

# Medicaid: Turning the Serbonian Bog into a Smooth Path toward Healthcare Coverage

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# Objectives


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- Strategies for Covering More People under Medicaid
- Strategies for Retaining Medicaid Enrollees and Providers
- General Information on Eligibility and Funding of CT's Medicaid Program

# Who is Not Covered by Medicaid

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- Non-disabled adults without children
  - Aged, blind or disabled adults\* who do not meet income and/or asset requirements
  - Parents and children\* who do not meet income and/or asset requirements
  - Undocumented non-citizens (exception: Medicaid for emergency services)
- \*individuals can “spenddown” to very low Medicaid income limits (asset tests apply)



# We already use Medicaid Waivers and Options to Expand Coverage and Reduce Costs

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- In CT we have chosen a mix of options and waivers to expand coverage
- With regard to disabled and elderly, we prefer waivers where we can better predict spending (capped enrollment)
  - Exs: Home & Community Based Waivers, Katie Beckett Waiver, DMR Waivers



# We can cover more individuals under Medicaid

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- Use Medicaid options, for example
  - section "1931" income/asset disregards
  - rehabilitation option
- Use Medicaid waivers
  - expand home & community based waivers
  - cover Charter Oak/SAGA adults



# Participant Retention Issues

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- Even if our state can increase enrollment in Medicaid, we face issues of keeping individuals continuously enrolled so they can receive the care they need.



# HUSKY Retention Strategies Already in Place

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- Self-declaration of income
- Presumptive eligibility for children and pregnant women
- Shortened, simplified application
- Friendlier messaging of program/changing name of program
- Increasing income limits
- Aligning income limits between children and parents
- Eliminating asset tests
- Lengthening renewal periods

# Recommended Retention Strategies for Enrollees

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- Automatically enroll
- Implement “continuous eligibility”
- Increase income limits further
- Utilize one updated computer system to determine eligibility and enroll participants
- Expand effective outreach strategies





# Improve Provider Participation/Retention

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- Increase provider reimbursement fees (align with Medicare fee schedule)
- Reward providers for improved access (e.g, 24/7 coverage) and patient health outcomes
- Simplify procedures for providers (e.g., simplifying credentialing process; electronic health records)

# Over 400,000 residents rely on Medicaid statewide

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Categories of people that can be covered:

- Children under 19 (HUSKY A or B)
- Parents and caretaker relatives of children in HUSKY A (HUSKY A)
- Pregnant women (HUSKY A)
- 19 and 20 year olds (HUSKY A)
- Adults 65 or over (Medicaid Fee-For-Service)
- Disabled adults (Medicaid Fee-For-Service)

# Financial Eligibility

Insurance	Population	Eligibility	Countable Assets
<b>HUSKY A (Medicaid)</b>	Children from birth to 19	Up to 185% FPL	Not considered
	Parents with children from birth to 19	Up to 185% FPL	Not considered
	Pregnant women	Up to 250% FPL	Not considered
	Children 19 and 20 y.o.	VERY low income limit varies by DSS regions	\$2,000 maximum

# Financial Eligibility

Insurance	Population	Eligibility	Countable Assets
<b>HUSKY B (SCHIP)</b>	Children from birth to 19	Income over 185% FPL	Not considered
<b>Medicaid</b>	Elderly and disabled (living in the community)	Receiving SSI (\$637/mo; \$956/mo/couple) or Social Security income below poverty threshold or receiving State Supplemental Assistance	\$1,600 individuals or \$2,400 for couples
<b>Medicaid</b>	Elderly and disabled (nursing home or waiver program)	Income below 300% of SSI (\$1,911/mo)	\$1,600 individuals or \$2,400 for couples
<b>SAGA</b>	Adults 21 to 65 years of age	Very low income limits (e.g., \$491.92/mo)	\$1,000 per family; car with equity less than \$4,500

# Financial Eligibility

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Insurance	Population	Eligibility	Countable Assets
Charter Oak	19 to 64 not eligible for SAGA, Medicaid, HUSKY	All incomes (subsidized premiums below 300% FPL)	Not considered

# Spending in the Medicaid Population

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	Proportion of Medicaid Population (FY 2005)	Proportion of Medicaid Spending (FY 2005)
Children	54%	16%
Non-elderly Adults	21%	7%
Elderly	12%	37%
Disabled	12%	40%

# Elderly and disabled comprise smallest share of Medicaid population but account for the majority of costs.

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## Sharp discrepancies between beneficiary groups

- Average spending per elderly beneficiary (2001): \$20,954
  - CT ranked highest in spending for this group, and nearly twice the national average of \$10,619.
- Average spending per child (2001): \$1,214
  - CT ranked 36<sup>th</sup> in the nation in spending for this group
- Average spending per adult (2001): \$1,266
  - CT ranked 46<sup>th</sup> in the nation in spending for this group

In 2001, when compared to all other states, CT had the highest share of health care dollars spent in nursing home care and the second highest share of health care dollars spent in home health care.

Source: J Meyer and J Handley, "Mapping Health Spending and Insurance Coverage in Connecticut," Social Economic Policy Research Center (February 2006).



# Sources of Federal Funding

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- Federal Funds (FY 2006: \$2.1 billion)
  - Medicaid: 50 cents reimbursement
  - SCHIP: 65 cents reimbursement
  - Disproportionate Share Hospital (DSH) Payments (FY 2008: \$188M)



# Can we use more of our DSH funds?

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- CT has not always drawn down full federal DSH allotment because state must spend state-only dollars to receive federal funds (state spending impacted by state spending cap)
- Some states (not CT) have been criticized for “creative” uses of DSH (and non-DSH supplemental) monies to maximize federal funding

*See Medicaid: CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments, available at*

*[www.gao.gov/new.items/d08614.pdf](http://www.gao.gov/new.items/d08614.pdf)*

# Can we use more of our federal SCHIP funds?

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- Why were \$109 M in federal SCHIP funds left on the table?
  - Over-estimated number of eligible HUSKY B children; more children actually eligible for HUSKY A
  - State must spend in order to receive reimbursement; state spending impacted by state spending cap
  - Now it may be too late (for the moment): August 2007 Directive from Centers for Medicare and Medicaid Services
    - Restrictions on state's ability to cover children above 250% FPL



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