shall be used by the Office of Policy and
3650 Management, in consultation with the chairperson of the Board of
3651 Trustees of the university, for the purpose of the UConn health
3652 network initiatives in the following manner: (1) Five million dollars of
3653 such proceeds shall be used by Hartford Hospital to develop a
3654 simulation and conference center on the Hartford Hospital campus to
3655 be run exclusively by Hartford Hospital, (2) five million dollars of such
3656 proceeds shall be used to fulfill the initiative for a primary care
3657 institute on the Saint Francis Hospital and Medical Center campus, (3)
3658 five million dollars of such proceeds shall be used to fulfill the
3659 initiatives for a comprehensive cancer center and The University of
3660 Connecticut-sponsored health disparities institute; (4) five million
3661 dollars of such proceeds shall be used to fulfill the initiatives for the
3662 planning, design, land acquisition, development and construction of
3663 (A) a cancer treatment center to be constructed by, or in partnership

3664 with, The Hospital of Central Connecticut, provided such cancer
3665 treatment center is located entirely within the legal boundaries of the
3666 city of New Britain, (B) renovations and upgrades to the oncology unit
3667 at The Hospital of Central Connecticut, and (C) if certificate of need
3668 approval is received, [pursuant to the provisions of subsection (b) of
3669 section 10a-109ii,] a Permanent Regional Phase One Clinical Trials Unit
3670 located at The Hospital of Central Connecticut in New Britain; and (5)
3671 two million dollars of such proceeds shall be used to fulfill the
3672 initiatives for patient room renovations at Bristol Hospital. In the event
3673 that the cancer treatment center authorized pursuant to subdivision (4)
3674 of this subsection is built in whole or in part outside the legal
3675 boundaries of the city of New Britain, The Hospital of Central
3676 Connecticut shall repay the entire amount of the proceeds used to
3677 fulfill the initiatives for the planning, design, development and
3678 construction of such center.

3679 Sec. 79. Subsection (d) of section 1-84 of the 2018 supplement to the
3680 general statutes is repealed and the following is substituted in lieu
3681 thereof (*Effective from passage*):

3682 (d) No public official or state employee or employee of such public
3683 official or state employee shall agree to accept, or be a member or
3684 employee of a partnership, association, professional corporation or
3685 sole proprietorship which partnership, association, professional
3686 corporation or sole proprietorship agrees to accept any employment,
3687 fee or other thing of value, or portion thereof, for appearing, agreeing
3688 to appear, or taking any other action on behalf of another person
3689 before the Department of Banking, the Office of the Claims
3690 Commissioner, the [Office of Health Care Access division within the
3691 Department of Public Health] <u>Health Systems Planning Unit of the</u>
3692 <u>Office of Health Strategy</u>, the Insurance Department, the Department
3693 of Consumer Protection, the Department of Motor Vehicles, the State
3694 Insurance and Risk Management Board, the Department of Energy and
3695 Environmental Protection, the Public Utilities Regulatory Authority,
3696 the Connecticut Siting Council or the Connecticut Real Estate
3697 Commission; provided this shall not prohibit any such person from

3698 making inquiry for information on behalf of another before any of said
3699 commissions or commissioners if no fee or reward is given or
3700 promised in consequence thereof. For the purpose of this subsection,
3701 partnerships, associations, professional corporations or sole
3702 proprietorships refer only to such partnerships, associations,
3703 professional corporations or sole proprietorships which have been
3704 formed to carry on the business or profession directly relating to the
3705 employment, appearing, agreeing to appear or taking of action
3706 provided for in this subsection. Nothing in this subsection shall
3707 prohibit any employment, appearing, agreeing to appear or taking
3708 action before any municipal board, commission or council. Nothing in
3709 this subsection shall be construed as applying (1) to the actions of any
3710 teaching or research professional employee of a public institution of
3711 higher education if such actions are not in violation of any other
3712 provision of this chapter, (2) to the actions of any other professional
3713 employee of a public institution of higher education if such actions are
3714 not compensated and are not in violation of any other provision of this
3715 chapter, (3) to any member of a board or commission who receives no
3716 compensation other than per diem payments or reimbursement for
3717 actual or necessary expenses, or both, incurred in the performance of
3718 the member's duties, or (4) to any member or director of a quasi-public
3719 agency. Notwithstanding the provisions of this subsection to the
3720 contrary, a legislator, an officer of the General Assembly or part-time
3721 legislative employee may be or become a member or employee of a
3722 firm, partnership, association or professional corporation which
3723 represents clients for compensation before agencies listed in this
3724 subsection, provided the legislator, officer of the General Assembly or
3725 part-time legislative employee shall take no part in any matter
3726 involving the agency listed in this subsection and shall not receive
3727 compensation from any such matter. Receipt of a previously
3728 established salary, not based on the current or anticipated business of
3729 the firm, partnership, association or professional corporation involving
3730 the agencies listed in this subsection, shall be permitted.

3731 Sec. 80. Sections 10a-109ii, 17b-234, 17b-235, 19a-617b, 19a-637, 19a-

3732 755 and 38a-558 of the general statutes are repealed. (*Effective from*
3733 *passage*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	19a-754a
Sec. 2	*from passage*	4-5
Sec. 3	*July 1, 2019*	4-5
Sec. 4	*from passage*	19a-755a
Sec. 5	*from passage*	19a-755b
Sec. 6	*from passage*	38a-477e(a)
Sec. 7	*from passage*	17b-59a
Sec. 8	*from passage*	17b-59c
Sec. 9	*from passage*	17b-59d(d)(1)
Sec. 10	*from passage*	17b-59d(f)
Sec. 11	*from passage*	17b-59f
Sec. 12	*from passage*	17b-59g
Sec. 13	*from passage*	2-124a(b)
Sec. 14	*from passage*	19a-612
Sec. 15	*from passage*	19a-612d
Sec. 16	*from passage*	19a-613
Sec. 17	*from passage*	19a-614
Sec. 18	*from passage*	19a-630
Sec. 19	*from passage*	19a-631(b)
Sec. 20	*from passage*	19a-632
Sec. 21	*from passage*	19a-632a(b)
Sec. 22	*from passage*	19a-632a(f)
Sec. 23	*from passage*	19a-633
Sec. 24	*from passage*	19a-634
Sec. 25	*from passage*	19a-638
Sec. 26	*from passage*	19a-639
Sec. 27	*from passage*	19a-639a
Sec. 28	*from passage*	19a-639b
Sec. 29	*from passage*	19a-639c
Sec. 30	*from passage*	19a-639e
Sec. 31	*from passage*	19a-639f
Sec. 32	*from passage*	19a-641
Sec. 33	*from passage*	19a-642
Sec. 34	*from passage*	19a-643
Sec. 35	*from passage*	19a-644

Sec. 36	*from passage*	19a-645
Sec. 37	*from passage*	19a-646
Sec. 38	*from passage*	19a-649
Sec. 39	*from passage*	19a-653
Sec. 40	*from passage*	19a-654
Sec. 41	*from passage*	19a-659
Sec. 42	*from passage*	19a-670
Sec. 43	*from passage*	19a-673(a)(1)
Sec. 44	*from passage*	19a-673a
Sec. 45	*from passage*	19a-673c
Sec. 46	*from passage*	19a-676
Sec. 47	*from passage*	19a-681
Sec. 48	*from passage*	19a-486
Sec. 49	*from passage*	19a-486a
Sec. 50	*from passage*	19a-486b
Sec. 51	*from passage*	19a-486d
Sec. 52	*from passage*	19a-486e
Sec. 53	*from passage*	19a-486f
Sec. 54	*from passage*	19a-486g
Sec. 55	*from passage*	19a-486h
Sec. 56	*from passage*	19a-486i(d) to (i)
Sec. 57	*from passage*	19a-508c(j) to (m)
Sec. 58	*from passage*	19a-509b(c) to (f)
Sec. 59	*from passage*	33-182bb(e) to (g)
Sec. 60	*from passage*	19a-493b(b) and (c)
Sec. 61	*from passage*	19a-6q
Sec. 62	*from passage*	19a-725
Sec. 63	*from passage*	20-195sss
Sec. 64	*from passage*	38a-47
Sec. 65	*from passage*	38a-48
Sec. 66	*from passage*	1-84b(c)
Sec. 67	*from passage*	3-123i
Sec. 68	*from passage*	4-101a(b)
Sec. 69	*from passage*	17b-337(c)
Sec. 70	*from passage*	17b-352(g)
Sec. 71	*from passage*	17b-353(e)
Sec. 72	*from passage*	17b-354(f)
Sec. 73	*from passage*	17b-356
Sec. 74	*from passage*	19a-7(b)
Sec. 75	*from passage*	19a-507(a)
Sec. 76	*from passage*	12-263q(c)

Sec. 77	*from passage*	PA 17-4 of the June Sp. Sess., Sec. 13(b)
Sec. 78	*from passage*	10a-109gg(b)
Sec. 79	*from passage*	1-84(d)
Sec. 80	*from passage*	Repealer section

Statement of Purpose:

To make the statutory changes necessary to implement the establishment of the Office of Health Strategy.

[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.]