Recent Changes In Connecticut Medicaid

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CT MEDICAID &
THE AFFORDABLE CARE ACT

A Primer
**Enacted in 1965**

- Also called Title 19, which is the section of the federal Social Security Act in which it resides

- Entitlement—anyone meeting eligibility criteria qualifies, unless there is a waiver or a block grant
States contract with the Federal Government to provide medical services to different coverage groups. The following coverage groups are required:

- Low-income families with children
- People receiving Disability under the SSI program
- Infants born to Medicaid-eligible pregnant women if the mother remains eligible or would be eligible if she were still pregnant
- Income eligible children under age six and pregnant women
MANDATORY COVERAGE GROUPS, CONT.

- Recipients of adoption assistance and foster care under Title IV-E of the Social Security Act

- Individuals eligible for both Medicare and Medicaid (“dually-eligible”)

- Special protected groups—e.g., SSI recipients who work and lose SSI due to earnings but who are allowed to continue their Medicaid coverage up to a certain income level
OPTIONAL COVERAGE GROUPS

- Medically needy; breast and cervical cancer prevention and treatment; and tuberculosis-related services to low-income individuals infected with TB.
HUSKY A

- Parents of HUSKY A children will remain eligible for HUSKY coverage with family income up to 185% of the federal poverty level (FPL) (e.g., $36,130 annually for a family of three).

- Individuals with income up to 133% of the FPL ($15,282 annually for an individual) will be eligible for Medicaid, beginning Jan. 1, 2014. The new budget eliminates the Medicaid program for low-income adults (LIA) that currently covers adults up to 56% FPL, as of Jan. 1, 2014, and merges these individual into a new “Medicaid Coverage for the Lowest Income Populations” (MCLIP) program as authorized by the federal Affordable Care Act (ACA), effective Jan. 1, 2014.
CT COVERAGE GROUPS AND ELIGIBILITY--HUSKY

- Aged, blind, disabled, receiving federal Social Security benefits, and income eligible.
- Conversion of State-Administered General Assistance (SAGA) to Medicaid for Low-Income Adults (LIA).
- One of the more significant enactments in 2010 was the conversion of the fully state-funded SAGA medical assistance program (for very low-income, primarily childless adults) to the LIA program, using the same income eligibility criteria as SAGA but no asset test. The change was effective retroactive to April 1, 2010. The income limit for the program is currently about $510 per month. About 45,000 individuals became eligible for LIA at that time (PAs 10-3, § 23; PA 10-1, JSS, §§ 23 and 24; and PA 10-6, JSS, § codified in 17b-261n).
- DSS previously had been directed to apply for a Medicaid waiver (Section 1115 of the federal Social Security Act) to convert the program but it never did so, in part because it believed it would be difficult to show the federal government that it would be cost neutral to the Medicaid program, an essential criterion for federal approval. The ACA made it possible for the state to make the conversion without a waiver.
Certain adults on Medicaid (HUSKY A, C and D) will be charged co-payment for nonemergency use of hospital emergency rooms beginning in 2014.

The Department of Social Services (DSS) is authorized to establish a “step therapy” program for prescription drugs available through Medicaid.
CT COVERAGE GROUPS AND ELIGIBILITY (Cont.)

- Section 1915(c) Home and Community-Based Services Waivers—Includes Connecticut Home Care Program for Elders, Personal Care Assistance, Acquired Brain Injury (DSS) and others run by DDS and DMHAS

- Income < 300% of the maximum monthly SSI benefit rate (currently $2,130 monthly for single person)

- Assets: Varies, depending on program
MEDICARE SAVINGS PROGRAM

1988 Medicare Catastrophic Coverage Act Created These Programs

- Provides Medicaid-funded assistance with Medicare Part A and B cost sharing (e.g., premiums)—and automatic eligibility for Medicare Part D Low-Income Subsidy (“extra help”)

- Consists of Qualified Medicare Beneficiaries (QMB), Specified Low-Income Beneficiaries (SLMB), and Qualified Individuals (QI)

- Income < $1,983.03 monthly for single person, $2,685.93 for couples living in most of state (QMB), higher for other two categories but fewer benefits
FAMILY PLANNING—authorized under federal Affordable Care Act, for non-pregnant women with income up to 250% of the FPL, limited to family planning services and supplies and related medical diagnosis and treatment
CT COVERAGE GROUPS

NON-CITIZENS

- In U.S. legally, must wait five years for federally matched coverage; most adults ineligible for state-funded assistance (certain elders can get state-funded long-term care), children eligible for federal benefits.
MANDATORY SERVICES

- Inpatient hospital services
- Outpatient hospital services
- Family planning services and supplies
- Physician services
- Nursing facilities for individuals aged 21 and older
- Home health services for individuals entitled to nursing home care
MANDATORY SERVICES, CONT.

- Federally qualified health centers (FQHC) and ambulatory services of an FQHC that would be available in another setting
- Rural health clinics
- Laboratory and x-ray services
- Nurse-midwife services
- Vaccines for children
MANDATORY SERVICES (CONT.)

- Freestanding birth centers when licensed or otherwise recognized by the state

- Transportation to medical care

- Tobacco cessation counseling for pregnant women

- Tobacco cessation
MANDATORY SERVICES, CONT.

- Family planning services and supplies
- 60 days post-partum-related services
- Certified pediatric and family nurse practitioner services
- Early and periodic screening, diagnostic and treatment (EPSDT) services for children under age 21
As of December 2012:

- 425,693 recipients in HUSKY A
- 63,199 recipients in HUSKY C
- 17,872 recipients were receiving Medicaid LTC
- 75,000 recipients in Medicare Savings Program
- 86,870 recipients in HUSKY D
- 1,973 recipients in TB or Family Planning
FEDERAL REIMBURSEMENT

- State receives 50% federal match for most Medicaid expenses

- Beginning January 1, 2014, federal match is 100% for “newly eligible” (i.e., HUSKY D) population
COST SHARING

- Federal law permits nominal cost sharing for adults; generally not permitted for children’s services

- State currently does not impose cost sharing (with exception of Medicaid for Working Disabled—once income reaches 200% of FPL and nursing home residents)
The legislature created the Medicaid Managed Care Council (MAPOC) in 1994 as a check on DSS’ administration of full-risk managed care organization (MCO) for the HUSKY A population, which began in 1995. When HUSKY B came into effect in 1998 (with 1997 federal SCHIP law passage), the council became responsible for overseeing this program as well. The council’s role continued to evolve to eventually include oversight of all DSS medical assistance programs, including SAGA medical assistance (precursor to Medicaid for Low-Income Adults), Charter Oak, and aged, blind, and disabled Medicaid beneficiaries. In 2011, the council name changed to the Council on Medicaid Assistance Program Oversight, which is commonly referred to as MAPOC.

The council has five committees, including:

1. Care Management
2. Complex Care
3. Consumer Access
4. Quality Improvement
5. Women’s Health

- Now, Administration Services Organization (ASO) provides administrative functions and beneficiaries receive services from any provider that has a contract (Provider agreement) with DSS
- ASO is paid a monthly amount to: (1) make referrals, (2) help with appointments, (3) provide intensive case management for clients with exceptional health challenges, (4) prior authorization, (5) quality management
- Includes “medical home” model—encourages primary care providers to help manage clients’ care—additional monthly fee is paid for this service
TRANSITION FROM MCO TO ASO

- Former Governor Rell terminated the MCO contracts due to Freedom Of Information and CT Uniform Trade Secrets litigation. See Health NET of CT v. FOI No. CV064010428S (2006) and McKesson Health Solutions, LLC v. Commissioner Starkowski, No. CV074029449 (2007). DSS’ intention was to try to continue to use the MCO model, with the idea that a contractor would agree to FOI requirements and release of data to make it possible to determine the best methods to provide the Medicaid population with health care coverage.

- Governor Malloy began the first step in the transition to an ASO by merging all public health coverage programs under one ASO structure. Once the MCOs were no longer administering public health coverage programs there was little support or coordination of care. Hence, DSS contracted with Anthem to provide help with administrative functions, paying it a nominal per-member, per-month amount. This arrangement continued until the conversion to the Administrative Service Organization (ASO) model was complete in early 2012.

- In the meantime, DSS began the Primary Care Case Management (PCCM) pilot program (called HUSKY Primary Care, for HUSKY A, recipients in Hartford, New Haven, and Waterbury and expanded to Torrington and Putnam (PA 07-2, June SS, codified in CGS § 17b-307). In 2011, the legislature gave DSS broad discretion to establish medical homes as a model for delivering health care to individuals enrolled in all DSS medical assistance programs (PA 11-44, CGS § 17b-263c).
With an ASO the state sets the policy and can now monitor the effectiveness of the implementation of the newly instituted coordination of health benefits through the use of Patient Centered Medical Homes and Health Neighborhoods.

MCO assume the risk and manage all aspect of the care. These insurance companies are unwilling to share the health care data instead calling it a Trade Secret which would not be subject to Connecticut’s Freedom of Information Act.

Now CT assumes the risk but it also has the data to analyze the best methods to employ so health care is rendered more efficiently.
Connecticut is one of 15 States to receive a Center for Medicare and Medicaid Innovation Center (CMMI) planning grant to develop a three year pilot program to better coordinate care for dually eligible for both Medicare and Medicaid (MMEs).

The Program will include MMEs between 18 and 65 who are not in a ACO or a Medicare Advantage Plan. There are approximately 64,000 MMEs in CT and 57,000 MMEs would be eligible for the program.
INNOVATION FOR MMEs

INTEGRATION OF MEDICARE AND MEDICAID LONG TERM CARE, BEHAVIOR SERVICES & SUPPORTS TO PROMOTE PRACTICE TRANSFORMATION

- Data integration and electronic care plans and integrated with CT Health Information Exchange.
- Care management and coordination to more effectively manage co-morbid chronic diseases.
- Expand Access to Person Centered Medical Homes PCMH. This is a way of providing health care that is patient focused and puts doctors not insurance companies in charge of health care. It makes providers and patients partners in the provision of medical care.
- Payment structure that rewards care coordination and positive health outcomes.
1. Enhanced Administrative Service Organization (ASO) functions and services. The ASO will provide more coordination to the MME population by integrating the Medicare and Medicaid data to create predictive medical modeling of this population.

2. The second step will be the development of three to five pilot “Health Neighborhoods.”
HEALTH NEIGHBORHOODS

- Health Neighborhoods will incorporate the information obtained from the ASO’s enhanced coordinated care data.
- A Health Neighborhood will be a network with a broad network of physicians, behavioral health providers, long term care providers, hospitals nursing homes and pharmacists.
- Each “Neighborhood” will identify a lead agency for oversight.
- This utilizes a “shared savings incentive model” where CT receives funding from CMS based on how much is saved in Medicare costs.
The New Medicaid Structure

- Medical ACO
- Oversees the following: Person Centered Medical Homes
- Fee For Service Providers
- Behavioral Health ASO
- The MME Pilot Enhanced ASO

Under the MME Pilot Enhanced ASO there will be 3 to 5 Pilot Health Neighborhoods for MMEs and Person Centered Medical Homes. This fits in with CTs “right-sizing” its long term care population moving more patients to out patient services instead of inpatient institutional care.
2012 Higher Reimbursement for Independent Pharmacies

During the June 2012 Special Session the legislature directed DSS to seek federal approval to reimburse pharmacies using a two-tiered system: one tier would cover chain pharmacies and the second would cover independent pharmacies. The independent pharmacies would receive a higher reimbursement for drugs dispensed to Medicaid recipients (PA 12-1, June 12 SS, § 18, codified in CGS § 17b-). The 2013 legislature repealed this (PA 13-234).
As previously stated, CT transitioned its State Assistance General Assistance SAGA program which provided medical coverage services to low income adults to the Husky D program or the Low Income Adult (LIA) program in 2010. This was supposed to be a cost savings measure because of the Medicaid expansion under the ACA. Despite the 50% reimbursement from the federal government the LIA program cost the state so much more than anticipated because of the high volume of applicants that CT sought a Waiver until the ACA went into full effect which will provide 100% coverage under the Medicaid Expansion provisions of the ACA.
The 2013 legislature requires the DSS commissioner to submit an eligibility and service plan for the Medicaid Coverage for the Lowest Income Populations program, which it is establishing pursuant to the ACA’s Medicaid expansion to cover childless adults with income up to 133% of the FPL and (established in the FY 14-15 budget, PA 13-184). The act also repeals LIA (HB 6705) which sought to limit access to LIA with a series of asset tests.
Summary of CT Service Delivery Changes

- The state’s public health insurance programs, collectively referred to as HUSKY and Charter Oak, have undergone significant changes in service delivery during the last several years.

- From 1996 until late 1997, the HUSKY A (Medicaid for children and their caretaker relatives) and B (SCHIP-funded health subsidized health insurance for higher income children) programs were administered by managed care organizations (MCO). In fall 2007, then-Governor Rell terminated the MCOs’ contracts with the state, largely because two of them refused to comply with the state’s Freedom of Information Act. At that time, DSS took over certain functions that the full-risk MCOs had assumed: provider rate setting, prior authorization criteria, and provider enrollment criteria. Other administrative functions were carried out through non-risk, administrative services organization (ASO) contracts, under which DSS paid a nominal per member, per month fee to the companies that performed these functions, including member services.

- Per legislative action, DSS transitioned its medical assistance programs to the ASO model, combined with PCMH. Community Health Network of Connecticut, Inc., a consortium of federally qualified health centers, is the ASO responsible for all of the administrative functions.