Appropriations Work Session Follow-Up Questions

1. Please attach the PDF's that were embedded in the response document.
    - Attached

2. Please share expenditures by Urgent Crisis Centers (UCC)- Can you include data prior to FY 25 for comparison purposes? (How much is budgeted for Urgent Crisis Centers? Please share Medicaid rates.)

UCCs became Medicaid reimbursable providers April 1, 2024. $2.8 million was added to the Medicaid budget in SFY 2024 to support the new service, which is billed from the Clinic fee schedule. Actual costs are dependent upon the utilization of Medicaid recipients. The three licensed UCCs were supported by grant funds through DCF prior to April. 2024.
UCC Provider Bulletin This is a standard state plan service. Billable under Medicaid. Annual expenditures for UCCs will be entirely dependent on utilization of this service.

Connecticut Department of Social Services

UCC Rates

96127 (brief emotional assessment): $25.00
T1001 (Nurse assessment): $98.53
T1002 (subsequent nurse assessment): $24.63
90791 (psychiatric evaluation at enhance care clinic (ECC)): $151.16
90792 (psychiatric evaluation with medical services at enhance care clinic (ECC): $162.78
90791 (non-ECC): $143.61
90792 (non-ECC): $154.65
90839 (psychiatric crisis service, first hour): $145.70
90840 (psychiatric crisis each additional 30 minute): $72.85
H2011 (crisis intervention services, per 15 minutes): $36.43

3. Please provide additional detail for items listed under response #6. Please include pharmacy cost/rebate information (year over year change for 3 years). (Please provide major drivers of Medicaid deficiency (category and amount, include federal/state share if possible)

Medicaid Primary Cost Drivers	**SFY 2025**
Enrollment Mix	$50,000,000
Prescription Drug Costs & Rebates*	90,000,000
Home Health, Home Care, and Waivers	75,000,000
Under-Funded Mandates	75,000,000
Total	$290,000,000

*Higher prescription costs and lower rebates

Enrollment Mix - $50 Million

Original caseload projections assumed membership decreases across HUSKY A, C, and D programs for SFY 2025. HUSKY A and D realized the anticipated decrease in membership; however, HUSKY C gained membership.

Compared to original projection, there are 10,000 additional members in HUSKY C. Of the CT Medicaid programs, HUSKY C has the highest per member per month (PMPM) cost at $3,300.

Prescription Drug Costs & Rebates -$90 million

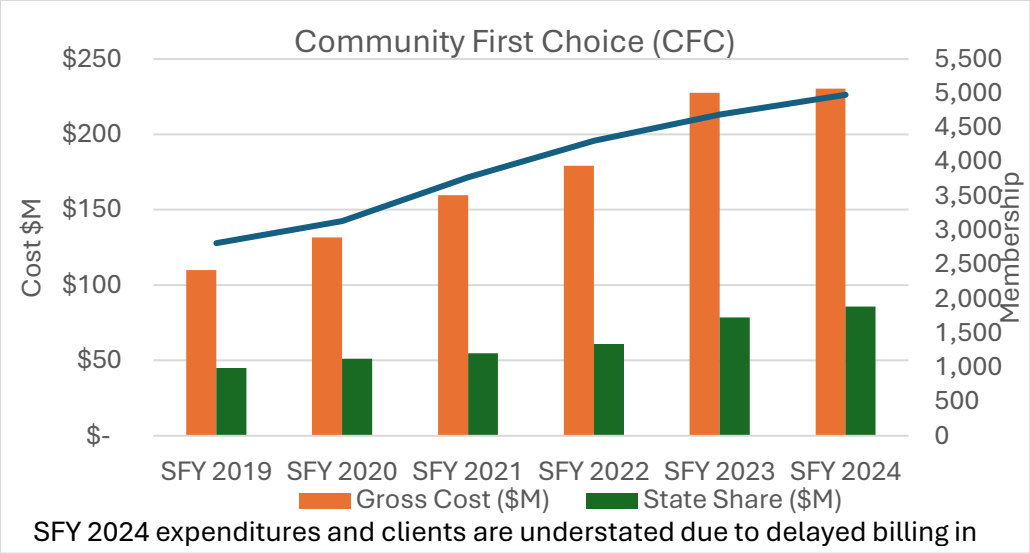
(in thousands)	SFY22	SFY23	SFY24	Orig Budget SFY25	Curr Budget SFY25	Orig to Curr Budget Deficit
Pharmacy Claims	$ 1,705,134	$ 1,932,539	$ 2,013,234	$ 1,828,638	$ 2,052,557	$ 223,919
Drug Rebates Received	$ 1,126,241	$ 1,272,724	$ 1,273,072	$ 1,274,068	$ 1,262,803	$ (11,265)
Pharmacy Claims Net of Rebates	$ 578,893	$ 659,815	$ 740,162	$ 554,570	$ 789,754	$ 235,184
Rebates as % of Pharmacy Claims	66.0%	65.9%	63.2%	69.7%	61.5%	
State Share Rx Claims Net of Rebates	$ 207,879	$ 239,513	$ 299,765	$ 221,828	$ 318,902	$ 89,567

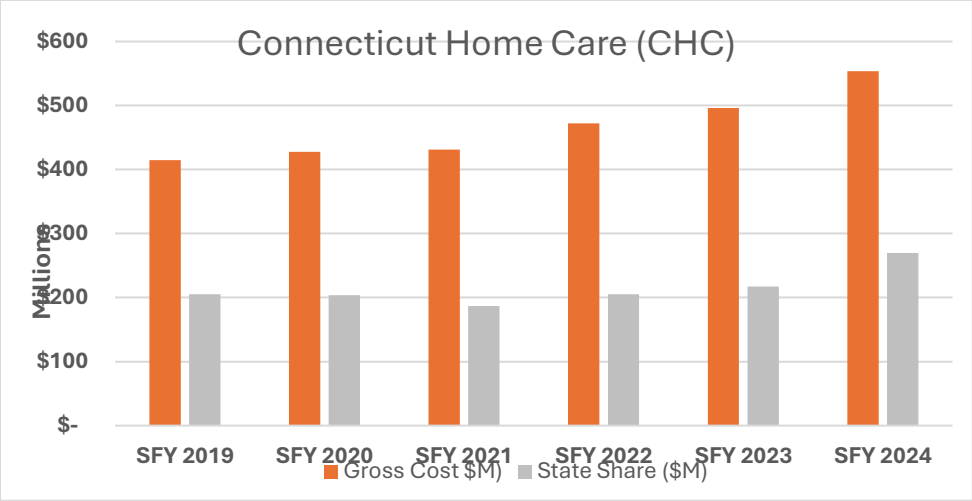
Compared to pre-pandemic levels, drug rebates as a % of pharmacy costs have been decreasing. Each 1% drop is a loss of approximately $20 million gross ($8 million State Share).

Examples of medication cost drivers: Antidiabetics (including off-label use of antidiabetics for weight loss) accounted for $53.4 million, and Dermatological drugs accounted for $24 million.

Home Health, Home Care, and Waivers- $75 Million

Home and Community Based Services (HCBS) have been both a preferred and a lower cost alternative to institutional care for recipients requiring Long Term Service and Supports (LTSS). The Connecticut Home Care Waiver, the largest of the DSS waivers with 14,600 monthly recipients and average per person costs of $3,500 per month, has added 100 participants a month since early in SFY 2023. Community First Choice, a state plan service with approximately 5,700 recipients and average per person costs of $5,100, has added approximately 650 recipients in the last year.





Under-Funded Mandates - $75 Million

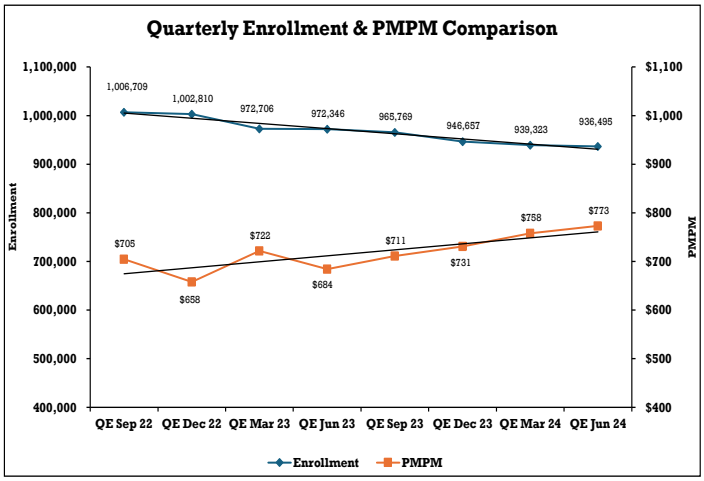
DSS implemented mandates for several program expansions. Cost estimates and appropriations for these mandates were based on data from SFY22 trends. An updated Medicaid budget was presented in the midterm legislative session for SFY25 which utilized updated trends and corrected for shortfalls. It added $106 million to DSS's baseline. DSS's budget was not adjusted. Below is a list of some of the mandates that were underfunded:

Continuous eligibility (Federal Mandate), $12M estimated
Expand Health Coverage to Children up to Age 12 Regardless of Status, $13M estimated
Multiple Rate increases for several categories of services, $17M estimated
HCBS costs related to collective bargaining agreement, $10M estimated
Expand Postpartum Coverage from 2 to 12 Months, $6M estimated
Provide Funding for Psychiatric Residential Treatment Facilities, $5M estimated
Add Periodontal Coverage for Certain Medicaid Members, $2M estimated

Other, $10M estimated

CONNECTICUT Social Services

Connecticut Trends - Per Member Per Month



- During the pandemic enrollment grew significantly. However, expenditures did not grow due to lower overall utilization.
- While enrollment has decreased because of the PHE unwind it remains higher than pre-pandemic levels. At the same time utilization continues to trend upwards
- The projected Medicaid shortfall for FY 2025 has increased from $106.8M last February to $290M today

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4. Please compare med admin rates to MA equivalent.

DSS can confirm the Medicaid Rate Study used Massachusetts as a comparison. The rate study comparison states were Maine, Massachusetts, New Jersey, New York, and Oregon. The rate study is also compared to Medicare when possible. The Mass Medicaid home health program is structured differently than Connecticut and reflects different rates based on decisions by each state. For example, the Medicaid Rate Study Phase 2 showed that 52 percent of the expenditures for CY 2023 (approximately $96 million of the total $187 million) related to the Home Health fee schedule are associated with procedure code T1502 and T1503. The rate study showed that the two codes in Connecticut are predominantly used for behavioral health medication management. Currently the service described for these codes provides support to individuals with behavioral health conditions including identifying indications of crisis and ensuring compliance with medication. These codes are not used for this purpose or population in the comparison states, so Myers and Stauffer did not compare the fees for these codes directly. Related to policy goals, Connecticut made 15% investments into the rates and add-on for escort services to reflect its policy goals for the program to ensure staff safety. The Department welcomes further discussion on policy goals for the program as any further rate increases are not contemplated in the Governor's recommended budget. DSS would need to defer on the policy and budget comments you outline below and recommend that those decisions go through the Appropriations Committee and legislative process.

Mass Health home health, medication administration rates:

T1502- Administration of medication oral, intramuscular, and/or subcutaneous medication by health care agency/professional per visit (RN or LPN) $71,52
T1503- Administration of medication other than oral, intramuscular, and/or subcutaneous medication by health care agency/professional per visit (RN or LPN) $71.52

Note: There was a question on our rate for more than one patient in the same setting, that is the T1502TT referenced in the second row on the document. The Department is happy to participate in any discussions and lend our expertise as needed.

5. Please provide additional detail re: response #8 (is it possible to link these expenditure trends to #6 home health/home care/waivers deficiency driver).

Gross Expenditures		
SFY	**Home and Community Based Services (HCBS)** Includes home health, waivers, and Community First Choice	**Long Term Care (LTC)** Includes nursing homes, intermediate care facilities, chronic disease hospital, and hospice long-term care services
2022	$1,021,200,000	$1,324,000,000
2023	$1,107,700,000	$1,437,900,000
2024	$1,181,500,000	$1,484,900,000
2025	$1,414,000,000	$1,598,900,000
2026	$1,504,000,000	$1,657,200,000
2027	$1,601,100,000	$1,702,600,000

As members have been diverted from nursing home care to home and community-based services, the Department has continued to see growth in both of these types of service. Additionally, the average annual caseload reflects the combined service categories (i.e., both nursing home care and HCBS). Caseloads have also shown growth over time, but the majority of the growth is in the HCBS utilization.

Please note, an increase in expenditures in home and community-based services does not necessarily have an impact on expenditures for nursing home level of care. The increase in both areas reflects that more people are being served through home and community-based services year over year and simultaneously, nursing homes are serving members who truly need nursing home level of care. A review of nursing home expenditure increases confirms that, since implementation of an acuity acuity-based reimbursement, nursing homes are in fact serving a more acute population. To illustrate, in FY24 the reimbursement system was still in transition to acuity and the average nursing home rate was $298.86; once fully transitioned in FY25, the average nursing home rate increased to $327.34. This increase is expected and reflective of targeting more spend to nursing home direct care services to care for more acute residents. As nursing homes continue to care for more acute and more resource intensive residents, the direct care spend will continue to adjust quarterly to ensure residents are receiving appropriate levels of care. This system is specifically designed to ensure those that need

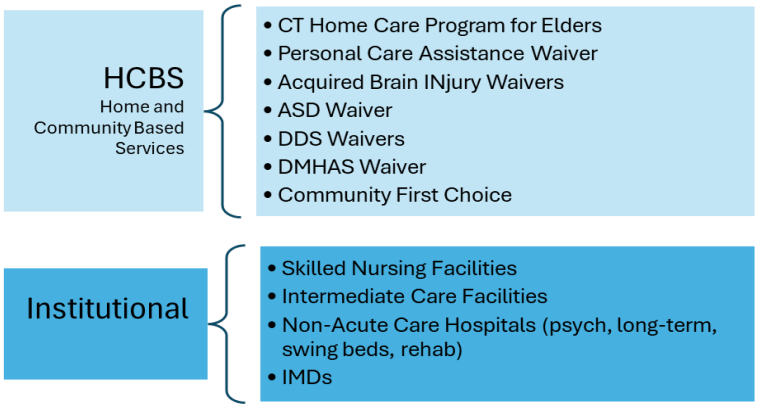
more intensive services in the nursing home receive them in the most appropriate setting while those with less acute needs are served in the community.

6. Can you share the impact of potential changes in federal funds by HUSKY group?

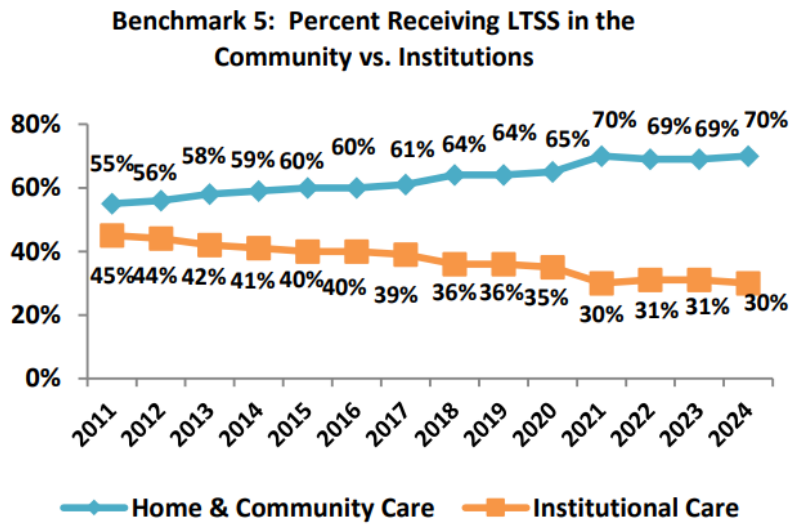
    1. If the HUSKY D current federal reimbursement rate (federal match) is reduced from the current 90% match to 50% match, the impact to the state budget will be approximately $948 million.
    2. If the minimum federal reimbursement rate/match is removed, the State federal match would be reduced from the current rate of 50% to 25.8%. This would have an approximate state budget impact of $2 billion.

7. Can you characterize savings related to Home and Community Based Services (HCBS, including MFP) vs institutionalization (5 years?)?

Over the last decade, CT has been focusing efforts on rebalancing Long Term Services and Supports in CT. DSS has grown enrollment, access and diverted individuals from institutional settings to Home and Community Based Services. HCBS and Institutional care settings are defined in this graphic:



This chart below represents the trend of Medicaid LTSS delivery location and demonstrates the effectiveness of providing member choice in how their LTSS services are delivered, at home or in an institution.



This chart below represents the trend lines of expenditure for LTSS and shows a mirror flip in expenditures in 2011 to 2024. However, there are far more members being served in the community in 2024 resulting in a lower per member cost for community care vs institutional care.