



Financial Trends in the Connecticut HUSKY Health Program - Transparency, Sustainability and COVID Impacts

Presentation to the
Medical Assistance Program Oversight Committee

January 8, 2021



- **Supporting transparency and sustainability**
 - The Department of Social Services (DSS) continues to demonstrate its commitment to these important tenets through this annual update, as well as monthly distribution of financial information to MAPOC and OFA legislative staff.
 - Our joint efforts have fostered a greater understanding of the financial position and achievements of CT's HUSKY Health program.
 - Medicaid finance trends will also be a focus of the Executive Order 6 Transparency Board that is being convened this month by DSS.



- Brief program context
- Transparency and sustainability benchmarks
 - Administrative expenses
 - Category of service alignment
 - Per member per month cost trends
 - State share of Medicaid expenses
 - Medicaid share of the total CT state budget
- Recap of financial results
- COVID-related financial impacts



COVID-19 has complicated the analysis of HUSKY Health financial trends:

- COVID-19 began to impact the utilization of services in the March 2020 quarter.
- There has been a significant impact on cost trends in many service areas.
- Trends for SFY 2020, the focus of this update, will be affected, complicating historical comparisons.
- Additional information on COVID-19 financial impacts by service category will be provided later in the presentation.

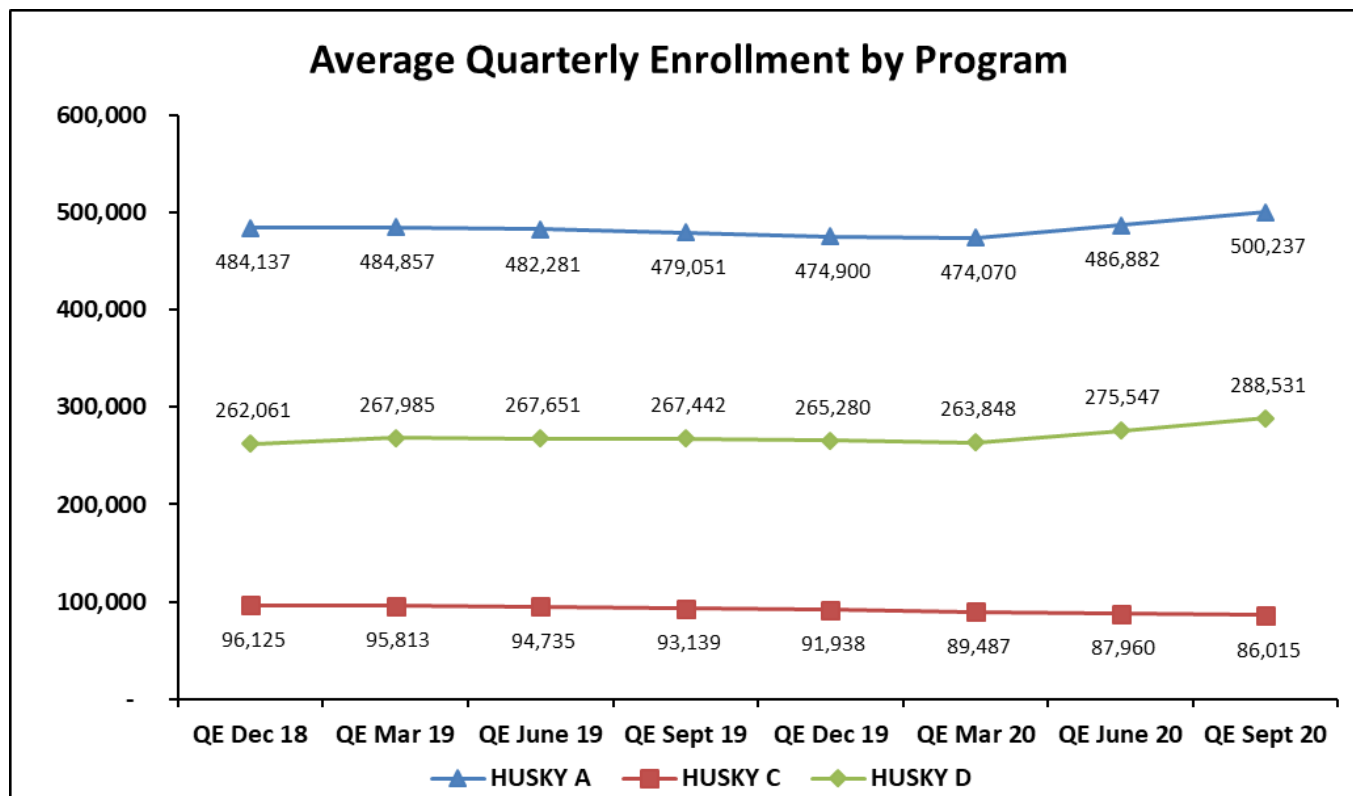


Brief Program Context



- Connecticut HUSKY Health (Medicaid and CHIP) currently serves 912,600 individuals as of November* (approximately 25% of the state population).
- Connecticut is a Medicaid expansion state, and optimized use of many other aspects of the Affordable Care Act (preventive services, health homes, long-term services and supports options).
- By contrast to many other Medicaid programs, Connecticut uses a self-insured, managed fee-for-service approach.
- The COVID-19 public health emergency has resulted in increased participation in HUSKY Health, but has also affected service utilization, both of which affect the financial trends presented.

*Excludes Medicare Savings Program (MSP) members who are not dually enrolled in both Medicare and Medicaid.



HUSKY A – Families and children

HUSKY C – Aged and disabled

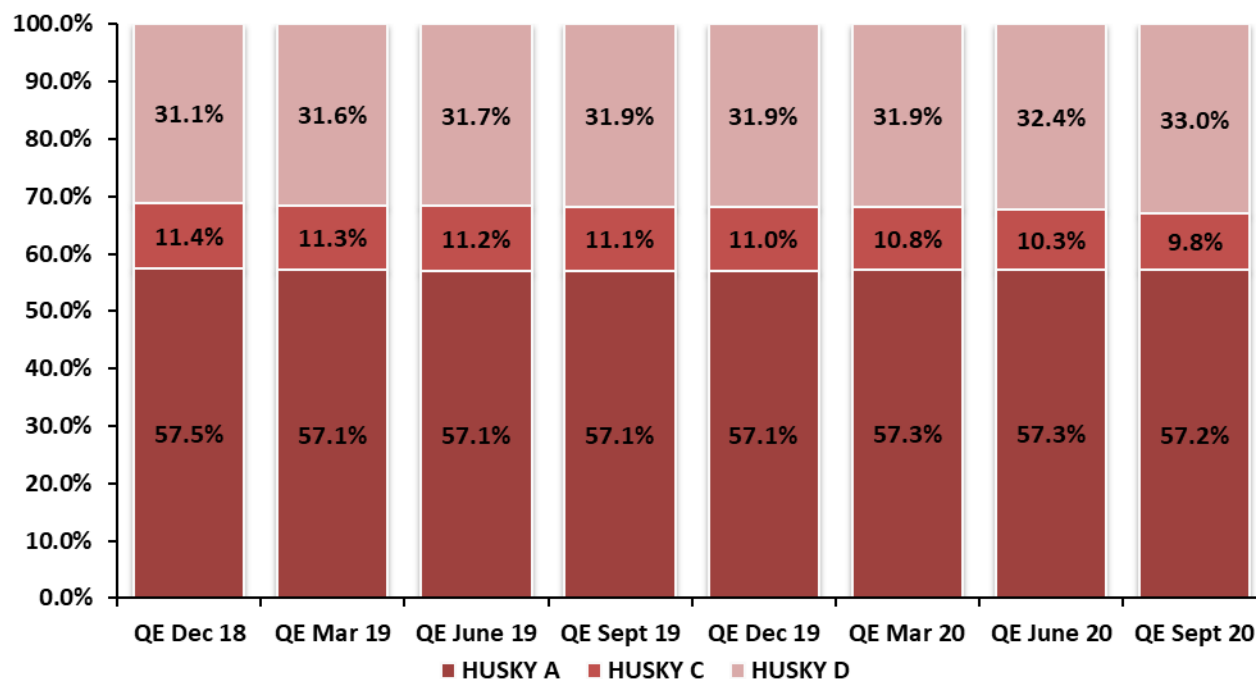
HUSKY D – Affordable Care Act (ACA) expansion, childless adults

Total average HUSKY Medicaid enrollment for the quarter ending Sept. 2020 was close to 875,000, with an additional 19,800 enrolled under HUSKY B.

Significant HUSKY D enrollee growth has contributed to an increasing share of overall Medicaid enrollees as evidenced on the next slide.



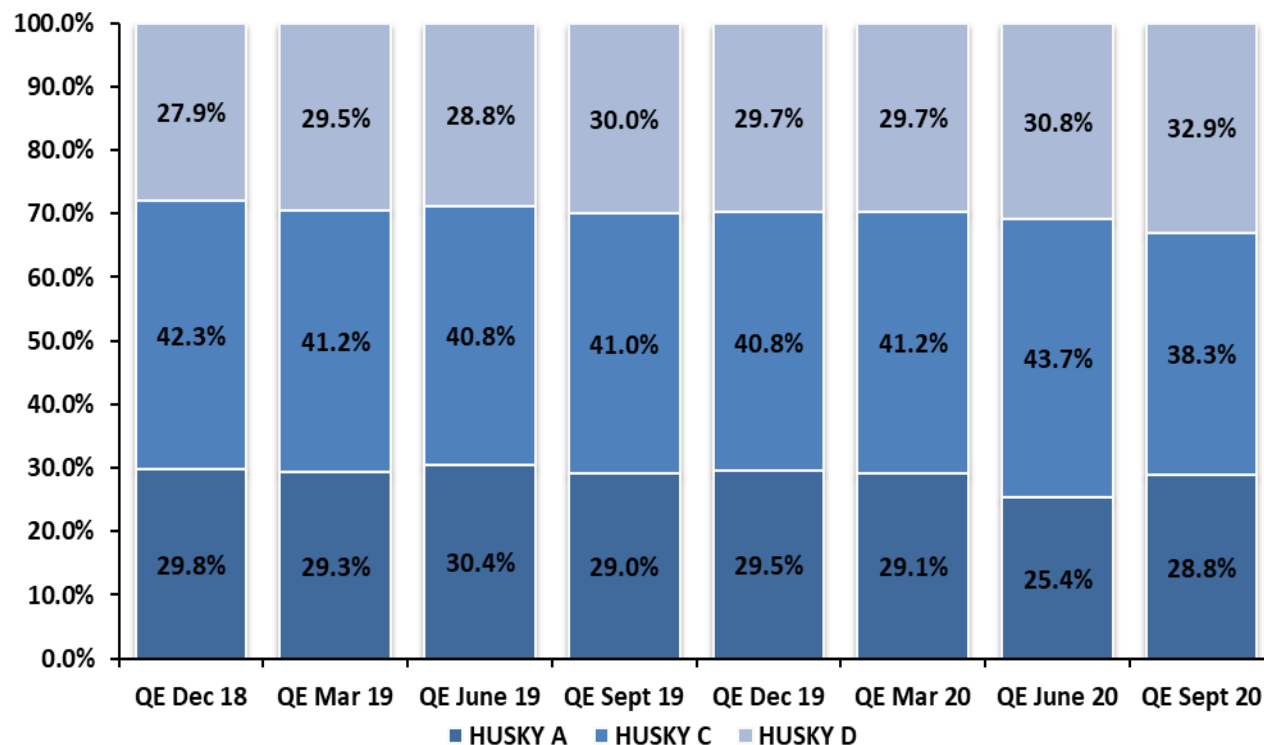
Quarterly Percentage of Enrollment by Program



HUSKY D enrollee growth has contributed to its increasing share of overall Medicaid enrollees, resulting in slightly smaller shares of both HUSKY C and HUSKY A enrollees.

HUSKY A – Families and children
HUSKY C – Aged and disabled
HUSKY D – ACA expansion, childless adults

Quarterly Percentage of Expenditures by Program



HUSKY A – Families and children
HUSKY C – Aged and disabled
HUSKY D – ACA expansion, childless adults

HUSKY D members represent 33% of enrollees, matching their 33% of overall expenditures.

HUSKY C members make up 10% of the enrollees but comprise 38% of expenses.

HUSKY A members comprise 57% of enrollees but account for just 29% of program costs.



Connecticut's Medicaid Financial Trends: Sustainability Benchmarks



- **Strategic financial benchmarks – five pillars**
 - 1. Administrative expense to total program cost ratio**
 - 2. Category of service alignment**
 - 3. Per member cost trends**
 - 4. State share of Medicaid expenses**
 - 5. Medicaid share of total state budget**



What trends are we seeing?

- Total expenditures have increased due to increases in enrollment, but **per member per month costs have remained remarkably steady over time.**
- The **state share** of HUSKY Health costs are **beginning to rise slightly**, in part due to declining federal HUSKY D reimbursement.
- **Cost trends** in select service categories generally **align with strategic objectives.**
- HUSKY Health **program and administrative cost trends compare very favorably with national Medicaid trends.**



Review of Medicaid Administrative Spending - Administrative Expense Ratio

Financial Benchmark #1



- CT's managed fee-for-service system clearly demonstrates administrative cost efficiencies – *with two adjustments, we estimate that CT ranks best in the nation for the lowest percent of administrative spending for FFY 2019 (2.8% versus the national average of 8.2%).*
- The first adjustment removes eligibility staff and systems expenses – this recognizes eligibility as a service, not an administrative cost, and neutralizes the impact of one-time systems development costs.
- The second, more important adjustment recognizes that managed care organization administrative costs are treated as program costs per CMS reporting conventions, significantly understating administrative costs for states with managed care.



- MACPAC* data shows CT FFY 2019 Medicaid administrative costs at 4.2%, lower than the national average of 4.7% - by this measure, CT would place 17th nationally for the lowest administrative cost ratio.
- The MACPAC data includes costs associated with all eligibility staff and systems operations and development. CT incurred over \$120 million in eligibility staff and system support costs in FFY 2019.
- If only eligibility and systems costs are removed, the adjusted administrative load for CT would be 2.8%, also lower than the adjusted national average of 3.4%.
- Additionally, the exclusion of managed care administrative costs from the MACPAC/CMS data has a major impact on these statistics.

*MACPAC-Medicaid and CHIP Payment and Access Commission, December 2020



- As managed care organization (MCO) administrative costs and profit are built into the overall capitation rates and are claimed as program expenses, we compare even more favorably to other states if MCO administrative costs are considered.
- MCO administrative costs and profit are generally documented in the 10-12% range.
- With MCO administrative costs included in the comparison, in addition to the eligibility adjustment, we estimate that the national average administrative cost ratio is closer to 8.2%, compared to CT's 2.8%.
- For an illustrative example of the math behind this adjustment for Medicaid managed care administrative expenses that are not captured in the traditional Medicaid administration expenditure comparisons, please see Appendix A.

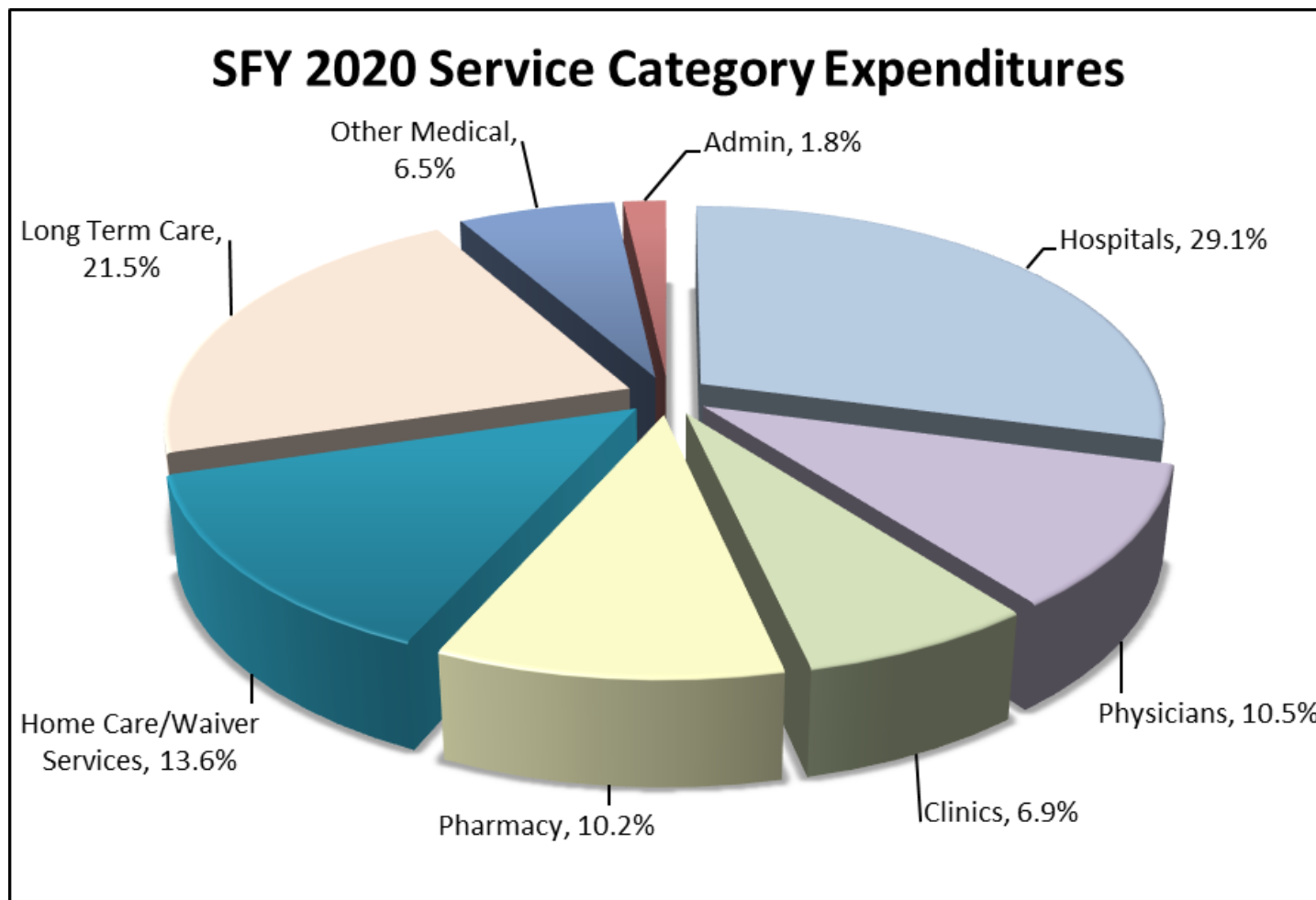


- DSS continues all possible efforts to maximize federal reimbursement for Medicaid administrative and eligibility costs.
- Based upon efforts with Access Health CT (AHCT) on the health insurance exchange, and DSS work on the ImpaCT system, we receive 75% on all Medicaid allocable eligibility staff and systems operation costs.
- Inclusive of one-time system development costs, which are generally reimbursable at 90%, the federal share of administrative costs has increased to 65.8% in FFY 2019 from 56.7% in FFY 2013.
- As a result of this enhanced reimbursement, CT's state share of Medicaid administrative costs has actually decreased when compared to 2013 costs.



Review of Medicaid Spending by Service Category in the Context of Policy Priorities

Financial Benchmark #2



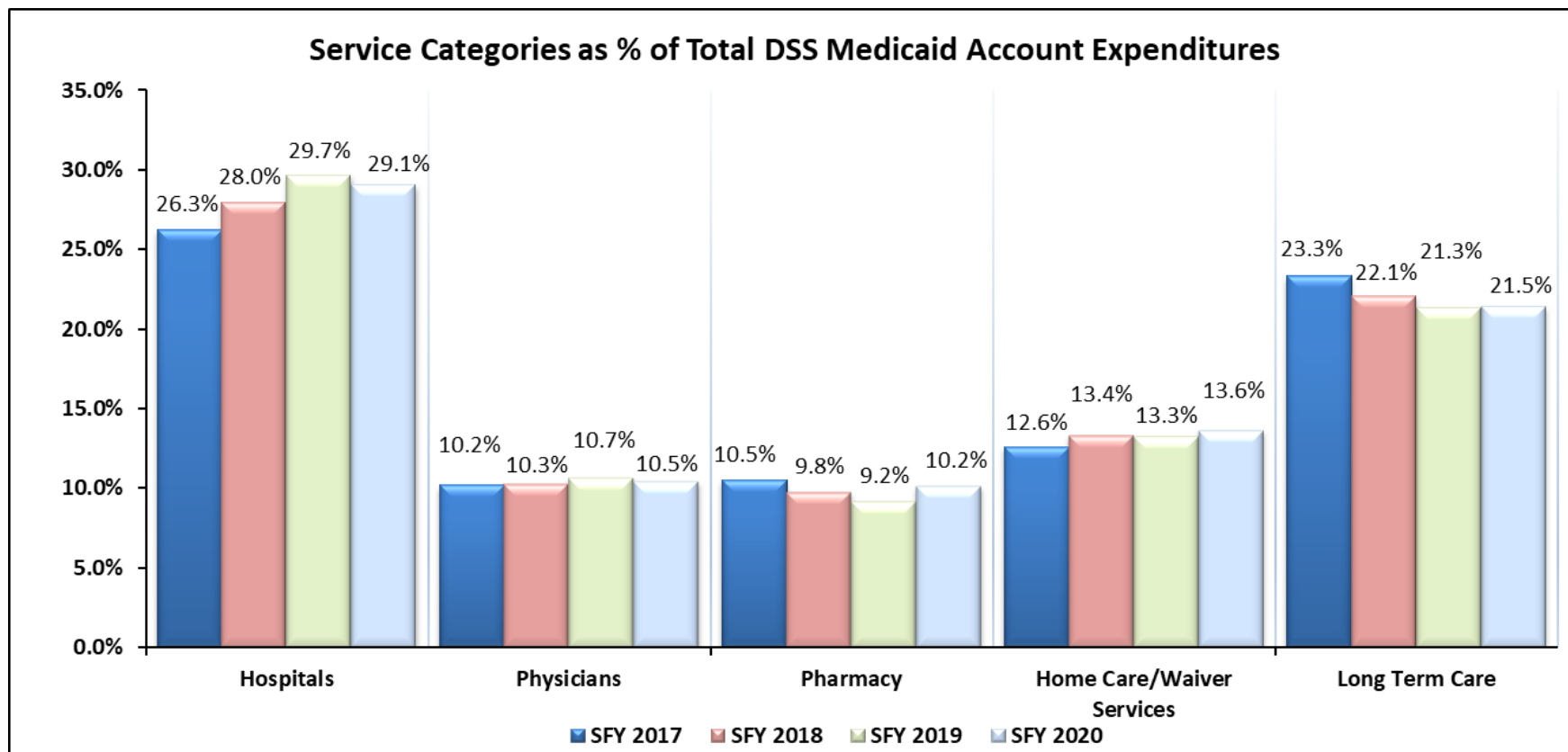
Reflects expenditures for Medicaid services paid directly from our DSS Medicaid account, and does not include Medicaid claimable expenditures provided by other state agencies.

- Changes in percentage share of the Medicaid budget over time for major categories of service:

Category of Service	SFY 2017	SFY 2018	SFY 2019	SFY 2020
Hospitals	26.3%	28.0%	29.7%	29.1%
Physicians	10.2%	10.3%	10.7%	10.5%
Clinics	7.0%	6.9%	6.9%	6.9%
Pharmacy	10.5%	9.8%	9.2%	10.2%
Home Care/Waiver Services	12.6%	13.4%	13.3%	13.6%
Long Term Care	23.3%	22.1%	21.3%	21.5%
Other Medical	8.0%	7.7%	7.1%	6.5%
Admin	2.2%	1.8%	1.8%	1.8%
TOTAL	100.0%	100.0%	100.0%	100.0%

*Reflects expenditures for Medicaid services paid directly from our DSS Medicaid account, and does not include Medicaid claimable expenditures provided by other state agencies.

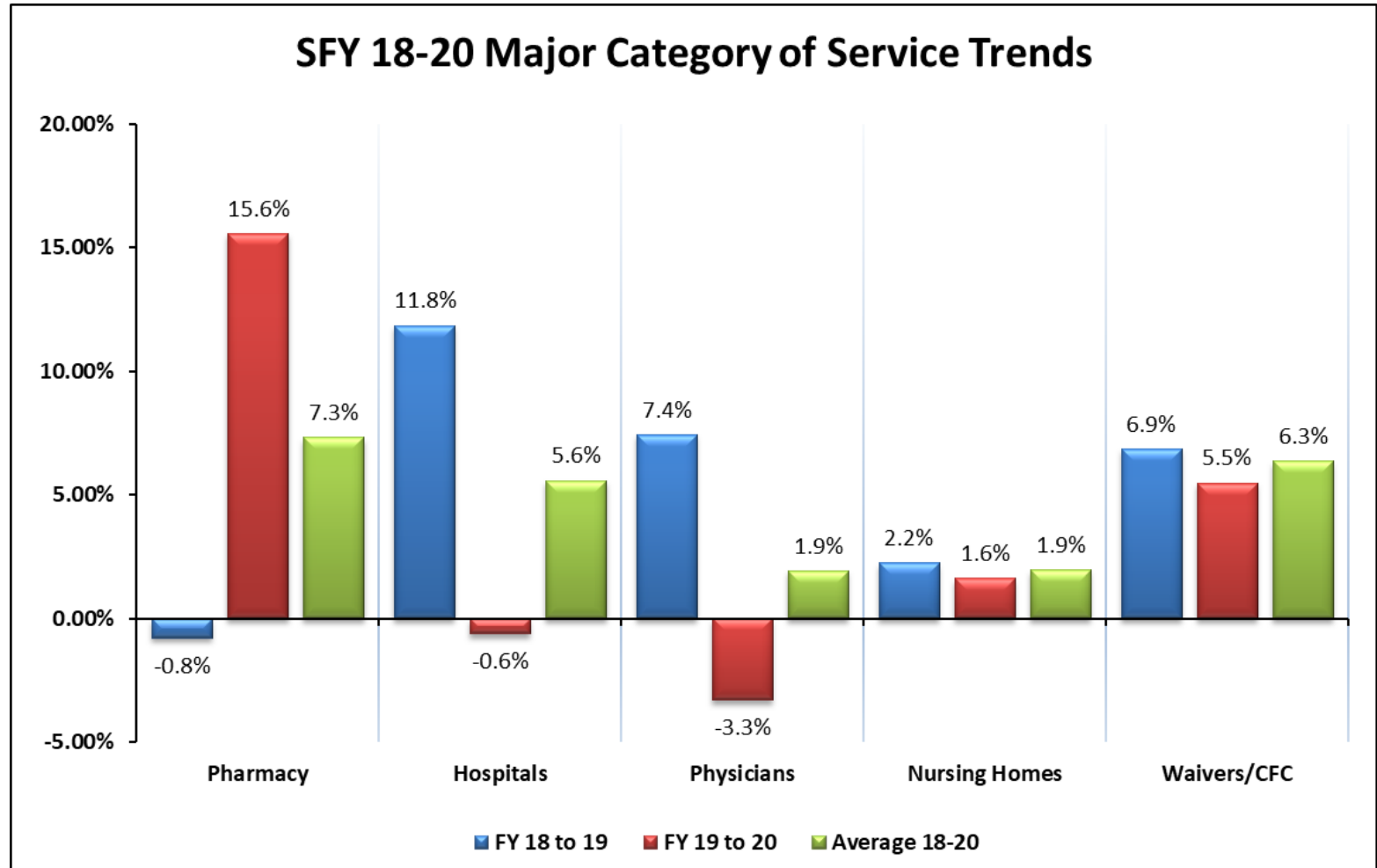
** Other Medical includes services such as dental, vision, durable medical equipment, lab and x-ray, emergency and non-emergency transportation, and other smaller categories.



Hospital expenses include inpatient and outpatient costs only; supplemental payments are not included.



- Highlights of category of service trends in major areas
- Major service area trends
 - Net pharmacy costs
 - Hospital costs
- Service investments
 - Increase in physician expenditures
 - Rebalancing and investment in long-term services and supports



Hospital expenses include inpatient and outpatient costs only; supplemental payments are not included.

■ Pharmacy expenses and rebates

- CT's rebate percentage grew from 49.4% in SFY 2015 to 68.9% in SFY 2019, before declining to 65.8% in SFY 2020.
- CT ranked 11th in the nation in terms of its rebate recovery percentage in FFY 2018; data for FFY 2019 infers a drop in that rank but complete data is not available.

Summary of Pharmacy Expenses						
	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020
Pharmacy	1,071,729,224	1,238,980,681	1,281,608,644	1,301,447,228	1,359,308,898	1,429,719,008
Pharmacy Rebates	(529,399,553)	(752,456,475)	(816,519,421)	(875,006,383)	(936,273,532)	(940,864,312)
Net Pharmacy after Rebates	542,329,671	486,524,207	465,089,223	426,440,845	423,035,366	488,854,696

- Despite the decline in SFY 2020 rebates as compared to the SFY 2019 peak, net pharmacy expenses are still almost 10% lower than SFY 2015 levels.

*Total spending on pharmacy services including both the federal and state share of expenses and rebates.



■ Hospital payments

- Significant rate increases for inpatient and outpatient services were provided in SFY 2018 (estimated at \$175 million once fully annualized).
- Hospital settlement agreement calls for annual rate increases of 2% each January 1st through SFY 2026.

Summary of Hospital Expenses							
	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	Change from 2015
Inpatient	829,467,388	849,065,795	843,173,368	881,827,156	1,021,395,036	1,053,118,107	223,650,719
Outpatient	706,823,261	764,201,753	736,146,297	819,260,999	881,150,907	837,409,811	130,586,550
Total w/o Supplemental	1,536,290,649	1,613,267,548	1,579,319,665	1,701,088,155	1,902,545,943	1,890,527,918	354,237,269

Excludes hospital supplemental payments, with the exception of the grouper supplemental payment adjustment.



■ Primary care investments

- Physician expenditures increased from \$302 million in SFY 2013 (pre-ACA fee increase) to \$514 million in SFY 2019:
 - The primary care fee increase to pay 95% of 2014 Medicare fees is estimated to account for \$52 million of that difference.
 - Some of that increase is attributable to a change in the categorization of hospital physician expenditures resulting from our Ambulatory Payment Classification (APC) conversion.
 - The balance of the increase can be attributed to enhanced reimbursement for PCMH practices and general increases in Medicaid caseload.
- Note that physician expenditures declined to \$497 million in SFY 2020 – this is primarily attributable to reduction in utilization related to the COVID-19 public health emergency (PHE).



- Long-term services and supports rebalancing:
 - Nursing home costs have held relatively steady with an average 2.0% increase from SFY 2018 to 2020, with a 1.6% increase in SFY 2020.
 - A 2% nursing home rate increase was implemented effective July 1, 2019 for enhancing staff wages and benefits (the first of three phased-in increases over the biennium – a 1% rate increase was also provided on October 1, 2020, with an additional 1% increase for January 1, 2021).
 - Waiver services and Community First Choice expenses increased over 6.4% on average from SFY 2018 to 2020, with a 5.5% increase in SFY 2020.



Review of Medicaid PMPM Trends

Financial Benchmark #3

- *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 with a 5.7% decrease.
- CT Medicaid per person cost trends have continued to compare favorably against many national measures of health care cost trends.
- More recently, CT Medicaid has also fared favorably in a CMS-issued scorecard that included a state-by-state per member per year cost benchmark.



- The recently issued annual CMS Medicaid and CHIP quality scorecard for the first time includes both results on adult and child quality measures and state-by-state detail on per capita Medicaid expenditures.
- This has enabled DSS to compare HUSKY Health's per capita expenses to Medicaid programs in all of the New England states, New York and New Jersey.
- ***Connecticut had the lowest per capita expenditures among those states in 2017, and second lowest in 2018.***

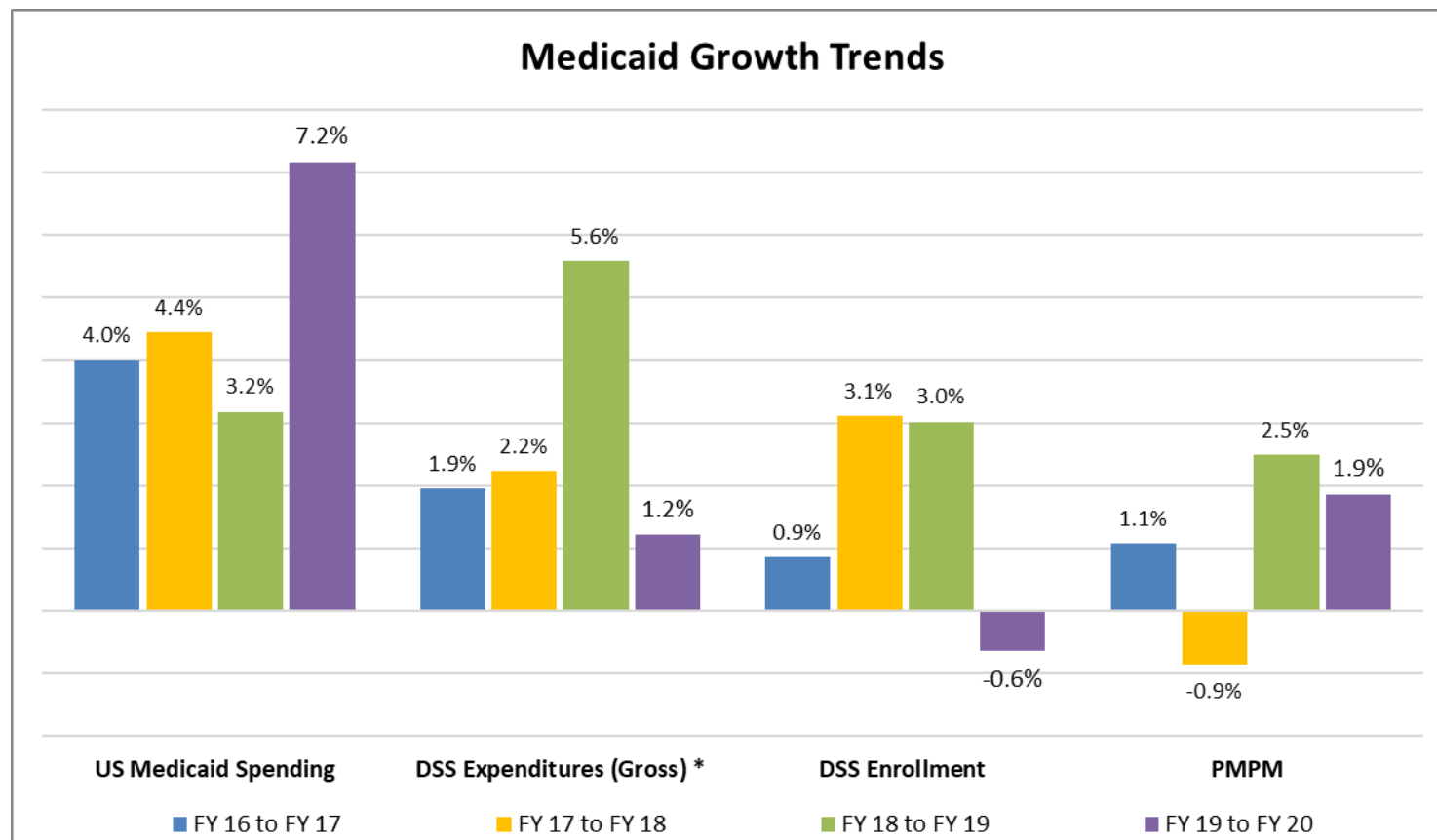


State	2018 per capita	2017 per capita
Connecticut	\$8,890	\$7,960
Maine	\$10,673	\$10,221
Massachusetts	\$10,386	\$9,561
New Hampshire	\$9,905	\$9,425
New Jersey	\$9,420	\$9,246
New York	\$11,831	\$11,796
Rhode Island	\$7,986	\$8,145

- Connecticut achieved these results through use of a managed fee-for-service approach; expansive eligibility guidelines that promote access; comprehensive coverage of preventive medical, behavioral health and dental services; and coordination and integration of care.



- DSS presents CT Medicaid per member per month (PMPM) costs in two distinct ways:
 - **DSS Medicaid Account:** Medicaid expenses including both state and federal shares.
 - **CMS 64 Expenditure Report:** Global measures of total Medicaid program expenses including all federally reimbursable expenses: DSS Medicaid account, hospital supplemental payments, DSH payments, other eligible state agency expenses (DDS, DMHAS, others).



** Expenditures are net of drug rebates and exclude hospital supplemental payments given the significant variance in that area over the years*



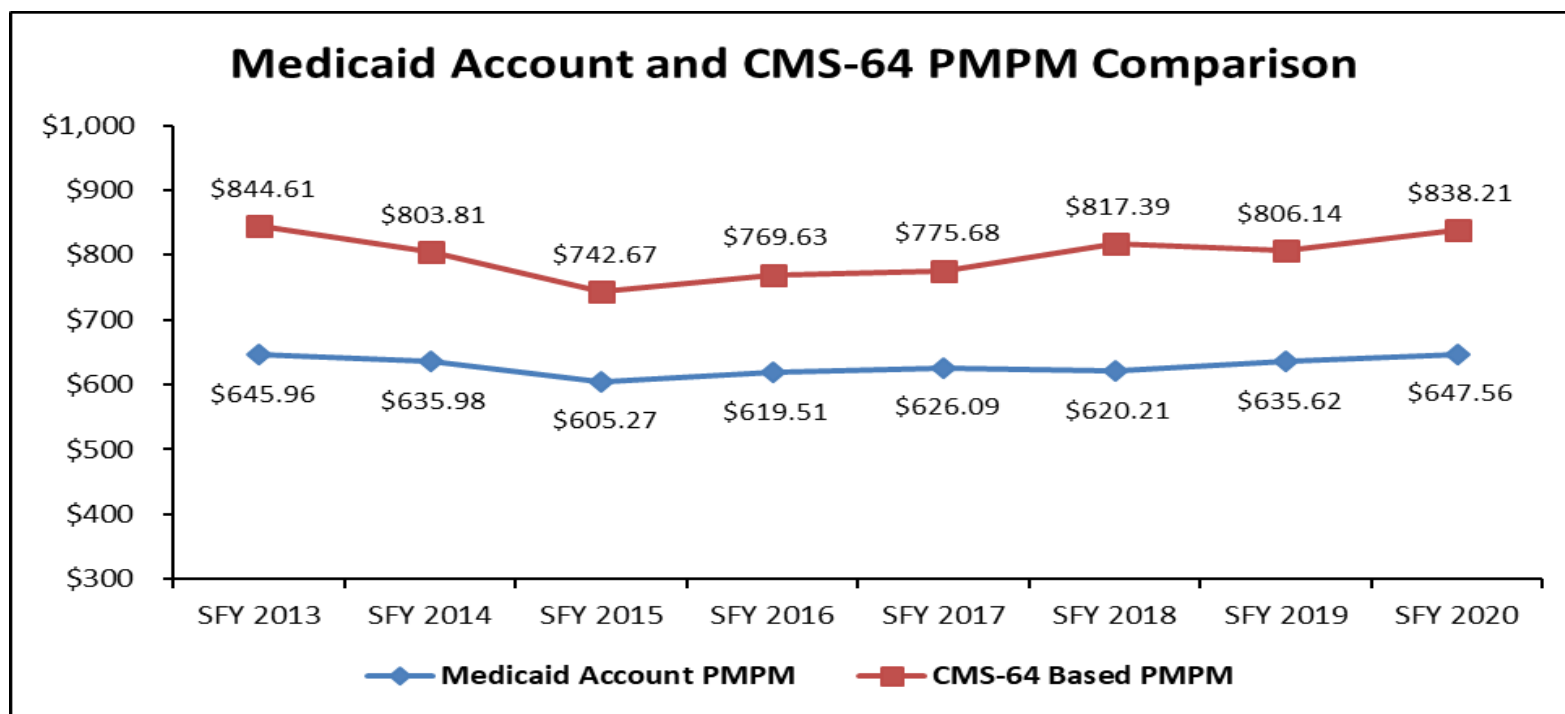
- PMPM & Spending Trends in the Medicaid Account
 - Average DSS Medicaid account PMPM growth has been approximately 1.35% annually from SFY 2015 to SFY 2020.
 - The most recent PMPM for SFY 2020 increased by 1.9% - without COVID-related service reductions for the last several months of the fiscal year, this increase would have been greater.
 - While national Medicaid spending was up 7.2% from SFY 2019 to 2020, CT Medicaid expenses were up only 1.2% - if CT Medicaid expenditures had grown at the national average for the SFY 2015 to SFY 2020 period, costs could have been \$700 million higher.

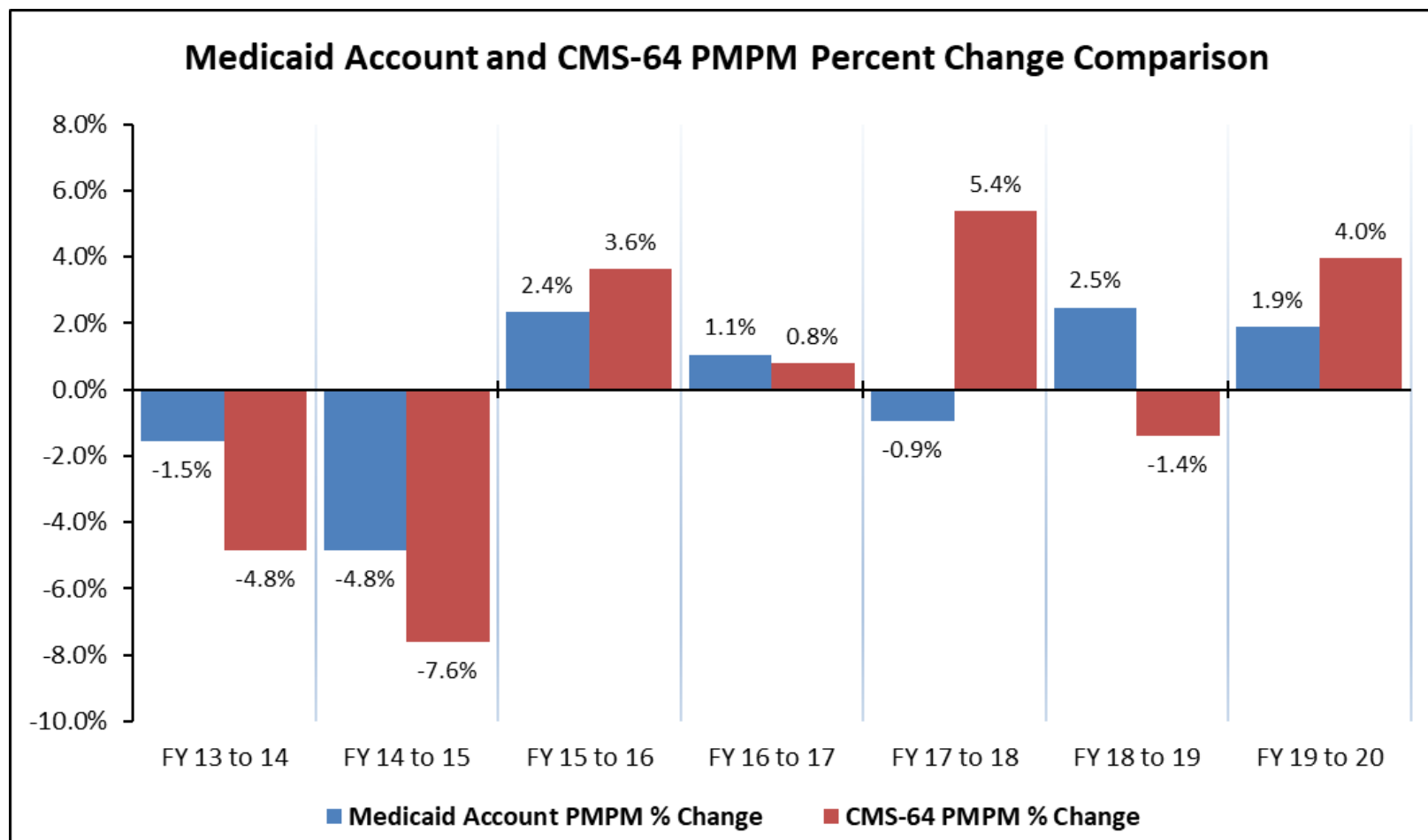


- **PMPM Review Using the Federal CMS-64 Report**
 - CMS-64 report is the federally required report used by the federal government to document all Medicaid services subject to federal reimbursement.
 - Differences between the Medicaid account and CMS-64 report include, but are not limited to:
 - Medicaid account includes State-funded elements and Administrative Services Organization (ASO) expenses; and
 - CMS-64 report includes disproportionate share hospital (DSH) expenses, reimbursable other state agency programs, and Medicare premiums (MSP).



- **PMPM Review Using the Federal CMS-64 Report**
 - Both the Medicaid Account and the Global CMS-64 PMPM have been favorable since SFY 2013.
 - Comparing SFY 2020 to SFY 2013, the PMPM in 2020 remains less than that in 2013, with some growth over recent years.





Please note SFY 18 includes significant additional expenditures associated with hospital supplemental payment increases (\$480 million above SFY 2017 levels)



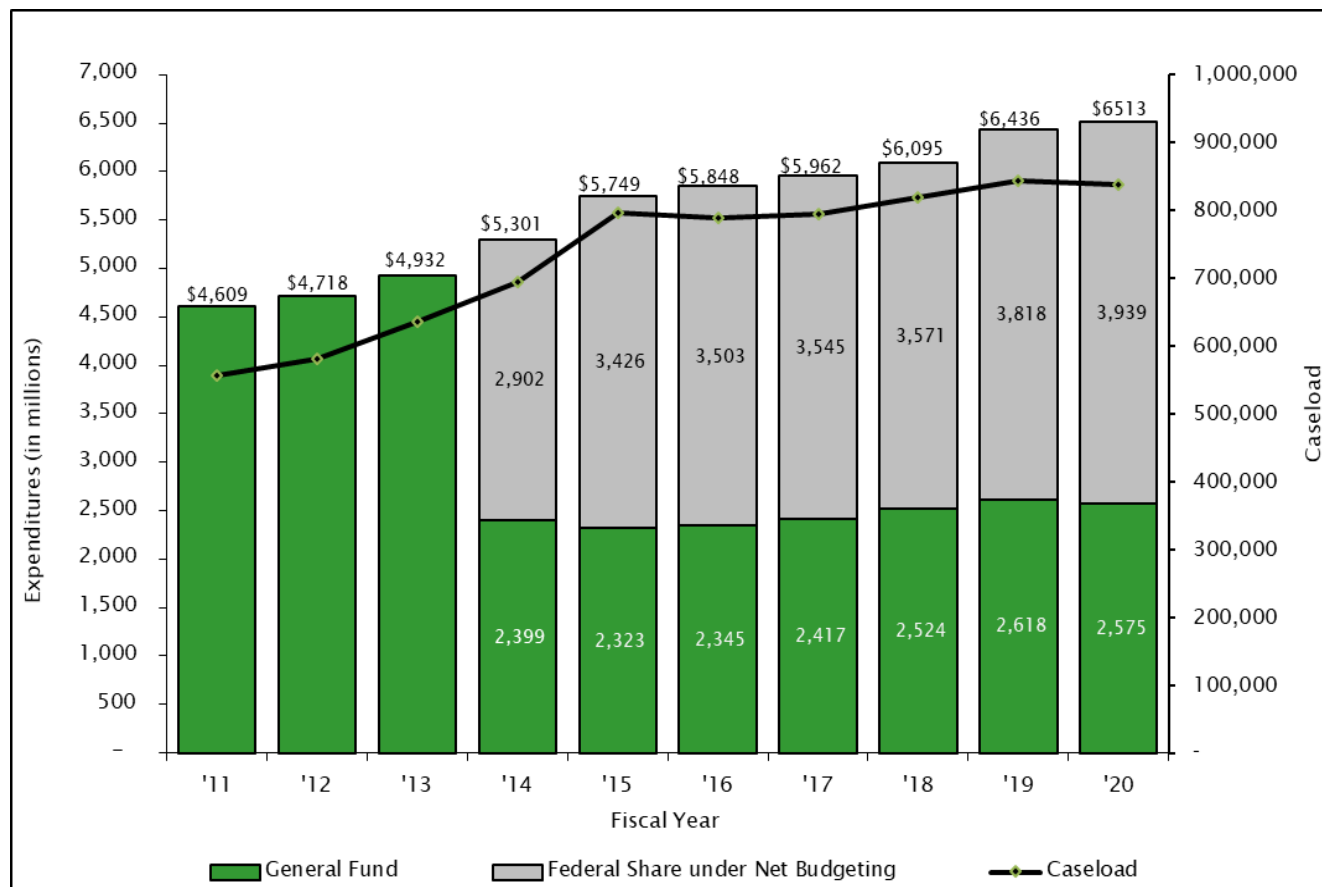
Trends in the State Share of Total Medicaid Spending

Financial Benchmark #4



While the state share of costs was virtually unchanged from SFY 2013 to 2017, since then the state share has risen due to lower federal reimbursement for single adults.

SFY 2020 state share was only \$108 million, or 4.4%, higher than the estimated SFY 2013 state share - this was impacted by enhanced 6.2% federal COVID-19 PHE reimbursement for the Jan-Jun 2020 period. If adjusted to remove the extra reimbursement, the increase would be \$248 million, or 10.1%, for an annual growth rate of 1.4%.



*Excludes hospital supplemental payments



- The federal share of Medicaid program expenses has increased to 60.5%, up from 50% pre-ACA, due to enhanced federal funding for HUSKY D, currently at 90% for calendar year 2020 and future years, and the enhanced federal reimbursement during the COVID-19 PHE.
- As a result, expenditures for total Medicaid services have increased by \$1.212 billion from SFY 2014 to SFY 2020, while the net state share of expenditures has increased only \$176 million.
- The enhanced federal funding has resulted in a net gain of over \$1 billion in new services for low-income citizens of the state, while providing additional revenue to CT providers and stimulus for the CT economy.



Connecticut Medicaid as a Share of the Overall State Budget

Financial Benchmark #5

- In SFY 2020, the “all states” average Medicaid expenditures as a percentage of total State expenditures was 28.6%*.
- Connecticut’s SFY 2020 Medicaid expenditures as a percentage of total State expenditures was 24.8%*.
- For the past decade, CT compares extremely favorably to its “peer” states (New England, NY and NJ). For the entire period, we have consistently been among the lowest three states.
- In SFY 2015 through 2017, CT had the lowest percentage share of the total state budget of all our peer states and had the second lowest percentage in SFY 2018 and 2019 (0.1% higher than NJ in both years). In SFY 2020, CT was the third lowest.

*Per the most recent National Association of State Budget Officers (NASBO) State Expenditure Report; includes both federal and state Medicaid shares.

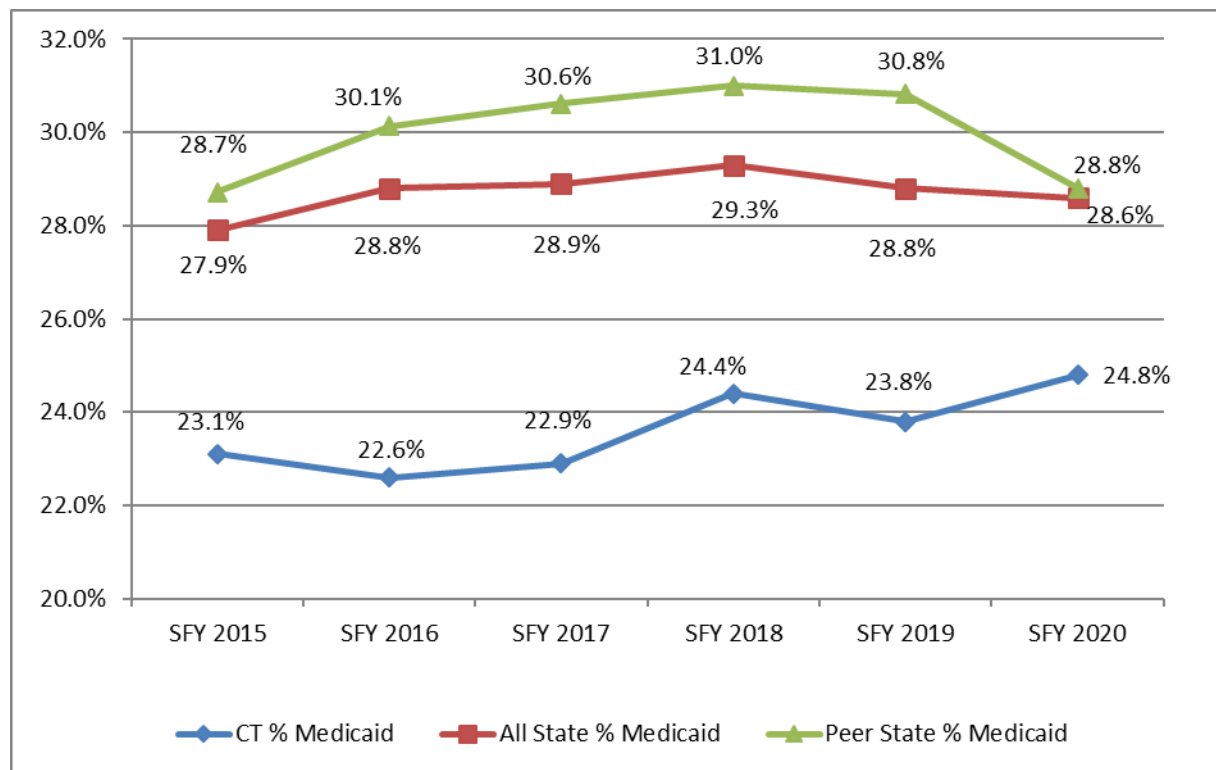
- Total Medicaid expenditures as a percentage of the total state budget - detail on peer states and national data*:

	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020
Connecticut	23.1%	22.6%	22.9%	24.4%	23.8%	24.8%
Maine	32.8%	33.0%	32.2%	33.6%	33.8%	30.9%
Massachusetts	23.7%	27.8%	28.0%	30.5%	29.8%	29.3%
New Hampshire	29.7%	34.7%	36.6%	35.5%	35.2%	30.0%
Rhode Island	30.4%	29.0%	29.9%	29.3%	28.6%	23.0%
Vermont	28.5%	29.5%	28.8%	28.2%	28.7%	27.0%
New Jersey	24.2%	25.0%	24.5%	24.3%	24.4%	24.3%
New York	31.7%	31.9%	34.3%	35.6%	35.3%	37.1%
Peer State Avg (w/o CT)	28.7%	30.1%	30.6%	31.0%	30.8%	28.8%
All States	27.9%	28.8%	28.9%	29.3%	28.8%	28.6%

CT's Medicaid to total State budget cost ratio was well below the all states average and the average of its peer states from SFY 2015 through 2020

*Per National Association of State Budget Officers (NASBO) State Expenditure Reports; includes both federal and state Medicaid shares.

- CT Medicaid expenditures as a percentage of the total state budget - detail on peer states and national data*:



CT has maintained a favorable position compared to other states, having a much lower Medicaid expense as a percentage of the total state budget compared to its peers and to the national average

*Per National Association of State Budget Officers (NASBO) State Expenditure Reports; includes both federal and state Medicaid shares.



Recap – Significant Financial Benchmarks



- Administrative expenses of approximately 3.0% are well under Medicaid managed care norms of close to 12%*.
- Service investments including enhanced primary care expenditures and shifts to community-based waiver and related services have aligned with policy priorities.
- The DSS Medicaid account PMPM has been very stable, reflecting only a 1.35% average annual increase from SFY 2015 to SFY 2020.

*Administrative loss ratio per 2018 Milliman Medicaid Managed Care Financial Results report, June 2019



- The Global CMS-64 PMPM has also been stable, growing on average at 2.45% annually since SFY 2015.
- SFY 2020 state share of Medicaid expenses was only \$108 million, or 4.4%, higher than the estimated SFY 2013 state share. This equates to an average annual increase of less than 1.0% (1.4% if adjusted to remove the federal COVID PHE enhanced reimbursement).
- Connecticut's percentage of Medicaid costs to overall State budget costs compares favorably by a significant 4% differential to both national averages and "peer" regional states.



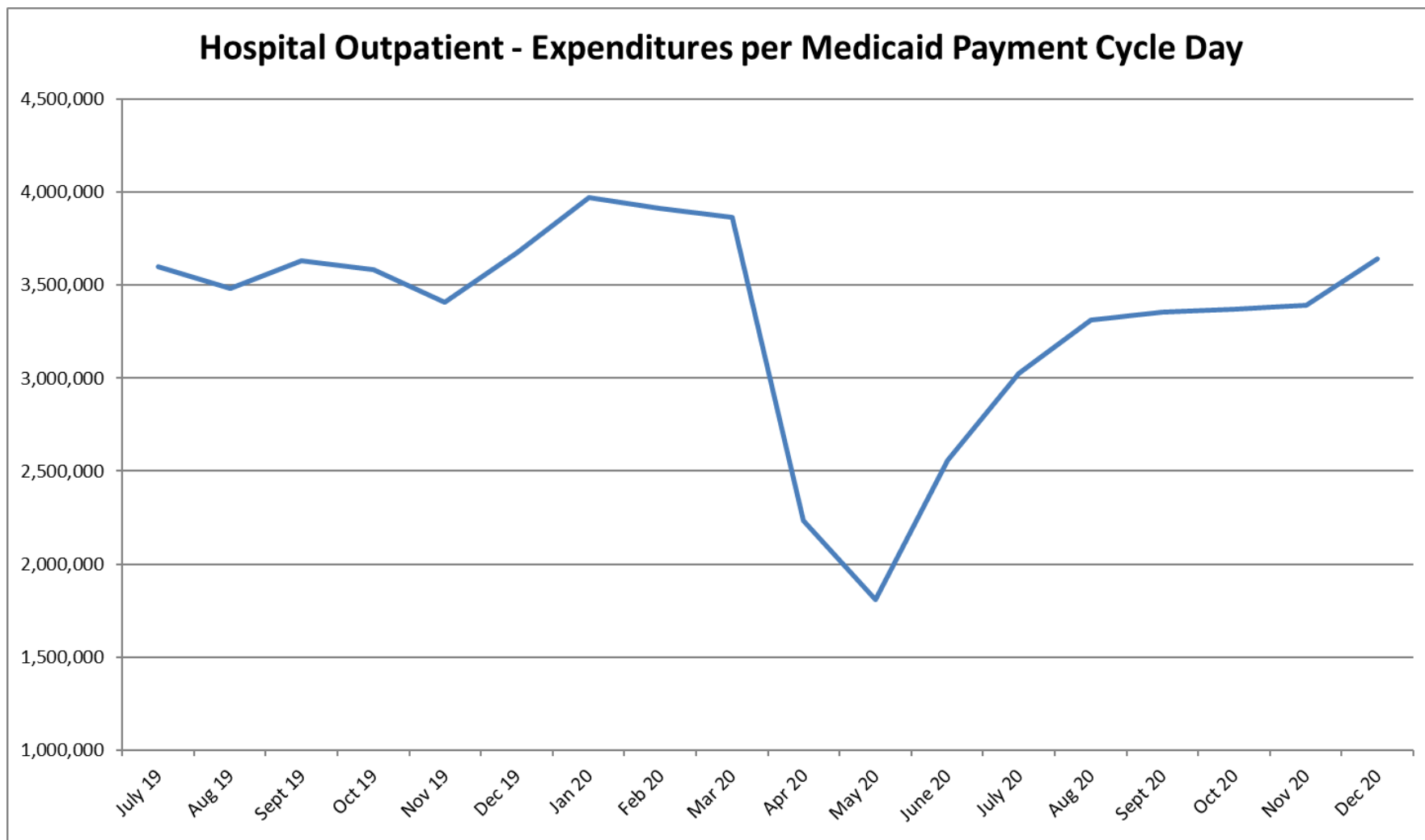
- COVID-related impacts on financial trends
 - Impact began in March 2020
 - COVID-19 resulted in significant reductions in utilization in many service categories
 - Trends have been affected, complicating historical comparisons

■ COVID-related impacts on financial trends

COMPARISON OF MEDICAID PAYMENTS FOR MAJOR SERVICE CATEGORIES*

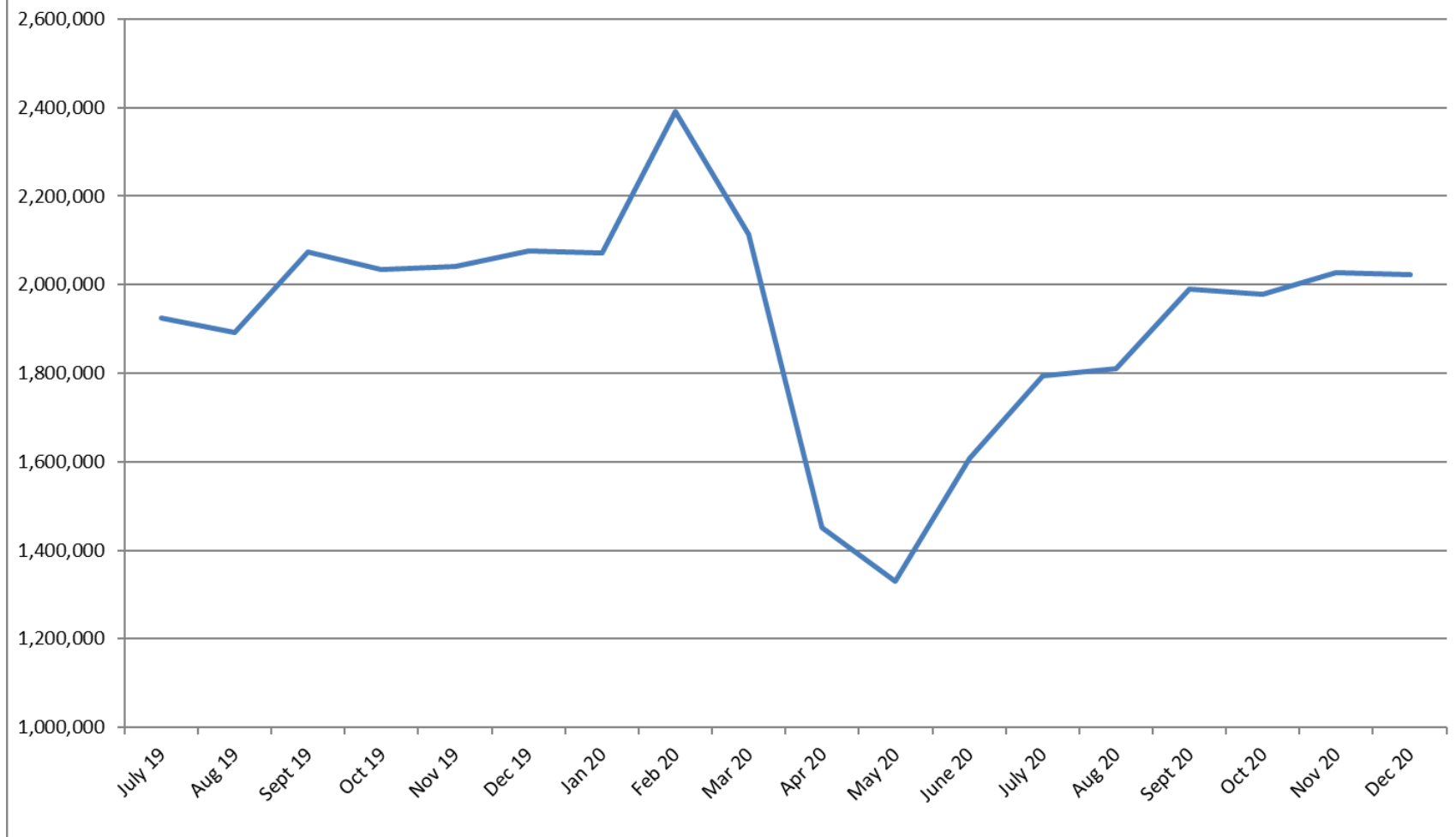
		Pmts per Day Oct-Dec 19	Pmts per Day Oct-Dec 20	Oct-Dec 20 as % of Oct-Dec 19
	Inpatient	12,344,652	13,444,663	108.91%
	Outpatient	11,529,944	10,406,312	90.25%
	Physician	6,649,677	6,025,650	90.62%
	Other Pract	2,449,718	2,480,490	101.26%
	Clinics	5,869,793	5,469,314	93.18%
	Pharmacy	18,201,293	18,169,058	99.82%
	Dental	2,277,672	1,925,915	84.56%
	Home Health	2,454,777	2,540,473	103.49%
	Vision	487,458	436,826	89.61%
	Lab & X-Ray	604,181	736,074	121.83%
	Nursing Homes	9,811,846	8,213,267	83.71%
		- above 2019 levels		
*The payments per day for Oct - Dec 19 were adjusted to account for the increases in enrollment that have occurred over this period				

While spending in several service categories has returned to, or is close to, pre-COVID levels, several services lag behind including Hospital Outpatient, Physician, Clinics, Dental, Vision and Nursing Home services.



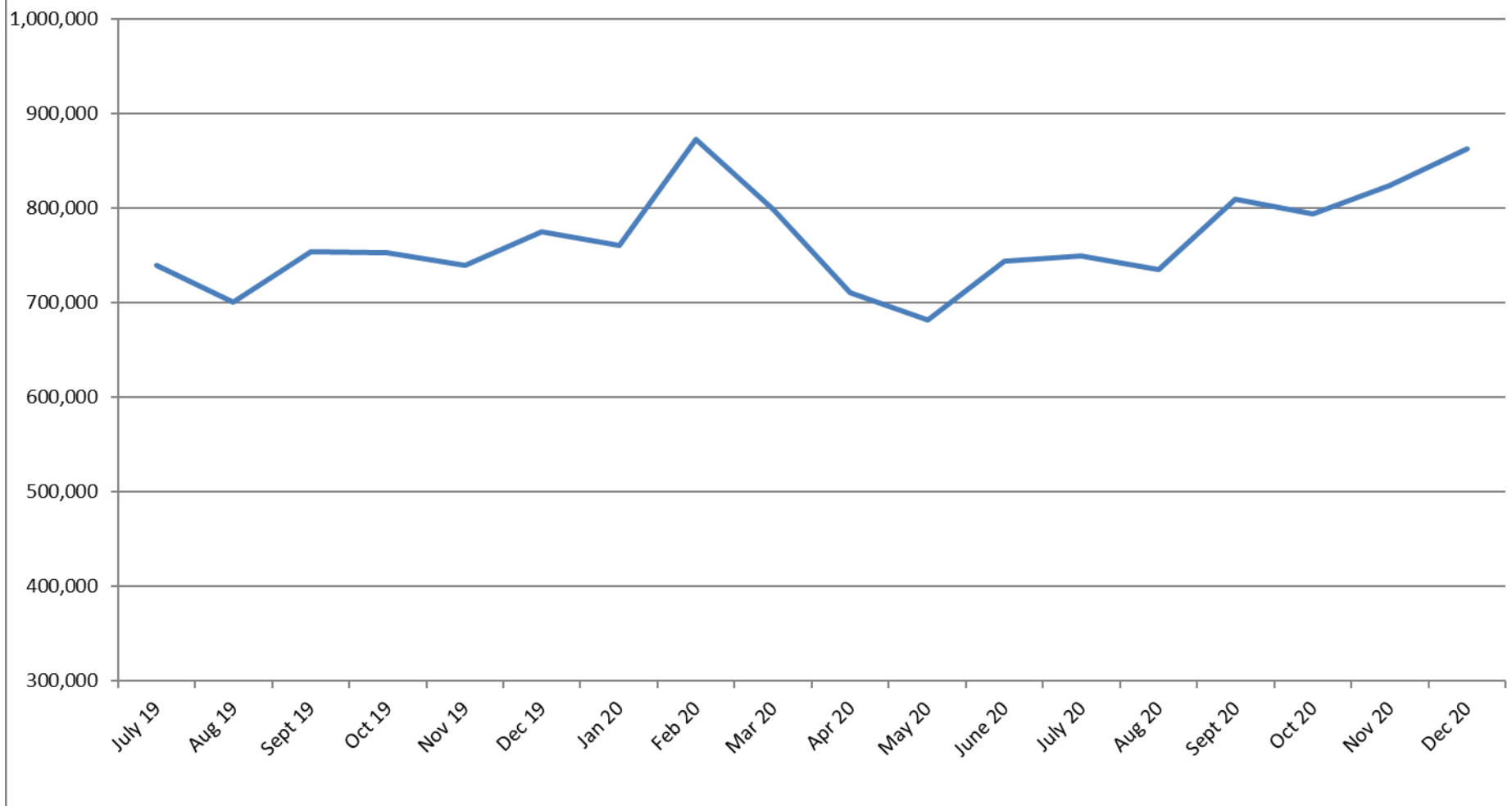


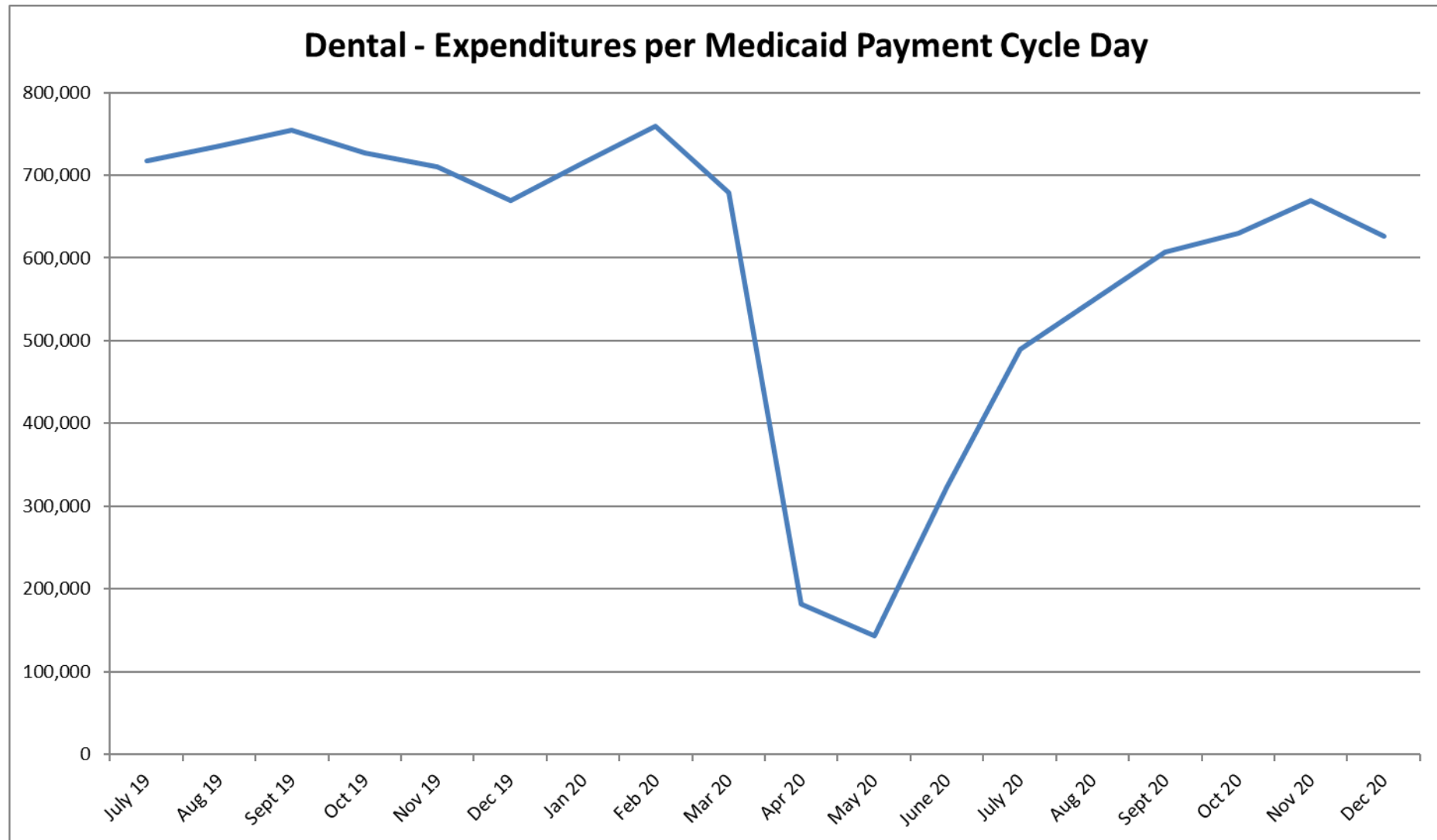
Physician - Expenditures per Medicaid Payment Cycle Day

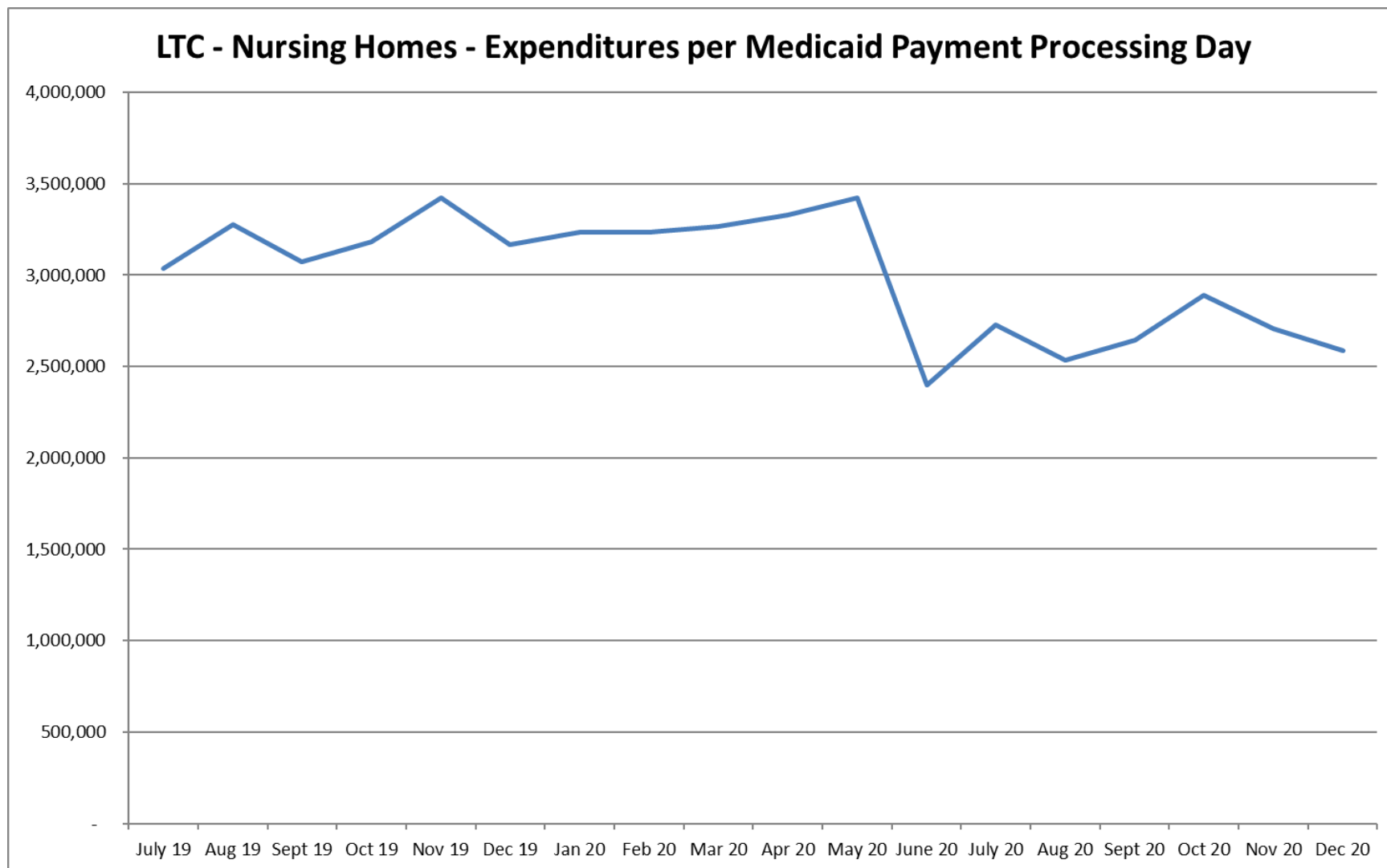




Other Practitioners - Expenditures per Medicaid Payment Cycle Day









Appendix A

Further Detail on Calculation of Administrative Expenses



Managed Care Adjusted Medicaid Admin Costs

- Hypothetical state example and assumptions:
 - MCO administrative costs, including profit, conservatively estimated at 10%
 - MCO administrative costs are included in capitation and reported as a program expense
 - MCO program service expenditure volume at 50% (50% of service costs provided by MCOs)
 - State administrative expenses calculated at 4.5% against all program expenses, but do not include MCO administration and profit
- *Results:*
 - *If MCO administrative expenses were included in this hypothetical state administrative cost structure, administrative expenses would be 5.5% higher*

- Potential impact of MCO administrative costs reported as program services for a “hypothetical” managed care state

Total program expense \$10 billion

MACPAC reported administrative cost at 4.5%, or \$450 million



MCO program component at 50%, or \$5 billion

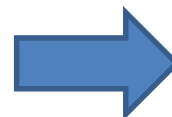
MCO administration at 10%, or \$500 million, but not included



Adjusted administrative expenses at \$950 million

Adjusted program expenditures of \$9.5 billion

Adjusted administrative expense ratio at 10%



CT's managed fee-for-service system demonstrates clear admin cost efficiencies – if MCO admin costs were considered, CT would rank best in the nation for lowest percent of administrative spending

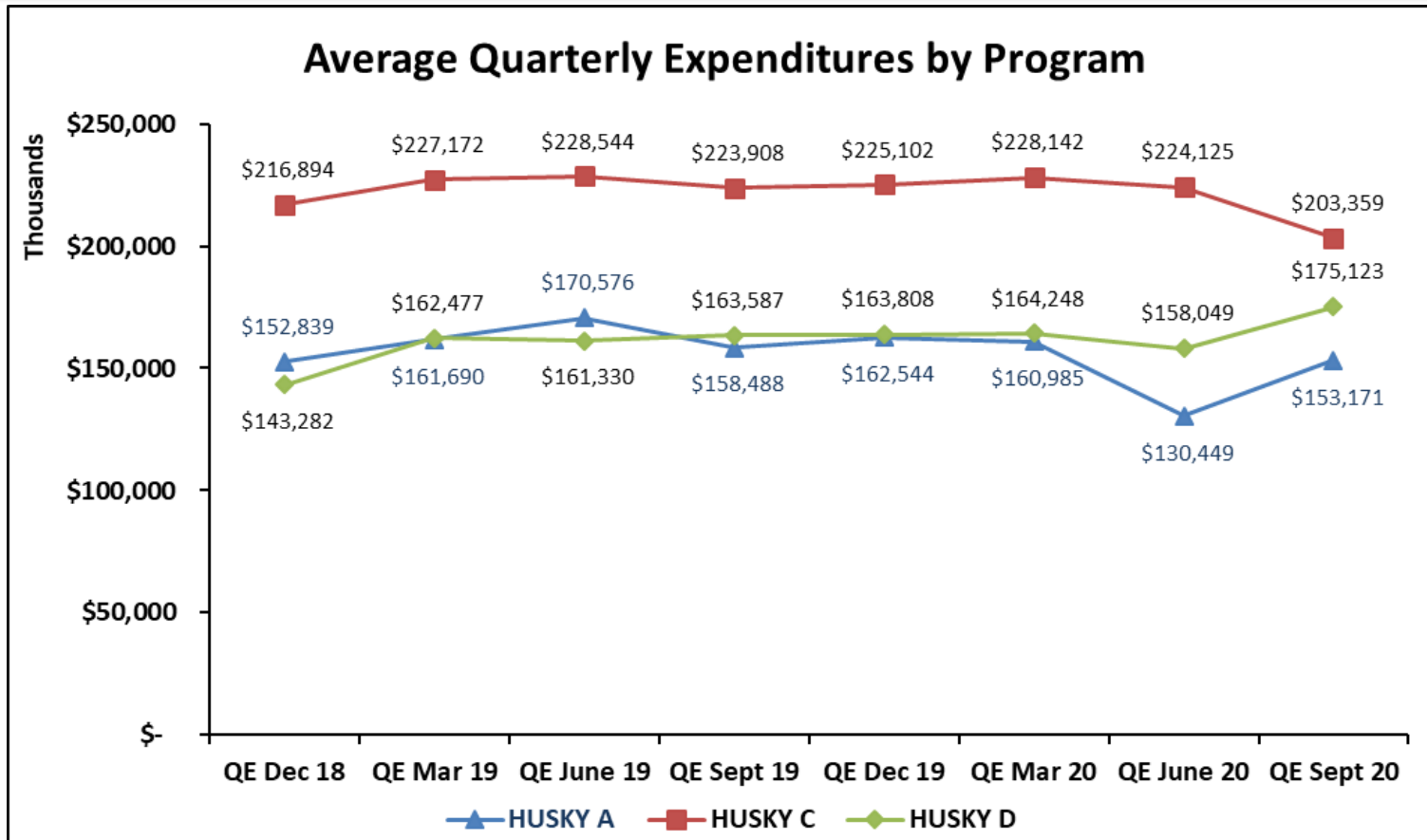


Appendix B

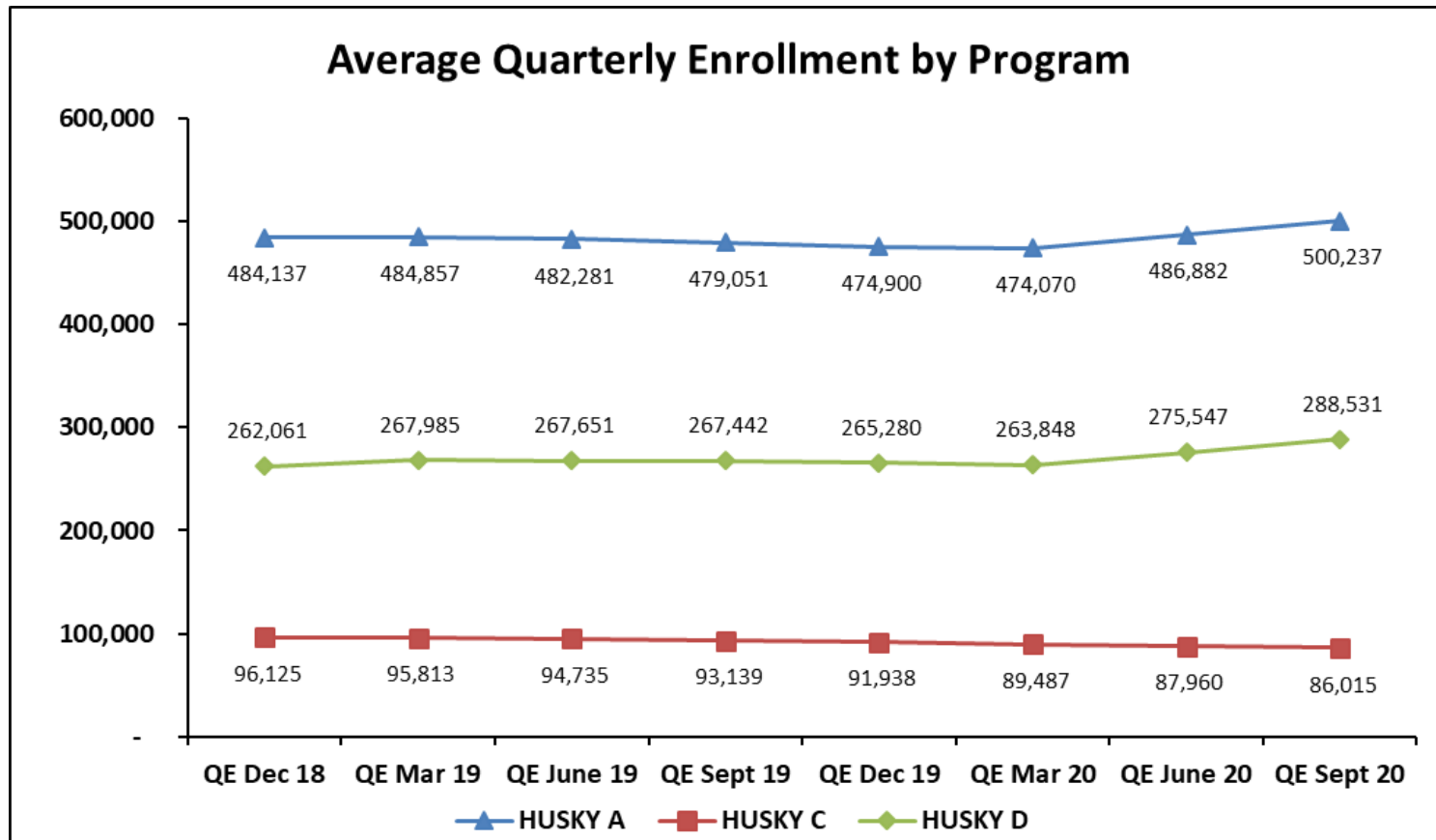
MAPOC Monthly Report Data

Trends in Enrollment and PMPM

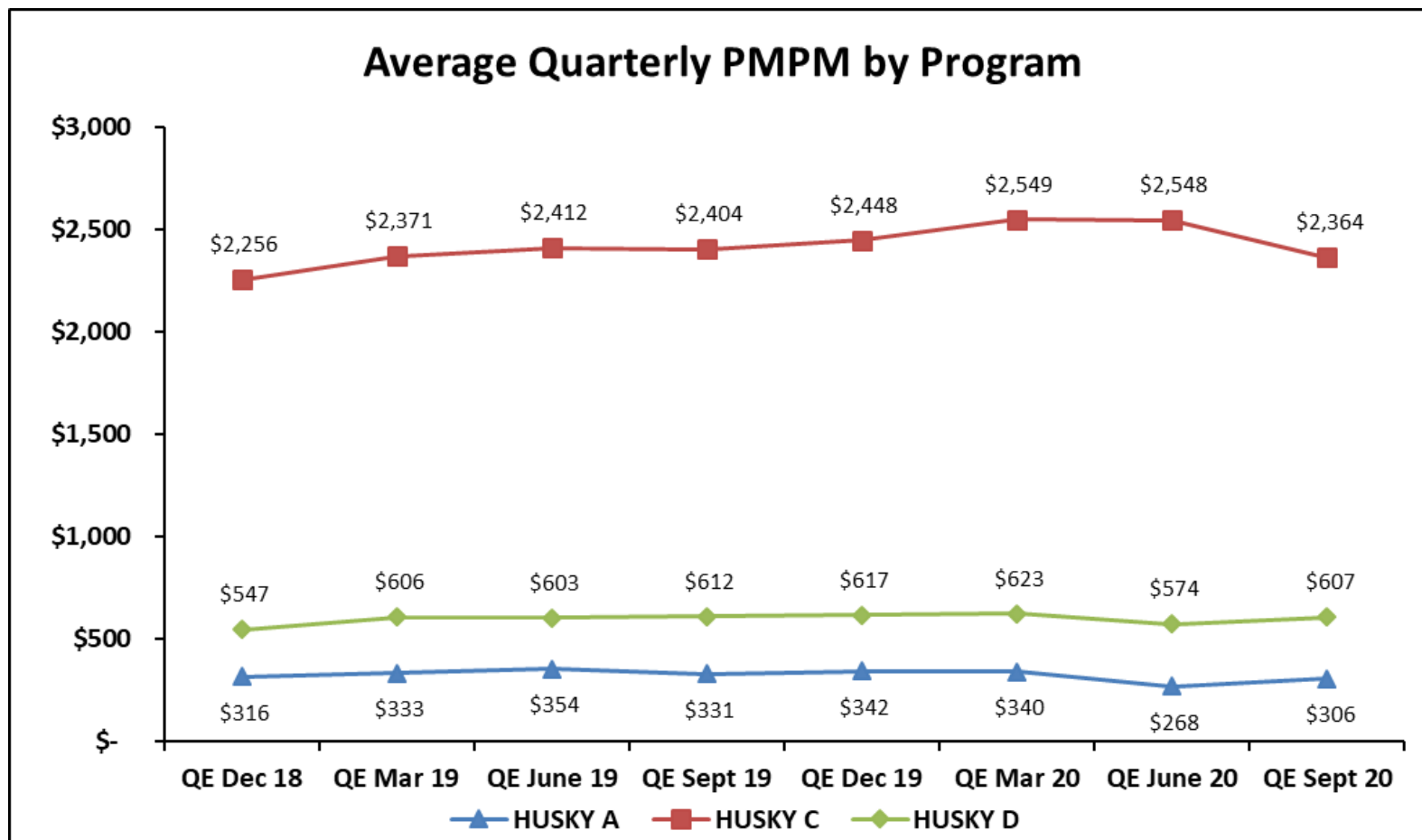
By HUSKY Health Program



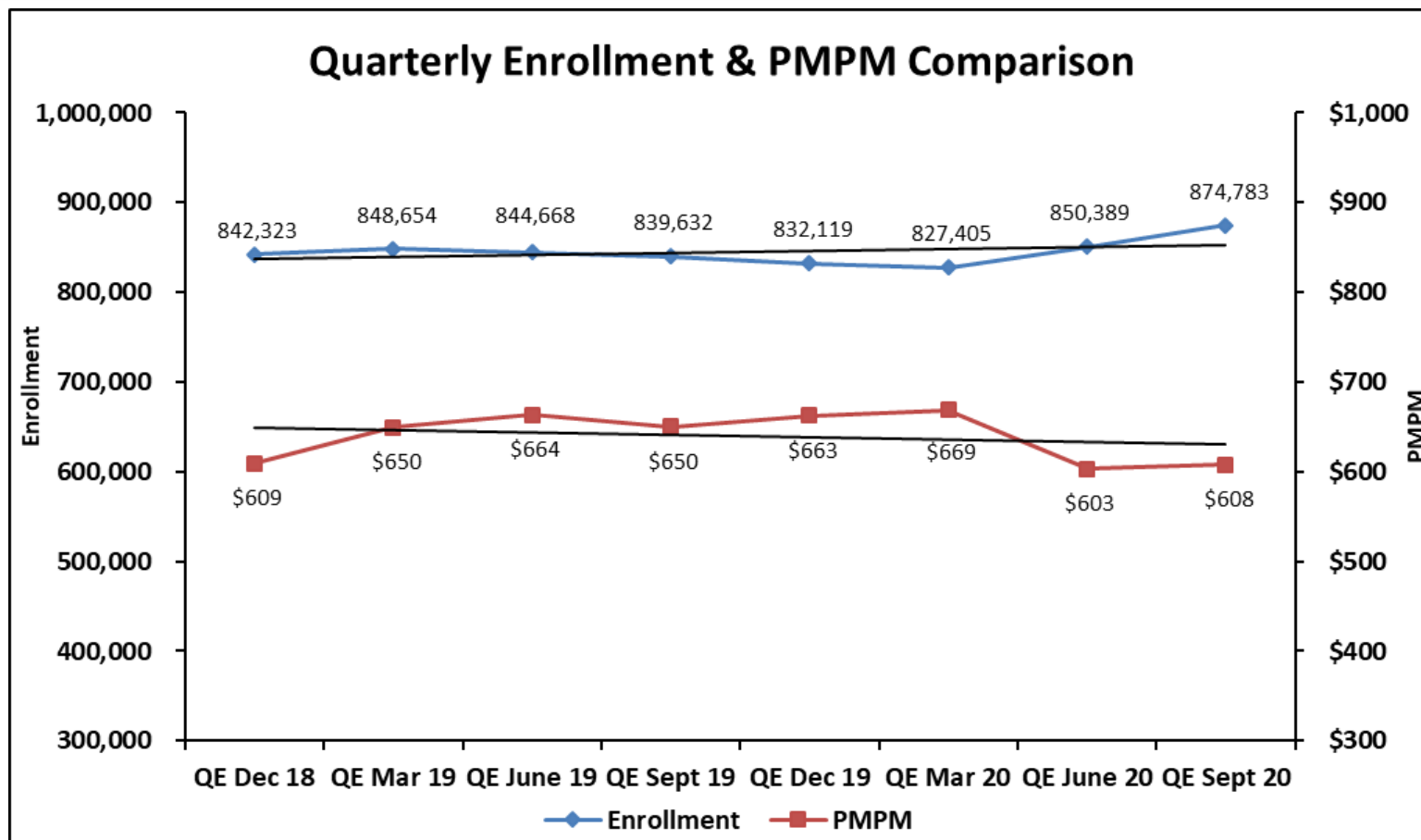
Expenditures have generally been steady across all HUSKY categories over the period, with exceptions for the more recent quarters. These quarters have been impacted by both reductions in service utilization and enrollment increases.



Enrollment, which had been declining or steady in the period leading up to the COVID-19 pandemic, has been rising for HUSKY A and D due to the suspension of discontinuances during the pandemic.



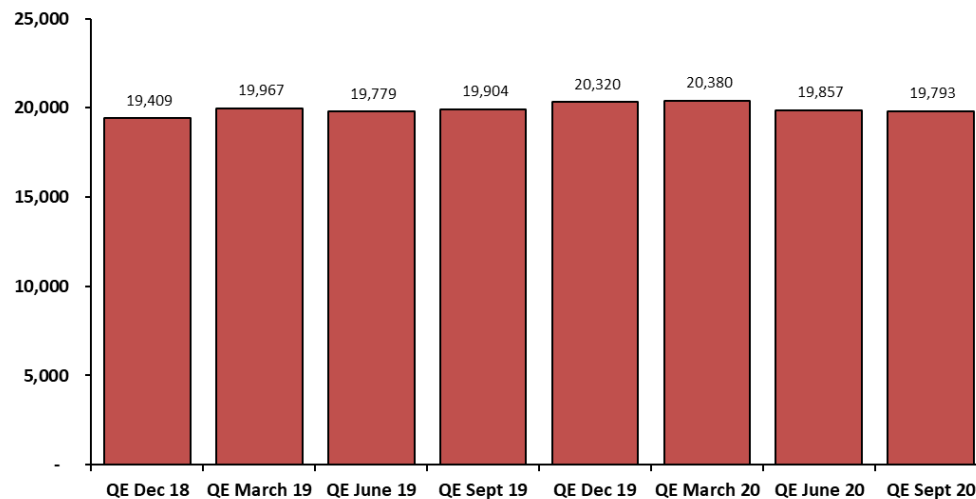
On average, PMPM trends have increased over the period with the exception of the June and September quarters where the COVID-19 pandemic impacted service utilization, resulting in declining PMPMs



Overall, quarterly PMPM trends have increased on average for the recent calendar year compared to the prior calendar year. Enrollment at the end of the two-year period under review is comparable to the beginning of the two-year period.



HUSKY B Average Quarterly Enrollment



HUSKY B average enrollment is at 19,793 in the September 2020 quarter and has been relatively steady through the period.

HUSKY B PMPM experienced a large decrease in the June 2020 quarter and is beginning to see a recovery to prior levels.

HUSKY B Average Quarterly PMPM

