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## **OLR Bill Analysis**

**sHB 5378 (as amended by House "A")\***

***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 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 hospital emergency departments (EDs) with high numbers of “frequent users” (i.e., Medicaid clients with 10 or more annual ED visits), (2) create regional intensive case management teams to work with ED doctors, and (3) assign at least one regional intensive case management team staff member to participating EDs during the EDs’ hours of highest use.

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 additionally requires certain DSS-contracted ASOs to annually report to DSS and the Council on Medical Assistance Program Oversight (MAPOC) information on Medicaid clients’, including frequent users’, ED use. Under the bill, the DSS commissioner must use the reports to monitor the ASOs’ performance.

The bill requires DSS to report on the feasibility of arranging visits by Medicaid clients with primary care providers within 14 days after an ED visit.

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. The bill also makes technical changes.

\*House Amendment "A" (1) removes the two-week deadline for visits with behavioral health or primary care providers following a frequent user's visit to the ED; (2) requires DSS to report, by December 31, 2014, on the feasibility of arranging visits with primary care providers within two weeks; and (3) changes the effective date of all provisions of the bill from July 1, 2014 to July 1, 2016, except for the DSS reporting provision, which is effective upon passage.

EFFECTIVE DATE: July 1, 2016, except for the reporting provision, which takes effect upon passage.

## **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 for Medicaid clients. 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) identify, based on their numbers of frequent users, EDs 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 ED during times when ED use is highest and

frequent users visit most.

The bill directs the agencies, in consultation with the Office of Policy and Management secretary, 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 (1) DSS to assess primary care providers and specialists and (2) 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 after treatment at EDs.

### ***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 MAPOC. The report must include the number of unduplicated Medicaid clients who visited an ED and, for frequent users:

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 a subsequent appointment with a community provider; 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 frequent users arrange visits to primary care providers after ED visits. The bill requires DSS to monitor contractual reporting requirements for ASOs to ensure reports are completed and disseminated as required.

### ***DSS Report***

The bill requires DSS to report, by December 31, 2014, to the Human Services and Program Review and Investigations committees on the feasibility of arranging visits by Medicaid clients with primary care providers (but not behavioral health providers) within 14 days after an ED visit.

## **BACKGROUND**

### ***Legislative History***

The House referred the original bill (File 211) to the Appropriations Committee, which reported a substitute that eliminated requirements that (1) children found eligible for HUSKY A and B remain eligible for at least 12 months in most circumstances (i.e., continuous enrollment); (2) DSS seek federal approval for a 12-month continuous eligibility period for Medicaid-eligible adults; and (3) DSS establish a demonstration project to offer telemedicine, telehealth, or both as Medicaid covered services at federally qualified health centers.

## **COMMITTEE ACTION**

Program Review and Investigations Committee

Joint Favorable Substitute

Yea 11    Nay 0    (03/13/2014)

Appropriations Committee

Joint Favorable Substitute

Yea 44    Nay 0    (04/15/2014)

