

# Connecticut Medicaid Medical Assistance Program Oversight Council

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## Overview of the Medicaid Medical Assistance Program Oversight Council

*The Medicaid Medical Assistance Program Oversight Council previously called the Medicaid Managed Care Council, is a collaborative body established by the General Assembly in 1994 to initially advise the Department of Social Services (DSS) on the development and implementation of Connecticut's Medicaid Managed Care Program (HUSKY A), in 1998 the State Children's Health Insurance Program (SCHIP)-HUSKY B and in 2006 the managed care portion of the state funded State General Assistance (SAGA) program that in July 2009 became the new Medicaid expansion group called the Medicaid low income adults (MLIA) program and the state subsidized Charter Oak Health Program (uninsured adults 19-64).*

*Legislation in 2011 revised 17b-28 to include Council oversight of the Medicaid HUSKY Health Program that encompasses all Medicaid enrollees' health care. The statute charges the Council with monitoring and advising DSS on matters including, but not limited to, program planning and implementation of the new delivery system under the Administrative Service Organization (ASO), transitional issues from managed care to this model, eligibility standards, benefits, health care access and quality measures. In addition the Council advises DSS on the development and implementation of the provider-level Person - Centered Medical Home model. The Council consists of legislators, consumers, advocates, health care providers, representatives of managed care plans (through 12-31-11), the medical ASO and state agencies. The Council has five Committees: **Consumer Access, Quality, Care Management/ PCMH, Women's Health and Complex Care Committee.***

## Description of the HUSKY program

Since 1995, DSS has contracted with multiple managed care organizations to manage the health care of enrollees in the HUSKY A (children/families) and HUSKY B (children only) and the state subsidized (2007) Charter Oak Health Plan for uninsured adults. Beginnings in 2006 service delivery changes were made that included:

- 2006 the CT Behavioral Health Partnership Program (CTBHP) , under the management of the Departments of Social Services and Children & Families, was created when mental health services for HUSKY A, B were 'carved-out' of Medicaid managed care plans and administered by a single Administrative Service Organization (Value Options) that had defined performance measures associated with financial incentives.
- The Department of Mental and Addiction Services joined the CT BHP as a partner in 2011 and mental health services for Medicaid members in the Fee-for-service program were included in the ASO responsibility. The State Subsidized Charter Oak Health Plan mental health services were also added to the ASO management in 2007.
- Dental services were removed from the MCO responsibility in Sept. 2009 and dental services for all Medicaid clients are managed through the selected ASO (Benecare) in the ca CT Dental Health Partnership.
- Pharmacy services, previously managed by the MCOs (HUSKY Program) were 'carved –

out' to a single Preferred Drug List system managed by DSS in 2009. Beginning in Jan. 2012, DSS plans to streamline Medicaid transportation services under one transportation contractor.

- Transportation services remained under the management of DSS for the Fee-fro service population and the managed care organizations for the HUSKY program. DSS expects to consolidate all transportation services under one transportation vendor in 2012.

February 2011 Governor Malloy announced a plan to streamline administration of health services for all Medicaid enrollees (~600,000 members) by moving to a non-captiated Administrative Service Organization (s) to achieve the goals of reduction of overhead cost, service delivery improvement and ensure the State's readiness to participate in federal health care reform. The plan also included the development of a primary care 'medical home' model that incorporates practice-based care coordination and creation of federally defined 'health homes' that will provide comprehensive care coordination for individuals (adults and children) with chronic illness.

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.

In January 2012 the new **HUSKY Health Program** managed by the ASO, Community Health Network of CT (CNHCT) will include:

- **HUSKY A** provides coverage to children at <185% FPL and adult parent/caregivers to 185% 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; the Plus Behavioral health program was ended and services are delivered under the CTBHP program.
- An health plan to cover uninsured adults, called the Charter Oak Health Plan remains with changes in 2011: The new policy:
  - Reduces state subsidized premium assistance to low income enrollees
  - Increased the premium to \$446/M effective 9-1-11
  - Limits eligibility in Charter Oak to applicants that do not qualify for the federal CT Pre-existing Condition Insurance Plan.
  - There are NO changes to deductible or co-insurance levels by income band. The 2011 legislation eliminated the annual benefit maximum (\$100,000), prescription maximum (\$7500) and medical equipment (\$4000).
- Based on the Affordable Care Act provision CMS provided CT with \$50M to create a pre-existing condition insurance plan (*PCIP*) individuals that have been uninsured for 6 months (no hardship exceptions) and demonstrate a pre-existing condition. Initially the premiums were high for older enrollees but in 2011 CMS has allowed CT to eliminate premium rates based on age and adopt a flat PMPM rate of \$381. Applicants to Charter

Oak are screened for eligibility in PCIP program, removing applicant choice of Charter Oak vs. PCIP.

- The previously State funded State Administered General Assistance (*SAGA*) enrollees were deemed Medicaid eligible in July 2009 when CT became the first state to create a Medicaid expansion plan under the federal Affordable Care Act. This population is referred to as the Medicaid low income adult (MLIA) group.
- Medicaid fee-for-service populations including the dual eligible (Medicaid/Medicare) and non-duals.

### Overview of the HUSKY Program Changes

{Updated 11-11}

HUSKY program changes since 2003 include:

- 2009: Development of a Primary Care Case Management pilot for HUSKY A in two regions that were over time expanded to several other areas.
- 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.
- Elimination of 12- month children’s continuous eligibility in 4/1/03 *has not been reinstated*.
- Elimination of adult 6-month guaranteed enrollment, 4/1/03.
- Elimination of children’s presumptive eligibility 8/03 was **reinstated November 2005**.
- ***Presumptive eligibility for pregnant women*** was implemented in **March 2010**. Prior to this changes were made in 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 were **Eliminated in SFY 05 before implementation**. The plan was to increase of prescription co-pays to \$1.50/script and new \$2.00 outpatient co-pay beginning November 1, 2003.
- 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. This provision was changed and never implemented.
- **April 1, 2003**: Reduction of HUSKY A adult parent/caregiver coverage from 150% to

100% FPL effective. 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 2<sup>nd</sup> 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:

- **The HUSKY A adult/caregiver income eligibility level was raised back to 150% FPL effective July 1, 2005.**
  - **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.
    - In **June 2004** DSS decided not to implement the HUSKY B premium increases.
    - Reinstated premiums effective **October 1, 2005**.
    - **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.

Despite multiple programmatic changes, 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 from seeking a federal waiver that would limit federal dollars.
- DSS was prevented from changing the HUSKY “medical necessity” definition in 2006 legislation.