

Medicaid Overview

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Overview

Definition

Coverage Groups

Affordable Care Act

Eligibility and Enrollment

Service Delivery and Covered Services

Long Term Services and Supports

Access

Recent and Upcoming Issues

Fiscal Overview (OFA)

Medicaid is:

a joint federal and state program that finances and administers the delivery of health services to various populations.

| | | | | | | | | |
|---------|---------|-----|----------|----------|-----------|--------|------------|-----|
| Defined | Covered | ACA | Eligible | Delivery | Long Term | Access | New Issues | OFA |
|---------|---------|-----|----------|----------|-----------|--------|------------|-----|

Medicaid is not:

- Medicare
- Children's Health Insurance Program (CHIP)
 - Husky B

Medicaid Defined

- Finances and administers the delivery of health services to various populations
- Joint federal and state program
- State plan and waivers
- Single State Agency
- Entitlement
- Mandatory and optional
 - Coverage Groups
 - Services

Defined

Covered

ACA

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Examples of Mandatory Coverage Groups

- Initially, families (parents and children) receiving cash assistance
- Supplemental Security Income (SSI) recipients, or similar (209b)
- Children under age 19 under certain income levels
- Pregnant women under certain income levels
- Certain “dual eligible”

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Examples of Mandatory Coverage Groups

- Certain protected groups (e.g., SSI recipients who work and lose SSI due to earnings but are allowed to continue their Medicaid coverage up to a certain income level)
- Certain individuals aging out of foster care up to age 26

Federal Poverty Guidelines

2015 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA

| Persons in family/household | Poverty guideline |
|---|-------------------|
| 1 | \$11,770 |
| 2 | 15,930 |
| 3 | 20,090 |
| 4 | 24,250 |
| 5 | 28,410 |
| 6 | 32,570 |
| 7 | 36,730 |
| 8 | 40,890 |
| For families/households with more than 8 persons, add \$4,160 for each additional person. | |

Source: [U.S. Department of Health and Human Services](#)

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Examples of Optional Coverage Groups

- Medically needy: individuals with significant health needs who meet Medicaid “categorical” eligibility requirements (e.g., elderly) but whose income is too high to qualify for Medicaid under other eligibility groups
- Breast and cervical cancer treatment
- Tuberculosis-related services to low-income individuals infected with TB
- Individuals under 138% FPL (i.e., Medicaid expansion population)

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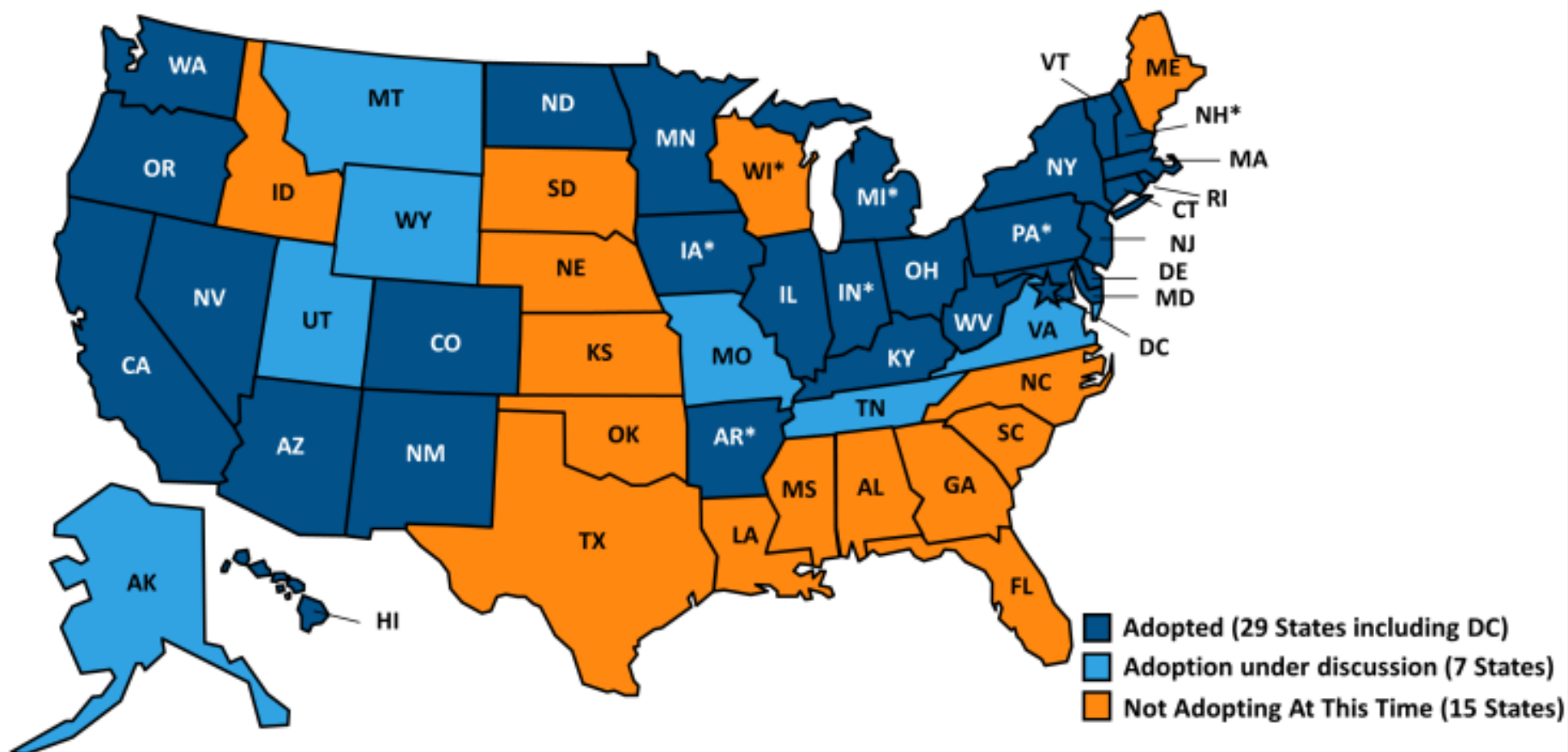
New
Issues

OFA

Affordable Care Act

- Allows states to receive a 100% federal reimbursement for expanding Medicaid to individuals with income up to 138% FPL who are:
 - single, childless adults under age 65
 - not pregnant or receiving Medicare
 - (i.e., the expansion population)

Current Status of State Medicaid Expansion Decisions



NOTES: Under discussion indicates executive activity supporting adoption of the Medicaid expansion. *AR, IA, IN, MI, and PA have approved Section 1115 waivers. Coverage under the PA waiver went into effect on January 1, 2015, but the newly-elected governor may opt for a state plan amendment. Coverage under the IN waiver is set to begin February 1, 2015. NH has submitted a waiver to continue their expansion via premium assistance. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.

SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated January 27, 2015.

<http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>

Affordable Care Act

- Calculation of income eligibility changed from system based on income deductions to **modified adjusted gross income (MAGI)** for certain Medicaid applicants
- MAGI is an individual's (or couple's) total income reported to the Internal Revenue Service plus tax-exempt interest and foreign earned income.
- Income limit=133% FPL + 5% disregard
- ACA also eliminated use of an asset test for those applicants

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Affordable Care Act

- Mandatory coverage for former foster children under age 26 who (1) are not otherwise Medicaid-eligible, and (2) were in the foster care system and were enrolled in Medicaid when they aged out of the system.
- Increased Medicaid primary care provider rates for a limited period of time.
- Other provisions:
 - Family planning
 - Tobacco cessation
 - Community First Choice Option

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HUSKY A

- Generally: (1) families with children and (2) pregnant women

Connecticut HUSKY Health Program Annual Income Guidelines – effective March 1, 2014

| Family of 2 | Family of 3 | Family of 4 | Family of 5 | Family of 6 | Overview |
|-------------------|-------------------|-------------------|-------------------|-------------------|--|
| under \$31,617 | under \$39,777 | under \$47,938 | under \$56,099 | under \$64,259 | <p>HUSKY A: Medicaid health care coverage for children under 19th birthday; and for parents or a relative caregiver with dependent child under 19 in household. No cost.</p> <p>Note: Parent/relative caregiver will lose HUSKY eligibility when youngest child turns 18 if the child is not going to graduate high school by 19th birthday (federal rule).</p> |
| under \$41,369 | under \$52,047 | under \$62,725 | under \$73,403 | under \$84,081 | <p>HUSKY A: Medicaid health care coverage for pregnant women. No cost.</p> <p>Note: for eligibility of pregnant women, unborn child is also counted as a family member.</p> |

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HUSKY A

- Income limits depend on family size
- No asset limit
- No cost sharing

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HUSKY C

- Generally: Aged, blind, living with a disability
- Many receiving federal SSI benefits
- Income under 143% of the state's family cash welfare benefit for the region where the applicant lives (currently \$523.38 monthly for single person, \$696.41 for couples living in most parts of CT)
- Applicants can disregard portion of unearned income, which may vary depending on their living situation.

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HUSKY C

- Assets: \$1,600 for singles, \$2,400 for married couples (except certain long-term care applicants)
- Spend-down option for people with excess income who have high monthly medical expenses

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HUSKY D

- Generally: low income adults without dependent children
- “Medicaid expansion” population (i.e., low income, childless adults between 19 and 64)
- For those who do not receive Medicare and are not pregnant.
- Income limit 138% FPL (133% plus 5% income disregard)

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Medicare Savings Program

- 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
- Consists of Qualified Medicare Beneficiaries (QMB), Specified Low-Income Beneficiaries (SLMB), and Additional Low Income Beneficiaries (ALMB)
- Income limit lowest for QMBs; limits higher for SLMBs and ALMBs, but fewer benefits

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MED-Connect

- Generally: employed individuals with disabilities
- Income below \$75,000
- Monthly premium
 - Income over 200% FPL
- Asset limits:
 - \$10,000 for an individual
 - \$15,000 for a married couple

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Non-Citizens

- In U.S. legally
 - Must have resided in the U.S. for five years
 - SSI recipients
 - Children under age 21 and pregnant or post-partum women
 - Exceptions include certain refugees, asylees
- In U.S. without documents
 - Only authorized emergency medical care

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Enrollment

- As of December 2014:
 - 476,872 recipients in HUSKY A
 - 95,355 recipients in HUSKY C
 - 177,068 recipients in HUSKY D
 - 1,574 recipients in limited benefits groups
 - TB or Family Planning

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Service Delivery

- Beginning in 1995, DSS delivered services to children and adult caretaker relatives through managed care organizations (MCOs), while all other recipients received care on a fee-for service basis
- Transition period
- Since 2012, administrative service organizations (ASOs) provide administrative functions and beneficiaries receive services from any provider that has a contract (provider agreement) with DSS
- ASOs paid monthly amount to provide (1) member and provider services, (2) intensive care management, (3) utilization review, and (4) quality management.

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Administrative Service Organizations (ASOs)

- Community Health Network (CHN)
 - Medical services
- Value Options
 - Behavioral health services
- BeneCare
 - Dental services
- Logisticare
 - Non-emergency medical transportation

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Service Delivery

- Medical Home Model
 - A medical home is a practice in which a primary care provider uses a team approach to plan and coordinate care. The team includes other health care professionals and the patient.
 - PA 11-44 § 110 allows the DSS commissioner to establish medical homes as a model for delivering care to recipients of DSS-administered medical assistance programs.

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Service Delivery

- Person Centered Medical Homes (PCMH)
 - DSS implemented its PCMH initiative on January 1, 2012.
 - According to DSS, under this model, practices and clinics that attain National Center for Quality Assurance recognition qualify for a higher level of reimbursement for primary care services.
 - Practices receive enhanced fee-for-service payments and are eligible for incentive payments for:
 - higher quality care
 - improvements over time

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Service Delivery

- Practices in the process of becoming qualified PCMH providers (i.e., on the “glide path”) may receive assistance from the ASO’s Community Practice Transformation Specialist team at no cost to the practice
- Qualified PCMH providers receive 20-24% higher Medicaid reimbursement rates for certain services; Glide path practices receive 14% higher Medicaid reimbursement

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Examples of Mandatory Services

- Inpatient hospital services
- Outpatient hospital services
- Family planning services
- Physician services
- Transportation to medical care
- Early and periodic screening, diagnostic, and treatment services (EPSDT)

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Examples of Optional Services

- Physical and occupational therapy
- Optometry Services
- Speech, hearing, and language disorder services
- Dentures and prosthetics
- Respiratory care services

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Cost Sharing

- Federal law permits nominal cost sharing for adults; generally not permitted for children's services
- State currently does not impose cost sharing
- Exceptions
 - Medicaid for Working Disabled—once income reaches 200% of FPL

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Long-Term Services and Supports

- **Transfers of assets—Look-back and penalty period**
 - Federal law requires states to review transfers made up to five years before someone applies for Medicaid LTSS
 - Law presumes that any such transfer was made to qualify for Medicaid but can be rebutted
 - Penalty period (i.e., period before an applicant may receive assistance) is calculated by dividing (1) the value of all assets transferred within the 60 months before application by (2) the average monthly cost to a private patient of nursing facility services.

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Long-Term Services and Supports

- **Spousal impoverishment provisions—Income**
 - Federal law allows the community spouse to keep a certain amount of income
 - Calculated using the Minimum Monthly Needs Allowance
 - Minimum: \$1966.25
 - Maximum: \$2980.50
 - Spouse receiving long-term care may keep only personal needs allowance, currently \$60 per month, with balance going to nursing home

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Long-Term Services and Supports

- **Spousal Impoverishment Provisions—Assets**
 - Spouse needing nursing home may keep up to \$1,600; remainder spent on care
 - Community spouse protected amount
 - Determined by spousal assessment
 - Calculated through a formula
 - Federal minimum and maximum

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Long-Term Services and Supports

- **Institutional Care**

- Nursing homes

- DSS determines Medicaid rates and need for beds
- Most nursing home beds are licensed at the skilled nursing facility level

- Interim rates

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Long-Term Services and Supports

- **Home and Community-Based Care Options**
 - Waivers
 - Money Follows the Person
 - Federal demonstration program
 - Designed to help states rebalance their long-term care systems to better support people living in institutions who want instead to live in the community
 - Strategic Plan to Re-Balance Long-Term Services and Supports

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- Provider participation (e.g., specialists)
- ACA with increased rates for primary care providers for a limited time
- Connecticut Dental Health Partnership
- No-show rates

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Armstrong v. Exceptional Child Center, Inc.

ISSUE:

- Whether Medicaid providers should be allowed to bring a lawsuit seeking to enforce the equal access provision of the federal Medicaid Act.

IMPLICATIONS:

- A ruling that providers have established a cause of action would allow the lower court rulings to stand.
- A ruling for Idaho's Medicaid agency could prevent Medicaid providers and beneficiaries from suing to enforce the Medicaid Act's equal access provision.

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Medicaid Funding

- In general, Connecticut is reimbursed by the federal government for 50% of the cost of services rendered. Some populations, services, and costs may be reimbursed at higher rates.
- The state appropriation for the Medicaid account reflects approximately 50% of the cost of HUSKY A and C.
- Approximately 93% of expenses under HUSKY D are considered ACA expansion costs and are therefore 100% reimbursed by the federal government. This match will be gradually reduced to 90% by 2020.
- Additional state expenditures in accounts other than the Medicaid account and in agencies other than DSS may be eligible for federal reimbursement.

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FY 14 Expenditures by Eligibility

- Total FY 14 expenditures (state and federal) under the Medicaid accounts totaled \$5.5 billion.
 - \$1.77 billion was spent on **HUSKY A** clients, with an average per person, per month cost of \$333.
 - \$2.74 billion was spent on **HUSKY C** clients, with an average per person, per month cost of \$2,372.
 - \$1.00 billion was spent on **HUSKY D** clients, with an average per person, per month cost of \$745.
 - Additional expenditures in other state agencies totaling \$1.2 billion were claimed for federal reimbursement.

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FY 14 Expenditures

- Expenditures by category and amount:
 - hospital services (\$1.72 billion)
 - long term care services (\$1.37 billion)
 - pharmaceuticals (\$770 million, offset by \$395 million in manufacturers' rebates)
 - home and community based services (\$485 million)
 - physician services (\$408 million)
 - clinic services (\$300 million)
 - dental services (\$194 million)

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Net Budgeting

- Prior to FY 14, the full cost of the Medicaid program (federal and state share) was appropriated in the General Fund. The federal share of the expenditures was reflected as General Fund revenue. This method is referred to as “gross appropriating”.

Net Budgeting

- Beginning in FY 14, only the state's share of the Medicaid account was appropriated. The matching federal reimbursement for the Medicaid account is received by Department of Social Services (DSS), and is not reflected in the budget. DSS uses these funds to pay claims for the program. This method is referred to as "net appropriating".

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Net Budgeting

- Only the DSS Medicaid account and the Department of Mental Health and Addiction Services' General Assistance Managed Care account were subjected to the net budgeting adjustment.

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Questions

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