



General Assembly

**Substitute Bill No. 7322**

January Session, 2007

\* HB07322GAE\_\_041807\_\_ \*

**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 Section 1-218 of the general statutes is repealed and the  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)
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.*

**GAE**     *Joint Favorable*