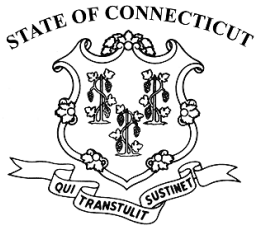

Substitute Senate Bill No. 289

Public Act No. 16-77

AN ACT CONCERNING PATIENT NOTICES, DESIGNATION OF A HEALTH INFORMATION TECHNOLOGY OFFICER, ASSETS PURCHASED FOR THE STATE-WIDE HEALTH INFORMATION EXCHANGE AND MEMBERSHIP OF THE STATE HEALTH INFORMATION TECHNOLOGY ADVISORY COUNCIL

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

Section 1. Subsection (e) of section 38a-1084a of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(e) (1) On and after **[**January 1, 2017**]** one hundred eighty days after the report described in subsection (c) of this section is initially made available to the public on the Insurance Department's and Department of Public Health's Internet web sites, each hospital shall, at the time of scheduling a diagnosis or procedure for nonemergency care, regardless of the location or setting where such services are delivered, that is included in the report submitted to the exchange by the Insurance Commissioner and the Commissioner of Public Health pursuant to subsection (c) of this section, notify the patient of the patient's right to make a request for cost and quality information. Upon the request of a patient for a diagnosis or procedure included in such report, the hospital shall, not later than three business days after scheduling such diagnosis or procedure, provide written notice,

electronically or by mail, to the patient who is the subject of the diagnosis or procedure concerning: (A) If the patient is uninsured, the amount to be charged for the diagnosis or procedure if all charges are paid in full without a public or private third party paying any portion of the charges, including the amount of any facility fee, or, if the hospital is not able to provide a specific amount due to an inability to predict the specific treatment or diagnostic code, the estimated maximum allowed amount or charge for the admission or procedure, including the amount of any facility fee; (B) the corresponding Medicare reimbursement amount or, if there is no corresponding Medicare reimbursement amount for such diagnosis or procedure, (i) the approximate amount Medicare would have paid the hospital for the services on the billing statement, or (ii) the percentage of the hospital's charges that Medicare would have paid the hospital for the services; (C) if the patient is insured, the allowed amount, the toll-free telephone number and the Internet web site address of the patient's health carrier where the patient can obtain information concerning charges and out-of-pocket costs; (D) The Joint Commission's composite accountability rating and the Medicare hospital compare star rating for the hospital, as applicable; and (E) the Internet web site addresses for The Joint Commission and the Medicare hospital compare tool where the patient may obtain information concerning the hospital.

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

Sec. 2. Subsections (d) to (g), inclusive, of section 19a-508c of the 2016 supplement to the general statutes are repealed and the following is substituted in lieu thereof (*Effective from passage*):

(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.

(e) The written notice 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.

(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 (k) 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.

Sec. 3. Section 38a-477e of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) On and after **[**July 1, 2016**]** January 1, 2017, each health carrier shall maintain an Internet web site and toll-free telephone number that enables consumers to request and obtain: (1) Information on in-network costs for inpatient admissions, health care procedures and services, including (A) the allowed amount for, at a minimum, admissions and procedures reported to the exchange pursuant to section 38a-1084a, as amended by this act, for each health care provider in the state; (B) the estimated out-of-pocket costs that a consumer would be responsible for paying for any such admission or procedure that is medically necessary, including any facility fee, coinsurance, copayment, deductible or other out-of-pocket expense; and (C) data or other information concerning (i) quality measures for the health care provider, (ii) patient satisfaction, to the extent such information is available, (iii) a list of in-network health care providers, (iv) whether a health care provider is accepting new patients, and (v) languages

spoken by health care providers; and (2) information on out-of-network costs for inpatient admissions, health care procedures and services.

(b) A health carrier shall advise the consumer when providing the information on out-of-pocket costs that the amounts are estimates and that the consumer's actual cost may vary due to health care provider contractual changes, the need for unforeseen services that arise out of the proposed admission or procedure or other circumstances.

(c) The provisions of this section shall not apply to a health carrier with less than forty thousand covered lives in the state. If in any year, a health carrier exceeds forty thousand covered lives in the state, the provisions of this section shall begin to apply on January first in the following year.

Sec. 4. (NEW) (*Effective from passage*) The Lieutenant Governor shall, within existing resources, designate an individual to serve as Health Information Technology Officer. The Health Information Technology Officer shall be responsible for coordinating all state health information technology initiatives and may seek private and federal funds for staffing to support such initiatives.

Sec. 5. Section 17b-59a of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) As used in this section:

(1) "Electronic health information system" means an information processing system, involving both computer hardware and software that deals with the storage, retrieval, sharing and use of health care information, data and knowledge for communication and decision making, and includes: (A) An electronic health record that provides access in real time to a patient's complete medical record; (B) a

personal health record through which an individual, and anyone authorized by such individual, can maintain and manage such individual's health information; (C) computerized order entry technology that permits a health care provider to order diagnostic and treatment services, including prescription drugs electronically; (D) electronic alerts and reminders to health care providers to improve compliance with best practices, promote regular screenings and other preventive practices, and facilitate diagnoses and treatments; (E) error notification procedures that generate a warning if an order is entered that is likely to lead to a significant adverse outcome for a patient; and (F) tools to allow for the collection, analysis and reporting of data on adverse events, near misses, the quality and efficiency of care, patient satisfaction and other healthcare-related performance measures.

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

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

(b) The Commissioner of Social Services<u>, in consultation with the Health Information Technology Officer,</u> shall (1) develop, throughout the Departments of Developmental Services, Public Health, Correction, Children and Families, Veterans' Affairs and Mental Health and Addiction Services, uniform management information, uniform statistical information, uniform terminology for similar facilities,

uniform electronic health information technology standards and uniform regulations for the licensing of human services facilities, (2) plan for increased participation of the private sector in the delivery of human services, (3) provide direction and coordination to federally funded programs in the human services agencies and recommend uniform system improvements and reallocation of physical resources and designation of a single responsibility across human services agencies lines to eliminate duplication.

(c) The **[**Commissioner of Social Services**]** Health Information Technology Officer, designated in accordance with section 4 of this act, shall, in consultation with the Commissioner of Social Services and the Health Information Technology Advisory Council, established pursuant to section 17b-59f, as amended by this act, implement and periodically revise the state-wide health information technology plan established pursuant to this section and shall establish electronic data standards to facilitate the development of integrated electronic health information systems for use by health care providers and institutions that receive state funding. Such electronic data standards shall: (1) Include provisions relating to security, privacy, data content, structures and format, vocabulary and transmission protocols; (2) limit the use and dissemination of an individual's Social Security number and require the encryption of any Social Security number provided by an individual; (3) require privacy standards no less stringent than the "Standards for Privacy of Individually Identifiable Health Information" established under the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time, and contained in 45 CFR 160, 164; (4) require that individually identifiable health information be secure and that access to such information be traceable by an electronic audit trail; (5) be compatible with any national data standards in order to allow for interstate interoperability; (6) permit the collection of health information in a standard electronic format; and (7) be compatible with the requirements for an electronic health

information system.

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

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

(f) Not later than February 1, **[**2016**]** 2017, and annually thereafter, the **[**Commissioner of Social Services**]** Health Information Technology Officer, in consultation with the State Health Information Technology Advisory Council, shall report in accordance with the provisions of section 11-4a to the joint standing committees of the General Assembly having cognizance of matters relating to human services and public health concerning: (1) The development and implementation of the state-wide health information technology plan and data standards, established and implemented by the **[**Commissioner of Social Services**]** Health Information Technology Officer pursuant to this section; (2) the establishment of the State-wide Health Information Exchange; and (3) recommendations for policy, regulatory and legislative changes and other initiatives to promote the state's health information technology and exchange goals.

Sec. 6. Section 17b-59d of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) There shall be established a State-wide Health Information Exchange to empower consumers to make effective health care decisions, promote patient-centered care, improve the quality, safety and value of health care, reduce waste and duplication of services, support clinical decision-making, keep confidential health information secure and make progress toward the state's public health goals.

(b) It shall be the goal of the State-wide Health Information Exchange to: (1) Allow real-time, secure access to patient health information and complete medical records across all health care provider settings; (2) provide patients with secure electronic access to their health information; (3) allow voluntary participation by patients to access their health information at no cost; (4) support care coordination through real-time alerts and timely access to clinical information; (5) reduce costs associated with preventable

readmissions, duplicative testing and medical errors; (6) promote the highest level of interoperability; (7) meet all state and federal privacy and security requirements; (8) support public health reporting, quality improvement, academic research and health care delivery and payment reform through data aggregation and analytics; (9) support population health analytics; (10) be standards-based; and (11) provide for broad local governance that (A) includes stakeholders, including, but not limited to, representatives of the Department of Social Services, hospitals, physicians, behavioral health care providers, long-term care providers, health insurers, employers, patients and academic or medical research institutions, and (B) is committed to the successful development and implementation of the State-wide Health Information Exchange.

(c) All contracts or agreements entered into by or on behalf of the state relating to health information technology or the exchange of health information shall be consistent with the goals articulated in subsection (b) of this section and shall utilize contractors, vendors and other partners with a demonstrated commitment to such goals.

(d) (1) The **[**Commissioner of Social Services**]** Health Information Technology Officer, designated in accordance with section 4 of this act, in consultation with the Secretary of the Office of Policy and Management and the State Health Information Technology Advisory Council, established pursuant to section 17b-59f, as amended by this act, shall, upon the approval by the State Bond Commission of bond funds authorized by the General Assembly for the purposes of establishing a State-wide Health Information Exchange, develop and issue a request for proposals for the development, management and operation of the State-wide Health Information Exchange. Such request shall promote the reuse of any and all enterprise health information technology assets, such as the existing Provider Directory, Enterprise Master Person Index, Direct Secure Messaging Health

Information Service provider infrastructure, analytic capabilities and tools that exist in the state or are in the process of being deployed. Any enterprise health information exchange technology assets purchased after the effective date of this section and prior to the implementation of the State-wide Health Information Exchange shall be capable of interoperability with a State-wide Health Information Exchange.

(2) Such request for proposals may require an eligible organization responding to the request to: (A) Have not less than three years of experience operating either a state-wide health information exchange in any state or a regional exchange serving a population of not less than one million that (i) enables the exchange of patient health information among health care providers, patients and other authorized users without regard to location, source of payment or technology, (ii) includes, with proper consent, behavioral health and substance abuse treatment information, (iii) supports transitions of care and care coordination through real-time health care provider alerts and access to clinical information, (iv) allows health information to follow each patient, (v) allows patients to access and manage their health data, and (vi) has demonstrated success in reducing costs associated with preventable readmissions, duplicative testing or medical errors; (B) be committed to, and demonstrate, a high level of transparency in its governance, decision-making and operations; (C) be capable of providing consulting to ensure effective governance; (D) be regulated or administratively overseen by a state government agency; and (E) have sufficient staff and appropriate expertise and experience to carry out the administrative, operational and financial responsibilities of the State-wide Health Information Exchange.

(e) Notwithstanding the provisions of subsection (d) of this section, if, on or before January 1, 2016, the Commissioner of Social Services, in consultation with the State Health Information Technology Advisory Council, established pursuant to section 17b-59f, as amended by this

act, submits a plan to the Secretary of the Office of Policy and Management for the establishment of a State-wide Health Information Exchange consistent with subsections (a), (b) and (c) of this section, and such plan is approved by the secretary, the commissioner may implement such plan and enter into any contracts or agreements to implement such plan.

(f) The **[**Department of Social Services**]** Health Information Technology Officer shall have administrative authority over the State-wide Health Information Exchange.

Sec. 7. Section 17b-59f of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) There shall be a State Health Information Technology Advisory Council to advise the **[**Commissioner of Social Services**]** Health Information Technology Officer, designated in accordance with section 4 of this act, in developing priorities and policy recommendations for advancing the state's health information technology and health information exchange efforts and goals and to advise the **[**commissioner**]** Health Information Technology Officer in the development and implementation of the state-wide health information technology plan and standards and the State-wide Health Information Exchange, established pursuant to section 17b-59d, as amended by this act. The advisory council shall also advise the **[**commissioner**]** Health Information Technology Officer regarding the development of appropriate governance, oversight and accountability measures to ensure success in achieving the state's health information technology and exchange goals.

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

(1) The Health Information Technology Officer, appointed in

accordance with section 4 of this act, or the Health Information Technology Officer's designee;

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

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

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

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

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

[(6)**]** (7) The Healthcare Advocate, or the Healthcare Advocate's designee;

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

[(8) Two**]** (9) Three members appointed by the president pro tempore of the Senate, one each who shall be (A) a representative of a federally qualified health center, **[**and**]** (B) a provider of behavioral health services, and (C) a representative of the Connecticut State Medical Society;

[(9) Two**]** (10) Three members appointed by the speaker of the House of Representatives, one each who shall be (A) a **[**representative of an outpatient surgical facility, and**]** technology expert who represents a hospital system, as defined in section 19a-486i, (B) a provider of home health care services, and (C) a health care consumer or a health care consumer advocate;

[(10)**]** (11) One member appointed by the majority leader of the Senate, who shall be a representative of an independent community hospital;

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

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

[(13)**]** (14) One member appointed by the minority leader of the House of Representatives, who shall be an expert in health care analytics and quality analysis;

[(14)**]** (15) The president pro tempore of the Senate, or the president's designee;

[(15)**]** (16) The speaker of the House of Representatives, or the speaker's designee;

[(16)**]** (17) The minority leader of the Senate, or the minority leader's designee; and

[(17)**]** (18) The minority leader of the House of Representatives, or the minority leader's designee.

(c) Any member appointed or designated under subdivisions **[**(8)**]** (9) to **[**(17)**]** (18), inclusive, of subsection **[**(c)**]** (b) of this section may be a member of the General Assembly.

(d) **[**All appointments to the council shall be made not later than August 1, 2015. The Commissioner of Social Services shall schedule the first meeting of the council, which shall be held not later than September 1, 2015. The Commissioner of Social Services**]** The Health Information Technology Officer, appointed in accordance with section 4 of this act, shall serve as a chairperson of the council. The council shall elect a second chairperson from among its members, who shall not be a state official. **[**The council shall meet not less than three times prior to January 1, 2016.**]** The terms of the members shall be coterminous with the terms of the appointing authority for each member and subject to the provisions of section 4-1a. If any vacancy occurs on the council, the appointing authority having the power to make the appointment under the provisions of this section and shall appoint a person in accordance with the provisions of this section. A majority of the members of the council shall constitute a quorum. Members of the council shall serve without compensation, but shall be reimbursed for all reasonable expenses incurred in the performance of their duties.

(e) Prior to submitting any application, proposal, planning document or other request seeking federal grants, matching funds or other federal support for health information technology or health information exchange, the Health Information Technology Officer or the Commissioner of Social Services shall present such application, proposal, document or other request to the council for review and comment.