

MEDICAID

Eligibility—Major Pathways

- ✓ **HUSKY A**—managed Medicaid for children and adult caretaker relatives with income under 185% of the federal poverty level (FPL) (\$32,560 annually for family of three), and pregnant women with income under 250% of FPL (\$44,000); no asset limit
- ✓ **Medically needy**—fee-for-service Medicaid primarily for aged, blind, and disabled individuals with income up to \$506.22 per month (single person) (after \$278 of unearned income deducted)—people with higher incomes can “spend-down” excess on medical bills; assets no higher than \$1,600 (\$2,400 for couples)
- ✓ **Long-term care**—nursing home and home- and community-based care for elderly—income limits vary, generally no more than cost of institutional care (for nursing home residents) for initial eligibility; once in nursing home, most income turned over to state unless community spouse needs for support; assets divided and community spouse gets to keep half, up to limit (currently \$110,000 for community spouse, \$1,600 for nursing home spouse), with excess assets used to pay for care before Medicaid pays; state recovers amount it spent from resident’s estate; asset transfers scrutinized
- ✓ **Dual-eligible**—individuals who are eligible for both Medicare and Medicaid receive help (Medicaid pays) paying Medicare cost sharing (including deductibles and premiums), as well as help with Medicare Part D (prescriptions); various income and asset limits; estate recovery for some

Services—

Mandatory

- Inpatient hospital
- Outpatient hospital
- Prenatal care
- Vaccines for children
- Physicians
- Nursing facilities for people age 21 and over
- Family planning services and supplies

- Rural health clinics
- Home health care for people eligible for nursing home care
- Laboratory and x-ray
- Pediatric and family nurse practitioner
- Nurse midwife
- Federally qualified health centers
- Early and Periodic Screening, Diagnostic and Treatment for children under age 21

Optional Services Available in Connecticut

- Optometrists
- Clinic services
- Dental
- Prescription drugs
- Dentures
- Prostheses
- Eyeglasses
- Diagnostic and Screening Services
- Personal care (under 1915c home- and community-based services waiver only)
- Preventive services
- Rehabilitative services
- ICF-MR
- Age 65 or older in institution for mental disease (IMDs): inpatient hospital and nursing homes
- Inpatient psychiatric for under 21
- Case management
- Hospice--pending state plan amendment per PA 08-158

Service Delivery

- HUSKY—Managed care from one of three insurers—Aetna Better Health (MCO), AmeriChoice (MCO), or Community Health Network of CT (consortium of federally qualified health centers)
- All other Medicaid provided on fee-for-service basis—providers must be certified by DSS

Rate Setting

- ❖ DSS sets rates paid to providers serving Medicaid fee-for-service clients, including hospitals, nursing homes, and physicians

In 2004, the Legislative Program Review and Investigations Committee (LPRI) studied Medicaid eligibility. One part of the study focused on the ACS contract, and its recommendations on the contract related were ultimately adopted by the 2005 legislature. These include requiring DSS to develop one or more contracts for these services, to limit the contracts' duration to seven years, and to ensure that future contracts contain performance measures (PA 05-280).

Oversight

For the last 10 years, the Medicaid Managed Care Council has served as the primary watchdog for HUSKY A and B. Established in 1994 (PA 94-5, May Special Session), the council is comprised of legislators, executive branch employees, health care providers and advocates, and consumers. It meets monthly and is charged with a variety of tasks, including making recommendations to the legislature regarding access to HUSKY A. To help with the large volume of work, the Council established four subcommittees that hold additional meetings during the month: Behavioral Health, Consumer Access, Public Health, and Quality Assurance.

Measuring Outcomes

As a condition of receiving federal funds for managed Medicaid and SCHIP programs, states must measure the performance of their MCOs to ensure that they meet certain minimum quality standards. Moreover, federal law requires that certain services be offered to program beneficiaries. States generally use the Health Plan Employer Data and Information Set (HEDIS), developed and maintained by the National Committee for Quality Assurance (NCQA) or some variation of it when evaluating their programs. Connecticut uses both of these. Surveys are also performed.

Mercer Report (April 2005) In 2004, DSS contracted with Mercer Government Human Services Consulting to perform an external quality review of HUSKY A. A summary chart, presented at the Medicaid Managed Care Council's April meeting, measuring the MCOs' success in meeting national benchmarks for a number of performance measures, such as the number of Neonatal Intensive Care Unit (NICU) admissions per 100 births and emergency department visits, shows that the NICU numbers for all four plans fell within both the national and state averages. The emergency visits for all but one plan (Health Net) were higher.

Mercer also reported on Performance Improvement Projects which measure how well a particular plan met its goals for improving health outcomes.

PROGRAM SUCCESSES

Effects on Number of Uninsured

Although a June 2005 Families USA report shows that over 11% of the state's population is uninsured in 2005, the HUSKY program can be credited for reducing the number of uninsured residents. A May 2005 Voices report notes that 75,000 more children have health insurance than in July 1998. And passage of the 2005 adult expansion is expected to reduce the number of uninsured adults by about 17,000 over the next two years.

More Screenings

At the June 2005 MMCC meeting, the state's Medicaid director, David Parrella, pointed to rising preventive services screenings in HUSKY A. In 1994, the preventive screen ratio (which measures the degree to which children get basic prevention screenings) was 49%. In the last half of 2004, all MCOs achieved an 80% ratio and cumulative ratio of 84% in the utilization reports, consistent with federal goals, according to Parrella.

LPRI Review

The LPRI Medicaid eligibility study and many of the issues it raised and subsequent recommendations pertain to HUSKY. One reason for the study was to get a sense of how state employee layoffs (about 25% of DSS eligibility workers statewide) had affected DSS' ability to process applications in a timely manner.

Some of the concerns the study raised included (1) high numbers of overdue family applications (pending DSS review and granting of eligibility) and disparities among the district offices; (2) difficulty in getting client information changes (such as address) processed; (3) lack of uniformity among the offices in notifying pregnant applicants when necessary application information is missing; and (4) frequent plan changes by HUSKY A beneficiaries.

Many of these recommendations were incorporated into PA 05-280, including a 12-month bar on HUSKY A recipients switching MCOs (previously, they could switch plans at any time).

PROGRAM SHORTCOMINGS

Access--Accountability

State law requires each participating MCO to have a sufficient number of appropriately trained and certified health care clinicians. It also requires that the plans maintain primary responsibility for ensuring that their dental and behavioral health care subcontractors adhere to the MCOs' contracts with DSS and requires that the MCOs impose a performance bond, letter of credit, statement of financial reserves, or payment withhold for these services. Over the years, a concern has been raised about the lack of information available on the plans, and the legislature has from time to time considered bills to obtain more information.

A recent *Hartford Courant* article highlights this issue as it relates to the number of providers with whom the HUSKY MCOs contract for services. In it, the author mentions several New Haven clinics that noticed their patients were having difficulty finding cardiologists and gastroenterologists and suspected low fees from the MCOs was a strong factor. But DSS has consistently argued that it does not have the information (the MCOs have it but apparently do not pass it on to DSS), thus it is not subject to the state's Freedom of Information laws. Although Attorney General Blumenthal is sympathetic to the people seeking the information, he is obliged to defend DSS' position. The MCOs have argued that the information is proprietary and would reveal commercial trade secrets, and they contend that they are not performing a government function.

The Mercer report referenced above had attempted to measure provider adequacy but limitations in encounter data prevented such measurement in a "meaningful" way, according to its authors. Mercer hopes to include this in future reviews.

Dental Services—Lawsuit and Delay of "Carve Out"

Dental participation in the Medicaid program has been poor for many years, even before HUSKY was established. (Connecticut has not raised dental reimbursement rates for children since 1993.) The lack of participation is due mainly to very low reimbursement rates and the fairly high patient no-show rates that have chronically plagued the program.

Medicaid managed care pushed reimbursement for most children's dental care into the monthly capitation rates DSS pays the MCOs, which in turn subcontract with two dental MCOs to serve clients. A 2004 report by Connecticut Voices for Children found that fewer than half of children enrolled in HUSKY A received any dental care in 2003. But Voices also found a steady increase in preventive care services over 2000.

PA 03-155 directed DSS to hire an administrative services organization (ASO) to manage dental services for HUSKY beginning in late 2004. It was believed that this "carve out" of dental services would improve access. DSS announced in early 2005 that it was abandoning this plan because it did not believe it would lead to greater access for patients. In the meantime, legal aid advocates sued the state in 2003 for failing to provide dental services to the poor. The case remains in federal court.

Legislation to increase dental rates has been proposed but not passed during the last several legislative sessions. But the federal Medicaid agency has recently approved the state's plan to allow federally qualified health centers (FQHC) to contract with local dentists. These centers generally get higher reimbursement from Medicaid, which could mean higher rates that might attract more providers willing to serve poor residents, including HUSKY recipients.

Disparities in Health Care

A June 2005 report by Voices shows continuing disparities between whites and non-whites in utilization rates of well-child care and hospital emergency rooms in 2003. The report's main conclusions were mixed: African American children were significantly less likely to receive well child care, other ambulatory care, and preventive care than white children, while Hispanic children were significantly more likely than white children to receive preventive dental care.

Hispanic children were more likely to have emergency care or be hospitalized than white children. And, both African American and Hispanic children had more asthma care and more emergency asthma care, but were no more likely to be hospitalized for asthma.

State Subsidizing Care for People Potentially Eligible for Employer Sponsored Health Insurance

Three OLR research reports from earlier this year highlight an emerging issue: for some of the largest employers, the state may be subsidizing the health insurance of employees when such coverage is

available from these employers. The legislature considered a bill (SB 1147) that would have required these employers to “pay or play,” but the Senate recommitted the bill to the Labor Committee on the last day of the regular session.

Bills to require DSS to report on the employers of people whose children receive HUSKY likewise did not pass in 2005 (PA 05-280).

Other Legislative Changes that Could Negatively Affect Enrollment and Access

Although the 2005 legislature increased the income limit for adult HUSKY A coverage, it also imposed new or higher cost sharing requirements in both A and B, such as monthly premiums and co-payments in HUSKY A. And it reduced from two years to one the time families can receive Transitional Medicaid.

This same legislation eliminated self-declaration of income in HUSKY A and B. Under this procedure, DSS had to rely on information that the recipient provided when determining whether someone continued to be eligible, rather than requiring a more in-depth review of the family’s financial circumstances.

These changes, along with cuts made in 2003 (e.g., elimination of continuous eligibility for children, which had provided continuous coverage during a 12-month period, even if the caretakers financial circumstances changed during that time), may be having a negative effect on enrollments.

Behavioral Health “Carve Out”—Waiver

For several years the state has been grappling with how to provide necessary mental health services to children and to ensure that the state has access to any available federal funding to pay for these services. As mentioned above, these services are available under HUSKY and HUSKY Plus, the funding for which comes from the monthly capitation the MCOs receive from DSS. But this system has continually been faulted for failing to meet the mental health needs of the state’s poor children, including creating long and unnecessary hospitalizations and emergency room visits.

DSS and the Department of Children and Families have been working for the last five years to fix the problem. In May 2005, they submitted a federal Medicaid waiver request to begin to build an integrated, family-driven behavioral health system that combines the broad ranges of

services and supports provided by both departments. It essentially "carves out" mental health services from the capitation and allows for HUSKY payments on a more traditional fee-for-service basis. An administrative service organization (ASO), Value Options, will administer the initiative, which DSS anticipates will start on January 1, 2006.

The legislature built on this initiative with passage of PA 05-280. This act, among other things, (1) expands community-based services, while reducing the state's reliance on institutional care; (2) improves performance monitoring, and (3) establishes a Behavioral Health Oversight Council.

Higher Cost of Employer Sponsored Coverage and Expansion Options

As employers continue to increase the amount employees must pay for coverage and small employers find it harder to pay rising premiums for their employees, the uninsured rates could rise further despite the success HUSKY has had in covering more children and adults. Some have called on the state to expand HUSKY further to cover those people, including childless adults, who cannot afford their employers' coverage or who are working for an employer that does not offer coverage. Federal waivers are available to states to do such expansions, which would give Connecticut a higher match (65% instead of 50% available for adult coverage in HUSKY A). The legislature has considered such initiatives but none have passed.

RC:dw



OLR RESEARCH REPORT

May 27, 2005

2005-R-0517

CONNECTICUT'S MEDICAID WAIVERS

By: Helga Niesz, Principal Analyst

You asked for a list of all Connecticut's Medicaid waivers, a brief description of them, and the dates the federal government first approved each one.

SUMMARY

The federal-state Medicaid program generally provides medical services to families with children who are on welfare or have very low incomes; low-income aged, blind, and disabled people; and people in nursing homes. Medicaid beneficiaries living in nursing homes and other institutions can have higher incomes than those in the community.

Medicaid waivers are a way for states to serve additional medically needy people living in the community who otherwise would not qualify for the regular Medicaid program because of income or other factors. When the federal Centers for Medicare and Medicaid Services approves a waiver, states can (1) set somewhat higher income limits for these groups, (2) limit the number of people who can qualify ("waiver slots"), and (3) make other adjustments to regular Medicaid rules. Waivers receive initial approval for three years and then the Department of Social Services (DSS), which administers the state's Medicaid program, must apply to CMS for renewal every five years. States can also ask for amendments to their waivers at any time, which Connecticut has done.

Connecticut has seven Medicaid waivers in effect. The first six are home and community-based services (HCBS) 1915 (c) waivers and the HUSKY A waiver is a 1915(b) general managed care and selective contracting waiver.

CONNECTICUT'S MEDICAID WAIVERS

Connecticut Home Care Program for Elders Waiver

This waiver provides home health care and related community-based services to people aged 65 and older who are not eligible for regular Medicaid and would otherwise be in nursing homes.

(First received CMS approval in 1987 and DSS is about to submit a renewal request to CMS for 2005)

Personal Care Assistance (PCA) Waiver

The PCA waiver provides consumer-directed personal care assistance services to people with physical disabilities who are between age 18 and 64 and who would otherwise require institutionalization. Participants must need help with activities of daily living and must be able to hire and direct their own personal care assistant (PCA).

The waiver was most recently renewed in 2004 and amended to (1) cover a personal emergency response system; (2) allow 16-year-olds to be PCAs; (3) allow PCAs to work more hours, provided the employer (client) pays worker's compensation; and (4) allow additional hours to account for trips to the emergency room.

(First received CMS approval in 1996)

Acquired Brain Injury (ABI) Waiver

The ABI Waiver provides a number of support services, including personal care assistance, to people between age 18 and 64 with ABI to help them remain in the community. (ABI is any combination of acquired focal and diffuse central nervous system dysfunctions, both immediate and delayed, at the brain stem level and above.)

(First received CMS approval in 1997)

Katie Beckett Waiver

This waiver, also known as a model waiver, provides full Medicaid eligibility, case management, and home health care to people (primarily children) with severe physical disabilities. They are eligible if they would otherwise require institutionalization and would not qualify for Medicaid based on their parents' or spouse's incomes.

(First received CMS approval in 1983)

Department of Mental Retardation (DMR) Waivers

Currently, DMR has two Medicaid waivers that provide a variety of home and community services to people with mental retardation who would otherwise be institutionalized. These are jointly administered by DSS and DMR.

- ***DMR Comprehensive Waiver*** provides services to people with mental retardation mainly in group homes and organized day programs, as well as some services to people living in their own homes. A renewal proposal would add more services for people who need extensive care in their own homes and do not qualify for the new IFS waiver (see below). (First received CMS approval in 1987. The current waiver expires and is up for renewal September 30, 2005.)
- ***DMR Individual and Family Support Waiver (IFS)***, also known as an Independence Plus Waiver, provides a variety of home and community services to people with mental retardation. It targets people living in their own or their family's home who do not need 24-hour services and provides them or their families opportunities to self-direct some of the services they need. (First received CMS approval February 1, 2005 for three years.)

HUSKY A Managed Care Waiver

This waiver allows DSS to provide Medicaid services through a capitated managed care HMO-type system to families with children who are on welfare or otherwise eligible because of low income. (The elderly, blind, and disabled receive their services through the regular Medicaid fee-for-service system). With a "capitated" system, the managed care organization receives a set amount per person monthly regardless of how much service it provides. Currently, DSS is in the process of submitting an amendment to this waiver to CMS. The amendment would carve out

behavioral health services from the capitated portion of the HUSKY program and return these services to a fee-for-service model where providers receive payment for the services they provide. The legislature's Appropriations and Human Services committees recently approved the waiver amendment on May 24, 2005 in preparation for its submission to CMS.

(First received CMS approval in 1995)

HN:dw



OLR RESEARCH REPORT

March 17, 2005

2005-R-0281

HUSKY A—NUMBER OF CHILDREN ENROLLED, BY EMPLOYER

By: Robin K. Cohen, Principal Analyst

As a follow-up to OLR report [2005-R-0129](#), you asked for the number of children covered by HUSKY A whose parents or caretakers were employed by the 25 employers with the largest number of HUSKY A recipients.

The Department of Social Services (DSS) is still trying to get us exact enrollment figures for these children. In the meantime, it suggested that we use a multiplier or “factor” to arrive at an approximate number of children. This factor is 1.37, and it is based on the average size of a HUSKY A assistance unit or “family” receiving HUSKY A coverage in February 2005. Multiplying the number of adults by this factor yields the number of covered children.

Table 1 presents an estimate of the children receiving HUSKY A coverage whose parents or caretaker relatives are employed by the top 25 HUSKY employers, as well as an estimate of the total number of HUSKY A recipients, which we calculated by adding the adult recipients and children.

Table 1: Estimated Children Covered by HUSKY A Whose Parents or Caretaker Relatives Worked for Top 25 HUSKY Employers [1]

<i>Employer</i>	<i>Adult Recipients Who Worked for Employer (A)</i>	<i>Non-Recipients [2] Who Worked for Employer (B)</i>	<i>Child Recipients (A+B) x 1.37 (C)</i>	<i>Total # of HUSKY A Recipients (A+C)</i>
Walmart	824	204	1,408	2,232
Stop and Shop	741	175	1,255	1,996
Dunkin Donuts	530	133	908	1,438
McDonalds	460	146	830	1,290
Laidlaw	460	115	788	1,248
Mohegan Sun	276	79	486	762
Shaw's	288	52	466	754
Burger King	243	41	389	632
Home Depot	197	76	374	571
CVS	221	40	358	579
First Student	212	46	353	565
Foxwoods	176	61	325	501
Fleet Bank	173	64	325	498
Filene's	177	49	310	487
ADECCO	181	44	308	489
Care for Kids	176	29	281	457
Hartford Hospital	141	49	260	401
Wendy's	145	35	247	392
Friendly's	178	[3]	244	422
Companions and Homemakers	177	[3]	242	419
Family Care VNA	159	[3]	218	377
Target	121	30	207	328
Subway	144	[3]	197	341
Walgreens	129	[3]	177	306
Sears	124	[3]	170	294

Source: DSS

[1] The adult recipients figure comes from employment data from DSS' Eligibility Management System (EMS) for September 2004. The non-recipients data is based on December EMS data. The 1.37 factor is based on February 2005 HUSKY A caseloads.

[2] Non-recipients are those employees whose children received HUSKY A coverage but they did not, presumably because they did not meet the program's eligibility requirements.

[3] The employer was not in the top 25 for adult's non-recipients. Consequently, we do not know how many non-recipients it employs.

RC:ts



OLR RESEARCH REPORT

April 4, 2005

2005-R-0276

HOME CARE FOR PEOPLE UNDER AGE 65

By: Robin K. Cohen, Principal Analyst

You asked (1) for a recent history of home health care assistance the state provides to individuals under age 65, including funding; (2) how other states provide this assistance; and (3) if the 2005 legislature is considering any bills in this area.

OLR Report 2004-R-0824 summarizes other states' home- and community-based services (HCBS) waiver programs, the primary means by which home care is offered to individuals under age 65. Additionally, we have attached a link to a Centers for Medicare and Medicaid Services (CMS) overview of states with HCBS waivers — <http://www.cms.hhs.gov/medicaid/1915c/default.asp>.

This report focuses on home and community-based services the Department of Social Services (DSS) provides, primarily to adults with physical disabilities. If you would like to know how other agencies (such as the Department of Mental Retardation) offer home care to their clients, please let us know. Children with special health care needs can receive some home care through the HUSKY Plus and Department of Public Health's Children with Special Health Care Needs programs.

You should also note that state law (CGS §§ 38a-493 and -520) mandates minimum insurance coverage for home health care in individual and group policies.

SUMMARY

For many years the state has offered home health care to individuals with disabilities under the age of 65 using both state and Medicaid funds. The state has also provided non-medical home care services, such as personal care assistance (PCA), and other community-based services through Medicaid home- and community-based services waivers. These waiver programs provide a richer benefit package than traditional Medicaid, allowing many more people to stay out of institutions.

This session the Human Services favorably reported several bills to address a perceived need to offer more options for these individuals. These bills are currently in the Appropriations Committee.

DSS HOME CARE PROGRAMS FOR PEOPLE UNDER AGE 65 WITH DISABILITIES

Personal Care Assistance (PCA) Waiver

In 1995, the legislature directed DSS to seek a HCBS waiver to offer PCA services to individuals aged 18 to 64 who would otherwise require institutionalization. Since 1997, this consumer-directed program (the individual with disabilities must be able to hire and direct the assistant) has offered help to individuals whose income is not more than 300% of the federal SSI limit (\$1,737 per month). But certain working adults with higher incomes can participate. Participants must need help with at least two activities of daily living. The waiver permits the program to accommodate up to 698 people.

According to Pam Giannini, director of DSS' Aging, Community Services, and Social Work Division, the waiver was recently amended to (1) cover a personal emergency response system; (2) allow 16-year-olds to be PCAs; (3) allow PCAs to work more hours, provided the employer (client) pays worker's compensation; and (4) allow additional hours to account for trips to the emergency room.

Estimated FFY 2004:

Average monthly caseload	485
Average monthly cost per client	\$ 1,735

Statutory Citation: CGS § 17b-605a

Acquired Brain Injury (ABI) Waiver

Also in 1995, the legislature directed DSS to seek an HCBS waiver to enable individuals with acquired brain injuries to remain in the community. (ABI is any combination of acquired focal and diffuse central nervous system dysfunctions, both immediate and delayed, at the brain stem level and above.) The income limit for the program is the same as for the PCA waiver.

The program, which has about 400 slots, currently offers 21 specific behavioral and support services to over 200 participants. An additional 204 people have applications pending with DSS.

FFY 2004 Actual

213 active clients
Average cost per client \$63,194
Annual cost of waiver \$13,460, 322

Statutory Cite: CGS § 17b-260a

Model ("Katie Beckett") Waiver

Since 1983, this program has offered full Medicaid eligibility, case management, and home health care to people (primarily children) with severe disabilities who would otherwise require institutionalization who would not traditionally qualify based on the income of the participant's parent or spouse. The waiver itself offers only case management services, but families can avail themselves of full Medicaid benefits, including home health care and physical therapy. The benefits must be cost effective.

In 2000, the legislature increased the number of waiver slots from 125 to 200, but funding for the program limits the number of filled slots at 125.

We are still awaiting expenditure information on this program.

Regular Medicaid—Home Health Care

Outside the waiver programs, individuals can get Medicaid-covered home health care services if they meet the Medicaid program's regular eligibility requirements, which set income and asset limits significantly lower than they are in the waiver programs. (People enrolled in the waiver programs automatically qualify financially for regular Medicaid.)

A physician must authorize a cost-effective plan of care every 60 days. A client is allowed 12 skilled nursing visits per month and 20 hours of home health aide services per week after which he needs prior authorization for these services. (The governor's FY 06 budget recommends reducing these thresholds.) Once a Medicaid client reaches either of these limits, his entire care plan comes up for review, including home health, waiver services, and durable medical equipment.

FY 04 total spending:

\$171,010,920 (includes \$2,449,230 for physical, occupational, and speech therapies; \$54,755,679 for medicine administration; and \$50,970,606 for other services provided by RNs or LPNs)

Statutory Cite: CGS § 17b-242

Community-Based Services (CBS)

Even before the waiver program started, the state offered home care services using state funds. The CBS program, currently run by DSS, provides homemakers, companions, personal emergency response systems, and adult companions to individuals who have disabilities but are not eligible for the PCA program, primarily because they do not have the functional limitations that someone receiving PCA services must have. Services are capped at \$650 per month.

Statutory Cite: CGS § 17b-605b

Current active caseload	1,387 (varies month to month)
Ave. cost per case	\$408 per month
Approximate annualized cost	\$6.5 million

Statutory Cite: CGS § 17b-283

2005 LEGISLATION ADDRESSING HOME HEALTH CARE FOR PEOPLE UNDER AGE 65

Human Services Committee

The Human Services Committee has considered several bills this session to address a perceived lack of community-based supports, including home health care, for individuals with disabilities under age 65. The committee favorably reported four of these to the Appropriations Committee: SB 1270, HB 6117, HB 6118, and HB 6880. HB 6786 (File 105) is on the House calendar.

SB 1270 directs the DSS commissioner to apply for a HCBS waiver to run a pilot program for home- and community-based services to people who (1) have tested positive for HIV or AIDS and (2) would be otherwise qualify for Medicaid-funded services in an institutional setting.

HB 6117 appropriates \$2 million to DSS to fully-fund the model waiver program.

HB 6118 directs the DSS commissioner, in consultation with the commissioner of mental retardation, to apply for a federal Medicaid waiver to secure increased funds to home- and community-based supports for children and adults with developmentally disabilities who do not have a diagnosis of mental retardation, but who require specialized services in their homes and communities.

HB 6786 requires the policy and plan created by the Long Term Care Planning Committee to provide that individuals with long-term care needs have the option to choose the least restrictive, appropriate setting.

And HB 6880 requires the DSS commissioner to establish a state-funded pilot program to allow up to 50 people with disabilities between the ages of 18 and 64 who are inappropriately institutionalized, or at risk of such, to receive the same services that are provided under the state-funded portion of the Connecticut Home Care Program for Elders (CHCPE) provided they meet the financial eligibility requirements for that program. It also requires the commissioner to amend the existing CHCPE waiver to allow 50 adults under age 65 to participate, provided they meet all of the other program requirements.

RC:ro



OLR RESEARCH REPORT

February 9, 2005

2005-R-0143

MEDICAID—OPTIONAL SERVICES

By: Robin K. Cohen, Principal Analyst

You asked for a history of the state's elimination of certain optional Medicaid services, starting with 1991. You also asked how long the Department of Social Services (DSS) paid for these services before they were altogether eliminated by PA 02-7, May 9 Special Session.

SUMMARY

Medicaid optional services, which are those that federal law gives states the option of providing to Medicaid recipients, have been cut twice and restored once since 1991. Both times the cuts were part of larger cuts in the state budget. The 1991 cuts were more limited in scope and duration: they affected only three types of practitioners and were restored the following year. More recently, the legislature directed DSS to find savings in the Medicaid budget, which DSS implemented through policy changes on January 1, 2003. These include eliminating payments to podiatrists and chiropractors, among other independent practitioners.

Connecticut has provided optional services to Medicaid recipients for at least 18 years, but possibly longer. DSS found policy dating back to 1986 indicating its predecessor agencies paid for these services.

HISTORY OF MEDICAID OPTIONAL SERVICE CUTS

PA 91-8, June Special Session (JSS) and PA 92-231

PA 91-8, JSS, contained numerous cost cutting measures, including a major restructuring of nursing home rates, and reductions, freezes, and limits in Medicaid reimbursements for a variety of services. It directed the DSS commissioner to eliminate Medicaid payments to chiropractors, podiatrists, and natureopaths as of October 1, 1991. (DSS would continue to pay physicians who provided these services. For example, it would pay an orthopedist who performed podiatry care on a Medicaid recipient.)

A year later, the legislature restored these payments, effective July 1, 1992 (PA 92-231). According to the fiscal note for the bill, DSS suspended payments for these services in February 1992. It also said the state could avoid future costs by restoring the services. (See attached OLR report [2002-R-0740](#) for a detailed explanation of the 1991 and 1992 actions).

PA 02-7, May 9 Special Session

As part of a bill implementing numerous cuts in DSS' FY 03 budget, PA 02-7, May 9 SS, directed DSS, by September 30, 2002, to submit an amendment to the state Medicaid plan to implement provisions concerning optional services to reflect a reduction in its budget. The law was written broadly and did not specify how the reduction was to occur.

In December 2002, DSS issued policy that enumerated specific services that would be eliminated. These cuts applied to both Medicaid and the State-Administered General Assistance programs (SAGA). Effective January 1, 2003, Medicaid would no longer pay for services to clients ages 21 and older from the following independently enrolled providers:

1. podiatrists,
2. chiropractors,
3. naturopaths,
4. independent therapists (i.e., physical therapists, licensed audiologists, and speech pathologists), and

5. psychologists.

(DSS also cut vision care services for SAGA recipients.)

We have attached a copy of an earlier OLR report (2003-R-0039) that addresses the 2002 cuts.

RC:ts



OFA ♦ OLR RESEARCH REPORT

February 9, 2005

2005-R-0129

HUSKY A — FOLLOW UP QUESTIONS TO OLR REPORT 2005-R-0017

By: Robin K. Cohen, Principal Analyst
Neil Ayers, Principal Analyst

You asked a number of follow-up questions based on an earlier OLR Report, 2005-R-0017. Specifically, you wanted to know (1) the names of the top employers of all parents of children receiving HUSKY A benefits (not just employers of parents who themselves receive HUSKY A coverage), (2) the same names for the adults who are not receiving HUSKY A, (3) the number of HUSKY A child recipients whose parents are ineligible for HUSKY A coverage, (4) the state and federal cost per person for HUSKY A and B coverage, and (5) employer information for Temporary Family Assistance (TFA) and Food Stamps recipients.

DSS recently provided us with hours worked data for the top 25 employers of working HUSKY A recipients. We have included this table at the end of this report for your review (Attachment 3).

We are still awaiting the number of HUSKY A child recipients whose parents are ineligible for coverage, which we will forward to you when we receive it.

SUMMARY

Wal-Mart, Stop and Shop, and Dunkin Donuts are the top three employers of adults who are the parents or caretaker relatives of children who receive HUSKY A benefits. Combined, these companies employ 2,607 adults. Most (80%) of these adults are also receiving HUSKY A coverage.

The top five employers of adults whose children or wards are receiving HUSKY A benefits but who are not themselves recipients (non-recipients) include Wal-Mart (204), Stop and Shop (175), McDonald's (146), Dunkin

Donuts (133), and Laidlaw (115). (Wal-Mart and Stop and Shop, respectively, are the top two employers of adults receiving HUSKY A, as reported in 2005-R-0017.) The top 25 employers in this category employ 1,692 adults, 63% of whom work more than 30 hours per week, with only 13% working less than 20 hours a week. (See Attachment 1 for a complete listing of the top 25 employers of non-recipient employees and hours worked information.)

DSS pays the managed care organizations (MCO) serving the HUSKY A and B populations "capitated" rates, which is essentially a per person monthly rate that is expected to cover the MCOs' monthly costs for managing the health care of that person. The rate is the same for children and adults enrolled in HUSKY A.

For HUSKY A, the monthly payment is \$189.80 for FY 05. This will rise to \$195.49 in FY 06. For HUSKY B, there are two capitated rates. For Band 1 (family income is up to 185% of the federal poverty level (FPL)), the rate is \$156.87 in FY 05; this rate rises to \$161.57 in FY 06. DSS pays the MCOs \$132.88 monthly in FY 05 for families in Band 2 (family income between 185% and 300% of the FPL). This rises to \$136.86 in FY 06. The lower payments for Part B recipients reflect the fact that families have cost sharing requirements (premiums and co-payments) that Part A families do not have.

The federal government reimburses the state 50% of what it spends for Part A; the federal block grant that funds HUSKY B pays 65% to the state's 35%.

DSS provided employer information for TFA and Food Stamp recipients for those employers employing at least 10 recipients (see Attachment 2a and Attachment 2b). For both programs, Stop and Shop was the top employer, followed by Wal-Mart. Of the 904 TFA recipients working for these employers, 66% worked at least 20 hours per week, with a little more than 25% working over 30 hours weekly.

TOP HUSKY EMPLOYERS FOR ALL ADULT CARETAKERS AND PARENTS

Table 1 lists the top 25 employers of parents and caretaker relatives of children receiving HUSKY A in December 2004. This includes both those adults who themselves receive HUSKY A and those who do not receive benefits but their children do. (In OLR Report 2005-R-0017 we focused only on those adults who were receiving HUSKY A.)

Table 1: Top 25 Employers for HUSKY A Recipient and Non-Recipient Adults

<i>Employer</i>	<i>Recipients</i>	<i>Non-Recipients</i>	<i>Total</i>
Wal-Mart	824	204	1028
Stop and Shop	741	175	916
Dunkin Donuts	530	133	663
McDonald's	460	146	606
Laidlaw	460	115	575
Mohegan Sun	276	79	355
Shaw's	288	52	340
Burger King	243	41	284
Home Depot	197	76	273
CVS	221	40	261
First Student	212	46	258
Foxwoods Casino	176	61	237
Fleet Bank	173	64	237
Filene's	177	49	226
ADECCO	181	44	225
Care for Kids	176	29	205
Hartford Hospital	141	49	190
Wendy's	145	35	180
Friendly's	178	[1]	178
Companions and Homemakers	177	[1]	177
Family Care VNA	159	[1]	159
Target	121	30	151
Subway	144	[1]	144
Walgreens	129	[1]	129
Sears	124	[1]	124

[1] The employer was not in the top 25 for this category of adults. Consequently, we do not know the number of these employers' non-recipient employees.

RC/NA:ro

**Attachment 1: Top 25 Employers of "HUSKY A" Non-Recipient
Parents/Caretakers (Includes TFA Medicaid)**

<i>Employer</i>	<i>Hours Worked Per Week</i>			<i>Total</i>
	<i>Less Than 20 Hrs.</i>	<i>20 Hrs. to 30 Hrs.</i>	<i>Greater Than 30 Hrs.</i>	
Wal*Mart	19	26	159	204
Stop & Shop	34	63	78	175
McDonald's	20	45	81	146
Dunkin Donuts	15	30	88	133
Laid Law	20	44	51	115
Mohegan Sun	5	3	71	79
Home Depot	11	17	48	76
Day Labor	6	13	56	75
Fleet	9	7	48	64
Foxwoods	1	8	52	61
Shaw's	8	20	24	52
Filene's	7	8	34	49
Hartford Hospital	9	9	31	49
First Student	9	17	20	46
ADDECCO	1	9	34	44
Burger King	6	16	19	41
CVS	4	8	28	40
Yale New Haven Hospital	3	5	32	40
Wendy's	7	6	22	35
KOHL'S	5	13	13	31
Target	3	7	20	30
Care For Kids (child care)	10	6	13	29
People's Bank	2	8	17	27
New England Home Care	8	5	13	26
BIG Y	5	5	15	25
TOTALS	227	398	1067	1692

This table represents Husky A employment data from DSS' Eligibility Management System (EMS) for the month of December 2004. EMS captures the employer name in a general text field which makes it difficult to unduplicate the total number of employers. If unduplicated completely, the employee counts would be slightly higher.

Please note that 'hours of employment' data collected in EMS is not required for eligibility purposes and therefore is not subject to verification.

Attachment 2a: Employers of TFA Recipients

Employer	Hours Worked Per Week			Total
	Less Than 20 Hrs.	20 Hrs. to 30 Hrs.	Greater Than 30 Hrs.	
Stop & Shop	27	50	21	98
Wal*Mart	16	30	25	71
McDonalds	30	25	15	70
Dunkin Donuts	17	26	23	66
Care For Kids (child care)	13	14	16	43
Burger King	18	11	5	34
Filene's	11	13	6	30
Target	4	15	6	25
Companions & Homemakers	15	3	5	23
Wendy's	7	11	5	23
Friendly's	8	10	4	22
LAIDLAW	7	9	4	20
KOHL'S	10	6	2	18
Sears	10	5	3	18
CVS	8	6	3	17
Marshall's	7	8	2	17
Burlington Coat Factory	2	8	6	16
Shaw's Supermarkets	6	9	1	16
Home Goods	1	5	9	15
Mohegan Sun Casino	3	2	10	15
BIG Y	5	5	4	14
Old Navy	3	9	2	14
Family Dollar Store	3	8	2	13
Hartford Hospital	5	3	5	13
Interim Health Care	10	2	1	13
DATTCO	4	3	5	12
First Student, Inc.	3	5	4	12
JC Penneys	5	6	1	12
Price Rite	4	5	3	12
Subway	7	3	2	12
Toys R Us	3	6	3	12
Yale University	5	2	5	12
Family Care VNA	3	5	3	11
Foxwoods Casino	1	2	8	11
Maxim Health Care	7	4	0	11
ShopRite	4	4	3	11
Taco Bell	5	5	1	11
Walgreens	2	5	4	11
City of Waterbury	6	1	3	10
Hamilton Connections	3	1	6	10
Home Depot	3	3	4	10
Total	311	353	240	904

This table represents TFA employment data from DSS' Eligibility Management System (EMS) for the month of December 2004. EMS captures the employer name in a general text field which makes it difficult to unduplicate the total number of employers. If unduplicated completely, the employee counts would be somewhat higher.

Please note that 'hours of employment' data collected in EMS is not required for eligibility purposes and therefore is not subject to verification.

Attachment 2b: Employers of FS Recipients

Employer	Hours Worked Per Week			Total
	Less Than 20 Hrs.	20 Hrs. to 30 Hrs.	Greater Than 30 Hrs.	
Stop & Shop	100	174	39	313
Wal*Mart	34	80	187	301
Dunkin Donuts	48	97	97	242
Care For Kids (child care)	74	57	108	239
McDonald's	64	70	80	214
Shaw's	39	75	40	154
Burger King	49	47	43	139
Laid Law	38	51	31	120
Companions & Homemakers	58	17	29	104
Filene's	21	40	31	92
Target	15	39	31	85
First Student	20	30	29	79
CVS	21	28	28	77
Wendy's	23	40	11	74
Family Care VNA	26	23	24	73
Mohegan Sun Casino	1	6	61	68
Foxwoods Casino	5	5	56	66
Sears	24	15	23	62
Labor Ready	36	8	16	60
Interim Health Care	31	15	11	57
Price Chopper	20	23	14	57
BIG Y	20	25	11	56
New England Home Care	24	20	11	55
City of New Haven	29	11	14	54
Friendly's	17	17	20	54
Marshall's	15	21	15	51
Shop Rite	7	20	21	48
Subway	12	15	20	47
Home Goods	5	11	30	46
ADDECO	15	7	22	44
Hamilton Connections	9	2	32	43
Taco Bell	9	14	20	43
Admiral Staffing	10	7	25	42
DATTCO	9	17	16	42
CW Resources	15	7	19	41
KOHL'S	15	20	6	41
UPS	13	20	8	41
City of Hartford	22	11	7	40
Home Depot	9	11	20	40
Walgreen's	4	13	22	39
Fleet Bank	4	18	15	37
Pinnacle Staffing	2	4	31	37
Price Rite	8	18	11	37
Priority Care	21	12	4	37
TJ Maxx	3	15	18	36
Odd Jobs	12	13	10	35
Utopia Home Care	18	15	2	35
Goodwill	11	8	15	34
Burlington Coat Factory	7	8	16	31

Employer	Hours Worked Per Week			Total
	Less Than 20 Hrs.	20 Hrs. to 30 Hrs.	Greater Than 30 Hrs.	
Kentucky Fried Chicken	14	9	8	31
Family Dollar	5	18	7	30
Haven Health	18	3	9	30
JC Penney	9	9	12	30
KMART	6	15	8	29
Yale New Haven University	14	4	11	29
Hartford Hospital	7	14	7	28
Hospital of St. Raphael	6	11	11	28
ARAMARK	7	4	16	27
Salvation Army	12	9	6	27
City of Waterbury	16	2	8	26
Motel 6	5	13	8	26
New Haven Register	5	12	9	26
Staples	8	12	6	26
City of Bridgeport	15	5	5	25
Dollar Tree	16	6	3	25
Hall Neighborhood House	1	5	18	24
Prime Resources	2	0	22	24
YMCA	13	5	6	24
BJ's Wholesale Club	3	11	9	23
Kelly Services	10	5	8	23
MARC, Inc	8	5	10	23
Maxim Health Care	12	7	4	23
Xpect Discount	6	8	9	23
Almost Family	7	8	7	22
MARRAKECH	12	5	5	22
Yale New Haven Hospital	8	3	11	22
Applebee's	8	8	5	21
Ocean State Job Lot	4	4	12	20
AJ Wright	8	11	0	19
Allied Community Resources	8	7	4	19
Extra Hand, Inc	8	6	5	19
New Haven Bd of Education	10	5	4	19
Rite Aid	3	10	6	19
Tim Horton's	1	8	10	19
Family Home Services	4	4	10	18
Holiday Inn	3	8	7	18
IKEA	5	7	6	18
Capitol Cleaning	1	4	12	17
Hometown Buffet	3	7	7	17
Waldbaums	7	8	2	17
Consolidated Schools	8	3	5	16
Cumberland Farms	5	5	6	16
Jaci Carroll	1	0	15	16
Ruby Tuesday	3	9	4	16
Toys R Us	4	7	5	16
Bank of America	4	9	2	15
CRT	2	4	9	15
Macy's	7	6	2	15
Workforce One	0	1	14	15
Domino's Pizza	3	6	5	14

Employer	Hours Worked Per Week			Total
	Less Than 20 Hrs.	20 Hrs. to 30 Hrs.	Greater Than 30 Hrs.	
Fed Ex	2	7	5	14
Franklin Farms	2	1	11	14
Old Navy	6	5	3	14
Point Staffing	7	2	5	14
Seven Eleven	2	3	8	13
Arby's	5	5	2	12
Bob's Stores	6	3	3	12
Double A Transportation	4	6	2	12
Keeper Corp	1	0	11	12
New Opportunities	6	2	4	12
Au Bon Pain	3	3	5	11
AutoZone	3	6	2	11
Lord & Taylor	7	1	3	11
Payless Shoes	1	5	5	11
Quality Homemakers	5	3	3	11
Alliance Staffing	7	0	3	10
Bridgeport Hospital	1	5	4	10
Fashion Bug	4	3	3	10
Total	1419	1561	1898	4878

This table represents FS employment data from DSS' Eligibility Management System (EMS) for the month of December 2004. EMS captures the employer name in a general text field which makes it difficult to unduplicate the total number of employers. If unduplicated completely, the employee counts would be somewhat higher.

Please note that 'hours of employment' data collected in EMS is not required for eligibility purposes and therefore is not subject to verification.

**Attachment 3: Top 25 Employers of HUSKY A Recipients
(Includes TFA Medicaid)**

Employer	Hours Worked Per Week			Total
	Less Than 20 Hrs.	20 Hrs. to 30 Hrs.	Greater Than 30 Hrs.	
Wal*Mart	77	159	588	824
Stop & Shop	159	337	245	741
Dunkin Donuts	81	144	305	530
McDonalds	60	117	283	460
Laid Law	96	227	137	460
Shaw's Supermarkets	46	124	118	288
Mohegan Sun Casino	26	30	220	276
Burger King	43	69	131	243
CVS	40	59	122	221
First Student, Inc,	45	102	65	212
The Home Depot	28	57	112	197
ADECCO	12	26	143	181
Friendly's	29	58	91	178
Filene's	42	59	76	177
Companions & Homemakers	98	38	41	177
Care For Kids (child care)	58	41	77	176
Foxwoods Casino	13	20	143	176
Fleet Bank	23	48	102	173
Family Care VNA	35	59	65	159
Wendy's	20	43	82	145
Subway	23	34	87	144
Hartford Hospital	28	40	73	141
Walgreens	13	22	94	129
Sears	24	30	70	124
Target	16	55	50	121

This table represents Husky A employment data from DSS' Eligibility Management System (EMS) for the month of September 2004. EMS captures the employer name in a general text field that makes it difficult to unduplicate the total number of employers. If unduplicated completely, the employee counts would be somewhat higher. These 'top 25' employers represent 13% of the approximately 52, 000 working recipients in EMS.

Please note that 'hours of employment' data collected in EMS is not required for eligibility purposes and therefore is not subject to verification.



OLR RESEARCH REPORT

January 10, 2005

2005-R-0017

HUSKY A AND B—ENROLLMENT AND EMPLOYER DATA

By: Robin K. Cohen, Principal Analyst

You asked for (1) the number of HUSKY A and B enrollees, with the adults broken down by gender; (2) employer information for HUSKY parents and caretaker relatives for the last few years; and (3) employer information for Temporary Family Assistance (TFA) and Food Stamp recipients.

We are still awaiting employer information for TFA and Food Stamp recipients. We will report this to you under separate cover.

SUMMARY

As of December 1, 2004, 305,689 people were enrolled in HUSKY A. Of these, 91,112 were adults aged 19 and older. Seventy-nine percent (79%) of the adults were women. The HUSKY B program had 15,254 enrollees (children under age 19) as of this date.

The same employers account for the highest number of employed parents of HUSKY A and B children. For example, Wal Mart employed the highest number of HUSKY A parents (824 in September 2004) and the second highest number of HUSKY B parents (79 in December 2004). The Department of Social Services (DSS) reports that the "top 25" employers in HUSKY A employed 6,653 parents in September 2004, which represented 13% of the approximately 52,000 working recipients. And an ad hoc DSS report from December 2004 shows that a relatively small number of employers (33) employed 14 or more parents (776 total) of

HUSKY B children. Of these HUSKY B parents, most (475) worked more than 30 hours per week, while only 10% (77) worked fewer than 20 hours per week.

HUSKY EMPLOYMENT DATA

Table 1 lists the top 25 employers in HUSKY A and shows how many of them also employ parents of children enrolled in HUSKY B. Table 2 compares HUSKY B employer data in January 2004 and December 2004, along with hours worked per week by parents of these enrollees. The data shows that these employers employ a relatively small number of the total number of working HUSKY parents and caretaker relatives. It also shows that more than half of the adults working for these employers work at least 30 hours a week, with 90% working at least 20 hours. The data show that four employers' HUSKY B enrollments dropped to zero between January 2004 and December 2004. We asked DSS for an explanation and it had none. (We have also asked DSS for hours worked data for HUSKY A adults.)

Attachment 1 provides data for all employers with at least 10 HUSKY B enrollees. (Confidentiality concerns preclude DSS from releasing the names of employers who employ fewer than 10 enrollees.)

DSS was unable to provide employer data for previous years.

Table 1: Top Employers of HUSKY A and Their HUSKY B Enrollment

<i>Employer</i>	<i>HUSKY A Enrollees</i>	<i>HUSKY B Enrollees</i>
Wal-Mart	824	79
Stop n Shop	744	99
Dunkin Donuts	530	39
Laidlaw	460	66
McDonalds	460	16
Shaws	288	22
Mohegan Sun	276	10
Burger King	243	0
CVS	221	0
First Student Inc.	212	21
Home Depot	197	45
ADECO	181	25
Friendly's	178	16
Companions & Homemakers	177	0
Filene's	177	17
Care 4 Kids	176	0
Foxwoods	176	0
Fleet Bank	173	29
Family Care VNA	159	39
Wendy's	145	0
Subway	144	16
Hartford Hospital	141	22
Walgreens	129	0
Sears	124	0
Target	121	0
Total	6,653	560

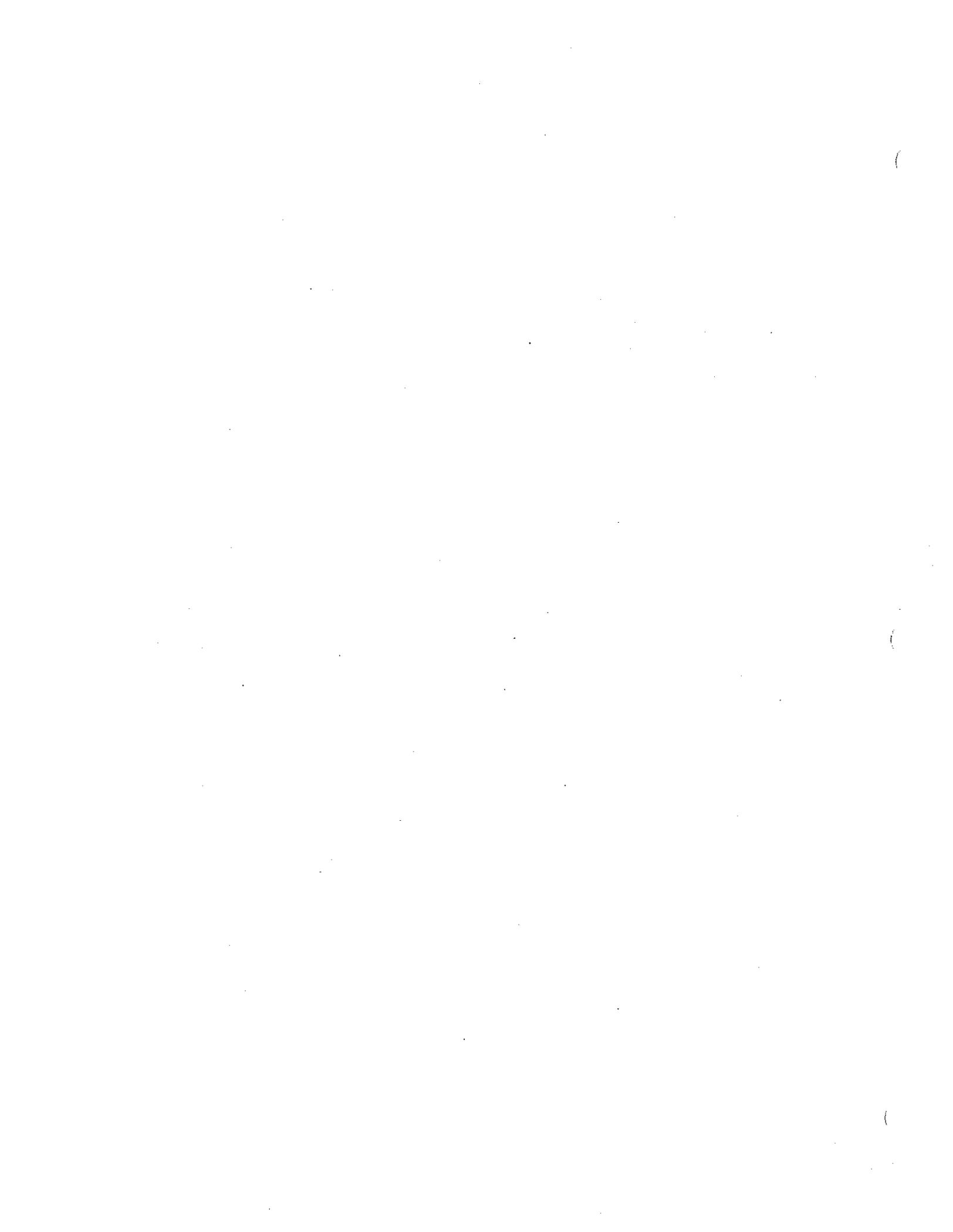
Source: DSS

Table 2: Top HUSKY B Employers and Hours Worked

Employer	Jan 2004 Enrollees	Dec 2004 Enrollees	Hours worked per week		
			<20	20-30	>30
Laidlaw	90	65	2	34	29
Stop & Shop	88	99	20	54	25
Wal-Mart	88	79	3	19	57
VNA	46	39	3	7	29
McDonalds	40	16	2	4	10
Dunkin Donuts	37	39	3	18	18
J. C. Penney	36	22	3	3	16
Home Depot	35	45	6	11	28
Foxwoods	34	0			
Hartford Hospital	27	22	0	3	19
First Student Transportation	23	21	1	13	7
Shaw's	22	22	2	8	12
Bank of America	21	29	1	5	23
Filene's	20	17	6	1	10
The Hartford	18	19	0	0	19
Peoples Bank	17	0 ¹			
Webster Bank	17	17	1	2	14
Adecco	16	25	2	0	23
K-Mart	16	12	0	3	9
New England Home Care	16	15	1	5	9
Pinkerton	16	0			
Mohegan Sun	16	10	2	1	7
CVS	16	0			
Yale Univ.	14	13	1	2	10
YMCA	0	18	2	6	10
Friendly's	0	16	3	3	10
Kohls	0	16	6	8	2
Subway	0	16	1	4	11
ACS	0	14	0	0	14
Dattco	0	14	0	2	12
Federal Express	0	14	3	0	11
Genesis Eldercare	0	14	1	5	8
Marrakech, Inc.	0	14	2	1	11
Middlesex Hospital	0	14	0	2	12
Totals	764	776	77	224	475

¹ Entries of "0" in the second and third columns mean the employer was not one of the "top 25," as reported in the "Jan. 2004" Enrollees column. It does not necessarily mean that the employer had no employees with children enrolled in HUSKY B.

RC:ro





JOINT OFA RESEARCH REPORT OLR

November 15, 2004

2004-R-0869

NONEMERGENCY MEDICAL TRANSPORTATION IN MEDICAID

By: Robin K. Cohen, Principal Analyst
Neil Ayers, Principal Budget Analyst

You asked how much someone with a disability has to pay for rides to medical appointments under the Medicaid program.

Medicaid recipients pay nothing for nonemergency transportation (i.e., trips to medical appointments). Section 11 of HB 5041, one of the governor's Department of Social Services (DSS) budget implementation bills, would have required a \$2 co-payment for each nonemergency medical transportation service provided to Medicaid recipients not enrolled in managed care or living in nursing homes. The legislature did not pass this provision as part of the 2004-05 budget. This means that Medicaid will continue to pay for all nonemergency transportation. The Office of Fiscal Analysis estimates that DSS will spend \$24.3 million in FY 2004-05 for this service.

RC/NA:ro





OLR RESEARCH REPORT

October 28, 2004

2004-R-0824

HOME AND COMMUNITY BASED CARE FOR ADULTS UNDER AGE 65

By: Robin K. Cohen, Principal Analyst

You asked which states have Medicaid waivers that permit them to offer home- and community-based services (HCBS), including self-directed personal care assistance (PCA) and attendant care, to adults under age 65.

SUMMARY

It appears that every state, except Nevada, and the District of Columbia offer home- and community-based care to adults under the age of 65 who have disabilities through federal HCBS waivers. Most of these states also offer PCA or attendant services, either as part of a range of home- and community-based services or as a separate HCBS waiver program.

This report includes those states that offer the range of services, including personal care assistance, to adults with disabilities (who are generally between the ages of 18 and 64) through federal HCBS waivers.

The report does not include waiver programs that target specific subgroups within the adults with disabilities population, such as adults with mental retardation, HIV/AIDS, or acquired brain injury. Many states, including Connecticut, have separate waiver programs for these populations. Let us know if you would like information on these programs.

It should also be noted that while many states have HCBS waivers, they serve a limited number of individuals. This is done in part to meet the federal government's rule that the waivers are cost-neutral, but also to allow states to control Medicaid costs.

For purposes of this report, PCA services are those that help individuals with activities of daily living during certain times of the day, while attendant services are those that an individual receives 24 hours a day, seven days a week. These terms are often used interchangeably.

MEDICAID WAIVERS

Home and Community Based Waivers—Section 1915(c) of the Social Security Act

In 1981, President Reagan signed into law Section 1915(c) of the federal Social Security Act, the Home and Community-Based Services Waiver program. Until that time, Medicaid's "institutional bias" meant that Medicaid would pay for long-term care only when it was provided in institutional settings. Since then, most states have used the waiver to create more appropriate, less costly alternatives for their elderly and disabled populations. For adults under 65, these programs generally combine medical and non-medical services in a community based setting. Sometimes, they include PCA or attendant care, where the individual hires someone directly to help with activities of daily living, such as bathing and dressing.

Table 1 shows the states that have HCBS waivers for these adults and which of these include PCA or attendant services, either as part of a larger service package or as a separate waiver program.

Table 1: State Medicaid HCBS Waivers for Adult Under-65 Populations

State	Home- and Community-Based Waiver	PCA and Attendant Care Included
Alabama	Yes	Yes
Alaska	Yes	No
Arkansas	Yes	Yes
California	Yes	Yes
Colorado	Yes	Yes
Connecticut	Yes	Yes [1]
Delaware	Yes	Yes

-Continued-

State	Home- and Community-Based Waiver	PCA and Attendant Care Included
District of Columbia	Yes	Yes
Florida	Yes	Yes
Georgia	Yes	Yes
Hawaii	Yes	Yes
Idaho	Yes	Yes
Illinois	Yes	Yes
Indiana	Yes	Yes
Iowa	Yes	Yes
Kansas	Yes	Yes
Kentucky	Yes	Yes
Louisiana	Yes	Yes
Maine	Yes	Yes
Maryland	Yes	Yes
Massachusetts	Yes	No
Michigan	Yes	Yes
Minnesota	Yes	Yes
Missouri	Yes	Yes
Mississippi	Yes	Yes
Montana	Yes	Yes
Nebraska	Yes	No
Nevada	No	NA
New Hampshire	Yes	Yes
New Jersey	Yes	Yes
New Mexico	Yes	Yes
New York	Yes	No
North Carolina	Yes	Yes
North Dakota	Yes	Yes
Ohio	Yes	Yes
Oklahoma	Yes	Yes
Oregon	Yes	Yes
Pennsylvania	Yes	Yes
Rhode Island	Yes	Yes
South Carolina	Yes	Yes
South Dakota	Yes	Yes
Tennessee	Yes	Yes
Texas	Yes	Yes
Utah	Yes	Yes
Vermont	Yes	Yes
Virginia	Yes	Yes
West Virginia	Yes	No
Washington	Yes	Yes
Wisconsin	Yes	Yes
Wyoming	Yes	Yes

Source: Centers for Medicare and Medicaid Services (2003, 2004 reports)

[1] Connecticut has a "stand-alone" HCBS waiver for PCA services for people with disabilities under age 65. Other HCBS services for this population are provided under state-funded programs.

RC:ts



OLR RESEARCH REPORT

December 4, 2003

2003-R-0846

HISTORY OF HUSKY

By: Robin K. Cohen, Principal Analyst

You asked for a summary of changes in the HUSKY program since its creation in 1997.

SUMMARY

The HUSKY program has provided managed health insurance coverage to children up to the age of 19 since 1998; certain adults have been receiving assistance since 2001. HUSKY Part A offers Medicaid coverage to children in families whose income does not exceed 185% of the federal poverty level (FPL) (currently \$34,040 for a family of four). There is no asset test. Until recently, the program had no cost sharing requirements. But under 2003 legislation, adults must now make co-payments and may have to pay premiums in the future. In September 2003, 203,558 children and 86,926 adults (over age 19) were enrolled in HUSKY A.

Children in families with incomes between 185% and 300% of the FPL (up to \$55,200) are eligible for Part B services, which are similar to the Medicaid benefits but, could change as a result of the same 2003 law. There is also no asset test for this program. The state uses a separate federal funding stream to pay 65% of the state's HUSKY B expenditures. All HUSKY B families must pay co-payments and higher income families also pay premiums. The 2003 law requires lower-income families to also pay premiums and increases the caps on co-payments. The law requires

the Department of Social Services (DSS) to change the service package and cost sharing requirements for HUSKY B so they more closely resemble a commercial HMO. In September 2003, 15,061 children were enrolled in HUSKY B.

Children with special health care needs (physical or behavioral) can supplement their medical coverage by participating in the HUSKY Plus program.

Unsubsidized coverage is also available to children in higher income families. These families pay the full premium cost of between \$151 and \$221 per month per child, plus the required co-payments.

An enrollment broker determines a family's eligibility for HUSKY and helps them enroll in one of the managed care organizations currently contracting with DSS to provide services.

Five legislative acts have caused significant changes in the program since its inception. First, in 1999 the legislature allowed parents and caretaker relatives of children enrolled in HUSKY A to participate in Part A. (The income limits for that coverage group were subsequently reduced (2000 and 2003). A pending court case will determine whether the most recent reduction can be fully implemented.) The next two most significant changes came in 2003 when the legislature (1) imposed new and higher premiums, (2) imposed higher co-payments on program beneficiaries, (3) potentially reduced benefit packages for program enrollees, and (4) potentially allowed pharmacies to refuse to fill prescriptions when program enrollees fail to pay their co-payments. A separate 2003 act paves the way for DSS to provide dental services to HUSKY A enrollees outside of the managed care model.

HUSKY—HISTORY

Enabling Federal Law and State Response

The federal Balanced Budget Act of 1997 created a new title XXI in the Social Security Act and designated it the State Children's Health Insurance Program or SCHIP. That legislation allowed states to initiate and expand health insurance coverage for uninsured children and to pay for it with \$.65 in SCHIP funds for every state dollar spent. Under this authority, the Connecticut legislature established the HUSKY program in a specially-called session in October 1997.

For several years before the passage of HUSKY, Connecticut had been incrementally increasing its child Medicaid program coverage. Thus, when HUSKY was established, children in families up to 185% of FPL (designated HUSKY A) were already covered. The state decided to use the SCHIP funds to cover two additional groups of children: (1) children in families with incomes between 185% and 300% of FPL (to be designated HUSKY B) and (2) 17- and 18-year-olds who were not HUSKY A-eligible (only kids aged 16 and under were Medicaid-eligible at the time the HUSKY law was passed).

PA 97-1, October 29 Special Session, also established annual co-payment and premium requirements for HUSKY B families. (There were no coinsurance requirements in HUSKY A.) For families with incomes between 185% and 235% of the FPL, the maximum annual co-payment was set at \$650 and there were no premiums. Families with incomes between 235% and 300% of FPL could not be required to pay out more than \$1,250 in combined premiums and co-payments. No co-payments or premiums were set for higher-income families. Rather, they would buy into the health plan at a negotiated group rate.

Adult Coverage

Until 2003, the most significant change in the program was the creation of a new Medicaid coverage group to help parents or other caretaker relatives of HUSKY A children. A prevailing view was that more children would enroll in HUSKY if their parents could also get coverage.

In 1999, the legislature took advantage of a provision in federal Medicaid law referred to as "Section 1931," to cover adults up to the same income limit applicable to children (185% of the FPL). This legislation (PA 99-279) became effective on July 1, 2000. But in 2000, the legislature reduced the income limit to 150% of the FPL and delayed the coverage until January 1, 2001 (PA 00-2, June Special Session).

In 2003, the income limit was reduced to 100% of the FPL (Section 10 of PA 03-2), effectively eliminating coverage for all adult caretakers except those receiving Temporary Family Assistance (cash welfare) and certain other very low-income families. Connecticut Legal Services sued the state to retain coverage. Most recently, the 2nd Circuit Court of Appeals issued a temporary injunction, staying the benefits for the adults with the higher incomes provided they had earnings. (We have attached a portion of a 2003 OLR public act summary that provides a more detailed chronology of the suit.)

Expanding Outreach and Easing Enrollment Process

Aside from the adult coverage provisions, the only other significant legislative change up until 2003 was enacted in 2001. PA 01-137 did a number of things to extend medical coverage to more families and ease the enrollment process. Some of its more important elements included:

1. reducing, from six to two months, the time that a child must have been without employer-sponsored health coverage to qualify for HUSKY B;
2. allowing more entities to grant children provisional or "presumptive" eligibility for HUSKY benefits;
3. making it easier for families to renew their HUSKY enrollments; and
4. allowing DSS to seek a federal waiver to use SCHIP funds to promote enrollment.

Eligibility, Premiums, Co-Payments, and Covered Benefits

The legislature made a number of changes in the HUSKY program under three separate 2003 acts. As described above, PA 03-2 reduced the income limits for adult coverage from 150% to 100% of the FPL. In addition, Section 7 of the act eliminated continuous eligibility for children.

PA 03-3, June 30 Special Session, made several significant changes in the areas of cost sharing and benefits. Among other things, these include raising the premiums for higher income HUSKY B families, instituting them for lower -income HUSKY B families and HUSKY A adults, increasing the overall cost sharing caps, imposing premiums on HUSKY A adults, and changing the benefit package for program enrollees.

Elimination of Continuous Eligibility. Section 7 of PA 03-2 eliminated continuous eligibility for children in HUSKY A. Being continuously eligible for HUSKY meant that children, once determined eligible for HUSKY A, remained eligible for 12 months, regardless of whether their parent's or caretaker's financial or other circumstances changed in a way that would make them ineligible for benefits. (Children losing their eligibility for HUSKY A would likely qualify for HUSKY B.)

Cost Sharing in HUSKY B. Section 55 of PA 03-3, June 30 Special Session, requires, rather than allows the DSS commissioner to impose cost sharing on HUSKY B participants, to the extent permissible by federal law. It allows the commissioner to increase the caps on cost sharing payments.

As mentioned above, under prior law, families with incomes between 185% and 235% of the FPL had a \$650 cap on cost sharing payments. Since they did not pay a premium, this was in effect a co-payment cap. Under the 2003 act, the commissioner can impose premiums on these families, and can increase their overall cost sharing cap to up to 5% of their total income. DSS has indicated that it will increase the co-payment cap to \$760 annually, effective February 2004. And it has proposed a \$30 monthly per child premium (\$50 maximum per family) for this group.

For families with incomes at the 235% to 300% of FPL range, the proposed annual co-payment cap is also rising from \$650 to \$760. And DSS has proposed raising the monthly premiums for these families from the current \$30 (\$50) to \$50 and \$75, respectively.

Cost Sharing in HUSKY Part A. Section 72 of PA 03-3, June 30 SS, sets a maximum \$3 co-payment for HUSKY A medical services and a \$1.50 cap on prescription drugs for FYs 2003-04 and 2004-05. (The co-payment had been \$1, per PA 03-2.) DSS has implemented a \$1.50 prescription co-payment and \$2 co-payment for medical services. In addition to the co-payments, the act requires the DSS commissioner to direct the managed care organizations (MCOs) to assess monthly premiums as follows:

<i>Family Income</i>	<i>Monthly Premiums— Per Person</i>	<i>Monthly Family Cap</i>
50% to 100% of FPL	\$10	\$25
100% to 185% of FPL	\$20	\$50

Previously, HUSKY A required no cost sharing.

Individuals participating in HUSKY A, but not enrolled in managed care, must be assessed similar co-payments and premium requirements. The act permits the DSS commissioner to deny coverage or discontinue HUSKY A eligibility when a recipient falls two months behind in making premium payments. But the termination cannot occur until 30 days after the clients is notified. (Federal Medicaid law gives individuals the right to appeal benefit terminations.)

PA 03-3, JSS requires the DSS commissioner to amend the state's Medicaid plan and to seek any necessary waivers to carry out these provisions. It requires her to implement the changes while in the process of adopting necessary policies and procedures in regulation form.

Federal regulations (42 CFR § 447.52, et. seq.) limit what cost sharing can be imposed on Medicaid recipients, both in terms of the actual amount that can be charged, as well as who can be required to pay (e.g., pregnant women and children under the age of 21 cannot be required to pay cost sharing). But states can get federal waivers to allow them to impose cost-sharing on otherwise exempted groups of program enrollees.

Nonpayment of Co-Payments. Section 69 of PA 03-3, June 30 SS, requires the DSS commissioner to submit to the federal Medicaid agency a Medicaid state plan amendment to allow pharmacies to refuse to fill Medicaid prescriptions, except those for psychotropic therapies, for program beneficiaries who demonstrate a documented and continuous failure to pay co-payments in spite of their ability to make them. (Federal regulations (42 CFR § 447.53) prohibit Medicaid providers from denying services to individuals who are Medicaid-eligible based on their inability to pay the program's cost sharing requirements.) Continuous failure is defined as failure to make required co-payments (1) within six months after a prescription is filled or (2) on six or more prescriptions when these prescriptions are filled during any six-month period. The amendment must allow for a resumption of drug benefits once the beneficiary pays all of his outstanding co-payments.

DSS has not yet received federal approval to implement this change.

Service Package for Program Beneficiaries. Section 56 of PA 03-3, June 30 Special Session, requires the HUSKY B services and cost-sharing requirements to be substantially similar to the services and cost sharing requirements of the largest available MCO offered to state residents, as measured by the number of covered lives reported to the Insurance Department in the most recent audited annual report.

For HUSKY A participants, the act requires that the managed care plan be substantially similar to the state employee "Non-Gatekeeper" POE Plan. It must also comply with all federal Medicaid rules.

Presently, HUSKY A beneficiaries receive their health care from one of four (three for HUSKY B) MCOs contracting with DSS. The state pays the MCOs a monthly capitation rate, which is expected to cover all of the services participants need in a given month.

Elimination of Presumptive Eligibility in HUSKY A. Sections 56 and 57 of PA 03-3, June 30 SS, eliminate presumptive eligibility in the HUSKY A program. Under presumptive eligibility, certain qualified entities could determine that HUSKY A children were eligible for benefits before the family's financial information was verified. (Under federal law, states can take up to 45 days to determine someone's eligibility for Medicaid.)

Dental Carve Out. Although dental services are currently part of the service package that HUSKY A and B beneficiaries receive (MCOs subcontract with dental plans), this will likely change as a result of new legislation. PA 03-155 requires the DSS commissioner to amend the state's Medicaid managed care waiver (governs HUSKY A) by July 1, 2004 to implement a statewide plan for dental services provided in the HUSKY program. This "carve out" of dental services is expected to include HUSKY A, HUSKY B, and the Medicaid fee-for service populations.

RC:eh



OLR RESEARCH REPORT

March 20, 2003

2003-R-0283

MEDICAID REIMBURSEMENTS TO PHYSICIANS

By: Robin K. Cohen, Principal Analyst

You asked (1) which state agency sets the rates that are paid to physicians treating Medicaid recipients and (2) for a brief explanation of the rate setting process.

The Department of Social Services (DSS), the state's Medicaid agency, sets the rates paid to physicians treating Medicaid recipients. The department produces a number of fee schedules for the various providers in the Medicaid program, including physicians. The physician schedule alone is 346 pages long and includes all of the services that physicians provide for which DSS has established a billing code. Each separate code has a fee attached to it.

According to DSS' David Parella, physicians' fees have not been adjusted since 1989. (In the interim, the legislature has made several attempts to increase these fees but these have failed due to a lack of funds in the department's budget.) When the department last adjusted the fees, they were "priced" at 55% of the 50th percentile of charges. Although DSS has not attempted to calculate where its physician fees stand now relative to current charges for services, Parella asserted that they probably fall somewhere between the 10th to 20th percentile of charges, depending on the service.

Despite this stagnation of fees, says Parella, the department does do some "repricing" every year to reflect adding codes for new medical procedures. These new codes are priced at 65% of the Medicare allowable

cost for the same service. Parella added that if these new prices "raise issues with the relative values assigned to existing codes," DSS relies on the Medicare Relative Value System to equalize pricing. We believe that this means, for example, that if a new procedure for diagnosing a particular disease is added to the list of covered procedures and there are existing procedures that perform the same function, DSS will look at the existing procedure's fee and potentially adjust it upward to make it more equitable with the new procedure's fee.

We asked if physicians had ever had any input into the fee setting process. Parella responded that they have not been involved since there has been no "comprehensive update" of the fees.

We have attached copies of several pages from the fee schedule for your additional information. The complete schedule can be found at http://www.ctmedicalprogram.com/prmanuals/fee_physician_20020501.pdf

RC:ro



Issues

- ✓ Low reimbursements to providers
- ✓ Managed care network adequacy
- ✓ Nursing home closures
- ✓ Caseload increases in economic downturn
- ✓ Citizenship verification
- ✓ Institutional bias for long-term care



OLR RESEARCH REPORT

December 23, 2008

2008-R-0664

VIABILITY OF STATE JOINING MULTI-STATE COMPACT FOR MEDICAID-COVERED PRESCRIPTION DRUGS

By: Robin K. Cohen, Principal Analyst

For more than a decade, states have been trying to save money in their Medicaid pharmacy budgets, including by instituting preferred drugs lists (PDL) that enable them to get additional manufacturer rebates on top of those that federal law requires them to receive. More recently, the Medicare Part D drug benefit has reduced state Medicaid rebates considerably, leading states to consider pooling their Medicaid lives to leverage even more rebates. (The rebate reduction results because many Medicaid recipients also qualify for Medicare and with the latter program now providing drug coverage, the former no longer does, hence the rebate amount has been reduced.)

Currently, 25 states participate in one of three multi-state pools, and Nebraska just released a request for proposals (RFP) for a vendor pharmacy benefit manager (PBM) to enable it to join one of the pools, beginning in February 2009. All three pools use PBMs to negotiate supplemental rebates for the states (hence the savings in Medicaid), but one gives more control to its member states.

It is difficult to say whether Connecticut would benefit from joining one of the pools. States choosing not to join pools cite different reasons. In a 2006 survey, they most often gave the reason that it believed it would be better off financially by not joining. Connecticut's Medicaid director says he believes there would be resistance to allowing other states to have a say over which drugs the state would want on a PDL.

MEDICAID PRESCRIPTION DRUG POOLS

Since early 2000, states have been looking at ways to save money in their Medicaid pharmacy budgets by joining one of three pools that negotiate supplemental rebates from drug manufacturers in exchange for putting their drugs on Medicaid PDLs.

National Medicaid Pooling Initiative (NMPI) (also known as Michigan Multi-State Pooling Agreement, MMSPA)

According to the National Conference of State Legislatures (NCSL), the NMPI/MMSPA was the first multi-state pool set up exclusively for Medicaid drug purchases. Michigan, Vermont, and South Carolina created the pool and received federal approval to begin in late 2003. The PBM First Health Services Corporation administers the program.

As of December 2008, 13 states are participating in the NMPI/MMSPA: Alaska, Georgia, Hawaii, Kentucky, Michigan, Minnesota, Montana, Nevada, New Hampshire, New York, Rhode Island, South Carolina, and Tennessee. (Vermont left this pool and joined the Sovereign States Drug Consortium in 2006, see below). When announcing that it had approved the Medicaid state plan amendments needed to make the states eligible for their federal matching funds, the federal Medicaid agency (CMS) published estimated savings that some of the states expected to achieve. These are shown in Table 1.

Table 1: National Medicaid Pooling Initiative (NMPI) States and Savings

State	Estimated Savings
Alaska	\$1 million; with PDL features state estimated \$20 million annual savings
Georgia	
Hawaii	\$3 million (between April 2004 and March 2005)
Kentucky	
Michigan	\$8 million in FY 2004
Minnesota	
Montana	
Nevada	\$1.9 million in 2004, \$4.3 million in 2005
New Hampshire	\$250,000 in 2004
New York	\$194 million in FY 06 and \$392 million in FY 07
Rhode Island	
South Carolina	
Tennessee	
Vermont [1]	\$1 million in FY 2004

[1] Vermont left the pool in 2006.

Source: NCSL (2008), National Association for State Medicaid Directors (2007)

The negotiated rebates are dependent on the number of lives in each state that selects a drug for inclusion on the PDL. The supplemental rebate agreements with manufacturers are fixed for two years, and the rebate amounts are based on reported Wholesale Acquisition Cost (WAC) for each individual drug. Supplemental rebates are not required for a drug to be on the PDL. Each state maintains its own Pharmaceutical and Therapeutics Committee (P&T) (these committees, which comprise medical professionals and other statutorily enumerated members, decide which drugs should go on the PDL) with an annual implementation schedule for changes to the PDL occurring in March.

Michigan Experience. A 2008 analysis prepared the Michigan Senate's nonpartisan fiscal agency reports significant savings in the state's Medicaid pharmacy program. But it points to both the state's own PDL (which it began in 2002) and the pool as generating these savings. During FY 07, the state collected over \$18 million in supplemental rebates. The analysis also notes the PDL's effect on the state's use of generic drugs, citing a 2004 federal report that the state had achieved a generic substitution rate of 90%.

Hawaii's Experience. In a report to the state legislature (in which the agency was advocating for removing pharmacy from its Medicaid managed care program), Hawaii's Department of Human Services stated that it had accurate data on the supplemental rebates and other savings the state had received by joining the pool in 2004. For the period between April 2004 and March 2005, it realized a net savings of \$3,000,199 from supplemental rebates for about 40,000 Medicaid fee-for-service recipients, with an additional \$2.6 million from its own PDL for 36 classes of drugs.

Top Dollar (Top \$)

Louisiana and Maryland joined forces to form the second pool, called Top \$, in mid-December 2004; CMS approved it in May 2005. Delaware, Idaho, Pennsylvania, and Wisconsin joined more recently. The pool is run by Provider Synergies, a for-profit PBM. NCSL reports that Louisiana and Maryland estimated \$27 million and \$19 million in savings in FY 2006, respectively.

According to an analysis done for the Texas legislature, TOP\$ member states represent approximately 2.1 million lives. Its PBM negotiates discounts based on the number of states that select a particular drug as a preferred product, rather than the number of recipient lives in each

state program. This means that not every state in the consortium must agree to every preferred drug product in order to get a benefit from participating.

Each participating state maintains a separate and individual P & T committee and each committee holds meetings in February and August. PDL changes are made in April and October. As in the NMPI pool, supplemental rebate amounts are based on the Wholesale Acquisition Cost (WAC) for each individual drug, and supplemental rebates are not required in order for a drug to be placed on the PDL.

Sovereign States Drug Consortium (SSDC)

The third pool is administered by its member states, which contract with a nonprofit PBM to negotiate the supplemental rebates. It is also unique in that it allows any state to participate, regardless of whether it administers its pharmacy benefit internally or through an outside contract. CMS approved the consortium in July 2006. Each participating state has its own, separate PDL. Members collectively review the bids from the pharmaceutical manufacturers, and independently decide “which approach is most appropriate for their individual program.” Estimated savings for this program are shown in Table 2.

Table 2: Estimated SSDC Savings

<i>State</i>	<i>Estimated Savings</i>
Iowa	\$1.8 million in FY 06
Maine	1 million between November 2005 and July 2006
Utah	1.5 million in FY 07
Vermont	\$5.3 million
West Virginia	NA
Wyoming	NA

Source: NCSL (2008)

SSDC-Vermont Perspective

The head of the SSDC, Ann Rugg, who is also the deputy director of the Office of Vermont Health Access, shared her experiences with the pools. Vermont was initially part of the NMPI but decided that it wanted to have more control over the formation of the pool and its activities. It joined the SSDC in 2006.

The consortium relies on a nonprofit PBM (MedMetrics) to negotiate the rebates. MedMetrics embraces a philosophy of open access to accurate information, including full disclosure of manufacturer drug discount contracts and terms, supporting documentation explaining discount revenue sources and calculation methodologies, and 100% pass-through of all discounts. The member states use their own resources to perform related activities, such as Medicaid management information systems, either in-house (as Utah does) or through a third party.

Rugg suggested that the other two pools provide states with less autonomy, asserting that the PBMs (First Health and Provider Synergies) make themselves available only to states willing to contract with them and use all of their services. In contrast, MetMetrics works for the SSDC and the states can change the vendor if they choose.

While the rebates depend on the number of states participating, Rugg indicated that the consortium does not pressure a member state to participate. And although there are fewer Medicaid recipients in the newer pool (which is composed of smaller states with fewer Medicaid recipients), Rugg asserts that it is getting the same level of rebates that were available in the larger pool. She added that the participating costs are considerably less: currently, MedMetrics charges \$150,000 annually, which is shared equally among the six member states. Previously, Vermont spent \$22,000 per month to participate in the NMPI. (States also pay an initial fee to "populate the data base.")

In terms of the negotiation process, the PBM provides the drug manufacturer with drug utilization data and information about the states' PDLs. Then it brings rebate offers for existing drug classes, based on the utilization figures. State staff (or its vendors) will review the offers as if they had negotiated them themselves. States can also confer with their P & T committees. Then the PBM does any fine tuning at the direction of the state Medicaid agencies.

Rugg emphasized that it is difficult to say with certainty whether a particular state would be better off by joining a pool, especially if it has a mature PDL that generates substantial supplemental rebates. She pointed to the potential that joining a pool could disrupt the administrative process as well as any existing contractual relationships.

FACTORS AFFECTING A STATE'S DECISION TO JOIN A POOL

NASMD Survey

According to the 2006 NASMD report, several factors affect a state's decision to join a bulk purchasing pool for its Medicaid programs. States not participating in the pools were asked why and their responses are listed in Table 3. Since that survey was done, six states whose responses are reflected in the table have joined pools.

Table 3: Reasons States Did Not Participate in Medicaid Drug Purchasing Pools

<i>Reason</i>	<i>Number Of States</i>
Administrative burden	2
Political pressures	2
State policy barrier	3
State better off financially not participating	14
State considering joining	4
No PDL	2
Data not available	5

Source: NASMD (2006)

Texas Analysis

The 2005 Texas legislature directed its Medicaid agency to perform a cost-benefit analysis and determine the feasibility of the state joining an existing pool. Provider Synergies estimated that the state would realize savings between \$3.8 and \$4.2 million by joining a pool. But this savings would be mitigated if the state (through its P & T committee) chose to have a different PDL from the pool states.

The Medicaid staff also pointed to differences between's Texas' and the other states' PDL processes that would need to be considered. For example, Texas law requires a supplemental rebate to be in effect in order for a product to be on its PDL. Other states do not have this requirement. And they pointed to the differing P & T schedules, suggesting that the lack of uniform schedules could make administering the multistate pool more difficult.

According to the agency, the state ultimately decided not to join the pool as it believed that it would not benefit. The state has achieved significant savings from its own PDL.

CONNECTICUT'S PDL AND POSITION TO JOIN A POOL

Recognizing that the state could realize additional savings in the Medicaid pharmacy budget, the legislature authorized DSS to adopt a PDL in 2002. As required by federal and state law, a P & T committee oversees the PDL. DSS is authorized to contract with a PBM to negotiate the supplemental rebates. DSS' pharmacy contractor, EDS, maintains a contract with Provider Synergies, the same PBM that administers the TOP\$ pool.

By law, the state's 14-member P & T committee meets at least once every three months and can adopt PDLs in the Medicaid, State-Administered General Assistance (SAGA) medical assistance, and Connecticut Pharmaceutical Assistance Contract to the Elderly and Disabled (ConnPACE) programs. To the extent possible, DSS must review all drugs on the PDL at least once a year and can recommend additions or deletions to it. Mental health-related and antiretroviral classes of drugs may not be included on the PDL (CGS § 17b-274d).

The state PDL has helped the state realize significant savings in its pharmacy programs, including Medicaid. A FY 2007 DSS report estimated annual savings of nearly \$30 million from the 36 classes of drugs on the PDL. (This amount was cut in half to reflect the transfer of clients into Medicare Part D, since the state no longer pays the drug costs for people dually eligible for Medicare and Medicaid.)

It is difficult to say whether Connecticut would benefit from joining a pool. DSS' Medicaid director, David Parrella, suggested that some might not find it "palatable" to have another state decide which drugs would be covered. He suggests that a better way to save money would be to place mental health drugs on the existing PDL.

Yet Vermont's experience with the SSDC suggests that states would retain their autonomy by maintaining their own PDLs. (For a fee, the SSDC will do a comparative analysis for any state considering joining the pool.) Moreover, Connecticut recently (February 2008) carved pharmacy benefits out of the HUSKY program, thereby adding 300,000 or more lives for whom DSS is now directly responsible for providing pharmacy benefits.

RC:df



OLR RESEARCH REPORT

November 20, 2008

2008-R-0615

HUSKY AND MEDICAID

By: Robin K. Cohen, Principal Analyst

You asked for brief summaries of the HUSKY and family Medicaid programs. You also wanted to know (1) whether medical providers have the option to accept patients with either insurance, (2) if program enrollees need referrals to see specialists, (3) what happens when no specialists are available, and (4) whether the managed care organizations (MCOs) operating the programs must send updated provider lists to enrollees.

SUMMARY

HUSKY A (Medicaid for children under 19 and families) and HUSKY B offer subsidized, managed health insurance to lower-income children and some adults. HUSKY A is available to families with incomes up to 185% of the federal poverty level (FPL, \$32,560 annually for a family of three in 2008). Enrollees pay nothing for care. HUSKY B (which serves children in families with incomes between 185% and 300% of the FPL) requires nominal co-payments, and premiums once income reaches 235% of the FPL. Unsubsidized HUSKY B coverage is available to children in families with incomes over 300% of the FPL.

During the last year, there has been significant turmoil in the HUSKY program. It began when the governor terminated the HUSKY contracts the Department of Social Services (DSS) maintained with four MCOs. The addition of the Charter Oak Health Plan has complicated things further as the governor required MCOs bidding on that plan also to serve HUSKY recipients. Most recently, the governor relaxed that requirement, but concerns about network adequacy have raised doubts about the future of managed care for HUSKY recipients.

The state (or the MCOs with which it contracts) cannot force medical providers to accept a certain number of HUSKY patients. Any attempts to do so could be counterproductive as the provider simply could decide to abandon the program altogether.

If a specialist is not available within an MCO's provider network, DSS expects it to find one outside the network. In some cases, these specialists are located out-of-state. According to DSS Medical Director, David Parrella, there is no longer any "gatekeeping" on referrals to specialists in either MCOs or fee-for-service (FFS) Medicaid. But most specialists will not schedule appointments without some clinical background from a primary care provider.

HUSKY B is funded in part by the federal State Children's Health Insurance Program (SCHIP). SCHIP regulations require the state to make available to HUSKY B applicants and enrollees the names and locations of current participating providers (42 CFR § 457.110). Federal Medicaid regulations require MCOs to supply provider names, locations, and phone numbers to prospective and current enrollees (42 CFR § 438.10). DSS' website (www.ctdssmap.com) contains this information for Medicaid FFS applicants and enrollees. And the HUSKY MCO contracts require each MCO to provide DSS with a monthly list of all network providers. DSS' Parrella reports that the HUSKY MCOs provide lists to their enrollees. And the program's enrollment broker maintains a composite list of all providers across the health plans.

HUSKY

HUSKY is the umbrella name for the state's insurance program for low-income families. HUSKY A provides Medicaid-covered benefits to children and adult caretaker relatives in families with incomes up to 185% of the FPL. HUSKY B provides subsidized health care to children in families with incomes between 185% and 300% of the FPL. Families with incomes above 300% of the FPL can buy into the HUSKY B program by paying the full monthly premium (\$195 per child per month). Families in HUSKY A have no cost sharing obligations; families with children enrolled in HUSKY B with incomes between 235% and 300% of the FPL pay premiums (\$30 per child per month, \$50 maximum per family), and all Part B families pay nominal co-payments. Cost sharing is capped for families in the subsidized part of HUSKY B.

HUSKY in Transition

Interim Program. HUSKY is currently in transition. Late last fall, Governor Rell terminated the contracts of the four MCOs administering the HUSKY program at that time, largely because two of them refused to comply with the state's Freedom of Information Act (FOIA). DSS instead decided to provide benefits through non-risk, administrative services organization (ASO) contracts, under which it paid a nominal per member, per month fee to companies to perform certain administrative functions.

Specifically, DSS took over certain functions that the full-risk MCOs had assumed: provider rate setting, prior authorization criteria, and provider enrollment criteria, while the ASOs were responsible for member services, provider enrollment, claims processing, case management, and outreach and education. HUSKY A recipients were asked to choose between Anthem, Community Health Network of Connecticut (CHNCT), or traditional FFS Medicaid (which was also the default for people who did not choose). HUSKY B recipients could move into Anthem or CHNCT; those failing to choose were placed in one or the other on a rotating basis. Non-subsidized HUSKY B recipients were disenrolled from the program until they selected one of the new plans and pre-paid the first month's premium.

Move Back to Managed Care. The transitional program was meant to be temporary, pending DSS' contracting with new full-risk plans willing to comply with the FOIA, and take on Charter Oak Health Plan members as well. DSS ultimately negotiated contracts with three health plans to do this: Aetna Better Health, AmeriChoice, and CHNCT. (CHNCT has been serving HUSKY recipients for many years and also serves State-Administered General Assistance (SAGA) medical assistance clients.) DSS began taking applications and enrolling people in Charter Oak on July 1, 2008. Since that time, HUSKY enrollees have been asked to voluntarily choose one of the three plans, which many have done.

But the move back to full-risk care has met obstacles, primarily the lack of an adequate provider network. (CHNCT is acknowledged to have a fairly robust provider network.) Advocates have repeatedly asked DSS to postpone the move, citing concerns about the lack of access that clients will face. Responding to these concerns, Governor Rell recently delayed until February 1 the December 1 deadline for HUSKY enrollees currently in FFS or Anthem to enroll in one of the new plans. (It is not clear what will happen to the nearly 170,000 clients currently enrolled in Anthem who do not choose a provider by December 31 when Anthem's ASO

contract expires. According to DSS' Parrella, these clients will have an additional month (until January 31, 2009), presumably as a result of a temporary contract extension).

Severing HUSKY/Charter Oak Link

Since the Charter Oak request for proposals (RFP) was issued last fall, many advocates and legislators have expressed concerns about the requirement that health plans serve both HUSKY and Charter Oak enrollees, with some suggesting that the combined program could dilute HUSKY's strengths. A 2008 bill (sHB 5618) would have severed the link, requiring separate contracts for each program, but it failed to pass. But last Friday (November 14, 2008), Governor Rell announced that she is going to allow the MCOs to enroll providers (e.g., doctors, hospitals) in HUSKY without requiring them to simultaneously enroll with Charter Oak. The plans will still administer both programs. The advocates and the Attorney General are pushing for a full de-linking of the two programs.

PROVIDER OPTION TO SERVE

Medical providers cannot be forced to accept patients and in fact, for financial and other reasons, most of them limit the number of public health insurance patients in their practices. In their provider agreements with the MCOs, providers are supposed to notify the plans if they are going to close their practices to HUSKY members. But according to DSS' Parrella, this rarely occurs.

Parrella adds that most pediatric and obstetric providers do at least some HUSKY work, simply because HUSKY is such a huge share of the market (over 340,000 enrolled as of November 1, 2008).

SPECIALISTS

When a HUSKY enrollee needs to see a specialist and none are available in the MCO's network, the MCO is expected to look outside their network and pay for the specialist care, if it is available. The contract between DSS and the MCOs requires DSS to measure this access by examining and reviewing confirmed complaints received by the MCOs, the enrollment broker, DSS, or the HUSKY hotline. But DSS can amend the specialist provisions in the contract, particularly as they relate to the network's adequacy of dermatologists, neurologists, orthopedists, and other specialists (these are specialties for which even commercially insured people have access problems).

ADDITIONAL INFORMATION

"Medicaid—Access to Providers," OLR report 2008-R-0601, October 30, 2008

RC:ts



OLR RESEARCH REPORT

October 30, 2008

2008-R-0601

MEDICAID—ACCESS TO PROVIDERS

By: Robin K. Cohen, Principal Analyst
Nicole Dube, Legislative Analyst II

You asked for a summary of the law that governs access to care under the Medicaid program, including the contracts that the Department of Social Services (DSS) maintains in the HUSKY program.

SUMMARY

Federal Medicaid law contains what has been dubbed an “equal access provision,” which requires state Medicaid payments to be both consistent with principles of economy and efficiency as well as ensure that program enrollees have the same access to care that is available to the general public.

Federal regulations address the issue in greater detail in the context of Medicaid managed care contracts. They prescribe how the entities (e.g., managed care organization, MCO) should develop their networks and show how these networks are adequate.

The state’s HUSKY law also includes language regarding access. It generally requires each managed care plan (includes MCOs and other health care providers) to include sufficient numbers of appropriately trained and certified pediatric providers and specifies the provider types.

The contracts DSS maintains with MCOs likewise contain provider network adequacy and maximum member enrollment language. This includes provider-to-member ratios and expectations for access to specialists. And they include provisions for sanctions when these requirements are not met.

ACCESS PROVISIONS FOR ALL MEDICAID SERVICE DELIVERY MODELS

The federal law that most directly addresses access, the so-called “equal access provision,” requires states to reimburse health care providers at a rate that is low enough to ensure efficiency and economy yet high enough to attract a sufficient number of providers to ensure enrollees have access to health care services to the same extent they are available to the general public in the same geographic area (42 U.S.C § 1396a(a)(30)(A)). A state’s Medicaid plan state must provide such assurances in writing.

Additionally, federal regulations require the state Medicaid agency to arrange for Medicaid services to be provided without delay to any Medicaid enrollee of (1) an MCO, prepaid inpatient health plan (PIHP, see below), prepaid ambulatory health plan (PAHP), or primary care case management (PCCM) whose contract is terminated and (2) who is disenrolled from any of these for reasons other than ineligibility for Medicaid (42 CFR § 438.62).

ACCESS UNDER MANAGED CARE

Federal Law—Managed Care Organizations (MCO) and Prepaid Inpatient Health Plans (PIHP)

Background. DSS’ current plan is to provide care to HUSKY and Charter Oak enrollees either through MCOs or a consortia of health care providers. Many HUSKY enrollees have voluntarily signed up for one of the three new plans with which DSS has contracts. But many enrollees are still covered through what DSS is calling a PIHP arrangement. (This was the result of the governor terminating the full-risk contracts DSS maintained with MCOs in November 2007.) Under federal regulations, a PIHP is an entity that (1) provides medical services to Medicaid enrollees under contract with the state agency on the basis of prepaid capitation payments; (2) provides, arranges for, or otherwise has responsibility for providing any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract (42 CFR § 438.2).

In Connecticut, DSS's PIHP is a limited-risk contract DSS maintains with Anthem to provide several functions (member services, case management, network development, and outreach and education). DSS pays Anthem a nominal per-member, per month fee, and Anthem's providers are reimbursed based on DSS' fee schedule for services (as opposed to the MCO model, in which the MCOs set the reimbursement rates).

Network Development. Federal regulations require states, through their contracts, to ensure that each MCO and PIHP has a contracted provider network that is sufficient to provide access to all services covered under the state's plan. When developing its network, the MCO or PIHP must consider the following:

1. anticipated Medicaid enrollment;
2. expected service utilization based on the Medicaid population's characteristics and health care needs;
3. the number and types of providers needed to provide contracted Medicaid services;
4. the number of network providers not accepting new Medicaid patients; and
5. the geographic location of providers and Medicaid enrollees, considering distance, travel time, transportation, and disability access (42 CFR § 438.206).

Network Requirements. MCOs and PIHPs must deliver ongoing primary care and coordinate health care services for their enrollees (42 CFR § 438.210). They are also required to provide women with direct access to an in-network women's health specialist to provide routine and preventive health care services. This is in addition to the women's designated source of primary care if that provider is not a women's health specialist (42 CFR § 438.206). Enrollees with special health care needs must have direct access to a specialist as appropriate for the individual's health care condition (42 CFR § 438.208). Enrollees must also be able to obtain a second opinion from an in-network provider or to have arrangements made to obtain one from an out-of-network provider at no cost (42 CFR § 438.206).

If the MCO or PIHP is unable to provide any contracted services to its enrollees, they must adequately cover those services out of network in a timely fashion, for as long as it is unable to provide them, at no additional cost to the enrollee. The entity is responsible for negotiating payment to out-of-network providers to which the enrollee is referred (42 CFR § 438.206).

States must also ensure their contracts with MCOs and PIHPs comply with certain timely access requirements and ensure their providers comply with these requirements. Providers must meet state standards for timely access to care and services, considering the urgency of the service need. Network providers must offer office hours at least equal to those offered to commercial enrollees or Medicaid fee-for-service participants, if the provider accepts only Medicaid patients. Contracted services must be made available 24 hours per day, seven days per week when medically necessary. Entities must establish mechanisms to ensure and monitor provider compliance and must take corrective action when noncompliance occurs (42 CFR § 438.206).

Finally, MCOs and PIHPs must demonstrate that their providers are credentialed. Contracts must also require these entities to participate in the state's efforts to promote culturally competent service delivery, although it doesn't specifically require the state or the entity to provide culturally competent care (42 CFR § 438.206).

Demonstrating Network Adequacy. Federal law requires each Medicaid MCO to provide the state and the U.S. Department of Health and Human Services secretary adequate assurances that it has sufficient capacity to serve the expected enrollment in its service area (42 U.S.C § 1396u-2(b)(5)). To meet this obligation, states must require MCOs and PIHPs to document in a state-specified format that meets its standards for access to care (42 CFR § 438.207).

Supporting documentation must show that the MCO or PIHP offers an adequate range of preventive, primary, and specialty services care for the anticipated number of enrollees in the service area. The network must contain providers who are sufficient in number, mix, and geographic distribution to meet the anticipated needs of enrollees. The regulations do not specify how to determine the anticipated number and needs of enrollees or who must make that determination (42 CFR § 438.207).

An entity must submit this documentation when it enters into a state contract. It must also submit this documentation any time that a significant change, as defined by the state, occurs in the entity's operations that would affect adequate capacity and services. Significant

changes include changes in services, benefits, geographic service area, or payments or the entity's enrollment of a new population (42 CFR § 438.207).

States are required to certify to the Centers for Medicare and Medicaid Services (CMS) that each MCO or PIHP has complied with state standards for service availability and must make all documentation available to CMS upon request (42 CFR § 438.207).

State Law

State law requires each HUSKY managed care plan to include a sufficient number of appropriately trained and certified pediatric care clinicians, including primary, medical subspecialty, and surgical specialty physicians. They must also include sufficient providers of necessary related services such as dental services, mental health services, social work services, developmental evaluation services, occupational and physical therapy services, speech therapy and language services, school-linked clinic services, and other public health services. (Dental and behavioral health services are no longer part of the contracts DSS maintains with managed care organizations. These services are provided under different contracts) (CGS § 17b-296).

Contract Requirements

DSS' contract with the MCOs includes network adequacy and maximum enrollment language. It requires DSS to evaluate the adequacy of an MCO's provider network on a quarterly basis using ratios of enrollees to specific types of providers. These ratios cannot be less than the access ratio based on the Medicaid fee-for-service delivery system for a similar population.

Table 1 illustrates the ratios for the three types of primary care providers.

Table 1: HUSKY MCO Provider: Member Ratios

Provider Group	Provider to Member Ratio
Adult PCP	1:387
Children's PCP	1:301
Women's PCP	1:835

The contract further provides that once the number of members in a given county equals or exceeds 90% of the established capacity, DSS must evaluate adequacy on a monthly basis.

The contract also permits DSS to establish a maximum enrollment level for members of the MCO on a county-specific basis. It must notify the MCO in writing at least 30 days before the maximum goes into effect. The MCO can subsequently increase the maximum by providing signature pages of newly enrolled providers, and DSS has 30 days to review the request.

Specialists. Additionally, DSS must measure access to specialists by examining and reviewing confirmed complaints received by the MCOs, the enrollment broker (an administrative services organization with which DSS contracts that helps HUSKY clients enroll in a particular MCO), DSS, or the HUSKY hotline. The contract enumerates the steps DSS must take when complaints come in, including referring them to the named MCO. DSS sends a "Complaint Report" to an MCO when it receives a certain number of "confirmed" access complaints from members during a quarter regarding a particular specialty. In determining whether to confirm a complaint, DSS must consider several factors, such as the member's PCP or other referring provider's medical opinion regarding how soon the member needs to see the specialist and the severity of the member's condition. DSS can amend the specialist provisions in the contract, particularly as they relate to the network's adequacy of dermatologists, neurologists, orthopedists, and other specialists.

Sanctions. In addition to sanctions for general noncompliance with the contract, DSS can impose sanctions when it determines that the MCO's provider network is incapable of accepting additional enrollment and lacks adequate access to providers. These include suspending new enrollments. If DSS determines that it has received sufficient confirmed complaints of specialist access problems to initiate a statewide default enrollment freeze, it must advise the MCO of this and its intention to impose the freeze in 30 days unless the MCO submits a satisfactory resolution of the issue in a corrective action plan. The MCO can ask to meet with DSS before it imposes the freeze. A freeze must remain in effect for at least three months. Before DSS can lift the freeze it must determine that the access problem has been resolved.

Geographic Coverage. The contract requires MCOs to serve members statewide. It also requires each MCO to ensure that its provider network includes access for each member to PCPs appropriate for his or her age or obstetric-gynecologic providers. The providers must be available within 15 miles.

The contract states that DSS will randomly monitor geographic access by reviewing the mileage to the nearest town containing a PCP for every town in which the MCO has members. If DSS finds that more than 2% of members reside in towns beyond the 15 miles, DSS can impose a strike towards a Class A sanction. (If a contractor receives three strikes for noncompliance with the contract that does not rise to a more serious level (Class A), DSS can impose a sanction of up to \$2,500 for the first three strikes (*DSS MCO Contract, § 6.05(a)1*).

If an MCO does not have a network provider capable of providing medically necessary contract services to a particular member, the contract requires it to adequately and timely cover the services through an out-of-network provider for as long as medically necessary and the MCO's network providers are unable to provide the services and at no additional cost to the member.

Each month, the MCOs must provide DSS with a list of all network providers (*DSS Contract MCO, § 3.09, et. seq.*).

ACCESS UNDER FEE-FOR-SERVICE (FFS) MEDICAID

Federal law does not require state Medicaid fee-for-service programs to enroll a certain number of Medicaid providers. As stated earlier, the equal access provision requires a state's Medicaid state plan to ensure that payments are sufficient to enlist enough providers. Federal regulations also require that the plan specify the amount, duration, and scope of each service that it provides for individuals eligible for Medicaid. And they require each service to be sufficient in amount, duration, and scope to reasonably achieve its purpose (42 CFR § 440.230).

The Medicaid provider agreements that DSS maintains with FFS providers likewise do not include minimum enrollment expectations.

Primary Care Case Management. Although care under the PCCM model is provided on a fee-for-service basis, because there is a contract between the state Medicaid agency and the primary care provider "manager," additional federal regulations governing network adequacy apply. Specifically, they require the contractor to restrict enrollment to recipients who live "sufficiently near" one of the manager's delivery sites

to reach the site within a reasonable amount of time. And they require the contractor to provide for arrangements with, or referrals to, sufficient numbers of physicians and other practitioners to ensure that services can be furnished promptly and without compromising the quality of care (42 CFR § 438.6(k)).

RC:dw/ts



OLR RESEARCH REPORT

May 17, 2007

2007-R-0387

PROOF OF CITIZENSHIP AND MEDICAID ELIGIBILITY

By: Robin K. Cohen, Principal Analyst

You asked if the new federal proof of citizenship requirement for Medicaid eligibility has had an impact on enrollment for children or their caretaker relatives.

SUMMARY

Since July 1, 2006, federal law has required the Department of Social Services (DSS) to obtain proof of citizenship before granting initial eligibility for Medicaid or redetermining eligibility for recipients. Citizenship was required previously, but clients could declare it without providing proof. While certain individuals are exempt from the new requirements, most children and their caretaker relatives applying for or receiving Medicaid (HUSKY A) are not.

Data from DSS show a significant rise in both the number of overdue applications and re-determinations for family Medicaid coverage (group that includes children in families with incomes up to 185% of the federal poverty level (FPL) and their caretaker relatives with incomes up to 150% of FPL) since July 2006. Indeed, DSS believes that the DSS eligibility reports make a "convincing case" that the delays are resulting from the citizenship requirements.

DSS has undertaken several initiatives to reduce the backlog and get applications and redeterminations processed sooner. These include working with the Department of Public Health (DPH) to match applications to birth records and designating community providers to reach out to clients to help them get the necessary documentation.

Federal Medicaid matching funds are available to offset any related administrative costs. The governor's FY 08 budget includes an additional six positions in DSS to help with the citizenship requirements.

FEDERAL LAW REQUIRING PROOF OF CITIZENSHIP

Section 6036 of the federal Deficit Reduction Act of 2005 (PL 109-171) requires certain people applying for or receiving Medicaid to document their U.S. citizenship and identity. Prior to the law's passage, proof was required but it could be offered simply through self-declaration, under penalty of perjury, with no documentation requirement. States not complying with this new requirement risk losing federal Medicaid matching funds (50% of program expenditures in Connecticut).

The law exempts a number of individuals, including those receiving Supplemental Security Income and Medicare. In general, families in which a child alone or a caretaker relative is applying for or already receiving Medicaid are subject to the new rules. (See Attachment 1 for a Voices for Children summary of those Medicaid-eligible individuals subject to the requirements and those who are exempt or may have additional time to get the documentation.)

Non-exempt individuals must document both their citizenship and identity. To prove citizenship, individuals must show one of several enumerated acceptable forms of proof, such as a U.S. passport or birth certificate. To prove identity, individuals may provide a state driver's license or one of several forms of identification the federal law allows states to accept.

The regulations allow states' Medicaid agencies (DSS in Connecticut) to electronically verify citizenship, such as searching birth record databases that are held by other state agencies (see below).

MEASURING THE IMPACT OF THE CHANGE

States were expected to start implementing the proof of citizenship and identity rules in July 2006. At that time, DSS reported that 2,920 family Medicaid (includes HUSKY A and certain others) applications were pending, as compared with 1,324 for aged, blind and disabled (ABD) Medicaid applicants and 1,430 applicants for long-term care Medicaid. In April 2007, the number of family cases pending rose to 4,753, a 63% increase. In contrast, the number of ABD cases stayed relatively constant (1,350) and pending long-term care applications rose more significantly (1,708, or 19%). These latter two groups of applicants are generally not subject to the new documentation requirements.

The new rules also apply when DSS annually re-determines whether a family still qualifies for Medicaid. This process begins in the 11th month of eligibility and is expected to be completed by the end of the 12th month. If a redetermination is not completed by that time, it is considered overdue. DSS data show that overdue redeterminations also rose between July 2006 and April 2007, from 3,962 to 17,227 (a 334% increase). The other Medicaid groups' (those generally exempt from citizenship documentation) redeterminations were also up but by a significantly smaller percentage.

Although the number of overdue family Medicaid redeterminations is considerably higher than the number of overdue applications, we should note that the federal regulations allow states to continue to cover families going through the redetermination process, provided they are making a good faith effort to produce the documentation. According to Kevin Loveland of DSS, DSS has not terminated any families for failure to produce citizenship documentation. Moreover, changes in Medicaid law (e.g., reduction of transitional Medicaid from two years to one) could be causing some of the redetermination backlog.

STEPS BEING TAKEN TO EXPEDITE ELIGIBILITY DETERMINATIONS

Loveland stated that DSS has undertaken a number of initiatives to help reduce the application and redetermination backlogs. It started a pilot program in the Waterbury and Bridgeport areas, partnering with the United Way to phone recipients with overdue redeterminations. The results from the pilot are due to DSS in mid-June.

The department is also conducting a data match with the Department of Public Health's (DPH) birth records registry for individuals born since January 1988. This match is currently being tested and should be running by the end of May or early June.

DPH also hired a consultant to put its birth records into a format that will make them accessible electronically. DPH intends to make the data available through the national Electronic Verification of Vital Events (EVVE) system. Once this is operating, DSS should be able to query and verify birth records. For several months, DSS has been doing this verification manually by sending DPH a form. It will continue to use this system for pre-1988 births until the EVVE system is available.

Additionally, DSS has designated certain community providers as "outstation locations," as allowed by the federal regulations, to receive and do initial processing (secure verifications) for certain Medicaid

applications. The providers include all of DSS Healthy Start sites, and DSS is also allowing the "qualified entities" authorized to grant presumptive Medicaid eligibility to do this.

Matching federal Medicaid funds are available to pay for the costs of administering the documentation requirements. Loveland stated that at this point, the only increased costs DSS has incurred are related to the DPH match and verification procedures. DSS intends to reimburse DPH for the information technology consulting costs of developing the data match and for a microfilm reader for the manual matches. A memorandum of understanding is awaiting DPH's signature. DSS has not added any staff, but the governor's FY 08 budget includes six additional staff related to the additional documentation-related workload.

RC:ts





OLR RESEARCH REPORT

March 7, 2007

2007-R-0223

MEDICAID COVERAGE OF PRENATAL CARE AND DELIVERY

By: Robin K. Cohen, Principal Analyst

You asked a number of questions about Medicaid coverage for obstetrical care. Specifically, you wanted to know (1) what Medicaid currently pays for these services and whether the payments are global (all-inclusive); (2) whether the services are provided on a fee-for-service or managed care basis; (3) if they are provided by managed care plans, whether the fees vary among the plans; (4) if the state pays rewards to physicians for positive birth outcomes; and (5) whether the state offers financial incentives to physicians to treat Medicaid patients.

The Department of Social Services (DSS) is in the process of compiling obstetrical care payments that Medicaid managed care organizations (MCO) pay providers. We will get this to you as soon as it is available.

SUMMARY

Although most obstetrical care is provided through Medicaid managed care, DSS maintains a fee schedule for these services. The schedule contains two global rates for obstetrical care: \$2,972.89 for vaginal births and \$3,373.59 for cesareans. In some limited instances, services are not reimbursed using the global rate. Likewise, certain nonroutine obstetrical services (e.g., amniocentesis) are paid separately.

DSS runs the Medicaid managed care program under a federal waiver, which requires that pregnant women's medical care be provided on a managed care basis. But in some instances, pregnant women may not present themselves for assistance until well into their pregnancies and DSS allows them to receive their care on a fee-for-service basis to ensure continuity of care.

The state offers little in the way of incentives to attract physicians to the Medicaid program. A loan repayment program is available to clinicians willing to work in medically underserved areas of the state, but it has minimal funding and hence low participation.

Likewise, the state does not presently offer any incentives to physicians who can show positive birth outcomes. But DSS asserts that Medicaid MCOs already pay providers who meet certain performance benchmarks. And the department is in the process of developing a results-based accountability model that it will use to reward MCOs that perform well. Positive birth outcomes could be one of the factors the model measures.

MEDICAID PAYMENTS FOR OBSTETRICS CARE

DSS maintains a fee schedule for all medical procedures billed for Medicaid patients who receive their care on a fee-for-service basis. In general, it pays a global rate for obstetrical care, which includes the costs of routine prenatal visits, delivery, and post partum care. There are exceptions, such as a woman going to a hospital to deliver the baby with no previous Medicaid involvement, in which case DSS pays a separate, smaller amount just for services rendered.

There are two global rates, one for a vaginal delivery and another for cesarean births. The former payment is \$2,972.89; the latter is \$3,373.59. DSS pays \$238.81 for amniocentesis (for diagnosing potential fetal abnormalities) and \$75.73 for a non-stress test, two common, but nonroutine procedures.

MANAGED CARE VS. FEE-FOR-SERVICE

The state's 1915(b) waiver, which authorizes Connecticut to offer Medicaid to families under a managed care service delivery model, mandates that pregnant women receive services under this model. As a practical matter, some women do not present themselves early enough in their pregnancies and could be covered under the fee-for-service system. DSS allows them to stay in that system to ensure continuity of care with their obstetrician.

FINANCIAL INCENTIVES FOR PHYSICIANS TO TREAT MEDICAID PATIENTS

The state does little to attract physicians to the Medicaid program. In fact, the low reimbursement rates have kept many physicians out of the program, or limited the number of patients they are willing to see.

The Department of Public Health's (DPH) loan repayment program, summarized in OLR Report 2006-R-0549, is available to clinicians, including physicians, working in eligible practice sites, such as community clinics. But funding for the program is relatively low (\$124,460 appropriated in FY 06) and only about 20 or so participate each year.

On February 21, the Public Health Committee heard a bill, PB 6694, that would increase funding in the loan repayment program. The committee has also heard bills that (1) establish a pilot for paid residency programs for family nurse practitioners in federally qualified health centers (PB 5751) and (2) require DPH to allocate funds for loan forgiveness for historically underrepresented students pursuing health careers (PB 263).

REWARDING PHYSICIANS FOR POSITIVE BIRTH OUTCOMES

At present the state does not provide any incentives to MCOs that can show positive birth outcomes for the HUSKY clients they serve. But according to DSS' Parrella, the MCOs on their own are providing some performance-based financial incentives to their providers. The notion of rewarded performance has gained considerable attention recently and some states have incorporated what is commonly called pay-for-performance (P4P) into their Medicaid programs.

DSS recently received a technical assistance grant from the Center for Health Care Strategies for P4P. According to the minutes from the Medicaid Managed Care Council's October 20, 2006 meeting, the program will follow the federal Centers for Medicare and Medicaid Services (CMS) P4P definition of using payments and incentives for patient-focused, high value care areas, "thus ensuring family and practitioner involvement in changing health care delivery."

DSS' Parrella stated that, starting in FY 08, his department hopes to begin increasing the capitation rates paid to those Medicaid managed care MCOs that meet certain results-based accountability measures.

RC:dw



OLR RESEARCH REPORT

February 7, 2007

2007-R-0170

MEDICAID COVERAGE OF CHILDLESS ADULTS

By: Robin K. Cohen, Principal Analyst

You asked if there are potential obstacles to offering Medicaid coverage through an 1115 waiver to childless adults who are not aged, blind, or disabled.

SUMMARY

If the legislature wants Medicaid to cover these particular childless adults it will need to direct DSS to seek a federal Section 1115 waiver to create a new coverage group for them. States that have 1115 waivers generally set an income limit for this coverage at 100% of the federal poverty level (FPL), but at least one state (Maine) goes up to 125% of the FPL.

The main obstacle to obtaining such a waiver is the cost neutrality test, which means that every additional federal dollar spent must be offset by a corollary reduction in other federal Medicaid spending. Some states have met this requirement by redirecting some of their unspent federal disproportionate share hospital (DSH) payments. Others have departed from Medicaid rules and limited the benefits offered or have required cost sharing. Often, states have employed multiple strategies. Massachusetts had an easier time showing neutrality as it made the adult coverage part of a much broader public health care expansion.

According to a 2004 Kaiser Commission report, *Medicaid and Other Public Programs for Low-Income Childless Adults: An Overview of Eight States*, 11 states provided childless adult coverage through 1115 waivers

as of January 2004. (New York operated both waiver- and fully state-funded programs.) A few others, including Connecticut, offered this coverage using state funds only.

MEDICAID COVERAGE FOR CHILDLESS ADULTS

Federal Limits

Since its inception, Medicaid has been available only to certain groups of low-income people. Enacted in the 1960s, it was meant to serve as an adjunct to cash assistance programs created during the Depression (e.g., Social Security, Aid to Dependent Children). While the program has been expanded over the years to cover more and more children and adult caretakers, childless adults have continually been excluded from these expansions, leading some to suggest that policymakers view them as less deserving than other groups.

Given these limitations, states have had two options for covering these adults: use state funds or seek 1115 waivers. In fact, some states, including Connecticut, have offered health care coverage to very low-income childless adults in state only programs for many years. Faced with growing budget deficits, several of these states have applied for the waivers to get federal matching funds to help offset program costs.

Unlike regular Medicaid, which is an entitlement (states must cover everyone who meets the program's eligibility criteria, regardless of cost), the 1115 route allows states to limit enrollment and impose cost sharing, by "waiving" federal rules that generally prohibit these restrictions. But because federal law requires that these waivers be budget neutral, that is federal costs under the waiver cannot exceed a state's projected federal spending "baseline" without the waiver, simply capping enrollments and imposing cost sharing may not be enough.

Thus, the states that have used 1115 waivers to offer this coverage have typically employed several strategies, including shifting disproportionate share hospital (DSH) payments, capping enrollment, requiring cost sharing, and limiting benefits.

Maine

Maine has a fully developed adult coverage program with matching federal Medicaid funds for individuals with income up to 100% of the FPL. (Although state law and the state's 1115 waiver permit coverage up

to 125% of FPL, it has never done so.) Previously, it had a state-funded program. The legislature pushed for Medicaid coverage as part of a larger effort for universal coverage begun in 2001.

To address cost neutrality, the state chose to tap unspent Medicaid DSH payments (this became the federal match). A 2004 paper by the Economic and Social Research Institute (ESRI) reported that a portion of the state's DSH allocation that had been divided up among psychiatric and community hospitals had not been used and neither group opposed the fund transfer. In fact, they had been pushing for the above coverage for years, in part because the lack of coverage was driving increases in emergency room use for nonemergency care.

Ultimately, a larger group of parties (e.g., hospitals, advocates, legislators, mental health agencies) proposed the DSH fund shift, mainly because of the rising number of uninsured workers and the nearly complete lack of commercial individual health coverage. They also believed that the community would pay the high cost of caring for the uninsured in the long run, either in the form of higher commercial coverage costs or hospital service shortages.

The outgoing governor's dislike of the law and the incoming governor's (Baldacci) budget concerns nearly ended the expansion in 2002 and 2003. But Governor Baldacci's commitment to health care, as seen by his Dirigo Health Universal Health plan, has ensured its sustainability for the time being, although the program is now closed (see below).

The ESRI paper also discussed the state's waiver discussions with the federal Centers for Medicare and Medicaid Services (CMS), which ultimately must approve these waivers. The authors characterized them as smooth, despite the fact they alerted federal policymakers to the unspent DSH funds. These discussions occurred as the Bush administration was introducing its Health Insurance Flexibility and Accountability (HIFA) initiative, which invited states to expand health care coverage using unspent DSH and State Children's Health Insurance Program (SCHIP) funds. (The Deficit Reduction Act of 2005 now prohibits states from covering childless adults with SCHIP funds.) ESRI characterized the state's proposal as "uncomplicated," which may also have helped it gain CMS' approval.

ESRI described anecdotal reports by hospitals that the childless adult expansion increased their costs due to a greater utilization of outpatient and specialty care services. But at the same time, these institutions receive higher payments than when they wrote these services off as

charity care. (More concern was expressed about costs to rural hospitals, often the only health care provider available, since they were providing all services, not just inpatient and outpatient care.)

Maine's waiver authorizes an expenditure cap, which allows it to limit enrollment. According to a 2005 interview with Trish Riley, director of the governor's Office of Health Policy and Finance, adult coverage was highly popular and enrollees were high service users. This resulted in the state reaching its DSH cap and ultimately forced it to cap program enrollment at about 13,000 (*State Coverage Initiatives, May 2005*). The cap has been in place ever since, according to state legislative staff. (In part, this may be due to the fact that these adults receive the same benefits as other Medicaid enrollees with no premiums and nominal co-payments.)

Massachusetts

Childless adult coverage in Massachusetts was part of a major public health insurance push begun in the early 1990s. The state submitted its 1115 proposal in 1994, the federal government approved it the following year, the legislature adopted it in 1996, and it began in 1997. (At that time, the Clinton Administration was encouraging states to expand coverage with 1115 waivers.) In addition to the childless adult coverage, the waiver expanded coverage for children and pregnant women, created several Medicaid coverage groups under a new umbrella MassHealth program, and integrated care for the uninsured by the state's two big safety net hospitals.

The legislature agreed to shift DSH funds and increased the state's tobacco tax to obtain the state's share of Medicaid funds for the expansion. To get the federal match, the state showed budget neutrality by transferring the Medicaid population into managed care.

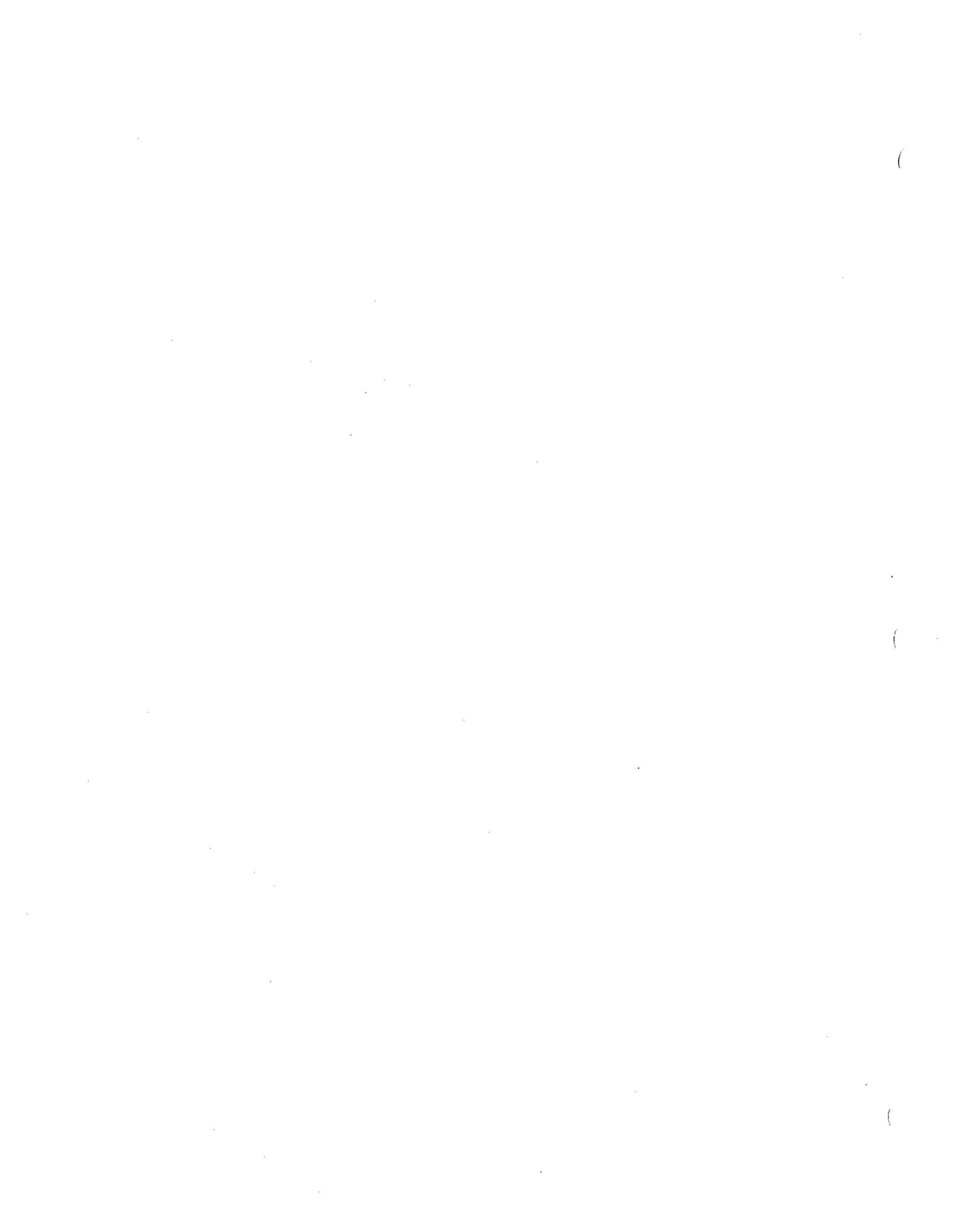
In designing the childless adult coverage, the state acknowledged that not all childless adults were the same and created categories that some could suggest deemed certain adults more deserving of coverage than others. For example, adults with disabilities were covered if their income was up to 133% of FPL with full benefits, while childless working adults could get premium assistance only if they had access to employer sponsored coverage. Budget constraints in recent years forced the state to tighten eligibility for this group and limit benefits further.

Massachusetts' new universal coverage initiative which, among other things, creates the Commonwealth Care Health Insurance Program (managed care for all residents through state-procured plans), continues

the state's coverage for childless adults. The state will pay full premium costs for adults with income up to 100% of the FPL and partial premiums for people with incomes up to 300% of the FPL. The state had to renegotiate its 1115 waiver with CMS so that Medicaid matching funds will be available for all these subsidies.

Childless adults with incomes less than 100% of FPL must still meet MassHealth's nominal co-payment requirements.

RC:dw





OLR RESEARCH REPORT

January 12, 2007

2007-R-0006

RAISING INCOME ELIGIBILITY FOR MEDICALLY NEEDY IN MEDICAID

By: Robin K. Cohen, Principal Analyst

You asked a number of questions related to changing the income eligibility rules for the Medicaid spend-down coverage group so that people with income up to 150% of the federal poverty level (FPL) would qualify. Specifically, you wanted to know (1) whether the state can establish an income limit at that higher level; (2) if not, could it establish a special income "disregard" which would have the same effect and what amount the disregard would have to be; (3) the number of people who this change would affect; and (4) the fiscal impact of this change.

This report addresses the first two questions. The Office of Fiscal Analysis will answer the remaining two.

SUMMARY

The state cannot raise the income limit in the medically needy program to 150% of the FPL because federal law does not allow states to set the limit this high. But, the state could establish a separate income disregard which, when combined with the existing unearned income disregard (\$227 per month), would effectively raise the income limit to the 150% of FPL level. The additional disregard would be \$524 for a single person and \$794 for a married one using the 2006 FPL. This change could be made through an amendment to the state's Medicaid State Plan.

MEDICAID MEDICALLY NEEDED

Federal law requires states with Medicaid programs to cover certain groups of individuals and allows them to cover certain other groups. The medically needy program is one of the optional coverage groups.

Medically Needy Program

States with medically needy programs must cover pregnant women and children if they also cover others, such as the aged, blind, and disabled. In Connecticut, the medically needy program consists of three groups, as shown in Table 1.

Table 1: Medically Needy Subgroups

Coverage Subgroup	Description
F99	Primarily 19- and 20-year-old children who because of age, do not qualify for HUSKY (Ribicoff children) but includes others
P99	Pregnant women with income above the 185% income limit
S99	Aged, blind, and disabled

Federal regulations limit the income (medically needy income limit (MNIL)) that people in the medically needy group may have to 133 1/3% of the maximum Aid to Families with Dependent Children (AFDC, replaced by the Temporary Assistance for Needy Families cash assistance programs (Temporary Family Assistance in Connecticut) benefit for a particular family size. (A federal waiver permits Connecticut to use a slightly higher percentage of poverty because the legislature reduced cash welfare benefits in 1995.) The state limit has not changed since 1990. Congress imposed the original limit, in part, to ensure that only the poorest individuals received assistance.

Once income rises above the MNIL, applicants are placed in a spend-down status. This essentially means that they are expected to be able to spend their excess income on unpaid medical bills within a six month period and when they do so, are eligible for Medicaid coverage.

OLR Report [2004-R-0554](#) provides a more detailed explanation of the MNIL and spend down rules.

Income Disregards. States have been able to get around the strict income limits to a certain degree by disregarding a portion of an applicant's or recipient's earned and unearned income. (As a rule, people who are able to work and hence have earnings are not in the medically needy coverage group. Rather, they are in a relatively new Medicaid buy-in program that allows them to have significant earnings with no cost sharing until their income reaches 200% of the FPL.) But these disregards are relatively low and until recently, had not been increased for many years. (PA 05-243 requires the state to increase the unearned disregard in the State Supplement Program each year by the amount of the increase in Social Security benefits. Since eligibility for State Supplement is related to Connecticut's medically needy program, the latter program's disregard is now also indexed for the Social Security cost-of-living adjustment.)

Implications of Low Income Limit

A Medicaid applicant whose income exceeds the MNIL and who has excess unpaid medical bills must spend that excess income paying those bills during a six-month, "spend-down" period before getting Medicaid coverage. Because the MNIL has remained the same for many years and the unearned income disregard did not increase until recently to reflect inflation, more individuals in the medically needy group have had their eligibility for Medicaid delayed while they remain in a "spend down" status.

DSS looks at the income expected over the six-month period and, once the excess is spent, begins Medicaid coverage for the duration of that period. Then, a new six-month period starts. In some instances, a person may not spend down until the fifth month, only to go back into a spend-down status once the new six-month period starts. Then the individual must accrue additional medical bills in order to spend down the excess anew.

Ways to Address the MNIL Limit—Separate Income Disregard

There are a few ways to address the MNIL limit. The best way to achieve an income limit closer to 150% of the FPL would be to take advantage of a provision in federal law, Section 1902(r)(2) of the Social Security Act. This provision allows states to use less restrictive eligibility criteria in their Medicaid programs than those they use in their cash assistance programs (which is where the 133 1/3% figure comes from). Regulations and related federal guidance for this statute make it clear that states can use the law to raise the income limits in their medically needy programs.

One way to do it, which is what advocates have requested, is to create a separate income disregard for the medically needy only. As we mentioned above, there is already a \$227 unearned income disregard. To this, the legislature would create an additional disregard, so that when combined with the existing \$227 disregard, a beneficiary's gross unearned income could go as high as 150% of the FPL.

And states can target fairly narrowly the disregard so that it applies to only some (e.g., aged, blind, disabled) of the medically needy group. Moreover, if they choose, they can disregard only certain types of income (e.g., Social Security Disability Income).

Disregard Level. As stated above, the state could target the additional disregard as narrowly as it chooses to reach the 150% of FPL level (currently \$1,225 per month for one person and \$1,650 for two). So, for example, it could apply it only to the aged, or the aged, blind, and disabled. This latter group consists primarily of single adults and married couples.

Currently, the MNIL for one person living in most areas of Connecticut is \$476 per month; for two people, the MNIL is \$629. But the state must disregard \$227 of unearned income each month, so gross monthly income can go as high as \$703 and \$856, respectively. This is about 85% of the FPL. (In married couple households, DSS applies the disregard once unless both spouses are applying for assistance.)

To raise the income limit to 150% of the 2006 FPL, the additional disregard would have to be \$522, a level that, when combined with the \$227 and the MNIL, would be less than \$1,225 per month. For a two person household, the additional disregard would be \$794 per month, the difference between 150% of the FPL for two people (the \$1,650) and the \$856.

New Eligibility Group for Aged and Disabled Up to 100% of FPL

We should also mention another strategy, which would be to create a new, optional Medicaid eligibility group, authorized by a 1986 federal law. This would cover aged and disabled people, but only up to 100% of the FPL (the state could layer the 1902(r)(2) disregard on top of this to reach the 150% of FPL level). Certain people in the medically needy group could move into this new group, but there would be no spend-down option for people with incomes above the disregard-adjusted level.

Other Considerations

Since the FPL normally increases each year to adjust for cost-of-living increases, it might be best to not specify a dollar amount in statute for the disregard. Instead, the law could require that the additional disregard be the difference between the 150% of FPL and the MNIL plus the existing unearned income disregard. And, to ensure that individuals do not lose eligibility if their net income, after the additional disregard is applied, is close to the 150% limit, the legislature would probably want to include an indexing provision so that the new disregard rises when Social Security benefits rise.

This disregard must be applied uniformly, regardless of the living arrangement of the person receiving assistance. For example, if the state chose to offer the disregard to aged, blind, and disabled medically needy people, it would have to offer it to both people living in the community and those living in licensed boarding homes.

The existing unearned income disregard is mentioned in statute only as it applies to the State Supplement Program. If the legislature did not wish this new disregard to apply to that program, it would be best to place it in the Medicaid statute.

Finally, although the income limit would effectively double, people with higher incomes would still be able to spend down to the higher limit.

RC:ro





OLR RESEARCH REPORT

November 9, 2006

2006-R-0693

IMPACT OF ELIMINATING MEDICAID COVERAGE FOR INDEPENDENT PRACTITIONER PODIATRISTS

By: Robin K. Cohen, Principal Analyst

You asked whether the Department of Social Services (DSS) had saved any money by eliminating Medicaid coverage for podiatrists in 2002.

SUMMARY

According to DSS, it does not appear that the state saved any money by eliminating Medicaid coverage for podiatrists in 2002, despite having factored savings into the FY 03 budget. Rather, the costs for these services have shifted from podiatrists to other medical providers.

IMPACT OF ELIMINATING MEDICAID COVERAGE FOR PODIATRISTS

PA 02-7, May 9 Special Session (§104), required DSS to submit an amendment to its Medicaid State Plan to implement provisions in the FY 03 budget act concerning "optional" services. (Optional services are those services that federal law allows states to provide under Medicaid versus services that are mandatory, such as emergency care.) Although the act did not explicitly require this, DSS interpreted it as a mandate to eliminate Medicaid payment to the following independently enrolled providers: podiatrists, chiropractors, naturopaths, "independent therapists" (physical therapists, licensed audiologists, and speech pathologists), and psychologists for any services they provided to Medicaid recipients aged 21 and older. (This coverage was also

eliminated from the then-General Assistance and State-Administered General Assistance programs.)

The change took effect January 1, 2003.

According to a DSS analysis of payments for podiatry services six months before and after the change occurred, Medicaid podiatry costs did not fall significantly. (DSS used the six-month period because it does not have data for any earlier period than six months before coverage was eliminated.) Rather, most costs were shifted from podiatrists to a category of providers called "Other MD," while a small percentage shifted to orthopedists.

Table 1 illustrates what occurred.

Table 1: Podiatry Services With Dates of Service in FY 03 [1]

		<i>July-December</i>	<i>Jan-June</i>
Physician/Group	Orthopedics	\$56,789.15	\$71,133.03
Physician/Group	Other MD	498,574.19	946,420.82
Podiatrist/Group	Podiatrist	577,360.11	45,595.88

Source: DSS (November 2006)

- [1] The data does not include podiatry services received in clinics or outpatient hospital settings. DSS pays an inclusive rate to these providers, and there is no way to break out podiatry costs. But one can assume that more people received podiatry services in these settings after the policy changed.

RC:ts



OLR RESEARCH REPORT

March 27, 2006

2006-R-0230

TRANSFER OF ASSET PROVISIONS IN DEFICIT REDUCTION ACT

By: Robin K. Cohen, Principal Analyst

You asked for a summary of the Medicaid long-term care transfer of asset provisions in the recently passed federal Deficit Reduction Act of 2005 and how they may affect Connecticut.

This report focuses on six of the major changes in the law. All except the last one took effect on the act's passage date (February 8, 2006) and apply to asset transfers made on or after that date.

SUMMARY

The Deficit Reduction Act of 2005 (PL 109-171) makes six changes in the law regarding transfers of assets for Medicaid long-term care eligibility. Specifically, it:

1. increases from 36 months to five years the period of time states must "look back" when determining whether individuals applying for Medicaid long-term care have transferred assets solely to qualify for Medicaid;
2. changes the start date of penalty periods (Medicaid ineligibility) states must impose when they determine such transfers have occurred,

3. requires states to impose penalty periods that include individual days of Medicaid ineligibility,
4. codifies federal guidance on when states may waive penalty periods when their imposition will pose a hardship for the person transferring the asset,
5. requires states to use a more restrictive methodology when determining the amount of support the spouse of a Medicaid recipient living in the community may receive, and
6. prohibits states from granting Medicaid to individuals who have substantial equity in home property.

Connecticut has already instituted items 3 and 5 and part of 4.

TRANSFER OF ASSET PROVISIONS

Increasing the "Look-Back" (§ 6011)

Federal law presumes that someone who transfers assets for less than fair market value during a certain period of time before applying for Medicaid long-term care (look-back) does so in order to qualify for assistance. If these transfers occur, and they are not successfully rebutted, states must impose periods of Medicaid eligibility based on the value of the uncompensated asset.

Prior law required states to look back 36 months for most transfers but 60 months for transfers made to certain trusts. The act requires a 60-month look back for all transfers.

This provision applies to transfers made on or after February 8, 2006.

Start Date of Penalty Period (§ 6011(b))

By law, if Medicaid applicants are found to have made transfers for less than fair market value within the look back period solely to qualify for Medicaid, states must impose periods of Medicaid ineligibility. The duration of the penalty is determined by dividing the uncompensated value of the asset in question by the average monthly cost of care in a nursing home.

Applicants who transferred assets early enough before they applied for Medicaid tended not to be penalized. This was because the penalty period began from the date the asset was transferred. For example, if someone's penalty was two months, and he transferred the asset a year before applying for Medicaid, the transfer would be scrutinized, but the penalty would expire 10 months before the person applied.

The act changes the start date of the penalty period to the later of (1) the first day of a month during or after which the assets have been transferred or (2) the date on which the person transferring the asset is eligible for Medicaid and would otherwise be receiving institutional care based on an approved application but for the application of the penalty period.

This provision was effective on February 8, 2006.

Imposing Partial Months of Ineligibility (§ 6016(a))

The act prohibits states from rounding down or otherwise disregarding any fractional period of ineligibility. Previously, when states calculated the penalty period (value or uncompensated asset/average cost of care in nursing facilities) and the quotient was a fraction, the law allowed them to round down or not include in the ineligibility period the quotient amounts that were less than one month. For example, if the average cost of care was \$5,000 and the asset was valued at \$56,000, the quotient would be 11.2 months of ineligibility. States could round this down to 11 months. Under the act, they must include the additional days in the penalty period.

DSS already imposes partial months of ineligibility so this provision should have no effect in Connecticut.

Hardship Waivers (§ 6011 (d)(e))

The act codifies federal guidance on when states may grant waivers of the penalty periods when the penalty will create a hardship on the person transferring the asset (transferor). Specifically, the waiver should be granted if a state finds that the penalty would deprive the individual of medical care to the extent that his health or life would be endangered or he would be deprived of food, clothing, shelter, or other life necessities.

The act requires states to provide for (1) notice to recipients that an opportunity for a hardship exception exists, (2) a timely process for determining whether a waiver will be granted, and (3) a process for appealing an adverse determination. It permits nursing facilities to file the hardship waiver applications on the resident's behalf, with consent. Department of Social Services (DSS) regulations already provides for hardship waivers (Uniform Policy Manual, Section 3028.25). But the nursing facilities' authority to request the waivers is new.

If applications for waivers meet established criteria (to be set by the secretary of HHS), states have the option of providing up to 30 days of payments to nursing facilities to hold the resident's bed while the application is pending. DSS indicates that it does not intend to do this.

Codifying "Income First" Methodology for Protecting Community Spouse

Existing Law. In 1988, Congress changed the Medicaid law to financially protect couples when one spouse entered an institution while the other remained in the community. The "spousal impoverishment" provisions were designed to give the "community" spouse a minimum amount of assets and monthly income with which to maintain herself without having to resort to institutional care herself.

The law exempts all of the community spouse's income (e.g., Social Security) from being considered available to the institutionalized spouse for Medicaid eligibility purposes. It also establishes a minimum monthly needs allowance (MMNA) to ensure she has enough resources to meet her monthly living costs.

States must also allocate a portion of a couple's combined assets to the community spouse, with the remainder going towards the institutionalized spouse's care costs. To establish the "community spouse protected amount" (CSPA), assets of both spouses are combined and then divided evenly, with the institutionalized spouse's share going directly into paying for the care (before Medicaid will pay) while the community spouse keeps her share, up to a specified limit.

States must attribute income to each spouse according to their ownership interest. Then, the state compares the community spouse's monthly income to the MMNA. If the community spouse's income is less than the MMNA, the institutionalized spouse can choose to transfer an amount of his income or assets to make up the shortfall.

Changing MMNA. If a community spouse wants to raise her income to the MMNA level, she appeals through a state's fair hearing process (DSS holds these in Connecticut). The state can then decide whether to allocate more of the institutionalized spouse's income or assets to her.

States have generally used two different methods when making these decisions. The "income first" methodology requires that the institutionalized spouse's income first be allocated to the community spouse, with the remainder, if any, going to pay for the institutionalized spouse's care costs. Unless the transferred income is insufficient to raise the community spouse's income to the agreed-upon level, using this method, the assets of the institutionalized spouse (e.g., an annuity or other income producing asset) cannot be transferred to her to raise her income. This method generally requires the couple to deplete a larger share of their assets, as the share the institutionalized spouse retains must be spent on his care before Medicaid pays.

Under the "resource first" method, the couple's assets are protected first for the community spouse's benefit to the extent necessary to ensure that her total income, including income generated by the CSPA meets (or exceeds, if allowed) the MMNA. Additional income from the institutionalized spouse that may be, but has not been, made available to the community spouse would be used toward the institutionalized spouse's care costs, making this spouse eligible for Medicaid more quickly.

The Deficit Reduction Act requires states to use the income first methodology. This change went into effective on February 8, 2006. Connecticut law (CGS § 17b-261(h)) has required DSS to use the income first approach since 2003.

Disqualification for Medicaid for Couples with Substantial Home Equity (§ 6014)

Under prior law, the value of an individual's home was not included in determining Medicaid eligibility. If an individual and a spouse (if any) moved out of the home with no intention of returning, the home became a countable resource, since it was no longer the individual's principal residence. In this instance, he would have to make a good faith effort to sell the home and Medicaid would pay for his care costs. Once he sold the home, Medicaid would stop and the proceeds would be used to pay for his care. When they were depleted, Medicaid coverage would resume.

If an individual left the home to live in an institution, the home was still considered to be the individual's principal place of residence, regardless of whether he intended to return, as long as the spouse or dependent relative continued to live there.

The federal act excludes from Medicaid long-term care eligibility individuals with an equity interest in the home of more than \$500,000, but it allows states to raise this amount to \$750,000. (These caps increase beginning in 2011.) This effectively means that the individual must sell the home and spend the proceeds on his care before Medicaid will pay. The act creates a hardship waiver and requires the federal government to establish a waiver process. As under prior law, the exclusion does not apply to individuals whose spouse or children who are under 21, blind, or disabled lawfully reside in the house.

The act does not prevent someone from using a reverse annuity mortgage to reduce his equity interest in the home.

This provision applies to individuals who are determined eligible for Medicaid based on an application filed on or after January 1, 2006. But DSS is still in the process of determining how it will implement it.

RC:ts





OLR RESEARCH REPORT

December 1, 2005

2005-R-0890

TRANSFER OF ASSETS LAW

By: Robin K. Cohen, Principal Analyst

You asked for a summary of the state's Medicaid long term care transfer of assets law. This report updates OLR Report 2003-R-0708, with a discussion of topics not covered in that report, including the debt creation for certain asset transfers.

SUMMARY

Federal Medicaid law generally requires states to impose a period of Medicaid ineligibility (penalty period) when an institutionalized individual or his spouse transfers assets for less than fair market value less than 36 months (60 months for transfers to certain trusts) before applying for Medicaid. (This is commonly referred to as the "look-back" period.) The law exempts a number of transfers from these penalties but requires the applicant or spouse to prove that a transfer during the look back period is exempt.

In 2000, the legislature amended the law to make it easier for the state to impose these penalties but later reversed itself when nursing home administrators and elderly advocates expressed concerns about its implications for access to care. In 2005, the legislature repealed these provisions after the governor rescinded the state's request to implement them (the request had languished for several years with the federal agency that must approve them).

A 2003 act made a number of additional changes in the transfer of assets law, some of which would be needed if the waiver was approved. These included (1) codifying a regulation that creates a rebuttable presumption that transfers resulting in penalty periods are made to qualify for Medicaid and requiring clear and convincing evidence to rebut it, (2) creating a debt on either the transferor or transferee when such transfers occurred and authorizing the state to recoup any benefits paid, (3) allowing the Department of Social Services (DSS) to grant financial relief to nursing homes that experienced hardships as a result of penalty periods being imposed, and (4) increasing the look-back for real property from three to five years. Only the first two remain in force after the waiver's withdrawal.

In spite of the reversal at the state level, Congress appears poised to pass some of the very things the state tried to do, with both chambers having recently passed budget bills that include measures to tighten the asset transfer rules.

TRANSFER OF ASSETS—LOOK BACK CHANGES THAT WERE REVERSED

Look-Back Period

Federal law currently requires the penalty period to run from the date the asset was transferred, rather than from when the person is determined eligible for Medicaid. Thus, penalty periods for transfers made within the 36 months (or 60 months for transfers to certain trusts) often expire before people actually apply for and become eligible for Medicaid.

In 2000, the legislature tightened this perceived loophole by changing the start date of the penalty period to the date someone was determined otherwise eligible for Medicaid (§ 17b-261a). But DSS could not implement this change until the federal Medicaid agency (Center for Medicare and Medicaid Service (CMS)) granted it a "waiver" of the federal rules.

DSS submitted the waiver request in 2002, despite significant opposition from legislators when the request went before the committees of cognizance for their review. CMS and DSS corresponded several times, but the waiver was never approved. In May 2005, Governor Rell directed DSS to withdraw the waiver, citing concerns that it would make access to long-term care more difficult. PA 05-209 repealed the waiver authority.

In addition to repealing the penalty start-date language, PA 05-209 repealed a number of related changes that the legislature added in 2003. These included (1) permitting DSS to provide financial relief to homes that experienced financial hardship as a result of the waiver's approval, (2) increasing the look back for home property transfers from three years to five, and (3) establishing thresholds below which DSS would not scrutinize transfers. (DSS had included the latter two provisions in the original waiver request but they were not part of the 2000 law.) The 2005 act inadvertently removed a 2003 provision that authorized DSS to waive the imposition of penalty periods when the person making the transfer suffered from dementia or was exploited into making it. (This provision was restored in PA 05-280).

TRANSFERS OF ASSETS—PROVISIONS THAT REMAIN IN LAW

Debt Created When Assets Transferred

The 2003 act also gave the state another opportunity to recover Medicaid benefits paid when transfers were made that resulted in a penalty period. It made such transfers a debt, as defined in the state Creditors' Collection Practices law, that the transferor or transferee owed DSS equaling the assistance DSS gave to or on behalf of the transferor on or after the transfer date, up to the asset's fair market value on that date. It also authorized DSS and the Department of Administrative Services (DAS) commissioners and the attorney general to seek administrative, legal, or equitable relief as allowed in other statutes or common law. According to DAS' Abbie Wotkyns, DSS has not referred any of these debts to her department for collection on DSS's behalf.

Transfers Presumed to Be Made To Qualify

The 2003 act also codified DSS regulations specifying that any asset transfer resulting in a penalty period is presumed to have been made to enable the transferor to become or remain eligible for Medicaid. It allows rebuttal of the presumption only by clear and convincing evidence to the contrary. (A more detailed explanation as to why this provision was simply a codification of existing regulations and not a policy change can be found in 2003-R-0708.)

RECENT FEDERAL DEVELOPMENTS

Both chambers of Congress have recently passed budget bills with Medicaid cost savings provisions that include transfers of assets. The House bill's provisions include (1) increasing the look-back period for all transfers from three to five years; (2) moving the start date of the penalty

period from the date of transfer to the date of Medicaid application or nursing admission, whichever is later; and (3) requires the federal government to establish a program to compensate institutional providers who incur bad debts as a result of these changes. The Senate bill's transfer of assets changes do not include any of these provisions. (A side-by-side comparison of these measures can be found at www.ncsl.org/statefed/health/1102ReconDocs.htm.)

RC:ro



OLR RESEARCH REPORT

August 2, 2005

2005-R-0592

HUSKY

By: Robin K. Cohen, Principal Analyst

You asked for a general overview of the HUSKY program (A and B). You specifically wanted to know its (1) history, (2) covered populations, (3) benefits and cost sharing, and (4) strengths and weaknesses.

SUMMARY

Since 1998, the HUSKY program has provided managed health care to the state's low-income children. Run by the Department of Social Services (DSS), the program consists of three parts—Part A, Part B, and HUSKY Plus. Part A is Medicaid for children living in families with income up to 185% of the federal poverty level (FPL, currently \$29,766 for a family of three) and their parent and caretaker relatives with incomes up to 150% of the FPL. Part B provides identical services to children in families with higher incomes. Unlike Part A, Part B families have cost sharing requirements, such as co-payments and premiums. In addition, the HUSKY Plus program provides supplemental coverage for children with severe behavioral and physical health care needs.

The program offers a very comprehensive service package, including well child visits and prescription drugs. One of its goals is to ensure that children receive routine, preventive care with a community provider rather than in the hospital emergency rooms.

Currently, four managed care organizations (MCOs) manage Part A enrollees' care (three in Part B), for which the state pays them a monthly "capitated" rate. It is expected that this per member, per month payment

will cover all services the enrollee needs during the month. The MCOs contract with dental and behavioral health subcontractors, which manage those benefits for HUSKY enrollees.

In addition, DSS contracts with an enrollment “broker” or “servicer,” to take applications and help enrollees choose a health plan.

DSS is responsible for providing outreach and currently maintains contracts with community providers, including 211-Infoline, to fulfill this mandate. State funding for this function has been reduced significantly over the last few years.

The statutorily established Medicaid Managed Care Council (MMCC) oversees the HUSKY program’s administration. This group meets monthly and makes recommendations for program changes to both DSS and the legislature. In addition, DSS maintains contracts with outside entities to perform quality reviews and measure how the program meets established goals.

The program has been very successful in decreasing the number of uninsured children and adults, although some contend numerous uninsured children are still not enrolled even though eligible for benefits. But the legislature has made program cuts, in both 2003 and 2005, that may reverse the first trend. Moreover, concerns have been raised about the lack of information available from the MCOs, especially concerning providers. This information is essential for the state to measure the program’s success in providing not only coverage but access to the coverage. Access to mental health services for children has been another issue. A new initiative is expected to address this concern.

Another concern has been raised about HUSKY subsidizing care for employees who do not have access to employer-sponsored health insurance or do but cannot afford the cost sharing. The legislature considered but did not pass two related bills—one would have required employers to cover their employees or pay into a fund (dubbed “pay or play”) and another would have required DSS to provide premium assistance. A third bill would have required DSS to report more regularly on the extent to which HUSKY provides coverage for employees working for employers in the state.

HUSKY—HISTORY, ELIGIBILITY, BENEFITS, ADMINISTRATION

Establishment

Since 1965, the federal Medicaid program has provided public health insurance for children living in Connecticut's low-income families. Although states that run Medicaid programs must cover certain low-income children, over the years, Connecticut has taken advantage of federal options to expand coverage to children at higher income levels.

As a result, when the legislature enacted the HUSKY law in 1997, Connecticut was ahead of most states in terms of its child coverage under Medicaid (up to 185% of FPL with no asset limit). PA 97-2, November Special Session, was the state's response to federal State Children's Health Insurance Program (SCHIP) legislation, enacted in 1997, which established a new federal block grant for states to provide more health insurance coverage to children. The state's primary SCHIP program became HUSKY B, which provides coverage to children with incomes above 185% of the FPL and subsidies to families with incomes up to 300% of the FPL. Medicaid (for children and subsequently caretaker adults) was re-named HUSKY A. (HUSKY Plus was also created at that time to provide supplemental coverage for children with severe physical or mental disabilities.)

Benefits

From the outset, HUSKY was to follow a managed medical care model, whereby the state contracted with a number of MCOs (currently four) to provide all of the covered benefits. The 1997 law enumerated what services had to be offered to HUSKY B recipients, which were and continue to be the same as those in HUSKY A.

Table 1 describes HUSKY B benefits, coverage limitations, and cost sharing requirements. Until 2005, HUSKY A had no cost sharing (see below).

Table 1: HUSKY B—Benefits, Coverage Limitations, and Co-Payments

<i>Benefit</i>	<i>Coverage Limitation, Co-Pays</i>
<i>Preventive care—periodic and well child visits, immunizations, WIC evaluations, and prenatal visits</i>	
Birth to age 1	Six exams
Ages 1-5	Six exams
Ages 6-10	One exam every two years
Ages 11-19 th birthday	One exam a year
Outpatient physician	100%
Inpatient hospital	100%
Outpatient surgical facility	100%
Ambulance	100% if determined to be an emergency, in accordance with state law
Pre-Admission/Continued Stay	Arranged through provider
Prescription Drugs	\$3 co-pay on generics, \$6 for brand names; formularies
Mental Health--Inpatient	100%, except 60 day limit for certain conditions, such as mental retardation, learning, motor skills communication, and caffeine-related disorders (HUSKY Plus available to supplement)
Mental Health--Outpatient	\$5 co-pay, with some exceptions
Substance abuse	100% for detoxification; 100% for inpatient with some exceptions and durational limits; 100% for outpatient with same limits as inpatient
Skilled nursing	100% with prior authorization
Home health	100%
Hospice	100%
Short-term rehabilitation and physical therapy (PT)	100%
Long-term rehabilitation and PT	Supplemental coverage available under HUSKY Plus for medically eligible children
Lab and X-Ray	100%
Pre-admission testing	100%
Emergency care	\$25 co-pay, unless determined to be an emergency in accordance with state law—fee waived if patient admitted
Durable medical equipment	100% with prior authorization
Prosthetics	100% with prior authorization; supplemental coverage available under HUSKY Plus
Eye care	\$5 co-pay on exams; optical hardware partially covered--lenses and up to \$50 for frames, once every two years, with \$100 maximum for lenses and frames per prescription
Hearing—exams and aids	\$5 co-pay; aids covered under HUSKY Plus
Nurse midwives	\$5 co-pay
Nurse practitioners	\$5 co-pay
Podiatrists, chiropractors, naturopaths	\$5 co-pay
Speech and occupational therapy	Short-term coverage with prior authorization
Dental	100% except co-pays for bridges and crowns, root canal, dentures, extractions; orthodontia covered up to allowance
Family planning	\$5 co-pay for contraceptives; family planning services covered in full

Source: DSS—HUSKY Website

Eligibility

HUSKY A. When first established, HUSKY covered children only. In 1999, the legislature expanded HUSKY A to cover adult caretaker relatives of children receiving HUSKY with incomes up to 185% of the FPL by taking advantage of a new federal Medicaid coverage group, Section 1931. (Adult coverage under HUSKY B was difficult to achieve because of the way the SCHIP law was written, although newer federal waivers have made this easier.). In addition to covering more uninsured adults, many believed that if the state covered these relatives, they would be more likely to sign up their kids for coverage. Adult coverage at this income level never took effect because in 2000, the legislature reduced the limit to 150% of the FPL and delayed its implementation until 2001.

In 2003, the legislature reduced the adult income limit to 100% of the FPL, effective April 1, 2003. But a lawsuit and subsequent Appeals Court ruling allowed most adults with incomes between 100% and 150% of the FPL to continue to receive benefits up until April 1, 2005. PA 05-1 extended this coverage until June 30, 2005, and PA 05-280 makes the income limit 150% of the FPL, effective July 1, 2005.

HUSKY B. The HUSKY B income limits have remained the same since the program was first created. Children in families with incomes up to 300% of the FPL are eligible for subsidized assistance.

Cost Sharing

HUSKY A. Until this year, there was no cost sharing in the HUSKY A program. The legislature had imposed co-payments in 2003 on families but subsequently rescinded them. (PA 03-3, June 30 SS imposed a \$3 maximum co-payment for medical services and \$1.50 for prescription drugs; PA 04-258 repealed them.)

PA 05-280 requires DSS to seek a federal waiver to impose a \$25 monthly premium and \$1 co-payments on HUSKY A families with incomes above 100% of the FPL. Both of these provisions are expected to be implemented in 2006.

HUSKY B. Since its inception, HUSKY B has had cost-sharing requirements for families. Families with incomes between 185% and 235% of the FPL (Band 1) made co-payments, up to a maximum of \$650 annually. Families with incomes between 235% and 300% of the FPL (Band 2) had a \$1,250 maximum annual cost sharing cap, which included premiums.

Until 2005, Band 1 families paid no premiums and Band 2 families paid \$30 per child, per month, with a \$50 maximum per family. PA 05-280 directs DSS to impose the \$30/\$50 premium on Band 1 families and raise the premiums to \$50 per child, with a \$75 maximum, for Band 2 families. The overall cost sharing caps can now go as high as 5% of family income.

Managed Care Networks

HUSKY services are managed by four MCOs that maintain contracts with DSS: Anthem Blue Care, Community Health Network (CHN), Health Net, and Preferred One/FC. Anthem had the largest number of HUSKY A enrollees in the beginning of June 2005 (129,827) and B enrollees (11,216), with the next highest CHN (57,401 and 2,499, respectively). (Health Net does not serve HUSKY B children.)

Capitation Rates

DSS pays the MCOs a monthly capitation rate, which is an amount that is expected to cover the plans' cost of caring for the enrollees. In FY 2006, the average per member per month (pmpm) rate will be \$194.56, which is almost a 50% increase since the program began in July 1998, when the average was \$132.22. Table 2 shows the average pmpm from FY 98 through FY 06 for HUSKY A. (The HUSKY B pmpms would be lower for Band 2, reflecting that enrollees have paid premiums and co-payments.)

Table 2: Average PMPM in HUSKY A—FY 98 through FY 06

<i>Fiscal Year</i>	<i>Average PMPM in HUSKY A</i>
FY 98	\$132.22
FY 99	143.65
FY 00	153.83
FY 01	146.91 ⁽¹⁾
FY 02	158.41
FY 03	173.17
FY 04	179.21
FY 05	187.85
FY 06	194.56

Source: OLR analysis of Office of Fiscal Analysis monthly figures.

⁽¹⁾ This figure should probably be higher. The methodology used to calculate the annual monthly average factors out a month in which the average was significantly lower than any other month that year.

Outreach

When first enacted, the HUSKY law directed the DSS commissioner to develop outreach for both parts in consultation with the Medicaid Managed Care Council, the Children's Health Council, and Infoline. The law requires DSS to report annually on its outreach efforts (CGS §17b-297(a)). (The legislature established the Children's Health Council (CHC) in 1995 to, among other charges, do outreach and ensure statewide uniform health care access for children.)

The CHC was the state's primary outreach entity for HUSKY, and DSS provided it with over \$1 million for these efforts until its funding was cut in half in early 2002. (Governor Rowland had recommended its elimination in FY 03.) Since then, the council's funding has continued to dwindle, and its functions have been taken up largely by Voices for Children, a New Haven based child advocacy group.

According to OFA, outreach funding for HUSKY in FY 06 is about \$850,000. Over \$700,000 funds DSS contract with 211-Infoline, as well as internal DSS outreach costs, such as mailings. An additional \$125,000 in DSS' Community Services line item, according to OFA, is a grant to the Hartford Foundation for Public Giving, which subcontracts with Connecticut Voices. And \$25,750 in a CHC line item goes directly to Voices. (A multi-year Robert Wood Johnson Foundation grant to Voices earmarked for outreach is ending in December 2005.)

Administration

Affiliated Computer Services-State Healthcare (ACS) has carried out four main HUSKY program functions. It (1) is the state's Medicaid managed care enrollment broker (since 1995) (2) serves as the single point of entry provider for family Medicaid (since 1998), (3) calculates monthly capitation fees due to HUSKY A MCOs (since 2001), and (4) determines HUSKY B eligibility. (Federal law requires the state's Medicaid agency to do eligibility determinations, but ACS determines whether applications should go to DSS or be redirected to HUSKY B). DSS paid ACS \$6.9 million for the period July 2003 through December 2004.