

OFFICE OF LEGISLATIVE RESEARCH
PUBLIC ACT SUMMARY



PA 14-62—sHB 5378

*Program Review and Investigations Committee
Appropriations Committee*

**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 certain services for Medicaid recipients. This act requires these ASOs to also provide intensive case management (ICM) services that include, among other things, (1) identifying hospital emergency departments (EDs) with high numbers of “frequent users” (i.e., Medicaid clients with 10 or more annual ED visits), (2) creating regional ICM teams to work with ED doctors, and (3) assigning at least one team staff member to participating EDs during hours of highest use.

The act requires certain ASOs to (1) assess primary care and behavioral health providers and (2) encourage Medicaid clients to use these providers. The act additionally requires certain DSS-contracted ASOs to annually report on Medicaid clients’ ED use to DSS and the Council on Medical Assistance Program Oversight (MAPOC). The DSS commissioner must use the reports to monitor the ASOs’ performance.

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

Finally, the act requires state-issued Medicaid benefits cards to include the name and contact information for the beneficiary’s primary care provider, if he or she has chosen one. (This requirement is effective July 1, 2016, despite an earlier specified deadline.) The act also makes minor and technical changes.

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

INTENSIVE CASE MANAGEMENT (ICM)

Contract Requirements

The act requires certain DSS, DCF, and DMHAS contracts with ASOs to provide for ICM 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

OLR PUBLIC ACT SUMMARY

Medicaid clients. Prior law allowed, but did not require, DSS to include ICM services in its Medicaid and HUSKY contracts with ASOs. Existing law already requires DSS contracts to include a provision to reduce inappropriate ED use.

Definition and Scope of ICM

Under the act, the ICM services ASOs provide must (1) identify, based on their number of frequent users, EDs that may benefit from the provision of ICM services to those users; (2) create regional ICM teams that work with doctors to identify, create care plans for, and monitor the progress of Medicaid clients who would benefit from ICM; and (3) assign at least one team member to each participating ED when ED use is highest and frequent users visit most.

The act directs the agencies, in consultation with the Office of Policy and Management secretary, to submit their eligible ICM expenditures for Medicaid reimbursement to the Centers for Medicare and Medicaid Services (CMS).

ADDITIONAL ASO REQUIREMENTS

Assessments

Under the act, ASOs contracting with (1) DSS must assess primary care providers and specialists and (2) the Connecticut Behavioral Health Partnership must 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 (1) inform Medicaid clients of the advantages of receiving care from these providers, (2) help connect them with such providers after they enroll in Medicaid, and (3) help arrange visits with such providers for frequent users after treatment at EDs.

Reporting Requirements

The act requires ASOs that (1) contract with DSS to provide care coordination for Medicaid and HUSKY A and B 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 reason for the visit, and its time and day;
3. whether the client has a primary care provider, if indicated in hospital records;
4. whether the client had a subsequent appointment with a community provider; and
5. the cost to the hospital and the state Medicaid program of the client's visit.

The DSS commissioner must use these 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 act requires DSS to monitor contractual reporting requirements for ASOs to ensure reports are completed and disseminated as required.

OLR PUBLIC ACT SUMMARY

DSS REPORT

The act 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 within 14 days after an ED visit.

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