

10 Things To Know About Connecticut Medicaid

- 1 **Connecticut Medicaid, which is administered by the Department of Social Services**, is a major health plan that covers over 800,000 Connecticut residents (22% of the state population).
- 2 **Connecticut Medicaid** is an investment in the future, by promoting the health, well-being and school readiness of more than 1/3 of Connecticut children.
- 3 **Connecticut Medicaid** is an investment in financial security, wellness and work for adults, and promotes independence for older adults and people with disabilities.
- 4 **Connecticut Medicaid** has improved health outcomes and experience for both members and health care providers.
- 5 **Connecticut Medicaid** has implemented a range of care delivery and value-based payment reforms that have improved care and saved money.
- 6 **Connecticut Medicaid** plays a major role in Connecticut's economy and health care system, and supports its workforce.
- 7 **Connecticut Medicaid** manages its own benefit, as opposed to using capitated managed care. It is efficient and effective, with administrative costs of 3.2%.
- 8 **Connecticut Medicaid** has reduced its per person costs more than any other state in the nation, while maintaining coverage and ensuring good outcomes.
- 9 **Connecticut Medicaid** is supported by both federal and state funds.
- 10 **Connecticut Medicaid** is planning for the future and is continuing to evolve.

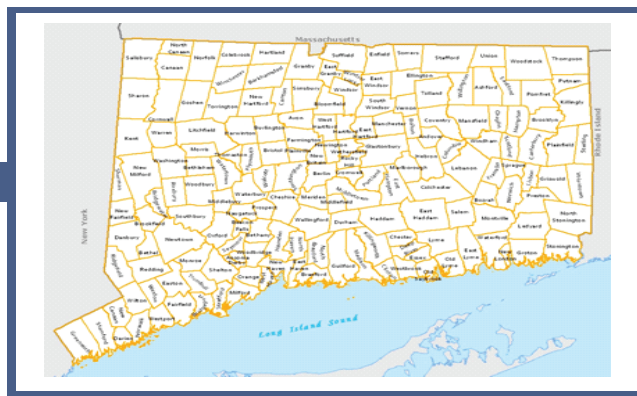
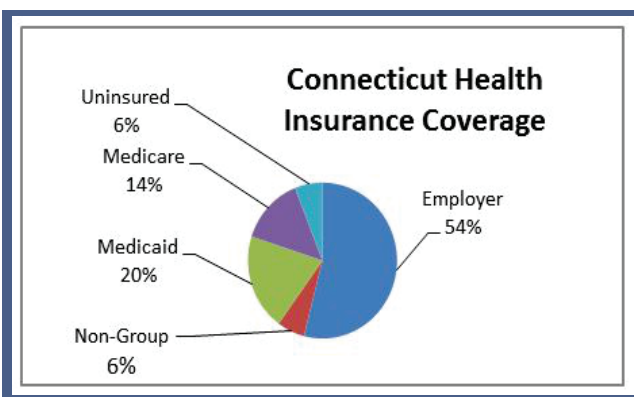


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Connecticut Medicaid is a major health plan that covers over 800,000 Connecticut residents (in 2018, 22% of the state population).

Connecticut Medicaid is a major health plan

People served by Connecticut Medicaid live in each and every town and city in Connecticut.



Medicaid covers over 800,000 Connecticut residents. Children and teens. Working families and individuals. Older adults and people with disabilities.

Over 1 in 5 CT citizens are helped. 4 in 10 Connecticut births are covered.

Medicaid Coverage Group	Provides comprehensive medical, dental and behavioral health service to...	Representing...
HUSKY A Parents and caregivers with incomes of up to 155% of the Federal Poverty Level (FPL) Pregnant women with incomes of up to 263% of FPL Children with income of up to 201% FPL	Over 450,000 parents and children	69% of members and 29% of total Medicaid program cost
HUSKY C Older adults, individuals with disabilities, and refugees with incomes up to approximately 52% of FPL; home and community-based services programs have higher income limits	Almost 94,000 older adults and people with disabilities	11% of members and 48% of total Medicaid program cost
HUSKY D Eligible adults age 19-64 with income up to 138% of FPL	Almost 240,000 Affordable Care Act eligibility expansion adults	29% of members and 25% of total Medicaid program cost
2018 FPL for 1 Person= \$12,140 2018 FPL for 4 People= \$25,100		

Connecticut Medicaid is an investment in the future, by promoting the health, well-being, and school readiness of more than 1/3 of Connecticut children.

Connecticut Medicaid . . .

Supports family planning services and pre- and postnatal care

- which promotes healthy moms, full-term births and healthy babies



Provides excellent access to pediatricians through Person-Centered Medical Homes

- which helps kids to develop appropriately and ensures that they are ready for and can regularly attend school



Ranks in the top three states in the country in terms of children's use of preventative dental care

- which results in children with healthy teeth and gums and lifetime oral health habits

Covers behavioral health and developmental screening and an array of supports for children who need them

- which prevents more serious conditions and risks



For more information see this link:

https://www.cga.ct.gov/med/council/2018/0608/20180608ATTACH_CHNCT%20Presentation.pdf

Connecticut Medicaid is an investment in financial security, wellness and work for adults, and promotes independence for older adults and people with disabilities.

Connecticut Medicaid . . .

Is a major health plan that covers over 800,000 citizens, which:

- Gives people financial security from catastrophic health costs.
- Improves mental health
- Enables earlier diagnosis of conditions such as diabetes

Covers extensive preventative medical, behavioral health, and dental benefits, which:

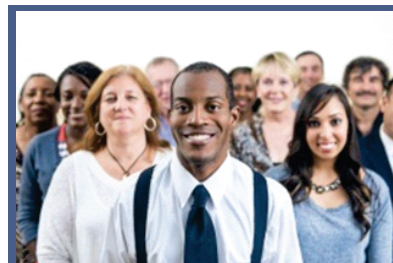
- Help to identify health conditions early and to prevent acute illness
- Enable effective management of chronic conditions
- Support work readiness
- Reduce absenteeism and attrition

Uses data to identify members with complex, unmanaged needs, and provides care coordination services, which:

- Helps people avoid non-urgent use of the emergency room
- Reduces hospital admissions
- Responds to holistic needs

Covers an extensive array of community-based services for older adults and people with disabilities, which:

- Support individuals in remaining independent
- Help people who reside in nursing homes to move back to the community



Many Connecticut Medicaid members work, but typically in positions that do not provide health insurance.



Connecticut Medicaid pays for most of the long-term services and supports that are provided in Connecticut, both in nursing facilities and at home in the community.

For more information see these links:

https://www.cga.ct.gov/med/council/2018/0608/20180608ATTACH_CHNCT%20Presentation.https://www.cga.ct.gov/med/council/2018/0608/20180608ATTACH_CHNCT%20Presentation./

[linkhttps://health.uconn.edu/aging/research-reports/](https://health.uconn.edu/aging/research-reports/)

Connecticut Medicaid's self-insured, managed fee-for-service model has improved outcomes both members and health care providers.





In the past, both members and providers struggled in working with Connecticut Medicaid's capitated managed care plans. By moving to a self-insured model, the program has addressed past problems by providing Intensive Care Management, standardizing member and provider supports, and providing new practice transformation resources.

Connecticut Medicaid . . .

Is improving use of preventative services and reducing hospitalization through Intensive Care Management and connections with behavioral health, and dental

Has increased member satisfaction by centralizing support in “one call does it all” contact numbers with Administrative Services Organizations (ASOs)

Has enrolled many new providers (both primary care and specialists) and has streamlined processes. . .

Indicator	Trend: Calendar Year 2015 through Calendar Year 2017
Use of routine preventative care (Physician services- all)	 16.3%
Hospital admissions (per 1,000)	 6.29%
Hospital Re-admissions (days/1,000)	 3.52%
Average length of hospital stay	 4.75%

- Surveys show that members report a 97% overall favorable rating of the medical ASO call center and a 95% overall favorable rating for HUSKY Health Intensive Care Management.
- Provider surveys show that providers report an 89% overall favorable rating of the HUSKY Health program.
- Person-Centered Medical Home (PCMH) feedback from primary care providers has been overwhelmingly positive.

“Participating in the PCMH program has been a most positive experience. We now have systems in place to track and measure the care and management of our patients. As a result, the patients are more actively involved in the management of their own well-being. Our Community Practice Transformation Specialist has been a wonderful asset in getting us through this process.”

~ Internal Medicine of Greater New Haven

Connecticut Medicaid has implemented a range of care delivery and value-based payment reforms that have improved care and

Connecticut Medicaid has focused on:

- building participation of primary care providers (medical, behavioral health, dental)
- transforming those practices to effectively support members, care coordination, and integration of services
- paying providers in ways that reward them for value, as opposed to volume

The emphasis is on getting people the care they need, at the right time, and in the right place.

The Connecticut Medicaid Equation:



Primary care practice transformation (PCMH)



Intensive Care Management



Integration of primary care, specialty care and social services (health homes, PCMH+)



Data analytics using a statewide set of claims



Pay-for-performance initiatives



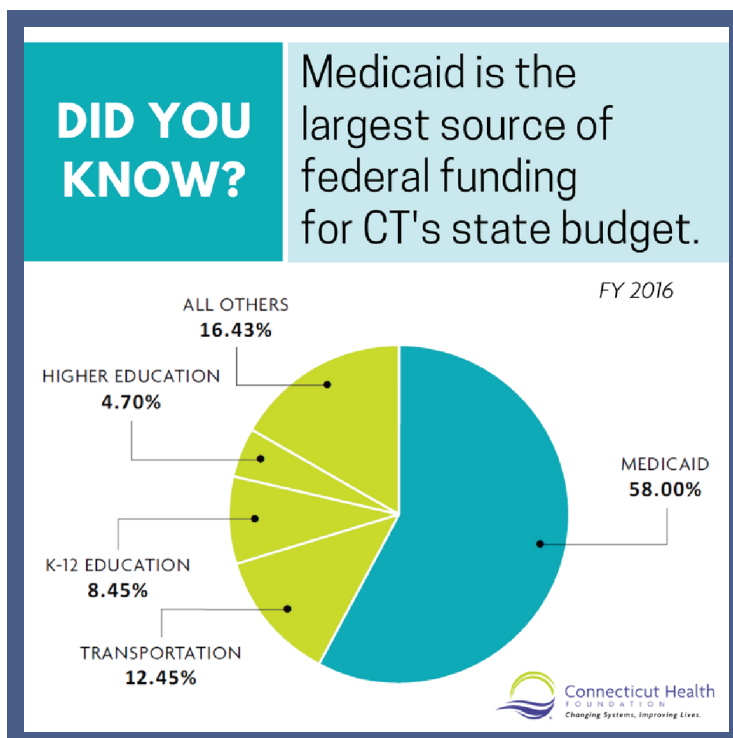
Value-based payment (PCMH+)



Better care, improved well-being, and cost savings

Connecticut Medicaid . . .

- finances almost 20% of all health care expenditures in the state
- represents the largest segment of federal funding in the Connecticut budget



- provides health insurance for the employees of many large Connecticut employers, which enables work readiness and employee retention
- partners with over 30,000 performing health care providers (including hospitals, nursing homes, physician practices, home health agencies, and many others), supporting them in employing countless health care staff.

For more information see this link:

<https://www.cthealth.org/publication/medicaids-role-in-connecticuts-economy-health-system-and-budget/>

Connecticut Medicaid manages its own benefit, as opposed to using capitated managed care, and is efficient and effective, with administrative costs of 3.2% (as compared with 11% - 18% costs that are typical of private health plans).

Historically, Connecticut Medicaid used capitated contracts, under which administration of the program was delegated to managed care organizations (MCOs). In contrast to most other states, but similar to many large employers, Connecticut Medicaid is now self-insured and does not use any capitated managed care arrangements. Migrating to this platform has enabled the program to:

- centralize and streamline operations, resulting in significant administrative cost savings
- create “one call does it all” entry points for members and providers
- standardize coverage and utilization guidelines, as well as provider rates, statewide
- produce a fully integrated set of all program claims data (medical, behavioral health, dental, pharmacy)
- implement new care delivery and payment reforms that have yielded improved outcomes and savings

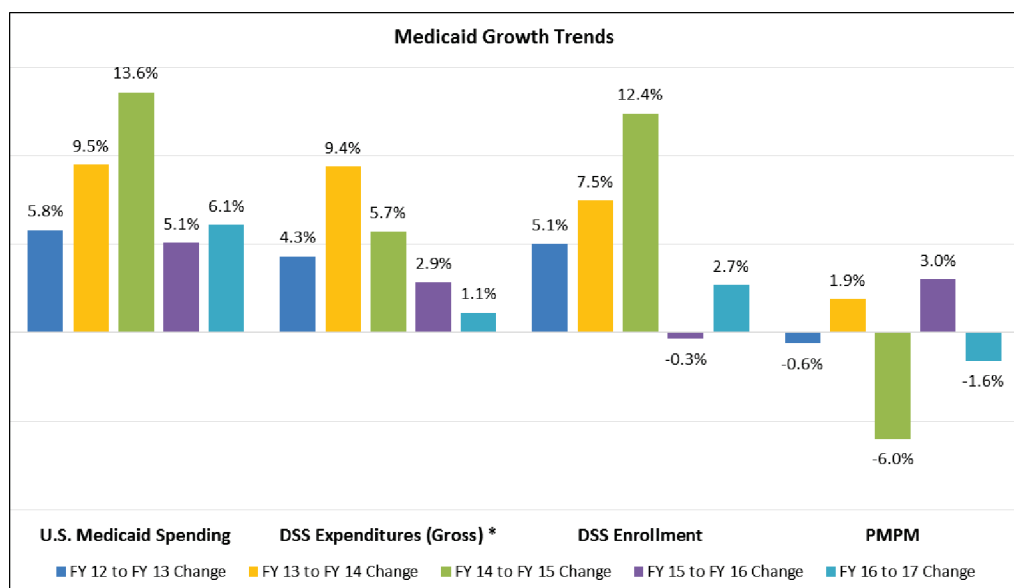
	Present Model: Self-Insured Managed Fee-for-Service	Old Model: Capitated Managed Care Contracts
Administrative/financial model	Self-insured, managed fee-for service model; Department of Social Services contracts with four Administrative Services Organizations (ASOs)	A mix of risk-based managed care contracts and central oversight
Financial trends	Overall expenditures are increasing proportionate to enrollment; per member per month spending is trending down	Significant year-over-year increases were typical
Data	Fully integrated set of claims data; program employs data analytics to identify members at risk, share data with providers and to make policy decisions	Limited encounter data was available from managed care organizations (MCOs)
Member experience	ASOs provide streamlined, statewide access points and Intensive Care Management	Members had different experiences depending on which MCO oversaw their services; MCOs relied upon traditional chronic disease management strategies
Provider experience	ASOs provide uniform, statewide utilization management; providers are paid on a bi-weekly basis	Provider experience varied across MCOs; payment was often slow or incomplete

Connecticut Medicaid has reduced its per member per month (PMPM) costs more than any state while maintaining coverage and good outcomes.

Health Affairs' July 2017 issue (Vol. 36, No. 7) reported that Connecticut's Medicaid program led the nation in controlling cost trends on a per enrollee basis for the period from 2010-2014. Connecticut reduced its per-person spending by a greater percentage (5.7%) than any other state in the country. Overall and in Connecticut, Medicaid tracked lower than private health insurance and Medicare.

Connecticut reduced its per-person spending by a greater percentage (5.7%) than any other state in the country.

As is illustrated below, Connecticut Medicaid's enrollment grew significantly from 2012 to the present, but its per person costs decreased over that period by 3.4%. Further, Connecticut Medicaid's overall expenditures only increased by 1.1% in 2017, by contrast to a 6.1% increase in overall U.S. Medicaid spending.



The state share of Connecticut Medicaid represents 23% of the state General Fund – this is the lowest percentage of all New England states (which range from 24.7 to 33.6%) and is lower than the all-states average of 28.7% (National Association of State Budget Officers, NASBO, 2016)

For more information see this link:

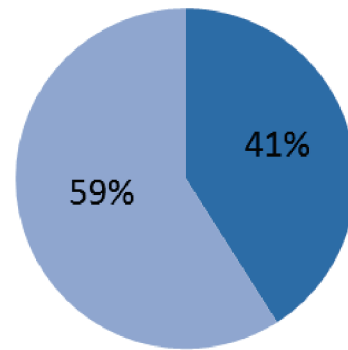
<https://portal.ct.gov/DSS/Press-Room/Press-Releases/2017/Connecticut-Medicaid-Best-in-Nation-For-Curbing-Per-Enrollee-Cost-Trend>

Connecticut Medicaid is supported by both federal and state funds.

Medicaid is . . . a program through which people who meet financial and other eligibility criteria receive health care. The federal government currently pays for 59% of the costs of the Connecticut program, but numerous features are matched at a higher rate, including the expansion population (HUSKY D – in 2018, federal government pays 94% of costs), eligibility functions (federal government pays 75% of costs) and health information technology (federal government pays 90% of costs).

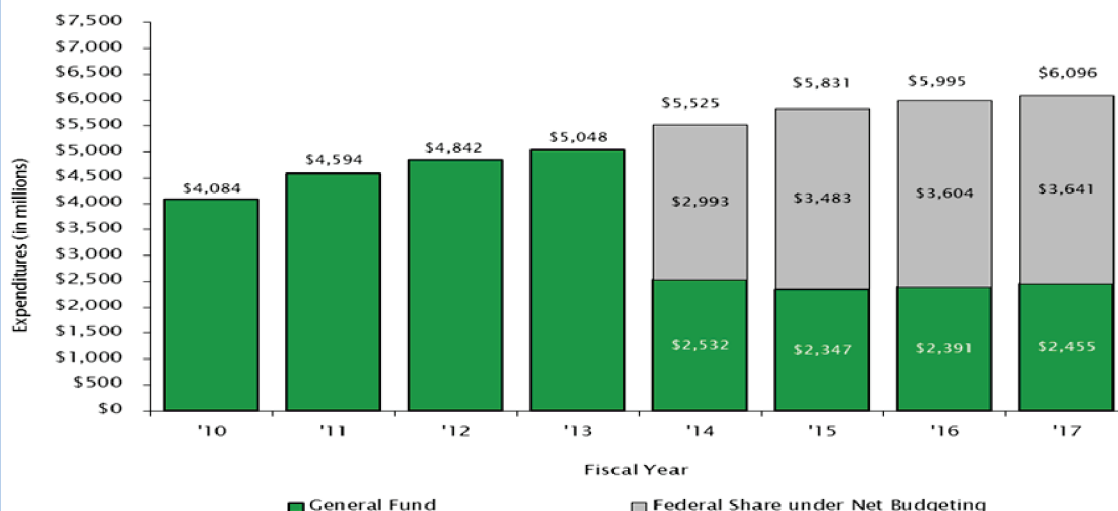
Connecticut Medicaid Funding

■ State share ■ Federal share



By contrast to Medicare, which is basic health insurance for retirees and some people with disabilities, Medicaid covers a full range of services including dental, behavioral health, and long-term care services for older adults and people with disabilities, in nursing homes and in the community.

The state share of Connecticut Medicaid was actually less in 2017 than it was in 2014.



Connecticut Medicaid is planning for the future and continuing to evolve.

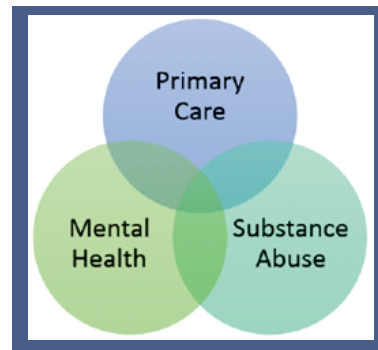
Connecticut Medicaid has made significant progress over the last five years, but is committed to building on present reforms by continuing to improve the quality of services and outcomes for members and supporting adequate rates and effective administrative processes for health care providers. Further, Connecticut Medicaid supports efforts to bring payers together to address the quality and cost of health care.

The program has opportunities for growth and improvement in each of the following areas:



Person-Centered Local Networks

Developing multidisciplinary health networks that address whole-person needs (medical, dental, behavioral health, social determinants) across the age continuum, from early childhood to old age



Supports for High Risk Members

Providing effective and timely supports for people with complex conditions (such as opioid dependence) that involve physical, behavioral health and substance use components



High Cost Pharmacy

Developing additional value-based payment strategies, with a focus on pharmacy purchasing



Long-Term Services and Supports in the Community

Accelerating efforts to serve people who need long-term services and supports in the community, as opposed to in institutional settings