



House of Representatives

General Assembly

File No. 627

February Session, 2014

Substitute House Bill No. 5440

House of Representatives, April 17, 2014

The Committee on Appropriations reported through REP. WALKER of the 93rd Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING MEDICAID REIMBURSEMENT FOR EMERGENCY DEPARTMENT PHYSICIANS.

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

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2 statutes is repealed and the following is substituted in lieu thereof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

4 (a) (1) Until the time subdivision (2) of this subsection is effective,
5 the rate to be paid by the state to hospitals receiving appropriations
6 granted by the General Assembly and to freestanding chronic disease
7 hospitals providing services to persons aided or cared for by the state
8 for routine services furnished to state patients, shall be based upon
9 reasonable cost to such hospital, or the charge to the general public for
10 ward services or the lowest charge for semiprivate services if the
11 hospital has no ward facilities, imposed by such hospital, whichever is
12 lowest, except to the extent, if any, that the commissioner determines
13 that a greater amount is appropriate in the case of hospitals serving a
14 disproportionate share of indigent patients. Such rate shall be

15 promulgated annually by the Commissioner of Social Services.

16 (2) On or after July 1, 2013, Medicaid rates paid to acute care and
17 children's hospitals shall be based on diagnosis-related groups
18 established and periodically rebased by the Commissioner of Social
19 Services, provided the Department of Social Services completes a fiscal
20 analysis of the impact of such rate payment system on each hospital.
21 The Commissioner of Social Services shall, in accordance with the
22 provisions of section 11-4a, file a report on the results of the fiscal
23 analysis not later than six months after implementing the rate payment
24 system with the joint standing committees of the General Assembly
25 having cognizance of matters relating to human services and
26 appropriations and the budgets of state agencies. The Commissioner of
27 Social Services shall annually determine in-patient rates for each
28 hospital by multiplying diagnostic-related group relative weights by a
29 base rate. Within available appropriations, the commissioner may, in
30 his or her discretion, make additional payments to hospitals based on
31 criteria to be determined by the commissioner. Nothing contained in
32 this section shall authorize Medicaid payment by the state to any such
33 hospital in excess of the charges made by such hospital for comparable
34 services to the general public.

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

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

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

69 (d) (1) Until such time as subdivision (2) of this subsection is
70 effective, 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.

74 (2) On or after July 1, 2013, hospitals shall be paid for outpatient and
75 emergency room episodes of care based on prospective rates
76 established by the commissioner in accordance with the Medicare
77 Ambulatory Payment Classification system in conjunction with a state
78 conversion factor, provided the Department of Social Services
79 completes a fiscal analysis of the impact of such rate payment system
80 on each hospital. The Commissioner of Social Services shall, in
81 accordance with the provisions of section 11-4a, file a report on the

82 results of the fiscal analysis not later than six months after
83 implementing the rate payment system with the joint standing
84 committees of the General Assembly having cognizance of matters
85 relating to human services and appropriations and the budgets of state
86 agencies. The Medicare Ambulatory Payment Classification system
87 shall be modified to provide payment for services not generally
88 covered by Medicare, including, but not limited to, pediatric, obstetric,
89 neonatal and perinatal services. Nothing contained in this subsection
90 shall authorize a payment by the state for such episodes of care to any
91 hospital in excess of the charges made by such hospital for comparable
92 services to the general public. Those outpatient hospital services that
93 do not have an established Medicare Ambulatory Payment
94 Classification code shall be paid on the basis of a ratio of cost to
95 charges, or the fixed fee in effect as of January 1, 2013. The
96 Commissioner of Social Services shall establish a fee schedule for
97 outpatient hospital services to be effective on and after January 1, 1995,
98 and may annually modify such fee schedule if such modification is
99 needed to ensure that the conversion to an administrative services
100 organization is cost neutral to hospitals in the aggregate and ensures
101 patient access. Utilization may be a factor in determining cost
102 neutrality.

103 (e) An emergency department physician may enroll separately as a
104 Medicaid provider and qualify for direct reimbursement for
105 professional services provided in the emergency department of a
106 hospital to a Medicaid recipient, including services provided on the
107 same day the Medicaid recipient is admitted to the hospital. The
108 commissioner shall pay to any such emergency department physician
109 the Medicaid rate in effect for such services as of January 1, 2013, for
110 applicable Current Procedural Terminology codes or successor codes
111 developed by the American Medical Association. If the commissioner
112 determines that payment to an emergency department physician
113 pursuant to this subsection results in an additional cost to the state, the
114 commissioner shall adjust such rate in consultation with the
115 Connecticut Hospital Association and the Connecticut College of
116 Emergency Physicians to ensure budget neutrality. No such

117 adjustment shall affect the rates paid to hospitals. Until such
118 adjustments are made, the applicable Current Procedural Terminology
119 codes or successor codes developed by the American Medical
120 Association shall remain in force.

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

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

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

140 [(h)] (i) The Commissioner of Social Services may implement
141 policies and procedures as necessary to carry out the provisions of this
142 section while in the process of adopting the policies and procedures as
143 regulations, provided notice of intent to adopt the regulations is
144 published in [the Connecticut Law Journal] accordance with the
145 provisions of section 17b-10 not later than twenty days after the date of
146 implementation.

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact: None

Municipal Impact: None

Explanation

The bill does not result in a cost to the Department of Social Services as the bill requires any rate established for emergency room physicians to be cost neutral. The bill allows emergency room physicians who are not employed by a hospital to qualify for direct reimbursement from Medicaid.

The Out Years

State Impact: None

Municipal Impact: None

OLR Bill Analysis**HB 5440*****AN ACT CONCERNING MEDICAID REIMBURSEMENT FOR EMERGENCY DEPARTMENT PHYSICIANS.*****SUMMARY:**

This bill allows an emergency department physician to (1) enroll separately as a Medicaid provider and (2) qualify for direct reimbursement for professional services he or she provides in a hospital emergency department to a Medicaid recipient. These include services provided on the same day the recipient is admitted to the hospital.

The bill requires the Department of Social Services (DSS) commissioner to pay these physicians 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 paying a physician under this provision increases the state's cost, the commissioner must adjust the physician's rates to ensure budget neutrality. The commissioner must do this in consultation with the Connecticut Hospital Association and the Connecticut College of Emergency Physicians. No such adjustment may affect the rates paid to hospitals. Until the adjustments are made, the applicable Current Procedural Terminology codes or successor codes remain in force.

By law, the commissioner may implement policies and procedures regarding Medicaid hospital rates while adopting the policies and procedures as regulations. The bill extends this provision to include the emergency department physician rates. Under current law, to use this provision, the commissioner must publish notice of intent to adopt the regulations in the *Connecticut Law Journal* not later than 20 days after the date of implementation. The bill instead requires DSS to (1)

submit the policy electronically to the secretary of the state for posting online before adopting the policy, (2) post the policy on its Internet web site, and (3) print notice of intent to adopt the regulation in the *Connecticut Law Journal* not later than 20 days after adopting the policy. The policy is valid until the final regulations go into effect.

EFFECTIVE DATE: July 1, 2014

COMMITTEE ACTION

Human Services Committee

Joint Favorable Change of Reference

Yea 18 Nay 0 (03/11/2014)

Appropriations Committee

Joint Favorable

Yea 49 Nay 0 (04/01/2014)