1. **Connecticut Medicaid**, which is administered by the Department of Social Services, is a major health plan that covers over 800,000 Connecticut citizens (22% of the state population).

2. **Connecticut Medicaid** is an investment in the future, 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 independence for older adults and people with disabilities.

4. **Connecticut Medicaid** has improved health outcomes and experience for both members and providers.

5. **Connecticut Medicaid** has implemented a range of 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, and is efficient and effective, with administrative costs of 3.2%.

8. **Connecticut Medicaid** has reduced its per person costs more than any other state, 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 continuing to evolve.
Connecticut Medicaid is a major health plan that covers over 800,000 Connecticut citizens (in 2018, 22% of the state population).

**Connecticut Medicaid** is a major health plan that 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.

<table>
<thead>
<tr>
<th>Medicaid Coverage Group</th>
<th>Provides comprehensive medical, dental and behavioral health service to...</th>
<th>Representing...</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HUSKY A</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults</td>
<td>Over 450,000 parents and children</td>
<td>69% of members and 29% of total Medicaid program cost</td>
</tr>
<tr>
<td>Pregnant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **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         | Almost 240,000 expansion adults                                   | 29% of members and 25% of total Medicaid program cost |

Medicaid covers over 800,000 Connecticut residents. People served by Connecticut Medicaid live in each and every town and city in Connecticut.

![Connecticut Health Insurance Coverage](chart)
Connecticut Medicaid is an investment in the future, 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 post-natal care

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

Provides excellent access to pediatricians through Person Centered Medical Homes

- which supports kids in developing appropriately and in ensuring that they are ready for school

Is in the top three states in the country for children's utilization of preventative dental benefits

- which results in children with healthy teeth 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 risks

Want more information? See this link
Connecticut Medicaid supports financial security, wellness and work for adults, and independence for older adults and people with disabilities.

Connecticut Medicaid . . .
Is a major health plan that covers over 800,000 citizens
► which, research shows:
  1) gives people financial security from catastrophic health costs;
  2) improves mental health
  3) enables earlier diagnosis of conditions such as diabetes

Covers extensive preventative medical, behavioral health and dental benefits
► which
  1) help to identify health conditions early and to prevent acute illness;
  2) enable effective management of chronic conditions;
  3) support work readiness; and
  4) reduce absenteeism and attrition

Uses data to identify members with complex, unmanaged needs, and provides care coordination services
► which
  1) helps people avoid non-urgent use of the emergency room;
  2) reduces hospital admissions; and
  3) 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, and in moving back to the community from nursing homes

Want more information? See these links:
linkhttps://health.uconn.edu/aging/research-reports/
Connecticut Medicaid's self-insured, managed fee-for-service model has improved outcomes for members and providers.

In the past, both members and providers struggled in working with Connecticut Medicaid's capitated managed care plans. In 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 . . .

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Trend: Calendar Year 2015 through Calendar Year 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of routine preventative care (Physician services – all)</td>
<td>↑16.3%</td>
</tr>
<tr>
<td>Hospital Admissions (per 1,000)</td>
<td>↓6.29%</td>
</tr>
<tr>
<td>Hospital Re-Admissions (days/ 1,000)</td>
<td>↓3.52%</td>
</tr>
<tr>
<td>Average Length of Hospital Stay</td>
<td>↓4.75%</td>
</tr>
</tbody>
</table>

- Experience surveys show members indicating 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 resulted in an 89% overall favorable rating by providers surveyed for satisfaction with the HUSKY Health program.
- Person-Centered Medical Home (PCMH) practice feedback 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 payment reforms that have improved care and saved money.

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:
Connecticut Medicaid plays a major role in Connecticut's economy and health system, and supports its workforce.

Connecticut Medicaid . . .

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

Want more information? See this link:
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

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

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.

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)

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).

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 integrate services and providers within local networks
- identifying and addressing the needs of high risk members
- attacking the serious challenge of high cost prescription drugs
- supporting individuals who have more typically received nursing home services in the past to access less costly services in the community

**Person-Centered Local Networks**

Pointing toward 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.

Produced by the Connecticut Department of Social Services