

Presentation to the Medicaid Care
Management Oversight Council
June 17, 2011



**Maintaining Coverage for
Children Turning Age 1**

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Department of Social Services

Maintaining Coverage for Children Turning Age 1

Background:

- Children are granted medical coverage up to age 1 regardless of household income changes during the one year coverage period.
- Medical coverage is granted for about 1,000 newborns by DSS each month.
- When child turns one, a renewal of eligibility is required by federal law. Income of household is then considered among other factors.

Maintaining Coverage for Children Turning Age 1

Number of Children Turning Age 1 By Month in 2011

	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER
Number of Newborns Turning Age 1	819	855	935	872	908	1013
Newborns - Only 1 Child in Assistance Unit	726	719	808	761	807	887
Newborns - More Than 1 Child in Assistance Unit	93	136	127	111	101	126
TOTAL	819	855	935	872	908	1013
<small>DSS Medicaid EMS Download Data as of 05/31/11</small>						

Maintaining Coverage for Children Turning Age 1

Number of Newborns with Ineligible Non-Citizen Parents by Month in 2011

	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER
Newborn with Ineligible Non Citizen Parents	158	207	277	273	187	263

Maintaining Coverage for Children Turning Age 1

Medical coverage may be discontinued after child turns age one
for these reasons:

- Current mailed renewal form is 8-pages long; is not prefilled and incorrectly asks for asset information;
- Age 1 child renewal process may not be coordinated with other family renewal periods, thus confusing to the family;
- Age 1 child renewal is not specifically identified for DSS worker; it exists among other monthly caseload renewals;
- Client notices provide confusing reasons for discontinuance;
- Federal law requires a renewal at age one for benefit maintenance.
- The above may lead to family not returning their renewal forms.

Maintaining Coverage for Children Turning Age 1

Solutions:

- Mail the abbreviated 4 page HUSKY application/renewal form (in a HUSKY envelope) rather than the 8-page multi-purpose renewal form;
 - Complete an analysis to determine if a pre-filled renewal form, as provided on other HUSKY renewals, is applicable;
 - Assess if current Age 1 cases are part of household with other siblings and grant ongoing eligibility before renewal period expires (Ex Parte Review);
 - Create unique monthly alert to notify DSS workers in advance of Age 1 children renewal due date;
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Maintaining Coverage for Children Turning Age 1

Solutions:

- Schedule refresher training for DSS staff and community partners using a "best practices" guide and client flowchart;
 - Develop reports to track, monitor and evaluate the effectiveness of these changes;
 - Review/rewrite all relevant client notices to insure clarity.
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Maintaining Coverage for Children Turning Age 1

Solutions:

- Work with Community Partners to educate families regarding their responsibilities to maintain coverage;
- Establish special outreach/retention efforts with Community Partners and CHIPRA outreach staff to directly contact only Age 1 cases that do not return the renewal form;
- These changes are a top priority for department staff. We have begun to implement some of these changes in June 2011.

Maintaining Coverage for Children Turning Age 1

Questions?

Closure of State Medical Assistance for Non-Citizens (SMANC)

SMANC Coverage Termination

- Closing SMANC effective June 30, 2011
- SMANC clients are primarily
 - legal permanent residents
 - 21 or older and not pregnant
 - in US less than 5 years and not qualified for Medicaid
- Initially SMANC closed November 2009, pursuant to PA 09-5, but was reinstated as result of lawsuit
- CT Supreme Court has now ruled state can close SMANC



SMANC Coverage Termination

- With the closing of SMANC, 4,889 individuals will lose coverage
- Exceptions:
 - Individuals receiving nursing home or home and community-based services as of June 30th
 - Individuals in nursing facilities who applied before June 1, 2011
- Closure of SMANC does not affect state's ability to provide federal Medicaid coverage for a medical emergency



SMANC Coverage Terminations

- Termination notices were mailed week of June 6
- Notices informed clients of Charter Oak Health Plan availability
- ACS will accept and expedite phone and mail-in applications allowing retroactive enrollment if necessary to minimize gaps in coverage.
- Notices informed clients of CADAP availability



Changes to ConnPACE



Changes to ConnPACE

- Effective 7/1/11, ConnPACE no longer available to individuals with Medicare, pursuant to FY 2012-2013 budget
- Affects approximately 25,000 individuals, most of whom are already on Medicare Savings Plan (MSP). Those already on MSP should not be significantly affected by closure
- 5,500 ConnPACE members not already on MSP are advised to apply
- 211 has been designated to assist with information on changes
- CHOICES and other Aging Services networks have been asked to assist with transition
- MSP applications being given priority handling



Changes to ConnPACE

- MSP makes members eligible for Low Income Subsidy (LIS – also known as 'extra help') under Medicare Part D
- Benefits to LIS
 - Co-pays \$6.30 or less
 - No Medicare Part D donut-hole
 - Medicare covers full cost of benchmark Part D premiums
 - Can change Medicare Part D plans at any time
 - DSS covers Medicare Part B premium



Changes to Long Term Care Medicaid Eligibility

Changes to Long Term Care Medicaid Eligibility

- Pursuant to Public Act 11-44
- Effective July 1, 2011
- Personal Needs Allowance change only affects individuals in nursing facilities
- Spousal Asset change affects individuals in nursing facilities and individuals needing home and community-based Medicaid waiver services

Personal Needs Allowance Decrease

- Reduced from \$69 to \$60 per month effective July 1st
- Clients, their representatives & nursing facilities notified of the change



Spousal Asset Changes

- As of July 1st, the community spouse can keep one-half of the spousal assets, up to \$109,560, plus the home and one car
- This reverts to the policy we used from 1989 until May 2010
- This change does not apply if we have determined that the institutionalized spouse is eligible for Medicaid before July 1st (assuming no break in coverage)



Preparing for Affordable Care Act (ACA) Enrollment Requirements and Administrative Services Organization (ASO)

Enrollment and Network Development

ACA Provider Enrollment Requirements

- ACA (Affordable Care Act) Sec. 6401(a)
 - Requires all ordering or referring practitioners be enrolled in Medicaid/SCHIP in addition to performing and billing providers
 - Most practitioners associated with clinics and hospitals must be individually enrolled in fee-for-service, including:
 - Physicians
 - APRN's
 - Certified Nurse Midwives (CNM's),
 - Physician Assistants (PA's not currently enrolled in fee-for-service Medicaid)

ACA Provider Enrollment Requirements

- ACA (Affordable Care Act) Sec. 6401(a)
 - Allows reliance on Medicare screening for providers currently enrolled in Medicare
 - Also allows reliance on other state's Medicaid screening for out of state providers currently enrolled in that state's Medicaid program
 - Includes many program integrity-focused provisions



ACA Provider Enrollment Requirements

- Requirements to some extent dovetail with Medicaid restructuring efforts, e.g., enrollment of individual practitioners who serve as primary care providers
- Also provides opportunities to streamline enrollment process
 - Improved form/on line web application
 - Data feed from DPH to automate licensure information
 - Automated validation of Medicare enrollment; may be able to simplify the provider application for Medicare enrolled providers
 - Simplify process for providers enrolled in another state's Medicaid program
- Implementation being planned; likely phased implementing. Awaiting CMS clarification of several questions



Provider enrollment for ASO

- Analyze extent of overlap between in-state MCO contracted providers & fee-for-service (FFS) providers
- Produce list of providers to target for outreach and recruitment (those MCO contracted but not enrolled in FFS) in support of a targeted outreach strategy
- Develop general communication plan for providers to inform them of the changes to the programs and to encourage them to enroll in DSS fee-for-service if not already enrolled
- Work with DCF to identify and enroll in FFS providers serving children residing in other states, as part of a plan to ensure uninterrupted access to such providers



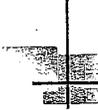
Provider enrollment for ASO

- Meet with Independent Practice Associations (IPAs), professional organizations, large provider practices, etc. to explain the changes and benefits of the new system
 - Single payer
 - One set of policies and procedures
 - Timely payment
 - 100% Medicare rate in 2013 for primary care providers



Examples of DSS tasks to address ACA and ASO provider enrollment

- Further refine provider types and/or specialties to facilitate the identification of primary care providers as well as various specialists
- Enroll clinic and hospital-based providers
- Develop policy to support enrollment of physician's assistants in FFS
- Implement revised and improved provider enrollment/reenrollment application process



Related DSS Tasks

- In addition to tasks to implement ACA changes and switchover to ASO, ensure enrollment of all providers necessary to:
 - facilitate Electronic Health Records (EHR) incentive payments for “eligible professionals”
 - facilitate compliance with National Correct Coding Initiative requirements, e.g. individual enrollment of certain types of clinicians associated with mental health clinics



Changes to the CT Dental Health Partnership

Changes to the CT Dental Health Partnership

- Effective July 1, 2011, there will be changes to the adult (21+) dental benefits
 - No services have been eliminated
 - Reductions in the number of services allowed per rolling 365 day period
 - Periodic examination
 - Cleaning
 - Bitewing X-rays
 - Prior authorization added to select services
- 365 day look-back from the date the service is performed

Changes to the CT Dental Health Partnership

- One time replacement per seven-year period for:
 - Partial dentures
 - Complete dentures
- Reduce coverage for posterior composite resins (white fillings) on posterior teeth
 - Remove molar teeth as eligible teeth, premolar teeth remain eligible for the service
- Limit the comprehensive examination to one time per client

Changes to the CT Dental Health Partnership

- Limit fluoride coverage to clients who have xerostomia (dry mouth) or had head and/or neck radiation treatment
- Limit periapical X-rays to no more than four per year
- Prior authorization necessary for panoramic X-rays except for orthodontists, oral surgeons and radiologists

Changes to the CT Dental Health Partnership

- On June 1, 2011, the ability to submit Prior Authorization requests via the Web went live
- Address is www.ctdhp.com under "Provider Partners"
- Allows providers to fill out an easy PA request form and submit digital X-rays
- Results in a cost savings for postage
- Ensures that requests are not lost in the mail



HUSKY B Band 2 Premium Refunds



HUSKY B Band 2 Premiums Reduced

- CT passed legislation in 2010 that raised premiums for families with income between 235% FPL and 300% FPL by \$8 or \$10 per month
- In February 2011, CMS clarified maintenance of effort rules for CHIP
- Clarification considers a premium increase to be a restriction on eligibility

HUSKY B Band 2 Premiums Reduced

- DSS must restore premiums to former levels and refund families
 - Invoices were adjusted with the new rates in April for the June service month
 - Families enrolled between 7/1/10 and 5/31/11 will be credited or refunded the difference in premium amounts
 - Families who disenrolled or were locked out due to unaffordability will be contacted and allowed to re-enroll retroactively if they remained uninsured during that period

HUSKY B Band 2 Premiums Reduced

- Families actively enrolled will receive a credit to their account by 7/1/11
- Other families will receive a refund check in the mail by 7/31/11
- Notices were sent to families on 6/15/11

HUSKY B Band 2 Premiums Reduced

	Premiums 7/1/10-5/31/11	Premiums on June 1, 2011 (& retro to 7/1/10)
Income Band 2		
One child	\$38	\$30
More than one child	\$60	\$50

HUSKY B Co-pay/Co-Insurance Refunds

HUSKY B Co-payment & Co-Insurance Refunds

- CMS notified DSS that increased co-payments and co-insurance amounts implemented in July 2010 could not be made effective until March 2011
- CMS is working with DSS on a plan to refund clients – not yet finalized
- DSS is working with ACS, MCOs and HP to identify the amount of cost-sharing clients paid out of pocket to refund families between 7/1/10 and 2/28/11
- Anticipate that ACS will be mailing refund checks directly to clients to avoid reprocessing claims and expecting health care providers to refund patients

Effects of HUSKY B Cost-sharing Changes

- Enrollment in HUSKY B band 2 has steadily trended upward despite last year's cost-sharing changes.
- Enrollment of children in band 2 increased approximately 3.3% overall between 7/1/10 and 3/31/11 as compared to 7/1/09 through 3/31/10



HUSKY Primary Care Update



HUSKY Primary Care Update

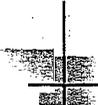
As of 6/1/11

- PCP enrollment: 250
- Member enrollment: 535
(For all four pilot areas: Waterbury,
Windham, New Haven & Hartford)



Putnam Area Expansion

- Mailed to 3,340 HUSKY A households in the seven towns:
 - Letter inviting members to participate
 - Brochure explaining HUSKY Primary Care
 - Enrollment form
 - List of participating PCPs
- New HUSKY A members will receive HUSKY Primary Care mailing

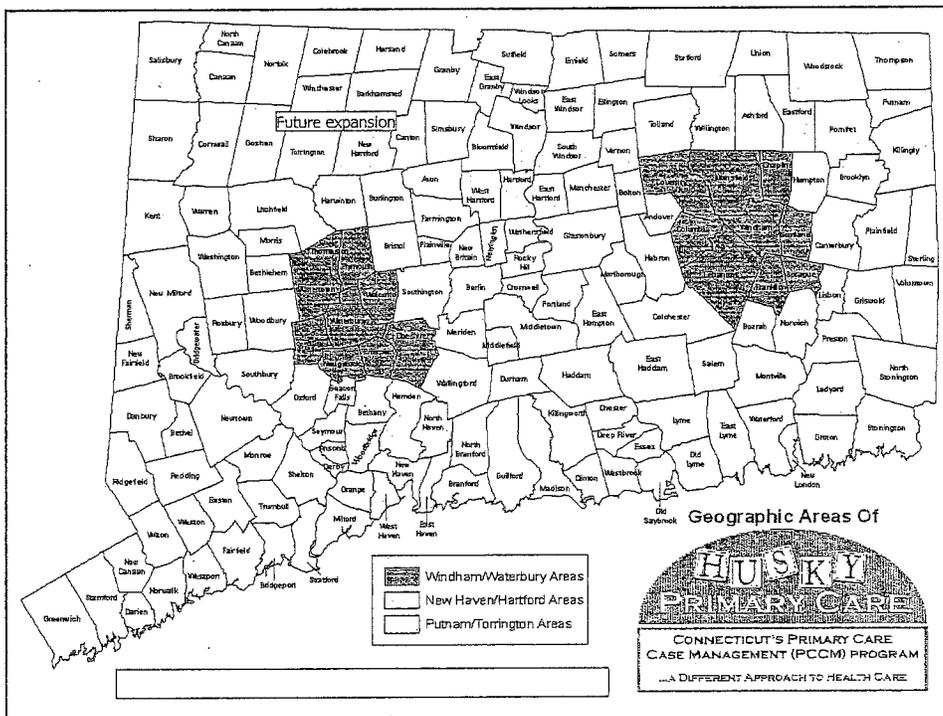


Putnam Area Expansion

- Recruited 22 providers practicing at 9 sites:
 - 9 Pediatrics MDs & 1 Pediatric APRN
 - 3 Internal Medicine MDs
 - 8 Family Practice MDs & 1 Family Practice APRN
- ACS is enrolling members effective July 1, 2011
- Addition of Putnam area brings to 5 the number of areas that have HUSKY Primary Care as an option

Torrington expansion

- Invited providers in towns that are part of Torrington area pilot:
 - Torrington, Barkhamsted, Winchester, Goshen, Litchfield, Harwinton & New Hartford
- Working with area hospital seeking providers who will participate
- Mailing sent to non-hospital affiliated providers





Person-Centered Medical Home (PCMH)



Person-Centered Medical Home (PCMH) Provider Advisory Council

First meeting: June 7, 2011 at DSS

Facilitators: Steve Schramm (Optumas),
Meryl Price (Health Policy Matters)

- Membership representing:
 - American Academy of Pediatrics
 - Community health centers (Charter Oak, Norwalk, CHC, Inc., Optimus, Staywell Health Centers)
 - Hospital-affiliated practices (Asylum Hill Family Practice, Burgdorf Health Center, Day Kimball Hospital, Franklin Medical Group, Middlesex Family Practice)
 - Multispecialty group practices (ProHealth Physicians)
 - Private practitioners
 - School-based health centers
 - Obstetric specialty practice
- Several attendees represent several practice types, settings
- Future meetings to be scheduled every 2 weeks



PCMH Provider Advisory Council Role and Purpose

- Advise DSS with respect to
 - definition and participation standards for Person-Centered Medical Homes
 - Attribution/assignment methods
 - Payment methods
- Assist the department in conducting an assessment of primary care practice's readiness to implement Person-Centered Medical Homes
- Assist the department in determining what assistance practices will need to implement Person-Centered Medical Homes



Questions?
