



**Senate Bill No. 1145**

**Public Act No. 07-149**

**AN ACT CONCERNING REVISIONS TO OFFICE OF HEALTH CARE ACCESS STATUTES.**

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

Section 1. Subsection (c) of section 19a-509b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(c) Each hospital [which] that holds or administers one or more hospital bed funds shall make available in a place and manner allowing individual members of the public to easily obtain it, a one-page summary in English and Spanish describing hospital bed funds and how to apply for them. The summary shall also describe any other [free or reduced cost] policies regarding the provision of charity care and reduced cost services for the indigent as reported by the hospital to the Office of Health Care Access pursuant to section 19a-649 and shall clearly distinguish hospital bed funds from other sources of financial assistance. The summary shall include notification that the patient is entitled to reapply upon rejection, and that additional funds may become available on an annual basis. The summary shall be available in the patient admissions office, emergency room, social services department and patient accounts or billing office, and from any collection agent. If during the admission process or during its

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review of the financial resources of the patient, the hospital reasonably believes the patient will have limited funds to pay for any portion of the patient's hospitalization not covered by insurance, the hospital shall provide the summary to each such patient.

Sec. 2. Subsection (b) of section 19a-535b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(b) A facility shall not transfer or discharge a patient from the facility except for medical reasons, or for [his] the patient's welfare or the welfare of other patients, as documented in [his] the patient's medical record; or, in the case of a self pay patient, for [his] nonpayment or arrearage of more than fifteen days of the per diem chronic disease hospital room rates [, approved by the Office of Health Care Access,] for [his] the patient's stay, except as prohibited by the Social Security Act. In the case of an involuntary transfer or discharge, the patient and, if known, [his] the patient's legally liable relative, guardian or conservator and the patient's personal physician, if the discharge plan is prepared by the medical director of the chronic disease hospital, shall be given at least thirty days written notice of the proposed action to ensure orderly transfer or discharge.

Sec. 3. Subsection (b) of section 19a-639 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(b) (1) The commissioner shall notify the Commissioner of Social Services of any certificate of need request that may impact [on] expenditures under the state medical assistance program. The office shall consider such request in relation to the community or regional need for such capital program or purchase of land, the possible effect on the operating costs of the health care facility or institution and such other relevant factors as the office deems necessary. In approving or

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modifying such request, the commissioner may not prescribe any condition, such as but not limited to, any condition or limitation on the indebtedness of the facility or institution in connection with a bond issue, the principal amount of any bond issue or any other details or particulars related to the financing of such capital expenditure, not directly related to the scope of such capital program and within control of the facility or institution.

(2) An applicant, prior to submitting a certificate of need application, shall submit a request, in writing, for application forms and instructions to the office. The request shall be known as a letter of intent. A letter of intent shall conform to the letter of intent requirements of subdivision (4) of subsection (a) of section 19a-638. No certificate of need application will be considered submitted to the office unless a current letter of intent, specific to the proposal and in compliance with this subsection, is on file with the office for at least sixty days. A current letter of intent is a letter of intent that has been on file at the office no more than one hundred twenty days, except that an applicant may request a one-time extension of a letter of intent of up to an additional thirty days for a maximum total of up to one hundred fifty days if, prior to the expiration of the current letter of intent, the office receives a written request to so extend the letter of intent's current status. The extension request shall fully explain why an extension is requested. The office shall accept or reject the extension request not later than five business days from the date the office receives the extension request and shall so notify the applicant. Upon a showing by such facility or institution that the need for such capital program is of an emergency nature, in that the capital expenditure is necessary to maintain continued access to the health care services provided by the facility or institution, or to comply with any federal, state or local health, fire, building or life safety code, the commissioner may waive the letter of intent requirement, provided such request shall be submitted at least ten business days before the proposed initiation

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date of the project. The commissioner shall grant, modify or deny such request not later than ninety days or not later than ten business days, as the case may be, [of] after receipt of such request, except as provided for in this section. Upon the request of the applicant, the review period may be extended for an additional fifteen days if the office has requested additional information subsequent to the commencement of the review period. The commissioner may extend the review period for a maximum of thirty days if the applicant has not filed, in a timely manner, information deemed necessary by the office. Failure of the office to act upon such request within such review period shall be deemed approval of such request. The ninety-day review period, pursuant to this section, for an application filed by a hospital, as defined in section 19a-490, and licensed as a short-term acute care general hospital or a children's hospital by the Department of Public Health or an affiliate of such a hospital or any combination thereof, shall not apply if, in the certificate of need application or request, the hospital or applicant projects either (A) that, for the first three years of operation taken together, the total impact of the proposal on the operating budget of the hospital or an affiliate or any combination thereof will exceed one per cent of the actual operating expenses of the hospital for the most recently completed fiscal year as filed with the office, or (B) that the total capital expenditure for the project will exceed fifteen million dollars. If the office determines that an application is not subject to the ninety-day review period pursuant to this subsection, it shall remain so excluded for the entire period of that application, even if the application or circumstances change and the application no longer meets the stated terms of the exclusion. The office shall adopt regulations, in accordance with chapter 54, to establish an expedited hearing process to be used to review requests by any facility or institution for approval of a capital expenditure to establish an energy conservation program or to comply with requirements of any federal, state or local health, fire, building or life safety code or final court order. The office shall adopt regulations in

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accordance with the provisions of chapter 54 to provide for the waiver of a hearing [.] for any part of a request by a facility or institution for a capital expenditure, provided such facility or institution and the office agree upon such waiver.

(3) The office shall comply with the public notice provisions of subdivision (4) of subsection (a) of section 19a-638, and shall hold a public hearing with respect to any complete certificate of need application filed under this section, if: (A) The proposal has associated total capital expenditures or total capital costs that exceed twenty million dollars for land, building or nonclinical equipment acquisition, new building construction or building renovation; (B) the proposal has associated total capital expenditures per unit or total capital costs per unit that exceed three million dollars for the purchase, lease or donation acceptance of major medical equipment; (C) the proposal is for the purchase, lease or donation acceptance of equipment utilizing technology that is new or being introduced into the state, including scanning equipment, cineangiography equipment, a linear accelerator or other similar equipment; or (D) three individuals or an individual representing an entity comprised of five or more people submit a request, in writing, that a public hearing be held on the proposal and such request is received by the office not later than twenty-one calendar days after the office deems the certificate of need application complete. At least two weeks' notice of such public hearing shall be given to the applicant, in writing, and to the public by publication in a newspaper having a substantial circulation in the area served by the applicant. At the discretion of the office, such hearing shall be held in Hartford or in the area so served or to be served.

Sec. 4. Subsection (d) of section 19a-639 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(d) Notwithstanding the provisions of section 19a-638 or subsection

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(a) of this section, no community health center, as defined in section 19a-490a, shall be subject to the provisions of said section 19a-638 or subsection (a) of this section if the community health center is: (1) Proposing a capital expenditure not exceeding three million dollars; (2) exclusively providing primary care or dental services; and (3) either (A) financing one-third or more of the cost of the proposed project [is financed] with moneys provided by the state of Connecticut, (B) [the proposed project is] receiving funds from the Department of Public Health for the proposed project, or (C) locating the proposed project [is located] in an area designated by the federal Health Resources and Services Administration as a health professional shortage area, a medically underserved area or an area with a medically underserved population. Each community health center seeking an exemption under this subsection shall provide the office with documentation verifying to the satisfaction of the office, qualification for this exemption. Each community health center proposing to provide any service other than a primary care or dental service at any location, including a designated community health center location, shall first obtain a certificate of need for such additional service in accordance with this section and section 19a-638. Each satellite, subsidiary or affiliate of a federally qualified health center, in order to qualify under this exemption, shall: (i) Be part of a federally qualified health center [,] that meets the requirements of this subsection; (ii) exclusively provide primary care or dental services; and (iii) be located in a health professional shortage area or a medically underserved area. If the subsidiary, satellite or affiliate does not so qualify, it shall obtain a certificate of need.

Sec. 5. Subsection (a) of section 19a-639b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(a) The Commissioner of [the Office of] Health Care Access or the

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commissioner's designee may grant an exemption from the requirements of section 19a-638 or subsection (a) of section 19a-639, or both, for any nonprofit facility, institution or provider that is currently under contract with a state agency or department and is seeking to engage in any activity, other than the termination of a service or a facility, otherwise subject to said section or subsection if:

(1) The nonprofit facility, institution or provider is proposing a capital expenditure of not more than three million dollars and the expenditure does not in fact exceed three million dollars;

(2) The activity meets a specific service need identified by a state agency or department with which the nonprofit facility, institution or provider is currently under contract;

(3) The commissioner, executive director, chairman or chief court administrator of the state agency or department that has identified the specific need confirms, in writing, to the office that (A) the agency or department has identified a specific need with a detailed description of that need and that the agency or department believes that the need continues to exist, (B) the activity in question meets all or part of the identified need and specifies how much of that need the proposal meets, (C) in the case where the activity is the relocation of services, the agency or department has determined that the needs of the area previously served will continue to be met in a better or satisfactory manner and specifies how that is to be done, (D) in the case where the activity is the transfer of all or part of the ownership or control of a facility or institution, the agency or department has investigated the proposed change and the person or entity requesting the change and has determined that the change would be in the best interests of the state and the patients or clients, and (E) the activity will be cost-effective and well managed; and

(4) In the case where the activity is the relocation of services, the

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Commissioner of [the Office of] Health Care Access or the commissioner's designee determines that the needs of the area previously served will continue to be met in a better or satisfactory manner.

(b) The Commissioner of [the Office of] Health Care Access or the commissioner's designee may grant an exemption from the requirements of section 19a-638 or subsection (a) of section 19a-639, or both, for any nonprofit facility, institution or provider that is currently under contract with a state agency or department and is seeking to terminate a service or a facility, provided (1) the commissioner, executive director, chairperson or chief court administrator of the state agency or department with which the nonprofit facility, institution or provider is currently under contract confirms, in writing, to the office that the needs of the area previously served will continue to be met in a better or satisfactory manner and specifies how that is to be done, and (2) the Commissioner of [the Office of] Health Care Access or the commissioner's designee determines that the needs of the area previously served will continue to be met in a better or satisfactory manner.

(c) A nonprofit facility, institution or provider seeking an exemption under this section shall provide the office with any information it needs to determine exemption eligibility. An exemption granted under this section shall be limited to part or all of any services, equipment, expenditures or location directly related to the need or location that the state agency or department has identified.

(d) The office may revoke or modify the scope of the exemption at any time following a public review that allows the state agency or department and the nonprofit facility, institution or provider to address specific, identified, changed conditions or any problems that the state agency, department or the office has identified. A party to any exemption modification or revocation proceeding and the original

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requesting agency shall be given at least fourteen calendar days written notice prior to any action by the office and shall be furnished with a copy, if any, of a revocation or modification request or a statement by the office of the problems that have been brought to its attention. If the requesting commissioner, executive director, chairman or chief court administrator or the Commissioner of Health Care Access certifies that an emergency condition exists, only forty-eight hours written notice shall be required for such modification or revocation action to proceed.

Sec. 6. Subsection (a) of section 19a-646 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(a) As used in this section:

(1) "Office" means the Office of Health Care Access;

(2) "Fiscal year" means the hospital fiscal year, as used for purposes of this chapter, consisting of a twelve-month period commencing on October first and ending the following September thirtieth;

(3) "Hospital" means any short-term acute care general or children's hospital licensed by the Department of Public Health, [in the state] including the John Dempsey Hospital of The University of Connecticut Health Center;

(4) "Payer" means any person, legal entity, governmental body or eligible organization [covered by the provisions of Section 1876] that meets the definition of an eligible organization under 42 USC Section 1395mm (b) of the Social Security Act, or any combination thereof, except for Medicare and Medicaid which is or may become legally responsible, in whole or in part for the payment of services rendered to or on behalf of a patient by a hospital. Payer also includes any legal entity whose membership includes one or more payers and any third-

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party payer; and

(5) "Prompt payment" means payment made for services to a hospital by mail or other means on or before the tenth business day after receipt of the bill by the payer.

Sec. 7. Section 19a-649 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(a) The office, in consultation with the Commissioner of Social Services, shall review annually the level of uncompensated care [including emergency assistance to families] provided by each hospital to the indigent. Each hospital shall file annually with the office its policies regarding the provision of [free or] charity care and reduced cost services to the indigent, excluding medical assistance recipients, and its debt collection practices. Each hospital shall obtain an independent audit of the level of charges, payments and discharges by primary payer related to Medicare, medical assistance, CHAMPUS or TriCare and nongovernmental payers as well as the amount of uncompensated care including emergency assistance to families. The results of this audit, including the above information, with an opinion, shall be provided to the office by each hospital by March thirty-first of each year, and the hospital's audited financial statements shall be provided by February twenty-eighth of each year. For purposes of this section, "primary payer" means the [final payer responsible for more than fifty per cent of the charges on the case, or, if no payer is responsible for more than fifty per cent of the charges the] payer responsible for the highest percentage of charges for a patient's inpatient or outpatient hospital services. The office shall evaluate the audit and may rely on the information contained in the independent audit or may require such additional audit as it deems necessary.

(b) Each hospital shall annually report, along with data submitted pursuant to subsection (a) of this section, (1) the number of applicants

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for [free] charity care and reduced cost services, (2) the number of approved applicants, and (3) the total and average charges and costs of the amount of [free] charity care and reduced cost [care] services provided.

Sec. 8. Section 19a-659 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

As used in sections 19a-659, 19a-662, 19a-669 to [19a-672] 19a-670a, inclusive, 19a-671, 19a-671a, 19a-672 and 19a-676:

(1) "Office" means the Office of Health Care Access;

(2) "Hospital" means [a hospital included within the definition of health care facilities or institutions under section 19a-630 and] any hospital licensed as a short-term acute care general or children's hospital by the Department of Public Health, [and] including John Dempsey Hospital of The University of Connecticut Health Center;

(3) "Fiscal year" means the hospital fiscal year consisting of a twelve-month period commencing on October first and ending the following September thirtieth;

(4) "Base year" means the fiscal year consisting of a twelve-month period immediately prior to the start of the fiscal year for which a budget is being determined or prepared;

(5) "Affiliate" means a person, entity or organization controlling, controlled by, or under common control with another person, entity or organization;

[(6) "Uncompensated care including emergency assistance to families" means the actual cost in the year prior to the base year of care written off as bad debts or provided free under a free care policy approved by the office including emergency assistance to families

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authorized by the Department of Social Services and not otherwise funded;]

(6) "Uncompensated care" means the total amount of charity care and bad debts determined by using the hospital's published charges and consistent with the hospital's policies regarding charity care and bad debts which have been approved by, and are on file at, the office;

(7) "Medical assistance" means (A) the programs for medical assistance provided under the state-administered general assistance program or the Medicaid program, including the HUSKY Plan, Part A, or (B) any other state-funded medical assistance program, including the HUSKY Plan, Part B;

(8) "CHAMPUS" or "TriCare" means [TriCare or] the federal Civilian Health and Medical Program of the Uniformed Services, [10 USC 1071 et seq.] as defined in 10 USC Section 1072(4), as from time to time amended;

(9) "Primary payer" means the payer responsible for the highest percentage of the charges [on the case] for a patient's inpatient or outpatient hospital services;

(10) "Case mix index" means [a hospital's case mix index calculated using the medical record abstract and billing data submitted by the hospital to the office] the arithmetic mean of the Medicare diagnosis related group case weights assigned to each inpatient discharge for a specific hospital during a given fiscal year. The case mix index shall be calculated by dividing the hospital's total case mix adjusted discharges [for the hospital] by the hospital's actual number of discharges [for the hospital] for the fiscal year. The total case mix adjusted discharges shall be calculated by (A) multiplying the number of discharges in each diagnosis-related group by the Medicare weights in effect for [the] that same diagnosis-related group [in effect for the] and fiscal

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year, and [adding the resultant procedures across] (B) then totaling the resulting products for all diagnosis-related groups;

(11) "Contractual allowances" means [, for the period October 1, 1992, to March 30, 1994, inclusive, the amount of discounts provided to nongovernmental payers pursuant to subsections (d) and (e) of section 19a-646, for the period beginning April 1, 1994, the amount of discounts provided to nongovernmental payers pursuant to subsections (c), (d) and (e) of section 19a-646 and on and after July 1, 2002, any amount of discounts provided to nongovernmental payers pursuant to a written agreement] the difference between hospital published charges and payments generated by negotiated agreements for a different or discounted rate or method of payment;

(12) "Medical assistance underpayment" means the [difference between the actual net revenue of a hospital times the ratio of medical assistance charges to total charges and the amount received by the hospital from the Department of Social Services for the year prior to the base year] amount calculated by dividing the total net revenue by the total gross revenue, and then multiplying the quotient by the total medical assistance charges, and then subtracting medical assistance payments from the product;

(13) "Other allowances" means the amount of any difference between charges for employee self-insurance and related expenses determined using the hospital's overall relationship of costs to charges;

(14) "Gross revenue" means the total gross patient charges for all patient [care] services provided by a hospital;

(15) "Net revenue" means total gross revenue less contractual allowance, less the difference between government charges and government payments, less uncompensated care [,] and other allowances, [,] plus [, for purposes of compliance, net payments from

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the uncompensated care pool in existence prior to April 1, 1994, and] uncompensated care program disproportionate share hospital payments from the Department of Social Services;

(16) "Emergency assistance to families" means assistance to families with children under the age of twenty-one who do not have the resources to independently provide the assistance needed to avoid the destitution of the child and which is authorized by the Department of Social Services pursuant to section 17b-107 and is not otherwise funded.

Sec. 9. Section 19a-669 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

Effective October 1, 1993, and October first of each subsequent year, the Secretary of the Office of Policy and Management shall determine and inform the Office of Health Care Access of the maximum amount of disproportionate share payments and emergency assistance to families eligible for federal matching payments under the Medical Assistance Program or the Emergency Assistance to Families Program pursuant to federal statute and regulations and subdivisions (2) and (28) of subsection (a) of section 12-407, subdivision (1) of section 12-408, subdivision (5) of section 12-412, section 12-414, section 19a-649 and this section and the actual and anticipated appropriation to the medical assistance disproportionate share-emergency assistance account authorized pursuant to sections 3-114i and 12-263a to 12-263e, inclusive, subdivisions (2) and (29) of subsection (a) of section 12-407, subdivision (1) of section 12-408, section 12-408a, subdivision (5) of section 12-412, subdivision (1) of section 12-414 and sections 19a-646, 19a-659, 19a-662, 19a-669 to [19a-673] 19a-670a, inclusive, 19a-671, 19a-671a, 19a-672, 19a-672a, 19a-673 and 19a-676, and the amount of emergency assistance to families' payments to eligible hospitals projected for the year, and the anticipated amount of any increase in payments made pursuant to any resolution of any civil action pending

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on April 1, 1994, in the United States district court for the district of Connecticut. The Department of Social Services shall inform the office of any amount of uncompensated care which the Department of Social Services determines is due to a failure on the part of the hospital to register patients for emergency assistance to families, or a failure to bill properly for emergency assistance to families' patients. If during the course of a fiscal year the Secretary of the Office of Policy and Management determines that these amounts should be revised, said secretary shall so notify the office and the office may modify its calculation pursuant to section 19a-671 to reflect such revision and its orders as it deems appropriate and the Commissioner of Social Services may modify said commissioner's determination pursuant to section 19a-671.

Sec. 10. Subsection (d) of section 19a-670 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

(d) Nothing in section 3-114i, subdivision (2) or (29) of subsection (a) of section 12-407, subdivision (1) of section 12-408, section 12-408a, subdivision (5) of section 12-412, subdivision (1) of section 12-414, or sections 12-263a to 12-263e, inclusive, section 19a-646, 19a-659, 19a-662 or 19a-669 to [19a-673] 19a-670a, inclusive, 19a-671, 19a-671a, 19a-672, 19a-672a, 19a-673 and section 19a-676, or section 1, 2, or 38 of public act 94-9\* shall be construed to require the Department of Social Services to pay out more funds than are appropriated pursuant to said sections.

Sec. 11. Section 19a-671 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

The Commissioner of Social Services is authorized to determine the amount of payments pursuant to sections 19a-670, [to 19a-672, inclusive,] 19a-670a, 19a-671, 19a-671a and 19a-672 for each hospital. The commissioner's determination shall be based on the advice of the

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office and the application of the calculation in this section. For each hospital, the Office of Health Care Access shall calculate the amount of payments to be made pursuant to sections 19a-670, [to 19a-672, inclusive,] 19a-670a, 19a-671, 19a-671a and 19a-672 as follows:

(1) For the period April 1, 1994, to June 30, 1994, inclusive, and for the period July 1, 1994, to September 30, 1994, inclusive, the office shall calculate and advise the Commissioner of Social Services of the amount of payments to be made to each hospital as follows:

(A) Determine the amount of pool payments for the hospital, including grants approved pursuant to section 19a-168k, in the previously authorized budget authorization for the fiscal year commencing October 1, 1993.

(B) Calculate the sum of the result of subparagraph (A) of this subdivision for all hospitals.

(C) Divide the result of subparagraph (A) of this subdivision by the result of subparagraph (B) of this subdivision.

(D) From the anticipated appropriation to the medical assistance disproportionate share-emergency assistance account made pursuant to sections 3-114i and 12-263a to 12-263e, inclusive, subdivisions (2) and (29) of subsection (a) of section 12-407, subdivision (1) of section 12-408, section 12-408a, subdivision (5) of section 12-412, subdivision (1) of section 12-414 and sections 19a-646, 19a-659, 19a-662, 19a-669 to [19a-673] 19a-670a, inclusive, 19a-671, 19a-671a, 19a-672, 19a-672a, 19a-673 and 19a-676, for the quarter subtract the amount of any additional medical assistance payments made to hospitals pursuant to any resolution of or court order entered in any civil action pending on April 1, 1994, in the United States District Court for the district of Connecticut, and also subtract the amount of any emergency assistance to families payments projected by the office to be made to hospitals in

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the quarter.

(E) The disproportionate share payment shall be the result of subparagraph (D) of this subdivision multiplied by the result of subparagraph (C) of this subdivision.

(2) For the fiscal year commencing October 1, 1994, and subsequent fiscal years, the interim payment shall be calculated as follows for each hospital:

(A) For each hospital determine the amount of the medical assistance underpayment determined pursuant to section 19a-659, plus the actual amount of uncompensated care including emergency assistance to families determined pursuant to section 19a-659, less any amount of uncompensated care determined by the Department of Social Services to be due to a failure of the hospital to enroll patients for emergency assistance to families, plus the amount of any grants authorized pursuant to the authority of section 19a-168k.

(B) Calculate the sum of the result of subparagraph (A) of this subdivision for all hospitals.

(C) Divide the result of subparagraph (A) of this subdivision by the result of subparagraph (B) of this subdivision.

(D) From the anticipated appropriation made to the medical assistance disproportionate share-emergency assistance account pursuant to sections 3-114i and 12-263a to 12-263e, inclusive, subdivisions (2) and (29) of subsection (a) of section 12-407, subdivision (1) of section 12-408, section 12-408a, subdivision (5) of section 12-412, subdivision (1) of section 12-414 and sections 19a-646, 19a-659, 19a-662, 19a-669 to [19a-673] 19a-670a, inclusive, 19a-671, 19a-671a, 19a-672, 19a-672a, 19a-673 and 19a-676, for the fiscal year, subtract the amount of any additional medical assistance payments made to hospitals pursuant to any resolution of or court order entered

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in any civil action pending on April 1, 1994, in the United States District Court for the district of Connecticut, and also subtract any emergency assistance to families payments projected by the office to be made to the hospitals for the year.

(E) The disproportionate share payment shall be the result of subparagraph (D) of this subdivision multiplied by the result of subparagraph (C) of this subdivision.

Sec. 12. Section 19a-672 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2007*):

The funds appropriated to the medical assistance disproportionate share-emergency assistance account pursuant to sections 3-114i and 12-263a to 12-263e, inclusive, subdivisions (2) and (29) of subsection (a) of section 12-407, subdivision (1) of section 12-408, section 12-408a, subdivision (5) of section 12-412, subdivision (1) of section 12-414 and sections 19a-646, 19a-659, 19a-662, 19a-669 to [19a-673] 19a-670a, inclusive, 19a-671, 19a-671a, 19a-672, 19a-672a, 19a-673 and 19a-676, shall be used by said account to make disproportionate share payments to hospitals, including grants to hospitals pursuant to section 19a-168k, and to make emergency assistance to families payments to hospitals. In addition, [the medical assistance disproportionate share-emergency assistance account may utilize] a portion of [these] funds appropriated to the medical assistance disproportionate share-emergency assistance account may be used to make outpatient payments as the Department of Social Services determines appropriate or to increase the standard medical assistance payments to hospitals if the Department of Social Services determines it to be appropriate to settle any civil action pending on April 1, 1994, in the United States District Court for the district of Connecticut. Notwithstanding any other provision of the general statutes, the Department of Social Services shall not be required to make any payments pursuant to sections 3-114i and 12-263a to 12-263e, inclusive,

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subdivisions (2) and (29) of subsection (a) of section 12-407, subdivision (1) of section 12-408, section 12-408a, subdivision (5) of section 12-412, subdivision (1) of section 12-414 and sections 19a-646, 19a-659, 19a-662, 19a-669 to [19a-673] 19a-670a, inclusive, 19a-671, 19a-671a, 19a-672, 19a-672a, 19a-673 and 19a-676, in excess of the funds available in the medical assistance disproportionate share-emergency assistance account.

Approved June 25, 2007