Medical Assistance Program Oversight Council
December 14, 2012

Connecticut Department of Social Services

Making a Difference

Connecticut Medicaid and Health Care Reform:

Where are we going?

A Snapshot of the Program: Participation

- Overall, Medicaid currently serves **611,128** beneficiaries (**20%** of the state population)
  - **425,933** HUSKY A adults and children
  - **96,608** HUSKY C older adults, blind individuals, individuals with disabilities and refugees
  - **86,503** HUSKY D low-income adults age 19-64
  - **2,084** limited benefit individuals (includes behavioral health for children served by DCF, tuberculosis services, and family planning services)

Where are we going, 2013?

- 2013 Affordable Care Act (ACA) mandatory provisions:
  - Primary care rate increases
  - Reduction in Disproportionate Share Payments (DSH)
- 2013 ACA optional provisions:
  - Medicaid preventative services

2013 ACA Mandatory Provisions: Primary Care Rate Increases

- Effective January 1, 2013, ACA requires states to increase Medicaid payments for primary care services provided by primary care doctors to 100% of the Medicare payment rate for 2013 and 2014 (financed with 100% federal funding)

- Final federal rule issued November 2, 2012

2013 ACA Mandatory Provisions: Primary Care Rate Increases (cont.)

- services must be delivered by a physician who specializes in family medicine, general internal medicine, or pediatric medicine

- certain physician subspecialists who are board certified in those specialties or provide primary care within the overall scope of those categories also qualify for the enhanced payment

2013 ACA Mandatory Provisions: Primary Care Rate Increases (cont.)

- higher payment will be made for primary care services rendered by practitioners (e.g. Advance Practice Registered Nurses, APRNs) working under the personal supervision of any qualifying physician

2013 ACA Mandatory Provisions: Reduction in DSH Payments

- Effective October 1, 2013, ACA reduces states' Medicaid Disproportionate Share Hospital (DSH) allotments and requires CMS to develop a methodology for distributing the DSH reductions

2013 ACA Optional Provisions: Medicaid Preventative Services

- Effective January 1, 2013, ACA provides a one percentage point increase in federal matching payments for preventive services in Medicaid for states that offer Medicaid coverage with no patient cost sharing for services recommended (rated A or B) by the U.S. Preventive Services Task Force and recommended immunizations

2013 ACA Optional Provisions: Medicaid Preventative Services

- Connecticut already the bulk of the listed preventative services and will be seeking the enhanced federal match for these

Where are we going, 2014?

- 2014 ACA mandatory provisions:
  - Coverage
  - Plan requirements
  - Health exchange related activities: web site, Navigator program, integrated eligibility determination
- 2014 ACA optional provisions:
  - Eligibility expansion

2014 ACA Mandatory Provisions: Coverage

- Effective January 1, 2014, ACA:
  - Requires U.S. citizens and legal residents to have qualifying health coverage (there is a phased-in tax penalty for those without coverage, with certain exemptions)

2014 ACA Mandatory Provisions: Coverage

- Effective January 1, 2014, ACA (cont.):
  - Provides refundable and advanceable tax credits and cost sharing subsidies to eligible individuals
    - Premium subsidies are available to families with incomes between 133-400% of the federal poverty level to purchase insurance through the Exchanges
    - Cost sharing subsidies are available to those with incomes up to 250% of the poverty level

2014 ACA Mandatory Provisions: Plan Requirements

- Effective January 1, 2014, ACA :
  - Requires guarantee issue and renewability of health insurance regardless of health status and allows rating variation based only on age (limited to a 3 to 1 ratio), geographic area, family composition, and tobacco use (limited to 1.5 to 1 ratio) in the individual and the small group market and the Exchanges
  - Prohibits annual limits on the dollar value of coverage

2014 ACA Mandatory Provisions: Exchange-related activities

- Effective January 1, 2014, ACA :
  - Requires states to operate an Internet website that links the Exchange, Medicaid, and Childrens Health Insurance Plan (CHIP) and permits individuals to compare available health subsidy programs and apply for or renew such coverage

2014 ACA Mandatory Provisions: Exchange-related activities (cont.)

- Requires CMS to develop a single, streamlined form (paper and online application) that states can use for all those applying on the basis of income to applicable State health subsidy programs (e.g. premium tax credits and cost-sharing reductions in the Exchange, Medicaid, CHIP, and state qualified basic health plans)

2014 ACA Mandatory Provisions: Exchange-related activities (cont.)

- Requires state Exchanges to establish "Navigator" and "In-Person Assistor" supports to provide fair and impartial, culturally and linguistically appropriate information concerning enrollment in qualified health plans and available subsidies through the Exchange, facilitate enrollment in qualified health plans, and provide referrals for complaints

2014 ACA Mandatory Provisions: Eligibility Determination

- Effective January 1, 2014, ACA requires states to remove asset tests and to use modified adjusted gross income (MAGI) for purposes of Medicaid/CHIP eligibility determination for parents, pregnant women and other non-elderly adults as well as children

2014 ACA Mandatory Provisions: Connecticut Plans

- A “no wrong door” approach to the citizen web portal that will provide access to Health Insurance Exchange services as well as to non-MAGI Medicaid, SNAP, and Temporary Assistance to Needy Families (TANF)-related services and data

2014 ACA Mandatory Provisions: Connecticut Plans (cont.)

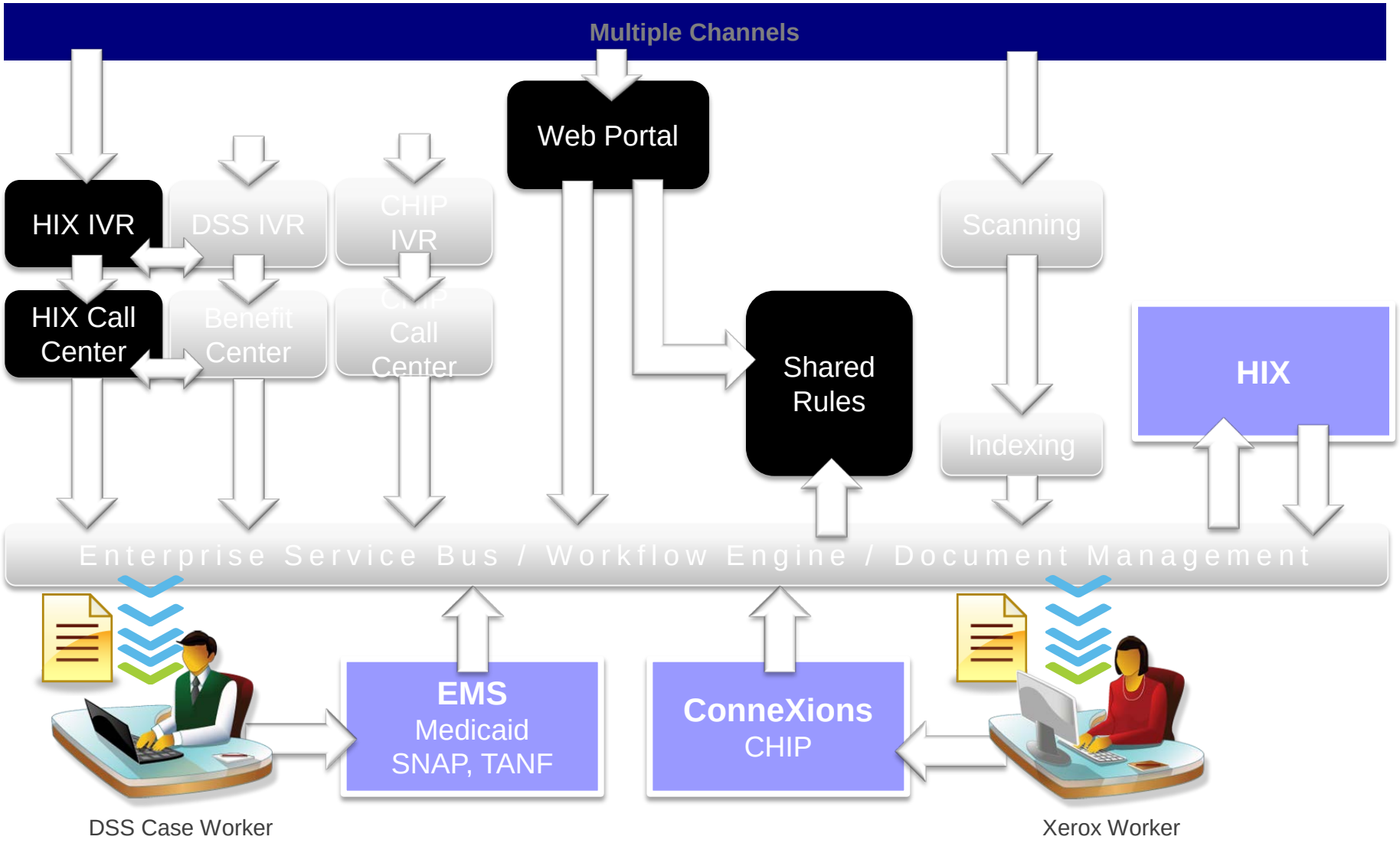
- A single shared eligibility service that will be used by both the Exchange and DSS to determine eligibility for Medicaid, CHIP, Advance Premium Tax Credits & Cost Sharing Reductions (APTC/CSR), as well as non-health public assistance programs such as SNAP and TANF

Overview

Series of projects has been broken into 4 Tiers

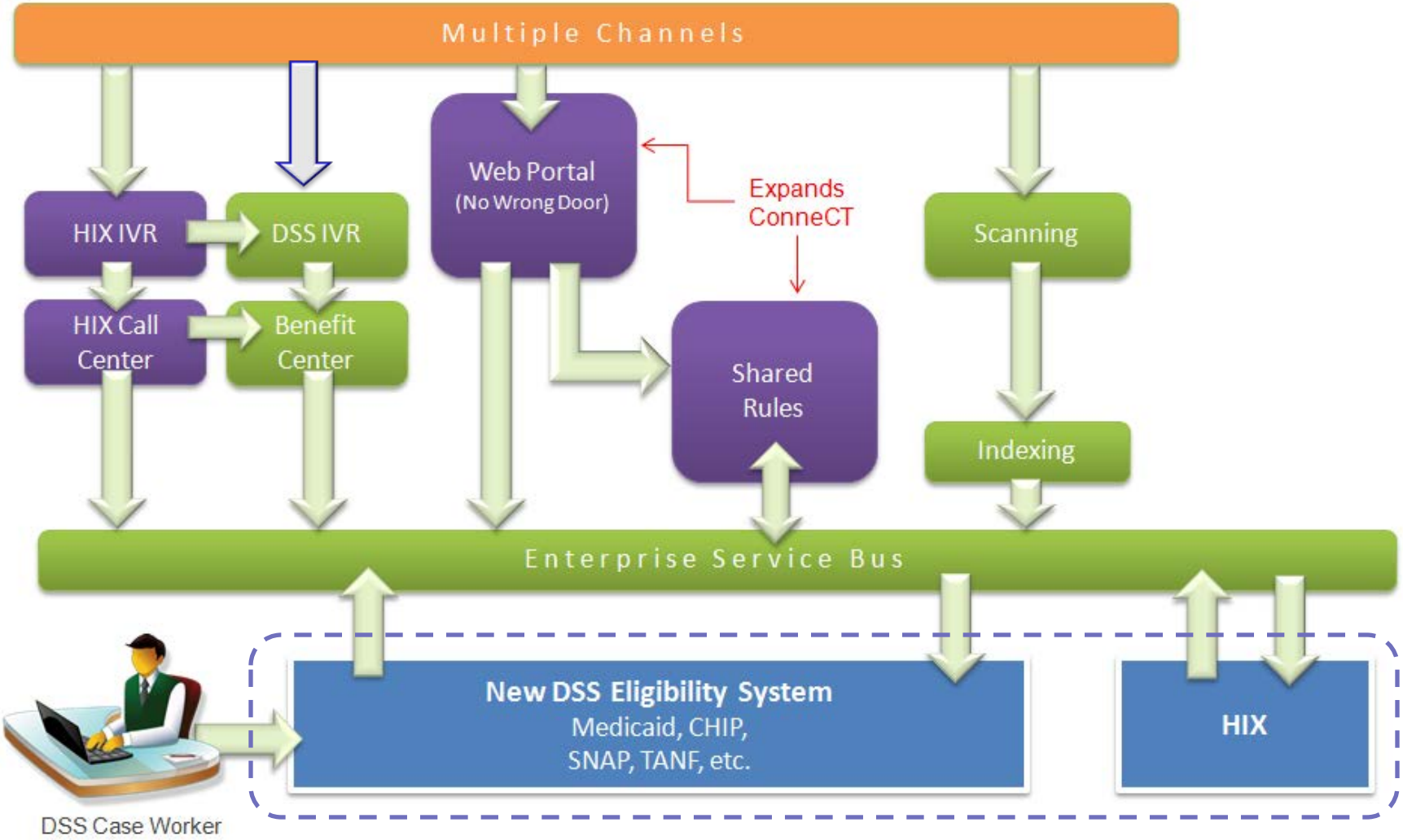
Tier	*Scope*
Tier I	CT HIX, MAGI Medicaid & CHIP
Tier II	Non MAGI Medicaid & CHIP and back office
Tier III	SNAP, TANF, RCA, RMA, SAGA, CADAP, (IE, back office)
Tier IV	TBD (LIHEAP, Child care, Employment, WIC, or DDS)

Systems – October 2013



Planned System

Planned – No later than end 2015



2014 ACA Optional Provisions: Medicaid Expansion

- Effective January 1, 2014, ACA as enacted required states to expand Medicaid to all individuals not eligible for Medicare under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL

2014 ACA Optional Provisions: Medicaid Expansion

- Note that Connecticut currently meets or exceeds this requirement through HUSKY A and B for all of these groups with the exception of childless adults

- Childless adults age 19-64 are currently covered under HUSKY D (the Medicaid for Low-Income Adults (MLIA) program) up to an income limit of 55% of FPL*

- 86,503 beneficiaries are currently being served by MLIA

* for regions B & C; 67% of FPL for region A

2014 ACA Optional Provisions: Medicaid Expansion (cont.)

- This expansion in coverage will be associated with enhanced federal match funds:
  - 100% match for calendar years 2014 through 2016
  - 95% match for calendar year 2017
  - 94% match for calendar year 2018
  - 93% match for calendar year 2019
  - 90% match for calendar years 2020 and ongoing

2014 ACA Optional Provisions: Medicaid Expansion (cont.)

On June 28, 2012, the Supreme Court issued a decision in a challenge to the constitutionality of the ACA: National Federation of Independent Business, *et al* v. Sebelius, Secretary of Health and Human Services, *et al*

2014 ACA Optional Provisions: Medicaid Expansion (cont.)

The Court:

- generally upheld the constitutionality of the law
- with respect to the mandate that States expand Medicaid coverage as described above held:

2014 ACA Optional Provisions: Medicaid Expansion (cont.)

- that while Congress acted constitutionally in offering federal match funds to states to expand coverage

- the provision that requires states to either expand coverage of forego <u>all</u> federal match funds for their Medicaid programs exceeded Congress' scope of authority under the Spending Clause of the Constitution

2014 ACA Optional Provisions: Medicaid Expansion (cont.)

- but, that this can be corrected by narrowly tailoring the expansion requirement to give states two options:
  - to accept federal match funds for expansion in compliance with the conditions associated with those funds; or
  - to refuse federal match funds for expansion and continue to operate their Medicaid programs as they do currently

2014 ACA Optional Provisions: Medicaid Expansion (cont.)

How many individuals are likely to be eligible under the expansion?

- approximately 129,786 uninsured Connecticut residents have incomes of less than 139% FPL (note that the 86,503 MLIA beneficiaries are a subset of this figure)

[Kaiser Commission on Key Facts: How Will the Medicaid Expansion for Adults Impact Eligibility and Coverage, July 2012]

2014 ACA Optional Provisions: Medicaid Expansion/Exchange “messaging”

A recent study funded by the Robert Wood Johnson polled a representative sample of individuals age 19-64 to yield information on public perceptions of Medicaid and recommendations for how to “message” expansion of eligibility and the Exchange.

2014 ACA Optional Provisions: Medicaid Expansion/Exchange “messaging”

- best “testing” description:

  Medicaid provides long-term care to millions of seniors, covers important services that help Americans with disabilities live independently and enables millions of children to see a doctor.

- note who is not referenced

2014 ACA Optional Provisions: Medicaid Expansion/Exchange “messaging”

- Medicaid is viewed as a good program
- there is high interest in enrolling in Medicaid
- but much of the expansion-eligible population doubts that they would ever be eligible for Medicaid and is unaware of new income guidelines

2014 ACA Optional Provisions: Medicaid Expansion/Exchange “messaging”

- most people want health insurance to:
  - be able to stay healthy (resonates more with women)
  - protect themselves from medical bills when the unexpected happens (resonates more with men)

2014 ACA Optional Provisions: Medicaid Expansion/Exchange “messaging”

- there is worry that people with Medicaid are not treated well
- “low-cost or free” is the best way to describe health insurance through Medicaid
- outreach should also mention covered services such as check-ups, hospital coverage and coverage for prescription drugs

2014 ACA Optional Provisions: Medicaid Expansion/Exchange “messaging”

- the Exchange is appealing to this population
- favorite aspects of the Exchange model include:
  - low-cost or free plans
  - ability to search for and compare plans
  - **availability of customer assistance**

2014 ACA Optional Provisions: Medicaid Expansion/Exchange “messaging”

- people want help using the Exchange – help is a key feature
- the most popular enrollment location is **from the convenience of home**, with the option for using call-in customer assistance
- **people do not like the idea of retail kiosks** – “it’s not private”

2014 ACA Optional Provisions: Means of Serving Certain Medicaid Eligible Individuals Under Exchange

Additionally, the Exchange will provide opportunities for alternative coverage of parents who are currently enrolled in Medicaid.

Making Coverage Affordable

Beginning in 2014, the Exchange offers the State of Connecticut a viable alternative for parents currently enrolled in Medicaid.

Premium tax credits and cost sharing reductions will be offered through the Exchange to make private insurance coverage affordable. These affordability subsidies will be fully financed by the federal government.

The amount of the federal subsidies and required premium contribution from the enrollee will be determined in relationship to household income.

	Annual Income	Monthly Income	Premiums	Avg. Cost Sharing
1	$15,950 - $21,497	$1,329 - $1,791	$45 - $100	$30 or $65
2	21,610 - 29,119	1,801 - 2,427	60 - 136	60 or 130
3	27,270 - 36,741	2,272 - 3,062	75 – 172	60 or 130
4	32,930 - 44,363	2,744 - 3,697	90 – 207	60 or 130
5	38,580 - 51,985	3,215 - 4,332	105 - 243	60 or 130

Advanced Premium Tax Credits

Based on cost of second lowest costing Silver plan, the maximum premium contribution for households with annual income between 138% and 185% of the federal poverty line will be held **constant** between 3.4 and 5.6% of their income.

- For an **Individual**: Assuming a $350 plan, the value of the premium subsidy will between $305 to $230 per month for an individual
- For a **Couple**: Assuming a $700 plan, the value of the premium subsidy will between $640 and $535 per month for a couple

Approximate Premium Contribution per Month

138%	$45	$60	$75
150%	60	80	100
175%	85	120	150
185%	100	136	172

Cost Sharing Reductions

In addition to Advanced Premium Tax Credits, this population would be eligible for **significant** cost sharing reductions.

These reductions in typical out-of-pocket ("OOP") expenditures effectively increase the actuarial value of the Silver plan, thereby lowering the overall cost of coverage.

- between 138 and 150% of FPL, the AV of the Silver would increase to 94% (holding premium constant)
- between 150 and 185% of FPL, the AV of the Silver would increase to 87% (holding premium constant)
- further, the maximum OOP limit would be reduced by 2/3rd:
  - for an individual parent, from $6,250 to $2,250;
  - for a couple, from $12,500 to $4,500

Comprehensive Benefits

The essential health benefits package will be equal to the scope of benefits under a typical employer-based plan.

Medicaid benefits not part of Essential Health Benefits include:

- adult vision (EHB includes coverage for vision screening only)
- adult dental
- non-Emergency Room transportation

Dental Benefits:

- Essential Health Benefit includes comprehensive dental coverage for children under age 19
- The Exchange will be offering stand-alone dental options for adults.
  - Early estimates on cost for a routine adult dental plan that provided coverage for preventive and diagnostic services, basic restorations, and extractions, but no major services, would be $27-29 PMPM
  - A more comprehensive plan comparable to CHIP in its scope of benefits would cost in the low $40 PMPM

Network Adequacy

Network Standards for Exchange products:

- Health plans sold through the Exchange must have a provider network that include 75% of all essential community providers, including 90% of all federal qualified health centers.
- In general, enrollees in Exchange products will have a higher level of access to health professionals and than they would in Medicaid.

Supporting research:

1) 2011 national survey of physicians: 31 percent of physicians were unwilling to accept any new Medicaid patients, compared to 18 percent of physicians who would not accept new privately insured patients. In Connecticut **nearly 40 percent of physicians would not accept new Medicaid patients**. (*Health Affairs*, August 2012)
2) 2012 Illinois-based study in which individuals, posing as mothers of children with common medical conditions requiring specialty care, called outpatient clinics asking for doctors' appointments: 68% of those representing themselves as Medicaid/CHIP enrollees were denied an appointment, compared to only 11 percent of those saying they had private insurance—a **ratio of 6 to 1**. (*New England Journal of Medicine*, August 2012)
3) Another study, using the same methodology, surveyed the ability of mothers to obtain urgent dentists' appointments for their kids: 63.5% of Medicaid/CHIP enrollees could not get an appointment, compared to a 4.6% rejection rate for those with private insurance—a **ratio of 14 to 1**. (*Pediatrics*, June 2012)

And, planning ahead . . .

Planning Ahead: Connecticut State Innovation Model (SIM) Application

- Under the leadership of the Office of Health Care Reform and Innovation (OHRI), DSS joined a broad range of state agency partners and other stakeholders in mutually drafting an application seeking funding from CMS for formal health care reform planning efforts

- This application was submitted in September, 2012

Planning Ahead: Connecticut State Innovation Model (SIM) Application

- The application acknowledges the many examples of state agency health care reform work that are already in evidence and seeks to map an overall agenda

- In support of enhancement of primary, preventative care:
  - DSS and Office of the State Comptroller PCMH
  - EHR funding

Planning Ahead: Connecticut State Innovation Model (SIM) Application (cont.)

- In support of integration of care across disciplines:
  - Co-location of Medicaid medical Administrative Services Organization (CHN-CT) with the behavioral health ASO (Value Options)
  - Substance Abuse and Mental Health Services Administration (SAMHSA)/Department of Mental Health and Addiction Services (DMHAS) funded primary care/behavioral health integration pilots
  - Duals demonstration

Planning Ahead: Connecticut State Innovation Model (SIM) Application (cont.)

- In support of efforts toward multi-payer approaches:
  - use of shared performance metrics and payment strategies in the DSS and OSC PCMH initiatives
- In support of engagement of consumers in informed decision-making:
  - Office of the Healthcare Advocate
  - CHOICES/Aging & Disability Resource Centers

Planning Ahead: Connecticut State Innovation Model (SIM) Application (cont.)

- In support of efforts to positively influence health care consumer behavior:
  - OSC Health Enhancement Program
  - DSS Rewards to Quit and ASO chronic disease self-management education
  - DPH Community Transformation Grant and promotion of Healthy People 2020

In conclusion . . .

- Connecticut Medicaid is already utilizing diverse strategies to support use of primary preventative care, integration of care, and rebalancing of long-term services and supports

- In collaboration with a broad range of state agency partners, DSS is partnering to plan for both mandatory and optional aspects of ACA implementation

Questions or comments?