OLR RESEARCH REPORT

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OLR BACKGROUNDER: GETTING UP TO SPEED ON MEDICAID AND HUSKY B

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This report answers several frequently asked questions about Connecticut's Medicaid and State Children's Health Insurance (SCHIP or HUSKY B) programs.

Who is eligible for Medicaid?

The state's Medicaid program provides fully subsidized health insurance to most very-low-income state residents. The program is divided into several coverage groups. The coverage category into which an applicant falls generally depends on his or her age and whether he or she has a disability. Table 1 depicts the main Medicaid coverage group eligibility requirements. Some requirements will change to conform with the federal Affordable Care Act on January 1, 2014, as discussed below.

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Table 1: Medicaid Coverage Group Eligibility

Medicaid Coverage Group	*Income Limits*[1]	*Asset Limit*	*Who is Covered*
HUSKY A	185% of the federal poverty level (FPL)($36,130 annually for a family of three)	None	Children under age 19 and their caretaker relatives
HUSKY C	143% of the Temporary Family Assistance (TFA) benefit level-$516.23 per month for one person in most parts of the state, plus $302 of unearned income is disregarded; spend-down option for individuals with higher incomes	$1,600 for one person, $2,000 for couple (for couples living in community; higher limits for nursing home resident's spouse after assessment	Aged, blind, disabled adults
HUSKY D (through December 31, 2013)	$517.32 per month, plus $150 earnings disregard; spend-down option for people with higher incomes	None	Adults between 19 and 64
HUSKY D (January 1, 2014 forward)	133% of the FPL plus a 5% earnings disregard (effectively, 138% of the FPL)	None	Adults between 19 and 64
Home- and community-based services waivers (e.g., Connecticut Home Care Program for Elders, Personal Care Assistance)	300% of maximum monthly SSI benefit ($2,130 per month for a single person in 2013)	Generally, $1,600 for single person	Generally elderly and individuals with disabilities
Medicare Savings Programs (includes Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries, and Qualified Individuals	QMB-$1,983.03 monthly for single person in 2013 SLMB--$2,169.23 in 2013 QI--$2,308.28 in 2013	None	Medicare beneficiaries Medicaid pays certain Medicare Parts A and B cost sharing (e.g., premiums)
Family planning (new in 2012)	250% of the FPL	None	Individuals of child-bearing age not otherwise eligible for Medicaid

[1]Income limits typically go up on a yearly basis due to changes in federal poverty guidelines and SSI benefit rates.

What is HUSKY B and who is eligible?

HUSKY B is the state's CHIP program and provides health insurance to uninsured children under age 19 who do not qualify for HUSKY A. Families must contribute towards the care cost, with these contributions rising as family income rises. A child falls into one of three eligibility

bands, depending on family income. (There is no asset test.) Table 2 presents the income guidelines and cost sharing for each of the three bands.

Table 2: Husky B Income Eligibility and Plan Features

Family of 2	*Family of 3*	*Family of 4*	*HUSKY B Cost Sharing*
Income from $28,693 to $36,448 (185-234% of the FPL)	Income from $36,130 to $45,895	Income from $43,567 to $55,342	**Band 1:** No monthly premiums; some co-payments. Eligible for HUSKY Plus Physical services (see below).
Income from $36,448 to $46,530 (235-300% of the FPL)	Income from $45,895 to $58,590	Income from $55,342 to $70,650	**Band 2:** $30 monthly premium for first child; maximum monthly premium $50, regardless of number of children; some co-payments. Eligible for HUSKY Plus Physical services (see below).
Income over $46,530 (over 300% of the FPL)	Income over $58,590	Income over $70,650	**Band 3:** Unsubsidized group premium rate of $314 monthly per child.

Source: DSS HUSKY Family Income Guidelines, effective 3/1/13

What services are covered by Medicaid and HUSKY B?

According to DSS' website, basic benefits for all HUSKY members include:

1. preventive care;
2. doctor visits;
3. women's health and maternity care;
4. family planning services;
5. hospital stays;
6. physical, occupational, and speech therapy;
7. audiology services;
8. physical rehabilitation;
9. dialysis;
10. durable medical equipment, hearing aids, and orthotic and prosthetic devices;

11. home health care and hospice services;

12. ambulatory surgery and hospital outpatient care;

13. laboratory tests, X-rays, and other radiology services;

14. vision care;

15. emergency care;

16. dental services (through the Connecticut Dental Health Partnership);

17. behavioral health services (through the Connecticut Behavioral Health Partnership); and

18. pharmacy (medications)

The following benefits are available only to HUSKY A, C, or D members:

1. non-emergency transportation to health care appointments;

2. smoking cessation services, including counseling and medications; and

3. Early and Periodic Screening, Diagnosis & Treatment (EPSDT), which provides comprehensive health services for infants, children, and adolescents enrolled in Medicaid.

HUSKY Plus Physical services are available for children in HUSKY B bands 1 and 2 with severe physical health problems not otherwise covered by HUSKY B. Families pay no additional co-pays or premiums for such services, which include:

1. care coordination,

2. advocacy,

3. family support,

4. case management,

5. long-term rehabilitation (e.g., physical therapy twice a week, occupational therapy once a week),

6. medical and surgical supplies, and

7. durable medical equipment.

Children with severe emotional or mental health needs may be eligible for additional services through the Behavioral Health Partnership.

How will Connecticut Medicaid eligibility and coverage change in January 2014 under the federal ACA?

Under the ACA, Connecticut must expand Medicaid to all adults under age 65 with incomes up to 133% of the FPL by January 1, 2014. Such individuals are currently covered under HUSKY D, but only if their income is under 53% of the FPL. The new income eligibility limit using the 2013 FPL will be up to $1,321 per month for a childless adult and up to $1,784 per month for a childless couple.

Although 133% of the FPL is the income limit for these "newly eligible" individuals, the effective limit is 5% higher. This is because the ACA requires states to use modified adjusted gross income (MAGI) to determine Medicaid eligibility. The MAGI determination is based on a tax based concept of family size and household income.

Coverage for Former Foster Children. The ACA establishes a mandatory Medicaid coverage group for former foster children under age 26 who (1) are not otherwise Medicaid-eligible, and (2) were in the foster care system when they turned 18 or a higher age that the state sets for ending foster care benefits and were enrolled in Medicaid when they aged-out of that system. Benefits include the regular Medicaid package, including services required under the EPSDT program.

Currently, children who age-out of the state's foster care system are covered up to age 21 through the state's HUSKY A program.

What is the role of the administrative service organization (ASO) in the HUSKY program?

Community Health Network of Connecticut (CHNCT), a nonprofit consortium of federally qualified health centers, currently serves as the state's ASO for the Medicaid, HUSKY B, and Charter Oak Health Plan (repealed, effective December 31, 2013) programs. Since 2012, its role has been to provide administrative functions for program beneficiaries who receive services from any medical providers enrolled with DSS.

DSS pays CHNCT a monthly amount to: (1) make referrals, (2) help with appointments, (3) provide intensive care management for clients with exceptional health challenges, (4) obtain prior authorizations, and (5) provide quality management.

According to CHNCT, it is also responsible for:

1. operating a call center for members and providers,
2. providing various services for members including provider selection and appointment scheduling assistance,
3. providing various supports to provider practices that are becoming person-centered medical homes,
4. administering the member and provider appeals process,
5. assisting in retaining and expanding the provider network, and
6. conducting data analytics and various reporting.

How many Connecticut medical providers participate in Medicaid?

According to CHNCT, as of October 2013, 3,111 primary care practitioners (including APRNs) and 12,350 specialists and other practitioners were enrolled Connecticut Medicaid providers.

What are medical homes?

PA 11-44 § 110 allows the DSS commissioner to establish medical homes as a model for delivering care to recipients of DSS-administered medical assistance programs. A medical home is a practice in which a primary care provider assembles a team of other health care professionals and designs a plan to coordinate all care the patient receives. The model, as defined by federal law, is for people who have (1) two chronic conditions, (2) one chronic condition with a risk of developing a second, or (3) a serious and persistent mental health or substance abuse condition. Its components include:

1. comprehensive case management;
2. care coordination and health promotion;
3. comprehensive transitional care, including appropriate follow up, from inpatient to other settings;

4. patient and family support;

5. referral to community and social support services, if relevant; and

6. use of health information technology to link services.

DSS described its person-centered medical home (PCMH) initiative in a 2011 provider bulletin:

> Under this new initiative, practices and clinics that demonstrate a higher standard of person-centered primary care service delivery will qualify for a higher level of reimbursement for primary care services from the Department. Practices will also be eligible for additional financial incentives based on performance measures.

In order for a practice to apply and qualify for PCMH status, it must:

1. be enrolled with DSS as (a) an independent physician group or solo practice, (b) federally qualified health center, or (c) a hospital outpatient clinic;

2. meet specific PCMH standards set by the National Committee for Quality Assurance; and

3. make all medical records for all patients treated in the primary care practice available to all its clinicians, as appropriate.

In addition, the practice must also meet federal EPSDT program requirements, adhere to consumer protections, and participate in (1) initiatives to decrease racial and ethnic health disparities and (2) activities related to DSS' iQUIT smoking cessation program.

ADDITIONAL RESOURCES

OLR Report 2013-R-0016, *Medicaid – Eligibility, Administration, and Provider Participation.*

OLR Report 2013-R-0045, *Connecticut Behavioral Health Partnership.*

OLR Report 2013-R-0391, *Community Health Network of Connecticut, Inc.*

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