

Connecticut HUSKY Health 101

**Vision, Structure, Strategies, Key Facts
Medicaid and CHIP in a Nutshell**

February 26, 2020

Connecticut HUSKY Health 101

- **Overview**
- **Vision**
- **Structure**
- **Strategies**
- **Key Facts**
- **Medicaid and CHIP in a Nutshell**



Overview

HUSKY Health touches everyone.

Over 820,000 people.

Children. Working families and individuals.

Older adults. People with disabilities.

Over 1 in 5 Connecticut residents are helped.

4 in 10 Connecticut births are covered.



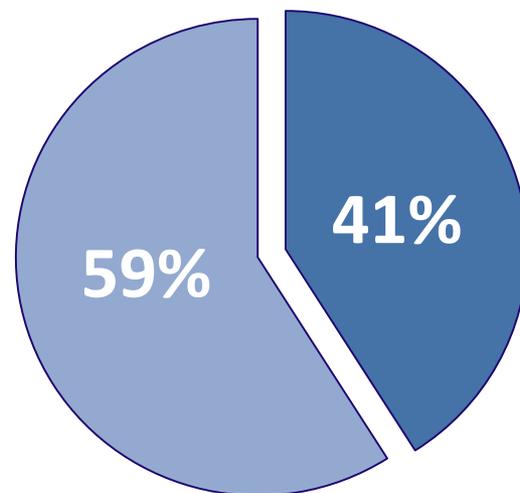
Connecticut HUSKY Health is made up of Medicaid and Children's Health Insurance Program (CHIP).

Medicaid is . . . a program through which people who meet financial and other eligibility criteria receive health care. It is a partnership between the state and the federal government. For SY2020, the **federal government pays for 59%** of Connecticut Medicaid program costs by making matching payments.

CHIP is . . . also a federal-state partnership that provides healthcare for uninsured children whose incomes are above the Medicaid eligibility limits. For FFY 2020, the **federal government pays for 76.5%** of Connecticut CHIP costs.

Connecticut Medicaid Funding

■ State share ■ Federal share



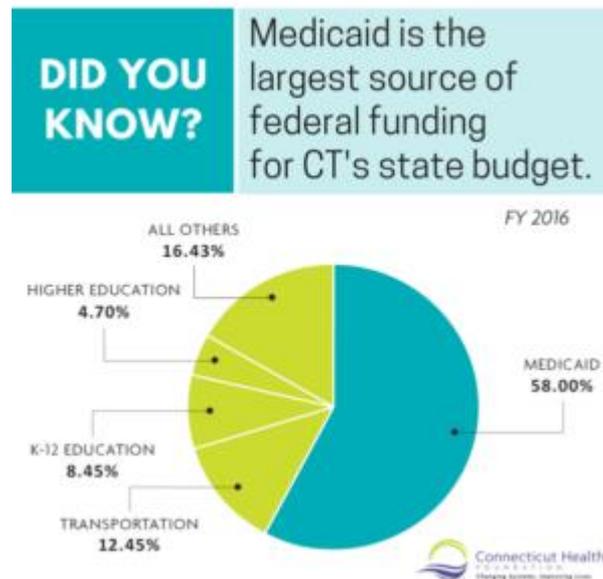
Contrasting Medicare and Medicaid

The federal **Medicare** program is basic health insurance for retirees and some people with disabilities. Its main focus is on coverage of hospital services and doctor's visits. Coverage for behavioral health and long-term services and supports (LTSS) is limited, and dental is not covered.

Medicaid, which is operated by states using federal and state funds, provides eligible people with medical, behavioral health, and dental benefits. Medicaid is also the majority payer for LTSS for older adults and people with disabilities who live in the community and in nursing homes. Some older adults and people with disabilities are **dually eligible** for Medicare and Medicaid.

Connecticut HUSKY Health . . .

- Finances almost **20% of health care expenditures in the state**
- Represents the largest segment of federal funding in the Connecticut budget
- Partners with over **30,000 performing health care providers** (hospitals, nursing homes, physician practices, home health agencies, and many others), supporting them in employing health care staff



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

Connecticut HUSKY Health covers a comprehensive array of health care benefits.

HUSKY A,C, & D Health Program Covered Services

Medical Services: 

Your doctor is the first stop for all your medical needs, such as:

- Medical check-ups
- When you are sick
- Immunizations or "shots"
- Laboratory tests, including blood tests, and X-rays

Find a primary care provider (PCP) in the Provider Directory at ct.gov/husky.

Behavioral Health Services: www.ctbhp.com

The Connecticut Behavioral Health Partnership (CT BHP) can help you find the mental health and/or substance abuse services you need. 

CT BHP Phone Number:

- 1.877.552.8247 Monday through Friday, 9 a.m. to 7 p.m.
- The number if you are deaf or hard of hearing is 711 or 1.866.218.0525.

Pharmacy: 

Pharmacy services and medicines that need a prescription are covered under the HUSKY Health program.

Connecticut Pharmacy Assistance Program Phone Number:

- 1.866.409.8430 Monday through Friday, 8 a.m. to 5 p.m.
- The number if you are deaf or hard of hearing is 711 or 1.866.604.3470.

Translation and American Sign Language Services: 

Our Member Engagement Services staff can:

- Call an interpreter line
- Translate any written material into the language you speak
- Print materials in a larger font
- Copy materials into Braille

Contact Member Engagement Services for assistance regarding interpretation services:

- 1.800.859.9889 Monday through Friday, 8 a.m. to 6 p.m.
- The number if you are deaf or hard of hearing is 711.

Vision: 

Services include medical equipment/supplies, eye exams, and eyeglasses.

Find an eye doctor in the Provider Directory at ct.gov/husky.

Dental: www.ctdhp.com 

The Connecticut Dental Health Partnership (CTDHP) can help you find a dentist to provide dental services.

CTDHP Phone Number:

- 1.855.283.3682 Monday through Friday, 8 a.m. to 5 p.m.
- The number if you are deaf or hard of hearing is 711.

Non-Emergency Medical Transportation: www.ct.ridewithvevo.com 

If you do not have transportation to your medical, dental, or behavioral health appointments, you may be able to get help to get there. You must request assistance in advance of your appointment.

Non-Emergency Medical Transportation Phone Number:

- 1.855.478.7350 Monday through Friday, 7 a.m. to 6 p.m.
- The number if you are deaf or hard of hearing is 711.

To view your handbook online or find a doctor/provider for any service:
Go to ct.gov/husky ➔ For Members or 

Call Member Engagement Services at 1.800.859.9889 Monday through Friday, 8 a.m. to 6 p.m.

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The HUSKY Health Program Has Gone Social
Find us on Facebook and Twitter  



HUSKY B' Program Covered Services

Medical Services: 

Your doctor is the first stop for all your medical needs, such as:

- Medical check-ups
- When you are sick
- Immunizations or "shots"
- Laboratory tests, including blood tests, and X-rays

Get HUSKY Plus information (supplemental services) for medically eligible members at 1.800.859.9889

Behavioral Health Services: www.ctbhp.com

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Copays may apply for some services
*Premium applies for Band 2

Medicaid Coverage Group	Provides comprehensive medical, dental, and behavioral health services to . . .	Representing . . .
<p>HUSKY A</p> <ul style="list-style-type: none"> Adults with incomes up to 160% of the Federal Poverty Level (FPL) Pregnant women with incomes up to 263% FPL Children with incomes up to 201% FPL 	<p>Almost 475,000 parents/ caregiver relatives and children</p>	<ul style="list-style-type: none"> 57% of total members 29.3% of total Medicaid program costs
<p>HUSKY C</p> <ul style="list-style-type: none"> Older adults, individuals with disabilities, and refugees with incomes up to approximately 52% FPL; home and community-based services programs have higher income limits 	<p>Over 90,000 older adults and people with disabilities</p>	<ul style="list-style-type: none"> 11% of total members 41% of total Medicaid program costs
<p>HUSKY D</p> <ul style="list-style-type: none"> Eligible adults age 19-64 with incomes up to 138% FPL (Affordable Care Act Medicaid expansion population) 	<p>Over 265,000 adults who do not have children or specified disabilities</p>	<ul style="list-style-type: none"> 32% of total members 29.7% of total Medicaid program costs

Children's Health Insurance Program (CHIP) Coverage Group	Provides comprehensive medical, dental, and behavioral health services to . . .
HUSKY B Band 1 <ul style="list-style-type: none">Family income up to 254% of the Federal Poverty Level (FPL)	Almost 13,000 children under 19th birthday
HUSKY B Band 2 (requires premium) <ul style="list-style-type: none">Family income between 254% and 323% of the FPL	Over 7,000 children under 19th birthday

For reference:

2020 FPL for 1 person = \$12,760

2020 FPL for 4 people = \$26,200



Vision

A stronger and healthier generation that avoids preventable conditions, and is economically secure, stably housed, food secure, and engaged with community.

Families that are intact, resilient, capable, and nurturing.

Choice, self-direction and integration of all individuals served by Medicaid in their chosen communities.

Empowered, local, multi-disciplinary health neighborhoods.





Structure

DSS is the single state Medicaid agency for Connecticut.

DSS partners with several sister state agencies (DMHAS, DCF, DDS) that have roles in managing Medicaid benefits.

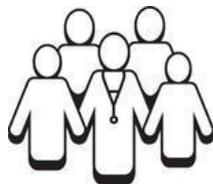
DSS works with DPH, the federally identified state licensing and survey agency, to ensure quality.

DSS oversees contracts with three Administrative Services Organizations (ASOs) (for medical, behavioral health, dental) and a non-emergency medical transportation broker.

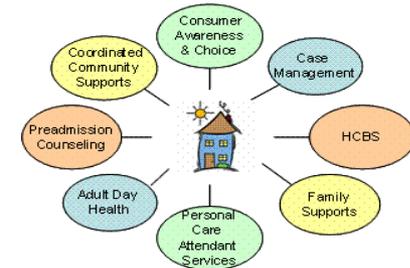




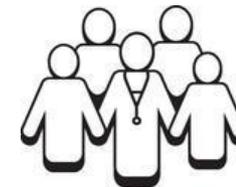
Prevention Agenda



Integration Agenda



LTSS Rebalancing Agenda



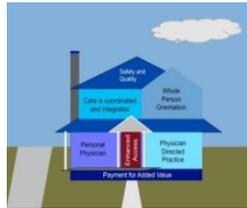
By contrast to most other state Medicaid programs, Connecticut Medicaid does not contract with capitated managed care organizations. Instead, like most large employers, the program is self-insured and uses a managed fee-for-service approach.

Self-Insured	vs.	Capitated Managed Care
Connecticut Medicaid does not make payments to managed care plans. It pays administrative costs and costs of health care claims.	Payments	Medicaid agency pays monthly premiums to a Medicaid managed care organization (MCO).
Connecticut Medicaid assumes financial risk.	Assumption of Risk	The Medicaid MCO assumes financial risk.
Connecticut Medicaid controls and has standardized coverage, utilization management and provider payment statewide.	Plan Design	Each Medicaid MCO determines its own coverage, utilization management, provider network, and provider payments.
Connecticut Medicaid has a fully integrated, statewide set of claims data.	Data	Each Medicaid MCO produces limited “encounter data” for the Medicaid program.



Strategies

On a foundation of



Person-Centered Medical Homes



ASO-Based Intensive Care Management (ICM)



Pay-for-Performance (PCMH, obstetrics)



Data Analytics/ Risk Stratification

we are building in



Community-based care coordination through expanded care team (health homes, PCMH+, Money Follows the Person)



Supports for social determinants (transition/tenancy sustaining services, PCMH+ connections with community organizations)



Value-based payment (PCMH, PCMH+, obstetrics pay-for-performance)

with the goal of creating



Multi-disciplinary (medical, behavioral health, dental services; social supports) health neighborhoods

HUSKY Health's key means of addressing cost drivers include:

Streamlining and optimizing administration of Medicaid through . . .

- **a self-insured, managed fee-for-service structure and contracts with Administrative Services Organizations**
- **unique, cross-departmental collaborations including administration of the Connecticut Behavioral Health Partnership (DSS, DCF, DMHAS), long-term services and supports (LTSS) rebalancing plan (DSS, DMHAS, DDS, DOH) and the ID Partnership (DDS and DSS)**

Improving access to primary, preventive care through . . .

- extensive new investments in primary care (PCMH payments, primary care rate bump, Electronic Health Record payments)
- comprehensive coverage of preventive behavioral health and dental benefits

Coordinating and integrating care through . . .

- ASO-based Intensive Care Management (ICM)
- PCMH practice transformation
- DMHAS-led behavioral health health homes
- Money Follows the Person “housing + supports” approach and Medicaid supportive housing services
- PCMH+ shared savings initiative

Re-balancing long-term services and supports (LTSS) through . . .

A multi-faceted Governor-led re-balancing plan that includes:

- Transitioning institutionalized individuals to the community with housing vouchers and services
- Prevention of institutionalization
- Nursing home “right sizing” (diversification of services) and closure
- Workforce initiatives
- Consumer education

Moving toward value-based payment approaches through . . .

- Hospital payment modernization
- Pay-for-performance initiatives
- PCMH+ shared savings initiative



Key Facts

- **Connecticut HUSKY Health is a major health plan that covers approximately 830,000 people.**
- **Connecticut HUSKY Health has improved health outcomes and member care experience while decreasing unnecessary use of the emergency department and inpatient hospital care.**
- **Connecticut HUSKY Health's performance in these measures compares favorably with national benchmarks.**
- **Connecticut HUSKY Health's statewide network of health providers has continued to expand.**

Key Quality Indicators

- In the initial reporting period for the national Medicaid scorecard, Connecticut's performance was well above the national median for the majority of State Health System Performance Measures, including well-child visits, immunizations for adolescents, use of multiple concurrent anti-psychotics in children and adolescents, preventive dental visits, and diabetes short-term complications admission
- These results reflect the trend from Calendar Year 2015 through Calendar Year 2018:

Indicator	Trend
Routine care – physician services	Up 15.6%
Hospital admissions per 1,000	Down 8%
Hospital re-admissions per 1,000	Up 0.18%
Average length of stay hospital	Down 2.4%

Our Provider Network Continues to Grow

Connecticut HUSKY Health Provider Participation CY 2015 – CY 2019

	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	Percent Change CY 2018- CY 2019
Total Primary Care Providers (PCPs)*	3,454	3,511	3,602	3,750	3,870	+3.20%
Total Specialty/ Ancillary/Facility Providers*	16,940	17,154	17,764	18,272	22,724**	+24.37%

* Totals include in-state and border providers.

** In 2019, state billing location indicators for providers were changed from out-of-state to border by DXC and DSS. 3,249 providers were changed from an out-of-state indicator to a border indicator.

Use of routine, preventive care is increasing

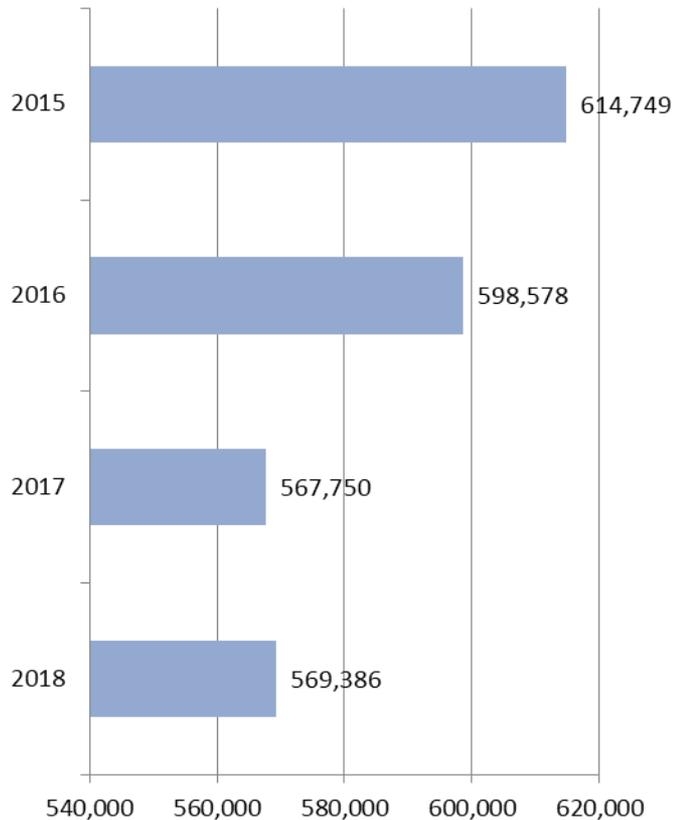
Service Description	CY 2015		CY 2016		CY 2017		CY 2018		CY 2015 vs CY 2018	
	Util	Util/1000	Util	Util/1000	Util	Util/1000	Util	Util/1000	Util/1000	%
Clinic Services	189,975	232	187,696	230.3	187,728	226.1	202,564	237.7	5.7	2.5%
FQHC – Medical	702,989	858.6	756,645	928.5	788,787	949.9	754,501	885.4	26.8	3.1%
Other Practitioner	459,228	560.9	526,855	646.5	580,637	699.2	668,212	784.2	223.3	39.8%
Physician Services – All	3,948,428	4,822.5	4,403,791	5,404.0	4,655,918	5,606.9	4,751,019	5,575.6	753.1	15.6%

Hospital utilization is decreasing

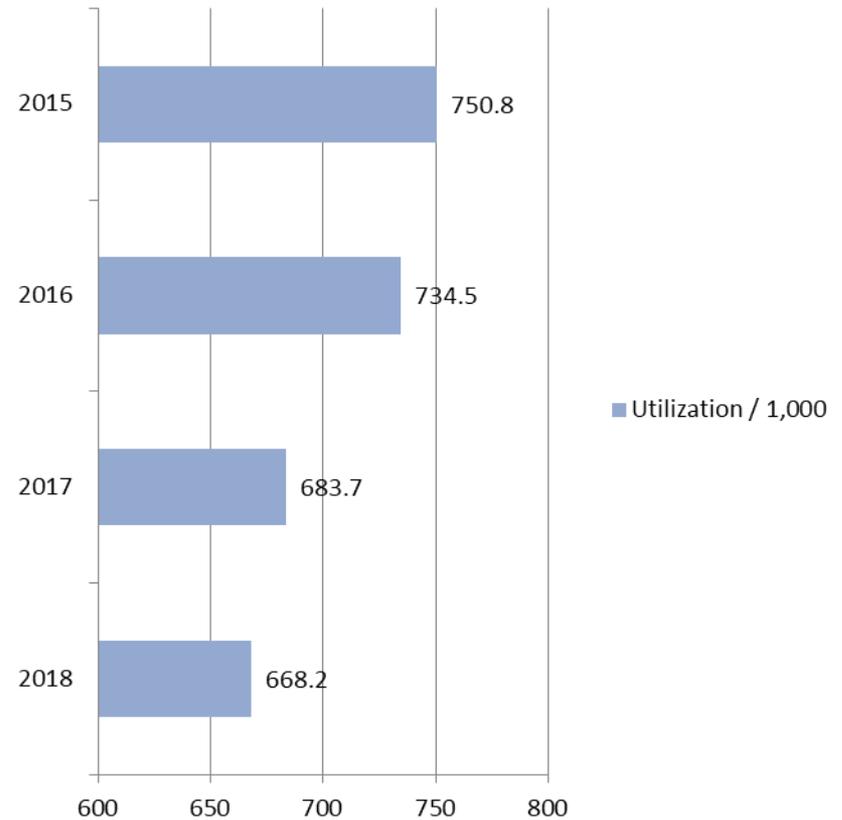
	2015	2016	2017	2018	CY 2015 vs CY 2018	
Admissions	84,777	85,618	80,573	81,004	-3,773	-4.45%
Admissions per 1,000	103.54	105.06	97.03	95.06	-8.48	-8.19%
Re-admission Rate	11.35%	11.26%	10.95%	11.37%	0.02%	0.18%
Days/1,000	479.7	472.4	428.1	430.1	-49.60	-10.34%
Average Length of Stay (ALOS)	4.63	4.5	4.41	4.52	-0.11	-2.38%

Emergency Department utilization is decreasing

Utilization



Utilization / 1,000



Member Program Satisfaction (CY 2018)

- Achieved an overall member satisfaction rating of 93.0% among adults surveyed with respect to experience with HUSKY Health PCMH practices
- Achieved a 94.6% overall favorable rating by members surveyed for satisfaction with the Intensive Care Management (ICM) program
- Achieved a 97.1% overall favorable rating by members surveyed for satisfaction after completion of a call with the CHNCT Member Engagement Services call center

Provider Program Satisfaction (CY 2018)

- Achieved a 91.3% overall favorable rating by providers surveyed for satisfaction with various aspects of the HUSKY Health program
- Achieved a 96.9% overall favorable satisfaction rating among those providers who worked with ICM

Connecticut Medicaid is efficient and effective

- **Low administrative load:** program has administrative costs of *only 3.0%*
- **Favorable per member, per month (PMPM) cost trends:**
 - reforms have reduced PMPM more than any other state in the country
 - Connecticut went from being in one of the three most costly states to being ranked 18th in the country
- **Low spending growth rate:** the program's growth rate is *less* than the national average, *less* than Medicare, and *less* than private health insurance

- **Stable state costs:** the program has maximized federal funding and the state share of funding for Connecticut Medicaid remained **virtually unchanged from SFYs 2013 to 2017, and in SFYs 2018 and 2019 began to rise due to lower federal reimbursement for single adults and hospital rate increases**
- **Stable proportion of budget:** Connecticut Medicaid represents 23.8% of the state General Fund budget, which is **lower than the all states average and the average of its peer states** (Maine, Massachusetts, New Hampshire, Rhode Island, Vermont, New Jersey and New York), from SFY 2015 through 2019

For more detail, please see this link:

https://www.cga.ct.gov/ph/med/related/20190106_Council%20Meetings%20&%20Presentations/20200214/HUSKY%20Financial%20Trends%20February%202020.pdf

Medicaid and CHIP in a Nutshell

- Purpose of Medicaid
- Medicaid State Plan
- Medicaid authorities
- Contrasting Medicaid and Medicare
- Purpose of CHIP and CHIP State Plan
- Eligibility and coverage groups
- Covered services
- Financing and provider reimbursement

- The purpose of Medicaid is to enable states **"to furnish rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care"**
- Further, the Medicaid Act requires that each state medical assistance program be administered **in the "best interests of the recipients"**

- **Medicaid State Plan:** A written plan between a State and the Federal Government that outlines Medicaid eligibility standards, provider requirements, payment methods, and health benefit packages. A Medicaid State Plan is submitted by each State and approved by the Centers for Medicare and Medicaid Services (CMS)

Generally, State Medicaid plans must, among other requirements:

- ensure that services are provided in all parts of the state (the “**statewideness**” requirement)
- ensure freedom of choice of providers
- provide a fair hearing process through which applicants and participants can appeal denials or failure to act on applications within standards

- establish or designate a single State agency to administer the plan - in Connecticut this is the Department of Social Services (DSS)
- require the State health agency - in Connecticut, this is the Department of Public Health (DPH) - to establish health standards for medical providers
- provide coverage to certain categorically eligible individuals

- describe the extent to which the State is covering optional groups of individuals
- provide services for all recipients in the same amount, duration and scope (the “**comparability**” requirement)
- impose cost sharing in a manner that is consistent with federal law

- describe financial eligibility standards
- implement estate recovery, asset transfer restrictions and evaluation of trusts in a manner that is consistent with federal law
- provide individualized plans of care for recipients

- **Federal law:**
 - 42 U.S.C. Section 1396 *et seq.*
 - 42 C.F.R. Parts 430-455

- **State law:**
 - Chapter 319v (Secs. 17b-220 to 17b-319), and various others

- **Department of Social Services Uniform Policy Manual (UPM)**
 - <https://portal.ct.gov/DSS/Lists/Uniform-Policy-Manual>

- The **Medicaid** program is a medical program based on financial and functional need
- Applicants must meet income and asset eligibility requirements, or must demonstrate a qualifying disability or functional need for services
- Generally, Medicaid has a more comprehensive array of covered services than does Medicare
- Further, with several important exceptions, recipients of Medicaid are not typically required to participate in cost sharing (e.g. copayments or deductibles)

- By contrast, eligibility for **Medicare** is not based on financial need
- Individuals who have met the required minimum number of “quarters” of work to qualify for Social Security retirement benefits, or have been receiving Social Security disability benefits for at least two years, automatically qualify for Medicare (children with End-Stage Renal Disease or Lou Gehrig’s Disease who meet identified criteria qualify more rapidly)

- Medicare provides a standard benefit that provides partial coverage of hospital and nursing facility services, physician services, some preventive services, and durable medical equipment
- Medicare beneficiaries are required to pay deductibles and copayments for most services, and there are strict durational limits for certain services: notably, coverage of care in a nursing facility

- The purpose of CHIP is to cover uninsured children in families with incomes that are modest but too high to qualify for Medicaid
- Unlike Medicaid, CHIP is not an entitlement program
- CHIP must periodically be re-authorized, and is dependent on appropriations from Congress for funding

- **CHIP State Plan:** A written plan between a State and the Federal Government that outlines CHIP eligibility standards, provider requirements, payment methods, and health benefit packages. A CHIP State Plan is submitted by each State and approved by the Centers for Medicare and Medicaid Services (CMS)

- States can choose health benefits coverage equivalent to those offered under:
 - the standard Blue Cross/Blue Shield preferred provider option offered to federal employees;
 - a health plan available to a state's public employees; or
 - the HMO within the state that has the highest commercial enrollment (excluding Medicaid enrollment)

- States may impose cost sharing (i.e., deductibles, coinsurance, and co-payments) for some children enrolled in CHIP, within federal guidelines
- In general, states cannot adopt cost-sharing or premium policies that impose costs that exceed five percent of family income or that favor higher-income families over lower-income families. They also are prohibited from imposing cost-sharing for well-baby and well-child care, including immunizations

- Medicaid is composed of different “**coverage groups,**” each with their own eligibility requirements
- Eligibility requirements include categorical, income, asset, and other requirements
- Categorical requirements describe categories of individuals eligible for coverage, such as aged, blind and disabled individuals, children under age 19 and their parents, pregnant women and low-income childless adults

- **HUSKY A child and family coverage**
 - Children under age 19 and their parents/caretaker relatives
 - Pregnant women
- **HUSKY C “Aged, Blind and Disabled” coverage**
 - Individuals age 65 and older
 - Individuals with disabilities
 - Individuals who are blind
- **HUSKY D Medicaid expansion group coverage**
 - Low-income adults age 19 through 64 who do not receive Medicare

- Since the passage of the federal Affordable Care Act (ACA), Medicaid is part of a health care coverage continuum that also includes:
 - the Children’s Health Insurance Program (HUSKY B), which provides coverage to uninsured children in families with incomes that are too high to qualify for Medicaid
 - subsidized Qualified Health Plans
 - unsubsidized Qualified Health Plans

- Household income is determined using Modified Adjusted Gross Income (MAGI) tax-based rules

- Since 2012, DSS has partnered with Access Health CT, which operates the state-based health insurance exchange portal through which Connecticut residents can apply for health insurance coverage, including HUSKY A & D (the “MAGI” groups), CHIP, and qualified health plans
- For MAGI Medicaid programs and CHIP, applications are taken on a rolling basis by telephone and through Access Health’s portal, which is available at this link:
<https://www.accesshealthct.com/AHCT/LandingPageCTHIX>

- By contrast, DSS directly receives and processes applications for HUSKY C

- This includes:
 - Aged, Blind and Disabled (ABD) coverage
 - Coverage under the home and community-based services “waivers”

- Applications may be submitted on line through this link:
<https://connect.ct.gov/access/jsp/access/Home.jsp>

“Aged, Blind and Disabled” Eligibility Criteria:

- An applicant must:
 - Be age 65 or older; be age 18 – 64 and have a disability according to Social Security criteria; or be blind; and
 - Have income less than the identified limit and have countable assets less than the identified limit (\$1,600 for individuals; \$2,400 for married couples)
- If an applicant is employed he or she must have income less than \$75,000 and countable assets less than identified limits (\$10,000 for individuals; \$15,000 for married couples)
- Note that some assets are considered to be exempt – one example is that the home in which an applicant resides is excluded

Spend-down option:

- Helps people who are over the income limit for ABD coverage, but meet all other requirements
- Person must “spend down” the amount by which his or her income exceeds the income limit by providing bills for medical expenses, for each six-month period, before Medicaid eligibility becomes effective
- This is similar to an insurance deductible
- The spend-down amount = (monthly income – income limit) x 6

Spend-Down Example

- Monthly applied income is \$960 per month
- The income limit, including disregards, is \$860
- The “excess” income is \$100 per month or \$600 for the 6-month spend-down period
- Once the individual has incurred \$600 in medical bills, HUSKY C will pay future medical bills for the rest of the 6-month spend-down period

Medicare Savings Programs (MSP)

These additional programs help to defray out-of-pocket health care costs for low-income people:

- Qualified Medicare Beneficiary (QMB)
 - Pays Medicare Part A and Part B premiums, deductibles and co-insurance
- Specified Low Income Medicare Beneficiary (SLMB) and Additional Low Income Medicare Beneficiary (ALMB)
 - Both pay Medicare Part B Premiums

All MSP categories qualify members for the Medicare Part D Prescription Drug Program's Low Income Subsidy (also known as "Extra Help")

- States must, under their Medicaid State Plans, cover identified mandatory services (e.g. inpatient hospital care, FQHC services, physicians' services) and may elect to cover optional services (e.g. dental, behavioral health, medical transportation)
- Connecticut covers a broad range of optional services

- Medicaid does not cover:
 - pilot projects or projects limited to a particular geographic area (unless through a waiver)
 - out-of-state care with providers who refuse to enroll in Connecticut Medicaid
 - experimental care
 - research

- For a summary of covered services under HUSKY A (children and parents/relative caregivers), C (older adults and people with disabilities) and D (single childless adults age 19-64), please use this link:

[https://www.huskyhealthct.org/members/Member%20PDFs/member benefits/HUSKY ACD Member Handbook.pdf](https://www.huskyhealthct.org/members/Member%20PDFs/member%20benefits/HUSKY%20ACD%20Member%20Handbook.pdf)

- For a summary of covered services for HUSKY B (Children's Health Insurance Program/CHIP, uninsured children under age 19), please use this link:

https://www.huskyhealthct.org/members/Member%20PDFs/member_benefits/HuskyB_MemberHandbook.pdf

If coverage is being expanded, DSS must define the service, identify credentials for providers, prepare a fiscal impact analysis, and determine how to reimburse for the service. HUSKY Health can expand coverage of services when:

- The federal government requires states to cover additional services (e.g. services for people with autism spectrum disorders) or offers financial incentives to cover additional services (e.g. self-directed services under Community First Choice)

- The program identifies that coverage of additional services would meet member needs and result in cost savings (e.g. coverage of supportive housing services)
- The legislature enacts authorizing language and appropriates funding

- The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid
- Under EPSDT, states are required to provide comprehensive services and furnish all Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, based on certain federal guidelines

- EPSDT is made up of the following screening, diagnostic, and treatment services:
 - Screening Services
 - Vision Services
 - Dental Services
 - Hearing Services
 - Other Necessary Health Care Services
 - Diagnostic Services
 - Treatment

- Another means of covering services is through “waivers”
- Waivers permit states to be excused from one or more of the Medicaid State Plan requirements – an example of this is the “statewideness” requirement
- The Affordable Care Act also provided some new options for coverage through State Plan Amendments

Authority	Features
<p>1915(c) home and community-based waiver</p> <p>In Connecticut: CT Home Care Program for Elders, Personal Care Assistance, Acquired Brain Injury, DDS, Mental Health, Autism</p>	<p>An option through which states can cover home and community-based long-term services and supports for target populations. Services can include care management, homemaker, home health aide, personal care, adult day health, habilitation, and respite care. Must identify a cap on participation.</p>
<p>1115 research and demonstration waiver</p>	<p>An option through which states can implement demonstration projects to expand eligibility, provide services not typically covered by Medicaid, and/or use innovative service delivery systems. Must demonstrate budget neutrality and accept a cap on total expenditures over a five-year period.</p>

Authority	Features
1915(b) managed care waiver	An option under which states can implement a managed care delivery system that restricts the types of providers from which beneficiaries can receive services and use associated savings to provide other services.
1915 (i) State Plan Amendment (SPA)	An option under which states can provide home and community-based services to individuals who meet identified functional criteria. In that it is a SPA, must serve all eligible individuals and cannot cap enrollment.

- Under the federal law, states are required to pay an identified percentage of total program costs and the Federal government pays the remainder
- This remainder is called the Federal Medical Assistance Percentage (FMAP)
- Connecticut's FMAP for most Medicaid services is 50%, and overall is 59%

- Connecticut's FMAP for CHIP services is currently 76.5%
- Connecticut's FMAP for newly eligible (ACA expansion) individuals on HUSKY D is 90%
- Several other initiatives (e.g. administrative activities of the medical Administrative Services Organization, Electronic Health Record project, health home) are eligible for FMAP that is greater than 50%

Medicaid programs must adhere to the following guidelines in reimbursing providers for services:

Payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that services under the plan are available to beneficiaries at least to the extent that those services are available to the general population.

[§1902(a)(30)(A) of the Social Security Act]

DSS reimbursement staff use a variety of primary data sources to determine Medicaid reimbursement:

- Costs and cost reconciliation as reported through annual provider cost reports
- Inflation index
- Prospective or historical costs
- Consumer price index
- Wages and geographic index
- Cost-of-living adjustments
- Acuity
- Market Basket Index

DSS must also ensure that costs:

- are “proper and efficient”
- are allocated in accordance with the benefits received by each participating program
- do not reflect general public health initiatives that are made available to all people
- Do not duplicate payment for activities that are being paid through other programs
- Are not funded through other federal sources
- Have adequate source documentation

DSS reimburses providers through diverse means, including, but not limited to, the following:

- Hospitals receive Diagnosis Related Group (DRG) payments for most inpatient services, and Ambulatory Payment Classification (APC) payments for most outpatient services
- Physicians receive payments that are specific to the service codes that are used to claim for payment
- Health centers receive “encounter rates” that are set based on a method identified in federal law and their cost reports
- Residential institutional providers (nursing homes, ICF-IID facilities) receive per diem payments that have historically been cost-based and are set using a statutory method