



# Senate

General Assembly

**File No. 533**

January Session, 2009

Substitute Senate Bill No. 678

*Senate, April 8, 2009*

The Committee on Public Health reported through SEN. HARRIS of the 5th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

***AN ACT IMPLEMENTING CHRONIC DISEASE MANAGEMENT AND WELLNESS AND PREVENTION STRATEGIES TO REDUCE HEALTH CARE COSTS.***

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

1 Section 1. (NEW) (*Effective July 1, 2011*) (a) There is hereby created as  
2 a body politic and corporate, constituting a public instrumentality and  
3 political subdivision of the state created for the performance of an  
4 essential public and governmental function, the Connecticut Health  
5 Care Cost Containment Authority which is empowered to carry out  
6 the purposes of the authority, as defined in subsection (b) of this  
7 section, which are hereby determined to be public purposes for which  
8 public funds may be expended. The Connecticut Health Care Cost  
9 Containment Authority shall not be construed to be a department,  
10 institution or agency of the state.

11 (b) "Purposes of the authority" means the purposes of the authority  
12 expressed in and pursuant to this section, including with respect to the  
13 promotion, planning and designing, developing, assisting, acquiring,

14 constructing, reconstructing, improving, maintaining and equipping  
15 and furnishing of health care, health care information technology and  
16 the health care delivery system and assisting directly or indirectly in  
17 the financing of the costs thereof.

18 (c) The Connecticut Health Care Cost Authority shall develop a  
19 community-based health care utility model that shall reform the  
20 delivery of health care services in the state and finance the  
21 procurement of the technology that is required for the implementation  
22 of a comprehensive chronic disease management program and a  
23 wellness and prevention program administered through use of  
24 medical homes. Such model shall: (1) Prioritize the use of medical  
25 homes to improve outcomes for those who are chronically ill; (2) place  
26 emphasis on the use of case management services, disease  
27 management and care coordination; (3) leverage federal dollars to the  
28 maximum extent permissible to establish a viable health information  
29 exchange throughout the state; (4) reduce reliance on emergency room  
30 care as a means of accessing health care; (5) promote preventive care  
31 and wellness programs; (6) promote shared decision making between  
32 health care providers and their patients; and (7) provide incentives to  
33 health care providers who demonstrate improved health outcomes for  
34 patients through implementation of the practices set forth in this  
35 subsection.

36 Sec. 2. (NEW) (*Effective July 1, 2011*) (a) As used in this section and  
37 section 3 of this act:

38 (1) "Shared decision making" means a process whereby a physician  
39 or other health care provider discusses with a patient, or his or her  
40 representative, the information specified in this section with the use of  
41 a patient decision aid and such patient shares personal information  
42 with the health care provider for purposes of evaluating treatment  
43 options and possible side effects associated with such treatment  
44 options; and

45 (2) "Patient decision aid" means a written, audio-visual, or online  
46 tool that provides a balanced presentation of the health condition and

47 treatment options, benefits and harms associated with such treatment  
48 options, including, if appropriate, a discussion of the limits of scientific  
49 knowledge about health outcomes. Any such patient decision aid shall  
50 be certified by one or more national certifying organizations.

51 (b) If a patient while legally competent, or his or her duly  
52 authorized legal representative if such patient is not competent, signs:  
53 (1) A consent form, prepared in language that the patient could  
54 reasonably be expected to understand that contains: (A) The nature  
55 and character of the proposed treatment; (B) the anticipated results of  
56 the proposed treatment; (C) the recognized possible alternative forms  
57 of treatment, including nontreatment; (D) the recognized serious  
58 possible risks, side effects and complications associated with such  
59 treatment; (E) anticipated benefits of such treatment; and (F) a  
60 statement that advises the patient of the actions that he or she should  
61 take should such patient experience any side effects or complications  
62 associated with such treatment; or (2) a statement that such patient has  
63 made an informed decision not to be apprised of the elements set forth  
64 in subdivision (1) of this subsection; then such signed consent form or  
65 signed statement of the patient's informed decision not to be apprised  
66 of treatment options shall constitute prima facie evidence that such  
67 patient provided informed consent to the health care provider for the  
68 treatment administered or alternatively made an informed decision not  
69 to be apprised about treatment options. The health care provider shall  
70 ensure that the patient is immediately provided with a copy of any  
71 statement signed pursuant to the provisions of this subsection. A  
72 patient who signs such consent form or statement indicating that such  
73 patient has made an informed decision not to be apprised of treatment  
74 options shall have the burden of rebutting by a preponderance of the  
75 evidence that such consent was not in fact informed consent or that  
76 such informed decision not to be apprised of treatment options was  
77 not in fact an informed decision.

78 (c) If a patient while legally competent, or his or her representative  
79 if he or she is not competent, signs an acknowledgement of shared  
80 decision making, such acknowledgement shall constitute prima facie

81 evidence that the patient gave his or her informed consent to the  
82 treatment administered and such patient shall have the burden of  
83 rebutting by clear and convincing evidence that such consent was not  
84 in fact informed consent. An acknowledgement of shared decision  
85 making shall include: (1) A statement that the patient, or his or her  
86 representative, and the health care provider have engaged in shared  
87 decision making as an alternative means of satisfying informed  
88 consent requirements by law or professional accreditation standards;  
89 (2) a brief description of the services that the patient and provider  
90 jointly have agreed will be furnished on the patient's behalf; (3) a brief  
91 description of the patient decision aid or aids that have been used by  
92 the patient and provider to address: (A) High-quality, up-to-date  
93 information about the patient's condition, including, treatment  
94 options, benefits and harms associated with such treatment options,  
95 and, if appropriate, a discussion of the limits of scientific knowledge  
96 about health outcomes; (B) values clarification that assists the patient  
97 in selecting treatment options that conform with the patient's values  
98 and preferences; and (C) guidance in the deliberative decision process,  
99 that is designed to improve the patient's involvement in such decision  
100 process; (4) a statement that the patient, or his or her representative,  
101 understands the risk or seriousness of the disease or condition to be  
102 prevented or treated, the available treatment alternatives, including  
103 nontreatment, and the risks, benefits and uncertainties of the treatment  
104 alternatives, including nontreatment; (5) a statement that advises the  
105 patient of the actions that he or she should take should such patient  
106 experience any side effects or complications associated with such  
107 treatment; and (6) a statement certifying that the patient, or his or her  
108 representative, has had the opportunity to ask the provider questions  
109 and to have any questions answered to the patient's satisfaction, and  
110 that indicates the patient's intent to receive the identified services. A  
111 health care provider shall ensure that a patient who signs an  
112 acknowledgement of shared decision making is immediately provided  
113 with a copy of the signed document.

114 (d) A health care provider's failure to use a prescribed form shall not  
115 be admissible as evidence of failure to obtain informed consent. A

116 health care provider's failure to engage in shared decision making,  
117 with or without the use of a patient decision aid, shall not be  
118 admissible as evidence of failure to obtain informed consent. There  
119 shall be no liability, civil or otherwise, resulting from a health care  
120 provider's choice to obtain informed consent by means of the signed  
121 consent form described in subsection (b) of this section or the signed  
122 acknowledgement of shared decision making described in subsection  
123 (c) of this section.

124 Sec. 3. (NEW) (*Effective July 1, 2011*) (a) The Department of Public  
125 Health, in collaboration with the State Comptroller, shall develop and  
126 implement a shared decision-making demonstration project. The  
127 demonstration project shall be conducted at one or more  
128 multispecialty group practice sites providing state purchased health  
129 care.

130 (b) The demonstration project shall include the following elements:  
131 (1) Incorporation into clinical practice of one or more patient decision  
132 aids for one or more identified preference-sensitive care areas  
133 combined with ongoing training and support of involved health care  
134 providers and practice teams, preferably at sites with necessary  
135 supportive health information technology; and (2) an evaluation of: (A)  
136 The impact of the use of shared decision making with patient decision  
137 aids, including the use of preference-sensitive health care services  
138 selected for the demonstration project and expenditures for those  
139 services; (B) the impact on patients, including patient understanding of  
140 the treatment options presented and the affinity between patient  
141 values and the care received; and (C) patient and provider satisfaction  
142 with the shared decision-making process.

143 (c) As a condition of participating in the demonstration project, a  
144 participating practice site shall bear the cost of selecting, purchasing  
145 and incorporating the chosen patient decision aids into clinical  
146 practice.

147 (d) Not later than July 1, 2012, the Commissioner of Public Health  
148 shall report, in accordance with the provisions of section 11-4a of the

149 general statutes, on the status of the demonstration project to the joint  
150 standing committee of the General Assembly having cognizance of  
151 matters relating to public health.

152 Sec. 4. Section 20-7a of the general statutes is repealed and the  
153 following is substituted in lieu thereof (*Effective July 1, 2009*):

154 (a) Any practitioner of the healing arts who agrees with any clinical  
155 laboratory, either private or hospital, to make payments to such  
156 laboratory for individual tests or test series for patients shall disclose  
157 on the bills to patients or third party payors the name of such  
158 laboratory, the amount or amounts charged by such laboratory for  
159 individual tests or test series and the amount of his procurement or  
160 processing charge, if any, for each test or test series. Any person who  
161 violates the provisions of this section shall be fined not more than one  
162 hundred dollars.

163 (b) Each practitioner of the healing arts who recommends a test to  
164 aid in the diagnosis of a patient's physical condition shall, to the extent  
165 the practitioner is reasonably able, inform the patient of the  
166 approximate range of costs of such test.

167 (c) Each practitioner of the healing arts who (1) has an ownership or  
168 investment interest in an entity that provides diagnostic or therapeutic  
169 services, or (2) receives compensation or remuneration for referral of  
170 patients to an entity that provides diagnostic or therapeutic services  
171 shall disclose such interest to any patient prior to referring such patient  
172 to such entity for diagnostic or therapeutic services and provide  
173 reasonable referral alternatives. Such information shall be verbally  
174 disclosed to each patient or shall be posted in a conspicuous place  
175 visible to patients in the practitioner's office. The posted information  
176 shall list the therapeutic and diagnostic services in which the  
177 practitioner has an ownership or investment interest and therapeutic  
178 and diagnostic services from which the practitioner receives  
179 compensation or remuneration for referrals and state that alternate  
180 referrals will be made upon request. Therapeutic services include  
181 physical therapy, radiation therapy, intravenous therapy and

182 rehabilitation services including physical therapy, occupational  
 183 therapy or speech and language pathology, or any combination of such  
 184 therapeutic services. This subsection shall not apply to in-office  
 185 ancillary services. As used in this subsection, "ownership or  
 186 investment interest" does not include ownership of investment  
 187 securities that are purchased by the practitioner on terms available to  
 188 the general public and are publicly traded; and "entity that provides  
 189 diagnostic or therapeutic services" includes services provided by an  
 190 entity that is within a hospital but is not owned by the hospital.  
 191 Violation of this subsection constitutes conduct subject to disciplinary  
 192 action under subdivision (6) of subsection (a) of section 19a-17.

193 (d) A provider of anatomic pathology services shall not submit a bill  
 194 for the provision of such services to any person or entity other than the  
 195 patient, the responsible insurer of a third party payor, or a  
 196 governmental agency or such agency's public or private agent that is  
 197 acting on behalf of the recipient of such services. For purposes of this  
 198 subsection, "anatomic pathology services" means histopathology or  
 199 surgical pathology, cytopathology, hematology, subcellular pathology  
 200 or molecular pathology or blood banking service performed by a  
 201 pathologist and "provider" means any person or organization that  
 202 furnishes health care services and is licensed or certified to furnish  
 203 such services pursuant to chapter 368a or chapter 370.

This act shall take effect as follows and shall amend the following sections:

Section 1	July 1, 2011	New section
Sec. 2	July 1, 2011	New section
Sec. 3	July 1, 2011	New section
Sec. 4	July 1, 2009	20-7a

**PH** Joint Favorable Subst.

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

### **OFA Fiscal Note**

#### **State Impact:**

<b>Agency Affected</b>	<b>Fund-Effect</b>	<b>FY 12 \$</b>
Public Health, Dept.	GF - Cost	79,000
Comptroller Misc. Accounts (Fringe Benefits) <sup>1</sup>	GF - Cost	19,650

Note: GF=General Fund

**Municipal Impact:** None

#### **Explanation**

Section 1 establishes a Connecticut Health Care Cost Containment Authority, as of July 1, 2011 and specifies that it is not a department, institution or agency of the state. The bill further specifies that public funds may be expended to meet its purposes. At this time, no future public funds for this purpose are identified.

Section 3 requires the Department of Public Health, in collaboration with the State Comptroller, to establish a pilot shared decision-making project and report on the same by July 1, 2012. In FY 12, the Department will require 1 Epidemiologist, at an annualized salary of \$79,268, and other expenses and equipment costing approximately \$1,750. It is anticipated that the Office of the State Comptroller will participate to the extent that its resources allow.

Other provisions in the bill are not anticipated to result in a fiscal

<sup>1</sup> The fringe benefit costs for state employees are budgeted centrally in the Miscellaneous Accounts administered by the Comptroller on an actual cost basis. The following is provided for estimated costs associated with additional personnel. The estimated non-pension fringe benefit rate as a percentage of payroll is 25.43%. Fringe benefit costs for new positions do not initially include pension costs as the state's pension contribution is based upon the 6/30/08 actuarial valuation for the State Employees Retirement System (SERS) which certifies the contribution for FY 10 and

impact.

***The Out Years***

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

*Source: Department of Public Health*

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FY 11. Therefore, new positions will not impact the state's pension contribution until FY 12 after the next scheduled certification on 6/30/2010.

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**OLR Bill Analysis****sSB 678*****AN ACT IMPLEMENTING CHRONIC DISEASE MANAGEMENT AND WELLNESS AND PREVENTION STRATEGIES TO REDUCE HEALTH CARE COSTS.*****SUMMARY:**

This bill establishes a process for health care providers and patients to engage in “shared decision making” concerning treatment options for the patient. In effect, this process involves the provider sharing with the patient all relevant risk and benefit information on all treatment alternatives, and the patient sharing with the provider all relevant personal information that may indicate that one treatment or side effect may be more or less tolerable than others. In addition, the bill formally recognizes shared decision making in informed consent law, and encourages collaborative efforts to develop and use “patient decision aids.”

The bill requires the Department of Public Health (DPH) to develop and implement a shared decision making demonstration project.

The bill creates the Connecticut Health Care Cost Containment Authority to develop a community-based health care utility model for the reform of health care service delivery.

Finally, the bill prohibits certain billing practices concerning anatomic pathology services.

EFFECTIVE DATE: July 1, 2011, except for the section on anatomic pathology services, which takes effect July 1, 2009.

**SHARED DECISION MAKING*****Terms***

The bill establishes a shared decision making process between a

health care provider and a patient for purposes of evaluating and consenting to treatment options. The bill defines “shared decision making” as a process whereby a physician or other health care provider discusses with a patient, or his or her representative, certain information with the use of a patient decision aid and the patient shares personal information with the provider in order to evaluate treatment options and possible side effects associated with the treatment.

A “patient decision aid” is a written, audio-visual, or online tool that provides a balanced presentation of the health condition and treatment options and benefits and harms associated with treatment options including, if appropriate, a discussion of the limits of scientific knowledge about health outcomes. A patient decision aid must be certified by one or more national certifying organizations. (The bill does not specify any particular organizations.)

#### ***Informed Consent — Signed Consent Form***

Under the bill, if a legally competent patient, or his or her legal representative if not competent, signs (1) a consent form written in language that a patient could reasonably be expected to understand and that contains (a) the nature and character of the proposed treatment; (b) the anticipated results and benefits of the treatment; (c) the recognized possible alternative forms of treatment, including nontreatment; (d) the recognized serious possible risks, side effects and complications associated with the treatment; and (e) a statement advising the patient of actions to take if he or she experiences any side effects or complications; or (2) a statement that the patient has made an informed decision not to be informed of the elements noted above, then the form or statement constitutes prima facie evidence that the patient provided informed consent to the provider for the treatment administered or made an informed decision not to be informed of such options.

The bill requires the provider to ensure that the patient is immediately given a copy of any signed statement. A patient signing

the consent form or statement has the burden of rebutting, by a preponderance of the evidence, that such consent was not informed or that the decision not to be informed was an informed one.

***Informed Consent - Shared Decision Making***

Under the bill, if a legally competent patient or his or her representative if not competent, signs an acknowledgement of shared decision making, that acknowledgment constitutes prima facie evidence that the patient gave informed consent to the treatment administered. The patient has the burden of rebutting by clear and convincing evidence that consent was not informed.

These acknowledgments must include (1) a statement that the patient, or his or her representative, and the health care provider have engaged in shared decision making as an alternative means of satisfying informed consent requirements by law or professional accreditation standards; (2) a brief description of the services that the patient and provider jointly have agreed will be provided to the patient; (3) a brief description of the patient decision aids used by both to address (a) high quality, up-to-date information about the patient's condition such as treatment options, benefits, and harms associated with the options and, if appropriate, a discussion of the limits of scientific knowledge about health outcomes; (b) values clarification that help the patient select treatment options that conform with the patient's values and preferences; and (c) guidance in the deliberative decision process designed to improve the patient's involvement in the decision; (4) a statement that the patient or representative understands the risk or seriousness of the disease or condition to be prevented or treated, available treatment alternatives including nontreatment, and the risks, benefits, and uncertainties of the treatment and nontreatment alternatives; (5) a statement advising the patient of actions he or she should take when experiencing any side effects or complications; and (6) a statement certifying the patient or representative had the opportunity to ask the provider questions and to have them answered satisfactorily, and that indicates the patient's intent to receive the services.

A provider must ensure that a patient signing an acknowledgment of shared decision making is immediately given a copy.

### ***Failure to Use a Prescribed Form or Engage in Shared Decision Making***

The bill specifies that a provider's failure to use a prescribed form is not admissible as evidence of failure to obtain informed consent. Nor is a provider's failure to engage in shared decision making, with or without the use of a patient decision aid. Also, the bill provides that there is no liability, civil or otherwise, resulting from a provider's choice to obtain informed consent by use of the signed consent form or the signed acknowledgement of shared decision making.

### ***Demonstration Project***

The bill requires DPH, in collaboration with the state comptroller, to develop and implement a shared decision making demonstration project at one or more multispecialty group practice sites providing "state purchased health care."

The project must include (1) the incorporation into clinical practice of one or more patient decision aids for one or more identified preference-sensitive care areas combined with ongoing training and support of involved health care providers and practice teams, preferably at sites with necessary supportive health information technology ("preference-sensitive care area" is not defined) and (2) an evaluation of (a) the impact of using the techniques in (1) above and the cost; (b) the effect on patients, including patient understanding of the treatment options presented and the affinity between patient values and care received; and (c) patient and provider satisfaction with the shared decision making process.

Under the bill, a participating practice site bears the cost of selecting, purchasing, and incorporating the selected patient decision aids into clinical practice. By July 1, 2012, the DPH commissioner must report on the demonstration project's status to the Public Health committee.

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**CONNECTICUT HEALTH CARE COST CONTAINMENT AUTHORITY**

The bill creates the Connecticut Health Care Cost Containment Authority as a public instrumentality and political subdivision of the state. The bill specifies that it is not a department, institution, or agency of the state, but public funds may be spent to meet the authority's purposes. The authority's purposes are the promotion, planning and designing, developing, assisting, acquiring, constructing, reconstructing, improving, maintaining and equipping, and furnishing of health care, health care information technology, and the health care delivery system and assisting directly or indirectly in the financing of related costs.

The authority must develop a community-based health care utility model that reforms health care service delivery in the state and finances technology procurement required for implementing a comprehensive chronic disease management and wellness and prevention program using medical homes. This model must (1) prioritize the use of medical homes to improve outcomes for the chronically ill; (2) emphasize the use of case management services, disease management, and care coordination; (3) leverage federal dollars to the maximum extent permissible to establish a viable health information exchange throughout the state; (4) reduce reliance on emergency room care; (5) promote preventive care and wellness programs; (6) promote shared decision making between providers and their patients; and (7) provide incentives to providers who show improved patient health outcomes by implementing the above practices.

**ANATOMIC PATHOLOGY SERVICES**

The bill requires direct billing to the patient or insurer by a clinical laboratory performing anatomic pathology services. It prohibits a provider of anatomic pathology services from billing for such services any person or entity other than the patient, responsible insurer of a third party payor, or a governmental agency or the agency's public or private agent. "Anatomic pathology services" means histopathology

or surgical pathology, cytopathology, hematology, subcellular pathology, molecular pathology, or blood banking service performed by a pathologist. Under the bill, “provider” means a licensed physician or surgeon or a licensed clinical laboratory.

**COMMITTEE ACTION**

Public Health Committee

Joint Favorable Substitute

Yea 29    Nay 1    (03/23/2009)