[Conn. Gen. Stat. § 17b-239.]

§ 17b-239. Payments to hospitals, emergency department physicians. Regulations: Medical Assistance

(a) Medicaid rates paid to acute care hospitals, including children's hospitals, shall be based on diagnosis-related groups established and periodically rebased by the Commissioner of Social Services in accordance with 42 USC 1396a(a)(30)(A), provided the Department of Social Services completes a fiscal analysis of the impact of such rate payment system on each hospital. The commissioner 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. Within available appropriations, the commissioner shall annually determine in-patient payments for each hospital by multiplying diagnosis-related group relative weights by a base rate. Over a period of up to four years beginning on or after January 1, 2016, within available appropriations and at the discretion of the commissioner, the Department of Social Services shall transition hospital-specific, diagnosis-related group base rates to state-wide diagnosis-related group base rates by peer groups determined by the commissioner. For the purposes of this subsection and subsection (c) of this section, “peer group” means a group comprised of one of the following categories of acute care hospitals: Privately operated acute care hospitals, publicly operated acute care hospitals, or acute care children's hospitals licensed by the Department of Public Health. At the discretion of the Commissioner of Social Services, the peer group for privately operated acute care hospitals may be further subdivided into peer groups for privately operated acute care hospitals. For inpatient hospital services that the Commissioner of Social Services determines are not appropriate for reimbursement based on diagnosis-related groups, the commissioner shall reimburse for such services using any other methodology that complies with 42 USC 1396a(a)(30)(A). 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. Upon the conversion to a hospital payment methodology based on diagnosis-related groups, the commissioner shall evaluate payments for all hospital services, including, but not limited to, a review of pediatric psychiatric inpatient units within hospitals. The commissioner may, within available appropriations, implement a pay-for-performance program for pediatric psychiatric inpatient care. 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 pursuant to 42 USC 1396a(a)(30)(A) and within available appropriations. 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) (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 rate established by the commissioner for each hospital pursuant to 42 USC 1396a(a)(30)(A) and within available appropriations.

(2) On or after July 1, 2016, with the exception of publicly operated psychiatric hospitals, hospitals shall be paid for outpatient and emergency room services based on prospective rates established by the commissioner within available appropriations and in accordance with an ambulatory payment classification system, provided the Department of Social Services completes a fiscal analysis of the impact of such rate payment system on each hospital. Such ambulatory payment classification system may include one or more peer groups established by the Department of Social Services. 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. Nothing contained in this subsection 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. Effective upon implementation of the ambulatory payment classification system, a covered outpatient hospital service that is not being reimbursed using such ambulatory payment classification system shall be paid in accordance with a fee schedule or an alternative payment methodology, as determined by the commissioner. The commissioner may, within available funding for implementation of the ambulatory payment classification methodology, establish a supplemental pool to provide payments to offset losses incurred, if any, by publicly operated acute care hospitals and acute care children's hospitals licensed by the Department of Public Health as a result of the implementation of the ambulatory payment classification system. Prior to the implementation of the ambulatory payment classification system, each hospital's charges shall be based on the charge master in effect as of June 1, 2015. After implementation of such system, annual increases in each hospital's charge master shall not exceed, in the aggregate, the annual increase in the Medicare economic index.

(d) Concurrent with the implementation of the ambulatory payment classification methodology of payment to hospitals, 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 department physician the Medicaid rate for physicians in accordance with the applicable physician fee schedule in effect at that time. 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 rate in consultation with the Connecticut Hospital Association and the Connecticut College of Emergency Physicians to ensure budget neutrality.

(e) The commissioner may 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 in accordance with subsection (c) of this section. 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 may impose cost-sharing requirements under the medical assistance program for nonemergency use of hospital emergency room services.

(f) The commissioner shall establish rates to be paid to freestanding chronic disease hospitals within available appropriations.

(g) 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 accordance with the provisions of section 17b-10 not later than twenty days after the date of implementation.

(h) In the event the commissioner is unable to implement the provisions of subsection (d) of this section by January 1, 2015, the commissioner shall submit written notice, not later than thirty-five days prior to January 1, 2015, to the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations and the budgets of state agencies indicating that the department will not be able to implement such provisions on or before such date. The commissioner shall include in such notice (1) the reasons why the department will not be able to implement such provisions by such date, and (2) the date by which the department will be able to implement such provisions.

(i) Not later than fifteen days after passage of this section or December 1, 2017, whichever is sooner, the commissioner shall publish public notice of the intent to submit a Medicaid state plan amendment to provide for the rate increases set forth in this subsection. Not later than five days after the expiration of the thirty-day public comment period for such Medicaid state plan amendment, the commissioner shall submit such Medicaid state plan amendment to the Centers for Medicare and Medicaid Services for approval. Subject to federal approval, the commissioner shall increase rates effective January 1, 2018, for hospitals, implementing those increases on the earliest available date, as follows: (1) The diagnosis-related group base rate for inpatient hospital services provided by privately operated acute care general hospitals shall be increased by thirty-one and sixty-five-hundredths per cent from the level in effect on July 1, 2017, and (2) the ambulatory payment classification base conversion factor for outpatient hospital services provided by acute care general hospitals shall be increased by six and one-half per cent from the level in effect on July 1, 2017. For dates of service only from January 1, 2018, through June 30, 2018, commencing January 1, 2018, the Commissioner of Social Services shall pay at the increased rates set forth in this subsection even if each applicable Medicaid state plan amendment approval has not been received from the Centers for Medicare and Medicaid Services prior to January 1, 2018, provided the implementation of such rate increases remains subject to federal approval and payment of such increases may later be recovered if federal approval is not obtained. For dates of service on or after July 1, 2018, the rate increases set forth in this subsection shall be implemented not later than thirty days after receiving federal approval of applicable Medicaid state plan amendments. Subject to continuing approvals from the Centers for Medicare and Medicaid Services and ongoing compliance with applicable federal Medicaid requirements, for the fiscal year commencing July 1, 2018, and annually thereafter, the commissioner shall not remove the rate increases set forth in this subsection. No provision of this subsection shall affect implementation of state-wide diagnosis-related group base rates in accordance with subsection (a) of this section.

(j) Except as otherwise specifically required in subsection (i) of this section, notwithstanding the provisions of this chapter or regulations adopted thereunder, the Department of Social Services is not required to increase rates paid, or to set any rates to be paid to or adjust upward any method of payment to, any hospital based on inflation or based on any inflationary factor, including, but not limited to, any current payments or adjustments that are being made based on dates of service in previous years. The Department of Social Services shall not increase or adjust upward any rates or method of payment to hospitals based on inflation or

based on any inflationary factor unless the approved state budget includes appropriations for such increases or upward adjustments.