



# House of Representatives

## File No. 741

General Assembly

February Session, 2014

**(Reprint of File Nos. 211 and 672)**

Substitute House Bill No. 5378  
As Amended by House Amendment  
Schedule "A"

Approved by the Legislative Commissioner  
May 2, 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2 statutes is repealed and the following is substituted in lieu thereof  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, 2016*):

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 after such clients are treated at an  
54 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 who visited an emergency department, and (2) for  
63 frequent users of emergency departments, (A) the number of visits  
64 categorized into specific ranges as determined by the Department of  
65 Social Services, (B) the time and day of the visit, (C) the reason for the  
66 visit, (D) whether hospital records indicate such user has a primary  
67 care provider, (E) whether such user had an appointment with a  
68 community provider after the date of the hospital emergency  
69 department visit, and (F) the cost of the visit to the hospital and to the  
70 state Medicaid program. The Department of Social Services shall  
71 monitor its reporting requirements for administrative services  
72 organizations to ensure all contractually obligated reports, including  
73 any emergency department provider analysis reports, are completed  
74 and disseminated as required by contract.

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

82       Sec. 2. (NEW) (*Effective July 1, 2016*) Not later than January 1, 2015,  
83 the Commissioner of Social Services shall require that state-issued  
84 Medicaid benefits cards contain the name and contact information for  
85 a Medicaid client's primary care provider, if such client has chosen a  
86 primary care provider.

87       Sec. 3. Section 17a-476 of the general statutes is repealed and the  
88 following is substituted in lieu thereof (*Effective July 1, 2016*):

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

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

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

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

139 Sec. 4. Section 17a-22f of the 2014 supplement to the general statutes  
140 is repealed and the following is substituted in lieu thereof (*Effective July*  
141 *1, 2016*):

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

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

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

177 (c) The Commissioners of Social Services, Children and Families,  
178 and Mental Health and Addiction Services shall require that  
179 administrative services organizations managing behavioral health  
180 services for Medicaid clients develop intensive case management that

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

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

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

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

225 Sec. 5. Section 17b-241a of the general statutes is repealed and the  
226 following is substituted in lieu thereof (*Effective July 1, 2016*):

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

239 Sec. 6. (*Effective from passage*) Not later than December 31, 2014, the  
240 Commissioner of Social Services shall report in accordance with the  
241 provisions of section 11-4a of the general statutes to the joint standing  
242 committees of the General Assembly having cognizance of matters  
243 relating to human services and program review and investigations on  
244 the feasibility of arranging visits by Medicaid clients with primary care  
245 providers not later than fourteen days after such clients are treated at  
246 emergency departments.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>July 1, 2016</i>	17b-261m
Sec. 2	<i>July 1, 2016</i>	New section
Sec. 3	<i>July 1, 2016</i>	17a-476
Sec. 4	<i>July 1, 2016</i>	17a-22f
Sec. 5	<i>July 1, 2016</i>	17b-241a
Sec. 6	<i>from passage</i>	New section

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

**OFA Fiscal Note**

**State Impact:**

Agency Affected	Fund-Effect	FY 17 \$
Department of Social Services	GF - Potential Savings	See Below

**Municipal Impact:** None

**Explanation**

Sections 1 and 3 through 5 require the Departments of Social Services (DSS), Mental Health and Addiction Services (DMHAS) and Children and Families (DCF), through their contract with their administrative services organizations (ASO), to provide intensive case management (ICM) services to Medicaid clients, including those with behavioral health needs, effective July 1, 2016. ICM is already being utilized in the Medicaid population. To the extent that this bill results in additional clients being served by ICM or results in an impact on the mix of services being utilized by Medicaid clients, there may be savings to the state. A 1% reduction in total annual emergency department expenditures will result in a \$2.3 million savings. The ASO ICM services in the bill are targeted at all Medicaid clients who might benefit from ICM, but particularly high utilizers of emergency departments. The bill requires various reporting and assessment requirements of the ASO which are not anticipated to result in a cost to the state Medicaid program. Lastly, the bill requires DSS and DMHAS, in consultation with the Office of Policy and Management to ensure all expenditures for ICM eligible for reimbursement be submitted to the Centers for Medicare and Medicaid Services.

Section 2 does not result in a fiscal impact to the DSS. The section

requires DSS to print the name and contact information of the Medicaid client's primary care physician, if one has been chosen, on a state issued Medicaid benefits card.

The bill also requires DSS to report certain information to the General Assembly. This is not anticipated to result in any fiscal impact.

House "A" moved the effective date of the first five sections of the underlying bill to July 1, 2016. This delayed the fiscal impact identified in the underlying bill. The amendment also added the provision concerning the report to the General Assembly.

### ***The Out Years***

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

---

**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)