

PA 14-160

HB5440

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**CONNECTICUT
GENERAL ASSEMBLY
HOUSE**

**PROCEEDINGS
2014**

**VOL.57
PART 6
1681 – 2023**

law/gbr
HOUSE OF REPRESENTATIVES

210
April 23, 2014

Those voting Nay 6

Those absent and not voting 5

DEPUTY SPEAKER ORANGE:

The bill passes. Thank you, Mr. Clerk. Will the Clerk please call Calendar Number 397.

THE CLERK:

House Calendar 397 on page 31, Madam Speaker, favorable report of the joint standing committee on appropriations, substitute House Bill 5440, AN ACT CONCERNING MEDICAID REIMBURSEMENT FOR EMERGENCY DEPARTMENT PHYSICIANS.

DEPUTY SPEAKER ORANGE:

Representative Abercrombie.

REP. ABERCROMBIE (83rd):

Good evening, Madam. Nice to see you up there. Madam Speaker, I move for the acceptance of the joint committee's favorable report and passage of the bill.

DEPUTY SPEAKER ORANGE:

The question before the Chamber is on acceptance of the joint committee's favorable report and passage of the bill.

REP. ABERCROMBIE (83rd):

Madam Speaker.

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HOUSE OF REPRESENTATIVES

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April 23, 2014

DEPUTY SPEAKER ORANGE:

Representative Abercrombie.

REP. ABERCROMBIE (83rd):

I apologize. Madam Speaker, the Clerk is in possession of amendment LCO 4091. I ask that they please call the amendment and I'm granted leave of the Chamber.

DEPUTY SPEAKER ORANGE:

Will the Clerk please call LCO Number 4091 which will be designated House Amendment Schedule A.

THE CLERK:

House Amendment Schedule A, LCO 4091 introduced by Representative Abercrombie and Senator Slossberg.

DEPUTY SPEAKER ORANGE:

The good Representative seeks leave of the Chamber to summarize. Is there objection? Objection? Seeing no objection, Representative Abercrombie.

REP. ABERCROMBIE (83rd):

Thank you, Madam Speaker. Madam Speaker, this is a bill that we've been working on for a number of years and what this bill does is it allows emergency room doctors to be able to submit to Medicaid for separate services in the ER and to get paid under the Medicaid rate. I move adoption.

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HOUSE OF REPRESENTATIVES

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April 23, 2014

DEPUTY SPEAKER ORANGE:

The question before the Chamber is on adoption of House Amendment Schedule A. Will you remark on the amendment? Will you remark on House Amendment Schedule A? Representative Wood.

REP. WOOD (141st):

Thank you, Madam Speaker. I stand in support of the amendment. It is something we've been working on for a couple of years. And if I could also speak to the underlying bill and kill two birds with one stone.

DEPUTY SPEAKER ORANGE:

well we should move the amendment first.

REP. WOOD (141st):

All right. Move the amendment. I stand in support of the amendment. I support my colleague in this.

DEPUTY SPEAKER ORANGE:

Will you care to remark further on the amendment before us? Will you care to remark further on House Amendment Schedule A? If not, let me try your minds. All those in favor please signify by saying aye.

REPRESENTATIVES:

Aye.

DEPUTY SPEAKER ORANGE:

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April 23, 2014

All those opposed nay. The ayes have it. The
amendment is adopted. Will you care to remark further
on the amendment as -- the bill as amended?

Representative Wood, you have the floor, Madam.

REP. WOOD (141st):

Thank you, Madam Speaker. This is direct
Medicaid payment to ER doctors who provide care in the
emergency room who are employed outside of the
hospital. It is something as my colleague said we've
been working on for a couple of years.

And I think it's unusual in here when we get to
simplify something and this does simplify payment to
the ER docs and I think it's absolutely something we
should be doing. It takes effect January 1. It was
unanimous out of human services and appropriations.
And I urge everyone to support this. Thank you very
much.

DEPUTY SPEAKER ORANGE:

Thank you, Representative Wood. Would you care
to remark further on the bill as amended? Would you
care to remark further on the bill as amended? Would
you care to remark further on the bill as amended? If
not, staff and guests please come to the well of the

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HOUSE OF REPRESENTATIVES

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April 23, 2014

House. Members take your seats. The machine will be opened.

THE CLERK:

The House of Representatives is voting by roll.

The House of Representatives is voting by roll. Will members please return to the Chamber immediately.

DEPUTY SPEAKER ORANGE:

Have all members voted? Have all members voted? Please check the board to determine if your vote has been properly cast. If so the machine will be locked and the Clerk will take a tally. And will the Clerk please announce the tally.

THE CLERK:

House Bill 5440 as amended by House A.

Total Number Voting	143
Necessary for Passage	72
Those voting Yea	143
Those voting Nay	0
Those absent and not voting	7

DEPUTY SPEAKER ORANGE:

The bill as amended passes. And will the Clerk please call Calendar Number 292.

THE CLERK:

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CONNECTICUT
GENERAL ASSEMBLY
SENATE**

**PROCEEDINGS
2014**

**VETO
SESSION**

**VOL. 57
PART 11
3246 – 3508**

pat/gbr
SENATE

271
May 7, 2014

SENATOR LOONEY:

Calendar 456, House Bill 5440, move to place on the
Consent Calendar.

THE CHAIR:

So ordered, sir.

SENATOR LOONEY:

Calendar 459, House Bill 5321, move to place on the
Consent Calendar.

THE CHAIR:

So ordered, sir.

SENATOR LOONEY:

And Calendar 461, House Bill 5140, move to place on
the Consent Calendar.

THE CHAIR:

So ordered, sir.

SENATOR LOONEY:

Thank you, Madam President. Moving to Calendar Page
16, Calendar 474, House Bill 5337, move to place on
the Consent Calendar.

THE CHAIR:

So ordered, sir. Senator, is there also on Page 15
that you might have missed.

SENATOR LOONEY:

The matter on Page 15 we have already voted, Madam
President.

THE CHAIR:

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SENATE

289
May 7, 2014

Calendar 334, House Bill 5339.
Calendar 336, House Bill 5056.
On Page 7, Calendar 345, House Bill 5443.
On Page 9, Calendar 417, House Bill 5410.
On Page 10, Calendar 420, House Bill 5258.
Calendar 421, House Bill 5263.
Calendar 424, House Bill 5439.
On Page 11, Calendar 429, House Bill 5581.
On Page 12, Calendar 445, House Bill 5418.
Calendar 438, House Bill 5336.
On Page 13, Calendar 453, House Bill 5133.
Calendar 446, House Bill 5150.
Calendar 452, House Bill 5531.
On Page 14, Calendar 457, House Bill 5516.
Calendar 455, House Bill 5325.
Calendar 456, House Bill 5440.
Calendar 459, House Bill 5321.
Calendar 461, House Bill 5140.
On Page 15, Calendar 468, House Bill 5450.
Calendar 465, House Bill 5341.
On Page 16, Calendar 474, House Bill 5337.
Calendar 469, 5538.
Calendar 473, House Bill 5328.
On Page 17, Calendar 496, House Bill 5115.

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SENATE

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May 7, 2014

SENATOR LOONEY:

If we might pause for just a moment to verify a couple of additional items.

Madam President, to verify an additional item, I believe it was placed on the Consent Calendar and Calendar Page 30, on Calendar Page 30, Calendar 592, Substitute for House Bill 5476.

THE CHAIR:

It is, sir.

SENATOR LOONEY:

It is on? Okay. Thank you. Thank you, Madam President. If the Clerk would now, finally, Agenda Number 4, Madam President, Agenda Number 4 one additional item ask for suspension to place up on Agenda Number 4 and that is, ask for suspension to place on the Consent Calendar an item from Agenda Number 4.

THE CHAIR:

Seeing no objection, so ordered, sir.

SENATOR LOONEY:

Thank you, Madam President, and that item is Substitute House Bill Number 5566 from Senate Agenda Number 4.

Thank you, Madam President. If the Clerk would now, if we might call for a vote on the Consent Calendar.

THE CHAIR:

Mr. Clerk. Will you please call for a Roll Call Vote on the Consent Calendar. The machine will be opened.

THE CLERK:

An immediate Roll Call has been ordered in the Senate.

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SENATE

296
May 7, 2014

An immediate Roll Call on Consent Calendar Number 2 has been ordered in the Senate.

THE CHAIR:

If all members have voted, all members have voted, the machine will be closed. Mr. Clerk will you please call the tally.

THE CLERK:

Consent Calendar Number 2.

Total number voting	36
Necessary for adoption	19
Those voting Yea	36
Those voting Nay	0
Those absent and not voting	0

THE CHAIR:

The Consent Calendar passes. Senator Looney.

SENATOR LOONEY:

Thank you, Madam President. Two additional items to take up before the, our final vote on the implementer. If we might stand for just, for just a moment.

The first item to mark Go is, Calendar, to remove from the Consent Calendar, Calendar Page 22, Calendar 536, House Bill 5546. If that item might be marked Go.

And one additional item, Madam President, and that was from Calendar, or rather from Agenda Number 4, ask for suspension to take it up for purposes of marking it Go, that is House Bill, Substitute for House Bill 5417. Thank you, Madam President.

THE CHAIR:

Seeing no objection, so ordered, sir.

SENATOR LOONEY:

**JOINT
STANDING
COMMITTEE
HEARINGS**

**HUMAN
SERVICES
PART 2
505 – 933**

2014

1

March 6, 2014

jat/mcr HUMAN SERVICES COMMITTEE

11:00 A.M.

CHAIRMAN: Senator Slossberg
 Representative Abercrombie
 Senator Coleman
 Representative Stallworth

MEMBERS PRESENT:

SENATORS: Markley

REPRESENTATIVES:

Ackert, Bowles, Butler,
 Case, Cook, McGee, Miller,
 Morris, Ritter,
 Rutigliano, Santiago,
 Wood, Zupkus

REP. ABERCROMBIE: I'd like to combine the Human
 Services public hearing for today.

SENATOR SLOSSBERG: Combine.

REP. ABERCROMBIE: Madam Co-Chair any opening --
 what did I say?

SENATOR SLOSSBERG: Combine.

REP. ABERCROMBIE: Oh, sorry. Oh, wow, if I'm
 starting this way, it's going to be a long
 hearing. Sorry about that, guys. Maybe I need
 more coffee. No comment? Okay.

So with that we'll move on to the Commissioner
 Bremby.

Good morning, sir. Thank you for being here.

COMMISSIONER BREMBY: Morning, Senator Slossberg,
 Representative Abercrombie, members of the
 Human Services Committee. I'm Rod Bremby. I'm
 the Commissioner of Department of Social
 Services, and I'm pleased to be back before you
 again to testify on bills related to the
 Department, raised on behalf of the Department,
 and we offer written remarks on several of the

HB 5443 HB 5439HB 5441 SB 324SB 252 SB 328SB 322 SB 323HB 5444 HB 5440HB 5446

bills on today's agenda which impact the Department.

In terms of bills raised by the Department or on behalf of the Department, House Bill 5443 is an act concerning Medicaid coverage for certain over-the-counter drugs. This proposal, while adding very modest additional Medicaid over-the-counter drug coverage, is necessary to comply with federal requirements for the Medicaid expansion. This change is necessary to allow cover of over-the-counter drugs that are required to be included in the benefits package for the Medicaid expansion to non-disabled, non-elderly person, adults with dependent children.

At this time, the only additional over-the-counter drugs that would be required to be covered by this change are those listed in the U.S. Preventative Services Task Force A and B recommendations. Specifically, those drugs include only, one, low dose aspirin to prevent cardiovascular disease for men ages 45 to 79 years of age and women ages 55 to 79 years of age where the potential benefit outweighs the potential harm, and, two, folic acid for women who are planning or are capable of becoming pregnant. Folic acid is already covered for women who are already pregnant.

Connecticut's Medicaid program already covers the vast majority of preventative services included in these guidelines. The only items not currently covered are the OTC that are within the USPSTF. So recognizing the benefits of this expansion outweigh the costs as well as the advantages in managing a uniform program from an administrative standpoint. This bill also extends coverage to these drugs to other Medicaid eligible. We ask for your support of this bill.

agencies, the Department of Mental Health and Addiction Services, as the lead agency for adult behavioral health, and the Department of Children and Families as the lead agency for children's behavioral health be included in any discussions about where the clearinghouse should reside.

In addition, it is our hope that this initiative would not be redundant of or impact any services already being provided by 2-1-1 Infoline, the state's contracted informational and referral partner.

House Bill 5444, an act concerning Medicaid coverage of chiropractic services. This proposal requires the Department to add chiropractic services to the Medicaid state plan as an optional service. Currently there are no funds included in the Governor's recommended budget adjustments to support this addition. Therefore, the Department must oppose it.

And I believe the last bill we have in front of you -- next to last in front of you is House Bill 5440, an act concerning Medicaid reimbursement for emergency department physicians. This bill would allow ED docs to enroll independently as Medicaid providers, thereby, qualifying to be directly reimbursed for professional services provided to Medicaid recipients in hospital emergency departments.

Under this legislation, physicians would bill and be paid using applicable current procedural terminology codes rather than the all-inclusive revenue center codes currently paid to hospitals, which includes the physician's reimbursement. Such reimbursement change under this bill would expose the state to significant additional costs in several ways.

First, any additional procedures performed and billed by the physician would be added cost to the state, whereby the global RCC includes the cost of any procedures. For example, the hospital would be paid no more than the standard visit fee if an emergency physician sets a fractured arm under RCC. In contrast, an independently enrolled physician -- emergency physician would be paid for the visit and the setting of the fracture. Ultimately, the Department is limited in its ability to predict fiscal impact of procedures performed because we do not capture these extra procedures in claims under the current methodology. We are concerned, however, that paying separately for these procedures will create a financial incentive to perform more of them.

Second, payment for professional services for Medicaid recipients admitted to hospitals as inpatients on the same day the emergency services are provided are currently rolled into the hospital's reimbursement for the day of admission. If the ED physician's fees are paid separately, these fees would be an added expense to the state.

Third, professional fees for many patients admitted for observation, which is frequently provided in the ED or in a nearby area staffed by the ED would also represent an additional cost to the state, particularly since the fees paid to the hospital will not change.

And finally, the state does not pay an additional professional fee for urgent care provided in the ED, but rather includes this fee in an urgent care bundled rate. Any professional fees associated with these services would also be new state expenses.

Although the language of this legislation holds hospitals harmless and has a provision for cost neutrality, we believe this proposal will result instead in significant additional cost to the state. RCCs are set for each hospital based upon their cost reports, which include professional services. Paying ED physicians separately, while adjusting the RCC accordingly, would result in the state paying twice for the same service.

Last year, at the direction of the Department, our contractor, Mercer, completed an analysis of the possible costs of this proposal. Based on their analysis using two different modeling options, the estimated impact could be anywhere between \$1 to \$9 million.

In addition, CMS advised the Department that were we to unbundle any hospital rate, we would be required to do so for all other bundled hospital rates. Based on this guidance, we estimate the cost implications of unbundling all hospital rates to be at least \$25 million.

Given that the Department is currently in the process of replacing the current method of reimbursement with DRG for inpatient services and APCs, or ambulatory payment classifications, for outpatient services, additional changes, as required in this bill, are not recommended at this time.

For all of these reasons, DSS opposes this legislation.

And lastly, House Bill 5446, an act concerning the prevention or elimination of double childcare subsidies. This bill would prohibit the Department from providing a childcare subsidy payment to a provider any time period

we think we can get this issue resolved.

REP. E. RITTER: That would be very helpful because my next question was, I guess I seem to sense an inconsistency between -- not understanding if that's the case then, vehement opposition to the legislation, if, in fact, all it would do would be to clarify the very good efforts that you've made through your agency to keep this from happening. I guess I don't understand then why it needs to be opposed.

COMMISSIONER BREMBY: I don't think that the opposition is vehement, but I do believe that we can find an administrative solution to ensure that this sort of double billing doesn't occur. To place it in statute may -- I don't know. We try to look for administrative solutions as opposed to burdening you with statutory construct.

REP. E. RITTER: Fair enough. And we tend to seek a statutory solution on this side of the table. I understand that, but I just wanted to make sure I kind of understood that. Thank you.

The previous bill 5440 contained an interesting discussion about unbundling services, and I had -- I guess my initial questions was the cost implications of unbundling all hospital rates. I see your estimate of about 25 million. I assume that's net to the state. I'm interested in what all those other services are; it might be my first question.

COMMISSIONER BREMBY: I'm going to look quickly through the report and see if they have listed --

REP. E. RITTER: Thank you.

COMMISSIONER BREMBY: -- out those types of

services.

REP. E. RITTER: So I don't want to have everybody have to wait, Commissioner, but it might be helpful to the committee if we knew that, and the reason is that in previous years, at different times, we've discussed other bundled services and how they are treated as a bundle or not as a bundle actually; and it's kind of complex.

And so what I'm trying to do is to understand where this particular instance, how that fits in with the ones that are currently bundled versus the ones that are unbundled and how that kind of works.

COMMISSIONER BREMBY: This is a very interesting, and timely, and complex matter in that we're in the middle of a conversation with a number of providers, most notably the hospital association around how we pay for services, and that transformation has been something that has been very deliberately and carefully thought through. We're constantly meeting.

But we do not use a grouper model for payment. Most other Medicaid programs do. The DRG model was created in, I think, Yale back in the 1970s, and at one time the state used that. But we no longer do that. We moved away from that.

In looking forward to transformation of payment for health services, we need to find ways to bundle service or care models. So this bill would, in effect, disrupt that planning effort and that process by which we come to some resolution around how we bundle payments. If we unbundle here, CMS says we have to unbundle everything, and so we would like to -- and we believe that the providers would like to see a

bundle set of services also.

We don't believe that we will start with all services, but we believe that there are an array of services we could start with and pilot and hopefully see if we can get better quality outcomes at lower cost, lower overall cost rather than an incremental approach to payment.

REP. E. RITTER: And I don't disagree with that. I'm just trying to sort of fit it into the whole conversation because it has been some of my experience here when dealing with some of these other issues around bundled payments that motivations and the economies around bundling versus unbundling can be very different across providers and its implications for the state. And so I'm just trying to seek a wider understanding of that, and I appreciate that. Any additional information I think, ultimately, would be very helpful for us because I suspect these are conversations that, future sessions as well --

COMMISSIONER BREMBY: Yes.

REP. E. RITTER: -- we're going to be having, you know. We're the hardest group probably in your sphere to bring up to the same understanding of how it could work. So --

COMMISSIONER BREMBY: We'll do that.

REP. E. RITTER: That would be helpful.

Another -- I'll let it go at that. I know other people had questions. Thank you. And I'll look forward to that discussion.

REP. ABERCROMBIE: Thank you, Representative. Senator Markley, followed by Representative Ackert.

it's not an easy thing to figure out because we're trying to say -- I guess you'd be looking at something like we spent X amount on these chiropractic services and Y amount on back surgery or whatever. And is there some way that a correlation could be found? And I'm not expecting that that could be perfect or easy, but it certainly would be interesting to try to find out if you think -- if you think there's anything there that could give us an indication.

ROBERT SIVOSKY: Well, a number of states do cover chiropractic in various forms, so we can certainly compare with those other states. There are other programs, one in Rhode Island, that has used chiropractic care for pain management. So there are models out there that we can compare and contrast and try to get you an answer.

SENATOR MARKLEY: Thank you. I would think that chiropractors themselves would be doing their best to aggregate information across the states and share it with us if, in fact, it is favorable to the argument that they're making. So maybe if they don't have it, that's telling us something too, but we'll find out. Thank you very much, Doctor.

If I may ask on one other bill, Madam Chair.

The reimbursement for the emergency department physicians is something that seems to be coming back, which I get a very different story, depending who I'm talking to about it. And I guess I'd say when I talk to the physicians themselves, they say, "We're in a unique position in terms of being" -- in so far as they are members of a private group like other doctors, they indicate to me that they're treated differently from other private group

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physicians in the way that they're reimbursed in that it has to go through the hospital, et cetera.

From your perspective, it's just the opposite. They're looking to become different in the way they're reimbursed, not that -- let's say if I'm understanding what you're saying, they're looking to be reimbursed differently than other specialties within the hospital. And I guess I'd say, as is often the case, it's all a little unclear in my mind. Could you help me see through this?

COMMISSIONER BREMBY: I think the best way to help you see through it is to ask someone who actually sets the rates to clarify why the rates are the way that they are for different types of services provided in different locations within the hospital.

So let us get some information to help make that argument and to help clarify why it is the way that it is.

SENATOR MARKLEY: Thank you very much, Commissioner.

REP. ABERCROMBIE: Representative Ackert.

REP. ACKERT: Thank you, Madam Chair. And good to see you, Commissioner.

Just clarification, if I could, on the first bill that you testified -- actually, second, 5441, the direct payment for residential care facilities.

I read your notes, read through it. It makes sense to me in terms of, you know, allocating - - other testimony backs it also. But you asked about, you know, maybe having a clarification of boarding homes, and then I read your

year once fair end gets pushed into the rate. So the \$10,000 limit will just allow the Department to use five years as the pay down period rather than the IRS book that we use. So, for example, if we put in a new boiler -- if a home puts in a new boiler for \$8,000, typically we'll look it up in the IRS book, and it may be a 15-year pay down. So this will tell us to put it in for 5 years, which lets the money flow out.

So we don't see a really large financial impact because for \$10,000 and below, five years is probably what we use the majority of the time anyways.

REP. ACKERT: Excellent. Thank you for the clarification. Thank you, Madam Chair.

REP. ABERCROMBIE: Thank you. Further questions? Representative Bowles.

REP. BOWLES: Thank you, Madam Chair. Good to see you again, Commissioner.

COMMISSIONER BREMBY: Good morning.

REP. BOWLES: You certainly have a lot of perseverance, but very thoughtful and well written comments regarding legislation.

I just have questions concerning two particular pieces of legislation. A number of my colleagues have asked here about House Bill 5440 in terms of the reimbursement for emergency department physicians. I had the privilege of working for the Department for a number of years and actually was involved in CPT codes. It was the most brain-numbing stuff I've worked on in my life, very difficult to (inaudible) a lot of it, but it was relatively straightforward. It's actually good to see a

couple of my old colleagues here as well.

The RCC codes though were even more byzantine in nature, and if we tried to take a look at it historically. I am aware of the costs, you know, or that they established them. But my recollection is that the reimbursement for emergency room visit, what is the average? Do you have any sense of that currently as it stands now? I know it varies from hospital to hospital.

COMMISSIONER BREMBY: We would be taking a shot in the dark. We can get that level of detail to you.

REP. BOWLES: That information together with how those RCC, the revenue code, particularly for the emergency room visits I think would be very helpful, and I know you're going to be providing additional information on that. But I would be very, very interested. There may have been some further clarification on that since I've worked at the agency.

The second issue I just want to touch upon briefly is 322, the behavioral health clearinghouse. I see there's quite a bit of testimony, including from your colleague, Commissioner Rehmer from DMHAS and 2-1-1 Infoline. I certainly share your comments relative to not being redundant.

The one -- and this is more a comment than a question. But if you could please take a look at the work or at least invite DCF to incorporate in their discussions about the possibility of setting up this clearinghouse. The work that the Child Health and Development Institute has done, CHDI, they have spent a number of years now working particularly in trying to create a family-friendly website for

this bill is to allow service by a copy of the order and not the original because that will expedite the service and make it a lot easier to not -- so that the (inaudible) is not released from court because he's able to be apprehended on the child support civil arrest warrant.

REP. ABERCROMBIE: So if I understand you, we're not changing the roles of what the judicial marshals do or the state marshals do?

DAVID MULLIGAN: No, no.

REP. ABERCROMBIE: It's current practice for the judicial marshals to be able to service this. All this legislation does is say that they can serve copy now versus the original?

DAVID MULLIGAN: Right. They have been serving these warrants already. It's just more cumbersome if we have to obtain the original because the original may be in the hands of a state marshal, or it may be in the hands of one of our capias officers employed by DSS. So it may not be received in time for them to hold the person and turn them over to a capias officer for deliver to the child support magistrate.

REP. ABERCROMBIE: Okay. Thank you. I appreciate the clarification on that.

DAVID MULLIGAN: Thank you.

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REP. ABERCROMBIE: And then my final question is on the -- I guess I have to, in all honesty, Commissioner, I guess I have to go back to the emergency room issue.

You know, this has been something that has been coming up year after years. So I guess my

question is, currently -- and correct me if I'm wrong -- currently we have two hospitals that do get a separate benefit for emergency docs.

So I guess there is some data that we have that can tell us what it costs with the de-bundling, right, if that's how we want to clarify it. So I'm not sure I understand why we think that it's going to, one, cost more, and, two, why we do, do it currently at two hospitals; and why we don't do it across the board?

COMMISSIONER BREMBY: Let me take the last question first. And just be quite frank with you, several hospitals were authorized some time ago, I believe the late 1990s, to bill in this way. It was an administrative error, shouldn't have been done. We do need to correct this. It's unfair the way it's currently situated, and as we're looking at our payment methodology, we want to bring everything in line.

So instead of compounding an error, we'd like to correct this so that the entire system works better for all of us.

REP. ABERCROMBIE: So I guess the other part I'm having a little bit of a hard time with is the hospitals also do not see this as costing more money, and they have agreed that this is probably a practice that's acceptable to them.

So I guess I'm still having a hard time understanding why -- I understand what you're saying, how you think with the de-bundling how it's going to cost more, but it seems like there's a lot of people that are not convinced that that's the way it's going to be, if we go down that road. So I guess there's more conversation that we have to have around this.

And I guess the other part of it is, my understanding is that currently Westerly, Rhode Island, which is on the border of Connecticut, their hospital is able to submit to our Medicaid program for a separate benefit. Is that current practice? Do you know?

COMMISSIONER BREMBY: I don't know. I don't know about that. We'll check into that.

But I do want to make a quick comment on the last point you were making. While there may be some hospitals who are not very concerned about additional costs, I have not yet heard from a single hospital who would be okay with us reducing their costs in order to pass this price on to -- or the cost onto the ED docs.

So if it has to come out of a pool for payment, I don't think they -- I've not heard them express any interest in reducing their share of the payment.

REP. ABERCROMBIE: Well, I don't think it's actually a reduction because my understanding is, the way that the current practice is, is that the payment goes to the hospital, and the hospital de-bundles it and gives it to the ER. So I'm not exactly sure where we think there's going to be an added cost.

COMMISSIONER BREMBY: Okay. So, again, we'll bring back information and lay this out. It's not to be argumentative but just to hopefully provide additional information from which policy could be made.

REP. ABERCROMBIE: That would be great, and if you could check into the Westerly, Rhode Island situation because, you know, I think it's a little unfair if we're willing to give a separate benefit to a hospital that's outside

of the state. And my understanding is this was currently -- this was done currently. This wasn't something that was done years ago with the other two hospitals. So I'd be interested to know the reasoning behind that.

So it's June of 2013 it went into effect. So that's interesting to know why we're allowing it with them and not our own hospitals in the state.

For me, that's all the questions I have.

Can you mention the two hospitals that currently get the separate benefit for the ER docs? I think it's Lawrence & Memorial and -- no. It's not (inaudible).

COMMISSIONER BREMBY: We'll provide that in a complete set of information.

REP. ABERCROMBIE: That'd be great. Any further -- yes. Representative Zupkus.

REP. ZUPKUS: Thank you, and thank you for being here. I don't envy you for all the conversation and talking that you do all the time here.

But I did just want to piggyback on Representative Abercrombie because I know private practices are able to get reimbursements for Medicaid, and I struggle with, if an emergency room is its own private practice, so to speak, why they're not able to do that. Is there a reason why it's just the emergency rooms and not others, or why that discussion is on emergency rooms?

COMMISSIONER BREMBY: I think it's easier for us. I don't have that information, but I think it's easier for us to bundle a lot of information

and bring it back to you directly as a group.

REP. ZUPKUS: Thank you.

REP. ABERCROMBIE: Any further questions? Yes, Representative Cook.

REP. COOK: Thank you. I just have a follow-up. And, Commissioner, it was just something that was said by David Mulligan.

On Senate Bill 328, they were talking about giving a copy versus an original. Do we find any legal ramifications with that moving forward? I don't -- and I'm not saying that there is or there's not. I'm just saying that a lot of times if we have a copy versus an original, sometimes that can become an issue in court. I'm just wondering if we have assurance that we wouldn't have an issue going forward, or is this not a problem?

COMMISSIONER BREMBY: We'll check Dave again.

DAVID MULLIGAN: Dave Mulligan again. I don't believe there is because that is done in other situations with *capias mittimus*.

REP. COOK: Other situations with the state of Connecticut or --

DAVID MULLIGAN: Yes. No. With *capias mittimus* orders.

REP. COOK: Okay. I just want to make sure that if we move forward doing this, I don't want to find ourselves in any legal ramifications later on. So thank you for clarifying.

DAVID MULLIGAN: Okay.

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REP. ABERCROMBIE: And just for the Department, it

looks like it's Lawrence & Memorial is one of the hospitals and Stamford is the other hospital that currently does the separate benefit. So if you can just verify that; that'd be great.

Representative Ritter.

REP. E. RITTER: I'm sorry. I have another question on the marshals. I tried to -- I tried to flag you before you got up.

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So the question is I understand from your responses to Representative Abercrombie that there is no change in the roles, in other words, it's only in what I would describe as in the piece of paper that is carried.

DAVID MULLIGAN: That is correct. The role of the state marshal will remain as it is now, and the role of the judicial marshal will remain, including all their other duties that they have for courthouse supervision, but they're already doing this in many cases. This just expedites the process.

REP. E. RITTER: Thank you. So that leads me to wonder why -- and I have also been contacted by many people who are concerned that their current roles, as one of these kinds of marshals -- I don't remember -- would be diminished by this change. And I wonder if you have -- if you can enlighten me as to why then they would feel that way.

DAVID MULLIGAN: The role of the judicial marshal would be diminished; that's what I'm wondering?

REP. E. RITTER: No. I believe it's the role of the state marshal.

DAVID MULLIGAN: Okay. The role of the state

CHRIS CONNAUGHTY: Thank you very much.

REP. ABERCROMBIE: Moving on to House Bill 5440, Michael Zanker, and then, Lisa, you'll be up after that, okay.

DR. MICHAEL ZANKER: Good afternoon, Senator Slossberg, Representative Abercrombie, ranking members, Senator Markley, and Representative Wood, and members of the Human Services Committee.

Thank you for the opportunity to present this testimony on House Bill 5440. My name is Dr. Michael Zanker, and I'm the Legislative Committee Chairman for the Connecticut College of Emergency Physicians, a professional organization representing over 400 physicians dedicated to providing care to all the citizens of the state of Connecticut.

We as emergency physicians provide a 24/7, 365 safety net for the ill and injured no matter what their insurance status. While this is mandated by state and federal regulation and statute, we do it out of a deep personal commitment to the care of our fellow citizens. We are on duty before most people start their day and well after they go to bed. We work weekends, overnights, every holiday. We provide care to every patient no matter what the problem, no matter how minor, how life threatening, mental health issues.

We provide care no matter what their insurance status. We don't ask what their insurance status is, nor do we care. We're not allowed to deny or refer any patient to another provider based on their insurance status. We basically provide the safety net to a fragmented healthcare system while it struggles to find a means to sustainability.

The provision of this level of care required an enormous commitment of human resources and material. While the public and our elected officials understand and are willing to accept the costs of public safety, our departments are funded solely by healthcare reimbursement.

Patients receive care in our emergency departments, undoubtedly never stop to wonder who we are or who we're paid by, and likely would assume, in fact, that we're all employees of the hospital.

For many reasons not important here in this testimony, the model of hospital-based emergency physicians has shifted, and more hospitals are contracting out their emergency departments to private physician groups every year. These groups are analogous to private practices and rely solely on reimbursement from payers to maintain their services.

Currently in the state of Connecticut, the Department of Social Services does not allow for emergency physicians to bill Medicaid directly for their professional fees, but rather bundles these fees into hospital facility charges. While this doesn't mean the private groups are unable to recoup their fees, they do have to negotiate with every hospital in order to recoup -- to collect payment for our professional fees.

As many of our departments are moving toward a private practice model, we seek equity with our colleagues already in private practice to whom Medicaid reimbursement is allowed. We're the only specialty bound by EMTALA to see Medicaid patients in our practice, and yet the only specialty not allowed to bill directly for our services.

In summary, the Connecticut College of Emergency Physicians supports House Bill 5440 in allowing emergency physicians to bill for Medicaid fees, professional fees. We merely seek equity with our colleagues in private practice in terms of recouping our fees and billing practices.

We look forward to working with the Legislature in the future on various aspects of emergency care, and I will stop here. Thank you.

REP. ABERCROMBIE: Thank you, and thank you for your testimony. Questions from committee members?

I have a couple of questions for you. So one of the things that the Commissioner talked about was CMS is looking at not having us debundle. Can you comment on that at all? Are you aware of any changes through CMS? I know other states are doing it.

DR. MICHAEL ZANKER: Other states are doing it, and, in fact, there are two hospitals, as you know, in the state which are allowed for their emergency physicians to bill for their professional fees as well as CMS or Human Services paying Medicaid care for patients receiving care in hospitals across the Rhode Island border.

I am personal not aware of the requirements or the mandate stated by Human Services.

REP. ABERCROMBIE: Okay. Thank you for that. I appreciate it because sometimes I think that we try to throw it on CMS without having verified that's accurate information. So, you know, if you can lend anything to that, that would be great.

And I think the other piece of this that, you know, DSS is missing is that we're not making this mandatory that all hospitals do this, you know. We're just giving you guys the option, if your hospital is in favor of it.

So I'll give you an example. I represent Meriden. MidState Medical Center, I had a meeting with them two weeks ago. They're in favor of this, you know. The hospital association signed on to the letter saying that they agree that this is probably best practices and the way to go.

So, you know, we're going to continue to have this dialogue, as you heard from the Commissioner. I think there's a lot of support for what you guys are looking for, and I think it goes to what you said, you know, you just want fairness across the board.

So I appreciate you being here. I thank you because every (recording skipped)-- you know, we bring this up, then every year we try a different strategy, and maybe this will be the year that they'll give a little bit.

DR. MICHAEL ZANKER: Thank you.

REP. ABERCROMBIE: Representative Wood.

REP. WOOD: Thank you.

And thank you, certainly, for all you do. I have three kids who are EMTs, and I know what it's like -- I mean, I don't know what it's like, but I know through them what it's like to be on the front lines. And we're a better world for everything you do.

I have a very simple question. What's the reasoning that we're not allowing direct

payment of Medicaid to the emergency room doctors?

DR. MICHAEL ZANKER: Well, we ask -- we ask that same question every year we sit in front of you, and the response we get is the cost of it, the additional cost to the Medicaid system of providing the professional fees to the emergency physicians.

We, actually -- our National American College of Emergency Physicians, has looked at this, and we as emergency medicine actually comprise 2 percent of the healthcare budget. And, yet, every year are providing more care than virtually any other specialty with over 100 million visit annually, and increasing. And seeing the number of borders in our emergency departments increasing.

(Comment from audience)

Borders, people who are admitted, yet there's no inpatient bed ready for them.

Staying in our emergency departments, dealing with more and more mental health issues. We've become, truly, the safety net, and as more and more private practices, community health centers, clinics are being full, there's no longer the day of calling your doctor and being able to fit someone in; and the clinics are being overburdened. The whole system is becoming overstressed.

And I think a big part of our increase in volume is people are just unable to be seen by primary care, and they're having trouble just navigating the system.

And I think as we see more and more -- and there's been examples of it in Massachusetts --

as we insure the population, we're not increasing the number of primary care providers in our state. And now we're going to probably see is more of our self-paid patients in the emergency department are the same patients, only now they're insured. I think we're probably going to see a steady increase of Medicaid patients in the emergency department.

And, again, all we're asking is equity in payment.

REP. WOOD: Do other states pay directly to the ER physicians?

DR. MICHAEL ZANKER: Yes.

REP. WOOD: How many -- please don't say we're the only state that doesn't.

DR. MICHAEL ZANKER: No.

REP. WOOD: One of ten, one of --

DR. MICHAEL ZANKER: I don't have the specific number.

REP. WOOD: How many people do you see that could be in a critical care facility and not the ER, for critical care -- what did we call it, Stamford Hospital? They've got an urgent care as opposed to -- I think that's what they call it. Thankfully I don't know what that is because I haven't been there. But what percentage of people do you see in the ER that really don't need to be in the ER but could be in urgent care?

DR. MICHAEL ZANKER: Well, virtually all of the departments in the state run an urgent care associated with their emergency departments. It's actually physically located within and

staffed by the emergency department. So it's probably, from my practicing the last 15 years, about 30 percent of the patients are placed in urgent care, but, again, they're seen by us, just in a different capacity, where, once again, we're not allowed to bill for professional fees.

REP. WOOD: Okay. Great. Thank you very much. Thank you for being here.

Thank you, Madam Chair.

REP. ABERCROMBIE: Yeah. Senator Slossberg.

SENATOR SLOSSBERG: Thank you so much, Dr. Zanker for being here. We appreciate it.

I'm just -- there were a couple questions asked by the committee members that, based on the information we were given, I think we need to confirm this yet. But we were given information that does say, in fact, that we are -- the ER docs are the only specialty in our state and in the country where ER docs do not have a separate provider number.

So I think we're waiting for information from research to confirm that. We do know that New York State allows the ER physicians to enroll as Medicaid providers.

And to your question, Representative Wood about why -- you know, how did this happen that way? I think it comes from the change in the hospital model. It used to be that your ER docs were directly hospital employees, and so they're payment, like many doctors who are hired directly by the hospital, was negotiated directly with the hospital.

And now with all of the changes were so many of

the doctors' practices are becoming private practices, and hospitals are now contracting out to private practices, the model has changed. And this is sort of the last vestige, at least that's my understanding of that model. But as a result, it leaves the ER docs with no real -- with no one really to bill, quite frankly, for seeing Medicaid patients.

So, please, Dr. Zanker, correct me if I'm wrong.

DR. MICHAEL ZANKER: Actually, just recently the rules have changed and emergency physicians were required by DSS to register with Medicaid, not, however, for our billing ability, but rather when we see a patient in the emergency department, CMS now requires us to be registered in order for us to -- well, in order for the patient to have a prescription filled at a pharmacy. So through their prescription program, we need to be registered Medicaid billers in order for that to be paid. However, we still fight the battle of we're now registered as Medicaid providers, yet we're not allowed to bill as Medicaid providers.

SENATOR SLOSSBERG: Thank you, Madam Chair, and thank you, Dr. Zanker, for being here and for the good work that you do.

REP. ABERCROMBIE: Representative Bowles.

REP. BOWLES: Yeah. I'm just interested in following up on this. I don't quite understand. How do you actually get paid? Who do you actually -- you know, I mean, you really -- you provide critical service, obviously.

In the absence of a contract with the hospital, without being an employee, without being able to reimburse -- and I guess the concern is -- I

think we all share is that emergency rooms now will be, as you've already indicated, it will be even more frequently used by Medicaid. So we'll have really a kind of two-tier medical system in this country as a result of this. But how do you actually get paid?

DR. MICHAEL ZANKER: I actually get paid. I'm formerly Hartford Hospital, newly on staff at Middlesex, both of which are the old systems. I am a Middlesex Hospital employee. I am paid by Middlesex Hospital on an hourly rate.

More and more departments in this state are going to the private practice model, whereby there are either physician groups who staff that emergency department, or large national companies, which staff departments all across the country, come in and the emergency physicians are actually employees of that company. So it's now I guess through either a private practice or pro-health physician type of practice, a large group practice. You're paid basically through your group, not by the hospital, and the group counts on revenues coming from billing to pay their physician employees.

So there's still two models. There's the hospital-based model, like myself, who is paid directly by the hospital as a hospital employee, as they pay the nursing staff; the housekeeping staff. But there's others where they are a group that provides care within the emergency department.

REP. BOWLES: No. I understand that, but there are situations, I believe, where you can have a specialist come in. For instance, I was made aware of a case a number of years ago at L & M Hospital where an eye surgeon was brought into emergency room setting, performed emergency

room procedures in that setting, and was -- and, correct me if I'm wrong, was not allowed to bill for that service.

There are holes in this across the board too as well because the nature of emergency room service. I mean, you could provide any kinds of, you know, medical services in that setting, correct?

DR. MICHAEL ZANKER: Typically when we call in a consultant, they bill separately. They bill for a consultation fee, any follow-up fees that they have with their office practice.

REP. BOWLES: Okay. Thank you. Thank you, Madam Chair.

REP. ABERCROMBIE: Any further questions or -- Senator Markley.

SENATOR MARKLEY: Two quick and kind of global questions.

Could you estimate what percentage of emergency room physicians are in which model at this point in time? How many of them are employees of the hospital versus private practice physicians?

DR. MICHAEL ZANKER: Here in the state?

SENATOR MARKLEY: Here in the state. Yes.

DR. MICHAEL ZANKER: That is a difficult one, and it changes every year. Just mapping out the state in my head, we're probably heading towards a 50/50 split in the state if not more.

SENATOR MARKLEY: And, similarly, something that I won't expect you to give an exact answer to, but is it your expectation -- I mean, do you

think we're changing completely from one model to another, or will there always be a place for some hospitals keeping emergency room physicians as direct employees?

DR. MICHAEL ZANKER: There is a big push and a lean towards these large group practices. Obviously, their businesses, and they figured out how to provide emergency care and make a profit out of it.

So the push on the private side is to move towards every department in the country becoming privately run. There's a number of hospitals that have given up ownership of their emergency physicians based upon losses in their own accounting, but there are a number that are really committed to maintaining hospital-based emergency physicians. Obviously, when we're paid by the hospital, there's more control over us, how we practice, what we do.

So I think they'll be a small number of hospitals in the state who will forever maintain themselves as hospital-based, but I think you're going to see a much larger surge. And, you know, just my own estimation would probably be 75 percent of the state will probably end up in a private practice model.

SENATOR MARKLEY: Thank you, Doctor. Thank you, Madam Chair.

REP. ABERCROMBIE: And just to add to that, Senator, what we might want to do is see if OLR can come up with those numbers. That might be helpful as we go down this path, you know. Thank you.

Representative Zupkus.

REP. ZUPKUS: Thank you, Madam Chair.

Welcome, and I apologize if these questions have already been asked. But I'm just curious, when the Commissioner was in earlier he spoke of it costing more money this way as opposed for it to be reimbursed to a private practice versus the way it's done now. Do you know why that's the case?

DR. MICHAEL ZANKER: No. And we hear that same argument. What we're merely asking for, and I think what they're referring to is by unbundling our professional fees and paying them to the groups, they then are opening to unbundling of all.

And I did note a comment in the testimony of now having to pay procedural fees, and splinting of limbs, splinting of fractures and how that might lead to a greater number of procedures being performed and billed.

This was actually looked at through the years as we developed these private groups, as to whether people are going to receive three additional sutures or a splint when they don't need one, and the groups themselves, in order to maintain their CMS payments, have monitored -- there's been no shown increase in the number of procedures billed, unnecessary procedures billed. They've actually gone down a lot in that the groups don't want to be caught doing unnecessary procedures. They actually have monitored and policed themselves, and the number of, not unnecessary, but perhaps splints being applied, or number of sutures being used has gone down based upon this direct payment to the groups.

We hear the same argument about the cost going up, and I think what they're referring to mostly is the unbundling of costs; and now they're going to have to pay out or unbundle

through the whole hospital admission.

REP. ZUPKUS: Thank you. And if I may, just one more. And my other question was -- it was also mentioned that hospitals really might not want this, and I know they're -- you said you work for a hospital; and you are employed by the hospital. How does your -- does your hospital see this as a problem, or are they -- what's their feeling on it?

DR. MICHAEL ZANKER: My new employer -- I've been employed for a week at Middlesex. But, again, it provides the option for this to occur.

At Hartford Hospital, we were all employed by the hospital, and Middlesex is the same model. I'm not certain that they're going to want to go through the unbundling of all of their costs to receive the same reimbursement.

So I don't think it will affect the hospitals as much that are hospital-based practices. It will only help out in the practices that are private groups.

REP. ZUPKUS: Great. Well, thank you. I know that being an ER physician, it's tough work, and you get what you get coming through the door. I think out of all of them, kudos to you, and thank you for doing for you do because it's brutal in the ED. So thank you. Thank you.

DR. MICHAEL ZANKER: Thank you.

REP. ABERCROMBIE: Representative, just to add to that because I -- just so people are aware, you know, are colleagues are in a lot of different meetings throughout the day. So if you see people coming in, it's not that they're not paying attention to what's going on. It's just that we can't be in every place at once.

But one of the comments that I had made early on was my hospital, MidState, I had a meeting with them a couple of weeks ago around this issue, and they are very open to doing it. They don't see any issues in it at all.

So I'll be honest with you, what I think it is, personally, I think it's just that DSS does not want to have to do the separate billing. That's my personal opinion. I don't see any other reason why they don't want to do it. It's that they just don't want to have to separate it. That's all. My hospital doesn't feel that they're going to lose any money, you know, because it goes into the hospital, and then the hospital is the one that has to separate it and pay these guys.

And the other part of it is, we talked about too, we're not mandating that all hospitals do this. They still have the opportunity. If their ER docs are part of the system right now and they're fine with that, they can do that. If they want them to be a separate -- because in my hospital they're contracting with them. They are a separate unit. So why not, you know.

So thank you very much for your testimony. We do appreciate it.

Any further questions or comments? So this isn't done. We will continue the conversation. Thank you.

Lisa Stevenson. Thank you so much for waiting. We appreciate it.

LISA STEVENSON: Thank you for letting me speak. My name is Lisa Stevenson. I am an officer of the State Marshals Local Council 4 AFSCME, and I'm

SB 328

Testimony of Michael Zanker, MD FACEP
Legislative Chair, Connecticut College of Emergency Physicians
Committee on Human Services

March 6, 2014

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THE CONNECTICUT COLLEGE OF EMERGENCY PHYSICIANS SUPPORTS HB-5440
AN ACT CONCERNING MEDICAID REIMBURSEMENT FOR EMERGENCY DEPARTMENT
PHYSICIANS

Good afternoon Senator Slossberg, Representative Abercrombie, Senator Markley and Representative Wood and the distinguished members of the Human Services Committee. Thank you for the opportunity to present this testimony in support of House Bill 5440, An Act Concerning Medicaid Reimbursement for Emergency Department Physicians. My name is Dr. Michael Zanker and I am the Legislative Chairman for the Connecticut College of Emergency Physicians, the professional organization representing over 400 emergency physicians dedicated to providing care to all of the citizens of the State of Connecticut.

We as emergency physicians provide a 24/7/365 safety net for the ill or injured no matter what their insurance status. While this is mandated by state and federal regulation and statute, we do it out of a deep personal commitment to care for our fellow citizens. We are on duty before others start their day and after they end their day. We work through the night, on weekends and every holiday. We provide care to every patient no matter what the problem from the most minor to the most life-threatening. We do not ask about insurance status, nor do we care. We are not allowed to deny care nor refer to another provider based upon insurance status. We provide the safety net to a fragmented healthcare system while it struggles to find a means of sustainability.

The provision of this level of care requires an enormous commitment of human and material resources. While the public and our elected leaders understand and are willing to accept the costs of our public safety colleagues in the law enforcement, fire and EMS communities our emergency departments are funded solely by health insurance reimbursement. Patients receiving care in our emergency departments undoubtedly never stop to wonder who we are or how we are paid and likely would assume if asked that we are all employees of the hospital. For many reasons not important to this testimony, the model of hospital employed emergency physicians has shifted and more hospitals are contracting out their emergency departments to private physician groups each year. These groups are analogous to private practices and rely on reimbursement from payers to maintain their services.

Currently in the State of Connecticut the Department of Social Services does not allow for emergency physicians to bill Medicaid directly for their professional fees but rather bundles these fees into hospital facility charges. While this does not mean that the private groups staffing our emergency departments cannot recoup their fees, it relies on a system whereby the group must negotiate with the hospital to collect payment from them. As many of our emergency departments are moving toward a private practice

model we seek equity with our colleagues already in private practice to whom Medicaid reimbursement is allowed. We are the only specialty bound by EMTALA to see Medicaid patients in our practice and yet the only specialty which is not allowed to bill for our services directly.

Many studies have shown that the majority of the cost of health care today is generated by inpatient care. Emergency care accounts for 2% of our healthcare expenses. Yet our emergency departments are providing care to more patients every year, well over 100 million visits annually. The reasons for this are manifold and are based on the fact that our system is being overstressed. Private physicians are seeing more patients in their offices and are more often unable to "fit a patient in during office hours". Our community health centers and clinics are full and cannot take on new patients or unscheduled visits. Patients are referred to the emergency department or simply find the system too confusing to navigate and know the only place they can walk in and see a provider is in the emergency department. To fix our healthcare system will require cultural change, not just in how we deliver and pay for healthcare but in how we as a society expect healthcare. In the meantime, we as emergency physicians welcome the visits to our department and the satisfaction of caring for our fellow citizens. While we are a relatively young specialty, we face many challenges and are eager to make our voices and ideas on healthcare reform heard.

In summary, the Connecticut College of Emergency Physicians supports HB-5440 and the prohibition of allowing emergency physicians to bill Medicaid for professional fees. We merely seek equity with our colleagues in private practice. We accept that there are many challenges ahead on the fronts of liability and battling overcrowding in our departments and look forward to working with the legislature in the future as we all work toward the common goal of creating a safe and sustainable healthcare system here in Connecticut and throughout the nation. Thank you again for allowing this testimony.



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Testimony before the Human Services Committee
Roderick L. Bremby, Commissioner
March 6, 2014

HB 5439 HB 5441
SB 324 SB 252
SB 328 SB 322
SB 323 HB 5444

HB 5440
HB 5446

Good morning, Senator Slossberg and Representative Abercrombie and distinguished members of the Human Services Committee. My name is Roderick Bremby and I am the Commissioner of the Department of Social Services. I am pleased to be before you today to testify on several bills raised on behalf of the Department. In addition, I offer written remarks on several other bills on today's agenda that impact the Department.

Bills Raised on Behalf of DSS:

H.B. No. 5443 (RAISED) AN ACT CONCERNING MEDICAID COVERAGE FOR CERTAIN OVER-THE-COUNTER DRUGS.

This proposal, while adding very modest additional Medicaid over-the-counter drug coverage, is necessary to comply with federal requirements for the Medicaid expansion. This change is necessary to allow coverage of over-the-counter drugs that are required to be included in the benefits package for the Medicaid expansion to non-disabled, non-elderly adults without dependent children (Medicaid Coverage for the Lowest Income Populations or HUSKY D) earning up to 138% of the federal poverty level. At this time, the only additional over-the-counter drugs that would be required to be covered by this change are those listed in the U.S. Preventive Services Task Force A and B recommendations. Specifically, those drugs include only: (1) low-dose aspirin to prevent cardiovascular disease for men ages 45 to 79 years of age and women ages 55 to 79 years of age when the potential benefit outweighs the potential harm; and (2) folic acid for women who are planning or are capable of becoming pregnant (folic acid is already covered for women who are pregnant).

The Medicaid expansion is governed by federal law, pursuant to section 2001 of the Affordable Care Act. Beginning January 1, 2014, federal law requires the benefit package provided to individuals in the Medicaid expansion to offer ten Essential Health Benefits. These requirements apply both to newly eligible individuals under the Medicaid expansion and also to individuals previously included in Connecticut's partial expansion of Medicaid to low-income adults beginning in April 2010, pursuant to 42 U.S.C. § 1396a(k)(2).

Connecticut's Medicaid program already covers the vast majority of the preventive services included in those guidelines. The only items not currently covered are the over-the-counter medications recommended for individuals with certain diagnoses in the U.S. Preventive Services Task Force ("USPSTF") recommendations. Those over-the-counter drugs are not currently covered because Conn. Gen. Stat. § 17b-280a, which was adopted in 2010, prohibits such

Other Legislation Impacting the Department:

S.B. No. 322 (RAISED) AN ACT CONCERNING A BEHAVIORAL HEALTH CLEARINGHOUSE.

This proposal seeks to create a centralized repository for available behavioral health services to be located within the Office of the Healthcare Advocate. If the goal of the bill is to create a comprehensive clearinghouse of publicly funded and privately funded behavioral health services, we feel that this has merit and should be explored. While we do not object to this legislation in principle, we would recommend that our sister agencies, the Department of Mental Health and Addiction Services, as the lead agency for adult behavioral health, and the Department of Children and Families, as the lead agency for children's behavioral health, be included in any discussions about where the clearinghouse should reside. In addition, it is our hope that this initiative would not be redundant of or impact any services already being done by 2-1-1 Infoline, the state's contracted informational and referral partner.

S.B. No. 323 (RAISED) AN ACT CONCERNING CAPITAL EXPENDITURES AT RESIDENTIAL CARE HOMES.

This bill would allow DSS to reimburse Residential Care Home (RCH) providers for "land, building or non-movable equipment, repair, maintenance or improvement" to the facility that cost \$10,000 or less per year. The reimbursement would be included in the fair rent component of the RCH rate for five years or less, depending on the useful life of the improvements.

DSS does not oppose the general concept of the bill, but "maintenance" activities are not a cost that can be capitalized and, as such, references to maintenance activities should be removed from the bill. The Department believes this change will only standardize the useful life to five years for costs of \$10,000 or less, and that any additional costs would be negligible if "maintenance" is removed.

H.B. No. 5444 (RAISED) AN ACT CONCERNING MEDICAID COVERAGE OF CHIROPRACTIC SERVICES.

This proposal requires the Department to add chiropractic services to the Medicaid State Plan as an optional service. There are currently no funds included in the Governor's recommended budget adjustments to support this addition; therefore, the department must oppose it.

H.B. No. 5440 (RAISED) AN ACT CONCERNING MEDICAID REIMBURSEMENT FOR EMERGENCY DEPARTMENT PHYSICIANS.

This bill would allow emergency department (ED) physicians to enroll independently as Medicaid providers, thereby qualifying to be directly reimbursed for professional services provided to Medicaid recipients in hospital emergency departments. Under this legislation, physicians would bill and be paid using applicable Current Procedural Terminology (CPT) codes, rather than the all-inclusive Revenue Center Codes (RCC) currently paid to hospitals and

which includes the physician's reimbursement. Such reimbursement change under this bill would expose the state to significant additional costs in several ways.

First, any additional procedures performed and billed by the physician would be an added cost to the state, whereas the global RCC includes the cost of any procedures. For example, the hospital would be paid no more than the standard visit fee if an emergency physician sets a fractured arm under an RCC. In contrast, an independently enrolled emergency physician would be paid for the visit and for the setting of the fracture. Unfortunately, the Department is limited in its ability to predict fiscal impact of procedures performed because we do not capture these extra procedures in claims under the current methodology. We are concerned, however, that paying separately for these procedures will create a financial incentive to perform more of them.

Second, payment for professional services for Medicaid recipients admitted to hospitals as inpatients on the same day the emergency services are provided are currently rolled into the hospital's reimbursement for the day of admission. If ED physicians' fees are paid separately, these fees would be an added expense to the state.

Third, the professional fees for many patients admitted for observation, which is frequently provided in the emergency department or in a nearby area staffed by the emergency department, would also represent an additional cost to the state, particularly since the fees paid to the hospital will not change.

Finally, the state does not pay an additional professional fee for urgent care provided in the ED, but rather includes this fee in the urgent care RCC. Any professional fees associated with these services would also be new state expenses.

Although the language of this legislation holds hospitals harmless and has a provision for cost neutrality, we believe that this proposal will instead result in significant additional costs to the state. RCCs are set for each hospital based upon their cost reports, which include the professional costs. Paying ED physicians separately without adjusting the RCC accordingly would result in the state paying twice for the same service.

Alternatively, to ensure cost neutrality and hold the hospital harmless, the current emergency department professional fee would need to be adjusted downward to account for the claims for the same-day admissions and observation stays. In addition, since the current volume of procedures is unclear and the future volume will likely grow due to the added financial incentive to perform them, the Department may need to pay only the adjusted professional fees for the visits and not the procedures.

Last year, at the direction of the Department, our contractor (Mercer) completed an analysis of the possible costs of this proposal. Based on their analysis and using two different modeling options, the estimated impact could be anywhere from \$1 million to \$9 million.

In addition, the U.S. Centers for Medicare and Medicaid Services advised the Department that were we to unbundle any hospital rate, we would be required to do so for all other bundled

hospital rates. Based on this guidance, we estimate the cost implications of unbundling all hospital rates to be at least \$25 million.

Given that the Department is currently in the process of replacing the current method of reimbursement with Diagnosis-Related Groups (DRGs) for inpatient services and Ambulatory Payment Classification (APC) for outpatient services, additional changes as required in this bill are not recommended at this time.

For all of these reasons, DSS opposes this legislation.

H.B. No. 5446 (RAISED) AN ACT CONCERNING THE PREVENTION OR ELIMINATION OF DOUBLE CHILD CARE SUBSIDIES.

This bill would prohibit the Department from providing a child care subsidy payment to a provider for any time period for which the Department of Children and Families may have made child care payments on behalf of the recipient. It is our understanding that the intent of this bill is to ensure that providers are not receiving double payments from two separate agencies for the same recipient when a Care 4 Kids eligibility determination is made and granted retroactively. While we understand the intent of this legislation, there are already administrative efforts underway by our Care 4 Kids contractor, United Way of Connecticut, to address this specific issue. We urge the committee to allow United Way the time to address this through administrative means, as opposed to legislation.

Thank you for the opportunity to testify on these bills today. My staff and I would be happy to answer any questions that you may have.