

Connecticut Medicaid Managed Care Council

Legislative Office Building Room 3000, Hartford CT 06106
(860) 240-0321 Info Line (860) 240-8329 FAX (860) 240-8307
www.cga.state.ct.us/ph/medicaid

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Implementation of Legislative Changes in HUSKY/Medicaid: Updated November 17, 2003

The Department has described a phase-in implementation approach for the numerous legislative changes in the HUSKY programs, Medicaid and State Assistance (SAGA) over the past several Medicaid Council meetings. To summarize:

Public Act Provisions	Implementation Date	Implementation Vehicle	Details
(Pa 03-3, sec 72) Medicaid pharmacy/ambulatory care service co pays : PA03-3, Sec 43 SAGA	November 1, 2003 For more information, see DSS 'provider bulletins' at http://www.ctmedicalprogram.com/	State Medicaid Plan amendment	Applies to non-exempt ADULTS in FFS, HUSKY A: <ul style="list-style-type: none"> • Prescriptions: increase from \$1 to \$1.50/script • Medical Services: \$2.00 per visit. SAGA: \$1.50/script. No co pays for medical services.
PA 03-3,Sec 69: consistent failure to pay Medicaid pharmacy co pays	Requires further discussion with CMS	May be State Plan amendment if DSS can ID recipient categories by some factor (i.e. household income) to satisfy CMS/federal law	Pharmacies are allowed to deny filling scripts for Medicaid recipients who consistently fail to pay co pays over 6 months. Initially thought to require waiver authority to deny care in Medicaid, CMS may allow this under the State Plan if DSS can identify recipient categories.
PA 03-3. Sec. 55,56: HUSKY B benefit restructuring/cost share increases	Premium changes: 2/1/04 Benefit changes & >co payments: July 1, 2004	State SCHIP Plan Amendment	<ul style="list-style-type: none"> • Benefit & cost sharing structure similar to largest CT HMO commercial plan • >Premiums for families with income 235-

Public Act Provisions	Implementation Date	Implementation Vehicle	Details
			300% FPL (band 2). <ul style="list-style-type: none"> • Add per month premiums to families with income 185-235% FPL (band 1). Aggregate cost sharing not to exceed 5% of family's gross annual income.
PA 03-3, Sec 72 HUSKY A benefit & cost sharing per month (PM)	When waiver application process, including public comment & GA approval, completed. Anticipated Date: July 2005 (May include dual eligibles, under some form of managed care, in the HIFA waiver)	Requires CMS approval of waiver authority	<ul style="list-style-type: none"> • Benefits similar to State Employee non-gate keeper POE plan. • Premium cost sharing: *0-50% FPL: 0 \$ *50-100% FPL - \$10 Individual PM, \$25 family PM max. *>100% FPL: \$20 individual PM, \$50 family PM max.
PA 03-1, sec 11; <i>Sept Special Session</i> Premiums for Medicaid FFS*	April 1, 2004	Medicaid State Plan Amendment	Initially applies to Medicaid FFS adult recipients, based on federal Medicaid rules, in the <u>medical spend down category</u> , (generally those > 65 years or disabled). Recipient will receive 30-day termination notice from DSS the third month if premium payments are <i>2 months</i> overdo. Medicaid eligibility could be reinstated upon DSS receipt of premium payments.

* From the MMCC October 10, 2003 meeting: Initially, premiums will apply to Medicaid FFS recipients, (see Sept Special Session, PA 03-1, sec. 11) possibly ranging from \$7–19 dollars per month. The calculation of these premiums has to be done on an individual basis, (unlike the income bands in HUSKY B).

Addendum: The DSS was later asked to clarify those FFS groups that will be assessed a monthly

premium. Current federal regulations allow premiums to be applied to the Medicaid medically needy category that includes those in medical ‘spend down’ and ‘Zero spend down’ groups.

- The medical spend down Medicaid eligibility is based on the amount of income exceeding the medically needy income limit (MNIL) within a six-month period. Medical out-of-pocket (OOP) expenditures are used to offset the excess income, which allows the recipient to meet Medicaid income eligibility requirements.
- The zero spend down category eligibility is also based on the MNIL, which varies according to income level per state region. However for zero spend down, there is no excess income to be offset. Income levels are compared to net monthly income. For example:

	Region C - Hartford	Region A - Fairfield
Individual income limit	\$476/month	\$575/month
Two adults	\$629/month	\$737/month

The recipients in these categories are generally over age 65 years or disabled. Some of these individuals live in group homes; the DSS has not been advised as to whether any individuals in group homes would be required to pay monthly premiums. This legislative mandate implementation is scheduled for 4/1/04 as it requires development of a DSS system that links premium payments and eligibility status. Recipients that are delinquent in paying premiums for two months will receive a notice in the 3rd month that their eligibility will be terminated that month if the premium payments are not made. The recipient can be reinstated in Medicaid once DSS receives payment of the back premiums).

Other:

Service Carve out Status (Dental & BH)

Decisions about the service carve outs were dependent on the final budget resolution:

- Dental: The Governor’s proposal included the elimination of adult Medicaid dental services, which was NOT approved by the legislature. Now that the Medicaid dental population is defined as including HUSKY A & B and Medicaid FFS recipients (SAGA dental services will be under the grant funded medical services plan), **the DSS will proceed with plans to carve out dental services July 1, 2004.**
- Behavioral Health Partnership (BHP) and HUSKY BH carve out: legislative authority was sought to place BHP funds into special accounts in DSS & DCF. This authority was not approved, which effectively halts the BHP restructuring process of BH in the Medicaid program & within DCF. Until there is authority to move forward with the BHP, the time frame for the carve out of HUSKY BH services is uncertain.