



House of Representatives

General Assembly

File No. 296

January Session, 2007

Substitute House Bill No. 7375

House of Representatives, April 3, 2007

The Committee on Human Services reported through REP. VILLANO of the 91st Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING HEALTH CARE ACCESS AND EXPANSION OF THE HUSKY PROGRAM.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Section 17b-261 of the general statutes is repealed and the
2 following is substituted in lieu thereof (*Effective July 1, 2007*):

3 (a) Medical assistance shall be provided for any otherwise eligible
4 person whose income, including any available support from legally
5 liable relatives and the income of the person's spouse or dependent
6 child, is not more than one hundred forty-three per cent, pending
7 approval of a federal waiver applied for pursuant to subsection (d) of
8 this section, of the benefit amount paid to a person with no income
9 under the temporary family assistance program in the appropriate
10 region of residence and if such person is an institutionalized
11 individual as defined in Section 1917(c) of the Social Security Act, 42
12 USC 1396p(c), and has not made an assignment or transfer or other
13 disposition of property for less than fair market value for the purpose
14 of establishing eligibility for benefits or assistance under this section.

15 Any such disposition shall be treated in accordance with Section
16 1917(c) of the Social Security Act, 42 USC 1396p(c). Any disposition of
17 property made on behalf of an applicant or recipient or the spouse of
18 an applicant or recipient by a guardian, conservator, person
19 authorized to make such disposition pursuant to a power of attorney
20 or other person so authorized by law shall be attributed to such
21 applicant, recipient or spouse. A disposition of property ordered by a
22 court shall be evaluated in accordance with the standards applied to
23 any other such disposition for the purpose of determining eligibility.
24 The commissioner shall establish the standards for eligibility for
25 medical assistance at one hundred forty-three per cent of the benefit
26 amount paid to a family unit of equal size with no income under the
27 temporary family assistance program in the appropriate region of
28 residence, [, pending federal approval, except that the] The medical
29 assistance program shall provide coverage to persons under the age of
30 nineteen [up to one hundred eighty-five per cent of the federal poverty
31 level without an asset limit. Said medical assistance program shall also
32 provide coverage to persons under the age of nineteen] and their
33 parents and needy caretaker relatives, who qualify for coverage under
34 Section 1931 of the Social Security Act, with family income up to one
35 hundred [fifty] eighty-five per cent of the federal poverty level without
36 an asset limit. [, upon the request of such a person or upon a
37 redetermination of eligibility.] Such levels shall be based on the
38 regional differences in such benefit amount, if applicable, unless such
39 levels based on regional differences are not in conformance with
40 federal law. Any income in excess of the applicable amounts shall be
41 applied as may be required by said federal law, and assistance shall be
42 granted for the balance of the cost of authorized medical assistance. All
43 contracts entered into on and after July 1, 1997, pursuant to this section
44 shall include provisions for collaboration of managed care
45 organizations with the Nurturing Families Network established
46 pursuant to section 17a-56. The Commissioner of Social Services shall
47 provide applicants for assistance under this section, at the time of
48 application, with a written statement advising them of (1) the effect of
49 an assignment or transfer or other disposition of property on eligibility

50 for benefits or assistance, and (2) the availability of, and eligibility for,
51 services provided by the Nurturing Families Network established
52 pursuant to section 17a-56.

53 (b) For the purposes of the Medicaid program, the Commissioner of
54 Social Services shall consider parental income and resources as
55 available to a child under eighteen years of age who is living with his
56 or her parents and is blind or disabled for purposes of the Medicaid
57 program, or to any other child under twenty-one years of age who is
58 living with his or her parents.

59 (c) For the purposes of determining eligibility for the Medicaid
60 program, an available asset is one that is actually available to the
61 applicant or one that the applicant has the legal right, authority or
62 power to obtain or to have applied for the applicant's general or
63 medical support. If the terms of a trust provide for the support of an
64 applicant, the refusal of a trustee to make a distribution from the trust
65 does not render the trust an unavailable asset. Notwithstanding the
66 provisions of this subsection, the availability of funds in a trust or
67 similar instrument funded in whole or in part by the applicant or the
68 applicant's spouse shall be determined pursuant to the Omnibus
69 Budget Reconciliation Act of 1993, 42 USC 1396p. The provisions of
70 this subsection shall not apply to special needs trust, as defined in 42
71 USC 1396p(d)(4)(A).

72 (d) The transfer of an asset in exchange for other valuable
73 consideration shall be allowable to the extent the value of the other
74 valuable consideration is equal to or greater than the value of the asset
75 transferred.

76 (e) The Commissioner of Social Services shall seek a waiver from
77 federal law to permit federal financial participation for Medicaid
78 expenditures for families with incomes of one hundred forty-three per
79 cent of the temporary family assistance program payment standard.

80 (f) To the extent permitted by federal law, Medicaid eligibility shall
81 be extended for [one year] two years to a family that becomes

82 ineligible for medical assistance under Section 1931 of the Social
83 Security Act due to income from employment by one of its members
84 who is a caretaker relative or due to receipt of child support income.
85 [A family receiving extended benefits on July 1, 2005, shall receive the
86 balance of such extended benefits, provided no such family shall
87 receive more than twelve additional months of such benefits.]

88 (g) An institutionalized spouse applying for Medicaid and having a
89 spouse living in the community shall be required, to the maximum
90 extent permitted by law, to divert income to such community spouse
91 in order to raise the community spouse's income to the level of the
92 minimum monthly needs allowance, as described in Section 1924 of
93 the Social Security Act. Such diversion of income shall occur before the
94 community spouse is allowed to retain assets in excess of the
95 community spouse protected amount described in Section 1924 of the
96 Social Security Act. The Commissioner of Social Services, pursuant to
97 section 17b-10, may implement the provisions of this subsection while
98 in the process of adopting regulations, provided the commissioner
99 prints notice of intent to adopt the regulations in the Connecticut Law
100 Journal within twenty days of adopting such policy. Such policy shall
101 be valid until the time final regulations are effective.

102 [(h) The Commissioner of Social Services shall, to the extent
103 permitted by federal law, or, pursuant to an approved waiver of
104 federal law submitted by the commissioner, in accordance with the
105 provisions of section 17b-8, impose the following cost-sharing
106 requirements under the HUSKY Plan, on all parent and needy
107 caretaker relatives with incomes exceeding one hundred per cent of the
108 federal poverty level: (1) A twenty-five-dollar premium per month per
109 parent or needy caretaker relative; and (2) a copayment of one dollar
110 per visit for outpatient medical services delivered by an enrolled
111 Medicaid or HUSKY Plan provider. The commissioner may implement
112 policies and procedures necessary to administer the provisions of this
113 subsection while in the process of adopting such policies and
114 procedures as regulations, provided the commissioner publishes notice
115 of the intent to adopt regulations in the Connecticut Law Journal not

116 later than twenty days after implementation. Policies and procedures
117 implemented pursuant to this subsection shall be valid until the time
118 final regulations are adopted.]

119 [(i)] (h) Medical assistance shall be provided, in accordance with the
120 provisions of subsection (e) of section 17a-6, to any child under the
121 supervision of the Commissioner of Children and Families who is not
122 receiving Medicaid benefits, has not yet qualified for Medicaid benefits
123 or is otherwise ineligible for such benefits because of institutional
124 status. To the extent practicable, the Commissioner of Children and
125 Families shall apply for, or assist such child in qualifying for, the
126 Medicaid program.

127 [(j)] (i) The Commissioner of Social Services shall provide Early and
128 Periodic Screening, Diagnostic and Treatment program services, as
129 required and defined as of December 31, 2005, by 42 USC 1396a(a)(43),
130 42 USC 1396d(r) and 42 USC 1396d(a)(4)(B) and applicable federal
131 regulations, to all persons who are under the age of twenty-one and
132 otherwise eligible for medical assistance under this section.

133 Sec. 2. Section 17b-292 of the general statutes is repealed and the
134 following is substituted in lieu thereof (*Effective July 1, 2007*):

135 (a) A child who resides in a household with a family income which
136 exceeds one hundred eighty-five per cent of the federal poverty level
137 and does not exceed [three] four hundred per cent of the federal
138 poverty level may be eligible for subsidized benefits under the HUSKY
139 Plan, Part B.

140 (b) A child who resides in a household with a family income over
141 [three] four hundred per cent of the federal poverty level may be
142 eligible for unsubsidized benefits under the HUSKY Plan, Part B.

143 (c) Whenever a court or family support magistrate orders a
144 noncustodial parent to provide health insurance for a child, such
145 parent may provide for coverage under the HUSKY Plan, Part B.

146 (d) A child who has been determined to be eligible for benefits

147 under either the HUSKY Plan, Part A or Part B shall remain eligible for
148 such plan for a period of twelve months from such child's
149 determination of eligibility unless the child attains the age of nineteen
150 or is no longer a resident of the state, regardless of changes in family
151 composition or family income. During the twelve-month period
152 following the date that a child is determined eligible for the HUSKY
153 Plan, Part A or Part B, the family of such child shall comply with
154 federal requirements concerning the reporting of information to the
155 department, including, but not limited to, change of address
156 information.

157 [(d)] (e) To the extent allowed under federal law, the commissioner
158 shall not pay for services or durable medical equipment under the
159 HUSKY Plan, Part B if the enrollee has other insurance coverage for
160 the services or such equipment.

161 [(e)] (f) A newborn child who otherwise meets the eligibility criteria
162 for the HUSKY Plan, Part B shall be eligible for benefits retroactive to
163 his date of birth, provided an application is filed on behalf of the child
164 within thirty days of such date.

165 [(f)] (g) The commissioner shall implement presumptive eligibility
166 for children applying for Medicaid. Such presumptive eligibility
167 determinations shall be in accordance with applicable federal law and
168 regulations. The commissioner shall adopt regulations, in accordance
169 with chapter 54, to establish standards and procedures for the
170 designation of organizations as qualified entities to grant presumptive
171 eligibility. Qualified entities shall ensure that, at the time a
172 presumptive eligibility determination is made, a completed application
173 for Medicaid is submitted to the department for a full eligibility
174 determination. In establishing such standards and procedures, the
175 commissioner shall ensure the representation of state-wide and local
176 organizations that provide services to children of all ages in each
177 region of the state.

178 [(g)] (h) The commissioner shall enter into a contract with an entity
179 to be a single point of entry servicer for applicants and enrollees under

180 the HUSKY Plan, Part A and Part B. The servicer shall jointly market
181 both Part A and Part B together as the HUSKY Plan. Such servicer shall
182 develop and implement public information and outreach activities
183 with community programs. Such servicer shall electronically transmit
184 data with respect to enrollment and disenrollment in the HUSKY Plan,
185 Part B to the commissioner.

186 [(h)] (i) Upon the expiration of any contractual provisions entered
187 into pursuant to subsection [(g)] (h) of this section, the commissioner
188 shall develop a new contract for single point of entry services and
189 managed care enrollment brokerage services. The commissioner may
190 enter into one or more contractual arrangements for such services for a
191 contract period not to exceed seven years. Such contracts shall include
192 performance measures, including, but not limited to, specified time
193 limits for the processing of applications, parameters setting forth the
194 requirements for a completed and reviewable application and the
195 percentage of applications forwarded to the department in a complete
196 and timely fashion. Such contracts shall also include a process for
197 identifying and correcting noncompliance with established
198 performance measures, including sanctions applicable for instances of
199 continued noncompliance with performance measures.

200 [(i)] (j) The single point of entry servicer shall send an application
201 and supporting documents to the commissioner for determination of
202 eligibility of a child who resides in a household with a family income
203 of one hundred eighty-five per cent or less of the federal poverty level.
204 The servicer shall enroll eligible beneficiaries in the applicant's choice
205 of managed care plan. Upon enrollment in a managed care plan, an
206 eligible HUSKY Plan Part A or Part B beneficiary shall remain enrolled
207 in such managed care plan for twelve months from the date of such
208 enrollment unless (1) an eligible beneficiary demonstrates good cause
209 to the satisfaction of the commissioner of the need to enroll in a
210 different managed care plan, or (2) the beneficiary no longer meets
211 program eligibility requirements.

212 [(j)] (k) Not more than twelve months after the determination of

213 eligibility for benefits under the HUSKY Plan, Part A and Part B and
214 annually thereafter, the commissioner or the servicer, as the case may
215 be, shall determine if the child continues to be eligible for the plan. The
216 commissioner or the servicer shall mail an application form to each
217 participant in the plan for the purposes of obtaining information to
218 make a determination on eligibility. To the extent permitted by federal
219 law, in determining eligibility for benefits under the HUSKY Plan, Part
220 A or Part B with respect to family income, the commissioner or the
221 servicer shall rely upon information provided in such form by the
222 participant unless the commissioner or the servicer has reason to
223 believe that such information is inaccurate or incomplete. The
224 Department of Social Services shall annually review a random sample
225 of cases to confirm that, based on the statistical sample, relying on such
226 information is not resulting in ineligible clients receiving benefits
227 under HUSKY Plan Part A or Part B. The determination of eligibility
228 shall be coordinated with health plan open enrollment periods.

229 [(k)] (l) The commissioner shall implement the HUSKY Plan, Part B
230 while in the process of adopting necessary policies and procedures in
231 regulation form in accordance with the provisions of section 17b-10.

232 [(l)] (m) The commissioner shall adopt regulations, in accordance
233 with chapter 54, to establish residency requirements and income
234 eligibility for participation in the HUSKY Plan, Part B and procedures
235 for a simplified mail-in application process. Notwithstanding the
236 provisions of section 17b-257b, such regulations shall provide that any
237 child adopted from another country by an individual who is a citizen
238 of the United States and a resident of this state shall be eligible for
239 benefits under the HUSKY Plan, Part B upon arrival in this state.

240 Sec. 3. (NEW) (Effective July 1, 2007) Any managed care organization
241 under contract with the Department of Social Services to provide
242 services under the HUSKY Plan, Part A or Part B, or both, shall
243 reimburse providers utilized to provide services to program
244 beneficiaries at a rate that is not less than the applicable rate paid to
245 providers for such services under the Medicare program. If the

246 services are provided in a geographic area for which there is no
247 comparable Medicare rate, the provider shall be reimbursed at a rate
248 that is the usual and customary rate paid to private providers for such
249 services in the geographic area. Federally qualified health centers shall
250 receive prospective payment rates as prescribed by federal law. Fees
251 provided to dental providers by such managed care organizations
252 shall be equal to the seventieth percentile of the normal and customary
253 private provider fee, as defined by the National Dental Advisory
254 Service Comprehensive Fee Report. Providers under the Medicaid fee-
255 for-service program and under any system of primary care case
256 management implemented for the benefit of Medicaid, HUSKY Plan
257 Part, A or HUSKY Plan, Part B beneficiaries shall be reimbursed at
258 rates that are in accordance with the provisions of this section.

259 Sec. 4. Subsection (a) of section 17b-296 of the general statutes is
260 repealed and the following is substituted in lieu thereof (*Effective July*
261 *1, 2007*):

262 (a) Each managed care plan shall include sufficient numbers of
263 appropriately trained and certified clinicians of pediatric care,
264 including primary, medical subspecialty and surgical specialty
265 physicians, as well as providers of necessary related services such as
266 dental services, mental health services, social work services,
267 developmental evaluation services, occupational therapy services,
268 physical therapy services, speech therapy and language services,
269 school-linked clinic services and other public health services to assure
270 enrollees the option of obtaining benefits through such providers. Any
271 such health care provider may, prior to contracting with the
272 Department of Social Services, provide notice to the department of the
273 health care provider's capacity in accepting HUSKY Plan, Part A or
274 Part B beneficiaries in their practice.

275 Sec. 5. Subsection (a) of section 17b-297 of the general statutes is
276 repealed and the following is substituted in lieu thereof (*Effective July*
277 *1, 2007*):

278 (a) The commissioner, in consultation with the Children's Health

279 Council, the Medicaid Managed Care Council and the 2-1-1 Infoline [of
 280 Connecticut] program, shall develop mechanisms [for outreach for] to
 281 increase outreach and maximize enrollment of eligible children and
 282 adults in the HUSKY Plan, Part A [and] or Part B, including, but not
 283 limited to, targeted outreach in communities that have been identified
 284 by the commissioner as having underutilized the HUSKY Plan,
 285 development of [mail-in applications and appropriate outreach
 286 materials] an on-line and mail-in application process, and
 287 development of appropriate outreach materials, including on-line
 288 outreach materials through the Department of Revenue Services, the
 289 Labor Department, the Department of Social Services, the Department
 290 of Public Health, the Department of Children and Families and the
 291 Office of Protection and Advocacy for Persons with Disabilities.

292 Sec. 6. (NEW) (*Effective July 1, 2007*) The Commissioner of Social
 293 Services, in consultation with the Commissioner of Public Health, shall
 294 develop a plan to implement a system of preventive health care
 295 services for children under the HUSKY Plan, Part A and Part B,
 296 including, but not limited to, ophthalmologic care, oral health care and
 297 chronic disease management.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>July 1, 2007</i>	17b-261
Sec. 2	<i>July 1, 2007</i>	17b-292
Sec. 3	<i>July 1, 2007</i>	New section
Sec. 4	<i>July 1, 2007</i>	17b-296(a)
Sec. 5	<i>July 1, 2007</i>	17b-297(a)
Sec. 6	<i>July 1, 2007</i>	New section

HS *Joint Favorable Subst.*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either chamber thereof for any purpose:

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 08 \$	FY 09 \$
Social Services, Dept.	GF - Cost	Significant	Significant

Municipal Impact: None

Explanation

This bill makes various changes to the Department of Social Services' (DSS) HUSKY and Medicaid programs. The quantifiable costs of the bill, as detailed below, total \$787,600,000 in FY08 and \$845,900,000 in FY09.

Section 1 of the bill expands eligibility for parents of children enrolled in the HUSKY A program from 150% of the federal poverty level (FPL) to 185% FPL. The Office of Fiscal Analysis (OFA) estimates that this will add an additional 9,700 clients to the program when fully annualized, at a cost of \$23,500,000 in FY08 and \$31,300,000 in FY09. This estimate includes the rate increases implemented in section 3 of the bill. These costs would be reimbursed 50% by the federal government under the Medicaid program.

Section 1 also increases transitional Medicaid benefits from 12 months to 24 months. These benefits are extended when a HUSKY family becomes ineligible for the program due to increased income. Assuming the rate increases implemented in section 3 of this bill, OFA estimates that this change will cost \$19,400,000 in FY08 and \$20,400,000 in FY09. These costs would be reimbursed 50% by the federal government under the Medicaid program.

Section 1 also eliminates certain cost sharing requirements for

parents in HUSKY A. As this policy was never implemented, this provision has no fiscal impact.

Section 2 of the bill increases the eligibility limits for the HUSKY plan, part B from 300% of the Federal Poverty Level (FPL) to 400% FPL. Although the bill does not specify, it is assumed that this expansion would include the premium and cost sharing requirements currently in place for children enrolled in HUSKY B, Band 2 (236%-300% FPL). OFA estimates that this expansion will enroll an additional 7,100 children when fully annualized in FY09. Including the rate increases implemented in section 3 of the bill, this expansion is expected to cost \$10,900,000 in FY08 and \$17,700,000 in FY09.

Currently, expenditures under the HUSKY B program are reimbursed 65% by the federal government under the SCHIP program. Connecticut operates under a federal waiver that allows the state to cover children up to 300% FPL. It is uncertain whether the federal government would approve a coverage expansion above 300% FPL. Therefore, the costs of the children covered between 300% and 400% FPL may be fully state funded.

Section 2 also re-establishes the continuous eligibility policy for children in the HUSKY plan. Assuming the rate increases included in section 3, this change is estimated to cost \$2,800,000 annually. These costs would be reimbursed 50% by the federal government under the Medicaid program.

Section 3 requires the managed care organizations (MCO's) that operate the HUSKY program to reimburse providers at a rate which is not less than the rate paid for the provision of such services under the Medicare program, or the usual and customary rate if no applicable Medicare rate is available. It should first be noted that given the disparate populations served (HUSKY is predominantly women and children, while Medicare serves the elderly and disabled), there may often not be Medicare rates that correspond with HUSKY rates. Also, rates currently paid by the MCO's to providers in their system are not available as they are considered proprietary. Therefore, a direct

comparison of rates is not possible.

Assuming that DSS was to implement the provisions of this section by increasing the rates under the behavioral health partnership and the capitated rates paid to the HUSKY MCO's, OFA estimates that this would cost approximately \$326,700,000 in FY08 and \$345,800,000 in FY09. As stated above, exact comparisons between current HUSKY rates and other rates are not possible. Based on data included in the Office of Health Care Access' 2005 Annual Report on the financial status of Connecticut's hospitals, it would require a 38% Medicaid rate increase to match the hospital rates paid under the Medicare program. As reliable data does not exist for rate comparisons, OFA used this 38% rate increase as a proxy. The increases cited above would be eligible for federal reimbursement under the Medicaid and SCHIP program, which would generate an estimated reimbursement of \$165,000,000 in FY08 and \$175,100,000 in FY09.

Section 3 also requires that the reimbursement to dental providers under the HUSKY program be equal to the 70th percentile of the normal and customary fee, as defined by the National Dental Advisory Service Comprehensive Fee Report. Based on the latest such fee report, OFA estimates that this would cost \$27,000,000 annually over the current HUSKY dental expenditures. It would represent a \$20,000,000 increase over the Medicaid to Medicare rate increases calculated above. These costs would be reimbursed 50% by the federal government under the Medicaid program.

Finally, section 3 requires that DSS increase rates paid to medical providers under the Medicaid fee-for-service in a similar manner. Using the methodology outlined above, OFA estimates that this rate increase would cost an additional \$384,300,000 in FY08 and \$407,900,000 in FY09. These costs would be reimbursed 50% by the federal government under the Medicaid program.

The rate increases included in this section of the bill may lead to increased access to services as providers may be more willing to serve HUSKY and Medicaid clients. Should this be the case, it is likely that

the MCO's would seek a future increase in their capitated rates to compensate for this change. It is not known what this increased utilization may be. However, any increased utilization in either the HUSKY or Medicaid fee-for-service programs will result in significant increased state costs. For example, a 5% increased utilization for all services would result in increased costs of \$118,000,000 annually.

Section 4 requires providers to report certain information to DSS. There is no direct fiscal impact.

Section 5 requires DSS to increase outreach and maximize enrollment of eligible children and adults in the HUSKY programs. Increased outreach will result in increased administrative costs, the extent of which is dependent upon the outreach mechanisms used. Should such outreach efforts succeed, additional enrollment in these programs would result in additional state costs.

Section 6 requires DSS, in consultation with the Department of Public Health, to develop a plan to implement a system of preventative health care services for children in the HUSKY programs. The departments would likely incur administrative costs in developing such a plan. Further state costs would be incurred should this plan include services over and above those currently available in the HUSKY plans. The extent of these costs cannot be known until such a system is developed.

The Out Years

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

OLR Bill Analysis**sHB 7375****AN ACT CONCERNING HEALTH CARE ACCESS AND EXPANSION OF THE HUSKY PROGRAM.****SUMMARY:**

This bill makes a number of changes in the HUSKY program. Specifically, it:

1. increases the HUSKY A (Medicaid) income limit for caretaker relatives;
2. increases the income limit for subsidized HUSKY B coverage;
3. extends transitional Medicaid coverage from one to two years;
4. repeals never-implemented cost sharing requirements in HUSKY A;
5. restores continuous eligibility in HUSKY A and B;
6. requires the Department of Social Services (DSS) to increase reimbursement rates to HUSKY and other Medicaid providers;
7. requires DSS to do additional outreach for HUSKY; and
8. requires the DSS commissioner, in consultation with the commissioner of the Department of Public Health (DPH) to develop a preventive health care system for children enrolled in HUSKY.

EFFECTIVE DATE: July 1, 2007

INCREASE IN INCOME LIMIT FOR HUSKY A CARETAKER COVERAGE (§ 1(A))

The bill increases, from 150% to 185% of the federal poverty level (FPL) (from \$25,755 to \$31,764 annually for a family of three), the income limit for HUSKY A adult caretaker coverage. This higher limit already applies to children in the HUSKY A program.

INCREASE IN INCOME LIMIT FOR HUSKY B COVERAGE (§ 2(A))

The bill increases, from 300% to 400% of the FPL (\$51,510 to \$68,680 annually for family of three), the income limit for children to receive subsidized coverage under HUSKY B. It is not clear whether the federal government will allow the state to use State Children's Health Insurance Program (SCHIP) block grant (pays primarily for HUSKY B) funds to pay the federal share of this coverage (65%) without granting DSS a waiver, or if it would allow the state to set the limit this high even with a waiver.

TRANSITIONAL MEDICAID (§ 1(F))

The bill extends, from one to two years, the amount of transitional Medicaid families may receive. By law, and to the extent federal law allows, DSS must extend Medicaid eligibility to families who lose eligibility because their income from either earnings or child support exceeds the program's limit (150% of FPL). Currently, federal law requires states to provide one year of transitional Medicaid, but allows states to extend this coverage.

REPEAL OF COST SHARING IN HUSKY A (§ 1(H))

The bill repeals provisions requiring DSS to require HUSKY A families with incomes above 100% of the FPL (\$17,170 annually for family of three) to pay cost sharing, including premiums and co-payments, as allowed by federal law or waivers granted by the federal Medicaid agency. (DSS has never implemented these provisions.)

CONTINUOUS ELIGIBILITY (§ 2(D))

The bill restores continuous HUSKY eligibility, which was eliminated by PA 03-2. It prohibits DSS from terminating HUSKY A or B coverage for 12 months after it determines that a child is eligible, unless the child is no longer a state resident or turns 19. During this

period of continuous eligibility, the family must comply with the federal requirements concerning the reporting of information to DSS, including change of address. Currently, families must report changes in financial circumstances within the 12-month period, which can render the child ineligible for assistance.

REIMBURSEMENT RATES (§ 3)

General Managed Care

The bill requires any managed care organization (MCO) contracting with DSS under HUSKY to reimburse all providers serving HUSKY clients at rates no less than the applicable rates paid to providers for similar services under the Medicare program. If the service is provided in a geographic area for which there is no comparable Medicare rate, the MCO must reimburse at the usual and customary rate paid to private providers for such services in that area. (A recent DSS analysis shows that Medicaid reimbursement rates for medical procedures are 48.7% of what Medicare pays. For surgical services, the rate is 57%.)

Federally-Qualified Health Centers (FQHC)

The bill also requires the MCOs to pay federally qualified health centers (FQHC) (presumably all those serving HUSKY recipients) prospective payment rates as federal law prescribes. Under a prospective payment system, state Medicaid agencies establish a per center visit payment in advance, which is based on earlier years' costs that are indexed for inflation. In practice, DSS already reimburses the FQHCs using prospective rates. Existing law, unchanged by the bill, requires the DSS commissioner to apply a maximum allowable per-visit cost of 115% of the median visit cost. In practice, DSS has never applied this limit when setting the FQHC rates and it is not part of the Medicaid state plan.

Dental Services

The bill further requires that the MCOs pay HUSKY dental providers fees equaling the 70th percentile of the normal and customary private provider fee, as defined by the National Dental Advisory Service (NDAS) Comprehensive Fee Report. A separate DSS

analysis comparing the NDAS fees at the 70th percentile with average Husky MCO's fees shows that this change would at least double the amount paid to providers. For example, the MCO average fee for an initial exam is \$24; the NDAS fee at the 70th percentile is \$65.

Reimbursement for Other Service Delivery Models

The bill requires that providers under the Medicaid fee-for-service program and under any system of primary care case management that might be implemented for HUSKY A or B or other Medicaid recipients, be reimbursed at these same rates.

MCO CAPACITY (§ 4)

The bill permits any health care provider serving HUSKY recipients, before contracting with DSS, to tell the department how many HUSKY recipients it can serve. But since in the HUSKY program, health care providers contract with the MCOs, not DSS, it appears that this notification would have to occur between the providers and the MCOs. Presumably, this already occurs.

OUTREACH (§ 5)

Current law requires DSS, in consultation with the now defunct Children's Health Council, the Medicaid Managed Care Council, and 2-1-1 Infoline, to develop outreach mechanisms for HUSKY, including mail-in applications, which get disseminated through a number of state agencies. The bill requires the department instead to increase outreach and maximize enrollment of eligible children and adults. At a minimum, it must (1) target outreach in communities that the DSS commissioner identifies as underutilizing HUSKY; (2) develop an on-line, as well as the existing mail-in, application process; and (3) include on-line outreach materials, in addition to written ones.

SYSTEM OF PREVENTIVE CARE (§ 6)

The bill requires the DSS commissioner, in consultation with the Department of Public Health commissioner, to develop a plan to implement a preventive health care system for children enrolled in HUSKY A or B. This must include, at a minimum, eye care, oral health

care, and chronic disease management.

BACKGROUND

Related Bills

Several legislative committees have favorably reported bills broadly addressing health care access that contain provisions similar to those in sHB 7375. They are:

<i>Bill Number</i>	<i>Committee</i>
SB 1	Public Health
SB 3	Human Services
SB 70	Insurance
SB 1127	Human Services
SB 1371	Insurance
HB 6158	Children
HB 6652	Insurance
HB 7314	Labor

sHB 6646, favorably reported by the Human Services Committee, makes changes in the way DSS reimburses FQHCs.

Reimbursement to FQHCs

Since 2001, federal law has required state Medicaid programs to reimburse FQHCs using a prospective payment system (PPS). This replaced a cost-based reimbursement system. The system establishes a per-visit payment for each FQHC in advance. The 2001 rate was based on earlier year averages of reasonable visit costs and have been adjusted annually for inflation using the Medicare Economic Index. Payments are also adjusted when a center changes the scope of services it provides during the visit. States must make supplemental payments to the centers that provide care to Medicaid managed care enrollees to cover the difference between the PPS rate and what the MCO pays. This was added to encourage FQHCs to participate in the

Medicaid managed care program.

COMMITTEE ACTION

Human Services Committee

Joint Favorable Substitute

Yea 15 Nay 2 (03/20/2007)