



Senate

General Assembly

File No. 692

January Session, 2007

Substitute Senate Bill No. 1425

Senate, May 2, 2007

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

***AN ACT CONCERNING MANAGED CARE ORGANIZATIONS
CONTRACTING WITH THE DEPARTMENT OF SOCIAL SERVICES.***

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

1 Section 1. Section 1-218 of the general statutes is repealed and the
2 following is substituted in lieu thereof (*Effective July 1, 2007*):

3 (a) Each contract in excess of two million five hundred thousand
4 dollars between a public agency and a person for the performance of a
5 governmental function shall (1) provide that the public agency is
6 entitled to receive a copy of records and files related to the
7 performance of the governmental function, and (2) indicate that such
8 records and files are subject to the Freedom of Information Act and
9 may be disclosed by the public agency pursuant to the Freedom of
10 Information Act, except that the Department of Social Services may
11 withhold from public disclosure any such records and files that are
12 exempt from disclosure under section 1-210. No request to inspect or
13 copy such records or files shall be valid unless the request is made to
14 the public agency in accordance with the Freedom of Information Act.

15 Any complaint by a person who is denied the right to inspect or copy
16 such records or files shall be brought to the Freedom of Information
17 Commission in accordance with the provisions of sections 1-205 and 1-
18 206.

19 (b) Any managed care organization providing managed care
20 services or administrative services to the Department of Social Services
21 under contracts authorized by section 17b-28a or 17b-192 shall be
22 subject to the provisions of subsection (a) of this section, with regard to
23 records and files created for the purpose of performing a governmental
24 function under such a contract. The obligation of a managed care
25 organization to disclose information in response to requests pursuant
26 to this section shall be limited to records or files created for the
27 purpose of performing a governmental function under its contract
28 with the department and shall not, for any purpose, extend to
29 documents related to other programs or functions of the managed care
30 organization. The rates paid by the managed care organizations to
31 providers of medical services for Medicaid managed care services shall
32 be disclosed to the department and may be disclosed by the
33 department pursuant to this section.

34 Sec. 2. Section 17b-28 of the general statutes is repealed and the
35 following is substituted in lieu thereof (*Effective July 1, 2007*):

36 (a) There is established a council which shall advise the
37 Commissioner of Social Services on the planning and implementation
38 of a system of Medicaid managed care and shall monitor such
39 planning and implementation and shall advise the Waiver Application
40 Development Council, established pursuant to section 17b-28a, on
41 matters including, but not limited to, eligibility standards, benefits,
42 access and quality assurance. The council shall be composed of the
43 chairpersons and ranking members of the joint standing committees of
44 the General Assembly having cognizance of matters relating to human
45 services, public health and appropriations and the budgets of state
46 agencies, or their designees; two members of the General Assembly,
47 one to be appointed by the president pro tempore of the Senate and

48 one to be appointed by the speaker of the House of Representatives;
49 the director of the Commission on Aging, or a designee; the director of
50 the Commission on Children, or a designee; the Healthcare Advocate,
51 or a designee; two community providers of health care, to be
52 appointed by the president pro tempore of the Senate; two
53 representatives of the insurance industry, to be appointed by the
54 speaker of the House of Representatives; two advocates for persons
55 receiving Medicaid, one to be appointed by the majority leader of the
56 Senate and one to be appointed by the minority leader of the Senate;
57 one advocate for persons with substance abuse disabilities, to be
58 appointed by the majority leader of the House of Representatives; one
59 advocate for persons with psychiatric disabilities, to be appointed by
60 the minority leader of the House of Representatives; two advocates for
61 the Department of Children and Families foster families, one to be
62 appointed by the president pro tempore of the Senate and one to be
63 appointed by the speaker of the House of Representatives; two
64 members of the public who are currently recipients of Medicaid, one to
65 be appointed by the majority leader of the House of Representatives
66 and one to be appointed by the minority leader of the House of
67 Representatives; two representatives of the Department of Social
68 Services, to be appointed by the Commissioner of Social Services; two
69 representatives of the Department of Public Health, to be appointed by
70 the Commissioner of Public Health; two representatives of the
71 Department of Mental Health and Addiction Services, to be appointed
72 by the Commissioner of Mental Health and Addiction Services; two
73 representatives of the Department of Children and Families, to be
74 appointed by the Commissioner of Children and Families; two
75 representatives of the Office of Policy and Management, to be
76 appointed by the Secretary of the Office of Policy and Management;
77 one representative of the office of the State Comptroller, to be
78 appointed by the State Comptroller and the members of the Health
79 Care Access Board who shall be ex-officio members and who may not
80 designate persons to serve in their place. The council shall choose a
81 chair from among its members. The [joint committee] Joint Committee
82 on Legislative Management shall provide administrative support to

83 such chair. The council shall convene its first meeting no later than
84 June 1, 1994.

85 (b) The council shall make recommendations concerning (1)
86 guaranteed access to enrollees and effective outreach and client
87 education; (2) available services comparable to those already in the
88 Medicaid state plan, including those guaranteed under the federal
89 Early and Periodic Screening, Diagnostic and Treatment Services
90 Program under 42 USC 1396d; (3) the sufficiency of provider networks;
91 (4) the sufficiency of capitated rates provider payments, financing and
92 staff resources to guarantee timely access to services; (5) participation
93 in managed care by existing community Medicaid providers; (6) the
94 linguistic and cultural competency of providers and other program
95 facilitators; (7) quality assurance; (8) timely, accessible and effective
96 client grievance procedures; (9) coordination of the Medicaid managed
97 care plan with state and federal health care reforms; (10) eligibility
98 levels for inclusion in the program; (11) cost-sharing provisions; (12) a
99 benefit package; (13) coordination with coverage under the HUSKY
100 Plan, Part B; (14) the need for program quality studies within the areas
101 identified in this section and the department's application for available
102 grant funds for such studies; (15) managed care portion of the state-
103 administered general assistance program; and (16) other issues
104 pertaining to the development of a Medicaid Research and
105 Demonstration Waiver under Section 1115 of the Social Security Act.

106 (c) The Commissioner of Social Services shall seek a federal waiver
107 for the Medicaid managed care plan. Implementation of the Medicaid
108 managed care plan shall not occur before July 1, 1995.

109 (d) Not later than January 1, 2008, and annually thereafter, the
110 Commissioner of Social Services shall report to the council on: (1) Any
111 sanction imposed by the department on a managed care organization
112 with whom the department contracts for administration of the HUSKY
113 Plan, Part A and Part B, and (2) any information received from a
114 managed care organization pursuant to subsection (e) of this section.
115 The report shall include the reasons for the imposition of any sanction

116 and any penalty, including, but not limited to, a financial penalty,
117 imposed on a managed care organization as the result of any sanction.
118 The initial report from the department shall report on any sanctions
119 imposed during the time period from January 1, 2000, to June 30, 2007.
120 Annual reports thereafter shall include data on sanctions imposed in
121 subsequent calendar years.

122 (e) Not later than July 1, 2008, and annually thereafter, any managed
123 care organization with whom the department contracts for
124 administration of the HUSKY Plan, Part A and Part B, shall report to
125 the department on the application of such organization's annual rate
126 adjustment received during the previous fiscal year to subcontracted
127 services, including, but not limited to, dental, vision and pharmacy
128 services.

129 ~~[(d)]~~ (f) The Commissioner of Social Services shall provide monthly
130 reports on the plans and implementation of the Medicaid managed
131 care system to the council.

132 ~~[(e)]~~ (g) The council shall report its activities and progress once each
133 quarter to the General Assembly.

134 Sec. 3. Section 17b-274 of the general statutes is repealed and the
135 following is substituted in lieu thereof (*Effective July 1, 2007*):

136 (a) The Division of Criminal Justice shall periodically investigate
137 pharmacies to ensure that the state is not billed for a brand name drug
138 product when a less expensive generic substitute drug product is
139 dispensed to a Medicaid recipient. The Commissioner of Social
140 Services shall cooperate and provide information as requested by such
141 division.

142 (b) A licensed medical practitioner may specify in writing or by a
143 telephonic or electronic communication that there shall be no
144 substitution for the specified brand name drug product in any
145 prescription for a Medicaid, state-administered general assistance [,] or
146 ConnPACE recipient, provided (1) the practitioner specifies the basis

147 on which the brand name drug product and dosage form is medically
148 necessary in comparison to a chemically equivalent generic drug
149 product substitution, and (2) the phrase "brand medically necessary"
150 shall be in the practitioner's handwriting on the prescription form or, if
151 the prohibition was communicated by telephonic communication, in
152 the pharmacist's handwriting on such form, and shall not be
153 preprinted or stamped or initialed on such form. If the practitioner
154 specifies by telephonic communication that there shall be no
155 substitution for the specified brand name drug product in any
156 prescription for a Medicaid, state-administered general assistance [.] or
157 ConnPACE recipient, written certification in the practitioner's
158 handwriting bearing the phrase "brand medically necessary" shall be
159 sent to the dispensing pharmacy within ten days. A pharmacist shall
160 dispense a generically equivalent drug product for any drug listed in
161 accordance with the Code of Federal Regulations Title 42 Part 447.332
162 for a drug prescribed for a Medicaid, state-administered general
163 assistance [.] or ConnPACE recipient unless the phrase "brand
164 medically necessary" is ordered in accordance with this subsection and
165 such pharmacist has received approval to dispense the brand name
166 drug product in accordance with subsection (c) of this section.

167 (c) The Commissioner of Social Services shall implement a
168 procedure by which a pharmacist shall obtain approval from an
169 independent pharmacy consultant acting on behalf of the Department
170 of Social Services, under an administrative services only contract,
171 whenever the pharmacist dispenses a brand name drug product to a
172 Medicaid, state-administered general assistance [.] or ConnPACE
173 recipient and a chemically equivalent generic drug product
174 substitution is available. The length of authorization for brand name
175 drugs shall be in accordance with section 17b-491a. In cases where the
176 brand name drug is less costly than the chemically equivalent generic
177 drug when factoring in manufacturers' rebates, the pharmacist shall
178 dispense the brand name drug. If such approval is not granted or
179 denied within two hours of receipt by the commissioner of the request
180 for approval, it shall be deemed granted. Notwithstanding any
181 provision of this section, a pharmacist shall not dispense any initial

182 maintenance drug prescription for which there is a chemically
183 equivalent generic substitution that is for less than fifteen days without
184 the department's granting of prior authorization, provided prior
185 authorization shall not otherwise be required for atypical antipsychotic
186 drugs if the individual is currently taking such drug at the time the
187 pharmacist receives the prescription. The pharmacist may appeal a
188 denial of reimbursement to the department based on the failure of
189 such pharmacist to substitute a generic drug product in accordance
190 with this section.

191 (d) In all cases where a Medicaid, state-administered general
192 assistance or ConnPACE recipient presents to a pharmacist a
193 prescription for a drug requiring prior approval, but for which prior
194 approval has not been obtained by such recipient, the Department of
195 Social Services or any entity that administers a Medicaid managed care
196 health plan shall:

197 (1) Ensure the immediate authorization of up to a thirty-day supply
198 of the originally prescribed drug covered under the Department of
199 Social Services purchase of service agreement and require that the
200 initial response to a pharmacist requesting authorization for the drug
201 include confirmation of the availability of payment for dispensing such
202 a temporary supply;

203 (2) Ensure that contemporaneous written notification, in a format
204 that has been developed and created by the department or such entity
205 is provided by the pharmacy to such recipient that (A) informs the
206 recipient that the drug may be covered but that prior approval from
207 the prescriber is first required in order to obtain the prescribed drug,
208 and (B) instructs such recipient that he or she should contact their
209 prescriber to obtain such prior approval; and

210 (3) Provide notification to the prescriber, not later than seventy-two
211 hours after receipt of the prescription by the pharmacy, by facsimile
212 transmission, telephone or electronic mail, that prior approval is
213 required in order for the recipient to receive the prescribed drug.

214 [(d)] (e) A licensed medical practitioner shall disclose to the
215 Department of Social Services or such consultant, upon request, the
216 basis on which the brand name drug product and dosage form is
217 medically necessary in comparison to a chemically equivalent generic
218 drug product substitution. The Commissioner of Social Services shall
219 establish a procedure by which such a practitioner may appeal a
220 determination that a chemically equivalent generic drug product
221 substitution is required for a Medicaid, state-administered general
222 assistance [.] or ConnPACE recipient.

223 Sec. 4. (NEW) (*Effective July 1, 2007*) Not later than January 1, 2008,
224 the Department of Social Services shall hire a medical director, whose
225 prescribed duties shall include, but not be limited to, determinations as
226 to which services qualify as being medically necessary for each
227 medical assistance program administered by the department.

228 Sec. 5. (NEW) (*Effective July 1, 2007*) Notwithstanding any provision
229 of the general statutes, not later than January 1, 2008, the Department
230 of Social Services shall develop and implement a pilot program for the
231 delivery of health care services through a system of primary care case
232 management to not more than one thousand individuals who are
233 otherwise eligible to receive HUSKY Plan, Part A benefits. The pilot
234 program shall be implemented in Windham and Waterbury and shall
235 partially or wholly bear the medical risk for the enrollees in such
236 program. Primary care providers participating in the primary care case
237 management system shall provide program beneficiaries with primary
238 care medical services and arrange for specialty care as needed. For
239 purposes of this section, "primary care case management" means a
240 system of care in which the health care services for program
241 beneficiaries are coordinated by a primary care provider chosen by or
242 assigned to the beneficiary.

243 Sec. 6. (NEW) (*Effective July 1, 2007*) The Department of Social
244 Services, in collaboration with the council established pursuant to
245 section 17b-28 of the general statutes, as amended by this act, shall
246 develop a pay-for-performance system that rewards a managed care

247 organization with whom the department contracts for the provision of
 248 services to HUSKY Plan, Part A and Part B beneficiaries for superior
 249 performance in beneficiary satisfaction, provider access and
 250 satisfaction and overall beneficiary health outcomes. The department
 251 and the council shall ensure that there is public input on the
 252 development of such system. The department, after receiving such
 253 public input, shall develop standards to be used in determining
 254 whether a managed care organization is eligible for a pay-for-
 255 performance bonus payment. Pay-for-performance bonus payments
 256 shall only be made when the department determines that a managed
 257 care organization has met or surpassed all standards established by the
 258 department. If no managed care organization meets the department's
 259 standards then no bonus payment shall be made. Any plan developed
 260 by the department in collaboration with the council shall not be
 261 implemented unless approved by the General Assembly.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>July 1, 2007</i>	1-218
Sec. 2	<i>July 1, 2007</i>	17b-28
Sec. 3	<i>July 1, 2007</i>	17b-274
Sec. 4	<i>July 1, 2007</i>	New section
Sec. 5	<i>July 1, 2007</i>	New section
Sec. 6	<i>July 1, 2007</i>	New section

INS *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
Department of Social Services	GF - See Below

Municipal Impact: None

Explanation

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

Section 1 of the bill makes managed care contracts subject to Freedom of Information policies. This change is not expected to have a direct fiscal impact on the state.

Section 2 changes the membership of the Medicaid Managed Care Council and requires DSS to report additional information to the council. These changes are not expected to have a direct fiscal impact on the state.

Section 3 requires the HUSKY managed care organizations (MCO's) to provide a minimum temporary supply of drugs when prior authorization has not been obtained. This stipulation is not expected to have any fiscal impact as the HUSKY MCO's already have such procedures in place.

Section 4 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.¹

Section 5 requires DSS to establish a primary care case management (PCCM) pilot for at least 1,000 HUSKY clients in Windham and Waterbury. The bill specifies that the pilot shall partially or wholly bear the medical risk for enrollees.

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. Under this system, annualized costs for 1,000 clients would be approximately \$2,570,000. Given the specifications of the bill, it is not known whether this model will be more or less expensive than the current program. sHB 7077 (the Appropriations Act, as passed by the Appropriations Committee) contains \$2.5 million in each year of the biennium for such a pilot.

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.

Section 6 of the bill establishes a pay-for-performance system for the HUSKY MCO's. 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 whether the factors upon which the rewards are to be based will necessarily result in savings to the system. As such, it is uncertain whether there would be funds available within the capitated system to make such rewards. A potentially significant increased cost will therefore result, dependent upon the size of the rewards established.

The Out Years

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

OLR Bill Analysis**sSB 1425*****AN ACT CONCERNING MANAGED CARE ORGANIZATIONS
CONTRACTING WITH THE DEPARTMENT OF SOCIAL SERVICES.*****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. Specifically, it:

1. makes the performance of HUSKY managed care contracts a governmental function under the Freedom of Information Act (FOIA);
2. requires HUSKY managed care organizations (MCO) to report on rates they pay to service providers;
3. requires DSS to report on sanctions it imposes on the HUSKY MCOs;
4. requires DSS to develop and implement a voluntary primary care case management (PCCM) pilot program for up to 1,000 HUSKY recipients in Windham and Waterbury;
5. requires DSS to develop a pay-for-performance system to reward HUSKY MCOs that meet certain performance benchmarks; and
6. specifies the minimum temporary supply of drugs that pharmacists must dispense when prior authorization (PA) for drugs dispensed under DSS' pharmacy assistance programs has not been obtained, and directs the entity administering the drug program to take certain actions when this occurs.

By January 1, 2008, the bill requires DSS to hire a medical director whose duties must include, at a minimum, determining which services qualify as being medically necessary for each medical assistance program DSS runs.

Finally, the bill adds the healthcare advocate, or his designee, to the Medicaid Managed Care Council, which oversees the HUSKY and SAGA medical assistance programs.

EFFECTIVE DATE: July 1, 2007

MEDICAID MANAGED CARE MCOS DISCLOSURE OF RECORDS
DSS Contracts and FOIA

By law, any contract between a public agency and a person for the performance of a governmental function with a value of more than \$2.5 million must state that (1) the public agency is entitled to receive copies of records and files related to the performance of the function and (2) indicate that the records and files are subject to disclosure under FOIA.

The bill provides that any MCO providing managed care or administrative services to DSS under contracts authorized by law are subject to the above law with regard to records and files to the extent that these are created for the purpose of performing the governmental function under the contract.

The bill also allows DSS to withhold from disclosure any records and files that are exempt under FOIA (see BACKGROUND). The bill further limits the MCOs' obligation to disclose by providing that the obligation does not extend to documents related to the MCOs' other programs or functions.

The bill requires that the rates that the MCOs pay to medical service providers caring for Medicaid managed care patients be disclosed to DSS and permits DSS to further disclose them.

REPORTS ON RATE ADJUSTMENTS AND SANCTIONS IMPOSED ON MCOS

By July 1, 2008 and annually thereafter, the bill requires any MCO contracting with DSS under HUSKY A or B to report to the department on how it applies any annual rate adjustment it received during the previous fiscal year to subcontracted services, including dental, vision, and pharmacy services. DSS pays MCOs monthly payments to provide all HUSKY A- and B-covered services to program enrollees.

The bill also requires the DSS commissioner, annually beginning January 1, 2008, to report to the Medicaid Managed Care Council on (1) any sanction it imposed on a HUSKY MCO and (2) any information it receives from MCOs regarding the rate adjustments for subcontracted services. The report must include the reasons for imposing the sanction and any penalty, including a financial one. The first report must include sanctions imposed between January 1, 2000 and June 30, 2007. Subsequent reports must include data on sanctions imposed in subsequent calendar years. (This appears to omit any sanctions imposed between July 1, 2007 and December 31, 2007.)

PRIMARY CARE CASE MANAGEMENT (PCCM)

Regardless of any other law to the contrary, by January 1, 2008, DSS must develop and implement a PCCM pilot program for up to 1,000 people otherwise eligible for HUSKY A. It must be implemented in Windham and Waterbury. It must partially or wholly bear the medical risk for enrollees. Participating primary care providers must provide program enrollees with primary care medical services and arrange for specialty care as needed. The bill defines PCCM as a system of care in which health care services are coordinated by a primary care provider assigned to, or chosen by, the program beneficiary.

Currently, HUSKY A and B is a capitated health care system in which DSS pays a monthly rate to MCOs for each HUSKY participant enrolled in that MCO, and the MCO is expected to provide all the HUSKY-covered health services the enrollee receives. The MCO assumes full risk for these enrollees' medical services.

PAY-FOR-PERFORMANCE 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 public participation in developing the system.

Once the public provides its information, DSS must develop standards to use in determining whether an MCO is eligible for a P4P bonus payment. Bonuses can be given only when the department determines that an MCO has met or surpassed the standards. If no MCO meets the standards, DSS does not pay any bonuses.

The bill provides that any plan DSS develops in collaboration with the council cannot be implemented unless the General Assembly approves it. Presumably the plan refers to the P4P system.

DSS does not currently offer P4P to the HUSKY MCOs, but apparently some of the MCOs have their own programs. (DSS has received a federal P4P technical assistance planning grant.)

PRIOR AUTHORIZATION (PA) FOR PRESCRIPTION DRUGS

In general, when someone enrolled in any of DSS's pharmacy assistance programs (i.e., ConnPACE, Medicaid and State-Administered General Assistance (SAGA)) wishes to receive a brand-name drug when a chemically equivalent generic is available, the pharmacist dispensing the drug must get PA from an independent pharmacy consultant acting on DSS' behalf. In the HUSKY program, the MCOs use pharmacy benefit managers that have their own PA system. If PA is not granted or denied within two hours, the law deems it granted (see BACKGROUND).

The bill requires the department, or in the case of HUSKY A, the entity administering the MCO's pharmacy benefit, to take the following actions whenever a Medicaid, SAGA, or ConnPACE recipient presents a prescription requiring PA but the recipient has not obtained it:

1. ensure the immediate electronic authorization of up to a 30-day supply of the originally prescribed drug covered under the DSS purchase of service agreement and require that the initial response to a pharmacist requesting PA confirm that the pharmacist dispensing the temporary supply will be paid;
2. ensure that at the same time, the pharmacy notifies the recipient in writing, in a form that DSS or the entity develops, that (a) the drug may be covered but that PA is required before it can be obtained and (b) the recipient should contact his or her prescriber to obtain PA; and
3. notify the prescriber via fax, telephone, or electronic mail, no later than 72 hours after the pharmacy receives the prescription, that PA is required for the drug to be dispensed.

BACKGROUND

Legislative History

The Senate referred the bill (File 357) to the Insurance Committee, which favorably reported this substitute. The file version (1) made the performance of DSS MCO contracts a governmental function, regardless of the contract amount; (2) required a larger PCCM pilot in unspecified parts of the state; and (3) with respect to prior authorization, required (a) a 15-day temporary supply of drugs and (b) DSS to notify prescribers within 24 hours.

FOIA, Governmental Function, HUSKY Managed Care, and Case Law

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.

The law defines governmental function as the administration or

management of a public agency's program that 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 MCOs have refused to provide the information because they believe it is proprietary.

Those seeking the information attempted to get the information through an FOIA request, which the FOI commission granted. But the MCOs (except for WellCare) appealed this decision 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 are therefore subject to the FOIA (*Health Net of Connecticut, et. al, vs. Freedom of Information Commission*, Nos. CV 06401028S, 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.

Records Exempt from FOIA

The law (CGS § 1-210) exempts from FOIA numerous records. Some of these include:

1. personnel or medical files and similar files the disclosure of which would constitute an invasion of privacy;
2. records pertaining to strategy and negotiations with respect to pending claims or litigation to which the public agency is a party until the claim or litigation is finally adjudicated or

settled;

3. commercial or financial information given in confidence that the law does not require; and
4. records of standards, procedures, processes, software, and codes not otherwise available to the public, the disclosure of which would compromise the security or integrity of an information technology system.

Prior Authorization in Pharmacy Assistance Programs

Although the law deems PA granted if it is not granted or denied within two hours, in practice, it frequently takes longer to make final decisions to approve or deny, often because the prescriber cannot be reached within that time. While awaiting PA decisions, pharmacists will often dispense a temporary supply of the requested drug. Once all the necessary information is obtained, the final decision to approve or deny the PA must be made.

Pharmacy benefits for certain children and adults (HUSKY A) are managed by the MCOs, while ConnPACE recipients who qualify for Medicare receive their pharmacy benefits through the Medicare Part D program. Both the HUSKY MCOs and the Medicare Part D plans have drug formularies and their own PA systems.

The HUSKY A contracts between DSS and the MCOs call for a 30-day supply, but the process for ultimately authorizing the supply differs. (Apparently, one HUSKY MCO automatically grants a 30-day temporary supply for drugs requiring PA.) In ConnPACE, the state will pay if a recipient needs a drug that is not on his or her Part D plan's formulary and, at present, no further PA is done by DSS' pharmacy contractor. An individual enrolled in the Medicaid fee-for-service program can receive a five-day temporary supply if the individual's prescriber has indicated to the pharmacist that PA is needed.

Medically Necessary Services

The HUSKY A and B contracts between DSS and the MCOs contain a definition of medically necessary services, which apparently also applies to fee-for-service Medicaid. Medically necessary health care is defined as health care provided to (1) correct or diminish the adverse effects of a medical condition or mental illness, (2) assist an individual in attaining or maintaining an optimal level of health, and (3) diagnose or prevent a medical condition from occurring.

Related Bills

Several legislative committees have favorably reported bills broadly addressing health care reform. They are:

sHB 7322 (File 380) contains provisions concerning FOIA and HUSKY MCOs. sSB 1290 (File 446) extends the definition of performing a governmental function.

COMMITTEE ACTION

Human Services Committee

Joint Favorable Substitute
Yea 19 Nay 0 (03/22/2007)

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 11 Nay 2 (04/19/2007)