



General Assembly

Substitute Bill No. 5378

February Session, 2014



**AN ACT IMPLEMENTING THE RECOMMENDATIONS OF THE
LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS
COMMITTEE CONCERNING MEDICAID-FUNDED EMERGENCY
DEPARTMENT VISITS.**

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

1 Section 1. Section 17b-261m of the 2014 supplement to the general
2 statutes is repealed and the following is substituted in lieu thereof
3 (*Effective July 1, 2014*):

4 (a) The Commissioner of Social Services may contract with one or
5 more administrative services organizations to provide care
6 coordination, utilization management, disease management, customer
7 service and review of grievances for recipients of assistance under
8 Medicaid and HUSKY Plan, Parts A and B. Such organization may also
9 provide network management, credentialing of providers, monitoring
10 of copayments and premiums and other services as required by the
11 commissioner. Subject to approval by applicable federal authority, the
12 Department of Social Services shall utilize the contracted
13 organization's provider network and billing systems in the
14 administration of the program. In order to implement the provisions of
15 this section, the commissioner may establish rates of payment to
16 providers of medical services under this section if the establishment of
17 such rates is required to ensure that any contract entered into with an

18 administrative services organization pursuant to this section is cost
19 neutral to such providers in the aggregate and ensures patient access.
20 Utilization may be a factor in determining cost neutrality.

21 (b) Any contract entered into with an administrative services
22 organization, pursuant to subsection (a) of this section, shall include a
23 provision to reduce inappropriate use of hospital emergency
24 department services, which may include a cost-sharing requirement.
25 Such provision [may include] shall require intensive case management
26 services, [and a cost-sharing requirement.] including, but not limited
27 to: (1) The identification by the administrative services organization of
28 hospital emergency departments which may benefit from intensive
29 case management based on the number of Medicaid clients who are
30 frequent users of such emergency departments; (2) the creation of
31 regional intensive case management teams to work with emergency
32 department doctors to (A) identify Medicaid clients who would benefit
33 from intensive case management, (B) create care plans for such
34 Medicaid clients, and (C) monitor progress of such Medicaid clients;
35 and (3) the assignment of at least one staff member from a regional
36 intensive case management team to participating hospital emergency
37 departments during hours when Medicaid clients who are frequent
38 users visit the most and emergency department use is at its highest.
39 For purposes of this section and sections 17a-476 and 17a-22f, as
40 amended by this act, "frequent users" means a Medicaid client with ten
41 or more annual visits to a hospital emergency department.

42 (c) The commissioner shall ensure that any contracts entered into
43 with an administrative services organization include a provision
44 requiring such administrative services organization to (1) conduct
45 assessments of primary care doctors and specialists to determine
46 patient ease of access to services, including, but not limited to, the wait
47 times for appointments and whether the provider is accepting new
48 Medicaid clients, and (2) perform outreach to Medicaid clients to (A)
49 inform them of the advantages of receiving care from a primary care
50 provider, (B) help to connect such clients with primary care providers

51 soon after they are enrolled in Medicaid, and (C) for frequent users of
52 emergency departments, help to arrange visits by Medicaid clients
53 with primary care providers not later than fourteen days after such
54 clients are treated at an emergency department.

55 (d) The Commissioner of Social Services shall require an
56 administrative services organization with access to complete client
57 claim adjudicated history to analyze and annually report, not later
58 than February first, to the Department of Social Services and the
59 Council on Medical Assistance Program Oversight, on Medicaid
60 clients' use of hospital emergency departments. The report shall
61 include, but not be limited to: (1) A breakdown of the number of
62 unduplicated clients visiting an emergency department, and (2) for
63 such clients with ten or more annual visits to any hospital, (A) the
64 number of visits categorized into specific ranges as determined by the
65 Department of Social Services, (B) the time and day of the visit, (C) the
66 reason for the visit, (D) whether hospital records indicate the client has
67 a primary care provider, (E) whether the client had an appointment
68 with a community provider not later than fourteen days after the date
69 of the hospital emergency department visit, and (F) the cost of the visit
70 to the hospital and to the state Medicaid program. The Department of
71 Social Services shall monitor its reporting requirements for
72 administrative services organizations to ensure all contractually
73 obligated reports, including any emergency department provider
74 analysis reports, are completed and disseminated as required by
75 contract.

76 (e) The Commissioner of Social Services shall use the report
77 required pursuant to subsection (d) of this section to monitor the
78 performance of an administrative services organization. Performance
79 measures monitored by the commissioner shall include, but not be
80 limited to, whether the administrative services organization helps to
81 arrange visits by Medicaid clients who are frequent users of emergency
82 departments to primary care providers not later than fourteen days
83 after treatment at an emergency department.

84 Sec. 2. (NEW) (*Effective July 1, 2014*) Not later than January 1, 2015,
85 the Commissioner of Social Services shall require that state-issued
86 Medicaid benefits cards contain the name and contact information for
87 a Medicaid client's primary care provider, if such client has chosen a
88 primary care provider.

89 Sec. 3. Section 17a-476 of the general statutes is repealed and the
90 following is substituted in lieu thereof (*Effective July 1, 2014*):

91 (a) Any general hospital, municipality or nonprofit organization in
92 Connecticut may apply to the Department of Mental Health and
93 Addiction Services for funds to establish, expand or maintain
94 psychiatric or mental health services. The application for funds shall be
95 submitted on forms provided by the Department of Mental Health and
96 Addiction Services, and shall be accompanied by (1) a definition of the
97 towns and areas to be served; (2) a plan by means of which the
98 applicant proposes to coordinate its activities with those of other local
99 agencies presently supplying mental health services or contributing in
100 any way to the mental health of the area; (3) a description of the
101 services to be provided, and the methods through which these services
102 will be provided; and (4) indication of the methods that will be
103 employed to effect a balance in the use of state and local resources so
104 as to foster local initiative, responsibility and participation. In
105 accordance with subdivision (4) of section 17a-480 and subdivisions (1)
106 and (2) of subsection (a) of section 17a-484, the regional mental health
107 board shall review each such application with the Department of
108 Mental Health and Addiction Services and make recommendations to
109 the department with respect to each such application.

110 (b) Upon receipt of the application with the recommendations of the
111 regional mental health board and approval by the Department of
112 Mental Health and Addiction Services, the department shall grant such
113 funds by way of a contract or grant-in-aid within the appropriation for
114 any annual fiscal year. No funds authorized by this section shall be
115 used for the construction or renovation of buildings.

116 (c) The Commissioner of Mental Health and Addiction Services
117 shall require an administrative services organization with which it
118 contracts to manage mental and behavioral health services to provide
119 intensive case management. Such intensive case management shall
120 include, but not be limited to: (1) The identification by the
121 administrative services organization of hospital emergency
122 departments which may benefit from intensive case management
123 based on the number of Medicaid clients who are frequent users of
124 such emergency departments; (2) the creation of regional intensive
125 case management teams to work with emergency department doctors
126 to (A) identify Medicaid clients who would benefit from intensive case
127 management, (B) create care plans for such Medicaid clients, and (C)
128 monitor progress of such Medicaid clients; and (3) the assignment of at
129 least one staff member from a regional intensive case management
130 team to participating hospital emergency departments during hours
131 when Medicaid clients who are frequent users visit the most and when
132 emergency department use is at its highest.

133 [(c)] (d) The Commissioner of Mental Health and Addiction Services
134 may adopt regulations, in accordance with the provisions of chapter
135 54, concerning minimum standards for eligibility to receive said state
136 contracted funds and any grants-in-aid. Any such funds or grants-in-
137 aid made by the Department of Mental Health and Addiction Services
138 for psychiatric or mental health services shall be made directly to the
139 agency submitting the application and providing such service or
140 services.

141 Sec. 4. Section 17a-22f of the 2014 supplement to the general statutes
142 is repealed and the following is substituted in lieu thereof (*Effective July*
143 *1, 2014*):

144 (a) The Commissioner of Social Services may, with regard to the
145 provision of behavioral health services provided pursuant to a state
146 plan under Title XIX or Title XXI of the Social Security Act: (1) Contract
147 with one or more administrative services organizations to provide
148 clinical management, intensive case management, provider network

149 development and other administrative services; (2) delegate
150 responsibility to the Department of Children and Families for the
151 clinical management portion of such administrative contract or
152 contracts that pertain to HUSKY Plan Parts A and B, and other
153 children, adolescents and families served by the Department of
154 Children and Families; and (3) delegate responsibility to the
155 Department of Mental Health and Addiction Services for the clinical
156 management portion of such administrative contract or contracts that
157 pertain to Medicaid recipients who are not enrolled in HUSKY Plan
158 Part A.

159 (b) For purposes of this section, the term "clinical management"
160 describes the process of evaluating and determining the
161 appropriateness of the utilization of behavioral health services and
162 providing assistance to clinicians or beneficiaries to ensure appropriate
163 use of resources and may include, but is not limited to, authorization,
164 concurrent and retrospective review, discharge review, quality
165 management, provider certification and provider performance
166 enhancement. The Commissioners of Social Services, Children and
167 Families, and Mental Health and Addiction Services shall jointly
168 develop clinical management policies and procedures. [The
169 Department of Social Services may implement policies and procedures
170 necessary to carry out the purposes of this section, including any
171 necessary changes to existing behavioral health policies and
172 procedures concerning utilization management, while in the process of
173 adopting such policies and procedures in regulation form, provided
174 the Commissioner of Social Services publishes notice of intention to
175 adopt the regulations in the Connecticut Law Journal within twenty
176 days of implementing such policies and procedures. Policies and
177 procedures implemented pursuant to this subsection shall be valid
178 until the time such regulations are adopted.]

179 (c) The Commissioners of Social Services, Children and Families,
180 and Mental Health and Addiction Services shall require that
181 administrative services organizations managing behavioral health

182 services for Medicaid clients develop intensive case management that
183 includes, but is not limited to: (1) The identification by the
184 administrative services organization of hospital emergency
185 departments which may benefit from intensive case management
186 based on the number of Medicaid clients who are frequent users of
187 such emergency departments; (2) the creation of regional intensive
188 case management teams to work with emergency department doctors
189 to (A) identify Medicaid clients who would benefit from intensive case
190 management, (B) create care plans for such Medicaid clients, and (C)
191 monitor progress of such Medicaid clients; and (3) the assignment of at
192 least one staff member from a regional intensive case management
193 team to participating hospital emergency departments during hours
194 when Medicaid clients who are frequent users visit the most and when
195 emergency department use is at its highest.

196 (d) The Commissioners of Social Services, Children and Families,
197 and Mental Health and Addiction Services shall ensure that any
198 contracts entered into with an administrative services organization
199 require such organization to (1) conduct assessments of behavioral
200 health providers and specialists to determine patient ease of access to
201 services, including, but not limited to, the wait times for appointments
202 and whether the provider is accepting new Medicaid clients; and (2)
203 perform outreach to Medicaid clients to (A) inform them of the
204 advantages of receiving care from a behavioral health provider, (B)
205 help to connect such clients with behavioral health providers soon
206 after they are enrolled in Medicaid, and (C) for frequent users of
207 emergency departments, help to arrange visits by Medicaid clients
208 with behavioral health providers not later than fourteen days after
209 such clients are treated at an emergency department.

210 (e) The Commissioners of Social Services, Children and Families,
211 and Mental Health and Addiction Services, in consultation with the
212 Secretary of the Office of Policy and Management, shall ensure that all
213 expenditures for intensive case management eligible for Medicaid
214 reimbursement are submitted to the Centers for Medicare and

215 Medicaid Services.

216 (f) The Department of Social Services may implement policies and
217 procedures necessary to carry out the purposes of this section,
218 including any necessary changes to procedures relating to the
219 provision of behavioral health services and utilization management,
220 while in the process of adopting such policies and procedures in
221 regulation form, provided the Commissioner of Social Services
222 publishes notice of intention to adopt the regulations in accordance
223 with the provisions of section 17b-10 not later than twenty days after
224 implementing such policies and procedures. Policies and procedures
225 implemented pursuant to this subsection shall be valid until the time
226 such regulations are adopted.

227 Sec. 5. Section 17b-241a of the general statutes is repealed and the
228 following is substituted in lieu thereof (*Effective July 1, 2014*):

229 Notwithstanding any provision of the general statutes, [and the
230 regulations of Connecticut state agencies,] the Commissioner of Social
231 Services may reimburse the Department of Mental Health and
232 Addiction Services for targeted case management services that it
233 provides to its target population, which, for purposes of this section,
234 shall include individuals with severe and persistent psychiatric illness
235 and individuals with persistent substance dependence. The
236 Commissioners of Social Services and Mental Health and Addiction
237 Services, in consultation with the Secretary of the Office of Policy and
238 Management, shall ensure that all expenditures for intensive case
239 management eligible for Medicaid reimbursement are submitted to the
240 Centers for Medicare and Medicaid Services.

241 Sec. 6. Section 17b-245c of the general statutes is repealed and the
242 following is substituted in lieu thereof (*Effective July 1, 2014*):

243 (a) [(1)] As used in this section: [, "telemedicine"]

244 (1) "Telemedicine" means the use of interactive audio, interactive
245 video or interactive data communication in the delivery of medical

246 advice, diagnosis, care or treatment, and includes the types of services
247 described in subsection (d) of section 20-9 and 42 CFR 410.78(a)(3).
248 "Telemedicine" does not include the use of facsimile or audio-only
249 telephone.

250 (2) "Telehealth" or "telemonitoring" means the use of
251 telecommunications and information technology to provide access to
252 health assessment, diagnosis, intervention, consultation, supervision
253 and information across distance. Telehealth or telemonitoring includes
254 technologies such as (A) telephones, (B) facsimile machines, (C)
255 electronic mail systems, and (D) remote patient monitoring devices
256 used to collect and transmit patient data for monitoring and
257 interpretation.

258 [(2)] (3) "Clinically appropriate" means care that is (A) provided in a
259 timely manner and meets professionally recognized standards of
260 acceptable medical care, [;] (B) delivered in the appropriate medical
261 setting, [;] and (C) the least costly of multiple, equally effective
262 alternative treatments or diagnostic modalities.

263 (b) [The] Not later than January 1, 2015, the Commissioner of Social
264 Services [may] shall establish a demonstration project to offer
265 telemedicine, telehealth or both as [a] Medicaid-covered [service]
266 services at federally qualified community health centers. Under the
267 demonstration project, in-person contact between a health care
268 provider and a patient shall not be required for health care services
269 delivered by telemedicine or telehealth that otherwise would be
270 eligible for reimbursement under the state Medicaid plan program, to
271 the extent permitted by federal law and where deemed clinically
272 appropriate.

273 (c) The Commissioner of Social Services may establish rates for cost
274 reimbursement for telemedicine and telehealth services provided to
275 Medicaid recipients under the demonstration project. The
276 commissioner shall consider, to the extent applicable, reductions in
277 travel costs by health care providers and patients to deliver or to access

278 health care services and such other factors as the Commissioner of
279 Social Services deems relevant.

280 (d) The Commissioner of Social Services may apply, if necessary, to
281 the federal government for an amendment to the state Medicaid plan
282 to establish the demonstration project.

283 (e) The transmission, storage and dissemination of data and records
284 related to telemedicine and telehealth services provided under the
285 demonstration project shall be in accordance with federal and state law
286 and regulations concerning the privacy, security, confidentiality and
287 safeguarding of individually identifiable information.

288 (f) [The] Not later than July 1, 2015, the commissioner shall submit a
289 report, in accordance with section 11-4a, on any demonstration project
290 established pursuant to this section to the joint standing committees of
291 the General Assembly having cognizance of matters relating to
292 appropriations and human services. The report shall concern the
293 services offered, [and] the cost-effectiveness of the program and
294 whether it should be extended to other areas of the state.

295 Sec. 7. Section 17b-292 of the general statutes is amended by adding
296 subsection (m) as follows (*Effective July 1, 2014*):

297 (NEW) (m) A child who has been determined to be eligible for
298 benefits under either the HUSKY Plan, Part A or Part B shall remain
299 eligible for such plan for a period of not less than twelve months from
300 such child's determination of eligibility unless the child attains
301 nineteen years of age or is no longer a resident of the state.

302 Sec. 8. Subsection (f) of section 17b-261 of the 2014 supplement to
303 the general statutes is repealed and the following is substituted in lieu
304 thereof (*Effective July 1, 2014*):

305 (f) To the extent permitted by federal law, Medicaid eligibility shall
306 be extended for one year to a family that becomes ineligible for
307 medical assistance under Section 1931 of the Social Security Act due to

308 income from employment by one of its members who is a caretaker
 309 relative or due to receipt of child support income. A family receiving
 310 extended benefits on July 1, 2005, shall receive the balance of such
 311 extended benefits, provided no such family shall receive more than
 312 twelve additional months of such benefits. On and after July 1, 2014,
 313 the Commissioner of Social Services shall seek federal approval for a
 314 continuous eligibility period of twelve months for an adult who has
 315 been determined eligible for the Medicaid program.

316 Sec. 9. Section 17b-261c of the general statutes is repealed and the
 317 following is substituted in lieu thereof (*Effective July 1, 2014*):

318 In no event shall an individual eligible for medical assistance under
 319 section 17b-261, as amended by this act, be guaranteed eligibility for
 320 such assistance for [six] more than twelve consecutive months without
 321 regard to changes in certain circumstances that would otherwise cause
 322 the individual to become ineligible for assistance.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>July 1, 2014</i>	17b-261m
Sec. 2	<i>July 1, 2014</i>	New section
Sec. 3	<i>July 1, 2014</i>	17a-476
Sec. 4	<i>July 1, 2014</i>	17a-22f
Sec. 5	<i>July 1, 2014</i>	17b-241a
Sec. 6	<i>July 1, 2014</i>	17b-245c
Sec. 7	<i>July 1, 2014</i>	17b-292
Sec. 8	<i>July 1, 2014</i>	17b-261(f)
Sec. 9	<i>July 1, 2014</i>	17b-261c

PRI *Joint Favorable Subst.*