Agency Legislative Proposal – 2024 Session
Document Name:

Document Name	**OHS 1**
Legislative Liaison	Cindy Dubuque-Gallo
Division Requesting This Proposal	OHS
Drafter	Cindy Dubuque-Gallo

Title of Proposal	AAC THE ALL-PAYERS CLAIMS DATABASE
Statutory Reference, if any	19a-127k and 19a-755a.
Brief Summary and Statement of Purpose	To make technical and other revisions to the All Payers Claims Database

SECTION-BY-SECTION SUMMARY
Summarize sections in groups where appropriate

Section 1 removes language suggesting that hospitals need to receive APCD data prior to submitting their community benefits report data to OHS.

Section 2 expands data collection by OHS to include non-claims data.

Section 3. Outlines process and timeline for non-claims data reporting requirements.

BACKGROUND

Origin of Proposal **[X] New Proposal** **[ ] Resubmission**

Agency Legislative Proposal – 2024 Session
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If this is a resubmission, please share the prior bill number, the reason the bill did not move forward, and any changes made or conversations had since it was last proposed:

Please consider the following, if applicable:

How does this proposal connect to the 10-year vision for the agency's mission?	Section 1. APCD data is not an essential data set for hospitals to complete their community benefit reporting to the State. Community Health Needs Assessments (CHNAs) and Implementation Strategies are federal requirements pursuant to Internal Revenue Code section §501(r). Neither these documents nor the reports required by the State of Connecticut require APCD data in order to complete. Additionally, the Annual Status report does not require APCD data in order to complete, as it focuses on four questions (updates on health needs, priorities, target populations; changes to Implementation Strategies; progress hospitals have made on their implementation strategies; description of how funds were used to support the hospitals' Implementation Strategy). All items hospitals should be able to answer without the APCD. Section 2. Created in 2012 by Public Act 12-166, Connecticut's All Payer Claims Database (APCD) was established as a program to receive, store, and analyze health insurance claims data. The Act requires health insurers of health care services to submit medical and pharmacy claims data, as well as information on providers and eligibility. Information derived from this data seeks to improve the health of Connecticut's residents through the collection and analysis of data and the promotion of research addressing safety, quality, transparency, access, and efficiency at all levels of health care delivery. Expansion of data collection to non-claims will provide greater ability to address our agency's mission.
How will we measure if the proposal successfully accomplishes its goals?	Our goal is to better understand healthcare cost drivers. We will accomplish our goal through collection of non-claims data when the state of Connecticut is able to identify through the data additional cost drivers that could not be identified through claims data alone.
Have there been changes in federal/state laws or regulations that make this legislation necessary?	Not aware of any

Has this proposal or a similar proposal been implemented in other states? If yes, to what result?	Colorado, Delaware, Massachusetts, and Oregon collect non-claims data in order to get a sharper picture of healthcare cost drivers. There are other elements within the healthcare system that impact one's health or cost of care that are not captured by claims data. Colorado collects non-claims data related to Alternative Payment Models and on prescription drug rebates. The Milbank Memorial Fund has also published content on how to measure non-claims.
Have certain constituencies called for this proposal?	

INTERAGENCY IMPACT
List each affected agency. Copy the table as needed.

[ ] Check here if this proposal does NOT impact other agencies

1. Agency Name	Department of Social Services
Agency Contact (name, title)	Jalmar Rios and David Seifel
Date Contacted	10/2/23
Status	[ ] Approved [ ] Talks Ongoing
Open Issues, if any	Emailed that we would be adding non-claims data to collection for APCD.

FISCAL IMPACT
Include the section number(s) responsible for the fiscal impact and the anticipated impact

[x] Check here if this proposal does NOT have a fiscal impact

State	
Municipal (Include any municipal mandate that can be found within legislation)	

Federal	
Additional notes	

MONITORING & EVALUATION PLAN
If applicable, please describe the anticipated measurable outcomes and the data that will be used to track those outcomes. Include the section number(s) responsible for those outcomes

[ ] Check here if this proposal does NOT lead to any measurable outcomes

ANYTHING ELSE WE SHOULD KNOW?

INSERT FULLY DRAFTED BILL HERE

Section 1. Subsections (f) through (i) of section 19a-127k of the general statues is repealed and the following is substituted in lieu thereof *(effective October 1, 2024)*:

(f)[Notwithstanding the provisions of section 19a-755a, and] to the full extent permitted by 45 CFR 164.514(e), the Office of Health Strategy shall make data in the all-payer claims database available to hospitals for use in their community benefit programs and activities solely for the purposes of (1) preparing the hospital's community health needs assessment, (2) preparing and executing the hospital's implementation strategy, and (3) fulfilling community benefit program reporting, as described in subsections (c) to (e), inclusive, of this section. Any disclosure made by said office pursuant to this subsection of information other than health information shall be made in a manner to protect the confidentiality of such information as may be required by state or federal law.

[(g) A hospital shall not be responsible for limitations in its ability to fulfill community benefit program reporting requirements, as described in subsections (c) to (e), inclusive, of this section, if the

all-payer claims database data is not provided to such hospital, as required by subsection (f) of this section.]

[(h)] (g) On or before April 1, 2024, and annually thereafter, the executive director of the Office of Health Strategy shall develop a summary and analysis of the community benefit program reporting submitted by hospitals under this section during the previous calendar year and post such summary and analysis on its Internet web site and solicit stakeholder input through a public comment period. The Office of Health Strategy shall use such reporting and stakeholder input to:

(1) Identify additional stakeholders that may be engaged to address identified community health needs including, but not limited to, federal, state and municipal entities, nonhospital private sector health care providers and private sector entities that are not health care providers, including community-based organizations, insurers and charitable organizations;

(2) Determine how each identified stakeholder could assist in addressing identified community health needs or augmenting solutions or approaches reported in the implementation strategies;

(3) Determine whether to make recommendations to the Department of Public Health in the development of its state health plan; and

(4) Inform the state-wide health care facilities and services plan established pursuant to section 19a-634.

[(i)] (h) Each for-profit entity licensed as an acute care general hospital shall submit community benefit program reporting consistent with the reporting schedules of subsections (c) to (e), inclusive, of this section, and reasonably similar to what would be included on such hospital's federal filings to the Internal Revenue Service, where applicable.

Section 2. Subdivision (1) of subsection (a) of section 19a-755a of the general statues is repealed and the following is substituted in lieu thereof *(effective October 1, 2024)*:

(1) "All-payer claims database" means a database that receives and stores data from a reporting entity relating to (A) medical insurance claims, dental insurance claims, pharmacy claims and other insurance claims information from enrollment and eligibility files, and (B) non-claims data including but not limited to alternative payment models (care management, shared savings, quality payments and bonuses), pharmacy rebates and other price concessions paid by pharmacy benefit management and drug manufacturers to a health insurance payer, and Information Technology or Electronic Medical Record investments information.

Section 3. (NEW) Add to 19a-755a.

A reporting entity shall submit to the Office of Health Strategy the non-claims data identified in subsection (a)(1)(B) of section 19a-755a. The APCD Advisory Group set forth in section 17b-59f shall recommend reporting requirements for the non-claims data to the executive director of the Office of Heath Strategy.

On or before February 1, 2025, the Advisory Group shall report to the executive director of the Office of Health Strategy its recommendations. Upon adoption of reporting requirements as set forth in subdivision (1) of this subsection, reporting entities shall submit their 2025 calendar year non-claims data to the Office of Health Strategy not later than June 30th, 2026.

On June 30th and annually thereafter, reporting entities shall submit to OHS the preceding calendar year non-claims data.

Agency Legislative Proposal – 2024 Session
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Document Name	**OHS 2**
Legislative Liaison	Cindy Dubuque-Gallo
Division Requesting This Proposal	OHS
Drafter	Cindy Dubuque-Gallo
Title of Proposal	AAC Revisions to the Certificate of Need Program
Statutory Reference, if any	19a-486b; 19a-486i; 19a-630; 19a-638; 19a-639;
Brief Summary and Statement of Purpose	To increase oversight of CON transactions involving public companies and large group practices.

SECTION-BY-SECTION SUMMARY

Summarize sections in groups where appropriate

Agency Legislative Proposal – 2024 Session
Document Name:

Section 1. Definition of "Large Group Practice"

Section 2. Definition of "Group Practice"

Section 3. Increase reporting of group practices

Section 4. Modify review of transfer of ownership of any large practice to any "person". Require CON for proton radiotherapy machine.

Section 5. Requires large group practices to report transfer of ownership and delays implementation of removing exemptions from CON requirements for such transfers of ownership until December 31, 2025.

Section 6. Eliminate presumption in favor of CON application for transfer of ownership for large group practices.

Section 7. Conforming amendment to align with removal of subdivision (b) in subsection 19a-639.

BACKGROUND

Origin of Proposal **[x] New Proposal** **[] Resubmission**

If this is a resubmission, please share the prior bill number, the reason the bill did not move forward, and any changes made or conversations had since it was last proposed:

Please consider the following, if applicable:

How does this proposal connect to the 10-year vision for the agency's mission?	The Certificate of Need program is a tool that the state uses to ensure appropriate health care systems planning for the State of Connecticut. These updates and clarifications to the CON statutes seek to ensure that transfers of ownership for large group practices and group practices are reviewed and meet the best interests of the state.
How will we measure if the proposal successfully	

accomplishes its goals?	
Have there been changes in federal/state laws or regulations that make this legislation necessary?	
Has this proposal or a similar proposal been implemented in other states? If yes, to what result?	
Have certain constituencies called for this proposal?	

INTERAGENCY IMPACT

List each affected agency. Copy the table as needed.

[X] Check here if this proposal does NOT impact other agencies

2. Agency Name	OAG
Agency Contact (name, title)	Cara Passaro

Date Contacted	
Status	**[ ] Approved [x] Talks Ongoing**
Open Issues, if any	

FISCAL IMPACT

Include the section number(s) responsible for the fiscal impact and the anticipated impact

[X] Check here if this proposal does NOT have a fiscal impact

State	
Municipal (Include any municipal mandate that can be found within legislation)	
Federal	
Additional notes	

MONITORING & EVALUATION PLAN

If applicable, please describe the anticipated measurable outcomes and the data that will be used to track those outcomes. Include the section number(s) responsible for those outcomes

[ ] Check here if this proposal does NOT lead to any measurable outcomes

ANYTHING ELSE WE SHOULD KNOW?

INSERT FULLY DRAFTED BILL HERE

Section. 1. Subsection (9) of section 19a-630 of the general statutes is repealed and the following is substituted in lieu thereof (Effective from passage):

(9) "Large group practice" means eight or more full-time equivalent physicians, legally organized in a (A) partnership, (B) professional corporation, (C) limited liability company formed to render professional services, (D) medical foundation, (E) not-for-profit corporation, (F) faculty practice plan, (G) group owned or controlled by a public company or an entity as defined in Conn. Gen. Stat. Sec. 33-602(14), (H) entity where both the payer and provider share the financial risk of managed care; provider entity serving as both a payer and provider, including a payer that offers health care, a provider that offers health care insurance, and joint ventures between payers and providers or (I) other similar entity [(A)] (i) in which each physician who is a member of the group, including any physicians working under a Professional Service Agreement , provides substantially the full range of services that the physician routinely provides, including, but not limited to, medical care, consultation, diagnosis or treatment, through the joint use of shared office space, facilities, equipment or personnel; [(B)] (ii) for which substantially all of the services of the physicians who are members of the group are provided through the group and are billed in the name of the group practice and amounts so received are treated as

receipts of the group; or [(C)] (iii) in which the overhead expenses of, and the income from, the group are distributed in accordance with methods previously determined by members of the group. An entity that otherwise meets the definition of group practice under this section shall be considered a group practice although its shareholders, partners or owners of the group practice include single-physician professional corporations, limited liability companies formed to render professional services or other entities in which beneficial owners are individual physicians.

Sec. 2. Subdivision (10) of subsection (a) of section 19a-486i of the general statutes is repealed and the following is substituted in lieu thereof *(effective October 1, 2024*):

(10) "Group practice" means two or more physicians, legally organized in a (A) partnership, (B) professional corporation, (C) limited liability company formed to render professional services, (D) medical foundation, (E) not-for-profit corporation, (F) faculty practice plan, (G) group owned or controlled by a public company or an entity as defined in Conn. Gen. Stat. Sec. 33-602(14), (H) entity where both the payer and provider share the financial risk of managed care; provider entity serving as both a payer and provider, including a payer that offers health care, a provider that offers health care insurance, and joint ventures between payers and providers, or (I) other similar entity [(A)] (i) in which each physician who is a member of the group, including any physicians working under a Professional Service Agreement, provides substantially the full range of services that the physician routinely provides, including, but not limited to, medical care, consultation, diagnosis or treatment, through the joint use of shared office space, facilities, equipment or personnel; [(B)] (ii) for which substantially all of the services of the physicians who are members of the group are provided through the group and are billed in the name of the group practice and amounts so received are treated as receipts of the group; or [(C)] (iii) in which the overhead expenses of, and the income from, the group are distributed in accordance with methods previously determined by members of the group. An entity that otherwise meets the definition of group practice under this section shall be considered a group practice although its shareholders, partners or owners of the group practice include single-physician professional corporations, limited liability companies formed to render professional services or other entities in which beneficial owners are individual physicians;

Sec. 3. Subsection (h) of section 19a-486i of the general statutes is repealed and the following is substituted in lieu thereof (*effective October 1, 2024*):

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

Section 4. Subdivisions (3) and (11) of subsection (a) of 19a-638 of the general statutes is repealed and the following is substituted in lieu thereof *(effective October 1, 2024)*

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

(11) The acquisition of a proton radiotherapy machine or nonhospital based linear accelerators;

Sec. 5. a new Subsection (XX) of 19a-638 of the general statutes is added:

Notwithstanding the provisions of this section and sections 19a-639, as amended by this act, and 19a-639a, on or before December 31, 2025, upon the applicant's submission of a certificate of need request for determination to the unit, the unit shall automatically issue a certificate of need to any large group practice for a transfer of ownership to any (A) physician, or (B) group of two or more physicians, legally organized in a partnership, professional corporation or limited liability company formed to render professional services and not employed by or an affiliate of any hospital, medical foundation, insurance company or other similar entity.

Sec. 6. Subsection (b) of 19a-639 of the general statutes is repealed (effective October 1, 2024)

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

Sec. 7. Subsection (b) of section 19a-486b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2024*):

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

Agency Legislative Proposal – 2024 Session
Document Name:

Document Name	**OHS 3**

Naming Format: AGENCY ACRONYM PROPOSAL NUMBER - TOPIC

Please insert a copy of the fully drafted bill at the end of this document (required for review)

Legislative Liaison	Cindy Dubuque-Gallo
Division Requesting This Proposal	OHS
Drafter	Cindy Dubuque-Gallo
Title of Proposal	AAC 340B Program Transparency
Statutory Reference, if any	19a-649
Brief Summary and Statement of Purpose	To enhance the transparency of the Federal 340B drug pricing program and how savings from the program are being used by covered entities to benefit low income communities.

SECTION-BY-SECTION SUMMARY

Summarize sections in groups where appropriate

Agency Legislative Proposal – 2024 Session
Document Name:

Section 1. Definitions

Section 2. Reporting requirements

BACKGROUND

Origin of Proposal **[ ] New Proposal** **[x] Resubmission**

If this is a resubmission, please share the prior bill number, the reason the bill did not move forward, and any changes made or conversations had since it was last proposed:

2023 HB 6669 Section 19. Updated to reflect MN language.

Please consider the following, if applicable:

How does this proposal connect to the 10-year vision for the agency's mission?	
How will we measure if the proposal successfully accomplishes its goals?	
Have there been changes in federal/state laws or regulations that make this legislation necessary?	
Has this proposal or a similar proposal been implemented	

in other states? If yes, to what result?	Yes, Minnesota and Maine
Have certain constituencies called for this proposal?	

INTERAGENCY IMPACT

List each affected agency. Copy the table as needed.

[X] Check here if this proposal does NOT impact other agencies

3. Agency Name	
Agency Contact (name, title)	
Date Contacted	
Status	**[ ] Approved [ ] Talks Ongoing**
Open Issues, if any	

FISCAL IMPACT

Include the section number(s) responsible for the fiscal impact and the anticipated impact

[X] Check here if this proposal does NOT have a fiscal impact

State	
Municipal (Include any municipal mandate that can be found within legislation)	
Federal	
Additional notes	

MONITORING & EVALUATION PLAN

If applicable, please describe the anticipated measurable outcomes and the data that will be used to track those outcomes. Include the section number(s) responsible for those outcomes

[ ] Check here if this proposal does NOT lead to any measurable outcomes

Agency Legislative Proposal – 2024 Session
Document Name:

ANYTHING ELSE WE SHOULD KNOW?

INSERT FULLY DRAFTED BILL HERE

Sec. 1. Section 19a-649 of the general statutes is amended by adding subsection (d) as follows (*Effective October 1, 2024*):

(NEW) (d) (1) As used in this subsection:

(A) “340B program" means the plan described in Section 340B of the Public Health Service Act, 42 USC 256b, as amended from time to time, that instructs the federal Secretary of Health and Human Services to enter into agreements with any manufacturer of covered outpatient drugs under which the amount paid to any manufacturer by certain statutorily defined covered entities does not exceed the 340B ceiling price; and

(B) "Covered entity" has the same meaning as Section 340B(a)(4) of the Public Health Service Act, 42 USC 256b(a)(4);

(2) Not later than April 1, 2025, and annually thereafter, each covered entity that participates in the federal 340B program shall file the following information with the Unit:

(A) The aggregated acquisition cost for prescription drugs obtained under the 340B program;

(B) The aggregated payment amount received for drugs obtained under the 340B program and dispensed to patients;

(C) The aggregated payment made to pharmacies under contract to dispense drugs obtained under the 340B program; and

(D) the number of claims for prescription drugs described in paragraph (B).

(3) The information required under subdivision (2) must be reported by payer type, including commercial insurance, Medicaid, and Medicare, in the form and manner defined by the Executive Director. For covered entities that are hospitals, the information required under subdivision (2) must also be reported at the national drug code level for the 50 most frequently dispensed drugs by the facility under the 340B program.

(4) Data submitted under subdivision (2) must include prescription drugs dispensed by outpatient facilities that are identified as child facilities under the federal 340B program based on their inclusion on the hospital's Medicare cost report.

(5) The Office of Health Strategy shall produce and post on its publicly accessible website a report that includes a summary of the aggregate information received from covered entities required to report.