Connecticut HUSKY Health:

Cost Drivers, Reform Agenda, Outcomes, and Recommendations for Future State

Presentation to the

Connecticut Fiscal Stability Commission

January 24, 2018

- Key messages
- Overview
- Cost drivers
- Reform agenda
- Documented outcomes
- Budget overview and financial trends
- Recommendations for future state

Key Messages

Key Messages

- HUSKY Health (Medicaid and Children's Health Insurance Program) is a major payer of health services and currently serves over **800,000** members (over 22% of the state population)

- **4 out of 10 births in Connecticut** are to mothers who are Medicaid members

- HUSKY Health has a unique, self-insured, managed fee-for-service structure and uses data analytics to inform policy and target services to members in need

Eligibility Category	Details
HUSKY A	Adults with incomes of up to 138% of FPL Pregnant women with incomes of up to 258% of FPL Children with incomes of up to 201% of FPL
HUSKY B/ Children's Health Insurance Program (CHIP)	Children with household incomes between 201% and 323% of FPL
HUSKY C	Older adults, individuals with disabilities, and refugees with incomes up to approximately 52% of FPL; waiver programs have higher thresholds
HUSKY D	Eligible adults age 19-64 with incomes up to 138% of FPL

HUSKY Health is **improving outcomes while controlling costs.**

Health outcomes and care experience are improving through use of data to identify and support those in greatest need, care delivery reforms and use of community-based services.

Provider participation has increased as a result of targeted investments in prevention, practice transformation, and timely payment for services provided.

Enrollment is up, but **per member per month costs are stable**. Connecticut has maximized use of federal funds. The **state share** of HUSKY Health costs **is stable.**

There remain **significant opportunities to address high cost, high need members** and **to make the program as efficient and effective as possible**:

- Implementation of regional health neighborhoods composed of Person Centered Medical Home (PCMH) practices, specialties, and non-medical services and supports
- Development of additional value-based payment strategies, with a focus on pharmacy purchasing
- Acceleration of efforts to serve people who need long-term services and supports in the community, as opposed to in institutional settings

HUSKY Health
Overview

HUSKY Health touches **everyone**.

Children. Working families and individuals. Older adults. People with disabilities. Your neighbor. Your cousin.

1 in 5 CT citizens is served by HUSKY Health.

4 in 10 Connecticut births are covered by HUSKY Health.

HUSKY Health . . .

- extends financial security from the catastrophic costs of a serious health condition
- enables people to stay well, through prevention, and to work
- promotes the health, well-being and school readiness of children
- supports independence in the community

HUSKY Health at a Glance

Critical source of economic security and well-being to over 800,000 individuals (22% of the population of Connecticut).

- Serves adults, working families, their children, their parents and their loved ones with disabilities.
- Covers an extensive array of preventative services (primary care through Person-Centered Medical Homes, dental and behavioral health coverage) as well as care coordination.
- Successful in improving quality, satisfaction and independence through prevention and integration.

Data driven.

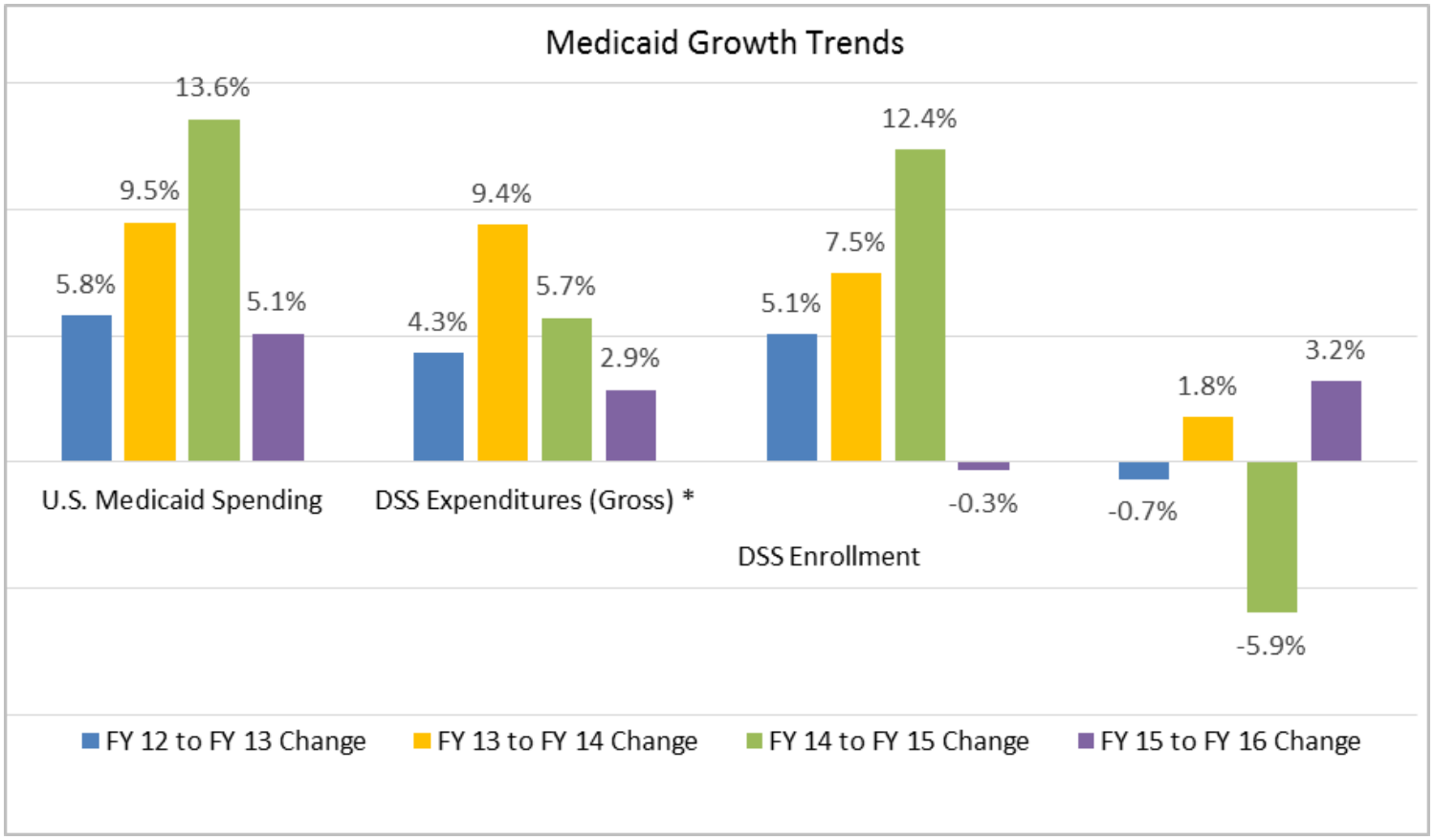
- Maintains a fully integrated set of claims data for all covered individuals and all covered services.
- Uses data analytics to direct policy-making, program development and operations.
- Employs predictive modeling to identify both those in present need of care coordination, and those who will need it in the future.

Already doing more with less.

- Total staffing has held relatively constant while the number of individuals served has dramatically increased.
- 59% of Connecticut Medicaid and 88% of CHIP (HUSKY B) expenditures are federally reimbursed.
- Health expenditures (77% of department budget) are increasing based on caseload growth, but trends in per person costs are stable and quality outcomes have improved.

Comparison with National Trends

- All states SFY 2017 Medicaid growth is estimated at 6.1% per NASBO.
- SFY 2017 DSS gross Medicaid expenditure growth was minimal at 1.7%; PMPM computations should be flat or negative.



** Expenditures are net of drug rebates and include DMHAS' behavioral health costs claimable under Medicaid.*

Comparison with National Trends

- *Health Affairs'* June 2017 issue reported that Connecticut's Medicaid program led the nation in controlling cost trends on a per enrollee basis for the 2010-2014 period.

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

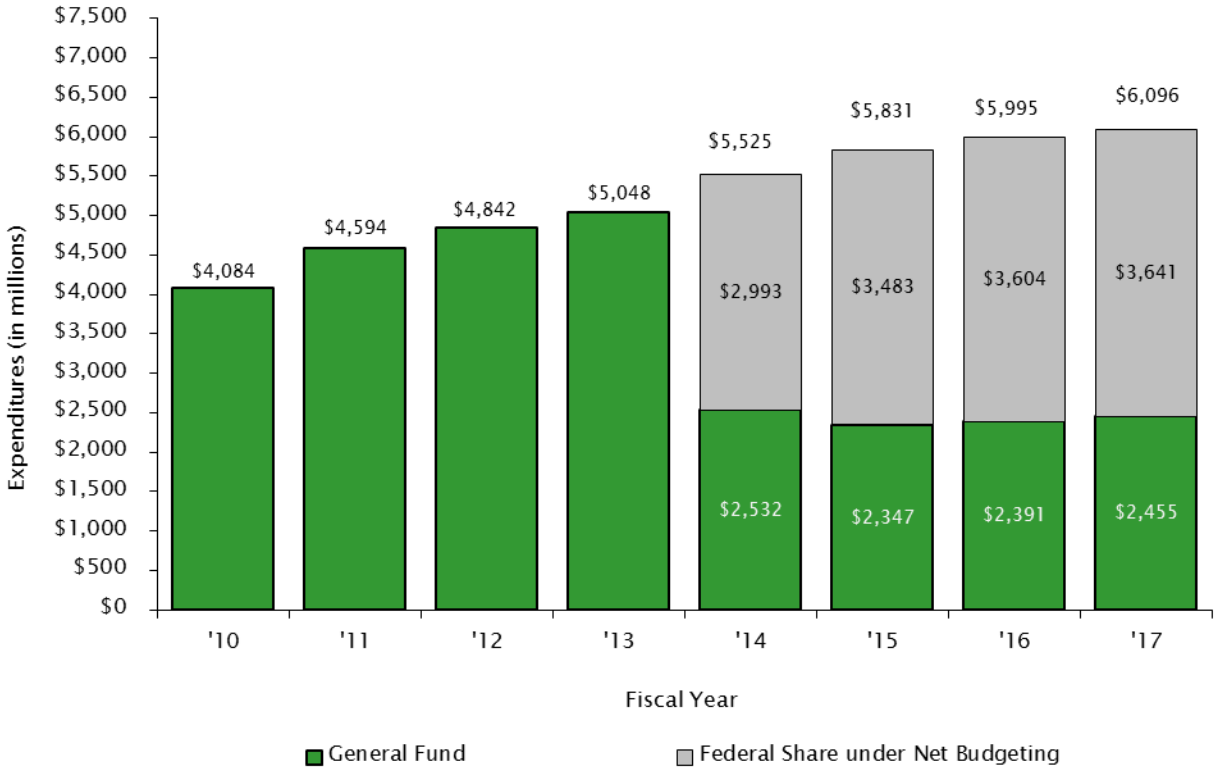
- Overall and in Connecticut, Medicaid tracked lower nationally than both private health insurance and Medicare in the cost trend comparisons.

Federal and State Share of Medicaid

CT's state share of Medicaid costs have dramatically stabilized.

The net state share of costs was lower in SFY 2017 than it was in SFY 2014.

The federal share has increased to 59%, up from 50% pre-ACA, due to enhanced federal funding for HUSKY D.



Medicaid Share of CT Budget

- In SFY 2016, the "all states" average Medicaid expenditures as a percentage of total State expenditures:
  - 28.7% (SFY 2009 – 21.9%)
- Connecticut's SFY 2016 Medicaid expenditures as a percentage of total State expenditures:
  - 22.7% (SFY 2009 – 27.9%)
- CT peer averages:
  - Maine - 33.0%
  - Massachusetts - 24.7%
  - New Hampshire - 33.6%
  - New York - 31.9%
  - New Jersey - 25.0%
  - Rhode Island - 29.8%
  - Vermont - 29.5%

Per the most recent 2017 National Association of State Budget Officers (NASBO) State Expenditure Report (SFY 2009 data from the 2010 report)

Conceptual framework

DSS and its state agency partners (DCF, DDS, DMHAS) are motivated and guided by the Centers for Medicare and Medicaid Services (CMS) "Triple Aim":

- improving the patient experience of care (including quality and satisfaction)
- improving the health of populations
- reducing the per capita cost of health care

We are also influenced by a value-based purchasing orientation. The Centers for Medicare and Medicaid Services (CMS) define **value-based purchasing** as a method that provides for:

Linking provider payments to improved performance by health care providers. This form of payment holds health care providers accountable for both the cost and quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best-performing providers.

Cost Drivers

Key cost drivers for Medicaid include the following:

- "high need, high cost" individuals with complex needs
- individuals who receive long-term services and supports (LTSS)

High Need, High Cost Individuals

Using dates of services in CY 2014 and stratifying by child (0-20) and adult (21 +), the Administrative Services Organizations were asked to provide the department the following information:

1. Highest 10% members by cost, excluding nursing home (NH) residents
2. Highest 10% of members with hospital admission
3. Highest 10 % of members with ED utilization
4. Total unduplicated members from a, b, & c

Hospital Inpatient Conditions Adults & Children

Inpatient Conditions	Total Adults admits: 7,457	Total Children admits: 3,315
Infectious/Neoplasms/Nutritional/ Diseases of Blood	1,459 (20%)	419 (13%)
Mental Disorder	1,413 (19%)	669 (20%)
Diseases of Nervous/Circulatory/Genitourinary System	1,251 (17%)	264 (8%)
Diseases of Respiratory/Digestive	1,627 (22%)	654 (20%)
Pregnancy	100 (1%)	453 (14%)
Disease of Skin/Musculoskeletal	351 (5%)	154 (5%)
Ill-defined conditions/Injury&Poisoning	1,259 (17%)	702 (21%)

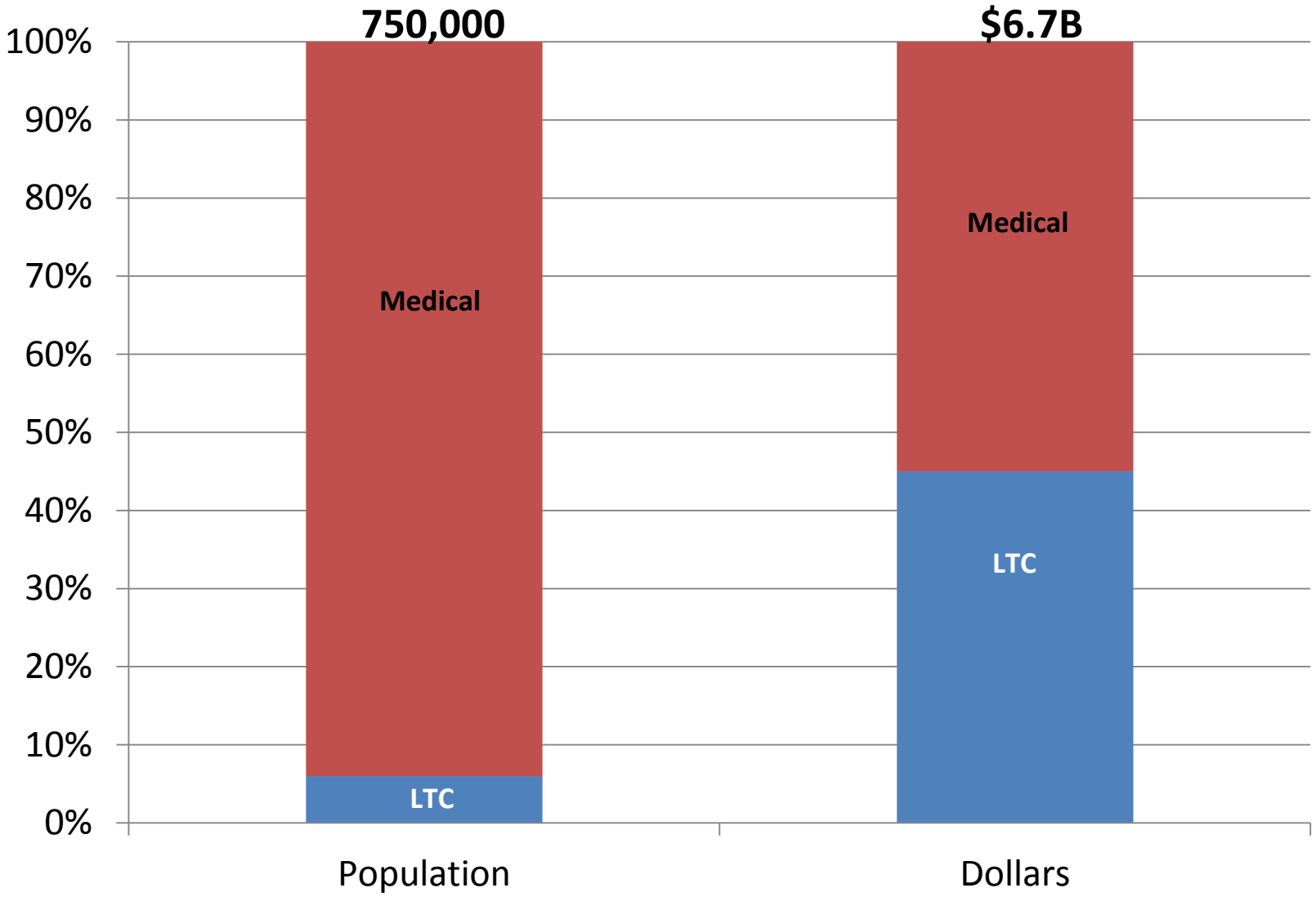
Recipients of LTSS

Individuals who receive long-term services and supports:

- A relatively small number of individuals use LTSS, but their **costs are a significant proportion of the Medicaid budget**

- Individuals who use LTSS typically have **high needs and high costs** and **benefit from coordination** of their services and supports

- Average per member per month **costs are less in the community**.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Medical
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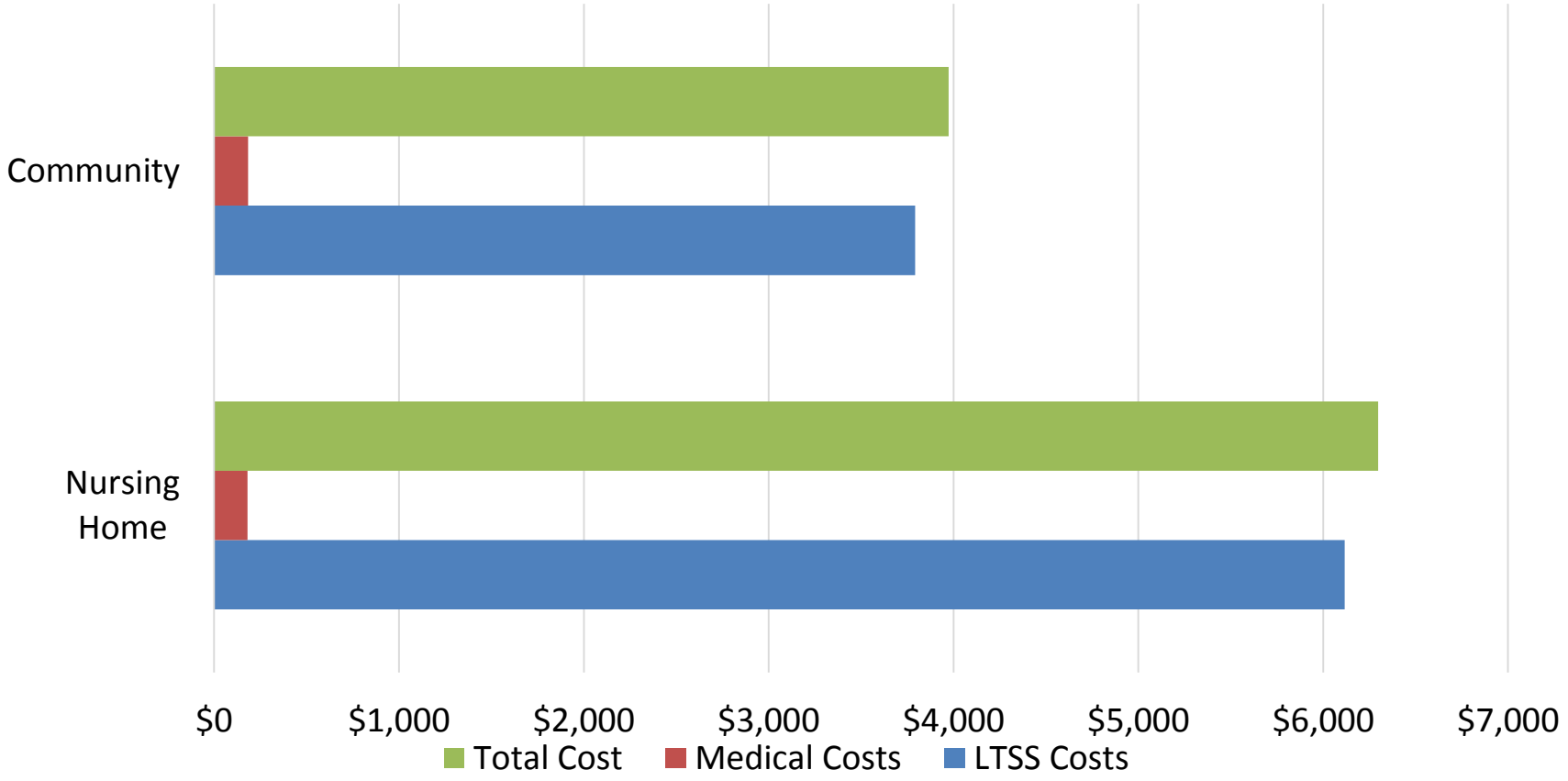
A comparison of average community and institutional costs for individuals at nursing home level of care (2012)



Connecticut Medicaid Reform Agenda

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

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

Improving access to primary, preventative care through . . .	• **extensive new investments in primary care (PCMH payments, primary care rate bump, EHR payments)** • **comprehensive coverage of preventative behavioral health and dental benefits**
Coordinating and integrating care through . . .	• ASO-based Intensive Care Management (ICM) • PCMH practice transformation • DMHAS-led behavioral health health homes • Money Follows the Person "housing + supports" approach and Innovation Accelerator Program • PCMH+ shared savings initiative

Re-balancing long-term services and supports (LTSS) through . . .	**A multi-faceted Governor-led re-balancing plan that includes:** • **Transitioning institutionalized individuals to the community with housing vouchers and services** • **Prevention of institutionalization** • **Nursing home "right sizing" (diversification of services) and closure** • **Workforce initiatives** • **Consumer education**
Moving toward Value-Based Payment approaches through . . .	• Hospital payment modernization • Pay-for-performance initiatives • PCMH+ shared savings initiative

Documented Outcomes

HUSKY Health analyzes its outcomes through the following means:

- Use of a broad array of HEDIS and hybrid measures
- Use of CAHPS and mystery shopper approach
- Geo-access analyses of provider participation
- Provider surveys
- Review of financial trends: overall expenditures and per member per month spend, stratified across all HUSKY Health coverage groups

What relevant results do we see in Connecticut, related to our Person-Centered Medical Home initiative?

- PCMH practices achieved better results than non-PCMH practices on measures including, but not limited to ambulatory ED visits and asthma ED visits

- Immediate access to primacy care visits, for both adults and children, has increased

What relevant results do we see in Connecticut, related to our Intensive Care Management (ICM) initiatives?

- Over CY'16, Connecticut Medicaid's medical ASO, CHNCT:
  - **reduced emergency department** (ED) usage for members engaged in the CHNCT ICM program **by 19.25% and inpatient admissions by 43.46%**
  - **reduced readmissions by 53.57%** for those members who received Intensive Discharge Care Management (IDCM) services

- Over SFY'17, through a range of strategies (Intensive Care Management, behavioral health community care teams) and in cooperation with the Connecticut Hospital Association, **the Emergency Department visit rate was reduced** by:

  - 2.38% for HUSKY C
  - 4.60% for HUSKY D

Over SFY'17:

- Inpatient days per 1,000 member months (MM) decreased by 1.3%
- The average length of stay decreased by 2.9%
- Utilization per 1,000 MM for emergent medical visits decreased by 1.1%
- Utilization per 1,000 MM for non-emergent medical visits decreased by 7.3%

Budget Overview and Financial Trends

Budget Overview and Trends

What trends are we seeing?

- **Cost trends** in select service categories **align with strategic objectives.**
- The state share of HUSKY Health costs are stable while the **federal share has increased**.
- Total expenditures have increased due to increases in enrollment, but **per member per month costs have remained remarkably steady over time**.
- HUSKY Health's **financial trends compare very favorably with national Medicaid trends**.

DSS Budget at a Glance

- Programs supported include:

  Medicaid, CHIP (HUSKY B), SNAP, TFA, Child Support, State Supplement (AABD), SAGA, Energy Assistance, Community Action Agencies

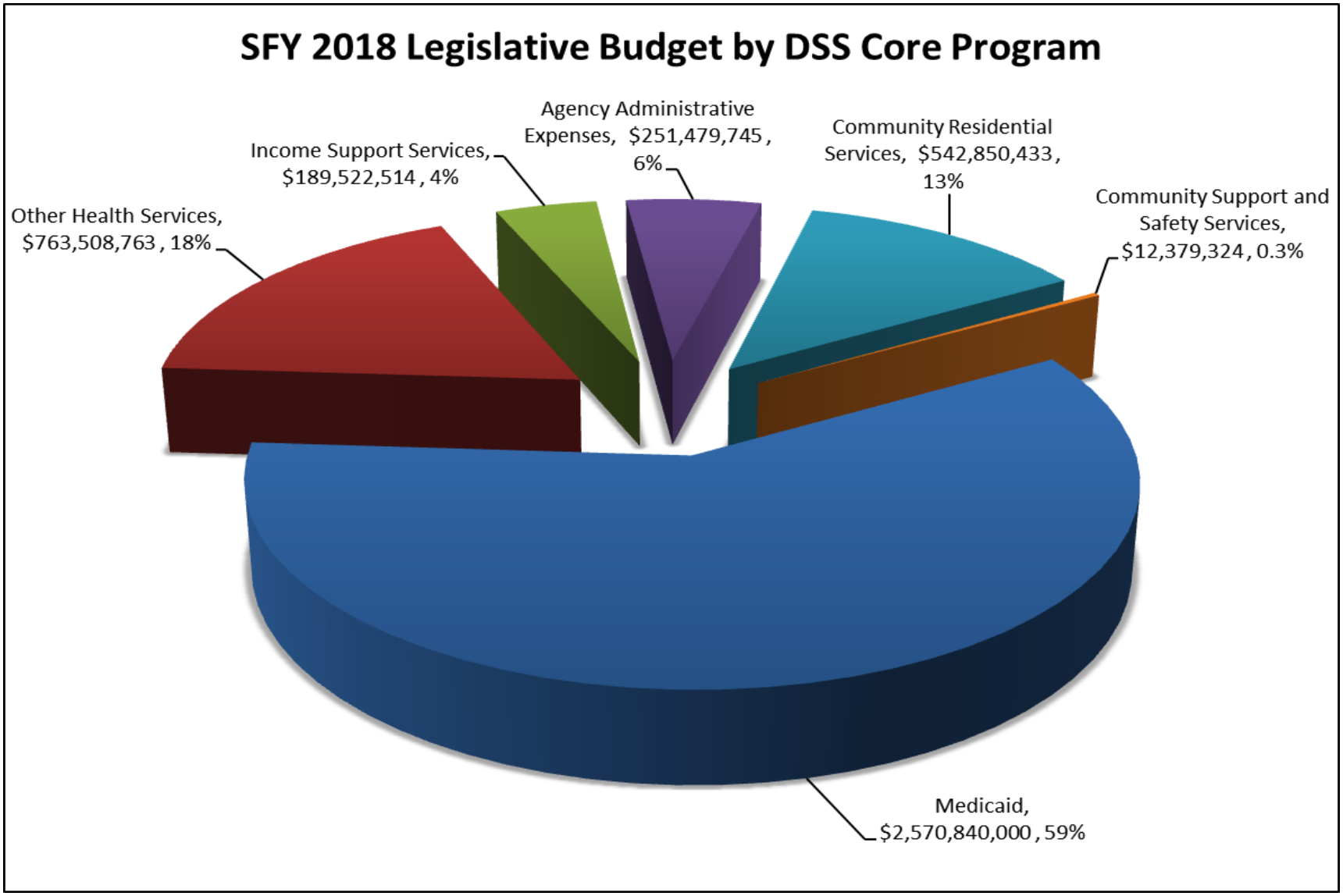
- SFY 2017 staffing costs:
  - $ 116.6 m
- Major operating expenses:
  - Estimated 2017 expense: $133.5 m
  - Operating Contracts: 87%
  - Facilities & Operational: 13%
- Administrative cost ratio:
  - 3.45% (includes field eligibility staff)

- Program outcome highlights:
  - Application processing timeliness
  - SNAP improvements
  - Stable Medicaid cost trends and enhanced outcomes

- SFY 2018 budget:
- **Total:**
  - SFY 18 $4.33 b (net); $8.07 b (gross)
- **Program:**
  - SFY 18 $4.08 b (net); $7.82 b (gross)
- **Administrative:**
  - SFY 18 $251.5 m

- Federal reimbursement:
  - 59% - Medicaid program costs
  - 75% - Medicaid systems and eligibility (staff & contracts), & new IT system operational costs
  - 50% - Medicaid administrative costs
  - 50% - SNAP administrative support
  - 66% - Child support
  - 85 to 90% - IT systems development
  - 88% - CHIP (HUSKY B)
  - 100% - TANF administrative support

DSS Budget Overview



HUSKY Health Financial Snapshot

Programs supported:

Medicaid, HUSKY B (Children's Health Insurance Program), long-term services and supports

SFY'18 proposed program budget:

- $3.34 billion (appropriated state share)
- $7.07 billion (total)

SFY 2017 actual staffing costs:

$9.1 million

Estimated program federal reimbursement:

59% - Medicaid, 88% - HUSKY B (CHIP)

Estimated administrative federal reimbursement:

75% for systems, eligibility, MFP, specialized medical staff; 50% for all other activities

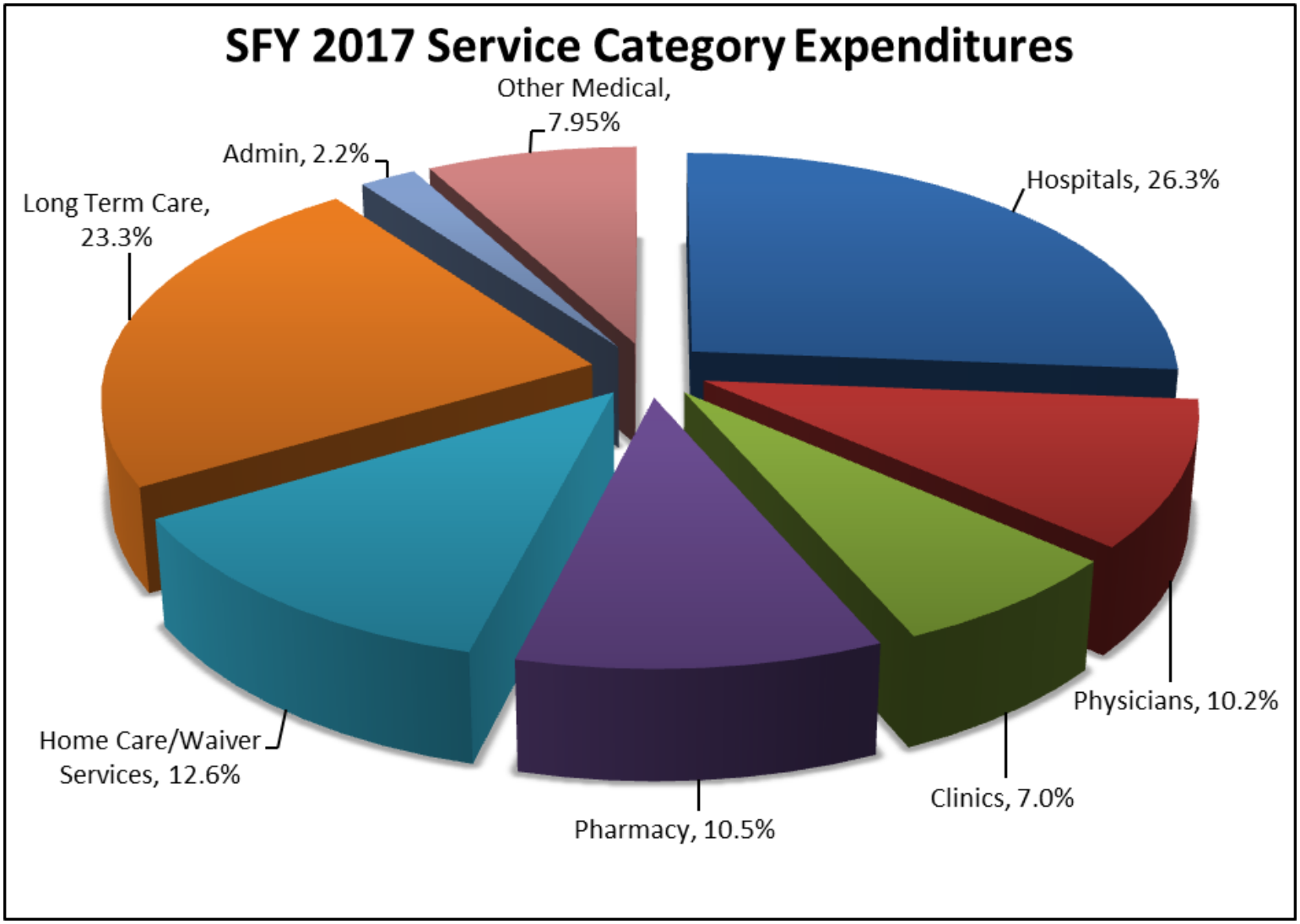
Program outcome highlights:

- Supporting members in accessing primary care and avoiding use of the ED through ICM, PCMH, and comprehensive coverage of behavioral health and dental services
- Integrating care through initiatives including DMHAS health homes and PCMH practices
- Rebalancing long-term services and supports
- Supporting providers through primary care investments, Person-Centered Medical Home initiative, and streamlined administration

Medicaid Administrative Costs

- Recent MACPAC report for FFY 2016 cites CT Medicaid administrative costs at 5.73%, above the national average of 4.56%.
- The MACPAC approach includes costs associated with all eligibility staff and eligibility systems operations and development.
- Once these eligibility costs are removed, the MACPAC adjusted admin load for CT would be 3.2% which is actually under the national average of 3.4%, if a similar adjustment is made to all other states.
- As MCO administrative costs and profit are built into the overall capitation rates and are likely claimed as program expenses, we would compare even more favorably to other states if MCO administrative costs were considered.

Medicaid Service Categories



Medicaid by Service Category

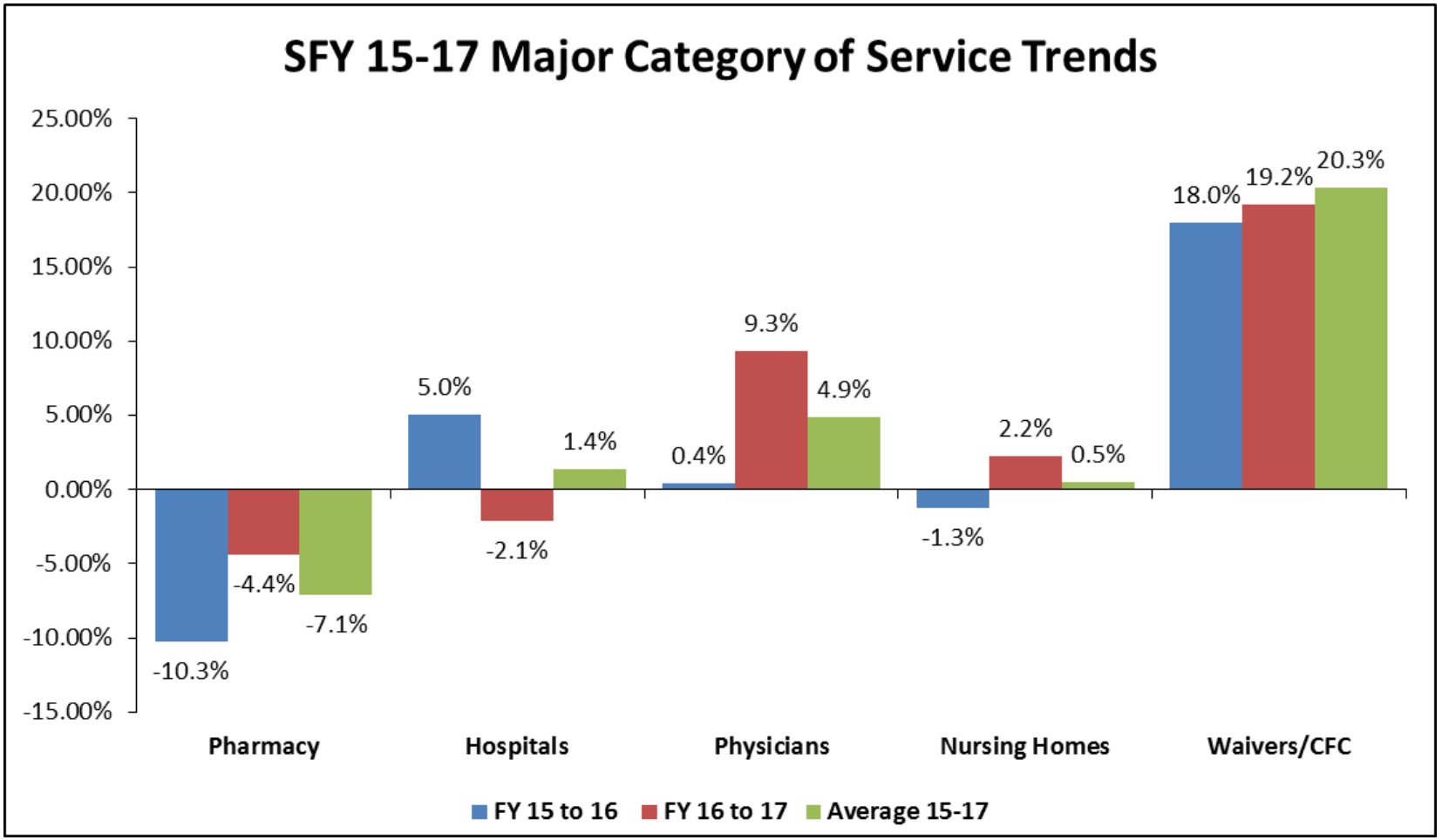
- Category of services trends in major areas

- Rebalancing long term supports and services (LTSS)
  - Investment in long term services and support waivers
  - Stability in nursing home costs

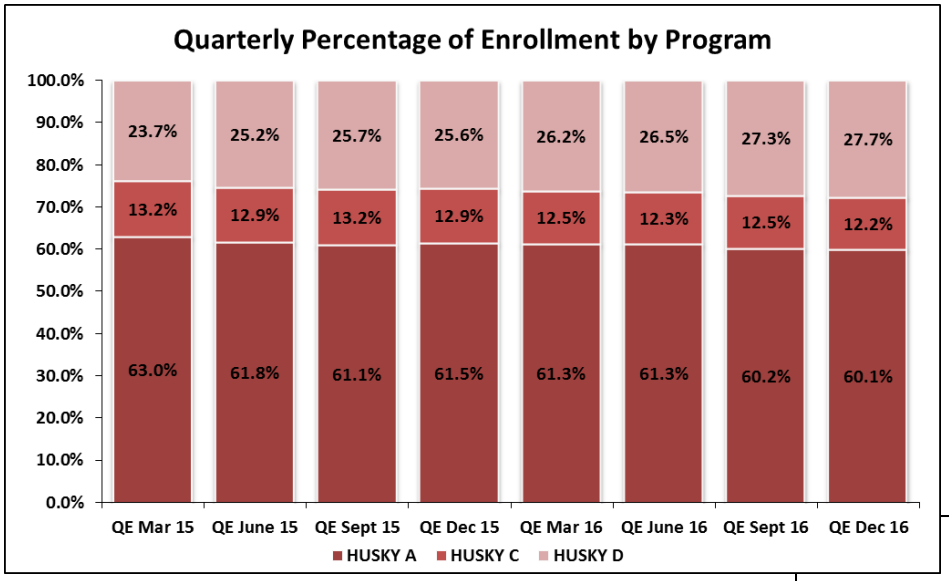
- Payment reform/cost controls
  - Stability in net pharmacy services
  - Stability in hospital services

- Service investments
  - Increase in physician services

Medicaid by Service Category

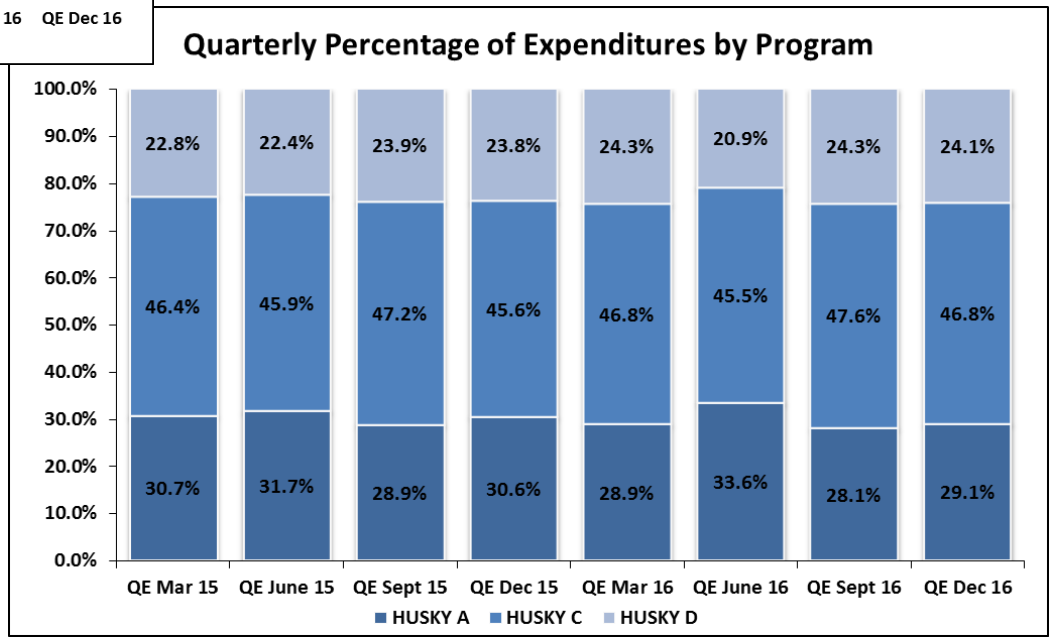


Medicaid Enrollees & Expenses

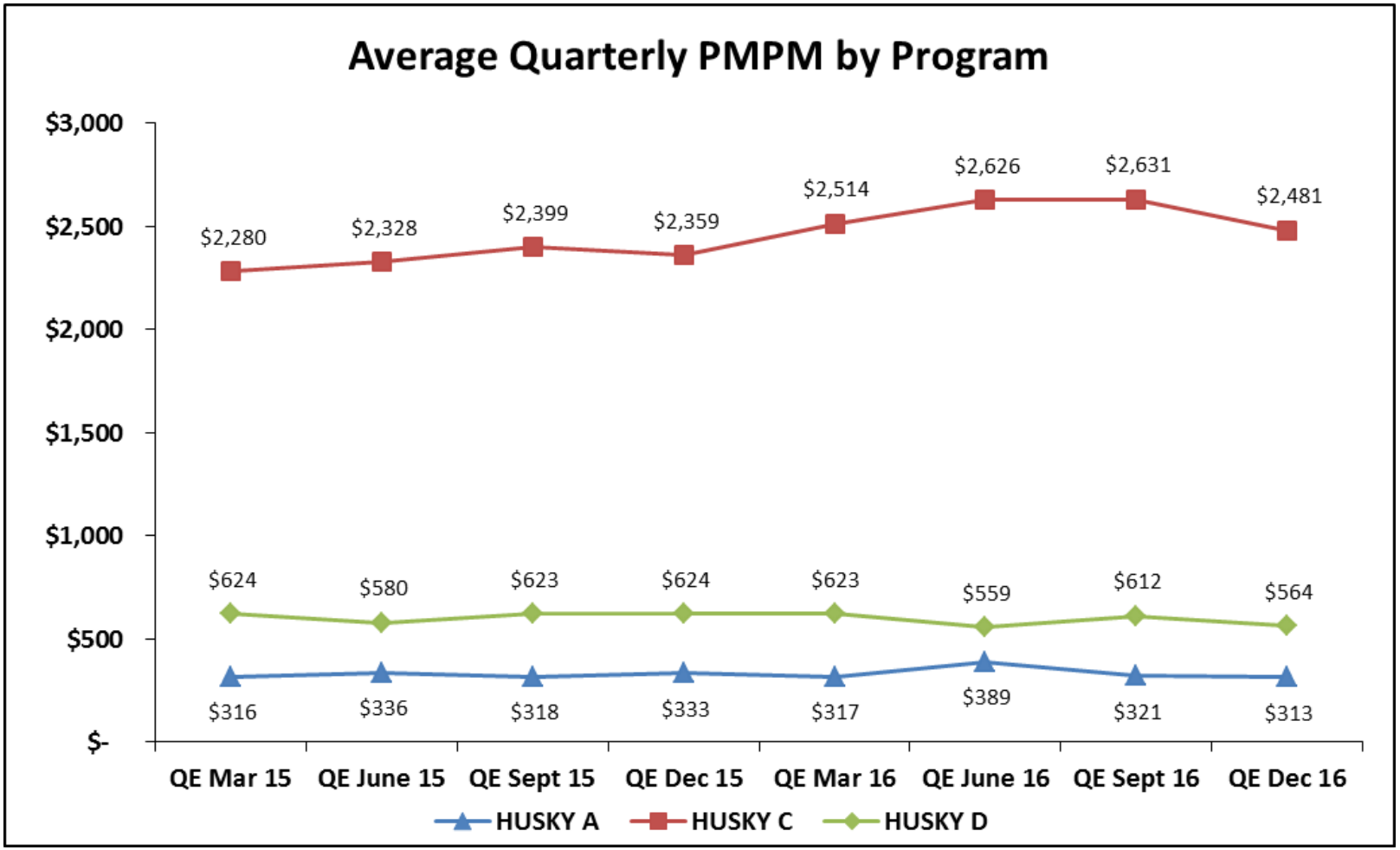


HUSKY A – Families and children
HUSKY C – Aged and disabled
HUSKY D – ACA single adults

- Children and families are 60% of enrollees, but only 29% of costs
- Aged and disabled are 12% of enrollees and 47% of costs
- Single adults are 28% of enrollees and 24% of costs

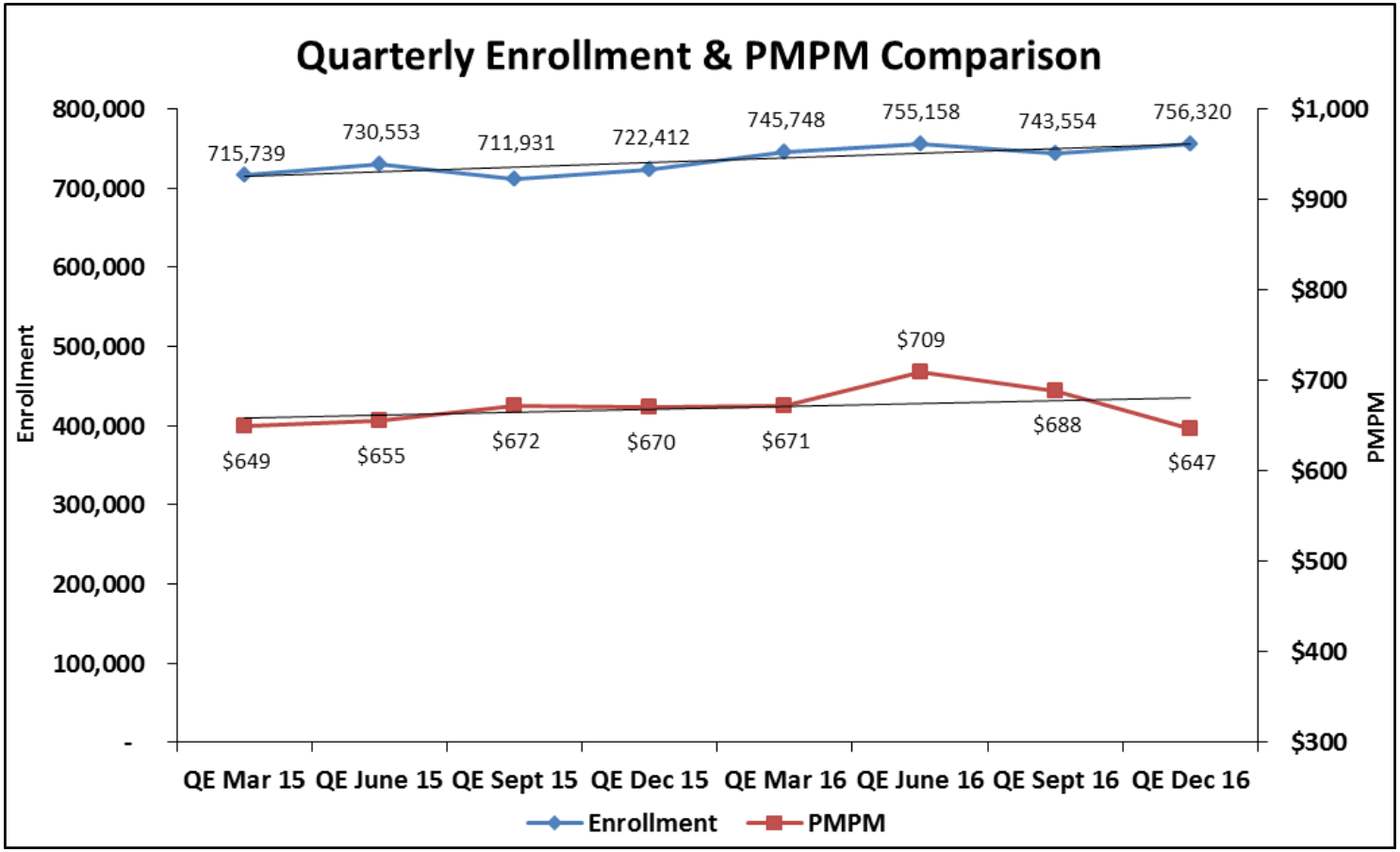


PMPM Trends (cont.)



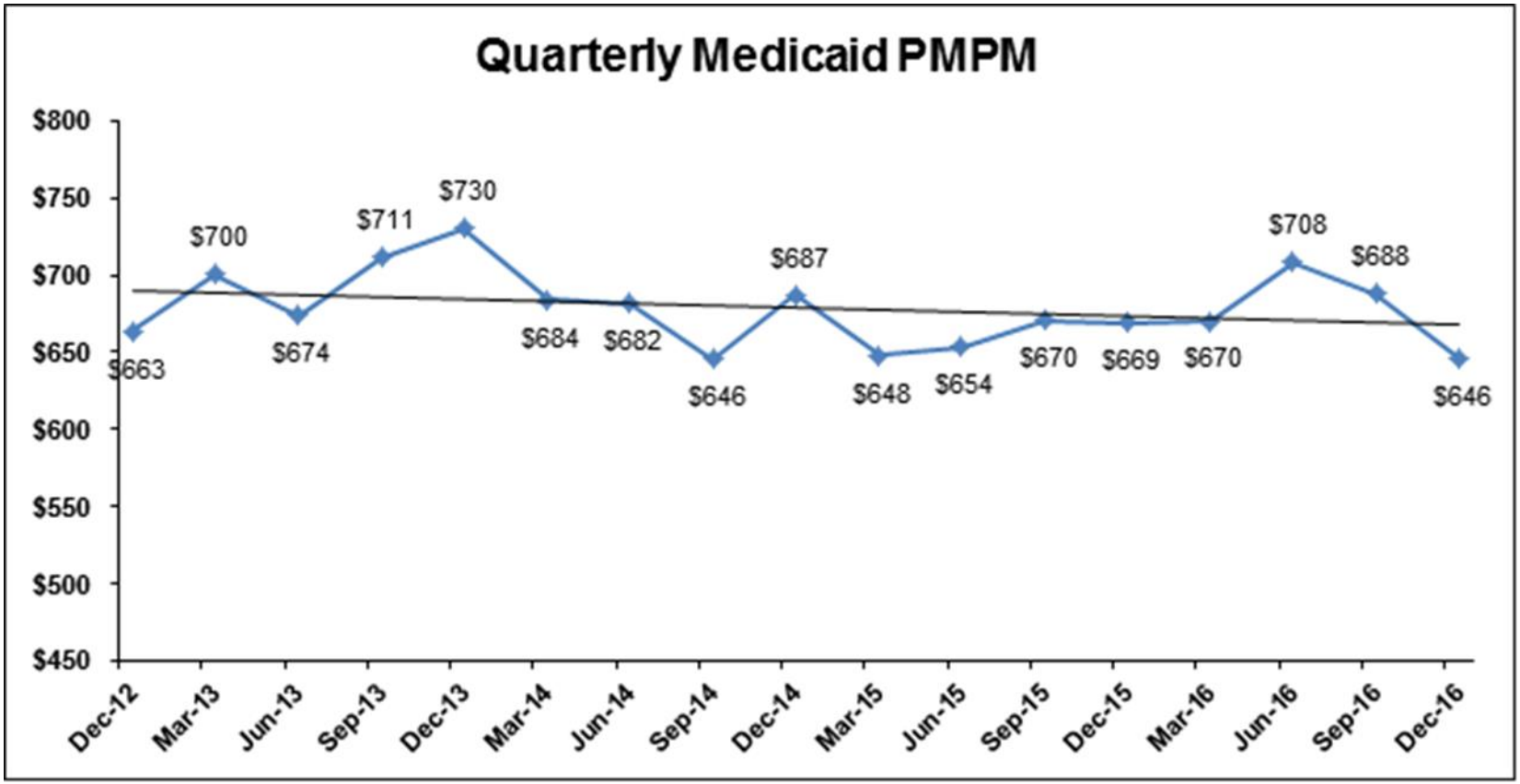
While the PMPM for HUSKY C (services for older adults and people with disabilities) has increased, HUSKY A and D have been stable or decreased.

Enrollment and PMPM



Total expenditures have generally increased due to the increase in enrollment, but per member per month costs have remained remarkably steady.

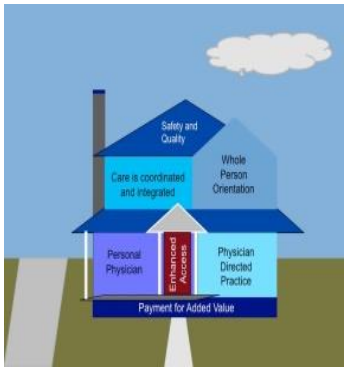
PMPM Trends



Quarterly per member, per month (PMPM) trends have remained stable under the Department's self-insured, managed fee-for-service model.

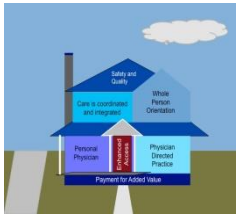
Long-Term Strategies for Cost Containment: The Future State

HUSKY Health 2017 and ongoing



Implementation of neighborhoods composed of PCMH practices, specialties, community health workers and non-medical services and supports.

Development of additional value-based payment strategies



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PCMH+

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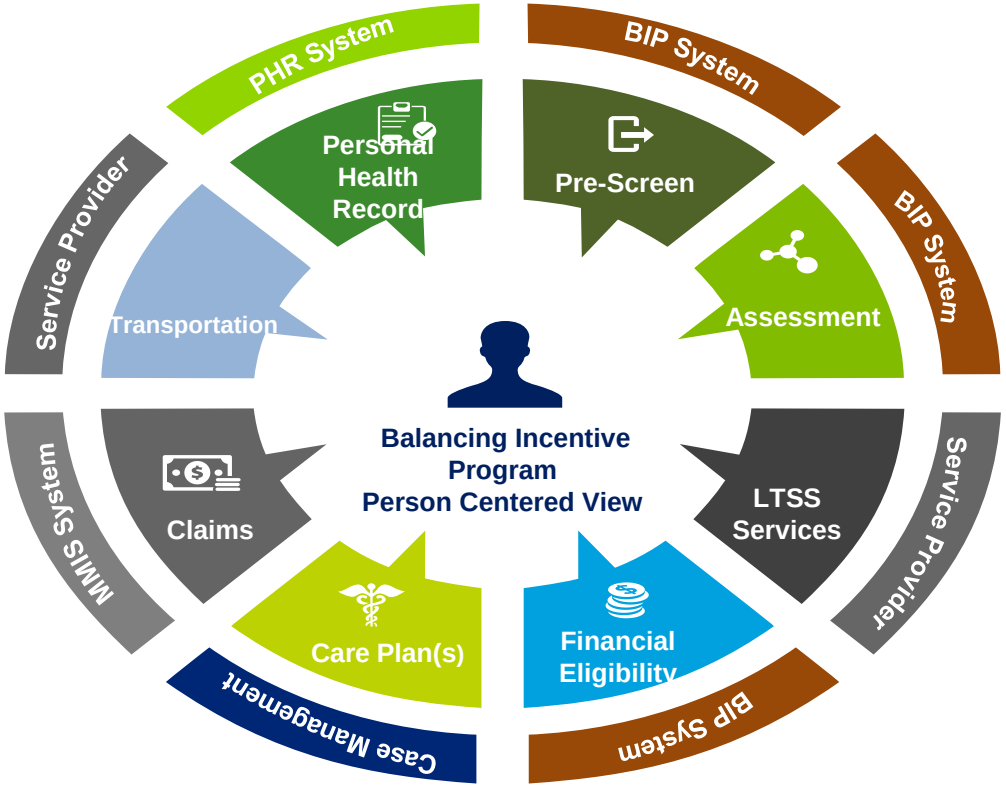
PCMH enhanced fees and performance payments

Upside-only shared savings arrangements

Value-based pharmacy purchasing

Episodes of care



Acceleration of efforts to serve people in the community, as opposed to in institutional settings.

HUSKY HEALTH CONNECTICUT

Appendix

Key Terms

Term	Acronym	Detail
Administrative Services Organization	ASO	DSS has contracted with four organizations (CHN, Beacon, Benecare and Logisticare) to act as statewide ASOs. The ASOs perform many traditional member support functions , but are also responsible for data analytics and ICM.
Behavioral health home	BHH	DMHAS and DSS have partnered to implement this new means of integrating behavioral health, medical care and social service supports for individuals with Serious & Persistent Mental Illness.
Expansion group	HUSKY D	Connecticut's Medicaid expansion group includes adults at 18-64 who are not otherwise eligible for another Medicaid coverage group.
Fee for Service	FFS	A method in which doctors and other health care providers are paid for each service performed. Examples of services include tests and office visits.
Intensive Care Management	ICM	A set of services that help people with complex health care needs to better understand and manage their care.
Long-term services and supports	LTSS	Long-term services and supports (LTSS) are a spectrum of health and social services that support elders or people with disabilities who need help with daily living tasks.
Pay-for-performance	P4P	P4P rewards health care providers for attaining targeted service goals, like meeting health care quality or efficiency standards.
Person-Centered Medical Home	PCMH	PCMH is a model for the organization of primary care that ensures effective delivery of the core functions of primary health care.
Person-Centered Medical Home Plus	PCMH+	MQISSP is a Connecticut Medicaid initiative under which DSS will enter into shared savings arrangements with FQHCs and advanced networks.
Value-Based Payment	VBP	VBP links provider payments to improved performance on quality measures.

Past, Present and Future

	Past	Present	Future
Administrative/ financial model	A mix of risk-based managed care contracts and central oversight	Self-insured, managed fee-for service model; contracts with four Administrative Services Organizations (ASOs)	Self-insured, managed fee-for-service model that incorporates health neighborhoods and Value-Based Payment (VBP) approaches
Financial trends	Double digit year-over-year increases were typical	Overall expenditures are increasing proportionate to enrollment; per member per month spending is trending down	Quality-premised VBP strategies will enable further progress on trends
Data	Limited encounter data from managed care organizations	Fully integrated set of claims data; program employs data analytics to risk stratify and to make policy decisions	Data match across human services and corrections data sets will enable more intelligent policy making

	Past	Present	Future
Member experience	Members had different experiences depending on which MCO oversaw their services; MCOs relied upon traditional chronic disease management strategies	ASOs provide streamlined, statewide access points and Intensive Care Management; PCMH practices enable coordination of primary and specialty care; health homes enable integration of medical, behavioral health and social services	Health neighborhoods will address both health needs and social determinants of health (e.g. housing stability)
Provider experience	Provider experience varied across MCOs; payment was often slow or incomplete	ASOs provide uniform, statewide utilization management and ICM; providers can bill on a bi-weekly basis	Consideration of migration to health neighborhood self-management of provider relationships