Connecticut Health Policy Project

POLICYMAKER ISSUE BRIEF

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Questions for Connecticut

How will we implement national Medicaid health care reforms?

Passage of a federal bill to reform our broken health care system is imminent. While some final, and very contentious, details have yet to be decided, House and Senate versions have more overlap than differences. The broad structure of likely Medicaid reform is fairly clear.

Both versions of the current reform bills place a great deal of responsibility on states. Connecticut has struggled to implement even the basic Medicaid programs we now have. Additional state responsibility for potentially over 100,000[1] new Medicaid members is troubling to Connecticut's consumer advocates. Our state has had great difficulty protecting Medicaid consumers, ensuring fiscal integrity, promoting accountability, and freedom of information under our current, simple programs, before recent early retirements.

Under either the House or Senate health reform bills, over 100,000 more uninsured Connecticut residents could become eligible for Medicaid.

Our experience with SCHIP and HUSKY shows that legislation that passes in Washington means little to consumers here in Connecticut unless programs are well-designed, monitored closely and adjusted as necessary.

We have posed some questions to consider in planning for implementation of national health reforms in Connecticut. This is only a partial list of policy questions Connecticut needs to address. Thankfully, PA 09-148, the SustiNet law, created a comprehensive planning process of committees and task forces that is working to address these issues and more. As originally designed, a fully implemented SustiNet plan would solve many of these problems.

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How will DSS handle the influx of 100,000 or more new Medicaid enrollees?

- How will offices staff up to accept and process applications? The state's enrollment systems were overwhelmed with approximately 25,000 Charter Oak applications. Almost 20,000 of those applications were denied due to administrative problems.
- How will new and current staff be trained in the new system?
- How will cases be reassigned to even out caseloads?
- How will IT systems be re-programmed for new eligibility standards?
- How will the state handle any changes in quality control cases (requirements for face-to-face reviews), fraud referrals and grievances and appeals?
- How will the state handle creating and publishing **new applications, program brochures and web site changes**?
- How will the state educate advocates, community organizations, outreach workers, and providers about program changes?
- How will the state **inform current beneficiaries** and providers about program changes? Client and provider notification of changes in HUSKY during the recent HMO changes were late, confusing, and sometimes inaccurate, making the transitions more disruptive than necessary. Both clients and providers depended on advocates for accurate, timely information on program updates and plans, as well as for opportunities for input on those changes.
- Will new members be enrolled in the fee-for-service or managed care programs? If managed care, are our current HUSKY HMOs able or willing to accept and care for these new populations? Will PCCM finally be expanded to meet the need?
- How will the state review all current Medicaid recipients for changes in eligibility category, costs, and new eligibility?
- Will current members have to re-verify eligibility? How will this be implemented?
- How will new income and asset changes be incorporated into eligibility systems?
- A **lack of participating providers** has been a chronic problem in both HUSKY and fee-for-service Medicaid. How will the state ensure sufficient capacity to care for the new members without sacrificing care for current members? Pent up demand will be a serious concern in the short term given that many of these new members have been uninsured for long periods and likely delayed accessing needed care.
- **Rate increases are not enough.** There is no evidence that the rate increases implemented two years ago had any impact on the number of participating providers. Research shows little relationship between Medicaid rates and provider participation[2]. What will the state do to reduce the hassles and payment delays under Medicaid and the HUSKY HMOs?

- How will the state implement proposed consumer incentives for behavior modification? Our state currently is one of the few that does not cover smoking cessation; will that change if consumers are penalized for smoking?
- **How will current SAGA recipients be rolled into Medicaid?** Will they have new choices of plans? How will they be notified and supported in making the right choice for their needs? Will SAGA and HUSKY case units be merged?
- How will clients currently in "spend-down" be notified that they may be eligible categorically?
- How will the state handle the increased requirements for notices and information to new clients and notify current clients of changes?
- How will the state ensure that HUSKY HMOs spend at least 85% of capitated rates on medical services? Oversight of HMO financial reports by DSS has been lax in the past.
- How will the state handle improvements to Medicare for **dual eligibles** including incentives for primary care, increasing asset tests, elimination of cost sharing for proven preventive services, behavior modification incentives, value-based purchasing, medical homes, care coordination, language and cultural competence programs?
- Are you considering reducing benefits and/or increasing consumer costs if allowed flexibility by reforms?
- Are you considering other health budget cuts to pay for state costs of health care reform?
- How will the state implement aggressive new **waste and fraud surveillance** monitoring? Which agency will be responsible?
- What anti-crowd out provisions would the state consider if allowed under federal law?
- The House bill increases Medicaid primary care **provider payment rates** to Medicare levels. How will DSS implement the rate increases given that a far more modest and simple rate increase in 2008 took six months to implement?
- How will the state restructure rates to support primary care and care coordination as required?
- **How will DSS ensure that taxpayer dollars into capitated systems result in care delivery?**
    - A ground breaking, single event secret shopper survey of HUSKY patients' ability to get appointments with providers listed on HMO panels completed two years ago showed that DSS' monitoring of program capacity was inadequate. That study has not been repeated.
    - Another ground breaking, single event audit of HUSKY rate setting by the Comptroller's Office last year found $50 million in overpayments to the HMOs. However, there are no plans to repeat this audit, or expand it, in the future. Given that an $80,000 investment in auditing netted the state $50 million savings in one year alone, it seems prudent to make this permanent and to expand its scope.

- How will Connecticut hospitals manage with **reduced DSH payments**? Both bills significantly reduce the DSH program on the grounds that if there are far fewer uninsured patients, DSH is not needed. However, it is not clear that hospitals will be held harmless in this transition. What is Connecticut prepared to do to support hospitals if they claim losses?
- How will the state **implement a premium assistance program** for Medicaid eligible residents if the Senate version prevails?
  - How will the state assess the cost-effectiveness of each private plan relative to providing each individual or family with coverage through Medicaid/HUSKY/Charter Oak? How often will cost-effectiveness be reassessed? Given the much higher rise in costs of private insurance premiums compared to public programs, that decision should be re-visited annually if not more often.
  - How will the state provide wrap-around services not covered in private plans but included in Medicaid?
  - How will the state pay providers for copays and payments within deductibles that eligible members are not liable for? Will the state require low-income residents to up front those costs and rely on reimbursement from the state at some later date?
  - How will the state ensure that low-income workers do not have full premiums deducted from paychecks and rely on reimbursement of subsidies from the state at some later date?
  - How will the state ensure that providers do not refuse to see premium assistance patients because of administrative burdens such as those described?
  - How will the state cover the significant costs of administering this program? Will the state hire the staff necessary to ensure smooth operation of such a complex program?
- Who will be responsible to assess state laws for compliance with new federal law? What will the General Assembly's role be in developing those revisions?
- How will the state's fragmented and dysfunctional **health data systems** be improved to meet new demands and standards?
- Are there plans to incorporate comparative clinical effectiveness research into Medicaid health care purchasing?
- How will Connecticut implement federal provider conflict of interest and financial relationship disclosure provisions, e.g. physician or hospital payments from drug companies or medical equipment suppliers, gift bans?
- How will the state support and expand **medical home initiatives**? The state's record in implementation of Primary Care Case Management, medical homes for HUSKY families, has been resistant at best.

- How will the state implement **value-based purchasing** for Medicaid?
    - How will the state encourage all payers to submit quality and cost data to a common source for aggregation, value analysis and reporting?
    - How will the state promote and encourage adoption of health information technology and health information exchange?
    - How will the state implement rigorous quality of care surveillance and reporting that can be used by consumers in their purchasing decisions including identification of hospitals, clinics, outpatient surgery centers, and individual physicians?
    - Are there plans to encourage Accountable Care Organization formation?
    - Is Connecticut considering pay-for-performance programs, particularly for health plans, tiering of payments or cost sharing based on efficiency, shared savings, quality/efficiency based contracting, or bundling payments for state programs? At what stage are those plans? What populations, programs and services are being considered?
    - How will the state evaluate, monitor and adjust value-based purchasing initiatives?
- How will the state incorporate **public input**, advocate feedback, provider satisfaction, CMS supervision and legislative initiatives into policy to ensure effective monitoring, clear communications and common goals?
- Does the state have sufficient capacity to track federal policy updates and to communicate with federal agencies to ensure compliance?
- Will health care planning be transparent with adequate public notice and opportunities for input? As an example, DSS' HUSKY application waiver last year was submitted to the General Assembly and scheduled for public input on the last possible day without adequate opportunities for thoughtful policymaking.

Notes:

1 - In 2007/08 there were 110,200 adults and 27,000 children living below 133% of the Federal Poverty Level (FPL) in CT without insurance, according to Kaiser State Health Facts Online and the US Census Bureau. It is very likely that those numbers have risen in the last two years. The Senate bill increases Medicaid eligibility to 133% FPL; the House bill goes further to 150% FPL. This does not count the current eligible but not enrolled at higher income levels, who may be more likely to sign up, even if they have in the past and seen no benefit to it, with an individual mandate penalty and public education/outreach. 100,000 new Medicaid enrollees in CT could be a very conservative estimate.

2 - S. Zuckerman, et. Al., *Trends in Medicaid Physician Fees 2003-2008*, Health Affairs, 28:w510-w519, April 2009.
http://content.healthaffairs.org/cgi/reprint/28/3/w510?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=Medicaid+rates&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT