State of Connecticut

Department of Social Services

Report Regarding the HUSKY Health Program

Pursuant to Section 17 of Public Act 23-171

February 4, 2025

CONTENTS

1. EXECUTIVE SUMMARY

The Connecticut Department of Social Services (DSS) administers Medicaid and the Children's Health Insurance Program (CHIP), collectively known as HUSKY Health, which provides health and long-term services and supports to over 1 million people. DSS' priority is for HUSKY Health members to receive the best possible supports to maximize their health and well-being.

Findings.

Successes: As detailed in the recent Medicaid Landscape Analysis performed by Accenture and Manatt on behalf of DSS, HUSKY Health:

- Ranks highly across most federal core quality performance measures,
- Is financially efficient, providing services at a lower cost than peer states ($749 per-member per-month (PMPM) vs. $873 PMPM in Northeastern states) and much lower administrative costs at 3.8% vs. 9.4% for states with significant managed care, and
- Average access to care based on survey data.

Other successes include:

- High and stable access to primary care and other services,
- Positive ratings from providers, and
- Coverage of a broad set of services.

Challenges: The Medicaid Landscape Analysis highlights several areas for improvement:

- High costs to serve members with disabilities and over age 65, with average performance,
- Less favorable performance measures for some acute and chronic conditions and declining rates for certain behavioral health measures, and
- Increasing prescription drug costs.

Other challenges include:

- Limited access for certain service categories, geographic areas, and specific needs, and
- Inconsistent coordination among providers, including transitions between levels of care.

Initiatives. This report highlights recent changes to HUSKY Health in each major area of the program. DSS' improvement strategy includes upcoming or planned initiatives designed to enhance the program in each area. Common themes include working to support person-centered services, improving coordination among service types, and enhancing collaboration between health and other service systems.

2. BACKGROUND and SCOPE

Statutory Mandate: This report implements section 17 of Public Act 23-171, which provides:

(a) The Commissioner of Social Services, in consultation with the executive director of the Office of Health Strategy, the Secretary of the Office of Policy and Management and other agencies as appropriate, shall develop a strategy to improve health care outcomes, community health and health equity to support HUSKY Health members. The Department of Social Services shall consult with an association of hospitals in the state, Connecticut acute care and children's hospitals, and other community health care providers and community stakeholders to inform community-based prevention policies and wellness, care delivery and financing strategies.

(b) Such strategy shall address improved health equity by identifying barriers and influences that impact health and health care outcomes for HUSKY Health members and articulate options to achieve the following goals:

(1) Improve health care access and outcomes
(2) Increase adoption of interventions to support improved access to preventive care services
(3) Identify and address social, economic, and environmental drivers of health to advance long-term preventive health and health care outcomes
(4) Explore innovative financing reforms that support high quality care, promote integration of primary, preventive, and behavioral health care and address health-related social needs and long-term preventive outcomes
(5) Improve collaboration and coordination among health care providers and cross-sector community partners
(6) Improve Medicaid reimbursement and performance to achieve a sustainable health care delivery system and improve health care affordability for all.

(c) Such strategy shall include approaches designed to improve performance in prevention measures, clinical outcomes, improved access to preventative services and health equity measures recommended by the Connecticut Medicaid Transparency Advisory Board established pursuant to Executive Order Number 6 of Governor Ned Lamont in 2020.

(d) Not later than January 1, 2025, the Commissioner of Social Services shall submit recommendations for reform to the Medical Assistance Program Oversight Council, including, but not limited to, recommendations for filing any state plan amendments or federal waivers with the federal Centers for Medicare and Medicaid Services to achieve the goals identified in subsection (b) of this section and agreed upon as a result of the strategy developed pursuant to subsection (a) of this section. The commissioner may provide updates and other status reports to said council on or before December 31, 2024, on the progress of the strategic work of the department on such goals.

Scope: Because HUSKY Health is a broad, complex program, it is not feasible for this report to be an exhaustive inventory. Rather, this report covers key areas for attention and improvement. Due to time constraints, this report primarily focuses on areas administered directly by DSS, although, as noted below, several other agencies (especially the Department of Developmental Services (DDS), Department of Mental Health and Addiction Services (DMHAS), and Department of Children and Families (DCF)) also have a significant role in administering HUSKY Health, including programs and services funded in their budgets.

In addition, this report intends not to overlap or duplicate other reports, which is why certain areas of the program have much less detail in this report (such as cost containment). Examples of such reports or presentations about HUSKY include:

- Medicaid Rate Study (including the Waiver Rate Study), required by Public Act 23-186, which measures how Medicaid rates compare to benchmarks for rate sufficiency.
- Medicaid Landscape Analysis, requested by the Governor, which looks across the Medicaid program on key metrics (cost, access, experience, quality) to analyze the potential impact of Medicaid managed care and an analysis of home and community-based services.
- Topic-specific reports required by state legislation.
- Areas routinely covered by public presentations to MAPOC, BHPOC and their committees.

a. DSS AND HUSKY HEALTH OVERVIEW

DSS Overview: DSS administers HUSKY Health and other health and social service programs and services for over 1.2 million Connecticut residents. DSS provides healthcare coverage, food and nutrition assistance, financial assistance, child support services, energy aid, independent living services, social work services, protective services for the elderly, home-heating aid, and additional vital assistance. Additional information is in the agency's annual report, posted on the DSS website here: dss-annual-report-sfy-2023.pdf (ct.gov).

DSS Vision: DSS envisions a Connecticut where all are healthy, secure, and thriving.

DSS Mission: To make a positive impact on the health and well-being of Connecticut's individuals, families, and communities.

DSS Values:

- Pride in Public Service
- Excellence and Integrity
- Compassion and Empathy
- Equity and Inclusion
- Racial Justice
- Collaboration and Communication
- Learning and Innovation

Relevant to HUSKY Health, DSS prioritizes strategic objectives with significant positive impact on the people the agency serves. DSS works to create a dignified experience for obtaining and maintaining benefits, which informs efforts to improve eligibility operations and policy. DSS focuses on helping DSS customers live longer and healthier lives, which guides work to improve coverage, payment, and administration. DSS looks to leverage innovative ways to improve economic security and success for DSS customers, which expands connections between health and non-health programs.

HUSKY Health Overview: HUSKY Health includes Connecticut's Medicaid program, Children's Health Insurance Program (CHIP), and related state-funded healthcare programs. Nationally, Medicaid was established in 1965 by Title XIX of the Social Security Act. Medicaid is a jointly funded state and federal program that provides health and long-term care coverage to over 72 million individuals nationwide, including children, pregnant women, low-income adults under age 65, individuals with disabilities, and older adults. It is voluntary for each state to participate in Medicaid. Consistent with federal requirements, each state has significant flexibility to adjust eligibility rules, cover optional services, set provider payment rates and methods, and program administration. Nationally, CHIP was established in 1997 by Title XXI of the Social Security Act and now provides coverage to over 9 million low-income children with incomes above Medicaid limits.

HUSKY Health (including full-benefit coverage and benefits under the Medicare Savings Program (MSP)) covers 1 in 3 Connecticut children and 1 in 6 Connecticut adults. HUSKY Health is a major payer in several areas, including maternity services, behavioral health, and services for persons with disabilities and chronic conditions (including intellectual and developmental disabilities). Unlike health insurance and Medicare, Medicaid covers long-term services and supports in addition to healthcare services and is the major payer of nursing homes and home and community-based services.

Eligibility Groups: HUSKY Health includes the following broad eligibility groups, which include most HUSKY Health members:

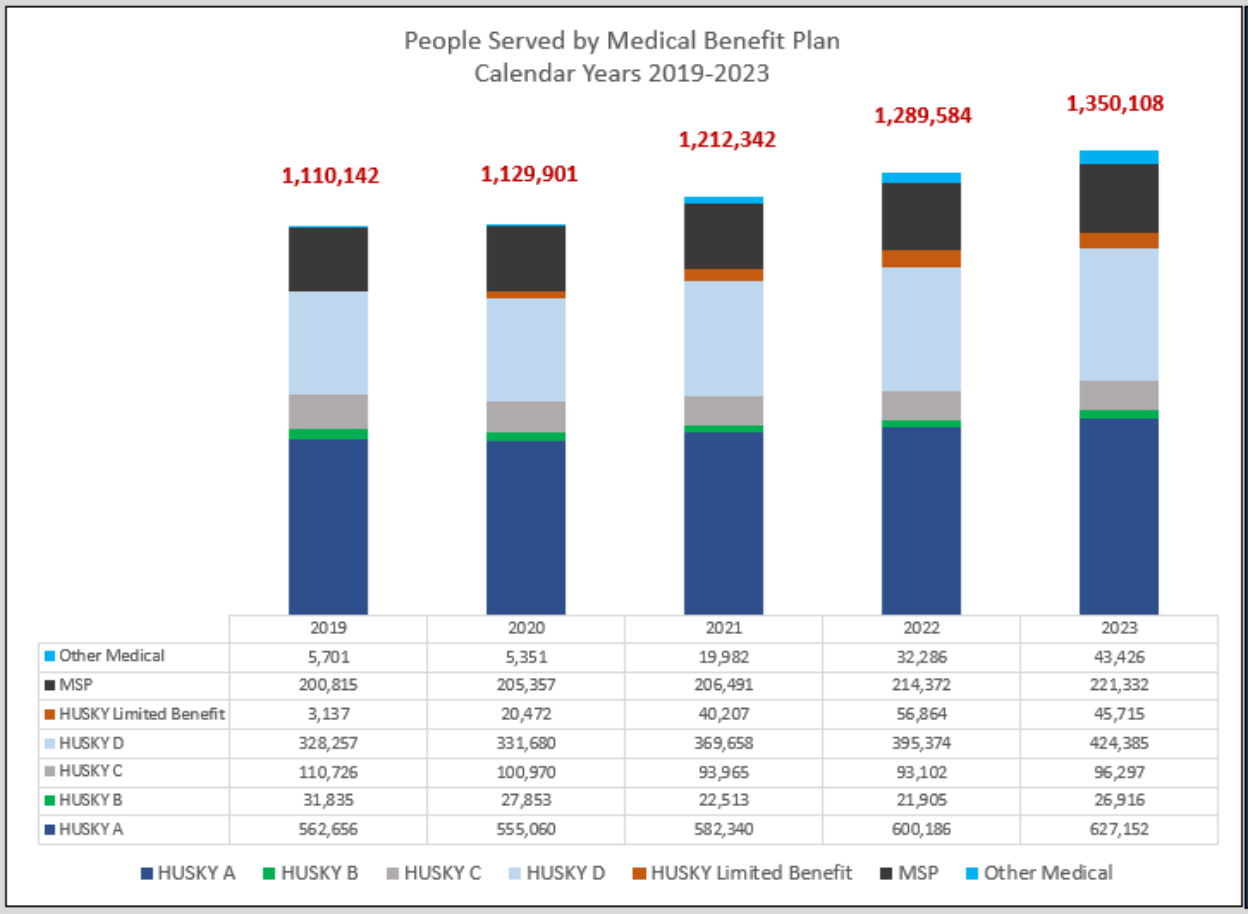
Category	Brief Summary of Populations (each has applicable requirements)
HUSKY A (Medicaid)	Children, Parents/Caretakers of Minor Children, Pregnant Individuals
HUSKY B (CHIP)	Children over Income for Medicaid (within applicable CHIP limits). In addition, HUSKY B includes prenatal care coverage for unborn children of non-citizen pregnant individuals (also known as HUSKY B Prenatal)
HUSKY C (Medicaid)	Age over 65, Blindness, Disability (asset limits apply, in addition to income limits)
HUSKY D (Medicaid)	Adults ages 19-64 (not parents/caretakers of minor children), also known as Low-Income Adults or the Medicaid Expansion group (added by the Affordable Care Act)

Additional eligibility groups beyond HUSKY A, B, C, and D include:

- Medicaid for Employees with Disabilities (**MED-Connect**) – allows eligible persons with a disability to be employed, earn income and receive medical assistance under Medicaid,
- Medicaid **Limited Benefits** – currently for family planning services and for individuals with tuberculosis and individuals with breast and cervical cancer,
- **Medicare Savings Program** (MSP) – for certain individuals eligible for Medicare , MSP provides Medicaid support for premiums and, for some individuals, also Medicaid support for Medicare cost-sharing. Individuals on MSP who also meet standard Medicaid eligibility requirements receive full Medicaid benefits, including available Medicaid services that Medicare does not cover,
- **Covered CT** – provides support for cost-sharing after application of federal subsidies and credits, plus dental and non-emergency medical transportation services, for eligible individuals above income for Medicaid who select a silver-level qualified health plan on Access Health CT, the state-operated health insurance exchange,
- **Emergency Medicaid** – for individuals who would otherwise qualify for Medicaid but for their immigration status, which includes coverage for emergency services as defined for this portion of the program, as well as dialysis for end-stage renal disease (ESRD),
- **State HUSKY** – state-only funded coverage (*i.e.*, not part of Medicaid or CHIP) for children up to the age authorized in state law and postpartum coverage for pregnant individuals who previously were enrolled in HUSKY B Prenatal or whose labor and delivery were covered by Emergency Medicaid, as provided by state law, which sets the same income eligibility requirements as Medicaid or CHIP for individuals who are ineligible under federal law because of their immigration status, and

- **State-Funded Portion of the Connecticut Home Care Program for Elders (CHCPE)** – provides state-funded coverage for CHCPE services for certain individuals who are over income for Medicaid but meet specified eligibility requirements, which is funded in the DSS budget by a separate line item from the Medicaid account.

Figure 1. (*Includes a breakdown of HUSKY Health enrollment, excluding Covered CT*)



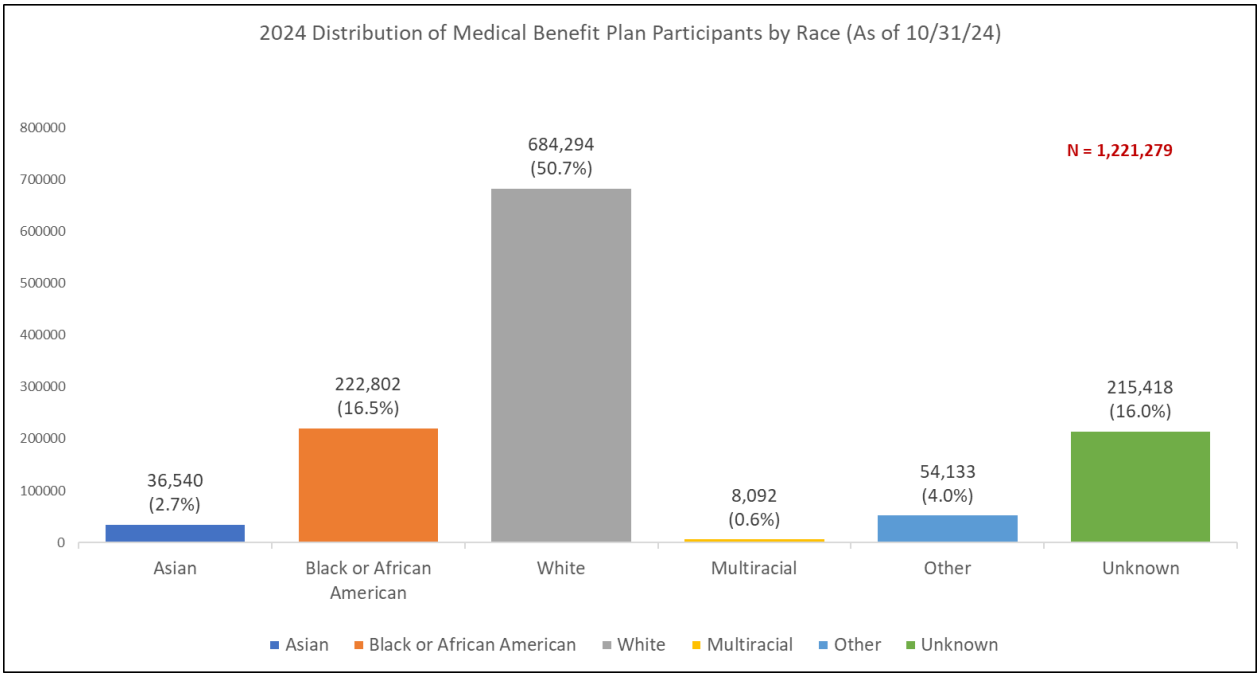
	2019	2020	2021	2022	2023
Other Medical	5,701	5,351	19,982	32,286	43,426
MSP	200,815	205,357	206,491	214,372	221,332
HUSKY Limited Benefit	3,137	20,472	40,207	56,864	45,715
HUSKY D	328,257	331,680	369,658	395,374	424,385
HUSKY C	110,726	100,970	93,965	93,102	96,297
HUSKY B	31,835	27,853	22,513	21,905	26,916
HUSKY A	562,656	555,060	582,340	600,186	627,152

Source: DSS Persons Served Dashboard. Note: Numbers in red refer to total unique participants across programs. The sum of individual programs do not add up to the total, as individuals may be in more than one coverage group.

- The average annual increase in total participants in the 2019-2023 period was 4% per year.
- In 2020, HUSKY Limited Benefit coverage increased more than five-fold, from 3,137 to 20,472, which reflects the inclusion of the COVID-19 testing and treatment limited benefit category, which sunset at the end of the federal COVID-19 public health emergency (PHE) in spring 2023.
- HUSKY B and C participants decreased between 2020-2022 but increased in 2023; the decrease in HUSKY B was largely due to the suspension of Medicaid discontinuances during the PHE.

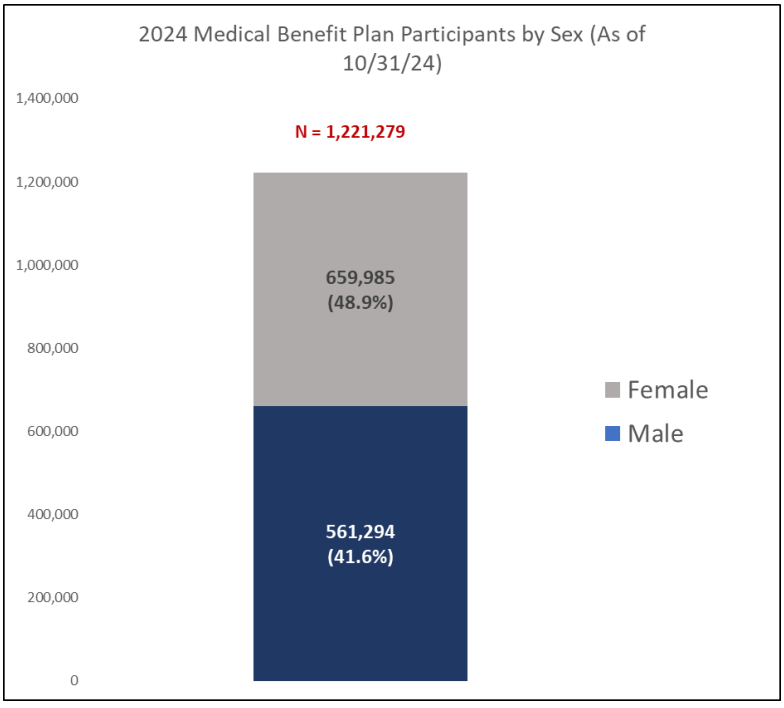
Figures 2 and 3 provide more details on race/ethnicity and sex of HUSKY Health members:

Figure 2.



Source: DSS Persons Served Dashboard.

Figure 3.



Multi-Agency Collaboration. While DSS is the primary agency overseeing HUSKY Health overall, DSS partners with other state agencies on key aspects of administering the program.

DSS. Under state and federal law, DSS is the single state agency that administers Medicaid and CHIP. DSS is responsible for HUSKY Health overall, including eligibility, coverage, payment, and program administration. DSS manages contractors, oversees healthcare providers, and claims for federal matching funds. Most of HUSKY Health is administered directly by DSS, in which the state share (and in specific contexts, including hospital supplemental payments, the state and federal share) are appropriated directly to DSS.

Department of Developmental Services (DDS). DDS receives state and federal share funding to administer several portions of HUSKY Health, including three section 1915(c) home and community-based services (HCBS) waivers for individuals with intellectual and developmental disabilities, state-operated intermediate care facilities for persons with intellectual disabilities (ICF/IIDs), and targeted case management (TCM) for individuals with developmental disabilities. In addition to managing the services covered by the HCBS waivers, DDS also plays a significant role in managing private ICF/IIDs and other residential settings where HUSKY Health members with intellectual and developmental disabilities reside, and overall coordination of medical services for DDS clients who are in HUSKY Health.

Department of Mental Health and Addiction Services (DMHAS). The lead state agency for adult mental health, DMHAS receives state and federal share funding to administer several portions of HUSKY Health, including the mental health section 1915(c) HCBS waiver, state-operated local mental health authorities and hospitals, behavioral health home, and TCM for individuals with chronic mental illness. DMHAS, together with DSS and the Department of Children and Families, co-manages the Connecticut Behavioral Health Partnership (CT BHP), which oversees behavioral health services under HUSKY Health.

Department of Children and Families (DCF). The lead state agency for children's behavioral health, DCF receives state and federal share funding to administer the state-operated children's psychiatric hospital and state-operated psychiatric residential treatment facility (Solnit Center) and funds and oversees privately operated providers of rehabilitation services in residential treatment settings. In addition, DCF, together with DSS and DMHAS, co-manages the CT BHP. DCF also plays a significant role in licensing children's behavioral health providers.

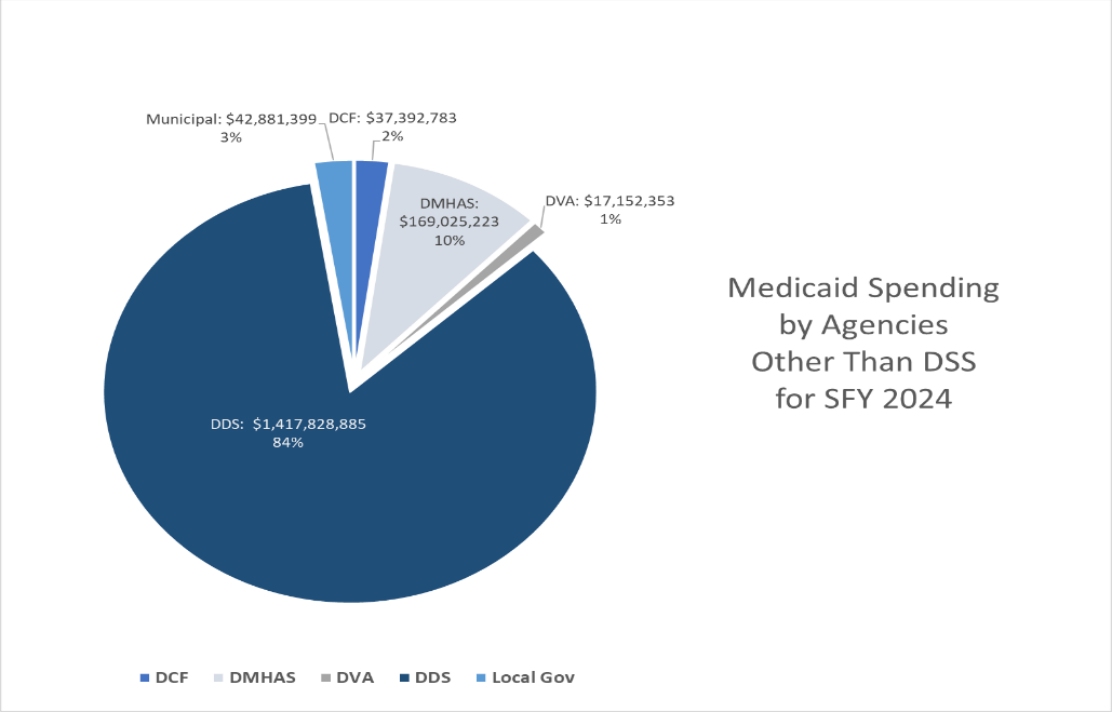
Department of Veterans Affairs (DVA). DVA receives state and federal share in its budget to operate the Sgt. John L. Levitow Healthcare Center, which is a state-operated nursing home.

Other State Government Agency Roles in HUSKY Health. In addition to DDS, DMHAS, DCF, and DVA, several other state agencies collaborate with DSS in various ways to administer HUSKY Health, many of which are referenced in this report, including the Office of Policy and Management (OPM), Office of Health Strategy (OHS), Office of Early Childhood (OEC), Department of Aging and Disability Services (ADS), Department of Public Health (DPH), Department of Housing (DOH), Department of Revenue Services (DRS), Department of Administrative Services (DAS), and the Office of the State Comptroller (OSC).

Local Government: Some of the special education and related services that public school districts provide to students enrolled in Medicaid are covered and claimed as school-based child health (SBCH) services under Medicaid.

Figure 4 below shows Medicaid spending by agencies other than DSS in SFY 2024. Totals and the allocation are approximate figures and do not include spending on Medicaid by DSS.

Figure 4.



Non-DSS Agency	Medicaid Spending SFY 2024
DCF	$37,392,783
DMHAS	$169,025,223
DVA	$17,152,353
DDS	$1,417,828,885
Local Government	$42,881,399
TOTAL Non-DSS Agencies	**$1,684,280,642**

Notes: Source is DSS financial records. These figures reflect total (i.e., state/non-federal share and federal share combined) Medicaid expenditures by agencies other than DSS. These figures do not include institutions for mental diseases (IMD) disproportionate share hospital (DSH) payments for DMHAS nor do they include non-Medicaid claiming, such as the portion of the DPH Vaccines for Children program that is claimed under CHIP.

b. STAKEHOLDER ENGAGEMENT FOR THE REPORT

Many people and organizations contributed to this report. In addition to DSS staff across various units, DSS consulted with the following state agencies: OPM, OHS, ADS, DCF, DDS, DMHAS, and DPH. DSS consulted with the medical administrative services organization (ASO), Community Health Network of Connecticut (CHNCT); the CHNCT Member Advisory Workgroup (MAW); the behavioral health ASO, Carelon, which operates CT BHP; the dental ASO, BeneCare, which operates the Connecticut Dental Health Partnership (CTDHP) portion of HUSKY Health; and the University of Connecticut (UConn) Center on Aging, which provides research, evaluation, and support for various aspects of HUSKY Health long-term services and supports.

As required by section 17 of Public Act 23-171, DSS consulted with the Connecticut Hospital Association (CHA) and the state's acute and children's hospitals, including two meetings specifically convened to obtain feedback for this report – one with CHA alone and another that was open to all acute and children's hospitals plus CHA. DSS also consulted with other healthcare providers and associations, including Leading Age CT, Connecticut Association of Health Care Facilities (CAHCF), Community Health Center Association of Connecticut (CHC/ACT), Community Health Center, Inc. (CHC, Inc.), Doulas for Connecticut, and Community Health Workers Association of Connecticut.

DSS circulated an open public comment opportunity through the Medical Assistance Program Oversight Council (MAPOC) and the Behavioral Health Partnership Oversight Council (BHPOC) email lists. Written comments are attached in the **Appendix**.

Stakeholder Engagement Summary	
State Agencies	• Department of Aging and Disability Services (ADS) • Department of Children and Families (DCF) • Department of Developmental Services (DDS) • Department of Mental Health and Addiction Services (DMHAS) • Department of Public Health (DPH) • Office of Health Strategy (OHS) • Office of Policy and Management (OPM)
Administrative Services Organizations (ASOs) and Contractors	• Community Health Network of CT (CHNCT) – Medical ASO • Carelon – Behavioral Health ASO • BeneCare – Dental ASO • UConn Center on Aging
Medicaid Members	• CHNCT Member Advisory Workgroup
Trade Associations and other Providers	• Connecticut Hospital Association and Hospitals • LeadingAge CT • Connecticut Association of Healthcare Facilities • Community Health Care Association of Connecticut • Community Health Center, Inc. • Doulas for Connecticut • Community Health Worker Association of Connecticut
Legislative Engagement and Open Comment Opportunity	• Medical Assistance Program Oversight Committee (MAPOC) • Behavioral Health Program Oversight Committee (BHPOC)

3. IMPROVEMENT STRATEGY

a. OVERALL PERFORMANCE

HUSKY Health strives to continually improve access to care, enhance quality of care, improve member engagement and experiences, and advance health equity. The program is also mindful of its role as steward of public resources and strives to identify cost-effective and sustainable approaches, emphasizing operational excellence and effectiveness.

i. Access

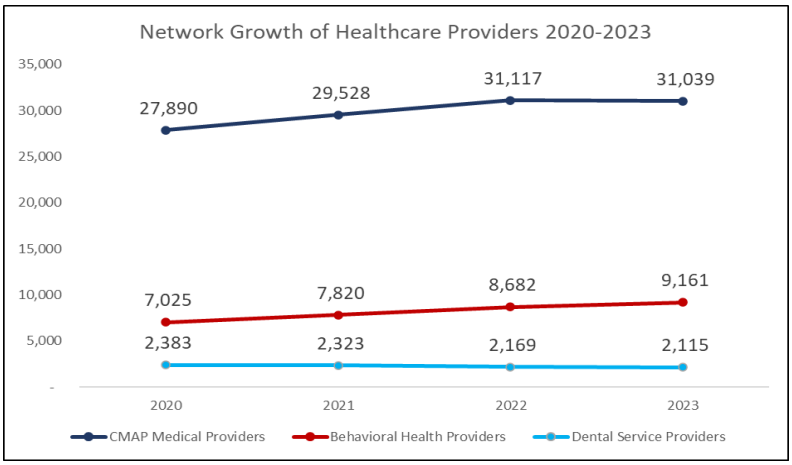
DSS prioritizes ensuring that HUSKY Health members have access to services they need from providers enrolled in HUSKY Health. While access for some services is generally consistent and strong (such as primary care, maternity services, pharmacy, and others), members, providers, and other stakeholders have periodically identified challenges in access for certain services, provider categories, or geographic areas, as well as for people with certain types of needs (such as tailored services for people with developmental disabilities, chronic pain, and others).

In Connecticut and nationally, it is widely acknowledged that Medicaid's structure makes it challenging to maintain consistent access to all covered services. Each state's budget must provide for sufficient state share, inherently competing with other state programs and priorities, which becomes more challenging as healthcare costs rise. Medicaid is also a safety net program that supports people with a variety of needs, including some with very high needs. Some services have limited access regardless of payer, not specific to Medicaid, including healthcare practitioner types with limited workforce and in rural areas. There are also unique access challenges for individuals who require higher intensity or more specialized services.

While federal law and regulations broadly define access, it is difficult to measure access objectively. As required by federal access regulations in effect from 2016 through mid-2024, in 2016, DSS prepared and later updated an Access Monitoring Review Plan, which focused on comparing rates to Medicare and other states, provider enrollment over time, and other factors. In 2024, CMS adopted a new federal access regulation, which has a gradual implementation. As referenced in the introduction, DSS is also conducting the Medicaid rate study, which will analyze Medicaid rates compared to benchmarks from Medicare and other states but does not include an analysis of access issues. One measure of access is the number of enrolled providers.

The chart below (Figure 5) shows the number of providers (broken out separately by medical, behavioral health, and dental providers) over time for the previous four years. As aggregate data, it does not break out enrollment trend by specialty, which would be relevant for a more detailed analysis of access.

Figure 5.



Note: Data provided by CHNCT, Carelon, and BeneCare. Providers counted in this chart include in-state and border-state providers' billing locations (does not include non-border-state out-of-state providers). This chart also does not include long-term services and supports provider categories other than nursing facility and home health agency.

As shown in Figure 5, in the 2020–2023 period, the network of HUSKY Health medical providers grew by 11% (or by 3,149 providers) and the network of behavioral health providers grew by 30% (or by 2,136 providers). However, the network of dental service providers declined every year, with an 11% (or by 268 providers) overall statewide decline for the period 2020–2023.

In addition to the rate study and implementation of the new CMS access regulation, DSS measures and works to maintain access in various ways, in partnership with the ASOs, including:

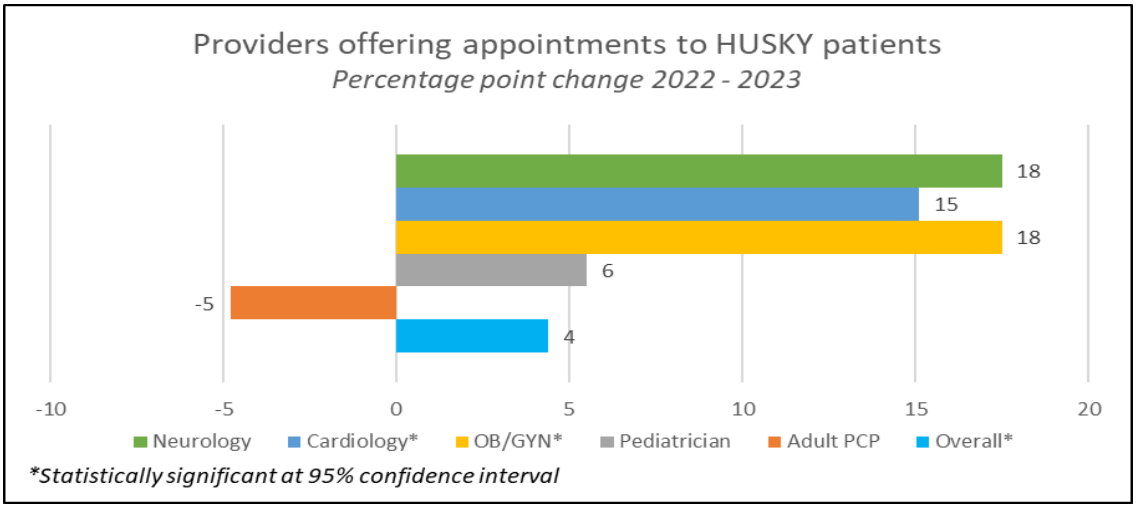
- Conducting mystery shopper surveys to determine if enrolled providers are accepting HUSKY Health members.
- Monitoring the network of enrolled providers in applicable categories and engaging with providers to encourage them to enroll or reenroll. Specifically, CHNCT's Provider Engagement Services (PES) department is responsible for ensuring the Connecticut Medical Assistance Program (CMAP) provider network meets the accessibility needs of HUSKY Health program members. This includes maintaining the current provider network, as well as

increasing the network in those geographical areas and/or provider specialties that may not provide sufficient access to services or where there is significant demand.

- Conducting the Consumer Assessment of Healthcare Providers and Systems (CAHPS), which evaluates both member access and experience.
- Referring members who seek help finding a provider to an enrolled provider.
- Receiving and evaluating member complaints to an ASO or DSS regarding lack of access.

Figure 6 summarizes CHNCT's mystery shopper survey conducted on behalf of DSS.

Figure 6.



As shown in Figure 6, appointment offers improved for HUSKY patients in 2023 compared to 2022 overall by 4 percentage points (statistically significant) and in all surveyed specialties except for Adult PCP (i.e., primary care providers) where it fell by 5 percentage points. Statistically significant increases were seen in OB/GYN (+18 percentage points) and Cardiology (+15 percentage points).

Figure 7.

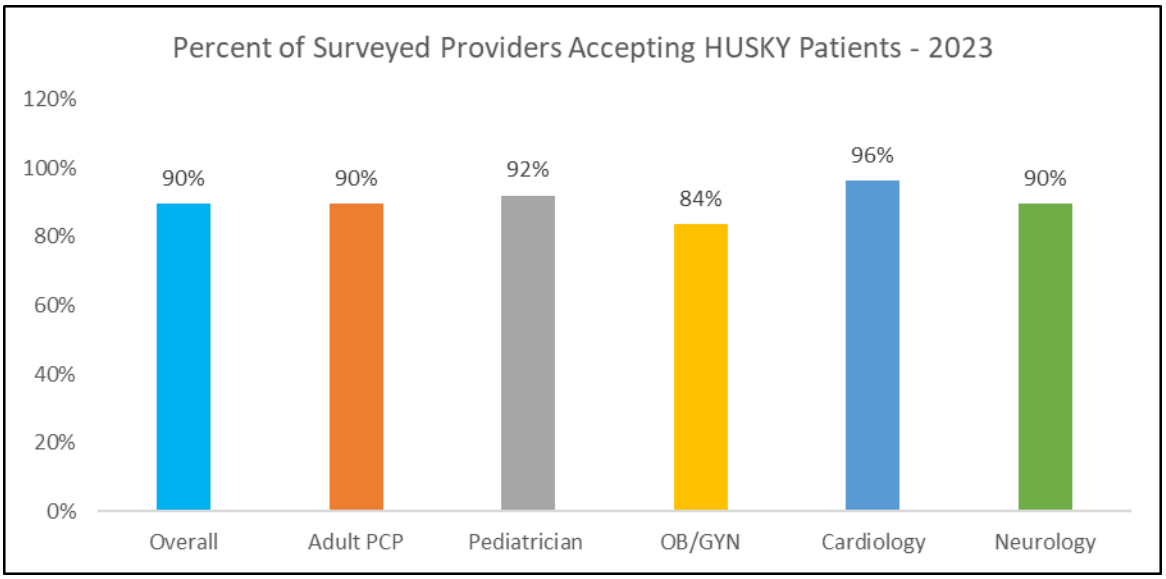
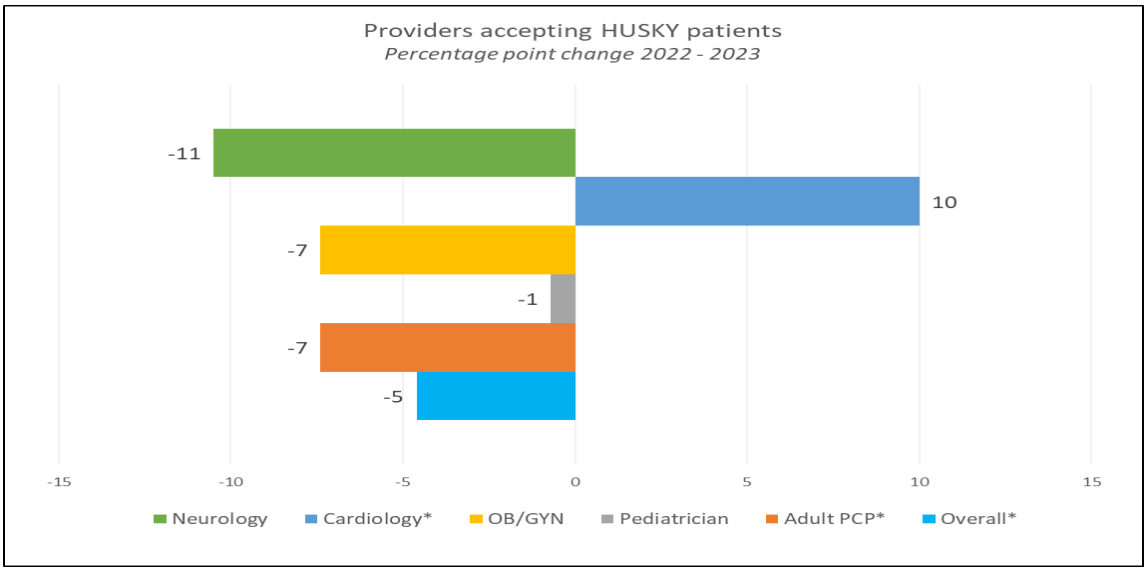


Figure 7 shows that, for the most recent year of data, a significant majority of enrolled providers in each of the specialties included above continue to accept HUSKY Health patients.

Figure 8.



The mystery shopper survey results detailed in Figure 8 above show a statistically significant 5 percentage point decrease in the number of providers accepting HUSKY patients from 2022 – 2023. Except for cardiology, which presents a statistically significant 10 percentage point increase, all other specialist providers surveyed record a decrease in accepting HUSKY patients, with the reductions being statistically significant for Cardiology and Adult PCP.

Some observations on 2022-2023 comparisons of the mystery shopper information include:

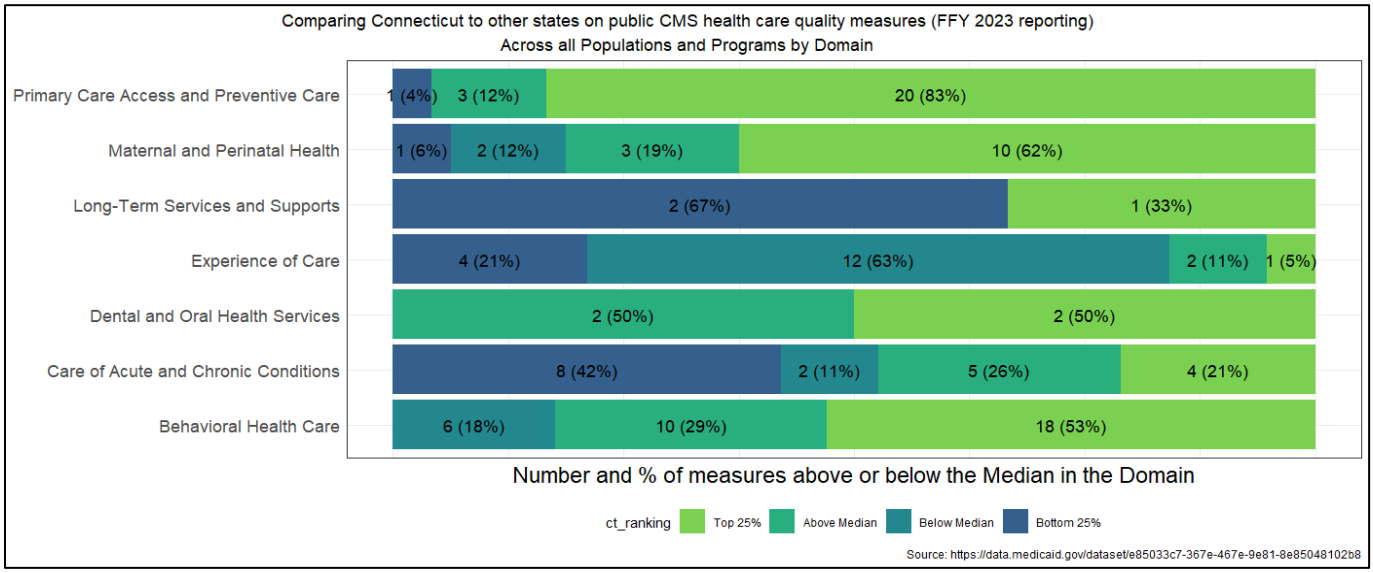
- Providers accepting HUSKY patients decreased across all the types surveyed (Neurology, OB/GYN, Pediatrician, Adult PCP), except for Cardiology. The percentage change was statistically significant for Overall, Adult PCP, and Cardiology.
- Appointment offers improved in 2023 for HUSKY patients except for Adult PCPs; statistically significant increases for Overall, OB/GYN, and Cardiology.
- Percentage of providers accepting new patients for callers also identifying as HUSKY members saw a decline overall and for provider types excluding Pediatrician and Cardiology.
- Percentage of providers accepting HUSKY patients decreased from 2022-2023. Reductions for Overall and Adult PCPs were both statistically significant. Only Cardiology had increases.

ii. Quality and Experience

Overall, HUSKY Health shows high quality of care, although there are some specific areas with opportunity for improvement. DSS continually works to improve the quality and members' experience of HUSKY Health in partnership with the ASOs, including engaging healthcare providers to enhance quality and members' experience.

CMS Child and Adult Core Set Measures: In general, HUSKY Health ranks highly nationally on the federal CMS Child and Adult Core Set measures, ranking in the top quartile in 47% of those quality measures. The graph below displays Connecticut's performance relative to other states on the CMS Child and Adult Core Set across multiple domains of care. As for **key areas of success**, it shows HUSKY Health performs at or above the median on the following: Primary Care Access and Preventive Care, Maternity and Perinatal Health, Dental and Oral Health Services, and Behavioral Health Care. However, **key areas of opportunity for improvement**, where HUSKY ranks lower than the median, are on measures related to Long-Term Services and Supports, Experience of Care, and Care of Acute and Chronic Conditions.

Figure 9.



Combining these measures, Figure 10 shows that Connecticut is above the median in 68% of the core measures:

Figure 10.

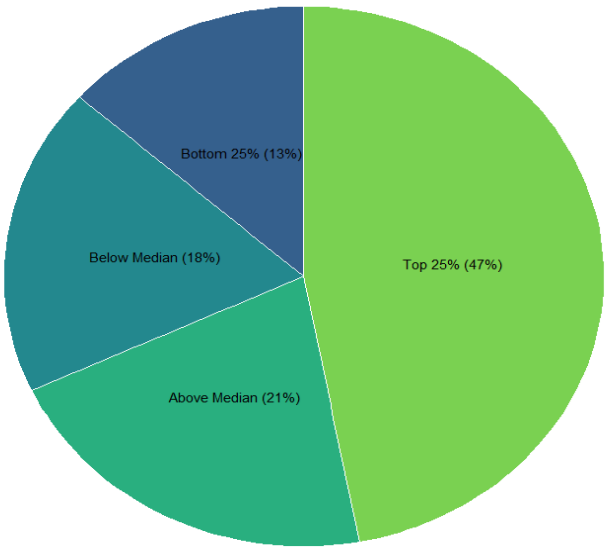
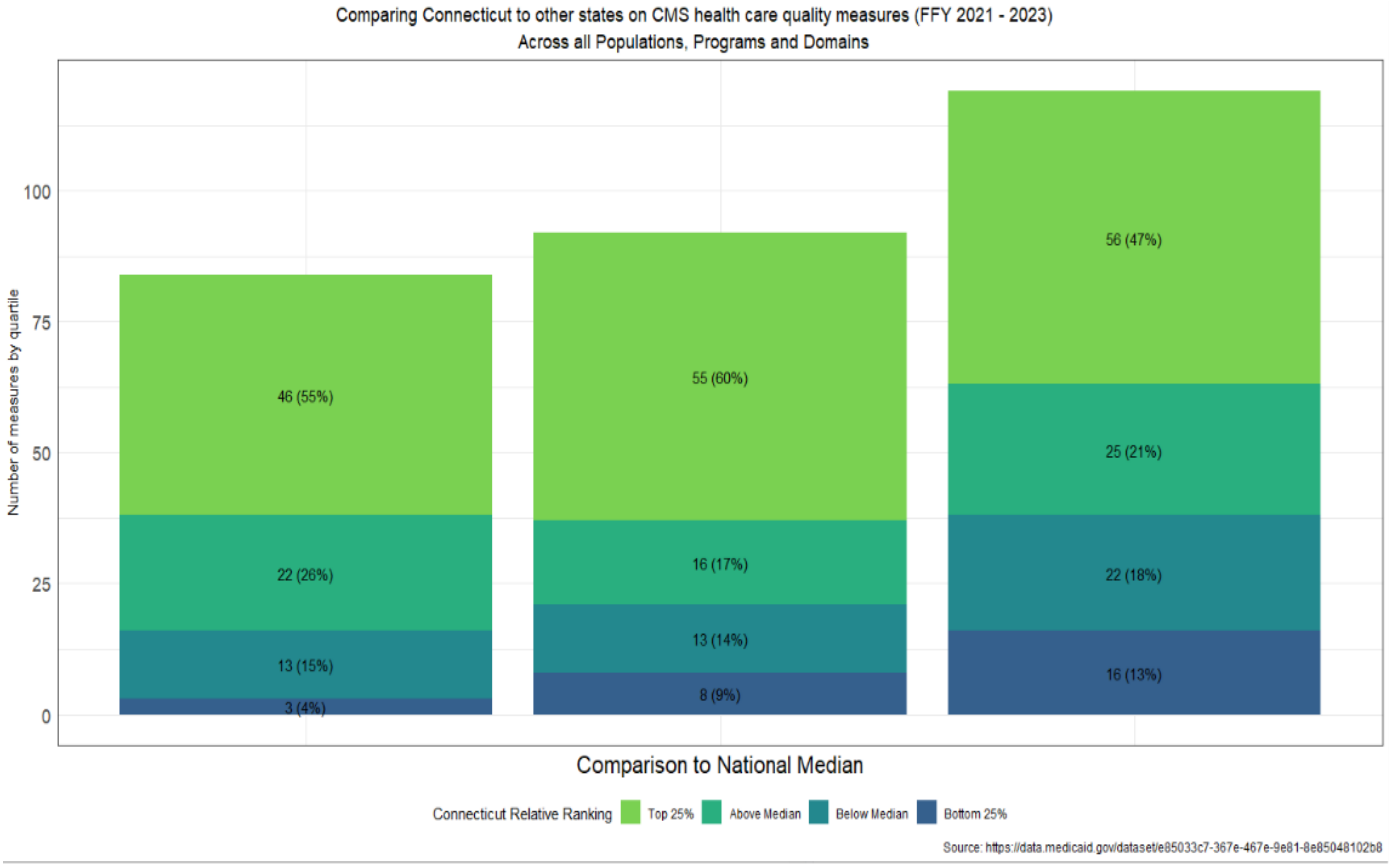


Figure 11 shows how Connecticut Medicaid compares to other states over time for the most recent and two previous federal fiscal years (FFYs). Each year cannot be directly compared to others because CMS changes the core measure set each year. This information shows that Connecticut generally performs well in the core set measures compared with other states.

Figure 11.



Member Experience – Survey Data: The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is used to collect data on member satisfaction of health plans using standardized administrative criteria, allowing comparison across plans and action-oriented results. The CAHPS program is overseen by the Agency for Healthcare Research and Quality (AHRQ) and administered by the National Committee for Quality Assurance (NCQA). CHNCT conducts the CAHPS survey annually to assess the perception of care received by HUSKY Health members. The information received through the survey is used to develop interventions to improve member experience. NCQA includes the CAHPS Health Plan Survey 5.1, Adult Version (Medicaid) and the CAHPS Health Plan Survey 5.1, Child Version (without children with chronic conditions measures) in its annual Healthcare Effectiveness and Data Information Set (HEDIS); acknowledging that member experience affects care outcomes and is a critical component of healthcare quality. In 2024, Press Ganey Solutions, an NCQA certified CAHPS vendor, conducted

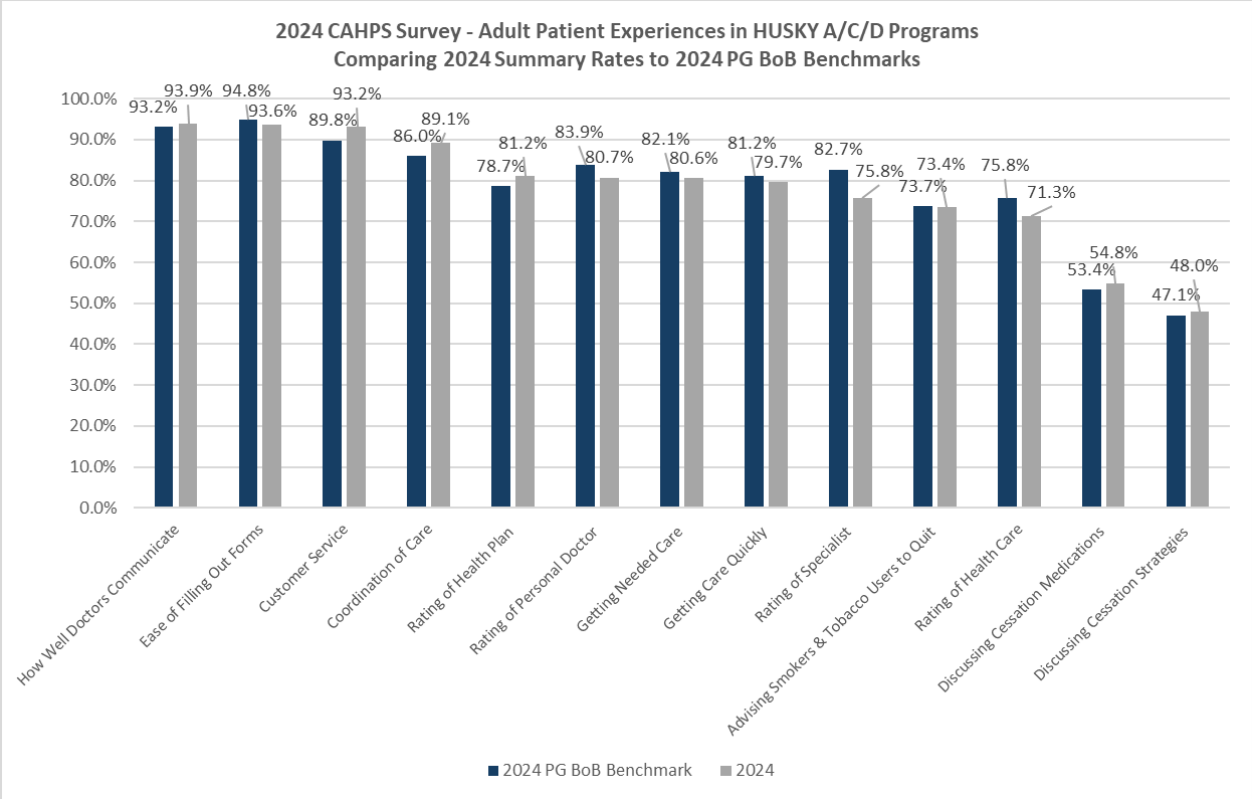
the CAHPS surveys for Connecticut HUSKY A/C/D adults, HUSKY A/C/D children, and HUSKY B children separately.

Adult HUSKY A/C/D survey results:

This survey demonstrates that Connecticut **exceeded** both the Press Ganey Medicaid Book of Business (BoB) and the 2023 NCQA Quality Compass **national benchmark rates** on the Rating of Health Plan rating measure, and the Customer Service, How Well Doctors Communicate, and Coordination of Care composite measures. From a **regional perspective**, Connecticut also **rated above** the 2024 Press Ganey BoB in the Northeast in Rating of Health Plan, and the Customer Service, How Well Doctors Communicate, and the Coordination of Care composite measures. The 2024 Press Ganey BoB contained 174 Medicaid plans that conducted surveys with the vendor in 2024 and submitted data to NCQA, while the NCQA Quality Compass national benchmarks included 189 Medicaid plans that submitted data to NCQA in 2023. Connecticut's **highest performing measures** in the 2024 Adult CAHPS survey were How Well Doctors Communicate (93.9%), Ease of Filling Out Forms (93.6%), and Customer Service (93.2%).

In terms of **access to care**, on both Getting Needed Care and Getting Care Quickly, Connecticut **falls short** of the national and Press Ganey BoB benchmark rates. Connecticut also fell below the national and Press Ganey BoB in the Rating of Personal Doctor and Rating of Specialist. The lowest scores were in Rating of Health Care (71.3%), Discussing Cessation Medications (54.8%), and Discussing Cessation Strategies (48%), although Connecticut met the benchmark or exceeded the benchmark on the latter two sub-measures of the Effectiveness of Care composite measure. The most recent results compared with Press Ganey BoB benchmark rates are in the chart below.

Figure 12.

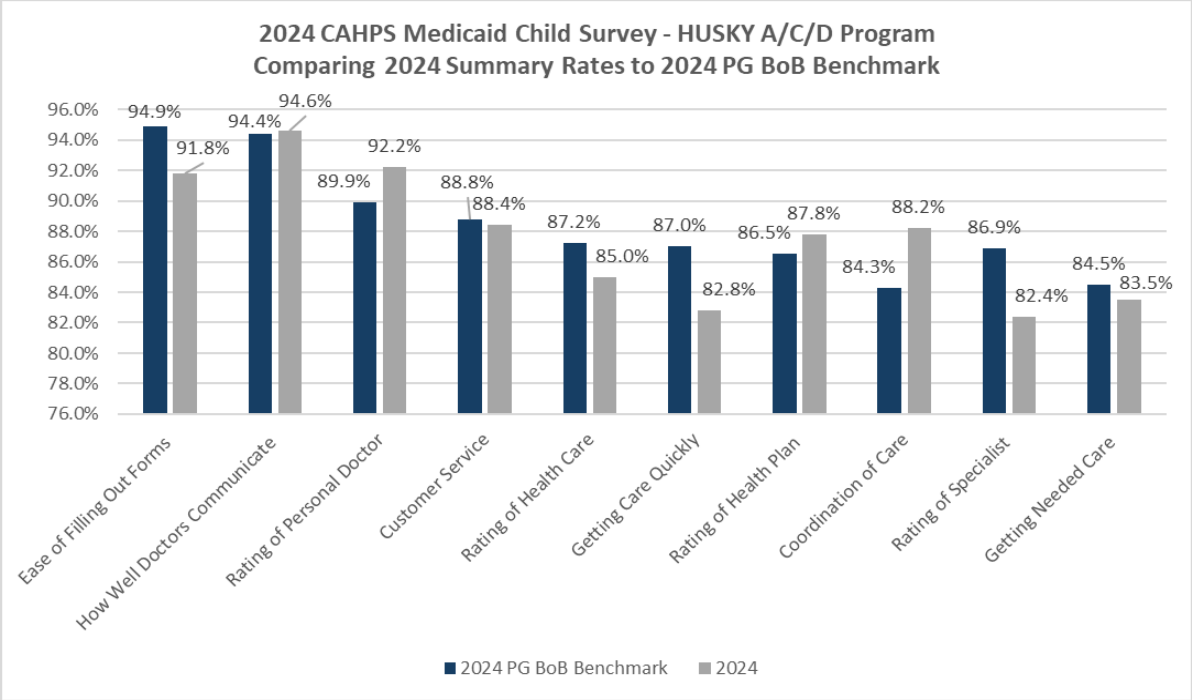


Child HUSKY A/C/D results:

Child HUSKY A/C/D survey results demonstrate that Connecticut **exceeded** both the Press Ganey Medicaid BoB and the 2023 NCQA Quality Compass **national benchmark rates** on the Rating of Health Plan and Rating of Personal Doctor rating measures, and the Coordination of Care and How Well Doctors Communicate composite measures. Connecticut performs slightly below the 2023 NCQA Quality Compass national benchmark but above the Press Ganey Medicaid BoB for Customer Service. Regionally, Connecticut **rated above** the 2024 Press Ganey BoB in the **Northeast** for Rating of Health Plan and Rating of Personal Doctor, and the Coordination of Care composite measure. In 2024, the Press Ganey BoB contained 200 Medicaid plans that contracted with Press Ganey to administer the 2024 child survey and submitted data to NCQA. NCQA Quality Compass national benchmarks included 177 Medicaid plans that submitted data to NCQA in 2023 for child samples. For the child HUSKY A/C/D survey results, Connecticut's **top performing measures** are How Well Doctors Communicate (94.6%), Rating of Personal Doctor (92.2%), and Ease of Filling Out Forms (91.8%). Although Ease of Filling Out Forms was a high performing measure, it fell below the national and Press Ganey BoB benchmark scores.

Connecticut scored below both the Press Ganey Medicaid BoB and the 2023 NCQA Quality Compass national benchmark rates for Rating of Health Care, Rating of Specialist, and Getting Care Quickly and Ease of Filling out Forms composite measures. Connecticut fell below the 2023 NCQA Quality Compass national benchmark but above the Press Ganey Medicaid BoB for Getting Needed Care. The lowest performing measures were in Rating of Specialist (82.4%), Getting Care Quickly (82.8%), and Getting Needed Care (83.5%). The most recent results compared with national benchmarks for the child HUSKY A/C/D survey are in the chart below.

Figure 13.



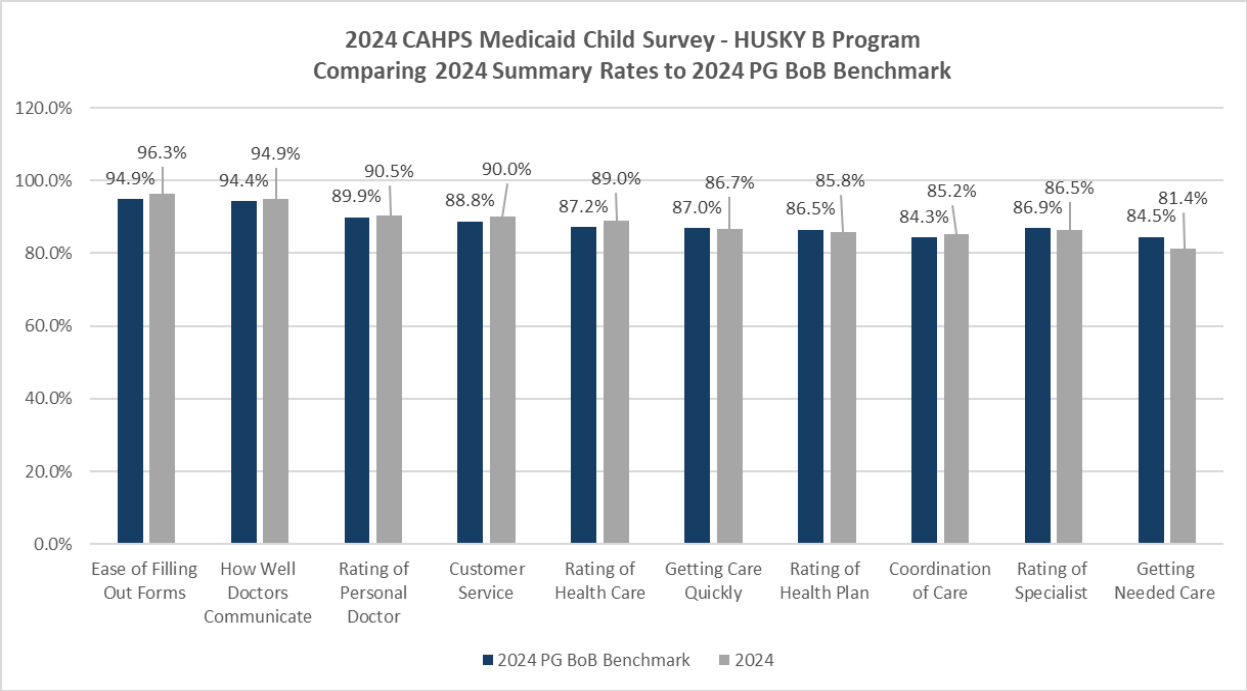
Child HUSKY B:

The CAHPS survey results for the HUSKY B population showed that Connecticut outperformed the Press Ganey Medicaid BoB and the national benchmark rates on the Rating of Health Care and the Rating of Personal Doctor rating measures, and the Coordination of Care, Customer Service, and How Well Doctors Communicate composite measures. Regionally, Connecticut rated above the 2024 Press Ganey BoB in the Northeast for Rating of Health Care, Rating of Personal Doctor, Rating of Specialist, Ease of Filling Out Forms and the Customer Service composite measure.

For the HUSKY B survey, Connecticut's **top performing measures** are Ease of Filling Out Forms (96.3%), How Well Doctors Communicate (94.9%), and Rating of Personal Doctor (90.5%).

Connecticut scored **below** both the Press Ganey Medicaid BoB and the 2023 NCQA Quality Compass national benchmark rates for Rating of Health Plan and Getting Needed Care. Connecticut fell below the 2023 NCQA Quality Compass national benchmark but above the Press Ganey Medicaid BoB for Getting Care Quickly. The **lowest 3 favorability percentages** were for Getting Needed Care (81.4%), Coordination of Care (85.2%), and Rating of Health Plan (85.8%).

Figure 14.



Improvement Strategy

In addition to using quality measures and CAHPS survey results, DSS also monitors and seeks to maintain or improve the quality and member experience of HUSKY Health in more targeted ways, in partnership with the ASOs, including:

- Convening members to participate in advisory groups. As the medical ASO, CHNCT administers a general member advisory workgroup and the behavioral health ASO (Carelon) administers consumer and family advisory committees specific to behavioral health. The dental ASO (BeneCare) participates in the member advisory workgroup administered by CHNCT. In addition, in compliance with the federal access rule referenced above, DSS is in the process of establishing a Medicaid Advisory Committee (which will include at least 25% Medicaid members as specified by federal regulation) and a Beneficiary Advisory

Committee, which will be comprised of members who will advise DSS on the overall program. Overall, these groups provide valuable input on access, quality, experience, and overall program administration, receiving, monitoring, and following up based on member complaints regarding the care they receive, as well as challenges with quality reported by DPH or other relevant agencies.

- Proactive monitoring of quality for certain provider types and/or certain specific providers where there is a particular priority for quality or if there have been reports regarding challenges with quality. Each of the ASOs monitors specific areas of quality relevant to their areas of the program.
- Coordinating with DPH and DCF as provider licensing agencies, especially for categories of providers for which federal CMS certification (through DPH as the state survey agency) is required for participation in Medicare and Medicaid (nursing homes, hospitals, ICF/IIDs, home health agencies, and psychiatric residential treatment facilities).
- Indirect monitoring of quality monitoring that occurs in the context of prior authorization or other utilization review or audits of claims.
- Providing all new HUSKY Health members an outbound "welcome" call from CHNCT's Member Engagement Services team. In addition to this initial call, new members also receive a call to complete a Health Risk Questionnaire (HRQ). This survey allows CHNCT to gather vital information to help assist members in areas such as finding a PCP, connecting to CHNCT's care management program for specific medical needs or the crisis line for immediate assistance, and providing information related to addressing social determinants of health (SDoH), including help finding food, housing, and other basic needs.
- Employing a variety of other education and member engagement strategies through CHNCT to augment the care experience, such as digital and telephonic engagement, care management, and the 24/7 nurse helpline.
- Considering reinstating coverage of electronic consultations ("e-consults"), in which applicable specialist providers are reimbursed for providing electronic consultations to a member's primary care provider to address that member's specific clinical needs and for which the medical advice of a specialist is necessary. The purpose of reinstating coverage of e-consults would be to improve the quality of primary care services and expand access to specialist services.

iii. Equity / Reducing Disparities

In collaboration with the ASOs and other partners, DSS strives to improve health equity for its members. Despite many efforts across the healthcare system, healthcare disparities remain a significant problem. Many of these challenges relate to SDoH which traditionally lie outside the

purview of a healthcare payer. In stakeholder engagement and written comments submitted for this report, CHA, several hospitals/health systems, and other health or social services organizations emphasized the importance of SDoH and individual circumstances, and health-related social needs (HRSN) as having a larger impact on health than healthcare services. These comments also referenced multiple existing initiatives in specific communities designed to reduce disparities and improve health and well-being.

All three ASOs (CHNCT, Carelon, and BeneCare) engage in significant work to reduce healthcare disparities for HUSKY Health members and improve health equity. As an example, CHNCT's 2023 health equity activities and results are summarized in a health equity report. CHNCT held a health equity summit and, in follow-up to that summit, is conducting a series of roundtable discussions focusing on issues related to racial and ethnic disparities in health and healthcare and SDoH, and the development of health equity resources, initiatives, and strategies to reduce disparities. This will be an opportunity for community organizations and community health workers (CHWs) to be a part of a conversation to strategize on what can be done when resources are scarce. Going forward, CHNCT will continue strategies to address health disparities and SDoH/HRSN, including:

- Ensuring equitable access to care for the LGBTQ+ community;
- Promoting culturally and linguistically appropriate services for HUSKY Health members to help improve the member's experience and bring about positive outcomes;
- Collecting more complete race and ethnicity information; and
- Developing a process to identify a member's disability status that will allow us to stratify health measures to determine if potential disparities exist.

Some highlights of CHNCT's recent activities to improve health equity, as detailed in CHNCT's health equity report, include work to improve PCP attribution and targeted interventions by care management for chronic diseases where there are significant health disparities. CHNCT also uses the mystery shopper survey to highlight disparities in access in conjunction with provider engagement work as part of a broader strategy to improve equity of access.

As documented in the report, slightly more providers were accepting new patients when the caller posing as a HUSKY Health member used a nonethnic sounding name (66.1%) compared to an ethnic sounding name (65.5%) in 2023. The difference in providers accepting new patients for callers with a nonethnic sounding name in 2023 (66.1%) as compared to 2022 (54%) was found to be statistically significant. Identifying as a member with an ethnic sounding name or as

a member of the LGBTQ+ community generally has an adverse effect on appointment availability.

In addition to this and other work by each of the ASOs, DSS also works to improve equity through several HUSKY Health initiatives described in this report, including the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) federal innovation model, maternity bundle payments, PCMH and PCMH+, the substance use disorder (SUD) demonstration waiver, the justice-involved demonstration waiver, newer healthcare practitioner categories, and others.

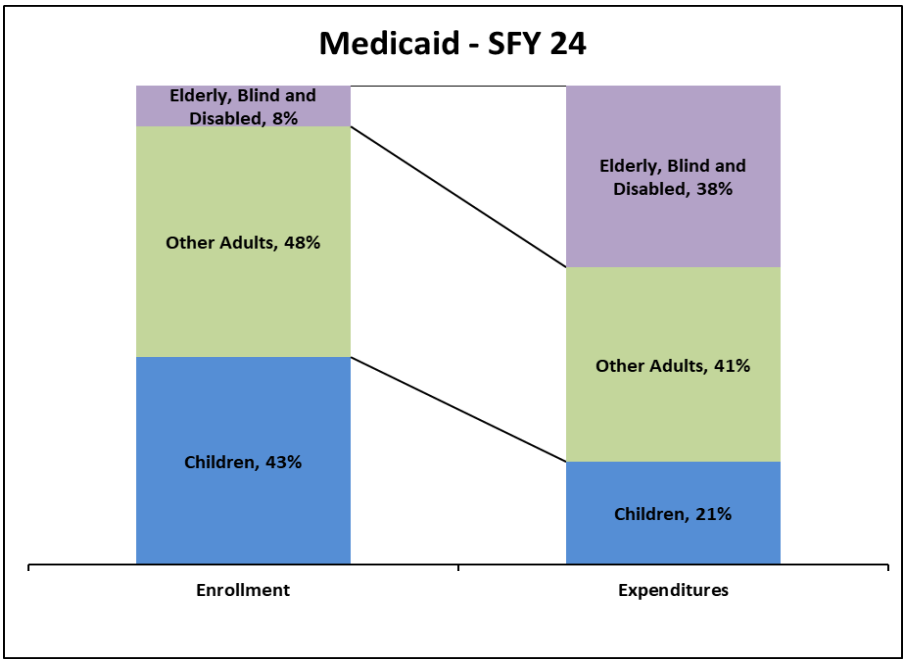
iv. Cost Containment

Containing the growth of Medicaid costs is an important priority for DSS to ensure that the program is fiscally sustainable. The Medicaid Landscape Analysis shows that, overall, the Medicaid program achieves good quality compared with national benchmarks, spends significantly **less per member than other Northeastern states and national average, cost growth below medical inflation, and much less on administrative costs** than states that primarily use a managed care delivery system.

From a statewide perspective across all healthcare payers, OHS' cost growth benchmark shows that Medicaid is growing much slower than other payer categories, which means that Medicaid is significantly contributing towards improving the state's progress in getting closer to meeting its targets to slow the growth of healthcare spending.

While acknowledging that Connecticut Medicaid spends less than its peer states, the Medicaid Landscape Analysis also identified key cost drivers, including increasing hospital costs, rising drug costs (although rising more slowly than national trends), and high long-term services and supports (LTSS) (especially HCBS) spending relative to peer states. As highlighted by the Medicaid Landscape Analysis, spending on HUSKY C categories for individuals with disabilities and individuals over age 65 is significantly higher than other Northeastern states. Spending on these areas is also much higher per person than under HUSKY A and D. Figure 15 shows percent enrollment compared with percent of expenditures under DSS' Medicaid account.

Figure 15



Although Medicaid enrollment is slowly declining since the unwinding of the suspension of Medicaid eligibility redeterminations during the PHE, per-member per-month (PMPM) costs are rising.

Note: Figures in this section exclude non-DSS Medicaid spending (see overview above) and also exclude hospital supplemental payments (see hospital section below), and show pharmacy spending net of rebates.

Figure 16a.

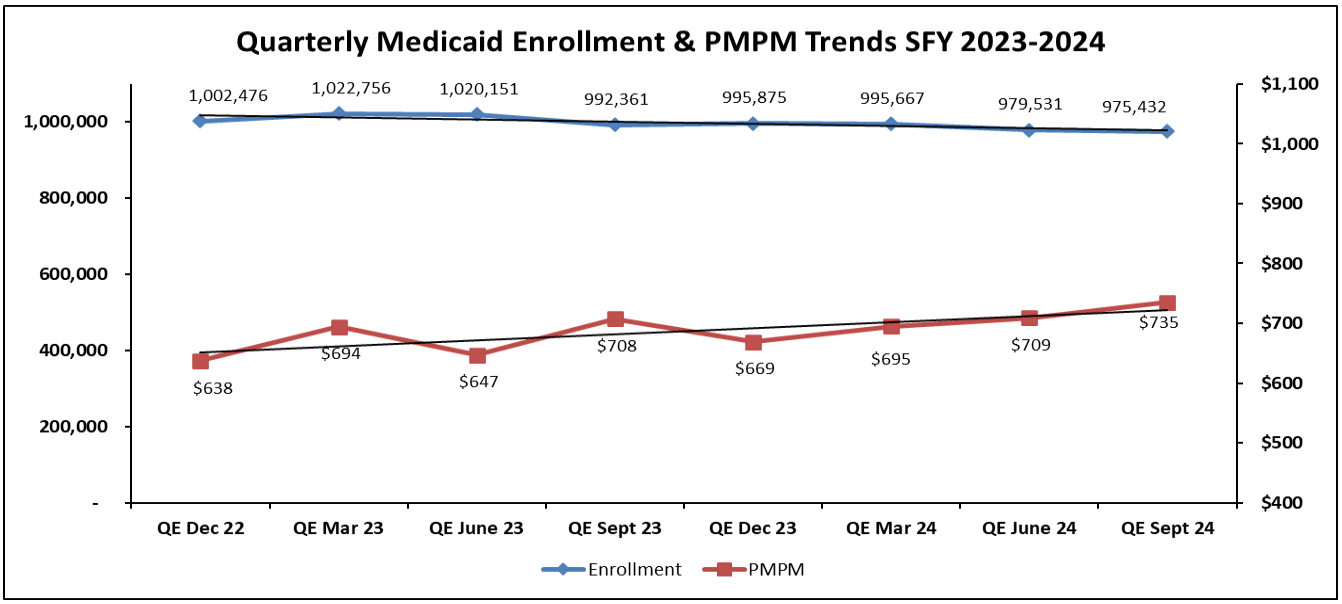


Figure 16b. (This shows similar information to Figure 16a in aggregate, rather than PMPM.)

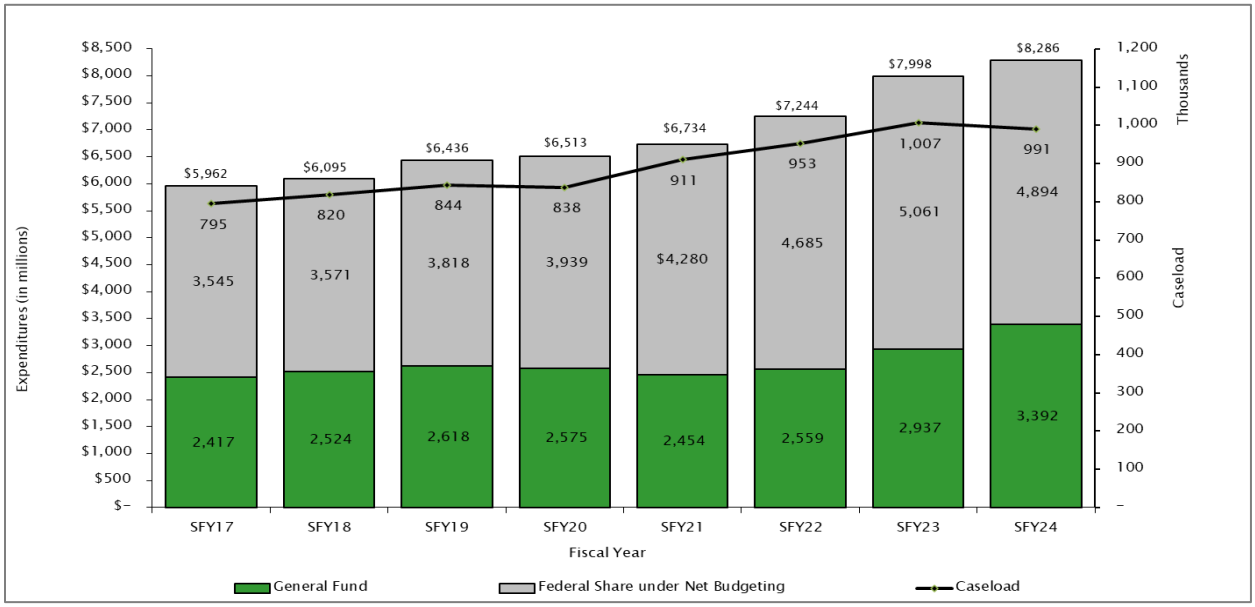


Figure 17 shows overall spending by broad service category.

Figure 17.

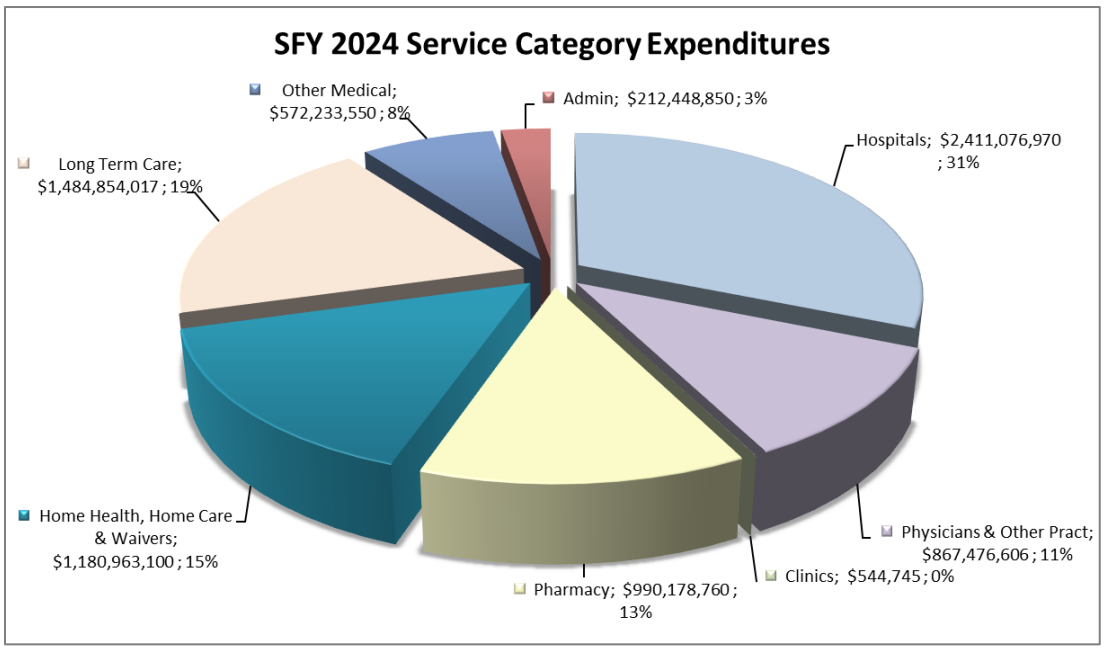
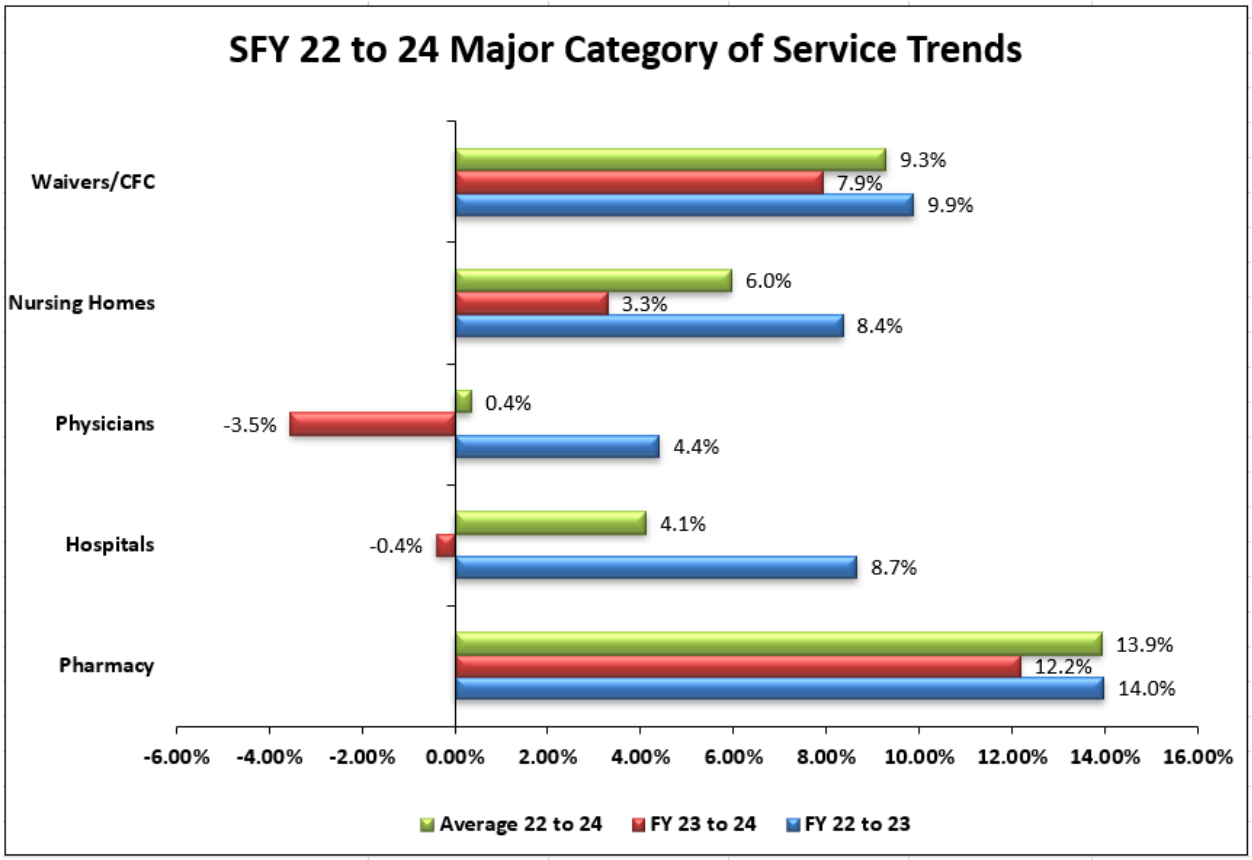


Figure 18 shows the rate of change in the same broad categories for SFY 2022-2023, for SFY 2023-2024 and the average change from SFY 2022-2024. Overall, it shows that while every category is increasing, the increases are concentrated in pharmacy and home and community-based services (referenced here as “Waivers/CFC” (Community First Choice)).

Figure 18.



v. Transparency

In response to Governor Lamont's Executive Order No. 6, DSS convened an Advisory Board for Transparency on Medicaid Cost and Quality. As part of that process, DSS implemented a dashboard to present results on people served by DSS' programs. This board made several recommendations, including that DSS continue to expand capabilities to filter the data in the people served dashboard on the website and continue to update the data on people served by DSS' programs. Both of those activities have been achieved. DSS does not, however, have sufficient staff with the expertise to analyze and present data to fully implement the board's recommendations for improved transparency. Although staffing has modestly increased, other challenges remain, including data fragmented across multiple internal systems and ASOs, lack of an established mechanism to pull together existing data within DSS systems, the lengthy process to obtain data from various sources, and legal/procedural barriers for DSS to obtain external data.

In response to the request for comments for this report and for the Medicaid Landscape Analysis referenced above, DSS also received comments recommending further improvements to transparency, including publicly posting results on performance measures in a timely manner and updating the Medicaid Transparency website on a continuous basis.

b. ELIGIBILITY

This section describes recent changes and strategies for improvement for HUSKY Health: (1) eligibility operations, which are the operational processes for how people apply for and receive HUSKY Health, including periodic renewals (also known as redeterminations); and (2) eligibility policy, which is the set of income limits and other rules that govern who can be eligible. As required by federal law, there is one set of eligibility rules based on Modified Adjusted Gross Income (MAGI) for HUSKY A, B, and D, which in Connecticut is administered by the state's health insurance exchange, Access Health CT, on behalf of DSS. There is another set of eligibility rules for HUSKY C, incorporating relevant income and asset limits, administered directly by DSS staff. There is a more detailed description on the CMS website here: Eligibility Policy | Medicaid and here: CHIP Eligibility & Enrollment | Medicaid.

i. Eligibility Operations

Recent Changes

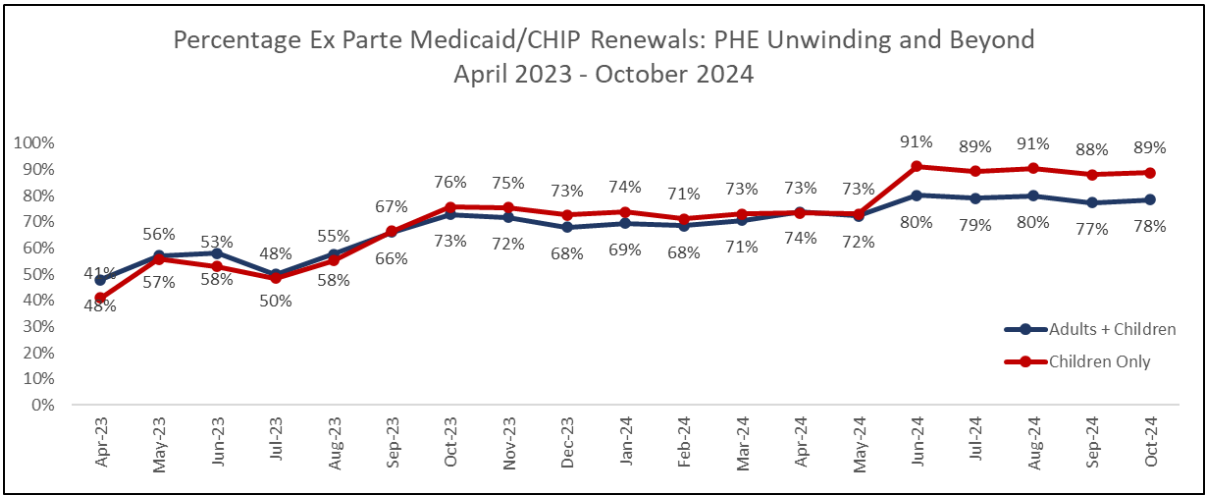
Unwinding of PHE Suspension of Redeterminations: During the federal public health emergency for Coronavirus 2019 (COVID-19), consistent with conditions in federal law that accompanied temporary enhancements to federal Medicaid matching funds, Connecticut paused the requirement for individuals to be periodically redetermined for Medicaid coverage. Pursuant to the federal Consolidated Appropriations Act (CAA), 2023, redeterminations were gradually resumed beginning in April 2023 under the unwinding process.

As a state priority, DSS and partner agencies and organizations worked to maximize the number of eligible people who would retain HUSKY Health coverage during this unwinding. These measures were successful, as Connecticut has maintained high Medicaid/CHIP enrollment retention rates for children and adults despite the challenges of ensuring timely and continuous access to coverage for its citizens. Notably, as reported by Georgetown University, Connecticut

ranks among the top 10 states for Medicaid/CHIP enrollment retention rates for children. DSS maintained reports of the PHE unwinding data through an interactive dashboard which was updated monthly, but has since been deactivated with the ending of the unwinding period. DSS does, however, maintain an interactive dashboard of renewal outcomes for HUSKY Health and MSP here.

One of the key strategies for improving rates of enrollment is the increased use of ex parte renewals, where individuals' coverage is renewed based on information that DSS has from various sources indicating that they remain eligible, without needing the individual to affirmatively provide additional information. Rates of ex parte renewals during the PHE unwinding are included in Figure 19 below:

Figure 19.



Note: The denominator for the ex parte renewals metric is the total number of renewals due in the corresponding month. Business process improvements – changing renewal determinations and outcomes from households to individuals, and the updating of personal information since the end of the PHE unwinding – enabled increases in the percentage of ex parte renewals from July 2023 and from May 2024 (particularly for children only).

Throughout the COVID-19 pandemic and the unwinding, DSS sustained high levels of timeliness and application processing. From April 2023 to March 2024, an average of 83% of individuals maintained their coverage at month-end. Those who disenrolled often re-enrolled after the month-end, with nearly 40% of those who disenrolled regaining coverage 30 to 90 days later. DSS consistently maintains an average of 98% processing timeliness, with a median processing time of less than 24 hours for new MAGI-based Medicaid applications. The median processing time for new non-MAGI applications is 33 days. Across all HUSKY Health contact centers

administered through Access Health CT for MAGI-based Medicaid applications, the average wait time is one minute, with an abandonment rate of 2%. Overall, DSS retained over 80% of Medicaid members and have a high passive renewal rate, which is among the best in the nation.

Improved Processes Customer Communication: DSS has expanded communication methods with its customers, including text messaging, handling of returned mail, social media, and billboards. Through the Customer Experience Continuous Improvement Project (CECIP), DSS has improved processes to enhance its customers' user interface, including first-touch phone triage, updating the agency home page to improve accessibility and clarity of information, community partner bulletins, and other improvements to customer communication. DSS has also improved customer experience at every stage of applications and renewals and have increased the portion of first phone contacts for non-MAGI applications. In addition, DSS streamlined enrollment and eligibility processes for MSP, which improves alignment with requirements and processes for other public programs. These changes consequently reduced application complexity and improved the MSP re-enrollment process.

Improvement Strategy

General: DSS will continue working to improve customers' eligibility experience and operations process by adapting lessons learned during the PHE unwinding and exploring additional ways to streamline processes. DSS updates eligibility results regularly on DSS' website and in reports to MAPOC. DSS intends to continue exploring how the department can further improve collaboration among agencies and programs to help people find all relevant benefits.

Opportunity Center: As part of the broader priority to offer holistic person-centered services, DSS is piloting an Opportunity Center, in which DSS staff are co-located with staff from other agencies, including staff from the Department of Housing (DOH), with a focus on housing subsidies, and the Office of Early Childhood (OEC), with a focus on the Care 4 Kids childcare subsidy program.

Automation: Where feasible, a key priority is to continue increasing automation for adding coverage. An example is using other available data, including Supplemental Nutrition Assistance Program (SNAP) data, to process ex parte renewals, as refenced above. DSS also is evaluating additional ongoing data sharing across programs to streamline eligibility.

Long-Term Services and Supports Applications: For individuals applying for Medicaid to receive LTSS, DSS is improving eligibility operations by enhancing standardization and efficiency. DSS

plans to improve usability and the front-end client interface by creating new and easier-to-use application forms, customer notices, and enhancements to the application renewal form.

ii. Eligibility Policy

Recent Changes

General: Consistent with recent changes to federal and state law, DSS has implemented several changes to eligibility policy. On January 1, 2024, DSS implemented continuous eligibility for children under 19, providing uninterrupted coverage for 12 months. As provided by state statute, effective October 1, 2024, the income threshold for HUSKY A parent/caretaker adults was lowered to 138% of the Federal Poverty Level (FPL). Most of the individuals affected by this change will be eligible for Transitional Medical Assistance to retain Medicaid eligibility for 12 months and most of the affected individuals will be eligible for Covered CT. Also effective October 1, 2024, as provided by state statute, DSS increased the HUSKY C income limit to 159% of the Temporary Family Assistance (TFA) payment standard.

Prenatal and Postpartum Coverage: On April 1, 2022, DSS extended postpartum coverage from 2 months to 12 months for Medicaid and CHIP enrollees. DSS expanded CHIP prenatal coverage to pregnant individuals up to 263% of the FPL for those who do not qualify for Medicaid/CHIP due to immigration status through the federal From-Conception-to-End-of-Pregnancy Option (FCEP), also known as the Unborn Child Option. On April 1, 2023, DSS implemented 12 months of state-funded postpartum coverage to individuals enrolled in the CHIP prenatal care program.

State-Funded Coverage: As required by state law, DSS implemented state-funded HUSKY Health comparable to Medicaid and CHIP for individuals who are ineligible for Medicaid or CHIP because of their immigration status. DSS increased coverage for children under age 13 in Medicaid/CHIP with income up to 323% FPL on January 1, 2023, and further increased the age limit to children under age 16 on July 1, 2024. Once enrolled, children can remain on the program through age 18 as long as they continue to meet the program's eligibility requirements.

Covered CT: In collaboration with OHS, Access Health CT, and other partners, DSS administers the Covered CT program. This program is available to adults ages 19-64 who are not Medicaid-eligible and whose income does not exceed 175% of the FPL and who select a silver-level qualified health plan on Access Health CT. As established by state law and authorized by a federal demonstration waiver under section 1115 of the Social Security Act, Covered CT provides support for cost-sharing after application of federal subsidies and credits, plus dental

and non-emergency medical transportation (NEMT) services. This program, which currently serves over 40,000 individuals, enhances access to healthcare coverage for eligible individuals and helps address the benefit cliff for medical coverage for individuals above income for Medicaid. Covered CT also provides a highly cost-effective option for fully subsidized health insurance through commercial insurance on the exchange for parents and caretaker adults earing above 138 % FPL, when eligibility for HUSKY A was adjusted in 2024.

MED-Connect: DSS administers Medicaid for Employees with Disabilities, known as MED-Connect, which provides Medicaid eligibility for employed individuals with disabilities who meet applicable requirements. State law recently was amended to gradually expand the eligibility rules for MED-Connect. DSS is conducting a study of the potential impact of expanding eligibility for MED-Connect.

Improvement Strategy

General: Currently, DSS is examining methods to simplify Medicaid spend-down (which is for individuals in circumstances where Medicaid rules allow them to spend down their income due to allowable medical expenses) based on a federal option that would allow individuals to deduct prospective medical expenses.

Ex Parte Renewals Across Programs: DSS intends to continue streamlining benefits determination and renewals, improving automation, such as passive renewals between different benefit programs and targeted continuous eligibility. As mentioned above, DSS is currently authorized to use SNAP eligibility data to determine individuals' eligibility for Medicaid, which reduces administrative work and complexity for members and DSS, improving continuity of coverage. This federal flexibility is currently temporary, so DSS is evaluating options to continue this flexibility longer-term.

CHCPE Presumptive Eligibility: Recently adopted state law requires DSS to implement presumptive eligibility in specified parameters for the Connecticut Home Care Program for Elders (CHCPE), which is one of the Medicaid section 1915(c) HCBS waivers. The goal of presumptive eligibility is to expedite access to CHCPE, which, for some individuals, may provide services that could delay or prevent the need for institutionalization in a nursing home. Based on CMS guidance, DSS will need to submit and receive federal approval for a demonstration waiver under section 1115 of the Social Security Act. DSS is in the process of developing the waiver application.

Maximizing Medicare: DSS continues to evaluate options to help ensure that individuals enrolled in Medicaid or other DSS services, who are also eligible for Medicare, do in fact apply for and receive Medicare to the fullest extent possible. DSS staff help coordinate with people who are on Medicaid to enroll in Medicare as soon as they are eligible. DSS also works with ADS and its partners to assist people aging out of HUSKY D at age 65 with enrolling in Medicare.

c. SERVICE CATEGORIES

i. Medical

Most of the categories of services covered in HUSKY Health fall into a broad category of medical services. Within medical services, this section highlights a few key agency priorities, recognizing that there are also many additional services that are not feasible to address in this report.

1. Primary Care

Recent Changes

For individuals newly enrolled in HUSKY Health and for individuals who are not currently attributed to a primary care provider, CHNCT works one-on-one with HUSKY Health members to select and visit their PCP, informing them of the importance of well-care and preventive services through member engagement calls. CHWs at CHNCT also conduct outreach to HUSKY Health's unattributed members to encourage PCP attribution and assist with scheduling a primary care visit, and educate on benefits, the importance of accessing care, and receiving screenings through the CHW Ambassador Program.

This engagement has helped improve and maintain significant rates of members being attributed to PCPs, which helps enhance their overall health and coordination among various types of healthcare providers and services. For example, CHNCT's CHW outreach team conducted outreaches in 2023 to unattributed members to encourage PCP attribution and assist with scheduling a primary care visit. The share of attributions was 21.65% in the intervention group vs. 18.24% in the control group. Rates of attribution also reflect that some members choose not to see a PCP for various reasons, such as because they focus on care for a chronic condition primarily managed by a specialist rather than a PCP or they choose not to see a PCP.

CHNCT regularly tracks and reports on members attributed to a PCP. The charts below were adapted from a prior presentation from CHNCT to the MAPOC Care Management Committee and show the number and percent of members who are attributed to a PCP, including both attribution to any PCP and the subset of those members who are attributed to a PCP who participates in the PCMH program (described below). In general, these charts show that there has been modest improvement in overall member attribution to PCPs over time.

Figure 20.

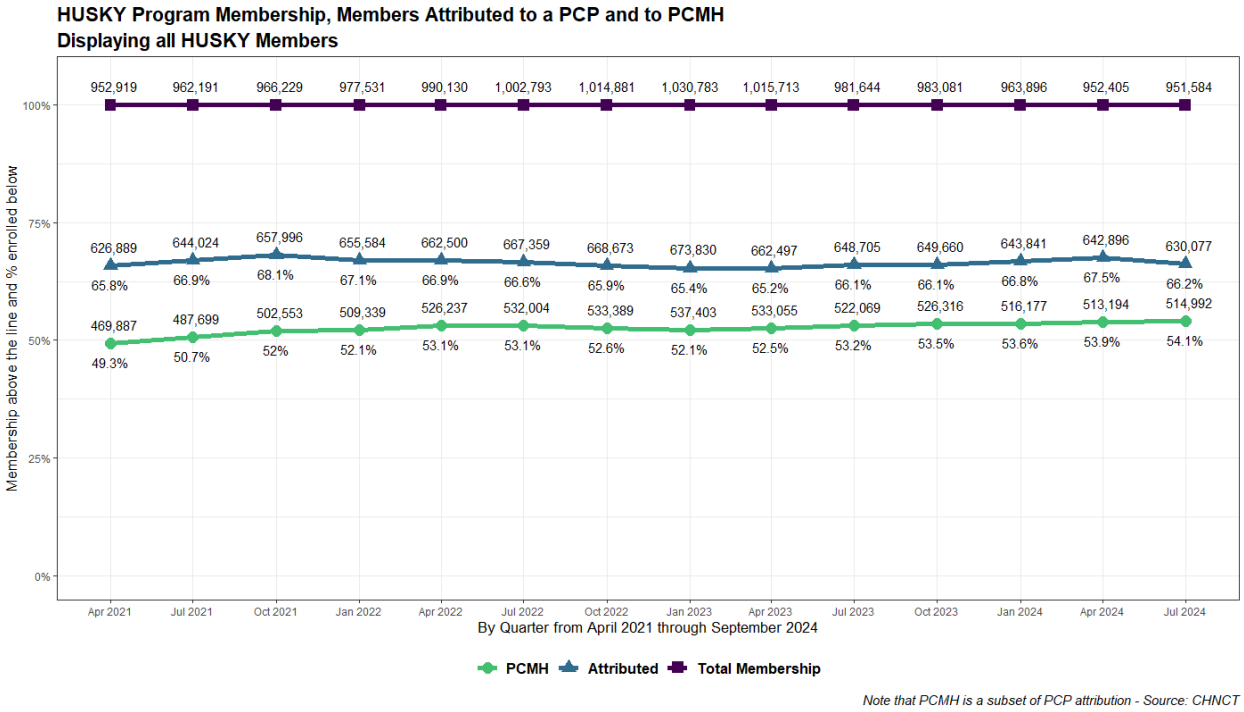
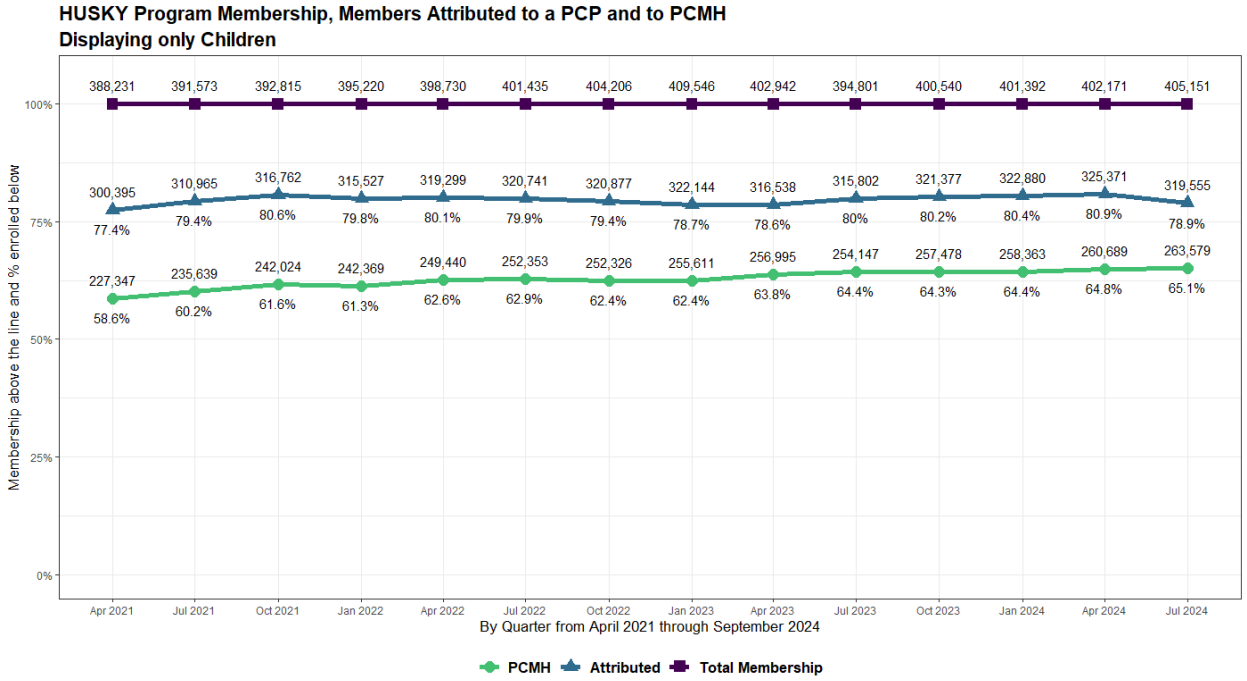
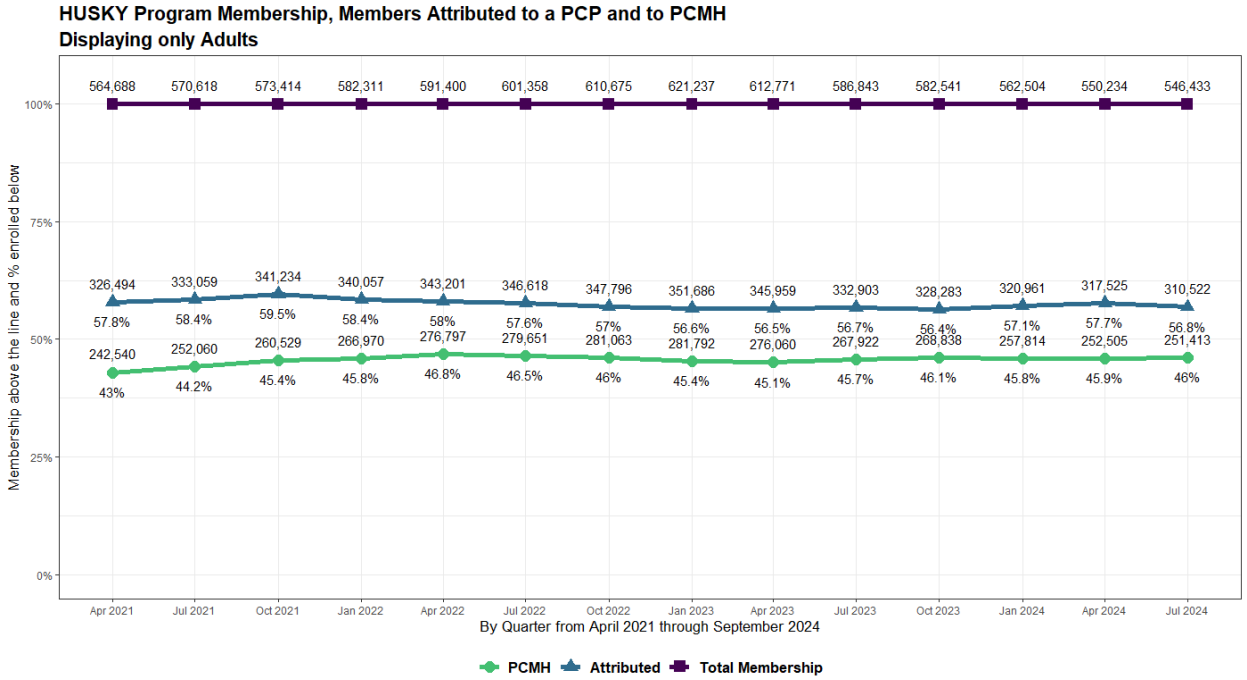


Figure 21.



Note that PCMH is a subset of PCP attribution - Source: CHNCT

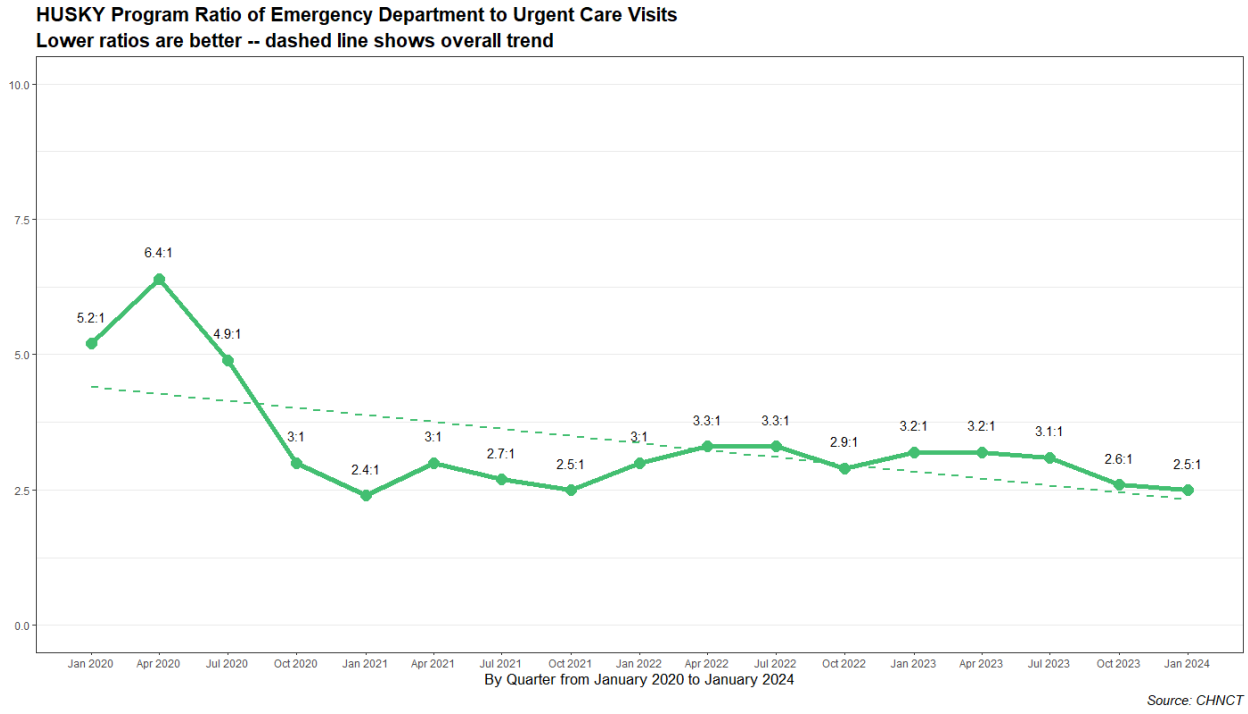
Figure 22.



Note that PCMH is a subset of PCP attribution - Source: CHNCT

One of the key goals of expanding access to primary care is to reduce the amount of avoidable hospital emergency department visits. Figure 23 shows that the ratio of hospital emergency department visits to urgent care visits has been declining over time since 2020, which is a positive trend.

Figure 23.



PCMH: DSS' Person-Centered Medical Home (PCMH) program is designed to improve the quality of and access to primary care and enhance care coordination provided through a PCP who has achieved a national PCMH certification designated by DSS. PCMH provides technical assistance and, for private practice PCPs, also enhanced payment for primary care provider practices. PCMH also includes a relatively small quality payment for private practices in PCMH to encourage and reward high performance on the PCMH quality measures. CHNCT staff support PCPs in achieving and maintaining PCMH certification and participation, providing technical assistance and engaging with practices. PCMH includes both private practices and federally qualified health centers (FQHCs). Over half of PCPs enrolled in HUSKY Health participate in PCMH and over half of HUSKY Health members are patients in a PCMH practice.

PCMH, which launched in 2012 at the same time as the medical ASO, together with the higher rates for primary care services as a percentage of Medicare compared to specialists, is a key program to maintain access to primary care services for HUSKY Health members. The PCMH

certification model and enhanced payment also support PCPs in providing high quality care and providing care coordination for their patients as part of primary care services, such as referring people to necessary services from specialists and other medical and non-medical care.

PCMH+: Expanding on PCMH, Person-Centered Medical Home Plus (PCMH+) is a shared savings and quality incentive payment model for PCPs who participate in PCMH and, either as a separate entity (FQHC or private practice) or as a network of practices, serve at least 2,500 HUSKY Health members who are eligible for PCMH+. PCMH+ launched in 2017 as part of the state's participation in the federal Center for Medicare and Medicaid Innovation (CMMI) State Innovation Model (SIM) grant. PCMH+ provides a framework and financial incentives to PCPs (either FQHCs or advanced networks of private practices) to improve quality outcomes and enhanced primary care-based care coordination, such as assisting patients with accessing healthy food, transportation to appointments, and finding community agencies that support housing or employment.

PCMH+ provides upfront care coordination add-on payments to FQHCs to provide additional care coordination for their patients, especially to enhance the integration of physical and behavioral health. PCMH+ also provides shared savings payments (through individual and challenge pools), which, collectively, allocate incentive payments based on applicable savings and performance on quality measures. The SIM program's evaluation of PCMH+ shows that it generally had favorable outcomes, including generally meeting its goals of reducing hospital admissions and emergency department visits. In addition, PCMH+ has demonstrated savings to the system by reducing cost growth below the benchmark.

Improvement Strategy

Primary Care Redesign: This is being conducted with the overarching goal of improving the biopsychosocial health and well-being of HUSKY members, especially for the most historically disadvantaged members, in a way that reduces inequities and racial disparities. The Primary Care Program Advisory Committee (PCPAC) began meeting in April 2023 and is charged with engaging critically to help DSS develop a primary care program that promotes health equity and improves the health and well-being of members. The PCPAC engaged in extensive discussions related to primary care program design elements, including care delivery requirements, performance measurement, payment model and equity strategy. By May 2024, DSS, with extensive input from the PCPAC, established a primary care payment model proposal to support primary care redesign consistent with PCPAC feedback.

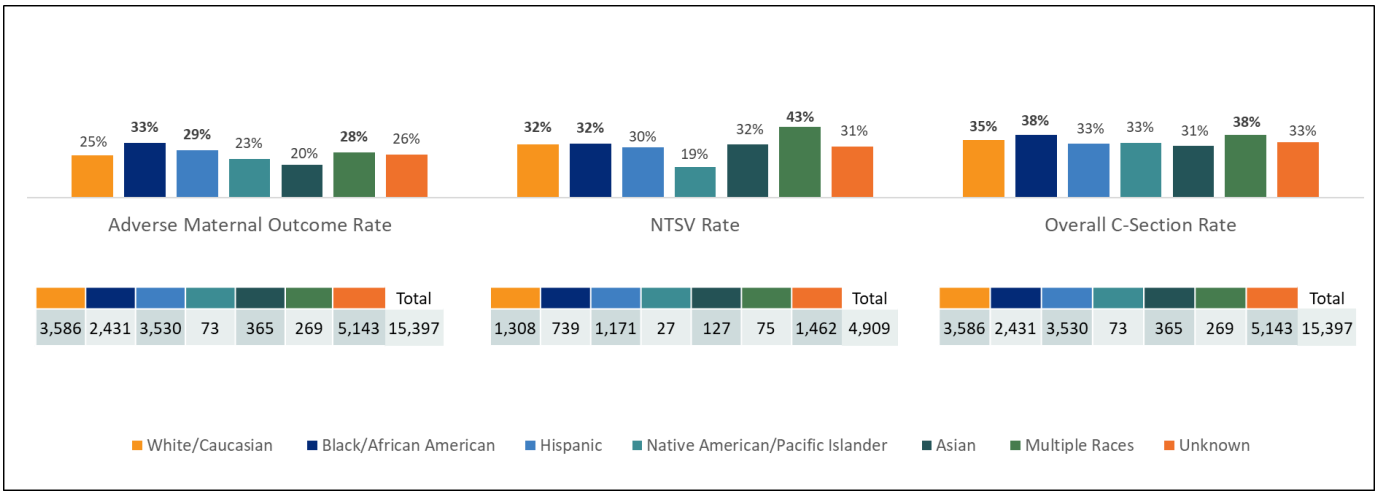
Primary Care AHEAD: In July 2024, CMS awarded the state the States Advancing All-Payer Health Equity Approaches and Development Model (Connecticut AHEAD) federal grant. In relation to primary care, any practice participating in a Medicaid advanced payment model would also be eligible to participate in Primary Care AHEAD, which provides approximately $17 per member per month payments for Medicare fee-for-service members. Practices would be required to undertake care transformation activities related to behavioral health, care management and/or health-related social needs, broadly consistent with goals established by the PCPAC. Planning for the Medicaid portion of Primary Care AHEAD is underway and will build on the experience of PCMH+ and the work of the PCPAC, involve additional stakeholder engagement, including with the PCPAC and the AHEAD Advisory Committee, with an anticipated launch of January 2027.

2. Maternity Services

Maternity services are a key focus of HUSKY Health because of its critical importance in the health and well-being of parents and children alike, especially because HUSKY Health is the largest payer of perinatal services in the state (across prenatal, delivery, and postpartum services). In 2023, HUSKY Health paid for 45% of births in the state. This high percentage results from the state's eligibility threshold for pregnancy, which is significantly higher than any other full-benefit Medicaid category. Broadly, HUSKY Health supports maternity services in several ways, including a higher eligibility threshold for pregnancy, the recent addition of twelve months of postpartum eligibility (referenced above under Eligibility Policy), and comparatively higher payment rates for obstetrics services, which are at significantly higher percentages of Medicare than any other rates on the HUSKY Health fee schedule. In addition to this broad framework, DSS continues to work to improve maternal and child outcomes, including through education and care management, financial incentives for maternity practitioners (including the maternity bundle payment starting January 1, 2025), and coverage for birth doulas (also starting January 1, 2025).

Below is a graph showing key maternal health outcome metrics among HUSKY Health members based on race/ethnicity. Note that NTSV stands for nulliparous, term, singleton, vertex (NTSV) Caesarian sections and has also been used because it measures low-risk C-sections among first-time pregnant individuals:

Figure 24.

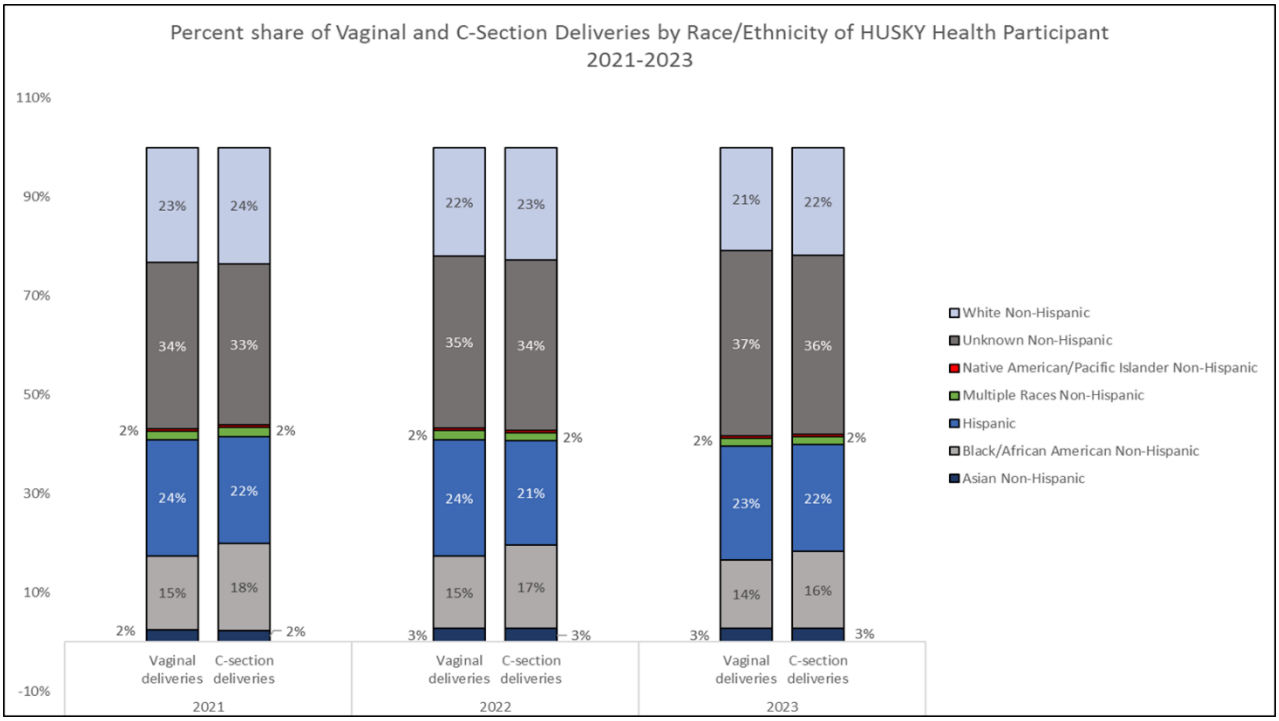


Source: CT DSS Provided Data, provided by CHN

About the Metrics:*Adverse Maternal Outcome* – Race based on mother's member record. Current outcomes defined as Adverse Maternal Outcomes: Acute Myocardial Infarction, Cerebral Infarction, Disseminated Intravasular Coagulation, Eclampsia, HELLP Syndrome, Hemorrhage, Maternal Death within 1 year, Peripartum Cardiomyopathy, Placenta Accreta, Placenta Increta, Placenta Infarction, Placenta Percreta, Placenta Previa, Preeclampsia, Premature Separation of Placenta, Stillborn, Thrombosis Embolism. ***NTSV*** – Race based on mother's member record. ***Overall C-Section*** – Race based on mother's member record. Determined by match in the C -Section value set.

Figure 25, also pulled from DSS data provided by CHNCT and compiled by DSS, is a breakdown of total vaginal and C-section deliveries based on reported race/ethnicity.

Figure 25.



Note: Data for Native American & Pacific Islander Non-Hispanic group not displayed in the graph above. The group accounted for less than 0.5% of the deliveries in the 2021-2023 period. Their share in the Vaginal deliveries are 0.49%, 0.45%, and 0.46% respectively for 2021-2023 and for C-Section deliveries it was 0.47%, 0.49%, and 0.40% respectively. Percentage shares of both Vaginal and C-Section births by race have been stable during 2021-2023.

Recent Changes

Member Education and Care Management: CHNCT's High-Risk Perinatal Program provides services to high-risk members who are pregnant or have recently given birth and have certain health and social risk factors that may require special monitoring or attention. Nurses work with pregnant members and their families to support engagement in recommended care with providers, address risk factors, and resolve barriers to obtaining needed services and supplies. They also provide education on pregnancy-related topics. CHNCT's clinical pharmacist also supports perinatal members with substance use to enhance access to behavioral health services.

Obstetrics Pay-for-Performance Program (OBP4P): This program provides financial incentives for maternity providers to improve outcomes, including reducing avoidable maternal morbidity and mortality. These providers are eligible for bonus payments if they meet thresholds for specified quality and access measures. During a recent cycle of OBP4P, there was an increase in participating providers' success rates across six scoring metrics, with a less than 1% decline in two of the scoring metrics, achieving an overall success rate 5.8% higher than the previous 12-month cycle. Going forward, the focus of financial incentives and support for improving maternity outcomes will shift to the maternity bundle payment (described below), although for the time being, OBP4P will remain in effect for maternity providers not eligible to participate in the maternity bundle (generally due to a small number of births covered by HUSKY Health).

Improvement Strategy

Maternity Bundle Payment: The Maternity Bundle Payment, which will launch January 1, 2025, is designed to improve maternal and birth health outcomes and health equity. Specifically motivating this program, from 2017-2021, DSS observed a rise in adverse maternal outcomes, C-section deliveries, and neonatal intensive care unit (NICU) utilization among HUSKY Health members. Maternal outcomes also show significant disparities by race and ethnicity, which the maternity bundle payment is designed to address.

DSS gathered information from many providers and other stakeholders, including through DSS' Maternity Bundle Stakeholder Advisory Council, member focus groups, MAPOC, and other forums, and incorporated as much of the feedback as feasible into the program design.

The maternity bundle payment is episode-based, in which the episode describes the total amount of care provided to a member during a set timeframe. The maternity bundle episode

will include services and care delivered during the perinatal period (prenatal, labor and birth, and postpartum), spanning 280 days before the date of delivery to 90 days after the date of delivery. The Maternity Bundle Payment Program includes two key financial components to enable maternity providers to improve quality outcomes for Medicaid members:

- Case rate monthly payments for certain services included in the maternity bundle episode, plus funding for the maternity provider practice to offer doula services and lactation supports to their attributed members, which are high-value services associated with positive maternal and infant health outcomes.
- Incentive payments for providers who deliver high-quality, cost-effective services throughout the episode. These are upside-only payments provided when the actual total cost of care for the maternity episode does not exceed the target price (i.e., the expected total cost of care for the maternity episode) and they also meet quality performance criteria and comply with under-service prevention requirements.

As part of the maternity bundle case rates, DSS also includes payment to obstetrics providers for arranging for lactation supports and doula services, both of which are designed to improve member experience and outcomes, enhance coordination of services, and reduce healthcare disparities. Obstetrics providers may choose to opt out of receiving funding for arranging for doula services for their patients, although doulas will be covered separately, as noted below.

Doula Services: Effective January 1, 2025, at the same time as implementing the maternity bundle payment, DSS is adding coverage for birth doula services. Certified doulas are trained, nonmedical professionals who provide physical, emotional, and informational support to a pregnant person during the perinatal period. This addition is designed to improve maternal and newborn/infant outcomes, health equity, and coordination with other services in the perinatal period. To be eligible for Medicaid payment, the doula must be certified by DPH. As part of the stakeholder engagement for this report, doulas expressed interest in participating in this new coverage to provide services to Medicaid members. They also expressed interest in facilitated collaboration and mutual education with doulas and medical providers to improve clarity on roles and highlight the value that doulas provide for patients and healthcare teams.

Additional Improvement Strategies:

- Evaluate and improve maternity bundle payment over time, including potential inclusion of hospital services in the maternity bundle payment case rates and/or incentive payments.
- Evaluate the effectiveness of adding separate coverage of doula services on quality outcomes, member experience, and containing cost growth, including potential for

improved coordination with medical providers, other community-based practitioners, and various initiatives designed to improve care coordination.

- Coordinate with other initiatives that benefit pregnant and postpartum individuals, including Integrated Care for Kids (InCK) and early childhood services, including the Universal Nurse Home Visiting pilot program.

3. Early Childhood Services

Recent Changes

DSS, in collaboration with OHS and OEC, utilized American Rescue Plan Act (ARPA) funding to fund the Universal Nurse Home Visiting (UNHV) – Community Health Worker (CHW) Pilot to improve services and outcomes for infants. Note that HUSKY Health is already the largest payer of Birth to Three, administered by OEC, which is Connecticut's program of early intervention services under Part C of the Individuals with Disabilities Education Act (IDEA) for infants and young children with significant developmental delays as defined in federal law.

Improvement Strategy

Based on the results of the UNHV pilot, DSS will evaluate the feasibility of potential HUSKY Health coverage of these or similar services. OEC also covers several other evidence-based early childhood home visiting models. DSS, together with OEC, is analyzing the potential impact of adding coverage for one or more of these models and exploring ongoing sustainability efforts, including through commercial insurance.

4. Medical Chronic Conditions

Recent Changes

As detailed below under the Care Coordination section, CHNCT, the medical ASO, provides supports for high-risk members with certain chronic conditions. For example, as part of broader strategies to reduce health disparities and improve chronic disease management, CHNCT works with members to improve management of high-prevalence diseases, including the following:

- Diabetes -- improving outcomes through targeted care management interventions. Achieve a 10% rate of improvement in HbA1c levels for Black/African American and Hispanic members with diabetes and an HbA1C level of 9% or greater. As a result of

high-risk care management efforts, of the 98 members engaged in Intensive Care Management (ICM) meeting this criteria, 67 members improved their HbA1c levels (a 68.4% improvement).

- Hypertension – improving outcomes through targeted care management interventions. Achieve a rate of 50% for unattributed or high-risk Black/African American members with hypertension attending a provider appointment following engagement in care management. As a result of care management efforts, of the 1,063 members engaged, 808 (or 76.0%) attended a provider appointment. In calendar year 2024, this program was expanded to address both hypertension and diabetes.
- Transitional Care Management – nurses support smooth transitions from a healthcare facility to home and participation in recommended follow-up care. In calendar year 2023, referrals were made to CHNCT CHWs to conduct home visits with high-risk, unattributed members who were unable to be contacted by phone following a hospital stay to assist with connecting them to a primary care provider and care management if needed. In 2023, unplanned readmissions for members engaged in care management decreased by 49.9% comparing six months prior to engagement and six months post engagement.

Improvement Strategy

Going forward, DSS is exploring how to improve outcomes for people with chronic conditions, including as new models emerge and new research and other evidence becomes available. The Medicaid Landscape Analysis referenced above identifies improving care coordination for individuals with acute and chronic conditions as a key priority. Specifically, the landscape analysis recommends reviewing current data and care management delivery models to identify key areas of opportunity, identifying relevant disease care management models in other states, and evaluating potential models for implementation, including the AHEAD model (referenced in the Hospital and Primary Care sections of this report).

ii. Behavioral Health

The Connecticut Behavioral Health Partnership is a partnership among DSS, DCF, and DMHAS, with Carelon Behavioral Health Connecticut serving as the behavioral health ASO. CT BHP provides a robust benefit package of behavioral health services to support HUSKY Health members. Behavioral health services are a key priority both because of its importance to overall health and well-being and also because Medicaid is the largest payer of behavioral

health services in the state. Recent priorities of CT BHP include addressing the number of youth in emergency departments waiting for placements, increasing the initiation of medications for opioid use disorder, and addressing health disparities.

1. Substance Use Disorder (SUD)

Recent Changes

In 2018, Carelon and the CT BHP launched Changing Pathways to reduce opioid overdoses by providing education on treatment options and medication for opioid use disorder (MOUD). As part of this initiative, there were significant clinical improvements for members who adhered to MOUD following discharge (including reductions in inpatient days, emergency department visits, and significant reductions in overdoses). There were also improvements for members who initiated MOUD during a medically monitored intensive inpatient withdrawal management episode (including reduced readmissions and increased MOUD adherence). Additionally, through the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act, the partnership analyzed substance use disorder treatment and took steps designed to increase specialized provider capacity for treating sub-populations (e.g., pregnant and postpartum women, individuals with HIV/AIDS, young adults, and infants exposed in utero).

In 2022, DSS received federal approval for a Substance Use Disorder Demonstration Project through a demonstration waiver under section 1115 of the Social Security Act. The waiver enables the state to receive federal financial participation (FFP) (i.e., federal match) for services provided to Medicaid beneficiaries, who are primarily receiving treatment and withdrawal management services for SUD while residing in institutions for mental diseases (IMD), with overall care consistent with American Society of Addiction Medicine (ASAM) standards. The demonstration's goal is to maintain and enhance access to SUD services and continue delivery system improvements to provide more coordinated and comprehensive treatment for beneficiaries with SUD and has six major objectives:

1. Increase rates of identification, initiation, and engagement in treatment.
2. Increase adherence to and retention in treatment.
3. Reduce overdose deaths, particularly those due to opioids.
4. Reduce utilization of emergency department and inpatient hospital settings for treatment, where the utilization is preventable or medically inappropriate, through improved access to other continuum of care services.

5. Reduce readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate.
6. Improve access to care for physical health conditions among beneficiaries.

Improvement Strategy

Going forward, DSS, DMHAS, and DCF are working to improve the quality and cost-effectiveness of SUD services, including revamping the payment methodology and certification process for SUD residential facilities.

2. Youth and Family Initiatives

Recent Changes

Psychiatric Residential Treatment Facility (PRTF) services are non-hospital inpatient psychiatric services for HUSKY Health members primarily for members under age 18, although federal rules allow PRTF coverage for individuals under age 21 (or under age 22 if admitted to the facility before turning 21). Together with state agency partners, especially DPH and DCF, DSS has been working to improve the quality of PRTF services, including a previous rate increase that was tied to various improvements. Given the ongoing challenges with quality of care and limited access to PRTF services, DSS continues to identify opportunities to improve PRTF services.

In 2023, four behavioral health urgent crisis centers (UCC) for youth opened in response to the youth mental health crisis and to provide alternative sites of care from often overcrowded emergency departments. UCCs provide de-escalation services, evaluation, referrals, and connection to services. DSS recently added Medicaid coverage for UCC services for youth. Effective July 1, 2024, as required by legislation, DSS increased Medicaid rates for behavioral services for children by a total of approximately $14 million annually, which included targeted increases for the home-based model Intensive In-Home Child and Adolescent Psychiatric Service (IICAPS). DSS has also administered an initiative to support infant and early childhood mental health services, which is funded with ARPA dollars.

Strategy for Ongoing Improvement

In the near future, DSS continues to look for ways to improve behavioral health services for youth, including to address the crisis of children in hospital emergency departments with no

appropriate discharge options (discussed in more detail below under Inpatient Behavioral Health).

3. Outpatient Behavioral Health

Successes

The Behavioral Health Home (BHH) model provides reimbursement to local mental health authorities to provide wrap-around care coordination and primary care in addition to the behavioral health clinic model, which is targeted for people with severe mental illness and who meet other criteria. BHHs have demonstrated positive outcomes based on quality measures.

Coverage for behavioral health mobile crisis services for adults is currently funded through various non-Medicaid sources. To maximize federal support for these services, DSS and DMHAS, together with DCF, are working to add coverage soon for mobile crisis services for adults.

Improvement Strategy

DCF administers a 24/7 mobile crisis system for children, which is currently covered by HUSKY Health, although many of these services are not currently being billed to HUSKY Health, which could enable additional federal Medicaid funding to further support that service system. Similarly, DMHAS operates a 24/7 behavioral health mobile crisis system for adults, which DSS is working in partnership with DMHAS to add Medicaid reimbursement.

DSS is also evaluating the potential impact of expanding the BHH model (which currently focuses on adults) to a lifespan model that also includes children. Enhanced Care Clinic (ECC) is another model to improve the quality of outpatient behavioral health services, in which qualified behavioral health clinics that meet enhanced requirements for access, quality, and member experience receive a higher rate. For several years, DSS, DCF, and DMHAS have been working together to develop improvements in the payment and coverage model for outpatient behavioral health services, which would likely build on the existing ECC and BHH models.

Connecticut recently applied for a federal planning grant for Certified Community Behavioral Health Clinics (CCBHCs), which is a model that provides enhanced reimbursement to behavioral health clinics for offering a specified comprehensive package of services. If Connecticut receives this grant, DSS will evaluate the potential impact of adopting a CCBHC payment model, in part

based on comparison to results in other states on cost increases and clinical outcomes. In addition, DSS will continue work to evaluate a broader model for behavioral health outpatient redesign as noted above, likely building on the ECC and BHH models.

4. Inpatient Behavioral Health Services

Recent Changes

Together with DCF, Carelon, and other partners, DSS has been collectively working to address the challenge of children in the hospital emergency department due to a lack of available, clinically appropriate, acute and non-acute discharge options. Based on 2023 data gathered by Carelon, most of the children in this situation are waiting available beds at an inpatient psychiatric hospital. The second highest volume of youth are awaiting access to community-based services (intensive outpatient, home based, outpatient or care coordination), with a smaller volume of youth awaiting access to a PRTF or the state-operated pediatric psychiatric hospital (Solnit Center). One of the key initiatives to address this challenge is to improve the access to and quality of inpatient services, including current rate add-ons for pediatric inpatient psychiatric services. DSS also recently coordinated with DMHAS to administer an ARPA-funded grant for the Connecticut Children's Medical Center (CCMC) to establish a medical-psychiatric unit, which is the first set of inpatient psychiatric services offered at CCMC.

More broadly for inpatient hospital services, DSS, DMHAS, DCF, and Carelon continue to work to avoid unnecessary hospitalization for behavioral health and improve the quality of hospital behavioral health services, especially enhancing discharge planning. One key initiative includes Community Care Teams (CCTs), which are multi-disciplinary teams that work to improve the integration of care for individuals receiving behavioral health services in hospitals. Carelon's ICM services, including, where applicable, peer support specialists, also assist members with improving the coordination of care across levels of care.

Improvement Strategy

Starting January 1, 2025, DSS and Carelon are using claims data from hospitals providing pediatric inpatient psychiatric services to inform and finalize a value-based payment (VBP) methodology starting January 1, 2027. This model will provide financial incentives for these hospitals to improve quality, especially improved discharge planning to less acute settings. Based on the results of this new upcoming VBP, DSS will evaluate the potential for developing a VBP for inpatient hospital behavioral health services for all ages. Critically, these ongoing efforts

on behavioral health outpatient redesign referenced above are intended to improve access and quality of various levels of outpatient behavioral health, which are designed to reduce the need for inpatient services and improve discharge options for people who need inpatient care.

iii. Long-Term Services and Supports (LTSS)

As mentioned previously, unlike Medicare or commercial health insurance, Medicaid covers both health services and LTSS. DSS, in collaboration with many partners, has been working for decades to rebalance LTSS to expand options for people to remain in their homes through home and community-based services. DSS works in collaboration with other agency partners to improve the quality of LTSS, including through DPH, DDS, DMHAS, and ADS (various units, including the ombudsman programs for both institutional LTSS and HCBS).

1. Home and Community-Based Services (HCBS)

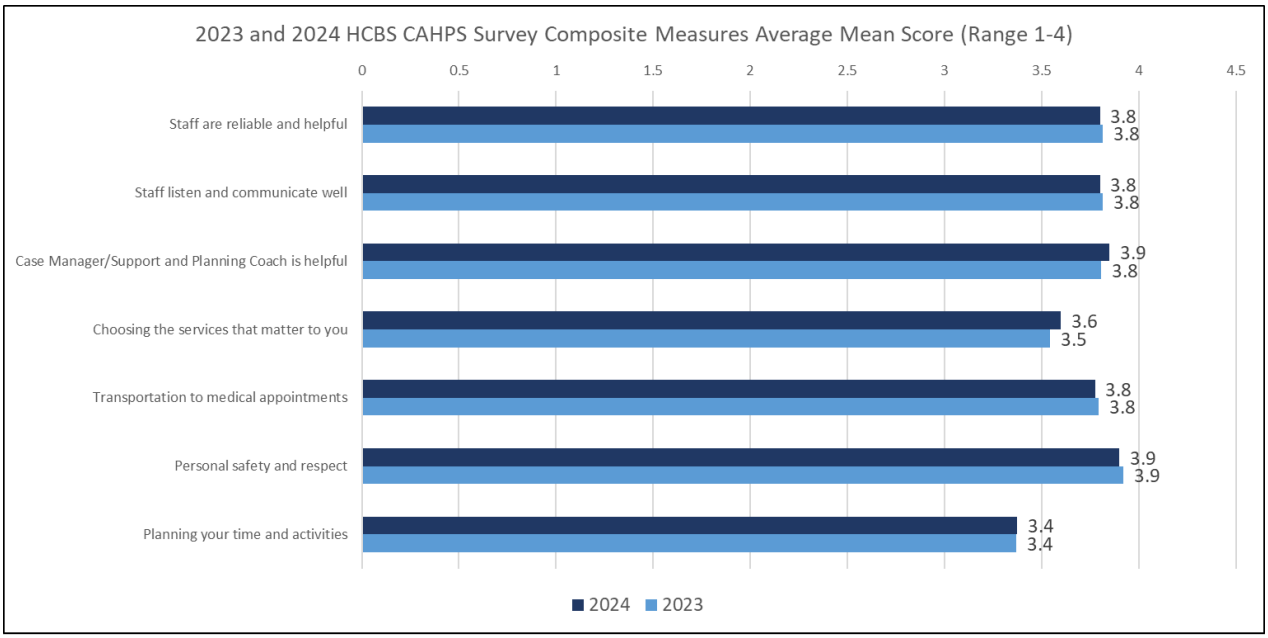
Recent Changes

In conjunction with various partners, including the UConn Center on Aging, DSS has implemented various initiatives to improve HCBS. To increase access to LTSS, DSS and partners created the website My Place CT to assist with understanding and obtaining long-term services and supports. DSS and the UConn Center on Aging continue to evaluate performance on rebalancing LTSS, person-centered care, prevention, care access, and clinical outcomes, including through the HCBS CAHPS and National Core Indicators-IDD surveys, quarterly Money Follows the Person Report, and various annual and ad hoc reports. Additional information can be found here. DSS is actively working to improve the quality and program integrity of the HCBS programs, including clarifying procedures, enhancing quality control safeguards, and improving accountability.

In accordance with recent state legislation, DSS is working to develop a searchable registry for home care workers, allowing Medicaid members to find caregivers based on skills, specialized training, languages spoken and other suitable characteristics. This project is designed to broaden access and improve customer service by creating a public facing repository of information for the benefit of members. DSS is also working with ADS to develop a report that explores ways to enhance family caregiving supports.

HCBS CAHPS Results: Figure 26 below shows HCBS CAHPS composite results for 2023 and 2024:

Figure 26.



The HCBS CAHPS survey elicits program participant feedback on their daily experience with their HCBS. It provides Connecticut with one consistent approach to reward quality and facilitate reporting across waiver programs and care management provider agencies. It includes participants in the following programs: Connecticut Home Care Program Categories 3 and 5 (CHCP), Personal Care Assistance (PCA), Acquired Brain Injury I and II (ABI), Autism, and Katie Beckett (KBW) Waivers, and Mental Health Waiver (MHW).

Programs included above are the CHCP, PCA, ABI, and Autism waivers. KBW and MHW are excluded as mean scores data were unavailable for all 7 composite measures. On 6 of the 7 composite measures included in the 2024 CAHPS survey, the mean score exceeded 3.5 on a scale of 1-4. The mean score is slightly lower (3.4) for the measure "Planning your time and activities," which includes items which assess the participant's ability to choose and control social interactions, community engagement, and daily activities. The HCBS CAHPS report notes that this finding is not unique to the CFC population and represents an opportunity for improvement in the DSS waiver programs as well as CFC. The 2024 mean scores show little to no change from 2023.

The HCBS CAHPS survey is also conducted with Community First Choice participants. Results of the CFC CAHPS survey can be found here.

ARPA HCBS Initiatives: As part of its implementation of section 9817 of the American Rescue Plan Act (ARPA), DSS implemented several improvements in HCBS, including providing funding to recruit and retain the HCBS workforce, efforts to increase discharges from hospital to the community, standardization of person-centered goal setting and measurement, and enhancing models of care. Also included under this initiative and as provided in recent legislation were one-time in-home safety enhancement grants for home health agencies and access agencies. DSS made enhanced payments to providers to connect to the health information exchange (Connie) to better coordinate their patients' care and reduce healthcare disparities. Planned enhancements to Connie will provide features targeted for HCBS providers, including access to consumer goals, risks for avoidable hospitalizations, and results from the CT HCBS universal assessment. This access will improve care and service coordination among HCBS providers, supporting consumers' health, well-being, and goal attainment. DSS also implemented Medicaid coverage for these evidence-based models of care: Care of Older Persons in their Environment (COPE) and Confident Caregiver, both of which support informal caregivers, and Community Aging in Place – Advancing Better Living for Elders (CAPABLE), which provides additional supports and targeted interventions to improve function.

Improvement Strategy

The Medicaid Landscape Analysis, referenced above, highlighted HCBS as a key area for innovation because of available options for improvement and due to significantly higher costs compared with other states. Specifically, the Medicaid Landscape Analysis recommended articulating DSS goals and objectives for HCBS innovation strategy, analyzing HCBS by program and population, evaluating potential program models based on defined criteria, and selecting program model(s) and developing an implementation workplan. Examples of potential models for further consideration identified in the Medicaid Landscape Analysis include Program of All-Inclusive Care for the Elderly (PACE), Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNP), comprehensive care management for HCBS users, and managed LTSS models. Based on that analysis, DSS will evaluate future options for potential changes to HCBS, which may include one or more of the recommendations in that analysis and/or additional options based on further analysis.

2. Nursing Homes

There are currently 209 nursing homes and 24,522 licensed beds in Connecticut. Medicaid is the funding source for approximately 74% of nursing home care in Connecticut. In addition to nursing home care, the other broad category of institutional LTSS is ICF/IID services, which is not

highlighted in this report because, although it is a Medicaid covered service, DDS primarily manages this service category.

Recent Changes

In recent years, DSS has continued to enhance fiscal oversight and implement new payment models better aligned with improving member access and experience. DSS has enhanced and clarified nursing home fiscal reporting requirements, made narrative summaries on nursing homes' financial positions publicly available, and developed a guidebook to facilitate the public's access to available cost reports. As provided in legislation and budget appropriations in some of the recent state fiscal years, DSS has targeted some of the prior rate increases for nursing homes to focus on enhancing staff wages and/or benefits. DSS also works closely with DPH to monitor for any changes in nursing home ownership.

Acuity-Based Reimbursement: This payment system adjusts nursing home payments according to the acuity of the resident and thus better incentivizes nursing homes to take on and care for sicker members. The system was fully phased-in in July 2024 and will be monitored going forward.

Improvement Strategy

In terms of ongoing plans for improvement, DSS has developed a framework for value-based payment, including details at this website: Nursing Home Reimbursement Acuity Based Methodology; DSS contracted with the UConn Center on Aging to conduct a resident and family satisfaction survey; and DSS will be closely monitoring nursing home bed capacity in the context of market changes and potential nursing home closures.

Nursing home associations emphasized the challenges in recruiting and retaining staff given the broader shortage of healthcare workers, which is further challenged by aging demographics that will increase the demand for LTSS. They seek a balanced payment system that encourages improved quality of care. In conjunction with DPH and OPM, DSS is also exploring a Centers for Excellence model that can help promote quality of care in nursing facilities. They share a vision of an appropriately balanced LTSS system that rebalances with a focus on consumer choice and HCBS while ensuring sufficient supply of nursing home services for people who need them. There is also an ongoing conversation about how to provide specialty nursing home services for particular populations and services, reducing the need for people to seek care out of state.

iv. Pharmacy/Prescription Drugs

Recent Changes

DSS implemented several measures to the prescription drug benefit to improve cost effectiveness, increase access, and enhance health outcomes. DSS adopted methods to prevent the overprescription of opioids and promote safer prescribing practices. Through the Pharmaceutics and Therapeutics Committee, DSS maintains a preferred drug list, which contains cost-effective medications that are appropriate for specific drug categories. DSS also set a cap on diabetic products to prevent overbilling. Certain high-cost drugs require prior authorization from a clinician to ensure that medications are provided when medically necessary for each person and to be a careful steward of program resources.

To ensure prompt access to medication, DSS processes prior authorization requests within 24 hours, does not require prior authorization for Hepatitis C medications, and added diabetic supplies to pharmacy coverage. DSS also provides an override option that provides 14 days of coverage for non-preferred medications to prevent gaps in medication access to enable individuals to coordinate with their prescribing provider to obtain alternatives or submit prior authorization requests. Medicaid members can also participate in mail-order medications services if offered by their pharmacies to facilitate compliance with prescribed medications.

Improvement Strategy

DSS is actively evaluating the potential benefits of using value-based contracts with pharmaceutical manufacturers to improve care and contain costs. For example, DSS is exploring the Center for Medicare and Medicaid Innovation (CMMI) Cell and Gene Therapy Access Model that provides participating states with technical assistance and funding.

DSS also plans to mitigate polypharmacy through the Pharmacy Lock-In Program. Through this program, patients who meet criteria for polypharmacy are locked into a particular pharmacy to prevent overutilization, streamline access, monitor care and control the review process. As noted in DSS' report issued in late January 2024 regarding the federal prescription drug discount program under section 340B of the Public Health Service Act, DSS gathered feedback from a workgroup to develop ideas to improve the cost-effectiveness of prescription drugs purchased through the 340B program. Additionally, the Drug Utilization Review Board continually evaluates areas for improvement in medication usage. In several areas of the pharmacy benefit, DSS is

planning and implementing further changes designed to ensure that medications are provided only when covered and medically necessary.

In comments submitted to DSS for this report, certain associations of pharmacists and pharmacies recommended that DSS consider covering services of clinical pharmacists under Medicaid that may help improve quality and contain cost growth.

v. Dental

The Connecticut Dental Health Partnership (CTDHP), Connecticut Medicaid's dental program, is administered by the dental ASO, BeneCare Dental Plans, in collaboration with DSS. CTDHP has become one of the top three Medicaid dental programs nationally for preventive services utilization for children's dental care. CTDHP's primary goal is to promote early oral healthcare intervention and instill good habits that can be maintained for a lifetime. Programs, services, and quality improvement initiatives all focus on supporting HUSKY Health members to receive early oral health prevention and treatment to improve overall health and avoid more costly dental services. CTDHP implemented various quality improvement projects and other programs to improve access, reduce disparities, and integrate dental care with other healthcare services, especially primary care, known as medical-dental integration.

Recent Changes

CTDHP's model of emphasizing oral health maintenance and routine preventive care has significantly contained cost growth over the years. Following continuously enrolled HUSKY members shows that preventive services remain higher than treatment services.

Figure 27.

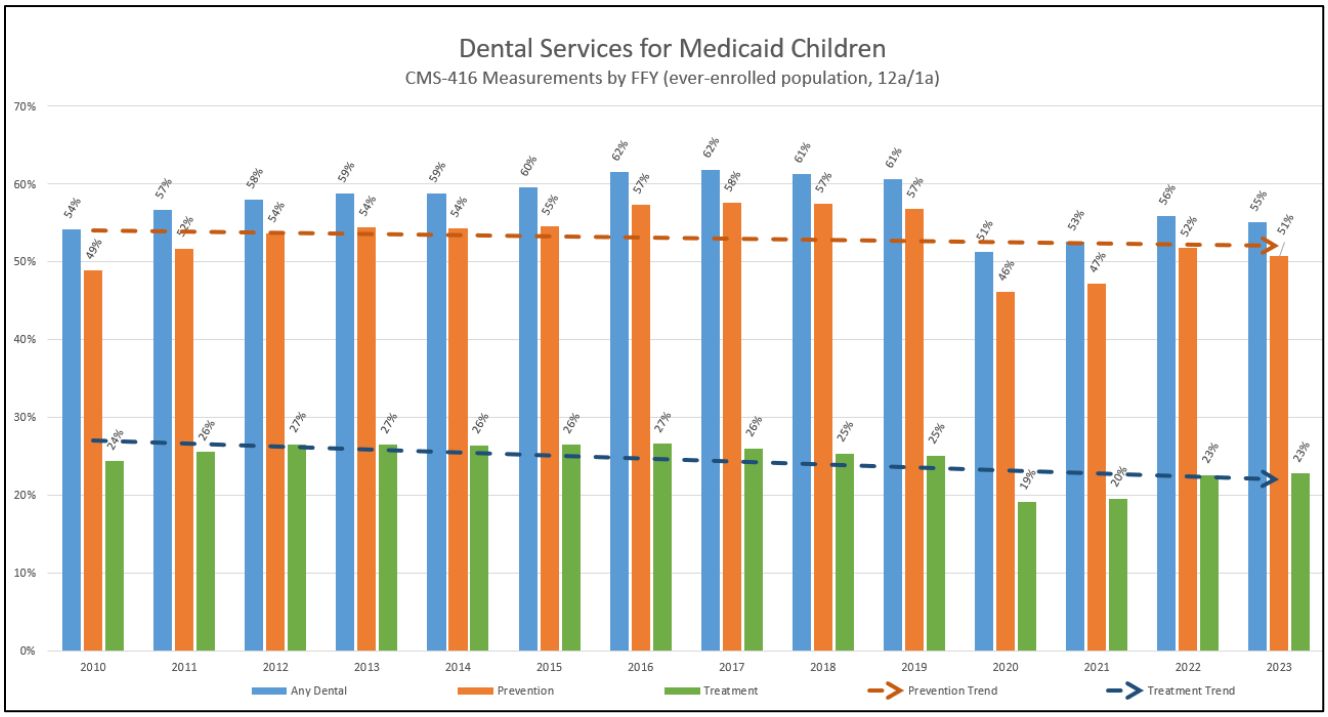
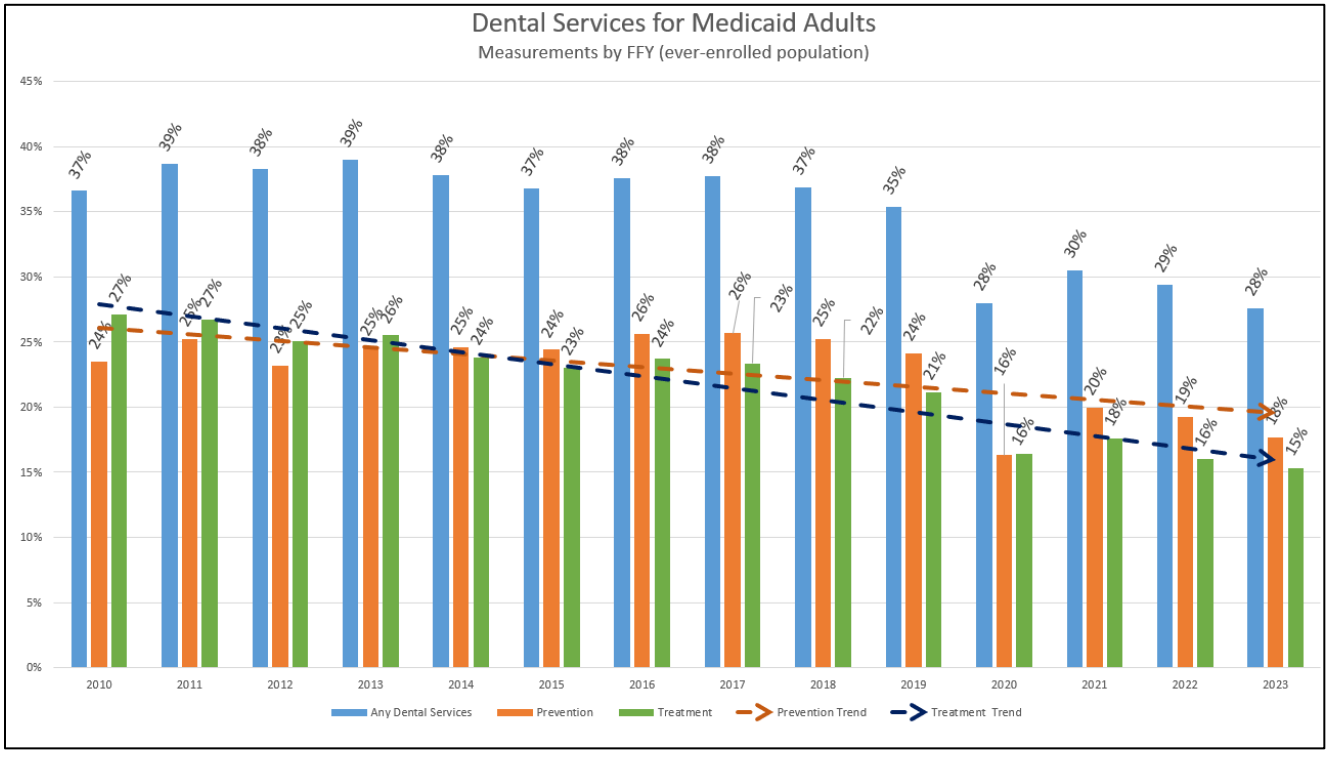
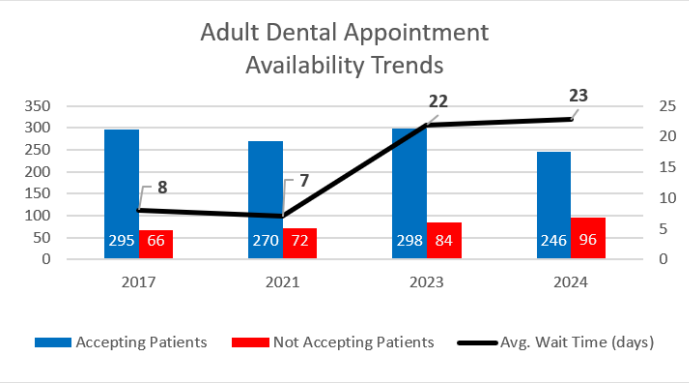


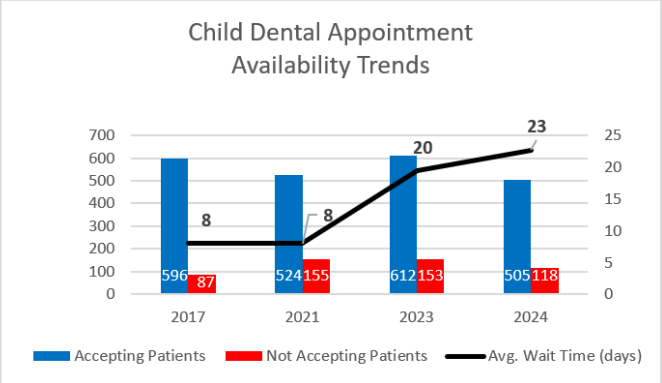
Figure 28.



Provider Appointment Availability and Member Experience Surveys: CTDHP conducts dental provider appointment availability and annual member experience surveys, inclusive of CAHPS ratings for dental providers, to understand access, availability, and the member experience to inform intervention strategies. Recent surveys indicate that appointment wait time for non-urgent dental services is increasing post-pandemic for adults and children. Adult providers who were not accepting patients at the time of the survey continue to increase as well.

Figures 29 & 30, show Appointment Availability Survey Results from 2017 through 2024





The 2024 Annual Member Experience Survey indicates that the top three barriers to accessing care for adults and children were the inability to find a dentist accepting new HUSKY patients, the inability to find a dentist with available appointments, and the fear of or not liking going to the dentist. See DHP Survey Report 2024 FINAL.

Health Equity Reporting and Interventions: Recognizing that oral health is not immune from health disparities, CTDHP has conducted annual Oral Health Equity Reporting since 2021. There are five key dental utilization disparities within the Medicaid population: adults, rural geographies, males, and within racial and ethnic populations. The Asian and Pacific Islander populations experience the most disparities across all dental core measures, and African American children experience more disparities across dental core measures for children. CTDHP has deployed targeted, community-based interventions to reduce these disparities, including developing "Pop-Up Resource Centers" to connect members to care in the community, establishing strategic partnerships with OEC's Family Visiting Program, and implementing media campaigns in specific geographies promoting oral health and connection to care. See: SR Edit of 2023 Oral Health Disparity Report and 2024 Oral Health Disparity Report.

Medical Dental Integration: CTDHP administers the Access to Baby Care (ABC) Program, which educates, certifies, and provides performance improvement support to medical practitioners who receive reimbursement to conduct oral health assessments and apply fluoride varnish to

children up to age seven at medical well-child visits. Utilization continues to rise year-over-year, with the highest volume of children receiving services in 2023, with 6% of eligible children receiving oral health assessments and 3% of eligible children receiving fluoride varnish applications. Trained providers continue to trend upward, totaling 817 certified providers in 2024. The ABC Program model has garnered national attention, serves as a model program for the CMS, and is a "Best Practice Approach" by the Association of State and Territorial Dental Directors.

In January 2024, DSS authorized services to qualified HUSKY adults to treat periodontal disease. Periodontal disease can significantly impact overall health and, if left untreated, can lead to and exacerbate health conditions, including heart disease, diabetes, and respiratory disease. The benefit is targeted specifically to members with certain medical diagnoses known to be influenced by the disease.

Innovative Services: CTDHP's Oral Health Navigation Program deploys social workers and certified CHWs as oral health navigators to work with HUSKY Health members with acute oral health needs or complex social, medical, and/or behavioral health barriers to care. The navigators support members in meeting their dental treatment needs, reducing barriers to care, and increasing oral health literacy. The CTDHP team found that two years after completing the program, participating members had a 76% overall dental utilization rate, 68% preventive dental utilization rate, and 4% emergency department utilization for oral health-related conditions with a total emergency department spend of $8,797. As a comparison group, members who were referred to the program but never engaged had a 6% emergency department utilization rate and a total spend of $63,910. Thus, the Oral Health Navigation Program has been found to increase dental utilization and decrease emergency department / medical costs.

CTDHP also deploys a Community Engagement Specialist Team comprised of CHW who reach out to community-based organizations and partners to promote oral health literacy and advance dental care access. This trusted person model of outreach is performed at the local level and within zip codes with lower-than-average dental utilization rates. In 2023, the team conducted 2,868 outreach activities in the local community. BeneCare also provides professional services support to the dental provider community, working to recruit and retain providers and ease administrative burdens for enrollment and billing. In 2023, BeneCare visited 256 dental provider offices and conducted over 1,000 phone calls for credentialing and re-credentialing support.

CTDHP maintains a local, bilingual member services/call center that responds to an average of 60,000 phone calls annually. Additionally, BeneCare uses a population health risk stratification

model for its direct-to-member contact via phone, email, letter, and text channels to conduct information and awareness campaigns to members regarding their dental benefits. In 2023, CTDHP successfully reached 556,528 members. Of these, 72,348 members or 13% utilized dental services post-communication. Targeted members include members visiting the emergency department for an oral health-related complaint, children identified in the community as being at high risk for cavities, and newly enrolled members via a welcome call.

Improvement Strategy

Fewer dentists are accepting adults on HUSKY Health, which is attributed to the disparity in payment rates for dental services for adults versus children. Adults also have significantly lower rates of preventive dental care than children. In 2023, children's prevention rate was at 51% while the adult rate was at 18%. CTDHP is evaluating ways to increase the utilization of appropriate dental services throughout the program, especially for groups and communities where utilization is lower. To that end, CTDHP has developed a strategy framework to achieve integrated dental practice within medical and community-based settings. The framework identifies co-location of dental and medical services as a strategy to effectively engage individuals who do not routinely have access to dental services and to foster holistic and comprehensive care. Additionally, CTDHP envisions enabling dental care services across various community-based settings, such as in-home, nursing homes, homeless shelters, and community-based social service and health organizations, to bring dental medicine to members. This framework can be found in the 2024 Connecticut Medical/Dental Integration Report: Medical-Dental-Integration-Report-CTDHP-June-2024.pdf.

Similar to other programs within HUSKY Health, CTDHP continues to evaluate ways to further improve the integration of dental care with other services, enhance coordination to help members receive the most appropriate dental care, and examine system delivery and payment models used in other states to improve the quality of care. In the stakeholder engagement for this report, multiple commenters expressed challenges in finding dentists who participate in Medicaid and in applying certain limits on dental benefits, such as root canal therapy and crown and denture restrictions (including the requirement for prior authorization for adult preventive dental services more than once a year).

vi. Non-Emergency Medical Transportation

The Medicaid Non-Emergency Medical Transportation (NEMT) program provides transportation for Medicaid members who need to get to and from Medicaid-covered medical services but

have no means of transportation. In parallel, the behavioral health, medical and dental ASOs actively assist individuals in locating their nearest healthcare providers.

Recent Changes

Recent improvements include stationing transportation providers at specific locations for urgent trips and hospital discharges, adding a member and provider portal with real-time GPS tracking for rides, and removing prior authorization requirements for certain older adults and those with chronic conditions to streamline access to transportation. Additionally, licensed clinicians can now schedule urgent methadone trips on behalf of their clients, including after hours and on weekends, addressing previous limitations regarding methadone clinic appointments.

Improvement Strategy

Efforts are ongoing to improve the member experience and improve operations, including close monitoring of performance by DSS staff and regular high-level meetings between DSS and NEMT leadership teams. Other efforts include enabling facilities such as nursing homes to transport their patients and others. Specifically, there are ongoing efforts to educate LTSS facilities on the requirements and process to become an NEMT provider and to be able to receive Medicaid payment for transporting their own patients and others. Improvements to the provider credentialing process and expanding provider recruitment are also underway. For additional information see June 2024 MAPOC presentation.

vii. Hospital Services

As referenced above, inpatient and outpatient hospital services are the largest component of expenditures for HUSKY Health, representing in total approximately $3 billion in payments to hospitals in SFY 2024, counting rate payments of approximately $2.4 billion and supplemental payments of approximately $600 million.

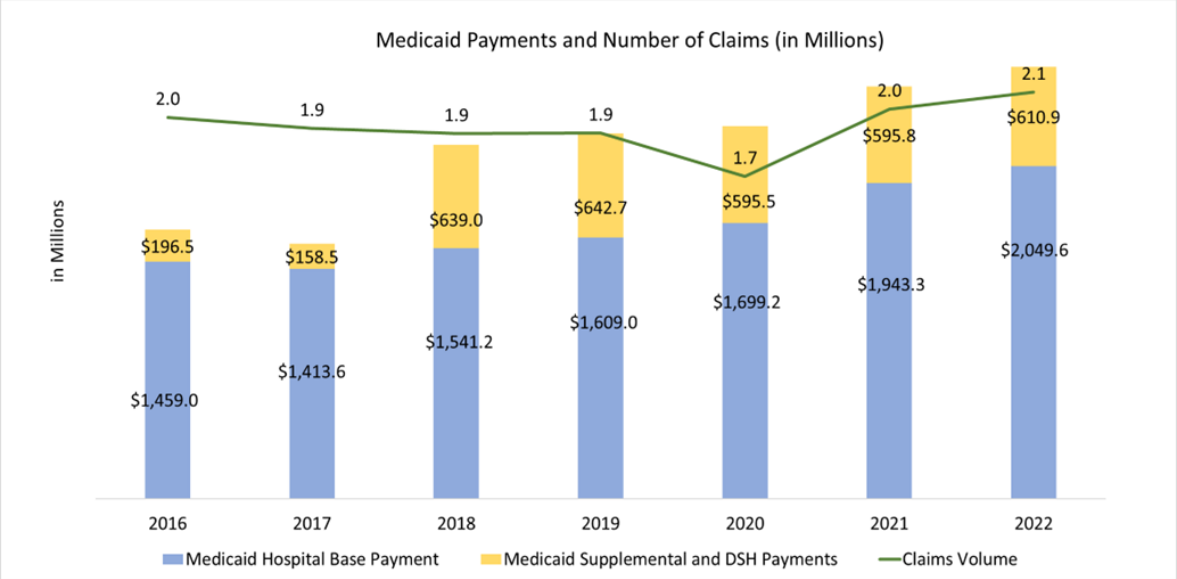
Specific aspects of services provided by hospitals or coordination with hospitals (including initiatives designed to coordinate care to reduce unnecessary hospital emergency department visits and inpatient hospital admissions) are referenced in various other sections of this report as relevant to particular areas, including, for example, care coordination, behavioral health, equity, cost containment, and LTSS.

Recent Changes

Hospital Settlement Agreement: Payments made by Medicaid to most hospitals is largely governed by the Hospital Settlement Agreement, which is in force from SFYs 2020–2026, expiring June 30, 2026. In brief the agreement: (1) settled hospitals' legal challenges to the first hospital user fee and certain Medicaid rates; (2) limited the state's exposure and improved state's financial stability; (3) provided predictability and fiscal stability for hospitals; and (4) provided benefits to the state and hospitals by accessing federal Medicaid matching funds through increased Medicaid base and supplemental payments. During the agreement, inpatient rate payments increased by 2% per year while most outpatient rate payments increased by 2.2% per year. The agreement prohibits the state from modifying the Medicaid payment methodology and establishes both the amounts of the supplemental payments (which increased from the amounts paid before the settlement agreement) and the user fees the participating hospitals are charged (which are gradually reduced during the term of the settlement agreement). In addition, the state cannot impose any mandatory value-based payment model that entails downside risk to hospitals for the life of the settlement agreement.

Hospital Payments Over Time: In part because of the rate increases and higher supplemental payments established by the settlement agreement, Medicaid payment to hospitals has risen significantly in recent years. Figure 31 shows the increases from Federal Fiscal Year (FFY) 2016 through FFY 2022, with the rate (or base) payments shown separately from the supplemental payments and disproportionate share hospital (DSH) payments. This figure also overlays the total number of Medicaid hospital claims, which shows that, while the total number of hospital claims has been fairly steady over time, the amount of payment has increased significantly, again reflecting the increases set forth in the settlement agreement.

Figure 31.



Hospital Quality and Utilization: These topics are addressed in several ways such as intensive case management, pediatric inpatient behavioral health payment models and Community Care Teams (CCT), each of which is described elsewhere in this report.

Hospital Community Benefit: Hospitals play an important role in their communities. In general, hospitals report their calculations of uncompensated care and their calculations of Medicaid underpayment (compared with the hospitals' calculation of their documented costs) as the largest portions of the hospital's benefit to their community in their Community Health Needs Assessments (CHNAs), which are required by the Affordable Care Act for nonprofit hospitals.

Hospital Payment Sufficiency: As noted above, in large part as a direct result of the settlement agreement, Medicaid hospital payments have increased significantly in recent years. Especially given the contrast between those payment increases and hospitals' assertions that Medicaid payment is still not sufficient even after these large increases, DSS is working closely with OHS (which publishes the annual hospital financial stability report) to understand the concerns raised by hospitals as well as to improve clarity and transparency related to how hospitals report this asserted underpayment as part of the community benefit in hospitals' CHNAs.

DSS and OHS have had extensive dialogue with CHA, multi-hospital health systems, and individual hospitals to understand the hospitals' assertions of Medicaid payment in more detail and explore various ways of calculating the impact of Medicaid payment on hospitals' finances. As referenced above, this report aims not to duplicate other reports being prepared by, or on behalf of, DSS. The purpose of the Medicaid rate study is to analyze how payment rates

compare to an available and relevant benchmark; phase 2 of the rate study looks at various categories of providers, including inpatient and outpatient hospital services. It is beyond the scope of this report to perform any analysis of payment sufficiency for hospitals or any other provider category.

Improvement Strategy

States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Hospital Global Budget Payment Model: Connecticut was selected as one of six states to participate in the CMMI AHEAD model federal grant, which aims to address total statewide healthcare costs, enhance primary care and support the state Medicaid program (along with Medicare fee-for-service, and participating commercial plans) to enter into a global budget payment system with voluntarily participating hospitals. Based on results from the Maryland Total Cost of Care model, the global budget payment system can reduce unnecessary hospital utilization, preserve quality, and facilitate hospital investment in care coordination and health-related social needs. DSS is working to implement AHEAD by designing a hospital global budget payment methodology and updating primary care value-based payments, as referenced above.

Hospitals' Proposal on Medicaid Community-Based Investment: Hospitals and related stakeholder groups have advocated for maintaining or increasing Medicaid hospital reimbursement, engaging multi-sector community-based partnerships to address root causes of poor health, and establishing a regional financing and accountability model. A full description of these proposals is found in the attached comments (see October 25, 2024, letter from the Connecticut Hospital Association).

viii. Health-Related Social Needs (HRSN)

Recent Changes

Similar to Social Determinants of Health (SDoH), which are social drivers in which people live that affect health and well-being, health-related social needs (HRSNs) are more specific social needs that affect an individual's health, such as a particular person's housing or food insecurity. HUSKY Health currently has one program specifically focused on HRSN, which is the Connecticut Housing Engagement and Support Services (CHESS) initiative that provides coordinated healthcare and housing services to individuals with mental health, substance use and other serious health conditions through Medicaid for individuals struggling with homelessness. DSS is preparing a separate report about CHESS in collaboration with DMHAS and DOH.

HUSKY Health also has several other categories of services that address HRSN in various ways, although each of these services primarily focus on clinical services and/or case management or similar services, including several current service categories (e.g., PCMH, PCMH+, InCK, BHH, ECC, VPP); several categories under active development or nearing implementation (e.g., maternity bundle payment, AHEAD hospital global budget methodology, behavioral health outpatient redesign), and others in exploration (e.g., UNHV, CHW, peer support specialists).

Improvement Strategy

On March 27, 2024, consistent with federal guidance, Connecticut submitted a section 1115 demonstration waiver, seeking federal authority to provide transition-related services for people who are incarcerated and certain services for individuals after release to assist with their transition to the community. Under this Justice-Involved (JI) waiver, subject to federal approval, the state will be able to claim Medicaid reimbursement for services provided up to 90 days before expected release for transition-related services as well as certain services for individuals after release to facilitate continuity of care. The JI waiver application also includes an HRSN component in which the state, upon federal approval, will provide specified housing supports and time-limited funding for housing to eligible individuals after release from incarceration. This initiative builds upon other states that previously received this federal approval (starting with California); their experiences will be carefully analyzed to maximize the effectiveness of Connecticut's program. DSS will also continue to monitor ongoing federal guidance on HRSN and other states' approvals for various types of HRSN section 1115 demonstration waivers, which have included housing, nutrition, and climate adaptations, among others.

As noted under the Hospital Services section of this report, CHA and various hospitals submitted comments to DSS in which they recommend consideration of a model that would involve Medicaid providing investment further upstream than HRSN to help promote health and prevent disease. DSS will continue to evaluate this and other proposals.

d. Coordination and Prevention

i. Care Management/Care Coordination

OHS oversees Connie, the Connecticut health information exchange, which allows participating providers to share health information. Connie already provides tools to improve coordination

for Medicaid members, including implementing an alert for providers to notify their patients if their eligibility deadline is coming soon, indicating which referrals to specialists have not been fulfilled, and enabling providers to refer members to community-based organizations. In collaboration with OHS, DSS is evaluating how to further leverage Connie to help improve care coordination for Medicaid members.

1. ASO Care Management

Recent Changes

HUSKY Health's ASOs operate intensive care management (ICM) and similar programs to assist members with finding and connecting to the services they need. There is a specific emphasis on individuals who have complex conditions and/or need complex sets of services. These areas include individuals with chronic conditions, those experiencing various barriers to care, and those not engaging with appropriate services. Overall, these programs have shown positive results in improving members' engagement in appropriate preventive care, reducing avoidable emergency department use, and reducing hospital admissions.

Improvement Strategy

Going forward, DSS, in collaboration with each ASO and other partners, will continue to evaluate the most effective ICM and other ASO care coordination and care management interventions. The Medicaid Landscape Analysis referenced above includes some recommendations that include considerations of expanding the role for ASO care coordination. DSS will also continue to evaluate the connections between ASO care coordination and provider care coordination (described below), including determining which intervention is the most effective in different contexts and in which contexts both systems work best together.

2. Provider Care Coordination

Recent Changes

HUSKY Health includes several initiatives that provide additional supports for providers to help coordinate care for HUSKY Health members. The broadest programs include PCMH and PCMH+, both of which are described above under the Medical – Primary Care section, because they increase care coordination provided by primary care providers, both private practices and

FQHCs. Similarly, the BHH and ECC models described in the Behavioral Health section above also support providers in coordinating care for their patients.

More directly, HUSKY Health reimburses behavioral health clinics for performing care coordination for children. HUSKY Health also covers Targeted Case Management (TCM) for individuals with chronic mental illness (administered by DMHAS) and for individuals with intellectual disabilities (administered by DDS). Also as a TCM category, DSS launched the Integrated Care for Kids (InCK) Model in New Haven, Connecticut, which is a child-centered local service delivery and state payment model intended to increase access to preventive care services and early intervention for behavioral and physical needs to reduce expenditures. InCK implements a federal CMMI model and will be evaluated in detail and, depending on its results in improving outcomes and containing cost growth, may be considered for potential adaptation or expansion in the future.

Improvement Strategy

DSS continues to evaluate the most effective ways to support care coordination for HUSKY Health members. Key areas include care coordination as an essential component of most of the primary care initiatives described above, including primary care payment reform (in general and Primary Care AHEAD), behavioral health outpatient redesign (including consideration of the CCBHC model), and various dental and HCBS initiatives also referenced above. Other care coordination efforts include the newer practitioner categories detailed below.

3. Newer Practitioner Categories

Recent Changes

Licensed Acupuncturist Services: Effective October 1, 2021, DSS added coverage for independent acupuncturists in the office setting under Medicaid. Acupuncturists licensed by DPH may enroll with HUSKY Health and provide acupuncture services, infrared and manual therapies.

Violence Prevention Professional (VPP) Services: Effective July 1, 2022, DSS added coverage for community violence prevention services provided by a certified violence prevention professional. Community violence prevention services are evidence-based, trauma-informed, supportive, and non-psychotherapeutic services provided by a VPP within or outside of a clinical setting for the purpose of promoting improved health outcomes and positive behavioral change,

preventing injury, recidivism and reducing the likelihood that individuals who are victims of community violence will commit or promote violence themselves.

Peer Support Specialists: Peer support specialists are individuals with lived personal or family experience recovering from a behavioral health condition and applicable training, experience and certification. While not covered separately by HUSKY Health, peer support specialists are included as practitioner types within certain behavioral health clinic services, certain SUD services, and as care coordination staff employed by Carelon, the behavioral health ASO.

Community Health Worker: Currently, CHNCT, the medical ASO, employs CHWs to assist with care coordination and outreach. As part of the JI waiver referenced above, DSS plans to include CHW services to assist people transitioning from incarceration. In addition, as required by state law, DSS consulted with certified CHWs, Medicaid beneficiaries and advocates to design a program to provide Medicaid reimbursement to CHWs. DSS established a CHW working group in collaboration with the CT Health Foundation. This working group, comprised of 15 members, including 5 CHWs and 10 individuals representing various CHW organizations, advocates, and Medicaid members, engaged in seven virtual meetings from May 2024 to July 2024 and provided feedback to DSS on various topics, including CHW scope of services, roles and responsibilities, safety, health equity, and workforce considerations. DSS is preparing a separate report based on this workgroup and continues to evaluate potential opportunities for engaging with CHWs.

Birth Doulas: See Maternity Services section above.

Improvement Strategy

DSS will continue to evaluate services described above to determine if there are opportunities to adjust and/or expand the role for these and similar practitioner types to improve outcomes and contain cost growth. DSS also monitors experiences in other states, including available research and guidance for best ways to incorporate these and other newer practitioner types.

e. Healthcare Workforce Development

Recent Changes

Providers and other stakeholders frequently emphasize the shortage of qualified individuals in healthcare practitioner roles. Providers note that these workforce shortages have resulted in

increased demand for higher practitioner wages, which puts financial strain on many categories of providers. Currently, DSS contributes to workforce development by paying hospitals Graduate Medical Education (GME) supplemental payments to help fund part of the resident physician education at teaching hospitals. Less directly, by paying for a wide variety of healthcare services and LTSS, HUSKY Health improves workforce development by enabling a career path for many individuals, especially rate structures or increases specifically targeted to improving wages and/or benefits, such as for nursing homes and ICF/IIDs.

Improvement Strategy

DSS is looking at available federal Medicaid opportunities to improve workforce capacity and quality, including other states that have received section 1115 demonstration waiver for workforce development initiatives (including training, education reimbursement, and loan forgiveness programs) and more broadly through Designated State Health Programs (DSHP). DSS will also collaborate with DPH to evaluate the state's student loan repayment program targeted for health shortage areas and explore potential opportunities for federal funding to continue this initiative. DSS welcomes ongoing dialogue with providers and other stakeholders to find ways to collectively invest in and improve the healthcare practitioner workforce.

4. CONCLUSION

DSS is proud of how HUSKY Health improves the lives of the over 1.3 million people served, some of which are described in this report. DSS embraces ongoing opportunities to improve the program. As noted above, there some ongoing challenges to improve access, quality, equity, and cost containment for certain areas of HUSKY Health. DSS is actively developing plans to address top priorities for improvement, while building on existing successes.

Acknowledgements

DSS is grateful for the contributions of numerous DSS staff as well as state agencies that reviewed and contributed to this report including DDS, DMHAS, DCF, OHS, DPH, as well as DSS' contracted partners, CHNCT, Carelon, BeneCare, and the UConn Center on Aging. DSS would also like to thank Dr. Doreen Agboh of the Yale National Clinician Scholars Program for her essential contributions.

APPENDIX 1: BRIEF SUMMARY OF WRITTEN COMMENTS

COMMENTER(S)	BRIEF SUMMARY OF WRITTEN COMMENTS
Connecticut Hospital Association (CHA), multi-hospital health systems, individual hospitals, and hospital-affiliated stakeholders	- Hospitals advocate increasing Medicaid reimbursement to hospitals, including annual rate increases after the settlement agreement expires, based on the hospitals' assertion that Medicaid underpays hospitals. - Support and strengthen the role of multi-sector local or regional health partnerships to address root causes of poor health and engage in upstream place-based prevention interventions (e.g., address food deserts), including a proposal to provide substantial and sustained new investment funding for the work of hospitals and community-led multi-sector partnerships. - Establish a regional financing and accountability framework using regional cost benchmarks. This proposal would call for returning 100% of the potential savings from such a framework to hospitals, primary care, and community-based organizations that result from achieving cost-savings related to long-term prevention, healthcare, and equity outcomes.
Members of MAPOC who are advocates for Medicaid members	- Improve access to services, including various eligibility operations topics and expand access to HCBS - Improve access for individuals with disabilities - Proposal to cover CHW services and other similar supports - Proposal to improve transparency
Non-hospital provider trade associations, individual provider organizations, and affiliates	- Commenters' assertions of insufficient payment and proposals to increase rates - Proposals to address insufficient healthcare workforce - Proposals to add or expand Medicaid coverage for various types of services (e.g., services of clinical pharmacists)
Former DSS Employee	- Proposals to improve transparency, quality measurement, and program integrity