
OLR Bill Analysis

sHB 5378

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

SUMMARY:

The departments of Social Services (DSS), Children and Families (DCF), and Mental Health and Addiction Services (DMHAS) contract with administrative service organizations (ASOs) to administer and manage the medical and behavioral health services provided to Medicaid recipients. This bill requires these ASOs to also provide intensive case management services that, among other things, (1) identify emergency departments with high numbers of Medicaid clients who frequently use them, and (2) create regional intensive case management teams to work with emergency department doctors.

The bill also requires these ASOs to (1) assess medical and behavioral health providers on certain criteria including ease of access and (2) perform outreach to Medicaid clients to encourage their use of these providers.

The bill requires children eligible for HUSKY A and B to remain eligible for at least 12 months, with certain exceptions. It also directs DSS to seek federal approval for a similar provision that would allow 12-month continuous eligibility for adults eligible for Medicaid. Current law allows changes in circumstances to cause enrollees to become ineligible for HUSKY A and B services within the first year of coverage.

The bill also requires DSS to establish a demonstration project to offer telemedicine, telehealth, or both as services covered by Medicaid through federally qualified health centers, and report on whether this project should be expanded. Current law allows, rather than requires,

DSS to establish such a project to provide telemedicine services.

Finally, the bill requires state-issued Medicaid benefits cards to include the name and contact information for the Medicaid beneficiary's primary care provider, if he or she has chosen one.

EFFECTIVE DATE: July 1, 2014

INTENSIVE CASE MANAGEMENT

Contract Requirements

The bill requires certain DSS, DCF, and DMHAS contracts with ASOs to provide for intensive case management services. This requirement applies to (1) DSS contracts with ASOs providing care coordination and other services for Medicaid and HUSKY A and B, (2) DMHAS contracts with ASOs managing mental and behavioral health services, and (3) DSS, DCF, and DMHAS (i.e., the Connecticut Behavioral Health Partnership) contracts with ASOs managing behavioral health services. Current law allows, but does not require, DSS to include intensive case management services in its Medicaid and HUSKY contracts with ASOs.

Definition and Scope of Intensive Case Management

Under the bill, the intensive case management services provided by the ASOs must (1) based on their numbers of frequent users (i.e., more than 10 annual visits), identify hospital emergency departments that may benefit from the provision of intensive case management services to those users; (2) create regional intensive case management teams that work with doctors to (a) identify Medicaid clients who may benefit from intensive case management, (b) create care plans for them, and (c) monitor their progress; and (3) assign at least one team member to each participating hospital emergency department during times of heavy emergency department use when Medicaid clients who are frequent users visit most.

The bill directs the agencies to submit their eligible expenditures for intensive case management for reimbursement to the Centers for Medicare and Medicaid Services (CMS).

ASO Assessments

The bill requires ASOs in contracts with DSS to assess primary care providers and specialists and those in contracts with the Connecticut Behavioral Health Partnership to assess behavioral health providers and specialists. The assessments must determine how easily Medicaid patients may access provider or specialist services by considering waiting times for appointments and whether a provider is accepting new Medicaid clients. ASOs must also perform outreach to Medicaid clients to (1) inform them of the advantages of receiving care from these providers, (2) help connect clients with providers as soon as they are enrolled in Medicaid, and (3) help arrange visits with providers for frequent users within 14 days of an emergency department visit.

Reporting Requirements

The bill requires ASOs that (1) contract with DSS to provide care coordination for Medicaid and HUSKY and (2) have access to complete client claim adjudicated history, to report annually, by February 1, to DSS and the Council on Medical Assistance Program Oversight. The report must include the number of unduplicated Medicaid clients visiting an emergency department and, for those clients with 10 or more annual visits to any hospital:

1. the number of visits grouped into DSS-determined ranges,
2. the time and day of the visit,
3. the reason for the visit,
4. if the client has a primary care provider,
5. if the client had an appointment with the community provider within 14 days after the date of the emergency department visit, and
6. the cost to the hospital and the state Medicaid program of the client's visit.

The DSS commissioner must use these annual reports to monitor the

ASOs' performance. Performance measures must include whether the ASO helps Medicaid clients who are frequent users of emergency departments arrange visits to primary care providers within 14 days after an emergency department visit. The bill requires DSS to monitor reporting requirements for ASOs to ensure reports are completed and disseminated as required.

CONTINUOUS ELIGIBILITY

The bill requires children eligible for HUSKY A and B to remain eligible for at least 12 months unless, during that time, they reach age 19 or move outside of Connecticut. This Medicaid program option, known as "continuous enrollment," allows the enrollees to receive ongoing assistance for 12 months even if the parent's or caretaker's financial circumstances change during that time. Connecticut does not currently participate in this option, and as a result, changes in circumstances may cause families to become ineligible for HUSKY A and B services within the first year of coverage.

Federal law requires families receiving services to report any changes in circumstances that may affect eligibility between eligibility reviews. During a period of continuous enrollment, the family must comply with federal requirements for reporting information to DSS, such as a change of address.

TELEHEALTH AND TELEMONTORING

Current law allows DSS to establish a demonstration project to offer telemedicine as a Medicaid-covered service at federally qualified health centers. It defines "telemedicine" as using interactive audio, interactive video, or interactive data communication in the delivery of medical advice, diagnosis, care, or treatment. The definition excludes the use of fax or audio-only telephone.

The bill instead requires DSS to establish such a project by January 1, 2015, and permits the project to provide telemedicine, telehealth, or both. This bill defines "telehealth" and "telemontoring" as using telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision,

and information across distance. Telehealth includes use of telephones, fax machines, e-mail systems, and remote patient monitoring devices used to collect and transmit patient data.

By July 1, 2015, DSS must submit a report on the demonstration project to the Appropriations and Human Services committees. The report must include the services offered, the cost-effectiveness of the program, and whether the program should be extended to other areas of the state (presumably, areas other than where the demonstration project takes place).

BACKGROUND

Related Bills

HB 5137, favorably reported by the Human Services Committee, requires children determined eligible for benefits under HUSKY A or B to remain eligible for at least 12 months, unless, during that time, the child reaches age 19 or moves out of Connecticut.

HB 5445, favorably reported by the Human Services Committee, extends Medicaid coverage for telemonitoring services as part of an integrated plan of care signed by a treating physician. The services must be provided by home health care agencies licensed in the state.

COMMITTEE ACTION

Program Review and Investigations Committee

Joint Favorable Substitute

Yea 11 Nay 0 (03/13/2014)