AN ACT CONCERNING MEDICAID REIMBURSEMENT FOR EMERGENCY DEPARTMENT PHYSICIANS.

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

Section 1. Section 17b-239 of the 2014 supplement to the general statutes is repealed and the following is substituted in lieu thereof (Effective July 1, 2014):

(a) (1) Until the time subdivision (2) of this subsection is effective, the rate to be paid by the state to hospitals receiving appropriations granted by the General Assembly and to freestanding chronic disease hospitals providing services to persons aided or cared for by the state for routine services furnished to state patients, shall be based upon reasonable cost to such hospital, or the charge to the general public for ward services or the lowest charge for semiprivate services if the hospital has no ward facilities, imposed by such hospital, whichever is lowest, except to the extent, if any, that the commissioner determines that a greater amount is appropriate in the case of hospitals serving a disproportionate share of indigent patients. Such rate shall be promulgated annually by the Commissioner of Social Services.
(2) On or after July 1, 2013, Medicaid rates paid to acute care and children's hospitals shall be based on diagnosis-related groups established and periodically rebased by the Commissioner of Social Services, provided the Department of Social Services completes a fiscal analysis of the impact of such rate payment system on each hospital. The Commissioner of Social Services shall, in accordance with the provisions of section 11-4a, file a report on the results of the fiscal analysis not later than six months after implementing the rate payment system with the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies. The Commissioner of Social Services shall annually determine in-patient rates for each hospital by multiplying diagnostic-related group relative weights by a base rate. Within available appropriations, the commissioner may, in his or her discretion, make additional payments to hospitals based on criteria to be determined by the commissioner. Nothing contained in this section shall authorize Medicaid payment by the state to any such hospital in excess of the charges made by such hospital for comparable services to the general public.

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

(c) The term "reasonable cost" as used in this section means the cost of care furnished such patients by an efficient and economically operated facility, computed in accordance with accepted principles of hospital cost reimbursement. The commissioner may adjust the rate of payment established under the provisions of this section for the year during which services are furnished to reflect fluctuations in hospital
costs. Such adjustment may be made prospectively to cover anticipated
fluctuations or may be made retroactive to any date subsequent to the
date of the initial rate determination for such year or in such other
manner as may be determined by the commissioner. In determining
"reasonable cost" the commissioner may give due consideration to
allowances for fully or partially unpaid bills, reasonable costs
mandated by collective bargaining agreements with certified collective
bargaining agents or other agreements between the employer and
employees, provided "employees" shall not include persons employed
as managers or chief administrators, requirements for working capital
and cost of development of new services, including additions to and
replacement of facilities and equipment. The commissioner shall not
give consideration to amounts paid by the facilities to employees as
salary, or to attorneys or consultants as fees, where the responsibility
of the employees, attorneys or consultants is to persuade or seek to
persuade the other employees of the facility to support or oppose
unionization. Nothing in this subsection shall prohibit the
commissioner from considering amounts paid for legal counsel related
to the negotiation of collective bargaining agreements, the settlement
of grievances or normal administration of labor relations.

(d) (1) Until such time as subdivision (2) of this subsection is
effective, the state shall also pay to such hospitals for each outpatient
clinic and emergency room visit a reasonable rate to be established
annually by the commissioner for each hospital, such rate to be
determined by the reasonable cost of such services.

(2) On or after July 1, 2013, hospitals shall be paid for outpatient and
emergency room episodes of care based on prospective rates
established by the commissioner in accordance with the Medicare
Ambulatory Payment Classification system in conjunction with a state
conversion factor, provided the Department of Social Services
completes a fiscal analysis of the impact of such rate payment system
on each hospital. The Commissioner of Social Services shall, in
accordance with the provisions of section 11-4a, file a report on the
results of the fiscal analysis not later than six months after implementing the rate payment system with the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies. The Medicare Ambulatory Payment Classification system shall be modified to provide payment for services not generally covered by Medicare, including, but not limited to, pediatric, obstetric, neonatal and perinatal services. Nothing contained in this subsection shall authorize a payment by the state for such episodes of care to any hospital in excess of the charges made by such hospital for comparable services to the general public. Those outpatient hospital services that do not have an established Ambulatory Payment Classification code shall be paid on the basis of a ratio of cost to charges, or the fixed fee in effect as of January 1, 2013. The Commissioner of Social Services shall establish a fee schedule for outpatient hospital services to be effective on and after January 1, 1995, and may annually modify such fee schedule if such modification is needed to ensure that the conversion to an administrative services organization is cost neutral to hospitals in the aggregate and ensures patient access. Utilization may be a factor in determining cost neutrality.

(e) An emergency department physician may enroll separately as a Medicaid provider and qualify for direct reimbursement for professional services provided in the emergency department of a hospital to a Medicaid recipient, including services provided on the same day the Medicaid recipient is admitted to the hospital. The commissioner shall pay to any such emergency physician the Medicaid rate already in effect for such services as of January 1, 2013, for applicable Current Procedural Terminology codes or successor codes developed by the American Medical Association. If the commissioner determines that payment to an emergency department physician pursuant to this subsection results in an additional cost to the state, the commissioner shall adjust such rates in consultation with the Connecticut Hospital Association and the Connecticut College of
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Emergency Physicians to ensure budget neutrality. No such adjustment shall affect the rates paid to hospitals. Until such adjustments are made, the applicable Current Procedural Terminology codes or successor codes developed by the American Medical Association shall remain in force.

[(e)] (f) The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, establishing criteria for defining emergency and nonemergency visits to hospital emergency rooms. All nonemergency visits to hospital emergency rooms shall be paid at the hospital's outpatient clinic services rate. Nothing contained in this subsection or the regulations adopted under this section shall authorize a payment by the state for such services to any hospital in excess of the charges made by such hospital for comparable services to the general public. To the extent permitted by federal law, the Commissioner of Social Services shall impose cost-sharing requirements under the medical assistance program for nonemergency use of hospital emergency room services.

[(f)] (g) On and after July 1, 1995, no payment shall be made by the state to an acute care general hospital for the inpatient care of a patient who no longer requires acute care and is eligible for Medicare unless the hospital does not obtain reimbursement from Medicare for that stay.

[(g)] (h) The commissioner shall establish rates to be paid to freestanding chronic disease hospitals.

[(h)] (i) The Commissioner of Social Services may implement policies and procedures as necessary to carry out the provisions of this section while in the process of adopting the policies and procedures as regulations, provided notice of intent to adopt the regulations is published in [the Connecticut Law Journal] accordance with the provisions of section 17b-10 not later than twenty days after the date of implementation.
This act shall take effect as follows and shall amend the following sections:

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<td>July 1, 2014</td>
<td>17b-239</td>
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**Statement of Purpose:**
To allow emergency department physicians to be reimbursed separately from hospitals for treating Medicaid recipients.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]