Overview of the Medicaid Managed Care Council

The Medicaid Managed Care Council was established under CGS 17b-28 as a collaborative body consisting of legislators, Medicaid consumers, advocates, health care providers, insurers and state agencies to advise the Department of Social Services (DSS) on the development and implementation of Connecticut’s Medicaid (HUSKY Part A) and SCHIP (HUSKY Part B) Managed Care program and for ongoing legislative and public input in the monitoring of the program.

The Council, which convened its first meeting in the summer of 1994, has a legislative mandate to assess and make recommendations to the Department concerning:

- Access to the HUSKY program & health care services,
- Effective outreach and client education about the program, enrollment processes and program changes,
- Provider network sufficiency & participation of pre-existing community Medicaid providers in the managed care program,
- The quality of health care services,
- Coordination of health coverage under the HUSKY A & B plan, and between managed care plans and state/federal health care reforms,
- Timely accessible client grievance procedures,
- Financial status of the program and timely provider payments to guarantee access to quality services.

Due to the large volume of work the Council addresses, four subcommittees have been established, which include Behavioral Health, Consumer Access, Public Health, and Quality Assurance. Subcommittees convene work groups as needed to address specific issues. The Council holds public hearings and forums to assess the impact of Medicaid Managed Care.

The full Council and each Subcommittee meet once a month.

PA06-188 extended the oversight of the Council to the managed care portion of the State
Description of the HUSKY program

Initially called the Connecticut Access Program (1995-98) legislative changes resulted in the HUSKY program Plan A, HUSKY Plan B and HUSKY PLUS behavioral and physical health programs.

- **HUSKY A** provides coverage to children at <185% FPL and adult parent/caregivers to 150% FPL.

- **HUSKY B**, the non-entitlement State Child Health Insurance Program (SCHIP) program, provides health coverage to children within 3 income bands that require some co-pays & premiums (186-300%FPL) or full premium payment (>300%FPL).

- The HUSKY B PLUS program provides supplemental services for children in band 1 and 2 with special medical needs.

- January 1, 2006 Behavioral Health Services for HUSKY A child/adults and HUSKY B children were removed from the managed care program into the Behavioral Health Partnership Program. The Departments of Social Services and Children and Families assumed responsibility for behavioral health services for these enrollees and delegated administrative functions to an Administrative Service Organization, ValueOptions. The HUSKY managed care organizations remain responsible for medical services, transportation (HUSKY A), pharmacy and coordinated care management with ValueOptions.

Four managed care organizations (MCOs) provide managed care services to HUSKY A and three MCOs (Anthem, CHNCT and WellCare/Preferred One) participate in HUSKY B. Anthem Blue Care Family Plan and Health Net have commercial & Medicaid business lines while Community Health Network of CT and WellCare/Preferred One are Medicaid only plans. The plans all subcontract for dental and transportation services and pharmacy management; plans individually subcontract for other services (i.e. durable medical equipment, home care services).

Overview of the HUSKY Program Changes

{Updated 8-06}

HUSKY changes implemented to date include:

- Elimination of 12-month children’s continuous eligibility, 4/1/03.
- Elimination of adult 6-month guaranteed enrollment, 4/1/03.
- Elimination of children’s presumptive eligibility 8/03. **Reinstatement of Presumptive Eligibility November 2005.**
- Change from statutory language for “presumptive eligibility for pregnant women” to “expedited eligibility” in 2005. Pregnant women’s Medicaid eligibility (income at 185% FPL) is to be determined within 24 hours for emergencies and within 5 days for other pregnancies. DSS established 3 Regional Processing Units to process pregnancy-related
HUSKY applications. Implemented November 2005.

• HUSKY A adult co-pays: increase of prescription co-pays to $1.50/script and new $2.00 outpatient co-pay beginning November 1, 2003. **Eliminated in SFY 05.**

• 2005 legislation included imposing **HUSKY A adult premiums of $25/adult/month for members with income >100% FPL ($300/year/adult) plus $1.00/outpatient visit co-pay.** Implementation requires a waiver from CMS. As of August 2007, this provision has not been applied.

• Reduction of HUSKY A adult parent/caregiver coverage from 150% to 100%FPL effective **April 1, 2003.** Initially 24,000 adults were to be dis-enrollment but remained in HUSKY A due to a court injunction. The case was decided in favor of the State May 2003. Subsequently 15,000 adults with earned income remained enrolled after an injunction by the 2nd Circuit Court of Appeals March 26, 2004. These adults continued to be enrolled in HUSKY for the total 24-month transitional medical assistance (TMA) period, which began April 1, 2003. Two changes were made in 2005:
  o The HUSKY A adult/caregiver income eligibility level was raised back to 150% FPL effective July 1, 2005.
  o The TMA period was reduced from 24 months to 12 months, effective June 30, 2005. Many parents/children could be eligible for HUSKY A/B (children only) and were encouraged to renew Medicaid coverage. In July 2006, HUSKY A enrollment dropped by 14,878. DSS said this reflected the 12 month TMA coverage period that ended for about 8,600 families on June 30, 2006.

• Premiums were added to HUSKY B Band 1 and increased for Band 2 effective February 1, 2004. In the first month approximately 2400 children would have been dis-enrolled for failure to pay the February monthly premium if the State had not established a transitional period until May.
  o In **June 2004** DSS decided not to implement the HUSKY B premium increases.
  o Reinstate premiums effective **October 1, 2005.**
  o **Elimination of new premiums in the Nov. 2005 special session.**

• HUSKY self declaration of income, with DSS monitoring, begun in 2001 was **eliminated effective July 1, 2005.** Subsequent enrollment losses and significant increases in the numbers of pending and discontinued applications due to ‘incomplete documentation’ resulted in legislation to **restore self-declaration of income, with DSS monitoring, effective July 1, 2007.**

**Other Changes**

• 2005: expansion of the Katie Beckett model waiver slots from 125 – 180.

• 2005: 2 year SAGA pilot for 100 individuals ages 19-20 with chronic medical & behavioral health conditions who are uninsured and live with their families.

• 2005: Family Planning Waiver that would provide federally-defined family planning services to uninsured women up to 185% FPL. As of August 2007 waiver has not been submitted to CMS.

• 2006:
  o **$2.95 million, outside of managed care, for Medicaid dental well baby/sealants program.**
  o Unfunded Medical Home pilot in HUSKY A
- $5.1 million for SAGA federally qualified health clinics (FQHC) reimbursement and limited transportation and optical hardware benefit.

- **Proof of Citizenship & Identity:** On **July 1, 2007** DSS implemented the federal law in the 2005 Deficit Reduction Act (DRA) that requires all Medicaid applicants and recipients that declare or declared U.S. citizenship to provide original documentation of citizenship and identity at the time of application or next renewal. Subsequent changes to the initial CMS guideline in the interim regulations exempt “dual eligible” and SSI recipients from duplicating such documentation and allows states some flexibility in using vital statistic data matches for proof of citizenship. The DSS Commission has request regional DSS offices not to deny or discontinue a case because of failure of citizenship verification without first contacting DSS central office.

Significant proposed changes to the HUSKY A & B programs over the last several years that were NOT implemented included:
- Restructuring HUSKY A benefit package to one similar to the State Employee Non-gate Keeper Point of Enrollment plan with cost sharing.
- Restructuring HUSKY B benefit package and co-pays similar to the State’s largest commercial HMO.
- Submission of a HIFA waiver for Medicaid. State legislation in 2005 and 2006 precluded DSS form seeking a federal waiver that would limit federal dollars.
- DSS was prevented from changing the HUSKY “medical necessity” definition in 2006 legislation.
- Carve-out of dental services in HUSKY was planned but abandoned in 2005.