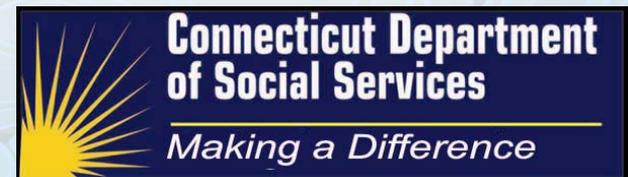


Informational Briefing Before the Human Services Committee on Medicaid

Michael P. Starkowski
Commissioner, DSS
January 22, 2009



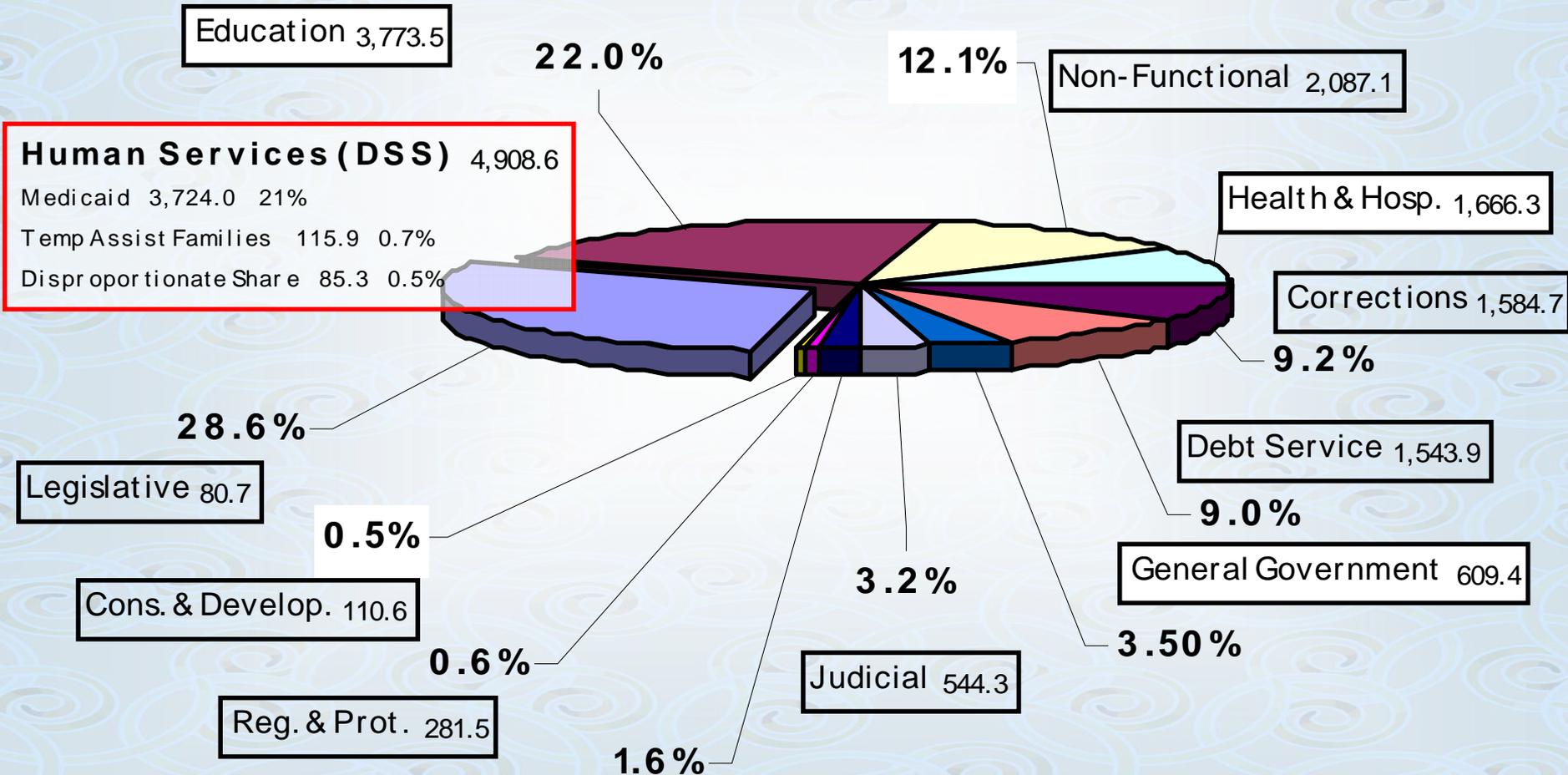


"While I can explain the meaning of life, I don't dare try to explain how the Medicaid system works."

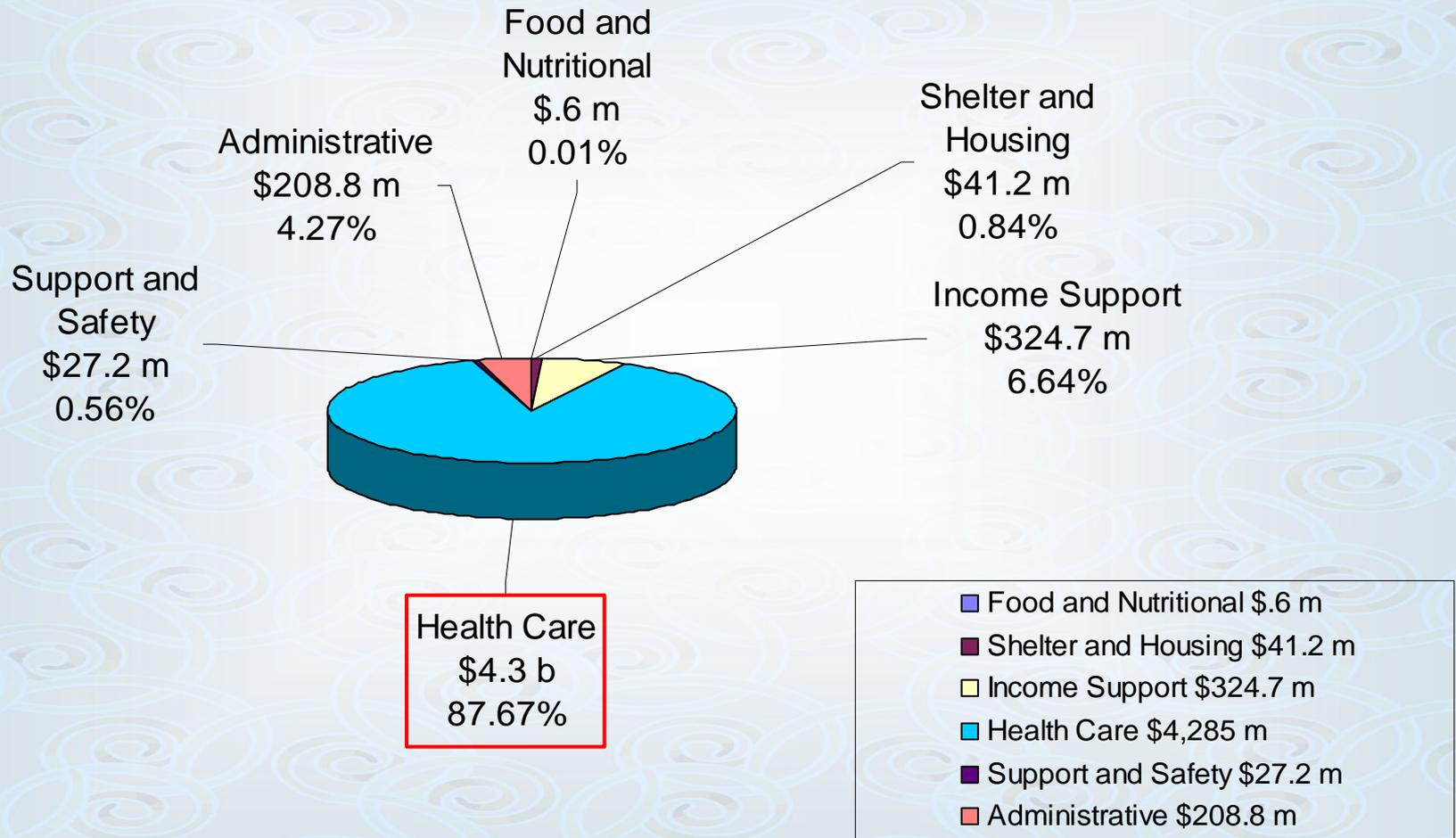
State of Connecticut Appropriations (General Fund)

SFY 2009 \$17.1 Billion

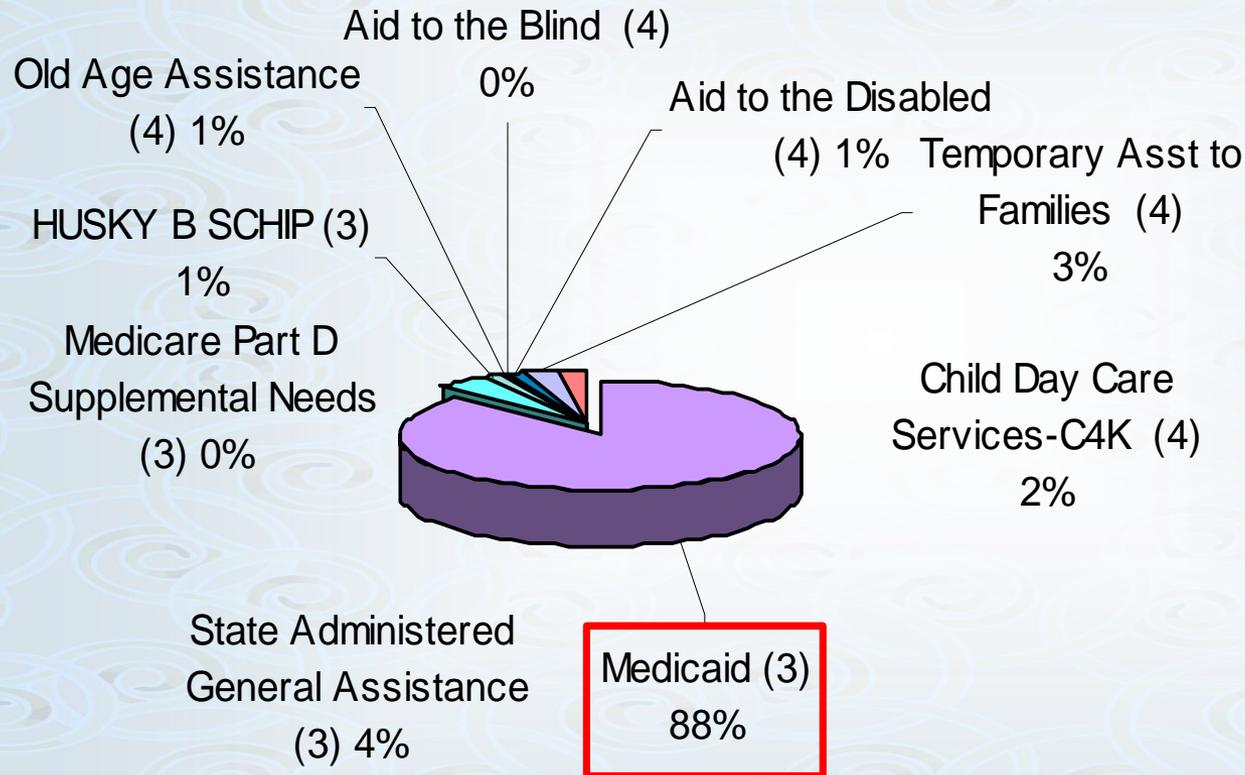
(Legend Amounts in Millions)



Core Programs Based on Appropriated SFY 2009 Funds



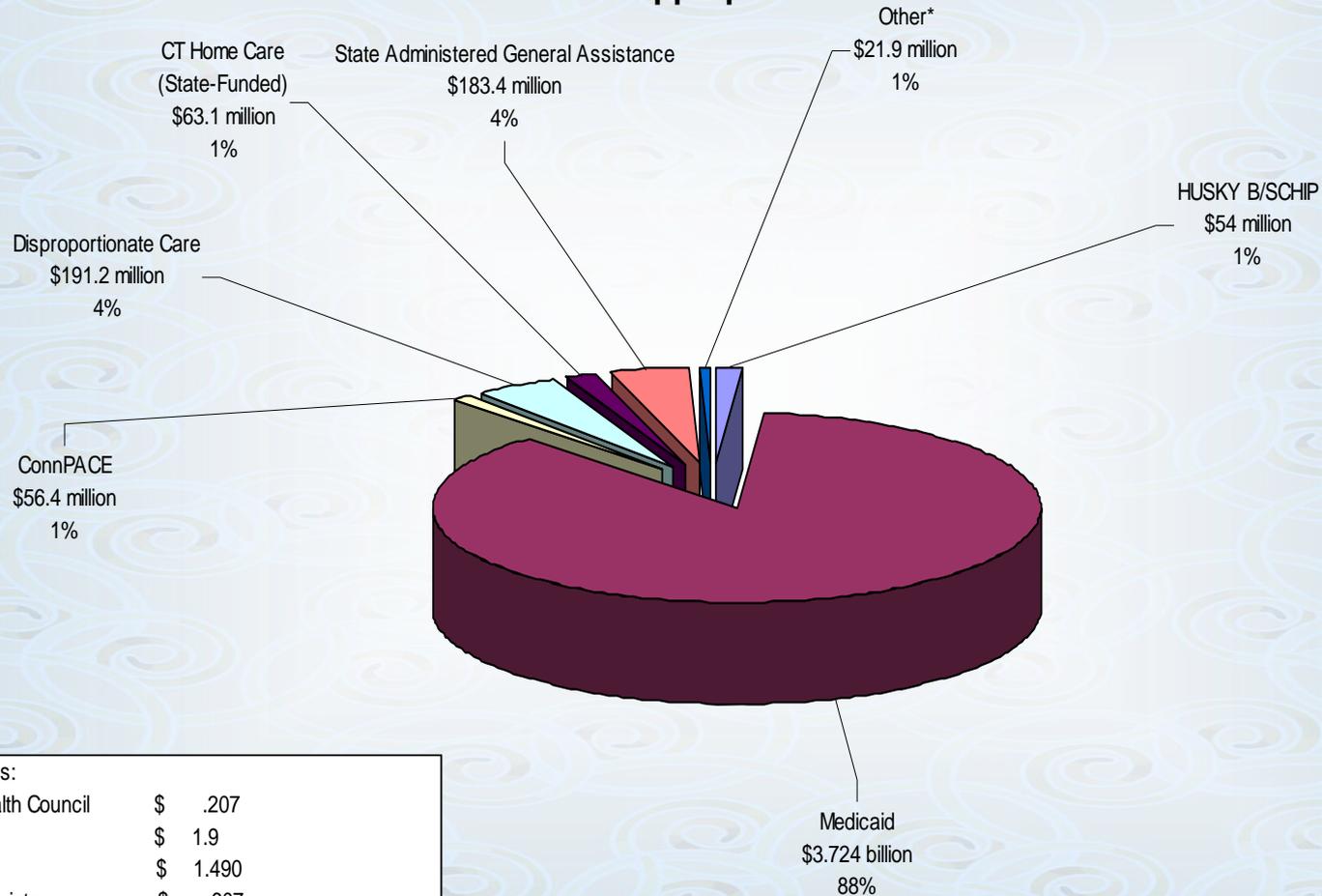
SFY 2009 DSS Appropriation for Core Programs



- Core Program Categories:
1. Administration
 2. Food and Nutrition
 3. Health Care
 4. Income Support
 5. Shelter and Housing
 6. Support and Safety

DSS Health Care Appropriations SFY 2009

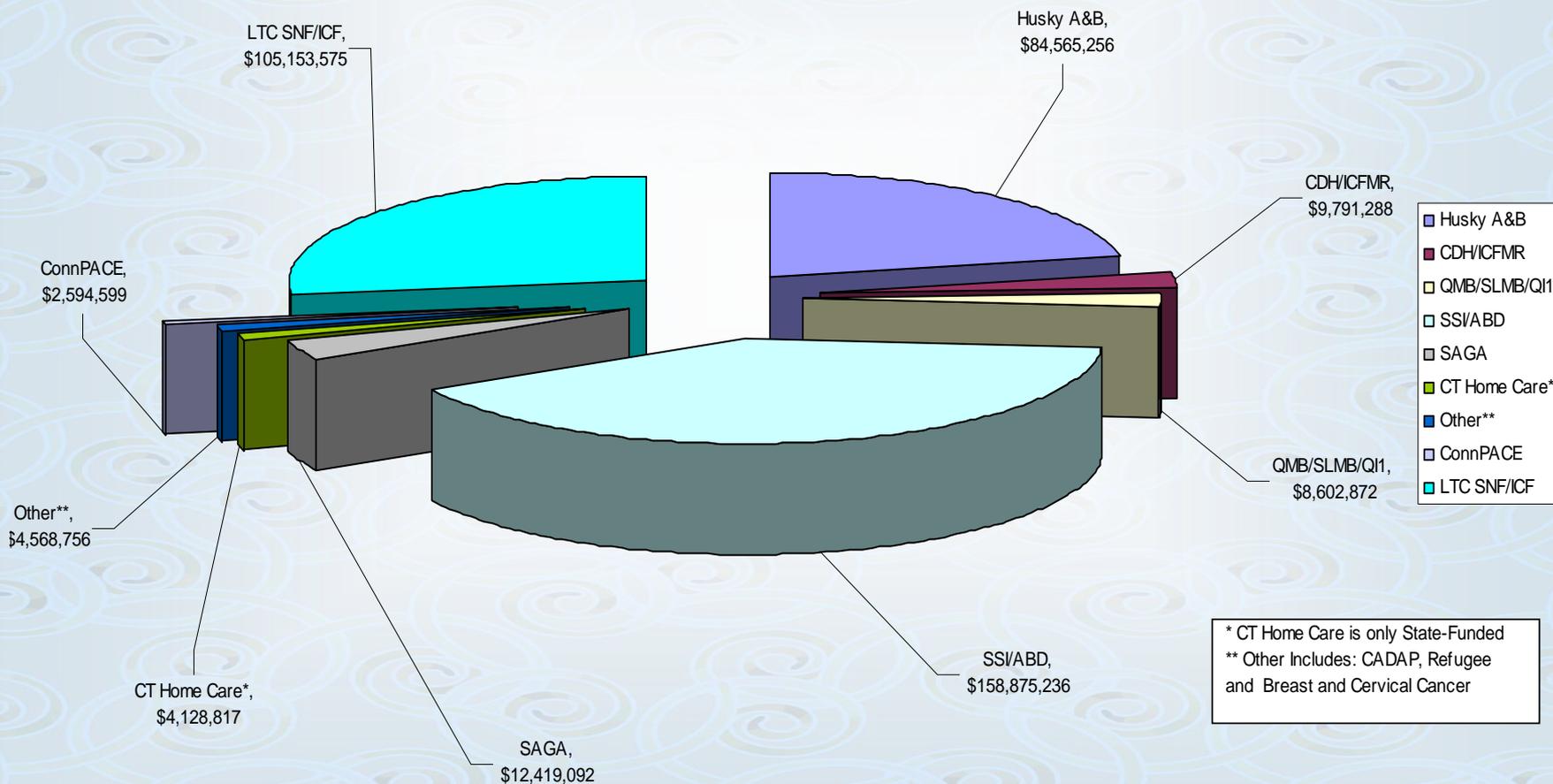
DSS Health Care Appropriations for SFY 2009



***Other Includes:**

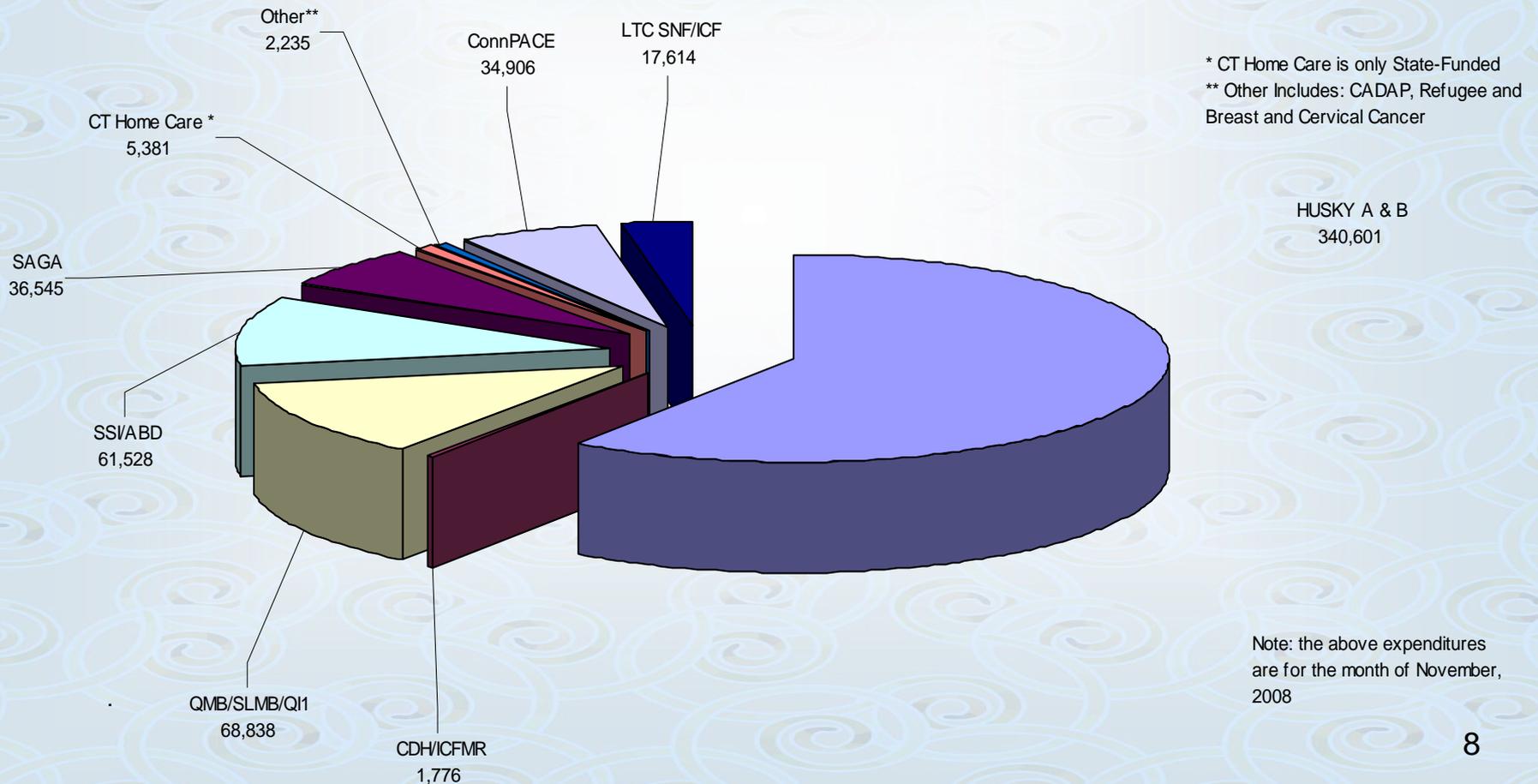
Children's Health Council	\$.207
Lifestar	\$ 1.9
Healthy Start	\$ 1.490
AIDS Drug Assistance	\$.607
CT Children's Medical Center	\$ 11.020
Alzheimer's Respite Care	\$ 2.294
Medicare Part D Sup. Needs	\$ 5.000
Total	\$ 21.937

Total Expenditures by Category for Health Care Services for the Month of November, 2008

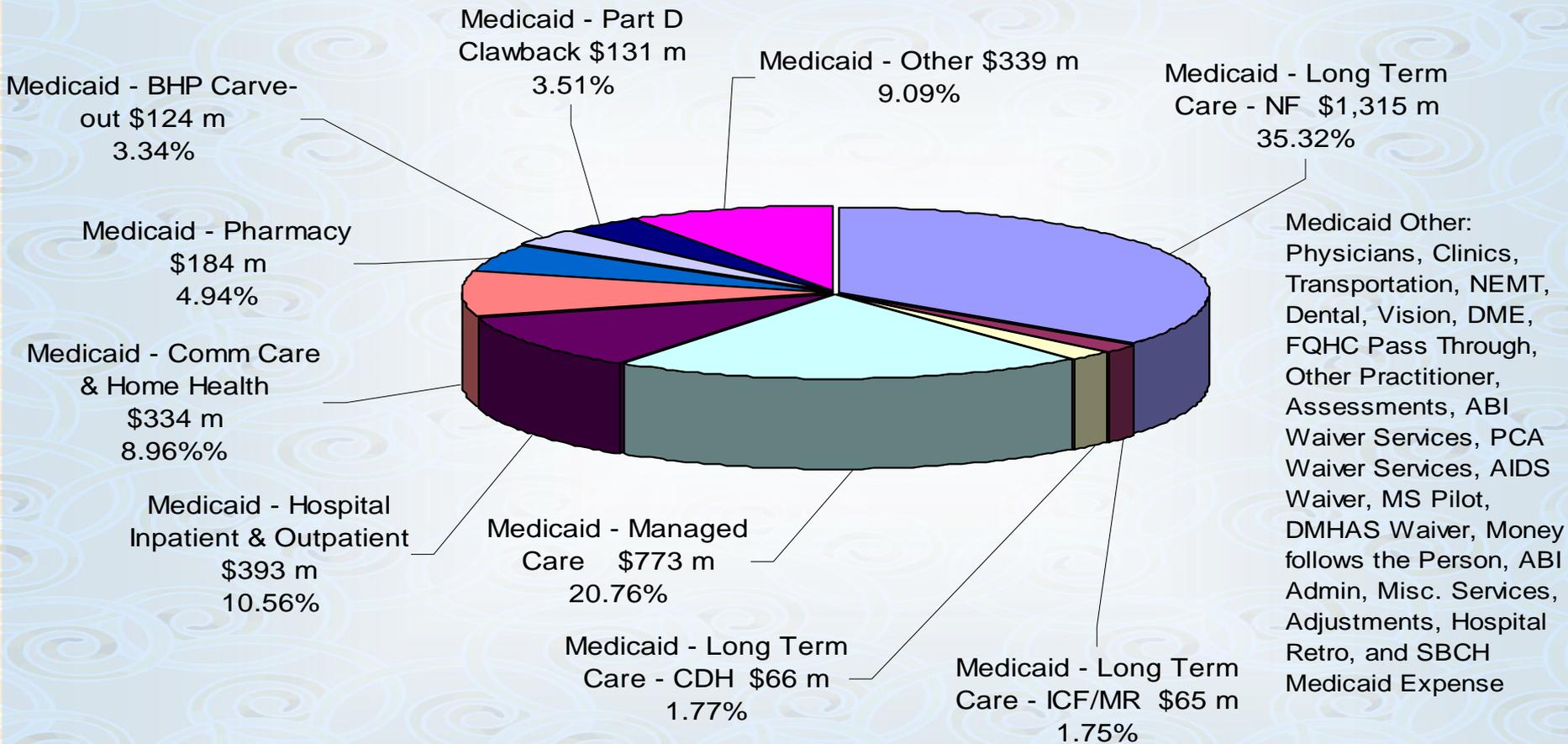


Total Population that Received Health Care Services from DSS in November, 2008

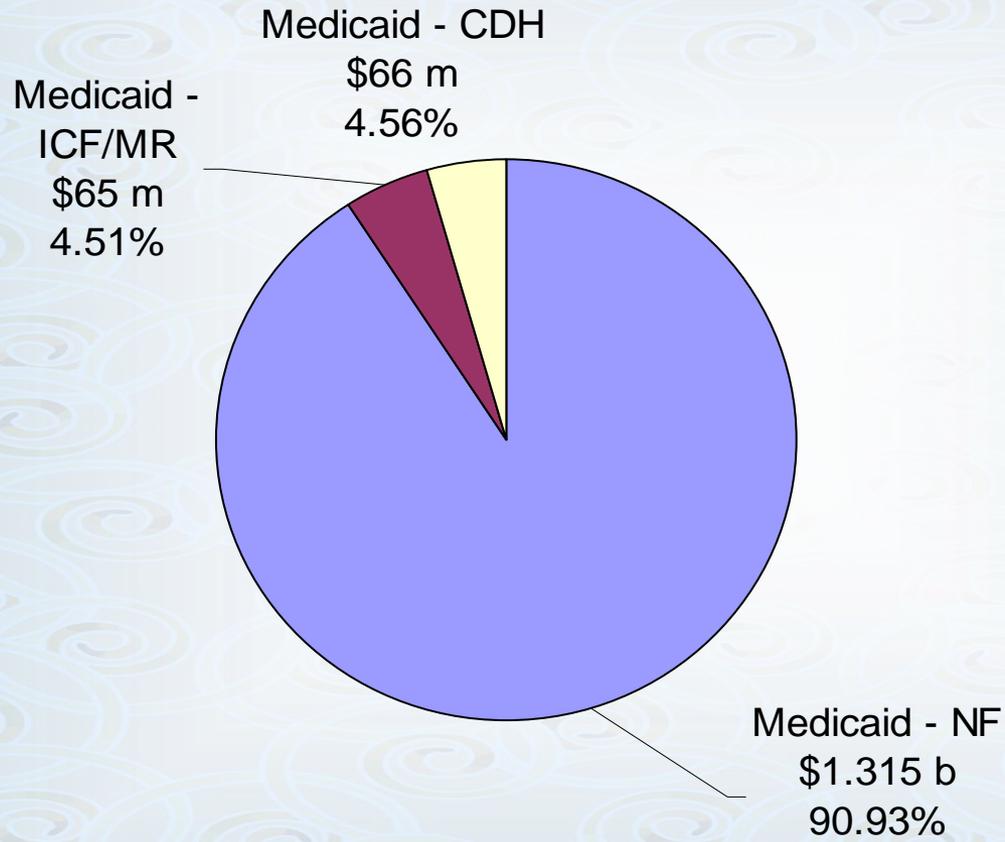
TOTAL – 569,424



Medicaid Services by Category SFY 2009



Long Term Care by Category SFY 2009

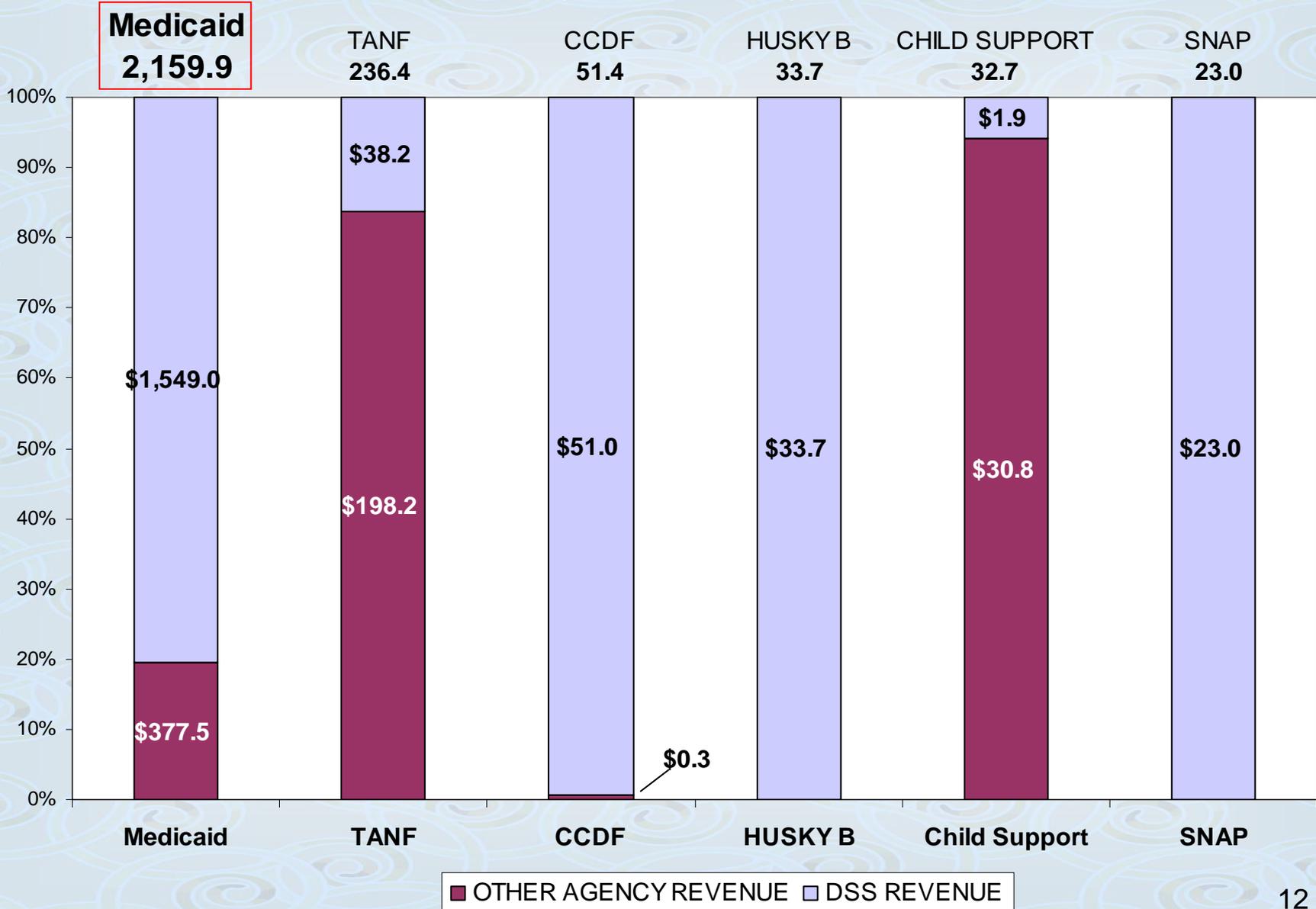


CT FEDERAL REIMBURSEMENT LEVELS

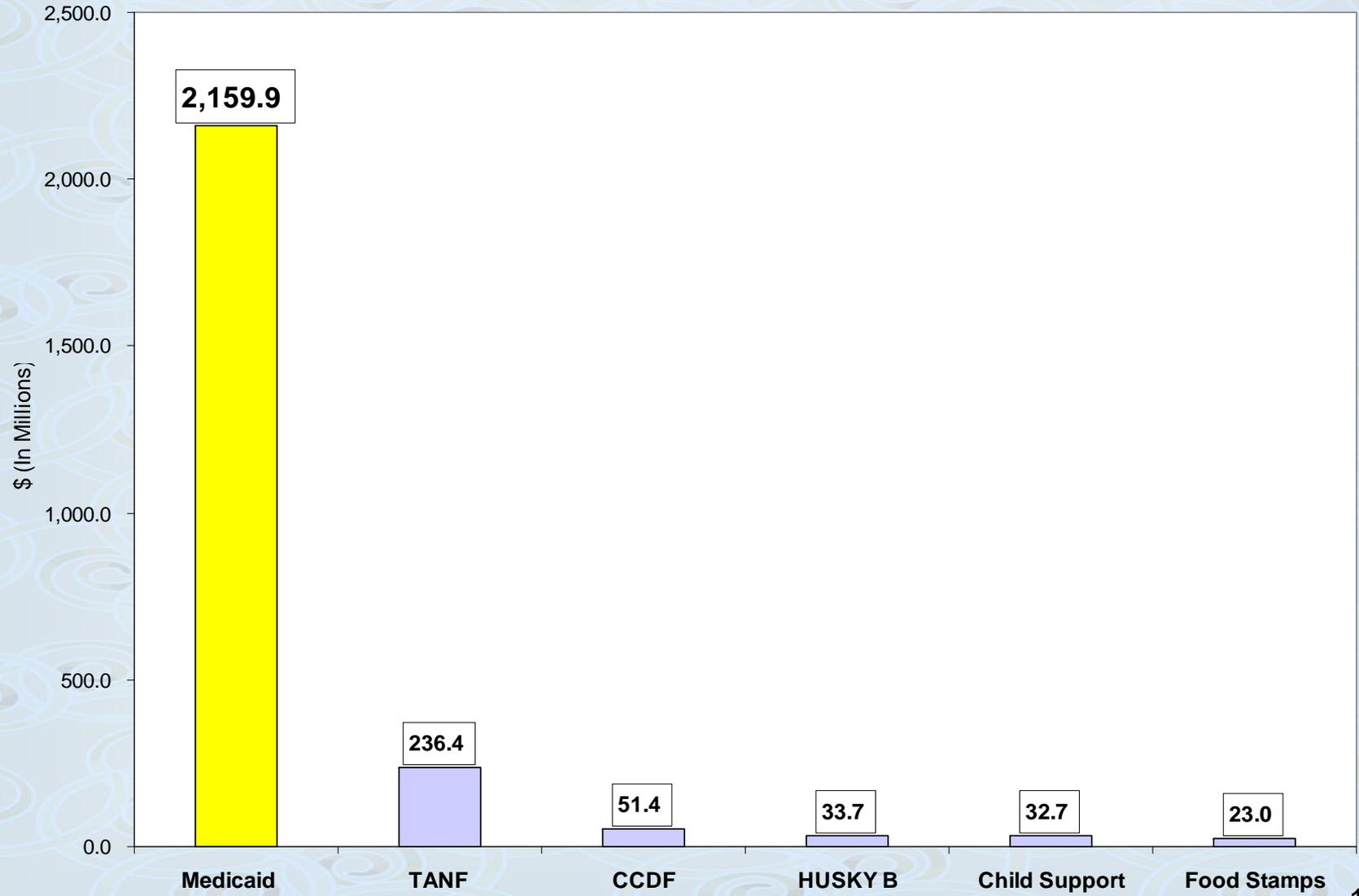
- Normal Medicaid FMAP 50%
- Skilled Professional Services 75%
- Systems Operation 75%
- Systems Development 90%
- Family Planning 90%

DSS SFY 2008 REVENUE - TOTAL \$2,537

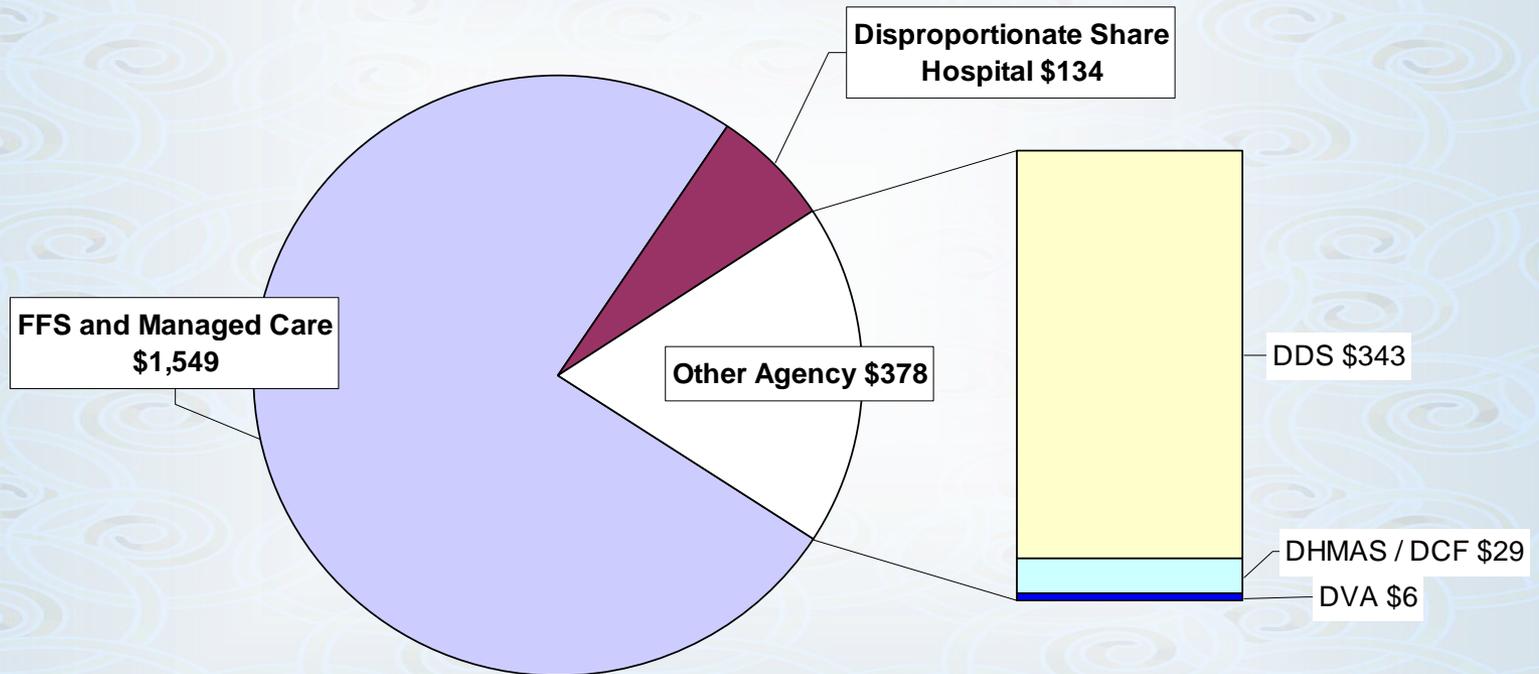
(Dollars in Millions)



DSS SFY 2008 REVENUE



SFY 2008 MEDICAID PROGRAM REVENUE \$2,061
(Dollars in Millions)



Medicaid

- Medicaid in an Historical Context
- State Plan
- Medicaid Eligibility
- Covered Services
- Managed Care
- Nursing Home

The Historical Context

- 1965, Lyndon Johnson Signs An Act Amending the Social Security Act
- Federal Commitment to Medicaid (Title XIX) and Medicare (Title XVIII)
- Medicaid is a State/Federal partnership, shared cost

Medicaid State Plan

- Formal contract that defines the Medicaid Program
- State Plan sets the parameters for Federal Financial Participation (FFP) or Federal Medical Assistance Percentages (FMAP)
- Establishes who is eligible for coverage and what services are covered
- State plan amendment process is used to:
 - ◆ Add or reduce coverage
 - ◆ Change payment rates or methods
- Must get CMS approval to amend state plan
- For the most part, amendments must be prospective

Medicaid Eligibility

- Must meet both categorical (group) and financial requirements
- Categorical eligibility requires that a person be a member of an eligible “coverage group”
- Two general categories:
 - Child, caretaker of a child or pregnant woman (FMA or HUSKY A)
 - Aged, blind or disabled (MAABD)

Medicaid Eligibility

- **Family Medical Assistance (HUSKY A - FMA)**
 - Caretaker Relatives and Their Children age 19 up to 185% FPL
 - Children Under 19 Years of Age Under 185% FPL
 - Children 19 and 20 Years Old (Ribicoff Children)
 - Transitional benefits for families who become ineligible due to earnings or child support (one year)
 - DCF Foster Care, Subsidized Adoption and Transitioning Youth
 - Pregnant Women Under 250% FPL
 - Newborns for One Year
 - Post Partum Women (60 days)
 - Presumptive Eligibility for Children and Pregnant Women

Medicaid Eligibility

- Medicaid Assistance for the Aged, Blind and Disabled (MAABD)
 - Long Term Care residents
 - Community Medicaid with income below Medically Needy Income Limit (MNIL)
 - Medicaid for the Employed Disabled (MED)
 - Home and Community Based Waiver Recipients
 - Spenddown Recipients (Income above MNIL)
 - Breast and Cervical Cancer

Medicaid Eligibility

- Besides Income and Asset Tests, there are categorical, technical and procedural requirements including
 - Citizenship – Must be a citizen or eligible non-citizen
 - Citizens must verify citizenship and identity
 - There is no FFP for non-citizens in the US less than 5 years
 - Must provide a Social Security Number or apply for one
 - Must reside in Connecticut with intent to remain
 - Must cooperate with eligibility process and renew once per year

Other Eligibility Groups

- Medicare Savings Programs (MSP)
 - QMB (Qualified Medicare Beneficiary)
 - SLMB (Specified Low Income Medicare Beneficiary)
 - QI/ALMB (Qualified Individuals/Additional Low Income Medicare Beneficiary)
- MSP pays Part B premium
- QMB also pays Medicare co-pays and deductibles

Medically Needy Option

- People must meet categorical eligibility
- States can cover people with too much income to otherwise qualify
- Persons who qualify must “spend-down” to the medically needy income limit before becoming eligible for Medicaid benefits; that is, incur medical expenses that brings their income below the limit (like a deductible)
- Redetermination every 6 months

Optional Covered Groups

- Medically Needy Spend-Down, Nursing Home and Community (35 states)
- Home and Community Based Waivers – coverage under 1915(c) to 300% SSI
- Examples:
 - ◆ Frail Elderly
 - ◆ Acquired Brain Injury
 - ◆ Mental Illness
 - ◆ Developmentally disabled (2)
 - ◆ Personal Care Assistance
 - ◆ Katie Beckett

Who's Not Covered

- Single non-disabled adults without children
- People in Institutions for the Treatment of Mental Disease (IMDs), or Public Institutions (i.e. Corrections)
- Non-citizens with less than 5 years of official residency
 - ◆ State provides 100% funding for this eligibility group
- Nursing home residents and disabled individuals who haven't depleted their resources

Service Requirements

- Equal Amount, Scope and Duration
- Statewide and Comparability
- Freedom of Choice
- Continuum: Mandatory -> Optional -> Waiver Services

Covered Services

- **Mandatory Services**
 - ◆ Inpatient and outpatient hospital
 - ◆ Physician
 - ◆ Nursing Facility
 - ◆ Home Health
 - ◆ Family Planning
 - ◆ Lab and X-ray
 - ◆ Pediatric and Family Nurse Practitioners
 - ◆ Federally Qualified Health Centers (FQHCs)
 - ◆ Nurse Midwives
 - ◆ Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for children under 21. Requires coverage for all optional services prescribed for a child even if not in the Medicaid State Plan

Optional Medicaid Services

- Pharmacy
- Waivers
- Hospice
- Adult Dental
- Medical Supplies
- Rehabilitation services
- Physical therapy, Occupational therapy, Speech
- Medical Transportation

Home and Community Based Waivers

- HCBS waivers cover individuals and services beyond what can be covered in the state plan process as an alternative to institutional care.
- Examples:
 - ◆ Personal care
 - ◆ Chore services
 - ◆ Meals on wheels
 - ◆ Emergency response
 - ◆ Adult day care
 - ◆ Homemaker
 - ◆ Self-directed care

Connecticut's System of Home and Community-Based Service Waivers

CT Home Care Program for Elders	Current enrollment: 14,937
Personal Care Assistance Waiver	Current enrollment: 725
Acquired Brain Injury Waiver	Current enrollment waiver: 365
Katie Beckett Model Waiver	Current enrollment waiver: 187
Individual/Family Support Waiver (DDS)	Current enrollment waiver: 3,591
Comprehensive Waiver (DDS)	Current enrollment waiver: 4,546
Mental Health Waiver	Current enrollment waiver: Starting April 2009

Managed Care Models

- **Capitated MCO**
 - ◆ **Medicaid only**
- **Carve outs**
 - ◆ **Behavioral Health, Dental, Pharmacy**
- **Primary Care Case Management**
 - ◆ **Provider gatekeeper**

CT Managed Care Experience

- Began in October 1995
- Statewide mandatory enrollment TANF, Foster Care, Children, Pregnant Women
- Significant improvement in primary care
- Increased EPSDT participation
- Increased access to prenatal care
- Decrease in hospital inpatient days
- Decrease in ER utilization
- Original design included medical, dental, pharmacy and behavioral health
- Under current design dental, pharmacy and behavioral health are carved-out

Nursing Facility Rate Setting

- State specific subject to Federal CMS approval
- Cost Based
 - Current Year-2003 Operating, 2007 Property
- Cost Components
 - Direct, Indirect, Admin./Gen., Capital, Fair Rent (property)
- Year-to-Year Rate Increase Limits
 - 7/1/06: 3%; 7/1/07:2.9%; 7/1/08: 0%
- Interim Rates – Financially Distressed

Cost Limitations Under Medicaid

Sec. 17-311-52 Regs.

- **Administrator Salary/Relatives (b)**
- **Fair Rent (f) Replaces Depreciation and Interest**
- **Management Fees (g)**
- **Professional Associations (h)**
- **Tuition (i)(3)**
- **Directors Fees (i)(4)**
- **Travel (i)(6)- Out of US and limits to one person**
- **Bad Debts (i)(9)**
- **Advertising (i)(10)- Except “help wanted”**

Resident Day User Fee

- **Effective July 1, 2005**
- **\$15.90 per day user fee on non-Medicare resident days/\$12.20 for municipal owned and over 230 beds**
- **Payable to the Department of Revenue Services-Quarterly**
- **Non-payment of user fee results in “intercepts” to Medicaid payment to facilities**
 - **(7 facilities had Medicaid intercepts in December 2008)**

Resident Day User Fee Overview SFY 2006

- **Impact on Nursing Facilities:**
 - **Medicaid Rate Increases** **\$184 m**
 - **Estimated Resident User Fee** **(\$132) m**
 - **Net Gain** **\$ 52 m**
 - **Average net increase** **4%**

Resident Day User Fee

- Impact on State:
 - Medicaid Rate Increases (\$184) m
 - Federal Share \$ 92 m
 - User Fee Revenue \$132 m
 - Gain used for home care and other increases \$ 40 m

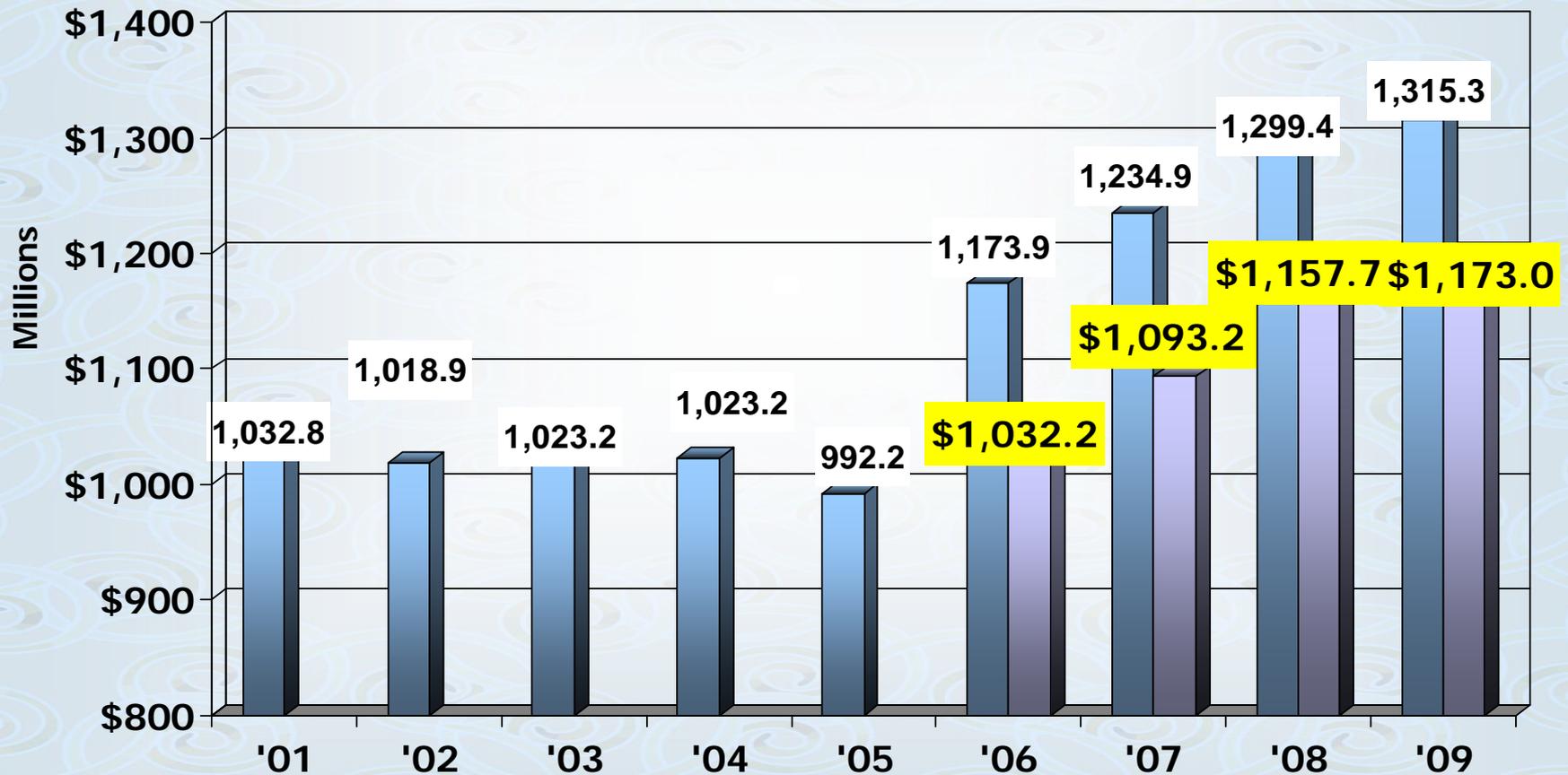
Nursing Home Expenditures

- SFY 2007 Expenditures
 - \$ 1,234,857,610
- SFY 2008 Expenditures
 - \$1,299,358,420
 - (Increase of 5.2%)

SFY 2008 Increase Analysis

- Elimination of June ½ Month \$52.0 mil
 - 2.9% Rate Increase \$39.0 mil.
 - Annualizations, Fair Rent, Interims \$15.5 mil.
 - Caseload Reduction Savings (\$42.0)mil.
- \$64.5 mil.

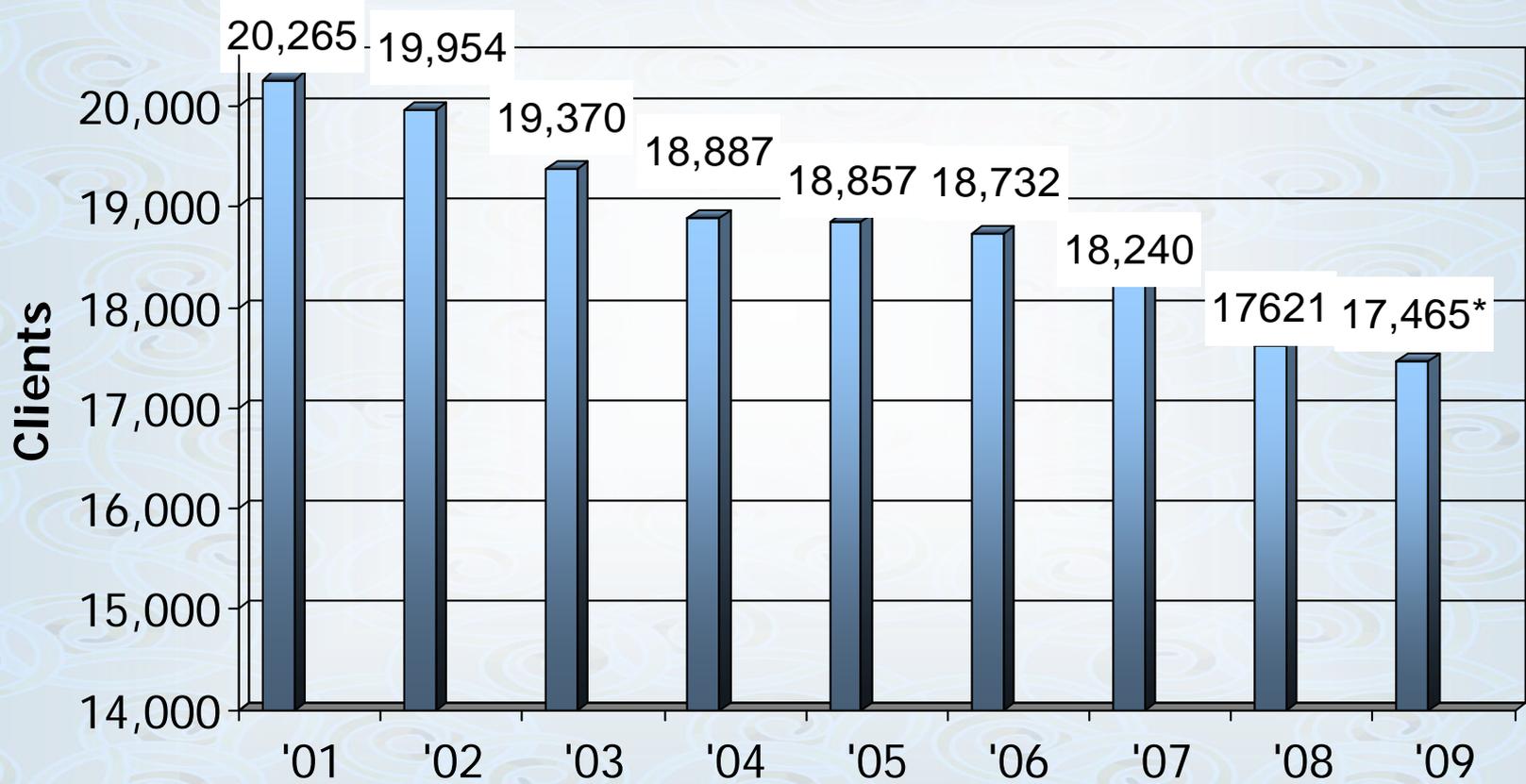
Medicaid Nursing Home Expenditure Comparison



*numbers in yellow represent costs minus user fee impact

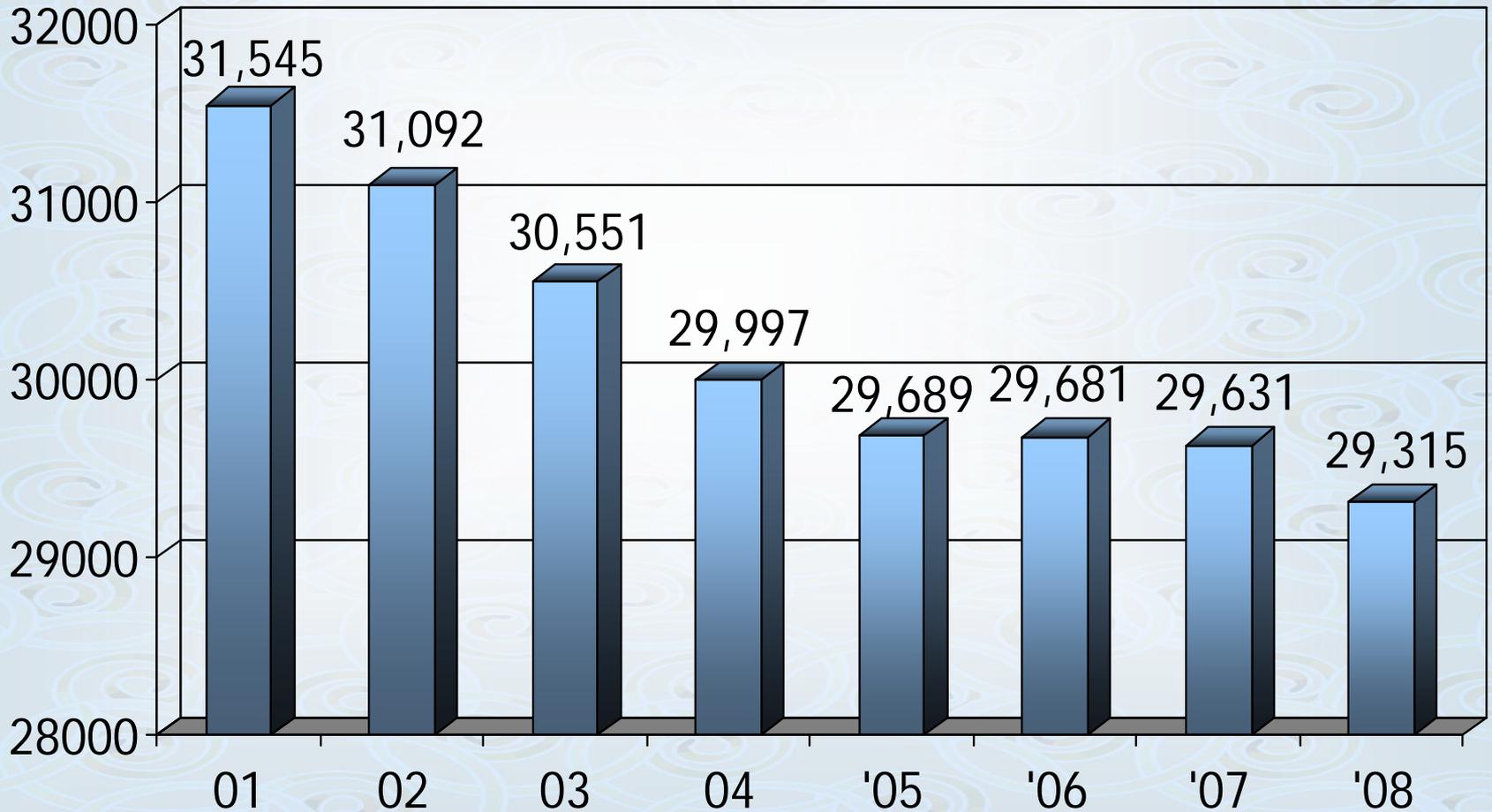
SFY 09 Based on Original Appropriation

Medicaid Nursing Home Client Comparison



*Average Medicaid Nursing home clients 7/08-12/08

Licensed Nursing Home Beds



Homecare Client Comparison



CON and Rate Setting- Int. Rate Requests

- **SFY 2007**
 - 47 facilities
 - Annual impact \$12.7 million- requested \$35.0 million
- **SFY 2008**
 - 16 facilities
 - Annual impact \$4.6 million- requested \$11.2 million
- **SFY 2009**
 - 30* facilities received rate relief to date, \$8.2 mil. – requested \$20.3
 - 13 pending, \$3.2 mil. requested
 - * 13 facilities were formerly Haven, \$5.3 mil. relief, \$9.0 requested

CON and Rate Setting- Rec./Bankruptcies

- Receiverships –
 - Haven 3 facilities (Danielson, Norwich, Waterford-closed, Windham)-**transition to Colonial Health 2/09**
 - Marathon 6 facilities (Prospect, Torrington, Norwalk, West Haven, Waterbury, New Haven)
 - Crescent Manor
- Bankruptcies –
 - Affinity Healthcare 4 facilities (Alexandria, Blair, Douglas, Ellis Manor)

Nursing Facility Closures

- Facility Closures

SFY	# Facilities	# Beds	Avg. Size
2002	3	267	89
2003	4	324	81
2004	5	498	100
2005	3	487	162
2006	1	59	59
2007	2	180	90
2008	0	0	0
2009 ytd	<u>2</u>	<u>190</u>	95
	20	2,005	

Nursing Facility Closures

- | | <u>Beds</u> |
|--|-------------------------------|
| • 2007 Closures | |
| • Darien Health Center | 120 |
| • Oakcliff, Waterbury | 60 |
| • 2008 | 0 |
| • 2009YTD | |
| • New Coleman Park | 100 |
| • Haven –Waterford | 90 |
| • Pending closure CON | |
| • Griswold Rehab | 90 (Public Hearing 2/3/2009) |
| • Sterling Manor, E. Hartford | 90(Public Hearing 2/5/2009) |
| • Within 30 days of the filing of a Letter of Intent for facility closure, DSS must hold a Public Hearing at the nursing home (PA 07-209). | |

Facility Closure

- Hearing at Facility within 30 day of CON intent notice
- Consideration of vacancies at other facilities in the area (10-15 miles)
- Consideration of town of origin for all residents
- Consideration of ability of clients to return to the community (MFP, Transitional services)
- If closure granted letters to all local Healthcare Organizations of availability of qualified Healthcare workers
- 2003 Average Occupancy 95%
- 2008 Average Occupancy 92%
- CT Estimates 130 beds per 1000 persons over age 75
- Maryland Health Commission Target of 102 beds per thousand over 75