Inventory of Affordable Care Act (ACA, Public Law 111-148) Provisions Impacting Connecticut Medicaid

Overall ACA approach: Require most U.S. citizens and legal residents to have health insurance. Create state-based American Health Benefit Exchanges through which individuals can purchase coverage, with premium and cost-sharing credits available to individuals/families with income between 133-400% of the federal poverty level and create separate Exchanges through which small businesses can purchase coverage. Require employers to pay penalties for employees who receive tax credits for health insurance through an Exchange, with exceptions for small employers. Impose new regulations on health plans in the Exchanges and in the individual and small group markets. Expand Medicaid to 133% of the federal poverty level. [1]

Overview of Connecticut implementation: As the first state to expand Medicaid under the Affordable Care Act in 2010, Connecticut has led the nation in effective implementation of health care reform in many respects. The 750,000-enrollee Medicaid program administered by the Department of Social Services is a unique, self-insured, managed fee-for service model that utilizes no for-profit managed care insurers. This ground-breaking initiative by the Malloy-Wyman Administration paved the way for myriad advances including intensive care management, person-centered medical homes, coverage of new Medicaid preventative benefits (e.g., tobacco cessation counseling and medications); and offering diverse long-term services and supports options, including Community First Choice, the Balancing Incentive Program and health homes. Connecticut Medicaid has maintained a robust array of medical, dental, behavioral health, pharmacy and other services for all eligible beneficiaries, while controlling per-member cost trends in support of overall sustainability.

Focus Area	Provision	Overview of Connecticut Implementation
Medicaid and CHIP-Related		
	Medicaid Eligibility Expansion Option to expand Medicaid to all non-Medicare eligible individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL based on modified adjusted gross income (MAGI) (under current law, undocumented immigrants are not eligible for Medicaid). All newly eligible adults are guaranteed a benchmark benefit package that meets the essential health benefits available through the Exchanges. States receive 100% federal funding for 2014 through 2016, 95% federal financing in 2017, 94% federal financing in 2018, 93% federal financing in 2019, and 90% federal financing for 2020 and subsequent years.	Effective April 1, 2010, Connecticut became the first state in the country to receive approval from CMS to cover an ACA Medicaid expansion group – Medicaid Coverage for the Lowest Income Populations (MCLIP/HUSKY D). Originally, income eligibility for this group was limited to otherwise eligible individuals [over age 18 and under age 65; not pregnant; ineligible for other specific coverage under Medicare, Medicaid, or CHIP; Connecticut resident; U.S. citizen or qualified alien] whose income was no greater than 56% of the FPL [DSS Regions A & B] and 65% of the FPL [DSS Region C]. Effective January 1, 2014, income eligibility for the coverage group was increased to 133% of the FPL [138% less a 5% disregard]. Access Health and DSS implemented an integrated eligibility process through Connecticut's state-based health insurance exchange for MAGI populations (HUSKY A & D).

[1] Material in this introduction and the "Provision" column is sourced from the Kaiser Family Foundation "Summary of the Affordable Care Act", April 25, 2013, *available at:* http://kff.org/health-reform/fact-sheet/summary-of-the-affordable-care-act/

		Over 206,000 adults are currently served by HUSKY D. Enhanced federal match for individuals participating in HUSKY D is expected to be $689 million in SFY 2017.
	Enhanced match associated with eligibility-related functions	Connecticut is claiming for the 75% match that is available for eligibility-related functions. Enhanced federal match for eligibility-related functions (75% as compared to 50%) is expected to be approximately $20.3 million in SFY 2017.
	Children's Health Insurance Program (CHIP) Beginning in October 2015, through September 2019, states started receiving a 23 percentage point increase in the CHIP match rate up to a cap of 100%. States are required to maintain current income eligibility levels for children in Medicaid and the Children's Health Insurance Program through FFY 2019. *Please note: the Affordable Care Act extended funding for CHIP through FFY 2015, and the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) extended funding for the program through FFY 2017. CHIP funding must again be re-authorized in order to continue beyond September 30, 2017.*	Connecticut is receiving a federal CHIP match of 88% for individuals served by HUSKY B. Over 16,500 individuals are currently covered by HUSKY B. Enhanced federal match for individuals participating in CHIP (through September 30, 2019, 88% FMAP as compared with 65%) is expected to be approximately $9.2 million in SFY 2017.
	Medicaid Health Homes Create a new Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home. Provide states taking up the option with 90% FMAP for two years for home health-related services, including care management, care coordination, and health promotion.	Led by DMHAS, in partnership with DSS, Connecticut has implemented health homes for individuals with Serious and Persistent Mental Illness who are served by Local Mental Health Authorities and affiliates. Approximately 2,400 individuals are currently served, and up to a total of 10,000 individuals are potentially eligible. Enhanced federal match for individuals participating in health homes (for eight calendar quarters, 90% FMAP as compared with 50%) is approximately $11.3 million over the eight calendar quarters. Connecticut is also reviewing use of health home

		State Plan Amendments for other qualifying health conditions (e.g. chronic conditions, childhood trauma).
	Coverage of Tobacco Cessation Services Require Medicaid coverage for tobacco cessation services for pregnant women.	Connecticut implemented comprehensive tobacco services (counseling, treatment, and medications including over-the-counter nicotine replacement products) for all pregnant women covered by HUSKY Health as well as coverage of required tobacco cessation products. As a frame of reference, from 1/1/16 - 6/30/16, the Department paid 18,035 claims for 10,893 members, totaling $945,485 in expenditures, for all tobacco cessation coverage (not limited to pregnant women).
	Optional Coverage of Family Planning	Federal funding enabled states to provide eligible men and women with Medicaid State Plan coverage of family planning and family planning-related services and supplies. Before ACA, states' only option was to offer these services through demonstration projects. Approximately 400 individuals are currently served. Enhanced federal match (90%) on total expenditures in SFY 2016 was $347,314.
	Community First Choice (CFC) Establish the Community First Choice Option in Medicaid to provide community-based attendant supports and services under the Medicaid State Plan to individuals with disabilities who require an institutional level of care. Provide states with an enhanced federal matching rate of an additional six percentage points for reimbursable expenses in the program.	Connecticut implemented CFC within the Connecticut Medicaid State Plan in Summer, 2015. The Connecticut Medicaid State Plan currently covers self-directed services (e.g. personal care assistants), adjunct supports that enable individuals to self-direct, and individual budgets. Enhanced federal match for self-directed services (56% as compared with historically typical 50%) is expected to be approximately $3.6 million in SFY 2017.
	Medicaid Prescription Drug Rebates Increase the Medicaid drug rebate percentage for brand name drugs to 23.1% (except the rebate for clotting factors and drugs approved exclusively for pediatric use increases to 17.1%); increase the Medicaid rebate for non-innovator, multiple source drugs to 13% of average manufacturer price.	Additional rebates revert to federal government.

	Reduction in Medicaid Disproportionate Share Hospital Payments Reduce aggregate Medicaid DSH allotments by $.5 billion in 2014, $.6 billion in 2015, $.6 billion in 2016, $1.8 billion in 2017, $5 billion in 2018, $5.6 billion in 2019, and $4 billion in 2020. Require the Secretary to develop a methodology to distribute the DSH reductions in a manner that imposes the largest reduction in DSH allotments for states with the lowest percentage of uninsured or those that do not target DSH payments, imposes smaller reductions for low-DSH states, and accounts for DSH allotments used for 1115 waivers. Note that the ACA reduced Medicaid DSH allotments on the assumption that there would be fewer uninsured and less uncompensated care with the expansion of health care coverage. Subsequent legislation delayed, extended, and/or modified the reductions. Most recently, the Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10) delayed the reductions until FY 2018, modified cuts in future years, and extended the reductions to FY 2025.	Connecticut's Medicaid hospital reimbursement has changed in recent years. DSH payments for private general acute care hospitals have been scaled back to a total of $100,000. Medicaid supplemental payments are made in lieu of DSH payments in order to take advantage of the enhanced match on the Medicaid expansion population. Significant DSH payments continue to be claimed for public hospitals for the following State-run facilities: John Dempsey, the Department of Veterans' Affairs, and the three DMHAS hospitals.
	Waste, Fraud and Abuse Reduce waste, fraud, and abuse in public programs by allowing provider screening, enhanced oversight periods for new providers and suppliers, including a 90-day period of enhanced oversight for initial claims of DME suppliers, and enrollment moratoria in areas identified as being at elevated risk of fraud in all public programs, and by requiring Medicare and Medicaid program providers and suppliers to establish compliance programs. Develop a database to capture and share data across federal and state programs, increase penalties for submitting false claims, strengthen standards for community mental health centers and increase funding for anti-fraud activities.	Procedures were adjusted to reflect ACA requirements.
	Ordering, Prescribing and Referring (OPR) Provider Enrollment	Connecticut implemented OPR requirements by developing an expedited, short-form enrollment process, required claim edits and procedures.

	Require all fee-for-service programs to individually enroll all ordering, prescribing and referring providers in Medicaid. This section had the effect of prohibiting Medicaid from paying a provider to whom a non-Medicaid enrolled provider referred or from whom a service was ordered or prescribed. For example, if a non-Medicaid enrolled surgeon prescribed a pain medication, Medicaid could not pay the pharmacy that dispensed the medication.	These allowed providers who preferred not to bill for Medicaid services to more easily enroll for the purpose of enabling payment to the providers to whom they referred, made orders or issued prescriptions.
Demonstration Grants		
	Money Follows the Person (MFP) Rebalancing Demonstration Extend the Medicaid Money Follows the Person Rebalancing Demonstration program through September 2016. *Note: Additional federal funding was appropriated that can be carried over and used through 2019.*	Connecticut has received MFP grant funds since the inception of the opportunity. Funds currently support systems transformation opportunities and transition assistance to individuals moving from institutional settings to the community. Enhanced federal match for all MFP activities (75% as compared with historically typical 50%) is expected to total approximately $12.3 million in SFY 2017.