Behavioral Health Partnership Oversight Council
July 10, 2013

Connecticut Department of Social Services

Making a Difference

Today's Agenda

- Overview of Medicaid-related results of legislative session
- Outpatient Re-design
- Smoking Cessation- Rewards 2 Quit
- Clinic Regulations Update

Overview of Legislative Results: Budget

- Connecticut is one of only a few states that has historically "gross appropriated“ its Medicaid program - the state budget has accounted for both the federal and state shares of spending as state expenditures toward our constitutional spending cap

- Under this budget this will change and only the state share will count toward the spending cap. This is the "net appropriation" method

Overview of Legislative Results: Budget (cont.)

- Medicaid is net appropriated (this does not include federal share) at $2,409,314,923 (SFY'14) and $2,289,569,579 (SFY'15)

- HUSKY B is funded at $30,460,000 (SFY'14) and $30,540,000 (SFY'15)

Overview of Legislative Results: Budget (Cont.)

- PA 13-247, Section 130:
  - For the fiscal year beginning July 1, 2014, the Behavioral Health Partnership Oversight Council, in consultation with the Departments of Children and Families, Social Services and Mental Health and Addiction Services shall identify a savings of one million dollars.

Overview of Legislative Results: Coverage Groups

- **HB6705** (the human services implementer) provides the following:
  - **Section 102** requires DSS to submit a plan for coverage of the new “Medicaid Coverage for the Lowest Income Populations” group
  - the new coverage group will include the current Low Income Adult (LIA, HUSKY D) beneficiaries plus the individuals who will become eligible under Medicaid income eligibility expansion effective January 1, 2014

Overview of Legislative Results: Coverage Groups (cont.)

Effective January 1, 2014, Connecticut will expand income eligibility for the existing Low-Income Adult (LIA, HUSKY D) Medicaid coverage group to 133% of FPL (effectively, 138% given the income disregard that will be utilized). In **2013**, this translates into the following income eligibility limits:

For . . .	2013 138% FPL Monthly	2013 138% FPL Annually
An individual without children	monthly income < $1,321	annual income < $15,856
A couple without children	monthly income < $1,784	annual income < $21,404

Overview of Legislative Results: Coverage Groups (cont.)

- To qualify for the new group, people will need to meet the above income limits, and also:
  - be at least age 19 or under age 65
  - not be pregnant
  - be ineligible for other specific coverage under Medicaid, Medicare and or CHIP
  - be a Connecticut resident
  - be a U.S. citizen or qualified alien (legally in the U.S. for at least five years unless under age 21 or pregnant)

Overview of Legislative Results: Coverage Groups (cont.)

This is anticipated to increase participation in the LIA group by 50,000 – 55,000 over and above the current enrollment of almost 89,500 people.

Overview of Legislative Results: Coverage Groups (cont.)

A final note about coverage groups: adults with incomes in excess of 133% of FPL who qualify for Medicaid under HUSKY A will continue to participate in Medicaid.

Overview of Legislative Results: Terms of Participation

- **HB6705** (the human services implementer) provides the following:

  - **Section 76(e) (effective 7/1/13)** requires DSS, to the extent permitted by federal law, to require Medicaid beneficiaries who use emergency departments for non-emergent care to make co-payments

Overview of Legislative Results: Terms of Participation (cont.)

According to **CMS requirements**, when co-payments are implemented, hospitals must do the following before providing a non-emergency service to a Medicaid beneficiary:

- The hospital must determine:
  - after an appropriate medical screening, that the individual does not need emergency medical services and

Overview of Legislative Results: Terms of Participation (cont.)

- that an alternative non-emergency services provider is actually available and accessible in a timely manner to provide the services needed by the individual with the imposition of no or a lesser copayment

- The hospital must provide the individual with (a) notice that a copayment may be required before the service is provided; (b) the name and location of an alternative non-emergency services provider (as described above); and (c) a referral to coordinate scheduling of the individual's treatment by this provider

Overview of Legislative Results: Terms of Participation (cont.)

- **Section 105 (effective 7/1/13)** confirms that coverage decisions made by the behavioral health Administrative Services Organization (Value Options) must be based solely on the statutory definition of medical necessity, but may use clinical management guidelines to inform and guide the authorization

Overview of Legislative Results: Related Notes (cont.)

- **HB6705** (the human services implementer) provides the following:

  - **Sections 86-87, 90-93, and 119-120** eliminate reference to Charter Oak – Charter Oak will sunset as of December 31, 2013 as the Access Health CT plans become effective January 1, 2014

Outpatient Re-Design Workgroup

- The Departments would like to initiate a workgroup with providers and ValueOptions to review innovative practice and payment models for outpatient services
- Pay for performance models will be considered
- The workgroup goals and objectives will be discussed at the next BHPOC- Operations sub-committee meeting

Smoking Cessation: "Rewards 2 Quit"

- Federal Grant from the Medicaid Incentives for Prevention of Chronic Diseases
- DSS published in the Law Journal our intent to implement group counseling for smoking cessation on July 1, 2013
- DSS plans to update that posting with an August 1, 2013 implementation date

R2Q Policy Questions

- Which provider types/specialties can provide the service
- What type of practitioners can facilitate the groups
- What is the actual procedure code and modifier(s) that providers will use to submit claims for the group
- How many people can be in a group
- What smoking cessations models/curricula can be used
- What is the reimbursement rate per member per group
- How many units should be authorized
- How do these policies intersect with the clinic regs
- What is the fiscal impact

Clinic Regulations Update

- Review Committee rejected the clinic regulations without prejudice
- Seeks clarification on the following:
  - Requisite licensure or certification requirements for individuals to conduct an evaluation
  - Further explanation of the sentence that reads: the evaluation informs the plan of care

Clinic Regulations Update Cont.

- Further clarification on who completes and updates the plan of care
- Further clarification on the terms “authorization” and “prior-authorization” and do not use them interchangeably
- Further clarification on payment section as it applies to the term “usual and customary”

Questions or comments?