General Assembly

Raised Bill No. 1145

January Session, 2007

LCO No. **3759**

____SB01145HS___050907___

Referred to Committee on Public Health

Introduced by:
(PH)

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 Subsection (c) of section 19a-509b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):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

17 services department and patient accounts or billing office, and from
18 any collection agent. If during the admission process or during its
19 review of the financial resources of the patient, the hospital reasonably
20 believes the patient will have limited funds to pay for any portion of
21 the patient's hospitalization not covered by insurance, the hospital
22 shall provide the summary to each such patient.

23 Sec. 2. Subsection (b) of section 19a-535b of the general statutes is
24 repealed and the following is substituted in lieu thereof (*Effective July*
25 *1, 2007*):

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

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40 repealed and the following is substituted in lieu thereof (*Effective*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

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

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

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

83 as the case may be, [of] after receipt of such request, except as
84 provided for in this section. Upon the request of the applicant, the
85 review period may be extended for an additional fifteen days if the
86 office has requested additional information subsequent to the
87 commencement of the review period. The commissioner may extend
88 the review period for a maximum of thirty days if the applicant has not
89 filed, in a timely manner, information deemed necessary by the office.
90 Failure of the office to act upon such request within such review
91 period shall be deemed approval of such request. The ninety-day
92 review period, pursuant to this section, for an application filed by a
93 hospital, as defined in section 19a-490, and licensed as a short-term
94 acute care general hospital or a children's hospital by the Department
95 of Public Health or an affiliate of such a hospital or any combination
96 thereof, shall not apply if, in the certificate of need application or
97 request, the hospital or applicant projects either (A) that, for the first
98 three years of operation taken together, the total impact of the proposal
99 on the operating budget of the hospital or an affiliate or any
100 combination thereof will exceed one per cent of the actual operating
101 expenses of the hospital for the most recently completed fiscal year as
102 filed with the office, or (B) that the total capital expenditure for the
103 project will exceed fifteen million dollars. If the office determines that
104 an application is not subject to the ninety-day review period pursuant
105 to this subsection, it shall remain so excluded for the entire period of
106 that application, even if the application or circumstances change and
107 the application no longer meets the stated terms of the exclusion. The
108 office shall adopt regulations, in accordance with chapter 54, to
109 establish an expedited hearing process to be used to review requests
110 by any facility or institution for approval of a capital expenditure to
111 establish an energy conservation program or to comply with
112 requirements of any federal, state or local health, fire, building or life
113 safety code or final court order. The office shall adopt regulations in
114 accordance with the provisions of chapter 54 to provide for the waiver
115 of a hearing [,] for any part of a request by a facility or institution for a
116 capital expenditure, provided such facility or institution and the office
117 agree upon such waiver.

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

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

144 (d) Notwithstanding the provisions of section 19a-638 or subsection
145 (a) of this section, no community health center, as defined in section
146 19a-490a, shall be subject to the provisions of said section 19a-638 or
147 subsection (a) of this section if the community health center is: (1)
148 Proposing a capital expenditure not exceeding three million dollars; (2)
149 exclusively providing primary care or dental services; and (3) either
150 (A) <u>financing</u> one-third or more of the cost of the proposed project **[**is
151 financed**]** <u>with moneys provided</u> by the state of Connecticut, (B) **[**the

152 proposed project is] receiving funds from the Department of Public
153 Health for the proposed project, or (C) locating the proposed project [is
154 located] in an area designated by the federal Health Resources and
155 Services Administration as a health professional shortage area, a
156 medically underserved area or an area with a medically underserved
157 population. Each community health center seeking an exemption
158 under this subsection shall provide the office with documentation
159 verifying to the satisfaction of the office, qualification for this
160 exemption. Each community health center proposing to provide any
161 service other than a primary care or dental service at any location,
162 including a designated community health center location, shall first
163 obtain a certificate of need for such additional service in accordance
164 with this section and section 19a-638. Each satellite, subsidiary or
165 affiliate of a federally qualified health center, in order to qualify under
166 this exemption, shall: (i) Be part of a federally qualified health center [,]
167 that meets the requirements of this subsection; (ii) exclusively provide
168 primary care or dental services; and (iii) be located in a health
169 professional shortage area or a medically underserved area. If the
170 subsidiary, satellite or affiliate does not so qualify, it shall obtain a
171 certificate of need.

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

175 (a) The Commissioner of [the Office of] Health Care Access or the
176 commissioner's designee may grant an exemption from the
177 requirements of section 19a-638 or subsection (a) of section 19a-639, or
178 both, for any nonprofit facility, institution or provider that is currently
179 under contract with a state agency or department and is seeking to
180 engage in any activity, other than the termination of a service or a
181 facility, otherwise subject to said section or subsection if:

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

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

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

205 (4) In the case where the activity is the relocation of services, the
206 Commissioner of **[**the Office of**]** Health Care Access or the
207 commissioner's designee determines that the needs of the area
208 previously served will continue to be met in a better or satisfactory
209 manner.

210 (b) The Commissioner of **[**the Office of**]** Health Care Access or the
211 commissioner's designee may grant an exemption from the
212 requirements of section 19a-638 or subsection (a) of section 19a-639, or
213 both, for any nonprofit facility, institution or provider that is currently
214 under contract with a state agency or department and is seeking to
215 terminate a service or a facility, provided (1) the commissioner,
216 executive director, chairperson or chief court administrator of the state
217 agency or department with which the nonprofit facility, institution or

218 provider is currently under contract confirms, in writing, to the office
219 that the needs of the area previously served will continue to be met in
220 a better or satisfactory manner and specifies how that is to be done,
221 and (2) the Commissioner of **[**the Office of**]** Health Care Access or the
222 commissioner's designee determines that the needs of the area
223 previously served will continue to be met in a better or satisfactory
224 manner.

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

231 (d) The office may revoke or modify the scope of the exemption at
232 any time following a public review that allows the state agency or
233 department and the nonprofit facility, institution or provider to
234 address specific, identified, changed conditions or any problems that
235 the state agency, department or the office has identified. A party to any
236 exemption modification or revocation proceeding and the original
237 requesting agency shall be given at least fourteen calendar days
238 written notice prior to any action by the office and shall be furnished
239 with a copy, if any, of a revocation or modification request or a
240 statement by the office of the problems that have been brought to its
241 attention. If the requesting commissioner, executive director, chairman
242 or chief court administrator or the Commissioner of Health Care
243 Access certifies that an emergency condition exists, only forty-eight
244 hours written notice shall be required for such modification or
245 revocation action to proceed.

246 Sec. 6. Subsection (a) of section 19a-646 of the general statutes is
247 repealed and the following is substituted in lieu thereof (*Effective July*
248 *1, 2007*):

249 (a) As used in this section:

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

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

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

258 (4) "Payer" means any person, legal entity, governmental body or
259 eligible organization [covered by the provisions of Section 1876] that
260 meets the definition of an eligible organization under 42 USC Section
261 1395mm (b) of the Social Security Act, or any combination thereof,
262 except for Medicare and Medicaid which is or may become legally
263 responsible, in whole or in part for the payment of services rendered to
264 or on behalf of a patient by a hospital. Payer also includes any legal
265 entity whose membership includes one or more payers and any third-
266 party payer; and

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

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

272 (a) The office, in consultation with the Commissioner of Social
273 Services, shall review annually the level of uncompensated care
274 [including emergency assistance to families] provided by each hospital
275 to the indigent. Each hospital shall file annually with the office its
276 policies regarding the provision of [free or] charity care and reduced
277 cost services to the indigent, excluding medical assistance recipients,
278 and its debt collection practices. Each hospital shall obtain an
279 independent audit of the level of charges, payments and discharges by
280 primary payer related to Medicare, medical assistance, CHAMPUS or

281 TriCare and nongovernmental payers as well as the amount of
282 uncompensated care including emergency assistance to families. The
283 results of this audit, including the above information, with an opinion,
284 shall be provided to the office by each hospital by March thirty-first of
285 each year, and the hospital's audited financial statements shall be
286 provided by February twenty-eighth of each year. For purposes of this
287 section, "primary payer" means the **[**final payer responsible for more
288 than fifty per cent of the charges on the case, or, if no payer is
289 responsible for more than fifty per cent of the charges the**]** payer
290 responsible for the highest percentage of charges for a patient's
291 inpatient or outpatient hospital services. The office shall evaluate the
292 audit and may rely on the information contained in the independent
293 audit or may require such additional audit as it deems necessary.

294 (b) Each hospital shall annually report, along with data submitted
295 pursuant to subsection (a) of this section, (1) the number of applicants
296 for **[**free**]** charity care and reduced cost services, (2) the number of
297 approved applicants, and (3) the total and average charges and costs of
298 the amount of **[**free**]** charity care and reduced cost **[**care**]** services
299 provided.

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

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

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

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

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

312 September thirtieth;

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

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

319 [(6) "Uncompensated care including emergency assistance to
320 families" means the actual cost in the year prior to the base year of care
321 written off as bad debts or provided free under a free care policy
322 approved by the office including emergency assistance to families
323 authorized by the Department of Social Services and not otherwise
324 funded;] (6) "Uncompensated care" means the total amount of charity
325 care and bad debts determined by using the hospital's published
326 charges and consistent with the hospital's policies regarding charity
327 care and bad debts which have been approved by, and are on file at,
328 the office;

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

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

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

341 (10) "Case mix index" means [a hospital's case mix index calculated

342 using the medical record abstract and billing data submitted by the
343 hospital to the office] the arithmetic mean of the Medicare diagnosis
344 related group case weights assigned to each inpatient discharge for a
345 specific hospital during a given fiscal year. The case mix index shall be
346 calculated by dividing the hospital's total case mix adjusted discharges
347 [for the hospital] by the hospital's actual number of discharges [for the
348 hospital] for the fiscal year. The total case mix adjusted discharges
349 shall be calculated by (A) multiplying the number of discharges in
350 each diagnosis-related group by the Medicare weights in effect for
351 [the] that same diagnosis-related group [in effect for the] and fiscal
352 year, and [adding the resultant procedures across] (B) then totaling the
353 resulting products for all diagnosis-related groups;

354 (11) "Contractual allowances" means [, for the period October 1,
355 1992, to March 30, 1994, inclusive, the amount of discounts provided to
356 nongovernmental payers pursuant to subsections (d) and (e) of section
357 19a-646, for the period beginning April 1, 1994, the amount of
358 discounts provided to nongovernmental payers pursuant to
359 subsections (c), (d) and (e) of section 19a-646 and on and after July 1,
360 2002, any amount of discounts provided to nongovernmental payers
361 pursuant to a written agreement] the difference between hospital
362 published charges and payments generated by negotiated agreements
363 for a different or discounted rate or method of payment;

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

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

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

377 (15) "Net revenue" means total gross revenue less contractual
378 allowance, less the difference between government charges and
379 government payments, less uncompensated care [,] and other
380 allowances, [;] plus [, for purposes of compliance, net payments from
381 the uncompensated care pool in existence prior to April 1, 1994, and]
382 uncompensated care program disproportionate share hospital
383 payments from the Department of Social Services;

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

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

392 Effective October 1, 1993, and October first of each subsequent year,
393 the Secretary of the Office of Policy and Management shall determine
394 and inform the Office of Health Care Access of the maximum amount
395 of disproportionate share payments and emergency assistance to
396 families eligible for federal matching payments under the Medical
397 Assistance Program or the Emergency Assistance to Families Program
398 pursuant to federal statute and regulations and subdivisions (2) and
399 (28) of subsection (a) of section 12-407, subdivision (1) of section 12-
400 408, subdivision (5) of section 12-412, section 12-414, section 19a-649
401 and this section and the actual and anticipated appropriation to the
402 medical assistance disproportionate share-emergency assistance
403 account authorized pursuant to sections 3-114i and 12-263a to 12-263e,
404 inclusive, subdivisions (2) and (29) of subsection (a) of section 12-407,
405 subdivision (1) of section 12-408, section 12-408a, subdivision (5) of
406 section 12-412, subdivision (1) of section 12-414 and sections 19a-646,

407 19a-659, 19a-662, 19a-669 to **[**19a-673**]** 19a-670a, inclusive, 19a-671, 19a-
408 671a, 19a-672, 19a-672a, 19a-673 and 19a-676, and the amount of
409 emergency assistance to families' payments to eligible hospitals
410 projected for the year, and the anticipated amount of any increase in
411 payments made pursuant to any resolution of any civil action pending
412 on April 1, 1994, in the United States district court for the district of
413 Connecticut. The Department of Social Services shall inform the office
414 of any amount of uncompensated care which the Department of Social
415 Services determines is due to a failure on the part of the hospital to
416 register patients for emergency assistance to families, or a failure to bill
417 properly for emergency assistance to families' patients. If during the
418 course of a fiscal year the Secretary of the Office of Policy and
419 Management determines that these amounts should be revised, said
420 secretary shall so notify the office and the office may modify its
421 calculation pursuant to section 19a-671 to reflect such revision and its
422 orders as it deems appropriate and the Commissioner of Social
423 Services may modify said commissioner's determination pursuant to
424 section 19a-671.

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

428 (d) Nothing in section 3-114i, subdivision (2) or (29) of subsection (a)
429 of section 12-407, subdivision (1) of section 12-408, section 12-408a,
430 subdivision (5) of section 12-412, subdivision (1) of section 12-414, or
431 sections 12-263a to 12-263e, inclusive, section 19a-646, 19a-659, 19a-662
432 or 19a-669 to **[**19a-673**]** 19a-670a, inclusive, 19a-671, 19a-671a, 19a-672,
433 19a-672a, 19a-673 and section 19a-676, or section 1, 2, or 38 of public act
434 94-9* shall be construed to require the Department of Social Services to
435 pay out more funds than are appropriated pursuant to said sections.

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

438 The Commissioner of Social Services is authorized to determine the

439 amount of payments pursuant to sections 19a-670, [to 19a-672,
440 inclusive,] 19a-670a, 19a-671, 19a-671a and 19a-672 for each hospital.
441 The commissioner's determination shall be based on the advice of the
442 office and the application of the calculation in this section. For each
443 hospital, the Office of Health Care Access shall calculate the amount of
444 payments to be made pursuant to sections 19a-670, [to 19a-672,
445 inclusive,] 19a-670a, 19a-671, 19a-671a and 19a-672 as follows:

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

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

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

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

458 (D) From the anticipated appropriation to the medical assistance
459 disproportionate share-emergency assistance account made pursuant
460 to sections 3-114i and 12-263a to 12-263e, inclusive, subdivisions (2)
461 and (29) of subsection (a) of section 12-407, subdivision (1) of section
462 12-408, section 12-408a, subdivision (5) of section 12-412, subdivision
463 (1) of section 12-414 and sections 19a-646, 19a-659, 19a-662, 19a-669 to
464 [19a-673] 19a-670a, inclusive, 19a-671, 19a-671a, 19a-672, 19a-672a, 19a-
465 673 and 19a-676, for the quarter subtract the amount of any additional
466 medical assistance payments made to hospitals pursuant to any
467 resolution of or court order entered in any civil action pending on
468 April 1, 1994, in the United States District Court for the district of
469 Connecticut, and also subtract the amount of any emergency assistance
470 to families payments projected by the office to be made to hospitals in

471 the quarter.

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

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

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

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

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

490 (D) From the anticipated appropriation made to the medical
491 assistance disproportionate share-emergency assistance account
492 pursuant to sections 3-114i and 12-263a to 12-263e, inclusive,
493 subdivisions (2) and (29) of subsection (a) of section 12-407,
494 subdivision (1) of section 12-408, section 12-408a, subdivision (5) of
495 section 12-412, subdivision (1) of section 12-414 and sections 19a-646,
496 19a-659, 19a-662, 19a-669 to **[**19a-673**]** <u>19a-670a</u>, inclusive, <u>19a-671, 19a-</u>
497 <u>671a, 19a-672, 19a-672a, 19a-673</u> and 19a-676, for the fiscal year,
498 subtract the amount of any additional medical assistance payments
499 made to hospitals pursuant to any resolution of or court order entered
500 in any civil action pending on April 1, 1994, in the United States
501 District Court for the district of Connecticut, and also subtract any

502 emergency assistance to families payments projected by the office to be
503 made to the hospitals for the year.

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

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

509 The funds appropriated to the medical assistance disproportionate
510 share-emergency assistance account pursuant to sections 3-114i and 12-
511 263a to 12-263e, inclusive, subdivisions (2) and (29) of subsection (a) of
512 section 12-407, subdivision (1) of section 12-408, section 12-408a,
513 subdivision (5) of section 12-412, subdivision (1) of section 12-414 and
514 sections 19a-646, 19a-659, 19a-662, 19a-669 to **[**19a-673**]** 19a-670a,
515 inclusive, 19a-671, 19a-671a, 19a-672, 19a-672a, 19a-673 and 19a-676,
516 shall be used by said account to make disproportionate share
517 payments to hospitals, including grants to hospitals pursuant to
518 section 19a-168k, and to make emergency assistance to families
519 payments to hospitals. In addition, **[**the medical assistance
520 disproportionate share-emergency assistance account may utilize**]** a
521 portion of **[**these**]** funds appropriated to the medical assistance
522 disproportionate share-emergency assistance account may be used to
523 make outpatient payments as the Department of Social Services
524 determines appropriate or to increase the standard medical assistance
525 payments to hospitals if the Department of Social Services determines
526 it to be appropriate to settle any civil action pending on April 1, 1994,
527 in the United States District Court for the district of Connecticut.
528 Notwithstanding any other provision of the general statutes, the
529 Department of Social Services shall not be required to make any
530 payments pursuant to sections 3-114i and 12-263a to 12-263e, inclusive,
531 subdivisions (2) and (29) of subsection (a) of section 12-407,
532 subdivision (1) of section 12-408, section 12-408a, subdivision (5) of
533 section 12-412, subdivision (1) of section 12-414 and sections 19a-646,
534 19a-659, 19a-662, 19a-669 to **[**19a-673**]** 19a-670a, inclusive, 19a-671, 19a-

535 671a, 19a-672, 19a-672a, 19a-673 and 19a-676, in excess of the funds
536 available in the medical assistance disproportionate share-emergency
537 assistance account.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2007*	19a-509b(c)
Sec. 2	*July 1, 2007*	19a-535b(b)
Sec. 3	*October 1, 2007*	19a-639(b)
Sec. 4	*October 1, 2007*	19a-639(d)
Sec. 5	*October 1, 2007*	19a-639b(a)
Sec. 6	*July 1, 2007*	19a-646(a)
Sec. 7	*July 1, 2007*	19a-649
Sec. 8	*July 1, 2007*	19a-659
Sec. 9	*October 1, 2007*	19a-669
Sec. 10	*October 1, 2007*	19a-670(d)
Sec. 11	*October 1, 2007*	19a-671
Sec. 12	*October 1, 2007*	19a-672

PH *Joint Favorable*

HS *Joint Favorable*