HIGHLIGHTS – PA 15-146, AAC Hospitals, Insurers, and Health Care Consumers

From Governor's Bill No. 954 – Enhances Transparency of Executive Pay in Hospital Transactions

- **Requires disclosure of the financial gain that high level staff will receive as the result of a proposed transfer of ownership of a hospital[i].** Certificate of need (CON) applicants for hospital ownership transfers will be required to submit to the Office of Health Care Access (OHCA), for both the hospital and purchaser, the salary, severance, stock offering, or other current or deferred financial gain that officers, directors, board members, or senior managers[ii] are expected to receive due to the transfer, or in relation to it. This information is also required to be included in the hospital's annual report to OHCA. (§§30 and 33)

Increases Consumer Access to Information on Health Care Costs and Coverage

- **Requires Access Health CT (AHCT) to establish and maintain a consumer health information website[iii] and include certain information collected and submitted by DPH[iv] and health carriers[v].** There is available capital funding[vi] in the Office of Policy and Management (OPM) Information Technology Capital Investment Program to fund AHCT's start-up costs to implement this website. The website will include, to the extent practicable, information comparing the quality, price, and costs of health care services – specifically, comparative price and cost information for the 50 most frequently occurring inpatient primary diagnoses and procedures as reported by DPH. Health carriers will also be required to annually submit to AHCT billed and allowed amounts paid to health care providers in the health carrier's network and the out-of-pocket (OOP) costs for the diagnoses and procedures reported by the Department of Public Health (DPH). (§§1-2)

- **Enables consumers to easily access cost and quality information regarding their health care.** Health carriers are required to maintain a web site and toll-free number to enable consumers to request and obtain information regarding cost and quality[vii]. In addition, health carriers are required to include specific information on their websites about each of their policies, including coverage exclusions, restrictions on covered benefits, and descriptions of drug coverage and costs[viii]. Hospitals, at the time of scheduling one of the top 50 most frequently occurring inpatient primary diagnoses and procedures as reported by DPH, must notify the patient of his or her right to make a request for certain cost and quality information, which includes, if the patient is uninsured, an estimate of the total costs, and, if the patient is insured, the allowed amount, toll-free number, and internet web site of the patient's health carrier[ix]. (§§2(e); 5; and 7)

- **Streamlines the process of determining health insurance coverage for treatment, by requiring each health care provider to determine whether a patient has coverage prior to scheduling any admission, procedure, or service**. If a patient does not have health insurance or the provider is out-of-network, the health care provider has to notify the patient in writing of the charges, disclose that the patient may be charged for unforeseen services, and, if the patient is out of network, that the out of network rates may apply[x]. (§3)

- **Requires that providers that refer a patient to other health care providers disclose, in writing, any affiliations that exist[xi].** The notice must also inform the patient that the patient is not required to see the referred provider and the number of the patient's health carrier in order for the patient to obtain information regarding in-network health care providers and estimated OOP costs. (§15)

HIGHLIGHTS – PA 15-146, AAC Hospitals, Insurers, and Health Care Consumers

Decreases Consumer Health Care Costs by Prohibiting Surprise Billing and Limiting Facility Fees

- **Prohibits "surprise billing" by limiting payment by patients to health carriers to in-network out-of-pocket (OOP) costs if they were not notified properly of their provider's out-of-network status[xii].** Health carriers are also prohibited from requiring prior authorization for emergency services or charging a patient any higher than in-network OOP costs for rendered emergency services. (§§9-12)
- **Prohibits the charging of facility fees for certain outpatient services provided off-site from a hospital campus.** On and after January 1, 2017, no hospital, health system, or hospital-based facility is allowed to collect a facility fee for outpatient health care services that use a current procedural terminology evaluation and management code and are provided at a hospital-based facility, other than a hospital emergency department, located off-site from a hospital campus. (§13(k))
- **Prohibits the charging of facility fees for uninsured patients receiving outpatient services located off-site of more than the Medicare rate.** On and after January 1, 2017, no hospital, health system, or hospital-based facility is allowed to collect a facility fee of more than the Medicare rate for outpatient health care services, other than those provided in an emergency department located off-site from a hospital campus, received by a patient who is uninsured. (§13(k))
- **Requires patient notification when facilities that did not previously charge facility fees are purchased by larger health systems/hospitals and may be likely to begin charging facility fees.** On or after January 1, 2016, the purchaser in any transaction that results in the establishment of a hospital-based facility in which facility fees will likely be billed, must provide written notification to each patient served within the previous three years by the health care facility that was purchased. (§13(j))

Advances Health Information Technology

- **Expands unfair trade practice law to include health information blocking[xiii].** Health information blocking includes knowingly using an electronic health record to prevent or unreasonably interfere with patient referrals to health care providers who are not affiliated providers. (§20)
- **Creates the Health Information Technology Council[xiv].** This 28-member Council will advise the Commissioner of Social Services in developing priorities and policy recommendations for advancing the state's health information technology and health information exchange efforts. (§25)

Enhances Monitoring of the Health Care Marketplace

- **Requires that group practices submit notice to DPH after making material changes to their business or corporate structure[xv]**. Group practices that engage in a transaction that results in a material change to its business or corporate structure must submit written notice to DPH not later than 30 days after the effective date of such a transaction. (§27(d)(2))

HIGHLIGHTS – PA 15-146, AAC Hospitals, Insurers, and Health Care Consumers

- **Requires that hospitals or hospital systems disclose their affiliations with other hospitals and hospital systems**. Not less than 30 days prior to the effective date of any transaction that results in an affiliation between hospitals or hospital systems, the parties have to submit written notice to the Attorney General (AG), with detailed information on the nature of the affiliation, the description of services to be provided at each location, and the primary service area to be served by each location[xvi]. In addition, each hospital and hospital system must file their affiliations annually to DPH and the AG in a written report[xvii]. (§§27(e) and 27(i))

- **Strengthens the certificate of need (CON) process for applications involving the transfer of ownership of a hospital to help ensure that affected communities have continued access to high quality and affordable health care.**

    - **Requires that CON applications that involve the transfer of ownership of a hospital include a detailed plan on how the new hospital will provide health care services for the first three years.** OHCA will have to take this plan into consideration and make written findings when making its application decision[xviii]. (§§28(d)(2)(B) and 30)

    - **Requires OHCA, if a CON application is approve, to hire an independent consultant to serve as a post-transfer compliance reporter for a period of three years after the completion of the transfer[xix].** This reporter will have access to the purchaser's records and facilities, and will have to meet with representatives of the purchaser, new hospital, and members of the affected community at least quarterly and report back to OHCA. The purchaser is required to provide funds for the hiring of the reporter of up to $200,000 annually. (§28(e))

    - **Requires OHCA to conduct a cost and market impact review for certain CON applications involving the transfer of ownership of a hospital[xx].** OHCA is required to retain an independent consultant with expertise on the economic analysis of the health care market and health care costs and prices. The purchaser will be billed for the services of not more than $200,000 per application. Results of the study are shared with the Attorney General (AG) if they meet certain conditions, and the AG may investigate whether the transacting parties are engaging in unfair methods or competition, anti-competitive behavior, or other conduct the violates CT's Antitrust or Unfair Trade Practices Act. (§29)

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[i] Applies to CON applications or determination letters filed on or after December 1, 2015
[ii] This information must be disclosed for all those individuals, regardless of whether or not they will hold a position at the hospital after the transaction.
[iii] On or after July 1, 2016, within available resources
[iv] Not later than July 1, 2016, and annually thereafter, to the extent information is available
[v] Not later than January 1, 2017, and annually thereafter
[vi] PA 15-1, JSS, sections 2(d)(5) and 21(c)(4)
[vii] On and after July 1, 2016
[viii] Effective January 1, 2016
[ix] On and after January 1, 2017
[x] On and after January 1, 2016
[xi] Effective October 1, 2015
[xiixii] Effective July 1, 2016
[xiii] Effective October 1, 2015

[xiv] All appointments must be made by August 1, 2015 and the first meeting must be held by September 1, 2015. The Council must meet at least three times before January 1, 2016.
[xv] Effective October 1, 2015
[xvi] Effective October 1, 2015
[xvii] Not later than December 31, 2015, and annually thereafter
[xviii] Applies to CON applications or determination letters filed on or after December 1, 2015
[xix] *Ibid.*
[xx] *Ibid.*

Study by the Health Care Cabinet (§17)

- **Requires the Health Care Cabinet, within available appropriations, to study health care cost containment models in other states (such as MA, MD, OR, RI, WA, and VT) to identify successful practices and programs that may be implemented in CT**
- **Must submit a report by December 1, 2016 to the General Assembly on the findings of the study and recommendations for administrative, regulatory, and policy changes** that will provide for:
    - 1) a framework for (A) the monitoring of and responding to health care cost growth on a health care provider and state-wide basis that may include establishing state-wide or health care provider or service-specific benchmarks or limits on health care cost growth, (B) the identification of health care providers that exceed such benchmarks or limits, and (C) the provision of assistance for such health care providers to meet such benchmarks or to hold them accountable to such limits,
    - (2) mechanisms to identify and mitigate factors that contribute to health care cost growth as well as price disparity between health care providers of similar services, including, but not limited to, (A) consolidation among health care providers of similar services, (B) vertical integration of health care providers of different services, (C) affiliations among health care providers that impact referral and utilization practices, (D) insurance contracting and reimbursement policies, and (E) government reimbursement policies and regulatory practices,
    - (3) the authority to implement and monitor delivery system reforms designed to promote value-based care and improved health outcomes,
    - (4) the development and promotion of insurance contracting standards and products that reward value-based care and promote the utilization of low-cost, high-quality health care providers, and
    - (5) the implementation of other policies to mitigate factors that contribute to unnecessary health care cost growth and to promote high-quality, affordable care.

Other

CID Evaluation of Insurance Company Compliance with ACA (§ 8)

This provision requires CID, within available appropriations, to evaluate and submit a report annually on whether insurance companies are in compliance with the ACA, including discriminatory benefit designs. CID would require an additional Insurance Examiner position (annualized cost of $100,000) in order to implement this provision.

CID Workgroup and Report on Rising Cost of Health Care (§19)

This provision requires CID, within available appropriations, to study health care cost containment models in other states that may be implemented in CT and produce a report with specific recommendations. CID would require $450,000 for a consultant in order to complete this study.

2015 Legislative Update
September 8, 2015

Governor's bills:

Enhancing Access to BH Services and Services for Youth with ASD
Provisions included in PA 15-5, JSS, §§347-353 (HB 6847)
Expands commercial coverage for ASD, helps ensure quality and consistency of ASD services across payers, updates insurance statutes to reflect current federal law, and requires the development of uniform BH utilization and quality data measures across payers.

Substance Abuse and Opioid Overdose Prevention
PA 15-198; one provision included in PA 15-5, JSS, §354 (HB 6856)
Requires continuing education for practitioners on pain management and controlled substance prescribing, strengthens the state's prescription monitoring program; increases access to the life-saving overdose reversal drugs, and reconstitutes the Alcohol and Drug Policy Council.

Transparency of Executive Pay in Certain Hospital Transactions
Provisions included in PA 15-146, §§ 30 & 33 (SB 954)
Requires reporting of anticipated changes in position or financial gain for board members and senior management in a hospital conversion application and requires reporting of this same information post-merger, on an annual basis, through OHCA's hospital financial review process.

Human Services and Public Health Budget Implementers
Provisions included in PA 15-5, JSS (HB 6846, SB 955)
Includes HUSKY adult transition, strengthening LTC rebalancing by extending moratorium on new NH beds and requiring notice when NH residents are becoming Medicaid eligible, statewide rates for hospital inpatient, and moving certain public health programs to the insurance fund.

State agency bills regarding access, quality, prevention, cost, and disparate impact:

Medicaid Coverage for OTC Drugs and Products and Requirements for Medicaid Benefit Cards and Notice of Regulations - ***PA 15-165 (HB 6770)***
Expands the types of OTC drugs and products that may be covered by Medicaid to include those the DSS Commissioner determines are appropriate based on clinical efficacy, safety, and cost effectiveness; and repeals a law that required DSS, by 1/1/16, to include the name of contact information of a PCP on beneficiaries' Medicaid benefit cards.

Emergency Medical Services - *PA 15-223 (SB 999)*
Establishes a hierarchy for emergency scene responsibilities.

Revisions to the DMHAS Statutes – *PA 15-120 (HB 6708)*
Among other provisions, clarifies and strengthens DMHAS ability to collect data from BH providers.

Definitions of Sedation and General Anesthesia – *PA 15-163 (HB 6937)*
For dentistry, eliminates "conscious sedation" and replaces it with new definitions for minimal, moderate, and deep sedation.

Massage Therapist Qualifications - *PA 15-3 (HB 6794)*
Allows licensing of new massage therapists by eliminating reference to an exam no longer used.

Childhood Lead Poisoning Prevention and Control – *PA 15-172 (HB 6884)*
Lowers the blood lead level threshold at which local health directors must inform parents about lead poisoning dangers, ways to reduce risks, and lead abatement laws.

State Payment to Certain Facilities for Reserved Beds - *PA 15-102 (SB 862)*
Clarifies that the state is not required to pay for beds that are not otherwise available.

Definition and Use of the Term Intellectual Disability - *PA 15-54 (HB 6815)*
Removes reference to mental retardation in statute.

Protective Services for Suspected Elderly Abuse Victims – *PA 15-233 (SB 896)*
Among other changes, allows DSS to obtain a probate court order in a narrowly defined situation to enter the premises of an elderly person to determine whether they need protective services.

Various Revisions to the Public Health Statutes – *PA 15-242 (HB 6987)*
This DPH bill has 70 sections making various changes including allowing out-of-state nurses to temporarily care for a patient in Connecticut for up to 72 hours without obtaining a DPH permit.

<u>Legislative Initiatives:</u>

<u>Hospitals:</u>

Bipartisan Roundtable on Hospital Bills - *PA 15-146 (SBs 807-815)*
Led by Senator Looney and Senator Fasano, a workgroup was convened during the Fall of 2014 to develop policy recommendations to ensure continued access to affordable

quality care. The group met five times on various topics, including the hospital conversion process, physician practice acquisitions and mergers, and facility fees. As a result nine bills were drafted addressing: expanded oversight of hospital sales, establishment of a statewide health information exchange, transparency regarding cost and quality, facility fees and site neutral reimbursement, surprise billing, tiered networking.

Patient-Designated Caregivers – ***PA 15-32 (290)***
Implements core concepts of the CARE (Caregiver Advise, Record, and Enable) Act, developed by AARP, to help ensure caregivers receive the information and training they need from hospitals to care for their loved ones at home.

Nursing Staffing Levels – ***PA 15-91 (SB 855)***
Requires hospitals to report annually to DPH on their prospective nurse staffing plans, rather than upon DPH request, and expands the information that must be included in the plans.

Language Interpreters in Hospitals – ***PA 15-34 (SB 856)***
Requires acute care hospitals to ensure that interpreter services are available to certain non-English speaking patients, instead of "to the extent possible".

Central Service Technicians – ***PA 15-11 (HB 5913)***
Requires anyone who practices as a central service technician (person who decontaminates reusable medical instruments or devices) to be certified and lays out requirements for that certification.

Hospital Training for Patients with Suspected Dementia – ***PA 15-129 (HB 6892)***
Requires hospitals to train direct staff in the symptoms of dementia as part of their regular staff training starting October 1, 2015.

Protections for Elderly:

Protecting Elderly Consumers from Exploitation – ***PA 15-236 (SB 1005)***
Criminalizes the exploitation of elderly persons, prevents perpetrators from profiting from the exploitation, adds certain financial institution employees to mandated reports of suspected abuse of elderly persons, and adopts the Connecticut Uniform Power of Attorney Act.

Bill of Rights for Residents of Continuing-Care Retirement Communities – *PA 15-115 (HB 5358)*
Among other provisions, establishes a bill of rights for residents of CCRCs and additional protections for residents.

Safeguarding of Funds for Residents of Certain LTC Facilities – *PA 15-130 (HB 6894)*
Extends to residential care homes (RCHs) the same statutory requirements that already apply to nursing homes regarding the management of residents' personal funds.

Study of Alternative Funding Sources for Nutritional Services for Senior Citizens – *PA 15-40 (SB 287)*
Requires DSS and SDA to study alternative sources of funding for nutrition services programs with nutrition service stakeholders and report back with recommendations to the Aging Committee by July 1, 2016.

Requirements for Facilities to Complete Medicare/Medicaid Applications for Patients – *PA 15-50 (SB 1022)*
Adds to the patients' bill of rights a provision entitling patients of nursing homes, RCHs, and chronic disease hospitals to receive a copy of any Medicare or Medicaid application completed by the facility on their behalf.

Notice of Abuse Reports Concerning Residents of LTC Facilities – *PA 15-150 (HB 5257)*
Requires DSS, after receiving a report of elder abuse, to notify the residents' legally liable relative or guardian/conservator no later than 24 hours after receiving the report, unless such relative or guardian/conservator is the suspected perpetrator.

Infant and Child Welfare:

Childhood Vaccinations - *PA 15-174 (HB 6949)*
Requires notarization of religious exemptions and attestation that such parents have reviewed and understand info regarding the risks of immunization and failure to immunize.

Cytomegalovirus – *PA 15-10 (HB 5525)*
Requires CMV testing of newborn infants who fail a newborn hearing screening. CMV is a type of herpesvirus (such as chickenpox, shingles, and mono) – while usually harmless in healthy adults and children, CMV in newborns can lead to hearing loss or developmental disabilities.

Infant Safe Sleep Practices – *PA 15-39 (SB 258)*
Requires hospitals, through their maternity programs, to provide new infants' parents or legal guardians with recommendation from the American Academy of Pediatrics' recommendations for safe sleep practices.

Developmental Screenings for Children – *PA 15-157 (HB 6579)*
Requires health care providers, when completing the state's early childhood health and public school health assessment forms for a child age 5 or younger, to indicate on the form whether a development screening was performed.

Adopting the Uniform Interstate Family Support Act of 2008 – *PA 15-71 (HB 6973)*
Adopts the 2008 revisions to UIFSA which includes provisions from a multilateral treaty to promote efficient child support services across states and improved services in international child support cases.

Insurance:

Facilitation of Telehealth – *PA 15-88 (HB 467)*
Establishes requirements for health care providers who provide medical services through the use of telehealth and requires commercial insurance coverage of telehealth to the same extent that they cover the same services through in-person visits.

Payment to an Ambulance Service – *PA 15-110 (SB 253)*
Requires an ambulance service to make a good faith effort to determine whether a person has health insurance before attempting to collect payment from the person for services provided.

Public Health:

Regulating Electronic Nicotine Delivery Systems and Vapor Products – *PA 15-206 (HB 6283)*
Prohibits the use of ENDS and vapor products in areas similar to where smoking tobacco products is currently prohibited.

Birth Certificate Amendments – *PA 15-132 (HB 7006)*
Allows people who have undergone surgical, hormonal, or other clinically appropriate treatment for gender transition to change the sex designate and name on their birth certificate.