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Connecticut Governor Signs Health Care Bill Revising Connecticut's Facility Fee Law

Authored by: Nathaniel T. Arden and Michael G. Lisitano

On June 27, 2023, Connecticut Governor Ned Lamont signed into law Public Act 23-171 entitled "An Act Protecting Patients and Prohibiting Unnecessary Health Care Costs" ("the Act"), which includes changes to Connecticut's facility fees law. The Act implements previously-announced legislative initiatives that are the product of collaboration between Governor Lamont and the Connecticut Hospital Association, as well as other health care stakeholders.

In general, existing Connecticut law places numerous obligations on hospitals, health systems, and hospital-based facilities that charge patients a "facility fee," including the placement of limits on the ability of such entities to charge facility fees for outpatient services provided off-site from a hospital campus. Existing law defines a facility fee as any fee a hospital or health system charges or bills for outpatient hospital services provided in a hospital-based facility that is (1) intended to compensate the hospital or health system for its operational expenses and (2) separate from a health care provider's professional fee.

Among other things, the Act (i) revises the facility fees law to prohibit charging facility fees in certain circumstances when services are provided on a hospital campus, (ii) gives the Office of Health Strategy (OHS) authority to enforce the law though civil monetary penalties, and (iii) creates new reporting requirements for hospitals and health systems. These changes are summarized below.

Pursuant to the Act, beginning on July 1, 2024, hospitals and health systems are prohibited from charging a facility fee for outpatient services provided on a hospital campus that use a current procedural terminology evaluation and management (CPT E/M) code or assessment and management (CPT A/M) code. A hospital campus is defined as the physical area immediately adjacent to a hospital's main buildings and other structures not contiguous to the main buildings but located within 250 yards of the main buildings, or any area determined to be a part of a hospital's campus by the Centers for Medicare and Medicaid Services. However, this prohibition does not apply to (A) an emergency department located on a hospital campus, or (B) observation stays on a hospital campus and CPT E/M and CPT A/M codes billed for: (i) wound care, (ii) orthopedics, (iii) anticoagulation, (iv) oncology, (v) obstetrics, and (vi) solid organ transplant services. Notably, for purposes of the above exception to the prohibition, "observation" is newly defined to mean services provided by a hospital, on its campus, including use of a bed and requiring periodic monitoring to evaluate an outpatient's condition or determine the need for admission to the hospital as an inpatient, regardless of length of stay. Despite this new prohibition, if a hospital or health system has in effect an insurance contract on July 1, 2024, that provides reimbursement for the newly-prohibited facility fees, a hospital or health system may continue to collect such reimbursement until the date of expiration, renewal or amendment of such contract, whichever occurs first.

To enforce the new and existing facility fee prohibitions, the Act grants OHS the ability to impose civil monetary penalties of up to $1,000 when it has a reasonable belief that a hospital, health system, or hospital-based facility has charged a facility fee in violation of Connecticut law. OHS may not impose these penalties until July 1, 2024. OHS must provide notice of the violation and civil monetary penalty and the hospital, health system, or hospital-based facility will have 10 business days from receipt of such notice to request a hearing to demonstrate the violation did not occur. Following a hearing, if OHS finds that such violation did occur it will issue a cease-and-

desist order in addition to any civil monetary penalty.

Finally, the Act revises existing law that requires each hospital and health system to report to OHS certain information concerning facility fees. The Act moves the initial reporting deadline from July 1 to October 1, 2023. Such report will then be due on July 1 annually thereafter, e.g., the next reporting deadline will be July 1, 2024. The Act also updates the content of the report required to be submitted by hospitals and health systems as follows: (i) for each facility that the applicable hospital or health system owns or operates and that charges a facility fee, the hospital or health system must indicate whether such facility is located on or off of the hospital or health system campus, (ii) a description of the 10 services generating the most facility fee gross revenue separated by CPT code and by on-campus or off-campus, and (iii) information regarding the top 10 procedures or services for which facility fees are charged by patient volume and the gross revenue for such, separated by on-campus and off-campus.

In addition to the above changes, the Act includes changes affecting the certificate of need process (see our summary here) and provider-payor contracts (see our summary here).

Connecticut Expands Applicability of State False Claims Act

Authored by: Conor O. Duffy and Michael G. Lisitano

On June 26, 2023, Connecticut Governor Ned Lamont signed into law Public Act 23-129: "An Act Concerning Liability for False and Fraudulent Claims" (the Act). The Act expands application of Connecticut's False Claims Act (CFCA) to *all* claims for money or property to the state of Connecticut (except as expressly provided in the CFCA) and accordingly expands the scope of conduct covered by the CFCA. The Act does so by removing the current limitation on the CFCA's applicability to only state-administered health or human services programs. The Act took effect July 1, 2023.

Currently, among other things, the CFCA makes it unlawful to knowingly present, or cause to be presented, a false or fraudulent claim for payment or approval under a state-administered health or human services program. A state-administered health or human services program is any program administered by: the Department of Children and Families; the Department of Developmental Services; the Department of Mental Health and Addiction Services; the Department of Public Health; the Department of Aging and Disability Services; the Department of Social Services; the Office of Early Childhood; the Office of the State Comptroller for the State Employee and Retiree Health programs and health care programs administered by the Office of the State Comptroller; and the Department of Administrative Services for Workers' Compensation medical claims. The CFCA has thus been limited to only claims that arise under those programs, such as claims submitted to the Department of Social Services under the state Medicaid program.

The Act removes references to state-administered health or human services programs in the text of the CFCA (including by deleting the definition thereof) in order to expand the scope of conduct covered by the CFCA. As a result of the Act, it is now unlawful under the CFCA to, among other things, knowingly (i) present, or cause to be presented, a false or fraudulent claim for payment or approval by the State of Connecticut, or any agency, department, or quasi-public agency of the State of Connecticut, or (ii) make, use, or cause to be made or used a false record or statement material to a false or fraudulent claim. The Act maintains the current definition of claim which applies to requests or demands for payment or property (i) presented to an officer, employee, or agent of the state, or (ii) made to a recipient of state funds if the payment or property is to be spent or used on the state's behalf or to advance a state program or interest (or reimbursed by the state), but which does not include compensation for state employees or unrestricted income subsidies paid to individuals.

The Act also adds a provision to the CFCA which provides that the CFCA does not apply to any claims, records, or statements made under tax laws administered by the state (or any political subdivision of the state), which mirrors a similar carveout for tax matters from the federal False Claims Act on which the CFCA is modeled. Finally, the Act includes a prohibition on the state asserting a counterclaim, set-off, or defense based on an alleged CFCA violation where the state is a defendant in a civil action, arbitration, or other civil proceeding, and removes the costs of CFCA investigations as a liability imposed on CFCA violators under the statute.

While the general intent of the Act is to expand the CFCA's application beyond state agencies related to health care, health care organizations should be aware of the changes and the continued applicability to claims for reimbursement for services to state health care programs and new broader application to all payment claims to the state. All state contractors and participants in state grant programs and other initiatives involving state money or property should also be aware that this expansion of the CFCA may result in additional scrutiny of claims made thereunder, including exposure to investigation by the Connecticut Attorney General and/or whistleblower suits.

If you have any questions, please contact any member of Robinson+Cole's Health Law Group.

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Above is a post from our *Health Law Diagnosis* blog, where we post on fraud and abuse, government enforcement, Medicare and Medicaid, reimbursement, hospitals and health systems, pharmaceuticals, medical devices, and other areas of interest.

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