



# House of Representatives

General Assembly

**File No. 380**

January Session, 2007

Substitute House Bill No. 7322

*House of Representatives, April 5, 2007*

The Committee on Human Services reported through REP. VILLANO of the 91st Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

## **AN ACT CONCERNING MEDICAID MANAGED CARE REFORM.**

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

1 Section 1. Section 17b-296 of the general statutes is amended by  
2 adding subsection (e) as follows (*Effective from passage*):

3 (NEW) (e) All contracts between the department and a managed  
4 care organization to provide services under the HUSKY Plan, Part A,  
5 the HUSKY Plan, Part B, or both, or the Medicaid program, and all  
6 documents maintained by a managed care organization related to the  
7 performance of its contracts with the department, including, but not  
8 limited to, contracts and agreements with providers and  
9 subcontractors, documents concerning rates paid to providers and  
10 subcontractors, and documents concerning operational standards,  
11 shall be deemed public records or files as defined in section 1-200 and  
12 shall be subject to disclosure in accordance with chapter 14.

13 Sec. 2. Section 1-218 of the general statutes is repealed and the  
14 following is substituted in lieu thereof (*Effective from passage*):

15 Each contract in excess of two million five hundred thousand  
16 dollars between a public agency and a person for the performance of a  
17 governmental function shall (1) provide that the public agency is  
18 entitled to receive a copy of records and files related to the  
19 performance of the governmental function, and (2) indicate that such  
20 records and files are subject to the Freedom of Information Act and  
21 may be disclosed by the public agency pursuant to the Freedom of  
22 Information Act. Any contract between the Department of Social  
23 Services and a managed care organization to provide services under  
24 the HUSKY Plan, Part A, the HUSKY Plan, Part B, or both, or the  
25 Medicaid program, irrespective of whether such contract is in excess of  
26 two million five hundred thousand dollars, shall be subject to the  
27 provisions of this section. No request to inspect or copy such records  
28 or files shall be valid unless the request is made to the public agency in  
29 accordance with the Freedom of Information Act. Any complaint by a  
30 person who is denied the right to inspect or copy such records or files  
31 shall be brought to the Freedom of Information Commission in  
32 accordance with the provisions of sections 1-205 and 1-206.

33 Sec. 3. Subdivision (11) of section 1-200 of the general statutes is  
34 repealed and the following is substituted in lieu thereof (*Effective from*  
35 *passage*):

36 (11) "Governmental function" means the administration or  
37 management of a program of a public agency, which program has  
38 been authorized by law to be administered or managed by a person,  
39 where (A) the person receives funding from the public agency for  
40 administering or managing the program, (B) the public agency is  
41 involved in or regulates to a significant extent such person's  
42 administration or management of the program, whether or not such  
43 involvement or regulation is direct, pervasive, continuous or day-to-  
44 day, and (C) the person participates in the formulation of  
45 governmental policies or decisions in connection with the  
46 administration or management of the program and such policies or  
47 decisions bind the public agency. "Governmental function" includes  
48 the provision of services by a managed care organization under the

49 HUSKY Plan, Part A, the HUSKY Plan, Part B, or the Medicaid  
50 program. "Governmental function" [shall] does not include the mere  
51 provision of goods or services to a public agency without the delegated  
52 responsibility to administer or manage a program of a public agency.

53 Sec. 4. (NEW) (*Effective July 1, 2007*) All contracts between the  
54 Department of Social Services and a managed care organization to  
55 provide services under the HUSKY Plan, Part A, the HUSKY Plan, Part  
56 B, or both, or the Medicaid program, and all documents maintained by  
57 a managed care organization related to the performance of its contracts  
58 with the department, including, but not limited to, contracts and  
59 agreements with providers and subcontractors, documents concerning  
60 rates paid to providers and subcontractors, and documents concerning  
61 operational standards shall be subject to review and inspection by the  
62 Attorney General. In conducting such review or inspection, the  
63 Attorney General shall ensure that the provisions of any contract  
64 between the department and a managed care organization shall inure  
65 to the benefit of the beneficiaries of health care services under the  
66 contract. The Attorney General, in the course of performing the duties  
67 prescribed in this section, may contemporaneously advise the  
68 Commissioner of Social Services, the Governor and the chairpersons of  
69 the joint standing committees of the General Assembly having  
70 cognizance of matters relating to human services and appropriations  
71 and the budgets of state agencies of any concerns that he or she may  
72 have concerning a contract between the department and a managed  
73 care organization.

74 Sec. 5. Subsection (d) of section 17b-28 of the general statutes is  
75 repealed and the following is substituted in lieu thereof (*Effective July*  
76 *1, 2007*):

77 (d) The Commissioner of Social Services shall provide monthly  
78 reports on the plans and implementation of the Medicaid managed  
79 care system to the council. Not later than January 1, 2008, the  
80 Commissioner of Social Services shall include with such reports the  
81 following information for contracts between the department and a

82 managed care organization: The total dollar value of the contract,  
83 along with an accounting of the sums within each contract that are  
84 allocated for and then actually expended on preventive care, primary  
85 care, specialty care, dental care, care and case management services,  
86 outreach and advertising activities, administrative costs, profit margin,  
87 subcontractors and any other nonmedical expenses. Not later than  
88 January 1, 2008, and annually thereafter, the commissioner shall  
89 provide the following information with respect to each managed care  
90 organization under contract with the department: (1) Any  
91 pharmaceutical rebates provided by a pharmaceutical manufacturer to  
92 a managed care organization, (2) the salaries and fringe benefits for the  
93 ten highest paid positions of those persons employed by the managed  
94 care organization who are responsible for the administration of  
95 HUSKY Plan, Part A, the HUSKY Plan, Part B, or both, (3) the total  
96 dollar value of any withheld pools representing sums that will be  
97 withheld from participating providers if the cost of services rendered  
98 by such providers is higher than expected, and (4) any other rebate  
99 provided by a manufacturer, vendor or distributor of health care  
100 products and equipment to a managed care organization or a  
101 subsidiary of such managed care organization.

102       Sec. 6. (NEW) (*Effective July 1, 2007*) The Department of Social  
103 Services shall, on an annual basis, conduct a secret shopper survey  
104 with respect to any managed care organization under contract to  
105 provide health care services to the department. Such survey shall  
106 gauge the effectiveness of the managed care organization's application  
107 and enrollment processes and assess the availability of health care  
108 provider services for both new and existing program beneficiaries. The  
109 department shall utilize a consistent methodology when conducting  
110 such survey so as to permit a fair comparison of the results of such  
111 survey on an annual basis. Not later than January 1, 2008, and annually  
112 thereafter, the Commissioner of Social Services shall report, in  
113 accordance with section 11-4a of the general statutes, on the results of  
114 such surveys to the joint standing committees of the General Assembly  
115 having cognizance of matters relating to human services and  
116 appropriations and the budgets of state agencies.

117 Sec. 7. (NEW) (*Effective July 1, 2007*) Not later than January 1, 2008,  
118 the Department of Social Services shall hire a medical director, whose  
119 prescribed duties shall include, but not be limited to, determining  
120 which services qualify as being medically necessary for each medical  
121 assistance program administered by the department and reviewing  
122 denials of medical services for program beneficiaries and the reasons  
123 for such denials.

124 Sec. 8. Section 38a-1041 of the general statutes is amended by adding  
125 subsection (f) as follows (*Effective July 1, 2007*):

126 (NEW) (f) The Office of the Healthcare Advocate shall provide  
127 informational assistance to recipients of HUSKY Plan, Part A or Part B  
128 benefits. Informational assistance provided by the Office of the  
129 Healthcare Advocate shall include, but not be limited to, information  
130 on: (1) Selection of the HUSKY Plan option that best meets the needs of  
131 the recipient; (2) the enrollment process; (3) primary care provider  
132 selection; (4) assistance in negotiating the managed care and Medicaid  
133 systems to access health care services; (5) assistance with billing issues;  
134 and (6) collaboration with state agency personnel to resolve eligibility,  
135 enrollment and access issues.

136 Sec. 9. (NEW) (*Effective July 1, 2007*) (a) Notwithstanding any  
137 provision of the general statutes, not later than January 1, 2008, the  
138 Department of Social Services shall begin implementing on not less  
139 than a regional basis, a system of primary care case management.  
140 Upon the implementation of a primary care case management system,  
141 HUSKY Plan, Part A and Part B beneficiaries shall be provided a  
142 choice of receiving medical assistance benefits through a primary care  
143 case management system or a managed care system. For purposes of  
144 this section, "primary care case management" means a system of care  
145 in which the health care services for program beneficiaries are  
146 coordinated by a primary care provider chosen by or assigned to the  
147 beneficiary. "Primary care case management" does not include  
148 capitation payment system for medical services provided. The  
149 department shall ensure that the primary care case management is

150 fully operational on a state-wide basis on or before January 1, 2013.

151 (b) Primary care providers participating in the primary care case  
152 management system shall be reimbursed by the state for medical  
153 services provided and for health care coordination services provided  
154 on behalf of program beneficiaries. Primary care providers shall  
155 provide beneficiaries with primary care medical services and arrange  
156 for specialty care as needed. The network of primary care providers  
157 utilized by the department shall include, but not be limited to, health  
158 care professionals employed at community health centers and school-  
159 based health clinics.

160 (c) The Department of Social Services shall contract with an  
161 administrative services organization to coordinate the availability of  
162 services under the primary care case management system. In addition,  
163 the department may directly contract with any medical provider or  
164 group of medical providers in order to facilitate implementation of the  
165 primary care case management system. The department when  
166 selecting an entity to administer the primary care case management  
167 system may not select any managed care organization, subsidiary of,  
168 affiliate of or any related company within the control of the managed  
169 care organization currently under contract with the department for the  
170 provision of managed care.

171 (d) The Commissioner of Social Services shall develop a program to  
172 involve the public in the design and implementation of the primary  
173 care case management system and to ensure ongoing public  
174 involvement. Such program shall include the opportunity to submit  
175 written comments and broad distribution of information and  
176 opportunities to the public and to consumers, consumer advocacy  
177 groups, medical providers and other organizations involved in health  
178 care. Information available to the public shall include one or more  
179 preliminary documents identifying the options under consideration by  
180 the department for implementation of the primary care case  
181 management system. All informational materials shall be available to  
182 persons with disabilities and to those who do not speak English. The

183 primary care case management system developed by the department  
184 in accordance with the provisions of this section shall include training  
185 and educational activities for (1) providers who participate in the  
186 program, (2) outreach personnel utilized to promote the program, and  
187 (3) beneficiaries who opt to enroll in the program.

188 (e) The primary care case management system shall be offered to  
189 HUSKY Plan, Part A and Part B beneficiaries on a voluntary basis. Any  
190 program beneficiary who elects to enroll in the primary care case  
191 management system shall be afforded the option of seeking a change  
192 of primary care provider which shall be decided on a case-by-case  
193 basis.

194 (f) The department shall ensure that a beneficiary that elects to  
195 participate in the primary case management system has access to  
196 dental services and behavioral health services as part of the system.

197 (g) The department shall provide monthly reports on the progress in  
198 planning and developing the primary care case management system to  
199 the council established pursuant to section 17b-28 of the general  
200 statutes. In addition, not later than six months after the date of  
201 implementation of the primary care case management system and  
202 annually thereafter, the department shall conduct a comprehensive  
203 review of the system that includes system costs, beneficiary  
204 satisfaction surveys, provider satisfaction surveys, access and  
205 utilization reports, administrative efficiency reports and  
206 recommendations for improvement of the system, and after  
207 completing such review, the department shall submit a written report  
208 on the results to said council.

209 (h) The Commissioner of Social Services may seek a waiver from  
210 federal law, if necessary, in order to implement the primary care case  
211 management system in accordance with the provisions of this section.

212 (i) The commissioner, pursuant to section 17b-10 of the general  
213 statutes, may implement policies and procedures to administer the  
214 provisions of this section while in the process of adopting such policies

215 and procedures as regulation, provided the commissioner prints notice  
216 of the intent to adopt the regulation in the Connecticut Law Journal  
217 not later than twenty days after the date of implementation. Such  
218 policy shall be valid until the time final regulations are adopted.

219 Sec. 10. Subsection (i) of section 17b-292 of the general statutes is  
220 repealed and the following is substituted in lieu thereof (*Effective July*  
221 *1, 2007*):

222 (i) The single point of entry servicer shall send an application and  
223 supporting documents to the commissioner for determination of  
224 eligibility of a child who resides in a household with a family income  
225 of one hundred eighty-five per cent or less of the federal poverty level.  
226 The servicer shall enroll eligible beneficiaries in the applicant's choice  
227 of managed care plan or in the primary care case management system.  
228 Upon enrollment in a managed care plan, an eligible HUSKY Plan,  
229 Part A or Part B beneficiary shall remain enrolled in such managed  
230 care plan for twelve months from the date of such enrollment unless  
231 (1) an eligible beneficiary demonstrates good cause to the satisfaction  
232 of the commissioner of the need to enroll in a different managed care  
233 plan, or (2) the beneficiary no longer meets program eligibility  
234 requirements.

235 Sec. 11. (NEW) (*Effective July 1, 2007*) The Department of Social  
236 Services, in collaboration with the council established pursuant to  
237 section 17b-28 of the general statutes, shall develop a pay-for-  
238 performance system that rewards a managed care organization with  
239 whom the department contracts for the provision of services to  
240 HUSKY Plan, Part A and Part B beneficiaries for superior performance  
241 in beneficiary satisfaction, provider access and satisfaction and overall  
242 beneficiary health outcomes. The department and the council shall  
243 ensure that there is public input on the development of such system.  
244 The department after receiving such public input shall develop  
245 standards to be used in determining whether a managed care  
246 organization is eligible for a pay-for-performance bonus payment. Pay-  
247 for-performance bonus payments shall only be made when the

248 department determines that a managed care organization has met or  
 249 surpassed all standards established by the department. If no managed  
 250 care organization meets the department's standards then no bonus  
 251 payment shall be made. Any bonus payment shall come from the  
 252 department's capitation payments to managed care organizations and  
 253 shall not result in additional appropriations to the department to make  
 254 such payment. Any plan developed by the department in collaboration  
 255 with the council shall not be implemented unless approved by the  
 256 General Assembly.

257 Sec. 12. (NEW) (*Effective July 1, 2007*) Any managed care  
 258 organization under contract with the Department of Social Services to  
 259 provide services under the HUSKY Plan, Part A or Part B, or both,  
 260 shall reimburse primary care physicians and pediatricians utilized to  
 261 provide services to program beneficiaries at a rate that is not less than  
 262 thirty per cent greater than the rate paid to such physicians and  
 263 pediatricians under the Medicaid fee-for-service program for the  
 264 provision of such services, except that federally qualified health  
 265 centers shall receive their prospective payment rates as prescribed by  
 266 federal law, and dental provider fees shall be equal to the seventieth  
 267 percentile of the normal and customary private provider fee, as  
 268 defined by the National Dental Advisory Service Comprehensive Fee  
 269 Report. A managed care organization or a subsidiary of such managed  
 270 care organization under contract with the department to provide  
 271 services under the HUSKY Plan, Part A or Part B, or both, shall  
 272 transfer any rebate it receives from a pharmaceutical manufacturer or a  
 273 manufacturer, vendor or distributor of health care products and  
 274 equipment to the department. The department shall apply any such  
 275 rebates received from the managed care organization to sums  
 276 budgeted for the operation of the HUSKY program in the fiscal year.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>from passage</i>	17b-296
Sec. 2	<i>from passage</i>	1-218
Sec. 3	<i>from passage</i>	1-200(11)

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Sec. 4	<i>July 1, 2007</i>	New section
Sec. 5	<i>July 1, 2007</i>	17b-28(d)
Sec. 6	<i>July 1, 2007</i>	New section
Sec. 7	<i>July 1, 2007</i>	New section
Sec. 8	<i>July 1, 2007</i>	38a-1041
Sec. 9	<i>July 1, 2007</i>	New section
Sec. 10	<i>July 1, 2007</i>	17b-292(i)
Sec. 11	<i>July 1, 2007</i>	New section
Sec. 12	<i>July 1, 2007</i>	New section

**HS**      *Joint Favorable Subst.*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either chamber thereof for any purpose:

**OFA Fiscal Note**

**State Impact:**

Agency Affected	Fund-Effect	FY 08 \$	FY 09 \$
Department of Social Services	GF - Cost	See Below	See Below
Office of Health Care Advocate	IN - Cost	220,000	226,000

**Municipal Impact:** None

**Explanation**

This bill makes numerous changes to the Department of Social Services' (DSS) HUSKY managed care programs.

**Sections 1 through 3** of the bill make managed care contracts subject to Freedom of Information policies. This change is not expected to have a direct fiscal impact on the state.

**Section 4** allows the Office of the Attorney General (OAG) to review and inspect certain contracts between DSS and a managed care organization to provide certain services. The OAG could accommodate this provision without requiring additional resources.

**Section 5** requires DSS to report additional information to the Medicaid Managed Care Council. These changes are not expected to have a direct fiscal impact on the state.

**Section 6** requires DSS to conduct an annual secret shopper survey with respect to HUSKY MCO's application and enrollment processes as well as the availability of health providers. DSS must report the result of this survey to the General Assembly annually. The cost will be dependent upon the design and scope of this survey, and is estimated to be between \$25,000 and \$50,000 annually.

**Section 7** of the bill requires DSS to hire a medical director by January 1, 2008. The bill does not specify the qualifications for the position. It is estimated that such a position would have an annual salary in the range of \$125,000 to \$150,000, not including fringe benefit costs.<sup>1</sup>

**Section 8** would result in a cost to the Office of the Healthcare Advocate (OHA) for additional staff resources for assisting HUSKY clients and performing outreach services. Detail appears below:

<b>Item</b>	<b>FY 08 (\$)</b>	<b>FY 09 (\$)</b>
Senior Case Manager Salary	70,000	72,100
Junior Case Manager Salary	55,000	56,650
Fringe Benefits	75,250	77,508
Other Expenses	20,000	20,000
<b>Total</b>	<b>220,250</b>	<b>226,258</b>

These case managers are required due to the anticipated significant increase in HUSKY cases referred to OHA, and the new job function of performing HUSKY outreach to qualified families.

**Section 9 and 10** require DSS to establish a primary care case management (PCCM) system for HUSKY clients on a regional basis. HUSKY beneficiaries would have the choice to enroll in the PCCM system or the existing MCO system. The bill requires DSS to reimburse providers in this pilot for any medical and health care coordination services. The bill specifies that the PCCM not utilize a capitated payment system. DSS must contract with an administrative service organization (ASO) to coordinate the PCCM.

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<sup>1</sup> The fringe benefit costs for state employees are budgeted centrally in the Miscellaneous Accounts administered by the Comptroller. The estimated first year fringe benefit rate for a new employee as a percentage of average salary is 25.8%, effective July 1, 2006. The first year fringe benefit costs for new positions do not include pension costs. The state's pension contribution is based upon the prior year's certification by the actuary for the State Employees Retirement System (SERS). The SERS 2006-07 fringe benefit rate is 34.4%, which when combined with the non pension fringe benefit rate totals 60.2%.

Under the current managed care system, DSS provides a capitated payment to the MCO's for each HUSKY client. The MCO's bear the risk for any costs which exceed their capitated payment.

The bill does not require the PCCM ASO to bear any risk for the cost of services provided to the HUSKY clients, nor to provide any utilization review. The ASO further has no incentive to negotiate rates paid to hospitals or other providers. Therefore, it is likely that the per-person cost under a PCCM model will exceed that under the current capitated model. The extent of this increase is not known. It is also not known how many HUSKY beneficiaries would choose the PCCM system over the MCO system. For purposes of illustration, a 5% increase in costs for a 10,000 person program would require an additional \$1.3 million annually.

The bill does not specify what entity is to be responsible for meeting federal and state reporting requirements under the PCCM system. It is not clear whether federal reimbursement can be received for services provided without such reporting.

The bill includes additional public input, review and reporting requirements for DSS concerning the PCCM that will result in increased administrative costs to the department.

**Section 11** of the bill establishes a pay-for-performance system for the HUSKY MCO's. The bill specifies that any bonuses must come from current capitated payments and must not result in any additional appropriations. Under this system, MCO's would be rewarded based on beneficiary satisfaction and health outcomes, as well as provider access and satisfaction. It is not clear that factors upon which the rewards are to be based will necessarily result in savings to the system. Therefore, it is uncertain whether there would be funds available within the capitated system to make such rewards.

**Section 12** of the bill requires the HUSKY MCO's to increase the rates paid to primary care physicians and pediatricians by 30%, and the rates paid to dentists to 70<sup>th</sup> percentile of the normal and customary

fee, as defined by the National Dental Advisory Service Comprehensive Fee Report. It is estimated that the rate increase for primary care physicians and pediatricians will cost \$36,000,000 annually. Based on the latest fee report, it is estimated that the dental rate increase would cost \$27,000,000 annually over the current HUSKY dental expenditures. These costs would be reimbursed 50% by the federal government under the Medicaid program.

The rate increases in this section lead to increased access to services as providers may be more willing to serve HUSKY clients. Should this be the case, it is likely that the MCO's would seek a future increase in their capitated rates to compensate for this change. It is not known what this increased utilization may be.

This section also requires the HUSKY MCO's to transfer to the department any drug or other rebates they may receive. As the MCO's use these rebates to offset the cost of providing services, it is likely that the MCO's would seek a future increase in their capitated rates to compensate for this change.

### ***The Out Years***

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

**OLR Bill Analysis****sHB 7322*****AN ACT CONCERNING MEDICAID MANAGED CARE REFORM.*****SUMMARY:**

This bill makes a number of changes in how the Department of Social Services (DSS) delivers, and is accountable for, health care services the law requires it to provide to HUSKY A and B beneficiaries. Specifically, it:

1. makes the performance of HUSKY managed care contracts a governmental function under the Freedom of Information Act (FOIA), regardless of the value of the contract;
2. subjects HUSKY and other Medicaid contracts between DSS and managed care organizations (MCO) to the attorney general's scrutiny;
3. requires the DSS commissioner to include additional MCO accounting information in the department's reports to the Medicaid managed Care Council;
4. requires DSS to develop and implement a voluntary primary care case management program for HUSKY recipients;
5. requires HUSKY MCOs to reimburse health care providers in their networks at or above minimum levels that the bill establishes;
6. requires MCOs to transfer to DSS any drug or other rebates they receive; and
7. requires DSS to develop a pay-for-performance system to reward HUSKY MCOs that meet certain performance

benchmarks.

The bill requires DSS to hire a medical director to make medical necessity determinations in all of the medical assistance programs it runs.

Finally, it requires the Office of the Health Care Advocate to provide informational assistance to HUSKY A and B recipients.

EFFECTIVE DATE: July 1, 2007, except for the FOIA provisions, which are effective upon passage.

### **MEDICAID MANAGED CARE MCOs DISCLOSURE OF RECORDS**

#### ***DSS Contracts and FOIA***

The bill requires that certain language be included in contracts, and documents related to the contracts, between DSS and managed care organizations serving individuals receiving HUSKY A or B or other Medicaid benefits. The bill specifies that the contracts and documents include contracts and agreements with providers and subcontractors, documents concerning rates paid to them, and documents concerning operational standards. The requirement applies to contracts of any value.

The bill includes MCOs providing services to HUSKY and other Medicaid beneficiaries in the definition of a governmental function. Thus the contracts must (1) entitle DSS to copies of records and files related to the contract's performance and (2) indicate that the records and files are subject to disclosure under FOIA. Anyone denied access to the records or files must first file a complaint with the Freedom of Information Commission.

### **ATTORNEY GENERAL'S REVIEW OF HUSKY CONTRACTS**

The bill subjects to the attorney general's review and inspection all (1) contracts DSS maintains with HUSKY A and B MCOs, as well as any covering other Medicaid beneficiaries and (2) all documents maintained by MCOs that are related to performing the contracts. These include (1) contracts and agreements with providers and

subcontractors, (2) documents concerning rates paid to the subcontractors and providers, and (3) documents concerning operational standards.

When conducting this review or inspection, the attorney general must ensure that the contract language benefits the HUSKY enrollees. The attorney general may, at the same time he does this review, advise the DSS commissioner, the governor, and the chairpersons of the Human Services and Appropriations committees of any concerns he has with the contracts.

Only HUSKY A and B enrollees use MCOs at this time. Other Medicaid recipients receive their services on a fee-for-service basis.

#### **REPORTS ON MCO CONTRACTS**

The bill requires DSS, by January 1, 2008, to include in its monthly report to the Medicaid Managed Care Council the total dollar value of each MCO contract, along with an accounting of money allocated for and actually spent on:

1. preventive, primary, specialty, and dental care;
2. care and case management services;
3. outreach and advertising;
4. administrative costs;
5. profit margins;
6. subcontractors; and
7. any other non-medical expenses.

Also by that date, and annually thereafter, the commissioner must provide (presumably to the council) the following for each MCO contracting with it:

1. any pharmaceutical rebates that pharmaceutical manufacturers

provide to the MCO,

2. salaries and fringe benefits for the 10 highest-paid MCO employees responsible for HUSKY administration,
3. the total dollar value of any pools that will be withheld from providers if the cost of services rendered is higher than expected, and
4. any other rebate a manufacturer, vendor, or health care product and equipment vendor or distributor provides to the MCO or one of its subsidiaries.

### **SECRET SHOPPER SURVEY**

The bill requires DSS, on an annual basis, to conduct a secret shopper survey of any MCO it contracts with. The survey must gauge the MCO's application and enrollment processes' effectiveness and assess the availability of "health care provider services" for new and existing enrollees. DSS must use a consistent methodology when conducting the survey to permit a fair comparison of results from one year to the next. Beginning January 1, 2008, the commissioner must annually report on the surveys' results to the Human Services and Appropriations committees.

### **PRIMARY CARE CASE MANAGEMENT**

By January 1, 2008, DSS must begin implementing a voluntary primary care case management (PCCM) program on no less than a regional basis for HUSKY A and B enrollees. Once implemented, HUSKY enrollees must be given a choice of receiving services through PCCM or managed care (presumably MCO-based care). (Presumably, only enrollees in regions that have PCCM would have this choice.) The program must be fully operational on a statewide basis by January 1, 2013.

The bill defines PCCM as a system of care in which health care services are coordinated by a primary care provider (PCP) assigned to, or chosen by, the program enrollee. It does not include a capitation

payment system. The bill requires DSS to ensure that PCCM enrollees have access to dental and behavioral health services, which must be part of the PCCM system.

Currently, HUSKY A and B is a capitated health care system in which DSS pays a fixed monthly rate to MCOs for each HUSKY recipient enrolled in that MCO, and the MCO is expected to provide all the HUSKY-covered health services the enrollee is entitled to receive.

Under the bill, participating PCPs must be reimbursed for any medical services and health care coordination they provide to PCCM enrollees. The PCPs must provide the enrollees' primary care services and arrange for specialty care as needed. The network of PCPs DSS uses must include health care professionals employed at community health centers and school-based health clinics.

The bill requires DSS to contract with an administrative services organization (ASO) to coordinate the availability of services under PCCM. And it permits the department to contract directly with any medical provider or group of providers to facilitate PCCM implementation. When selecting the entity to administer PCCM (which, presumably is the ASO), DSS may not select any MCO, or any subsidiary of, affiliate of, or related company in the control of "the" MCO currently under contract with DSS to serve the HUSKY population. (DSS currently contracts with four MCOs.)

The bill requires the DSS commissioner to develop a program to involve the public in the PCCM system's design and implementation and to ensure ongoing public involvement. The program must include the opportunity to submit written comments and broad distribution of information and opportunities to the public and to consumers, consumer advocacy groups, medical providers, and other organizations involved in health care. The information must include one or more preliminary documents identifying the options DSS is considering for implementing PCCM. All informational materials must be available to people with disabilities and to those who do not speak English. (The bill does not require the materials to be translated.)

The PCCM system must include training and educational activities for (1) participating providers, (2) outreach personnel who promote the program, and (3) HUSKY beneficiaries who opt to enroll in PCCM.

Any PCCM enrollee must be given the option of asking DSS to change his or her PCP; DSS determines these requests on a case-by-case basis.

The bill requires DSS to provide monthly reports on its progress in planning and developing the PCCM system to the Medicaid Managed Care Council. And annually, beginning no later than six months after PCCM is implemented, DSS must conduct a comprehensive review of the program that includes costs, beneficiary and provider satisfaction surveys, access and utilization reports, administrative efficiency reports, and recommendations for improvements. Once the review is complete, DSS must submit a report of its results to the council.

The bill permits the DSS commissioner to seek a waiver of federal Medicaid or State Children's Health Insurance Program law to implement PCCM. And the commissioner may implement policies and procedures to implement the program while in the process of adopting regulations, provided she publishes notice of intent in the Connecticut Law Journal within 20 days after implementation. The policies remain valid until final regulations are adopted.

Finally, the bill allows the HUSKY servicer (the administrative service organization that acts as the enrollment broker) to enroll HUSKY beneficiaries in PCCM, as well as managed care plans.

### **HUSKY REIMBURSEMENT OF PROVIDERS**

The bill requires any HUSKY A or B MCO to reimburse participating primary care physicians and pediatricians at a rate no less than 30% more than the rate paid to them under the Medicaid fee-for-service system. But federally qualified health centers (FQHCs) must receive prospective payment rates federal law requires. And dental providers must receive fees that equal the 70th percentile of the normal and customary private provider fee, as defined by the National

Dental Advisory Service Comprehensive Fee Report.

Under current practice, DSS maintains a pediatric dental fee schedule, but it is not used because children in HUSKY receive all medical services through the MCOs that contract with DSS. The MCOs subcontract with dental providers, including managed dental care plans, for these services, and these plans set the reimbursement rates that the dental providers receive.

Presumably, DSS will amend its contracts with the MCOs to ensure that the new rates are paid.

### **HUSKY MCOS TO TRANSFER REBATES TO DSS**

The bill requires HUSKY MCOs or their subsidiaries to transfer to DSS any rebate they receive from pharmaceutical companies or health care product and equipment manufacturers, vendors, or distributors. (Presumably, this would not apply to the MCOs commercial business but only to HUSKY business.) DSS must apply these amounts to its HUSKY budget for the fiscal year.

### **PAY-FOR-PERFORMANCE (P4P) SYSTEM**

The bill requires DSS, in collaboration with the Medicaid Managed Care Council, to develop a pay-for-performance (P4P) system that rewards a HUSKY MCO for superior performance in beneficiary satisfaction, provider access and satisfaction, and overall beneficiary health outcomes. The two must ensure a public role in the system's development.

Once the public role is concluded, DSS must develop standards to use in determining whether an MCO is eligible for a P4P bonus payment. P4P bonuses can be paid only when DSS determines that an MCO has met or surpassed all standards. If no MCO meets the standards, DSS does not pay any bonuses. Any bonus must come from DSS' capitation payments and cannot result in additional appropriations to DSS.

The bill requires that any "plan" DSS and the council develop to be

approved by the General Assembly before implementation. It is unclear whether this plan refers to the P4P system, or how the General Assembly approves it.

DSS does not currently offer P4P to the HUSKY MCOs, but apparently some of the MCOs have their own programs. DSS has received a grant to begin designing a P4P program.

### **HEALTH CARE ADVOCATE TO PROVIDE INFORMATION**

The bill requires the Office of the Health Care Advocate to provide informational assistance to HUSKY A and B recipients. It must include, at a minimum, information on:

1. selecting the HUSKY Plan option that best meets the enrollee's needs (presumably this is help with choosing an MCO or PCCM),
2. the enrollment process;
3. primary care provider selection;
4. assistance in negotiating the managed care and Medicaid systems to access health care services;
5. assistance with billing issues (in general, billing would only occur under HUSKY B for those families required to pay premiums or co-payments); and
6. collaboration with state agency personnel to resolve eligibility, enrollment, and access issues.

### **MEDICAL DIRECTOR DETERMINATION OF MEDICAL NECESSITY**

By January 1, 2008, the bill requires DSS to hire a medical director whose duties must include, at a minimum, (1) determining which services qualify as medically necessary for each medical assistance program DSS runs and (2) reviewing denials of medical services and the reasons for them.

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**BACKGROUND**
***Related Bills***

sSB 1425, favorably reported by the Human Services Committee, contains identical provisions related to the FOIA and MCOs, as well as provisions concerning PCCM, P4P, rebates, and medical necessity.

Several legislative committees have favorably reported bills broadly addressing health care access that contain provisions similar to those in sSB 7322, including raising rates paid to public health care providers. They are:

<b>Bill Number</b>	<b>Committee</b>
SB 1	Public Health
SB 3	Human Services
SB 70	Insurance
SB 1127	Human Services
SB 1371	Insurance
HB 6158	Children
HB 6652	Insurance
HB 7314	Labor
HB 7375	Human Services

***FOIA, Governmental Function, HUSKY Managed Care, and Caselaw***

By law, whenever a state agency has a contract with a person to perform a governmental function and the contract is worth more than \$2.5 million, the contract must (1) provide that the public agency is entitled to receive a copy of records and files related to the performance of the governmental function and (2) indicate that these records and files are subject to the FOIA and the agency can disclose them.

“Governmental function” is defined as the administration or management of a public agency’s program, which program has been authorized by law to be administered or managed by a person where (1) the person receives funding from the public agency to do so; (2) the agency is involved in or regulates to a significant extent these activities,

regardless of the degree; and (3) the person participates in formulating governmental policies or decisions in connection with the program's administration or management.

Over the last few years, academic researchers, health advocates, and others have tried to get information from DSS on the four MCOs currently serving the HUSKY A and B population, such as the number of specialists and the fees the MCOs pay for services rendered. In many instances, the information has been refused because the MCOs believe it is proprietary; DSS has generally gone along with that position. Those seeking the information have attempted to get the information through an FOIA request, which the FOI commission has granted.

But the MCOs (except for WellCare and DSS) appealed to the Superior Court, which dismissed the appeals, as a group, in November 2006, in part concluding that the MCOs, for all intents and purpose, are performing a government function and therefore subject to the FOIA (*Health Net of Connecticut, et. al, vs. Freedom of Information Commission, Nos. CV 060401028S, CV 064010429S, CV 064010430S,, CV 064009521S; November 29, 2006*). The case is on appeal to the Supreme Court and is currently awaiting further articulation from the Superior Court judge.

### ***Reimbursement for Medical Services***

MCO pediatric dental fees apparently fall well below the 70th percentile. For example, a recent DSS analysis shows that the HUSKY MCOs paid, on average, \$24 for an initial exam, compared with the NDAS 70th percentile rate of \$65. For cleanings, the rates were \$22 and \$52, respectively. It should be noted that the capitated rates that DSS pays the MCOs are based, in part, on fees that DSS set and paid dental providers before managed care (and still pays for children not enrolled in managed care), and these fees have not kept pace with inflation.

### **COMMITTEE ACTION**

Human Services Committee

Joint Favorable Substitute

Yea 19 Nay 0 (03/22/2007)