General Assembly **Substitute Bill No. 5290**

February Session, 2018

HB05290PH 032618

AN ACT CONCERNING THE OFFICE OF HEALTH STRATEGY.

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

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 Section 19a-754a of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

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

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

(1) Developing and implementing a comprehensive and cohesive health care vision for the state, including, but not limited to, a coordinated state health care cost containment strategy;

(2) Promoting effective health planning and the provision of quality health care in the state in a manner that ensures access for all state residents to cost-effective health care services, avoids the duplication

of such services and improves the availability and financial stability of such services throughout the state;

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

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

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

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

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

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

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

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

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

As used in sections 4-6, 4-7 and 4-8, the term "department head" means Secretary of the Office of Policy and Management, Commissioner of Administrative Services, Commissioner of Revenue Services, Banking Commissioner, Commissioner of Children and Families, Commissioner of Consumer Protection, Commissioner of Correction, Commissioner of Economic and Community Development, State Board of Education, Commissioner of Emergency Services and Public Protection, Commissioner of Energy and Environmental Protection, Commissioner of Agriculture, Commissioner of Public Health, Insurance Commissioner, Labor Commissioner, Commissioner of Mental Health and Addiction Services, Commissioner of Social Services, Commissioner of Developmental Services, Commissioner of Motor Vehicles, Commissioner of Transportation, Commissioner of Veterans Affairs, Commissioner of Housing, Commissioner of Rehabilitation Services, the Commissioner of Early Childhood, **[**and**]** the executive director of the Office of Military Affairs and the executive director of the Office of Health Strategy. As used in sections

4-6 and 4-7, "department head" also means the Commissioner of Education.

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

As used in sections 4-6, 4-7 and 4-8, the term "department head" means Secretary of the Office of Policy and Management, Commissioner of Administrative Services, Commissioner of Revenue Services, Banking Commissioner, Commissioner of Children and Families, Commissioner of Consumer Protection, Commissioner of Correction, Commissioner of Economic and Community Development, State Board of Education, Commissioner of Emergency Services and Public Protection, Commissioner of Energy and Environmental Protection, Commissioner of Agriculture, Commissioner of Public Health, Insurance Commissioner, Labor Commissioner, Commissioner of Mental Health and Addiction Services, Commissioner of Social Services, Commissioner of Developmental Services, Commissioner of Motor Vehicles, Commissioner of Transportation, Commissioner of Veterans Affairs, Commissioner of Housing, Commissioner of Rehabilitation Services, the Commissioner of Early Childhood, the executive director of the Office of Military Affairs, **[**and**]** the executive director of the Technical Education and Career System and the executive director of the Office of Health Strategy. As used in sections 4-6 and 4-7, "department head" also means the Commissioner of Education.

Sec. 4. Section 19a-755a of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) As used in this section:

(1) "All-payer claims database" means a database that receives and

stores data from a reporting entity relating to medical insurance claims, dental insurance claims, pharmacy claims and other insurance claims information from enrollment and eligibility files.

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

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

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

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

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

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

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

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

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

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

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

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

(B) "Reporting entity" does not include an employee welfare benefit plan, as defined in the federal Employee Retirement Income Security Act of 1974, as amended from time to time, that is also a trust

established pursuant to collective bargaining subject to the federal Labor Management Relations Act.

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

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

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

(3) (A) Upon the adoption of reporting requirements as set forth in **[**subsection (b) of section 19a-755**]** subdivision (1) of this subsection**,** a reporting entity shall report health care information for inclusion in the all-payer claims database in a form and manner prescribed by the **[**Health Information Technology Officer**]** executive director of the

Office of Health Strategy. The **[**Health Information Technology Officer**]** executive director may, after notice and hearing, impose a civil penalty on any reporting entity that fails to report health care information as prescribed. Such civil penalty shall not exceed one thousand dollars per day for each day of violation and shall not be imposed as a cost for the purpose of rate determination or reimbursement by a third-party payer.

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

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

(5) The **[**Health Information Technology Officer**]** executive director of the Office of Health Strategy shall: (A) Utilize data in the all-payer claims database to provide health care consumers in the state with information concerning the cost and quality of health care services for the purpose of allowing such consumers to make economically sound and medically appropriate health care decisions; and (B) make data in the all-payer claims database available to any state agency, insurer, employer, health care provider, consumer of health care services or researcher for the purpose of allowing such person or entity to review such data as it relates to health care utilization, costs or quality of health care services. If health information, as defined in 45 CFR 160.103, as amended from time to time, is permitted to be disclosed under the Health Insurance Portability and Accountability Act of 1996,

P.L. 104-191, as amended from time to time, or regulations adopted thereunder, any disclosure thereof made pursuant to this subdivision shall have identifiers removed, as set forth in 45 CFR 164.514, as amended from time to time. Any disclosure made pursuant to this subdivision of information other than health information shall be made in a manner to protect the confidentiality of such other information as required by state and federal law. The **[**Health Information Technology Officer**]** executive director of the Office of Health Strategy may set a fee to be charged to each person or entity requesting access to data stored in the all-payer claims database.

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

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

Sec. 5. Section 19a-755b of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

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

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

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

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

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

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

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

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

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

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

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

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

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

[Health Information Technology Officer**]** executive director of the Office of Health Strategy in a manner and time frame as may be organizationally and financially reasonable in his or her sole discretion.

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

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

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

(d) Not later than January 1, 2018, and annually thereafter, to the extent practicable, the **[**Health Information Technology Officer**]**

executive director of the Office of Health Strategy shall issue a report, in a manner to be decided by the **[**officer**]** executive director, that includes the (1) billed and allowed amounts paid to health care providers in each health carrier's network for each service and procedure service included pursuant to subsection (c) of this section, and (2) out-of-pocket costs for each such service and procedure.

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

accountability rating and the Medicare hospital compare star rating for the hospital, as applicable; and (E) the Internet web site addresses for The Joint Commission and the Medicare hospital compare tool where the patient may obtain information concerning the hospital.

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

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

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

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

(a) As used in this section:

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

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

(3) "Standard electronic format" means a format using open electronic standards that: (A) Enable health information technology to be used for the collection of clinically specific data; (B) promote the interoperability of health care information across health care settings, including reporting to local, state and federal agencies; and (C) facilitate clinical decision support.

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

(c) The **[**Health Information Technology Officer, designated in accordance with section 19a-755,**]** executive director of the Office of Health Strategy shall, in consultation with the Commissioner of Social Services and the State Health Information Technology Advisory Council, established pursuant to section 17b-59f, as amended by this act, implement and periodically revise the state-wide health information technology plan established pursuant to this section and shall establish electronic data standards to facilitate the development of integrated electronic health information systems for use by health care providers and institutions that receive state funding. Such electronic data standards shall: (1) Include provisions relating to security, privacy, data content, structures and format, vocabulary and transmission protocols; (2) limit the use and dissemination of an individual's Social Security number and require the encryption of any Social Security number provided by an individual; (3) require privacy standards no less stringent than the "Standards for Privacy of Individually Identifiable Health Information" established under the Health Insurance Portability and Accountability Act of 1996, P.L. 104-

191, as amended from time to time, and contained in 45 CFR 160, 164; (4) require that individually identifiable health information be secure and that access to such information be traceable by an electronic audit trail; (5) be compatible with any national data standards in order to allow for interstate interoperability; (6) permit the collection of health information in a standard electronic format; and (7) be compatible with the requirements for an electronic health information system.

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

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

any national data standards in order to allow for interstate interoperability, (C) permit the collection of health information in a standard electronic format, and (D) be compatible with the requirements for an electronic health information system.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(7) The Healthcare Advocate, or the Healthcare Advocate's

designee;

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

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

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

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

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

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

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

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

quality analysis;

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

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

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

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

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

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

(2) The chairpersons of the council may appoint up to four

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

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

(c) Any entity established or incorporated pursuant to subsection (b) of this section shall have its powers vested in and exercised by a board

of directors. The board of directors shall be comprised of the following members who shall each serve for a term of two years:

(1) One member who shall have expertise as an advocate for consumers of health care, appointed by the Governor;

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

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

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

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

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

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

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

(e) **[**The**]** Any entity established or incorporated under subsection **[**(c)**]** (b) of this section may (1) employ a staff and fix their duties, qualifications and compensation; (2) solicit, receive and accept aid or contributions, including money, property, labor and other things of value from any source; (3) receive, and manage on behalf of the state, funding from the federal government, other public sources or private sources to cover costs associated with the planning, implementation and administration of the State-wide Health Information Exchange; (4) collect and remit fees set by the Health Information Technology Officer charged to persons or entities for access to or interaction with said exchange; (5) retain outside consultants and technical experts; (6) maintain an office in the state at such place or places as such entity may designate; (7) procure insurance against loss in connection with such entity's property and other assets in such amounts and from such insurers as such entity deems desirable; (8) sue and be sued and plead and be impleaded; (9) borrow money for the purpose of obtaining working capital; and (10) subject to the powers, purposes and restrictions of sections 17b-59a, as amended by this act, 17b-59d, as amended by this act, and 17b-59f, as amended by this act, **[**and 19a-755,**]** do all acts and things necessary and convenient to carry out the purposes of this section and section 19a-754a, as amended by this act.

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

(b) Appointments to the working group pursuant to subsection (a) of this section shall include, but need not be limited to, the **[**Health Information Technology Officer, designated in accordance with section 19a-755**]** executive director of the Office of Health Strategy, or such executive director's designee, and representatives from the insurance industry, the health care industry, the Connecticut Education Network, broadband Internet service providers, the Connecticut Technology Council, the bioscience industry and public or private universities and research institutions. The working group shall also include the

Consumer Counsel, or the Consumer Counsel's designee. All appointments to the working group shall be made not later than thirty days after June 30, 2017. Any member of the working group established pursuant to this section may be a member of the working group established pursuant to special act 16-20 or a member of the General Assembly or the Commission on Economic Competitiveness.

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

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

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

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

Sec. 15. Section 19a-612d of the general statutes is repealed and the

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

(a) **[**Notwithstanding any provision of the general statutes, there shall be a Deputy Commissioner of Public Health who**]** The executive director of the Office of Health Strategy shall oversee the **[**Office of Health Care Access division of the Department of Public Health and who**]** Health Systems Planning Unit and shall exercise independent decision-making authority over all certificate of need decisions.

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

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

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

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

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

(3) Performing the duties and functions as enumerated in subsection

(b) of this section.

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

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

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

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

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

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

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

(1) "Affiliate" means a person, entity or organization controlling, controlled by or under common control with another person, entity or organization. Affiliate does not include a medical foundation

organized under chapter 594b.

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

(3) "Bed capacity" means the total number of inpatient beds in a facility licensed by the Department of Public Health under sections 19a-490 to 19a-503, inclusive.

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

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

(6) "Days" means calendar days.

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

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

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

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

[(10)**]** (9) "Large group practice" means eight or more full-time equivalent physicians, legally organized in a partnership, professional

corporation, limited liability company formed to render professional services, medical foundation, not-for-profit corporation, faculty practice plan or other similar entity (A) in which each physician who is a member of the group provides substantially the full range of services that the physician routinely provides, including, but not limited to, medical care, consultation, diagnosis or treatment, through the joint use of shared office space, facilities, equipment or personnel; (B) for which substantially all of the services of the physicians who are members of the group are provided through the group and are billed in the name of the group practice and amounts so received are treated as receipts of the group; or (C) in which the overhead expenses of, and the income from, the group are distributed in accordance with methods previously determined by members of the group. An entity that otherwise meets the definition of group practice under this section shall be considered a group practice although its shareholders, partners or owners of the group practice include single-physician professional corporations, limited liability companies formed to render professional services or other entities in which beneficial owners are individual physicians.

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

[(12)**]** (11) "Nonhospital based" means located at a site other than the

main campus of the hospital.

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

[(14)**]** (13) "Person" means any individual, partnership, corporation, limited liability company, association, governmental subdivision, agency or public or private organization of any character, but does not include the agency conducting the proceeding.

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

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

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

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

(b) Each hospital shall annually pay to the **[**Commissioner of Public Health**]** executive director of the Office of Health Strategy, for deposit in the General Fund, an amount equal to its share of the actual expenditures made by the **[**office**]** unit during each fiscal year including the cost of fringe benefits for **[**office**]** unit personnel as estimated by the Comptroller, the amount of expenses for central state services attributable to the **[**office**]** unit for the fiscal year as estimated by the Comptroller, plus the expenditures made on behalf of the **[**office**]** unit from the Capital Equipment Purchase Fund pursuant to section 4a-9 for such year. Payments shall be made by assessment of all hospitals of the costs calculated and collected in accordance with the provisions of this section and section 19a-632, as amended by this act.

If for any reason a hospital ceases operation, any unpaid assessment for the operations of the **[**office**]** unit shall be reapportioned among the remaining hospitals to be paid in addition to any other assessment.

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

(a) On or before September first, annually, the **[**Office of Health Care Access**]** Health Systems Planning Unit shall determine (1) the total net revenue of each hospital for the most recently completed hospital fiscal year beginning October first; and (2) the proposed assessment on the hospital for the state fiscal year. The assessment on each hospital shall be calculated by multiplying the hospital's percentage share of the total net revenue specified in subdivision (1) of this subsection times the costs of the **[**office**]** unit, as determined in subsection (b) of this section.

(b) The costs of the **[**office**]** unit shall be the total of (1) the amount appropriated for expenses for the operation of the **[**office**]** unit for the fiscal year, as estimated by the Comptroller, (2) the cost of fringe benefits for **[**office**]** unit personnel for such year, as estimated by the Comptroller, (3) the amount of expenses for central state services attributable to the **[**office**]** unit for the fiscal year as estimated by the Comptroller, and (4) the estimated expenditures on behalf of the **[**office**]** unit from the Capital Equipment Purchase Fund pursuant to section 4a-9 for such year, provided for purposes of this calculation the amount of expenses for the operation of the **[**office**]** unit for the fiscal year as estimated by the Comptroller, plus the cost of fringe benefits for personnel, the amount of expenses for said central state services for the fiscal year as estimated by the Comptroller, and said estimated expenditures from the Capital Equipment Purchase Fund pursuant to section 4a-9 shall be deemed to be the actual expenditures of the **[**office**]** unit.

(c) On or before December thirty-first, annually, for each fiscal year, each hospital shall pay the **[**office**]** unit twenty-five per cent of its proposed assessment, adjusted to reflect any credit or amount due

under the recalculated assessment for the preceding state fiscal year as determined pursuant to subsection (d) of this section or any reapportioned assessment pursuant to subsection (b) of section 19a-631, as amended by this act. The hospital shall pay the remaining seventy-five per cent of its assessment to the **[**office**]** unit in three equal installments on or before the following March thirty-first, June thirtieth and September thirtieth, annually.

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

(e) If any assessment is not paid when due, the **[**commissioner**]** executive director shall impose a fee equal to (1) two per cent of the assessment if such failure to pay is for not more than five days, (2) five per cent of the assessment if such failure to pay is for more than five days but not more than fifteen days, or (3) ten per cent of the assessment if such failure to pay is for more than fifteen days. If a hospital fails to pay any assessment for more than thirty days after the date when due, the **[**commissioner**]** executive director may, in addition

to the fees imposed pursuant to this subsection, impose a civil penalty of up to one thousand dollars per day for each day past the initial thirty days that the assessment is not paid. Any civil penalty authorized by this subsection shall be imposed by the **[**commissioner**]** executive director in accordance with subsections (b) to (e), inclusive, of section 19a-653, as amended by this act.

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

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

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

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

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

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

The **[**commissioner**]** executive director, or any agent authorized by **[**him**]** such executive director to conduct any inquiry, investigation or hearing under the provisions of this chapter, shall have power to administer oaths and take testimony under oath relative to the matter

of inquiry or investigation. At any hearing ordered by the **[**office**]** unit, the **[**commissioner**]** executive director or such agent having authority by law to issue such process may subpoena witnesses and require the production of records, papers and documents pertinent to such inquiry. If any person disobeys such process or, having appeared in obedience thereto, refuses to answer any pertinent question put to **[**him**]** such person by the **[**commissioner**]** executive director or **[**his**]** such executive director's authorized agent or to produce any records and papers pursuant thereto, the **[**commissioner**]** executive director or **[**his**]** such executive director's agent may apply to the superior court for the judicial district of Hartford or for the judicial district wherein the person resides or wherein the business has been conducted, or to any judge of said court if the same is not in session, setting forth such disobedience to process or refusal to answer, and said court or such judge shall cite such person to appear before said court or such judge to answer such question or to produce such records and papers.

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

(a) The **[**Office of Health Care Access**]** Health Systems Planning Unit shall conduct, on a biennial basis, a state-wide health care facility utilization study. Such study may include an assessment of: (1) Current availability and utilization of acute hospital care, hospital emergency care, specialty hospital care, outpatient surgical care, primary care and clinic care; (2) geographic areas and subpopulations that may be underserved or have reduced access to specific types of health care services; and (3) other factors that the **[**office**]** unit deems pertinent to health care facility utilization. Not later than June thirtieth of the year in which the biennial study is conducted, the **[**Commissioner of Public Health**]** executive director of the Office of Health Strategy shall report, in accordance with section 11-4a, to the Governor and the joint standing committees of the General Assembly having cognizance of matters relating to public health and human services on the findings of the study. Such report may also include the

[office's**]** unit's recommendations for addressing identified gaps in the provision of health care services and recommendations concerning a lack of access to health care services.

(b) The **[**office**]** unit, in consultation with such other state agencies as the **[**Commissioner of Public Health**]** executive director deems appropriate, shall establish and maintain a state-wide health care facilities and services plan. Such plan may include, but not be limited to: (1) An assessment of the availability of acute hospital care, hospital emergency care, specialty hospital care, outpatient surgical care, primary care and clinic care; (2) an evaluation of the unmet needs of persons at risk and vulnerable populations as determined by the **[**commissioner**]** executive director; (3) a projection of future demand for health care services and the impact that technology may have on the demand, capacity or need for such services; and (4) recommendations for the expansion, reduction or modification of health care facilities or services. In the development of the plan, the **[**office**]** unit shall consider the recommendations of any advisory bodies which may be established by the **[**commissioner**]** executive director. The **[**commissioner**]** executive director may also incorporate the recommendations of authoritative organizations whose mission is to promote policies based on best practices or evidence-based research. The **[**commissioner**]** executive director, in consultation with hospital representatives, shall develop a process that encourages hospitals to incorporate the state-wide health care facilities and services plan into hospital long-range planning and shall facilitate communication between appropriate state agencies concerning innovations or changes that may affect future health planning. The **[**office**]** unit shall update the state-wide health care facilities and services plan not less than once every two years.

(c) For purposes of conducting the state-wide health care facility utilization study and preparing the state-wide health care facilities and services plan, the **[**office**]** unit shall establish and maintain an inventory of all health care facilities, the equipment identified in

subdivisions (9) and (10) of subsection (a) of section 19a-638, as amended by this act, and services in the state, including health care facilities that are exempt from certificate of need requirements under subsection (b) of section 19a-638, as amended by this act. The **[**office**]** unit shall develop an inventory questionnaire to obtain the following information: (1) The name and location of the facility; (2) the type of facility; (3) the hours of operation; (4) the type of services provided at that location; and (5) the total number of clients, treatments, patient visits, procedures performed or scans performed in a calendar year. The inventory shall be completed biennially by health care facilities and providers and such health care facilities and providers shall not be required to provide patient specific or financial data.

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

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

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

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

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

(4) The establishment of a freestanding emergency department;

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

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

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

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

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

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

(11) The acquisition of nonhospital based linear accelerators;

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

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

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

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

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

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

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

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

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

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

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

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

(8) Outpatient rehabilitation facilities;

(9) Outpatient chronic dialysis services;

(10) Transplant services;

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

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

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

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

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

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

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

(18) Replacement of existing imaging equipment if such equipment

was acquired through certificate of need approval or a certificate of need determination, provided a health care facility, provider, physician or person notifies the **[**office**]** unit of the date on which the equipment is replaced and the disposition of the replaced equipment;

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

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

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

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

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

(d) The **[**Commissioner of Public Health**]** executive director of the Office of Health Strategy may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulation, provided the **[**commissioner**]** executive director holds a public hearing prior to implementing the policies and procedures and **[**prints**]** posts

notice of intent to adopt regulations **[**in the Connecticut Law Journal**]** on the office's Internet web site and the eRegulations System not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until the time final regulations are adopted. **[**Final regulations shall be adopted by December 31, 2011.**]**

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

(a) In any deliberations involving a certificate of need application filed pursuant to section 19a-638, as amended by this act, the **[**office**]** unit shall take into consideration and make written findings concerning each of the following guidelines and principles:

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

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

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

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

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

(6) The applicant's past and proposed provision of health care services to relevant patient populations and payer mix, including, but

not limited to, access to services by Medicaid recipients and indigent persons;

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

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

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

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

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

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

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

(c) The **[**office**]** unit, as it deems necessary, may revise or supplement the guidelines and principles, **[**through regulation

prescribed in subsection (a) of this section**]** set forth in subsection (a) of this section, through regulation.

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

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

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

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

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

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

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

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

(2) In any deliberations involving a certificate of need application filed pursuant to section 19a-638, as amended by this act, that involves

the transfer of ownership of a hospital, the **[**office**]** unit shall, in addition to the guidelines and principles set forth in subsection (a) of this section and those prescribed through regulation pursuant to subsection (c) of this section, take into consideration and make written findings concerning each of the following guidelines and principles:

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

(B) Whether the plan submitted pursuant to section 19a-639a, as amended by this act, demonstrates, in a manner consistent with this chapter, how health care services will be provided by the new hospital for the first three years following the transfer of ownership of the hospital, including any consolidation, reduction, elimination or expansion of existing services or introduction of new services.

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

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

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

(e) (1) If the certificate of need application (A) involves the transfer of ownership of a hospital, (B) the purchaser is a hospital, as defined in section 19a-490, whether located within or outside the state, that had net patient revenue for fiscal year 2013 in an amount greater than one billion five hundred million dollars or a hospital system, as defined in section 19a-486i, as amended by this act, whether located within or outside the state, that had net patient revenue for fiscal year 2013 in an amount greater than one billion five hundred million dollars, or any person that is organized or operated for profit, and (C) such application is approved, the **[**office**]** unit shall hire an independent consultant to serve as a post-transfer compliance reporter for a period of three years after completion of the transfer of ownership of the hospital. Such reporter shall, at a minimum: (i) Meet with representatives of the purchaser, the new hospital and members of the affected community served by the new hospital not less than quarterly; and (ii) report to the **[**office**]** unit not less than quarterly concerning (I) efforts the purchaser and representatives of the new hospital have taken to comply with any conditions the **[**office**]** unit placed on the approval of the certificate of need application and plans for future compliance, and (II) community benefits and uncompensated care

provided by the new hospital. The purchaser shall give the reporter access to its records and facilities for the purposes of carrying out the reporter's duties. The purchaser shall hold a public hearing in the municipality in which the new hospital is located not less than annually during the reporting period to provide for public review and comment on the reporter's reports and findings.

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

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

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

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

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

application fee of five hundred dollars.

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

(c) (1) Not later than five business days after receipt of a properly filed certificate of need application, the **[**office**]** unit shall publish notice of the application on its Internet web site. Not later than thirty days after the date of filing of the application, the **[**office**]** unit may request such additional information as the **[**office**]** unit determines necessary to complete the application. In addition to any information requested by the **[**office**]** unit, if the application involves the transfer of ownership of a hospital, as defined in section 19a-639, as amended by this act, the applicant shall submit to the **[**office**]** unit (A) a plan demonstrating how health care services will be provided by the new hospital for the first three years following the transfer of ownership of the hospital, including any consolidation, reduction, elimination or expansion of existing services or introduction of new services, and (B) the names of persons currently holding a position with the hospital to be purchased or the purchaser, as defined in section 19a-639, as amended by this act, as an officer, director, board member or senior manager, whether or

not such person is expected to hold a position with the hospital after completion of the transfer of ownership of the hospital and any salary, severance, stock offering or any financial gain, current or deferred, such person is expected to receive as a result of, or in relation to, the transfer of ownership of the hospital.

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

(d) Upon determining that an application is complete, the **[**office**]** unit shall provide notice of this determination to the applicant and to the public in accordance with regulations adopted by the department. In addition, the **[**office**]** unit shall post such notice on its Internet web site. The date on which the **[**office**]** unit posts such notice on its Internet web site shall begin the review period. Except as provided in this subsection, (1) the review period for a completed application shall be ninety days from the date on which the **[**office**]** unit posts such notice on its Internet web site; and (2) the **[**office**]** unit shall issue a decision on a completed application prior to the expiration of the ninety-day review period. The review period for a completed application that involves a transfer of a large group practice, as described in subdivision (3) of subsection (a) of section 19a-638, as amended by this act, when the offer was made in response to a request for proposal or similar voluntary offer for sale, shall be sixty days from the date on which the **[**office**]** unit posts notice on its Internet web site. Upon request or for good cause shown, the **[**office**]** unit may extend the review period for a period of time not to exceed sixty days. If the review period is extended, the **[**office**]** unit shall issue a decision on the completed application prior to the expiration of the extended review period. If the **[**office**]** unit holds a public hearing concerning a completed application in accordance with subsection (e) or (f) of this

section, the [office] unit shall issue a decision on the completed application not later than sixty days after the date the [office] unit closes the public hearing record.

(e) Except as provided in this subsection, the [office] unit shall hold a public hearing on a properly filed and completed certificate of need application if three or more individuals or an individual representing an entity with five or more people submits a request, in writing, that a public hearing be held on the application. For a properly filed and completed certificate of need application involving a transfer of ownership of a large group practice, as described in subdivision (3) of subsection (a) of section 19a-638, as amended by this act, when an offer was made in response to a request for proposal or similar voluntary offer for sale, a public hearing shall be held if twenty-five or more individuals or an individual representing twenty-five or more people submits a request, in writing, that a public hearing be held on the application. Any request for a public hearing shall be made to the [office] unit not later than thirty days after the date the [office] unit determines the application to be complete.

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

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

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

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

(a) A certificate of need shall be valid only for the project described in the application. A certificate of need shall be valid for two years from the date of issuance by the **[**office**]** unit. During the period of time that such certificate is valid and the thirty-day period following the expiration of the certificate, the holder of the certificate shall provide the **[**office**]** unit with such information as the **[**office**]** unit may request on the development of the project covered by the certificate.

(b) Upon request from a certificate holder, the **[**office**]** unit may extend the duration of a certificate of need for such additional period of time as the **[**office**]** unit determines is reasonably necessary to expeditiously complete the project. Not later than five business days after receiving a request to extend the duration of a certificate of need, the **[**office**]** unit shall post such request on its web site. Any person who wishes to comment on extending the duration of the certificate of need shall provide written comments to the **[**office**]** unit on the requested extension not later than thirty days after the date the **[**office**]** unit posts notice of the request for an extension of time on its web site. The **[**office**]** unit shall hold a public hearing on any request to extend the duration of a certificate of need if three or more individuals or an individual representing an entity with five or more people submits a

request, in writing, that a public hearing be held on the request to extend the duration of a certificate of need.

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

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

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

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

(a) Any health care facility that proposes to relocate a facility shall submit a letter to the **[**office**]** unit, as described in subsection (c) of section 19a-638, as amended by this act. In addition to the requirements prescribed in said subsection (c), in such letter the health care facility shall demonstrate to the satisfaction of the **[**office**]** unit that the population served by the health care facility and the payer mix will

not substantially change as a result of the facility's proposed relocation. If the facility is unable to demonstrate to the satisfaction of the **[**office**]** unit that the population served and the payer mix will not substantially change as a result of the proposed relocation, the health care facility shall apply for certificate of need approval pursuant to subdivision (1) of subsection (a) of section 19a-638, as amended by this act, in order to effectuate the proposed relocation.

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

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

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

writing, that a public hearing be held on the health care facility's proposal to terminate a service.

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

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

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

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

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

(b) Not later than twenty-one days after receipt of a properly filed certificate of need application involving the transfer of ownership of a hospital filed on or after December 1, 2015, as described in subsection (a) of this section, the **[**office**]** unit shall initiate such cost and market impact review by sending the transacting parties a written notice that shall contain a description of the basis for the cost and market impact review as well as a request for information and documents. Not later than thirty days after receipt of such notice, the transacting parties shall submit to the **[**office**]** unit a written response. Such response shall include, but need not be limited to, any information or documents requested by the **[**office**]** unit concerning the transfer of ownership of the hospital. The **[**office**]** unit shall have the powers with respect to the cost and market impact review as provided in section 19a-633, as amended by this act.

(c) The **[**office**]** unit shall keep confidential all nonpublic information and documents obtained pursuant to this section and shall not disclose the information or documents to any person without the consent of the person that produced the information or documents, except in a preliminary report or final report issued in accordance with this

section if the **[**office**]** unit believes that such disclosure should be made in the public interest after taking into account any privacy, trade secret or anti-competitive considerations. Such information and documents shall not be deemed a public record, under section 1-210, and shall be exempt from disclosure.

(d) The cost and market impact review conducted pursuant to this section shall examine factors relating to the businesses and relative market positions of the transacting parties as defined in subsection (d) of section 19a-639, as amended by this act, and may include, but need not be limited to: (1) The transacting parties' size and market share within its primary service area, by major service category and within its dispersed service areas; (2) the transacting parties' prices for services, including the transacting parties' relative prices compared to other health care providers for the same services in the same market; (3) the transacting parties' health status adjusted total medical expense, including the transacting parties' health status adjusted total medical expense compared to that of similar health care providers; (4) the quality of the services provided by the transacting parties, including patient experience; (5) the transacting parties' cost and cost trends in comparison to total health care expenditures state wide; (6) the availability and accessibility of services similar to those provided by each transacting party, or proposed to be provided as a result of the transfer of ownership of a hospital within each transacting party's primary service areas and dispersed service areas; (7) the impact of the proposed transfer of ownership of the hospital on competing options for the delivery of health care services within each transacting party's primary service area and dispersed service area including the impact on existing service providers; (8) the methods used by the transacting parties to attract patient volume and to recruit or acquire health care professionals or facilities; (9) the role of each transacting party in serving at-risk, underserved and government payer patient populations, including those with behavioral, substance use disorder and mental health conditions, within each transacting party's primary service area and dispersed service area; (10) the role of each transacting

party in providing low margin or negative margin services within each transacting party's primary service area and dispersed service area; (11) consumer concerns, including, but not limited to, complaints or other allegations that a transacting party has engaged in any unfair method of competition or any unfair or deceptive act or practice; and (12) any other factors that the **[**office**]** unit determines to be in the public interest.

(e) Not later than ninety days after the **[**office**]** unit determines that there is substantial compliance with any request for documents or information issued by the **[**office**]** unit in accordance with this section, or a later date set by mutual agreement of the **[**office**]** unit and the transacting parties, the **[**office**]** unit shall make factual findings and issue a preliminary report on the cost and market impact review. Such preliminary report shall include, but shall not be limited to, an indication as to whether a transacting party meets the following criteria: (1) Currently has or, following the proposed transfer of operations of the hospital, is likely to have a dominant market share for the services the transacting party provides; and (2) (A) currently charges or, following the proposed transfer of operations of the hospital, is likely to charge prices for services that are materially higher than the median prices charged by all other health care providers for the same services in the same market, or (B) currently has or, following the proposed transfer of operations of a hospital, is likely to have a health status adjusted total medical expense that is materially higher than the median total medical expense for all other health care providers for the same service in the same market.

(f) The transacting parties that are the subject of the cost and market impact review may respond in writing to the findings in the preliminary report issued in accordance with subsection (e) of this section not later than thirty days after the issuance of the preliminary report. Not later than sixty days after the issuance of the preliminary report, the **[**office**]** unit shall issue a final report of the cost and market impact review. The **[**office**]** unit shall refer to the Attorney General any

final report on any proposed transfer of ownership that meets the criteria described in subsection (e) of this section.

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

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

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

(j) The **[**office**]** unit shall retain an independent consultant with expertise on the economic analysis of the health care market and health care costs and prices to conduct each cost and market impact review,

as described in this section. The **[**office**]** unit shall submit bills for such services to the purchaser, as defined in subsection (d) of section 19a-639, as amended by this act. Such purchaser shall pay such bills not later than thirty days after receipt. Such bills shall not exceed two hundred thousand dollars per application. The provisions of chapter 57, sections 4-212 to 4-219, inclusive, and section 4e-19 shall not apply to any agreement executed pursuant to this subsection.

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

(l) The **[**Commissioner of Public Health**]** executive director of the Office of Health Strategy shall adopt regulations, in accordance with the provisions of chapter 54, concerning cost and market impact reviews and to administer the provisions of this section. Such regulations shall include definitions of the following terms: "Dispersed service area", "health status adjusted total medical expense", "major service category", "relative prices", "total health care spending" and "health care services". The **[**commissioner**]** executive director may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures in regulation form, provided the **[**commissioner**]** executive director publishes notice of intention to adopt the regulations on the **[**Department of Public Health's**]** office's Internet web site and the eRegulations System not later than twenty days after implementing such policies and procedures. Policies and procedures implemented pursuant to this subsection shall be valid until the time such regulations are effective.

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

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

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

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

Sec. 34. Section 19a-643 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) The **[**Department of Public Health**]** Office of Health Strategy shall adopt regulations, in accordance with the provisions of chapter 54, to carry out the provisions of sections 19a-630 to 19a-639e, inclusive, as amended by this act, and sections 19a-644, as amended by this act, and 19a-645, as amended by this act, concerning the submission of data by health care facilities and institutions, including data on dealings between health care facilities and institutions and their affiliates, and, with regard to requests or proposals pursuant to sections 19a-638 to 19a-639e, inclusive, as amended by this act, by state health care facilities and institutions, the ongoing inspections by the **[**office**]** unit of operating budgets that have been approved by the health care facilities and institutions, standard reporting forms and standard accounting procedures to be utilized by health care facilities

and institutions and the transferability of line items in the approved operating budgets of the health care facilities and institutions, except that any health care facility or institution may transfer any amounts among items in its operating budget. All such transfers shall be reported to the **[**office within**]** unit not later than thirty days **[**of**]** after the transfer or transfers.

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

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

(a) On or before February twenty-eighth annually, for the fiscal year ending on September thirtieth of the immediately preceding year, each short-term acute care general or children's hospital shall report to the **[**office**]** unit with respect to its operations in such fiscal year, in such form as the **[**office**]** unit may by regulation require. Such report shall include: (1) Salaries and fringe benefits for the ten highest paid hospital and health system employees; (2) the name of each joint venture, partnership, subsidiary and corporation related to the hospital; and (3) the salaries paid to hospital and health system employees by each such joint venture, partnership, subsidiary and related corporation and by the hospital to the employees of related corporations. For purposes of this subsection, "health system" has the same meaning as provided in section 33-182aa.

(b) The **[**Department of Public Health**]** Office of Health Strategy shall adopt regulations in accordance with chapter 54 to provide for the collection of data and information in addition to the annual report required in subsection (a) of this section. Such regulations shall provide for the submission of information about the operations of the following entities: Persons or parent corporations that own or control the health care facility, institution or provider; corporations, including limited liability corporations, in which the health care facility,

institution, provider, its parent, any type of affiliate or any combination thereof, owns more than an aggregate of fifty per cent of the stock or, in the case of nonstock corporations, is the sole member; and any partnerships in which the person, health care facility, institution, provider, its parent or an affiliate or any combination thereof, or any combination of health care providers or related persons, owns a greater than fifty per cent interest. For purposes of this **[**section**]** subsection, "affiliate" means any person that directly or indirectly through one or more intermediaries, controls or is controlled by or is under common control with any health care facility, institution, provider or person that is regulated in any way under this chapter. A person is deemed controlled by another person if the other person, or one of that other person's affiliates, officers, agents or management employees, acts as a general partner or manager of the person in question.

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

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

(e) The **[**office**]** unit shall require each hospital licensed by the Department of Public Health, that is not subject to the provisions of subsection (a) of this section, to report to said **[**office**]** unit on its operations in the preceding fiscal year by filing copies of the hospital's

audited financial statements, except a health system, as defined in section 19a-508c, as amended by this act, may submit to the **[**office**]** unit one such report that includes the audited financial statements for each of its hospitals. Such report shall be due at the **[**office**]** unit on or before the close of business on the last business day of the fifth month following the month in which a hospital's fiscal year ends.

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

A nonprofit hospital, licensed by the Department of Public Health, which provides lodging, care and treatment to members of the public, and which wishes to enlarge its public facilities by adding contiguous land and buildings thereon, if any, the title to which it cannot otherwise acquire, may prefer a complaint for the right to take such land to the superior court for the judicial district in which such land is located, provided such hospital shall have received the approval of the **[**Office of Health Care Access division**]** Health Systems Planning Unit of the **[**Department of Public Health**]** Office of Health Strategy in accordance with the provisions of this chapter. Said court shall appoint a committee of three disinterested persons, who, after examining the premises and hearing the parties, shall report to the court as to the necessity and propriety of such enlargement and as to the quantity, boundaries and value of the land and buildings thereon, if any, which they deem proper to be taken for such purpose and the damages resulting from such taking. If such committee reports that such enlargement is necessary and proper and the court accepts such report, the decision of said court thereon shall have the effect of a judgment and execution may be issued thereon accordingly, in favor of the person to whom damages may be assessed, for the amount thereof; and, on payment thereof, the title to the land and buildings thereon, if any, for such purpose shall be vested in the complainant, but such land and buildings thereon, if any, shall not be taken until such damages are paid to such owner or deposited with said court, for such owner's use, within thirty days after such report is accepted. If such application

is denied, the owner of the land shall recover costs of the applicant, to be taxed by said court, which may issue execution therefor. Land so taken shall be held by such hospital and used only for the public purpose stated in its complaint to the superior court. No land dedicated or otherwise reserved as open space or park land or for other recreational purposes and no land belonging to any town, city or borough shall be taken under the provisions of this section.

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

(a) As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

the third-party payer for service to the patient prior to the provision of that service.

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

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

(h) (1) Nothing in this section shall be construed to require payment by any payer or purchaser, under any program or contract for payment or reimbursement of expenses for health care services, for: (A) Services not covered under such program or contract; or (B) that portion of any charge for services furnished by a hospital that exceeds the amount covered by such program or contract.

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

(i) A hospital which has established a program approved by the **[**office**]** unit with one or more banks for the purpose of reducing the hospital's bad debt load, may reduce its published charges for that portion of a patient's bill for services which a payer who is a private individual is or may become legally responsible for, after all other

insurers or third-party payers have been assessed their full charges provided (1) prior to the rendering of such services, the hospital and the individual payer or parent or guardian or custodian have agreed in writing that after receipt of any insurer or third-party payment paid in accordance with the full hospital charges the remaining payment due from the private individual for such reduced charges shall be made in whole or in part from the balance on deposit in a bank account which has been established by or on behalf of such individual patient, and (2) such payment is made from such account. Nothing in this section shall relieve a patient or legally liable person from being responsible for the full amount of any underpayment of the hospital's authorized charges excluding any discount under this section, by a patient's insurer or any other third-party payer for that insurer's or third-party payer's portion of the bill. Any reduction in charges granted to an individual or parent or guardian or custodian under this subsection shall be reported to the **[**office**]** unit as a contractual allowance. For purposes of this **[**section**]** subsection "private individual" shall include a patient's parent, legal guardian or legal custodian but shall not include an insurer or third-party payer.

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

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

prescribed by the **[**office**]** unit.

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

(c) Each hospital recognized as a nonprofit organization under Section 501(c)(3) of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time, shall, along with data submitted annually pursuant to subsection (a) of this section, submit to the **[**office**]** unit (1) a complete copy of such hospital's most-recently completed Internal Revenue Service form 990, including all parts and schedules; and (2) in the form and manner prescribed by the **[**office**]** unit, data compiled to prepare such hospital's community health needs assessment, as required pursuant to Section 501(r) of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time, provided such copy and data submitted pursuant to this subsection shall not include: (A) Individual patient information, including, but not limited to, patient-identifiable information; (B) information that is not owned or controlled by such hospital; (C) information that such hospital is contractually required to keep confidential or that is prohibited from disclosure by a data use agreement; or (D) information concerning research on human subjects as described in section 45 CFR 46.101 et seq., as amended from time to time.

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

(a) Any person or health care facility or institution that is required to file a certificate of need for any of the activities described in section 19a-638, as amended by this act, and any person or health care facility or institution that is required to file data or information under any

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

(b) If the **[**Department of Public Health**]** Office of Health Strategy has reason to believe that a violation has occurred for which a civil penalty is authorized by subsection (a) of this section or subsection (e) of section 19a-632, as amended by this act, it shall notify the person or health care facility or institution by first-class mail or personal service. The notice shall include: (1) A reference to the sections of the statute or regulation involved; (2) a short and plain statement of the matters asserted or charged; (3) a statement of the amount of the civil penalty or penalties to be imposed; (4) the initial date of the imposition of the penalty; and (5) a statement of the party's right to a hearing.

(c) The person or health care facility or institution to whom the notice is addressed shall have fifteen business days from the date of mailing of the notice to make written application to the **[**office**]** unit to request (1) a hearing to contest the imposition of the penalty, or (2) an extension of time to file the required data. A failure to make a timely request for a hearing or an extension of time to file the required data or a denial of a request for an extension of time shall result in a final order for the imposition of the penalty. All hearings under this section shall be conducted pursuant to sections 4-176e to 4-184, inclusive. The

[Department of Public Health**]** Office of Health Strategy may grant an extension of time for filing the required data or mitigate or waive the penalty upon such terms and conditions as, in its discretion, it deems proper or necessary upon consideration of any extenuating factors or circumstances.

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

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

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

(a) As used in this section:

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

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

(b) Each short-term acute care general or children's hospital shall

submit patient-identifiable inpatient discharge data and emergency department data to the **[**Office of Health Care Access division**]** Health Systems Planning Unit of the **[**Department of Public Health**]** Office of Health Strategy to fulfill the responsibilities of the **[**office**]** unit. Such data shall include data taken from patient medical record abstracts and bills. The **[**office**]** unit shall specify the timing and format of such submissions. Data submitted pursuant to this section may be submitted through a contractual arrangement with an intermediary and such contractual arrangement shall (1) comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 P.L. 104-191 (HIPAA), and (2) ensure that such submission of data is timely and accurate. The **[**office**]** unit may conduct an audit of the data submitted through such intermediary in order to verify its accuracy.

(c) An outpatient surgical facility, as defined in section 19a-493b, as amended by this act, a short-term acute care general or children's hospital, or a facility that provides outpatient surgical services as part of the outpatient surgery department of a short-term acute care hospital shall submit to the **[**office**]** unit the data identified in subsection (c) of section 19a-634, as amended by this act. The **[**office**]** unit shall convene a working group consisting of representatives of outpatient surgical facilities, hospitals and other individuals necessary to develop recommendations that address current obstacles to, and proposed requirements for, patient-identifiable data reporting in the outpatient setting. On or before February 1, 2012, the working group shall report, in accordance with the provisions of section 11-4a, on its findings and recommendations to the joint standing committees of the General Assembly having cognizance of matters relating to public health and insurance and real estate. Additional reporting of outpatient data as the **[**office**]** unit deems necessary shall begin not later than July 1, 2015. On or before July 1, **[**2012**]** 2018, and annually thereafter, the Connecticut Association of Ambulatory Surgery Centers shall provide a progress report to the **[**Department of Public Health**]** Office of Health Strategy, until such time as all ambulatory surgery centers are in full compliance with the implementation of systems that

allow for the reporting of outpatient data as required by the **[**commissioner**]** executive director. Until such additional reporting requirements take effect on July 1, 2015, the department may work with the Connecticut Association of Ambulatory Surgery Centers and the Connecticut Hospital Association on specific data reporting initiatives provided that no penalties shall be assessed under this chapter or any other provision of law with respect to the failure to submit such data.

(d) Except as provided in this subsection, patient-identifiable data received by the **[**office**]** unit shall be kept confidential and shall not be considered public records or files subject to disclosure under the Freedom of Information Act, as defined in section 1-200. The **[**office**]** unit may release de-identified patient data or aggregate patient data to the public in a manner consistent with the provisions of 45 CFR 164.514. Any de-identified patient data released by the **[**office**]** unit shall exclude provider, physician and payer organization names or codes and shall be kept confidential by the recipient. The **[**office**]** unit may release patient-identifiable data (1) for medical and scientific research as provided for in section 19a-25-3 of the regulations of Connecticut state agencies, and (2) to (A) a state agency for the purpose of improving health care service delivery, (B) a federal agency or the office of the Attorney General for the purpose of investigating hospital mergers and acquisitions, or (C) another state's health data collection agency with which the **[**office**]** unit has entered into a reciprocal data-sharing agreement for the purpose of certificate of need review or evaluation of health care services, upon receipt of a request from such agency, provided, prior to the release of such patient-identifiable data, such agency enters into a written agreement with the **[**office**]** unit pursuant to which such agency agrees to protect the confidentiality of such patient-identifiable data and not to use such patient-identifiable data as a basis for any decision concerning a patient. No individual or entity receiving patient-identifiable data may release such data in any manner that may result in an individual patient, physician, provider or payer being identified. The **[**office**]** unit

shall impose a reasonable, cost-based fee for any patient data provided to a nongovernmental entity.

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

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

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

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

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

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

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

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

Health Center;

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

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

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

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

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

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

(9) "Case mix index" means the arithmetic mean of the Medicare diagnosis related group case weights assigned to each inpatient discharge for a specific hospital during a given fiscal year. The case mix index shall be calculated by dividing the hospital's total case mix adjusted discharges by the hospital's actual number of discharges for the fiscal year. The total case mix adjusted discharges shall be calculated by (A) multiplying the number of discharges in each diagnosis-related group by the Medicare weights in effect for that same diagnosis-related group and fiscal year, and (B) then totaling the

resulting products for all diagnosis-related groups;

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

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

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

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

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

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

The **[**office**]** unit shall, by September first of each year, report the results of the **[**office's**]** unit's review of the hospitals' annual and twelve-month filings under sections 19a-644, as amended by this act, 19a-649, as amended by this act, and 19a-676, as amended by this act, for the previous hospital fiscal year to the joint standing committee of the General Assembly having cognizance of matters relating to public health. The report shall include information concerning the financial stability of hospitals in a competitive market.

Sec. 43. Subdivision (1) of subsection (a) of section 19a-673 of the general statutes is repealed and the following is substituted in lieu

thereof (*Effective from passage*):

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

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

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

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

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

Sec. 46. Section 19a-676 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

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

hospital's twelve months' actual filing requirements.

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) No nonprofit hospital shall enter into an agreement to transfer a material amount of its assets or operations or a change in control of operations to a person that is organized or operated for profit without first having received approval of the agreement by the **[**commissioner**]** executive director and the Attorney General pursuant to sections 19a-486 to 19a-486h, inclusive, as amended by this act, and pursuant to the Attorney General's authority under section 3-125. Any such agreement without the approval required by sections 19a-486 to 19a-486h, inclusive, as amended by this act, shall be void.

(b) Prior to any transaction described in subsection (a) of this

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

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

(d) The **[**commissioner**]** executive director and the Attorney General shall review the certificate of need determination letter. The Attorney General shall determine whether the agreement requires approval pursuant to this chapter. If such approval is required, the **[**commissioner**]** executive director and the Attorney General shall

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

(e) No later than sixty days after the date of mailing of the application form, the nonprofit hospital and the purchaser shall concurrently file an application with the **[**commissioner**]** executive director and the Attorney General containing all the required information. The **[**commissioner**]** executive director and the Attorney General shall review the application and determine whether the application is complete. The **[**commissioner**]** executive director and the Attorney General shall, no later than twenty days after the date of their receipt of the application, provide written notice to the nonprofit hospital and the purchaser of any deficiencies in the application. Such application shall not be deemed complete until such deficiencies are corrected.

(f) No later than twenty-five days after the date of their receipt of

the completed application under this section, the **[**commissioner**]** executive director and the Attorney General shall jointly publish a summary of such agreement in a newspaper of general circulation where the nonprofit hospital is located.

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

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

(a) Not later than one hundred twenty days after the date of receipt of the completed application pursuant to subsection (e) of section 19a-486a, as amended by this act, the Attorney General and the **[**commissioner**]** executive director shall approve the application, with or without modification, or deny the application. The **[**commissioner**]** executive director shall also determine, in accordance with the provisions of chapter 368z, whether to approve, with or without modification, or deny the application for a certificate of need that is part of the completed application. Notwithstanding the provisions of section 19a-639a, as amended by this act, the **[**commissioner**]** executive director shall complete the decision on the application for a certificate of need within the same time period as the completed application. Such one-hundred-twenty-day period may be extended by (1) agreement of the Attorney General, the **[**commissioner**]** executive director, the nonprofit hospital and the purchaser, or (2) the **[**commissioner**]** executive director for an additional one hundred twenty days pending completion of a cost and market impact review conducted pursuant to section 19a-639f, as amended by this act. If the Attorney General initiates a proceeding to enforce a subpoena pursuant to section 19a-486c or 19a-486d, as amended by this act, the one-hundred-twenty-day period shall be tolled until the final court decision on the last pending enforcement proceeding, including any appeal or time for the filing of such appeal. Unless the one-hundred-twenty-day period is extended pursuant to this section, if the

[commissioner**]** executive director and Attorney General fail to take action on an agreement prior to the one hundred twenty-first day after the date of the filing of the completed application, the application shall be deemed approved.

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

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

(a) The **[**commissioner**]** executive director shall deny an application filed pursuant to subsection (d) of section 19a-486a, as amended by this act, unless the **[**commissioner**]** executive director finds that: (1) In a situation where the asset or operation to be transferred provides or has provided health care services to the uninsured or underinsured, the purchaser has made a commitment to provide health care to the uninsured and the underinsured; (2) in a situation where health care providers or insurers will be offered the opportunity to invest or own an interest in the purchaser or an entity related to the purchaser safeguard procedures are in place to avoid a conflict of interest in patient referral; and (3) certificate of need authorization is justified in accordance with chapter 368z. The **[**commissioner**]** executive director may contract with any person, including, but not limited to, financial or actuarial experts or consultants, or legal experts with the approval of the Attorney General, to assist in reviewing the completed application. The **[**commissioner**]** executive director shall submit any bills for such contracts to the purchaser. Such bills shall not exceed one hundred fifty thousand dollars. The purchaser shall pay such bills no

later than thirty days after the date of receipt of such bills.

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

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

Prior to making any decision to approve, with or without modification, or deny any application filed pursuant to subsection (d) of section 19a-486a, as amended by this act, the Attorney General and the **[**commissioner**]** executive director shall jointly conduct one or more public hearings, one of which shall be in the primary service area of the nonprofit hospital. At least fourteen days before conducting the public hearing, the Attorney General and the **[**commissioner**]** executive director shall provide notice of the time and place of the hearing through publication in one or more newspapers of general circulation in the affected community.

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

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

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

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

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

(2) There was a transaction described in section 19a-486a, as amended by this act, without the approval of the Attorney General, if such approval was required by sections 19a-486 to 19a-486h, inclusive, as amended by this act, and the Attorney General certifies to the **[**Commissioner of Public Health**]** executive director that such transaction involved a material amount of the nonprofit hospital's assets or operations or a change in control of operations; or

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

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

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

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

(d) (1) The written notice required under subsection (c) of this section shall identify each party to the transaction and describe the material change as of the date of such notice to the business or corporate structure of the group practice, including: (A) A description of the nature of the proposed relationship among the parties to the proposed transaction; (B) the names and specialties of each physician that is a member of the group practice that is the subject of the proposed transaction and who will practice medicine with the resulting group practice, hospital, hospital system, captive professional entity, medical foundation or other entity organized by, controlled by, or otherwise affiliated with such hospital or hospital system following the effective date of the transaction; (C) the names of the business entities that are to provide services following the effective date of the transaction; (D) the address for each location where such services are to be provided; (E) a description of the services to be provided at each such location; and (F) the primary service area to be served by each such location.

(2) Not later than thirty days after the effective date of any transaction described in subsection (c) of this section, the parties to the

transaction shall submit written notice to the **[**Commissioner of Public Health**]** executive director of the Office of Health Strategy. Such written notice shall include, but need not be limited to, the same information described in subdivision (1) of this subsection. The **[**commissioner**]** executive director shall post a link to such notice on the **[**Department of Public Health's**]** Office of Health Strategy's Internet web site.

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

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

(g) Not later than January 15, 2018, and annually thereafter, each hospital and hospital system shall file with the Attorney General and the **[**Commissioner of Public Health**]** executive director of the Office of Health Strategy a written report describing the activities of the group practices owned or affiliated with such hospital or hospital system. Such report shall include, for each such group practice: (1) A description of the nature of the relationship between the hospital or hospital system and the group practice; (2) the names and specialties of each physician practicing medicine with the group practice; (3) the

names of the business entities that provide services as part of the group practice and the address for each location where such services are provided; (4) a description of the services provided at each such location; and (5) the primary service area served by each such location.

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

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

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

(j) A hospital-based facility shall, when scheduling services for which a facility fee may be charged, inform the patient (1) that the

hospital-based facility is part of a hospital or health system, (2) of the name of the hospital or health system, (3) that the hospital or health system may charge a facility fee in addition to and separate from the professional fee charged by the provider, and (4) of the telephone number the patient may call for additional information regarding such patient's potential financial liability.

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

(2) Such notice shall include the following information:

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

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

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

(D) (i) A statement that the patient's actual financial liability will depend on the professional medical services actually provided to the patient, and (ii) an explanation that the patient may incur financial liability that is greater than the patient would incur if the hospital-based facility were not a hospital-based facility;

(E) The estimated amount or range of amounts the hospital-based facility may bill for a facility fee or an example of the average facility

fee billed at such hospital-based facility for the most common services provided at such hospital-based facility; and

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

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

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

(l) Notwithstanding the provisions of this section, on and after January 1, 2017, no hospital, health system or hospital-based facility shall collect a facility fee for (1) outpatient health care services that use a current procedural terminology evaluation and management code and are provided at a hospital-based facility, other than a hospital emergency department, located off-site from a hospital campus, or (2) outpatient health care services, other than those provided in an emergency department located off-site from a hospital campus, received by a patient who is uninsured of more than the Medicare rate. Notwithstanding the provisions of this subsection, in circumstances when an insurance contract that is in effect on July 1, 2016, provides reimbursement for facility fees prohibited under the provisions of this

section, a hospital or health system may continue to collect reimbursement from the health insurer for such facility fees until the date of expiration of such contract. A violation of this subsection shall be considered an unfair trade practice pursuant to chapter 735a.

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

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

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

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

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

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

(f) Each hospital which holds or administers one or more hospital bed funds shall maintain and annually compile, at the end of the fiscal year of the hospital, the following information: (1) The number of applications for hospital bed funds; (2) the number of patients

receiving hospital bed fund grants and the actual dollar amounts provided to each patient from such fund; (3) the fair market value of the principal of each individual hospital bed fund, or the principal attributable to each bed fund if held in a pooled investment; (4) the total earnings for each hospital bed fund or the earnings attributable to each hospital bed fund; (5) the dollar amount of earnings reinvested as principal if any; and (6) the dollar amount of earnings available for patient care. The information compiled pursuant to this subsection shall be permanently retained by the hospital and made available to the **[**Office of Health Care Access**]** Health Systems Planning Unit upon request.

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

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

(f) Any medical group clinic corporation formed under chapter 594 of the general statutes, revision of 1958, revised to 1995, which amends its certificate of incorporation pursuant to subsection (a) of section 33-182cc, shall file with the **[**Office of Health Care Access division of the Department of Public Health**]** Health Systems Planning Unit of the Office of Health Strategy a copy of its certificate of incorporation and any amendments to its certificate of incorporation, including any amendment to its certificate of incorporation that complies with the requirements of subsection (a) of section 33-182cc, not later than ten business days after the medical foundation files its certificate of incorporation or any amendments to its certificate of incorporation with the Secretary of the State.

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

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

(b) No entity, individual, firm, partnership, corporation, limited liability company or association, other than a hospital, shall individually or jointly establish or operate an outpatient surgical facility in this state without complying with chapter 368z, except as otherwise provided by this section, and obtaining a license within the time specified in this subsection from the Department of Public Health

for such facility pursuant to the provisions of this chapter, unless such entity, individual, firm, partnership, corporation, limited liability company or association: (1) Provides to the **[**Office of Health Care Access division of the Department of Public Health**]** Health Systems Planning Unit of the Office of Health Strategy satisfactory evidence that it was in operation on or before July 1, 2003, or (2) obtained, on or before July 1, 2003, from the Office of Health Care Access, a determination that a certificate of need is not required. An entity, individual, firm, partnership, corporation, limited liability company or association otherwise in compliance with this section may operate an outpatient surgical facility without a license through March 30, 2007, and shall have until March 30, 2007, to obtain a license from the Department of Public Health.

(c) Notwithstanding the provisions of this section, no outpatient surgical facility shall be required to comply with section 19a-631, as amended by this act, 19a-632, as amended by this act, 19a-644, as amended by this act, 19a-645, as amended by this act, 19a-646, as amended by this act, 19a-649, as amended by this act, 19a-664 to 19a-666, inclusive, 19a-673 to 19a-676, inclusive, as amended by this act, 19a-678, 19a-681, as amended by this act, or 19a-683. Each outpatient surgical facility shall continue to be subject to the obligations and requirements applicable to such facility, including, but not limited to, any applicable provision of this chapter and those provisions of chapter 368z not specified in this subsection, except that a request for permission to undertake a transfer or change of ownership or control shall not be required pursuant to subsection (a) of section 19a-638, as amended by this act, if the **[**Office of Health Care Access division of the Department of Public Health**]** Health Systems Planning Unit of the Office of Health Strategy determines that the following conditions are satisfied: (1) Prior to any such transfer or change of ownership or control, the outpatient surgical facility shall be owned and controlled exclusively by persons licensed pursuant to section 20-13 or chapter 375, either directly or through a limited liability company, formed pursuant to chapter 613, a corporation, formed pursuant to chapters

601 and 602, or a limited liability partnership, formed pursuant to chapter 614, that is exclusively owned by persons licensed pursuant to section 20-13 or chapter 375, or is under the interim control of an estate executor or conservator pending transfer of an ownership interest or control to a person licensed under section 20-13 or chapter 375, and (2) after any such transfer or change of ownership or control, persons licensed pursuant to section 20-13 or chapter 375, a limited liability company, formed pursuant to chapter 613, a corporation, formed pursuant to chapters 601 and 602, or a limited liability partnership, formed pursuant to chapter 614, that is exclusively owned by persons licensed pursuant to section 20-13 or chapter 375, shall own and control no less than a sixty per cent interest in the outpatient surgical facility.

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

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

(b) The commissioner shall, on or before January 15, 2015, and

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

Sec. 62. Section 19a-725 of the 2018 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2018*):

(a) There is established within the **[**office of the Lieutenant Governor**]** Office of Health Strategy, established under section 19a-754a, as amended by this act, the Health Care Cabinet for the purpose of advising the Governor on the matters set forth in subsection (c) of this section.

(b) (1) The Health Care Cabinet shall consist of the following

members who shall be appointed on or before August 1, 2011: (A) Five appointed by the Governor, two of whom may represent the health care industry and shall serve for terms of four years, one of whom shall represent community health centers and shall serve for a term of three years, one of whom shall represent insurance producers and shall serve for a term of three years and one of whom shall be an at-large appointment and shall serve for a term of three years; (B) one appointed by the president pro tempore of the Senate, who shall be an oral health specialist engaged in active practice and shall serve for a term of four years; (C) one appointed by the majority leader of the Senate, who shall represent labor and shall serve for a term of three years; (D) one appointed by the minority leader of the Senate, who shall be an advanced practice registered nurse engaged in active practice and shall serve for a term of two years; (E) one appointed by the speaker of the House of Representatives, who shall be a consumer advocate and shall serve for a term of four years; (F) one appointed by the majority leader of the House of Representatives, who shall be a primary care physician engaged in active practice and shall serve for a term of four years; (G) one appointed by the minority leader of the House of Representatives, who shall represent the health information technology industry and shall serve for a term of three years; (H) five appointed jointly by the chairpersons of the SustiNet Health Partnership board of directors, one of whom shall represent faith communities, one of whom shall represent small businesses, one of whom shall represent the home health care industry, one of whom shall represent hospitals, and one of whom shall be an at-large appointment, all of whom shall serve for terms of five years; (I) the **[**Lieutenant Governor**]** executive director of the Office of Health Strategy, or the executive director's designee; (J) the Secretary of the Office of Policy and Management, or the secretary's designee; the Comptroller, or the Comptroller's designee; the chief executive officer of the Connecticut Health Insurance Exchange, or said officer's designee; the Commissioners of Social Services and Public Health, or their designees; and the Healthcare Advocate, or the Healthcare Advocate's designee, all of whom shall serve as ex-officio voting

members; and (K) the Commissioners of Children and Families, Developmental Services and Mental Health and Addiction Services, and the Insurance Commissioner, or their designees, and the nonprofit liaison to the Governor, or the nonprofit liaison's designee, all of whom shall serve as ex-officio nonvoting members.

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

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

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

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

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

(2) Jointly evaluate, with the chief executive officer of the Connecticut Health Insurance Exchange, the feasibility of implementing a basic health program option as set forth in Section

1331 of the Affordable Care Act;

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

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

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

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

(e) The **[**office of the Lieutenant Governor and the Office of the Healthcare Advocate**]** Office of Health Strategy shall provide support staff to the Health Care Cabinet.

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

(a) As used in this section, "community health worker" means a public health outreach professional with an in-depth understanding of the experience, language, culture and socioeconomic needs of the community who (1) serves as a liaison between individuals within the community and health care and social services providers to facilitate

access to such services and health-related resources, improve the quality and cultural competence of the delivery of such services and address social determinants of health with a goal toward reducing racial, ethnic, gender and socioeconomic health disparities, and (2) increases health knowledge and self-sufficiency through a range of services including outreach, engagement, education, coaching, informal counseling, social support, advocacy, care coordination, research related to social determinants of health and basic screenings and assessments of any risks associated with social determinants of health.

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

(c) Not later than October 1, 2018, the executive director of the **[**state innovation model initiative program management office**]** Office of Health Strategy shall report, in accordance with the provisions of section 11-4a, on the results of such study and recommendations to the joint standing committees of the General Assembly having cognizance of matters relating to public health and human services.

Sec. 64. Section 38a-47 of the 2018 supplement to the general statutes

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

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

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

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

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

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

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

(c) Payments shall be made by assessment of all such domestic insurance companies and other domestic entities calculated and

collected in accordance with the provisions of section 38a-48, as amended by this act. Any such domestic insurance company or other domestic entity aggrieved because of any assessment levied under this section may appeal therefrom in accordance with the provisions of section 38a-52.

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

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

(b) On or before July thirty-first, annually, the Insurance Commissioner and the Office of the Healthcare Advocate shall render to each domestic insurance company or other domestic entity liable for payment under section 38a-47, as amended by this act: (1) A statement that includes (A) the amount appropriated to the Insurance Department, **[**and**]** the Office of the Healthcare Advocate and the Office of Health Strategy from the Insurance Fund established under section 38a-52a for the fiscal year beginning July first of the same year, (B) the cost of fringe benefits for department and office personnel for such year, as estimated by the Comptroller, (C) the estimated expenditures on behalf of the department and the **[**office**]** offices from the Capital Equipment Purchase Fund pursuant to section 4a-9 for such year, not including such estimated expenditures made on behalf of the Health Systems Planning Unit of the Office of Health Strategy, and (D) the amount appropriated to the Department of Social Services for the fall prevention program established in section 17a-303a from the Insurance Fund for the fiscal year; (2) a statement of the total taxes

imposed on all domestic insurance companies and domestic insurance entities under chapter 207 on business done in this state during the preceding calendar year; and (3) the proposed assessment against that company or entity, calculated in accordance with the provisions of subsection (c) of this section, provided for the purposes of this calculation the amount appropriated to the Insurance Department, **[**and**]** the Office of the Healthcare Advocate and the Office of Health Strategy from the Insurance Fund plus the cost of fringe benefits for department and office personnel and the estimated expenditures on behalf of the department and the office from the Capital Equipment Purchase Fund pursuant to section 4a-9, not including such expenditures made on behalf of the Health Systems Planning Unit of the Office of Health Strategy shall be deemed to be the actual expenditures of the department and the office, and the amount appropriated to the Department of Social Services from the Insurance Fund for the fiscal year for the fall prevention program established in section 17a-303a shall be deemed to be the actual expenditures for the program.

(c) (1) The proposed assessments for each domestic insurance company or other domestic entity shall be calculated by (A) allocating twenty per cent of the amount to be paid under section 38a-47, as amended by this act, among the domestic entities organized under sections 38a-199 to 38a-209, inclusive, and 38a-214 to 38a-225, inclusive, in proportion to their respective shares of the total taxes and charges imposed under chapter 207 on such entities on business done in this state during the preceding calendar year, and (B) allocating eighty per cent of the amount to be paid under section 38a-47, as amended by this act, among all domestic insurance companies and domestic entities other than those organized under sections 38a-199 to 38a-209, inclusive, and 38a-214 to 38a-225, inclusive, in proportion to their respective shares of the total taxes and charges imposed under chapter 207 on such domestic insurance companies and domestic entities on business done in this state during the preceding calendar year, provided if there are no domestic entities organized under sections

38a-199 to 38a-209, inclusive, and 38a-214 to 38a-225, inclusive, at the time of assessment, one hundred per cent of the amount to be paid under section 38a-47, as amended by this act, shall be allocated among such domestic insurance companies and domestic entities.

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

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

calculating the amount of payment and assessment for local domestic insurance companies, the amount used shall be the taxes and charges imposed before any tax credits allowed as provided in subsection (a) of section 12-202.

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

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

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

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

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

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

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

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

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

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

his agency.

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

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

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

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

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

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

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

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

(c) The Long-Term Care Planning Committee shall consist of: (1) The chairpersons and ranking members of the joint standing committees of the General Assembly having cognizance of matters relating to human services, public health, elderly services and long-

term care; (2) the Commissioner of Social Services, or the commissioner's designee; (3) one member of the Office of Policy and Management appointed by the Secretary of the Office of Policy and Management; (4) **[**two members**]** one member from the Department of Public Health appointed by the Commissioner of Public Health; **[**, one of whom is from the Office of Health Care Access division of the department;**]** (5) one member from the Department of Housing appointed by the Commissioner of Housing; (6) one member from the Department of Developmental Services appointed by the Commissioner of Developmental Services; (7) one member from the Department of Mental Health and Addiction Services appointed by the Commissioner of Mental Health and Addiction Services; (8) one member from the Department of Transportation appointed by the Commissioner of Transportation; **[**and**]** (9) one member from the Department of Children and Families appointed by the Commissioner of Children and Families; and (10) one member from the Health Systems Planning Unit of the Office of Health Strategy appointed by the executive director of the Office of Health Strategy. The committee shall convene no later than ninety days after June 4, 1998. Any vacancy shall be filled by the appointing authority. The chairperson shall be elected from among the members of the committee. The committee shall seek the advice and participation of any person, organization or state or federal agency it deems necessary to carry out the provisions of this section.

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

(g) The Commissioner of Social Services shall adopt regulations, in accordance with chapter 54, to implement the provisions of this section. **[**The commissioner shall implement the standards and procedures of the Office of Health Care Access division of the Department of Public Health concerning certificates of need established pursuant to section 19a-643, as appropriate for the

purposes of this section, until the time final regulations are adopted in accordance with said chapter 54.**]**

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

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

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

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

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

Any health care facility or institution, as defined in subsection (a) of section 19a-490, except a nursing home, rest home, residential care home or residential facility for persons with intellectual disability licensed pursuant to section 17a-227 and certified to participate in the Title XIX Medicaid program as an intermediate care facility for

individuals with intellectual disabilities, proposing to expand its services by adding nursing home beds shall obtain the approval of the Commissioner of Social Services in accordance with the procedures established pursuant to sections 17b-352, as amended by this act, 17b-353, as amended by this act, and 17b-354, as amended by this act, for a facility, as defined in section 17b-352, as amended by this act, prior to obtaining the approval of the **[**Office of Health Care Access division of the Department of Public Health**]** Health Systems Planning Unit of the Office of Health Strategy pursuant to section 19a-639, as amended by this act.

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

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

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

(a) Notwithstanding the provisions of chapter 368z, New Horizons, Inc., a nonprofit, nonsectarian organization, or a subsidiary organization controlled by New Horizons, Inc., is authorized to construct and operate an independent living facility for severely physically disabled adults, in the town of Farmington, provided such facility shall be constructed in accordance with applicable building

codes. The Farmington Housing Authority, or any issuer acting on behalf of said authority, subject to the provisions of this section, may issue tax-exempt revenue bonds on a competitive or negotiated basis for the purpose of providing construction and permanent mortgage financing for the facility in accordance with Section 103 of the Internal Revenue Code. Prior to the issuance of such bonds, plans for the construction of the facility shall be submitted to and approved by the **[**Office of Health Care Access**]** Health Systems Planning Unit of the Office of Health Strategy. The **[**office**]** unit shall approve or disapprove such plans within thirty days of receipt thereof. If the plans are disapproved they may be resubmitted. Failure of the **[**office**]** unit to act on the plans within such thirty-day period shall be deemed approval thereof. The payments to residents of the facility who are eligible for assistance under the state supplement program for room and board and necessary services, shall be determined annually to be effective July first of each year. Such payments shall be determined on a basis of a reasonable payment for necessary services, which basis shall take into account as a factor the costs of providing those services and such other factors as the commissioner deems reasonable, including anticipated fluctuations in the cost of providing services. Such payments shall be calculated in accordance with the manner in which rates are calculated pursuant to subsection (h) of section 17b-340 and the cost-related reimbursement system pursuant to said section except that efficiency incentives shall not be granted. The commissioner may adjust such rates to account for the availability of personal care services for residents under the Medicaid program. The commissioner shall, upon submission of a request, allow actual debt service, comprised of principal and interest, in excess of property costs allowed pursuant to section 17-313b-5 of the regulations of Connecticut state agencies, provided such debt service terms and amounts are reasonable in relation to the useful life and the base value of the property. The cost basis for such payment shall be subject to audit, and a recomputation of the rate shall be made based upon such audit. The facility shall report on a fiscal year ending on the thirtieth day of September on forms provided by the commissioner. The required

report shall be received by the commissioner no later than December thirty-first of each year. The Department of Social Services may use its existing utilization review procedures to monitor utilization of the facility. If the facility is aggrieved by any decision of the commissioner, the facility may, within ten days, after written notice thereof from the commissioner, obtain by written request to the commissioner, a hearing on all items of aggrievement. If the facility is aggrieved by the decision of the commissioner after such hearing, the facility may appeal to the Superior Court in accordance with the provisions of section 4-183.

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

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

the request is made.

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

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

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

(b) The proceeds of the sale of the bond issuance described in subsection (a) of this section shall be used by the Office of Policy and Management, in consultation with the chairperson of the Board of Trustees of the university, for the purpose of the UConn health network initiatives in the following manner: (1) Five million dollars of such proceeds shall be used by Hartford Hospital to develop a simulation and conference center on the Hartford Hospital campus to be run exclusively by Hartford Hospital, (2) five million dollars of such proceeds shall be used to fulfill the initiative for a primary care institute on the Saint Francis Hospital and Medical Center campus, (3)

five million dollars of such proceeds shall be used to fulfill the initiatives for a comprehensive cancer center and The University of Connecticut-sponsored health disparities institute; (4) five million dollars of such proceeds shall be used to fulfill the initiatives for the planning, design, land acquisition, development and construction of (A) a cancer treatment center to be constructed by, or in partnership with, The Hospital of Central Connecticut, provided such cancer treatment center is located entirely within the legal boundaries of the city of New Britain, (B) renovations and upgrades to the oncology unit at The Hospital of Central Connecticut, and (C) if certificate of need approval is received**,** **[**pursuant to the provisions of subsection (b) of section 10a-109ii,**]** a Permanent Regional Phase One Clinical Trials Unit located at The Hospital of Central Connecticut in New Britain; and (5) two million dollars of such proceeds shall be used to fulfill the initiatives for patient room renovations at Bristol Hospital. In the event that the cancer treatment center authorized pursuant to subdivision (4) of this subsection is built in whole or in part outside the legal boundaries of the city of New Britain, The Hospital of Central Connecticut shall repay the entire amount of the proceeds used to fulfill the initiatives for the planning, design, development and construction of such center.

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

(d) No public official or state employee or employee of such public official or state employee shall agree to accept, or be a member or employee of a partnership, association, professional corporation or sole proprietorship which partnership, association, professional corporation or sole proprietorship agrees to accept any employment, fee or other thing of value, or portion thereof, for appearing, agreeing to appear, or taking any other action on behalf of another person before the Department of Banking, the Office of the Claims Commissioner, the **[**Office of Health Care Access division within the

Department of Public Health**]** Health Systems Planning Unit of the Office of Health Strategy, the Insurance Department, the Department of Consumer Protection, the Department of Motor Vehicles, the State Insurance and Risk Management Board, the Department of Energy and Environmental Protection, the Public Utilities Regulatory Authority, the Connecticut Siting Council or the Connecticut Real Estate Commission; provided this shall not prohibit any such person from making inquiry for information on behalf of another before any of said commissions or commissioners if no fee or reward is given or promised in consequence thereof. For the purpose of this subsection, partnerships, associations, professional corporations or sole proprietorships refer only to such partnerships, associations, professional corporations or sole proprietorships which have been formed to carry on the business or profession directly relating to the employment, appearing, agreeing to appear or taking of action provided for in this subsection. Nothing in this subsection shall prohibit any employment, appearing, agreeing to appear or taking action before any municipal board, commission or council. Nothing in this subsection shall be construed as applying (1) to the actions of any teaching or research professional employee of a public institution of higher education if such actions are not in violation of any other provision of this chapter, (2) to the actions of any other professional employee of a public institution of higher education if such actions are not compensated and are not in violation of any other provision of this chapter, (3) to any member of a board or commission who receives no compensation other than per diem payments or reimbursement for actual or necessary expenses, or both, incurred in the performance of the member's duties, or (4) to any member or director of a quasi-public agency. Notwithstanding the provisions of this subsection to the contrary, a legislator, an officer of the General Assembly or part-time legislative employee may be or become a member or employee of a firm, partnership, association or professional corporation which represents clients for compensation before agencies listed in this subsection, provided the legislator, officer of the General Assembly or part-time legislative employee shall take no part in any matter

involving the agency listed in this subsection and shall not receive compensation from any such matter. Receipt of a previously established salary, not based on the current or anticipated business of the firm, partnership, association or professional corporation involving the agencies listed in this subsection, shall be permitted.

Sec. 80. Sections 10a-109ii, 17b-234, 17b-235, 19a-617b, 19a-637, 19a-755 and 38a-558 of the general statutes are repealed. (*Effective from 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	*July 1, 2018*	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 Legislative Commissioners:

In Sections 28(e) and 30(d), the last sentence was bracketed for consistency with other provisions of the bill.

PH *Joint Favorable Subst.*