



General Assembly

**Substitute Bill No. 5290**

February Session, 2018



**AN ACT CONCERNING THE OFFICE OF HEALTH STRATEGY.**

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

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2 statutes is repealed and the following is substituted in lieu thereof  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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

65 As used in sections 4-6, 4-7 and 4-8, the term "department head"  
66 means Secretary of the Office of Policy and Management,  
67 Commissioner of Administrative Services, Commissioner of Revenue  
68 Services, Banking Commissioner, Commissioner of Children and  
69 Families, Commissioner of Consumer Protection, Commissioner of  
70 Correction, Commissioner of Economic and Community Development,  
71 State Board of Education, Commissioner of Emergency Services and  
72 Public Protection, Commissioner of Energy and Environmental  
73 Protection, Commissioner of Agriculture, Commissioner of Public  
74 Health, Insurance Commissioner, Labor Commissioner, Commissioner  
75 of Mental Health and Addiction Services, Commissioner of Social  
76 Services, Commissioner of Developmental Services, Commissioner of  
77 Motor Vehicles, Commissioner of Transportation, Commissioner of  
78 Veterans Affairs, Commissioner of Housing, Commissioner of  
79 Rehabilitation Services, the Commissioner of Early Childhood, [and]  
80 the executive director of the Office of Military Affairs and the  
81 executive director of the Office of Health Strategy. As used in sections

82 4-6 and 4-7, "department head" also means the Commissioner of  
83 Education.

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

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

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

111 (a) As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

191 (5) The [Health Information Technology Officer] executive director  
192 of the Office of Health Strategy shall: (A) Utilize data in the all-payer  
193 claims database to provide health care consumers in the state with  
194 information concerning the cost and quality of health care services for  
195 the purpose of allowing such consumers to make economically sound  
196 and medically appropriate health care decisions; and (B) make data in  
197 the all-payer claims database available to any state agency, insurer,  
198 employer, health care provider, consumer of health care services or  
199 researcher for the purpose of allowing such person or entity to review  
200 such data as it relates to health care utilization, costs or quality of  
201 health care services. If health information, as defined in 45 CFR  
202 160.103, as amended from time to time, is permitted to be disclosed  
203 under the Health Insurance Portability and Accountability Act of 1996,

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

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

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

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



237 (a) For purposes of this section and sections 19a-904a, 19a-904b and  
238 38a-477d to 38a-477f, inclusive:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

397 (a) As used in this section:

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

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

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

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

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

463 191, as amended from time to time, and contained in 45 CFR 160, 164;  
464 (4) require that individually identifiable health information be secure  
465 and that access to such information be traceable by an electronic audit  
466 trail; (5) be compatible with any national data standards in order to  
467 allow for interstate interoperability; (6) permit the collection of health  
468 information in a standard electronic format; and (7) be compatible with  
469 the requirements for an electronic health information system.

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

619 designee;

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

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

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

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

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

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

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

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

648 quality analysis;

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

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

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

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

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

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

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

678 additional members to the council, who shall serve at the pleasure of  
679 the chairpersons.

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

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

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

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

707 (a) The state, acting by and through the Secretary of the Office of  
708 Policy and Management, in collaboration with the [Health Information

709 Technology Officer designated under section 19a-755, and the  
710 Lieutenant Governor] executive director of the Office of Health  
711 Strategy, shall establish a program to expedite the development of the  
712 State-wide Health Information Exchange, established under section  
713 17b-59d, as amended by this act, to assist the state, health care  
714 providers, insurance carriers, physicians and all stakeholders in  
715 empowering consumers to make effective health care decisions,  
716 promote patient-centered care, improve the quality, safety and value of  
717 health care, reduce waste and duplication of services, support clinical  
718 decision-making, keep confidential health information secure and  
719 make progress toward the state's public health goals. The purposes of  
720 the program shall be to (1) assist the State-wide Health Information  
721 Exchange in establishing and maintaining itself as a neutral and  
722 trusted entity that serves the public good for the benefit of all  
723 Connecticut residents, including, but not limited to, Connecticut health  
724 care consumers and Connecticut health care providers and carriers, (2)  
725 perform, on behalf of the state, the role of intermediary between public  
726 and private stakeholders and customers of the State-wide Health  
727 Information Exchange, and (3) fulfill the responsibilities of the Office  
728 of Health Strategy, as described in section 19a-754a, as amended by  
729 this act.

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

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



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

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

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

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

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

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

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

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

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

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

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

795 (b) Appointments to the working group pursuant to subsection (a)  
796 of this section shall include, but need not be limited to, the [Health  
797 Information Technology Officer, designated in accordance with section  
798 19a-755] executive director of the Office of Health Strategy, or such  
799 executive director's designee, and representatives from the insurance  
800 industry, the health care industry, the Connecticut Education Network,  
801 broadband Internet service providers, the Connecticut Technology  
802 Council, the bioscience industry and public or private universities and  
803 research institutions. The working group shall also include the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

865 (b) of this section.

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

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

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

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

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

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

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

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

894 organized under chapter 594b.

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

898 (3) "Bed capacity" means the total number of inpatient beds in a  
899 facility licensed by the Department of Public Health under sections  
900 19a-490 to 19a-503, inclusive.

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

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

909 (6) "Days" means calendar days.

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

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

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

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

920 [(10)] (9) "Large group practice" means eight or more full-time  
921 equivalent physicians, legally organized in a partnership, professional

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

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

954 [(12)] (11) "Nonhospital based" means located at a site other than the

955 main campus of the hospital.

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

958 [(14)] (13) "Person" means any individual, partnership, corporation,  
959 limited liability company, association, governmental subdivision,  
960 agency or public or private organization of any character, but does not  
961 include the agency conducting the proceeding.

962 [(15)] (14) "Physician" has the same meaning as provided in section  
963 20-13a.

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

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

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

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



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

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

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

998 (b) The costs of the [office] unit shall be the total of (1) the amount  
999 appropriated for expenses for the operation of the [office] unit for the  
1000 fiscal year, as estimated by the Comptroller, (2) the cost of fringe  
1001 benefits for [office] unit personnel for such year, as estimated by the  
1002 Comptroller, (3) the amount of expenses for central state services  
1003 attributable to the [office] unit for the fiscal year as estimated by the  
1004 Comptroller, and (4) the estimated expenditures on behalf of the  
1005 [office] unit from the Capital Equipment Purchase Fund pursuant to  
1006 section 4a-9 for such year, provided for purposes of this calculation the  
1007 amount of expenses for the operation of the [office] unit for the fiscal  
1008 year as estimated by the Comptroller, plus the cost of fringe benefits  
1009 for personnel, the amount of expenses for said central state services for  
1010 the fiscal year as estimated by the Comptroller, and said estimated  
1011 expenditures from the Capital Equipment Purchase Fund pursuant to  
1012 section 4a-9 shall be deemed to be the actual expenditures of the  
1013 [office] unit.

1014 (c) On or before December thirty-first, annually, for each fiscal year,  
1015 each hospital shall pay the [office] unit twenty-five per cent of its  
1016 proposed assessment, adjusted to reflect any credit or amount due

1017 under the recalculated assessment for the preceding state fiscal year as  
1018 determined pursuant to subsection (d) of this section or any  
1019 reapportioned assessment pursuant to subsection (b) of section 19a-  
1020 631, as amended by this act. The hospital shall pay the remaining  
1021 seventy-five per cent of its assessment to the [office] unit in three equal  
1022 installments on or before the following March thirty-first, June thirtieth  
1023 and September thirtieth, annually.

1024 (d) Immediately following the close of each state fiscal year the  
1025 [commissioner] executive director shall recalculate the proposed  
1026 assessment for each hospital based on the costs of the [office] unit in  
1027 accordance with subsection (b) of this section using the actual  
1028 expenditures made by the [office] unit during that fiscal year and the  
1029 actual expenditures made on behalf of the [office] unit from the Capital  
1030 Equipment Purchase Fund pursuant to section 4a-9. On or before  
1031 August thirty-first, annually, the [office] unit shall render to each  
1032 hospital a statement showing the difference between the respective  
1033 recalculated assessment and the amount previously paid. On or before  
1034 September thirtieth, the [commissioner] executive director, after  
1035 receiving any objections to such statements, shall make such  
1036 adjustments which in said [commissioner's] executive director's  
1037 opinion may be indicated and shall render an adjusted assessment, if  
1038 any, to the affected hospitals. Adjustments to reflect any credit or  
1039 amount due under the recalculated assessment for the previous state  
1040 fiscal year shall be made to the proposed assessment due on or before  
1041 December thirty-first of the following state fiscal year.

1042 (e) If any assessment is not paid when due, the [commissioner]  
1043 executive director shall impose a fee equal to (1) two per cent of the  
1044 assessment if such failure to pay is for not more than five days, (2) five  
1045 per cent of the assessment if such failure to pay is for more than five  
1046 days but not more than fifteen days, or (3) ten per cent of the  
1047 assessment if such failure to pay is for more than fifteen days. If a  
1048 hospital fails to pay any assessment for more than thirty days after the  
1049 date when due, the [commissioner] executive director may, in addition

1050 to the fees imposed pursuant to this subsection, impose a civil penalty  
1051 of up to one thousand dollars per day for each day past the initial  
1052 thirty days that the assessment is not paid. Any civil penalty  
1053 authorized by this subsection shall be imposed by the [commissioner]  
1054 executive director in accordance with subsections (b) to (e), inclusive,  
1055 of section 19a-653, as amended by this act.

1056 (f) The [office] unit shall deposit all payments received pursuant to  
1057 this section with the State Treasurer. The moneys so deposited shall be  
1058 credited to the General Fund and shall be accounted for as expenses  
1059 recovered from hospitals.

1060 Sec. 21. Subsection (b) of section 19a-632a of the general statutes is  
1061 repealed and the following is substituted in lieu thereof (*Effective from*  
1062 *passage*):

1063 (b) The [Department of Public Health] Office of Health Strategy may  
1064 require a hospital to pay an assessment levied pursuant to section 19a-  
1065 632, as amended by this act, by way of an approved method of  
1066 electronic funds transfer.

1067 Sec. 22. Subsection (f) of section 19a-632a of the general statutes is  
1068 repealed and the following is substituted in lieu thereof (*Effective from*  
1069 *passage*):

1070 (f) The [department] office shall deposit all payments received  
1071 pursuant to this section with the State Treasurer. The moneys so  
1072 deposited shall be credited to the General Fund and shall be accounted  
1073 for as expenses recovered from hospitals.

1074 Sec. 23. Section 19a-633 of the general statutes is repealed and the  
1075 following is substituted in lieu thereof (*Effective from passage*):

1076 The [commissioner] executive director, or any agent authorized by  
1077 [him] such executive director to conduct any inquiry, investigation or  
1078 hearing under the provisions of this chapter, shall have power to  
1079 administer oaths and take testimony under oath relative to the matter

1080 of inquiry or investigation. At any hearing ordered by the [office] unit,  
1081 the [commissioner] executive director or such agent having authority  
1082 by law to issue such process may subpoena witnesses and require the  
1083 production of records, papers and documents pertinent to such  
1084 inquiry. If any person disobeys such process or, having appeared in  
1085 obedience thereto, refuses to answer any pertinent question put to  
1086 [him] such person by the [commissioner] executive director or [his]  
1087 such executive director's authorized agent or to produce any records  
1088 and papers pursuant thereto, the [commissioner] executive director or  
1089 [his] such executive director's agent may apply to the superior court  
1090 for the judicial district of Hartford or for the judicial district wherein  
1091 the person resides or wherein the business has been conducted, or to  
1092 any judge of said court if the same is not in session, setting forth such  
1093 disobedience to process or refusal to answer, and said court or such  
1094 judge shall cite such person to appear before said court or such judge  
1095 to answer such question or to produce such records and papers.

1096 Sec. 24. Section 19a-634 of the general statutes is repealed and the  
1097 following is substituted in lieu thereof (*Effective from passage*):

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

1113 [office's] unit's recommendations for addressing identified gaps in the  
1114 provision of health care services and recommendations concerning a  
1115 lack of access to health care services.

1116 (b) The [office] unit, in consultation with such other state agencies as  
1117 the [Commissioner of Public Health] executive director deems  
1118 appropriate, shall establish and maintain a state-wide health care  
1119 facilities and services plan. Such plan may include, but not be limited  
1120 to: (1) An assessment of the availability of acute hospital care, hospital  
1121 emergency care, specialty hospital care, outpatient surgical care,  
1122 primary care and clinic care; (2) an evaluation of the unmet needs of  
1123 persons at risk and vulnerable populations as determined by the  
1124 [commissioner] executive director; (3) a projection of future demand  
1125 for health care services and the impact that technology may have on  
1126 the demand, capacity or need for such services; and (4)  
1127 recommendations for the expansion, reduction or modification of  
1128 health care facilities or services. In the development of the plan, the  
1129 [office] unit shall consider the recommendations of any advisory  
1130 bodies which may be established by the [commissioner] executive  
1131 director. The [commissioner] executive director may also incorporate  
1132 the recommendations of authoritative organizations whose mission is  
1133 to promote policies based on best practices or evidence-based research.  
1134 The [commissioner] executive director, in consultation with hospital  
1135 representatives, shall develop a process that encourages hospitals to  
1136 incorporate the state-wide health care facilities and services plan into  
1137 hospital long-range planning and shall facilitate communication  
1138 between appropriate state agencies concerning innovations or changes  
1139 that may affect future health planning. The [office] unit shall update  
1140 the state-wide health care facilities and services plan not less than once  
1141 every two years.

1142 (c) For purposes of conducting the state-wide health care facility  
1143 utilization study and preparing the state-wide health care facilities and  
1144 services plan, the [office] unit shall establish and maintain an  
1145 inventory of all health care facilities, the equipment identified in

1146 subdivisions (9) and (10) of subsection (a) of section 19a-638, as  
1147 amended by this act, and services in the state, including health care  
1148 facilities that are exempt from certificate of need requirements under  
1149 subsection (b) of section 19a-638, as amended by this act. The [office]  
1150 unit shall develop an inventory questionnaire to obtain the following  
1151 information: (1) The name and location of the facility; (2) the type of  
1152 facility; (3) the hours of operation; (4) the type of services provided at  
1153 that location; and (5) the total number of clients, treatments, patient  
1154 visits, procedures performed or scans performed in a calendar year.  
1155 The inventory shall be completed biennially by health care facilities  
1156 and providers and such health care facilities and providers shall not be  
1157 required to provide patient specific or financial data.

1158 Sec. 25. Section 19a-638 of the general statutes is repealed and the  
1159 following is substituted in lieu thereof (*Effective from passage*):

1160 (a) A certificate of need issued by the [office] unit shall be required  
1161 for:

1162 (1) The establishment of a new health care facility;

1163 (2) A transfer of ownership of a health care facility;

1164 (3) A transfer of ownership of a large group practice to any entity  
1165 other than a (A) physician, or (B) group of two or more physicians,  
1166 legally organized in a partnership, professional corporation or limited  
1167 liability company formed to render professional services and not  
1168 employed by or an affiliate of any hospital, medical foundation,  
1169 insurance company or other similar entity;

1170 (4) The establishment of a freestanding emergency department;

1171 (5) The termination of inpatient or outpatient services offered by a  
1172 hospital, including, but not limited to, the termination by a short-term  
1173 acute care general hospital or children's hospital of inpatient and  
1174 outpatient mental health and substance abuse services;

1175 (6) The establishment of an outpatient surgical facility, as defined in  
1176 section 19a-493b, as amended by this act, or as established by a short-  
1177 term acute care general hospital;

1178 (7) The termination of surgical services by an outpatient surgical  
1179 facility, as defined in section 19a-493b, as amended by this act, or a  
1180 facility that provides outpatient surgical services as part of the  
1181 outpatient surgery department of a short-term acute care general  
1182 hospital, provided termination of outpatient surgical services due to  
1183 (A) insufficient patient volume, or (B) the termination of any  
1184 subspecialty surgical service, shall not require certificate of need  
1185 approval;

1186 (8) The termination of an emergency department by a short-term  
1187 acute care general hospital;

1188 (9) The establishment of cardiac services, including inpatient and  
1189 outpatient cardiac catheterization, interventional cardiology and  
1190 cardiovascular surgery;

1191 (10) The acquisition of computed tomography scanners, magnetic  
1192 resonance imaging scanners, positron emission tomography scanners  
1193 or positron emission tomography-computed tomography scanners, by  
1194 any person, physician, provider, short-term acute care general hospital  
1195 or children's hospital, except (A) as provided for in subdivision (22) of  
1196 subsection (b) of this section, and (B) a certificate of need issued by the  
1197 [office] unit shall not be required where such scanner is a replacement  
1198 for a scanner that was previously acquired through certificate of need  
1199 approval or a certificate of need determination;

1200 (11) The acquisition of nonhospital based linear accelerators;

1201 (12) An increase in the licensed bed capacity of a health care facility;

1202 (13) The acquisition of equipment utilizing technology that has not  
1203 previously been utilized in the state;

1204 (14) An increase of two or more operating rooms within any three-  
1205 year period, commencing on and after October 1, 2010, by an  
1206 outpatient surgical facility, as defined in section 19a-493b, as amended  
1207 by this act, or by a short-term acute care general hospital; and

1208 (15) The termination of inpatient or outpatient services offered by a  
1209 hospital or other facility or institution operated by the state that  
1210 provides services that are eligible for reimbursement under Title XVIII  
1211 or XIX of the federal Social Security Act, 42 USC 301, as amended.

1212 (b) A certificate of need shall not be required for:

1213 (1) Health care facilities owned and operated by the federal  
1214 government;

1215 (2) The establishment of offices by a licensed private practitioner,  
1216 whether for individual or group practice, except when a certificate of  
1217 need is required in accordance with the requirements of section 19a-  
1218 493b, as amended by this act, or subdivision (3), (10) or (11) of  
1219 subsection (a) of this section;

1220 (3) A health care facility operated by a religious group that  
1221 exclusively relies upon spiritual means through prayer for healing;

1222 (4) Residential care homes, nursing homes and rest homes, as  
1223 defined in subsection (c) of section 19a-490;

1224 (5) An assisted living services agency, as defined in section 19a-490;

1225 (6) Home health agencies, as defined in section 19a-490;

1226 (7) Hospice services, as described in section 19a-122b;

1227 (8) Outpatient rehabilitation facilities;

1228 (9) Outpatient chronic dialysis services;

1229 (10) Transplant services;



1230 (11) Free clinics, as defined in section 19a-630, as amended by this  
1231 act;

1232 (12) School-based health centers and expanded school health sites,  
1233 as such terms are defined in section 19a-6r, community health centers,  
1234 as defined in section 19a-490a, not-for-profit outpatient clinics licensed  
1235 in accordance with the provisions of chapter 368v and federally  
1236 qualified health centers;

1237 (13) A program licensed or funded by the Department of Children  
1238 and Families, provided such program is not a psychiatric residential  
1239 treatment facility;

1240 (14) Any nonprofit facility, institution or provider that has a contract  
1241 with, or is certified or licensed to provide a service for, a state agency  
1242 or department for a service that would otherwise require a certificate  
1243 of need. The provisions of this subdivision shall not apply to a short-  
1244 term acute care general hospital or children's hospital, or a hospital or  
1245 other facility or institution operated by the state that provides services  
1246 that are eligible for reimbursement under Title XVIII or XIX of the  
1247 federal Social Security Act, 42 USC 301, as amended;

1248 (15) A health care facility operated by a nonprofit educational  
1249 institution exclusively for students, faculty and staff of such institution  
1250 and their dependents;

1251 (16) An outpatient clinic or program operated exclusively by or  
1252 contracted to be operated exclusively by a municipality, municipal  
1253 agency, municipal board of education or a health district, as described  
1254 in section 19a-241;

1255 (17) A residential facility for persons with intellectual disability  
1256 licensed pursuant to section 17a-227 and certified to participate in the  
1257 Title XIX Medicaid program as an intermediate care facility for  
1258 individuals with intellectual disabilities;

1259 (18) Replacement of existing imaging equipment if such equipment

1260 was acquired through certificate of need approval or a certificate of  
1261 need determination, provided a health care facility, provider,  
1262 physician or person notifies the [office] unit of the date on which the  
1263 equipment is replaced and the disposition of the replaced equipment;

1264 (19) Acquisition of cone-beam dental imaging equipment that is to  
1265 be used exclusively by a dentist licensed pursuant to chapter 379;

1266 (20) The partial or total elimination of services provided by an  
1267 outpatient surgical facility, as defined in section 19a-493b, as amended  
1268 by this act, except as provided in subdivision (6) of subsection (a) of  
1269 this section and section 19a-639e, as amended by this act;

1270 (21) The termination of services for which the Department of Public  
1271 Health has requested the facility to relinquish its license; or

1272 (22) Acquisition of any equipment by any person that is to be used  
1273 exclusively for scientific research that is not conducted on humans.

1274 (c) (1) Any person, health care facility or institution that is unsure  
1275 whether a certificate of need is required under this section, or (2) any  
1276 health care facility that proposes to relocate pursuant to section 19a-  
1277 639c, as amended by this act, shall send a letter to the [office] unit that  
1278 describes the project and requests that the [office] unit make a  
1279 determination as to whether a certificate of need is required. In the  
1280 case of a relocation of a health care facility, the letter shall include  
1281 information described in section 19a-639c, as amended by this act. A  
1282 person, health care facility or institution making such request shall  
1283 provide the [office] unit with any information the [office] unit requests  
1284 as part of its determination process.

1285 (d) The [Commissioner of Public Health] executive director of the  
1286 Office of Health Strategy may implement policies and procedures  
1287 necessary to administer the provisions of this section while in the  
1288 process of adopting such policies and procedures as regulation,  
1289 provided the [commissioner] executive director holds a public hearing  
1290 prior to implementing the policies and procedures and [prints] posts

1291 notice of intent to adopt regulations [in the Connecticut Law Journal]  
1292 on the office's Internet web site and the eRegulations System not later  
1293 than twenty days after the date of implementation. Policies and  
1294 procedures implemented pursuant to this section shall be valid until  
1295 the time final regulations are adopted. [Final regulations shall be  
1296 adopted by December 31, 2011.]

1297 Sec. 26. Section 19a-639 of the general statutes is repealed and the  
1298 following is substituted in lieu thereof (*Effective from passage*):

1299 (a) In any deliberations involving a certificate of need application  
1300 filed pursuant to section 19a-638, as amended by this act, the [office]  
1301 unit shall take into consideration and make written findings  
1302 concerning each of the following guidelines and principles:

1303 (1) Whether the proposed project is consistent with any applicable  
1304 policies and standards adopted in regulations by the [Department of  
1305 Public Health] Office of Health Strategy;

1306 (2) The relationship of the proposed project to the state-wide health  
1307 care facilities and services plan;

1308 (3) Whether there is a clear public need for the health care facility or  
1309 services proposed by the applicant;

1310 (4) Whether the applicant has satisfactorily demonstrated how the  
1311 proposal will impact the financial strength of the health care system in  
1312 the state or that the proposal is financially feasible for the applicant;

1313 (5) Whether the applicant has satisfactorily demonstrated how the  
1314 proposal will improve quality, accessibility and cost effectiveness of  
1315 health care delivery in the region, including, but not limited to,  
1316 provision of or any change in the access to services for Medicaid  
1317 recipients and indigent persons;

1318 (6) The applicant's past and proposed provision of health care  
1319 services to relevant patient populations and payer mix, including, but

1320 not limited to, access to services by Medicaid recipients and indigent  
1321 persons;

1322 (7) Whether the applicant has satisfactorily identified the population  
1323 to be served by the proposed project and satisfactorily demonstrated  
1324 that the identified population has a need for the proposed services;

1325 (8) The utilization of existing health care facilities and health care  
1326 services in the service area of the applicant;

1327 (9) Whether the applicant has satisfactorily demonstrated that the  
1328 proposed project shall not result in an unnecessary duplication of  
1329 existing or approved health care services or facilities;

1330 (10) Whether an applicant, who has failed to provide or reduced  
1331 access to services by Medicaid recipients or indigent persons, has  
1332 demonstrated good cause for doing so, which shall not be  
1333 demonstrated solely on the basis of differences in reimbursement rates  
1334 between Medicaid and other health care payers;

1335 (11) Whether the applicant has satisfactorily demonstrated that the  
1336 proposal will not negatively impact the diversity of health care  
1337 providers and patient choice in the geographic region; and

1338 (12) Whether the applicant has satisfactorily demonstrated that any  
1339 consolidation resulting from the proposal will not adversely affect  
1340 health care costs or accessibility to care.

1341 (b) In deliberations as described in subsection (a) of this section,  
1342 there shall be a presumption in favor of approving the certificate of  
1343 need application for a transfer of ownership of a large group practice,  
1344 as described in subdivision (3) of subsection (a) of section 19a-638, as  
1345 amended by this act, when an offer was made in response to a request  
1346 for proposal or similar voluntary offer for sale.

1347 (c) The [office] unit, as it deems necessary, may revise or  
1348 supplement the guidelines and principles, [through regulation

1349 prescribed in subsection (a) of this section] set forth in subsection (a) of  
1350 this section, through regulation.

1351 (d) (1) For purposes of this subsection and subsection (e) of this  
1352 section:

1353 (A) "Affected community" means a municipality where a hospital is  
1354 physically located or a municipality whose inhabitants are regularly  
1355 served by a hospital;

1356 (B) "Hospital" has the same meaning as provided in section 19a-490;

1357 (C) "New hospital" means a hospital as it exists after the approval of  
1358 an agreement pursuant to section 19a-486b, as amended by this act, or  
1359 a certificate of need application for a transfer of ownership of a  
1360 hospital;

1361 (D) "Purchaser" means a person who is acquiring, or has acquired,  
1362 any assets of a hospital through a transfer of ownership of a hospital;

1363 (E) "Transacting party" means a purchaser and any person who is a  
1364 party to a proposed agreement for transfer of ownership of a hospital;

1365 (F) "Transfer" means to sell, transfer, lease, exchange, option,  
1366 convey, give or otherwise dispose of or transfer control over,  
1367 including, but not limited to, transfer by way of merger or joint  
1368 venture not in the ordinary course of business; and

1369 (G) "Transfer of ownership of a hospital" means a transfer that  
1370 impacts or changes the governance or controlling body of a hospital,  
1371 including, but not limited to, all affiliations, mergers or any sale or  
1372 transfer of net assets of a hospital and for which a certificate of need  
1373 application or a certificate of need determination letter is filed on or  
1374 after December 1, 2015.

1375 (2) In any deliberations involving a certificate of need application  
1376 filed pursuant to section 19a-638, as amended by this act, that involves

1377 the transfer of ownership of a hospital, the [office] unit shall, in  
1378 addition to the guidelines and principles set forth in subsection (a) of  
1379 this section and those prescribed through regulation pursuant to  
1380 subsection (c) of this section, take into consideration and make written  
1381 findings concerning each of the following guidelines and principles:

1382 (A) Whether the applicant fairly considered alternative proposals or  
1383 offers in light of the purpose of maintaining health care provider  
1384 diversity and consumer choice in the health care market and access to  
1385 affordable quality health care for the affected community; and

1386 (B) Whether the plan submitted pursuant to section 19a-639a, as  
1387 amended by this act, demonstrates, in a manner consistent with this  
1388 chapter, how health care services will be provided by the new hospital  
1389 for the first three years following the transfer of ownership of the  
1390 hospital, including any consolidation, reduction, elimination or  
1391 expansion of existing services or introduction of new services.

1392 (3) The [office] unit shall deny any certificate of need application  
1393 involving a transfer of ownership of a hospital unless the  
1394 [commissioner] executive director finds that the affected community  
1395 will be assured of continued access to high quality and affordable  
1396 health care after accounting for any proposed change impacting  
1397 hospital staffing.

1398 (4) The [office] unit may deny any certificate of need application  
1399 involving a transfer of ownership of a hospital subject to a cost and  
1400 market impact review pursuant to section 19a-639f, as amended by this  
1401 act, if the [commissioner] executive director finds that (A) the affected  
1402 community will not be assured of continued access to high quality and  
1403 affordable health care after accounting for any consolidation in the  
1404 hospital and health care market that may lessen health care provider  
1405 diversity, consumer choice and access to care, and (B) any likely  
1406 increases in the prices for health care services or total health care  
1407 spending in the state may negatively impact the affordability of care.

1408 (5) The [office] unit may place any conditions on the approval of a  
1409 certificate of need application involving a transfer of ownership of a  
1410 hospital consistent with the provisions of this chapter. Before placing  
1411 any such conditions, the [office] unit shall weigh the value of such  
1412 conditions in promoting the purposes of this chapter against the  
1413 individual and cumulative burden of such conditions on the  
1414 transacting parties and the new hospital. For each condition imposed,  
1415 the [office] unit shall include a concise statement of the legal and  
1416 factual basis for such condition and the provision or provisions of this  
1417 chapter that it is intended to promote. Each condition shall be  
1418 reasonably tailored in time and scope. The transacting parties or the  
1419 new hospital shall have the right to make a request to the [office] unit  
1420 for an amendment to, or relief from, any condition based on changed  
1421 circumstances, hardship or for other good cause.

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

1442 provided by the new hospital. The purchaser shall give the reporter  
1443 access to its records and facilities for the purposes of carrying out the  
1444 reporter's duties. The purchaser shall hold a public hearing in the  
1445 municipality in which the new hospital is located not less than  
1446 annually during the reporting period to provide for public review and  
1447 comment on the reporter's reports and findings.

1448 (2) If the reporter finds that the purchaser has breached a condition  
1449 of the approval of the certificate of need application, the [office] unit  
1450 may, in consultation with the purchaser, the reporter and any other  
1451 interested parties it deems appropriate, implement a performance  
1452 improvement plan designed to remedy the conditions identified by the  
1453 reporter and continue the reporting period for up to one year  
1454 following a determination by the [office] unit that such conditions  
1455 have been resolved.

1456 (3) The purchaser shall provide funds, in an amount determined by  
1457 the [office] unit not to exceed two hundred thousand dollars annually,  
1458 for the hiring of the post-transfer compliance reporter.

1459 (f) Nothing in subsection (d) or (e) of this section shall apply to a  
1460 transfer of ownership of a hospital in which either a certificate of need  
1461 application is filed on or before December 1, 2015, or where a  
1462 certificate of need determination letter is filed on or before December 1,  
1463 2015.

1464 Sec. 27. Section 19a-639a of the general statutes is repealed and the  
1465 following is substituted in lieu thereof (*Effective from passage*):

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



1473 application fee of five hundred dollars.

1474 (b) Prior to the filing of a certificate of need application, the  
1475 applicant shall publish notice that an application is to be submitted to  
1476 the [office] unit in a newspaper having a substantial circulation in the  
1477 area where the project is to be located. Such notice shall (1) be  
1478 published (A) not later than twenty days prior to the date of filing of  
1479 the certificate of need application, and (B) for not less than three  
1480 consecutive days, and (2) contain a brief description of the nature of  
1481 the project and the street address where the project is to be located. An  
1482 applicant shall file the certificate of need application with the [office]  
1483 unit not later than ninety days after publishing notice of the  
1484 application in accordance with the provisions of this subsection. The  
1485 [office] unit shall not accept the applicant's certificate of need  
1486 application for filing unless the application is accompanied by the  
1487 application fee prescribed in subsection (a) of this section and proof of  
1488 compliance with the publication requirements prescribed in this  
1489 subsection.

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

1506 not such person is expected to hold a position with the hospital after  
1507 completion of the transfer of ownership of the hospital and any salary,  
1508 severance, stock offering or any financial gain, current or deferred,  
1509 such person is expected to receive as a result of, or in relation to, the  
1510 transfer of ownership of the hospital.

1511 (2) The applicant shall, not later than sixty days after the date of the  
1512 [office's] unit's request, submit any requested information and any  
1513 information required under this subsection to the [office] unit. If an  
1514 applicant fails to submit such information to the [office] unit within the  
1515 sixty-day period, the [office] unit shall consider the application to have  
1516 been withdrawn.

1517 (d) Upon determining that an application is complete, the [office]  
1518 unit shall provide notice of this determination to the applicant and to  
1519 the public in accordance with regulations adopted by the department.  
1520 In addition, the [office] unit shall post such notice on its Internet web  
1521 site. The date on which the [office] unit posts such notice on its Internet  
1522 web site shall begin the review period. Except as provided in this  
1523 subsection, (1) the review period for a completed application shall be  
1524 ninety days from the date on which the [office] unit posts such notice  
1525 on its Internet web site; and (2) the [office] unit shall issue a decision  
1526 on a completed application prior to the expiration of the ninety-day  
1527 review period. The review period for a completed application that  
1528 involves a transfer of a large group practice, as described in  
1529 subdivision (3) of subsection (a) of section 19a-638, as amended by this  
1530 act, when the offer was made in response to a request for proposal or  
1531 similar voluntary offer for sale, shall be sixty days from the date on  
1532 which the [office] unit posts notice on its Internet web site. Upon  
1533 request or for good cause shown, the [office] unit may extend the  
1534 review period for a period of time not to exceed sixty days. If the  
1535 review period is extended, the [office] unit shall issue a decision on the  
1536 completed application prior to the expiration of the extended review  
1537 period. If the [office] unit holds a public hearing concerning a  
1538 completed application in accordance with subsection (e) or (f) of this

1539 section, the [office] unit shall issue a decision on the completed  
1540 application not later than sixty days after the date the [office] unit  
1541 closes the public hearing record.

1542 (e) Except as provided in this subsection, the [office] unit shall hold  
1543 a public hearing on a properly filed and completed certificate of need  
1544 application if three or more individuals or an individual representing  
1545 an entity with five or more people submits a request, in writing, that a  
1546 public hearing be held on the application. For a properly filed and  
1547 completed certificate of need application involving a transfer of  
1548 ownership of a large group practice, as described in subdivision (3) of  
1549 subsection (a) of section 19a-638, as amended by this act, when an offer  
1550 was made in response to a request for proposal or similar voluntary  
1551 offer for sale, a public hearing shall be held if twenty-five or more  
1552 individuals or an individual representing twenty-five or more people  
1553 submits a request, in writing, that a public hearing be held on the  
1554 application. Any request for a public hearing shall be made to the  
1555 [office] unit not later than thirty days after the date the [office] unit  
1556 determines the application to be complete.

1557 (f) (1) The [office] unit shall hold a public hearing with respect to  
1558 each certificate of need application filed pursuant to section 19a-638, as  
1559 amended by this act, after December 1, 2015, that concerns any transfer  
1560 of ownership involving a hospital. Such hearing shall be held in the  
1561 municipality in which the hospital that is the subject of the application  
1562 is located.

1563 (2) The [office] unit may hold a public hearing with respect to any  
1564 certificate of need application submitted under this chapter. The  
1565 [office] unit shall provide not less than two weeks' advance notice to  
1566 the applicant, in writing, and to the public by publication in a  
1567 newspaper having a substantial circulation in the area served by the  
1568 health care facility or provider. In conducting its activities under this  
1569 chapter, the [office] unit may hold hearing on applications of a similar  
1570 nature at the same time.

1571 (g) The [Commissioner of Public Health] executive director of the  
1572 Office of Health Strategy may implement policies and procedures  
1573 necessary to administer the provisions of this section while in the  
1574 process of adopting such policies and procedures as regulation,  
1575 provided the [commissioner] executive director holds a public hearing  
1576 prior to implementing the policies and procedures and [prints] posts  
1577 notice of intent to adopt regulations on the [department's] office's  
1578 Internet web site and the eRegulations System not later than twenty  
1579 days after the date of implementation. Policies and procedures  
1580 implemented pursuant to this section shall be valid until the time final  
1581 regulations are adopted.

1582 Sec. 28. Section 19a-639b of the general statutes is repealed and the  
1583 following is substituted in lieu thereof (*Effective from passage*):

1584 (a) A certificate of need shall be valid only for the project described  
1585 in the application. A certificate of need shall be valid for two years  
1586 from the date of issuance by the [office] unit. During the period of time  
1587 that such certificate is valid and the thirty-day period following the  
1588 expiration of the certificate, the holder of the certificate shall provide  
1589 the [office] unit with such information as the [office] unit may request  
1590 on the development of the project covered by the certificate.

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

1604 request, in writing, that a public hearing be held on the request to  
1605 extend the duration of a certificate of need.

1606 (c) In the event that the [office] unit determines that: (1)  
1607 Commencement, construction or other preparation has not been  
1608 substantially undertaken during a valid certificate of need period; or  
1609 (2) the certificate holder has not made a good-faith effort to complete  
1610 the project as approved, the [office] unit may withdraw, revoke or  
1611 rescind the certificate of need.

1612 (d) A certificate of need shall not be transferable or assignable nor  
1613 shall a project be transferred from a certificate holder to another  
1614 person.

1615 (e) The [Commissioner of Public Health] executive director of the  
1616 Office of Health Strategy may implement policies and procedures  
1617 necessary to administer the provisions of this section while in the  
1618 process of adopting such policies and procedures as regulation,  
1619 provided the [commissioner] executive director holds a public hearing  
1620 prior to implementing the policies and procedures and [prints] posts  
1621 notice of intent to adopt regulations [in the Connecticut Law Journal]  
1622 on the office's Internet web site and the eRegulations System not later  
1623 than twenty days after the date of implementation. Policies and  
1624 procedures implemented pursuant to this section shall be valid until  
1625 the time final regulations are adopted. [Final regulations shall be  
1626 adopted by December 31, 2011.]

1627 Sec. 29. Section 19a-639c of the general statutes is repealed and the  
1628 following is substituted in lieu thereof (*Effective from passage*):

1629 (a) Any health care facility that proposes to relocate a facility shall  
1630 submit a letter to the [office] unit, as described in subsection (c) of  
1631 section 19a-638, as amended by this act. In addition to the  
1632 requirements prescribed in said subsection (c), in such letter the health  
1633 care facility shall demonstrate to the satisfaction of the [office] unit that  
1634 the population served by the health care facility and the payer mix will

1635 not substantially change as a result of the facility's proposed relocation.  
1636 If the facility is unable to demonstrate to the satisfaction of the [office]  
1637 unit that the population served and the payer mix will not  
1638 substantially change as a result of the proposed relocation, the health  
1639 care facility shall apply for certificate of need approval pursuant to  
1640 subdivision (1) of subsection (a) of section 19a-638, as amended by this  
1641 act, in order to effectuate the proposed relocation.

1642 (b) The [Commissioner of Public Health] executive director of the  
1643 Office of Health Strategy may implement policies and procedures  
1644 necessary to administer the provisions of this section while in the  
1645 process of adopting such policies and procedures as regulation,  
1646 provided the [commissioner] executive director holds a public hearing  
1647 prior to implementing the policies and procedures and [prints] posts  
1648 notice of intent to adopt regulations [in the Connecticut Law Journal]  
1649 on the office's Internet web site and the eRegulations System not later  
1650 than twenty days after the date of implementation. Policies and  
1651 procedures implemented pursuant to this section shall be valid until  
1652 the time final regulations are adopted. [Final regulations shall be  
1653 adopted by December 31, 2011.]

1654 Sec. 30. Section 19a-639e of the general statutes is repealed and the  
1655 following is substituted in lieu thereof (*Effective from passage*):

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

1668 writing, that a public hearing be held on the health care facility's  
1669 proposal to terminate a service.

1670 (b) Unless otherwise required to file a certificate of need application  
1671 pursuant to the provisions of subsection (a) of section 19a-638, as  
1672 amended by this act, any health care facility that proposes to terminate  
1673 all services offered by such facility, that were authorized pursuant to  
1674 one or more certificates of need issued under this chapter, shall  
1675 provide notification to the [office] unit not later than sixty days prior to  
1676 the termination of services and such facility shall surrender its  
1677 certificate of need not later than thirty days prior to the termination of  
1678 services.

1679 (c) Unless otherwise required to file a certificate of need application  
1680 pursuant to the provisions of subsection (a) of section 19a-638, as  
1681 amended by this act, any health care facility that proposes to terminate  
1682 the operation of a facility or service for which a certificate of need was  
1683 not obtained shall notify the [office] unit not later than sixty days prior  
1684 to terminating the operation of the facility or service.

1685 (d) The [Commissioner of Public Health] executive director of the  
1686 Office of Health Strategy may implement policies and procedures  
1687 necessary to administer the provisions of this section while in the  
1688 process of adopting such policies and procedures as regulation,  
1689 provided the [commissioner] executive director holds a public hearing  
1690 prior to implementing the policies and procedures and [prints] posts  
1691 notice of intent to adopt regulations [in the Connecticut Law Journal]  
1692 on the office's Internet web site and the eRegulations System not later  
1693 than twenty days after the date of implementation. Policies and  
1694 procedures implemented pursuant to this section shall be valid until  
1695 the time final regulations are adopted. [Final regulations shall be  
1696 adopted by December 31, 2015.]

1697 Sec. 31. Section 19a-639f of the general statutes is repealed and the  
1698 following is substituted in lieu thereof (*Effective from passage*):

1699 (a) The [Office of Healthcare Access division within the Department  
1700 of Public Health] Health Systems Planning Unit of the Office of Health  
1701 Strategy shall conduct a cost and market impact review in each case  
1702 where (1) an application for a certificate of need filed pursuant to  
1703 section 19a-638, as amended by this act, involves the transfer of  
1704 ownership of a hospital, as defined in section 19a-639, as amended by  
1705 this act, and (2) the purchaser is a hospital, as defined in section 19a-  
1706 490, whether located within or outside the state, that had net patient  
1707 revenue for fiscal year 2013 in an amount greater than one billion five  
1708 hundred million dollars, or a hospital system, as defined in section  
1709 19a-486i, as amended by this act, whether located within or outside the  
1710 state, that had net patient revenue for fiscal year 2013 in an amount  
1711 greater than one billion five hundred million dollars or any person that  
1712 is organized or operated for profit.

1713 (b) Not later than twenty-one days after receipt of a properly filed  
1714 certificate of need application involving the transfer of ownership of a  
1715 hospital filed on or after December 1, 2015, as described in subsection  
1716 (a) of this section, the [office] unit shall initiate such cost and market  
1717 impact review by sending the transacting parties a written notice that  
1718 shall contain a description of the basis for the cost and market impact  
1719 review as well as a request for information and documents. Not later  
1720 than thirty days after receipt of such notice, the transacting parties  
1721 shall submit to the [office] unit a written response. Such response shall  
1722 include, but need not be limited to, any information or documents  
1723 requested by the [office] unit concerning the transfer of ownership of  
1724 the hospital. The [office] unit shall have the powers with respect to the  
1725 cost and market impact review as provided in section 19a-633, as  
1726 amended by this act.

1727 (c) The [office] unit shall keep confidential all nonpublic information  
1728 and documents obtained pursuant to this section and shall not disclose  
1729 the information or documents to any person without the consent of the  
1730 person that produced the information or documents, except in a  
1731 preliminary report or final report issued in accordance with this



1732 section if the [office] unit believes that such disclosure should be made  
1733 in the public interest after taking into account any privacy, trade secret  
1734 or anti-competitive considerations. Such information and documents  
1735 shall not be deemed a public record, under section 1-210, and shall be  
1736 exempt from disclosure.

1737 (d) The cost and market impact review conducted pursuant to this  
1738 section shall examine factors relating to the businesses and relative  
1739 market positions of the transacting parties as defined in subsection (d)  
1740 of section 19a-639, as amended by this act, and may include, but need  
1741 not be limited to: (1) The transacting parties' size and market share  
1742 within its primary service area, by major service category and within  
1743 its dispersed service areas; (2) the transacting parties' prices for  
1744 services, including the transacting parties' relative prices compared to  
1745 other health care providers for the same services in the same market;  
1746 (3) the transacting parties' health status adjusted total medical expense,  
1747 including the transacting parties' health status adjusted total medical  
1748 expense compared to that of similar health care providers; (4) the  
1749 quality of the services provided by the transacting parties, including  
1750 patient experience; (5) the transacting parties' cost and cost trends in  
1751 comparison to total health care expenditures state wide; (6) the  
1752 availability and accessibility of services similar to those provided by  
1753 each transacting party, or proposed to be provided as a result of the  
1754 transfer of ownership of a hospital within each transacting party's  
1755 primary service areas and dispersed service areas; (7) the impact of the  
1756 proposed transfer of ownership of the hospital on competing options  
1757 for the delivery of health care services within each transacting party's  
1758 primary service area and dispersed service area including the impact  
1759 on existing service providers; (8) the methods used by the transacting  
1760 parties to attract patient volume and to recruit or acquire health care  
1761 professionals or facilities; (9) the role of each transacting party in  
1762 serving at-risk, underserved and government payer patient  
1763 populations, including those with behavioral, substance use disorder  
1764 and mental health conditions, within each transacting party's primary  
1765 service area and dispersed service area; (10) the role of each transacting

1766 party in providing low margin or negative margin services within each  
1767 transacting party's primary service area and dispersed service area;  
1768 (11) consumer concerns, including, but not limited to, complaints or  
1769 other allegations that a transacting party has engaged in any unfair  
1770 method of competition or any unfair or deceptive act or practice; and  
1771 (12) any other factors that the [office] unit determines to be in the  
1772 public interest.

1773 (e) Not later than ninety days after the [office] unit determines that  
1774 there is substantial compliance with any request for documents or  
1775 information issued by the [office] unit in accordance with this section,  
1776 or a later date set by mutual agreement of the [office] unit and the  
1777 transacting parties, the [office] unit shall make factual findings and  
1778 issue a preliminary report on the cost and market impact review. Such  
1779 preliminary report shall include, but shall not be limited to, an  
1780 indication as to whether a transacting party meets the following  
1781 criteria: (1) Currently has or, following the proposed transfer of  
1782 operations of the hospital, is likely to have a dominant market share  
1783 for the services the transacting party provides; and (2) (A) currently  
1784 charges or, following the proposed transfer of operations of the  
1785 hospital, is likely to charge prices for services that are materially higher  
1786 than the median prices charged by all other health care providers for  
1787 the same services in the same market, or (B) currently has or, following  
1788 the proposed transfer of operations of a hospital, is likely to have a  
1789 health status adjusted total medical expense that is materially higher  
1790 than the median total medical expense for all other health care  
1791 providers for the same service in the same market.

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

1799 final report on any proposed transfer of ownership that meets the  
1800 criteria described in subsection (e) of this section.

1801 (g) Nothing in this section shall prohibit a transfer of ownership of a  
1802 hospital, provided any such proposed transfer shall not be completed  
1803 (1) less than thirty days after the [office] unit has issued a final report  
1804 on a cost and market impact review, if such review is required, or (2)  
1805 while any action brought by the Attorney General pursuant to  
1806 subsection (h) of this section is pending and before a final judgment on  
1807 such action is issued by a court of competent jurisdiction.

1808 (h) After the [office] unit refers a final report on a transfer of  
1809 ownership of a hospital to the Attorney General under subsection (f) of  
1810 this section, the Attorney General may: (1) Conduct an investigation to  
1811 determine whether the transacting parties engaged, or, as a result of  
1812 completing the transfer of ownership of the hospital, are expected to  
1813 engage in unfair methods of competition, anti-competitive behavior or  
1814 other conduct in violation of chapter 624 or 735a or any other state or  
1815 federal law; and (2) if appropriate, take action under chapter 624 or  
1816 735a or any other state law to protect consumers in the health care  
1817 market. The [office's] unit's final report may be evidence in any such  
1818 action.

1819 (i) For the purposes of this section, the provisions of chapter 735a  
1820 may be directly enforced by the Attorney General. Nothing in this  
1821 section shall be construed to modify, impair or supersede the  
1822 operation of any state antitrust law or otherwise limit the authority of  
1823 the Attorney General to (1) take any action against a transacting party  
1824 as authorized by any law, or (2) protect consumers in the health care  
1825 market under any law. Notwithstanding subdivision (1) of subsection  
1826 (a) of section 42-110c, the transacting parties shall be subject to chapter  
1827 735a.

1828 (j) The [office] unit shall retain an independent consultant with  
1829 expertise on the economic analysis of the health care market and health  
1830 care costs and prices to conduct each cost and market impact review,

1831 as described in this section. The [office] unit shall submit bills for such  
1832 services to the purchaser, as defined in subsection (d) of section 19a-  
1833 639, as amended by this act. Such purchaser shall pay such bills not  
1834 later than thirty days after receipt. Such bills shall not exceed two  
1835 hundred thousand dollars per application. The provisions of chapter  
1836 57, sections 4-212 to 4-219, inclusive, and section 4e-19 shall not apply  
1837 to any agreement executed pursuant to this subsection.

1838 (k) Any employee of the [office] unit who directly oversees or assists  
1839 in conducting a cost and market impact review shall not take part in  
1840 factual deliberations or the issuance of a preliminary or final decision  
1841 on the certificate of need application concerning the transfer of  
1842 ownership of a hospital that is the subject of such cost and market  
1843 impact review.

1844 (l) The [Commissioner of Public Health] executive director of the  
1845 Office of Health Strategy shall adopt regulations, in accordance with  
1846 the provisions of chapter 54, concerning cost and market impact  
1847 reviews and to administer the provisions of this section. Such  
1848 regulations shall include definitions of the following terms: "Dispersed  
1849 service area", "health status adjusted total medical expense", "major  
1850 service category", "relative prices", "total health care spending" and  
1851 "health care services". The [commissioner] executive director may  
1852 implement policies and procedures necessary to administer the  
1853 provisions of this section while in the process of adopting such policies  
1854 and procedures in regulation form, provided the [commissioner]  
1855 executive director publishes notice of intention to adopt the  
1856 regulations on the [Department of Public Health's] office's Internet  
1857 web site and the eRegulations System not later than twenty days after  
1858 implementing such policies and procedures. Policies and procedures  
1859 implemented pursuant to this subsection shall be valid until the time  
1860 such regulations are effective.

1861 Sec. 32. Section 19a-641 of the general statutes is repealed and the  
1862 following is substituted in lieu thereof (*Effective from passage*):

1863 Any health care facility or institution and any state health care  
1864 facility or institution aggrieved by any final decision of said [office]  
1865 unit under the provisions of sections 19a-630 to 19a-639e, inclusive, as  
1866 amended by this act, may appeal from such decision in accordance  
1867 with the provisions of section 4-183, except venue shall be in the  
1868 judicial district in which it is located. Such appeal shall have  
1869 precedence in respect to order of trial over all other cases except writs  
1870 of habeas corpus, actions brought by or on behalf of the state,  
1871 including [informations] information on the relation of private  
1872 individuals, and appeals from awards or decisions of workers'  
1873 compensation commissioners.

1874 Sec. 33. Section 19a-642 of the general statutes is repealed and the  
1875 following is substituted in lieu thereof (*Effective from passage*):

1876 The Superior Court on application of the [office] unit or the  
1877 Attorney General, may enforce, by appropriate decree or process, any  
1878 provision of this chapter or any act or any order of the [office] unit  
1879 rendered in pursuance of any statutory provision.

1880 Sec. 34. Section 19a-643 of the general statutes is repealed and the  
1881 following is substituted in lieu thereof (*Effective from passage*):

1882 (a) The [Department of Public Health] Office of Health Strategy  
1883 shall adopt regulations, in accordance with the provisions of chapter  
1884 54, to carry out the provisions of sections 19a-630 to 19a-639e,  
1885 inclusive, as amended by this act, and sections 19a-644, as amended by  
1886 this act, and 19a-645, as amended by this act, concerning the  
1887 submission of data by health care facilities and institutions, including  
1888 data on dealings between health care facilities and institutions and  
1889 their affiliates, and, with regard to requests or proposals pursuant to  
1890 sections 19a-638 to 19a-639e, inclusive, as amended by this act, by state  
1891 health care facilities and institutions, the ongoing inspections by the  
1892 [office] unit of operating budgets that have been approved by the  
1893 health care facilities and institutions, standard reporting forms and  
1894 standard accounting procedures to be utilized by health care facilities

1895 and institutions and the transferability of line items in the approved  
1896 operating budgets of the health care facilities and institutions, except  
1897 that any health care facility or institution may transfer any amounts  
1898 among items in its operating budget. All such transfers shall be  
1899 reported to the [office within] unit not later than thirty days [of] after  
1900 the transfer or transfers.

1901 (b) The [Department of Public Health] Office of Health Strategy may  
1902 adopt such regulations, in accordance with the provisions of chapter  
1903 54, as are necessary to implement this chapter.

1904 Sec. 35. Section 19a-644 of the general statutes is repealed and the  
1905 following is substituted in lieu thereof (*Effective from passage*):

1906 (a) On or before February twenty-eighth annually, for the fiscal year  
1907 ending on September thirtieth of the immediately preceding year, each  
1908 short-term acute care general or children's hospital shall report to the  
1909 [office] unit with respect to its operations in such fiscal year, in such  
1910 form as the [office] unit may by regulation require. Such report shall  
1911 include: (1) Salaries and fringe benefits for the ten highest paid  
1912 hospital and health system employees; (2) the name of each joint  
1913 venture, partnership, subsidiary and corporation related to the  
1914 hospital; and (3) the salaries paid to hospital and health system  
1915 employees by each such joint venture, partnership, subsidiary and  
1916 related corporation and by the hospital to the employees of related  
1917 corporations. For purposes of this subsection, "health system" has the  
1918 same meaning as provided in section 33-182aa.

1919 (b) The [Department of Public Health] Office of Health Strategy  
1920 shall adopt regulations in accordance with chapter 54 to provide for  
1921 the collection of data and information in addition to the annual report  
1922 required in subsection (a) of this section. Such regulations shall  
1923 provide for the submission of information about the operations of the  
1924 following entities: Persons or parent corporations that own or control  
1925 the health care facility, institution or provider; corporations, including  
1926 limited liability corporations, in which the health care facility,

1927 institution, provider, its parent, any type of affiliate or any  
1928 combination thereof, owns more than an aggregate of fifty per cent of  
1929 the stock or, in the case of nonstock corporations, is the sole member;  
1930 and any partnerships in which the person, health care facility,  
1931 institution, provider, its parent or an affiliate or any combination  
1932 thereof, or any combination of health care providers or related persons,  
1933 owns a greater than fifty per cent interest. For purposes of this  
1934 [section] subsection, "affiliate" means any person that directly or  
1935 indirectly through one or more intermediaries, controls or is controlled  
1936 by or is under common control with any health care facility,  
1937 institution, provider or person that is regulated in any way under this  
1938 chapter. A person is deemed controlled by another person if the other  
1939 person, or one of that other person's affiliates, officers, agents or  
1940 management employees, acts as a general partner or manager of the  
1941 person in question.

1942 (c) Each nonprofit short-term acute care general or children's  
1943 hospital shall include in the annual report required pursuant to  
1944 subsection (a) of this section a report of all transfers of assets, transfers  
1945 of operations or changes of control involving its clinical or nonclinical  
1946 services or functions from such hospital to a person or entity organized  
1947 or operated for profit.

1948 (d) Each hospital that is a party to a transfer of ownership involving  
1949 a hospital for which a certificate of need application was filed and  
1950 approved pursuant to this chapter shall, during the fiscal year ending  
1951 on September thirtieth of the immediately preceding year, include in  
1952 the annual report required pursuant to subsection (a) of this section  
1953 any salary, severance payment, stock offering or other financial gain  
1954 realized by each officer, director, board member or senior manager of  
1955 the hospital as a result of such transaction.

1956 (e) The [office] unit shall require each hospital licensed by the  
1957 Department of Public Health, that is not subject to the provisions of  
1958 subsection (a) of this section, to report to said [office] unit on its  
1959 operations in the preceding fiscal year by filing copies of the hospital's

1960 audited financial statements, except a health system, as defined in  
1961 section 19a-508c, as amended by this act, may submit to the [office]  
1962 unit one such report that includes the audited financial statements for  
1963 each of its hospitals. Such report shall be due at the [office] unit on or  
1964 before the close of business on the last business day of the fifth month  
1965 following the month in which a hospital's fiscal year ends.

1966 Sec. 36. Section 19a-645 of the general statutes is repealed and the  
1967 following is substituted in lieu thereof (*Effective from passage*):

1968 A nonprofit hospital, licensed by the Department of Public Health,  
1969 which provides lodging, care and treatment to members of the public,  
1970 and which wishes to enlarge its public facilities by adding contiguous  
1971 land and buildings thereon, if any, the title to which it cannot  
1972 otherwise acquire, may prefer a complaint for the right to take such  
1973 land to the superior court for the judicial district in which such land is  
1974 located, provided such hospital shall have received the approval of the  
1975 [Office of Health Care Access division] Health Systems Planning Unit  
1976 of the [Department of Public Health] Office of Health Strategy in  
1977 accordance with the provisions of this chapter. Said court shall appoint  
1978 a committee of three disinterested persons, who, after examining the  
1979 premises and hearing the parties, shall report to the court as to the  
1980 necessity and propriety of such enlargement and as to the quantity,  
1981 boundaries and value of the land and buildings thereon, if any, which  
1982 they deem proper to be taken for such purpose and the damages  
1983 resulting from such taking. If such committee reports that such  
1984 enlargement is necessary and proper and the court accepts such report,  
1985 the decision of said court thereon shall have the effect of a judgment  
1986 and execution may be issued thereon accordingly, in favor of the  
1987 person to whom damages may be assessed, for the amount thereof;  
1988 and, on payment thereof, the title to the land and buildings thereon, if  
1989 any, for such purpose shall be vested in the complainant, but such land  
1990 and buildings thereon, if any, shall not be taken until such damages  
1991 are paid to such owner or deposited with said court, for such owner's  
1992 use, within thirty days after such report is accepted. If such application



1993 is denied, the owner of the land shall recover costs of the applicant, to  
1994 be taxed by said court, which may issue execution therefor. Land so  
1995 taken shall be held by such hospital and used only for the public  
1996 purpose stated in its complaint to the superior court. No land  
1997 dedicated or otherwise reserved as open space or park land or for  
1998 other recreational purposes and no land belonging to any town, city or  
1999 borough shall be taken under the provisions of this section.

2000 Sec. 37. Section 19a-646 of the general statutes is repealed and the  
2001 following is substituted in lieu thereof (*Effective from passage*):

2002 (a) As used in this section:

2003 [(1) "Office" means the Office of Health Care Access division of the  
2004 Department of Public Health;]

2005 (1) "Unit" means the Health Systems Planning Unit within the Office  
2006 of Health Strategy, established under section 19a-612, as amended by  
2007 this act;

2008 (2) "Fiscal year" means the hospital fiscal year, as used for purposes  
2009 of this chapter, consisting of a twelve-month period commencing on  
2010 October first and ending the following September thirtieth;

2011 (3) "Hospital" means any short-term acute care general or children's  
2012 hospital licensed by the Department of Public Health, including the  
2013 John Dempsey Hospital of The University of Connecticut Health  
2014 Center;

2015 (4) "Payer" means any person, legal entity, governmental body or  
2016 eligible organization that meets the definition of an eligible  
2017 organization under 42 USC Section 1395mm (b) of the Social Security  
2018 Act, or any combination thereof, except for Medicare and Medicaid  
2019 which is or may become legally responsible, in whole or in part for the  
2020 payment of services rendered to or on behalf of a patient by a hospital.  
2021 Payer also includes any legal entity whose membership includes one  
2022 or more payers and any third-party payer; and

2023 (5) "Prompt payment" means payment made for services to a  
2024 hospital by mail or other means on or before the tenth business day  
2025 after receipt of the bill by the payer.

2026 (b) No hospital shall provide a discount or different rate or method  
2027 of reimbursement from the filed rates or charges to any payer except as  
2028 provided in this section.

2029 (c) (1) Any payer may directly negotiate with a hospital for a  
2030 different rate or method of reimbursement, or both, provided the  
2031 charges and payments for the payer are on file at the hospital business  
2032 office in accordance with this subsection. No discount agreement or  
2033 agreement for a different rate or method of reimbursement, or both,  
2034 shall be effective until a complete written agreement between the  
2035 hospital and the payer is on file at the hospital. Each such agreement  
2036 shall be available to the [office] unit for inspection or submission to the  
2037 [office] unit upon request, for at least three years after the close of the  
2038 applicable fiscal year.

2039 (2) The charges and payments for each payer receiving a discount  
2040 shall be accumulated by the hospital for each payer and reported as  
2041 required by the [office] unit.

2042 (3) A full written copy of each agreement executed pursuant to this  
2043 subsection shall be on file in the hospital business office within twenty-  
2044 four hours of execution.

2045 (d) A payer may negotiate with a hospital to obtain a discount on  
2046 rates or charges for prompt payment.

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

2054 the third-party payer for service to the patient prior to the provision of  
2055 that service.

2056 (f) No hospital may require a payer to negotiate for another element  
2057 or any combination of the above elements of a discount, as established  
2058 in subsections (d) and (e) of this section, in order to negotiate for or  
2059 obtain a discount for any single element. No hospital may require a  
2060 payer to negotiate a discount for all patients covered by such payer in  
2061 order to negotiate a discount for any patient or group of patients  
2062 covered by such payer.

2063 (g) Any hospital which agrees to provide a discount to a payer  
2064 under subsection (d) or (e) of this section shall file a copy of the  
2065 agreement in the hospital's business office and shall provide the same  
2066 discount to any other payer who agrees to make prompt payment or  
2067 provide administrative services similar to that contained in the  
2068 agreement. Each agreement filed shall specify on its face that it was  
2069 executed and filed pursuant to this subsection.

2070 (h) (1) Nothing in this section shall be construed to require payment  
2071 by any payer or purchaser, under any program or contract for  
2072 payment or reimbursement of expenses for health care services, for:  
2073 (A) Services not covered under such program or contract; or (B) that  
2074 portion of any charge for services furnished by a hospital that exceeds  
2075 the amount covered by such program or contract.

2076 (2) Nothing in this section shall be construed to supersede or modify  
2077 any provision of such program or contract that requires payment of a  
2078 copayment, deductible or enrollment fee or that imposes any similar  
2079 requirement.

2080 (i) A hospital which has established a program approved by the  
2081 [office] unit with one or more banks for the purpose of reducing the  
2082 hospital's bad debt load, may reduce its published charges for that  
2083 portion of a patient's bill for services which a payer who is a private  
2084 individual is or may become legally responsible for, after all other

2085 insurers or third-party payers have been assessed their full charges  
2086 provided (1) prior to the rendering of such services, the hospital and  
2087 the individual payer or parent or guardian or custodian have agreed in  
2088 writing that after receipt of any insurer or third-party payment paid in  
2089 accordance with the full hospital charges the remaining payment due  
2090 from the private individual for such reduced charges shall be made in  
2091 whole or in part from the balance on deposit in a bank account which  
2092 has been established by or on behalf of such individual patient, and (2)  
2093 such payment is made from such account. Nothing in this section shall  
2094 relieve a patient or legally liable person from being responsible for the  
2095 full amount of any underpayment of the hospital's authorized charges  
2096 excluding any discount under this section, by a patient's insurer or any  
2097 other third-party payer for that insurer's or third-party payer's portion  
2098 of the bill. Any reduction in charges granted to an individual or parent  
2099 or guardian or custodian under this subsection shall be reported to the  
2100 [office] unit as a contractual allowance. For purposes of this [section]  
2101 subsection "private individual" shall include a patient's parent, legal  
2102 guardian or legal custodian but shall not include an insurer or third-  
2103 party payer.

2104 Sec. 38. Section 19a-649 of the general statutes is repealed and the  
2105 following is substituted in lieu thereof (*Effective from passage*):

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

2118 prescribed by the [office] unit.

2119 (b) Each hospital shall annually report, along with data submitted  
2120 pursuant to subsection (a) of this section, (1) the number of applicants  
2121 for charity care and reduced cost services, (2) the number of approved  
2122 applicants, and (3) the total and average charges and costs of the  
2123 amount of charity care and reduced cost services provided.

2124 (c) Each hospital recognized as a nonprofit organization under  
2125 Section 501(c)(3) of the Internal Revenue Code of 1986, or any  
2126 subsequent corresponding internal revenue code of the United States,  
2127 as amended from time to time, shall, along with data submitted  
2128 annually pursuant to subsection (a) of this section, submit to the  
2129 [office] unit (1) a complete copy of such hospital's most-recently  
2130 completed Internal Revenue Service form 990, including all parts and  
2131 schedules; and (2) in the form and manner prescribed by the [office]  
2132 unit, data compiled to prepare such hospital's community health needs  
2133 assessment, as required pursuant to Section 501(r) of the Internal  
2134 Revenue Code of 1986, or any subsequent corresponding internal  
2135 revenue code of the United States, as amended from time to time,  
2136 provided such copy and data submitted pursuant to this subsection  
2137 shall not include: (A) Individual patient information, including, but  
2138 not limited to, patient-identifiable information; (B) information that is  
2139 not owned or controlled by such hospital; (C) information that such  
2140 hospital is contractually required to keep confidential or that is  
2141 prohibited from disclosure by a data use agreement; or (D) information  
2142 concerning research on human subjects as described in section 45 CFR  
2143 46.101 et seq., as amended from time to time.

2144 Sec. 39. Section 19a-653 of the general statutes is repealed and the  
2145 following is substituted in lieu thereof (*Effective from passage*):

2146 (a) Any person or health care facility or institution that is required  
2147 to file a certificate of need for any of the activities described in section  
2148 19a-638, as amended by this act, and any person or health care facility  
2149 or institution that is required to file data or information under any

2150 public or special act or under this chapter or sections 19a-486 to 19a-  
2151 486h, inclusive, as amended by this act, or any regulation adopted or  
2152 order issued under this chapter or said sections, which wilfully fails to  
2153 seek certificate of need approval for any of the activities described in  
2154 section 19a-638, as amended by this act, or to so file within prescribed  
2155 time periods, shall be subject to a civil penalty of up to one thousand  
2156 dollars a day for each day such person or health care facility or  
2157 institution conducts any of the described activities without certificate  
2158 of need approval as required by section 19a-638, as amended by this  
2159 act, or for each day such information is missing, incomplete or  
2160 inaccurate. Any civil penalty authorized by this section shall be  
2161 imposed by the [Department of Public Health] Office of Health  
2162 Strategy in accordance with subsections (b) to (e), inclusive, of this  
2163 section.

2164 (b) If the [Department of Public Health] Office of Health Strategy  
2165 has reason to believe that a violation has occurred for which a civil  
2166 penalty is authorized by subsection (a) of this section or subsection (e)  
2167 of section 19a-632, as amended by this act, it shall notify the person or  
2168 health care facility or institution by first-class mail or personal service.  
2169 The notice shall include: (1) A reference to the sections of the statute or  
2170 regulation involved; (2) a short and plain statement of the matters  
2171 asserted or charged; (3) a statement of the amount of the civil penalty  
2172 or penalties to be imposed; (4) the initial date of the imposition of the  
2173 penalty; and (5) a statement of the party's right to a hearing.

2174 (c) The person or health care facility or institution to whom the  
2175 notice is addressed shall have fifteen business days from the date of  
2176 mailing of the notice to make written application to the [office] unit to  
2177 request (1) a hearing to contest the imposition of the penalty, or (2) an  
2178 extension of time to file the required data. A failure to make a timely  
2179 request for a hearing or an extension of time to file the required data or  
2180 a denial of a request for an extension of time shall result in a final order  
2181 for the imposition of the penalty. All hearings under this section shall  
2182 be conducted pursuant to sections 4-176e to 4-184, inclusive. The

2183 [Department of Public Health] Office of Health Strategy may grant an  
2184 extension of time for filing the required data or mitigate or waive the  
2185 penalty upon such terms and conditions as, in its discretion, it deems  
2186 proper or necessary upon consideration of any extenuating factors or  
2187 circumstances.

2188 (d) A final order of the [Department of Public Health] Office of  
2189 Health Strategy assessing a civil penalty shall be subject to appeal as  
2190 set forth in section 4-183 after a hearing before the [office] unit  
2191 pursuant to subsection (c) of this section, except that any such appeal  
2192 shall be taken to the superior court for the judicial district of New  
2193 Britain. Such final order shall not be subject to appeal under any other  
2194 provision of the general statutes. No challenge to any such final order  
2195 shall be allowed as to any issue which could have been raised by an  
2196 appeal of an earlier order, denial or other final decision by the  
2197 [Department of Public Health] office.

2198 (e) If any person or health care facility or institution fails to pay any  
2199 civil penalty under this section, after the assessment of such penalty  
2200 has become final the amount of such penalty may be deducted from  
2201 payments to such person or health care facility or institution from the  
2202 Medicaid account.

2203 Sec. 40. Section 19a-654 of the general statutes is repealed and the  
2204 following is substituted in lieu thereof (*Effective from passage*):

2205 (a) As used in this section:

2206 (1) "Patient-identifiable data" means any information that identifies  
2207 or may reasonably be used as a basis to identify an individual patient;  
2208 and

2209 (2) "De-identified patient data" means any information that meets  
2210 the requirements for de-identification of protected health information  
2211 as set forth in 45 CFR 164.514.

2212 (b) Each short-term acute care general or children's hospital shall

2213 submit patient-identifiable inpatient discharge data and emergency  
2214 department data to the [Office of Health Care Access division] Health  
2215 Systems Planning Unit of the [Department of Public Health] Office of  
2216 Health Strategy to fulfill the responsibilities of the [office] unit. Such  
2217 data shall include data taken from patient medical record abstracts and  
2218 bills. The [office] unit shall specify the timing and format of such  
2219 submissions. Data submitted pursuant to this section may be  
2220 submitted through a contractual arrangement with an intermediary  
2221 and such contractual arrangement shall (1) comply with the provisions  
2222 of the Health Insurance Portability and Accountability Act of 1996 P.L.  
2223 104-191 (HIPAA), and (2) ensure that such submission of data is timely  
2224 and accurate. The [office] unit may conduct an audit of the data  
2225 submitted through such intermediary in order to verify its accuracy.

2226 (c) An outpatient surgical facility, as defined in section 19a-493b, as  
2227 amended by this act, a short-term acute care general or children's  
2228 hospital, or a facility that provides outpatient surgical services as part  
2229 of the outpatient surgery department of a short-term acute care  
2230 hospital shall submit to the [office] unit the data identified in  
2231 subsection (c) of section 19a-634, as amended by this act. The [office]  
2232 unit shall convene a working group consisting of representatives of  
2233 outpatient surgical facilities, hospitals and other individuals necessary  
2234 to develop recommendations that address current obstacles to, and  
2235 proposed requirements for, patient-identifiable data reporting in the  
2236 outpatient setting. On or before February 1, 2012, the working group  
2237 shall report, in accordance with the provisions of section 11-4a, on its  
2238 findings and recommendations to the joint standing committees of the  
2239 General Assembly having cognizance of matters relating to public  
2240 health and insurance and real estate. Additional reporting of  
2241 outpatient data as the [office] unit deems necessary shall begin not  
2242 later than July 1, 2015. On or before July 1, [2012] 2018, and annually  
2243 thereafter, the Connecticut Association of Ambulatory Surgery Centers  
2244 shall provide a progress report to the [Department of Public Health]  
2245 Office of Health Strategy, until such time as all ambulatory surgery  
2246 centers are in full compliance with the implementation of systems that



2247 allow for the reporting of outpatient data as required by the  
2248 [commissioner] executive director. Until such additional reporting  
2249 requirements take effect on July 1, 2015, the department may work  
2250 with the Connecticut Association of Ambulatory Surgery Centers and  
2251 the Connecticut Hospital Association on specific data reporting  
2252 initiatives provided that no penalties shall be assessed under this  
2253 chapter or any other provision of law with respect to the failure to  
2254 submit such data.

2255 (d) Except as provided in this subsection, patient-identifiable data  
2256 received by the [office] unit shall be kept confidential and shall not be  
2257 considered public records or files subject to disclosure under the  
2258 Freedom of Information Act, as defined in section 1-200. The [office]  
2259 unit may release de-identified patient data or aggregate patient data to  
2260 the public in a manner consistent with the provisions of 45 CFR  
2261 164.514. Any de-identified patient data released by the [office] unit  
2262 shall exclude provider, physician and payer organization names or  
2263 codes and shall be kept confidential by the recipient. The [office] unit  
2264 may release patient-identifiable data (1) for medical and scientific  
2265 research as provided for in section 19a-25-3 of the regulations of  
2266 Connecticut state agencies, and (2) to (A) a state agency for the  
2267 purpose of improving health care service delivery, (B) a federal agency  
2268 or the office of the Attorney General for the purpose of investigating  
2269 hospital mergers and acquisitions, or (C) another state's health data  
2270 collection agency with which the [office] unit has entered into a  
2271 reciprocal data-sharing agreement for the purpose of certificate of need  
2272 review or evaluation of health care services, upon receipt of a request  
2273 from such agency, provided, prior to the release of such patient-  
2274 identifiable data, such agency enters into a written agreement with the  
2275 [office] unit pursuant to which such agency agrees to protect the  
2276 confidentiality of such patient-identifiable data and not to use such  
2277 patient-identifiable data as a basis for any decision concerning a  
2278 patient. No individual or entity receiving patient-identifiable data may  
2279 release such data in any manner that may result in an individual  
2280 patient, physician, provider or payer being identified. The [office] unit

2281 shall impose a reasonable, cost-based fee for any patient data provided  
2282 to a nongovernmental entity.

2283 (e) Not later than October 1, [2011] 2018, the [Office of Health Care  
2284 Access] Health Systems Planning Unit shall enter into a memorandum  
2285 of understanding with the Comptroller that shall permit the  
2286 Comptroller to access the data set forth in subsections (b) and (c) of  
2287 this section, provided the Comptroller agrees, in writing, to keep  
2288 individual patient and provider data identified by proper name or  
2289 personal identification code and submitted pursuant to this section  
2290 confidential.

2291 (f) The [Commissioner of Public Health] executive director of the  
2292 Office of Health Strategy shall adopt regulations, in accordance with  
2293 the provisions of chapter 54, to carry out the provisions of this section.

2294 (g) The duties assigned to the [Department of Public Health] Office  
2295 of Health Strategy under the provisions of this section shall be  
2296 implemented within available appropriations.

2297 Sec. 41. Section 19a-659 of the general statutes is repealed and the  
2298 following is substituted in lieu thereof (*Effective from passage*):

2299 As used in [this chapter] sections 19a-644, as amended by this act,  
2300 19a-649, as amended by this act, 19a-670, as amended by this act, and  
2301 19a-676, as amended by this act, unless the context otherwise requires:

2302 [(1) "Office" means the Office of Health Care Access division of the  
2303 Department of Public Health;]

2304 (1) "Unit" means the Health Systems Planning Unit within the Office  
2305 of Health Strategy, established under section 19a-612, as amended by  
2306 this act;

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

2310 Health Center;

2311 (3) "Fiscal year" means the hospital fiscal year consisting of a twelve-  
2312 month period commencing on October first and ending the following  
2313 September thirtieth;

2314 (4) "Affiliate" means a person, entity or organization controlling,  
2315 controlled by, or under common control with another person, entity or  
2316 organization;

2317 (5) "Uncompensated care" means the total amount of charity care  
2318 and bad debts determined by using the hospital's published charges  
2319 and consistent with the hospital's policies regarding charity care and  
2320 bad debts which are on file at the [office] unit;

2321 (6) "Medical assistance" means (A) the programs for medical  
2322 assistance provided under the Medicaid program, including HUSKY  
2323 A, or (B) any other state-funded medical assistance program, including  
2324 HUSKY B;

2325 (7) "CHAMPUS" or "TriCare" means the federal Civilian Health and  
2326 Medical Program of the Uniformed Services, as defined in 10 USC  
2327 1072(4), as from time to time amended;

2328 (8) "Primary payer" means the payer responsible for the highest  
2329 percentage of the charges for a patient's inpatient or outpatient  
2330 hospital services;

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

2340 resulting products for all diagnosis-related groups;

2341 (10) "Contractual allowances" means the difference between hospital  
2342 published charges and payments generated by negotiated agreements  
2343 for a different or discounted rate or method of payment;

2344 (11) "Medical assistance underpayment" means the amount  
2345 calculated by dividing the total net revenue by the total gross revenue,  
2346 and then multiplying the quotient by the total medical assistance  
2347 charges, and then subtracting medical assistance payments from the  
2348 product;

2349 (12) "Other allowances" means the amount of any difference  
2350 between charges for employee self-insurance and related expenses  
2351 determined using the hospital's overall relationship of costs to charges;

2352 (13) "Gross revenue" means the total gross patient charges for all  
2353 patient services provided by a hospital; and

2354 (14) "Net revenue" means total gross revenue less contractual  
2355 allowance, less the difference between government charges and  
2356 government payments, less uncompensated care and other allowances.

2357 Sec. 42. Section 19a-670 of the general statutes is repealed and the  
2358 following is substituted in lieu thereof (*Effective from passage*):

2359 The [office] unit shall, by September first of each year, report the  
2360 results of the [office's] unit's review of the hospitals' annual and  
2361 twelve-month filings under sections 19a-644, as amended by this act,  
2362 19a-649, as amended by this act, and 19a-676, as amended by this act,  
2363 for the previous hospital fiscal year to the joint standing committee of  
2364 the General Assembly having cognizance of matters relating to public  
2365 health. The report shall include information concerning the financial  
2366 stability of hospitals in a competitive market.

2367 Sec. 43. Subdivision (1) of subsection (a) of section 19a-673 of the  
2368 general statutes is repealed and the following is substituted in lieu

2369 thereof (*Effective from passage*):

2370 (1) "Cost of providing services" means a hospital's published  
2371 charges at the time of billing, multiplied by the hospital's most recent  
2372 relationship of costs to charges as taken from the hospital's most  
2373 recently available annual financial filing with the [office] unit.

2374 Sec. 44. Section 19a-673a of the general statutes is repealed and the  
2375 following is substituted in lieu thereof (*Effective from passage*):

2376 The [Commissioner of Public Health] executive director of the  
2377 Office of Health Strategy shall adopt regulations, in accordance with  
2378 chapter 54, to establish uniform debt collection standards for hospitals.

2379 Sec. 45. Section 19a-673c of the general statutes is repealed and the  
2380 following is substituted in lieu thereof (*Effective from passage*):

2381 On or before March 1, 2004, and annually thereafter, each hospital  
2382 shall file with the [office] unit a debt collection report that includes (1)  
2383 whether the hospital uses a collection agent, as defined in section 19a-  
2384 509b, as amended by this act, to assist with debt collection, (2) the  
2385 name of any collection agent used, (3) the hospital's processes and  
2386 policies for assigning a debt to a collection agent and for compensating  
2387 such collection agent for services rendered, and (4) the recovery rate on  
2388 accounts assigned to collection agents, exclusive of Medicare accounts,  
2389 in the most recent hospital fiscal year.

2390 Sec. 46. Section 19a-676 of the general statutes is repealed and the  
2391 following is substituted in lieu thereof (*Effective from passage*):

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

2399 hospital's twelve months' actual filing requirements.

2400 Sec. 47. Section 19a-681 of the general statutes is repealed and the  
2401 following is substituted in lieu thereof (*Effective from passage*):

2402 (a) For purposes of this section: (1) "Detailed patient bill" means a  
2403 patient billing statement that includes, in each line item, the hospital's  
2404 current pricemaster code, a description of the charge and the billed  
2405 amount; and (2) "pricemaster" means a detailed schedule of hospital  
2406 charges.

2407 (b) Each hospital shall file with the [office] unit its current  
2408 pricemaster which shall include each charge in its detailed schedule of  
2409 charges.

2410 (c) Upon the request of the [Department of Public Health] Office of  
2411 Health Strategy, established under section 19a-754a, as amended by  
2412 this act, or a patient, a hospital shall provide to the [department] office  
2413 or the patient a detailed patient bill. If the billing detail by line item on  
2414 a detailed patient bill does not agree with the detailed schedule of  
2415 charges on file with the [office] unit for the date of service specified on  
2416 the bill, the hospital shall be subject to a civil penalty of five hundred  
2417 dollars per occurrence payable to the state not later than fourteen days  
2418 after the date of notification. The penalty shall be imposed in  
2419 accordance with section 19a-653, as amended by this act. The [office]  
2420 unit may issue an order requiring such hospital, not later than fourteen  
2421 days after the date of notification of an overcharge to a patient, to  
2422 adjust the bill to be consistent with the detailed schedule of charges on  
2423 file with the [office] unit for the date of service specified on the  
2424 detailed patient bill.

2425 Sec. 48. Section 19a-486 of the general statutes is repealed and the  
2426 following is substituted in lieu thereof (*Effective from passage*):

2427 For purposes of sections 19a-486 to 19a-486h, inclusive, as amended  
2428 by this act:

2429 (1) "Nonprofit hospital" means a nonprofit entity licensed as a  
2430 hospital pursuant to this chapter and any entity affiliated with such a  
2431 hospital through governance or membership, including, but not  
2432 limited to, a holding company or subsidiary.

2433 (2) "Purchaser" means a person acquiring any assets of a nonprofit  
2434 hospital through a transfer.

2435 (3) "Person" means any individual, firm, partnership, corporation,  
2436 limited liability company, association or other entity.

2437 (4) "Transfer" means to sell, transfer, lease, exchange, option,  
2438 convey, give or otherwise dispose of or transfer control over,  
2439 including, but not limited to, transfer by way of merger or joint  
2440 venture not in the ordinary course of business.

2441 (5) "Control" has the meaning assigned to it in section 36b-41.

2442 (6) ["Commissioner" means the Commissioner of Public Health or  
2443 the commissioner's designee.] "Executive director" means the executive  
2444 director of the Office of Health Strategy, established under section 19a-  
2445 754a, as amended by this act, or the executive director's designee.

2446 Sec. 49. Section 19a-486a of the general statutes is repealed and the  
2447 following is substituted in lieu thereof (*Effective from passage*):

2448 (a) No nonprofit hospital shall enter into an agreement to transfer a  
2449 material amount of its assets or operations or a change in control of  
2450 operations to a person that is organized or operated for profit without  
2451 first having received approval of the agreement by the [commissioner]  
2452 executive director and the Attorney General pursuant to sections 19a-  
2453 486 to 19a-486h, inclusive, as amended by this act, and pursuant to the  
2454 Attorney General's authority under section 3-125. Any such agreement  
2455 without the approval required by sections 19a-486 to 19a-486h,  
2456 inclusive, as amended by this act, shall be void.

2457 (b) Prior to any transaction described in subsection (a) of this

2458 section, the nonprofit hospital and the purchaser shall concurrently  
2459 submit a certificate of need determination letter as described in  
2460 subsection (c) of section 19a-638, as amended by this act, to the  
2461 [commissioner] executive director and the Attorney General by serving  
2462 it on them by certified mail, return receipt requested, or delivering it  
2463 by hand to each office. The certificate of need determination letter shall  
2464 contain: (1) The name and address of the nonprofit hospital; (2) the  
2465 name and address of the purchaser; (3) a brief description of the terms  
2466 of the proposed agreement; and (4) the estimated capital expenditure,  
2467 cost or value associated with the proposed agreement. The certificate  
2468 of need determination letter shall be subject to disclosure pursuant to  
2469 section 1-210.

2470 (c) Not later than thirty days after receipt of the certificate of need  
2471 determination letter by the [commissioner] executive director and the  
2472 Attorney General, the purchaser and the nonprofit hospital shall hold a  
2473 hearing on the contents of the certificate of need determination letter in  
2474 the municipality in which the new hospital is proposed to be located.  
2475 The nonprofit hospital shall provide not less than two weeks' advance  
2476 notice of the hearing to the public by publication in a newspaper  
2477 having a substantial circulation in the affected community for not less  
2478 than three consecutive days. Such notice shall contain substantially the  
2479 same information as in the certificate of need determination letter. The  
2480 purchaser and the nonprofit hospital shall record and transcribe the  
2481 hearing and make such recording or transcription available to the  
2482 [commissioner] executive director, the Attorney General or members  
2483 of the public upon request. A public hearing held in accordance with  
2484 the provisions of section 19a-639a, as amended by this act, shall satisfy  
2485 the requirements of this subsection.

2486 (d) The [commissioner] executive director and the Attorney General  
2487 shall review the certificate of need determination letter. The Attorney  
2488 General shall determine whether the agreement requires approval  
2489 pursuant to this chapter. If such approval is required, the  
2490 [commissioner] executive director and the Attorney General shall



2491 transmit to the purchaser and the nonprofit hospital an application  
2492 form for approval pursuant to this chapter, unless the [commissioner]  
2493 executive director refuses to accept a filed or submitted certificate of  
2494 need determination letter. Such application form shall require the  
2495 following information: (1) The name and address of the nonprofit  
2496 hospital; (2) the name and address of the purchaser; (3) a description of  
2497 the terms of the proposed agreement; (4) copies of all contracts,  
2498 agreements and memoranda of understanding relating to the proposed  
2499 agreement; (5) a fairness evaluation by an independent person who is  
2500 an expert in such agreements, that includes an analysis of each of the  
2501 criteria set forth in section 19a-486c; (6) documentation that the  
2502 nonprofit hospital exercised the due diligence required by subdivision  
2503 (2) of subsection (a) of section 19a-486c, including disclosure of the  
2504 terms of any other offers to transfer assets or operations or change  
2505 control of operations received by the nonprofit hospital and the reason  
2506 for rejection of such offers; and (7) such other information as the  
2507 [commissioner] executive director or the Attorney General deem  
2508 necessary to their review pursuant to the provisions of sections 19a-486  
2509 to 19a-486f, inclusive, as amended by this act, and chapter 368z. The  
2510 application shall be subject to disclosure pursuant to section 1-210.

2511 (e) No later than sixty days after the date of mailing of the  
2512 application form, the nonprofit hospital and the purchaser shall  
2513 concurrently file an application with the [commissioner] executive  
2514 director and the Attorney General containing all the required  
2515 information. The [commissioner] executive director and the Attorney  
2516 General shall review the application and determine whether the  
2517 application is complete. The [commissioner] executive director and the  
2518 Attorney General shall, no later than twenty days after the date of their  
2519 receipt of the application, provide written notice to the nonprofit  
2520 hospital and the purchaser of any deficiencies in the application. Such  
2521 application shall not be deemed complete until such deficiencies are  
2522 corrected.

2523 (f) No later than twenty-five days after the date of their receipt of

2524 the completed application under this section, the [commissioner]  
2525 executive director and the Attorney General shall jointly publish a  
2526 summary of such agreement in a newspaper of general circulation  
2527 where the nonprofit hospital is located.

2528 (g) Any person may seek to intervene in the proceedings under  
2529 section 19a-486e, as amended by this act, in the same manner as  
2530 provided in section 4-177a.

2531 Sec. 50. Section 19a-486b of the general statutes is repealed and the  
2532 following is substituted in lieu thereof (*Effective from passage*):

2533 (a) Not later than one hundred twenty days after the date of receipt  
2534 of the completed application pursuant to subsection (e) of section 19a-  
2535 486a, as amended by this act, the Attorney General and the  
2536 [commissioner] executive director shall approve the application, with  
2537 or without modification, or deny the application. The [commissioner]  
2538 executive director shall also determine, in accordance with the  
2539 provisions of chapter 368z, whether to approve, with or without  
2540 modification, or deny the application for a certificate of need that is  
2541 part of the completed application. Notwithstanding the provisions of  
2542 section 19a-639a, as amended by this act, the [commissioner] executive  
2543 director shall complete the decision on the application for a certificate  
2544 of need within the same time period as the completed application.  
2545 Such one-hundred-twenty-day period may be extended by (1)  
2546 agreement of the Attorney General, the [commissioner] executive  
2547 director, the nonprofit hospital and the purchaser, or (2) the  
2548 [commissioner] executive director for an additional one hundred  
2549 twenty days pending completion of a cost and market impact review  
2550 conducted pursuant to section 19a-639f, as amended by this act. If the  
2551 Attorney General initiates a proceeding to enforce a subpoena  
2552 pursuant to section 19a-486c or 19a-486d, as amended by this act, the  
2553 one-hundred-twenty-day period shall be tolled until the final court  
2554 decision on the last pending enforcement proceeding, including any  
2555 appeal or time for the filing of such appeal. Unless the one-hundred-  
2556 twenty-day period is extended pursuant to this section, if the

2557 [commissioner] executive director and Attorney General fail to take  
2558 action on an agreement prior to the one hundred twenty-first day after  
2559 the date of the filing of the completed application, the application shall  
2560 be deemed approved.

2561 (b) The [commissioner] executive director and the Attorney General  
2562 may place any conditions on the approval of an application that relate  
2563 to the purposes of sections 19a-486a to 19a-486h, inclusive, as amended  
2564 by this act. In placing any such conditions the [commissioner]  
2565 executive director shall follow the guidelines and criteria described in  
2566 subdivision (4) of subsection (d) of section 19a-639, as amended by this  
2567 act. Any such conditions may be in addition to any conditions placed  
2568 by the [commissioner] executive director pursuant to subdivision (4) of  
2569 subsection (d) of section 19a-639, as amended by this act.

2570 Sec. 51. Section 19a-486d of the general statutes is repealed and the  
2571 following is substituted in lieu thereof (*Effective from passage*):

2572 (a) The [commissioner] executive director shall deny an application  
2573 filed pursuant to subsection (d) of section 19a-486a, as amended by this  
2574 act, unless the [commissioner] executive director finds that: (1) In a  
2575 situation where the asset or operation to be transferred provides or has  
2576 provided health care services to the uninsured or underinsured, the  
2577 purchaser has made a commitment to provide health care to the  
2578 uninsured and the underinsured; (2) in a situation where health care  
2579 providers or insurers will be offered the opportunity to invest or own  
2580 an interest in the purchaser or an entity related to the purchaser  
2581 safeguard procedures are in place to avoid a conflict of interest in  
2582 patient referral; and (3) certificate of need authorization is justified in  
2583 accordance with chapter 368z. The [commissioner] executive director  
2584 may contract with any person, including, but not limited to, financial  
2585 or actuarial experts or consultants, or legal experts with the approval  
2586 of the Attorney General, to assist in reviewing the completed  
2587 application. The [commissioner] executive director shall submit any  
2588 bills for such contracts to the purchaser. Such bills shall not exceed one  
2589 hundred fifty thousand dollars. The purchaser shall pay such bills no

2590 later than thirty days after the date of receipt of such bills.

2591 (b) The [commissioner] executive director may, during the course of  
2592 a review required by this section: (1) Issue in writing and cause to be  
2593 served upon any person, by subpoena, a demand that such person  
2594 appear before the [commissioner] executive director and give  
2595 testimony or produce documents as to any matters relevant to the  
2596 scope of the review; and (2) issue written interrogatories, to be  
2597 answered under oath, as to any matters relevant to the scope of the  
2598 review and prescribing a return date that would allow a reasonable  
2599 time to respond. If any person fails to comply with the provisions of  
2600 this subsection, the [commissioner] executive director, through the  
2601 Attorney General, may apply to the superior court for the judicial  
2602 district of Hartford seeking enforcement of such subpoena. The  
2603 superior court may, upon notice to such person, issue and cause to be  
2604 served an order requiring compliance. Service of subpoenas ad  
2605 testificandum, subpoenas duces tecum, notices of deposition and  
2606 written interrogatories as provided in this subsection may be made by  
2607 personal service at the usual place of abode or by certified mail, return  
2608 receipt requested, addressed to the person to be served at such  
2609 person's principal place of business within or without this state or such  
2610 person's residence.

2611 Sec. 52. Section 19a-486e of the general statutes is repealed and the  
2612 following is substituted in lieu thereof (*Effective from passage*):

2613 Prior to making any decision to approve, with or without  
2614 modification, or deny any application filed pursuant to subsection (d)  
2615 of section 19a-486a, as amended by this act, the Attorney General and  
2616 the [commissioner] executive director shall jointly conduct one or more  
2617 public hearings, one of which shall be in the primary service area of  
2618 the nonprofit hospital. At least fourteen days before conducting the  
2619 public hearing, the Attorney General and the [commissioner] executive  
2620 director shall provide notice of the time and place of the hearing  
2621 through publication in one or more newspapers of general circulation  
2622 in the affected community.

2623 Sec. 53. Section 19a-486f of the general statutes is repealed and the  
2624 following is substituted in lieu thereof (*Effective from passage*):

2625 If the [commissioner] executive director or the Attorney General  
2626 denies an application filed pursuant to subsection (d) of section 19a-  
2627 486a, as amended by this act, or approves it with modification, the  
2628 nonprofit hospital or the purchaser may appeal such decision in the  
2629 same manner as provided in section 4-183, provided that nothing in  
2630 sections 19a-486 to 19a-486f, inclusive, as amended by this act, shall be  
2631 construed to apply the provisions of chapter 54 to the proceedings of  
2632 the Attorney General.

2633 Sec. 54. Section 19a-486g of the general statutes is repealed and the  
2634 following is substituted in lieu thereof (*Effective from passage*):

2635 The Commissioner of Public Health shall refuse to issue a license to,  
2636 or if issued shall suspend or revoke the license of, a hospital if the  
2637 commissioner finds, after a hearing and opportunity to be heard, that:

2638 (1) There was a transaction described in section 19a-486a, as  
2639 amended by this act, that occurred without the approval of the  
2640 [commissioner] executive director, if such approval was required by  
2641 sections 19a-486 to 19a-486h, inclusive, as amended by this act;

2642 (2) There was a transaction described in section 19a-486a, as  
2643 amended by this act, without the approval of the Attorney General, if  
2644 such approval was required by sections 19a-486 to 19a-486h, inclusive,  
2645 as amended by this act, and the Attorney General certifies to the  
2646 [Commissioner of Public Health] executive director that such  
2647 transaction involved a material amount of the nonprofit hospital's  
2648 assets or operations or a change in control of operations; or

2649 (3) The hospital is not complying with the terms of an agreement  
2650 approved by the Attorney General and [commissioner] executive  
2651 director pursuant to sections 19a-486 to 19a-486h, inclusive, as  
2652 amended by this act.

2653 Sec. 55. Section 19a-486h of the general statutes is repealed and the  
2654 following is substituted in lieu thereof (*Effective from passage*):

2655 Nothing in sections 19a-486 to 19a-486h, inclusive, as amended by  
2656 this act, shall be construed to limit: (1) The common law or statutory  
2657 authority of the Attorney General; (2) the statutory authority of the  
2658 Commissioner of Public Health including, but not limited to, licensing;  
2659 [and] (3) the statutory authority of the executive director of the Office  
2660 of Health Strategy, including, but not limited to, certificate of need  
2661 authority; or [(3)] (4) the application of the doctrine of cy pres or  
2662 approximation.

2663 Sec. 56. Subsections (d) to (i), inclusive, of section 19a-486i of the  
2664 2018 supplement to the general statutes are repealed and the following  
2665 is substituted in lieu thereof (*Effective from passage*):

2666 (d) (1) The written notice required under subsection (c) of this  
2667 section shall identify each party to the transaction and describe the  
2668 material change as of the date of such notice to the business or  
2669 corporate structure of the group practice, including: (A) A description  
2670 of the nature of the proposed relationship among the parties to the  
2671 proposed transaction; (B) the names and specialties of each physician  
2672 that is a member of the group practice that is the subject of the  
2673 proposed transaction and who will practice medicine with the  
2674 resulting group practice, hospital, hospital system, captive professional  
2675 entity, medical foundation or other entity organized by, controlled by,  
2676 or otherwise affiliated with such hospital or hospital system following  
2677 the effective date of the transaction; (C) the names of the business  
2678 entities that are to provide services following the effective date of the  
2679 transaction; (D) the address for each location where such services are  
2680 to be provided; (E) a description of the services to be provided at each  
2681 such location; and (F) the primary service area to be served by each  
2682 such location.

2683 (2) Not later than thirty days after the effective date of any  
2684 transaction described in subsection (c) of this section, the parties to the

2685 transaction shall submit written notice to the [Commissioner of Public  
2686 Health] executive director of the Office of Health Strategy. Such  
2687 written notice shall include, but need not be limited to, the same  
2688 information described in subdivision (1) of this subsection. The  
2689 [commissioner] executive director shall post a link to such notice on  
2690 the [Department of Public Health's] Office of Health Strategy's Internet  
2691 web site.

2692 (e) Not less than thirty days prior to the effective date of any  
2693 transaction that results in an affiliation between one hospital or  
2694 hospital system and another hospital or hospital system, the parties to  
2695 the affiliation shall submit written notice to the Attorney General of  
2696 such affiliation. Such written notice shall identify each party to the  
2697 affiliation and describe the affiliation as of the date of such notice,  
2698 including: (1) A description of the nature of the proposed relationship  
2699 among the parties to the affiliation; (2) the names of the business  
2700 entities that are to provide services following the effective date of the  
2701 affiliation; (3) the address for each location where such services are to  
2702 be provided; (4) a description of the services to be provided at each  
2703 such location; and (5) the primary service area to be served by each  
2704 such location.

2705 (f) Written information submitted to the Attorney General pursuant  
2706 to subsections (b) to (e), inclusive, of this section shall be maintained  
2707 and used by the Attorney General in the same manner as provided in  
2708 section 35-42.

2709 (g) Not later than January 15, 2018, and annually thereafter, each  
2710 hospital and hospital system shall file with the Attorney General and  
2711 the [Commissioner of Public Health] executive director of the Office of  
2712 Health Strategy a written report describing the activities of the group  
2713 practices owned or affiliated with such hospital or hospital system.  
2714 Such report shall include, for each such group practice: (1) A  
2715 description of the nature of the relationship between the hospital or  
2716 hospital system and the group practice; (2) the names and specialties of  
2717 each physician practicing medicine with the group practice; (3) the

2718 names of the business entities that provide services as part of the  
2719 group practice and the address for each location where such services  
2720 are provided; (4) a description of the services provided at each such  
2721 location; and (5) the primary service area served by each such location.

2722 (h) Not later than January 15, 2018, and annually thereafter, each  
2723 group practice comprised of thirty or more physicians that is not the  
2724 subject of a report filed under subsection (g) of this section shall file  
2725 with the Attorney General and the [Commissioner of Public Health]  
2726 executive director of the Office of Health Strategy a written report  
2727 concerning the group practice. Such report shall include, for each such  
2728 group practice: (1) The names and specialties of each physician  
2729 practicing medicine with the group practice; (2) the names of the  
2730 business entities that provide services as part of the group practice and  
2731 the address for each location where such services are provided; (3) a  
2732 description of the services provided at each such location; and (4) the  
2733 primary service area served by each such location.

2734 (i) Not later than January 15, 2018, and annually thereafter, each  
2735 hospital and hospital system shall file with the Attorney General and  
2736 the [Commissioner of Public Health] executive director of the Office of  
2737 Health Strategy a written report describing each affiliation with  
2738 another hospital or hospital system. Such report shall include: (1) The  
2739 name and address of each party to the affiliation; (2) a description of  
2740 the nature of the relationship among the parties to the affiliation; (3)  
2741 the names of the business entities that provide services as part of the  
2742 affiliation and the address for each location where such services are  
2743 provided; (4) a description of the services provided at each such  
2744 location; and (5) the primary service area served by each such location.

2745 Sec. 57. Subsections (j) to (m), inclusive, of section 19a-508c of the  
2746 2018 supplement to the general statutes are repealed and the following  
2747 is substituted in lieu thereof (*Effective from passage*):

2748 (j) A hospital-based facility shall, when scheduling services for  
2749 which a facility fee may be charged, inform the patient (1) that the



2750 hospital-based facility is part of a hospital or health system, (2) of the  
2751 name of the hospital or health system, (3) that the hospital or health  
2752 system may charge a facility fee in addition to and separate from the  
2753 professional fee charged by the provider, and (4) of the telephone  
2754 number the patient may call for additional information regarding such  
2755 patient's potential financial liability.

2756 (k) (1) On and after January 1, 2016, if any transaction, as described  
2757 in subsection (c) of section 19a-486i, as amended by this act, results in  
2758 the establishment of a hospital-based facility at which facility fees will  
2759 likely be billed, the hospital or health system, that is the purchaser in  
2760 such transaction shall, not later than thirty days after such transaction,  
2761 provide written notice, by first class mail, of the transaction to each  
2762 patient served within the previous three years by the health care  
2763 facility that has been purchased as part of such transaction.

2764 (2) Such notice shall include the following information:

2765 (A) A statement that the health care facility is now a hospital-based  
2766 facility and is part of a hospital or health system;

2767 (B) The name, business address and phone number of the hospital  
2768 or health system that is the purchaser of the health care facility;

2769 (C) A statement that the hospital-based facility bills, or is likely to  
2770 bill, patients a facility fee that may be in addition to, and separate  
2771 from, any professional fee billed by a health care provider at the  
2772 hospital-based facility;

2773 (D) (i) A statement that the patient's actual financial liability will  
2774 depend on the professional medical services actually provided to the  
2775 patient, and (ii) an explanation that the patient may incur financial  
2776 liability that is greater than the patient would incur if the hospital-  
2777 based facility were not a hospital-based facility;

2778 (E) The estimated amount or range of amounts the hospital-based  
2779 facility may bill for a facility fee or an example of the average facility

2780 fee billed at such hospital-based facility for the most common services  
2781 provided at such hospital-based facility; and

2782 (F) A statement that, prior to seeking services at such hospital-based  
2783 facility, a patient covered by a health insurance policy should contact  
2784 the patient's health insurer for additional information regarding the  
2785 hospital-based facility fees, including the patient's potential financial  
2786 liability, if any, for such fees.

2787 (3) A copy of the written notice provided to patients in accordance  
2788 with this subsection shall be filed with the [Office of Health Care  
2789 Access] Health Systems Planning Unit of the Office of Health Strategy,  
2790 established under section 19a-612, as amended by this act. Said [office]  
2791 unit shall post a link to such notice on its Internet web site.

2792 (4) A hospital, health system or hospital-based facility shall not  
2793 collect a facility fee for services provided at a hospital-based facility  
2794 that is subject to the provisions of this subsection from the date of the  
2795 transaction until at least thirty days after the written notice required  
2796 pursuant to this subsection is mailed to the patient or a copy of such  
2797 notice is filed with the [Office of Health Care Access] Health Systems  
2798 Planning Unit, whichever is later. A violation of this subsection shall  
2799 be considered an unfair trade practice pursuant to section 42-110b.

2800 (l) Notwithstanding the provisions of this section, on and after  
2801 January 1, 2017, no hospital, health system or hospital-based facility  
2802 shall collect a facility fee for (1) outpatient health care services that use  
2803 a current procedural terminology evaluation and management code  
2804 and are provided at a hospital-based facility, other than a hospital  
2805 emergency department, located off-site from a hospital campus, or (2)  
2806 outpatient health care services, other than those provided in an  
2807 emergency department located off-site from a hospital campus,  
2808 received by a patient who is uninsured of more than the Medicare rate.  
2809 Notwithstanding the provisions of this subsection, in circumstances  
2810 when an insurance contract that is in effect on July 1, 2016, provides  
2811 reimbursement for facility fees prohibited under the provisions of this

2812 section, a hospital or health system may continue to collect  
2813 reimbursement from the health insurer for such facility fees until the  
2814 date of expiration of such contract. A violation of this subsection shall  
2815 be considered an unfair trade practice pursuant to chapter 735a.

2816 (m) (1) Each hospital and health system shall report not later than  
2817 July 1, 2016, and annually thereafter to the [Commissioner of Public  
2818 Health] executive director of the Office of Health Strategy concerning  
2819 facility fees charged or billed during the preceding calendar year. Such  
2820 report shall include (A) the name and location of each facility owned  
2821 or operated by the hospital or health system that provides services for  
2822 which a facility fee is charged or billed, (B) the number of patient visits  
2823 at each such facility for which a facility fee was charged or billed, (C)  
2824 the number, total amount and range of allowable facility fees paid at  
2825 each such facility by Medicare, Medicaid or under private insurance  
2826 policies, (D) for each facility, the total amount of revenue received by  
2827 the hospital or health system derived from facility fees, (E) the total  
2828 amount of revenue received by the hospital or health system from all  
2829 facilities derived from facility fees, (F) a description of the ten  
2830 procedures or services that generated the greatest amount of facility  
2831 fee revenue and, for each such procedure or service, the total amount  
2832 of revenue received by the hospital or health system derived from  
2833 facility fees, and (G) the top ten procedures for which facility fees are  
2834 charged based on patient volume. For purposes of this subsection,  
2835 "facility" means a hospital-based facility that is located outside a  
2836 hospital campus.

2837 (2) The [commissioner] executive director shall publish the  
2838 information reported pursuant to subdivision (1) of this subsection, or  
2839 post a link to such information, on the Internet web site of the Office of  
2840 Health [Care Access] Strategy.

2841 Sec. 58. Subsections (c) to (f), inclusive, of section 19a-509b of the  
2842 general statutes are repealed and the following is substituted in lieu  
2843 thereof (*Effective from passage*):

2844 (c) Each hospital that holds or administers one or more hospital bed  
2845 funds shall make available in a place and manner allowing individual  
2846 members of the public to easily obtain it, a one-page summary in  
2847 English and Spanish describing hospital bed funds and how to apply  
2848 for them. The summary shall also describe any other policies regarding  
2849 the provision of charity care and reduced cost services for the indigent  
2850 as reported by the hospital to the [Office of Health Care Access  
2851 division of the Department of Public Health] Health Systems Planning  
2852 Unit of the Office of Health Strategy pursuant to section 19a-649, as  
2853 amended by this act, and shall clearly distinguish hospital bed funds  
2854 from other sources of financial assistance. The summary shall include  
2855 notification that the patient is entitled to reapply upon rejection, and  
2856 that additional funds may become available on an annual basis. The  
2857 summary shall be available in the patient admissions office, emergency  
2858 room, social services department and patient accounts or billing office,  
2859 and from any collection agent. If during the admission process or  
2860 during its review of the financial resources of the patient, the hospital  
2861 reasonably believes the patient will have limited funds to pay for any  
2862 portion of the patient's hospitalization not covered by insurance, the  
2863 hospital shall provide the summary to each such patient.

2864 (d) Each hospital which holds or administers one or more hospital  
2865 bed funds shall require its collection agents to include a summary as  
2866 provided in subsection (c) of this section in all bills and collection  
2867 notices sent by such collection agents.

2868 (e) Applicants for assistance from hospital bed funds shall be  
2869 notified in writing of any award or any rejection and the reason for  
2870 such rejection. Patients who cannot pay any outstanding medical bill at  
2871 the hospital shall be allowed to apply or reapply for hospital bed  
2872 funds.

2873 (f) Each hospital which holds or administers one or more hospital  
2874 bed funds shall maintain and annually compile, at the end of the fiscal  
2875 year of the hospital, the following information: (1) The number of  
2876 applications for hospital bed funds; (2) the number of patients

2877 receiving hospital bed fund grants and the actual dollar amounts  
2878 provided to each patient from such fund; (3) the fair market value of  
2879 the principal of each individual hospital bed fund, or the principal  
2880 attributable to each bed fund if held in a pooled investment; (4) the  
2881 total earnings for each hospital bed fund or the earnings attributable to  
2882 each hospital bed fund; (5) the dollar amount of earnings reinvested as  
2883 principal if any; and (6) the dollar amount of earnings available for  
2884 patient care. The information compiled pursuant to this subsection  
2885 shall be permanently retained by the hospital and made available to  
2886 the [Office of Health Care Access] Health Systems Planning Unit upon  
2887 request.

2888 Sec. 59. Subsections (e) to (g), inclusive, of section 33-182bb of the  
2889 general statutes are repealed and the following is substituted in lieu  
2890 thereof (*Effective from passage*):

2891 (e) Any medical foundation organized on or after July 1, 2009, shall  
2892 file a copy of its certificate of incorporation and any amendments to its  
2893 certificate of incorporation with the [Office of Health Care Access  
2894 division of the Department of Public Health] Health Systems Planning  
2895 Unit of the Office of Health Strategy not later than ten business days  
2896 after the medical foundation files such certificate of incorporation or  
2897 amendment with the Secretary of the State pursuant to chapter 602.

2898 (f) Any medical group clinic corporation formed under chapter 594  
2899 of the general statutes, revision of 1958, revised to 1995, which amends  
2900 its certificate of incorporation pursuant to subsection (a) of section 33-  
2901 182cc, shall file with the [Office of Health Care Access division of the  
2902 Department of Public Health] Health Systems Planning Unit of the  
2903 Office of Health Strategy a copy of its certificate of incorporation and  
2904 any amendments to its certificate of incorporation, including any  
2905 amendment to its certificate of incorporation that complies with the  
2906 requirements of subsection (a) of section 33-182cc, not later than ten  
2907 business days after the medical foundation files its certificate of  
2908 incorporation or any amendments to its certificate of incorporation  
2909 with the Secretary of the State.

2910 (g) Any medical foundation, regardless of when organized, shall file  
2911 notice with the [Office of Health Care Access division of the  
2912 Department of Public Health] Health Systems Planning Unit of the  
2913 Office of Health Strategy and the Secretary of the State of its  
2914 liquidation, termination, dissolution or cessation of operations not later  
2915 than ten business days after a vote by its board of directors or  
2916 members to take such action. A medical foundation shall, annually,  
2917 provide the office with (1) a statement of its mission, (2) the name and  
2918 address of the organizing members, (3) the name and specialty of each  
2919 physician employed by or acting as an agent of the medical  
2920 foundation, (4) the location or locations where each such physician  
2921 practices, (5) a description of the services provided at each such  
2922 location, (6) a description of any significant change in its services  
2923 during the preceding year, (7) a copy of the medical foundation's  
2924 governing documents and bylaws, (8) the name and employer of each  
2925 member of the board of directors, and (9) other financial information  
2926 as reported on the medical foundation's most recently filed Internal  
2927 Revenue Service return of organization exempt from income tax form,  
2928 or any replacement form adopted by the Internal Revenue Service, or,  
2929 if such medical foundation is not required to file such form,  
2930 information substantially similar to that required by such form. The  
2931 [Office of Health Care Access] Health Systems Planning Unit shall  
2932 make such forms and information available to members of the public  
2933 and accessible on said [office's] unit's Internet web site.

2934 Sec. 60. Subsections (b) and (c) of section 19a-493b of the general  
2935 statutes are repealed and the following is substituted in lieu thereof  
2936 (*Effective from passage*):

2937 (b) No entity, individual, firm, partnership, corporation, limited  
2938 liability company or association, other than a hospital, shall  
2939 individually or jointly establish or operate an outpatient surgical  
2940 facility in this state without complying with chapter 368z, except as  
2941 otherwise provided by this section, and obtaining a license within the  
2942 time specified in this subsection from the Department of Public Health

2943 for such facility pursuant to the provisions of this chapter, unless such  
2944 entity, individual, firm, partnership, corporation, limited liability  
2945 company or association: (1) Provides to the [Office of Health Care  
2946 Access division of the Department of Public Health] Health Systems  
2947 Planning Unit of the Office of Health Strategy satisfactory evidence  
2948 that it was in operation on or before July 1, 2003, or (2) obtained, on or  
2949 before July 1, 2003, from the Office of Health Care Access, a  
2950 determination that a certificate of need is not required. An entity,  
2951 individual, firm, partnership, corporation, limited liability company or  
2952 association otherwise in compliance with this section may operate an  
2953 outpatient surgical facility without a license through March 30, 2007,  
2954 and shall have until March 30, 2007, to obtain a license from the  
2955 Department of Public Health.

2956 (c) Notwithstanding the provisions of this section, no outpatient  
2957 surgical facility shall be required to comply with section 19a-631, as  
2958 amended by this act, 19a-632, as amended by this act, 19a-644, as  
2959 amended by this act, 19a-645, as amended by this act, 19a-646, as  
2960 amended by this act, 19a-649, as amended by this act, 19a-664 to 19a-  
2961 666, inclusive, 19a-673 to 19a-676, inclusive, as amended by this act,  
2962 19a-678, 19a-681, as amended by this act, or 19a-683. Each outpatient  
2963 surgical facility shall continue to be subject to the obligations and  
2964 requirements applicable to such facility, including, but not limited to,  
2965 any applicable provision of this chapter and those provisions of  
2966 chapter 368z not specified in this subsection, except that a request for  
2967 permission to undertake a transfer or change of ownership or control  
2968 shall not be required pursuant to subsection (a) of section 19a-638, as  
2969 amended by this act, if the [Office of Health Care Access division of the  
2970 Department of Public Health] Health Systems Planning Unit of the  
2971 Office of Health Strategy determines that the following conditions are  
2972 satisfied: (1) Prior to any such transfer or change of ownership or  
2973 control, the outpatient surgical facility shall be owned and controlled  
2974 exclusively by persons licensed pursuant to section 20-13 or chapter  
2975 375, either directly or through a limited liability company, formed  
2976 pursuant to chapter 613, a corporation, formed pursuant to chapters

2977 601 and 602, or a limited liability partnership, formed pursuant to  
2978 chapter 614, that is exclusively owned by persons licensed pursuant to  
2979 section 20-13 or chapter 375, or is under the interim control of an estate  
2980 executor or conservator pending transfer of an ownership interest or  
2981 control to a person licensed under section 20-13 or chapter 375, and (2)  
2982 after any such transfer or change of ownership or control, persons  
2983 licensed pursuant to section 20-13 or chapter 375, a limited liability  
2984 company, formed pursuant to chapter 613, a corporation, formed  
2985 pursuant to chapters 601 and 602, or a limited liability partnership,  
2986 formed pursuant to chapter 614, that is exclusively owned by persons  
2987 licensed pursuant to section 20-13 or chapter 375, shall own and  
2988 control no less than a sixty per cent interest in the outpatient surgical  
2989 facility.

2990 Sec. 61. Section 19a-6q of the general statutes is repealed and the  
2991 following is substituted in lieu thereof (*Effective from passage*):

2992 (a) The Commissioner of Public Health, in consultation with the  
2993 [Lieutenant Governor, or the Lieutenant Governor's designee,]  
2994 executive director of the Office of Health Strategy, established under  
2995 section 19a-754a, as amended by this act, and local and regional health  
2996 departments, shall, within available resources, develop a plan that is  
2997 consistent with the Department of Public Health's Healthy Connecticut  
2998 2020 health improvement plan and the state healthcare innovation  
2999 plan developed pursuant to the State Innovation Model Initiative by  
3000 the Centers for Medicare and Medicaid Services Innovation Center.  
3001 The commissioner shall develop and implement such plan to: (1)  
3002 Reduce the incidence of chronic disease, including, but not limited to,  
3003 chronic cardiovascular disease, cancer, lupus, stroke, chronic lung  
3004 disease, diabetes, arthritis or another chronic metabolic disease and the  
3005 effects of behavioral health disorders; (2) improve chronic disease care  
3006 coordination in the state; and (3) reduce the incidence and effects of  
3007 chronic disease and improve outcomes for conditions associated with  
3008 chronic disease in the state.

3009 (b) The commissioner shall, on or before January 15, 2015, and



3010 biennially thereafter, submit a report, in consultation with the  
3011 [Lieutenant Governor or the Lieutenant Governor's designee]  
3012 executive director of the Office of Health Strategy, in accordance with  
3013 the provisions of section 11-4a to the joint standing committee of the  
3014 General Assembly having cognizance of matters relating to public  
3015 health concerning chronic disease and implementation of the plan  
3016 described in subsection (a) of this section. The commissioner shall post  
3017 each report on the Department of Public Health's Internet web site not  
3018 later than thirty days after submitting such report. Each report shall  
3019 include, but need not be limited to: (1) A description of the chronic  
3020 diseases that are most likely to cause a person's death or disability, the  
3021 approximate number of persons affected by such chronic diseases and  
3022 an assessment of the financial effects of each such disease on the state  
3023 and on hospitals and health care facilities; (2) a description and  
3024 assessment of programs and actions that have been implemented by  
3025 the department and health care providers to improve chronic disease  
3026 care coordination and prevent chronic disease; (3) the sources and  
3027 amounts of funding received by the department to treat persons with  
3028 multiple chronic diseases and to treat or reduce the most prevalent  
3029 chronic diseases in the state; (4) a description of chronic disease care  
3030 coordination between the department and health care providers, to  
3031 prevent and treat chronic disease; and (5) recommendations  
3032 concerning actions that health care providers and persons with chronic  
3033 disease may take to reduce the incidence and effects of chronic disease.

3034 Sec. 62. Section 19a-725 of the 2018 supplement to the general  
3035 statutes is repealed and the following is substituted in lieu thereof  
3036 (*Effective July 1, 2018*):

3037 (a) There is established within the [office of the Lieutenant  
3038 Governor] Office of Health Strategy, established under section 19a-  
3039 754a, as amended by this act, the Health Care Cabinet for the purpose  
3040 of advising the Governor on the matters set forth in subsection (c) of  
3041 this section.

3042 (b) (1) The Health Care Cabinet shall consist of the following

3043 members who shall be appointed on or before August 1, 2011: (A) Five  
3044 appointed by the Governor, two of whom may represent the health  
3045 care industry and shall serve for terms of four years, one of whom  
3046 shall represent community health centers and shall serve for a term of  
3047 three years, one of whom shall represent insurance producers and  
3048 shall serve for a term of three years and one of whom shall be an at-  
3049 large appointment and shall serve for a term of three years; (B) one  
3050 appointed by the president pro tempore of the Senate, who shall be an  
3051 oral health specialist engaged in active practice and shall serve for a  
3052 term of four years; (C) one appointed by the majority leader of the  
3053 Senate, who shall represent labor and shall serve for a term of three  
3054 years; (D) one appointed by the minority leader of the Senate, who  
3055 shall be an advanced practice registered nurse engaged in active  
3056 practice and shall serve for a term of two years; (E) one appointed by  
3057 the speaker of the House of Representatives, who shall be a consumer  
3058 advocate and shall serve for a term of four years; (F) one appointed by  
3059 the majority leader of the House of Representatives, who shall be a  
3060 primary care physician engaged in active practice and shall serve for a  
3061 term of four years; (G) one appointed by the minority leader of the  
3062 House of Representatives, who shall represent the health information  
3063 technology industry and shall serve for a term of three years; (H) five  
3064 appointed jointly by the chairpersons of the SustiNet Health  
3065 Partnership board of directors, one of whom shall represent faith  
3066 communities, one of whom shall represent small businesses, one of  
3067 whom shall represent the home health care industry, one of whom  
3068 shall represent hospitals, and one of whom shall be an at-large  
3069 appointment, all of whom shall serve for terms of five years; (I) the  
3070 [Lieutenant Governor] executive director of the Office of Health  
3071 Strategy, or the executive director's designee; (J) the Secretary of the  
3072 Office of Policy and Management, or the secretary's designee; the  
3073 Comptroller, or the Comptroller's designee; the chief executive officer  
3074 of the Connecticut Health Insurance Exchange, or said officer's  
3075 designee; the Commissioners of Social Services and Public Health, or  
3076 their designees; and the Healthcare Advocate, or the Healthcare  
3077 Advocate's designee, all of whom shall serve as ex-officio voting

3078 members; and (K) the Commissioners of Children and Families,  
3079 Developmental Services and Mental Health and Addiction Services,  
3080 and the Insurance Commissioner, or their designees, and the nonprofit  
3081 liaison to the Governor, or the nonprofit liaison's designee, all of whom  
3082 shall serve as ex-officio nonvoting members.

3083 (2) Following the expiration of initial cabinet member terms,  
3084 subsequent cabinet terms shall be for four years, commencing on  
3085 August first of the year of the appointment. If an appointing authority  
3086 fails to make an initial appointment to the cabinet or an appointment  
3087 to fill a cabinet vacancy within ninety days of the date of such vacancy,  
3088 the appointed cabinet members shall, by majority vote, make such  
3089 appointment to the cabinet.

3090 (3) Upon the expiration of the initial terms of the five cabinet  
3091 members appointed by SustiNet Health Partnership board of directors,  
3092 five successor cabinet members shall be appointed as follows: (A) One  
3093 appointed by the Governor; (B) one appointed by the president pro  
3094 tempore of the Senate; (C) one appointed by the speaker of the House  
3095 of Representatives; and (D) two appointed by majority vote of the  
3096 appointed board members. Successor board members appointed  
3097 pursuant to this subdivision shall be at-large appointments.

3098 (4) The [Lieutenant Governor] executive director of the Office of  
3099 Health Strategy, or the executive director's designee, shall serve as the  
3100 chairperson of the Health Care Cabinet.

3101 (c) The Health Care Cabinet shall advise the Governor regarding the  
3102 development of an integrated health care system for Connecticut and  
3103 shall:

3104 (1) Evaluate the means of ensuring an adequate health care  
3105 workforce in the state;

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

3109 1331 of the Affordable Care Act;

3110 (3) Identify short and long-range opportunities, issues and gaps  
3111 created by the enactment of federal health care reform;

3112 (4) Review the effectiveness of delivery system reforms and other  
3113 efforts to control health care costs, including, but not limited to,  
3114 reforms and efforts implemented by state agencies; and

3115 (5) Advise the Governor on matters relating to: (A) The design,  
3116 implementation, actionable objectives and evaluation of state and  
3117 federal health care policies, priorities and objectives relating to the  
3118 state's efforts to improve access to health care, (B) the quality of such  
3119 care and the affordability and sustainability of the state's health care  
3120 system, and (C) total state-wide health care spending, including  
3121 methods to collect, analyze and report health care spending data.

3122 (d) The Health Care Cabinet may convene working groups, which  
3123 include volunteer health care experts, to make recommendations  
3124 concerning the development and implementation of service delivery  
3125 and health care provider payment reforms, including multipayer  
3126 initiatives, medical homes, electronic health records and evidenced-  
3127 based health care quality improvement.

3128 (e) The [office of the Lieutenant Governor and the Office of the  
3129 Healthcare Advocate] Office of Health Strategy shall provide support  
3130 staff to the Health Care Cabinet.

3131 Sec. 63. Section 20-195sss of the 2018 supplement to the general  
3132 statutes is repealed and the following is substituted in lieu thereof  
3133 (*Effective from passage*):

3134 (a) As used in this section, "community health worker" means a  
3135 public health outreach professional with an in-depth understanding of  
3136 the experience, language, culture and socioeconomic needs of the  
3137 community who (1) serves as a liaison between individuals within the  
3138 community and health care and social services providers to facilitate

3139 access to such services and health-related resources, improve the  
3140 quality and cultural competence of the delivery of such services and  
3141 address social determinants of health with a goal toward reducing  
3142 racial, ethnic, gender and socioeconomic health disparities, and (2)  
3143 increases health knowledge and self-sufficiency through a range of  
3144 services including outreach, engagement, education, coaching,  
3145 informal counseling, social support, advocacy, care coordination,  
3146 research related to social determinants of health and basic screenings  
3147 and assessments of any risks associated with social determinants of  
3148 health.

3149 (b) The executive director of the [state innovation model initiative  
3150 program management office] Office of Health Strategy, established  
3151 under section 19a-754a, as amended by this act, shall, within available  
3152 resources and in consultation with the Community Health Worker  
3153 Advisory Committee established by [such] said office and the  
3154 Commissioner of Public Health, study the feasibility of creating a  
3155 certification program for community health workers. Such study shall  
3156 examine the fiscal impact of implementing such a certification program  
3157 and include recommendations for (1) requirements for certification  
3158 and renewal of certification of community health workers, including  
3159 any training, experience or continuing education requirements, (2)  
3160 methods for administering a certification program, including a  
3161 certification application, a standardized assessment of experience,  
3162 knowledge and skills, and an electronic registry, and (3) requirements  
3163 for recognizing training program curricula that are sufficient to satisfy  
3164 the requirements of certification.

3165 (c) Not later than October 1, 2018, the executive director of the [state  
3166 innovation model initiative program management office] Office of  
3167 Health Strategy shall report, in accordance with the provisions of  
3168 section 11-4a, on the results of such study and recommendations to the  
3169 joint standing committees of the General Assembly having cognizance  
3170 of matters relating to public health and human services.

3171 Sec. 64. Section 38a-47 of the 2018 supplement to the general statutes

3172 is repealed and the following is substituted in lieu thereof (*Effective*  
3173 *from passage*):

3174 (a) All domestic insurance companies and other domestic entities  
3175 subject to taxation under chapter 207 shall, in accordance with section  
3176 38a-48, as amended by this act, annually pay to the Insurance  
3177 Commissioner, for deposit in the Insurance Fund established under  
3178 section 38a-52a, an amount equal to: [the]

3179 (1) The actual expenditures made by the Insurance Department  
3180 during each fiscal year, and the actual expenditures made by the Office  
3181 of the Healthcare Advocate, including the cost of fringe benefits for  
3182 department and office personnel as estimated by the Comptroller; [,  
3183 plus (1) the]

3184 (2) The amount appropriated to the Office of Health Strategy from  
3185 the Insurance Fund for the fiscal year, including the cost of fringe  
3186 benefits for office personnel as estimated by the Comptroller;

3187 (3) The expenditures made on behalf of the department and [the  
3188 office] said offices from the Capital Equipment Purchase Fund  
3189 pursuant to section 4a-9 for such year, [and (2) the] but excluding such  
3190 estimated expenditures made on behalf of the Health Systems  
3191 Planning Unit of the Office of Health Strategy; and

3192 (4) The amount appropriated to the Department of Social Services  
3193 for the fall prevention program established in section 17a-303a from  
3194 the Insurance Fund for the fiscal year. [, but excluding]

3195 (b) The expenditures and amounts specified in subdivisions (1) to  
3196 (4), inclusive, of subsection (a) of this section shall exclude  
3197 expenditures paid for by fraternal benefit societies, foreign and alien  
3198 insurance companies and other foreign and alien entities under  
3199 sections 38a-49 and 38a-50.

3200 (c) Payments shall be made by assessment of all such domestic  
3201 insurance companies and other domestic entities calculated and

3202 collected in accordance with the provisions of section 38a-48, as  
3203 amended by this act. Any such domestic insurance company or other  
3204 domestic entity aggrieved because of any assessment levied under this  
3205 section may appeal therefrom in accordance with the provisions of  
3206 section 38a-52.

3207 Sec. 65. Section 38a-48 of the 2018 supplement to the general statutes  
3208 is repealed and the following is substituted in lieu thereof (*Effective*  
3209 *from passage*):

3210 (a) On or before June thirtieth, annually, the Commissioner of  
3211 Revenue Services shall render to the Insurance Commissioner a  
3212 statement certifying the amount of taxes or charges imposed on each  
3213 domestic insurance company or other domestic entity under chapter  
3214 207 on business done in this state during the preceding calendar year.  
3215 The statement for local domestic insurance companies shall set forth  
3216 the amount of taxes and charges before any tax credits allowed as  
3217 provided in subsection (a) of section 12-202.

3218 (b) On or before July thirty-first, annually, the Insurance  
3219 Commissioner and the Office of the Healthcare Advocate shall render  
3220 to each domestic insurance company or other domestic entity liable for  
3221 payment under section 38a-47, as amended by this act: (1) A statement  
3222 that includes (A) the amount appropriated to the Insurance  
3223 Department, [and] the Office of the Healthcare Advocate and the  
3224 Office of Health Strategy from the Insurance Fund established under  
3225 section 38a-52a for the fiscal year beginning July first of the same year,  
3226 (B) the cost of fringe benefits for department and office personnel for  
3227 such year, as estimated by the Comptroller, (C) the estimated  
3228 expenditures on behalf of the department and the [office] offices from  
3229 the Capital Equipment Purchase Fund pursuant to section 4a-9 for  
3230 such year, not including such estimated expenditures made on behalf  
3231 of the Health Systems Planning Unit of the Office of Health Strategy,  
3232 and (D) the amount appropriated to the Department of Social Services  
3233 for the fall prevention program established in section 17a-303a from  
3234 the Insurance Fund for the fiscal year; (2) a statement of the total taxes

3235 imposed on all domestic insurance companies and domestic insurance  
3236 entities under chapter 207 on business done in this state during the  
3237 preceding calendar year; and (3) the proposed assessment against that  
3238 company or entity, calculated in accordance with the provisions of  
3239 subsection (c) of this section, provided for the purposes of this  
3240 calculation the amount appropriated to the Insurance Department,  
3241 [and] the Office of the Healthcare Advocate and the Office of Health  
3242 Strategy from the Insurance Fund plus the cost of fringe benefits for  
3243 department and office personnel and the estimated expenditures on  
3244 behalf of the department and the office from the Capital Equipment  
3245 Purchase Fund pursuant to section 4a-9, not including such  
3246 expenditures made on behalf of the Health Systems Planning Unit of  
3247 the Office of Health Strategy shall be deemed to be the actual  
3248 expenditures of the department and the office, and the amount  
3249 appropriated to the Department of Social Services from the Insurance  
3250 Fund for the fiscal year for the fall prevention program established in  
3251 section 17a-303a shall be deemed to be the actual expenditures for the  
3252 program.

3253 (c) (1) The proposed assessments for each domestic insurance  
3254 company or other domestic entity shall be calculated by (A) allocating  
3255 twenty per cent of the amount to be paid under section 38a-47, as  
3256 amended by this act, among the domestic entities organized under  
3257 sections 38a-199 to 38a-209, inclusive, and 38a-214 to 38a-225, inclusive,  
3258 in proportion to their respective shares of the total taxes and charges  
3259 imposed under chapter 207 on such entities on business done in this  
3260 state during the preceding calendar year, and (B) allocating eighty per  
3261 cent of the amount to be paid under section 38a-47, as amended by this  
3262 act, among all domestic insurance companies and domestic entities  
3263 other than those organized under sections 38a-199 to 38a-209,  
3264 inclusive, and 38a-214 to 38a-225, inclusive, in proportion to their  
3265 respective shares of the total taxes and charges imposed under chapter  
3266 207 on such domestic insurance companies and domestic entities on  
3267 business done in this state during the preceding calendar year,  
3268 provided if there are no domestic entities organized under sections



3269 38a-199 to 38a-209, inclusive, and 38a-214 to 38a-225, inclusive, at the  
3270 time of assessment, one hundred per cent of the amount to be paid  
3271 under section 38a-47, as amended by this act, shall be allocated among  
3272 such domestic insurance companies and domestic entities.

3273 (2) When the amount any such company or entity is assessed  
3274 pursuant to this section exceeds twenty-five per cent of the actual  
3275 expenditures of the Insurance Department, [and] the Office of the  
3276 Healthcare Advocate and the Office of Health Strategy from the  
3277 Insurance Fund, such excess amount shall not be paid by such  
3278 company or entity but rather shall be assessed against and paid by all  
3279 other such companies and entities in proportion to their respective  
3280 shares of the total taxes and charges imposed under chapter 207 on  
3281 business done in this state during the preceding calendar year, except  
3282 that for purposes of any assessment made to fund payments to the  
3283 Department of Public Health to purchase vaccines, such company or  
3284 entity shall be responsible for its share of the costs, notwithstanding  
3285 whether its assessment exceeds twenty-five per cent of the actual  
3286 expenditures of the Insurance Department, [and] the Office of the  
3287 Healthcare Advocate and the Office of Health Strategy from the  
3288 Insurance Fund. The provisions of this subdivision shall not be  
3289 applicable to any corporation which has converted to a domestic  
3290 mutual insurance company pursuant to section 38a-155 upon the  
3291 effective date of any public act which amends said section to modify or  
3292 remove any restriction on the business such a company may engage in,  
3293 for purposes of any assessment due from such company on and after  
3294 such effective date.

3295 (d) For purposes of calculating the amount of payment under  
3296 section 38a-47, as amended by this act, as well as the amount of the  
3297 assessments under this section, the "total taxes imposed on all  
3298 domestic insurance companies and other domestic entities under  
3299 chapter 207" shall be based upon the amounts shown as payable to the  
3300 state for the calendar year on the returns filed with the Commissioner  
3301 of Revenue Services pursuant to chapter 207; with respect to

3302 calculating the amount of payment and assessment for local domestic  
3303 insurance companies, the amount used shall be the taxes and charges  
3304 imposed before any tax credits allowed as provided in subsection (a) of  
3305 section 12-202.

3306 (e) On or before September thirtieth, annually, for each fiscal year  
3307 ending prior to July 1, 1990, the Insurance Commissioner and the  
3308 Healthcare Advocate, after receiving any objections to the proposed  
3309 assessments and making such adjustments as in their opinion may be  
3310 indicated, shall assess each such domestic insurance company or other  
3311 domestic entity an amount equal to its proposed assessment as so  
3312 adjusted. Each domestic insurance company or other domestic entity  
3313 shall pay to the Insurance Commissioner on or before October thirty-  
3314 first an amount equal to fifty per cent of its assessment adjusted to  
3315 reflect any credit or amount due from the preceding fiscal year as  
3316 determined by the commissioner under subsection (g) of this section.  
3317 Each domestic insurance company or other domestic entity shall pay  
3318 to the Insurance Commissioner on or before the following April  
3319 thirtieth, the remaining fifty per cent of its assessment.

3320 (f) On or before September first, annually, for each fiscal year  
3321 ending after July 1, 1990, the Insurance Commissioner and the  
3322 Healthcare Advocate, after receiving any objections to the proposed  
3323 assessments and making such adjustments as in their opinion may be  
3324 indicated, shall assess each such domestic insurance company or other  
3325 domestic entity an amount equal to its proposed assessment as so  
3326 adjusted. Each domestic insurance company or other domestic entity  
3327 shall pay to the Insurance Commissioner (1) on or before June 30, 1990,  
3328 and on or before June thirtieth annually thereafter, an estimated  
3329 payment against its assessment for the following year equal to twenty-  
3330 five per cent of its assessment for the fiscal year ending such June  
3331 thirtieth, (2) on or before September thirtieth, annually, twenty-five per  
3332 cent of its assessment adjusted to reflect any credit or amount due  
3333 from the preceding fiscal year as determined by the commissioner  
3334 under subsection (g) of this section, and (3) on or before the following

3335 December thirty-first and March thirty-first, annually, each domestic  
3336 insurance company or other domestic entity shall pay to the Insurance  
3337 Commissioner the remaining fifty per cent of its proposed assessment  
3338 to the department in two equal installments.

3339 (g) If the actual expenditures for the fall prevention program  
3340 established in section 17a-303a are less than the amount allocated, the  
3341 Commissioner of Social Services shall notify the Insurance  
3342 Commissioner and the Healthcare Advocate. Immediately following  
3343 the close of the fiscal year, the Insurance Commissioner and the  
3344 Healthcare Advocate shall recalculate the proposed assessment for  
3345 each domestic insurance company or other domestic entity in  
3346 accordance with subsection (c) of this section using the actual  
3347 expenditures made during the fiscal year by the Insurance  
3348 Department, [and] the Office of the Healthcare Advocate [during that  
3349 fiscal year] and the Office of Health Strategy from the Insurance Fund,  
3350 the actual expenditures made on behalf of the department and the  
3351 [office] offices from the Capital Equipment Purchase Fund pursuant to  
3352 section 4a-9, not including such expenditures made on behalf of the  
3353 Health Systems Planning Unit of the Office of Health Strategy, and the  
3354 actual expenditures for the fall prevention program. On or before July  
3355 thirty-first, the Insurance Commissioner and the Healthcare Advocate  
3356 shall render to each such domestic insurance company and other  
3357 domestic entity a statement showing the difference between their  
3358 respective recalculated assessments and the amount they have  
3359 previously paid. On or before August thirty-first, the Insurance  
3360 Commissioner and the Healthcare Advocate, after receiving any  
3361 objections to such statements, shall make such adjustments which in  
3362 their opinion may be indicated, and shall render an adjusted  
3363 assessment, if any, to the affected companies.

3364 (h) If any assessment is not paid when due, a penalty of twenty-five  
3365 dollars shall be added thereto, and interest at the rate of six per cent  
3366 per annum shall be paid thereafter on such assessment and penalty.

3367 (i) The commissioner shall deposit all payments made under this

3368 section with the State Treasurer. On and after June 6, 1991, the moneys  
3369 so deposited shall be credited to the Insurance Fund established under  
3370 section 38a-52a and shall be accounted for as expenses recovered from  
3371 insurance companies.

3372 Sec. 66. Subsection (c) of section 1-84b of the general statutes is  
3373 repealed and the following is substituted in lieu thereof (*Effective from*  
3374 *passage*):

3375 (c) The provisions of this subsection apply to present or former  
3376 executive branch public officials or state employees who hold or  
3377 formerly held positions which involve significant decision-making or  
3378 supervisory responsibility and are designated as such by the Office of  
3379 State Ethics in consultation with the agency concerned except that such  
3380 provisions shall not apply to members or former members of the  
3381 boards or commissions who serve ex officio, who are required by  
3382 statute to represent the regulated industry or who are permitted by  
3383 statute to have a past or present affiliation with the regulated industry.  
3384 Designation of positions subject to the provisions of this subsection  
3385 shall be by regulations adopted by the Citizen's Ethics Advisory Board  
3386 in accordance with chapter 54. As used in this subsection, "agency"  
3387 means the [Office of Health Care Access division within the  
3388 Department of Public Health] Health Systems Planning Unit of the  
3389 Office of Health Strategy, the Connecticut Siting Council, the  
3390 Department of Banking, the Insurance Department, the Department of  
3391 Emergency Services and Public Protection, the office within the  
3392 Department of Consumer Protection that carries out the duties and  
3393 responsibilities of sections 30-2 to 30-68m, inclusive, the Public Utilities  
3394 Regulatory Authority, including the Office of Consumer Counsel, and  
3395 the Department of Consumer Protection and the term "employment"  
3396 means professional services or other services rendered as an employee  
3397 or as an independent contractor.

3398 (1) No public official or state employee in an executive branch  
3399 position designated by the Office of State Ethics shall negotiate for,  
3400 seek or accept employment with any business subject to regulation by

3401 his agency.

3402 (2) No former public official or state employee who held such a  
3403 position in the executive branch shall within one year after leaving an  
3404 agency, accept employment with a business subject to regulation by  
3405 that agency.

3406 (3) No business shall employ a present or former public official or  
3407 state employee in violation of this subsection.

3408 Sec. 67. Section 3-123i of the general statutes is repealed and the  
3409 following is substituted in lieu thereof (*Effective from passage*):

3410 For the fiscal year ending June 30, 2014, and for each fiscal year  
3411 thereafter, the Comptroller shall fund the fringe benefit cost  
3412 differential between the average rate for fringe benefits for employees  
3413 of private hospitals in the state and the fringe benefit rate for  
3414 employees of The University of Connecticut Health Center from the  
3415 resources appropriated for State Comptroller-Fringe Benefits in an  
3416 amount not to exceed \$13,500,000. For purposes of this section, the  
3417 "fringe benefit cost differential" means the difference between the state  
3418 fringe benefit rate calculated on The University of Connecticut Health  
3419 Center payroll and the average member fringe benefit rate of all  
3420 Connecticut acute care hospitals as contained in the annual reports  
3421 submitted to the [Office of Health Care Access] Health Systems  
3422 Planning Unit of the Office of Health Strategy pursuant to section 19a-  
3423 644, as amended by this act.

3424 Sec. 68. Subsection (b) of section 4-101a of the general statutes is  
3425 repealed and the following is substituted in lieu thereof (*Effective from*  
3426 *passage*):

3427 (b) Grants, technical assistance or consultation services, or any  
3428 combination thereof, provided under this section may be made to  
3429 assist a nongovernmental acute care general hospital to develop and  
3430 implement a plan to achieve financial stability and assure the delivery  
3431 of appropriate health care services in the service area of such hospital,

3432 or to assist a nongovernmental acute care general hospital in  
3433 determining strategies, goals and plans to ensure its financial viability  
3434 or stability. Any such hospital seeking such grants, technical assistance  
3435 or consultation services shall prepare and submit to the Office of Policy  
3436 and Management and the [Office of Health Care Access division of the  
3437 Department of Public Health] Health Systems Planning Unit of the  
3438 Office of Health Strategy a plan that includes at least the following: (1)  
3439 A statement of the hospital's current projections of its finances for the  
3440 current and the next three fiscal years; (2) identification of the major  
3441 financial issues which effect the financial stability of the hospital; (3)  
3442 the steps proposed to study or improve the financial status of the  
3443 hospital and eliminate ongoing operating losses; (4) plans to study or  
3444 change the mix of services provided by the hospital, which may  
3445 include transition to an alternative licensure category; and (5) other  
3446 related elements as determined by the Office of Policy and  
3447 Management. Such plan shall clearly identify the amount, value or  
3448 type of the grant, technical assistance or consultation services, or  
3449 combination thereof, requested. Any grants, technical assistance or  
3450 consultation services, or any combination thereof, provided under this  
3451 section shall be determined by the Secretary of the Office of Policy and  
3452 Management not to jeopardize the federal matching payments under  
3453 the medical assistance program and the emergency assistance to  
3454 families program as determined by the [Office of Health Care Access  
3455 division of the Department of Public Health] Health Systems Planning  
3456 Unit of the Office of Health Strategy or the Department of Social  
3457 Services in consultation with the Office of Policy and Management.

3458 Sec. 69. Subsection (c) of section 17b-337 of the 2018 supplement to  
3459 the general statutes is repealed and the following is substituted in lieu  
3460 thereof (*Effective from passage*):

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

3465 term care; (2) the Commissioner of Social Services, or the  
3466 commissioner's designee; (3) one member of the Office of Policy and  
3467 Management appointed by the Secretary of the Office of Policy and  
3468 Management; (4) [two members] one member from the Department of  
3469 Public Health appointed by the Commissioner of Public Health; [, one  
3470 of whom is from the Office of Health Care Access division of the  
3471 department;] (5) one member from the Department of Housing  
3472 appointed by the Commissioner of Housing; (6) one member from the  
3473 Department of Developmental Services appointed by the  
3474 Commissioner of Developmental Services; (7) one member from the  
3475 Department of Mental Health and Addiction Services appointed by the  
3476 Commissioner of Mental Health and Addiction Services; (8) one  
3477 member from the Department of Transportation appointed by the  
3478 Commissioner of Transportation; [and] (9) one member from the  
3479 Department of Children and Families appointed by the Commissioner  
3480 of Children and Families; and (10) one member from the Health  
3481 Systems Planning Unit of the Office of Health Strategy appointed by  
3482 the executive director of the Office of Health Strategy. The committee  
3483 shall convene no later than ninety days after June 4, 1998. Any vacancy  
3484 shall be filled by the appointing authority. The chairperson shall be  
3485 elected from among the members of the committee. The committee  
3486 shall seek the advice and participation of any person, organization or  
3487 state or federal agency it deems necessary to carry out the provisions  
3488 of this section.

3489 Sec. 70. Subsection (g) of section 17b-352 of the 2018 supplement to  
3490 the general statutes is repealed and the following is substituted in lieu  
3491 thereof (*Effective from passage*):

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

3498 purposes of this section, until the time final regulations are adopted in  
3499 accordance with said chapter 54.]

3500 Sec. 71. Subsection (e) of section 17b-353 of the 2018 supplement to  
3501 the general statutes is repealed and the following is substituted in lieu  
3502 thereof (*Effective from passage*):

3503 (e) The Commissioner of Social Services shall adopt regulations, in  
3504 accordance with chapter 54, to implement the provisions of this  
3505 section. [The commissioner shall implement the standards and  
3506 procedures of the Office of Health Care Access division of the  
3507 Department of Public Health concerning certificates of need  
3508 established pursuant to section 19a-643, as appropriate for the  
3509 purposes of this section, until the time final regulations are adopted in  
3510 accordance with said chapter 54.]

3511 Sec. 72. Subsection (f) of section 17b-354 of the 2018 supplement to  
3512 the general statutes is repealed and the following is substituted in lieu  
3513 thereof (*Effective from passage*):

3514 (f) The Commissioner of Social Services may adopt regulations, in  
3515 accordance with chapter 54, to implement the provisions of this  
3516 section. [The commissioner shall implement the standards and  
3517 procedures of the Office of Health Care Access division of the  
3518 Department of Public Health concerning certificates of need  
3519 established pursuant to section 19a-643, as appropriate for the  
3520 purposes of this section, until the time final regulations are adopted in  
3521 accordance with said chapter 54.]

3522 Sec. 73. Section 17b-356 of the general statutes is repealed and the  
3523 following is substituted in lieu thereof (*Effective from passage*):

3524 Any health care facility or institution, as defined in subsection (a) of  
3525 section 19a-490, except a nursing home, rest home, residential care  
3526 home or residential facility for persons with intellectual disability  
3527 licensed pursuant to section 17a-227 and certified to participate in the  
3528 Title XIX Medicaid program as an intermediate care facility for



3529 individuals with intellectual disabilities, proposing to expand its  
3530 services by adding nursing home beds shall obtain the approval of the  
3531 Commissioner of Social Services in accordance with the procedures  
3532 established pursuant to sections 17b-352, as amended by this act, 17b-  
3533 353, as amended by this act, and 17b-354, as amended by this act, for a  
3534 facility, as defined in section 17b-352, as amended by this act, prior to  
3535 obtaining the approval of the [Office of Health Care Access division of  
3536 the Department of Public Health] Health Systems Planning Unit of the  
3537 Office of Health Strategy pursuant to section 19a-639, as amended by  
3538 this act.

3539 Sec. 74. Subsection (b) of section 19a-7 of the general statutes is  
3540 repealed and the following is substituted in lieu thereof (*Effective from*  
3541 *passage*):

3542 (b) For the purposes of establishing a state health plan as required  
3543 by subsection (a) of this section and consistent with state and federal  
3544 law on patient records, the department is entitled to access hospital  
3545 discharge data, emergency room and ambulatory surgery encounter  
3546 data, data on home health care agency client encounters and services,  
3547 data from community health centers on client encounters and services  
3548 and all data collected or compiled by the [Office of Health Care Access  
3549 division of the Department of Public Health] Health Systems Planning  
3550 Unit of the Office of Health Strategy pursuant to section 19a-613, as  
3551 amended by this act.

3552 Sec. 75. Subsection (a) of section 19a-507 of the general statutes is  
3553 repealed and the following is substituted in lieu thereof (*Effective from*  
3554 *passage*):

3555 (a) Notwithstanding the provisions of chapter 368z, New Horizons,  
3556 Inc., a nonprofit, nonsectarian organization, or a subsidiary  
3557 organization controlled by New Horizons, Inc., is authorized to  
3558 construct and operate an independent living facility for severely  
3559 physically disabled adults, in the town of Farmington, provided such  
3560 facility shall be constructed in accordance with applicable building

3561 codes. The Farmington Housing Authority, or any issuer acting on  
3562 behalf of said authority, subject to the provisions of this section, may  
3563 issue tax-exempt revenue bonds on a competitive or negotiated basis  
3564 for the purpose of providing construction and permanent mortgage  
3565 financing for the facility in accordance with Section 103 of the Internal  
3566 Revenue Code. Prior to the issuance of such bonds, plans for the  
3567 construction of the facility shall be submitted to and approved by the  
3568 [Office of Health Care Access] Health Systems Planning Unit of the  
3569 Office of Health Strategy. The [office] unit shall approve or disapprove  
3570 such plans within thirty days of receipt thereof. If the plans are  
3571 disapproved they may be resubmitted. Failure of the [office] unit to act  
3572 on the plans within such thirty-day period shall be deemed approval  
3573 thereof. The payments to residents of the facility who are eligible for  
3574 assistance under the state supplement program for room and board  
3575 and necessary services, shall be determined annually to be effective  
3576 July first of each year. Such payments shall be determined on a basis of  
3577 a reasonable payment for necessary services, which basis shall take  
3578 into account as a factor the costs of providing those services and such  
3579 other factors as the commissioner deems reasonable, including  
3580 anticipated fluctuations in the cost of providing services. Such  
3581 payments shall be calculated in accordance with the manner in which  
3582 rates are calculated pursuant to subsection (h) of section 17b-340 and  
3583 the cost-related reimbursement system pursuant to said section except  
3584 that efficiency incentives shall not be granted. The commissioner may  
3585 adjust such rates to account for the availability of personal care  
3586 services for residents under the Medicaid program. The commissioner  
3587 shall, upon submission of a request, allow actual debt service,  
3588 comprised of principal and interest, in excess of property costs allowed  
3589 pursuant to section 17-313b-5 of the regulations of Connecticut state  
3590 agencies, provided such debt service terms and amounts are  
3591 reasonable in relation to the useful life and the base value of the  
3592 property. The cost basis for such payment shall be subject to audit, and  
3593 a recomputation of the rate shall be made based upon such audit. The  
3594 facility shall report on a fiscal year ending on the thirtieth day of  
3595 September on forms provided by the commissioner. The required

3596 report shall be received by the commissioner no later than December  
3597 thirty-first of each year. The Department of Social Services may use its  
3598 existing utilization review procedures to monitor utilization of the  
3599 facility. If the facility is aggrieved by any decision of the commissioner,  
3600 the facility may, within ten days, after written notice thereof from the  
3601 commissioner, obtain by written request to the commissioner, a  
3602 hearing on all items of aggrievement. If the facility is aggrieved by the  
3603 decision of the commissioner after such hearing, the facility may  
3604 appeal to the Superior Court in accordance with the provisions of  
3605 section 4-183.

3606 Sec. 76. Subsection (c) of section 12-263q of the 2018 supplement to  
3607 the general statutes is repealed and the following is substituted in lieu  
3608 thereof (*Effective from passage*):

3609 (c) Prior to January 1, 2018, and every three years thereafter, the  
3610 Commissioner of Social Services shall seek approval from the Centers  
3611 for Medicare and Medicaid Services to exempt financially distressed  
3612 hospitals from the net revenue tax imposed on outpatient hospital  
3613 services. Any such hospital for which the Centers for Medicare and  
3614 Medicaid Services grants an exemption shall be exempt from the net  
3615 revenue tax imposed on outpatient hospital services under subsection  
3616 (a) of this section. Any hospital for which the Centers for Medicare and  
3617 Medicaid Services denies an exemption shall be required to pay the net  
3618 revenue tax imposed on outpatient hospital services under subsection  
3619 (a) of this section. For purposes of this subsection, "financially  
3620 distressed hospital" means a hospital that has experienced over a five-  
3621 year period an average net loss of more than five per cent of aggregate  
3622 revenue. A hospital has an average net loss of more than five per cent  
3623 of aggregate revenue if such a loss is reflected in the five most recent  
3624 years of financial reporting that have been made available by the  
3625 [Office of Health Care Access] Health Systems Planning Unit of the  
3626 Office of Health Strategy for such hospital in accordance with section  
3627 19a-670, as amended by this act, as of the effective date of the request  
3628 for approval which effective date shall be July first of the year in which

3629 the request is made.

3630 Sec. 77. Subsection (b) of section 13 of public act 17-4 of the June  
3631 special session is repealed and the following is substituted in lieu  
3632 thereof (*Effective from passage*):

3633 (b) The commissioner may impose such conditions as the  
3634 commissioner determines to be necessary in making any advance in  
3635 accordance with this section, including, but not limited to, financial  
3636 reporting, schedule of recoupment of advance payments and  
3637 adjustments to any future payments to such hospital. For purposes of  
3638 this section, "distressed hospital" means a short-term general acute care  
3639 hospital licensed by the Department of Public Health that (1) the  
3640 Commissioner of Social Services determines is financially distressed in  
3641 accordance with financial criteria selected or developed by the  
3642 commissioner, and (2) is independent and is not affiliated with any  
3643 other hospital or hospital-based system that includes two or more  
3644 hospitals, as documented through the certificate of need process  
3645 administered by the [Department of Public Health, Office of Health  
3646 Care Access] Health Systems Planning Unit of the Office of Health  
3647 Strategy.

3648 Sec. 78. Subsection (b) of section 10a-109gg of the general statutes is  
3649 repealed and the following is substituted in lieu thereof (*Effective from*  
3650 *passage*):

3651 (b) The proceeds of the sale of the bond issuance described in  
3652 subsection (a) of this section shall be used by the Office of Policy and  
3653 Management, in consultation with the chairperson of the Board of  
3654 Trustees of the university, for the purpose of the UConn health  
3655 network initiatives in the following manner: (1) Five million dollars of  
3656 such proceeds shall be used by Hartford Hospital to develop a  
3657 simulation and conference center on the Hartford Hospital campus to  
3658 be run exclusively by Hartford Hospital, (2) five million dollars of such  
3659 proceeds shall be used to fulfill the initiative for a primary care  
3660 institute on the Saint Francis Hospital and Medical Center campus, (3)

3661 five million dollars of such proceeds shall be used to fulfill the  
3662 initiatives for a comprehensive cancer center and The University of  
3663 Connecticut-sponsored health disparities institute; (4) five million  
3664 dollars of such proceeds shall be used to fulfill the initiatives for the  
3665 planning, design, land acquisition, development and construction of  
3666 (A) a cancer treatment center to be constructed by, or in partnership  
3667 with, The Hospital of Central Connecticut, provided such cancer  
3668 treatment center is located entirely within the legal boundaries of the  
3669 city of New Britain, (B) renovations and upgrades to the oncology unit  
3670 at The Hospital of Central Connecticut, and (C) if certificate of need  
3671 approval is received, [pursuant to the provisions of subsection (b) of  
3672 section 10a-109ii,] a Permanent Regional Phase One Clinical Trials Unit  
3673 located at The Hospital of Central Connecticut in New Britain; and (5)  
3674 two million dollars of such proceeds shall be used to fulfill the  
3675 initiatives for patient room renovations at Bristol Hospital. In the event  
3676 that the cancer treatment center authorized pursuant to subdivision (4)  
3677 of this subsection is built in whole or in part outside the legal  
3678 boundaries of the city of New Britain, The Hospital of Central  
3679 Connecticut shall repay the entire amount of the proceeds used to  
3680 fulfill the initiatives for the planning, design, development and  
3681 construction of such center.

3682 Sec. 79. Subsection (d) of section 1-84 of the 2018 supplement to the  
3683 general statutes is repealed and the following is substituted in lieu  
3684 thereof (*Effective from passage*):

3685 (d) No public official or state employee or employee of such public  
3686 official or state employee shall agree to accept, or be a member or  
3687 employee of a partnership, association, professional corporation or  
3688 sole proprietorship which partnership, association, professional  
3689 corporation or sole proprietorship agrees to accept any employment,  
3690 fee or other thing of value, or portion thereof, for appearing, agreeing  
3691 to appear, or taking any other action on behalf of another person  
3692 before the Department of Banking, the Office of the Claims  
3693 Commissioner, the [Office of Health Care Access division within the

3694 Department of Public Health] Health Systems Planning Unit of the  
3695 Office of Health Strategy, the Insurance Department, the Department  
3696 of Consumer Protection, the Department of Motor Vehicles, the State  
3697 Insurance and Risk Management Board, the Department of Energy and  
3698 Environmental Protection, the Public Utilities Regulatory Authority,  
3699 the Connecticut Siting Council or the Connecticut Real Estate  
3700 Commission; provided this shall not prohibit any such person from  
3701 making inquiry for information on behalf of another before any of said  
3702 commissions or commissioners if no fee or reward is given or  
3703 promised in consequence thereof. For the purpose of this subsection,  
3704 partnerships, associations, professional corporations or sole  
3705 proprietorships refer only to such partnerships, associations,  
3706 professional corporations or sole proprietorships which have been  
3707 formed to carry on the business or profession directly relating to the  
3708 employment, appearing, agreeing to appear or taking of action  
3709 provided for in this subsection. Nothing in this subsection shall  
3710 prohibit any employment, appearing, agreeing to appear or taking  
3711 action before any municipal board, commission or council. Nothing in  
3712 this subsection shall be construed as applying (1) to the actions of any  
3713 teaching or research professional employee of a public institution of  
3714 higher education if such actions are not in violation of any other  
3715 provision of this chapter, (2) to the actions of any other professional  
3716 employee of a public institution of higher education if such actions are  
3717 not compensated and are not in violation of any other provision of this  
3718 chapter, (3) to any member of a board or commission who receives no  
3719 compensation other than per diem payments or reimbursement for  
3720 actual or necessary expenses, or both, incurred in the performance of  
3721 the member's duties, or (4) to any member or director of a quasi-public  
3722 agency. Notwithstanding the provisions of this subsection to the  
3723 contrary, a legislator, an officer of the General Assembly or part-time  
3724 legislative employee may be or become a member or employee of a  
3725 firm, partnership, association or professional corporation which  
3726 represents clients for compensation before agencies listed in this  
3727 subsection, provided the legislator, officer of the General Assembly or  
3728 part-time legislative employee shall take no part in any matter

3729 involving the agency listed in this subsection and shall not receive  
 3730 compensation from any such matter. Receipt of a previously  
 3731 established salary, not based on the current or anticipated business of  
 3732 the firm, partnership, association or professional corporation involving  
 3733 the agencies listed in this subsection, shall be permitted.

3734 Sec. 80. Sections 10a-109ii, 17b-234, 17b-235, 19a-617b, 19a-637, 19a-  
 3735 755 and 38a-558 of the general statutes are repealed. (*Effective from*  
 3736 *passage*)

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

Sec. 27	<i>from passage</i>	19a-639a
Sec. 28	<i>from passage</i>	19a-639b
Sec. 29	<i>from passage</i>	19a-639c
Sec. 30	<i>from passage</i>	19a-639e
Sec. 31	<i>from passage</i>	19a-639f
Sec. 32	<i>from passage</i>	19a-641
Sec. 33	<i>from passage</i>	19a-642
Sec. 34	<i>from passage</i>	19a-643
Sec. 35	<i>from passage</i>	19a-644
Sec. 36	<i>from passage</i>	19a-645
Sec. 37	<i>from passage</i>	19a-646
Sec. 38	<i>from passage</i>	19a-649
Sec. 39	<i>from passage</i>	19a-653
Sec. 40	<i>from passage</i>	19a-654
Sec. 41	<i>from passage</i>	19a-659
Sec. 42	<i>from passage</i>	19a-670
Sec. 43	<i>from passage</i>	19a-673(a)(1)
Sec. 44	<i>from passage</i>	19a-673a
Sec. 45	<i>from passage</i>	19a-673c
Sec. 46	<i>from passage</i>	19a-676
Sec. 47	<i>from passage</i>	19a-681
Sec. 48	<i>from passage</i>	19a-486
Sec. 49	<i>from passage</i>	19a-486a
Sec. 50	<i>from passage</i>	19a-486b
Sec. 51	<i>from passage</i>	19a-486d
Sec. 52	<i>from passage</i>	19a-486e
Sec. 53	<i>from passage</i>	19a-486f
Sec. 54	<i>from passage</i>	19a-486g
Sec. 55	<i>from passage</i>	19a-486h
Sec. 56	<i>from passage</i>	19a-486i(d) to (i)
Sec. 57	<i>from passage</i>	19a-508c(j) to (m)
Sec. 58	<i>from passage</i>	19a-509b(c) to (f)
Sec. 59	<i>from passage</i>	33-182bb(e) to (g)
Sec. 60	<i>from passage</i>	19a-493b(b) and (c)
Sec. 61	<i>from passage</i>	19a-6q
Sec. 62	<i>July 1, 2018</i>	19a-725
Sec. 63	<i>from passage</i>	20-195sss
Sec. 64	<i>from passage</i>	38a-47
Sec. 65	<i>from passage</i>	38a-48
Sec. 66	<i>from passage</i>	1-84b(c)



Sec. 67	<i>from passage</i>	3-123i
Sec. 68	<i>from passage</i>	4-101a(b)
Sec. 69	<i>from passage</i>	17b-337(c)
Sec. 70	<i>from passage</i>	17b-352(g)
Sec. 71	<i>from passage</i>	17b-353(e)
Sec. 72	<i>from passage</i>	17b-354(f)
Sec. 73	<i>from passage</i>	17b-356
Sec. 74	<i>from passage</i>	19a-7(b)
Sec. 75	<i>from passage</i>	19a-507(a)
Sec. 76	<i>from passage</i>	12-263q(c)
Sec. 77	<i>from passage</i>	PA 17-4 of the June Sp. Sess., Sec. 13(b)
Sec. 78	<i>from passage</i>	10a-109gg(b)
Sec. 79	<i>from passage</i>	1-84(d)
Sec. 80	<i>from passage</i>	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.*