



Agency Legislative Proposal - 2021 Session

Document Name: 10/01/2020, Office of Health Strategy, Facility Fee Statute (19a-508c) Revisions

(If submitting electronically, please label with date, agency, and title of proposal – 092620_SDE_TechRevisions)

State Agency: Office of Health Strategy

Liaison: Demian Fontanella

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Lead agency division requesting this proposal: Health Systems Planning

Agency Analyst/Drafter of Proposal: Demian Fontanella

Title of Proposal: An Act Concerning Various Revisions to Facility Fee Statute

Statutory Reference: Section 19a-508c of the Connecticut General Statutes

Proposal Summary:

The proposed changes will clarify and further strengthen the intent and enforcement of the existing statutory requirements mandating the transparency, patient notification and required annual filings to the Office of Health Strategy by hospitals and health systems which charge or bill Facility Fees.

PROPOSAL BACKGROUND

◇ Reason for Proposal

Please consider the following, if applicable:

- (1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
- (2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)? Are other states considering something similar this year?
- (3) Have certain constituencies called for this action?
- (4) What would happen if this was not enacted in law this session?

The proposed changes will clarify and further strengthen the intent and enforcement of the existing statutory requirements mandating the transparency, patient notification and required annual filings to the Office of Health Strategy by hospitals and health systems which charge or bill Facility Fees.



◇ **Origin of Proposal** **New Proposal** **Resubmission**

If this is a resubmission, please share:

- (1) *What was the reason this proposal did not pass, or if applicable, was not included in the Administration’s package?*
- (2) *Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?*
- (3) *Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?*
- (4) *What was the last action taken during the past legislative session?*

PROPOSAL IMPACT

◇ **AGENCIES AFFECTED** *(please list for each affected agency)*

Agency Name: Agency Contact (name, title, phone): Date Contacted:
Approve of Proposal <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Talks Ongoing
Summary of Affected Agency’s Comments
Will there need to be further negotiation? <input type="checkbox"/> YES <input type="checkbox"/> NO

◇ **FISCAL IMPACT** *(please include the proposal section that causes the fiscal impact and the anticipated impact)*

Municipal <i>(please include any municipal mandate that can be found within legislation)</i>
State – The proposed language imposes no additional fiscal liability for state entities subject to this section beyond what is currently in statute.
Federal
Additional notes on fiscal impact

◇ **POLICY and PROGRAMMATIC IMPACTS** *(Please specify the proposal section associated with the impact)*

The proposed language enhances the granularity of the data hospitals, hospital systems and hospital-based facility must already report to the Health Systems Planning Unit concerning the utilization of
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facility fees. The additional data will provide deeper insight into the impact of such fees on consumers, with detail by insurance status, the impact of and difference between gross charges and net revenue, by payer source.

◇ EVIDENCE BASE

Section 1

Sec. 19a-508c. Hospital and health system facility fees charged for outpatient services at hospital-based facilities. Notice re establishment of hospital-based facility at which facility fees billed. (a) As used in this section:

(1) “Affiliated provider” means a provider that is: (A) Employed by a hospital or health system, (B) under a professional services agreement with a hospital or health system that permits such hospital or health system to bill on behalf of such provider, or (C) a clinical faculty member of a medical school, as defined in section 33-182aa, that is affiliated with a hospital or health system in a manner that permits such hospital or health system to bill on behalf of such clinical faculty member;

(2) “Campus” means: (A) The physical area immediately adjacent to a hospital's main buildings and other areas and structures that are not strictly contiguous to the main buildings but are located within two hundred fifty yards of the main buildings, or (B) any other area that has been determined on an individual case basis by the Centers for Medicare and Medicaid Services to be part of a hospital's campus;

(3) “Facility fee” means any fee charged or billed by a hospital or health system for outpatient services provided in a hospital-based facility that is: (A) Intended to compensate the hospital or health system for the operational expenses of the hospital or health system, and (B) separate and distinct from a professional fee;

(4) “Health system” means: (A) A parent corporation of one or more hospitals and any entity affiliated with such parent corporation through ownership, governance, membership or other means, or (B) a hospital and any entity affiliated with such hospital through ownership, governance, membership or other means;

(5) “Hospital” has the same meaning as provided in section 19a-490;

(6) “Hospital-based facility” means a facility that is owned or operated, in whole or in part, by a hospital or health system where hospital or professional medical services are provided;



(7) “Payer mix” means the proportion of different payer categories from which a hospital receives payment. This includes, but is not limited to, Medicare, Medicaid, commercial insurers, other government insurance, uninsured and self-pay patients.

(8) “Professional fee” means any fee charged or billed by a provider for professional medical services provided in a hospital-based facility; and

[(8)] (9) “Provider” means an individual, entity, corporation or health care provider, whether for profit or nonprofit, whose primary purpose is to provide professional medical services.

(b) If a hospital or health system charges a facility fee utilizing a current procedural terminology evaluation and management (CPT E/M) code for outpatient services provided at a hospital-based facility where a professional fee is also expected to be charged, the hospital or health system shall provide the patient with a written notice that includes the following information:

(1) That the hospital-based facility is part of a hospital or health system and that the hospital or health system charges a facility fee that is in addition to and separate from the professional fee charged by the provider;

(2) (A) The amount of the patient's potential financial liability, including any facility fee likely to be charged, and, where professional medical services are provided by an affiliated provider, any professional fee likely to be charged, or, if the exact type and extent of the professional medical services needed are not known or the terms of a patient's health insurance coverage are not known with reasonable certainty, an estimate of the patient's financial liability based on typical or average charges for visits to the hospital-based facility, including the facility fee, (B) a statement that the patient's actual financial liability will depend on the professional medical services actually provided to the patient, (C) an explanation that the patient may incur financial liability that is greater than the patient would incur if the professional medical services were not provided by a hospital-based facility, and (D) a telephone number the patient may call for additional information regarding such patient's potential financial liability, including an estimate of the facility fee likely to be charged based on the scheduled professional medical services; and

(3) That a patient covered by a health insurance policy should contact the health insurer for additional information regarding the hospital's or health system's charges and fees, including the patient's potential financial liability, if any, for such charges and fees.

(c) If a hospital or health system charges a facility fee without utilizing a current procedural terminology evaluation and management (CPT E/M) code for outpatient services provided at a hospital-based facility, located outside the hospital campus, the hospital or health system shall provide the patient with a written notice that includes the following information:



(1) That the hospital-based facility is part of a hospital or health system and that the hospital or health system charges a facility fee that may be in addition to and separate from the professional fee charged by a provider;

(2) (A) A statement that the patient's actual financial liability will depend on the professional medical services actually provided to the patient, (B) an explanation that the patient may incur financial liability that is greater than the patient would incur if the hospital-based facility was not hospital-based, and (C) a telephone number the patient may call for additional information regarding such patient's potential financial liability, including an estimate of the facility fee likely to be charged based on the scheduled professional medical services; and

(3) That a patient covered by a health insurance policy should contact the health insurer for additional information regarding the hospital's or health system's charges and fees, including the patient's potential financial liability, if any, for such charges and fees.

(d) On and after January 1, 2016, each initial billing statement that includes a facility fee shall: (1) Clearly identify the fee as a facility fee that is billed in addition to, or separately from, any professional fee billed by the provider; (2) provide the corresponding Medicare facility fee reimbursement rate for the same service as a comparison or, if there is no corresponding Medicare facility fee for such service, (A) the approximate amount Medicare would have paid the hospital for the facility fee on the billing statement, or (B) the percentage of the hospital's charges that Medicare would have paid the hospital for the facility fee; (3) include a statement that the facility fee is intended to cover the hospital's or health system's operational expenses; (4) inform the patient that the patient's financial liability may have been less if the services had been provided at a facility not owned or operated by the hospital or health system; and (5) include written notice of the patient's right to request a reduction in the facility fee or any other portion of the bill and a telephone number that the patient may use to request such a reduction without regard to whether such patient qualifies for, or is likely to be granted, any reduction. The hospital, health system or hospital-based facility shall report by July 1st, 2023 and annually thereafter, to the Health Systems Planning Unit of the Office of Health Strategy, the number and total proportion of patients for each payer mix category who have contacted the hospital, health system or hospital-based facility to request a reduction in a facility fee and the number of patients who were granted such a reduction or waiver. The report shall include, by payer mix category, the total aggregated amount of original facility fees charged for all patients who requested a reduction, and the total aggregated amount said facility fees were reduced to. The reported information shall be for the previous calendar year. The hospital, health system or hospital-based facility shall also submit by July 1, 2021, and annually thereafter, to the Health Systems Planning Unit of the Office of Health Strategy, an example of a billing statement in accordance with subsection (d). The billing statement shall not contain patient identifying information but must represent the billing statement format that patients receive pursuant to subsection (d).



(e) The written notices described in subsections (b) to (d), inclusive, and (h) to (j), inclusive, of this section shall be in plain language and in a form that may be reasonably understood by a patient who does not possess special knowledge regarding hospital or health system facility fee charges. On or after July 1, 2021, the written notices in subsections (b) to (d), inclusive, shall include taglines in at least the top fifteen languages spoken by individuals with limited English proficiency in the state.

(f) (1) For nonemergency care, if a patient's appointment is scheduled to occur ten or more days after the appointment is made, such written notice shall be sent to the patient by first class mail, encrypted electronic mail or a secure patient Internet portal not less than three days after the appointment is made. If an appointment is scheduled to occur less than ten days after the appointment is made or if the patient arrives without an appointment, such notice shall be hand-delivered to the patient when the patient arrives at the hospital-based facility.

(2) For emergency care, such written notice shall be provided to the patient as soon as practicable after the patient is stabilized in accordance with the federal Emergency Medical Treatment and Active Labor Act, 42 USC 1395dd, as amended from time to time, or is determined not to have an emergency medical condition and before the patient leaves the hospital-based facility. If the patient is unconscious, under great duress or for any other reason unable to read the notice and understand and act on his or her rights, the notice shall be provided to the patient's representative as soon as practicable.

(g) Subsections (b) to (f), inclusive, and (l) of this section shall not apply if a patient is insured by Medicare or Medicaid or is receiving services under a workers' compensation plan established to provide medical services pursuant to chapter 568.

(h) A hospital-based facility shall prominently display written notice in locations that are readily accessible to and visible by patients, including patient waiting or appointment check-in areas, stating: (1) That the hospital-based facility is part of a hospital or health system, (2) the name of the hospital or health system, and (3) that if the hospital-based facility charges a facility fee, the patient may incur a financial liability greater than the patient would incur if the hospital-based facility was not hospital-based. On and after October 1, 2021, such written notices shall include taglines in at least the top fifteen languages spoken by individuals with limited English proficiency in the state. The hospital-based facility shall submit by July 1, 2021 and annually thereafter, to the Health Systems Planning unit of the Office of Health Strategy, a copy of the public notice displayed in accordance with this subsection.

(i) A hospital-based facility shall clearly hold itself out to the public and payers as being hospital-based, including, at a minimum, by stating the name of the hospital or health system in its signage, marketing materials, Internet web sites and stationery.



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

(k) (1) On and after January 1, ~~2016~~ 2022, if any transaction, as described in subsection (c) of section 19a-486i, results in the establishment of a hospital-based facility at which facility fees ~~will likely~~ may be billed, the hospital or health system, that is the purchaser in such transaction shall, not later than thirty days after such transaction, provide written notice, by first class mail or by other reasonable method, of the transaction to each patient served within the previous three years by the health care facility that has been purchased as part of such transaction.

(2) Such notice shall include the following information:

(A) A statement ~~that~~ indicating the full legal and business name of the health care facility, the date of acquisition, and that it is now a hospital-based facility and is part of a hospital or health system;

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

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

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

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

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



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

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

(5) By July 1, 2021, and annually thereafter, the hospital-based facility that is the subject of a transaction described in subsection (c) of section 19a-486i during the past calendar year, shall report to the Health Systems Planning Unit, the number of patients the hospital-based facility served for the preceding three years, the number of patients notified in accordance with this subsection by which delivery methods such patients were notified, how many patients were notified by which delivery methods, and the date or dates such notifications were sent. Within this annual filing, the hospital-based facility shall attest that the date or dates of notification to patients was within the 30 days from the completion date of the transaction, as required by subsection (k)(1).

(l) Notwithstanding the provisions of this section, no hospital, health system or hospital-based facility shall collect a facility fee for (1) outpatient health care services that use a current procedural terminology evaluation and management (CPT E/M) or assessment and management (CPT A/M) code and are provided at a hospital-based facility located off-site from a hospital campus, or (2) outpatient health care services provided at a hospital-based facility located off-site from a hospital campus, received by a patient who is uninsured of more than the Medicare rate. Notwithstanding the provisions of this subsection, in circumstances when an insurance contract that is in effect on July 1, 2016, provides reimbursement for facility fees prohibited under the provisions of this section, a hospital or health system may continue to collect reimbursement from the health insurer for such facility fees until the date of expiration of such contract, except that an amendment to any such contract extending the expiration date of said contract will not exempt said hospital, health system or hospital-based facility from complying with this subsection. A violation of this subsection shall be considered an unfair trade practice pursuant to chapter 735a. The provisions of this subsection shall not apply to a freestanding emergency department. As used in this subsection, "freestanding emergency department" means a freestanding facility that (A) is structurally separate and distinct from a hospital, (B) provides emergency care, (C) is a department of a hospital licensed under chapter 368v, and (D) has been issued a certificate of need to operate as a freestanding emergency department pursuant to chapter 368z.

(m) (1) Each hospital and health system shall report not later than July 1, 2022, and annually thereafter to the executive director of the Office of Health Strategy concerning facility fees charged



or billed during the preceding calendar year. The report shall be in such form as the Health Systems Planning Unit of the Office of Health Strategy may require. Such report shall include (A) the name and [location] full address of each facility owned or operated by the hospital or health system that provides services for which a facility fee is charged or billed, (B) the number of patient visits at each such facility for which a facility fee was charged or billed, (C) the number, total amount and range of allowable facility fees paid at each such facility by [Medicare, Medicaid, or under private insurance] payer mix policies, (D) for each facility, the total amount of revenue charged or billed by the hospital or health system, as well as the total amount of revenue received by the hospital or health system derived from facility fees, (E) the total amount of revenue charged or billed by the hospital or health system, as well as the total amount of revenue received by the hospital or health system from all facilities derived from facility fees, (F) a [description] list, which includes a current procedural terminology, category I code for each of the [ten] procedures or services provided by the hospital or health system overall that generated [the greatest amount of] facility fee gross revenue, including volume, for each of these [ten] procedures or services and gross and net revenue totals, for each such procedure or service, and, for each such procedure or service, the total net amount of revenue received by the hospital or health system derived from facility fees, and (G) a list of the [top ten] procedures or services, based on patient volume, provided by the hospital or health system overall for which facility fees are billed or charged [based on patient volume], including the gross and net revenue totals received for each such procedure or service. For purposes of this subsection, “facility” means a hospital-based facility that is located outside a hospital campus.

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



Agency Legislative Proposal - 2021 Session

Document Name: 10/01/20, Office of Health Strategy, Community Benefits Programs Statute (19a-127k) Revisions

(If submitting electronically, please label with date, agency, and title of proposal – 092620_SDE_TechRevisions)

State Agency: **Office of Health Strategy**

Liaison: Demian Fontanella

Phone: 860-418-7056

E-mail: demian.fontanella@ct.gov

Lead agency division requesting this proposal: **Health Systems Planning**

Agency Analyst/Drafter of Proposal: **Demian Fontanella**

Title of Proposal: An Act Concerning Various Revisions to Community Benefits Programs Statute

Statutory Reference: Section 19a-127k of the Connecticut General Statutes

Proposal Summary: The proposed changes will transfer the community benefits guidelines and reporting requirements outlined in §19a-127k in a manner that 1) promotes the Governor's commitment to addressing racial equity issues in health and healthcare and 2) shifts responsibility for community benefit data collection and analysis from the Office of Healthcare Advocate to the Office of Health Strategy (OHS).

The proposal will remove the references to Managed Care Organizations from the statute and makes other changes to the existing statute language to strengthen and improve the timing, content, regularity and uniformity of submissions from the hospitals including how community benefits are addressing the health care needs of populations served by the hospitals. The proposal will create a community benefit and community building spending floor and will require race and ethnicity data be collected during the community health needs assessment process. The proposal will require OHS to make the hospital submissions available to the public on the OHS website and will require OHS to annually develop a summary and analysis of such reports received. Lastly, the proposal will change the civil penalty reference to be aligned with the existing civil penalty statute under Chapter 368z.



PROPOSAL BACKGROUND

◇ Reason for Proposal

Please consider the following, if applicable:

- (1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary? **NO**
- (2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)? Are other states considering something similar this year? The trend to link community benefits with CHNAs is mirrored in at [least 10 other states](#). This proposal shifts existing requirements from one agency to another. This is consistent with OHS’ mission and focus on “promoting effective health planning and the provision of quality health care in the state”, which incorporates the community benefit activities into many of its decisions. This proposal more clearly and directly links these activities with the community health needs assessments (CHNA), which must be reported to OHS by Connecticut hospitals and managed care organizations.
- (3) Have certain constituencies called for this action? **NO**
- (4) What would happen if this was not enacted in law this session?

Failure to enact the proposed changes maintains the current statutory scheme, leaving reporting required by this statute under the authority of the Office of Healthcare Advocate. Hospitals would not be required to address the health needs of the communities each serves, as identified in the CHNA, nor commit to any consistent level of investment in these community needs.

- ◇ Origin of Proposal** **New Proposal** **Resubmission**

If this is a resubmission, please share:

- (1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration’s package? 2020 Legislative session ended abruptly due to Covid-19, and many proposals were not acted on.
- (2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
- (3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
- (4) What was the last action taken during the past legislative session?

PROPOSAL IMPACT

◇ AGENCIES AFFECTED (please list for each affected agency)

Agency Name: Office of Healthcare Advocate
Agency Contact (name, title, phone): Sean T. King, Staff Attorney 3, (860) 331-2463
Date Contacted: August 13, 2019 and September 24, 2019.

Approve of Proposal **YES** **NO** Talks Ongoing

Summary of Affected Agency’s Comments

OHA has not published any reports on hospital community benefit programs since 2010. OHA has communicated to OHS that they are not opposed to the transfer of this statute to OHS. On



July 30, 2020, OHA and OHS executed an MOU whereby OHA designated OHS as its agent for the enforcement of the community benefit statute.

Will there need to be further negotiation? YES NO

◇ **FISCAL IMPACT** *(please include the proposal section that causes the fiscal impact and the anticipated impact)*

Municipal *(please include any municipal mandate that can be found within legislation)*

N/A

State: In the event that hospitals required to report under this provision fail to do so, OHS may impose civil penalties in the amount of up to \$1,000/day.

Federal

N/A

Additional notes on fiscal impact

N/A

◇ **POLICY and PROGRAMMATIC IMPACTS** *(Please specify the proposal section associated with the impact)*

This proposal's shift of the required community benefit reporting from OHA to OHS promotes more consistent hospital reporting and data analysis, which is with OHS' statutory mandate. OHA's current guidance to hospitals regarding its enforcement of this statute directs hospitals to submit specified data to OHS, as OHA's designee, as satisfying the reporting requirement. OHS' mission and focus on "promoting effective health planning and the provision of quality health care in the state" leads to the incorporation of community benefits into many of its Certificate of Need (CON) decisions. This proposal requires that reporting entities clearly and directly links these activities to the community health needs assessments (CHNA), which Connecticut hospitals currently must report to OHS. Community Health Needs Assessments prioritize the community's health needs and investments. This proposal establishes a community benefit and community building spending floor as a factor in OHS' review of community benefit activities.

◇ **EVIDENCE BASE**

What data will be used to track the impact of this proposal over time, and what measurable outcome do you anticipate?



Data from hospital reporting, aggregated with additional hospital data provided to OHS will facilitate greater detail and granularity of analysis of hospital engagement with their communities, how hospitals prioritize and address community needs identified in their CHNA, and better inform OHS oversight of the impact of transactions within its oversight authority. Is that data currently available or must it be developed? All data required to be reported under this proposal is already required and being reported. No new methods, data or processes need to be developed.



Sec. 19a-127k. Community benefits programs. Penalty.

(a) As used in this section:

(1) "Community benefits program" means any program to promote preventive care and to reduce racial, ethnic, linguistic, and cultural disparities in health and to improve the health status for all populations residing in the communities within the geographic service areas of a hospital or managed care organization in accordance with guidelines established pursuant to subsection (c) of this section;

(2) ~~"Managed care organization" has the same meaning as provided in section 38a-478~~

~~(3)~~ "Hospital" has the same meaning as provided in section 19a-490;

(3) "Fiscal Year" has the same meaning as provided in section 19a-646.

(b) On or before January 1, 2021, and annually thereafter, each hospital ~~or managed care organization~~ shall submit to the ~~Healthcare Advocate~~, Health Systems Planning Unit of the Office of Health Strategy, or the Office of Health Strategy's Healthcare Advocate's designee, a report on whether the ~~managed care organization or~~ hospital has in place a community benefits program. If a ~~managed care organization or~~ hospital elects to develop a community benefits program, the report required by this subsection shall comply with the reporting requirements of subsection (d) of this section.

(c) A hospital ~~or managed care organization~~ shall develop community benefit guidelines intended to promote preventive care and to improve the health status for all populations residing in the communities within the geographic service area of the hospital, whether or not those individuals are patients of the hospital. The guidelines shall focus on the following principles:

(1) Adoption and publication of a community benefits policy statement setting forth the hospital's commitment to a formal community benefits program;

(2) The responsibility for overseeing the development and implementation of the community benefits program, the resources to be allocated and the administrative mechanisms for the regular evaluation of the program;

(3) Seeking assistance and meaningful participation from the communities within the hospital's geographic service areas in developing and implementing the program, as well as the plan for meaningful community benefit and community building investments, and in defining the targeted populations and the specific health care needs it should address. In doing so, the governing body or management of the hospital shall give priority to: (1) the public health needs outlined in the most recent version of the state health plan prepared by the Department of Public Health pursuant to section 19a-7, and (2) and each hospital's triennial community health needs assessment and implementation strategy. Community health needs assessments shall be prioritized with the input from the community and implementation strategies shall be based on the health needs identified and prioritized; and



(4) Developing its program based upon an assessment of the health care needs and resources of the targeted populations, particularly low and middle-income, medically underserved populations and barriers to accessing health care, including, but not limited to, cultural, linguistic and physical barriers to accessible health care, lack of information on available sources of health care coverage and services, and the benefits of preventive health care. The program shall consider the health care needs of and solicit and incorporate comments from a broad spectrum of age groups, racial and ethnic groups, and health conditions. Activities identified in the implementation strategy shall align with the needs identified in the corresponding community health needs assessment.

(d) Each hospital ~~or managed-care organization~~ shall include in the annual report required by subsection (b) of this section the following components: (1) The community benefits policy statement of the hospital ~~or managed-care organization~~; (2) the mechanism process by which community input and participation is solicited and incorporated in the community benefits program and the hospital's community benefit and community building investments; (3) identification of community health needs that were identified and prioritized in developing the implementation strategy required by required by 26 CFR 501(r)(3), (4) a narrative description of the community benefits, community services, and preventive health education provided or proposed, which may include measurements related to the number of people served and health status outcomes; (5) outcome measures taken to evaluate the ~~results~~ impact of the community benefits program and proposed revisions to the program; (6) to the extent feasible, a community benefits budget and a good faith effort to measure expenditures and administrative costs associated with the community benefits program, including both cash and in-kind commitments; and (7) a summary of the extent to which the hospital ~~or managed-care organization~~ has developed and met the guidelines listed in subsection (c) of this section; ~~and~~ (8) the demographics of the population in the geographic area served by the hospital or the hospital's affiliated clinics; (9) the cost and description of each investment included in the totals reported in Schedule H of the hospital's Form 990 submitted to the Internal Revenue Service; (10) An explanation of how each investment addresses needs identified in the hospital's triennial community health needs assessment and implementation strategy; (11) A description of available evidence that shows how each investment improves community health outcomes; (12) Process measures clarifying how community input was solicited and incorporated in these investment opportunities; and (13) For the last two tax years available, the total hospital expenditure for: (i) Other Community Benefits, as reported on the Internal Revenue Service form 990, Schedule H, Section 7, Other Benefits, lines (e) – (j), and (ii) Community Building Activities, as reported on the Internal Revenue Service form 990, Schedule H, Part II. The Office of Health Strategy shall make a copy of each report available to the public via its website.

(e) No later than January 1, 2022, and biannually thereafter, the Office of Health Strategy, or its designee, shall establish a minimum community benefit and community building spending threshold that hospitals subject to this section must meet or exceed during the biennium. Said threshold shall be based on objective data and criteria, including but not limited to the following:

(1) Historical and current expenditures on community benefits by the hospital;

(2) Community needs identified in the hospital's triennial Community Health Needs Assessment;



(3) The overall financial position of the hospital and the hospital's affiliated clinics based on audited financial statements and other objective data; and

(4) Taxes and payments in lieu of taxes paid by the hospital.

(f) In establishing the community benefit spending threshold under subsection (e) of this section, the Office of Health Strategy shall:

(1) Provide an opportunity for representatives of hospitals to provide input and respond to any findings;

(2) Solicit and consider comments from the general public; and

(3) Adopt reporting standards and rules necessary to carry out the provisions of this section.

(g) The community benefit and community building spending threshold established pursuant to subsection (e) of this section shall designate the minimum proportion of community benefit spending that must be directed to addressing health disparities identified in the community health needs assessment during the next biennium.

(h) [old (e)] The Office of Health Strategy ~~Healthcare Advocate~~, or the Office of Health Strategy's ~~Healthcare Advocate's~~ designee shall, within available appropriations, develop a summary and analysis of the community benefits program reports submitted by hospitals under this section and shall review such reports for adherence to the guidelines set forth in subsection (c) of this section. Not later than March 31, 2022 and biannually thereafter, the Office of Health Strategy shall hold a public hearing on such summary and analysis and make such summary and analysis available on its website.

(i) The Office of Health Strategy may, after notice and opportunity for a hearing, in accordance with chapter ~~54-368z~~, impose a civil penalty on any hospital that fails to submit the report required pursuant to this section by the date specified in subsection (b) of this section.

(j) The Office of Health Strategy shall provide a hospital that fails to meet the community benefit or community building spending floor established under subsection (e) of this section during the prior two-year period with written notice of said deficiency within 15 days of identifying the deficit.

(k) A hospital that fails to meet the community benefit or community building spending floor established under subsection (e) of this section shall:

(1) Provide to the Office of Health Strategy a plan, within 30 days of receipt of the notice required in subsection (k) of this section, detailing how the hospital will: (1) spend the difference between its community benefit and community building spending during the period assessed and the community benefit and building activities spending floor, established pursuant to subsection (e) of this section to address the needs identified in the hospital's most recent community health needs assessment, consistent with the guidelines established pursuant to subsection (c) of this section; and



(2) Not be exempt from taxation under Connecticut General Statutes §12-81 for the next 24 month period.



Agency Legislative Proposal - 2021 Session

Document Name: 10/01/2020, Office of Health Strategy, Race, Ethnicity and Language Data collection standards

(If submitting electronically, please label with date, agency, and title of proposal – 092621_SDE_TechRevisions)

State Agency: Office of Health Strategy

Liaison: Demian Fontanella

Phone: 860-418-7056

E-mail: demian.fontanella@ct.gov

Lead agency division requesting this proposal: Health Systems Planning

Agency Analyst/Drafter of Proposal: Demian Fontanella

Title of Proposal: An Act Concerning Revisions to the Connection to the State-wide Health Information Exchange Statute

Statutory Reference: Section 17b-59e of the Connecticut General Statutes

Proposal Summary:

The proposed changes promote the Governor's commitment to addressing racial equity and will standardize health care provider and hospital race, ethnicity and language data collection and submission requirements for participation in the State's Health Information Exchange (HIE).

PROPOSAL BACKGROUND

◇ Reason for Proposal

Please consider the following, if applicable:

- (1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary?
- (2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)? Are other states considering something similar this year?
- (3) Have certain constituencies called for this action?
- (4) What would happen if this was not enacted in law this session?

The proposed changes will clarify and enhance existing statutory requirements for participation in the State's HIE, and mandates that health care providers and hospitals connecting to the HIE pursuant to C.G.S. 17b-59e collect in their electronic health records (EHR) demographic data about patients' race, ethnicity and language. This does not mandate that hospitals and health care providers to require patients to provide this information. It merely requires that hospitals and health care providers include these data in their EHR for inclusion in the State's HIE to better facilitate the goals of the HIE, as set forth in C.G.S. 17b-59d



◇ **Origin of Proposal** **New Proposal** **Resubmission**

If this is a resubmission, please share:

- (1) *What was the reason this proposal did not pass, or if applicable, was not included in the Administration’s package?*
- (2) *Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?*
- (3) *Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?*
- (4) *What was the last action taken during the past legislative session?*

PROPOSAL IMPACT

◇ **AGENCIES AFFECTED** *(please list for each affected agency)*

Agency Name: Agency Contact (name, title, phone): Date Contacted:
Approve of Proposal <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Talks Ongoing
Summary of Affected Agency’s Comments
Will there need to be further negotiation? <input type="checkbox"/> YES <input type="checkbox"/> NO

◇ **FISCAL IMPACT** *(please include the proposal section that causes the fiscal impact and the anticipated impact)*

Municipal <i>(please include any municipal mandate that can be found within legislation)</i>
State – The proposed language imposes no additional fiscal liability for state entities subject to this section beyond what is currently in statute.
Federal
Additional notes on fiscal impact

◇ **POLICY and PROGRAMMATIC IMPACTS** *(Please specify the proposal section associated with the impact)*

The proposed language clarifies and standardizes race, ethnicity and language data collection requirements for hospitals and health care providers required to connect to the State’s HIE. This proposal does not mandate that patients must provide this information, but that hospitals and health care providers request it and include this data in their EHR for inclusion in the
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State's HIE. C.G.S. 17b-59d(b) establishes the goals of the HIE, which includes the ability to 1) support public health reporting, quality improvement, academic research and health care delivery and payment reform through data aggregation and analytics and 2) support population health analytics. Modifying C.G.S. 17b-59e in this manner facilitates consistent data collection.

◇ **EVIDENCE BASE**

Sec. 17b-59e. Electronic health record systems. Connection to State-wide Health Information Exchange.

(a) For purposes of this section:

(1) "Health care provider" means any individual, corporation, facility or institution licensed by the state to provide health care services; and

(2) "Electronic health record system" means a computer-based information system that is used to create, collect, store, manipulate, share, exchange or make available electronic health records for the purposes of the delivery of patient care.

(b) Not later than one year after commencement of the operation of the State-wide Health Information Exchange, each hospital licensed under chapter 368v and clinical laboratory licensed under section 19a-30 shall maintain an electronic health record system capable of connecting to and participating in the State-wide Health Information Exchange and shall apply to begin the process of connecting to, and participating in, the State-wide Health Information Exchange.

(c) Not later than two years after commencement of the operation of the State-wide Health Information Exchange, (1) each health care provider with an electronic health record system capable of connecting to, and participating in, the State-wide Health Information Exchange shall apply to begin the process of connecting to, and participating in, the State-wide Health Information Exchange, and (2) each health care provider without an electronic health record system capable of connecting to, and participating in, the State-wide Health Information Exchange shall be capable of sending and receiving secure messages that comply with the Direct Project specifications published by the federal Office of the National Coordinator for Health Information Technology.

(d) Each hospital and health care provider with an electronic health record system capable of connecting to, and participating in, the State-wide Health Information Exchange shall, not later than the date by which they are required to connect to the State-wide Health Information Exchange, collect and



include in their electronic health record system self-reported patient demographic data including, but not limited to, race, ethnicity, primary language, insurance status, and disability status.

(e) Each hospital and health care provider required to connect to the State-wide Health Information Exchange pursuant to this section shall adhere to the data collection standards promulgated by the U.S. Department of Health and Human Services' Office of Minority Health, as may be amended from time to time.



Agency Legislative Proposal - 2021 Session

Document Name: 10/01/20, Office of Health Strategy, All-Payer Claims Database Statute (19a-755a) Revisions

(If submitting electronically, please label with date, agency, and title of proposal – 092620_SDE_TechRevisions)

State Agency: **Office of Health Strategy**

Liaison: Demian Fontanella

Phone: 860-418-7056

E-mail: demian.fontanella@ct.gov

Lead agency division requesting this proposal:

Agency Analyst/Drafter of Proposal: **Demian Fontanella**

Title of Proposal: An Act Concerning Various Revisions to All-Payer Claims Database Programs Statute

Statutory Reference: Section 19a-755a of the Connecticut General Statutes

Proposal Summary: The proposed change adds employers that pay medical claims for services approved by the Workers' Compensation Commission to the list of entities required to report medical claims data to the All-Payer Claims Database (APCD).

PROPOSAL BACKGROUND

◇ Reason for Proposal

Please consider the following, if applicable:

- (1) Have there been changes in federal/state/local laws and regulations that make this legislation necessary? **NO**
- (2) Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)? Are other states considering something similar this year? **NO**
- (3) Have certain constituencies called for this action? **NO**
- (4) What would happen if this was not enacted in law this session?

The State's APCD currently does not require employers that pay for employees' medical care under the Workers' Compensation Program to submit those claims to the APCD. During FY20, the Workers' Claims Commission processed over 53,000 injuries through the Workers' Compensation Program, and any claims covered through an approved workers compensation plan are not available for analysis in the APCD, adversely affecting OHS' ability to fulfill its legal requirements.



Origin of Proposal
 New Proposal
 Resubmission

If this is a resubmission, please share:

- (1) What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?
- (2) Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?
- (3) Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?
- (4) What was the last action taken during the past legislative session?

PROPOSAL IMPACT

AGENCIES AFFECTED (please list for each affected agency)

Agency Name: Agency Contact (name, title, phone): Date Contacted:
Approve of Proposal <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Talks Ongoing
Summary of Affected Agency's Comments
Will there need to be further negotiation? <input type="checkbox"/> YES <input type="checkbox"/> NO

FISCAL IMPACT (please include the proposal section that causes the fiscal impact and the anticipated impact)

Municipal (please include any municipal mandate that can be found within legislation) N/A
State: N/A
Federal N/A
Additional notes on fiscal impact N/A

POLICY and PROGRAMMATIC IMPACTS (Please specify the proposal section associated with the impact)

The State's APCD currently does not require employers that pay for employees' medical care under the Workers' Compensation Program to submit those claims to the APCD. As the State continues to seek opportunities to reduce health care costs, improve equity, quality and access, consistent with the Governor's priorities for the 2021 session, the ability to maximize the detail, accuracy and efficiency of



the State's APCD analytics, which inform multiple health policy initiatives, including the cost growth and quality benchmarks, and primary care spending targets required by the Governor's Executive Order number 5. EO #5 requires the Office of Health Strategy to base these benchmarks on "the total health care expenditures in the state from private and public sources" for each calendar year. During FY20, the Workers' Claims Commission processed over 53,000 injuries through the Workers' Compensation Program, and any claims covered through an approved workers compensation plan may not be included or available for analysis in the APCD, adversely affecting OHS' ability to fulfill its statutory requirements.

◇ **EVIDENCE BASE**

What data will be used to track the impact of this proposal over time, and what measurable outcome do you anticipate?

The addition of workers' compensation claims in to the APCD will enable OHS to monitor costs across the health care landscape in Connecticut, identify outliers and work to address excessive increases, low quality care and health equity and access disparities.



Section 1: Section 19a-755a(a) is repealed and the following is substitute in lieu thereof:

Sec. 19a-755a. All-payer claims database program. (a) As used in this section:

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

(2) (A) “Reporting entity” means:

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

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

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

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

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

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

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

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

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

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

(xi) An entity that pays medical claims for services received pursuant to a medical plan approved by the chairman of the Workers’ Compensation Commission, for the provision of medical care that the employer, or the insurer acting on the employer’s behalf, receives for treatment of any injury or illness under a medical plan pursuant to Chapter 568 of the Connecticut General Statutes; and

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



Agency Legislative Proposal - 2021 Session

Document Name: 08/05/20, Office of Health Strategy, Health in All Policies Committee

(If submitting electronically, please label with date, agency, and title of proposal – 092620_SDE_TechRevisions)

State Agency: **Office of Health Strategy**

Liaison: Demian Fontanella
Phone: 860-418-7056
E-mail: demian.fontanella@ct.gov

Lead agency division requesting this proposal: **Health Innovation**

Agency Analyst/Drafter of Proposal: **Laura Morris**

Title of Proposal: An Act Concerning the establishment of a Health in All Policies Committee

Statutory Reference: 19a-754a (b) (6) of the Connecticut General Statutes

Proposal Summary: OHS to establish a Health in All Policies Committee, consistent with the Governor's commitment to addressing racial equity and justice, to consider the many factors that influence individual health beyond clinical services, including socioeconomic status, education, housing, nutrition, and more. Health in All Policies is a strategy that considers the factors that influence health across all levels of policymaking to improve health outcomes.

PROPOSAL BACKGROUND

◇ Reason for Proposal



Please consider the following, if applicable:

(1) *Have there been changes in federal/state/local laws and regulations that make this legislation necessary?* No

(2) *Has this proposal or something similar been implemented in other states? If yes, what is the outcome(s)? Are other states considering something similar this year?* Yes. The State of California was the first state to develop a Health in All Policies Task Force in 2010 through Executive Order S-04-10. In 2015, Vermont's Governor signed an Executive Order establishing a Health in All Policies Task Force to ensure that all people in Vermont have an equal opportunity to be healthy and live in healthy communities. Fairfax County, Virginia adopted a racial and social equity policies as part of their Health in All Policies Task Force initiative. Other states' counties and cities throughout the United States have followed suit in creating Health in All Policies.

(3) *Have certain constituencies called for this action?*

What would happen if this was not enacted in law this session? Important policy decisions will be made without full understanding of the myriad of ancillary factors that impact an individual's health. This approach is consistent with OHS' mission to:(1) Developing and implementing a comprehensive and cohesive health care vision for the state, including, but not limited to, a coordinated state health care cost containment strategy;(2) Promoting effective health planning and the provision of quality health care in the state in a manner that ensures access for all state residents to cost-effective health care services, avoids the duplication of such services and improves the availability and financial stability of such services throughout the state;

Origin of Proposal

New Proposal

Resubmission

If this is a resubmission, please share:

- (1) *What was the reason this proposal did not pass, or if applicable, was not included in the Administration's package?*
- (2) *Have there been negotiations/discussions during or after the previous legislative session to improve this proposal?*
- (3) *Who were the major stakeholders/advocates/legislators involved in the previous work on this legislation?*
- (4) *What was the last action taken during the past legislative session?*

PROPOSAL IMPACT



◇ **AGENCIES AFFECTED** (please list for each affected agency)

Agency Name: Department of Children and Families Agency Contact: Vincent Russo, Legislative Program Director, 860-461-6689 Date Contacted: 9/22/2020
Approve of Proposal <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Talks Ongoing
Summary of Affected Agency's Comments Agency approves of proposal
Will there need to be further negotiation? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO

Agency Name: Department of Economic and Community Development Agency Contact (name, title, phone): Tommy Hyde, Legislative Liaison, 860-500-2346 Date Contacted: 9/22/2020
Approve of Proposal <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Talks Ongoing
Summary of Affected Agency's Comments
Will there need to be further negotiation? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO

Agency Name: Department of Housing Agency Contact (name, title, phone): Aaron Turner, Legislative Liaison, 860-270-8103 Date Contacted: 9/22/2020
Approve of Proposal <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Talks Ongoing



Summary of Affected Agency's Comments

Will there need to be further negotiation? YES NO

Agency Name: Office of Early Childhood

Agency Contact (name, title, phone): Maggie Adair, Director Government & Community Relations, 860-500-4415

Date Contacted: 9/22/2020

Approve of Proposal YES NO Talks Ongoing

Summary of Affected Agency's Comments

Will there need to be further negotiation? YES NO

Agency Name: Department of Agriculture

Agency Contact (name, title, phone): Kayleigh Royston, Legislative Liaison, 860-713-2554

Date Contacted: 9/22/2020

Approve of Proposal YES NO Talks Ongoing

Summary of Affected Agency's Comments

Will there need to be further negotiation? YES NO

Agency Name: Department of Education



Agency Contact (name, title, phone): Laura Stefon, Legislative Liaison, 860-713-6493 Date Contacted: 9/22/2020
Approve of Proposal <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Talks Ongoing
Summary of Affected Agency's Comments
Will there need to be further negotiation? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO

Agency Name: Department of Public Health, Department of Social Services, Department of Mental Health and Addiction Services, Department of Energy and Environmental Services, Department of Insurance, Access Health CT Agency Contact (name, title, phone): Date Contacted: 9/22/2020
Approve of Proposal <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> Talks Ongoing
Summary of Affected Agency's Comments
No response from agency Legislative Liaisons as of submission
Will there need to be further negotiation? <input type="checkbox"/> YES <input type="checkbox"/> NO

◇ **FISCAL IMPACT** (please include the proposal section that causes the fiscal impact and the anticipated impact)



Municipal <i>(please include any municipal mandate that can be found within legislation)</i> N/A
State: N/A
Federal N/A
Additional notes on fiscal impact N/A

◇ **POLICY and PROGRAMMATIC IMPACTS** *(Please specify the proposal section associated with the impact)*

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◇ **EVIDENCE BASE**

<p><i>What data will be used to track the impact of this proposal over time, and what measurable outcome do you anticipate?</i> The Health in All Policies Committee will determine methods to evaluate and track process and impact.</p> <p><i>Is that data currently available or must it be developed?</i></p> <p>Data will be developed.</p>
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Section 1: (NEW) There is established within the Office of Health Strategy, pursuant to section 19a-754a, a Health in All Policies Committee to align around a common vision for a healthy and equitable society, and that health is considered in decision making across agencies, sectors and policy areas.

The Health In All Policies committee shall develop a comprehensive, cross-sectoral strategic plan to eliminate health disparities and inequities, including a broad set of recommendations at improving the efficiency, cost effectiveness, and collaborative nature of state government related to air and water quality, natural resources and agricultural land, affordable housing, infrastructure systems, public health, sustainable communities and climate change on health when formulating policy.

The plan developed by the Health In All Policies Committee shall address the following elements:

- (a) Promote health, equity and sustainability by incorporating health and equity into specific policies, programs and processes and by embedding health and equity considerations into government decision making processes
- (b) Support intersectoral collaboration by bringing together partners for many sectors to recognize the links between health and other issue and policy areas, break down silos, and build new partnerships to promote health and equity and increase government efficiency
- (c) Benefit multiple partners and simultaneously address the policy and programmatic goals of both public health and other agencies;
- (d) Engage stakeholders beyond government partners, such as community members, policy experts, advocates, the private sector and funders;
- (e) Create structural or procedural change in order to fundamentally change how government works by embedding health and equity into government decision-making processes at all levels.

The executive director of the Office of Health Strategy, or the executive director's designee, shall act as the chair of the Health in All Policies Committee and shall appoint the following members to said body:



- (1) The Commissioner of Public Health, or the commissioner's designee
- (2) The Commissioner of Department of Children and Families, or the commissioner's designee
- (3) The Commissioner of Office of Early Childhood, or the commissioner's designee
- (4) The Commissioner of Department of Housing, or the commissioner's designee
- (5) The Commissioner of Department of Social Services, or the commissioner's designee
- (6) The Commissioner of Department of Agriculture, or the commissioner's designee
- (7) The Commissioner of Department of Economic and Community Development, or the commissioner's designee
- (8) The Commissioner of Department of Education, or the commissioner's designee
- (9) The Chief Executive Officer of Access Health Connecticut or designee
- (10) Community organizations actively working on health disparities and inequities
- (11) Community members and community-based/non-governmental organizations