



House of Representatives

General Assembly

File No. 705

January Session, 2007

House Bill No. 7110

House of Representatives, May 2, 2007

The Committee on Appropriations reported through REP. MERRILL of the 54th Dist., Chairperson of the Committee on the part of the House, that the bill ought to pass.

***AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE
LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS
COMMITTEE CONCERNING THE FUNDING OF HOSPITAL CARE.***

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

1 Section 1. Section 17b-239 of the general statutes is repealed and the
2 following is substituted in lieu thereof (*Effective July 1, 2007*):

3 (a) The rate to be paid by the state to hospitals receiving
4 appropriations granted by the General Assembly and to freestanding
5 chronic disease hospitals, providing services to persons aided or cared
6 for by the state for routine services furnished to state patients, shall be
7 based upon reasonable cost to such hospital, or the charge to the
8 general public for ward services or the lowest charge for semiprivate
9 services if the hospital has no ward facilities, imposed by such
10 hospital, whichever is lowest, except to the extent, if any, that the
11 commissioner determines that a greater amount is appropriate in the
12 case of hospitals serving a disproportionate share of indigent patients.
13 Such rate shall be promulgated annually by the Commissioner of

14 Social Services. Nothing contained in this section shall authorize a
15 payment by the state for such services to any such hospital in excess of
16 the charges made by such hospital for comparable services to the
17 general public. Notwithstanding the provisions of this section, for the
18 rate period beginning July 1, 2000, rates paid to freestanding chronic
19 disease hospitals and freestanding psychiatric hospitals shall be
20 increased by three per cent. For the rate period beginning July 1, 2001,
21 a freestanding chronic disease hospital or freestanding psychiatric
22 hospital shall receive a rate that is two and one-half per cent more than
23 the rate it received in the prior fiscal year and such rate shall remain
24 effective until December 31, 2002. Effective January 1, 2003, a
25 freestanding chronic disease hospital or freestanding psychiatric
26 hospital shall receive a rate that is two per cent more than the rate it
27 received in the prior fiscal year. Notwithstanding the provisions of this
28 subsection, for the period commencing July 1, 2001, and ending June
29 30, 2003, the commissioner may pay an additional total of no more
30 than three hundred thousand dollars annually for services provided to
31 long-term ventilator patients. For purposes of this subsection, "long-
32 term ventilator patient" means any patient at a freestanding chronic
33 disease hospital on a ventilator for a total of sixty days or more in any
34 consecutive twelve-month period. Effective July 1, 2004, each
35 freestanding chronic disease hospital shall receive a rate that is two per
36 cent more than the rate it received in the prior fiscal year.

37 (b) Effective October 1, 1991, the rate to be paid by the state for the
38 cost of special services rendered by such hospitals shall be established
39 annually by the commissioner for each such hospital based on the
40 reasonable cost to each hospital of such services furnished to state
41 patients. Nothing contained herein shall authorize a payment by the
42 state for such services to any such hospital in excess of the charges
43 made by such hospital for comparable services to the general public.

44 (c) The term "reasonable cost" as used in this section means the cost
45 of care furnished such patients by an efficient and economically
46 operated facility, computed in accordance with accepted principles of
47 hospital cost reimbursement. The commissioner may adjust the rate of

48 payment established under the provisions of this section for the year
49 during which services are furnished to reflect fluctuations in hospital
50 costs. Such adjustment may be made prospectively to cover anticipated
51 fluctuations or may be made retroactive to any date subsequent to the
52 date of the initial rate determination for such year or in such other
53 manner as may be determined by the commissioner. In determining
54 "reasonable cost" the commissioner may give due consideration to
55 allowances for fully or partially unpaid bills, reasonable costs
56 mandated by collective bargaining agreements with certified collective
57 bargaining agents or other agreements between the employer and
58 employees, provided "employees" shall not include persons employed
59 as managers or chief administrators, requirements for working capital
60 and cost of development of new services, including additions to and
61 replacement of facilities and equipment. The commissioner shall not
62 give consideration to amounts paid by the facilities to employees as
63 salary, or to attorneys or consultants as fees, where the responsibility
64 of the employees, attorneys or consultants is to persuade or seek to
65 persuade the other employees of the facility to support or oppose
66 unionization. Nothing in this subsection shall prohibit the
67 commissioner from considering amounts paid for legal counsel related
68 to the negotiation of collective bargaining agreements, the settlement
69 of grievances or normal administration of labor relations.

70 (d) The state shall also pay to such hospitals for each outpatient
71 clinic and emergency room visit a reasonable rate to be established
72 annually by the commissioner for each hospital, such rate to be
73 determined by the reasonable cost of such services. [The emergency
74 room visit rates in effect June 30, 1991, shall remain in effect through
75 June 30, 1993, except those which would have been decreased effective
76 July 1, 1991, or July 1, 1992, shall be decreased.] Nothing contained
77 herein shall authorize a payment by the state for such services to any
78 hospital in excess of the charges made by such hospital for comparable
79 services to the general public. [For those outpatient hospital services
80 paid on the basis of a ratio of cost to charges, the ratios in effect June
81 30, 1991, shall be reduced effective July 1, 1991, by the most recent
82 annual increase in the consumer price index for medical care. For those

83 outpatient hospital services paid on the basis of a ratio of cost to
84 charges, the ratios computed to be effective July 1, 1994, shall be
85 reduced by the most recent annual increase in the consumer price
86 index for medical care. The emergency room visit rates in effect June
87 30, 1994, shall remain in effect through December 31, 1994. The
88 Commissioner of Social Services shall establish a fee schedule for
89 outpatient hospital services to be effective on and after January 1, 1995.
90 Except with respect to the rate periods beginning July 1, 1999, and July
91 1, 2000, such fee schedule shall be adjusted annually beginning July 1,
92 1996, to reflect necessary increases in the cost of services.
93 Notwithstanding the provisions of this subsection, the fee schedule for
94 the rate period beginning July 1, 2000, shall be increased by ten and
95 one-half per cent, effective June 1, 2001. Notwithstanding the
96 provisions of this subsection, outpatient rates in effect as of June 30,
97 2003, shall remain in effect through June 30, 2005. Effective July 1, 2006,
98 subject to available appropriations, the commissioner shall increase
99 outpatient service fees for services that may include clinic, emergency
100 room, magnetic resonance imaging, and computerized axial
101 tomography.] Not later than October 1, 2006, the commissioner shall
102 submit a report, in accordance with section 11-4a, to the joint standing
103 committees of the General Assembly having cognizance of matters
104 relating to public health, human services and appropriations and the
105 budgets of state agencies, identifying [such] fee increases that became
106 effective on July 1, 2006, and the associated cost increase estimates.
107 Effective October 1, 2007, and annually thereafter, the Commissioner
108 of Social Services shall adjust outpatient hospital services rates paid on
109 the basis of a fee schedule or on the basis of a ratio of cost to charges by
110 the most recent annual increase in the consumer price index for urban
111 consumers.

112 (e) The commissioner shall adopt regulations, in accordance with
113 the provisions of chapter 54, establishing criteria for defining
114 emergency and nonemergency visits to hospital emergency rooms. All
115 nonemergency visits to hospital emergency rooms shall be paid at the
116 hospital's outpatient clinic services rate. Nothing contained in this
117 subsection or the regulations adopted hereunder shall authorize a

118 payment by the state for such services to any hospital in excess of the
119 charges made by such hospital for comparable services to the general
120 public.

121 [(f) On and after October 1, 1984, the state shall pay to an acute care
122 general hospital for the inpatient care of a patient who no longer
123 requires acute care a rate determined by the following schedule: For
124 the first seven days following certification that the patient no longer
125 requires acute care the state shall pay the hospital at a rate of fifty per
126 cent of the hospital's actual cost; for the second seven-day period
127 following certification that the patient no longer requires acute care the
128 state shall pay seventy-five per cent of the hospital's actual cost; for the
129 third seven-day period following certification that the patient no
130 longer requires acute care and for any period of time thereafter, the
131 state shall pay the hospital at a rate of one hundred per cent of the
132 hospital's actual cost. On and after July 1, 1995, no payment shall be
133 made by the state to an acute care general hospital for the inpatient
134 care of a patient who no longer requires acute care and is eligible for
135 Medicare unless the hospital does not obtain reimbursement from
136 Medicare for that stay.

137 (g) Effective June 1, 2001, the commissioner shall establish inpatient
138 hospital rates in accordance with the method specified in regulations
139 adopted pursuant to this section and applied for the rate period
140 beginning October 1, 2000, except that the commissioner shall update
141 each hospital's target amount per discharge to the actual allowable cost
142 per discharge based upon the 1999 cost report filing multiplied by
143 sixty-two and one-half per cent if such amount is higher than the target
144 amount per discharge for the rate period beginning October 1, 2000, as
145 adjusted for the ten per cent incentive identified in Section 4005 of
146 Public Law 101-508. If a hospital's rate is increased pursuant to this
147 subsection, the hospital shall not receive the ten per cent incentive
148 identified in Section 4005 of Public Law 101-508. For rate periods
149 beginning October 1, 2001, through September 30, 2006, the
150 commissioner shall not apply an annual adjustment factor to the target
151 amount per discharge. Effective April 1, 2005, the revised target

152 amount per discharge for each hospital with a target amount per
153 discharge less than three thousand seven hundred fifty dollars shall be
154 three thousand seven hundred fifty dollars. Effective October 1, 2006,
155 subject to available appropriations, the commissioner shall establish an
156 increased target amount per discharge of not less than four thousand
157 dollars for each hospital with a target amount per discharge less than
158 four thousand dollars for the rate period ending September 30, 2006,
159 and the commissioner may apply an annual adjustment factor to the
160 target amount per discharge for hospitals that are not increased as a
161 result of the revised target amount per discharge. Not later than
162 October 1, 2006, the commissioner shall submit a report, in accordance
163 with section 11-4a, to the joint standing committees of the General
164 Assembly having cognizance of matters relating to public health,
165 human services and appropriations and the budgets of state agencies
166 identifying the increased target amount per discharge and the
167 associated cost increase estimates.]

168 (f) Effective October 1, 2006, subject to available appropriations, the
169 commissioner shall establish an increased target amount per discharge
170 of not less than four thousand dollars for each hospital with a target
171 amount per discharge less than four thousand dollars for the rate
172 period ending September 30, 2006, and the commissioner may apply
173 an annual adjustment factor to the target amount per discharge for
174 hospitals that are not increased as a result of the revised target amount
175 per discharge. Not later than October 1, 2006, the commissioner shall
176 submit a report, in accordance with section 11-4a, to the joint standing
177 committees of the General Assembly having cognizance of matters
178 relating to public health, human services and appropriations and the
179 budgets of state agencies identifying the increased target amount per
180 discharge and the associated cost increase estimates. Effective October
181 1, 2007, and for each succeeding hospital fiscal year thereafter, the
182 commissioner shall establish an inpatient hospital Medicaid fee-for-
183 service rate for acute care hospitals. The commissioner shall utilize a
184 prospective payment system to establish such rate. The base payment
185 rate under the prospective payment system shall be the hospital
186 Medicare base rate as adjusted by the Medicare wage index. The

187 commissioner shall then adjust the base payment rate for each hospital
188 by the following factors: (1) For teaching hospitals with indirect
189 medical education expenses, the base payment rate shall be adjusted to
190 reflect a Medicaid portion of such expenses. The Medicaid portion
191 shall be calculated using the amount of the expense in excess of the
192 Medicare base rate attributable to indirect medical education expenses
193 for each qualifying hospital and multiplying that amount by the ratio
194 of the number of Medicaid and state-administered general assistance
195 inpatient discharges to the total number of discharges for such
196 hospital, and (2) for each hospital the commissioner shall multiply the
197 hospital's Medicare wage adjusted base rate, or, in the case of teaching
198 hospitals, the Medicare wage adjusted base rate as adjusted in
199 accordance with the provisions of subdivision (1) of this subsection by
200 the hospital's most recent Medicaid case mix, as defined in subdivision
201 (10) of section 19a-659. Effective October 1, 2007, the Commissioner of
202 Mental Health and Addiction Services shall also utilize the payment
203 system set forth in this subsection in calculating inpatient hospital
204 rates paid on behalf of state-administered general assistance
205 beneficiaries.

206 Sec. 2. Section 17b-296 of the general statutes is amended by adding
207 subsection (e) as follows (*Effective July 1, 2007*):

208 (NEW) (e) When renewing a contract with a managed care
209 organization, the department shall: (1) Require that the managed care
210 organization increase rates paid to providers by the percentage
211 increase, if any, in the per client per month rate charged by the
212 managed care organization; and (2) shall establish the number of
213 emergency room visits allowed per client for nonemergency events
214 and to impose financial penalties on those managed care organizations
215 whose clients exceed limits established by the department. Any
216 moneys received as the result of the financial penalties imposed
217 pursuant to this subsection shall be used by the department to
218 supplement funding to hospitals experiencing an over use of the
219 emergency room for nonemergency events.

220 Sec. 3. Section 17b-239a of the general statutes is repealed and the
221 following is substituted in lieu thereof (*Effective July 1, 2007*):

222 [The] Subject to the provision of this section, the Department of
223 Social Services may, within available funds, make payments to all
224 short-term general hospitals located in distressed municipalities, as
225 defined in section 32-9p, or with a population greater than seventy
226 thousand, [and to all short-term general hospitals located in targeted
227 investment communities with enterprise zones, as defined in section
228 32-70, with a population greater than one hundred thousand.] The
229 payment amount for each hospital shall be determined by the
230 Commissioner of Social Services based upon the ratio that the number
231 of inpatient discharges paid by the state-administered general
232 assistance program and Medicaid on a fee-for-service basis to the
233 hospital for the most recently filed cost report period bears to the total
234 hospital discharges paid by the state-administered general assistance
235 program and Medicaid on a fee-for-service basis for all qualifying
236 hospitals. [Notwithstanding the provisions of this section, no] No
237 payment shall be made to a facility licensed as a children's hospital.

238 Sec. 4. (NEW) (*Effective July 1, 2007*) (a) Subject to the provisions of
239 this section, the Department of Social Services shall, within available
240 appropriations, make payments to hospitals that provide a
241 disproportionate share of outpatient services to Medicaid and state-
242 administered general assistance beneficiaries. The Commissioner of
243 Social Services shall determine eligibility standards for the receipt of
244 such payments and the amount of any payment made to a hospital
245 pursuant to this section. No payment shall be made to a facility
246 licensed as a children's hospital.

247 (b) The commissioner, pursuant to section 17b-10 of the general
248 statutes, may implement policies and procedures to administer the
249 provisions of this section while in the process of adopting such policies
250 and procedures as regulation, provided the commissioner prints notice
251 of the intent to adopt the regulation in the Connecticut Law Journal
252 not later than twenty days after the date of implementation. Such

253 policy shall be valid until the time final regulations are adopted.

254 Sec. 5. Subsection (b) of section 19a-649 of the general statutes is
255 repealed and the following is substituted in lieu thereof (*Effective July*
256 *1, 2007*):

257 (b) Each hospital shall [annually] report [, along with data] to the
258 office on an annual basis: Data submitted pursuant to subsection (a) of
259 this section, [(1)] the number of applicants for free and reduced cost
260 services, [(2)] the number of approved applicants, and [(3)] the total
261 and average charges and costs of the amount of free and reduced cost
262 care provided. After reviewing all data provided by hospitals to the
263 office pursuant to the requirements of this subsection, the office shall
264 conduct a comparative analysis of such data based on hospital bed size
265 and geographic location and report, in accordance with section 11-4a,
266 to the joint standing committees of the General Assembly having
267 cognizance of matters relating to public health and appropriations and
268 the budgets of state agencies advising on: Each hospital's policy
269 regarding the provision of free and reduced cost services, including
270 the availability of hospital bed funds, the number of applications for
271 free and reduced cost services, the number of granted applications for
272 free and reduced cost services, and the charges and costs incurred to
273 provide such free and reduced cost services.

274 Sec. 6. Subsection (a) of section 19a-613 of the general statutes is
275 repealed and the following is substituted in lieu thereof (*Effective July*
276 *1, 2007*):

277 (a) The Office of Health Care Access may employ the most effective
278 and practical means necessary to fulfill the purposes of this chapter,
279 which may include, but need not be limited to:

280 (1) Collecting aggregate financial data from health care facilities or
281 institutions, as defined in section 19a-630, and patient-level outpatient
282 data from [health care] such facilities or institutions [, as defined in
283 section 19a-630] and thereafter analyzing and reporting on such data,
284 in accordance with section 11-4a, to the joint standing committee of the

285 General Assembly having cognizance of matters relating to public
286 health;

287 (2) Establishing a cooperative data collection effort, across public
288 and private sectors, to assure that adequate health care personnel
289 demographics are readily available; and

290 (3) Performing the duties and functions as enumerated in subsection
291 (b) of this section.

292 Sec. 7. Subsection (a) of section 19a-644 of the general statutes is
293 repealed and the following is substituted in lieu thereof (*Effective July*
294 *1, 2007*):

295 (a) On or before February twenty-eighth annually, for the fiscal year
296 ending on September thirtieth of the immediately preceding year, each
297 short-term acute care general or children's hospital shall report to the
298 office with respect to its operations in such fiscal year, in such form as
299 the office may by regulation require. Such report shall include: (1)
300 Salaries and fringe benefits for the ten highest paid positions; (2) the
301 name of each joint venture, partnership, subsidiary and corporation
302 related to the hospital; [and] (3) the salaries paid to hospital employees
303 by each such joint venture, partnership, subsidiary and related
304 corporation and by the hospital to the employees of related
305 corporations; (4) the operating expenses per each case mix adjusted
306 discharge and equivalent discharge; and (5) the marketing expenses of
307 such hospitals.

308 Sec. 8. (NEW) (*Effective July 1, 2007*) Not later than October 1, 2007,
309 and for each hospital fiscal year thereafter, the Office of Health Care
310 Access shall report to the joint standing committees of the General
311 Assembly having cognizance of matters relating to public health and
312 appropriations and the budgets of state agencies, in accordance with
313 section 11-4a of the general statutes, on the financial status of
314 Connecticut's acute care hospitals for the fiscal year that ended on
315 September thirtieth of the preceding year. Such report shall contain, at
316 a minimum, all information required to be compiled pursuant to

317 subsection (a) of section 19a-644 of the general statutes, as amended by
318 this act.

319 Sec. 9. (*Effective from passage*) (a) There is established a panel which
320 shall advise the Governor and the General Assembly on matters
321 relating to health care. The panel shall advise on matters that include,
322 but are not limited to, examining health care costs, making private
323 health insurance more affordable and improving access to primary and
324 preventive health care. The panel shall provide legislative
325 recommendations to the Governor and the General Assembly
326 concerning health care reform.

327 (b) The panel shall consist of the following members:

328 (1) Ten appointed by the Governor, who shall include a
329 representative from: The Connecticut Hospital Association, the
330 Connecticut Business and Industry Association, the Connecticut State
331 Medical Society, the Connecticut Nurses' Association, the Connecticut
332 Primary Care Association, the Connecticut Association of Health Care
333 Facilities and the Connecticut Association of Health Plans;

334 (2) One appointed by the speaker of the House of Representatives;

335 (3) One appointed by the president pro tempore of the Senate;

336 (4) One appointed by the majority leader of the House of
337 Representatives;

338 (5) One appointed by the majority leader of the Senate;

339 (6) One appointed by the minority leader of the House of
340 Representatives;

341 (7) One appointed by the minority leader of the Senate;

342 (8) The Commissioners of the Office of Health Care Access, Social
343 Services, Public Health, Mental Health and Addiction Services, the
344 Insurance Commissioner and the Secretary of the Office of Policy and
345 Management, or their designees; and

346 (9) The chairpersons and ranking members of the joint standing
 347 committees of the General Assembly having cognizance of matters
 348 relating to human services, insurance, commerce, public health,
 349 appropriations and the budgets of state agencies and finance, revenue
 350 and bonding.

351 (c) All appointments to the panel shall be made not later than
 352 September 1, 2007. Any vacancy shall be filled by the appointing
 353 authority.

354 (d) The chairpersons of the joint standing committees of the General
 355 Assembly having cognizance of matters relating to public health and
 356 insurance shall schedule the first meeting of the panel. At the initial
 357 meeting of the panel, the convened membership shall select the
 358 chairpersons of the panel, from among the panel's membership.
 359 Thereafter, the panel shall meet monthly and more often upon the call
 360 of the chairpersons or a majority of its members.

361 (e) The Joint Committee on Legislative Management shall provide
 362 administrative support to the panel.

363 (f) On or before March 1, 2008, the panel shall report, in accordance
 364 with section 11-4a of the general statutes, on its activities to the joint
 365 standing committees of the General Assembly having cognizance of
 366 matters relating to human services, insurance, commerce, public
 367 health, appropriations and the budgets of state agencies and finance,
 368 revenue and bonding.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>July 1, 2007</i>	17b-239
Sec. 2	<i>July 1, 2007</i>	17b-296
Sec. 3	<i>July 1, 2007</i>	17b-239a
Sec. 4	<i>July 1, 2007</i>	New section
Sec. 5	<i>July 1, 2007</i>	19a-649(b)
Sec. 6	<i>July 1, 2007</i>	19a-613(a)
Sec. 7	<i>July 1, 2007</i>	19a-644(a)

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 chamber thereof for any purpose:

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 08 \$	FY 09 \$
Department of Social Services	GF - Cost	Significant	Significant
Office of Health Care Access	GF - Cost	\$45,000	See Below

Municipal Impact: None

Explanation

Section 1 of the bill requires the Department of Social Services (DSS) annually increase the Medicaid hospitals outpatient rate on the basis of a fee schedule or on the most recent increase in the consumer price index. It is not clear the impact of adjusting based on a fee schedule, as that fee is not specified in the bill. Based on the last 10 years average increase in the CPI (2.5%), increasing outpatient rates based on the CPI would cost \$2 million in FY08 and \$2.7 million in FY09.

Section 1 further requires DSS to establish an inpatient hospital rate using a prospective payment system. It is estimated that this change in fee structure will result in additional Medicaid costs of approximately \$30 million annually. These increases are to be provided within available appropriations. This section also requires the Department of Mental Health and Addiction Services (DMHAS) to utilize a prospective payment system when calculating inpatient rates for State Administered General Assistance (SAGA) clients.

SHB 7077 (the Appropriations Act, as approved by the Appropriations Committee), contains \$66.2 million in FY08 and \$92.6 million in FY09 to increase both inpatient and outpatient Medicaid rates. No funding is included to increase DMHAS SAGA inpatient rates.

Section 2 requires HUSKY managed Care Organizations (MCO's) to increase provider rates by the same percentage that DSS increases the capitation payment to the MCO's. This provision has no direct fiscal impact on the state.

This section also requires DSS to establish financial penalties on MCO's whose clients have an excess of emergency room visits. The penalties collected are to be redistributed to hospitals experiencing an overuse of emergency room services. As the penalties collected are to be redistributed, not net fiscal impact to the state is expected.

Section 3 changes the distribution formula for DSS Disproportionate Share Hospital (DSH) payments. As the DSH payments are made within available appropriations, changing the DSH distribution formula has no fiscal impact to the state. sHB 7077 has no new funding for the DSH programs.

Section 4 establishes a new DSH payment for Medicaid and SAGA outpatient services. DSS shall determine eligibility standards. As DSH payments are made within available appropriations, creating a new DSH payment does not require a new expenditure of funds by the state. sHB 7077 has no new funding for the DSH programs.

The Office of Health Care Access (OHCA) will incur one-time costs of approximately \$45,000 in FY 08 to support a part-time Principal Health Care Analyst needed to establish a protocol for conducting a comparative analysis of hospital policies regarding the provision of free and reduced cost services and prepare a report for submittal to the Public Health and Appropriations Committees, as required under **Section 5** of the bill. It is anticipated that once the analytical framework for this comparison is established, ongoing reporting in future fiscal years could be accommodated within the agency's normally budgeted resources.

A significant cost would result should the Office choose to initiate collection of aggregate financial data from health care facilities or institutions pursuant to **Section 6**. These costs would be associated

with developing an infrastructure to collect data from up to 23,000 entities, as well as additional staffing needed to analyze and report on the data. As no funding has been included within sHB 7077 for this purpose, it is anticipated that the agency's ability to exercise this new discretionary authority during the FY 08-09 biennium will be limited.

No fiscal impact is associated with **Section 7**, which expands the information that must be contained in a hospital's annual report to the Office. The agency can also accommodate provisions contained within **Section 8**, which requires its annual report on the financial status of hospitals to be submitted by 10/1/07 and annually thereafter, within its normally budgeted resources.

Section 9 establishes a panel to advise the Governor and General Assembly on matters related to health care. The panel shall report to the General Assembly on its activities by March 1, 2008. The state agencies involved with the panel can participate within normal budgetary resources.

The Out Years

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

OLR Bill Analysis**HB 7110****AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE
LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS
COMMITTEE CONCERNING THE FUNDING OF HOSPITAL CARE.****SUMMARY:**

This bill makes several changes in the way the state provides funding to hospitals for serving poor patients. It requires the Department of Social Services (DSS) to annually adjust its outpatient Medicaid hospital payment rates using the consumer price index for urban consumers (CPI-UC).

The bill requires DSS to reimburse hospitals for inpatient services using a prospective payment system, paying teaching hospitals a higher amount. It requires the Department of Mental Health and Addiction Services (DMHAS) to use this same methodology when paying hospitals for providing inpatient services to its clients.

The bill expands the number of hospitals eligible for urban disproportionate share hospital (DSH) payments the state pays them for providing inpatient services to poor patients and creates a new DSH payment for outpatient services.

The bill requires DSS, when renewing HUSKY contracts with managed care organizations (MCO) to require the MCOs to pass through to providers any capitation increases and limit the use of emergency room visits for nonemergency care.

The bill requires the Office of Health Care Access (OHCA) to compare hospitals' provision of free and reduced cost services. It also (1) allows OHCA to collect aggregate financial data from various

health care institutions and facilities and analyze and report on it to the legislature, (2) adds reporting requirements for acute care and children's hospitals, and (3) requires OHCA to report annually to the legislature on the financial status of the state's acute care hospitals.

The bill creates a health care panel to advise the governor and General Assembly on various health care reform matters and makes technical changes.

EFFECTIVE DATE: July 1, 2007, except for the health care panel provisions, which are effective upon passage.

§ 1 — HOSPITAL OUTPATIENT RATES

Beginning October 1, 2007, the bill requires the DSS commissioner to annually adjust hospital outpatient Medicaid fee-for-service rates on the basis of (1) a fee schedule or (2) a ratio of cost to charges by the most recent annual increase in the CPI-UC. By law, DSS must establish and make outpatient payments that are reasonable but not more than what the hospital charges the public for the same services. DSS currently pays hospitals using both a fee schedule and the cost-to-charge ratio, depending on the service provided. Under current law, the fee schedule must be adjusted annually to reflect necessary increases in service costs.

§ 1 — INPATIENT RATES

Beginning October 1, 2007, the bill requires the commissioner annually (for the hospital year, which starts on October 1) to establish an inpatient hospital Medicaid fee-for-service rate for acute care hospitals. The commissioner must use a prospective payment system to establish the rate. (Generally, under such a system, rates are set prospectively based on prior cost experience.)

To determine the system's payment rates, the bill specifies that the base payment rate must be the hospital Medicare base rate (based on the rate Medicare reimburses it for serving Medicare patients, which when adjusted for wages, tends to be higher than the current Medicaid rate), as adjusted by the Medicare wage index. This base must be

further adjusted by certain factors, depending on whether the hospital is a teaching hospital. For non-teaching hospitals, DSS takes the Medicare wage-adjusted base rate and multiplies it by the hospital's most recent case Medicaid case mix. (A case mix adjustment recognizes the differences in the severity of the Medicaid and State Administered General Assistance (SAGA) patients' illnesses. Hospitals report their case mix adjustment factors for different populations to OHCA. The Medicaid case mix factor for most hospitals is less than 1.)

Under current law, the DSS commissioner must establish inpatient hospital rates using methods established in regulation. These methods apply a prescribed inflation factor to a hospital's actual costs in one of two base years. DSS may update hospitals' rates or "target amount per discharge" for inflation.

TEACHING HOSPITALS

The bill provides an additional amount to teaching hospitals with indirect medical expenses to reflect that these hospitals have higher operating costs). Specifically, the bill requires the Medicare adjusted base rate to be further adjusted to reflect a Medicaid portion of those expenses. This portion is calculated by multiplying the amount of the expense above the Medicare base rate attributable to the indirect medical education expenses for each qualifying hospital by the ratio of the hospital's Medicaid and SAGA inpatient discharges to its total number of discharges. The calculation of this adjustment can be illustrated as follows:

$$\text{(Expenses over Medicare base rate attributable to indirect medical education expenses)} \times \frac{\text{Medicaid and SAGA discharges}}{\text{All discharges}}$$

As with the non-teaching hospital, once this adjustment is made, DSS must multiply this adjusted base rate by the hospital's most recent Medicaid case mix.

DMHAS Payments for SAGA Recipients

The bill requires DMHAS, beginning October 1, 2007, to use the

same prospective payment system when calculating inpatient rates it pays hospitals for SAGA recipients. (These would presumably be only for mental health and substance abuse-related inpatient costs hospitals incur for serving SAGA recipients.)

§ 3 — URBAN DISPROPORTIONATE HOSPITAL PAYMENTS

Current law allows DSS, within available funds, to make DSH payments to short-term general hospitals located in distressed municipalities with more than 70,000 residents or municipalities located in targeted investment communities with populations over 100,000. The bill instead allows DSH payments to these hospitals when they are located in a distressed municipality or town with a population greater than 70,000.

Under current law, DSH payments are based on the ratio of Medicaid fee-for-service inpatient discharges to the hospital's total number of inpatient discharges. The bill adds to the numerator inpatient discharges paid by the SAGA program.

§ 4 — NEW DSH FOR MEDICAID AND SAGA OUTPATIENT SERVICES

The bill requires DSS, within available appropriations, to pay hospitals that provide a disproportionate share of outpatient services to Medicaid and SAGA recipients. The commissioner must determine eligibility standards for receiving the payments and the amounts paid. The bill prohibits licensed children's hospitals from receiving these payments.

It permits the commissioner to implement policies and procedures to administer the outpatient DSH program while in the process of adopting them in regulation, provided notice is published in the *Connecticut Law Journal* no later than 20 days from the implementation date. The policy (but not the procedures) is valid until final regulations are adopted.

§ 2 — HUSKY MANAGED CARE CONTRACT PROVISIONS

Pass-Through of Rate Increases

The bill requires DSS, when renewing HUSKY contracts with MCOs, to require the MCOs to increase the rates they pay providers by the same percentage that DSS increases the per client per month “capitation” payment it pays the MCOs.

Limits and Financial Penalties for Nonemergency Use of ER

When renewing the MCO contracts, DSS must also establish a limit on the number of emergency room visits that clients may make for nonemergencies and impose financial penalties on MCOs whose clients exceed those limits. DSS must use any money received as the result of imposing a penalty to supplement funding to hospitals experiencing an over-use of emergency rooms for nonemergencies. (Since these penalties would presumably be deposited in the General Fund, it is not clear how DSS would be able to access them to provide the supplemental funding.)

§ 5 — UNCOMPENSATED CARE

By law, OHCA and DSS must review annually the level of uncompensated care, including emergency assistance to families, each hospital provides to indigent people. Hospitals must annually file with OHCA their policies on free or reduced cost services to the indigent, excluding Medicaid recipients, and their debt collection practices. Each hospital must get an independent audit

Also under existing law, hospitals must annually report (1) the number of applicants for free and reduced cost services, (2) the number of approved applicants and (3) the total and average charges and costs of the amount of free and reduced cost care provided.

This bill requires OHCA, after reviewing all of the above data, to conduct an analysis that compares hospitals based on bed size and geographic location. OHCA must report to the Public Health and Appropriations committees and advise them on (1) each hospital’s policy on free and reduced cost services, including availability of hospital bed funds; (2) the number of applications for free and reduced cost services and the number of granted applications; and (3) the

charges and costs incurred providing free and reduced-cost services.

§ 6 — OHCA OUTPATIENT DATA COLLECTION

Current law allows OHCA to collect patient-level outpatient data from any facility or institution engaged primarily in providing services for preventing, diagnosing, or treating human health conditions (i.e., a health care facility or institution). The bill expands OHCA's authority to collect data by allowing it to (1) collect aggregate financial data from these entities and (2) analyze and report on such data to the Public Health Committee.

§§ 7&8 — HOSPITAL REPORTS

By February 28 annually, the law requires each short-term acute care general or children's hospital to report to OHCA on its operations for the hospital fiscal year ending on the preceding September 30. The report must include (1) salaries and fringe benefits for the 10 highest paid positions; (2) the name of each joint venture, partnership, subsidiary, and corporation related to the hospital; and (2) the salaries paid to hospital employees by each joint venture, partnership, subsidiary, and related corporation, and by the hospital to employees of the related corporations.

The bill adds to these reporting requirements (1) the operating expenses per case mix adjusted discharge and equivalent discharge (a measure of the acuity of illness) and (2) the hospital's marketing expenses.

Also, the bill requires OHCA to report annually to the Public Health and Appropriations committees on the financial status of Connecticut's acute care hospitals. The first report is due October 1, 2007 and must be for the hospital fiscal year that ended on September 30, 2006. The report must include at least all of the information as specified above.

HEALTH CARE REFORM ADVISORY PANEL

The bill creates a 46-member panel to advise and make legislative recommendations to the governor and General Assembly on health care matters including health care costs, affordability of private health

insurance, and improved access to primary and preventive care. The panel must report on its activities, by March 1, 2008, to the Human Services; Insurance; Commerce; Public Health; Appropriations; and Finance, Revenue and Bonding committees.

The panel consists of the following:

1. 10 members appointed by the governor, including representatives from the Connecticut Hospital Association, Connecticut Business and Industry Association, Connecticut State Medical Society, Connecticut Nurses Association, Connecticut Primary Care Association, Connecticut Association of Health Care Facilities, and Connecticut Association of Health Plans;
2. six members appointed by legislative leaders, with one each appointed by the House speaker, Senate president pro tempore, and House and Senate majority and minority leaders;
3. the Office of Policy and Management secretary or his designee and the OHCA, DSS, DMHAS, Public Health, and Insurance commissioners, or their designees; and
4. the chairpersons and ranking members of the Human Services; Insurance; Commerce; Public Health; Appropriations; and Finance, Revenue and Bonding committees.

All appointments must be made by September 1, 2007; the appointing authority fills any vacancies. The chairpersons of the Insurance and Public Health committees must schedule the first meeting. At that meeting, the membership must select the panel's chairpersons. The panel must meet monthly and more often as called by the chairpersons or a majority of members. The Legislative Management Committee must provide administrative support to the panel.

BACKGROUND

Disproportionate Share Hospital Program

The DSH program is a joint federal-state program designed to reimburse hospitals that provide care to a high volume of Medicaid and other low-income patients. Connecticut has several DSH programs and accounts for specific hospital groups. DSS administers most of the DSH programs.

Related Bill

SB 1145 (File 474) redefines several terms OHCA uses in calculating uncompensated care for the DSH payment system. It also substitutes the term "charity care" for "free care" in laws governing DSH calculations and hospital reporting requirements.

COMMITTEE ACTION

Program Review and Investigations Committee

Joint Favorable Change of Reference

Yea 12 Nay 0 (03/09/2007)

Human Services Committee

Joint Favorable Change of Reference

Yea 17 Nay 0 (03/20/2007)

Appropriations Committee

Joint Favorable

Yea 48 Nay 0 (04/19/2007)