

# Connecticut HUSKY Health: The Benefits of Self-Insurance

Presentation for North Dakota Leadership

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- A snapshot of the program
- Transition from capitated managed care to self-insured structure
- Comparison of features
- Quality results
- Financial trends

# A Snapshot of the Program

- Connecticut HUSKY Health (Medicaid and CHIP) serves almost 850,000 individuals (21% of the state population)
- Connecticut is an expansion state, and optimized use of many other aspects of the Affordable Care Act (preventive services, health homes, Community First Choice, Balancing Incentive Program, State Innovation Model Test Grant)
- By contrast to many other Medicaid programs, Connecticut uses a self-insured, managed fee-for-service approach
- Connecticut has also implemented complementary initiatives, including justice reform and efforts to eliminate homelessness

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

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

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

**Empowered, local, multi-disciplinary health neighborhoods.**



# Elements of Our Reform Agenda

On a foundation of



Person-Centered Medical Homes



ASO-Based Intensive Care Management (ICM)



Pay-for-Performance (PCMH, OB)



Data Analytics/ Risk Stratification

we are building in



Community-based care coordination through expanded care teams (health homes, PCMH+)



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



Value-based payment approaches (PCMH+)

with the desired structural result of creating



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

## 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, long-term services and supports rebalancing plan and an Intellectual Disabilities (ID) Partnership

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
- behavioral health homes
- Money Follows the Person “housing + supports” approach and coverage of supportive housing services under the Medicaid State Plan
- 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 under Money Follows the Person
- Prevention of institutionalization
- Nursing home “right sizing” (diversification of services) and closure
- Workforce initiatives
- Consumer education

Implementation of Value-Based Payment approaches through . . .

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

## 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 have been reduced**. Connecticut has maximized use of federal funds. The **state share of HUSKY Health costs is stable**.

# Transition to Self-Insured Structure

Transition to a managed fee-for-service approach was an iterative process:

- **behavioral health services** have since January 1, 2006 been overseen by the Connecticut Behavioral Health Partnership, working with Administrative Services Organization (ASO) Beacon
- **dental services** have since September 1, 2008 been overseen by the Connecticut Dental Health Partnership, working with ASO BeneCare
- **medical services** were transitioned January 1, 2012, working with ASO CHN-CT

## Influencing factors for transition included:

- A desire to prioritize and to tailor behavioral health services to fit member need
- Settlement of a lawsuit over access to, and adequacy of provider reimbursement for, dental services
- A public impasse over release of utilization and cost data by the managed care plans
- Year-over-year cost trend

- The ASOs perform some functions that are typical of MCOs (member services, utilization management, first level grievances/appeals)
  
- They also perform some additional functions:
  - Intensive Care Management (nurse teams plus community health workers, peer supports, community educators)
  - Practice coaching for PCMH practices
  
- The ASOs do not enroll providers, set rates, process claims, or manage pharmacy – these are all standard statewide and managed by the Department



# Comparison of Features

Self-Insured/Managed FFS	vs.	Capitated Managed Care
<p>Connecticut Medicaid does not make payments to managed care plans. It pays administrative costs and has centralized and expedited processing of health care claims.</p> <p><b>Results: More timely provider payments; lower administrative costs (currently 3.5%); greater proportion of spending goes to direct services for members.</b></p>	<p><b>Payments</b></p>	<p>Medicaid agency pays monthly premiums to a Medicaid managed care organization (MCO). Each MCO pays its own health care claims.</p> <p><b>Implications: Less timely payments to providers; lack of standardization across plans; administrative costs typically in excess of 11%, which would result in an immediate 8%+ cost increase in Connecticut.</b></p>

Self-Insured/Managed FFS	vs.	Capitated Managed Care
<p>Connecticut Medicaid assumes financial risk.</p> <p><b>Results:</b> In periods of favorable trends, savings are immediately captured by the State; all pharmacy rebates inure directly to the State; if concerning trends emerge, the program can quickly course correct with policy interventions; while State expenditures may be less predictable, a statewide claims data set enables effective and timely financial analytics.</p>	<p><b>Assumption of Risk</b></p>	<p>The Medicaid MCO assumes financial risk.</p> <p><b>Implications:</b> In periods of favorable trends, savings inure to the benefit of the MCOs; limited encounter data does not effectively enable financial analytics or near-term policy interventions; while State payments can be more predictable, historically, Connecticut plans overran their PMPM.</p>

Self-Insured/Managed FFS	vs.	Capitated Managed Care
<p>Connecticut Medicaid controls and has standardized coverage, utilization management (including a statewide Preferred Drug List) and provider reimbursement statewide. Connecticut Medicaid has also implemented statewide care delivery and value-based payment reforms.</p> <p><b>Results: Lower administrative costs across the entire program; better member and provider literacy about program coverage and utilization standards; less administrative burden for providers; no migration of members from plan to plan; greater leverage for interventions to have impact on a program/population basis.</b></p>	<p><b>Plan Design</b></p>	<p>Each Medicaid MCO determines its own coverage, utilization management, provider network, and provider payments. Each MCO determines its own care delivery and value-based payment approach.</p> <p><b>Implications: Higher administrative costs caused by lack of standardization; more complicated for members and providers to understand; more administrative burden for providers, across varying plans; considerable migration of members among plans; varying reform approaches may have a more diluted effect.</b></p>

Self-Insured/Managed FFS	vs.	Capitated Managed Care
<p>Connecticut Medicaid has a fully integrated, statewide set of claims data.</p> <p><b>Results: Timely identification of and response to developing cost trends through informed policy interventions; strong capacity to be transparent and timely in reporting on program performance</b></p>	<p><b>Data</b></p>	<p>Each Medicaid MCO produces limited “encounter data” for the Medicaid program.</p> <p><b>Implications: Lack of data and associated analytics favors MCOs in negotiations over rates and slows the State’s capacity to respond through policy to emerging issues and trends; limited, retrospective capacity to report on program performance</b></p>

# Quality Results

## **HUSKY Health analyzes its outcomes through the following means:**

- Use of a fully integrated, statewide set of Medicaid claims data to report on a broad array of HEDIS and hybrid measures (Connecticut voluntarily reported on 18 of 21 measures in the CMS Medicaid/CHIP Child Core set and on 15 of 16 measures in the CMS Adult Core set)
- Extensive use of CAHPS and mystery shopper surveys
- Geo-access analyses of provider participation
- Provider surveys

## Key Quality Indicators

- In the initial reporting period for the national scorecard, Connecticut’s performance was well above the national median for the majority of State Health System Performance Measures, including well child visits, immunizations for adolescents, use of multiple concurrent anti-psychotics in children and adolescents, preventive dental visits, and diabetes short-term complications admission
- These results reflect the trend from Calendar Year 2015 through Calendar Year 2019:

Indicator	Trend
Routine care – physician services	Up 11%
Hospital admissions per 1,000	Down 10.6%
Hospital re-admissions per 1,000	Up 4.5%
Average length of stay hospital	Down 4%

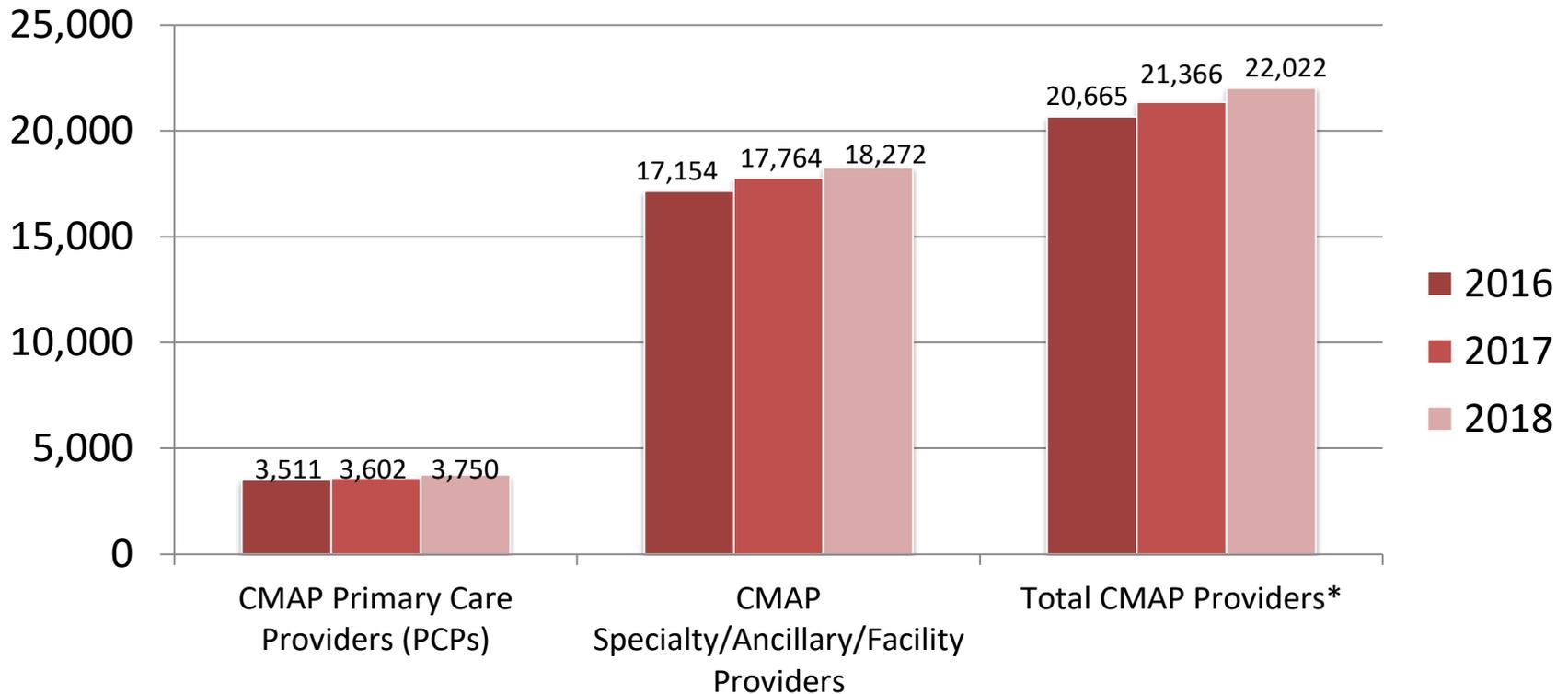
## Member Program Satisfaction

- Achieved an overall member satisfaction rating of 93.0% among adults surveyed with respect to experience with HUSKY Health PCMH practices
- Achieved a 94.6% overall favorable rating by members surveyed for satisfaction with the ICM program
- Achieved a 97.12% overall favorable rating by members surveyed for satisfaction after completion of a call with the CHNCT Member Engagement Services call center

## Provider Program Satisfaction

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

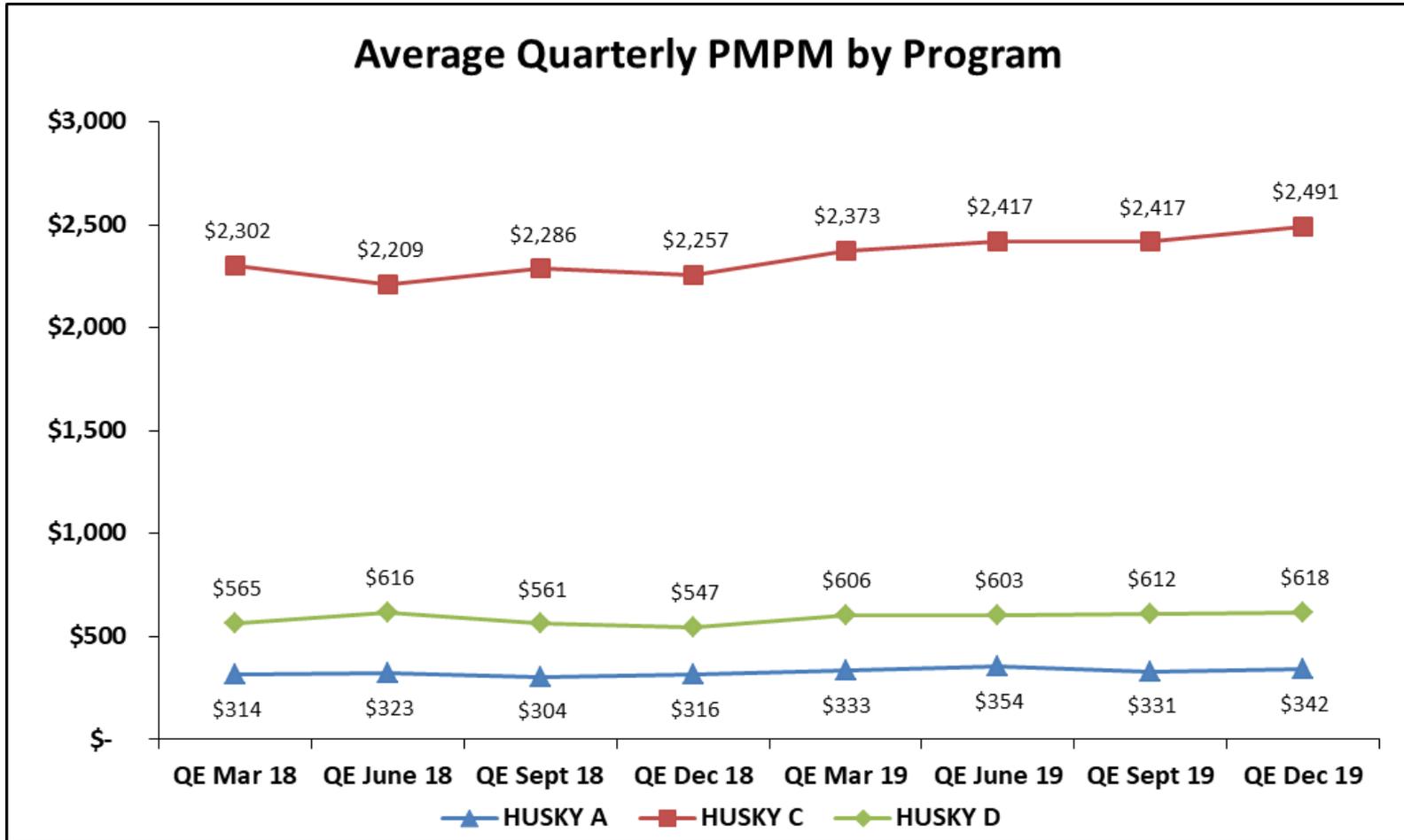
## Provider Network Growth 2016-2018



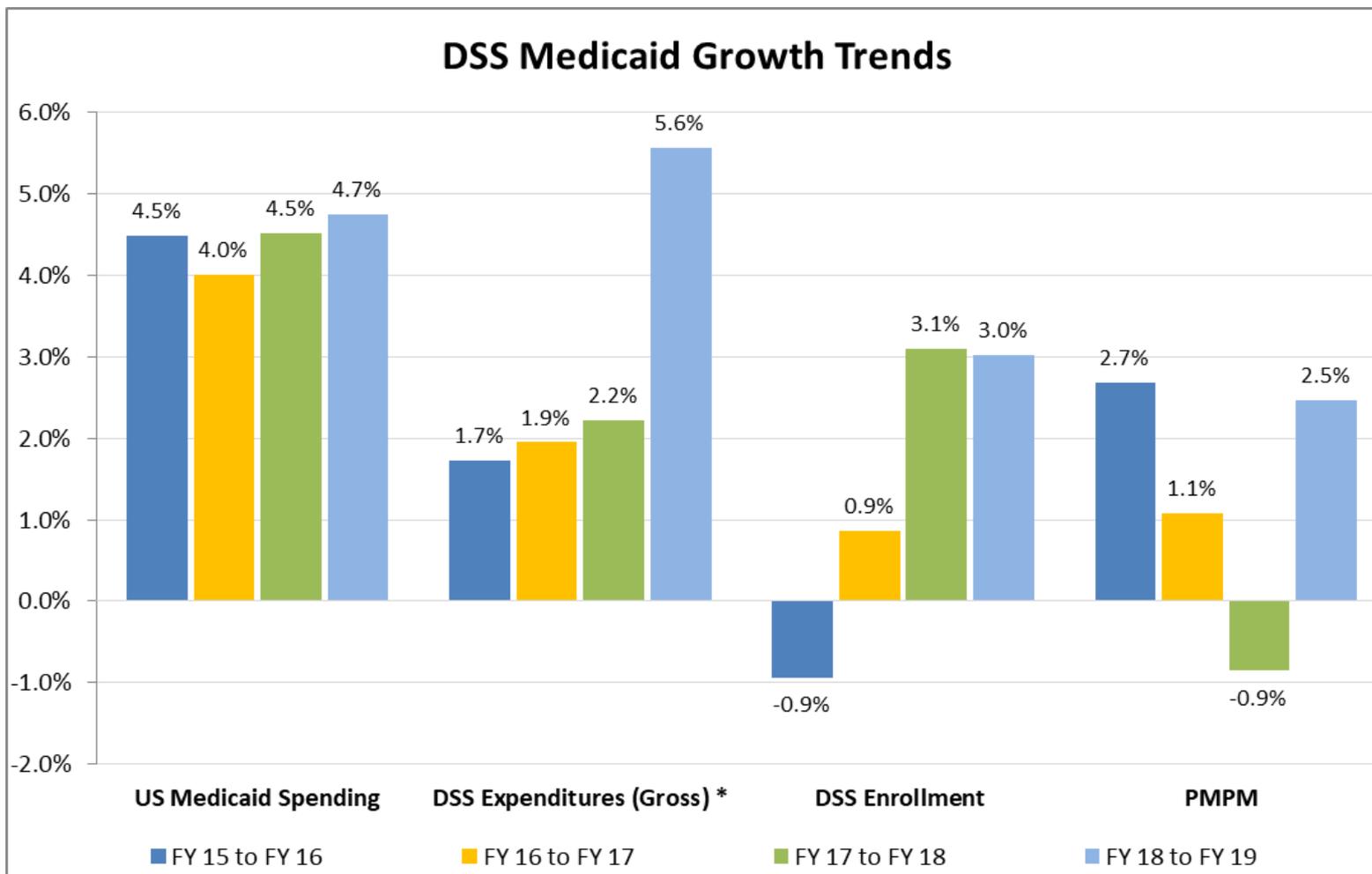
# Financial Trends

## Connecticut Medicaid is efficient and effective.

- **Low administrative load:** program has administrative costs of *only 3.0%*
- **Favorable per member, per month (PMPM) cost trends:**
  - reforms have reduced PMPM more than any other state in the country
  - Connecticut went from being in one of the three most costly states to being ranked 22<sup>nd</sup> in the country – lower than all New England states, New York and New Jersey
- **Low spending growth rate:** the program's growth rate is *less* than the national average, *less* than Medicare, and *less* than private health insurance
- **Stable state costs:** the program has maximized federal funding and the state share of funding for Connecticut Medicaid has *remained stable* since 2014
- **Low percentage of total state budget:** Connecticut Medicaid has the *lowest* Medicaid expense as a percentage of total state budget of any state in the region other than New Jersey, and is below the national average

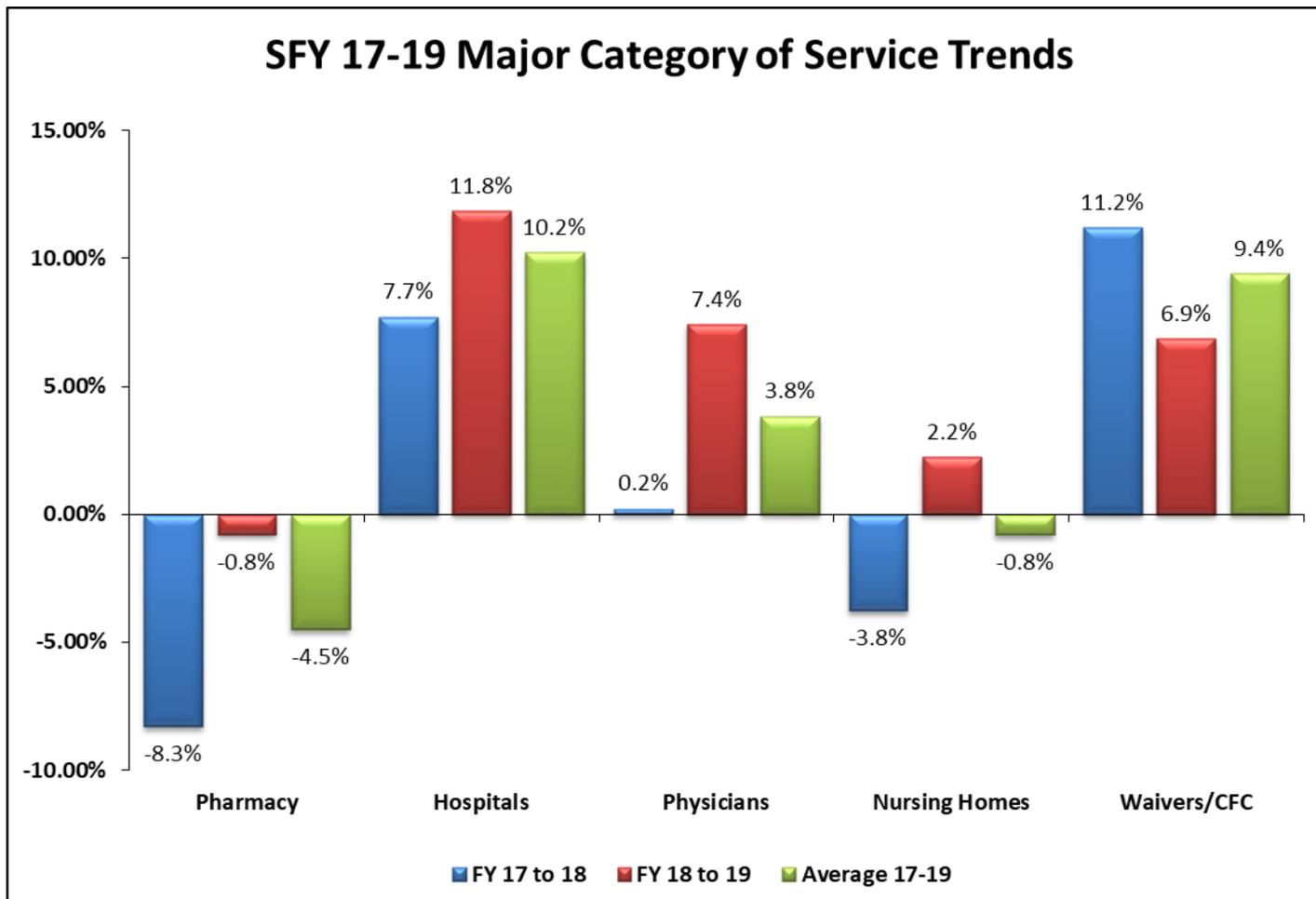


Expenditure trends have remained relatively steady over the past eight quarters across all HUSKY programs



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

- **PMPM Trends in the Medicaid Account**
  - Average DSS Medicaid account PMPM growth has been approximately 1.35% annually from SFY 2015 to SFY 2019
  - While not represented on the graphic, since SFY 2014 the PMPM has remained virtually unchanged
  - The most recent PMPM for SFY 2019 increased by 2.5%; without the annualization of the 2018 hospital rate increase, the PMPM increase would have been approximately 1.0%.
  - If CT Medicaid expenditures had grown at the national average for the SFY 2015 to SFY 2019 period, costs could have been \$400 million higher



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

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

	<u>SFY 2015</u>	<u>SFY 2016</u>	<u>SFY 2017</u>	<u>SFY 2018</u>	<u>SFY 2019</u>
Connecticut	23.1%	22.6%	22.9%	24.4%	23.8%
Maine	32.8%	33.0%	32.2%	33.6%	33.8%
Massachusetts	23.7%	27.8%	28.0%	29.2%	28.7%
New Hampshire	29.7%	34.7%	36.6%	35.5%	35.2%
Rhode Island	30.4%	29.0%	29.9%	29.3%	27.4%
Vermont	28.5%	29.5%	28.8%	28.2%	28.7%
New Jersey	24.2%	25.0%	24.5%	24.3%	23.7%
New York	31.7%	31.9%	34.3%	35.6%	35.3%
Peer State Avg (w/o CT)	28.7%	30.1%	30.6%	30.8%	30.4%
All States	27.9%	28.8%	28.9%	29.2%	28.9%

CT's Medicaid to total State budget cost ratio was lower than the all states average and the average of its peer states from SFY 2015 through 2019

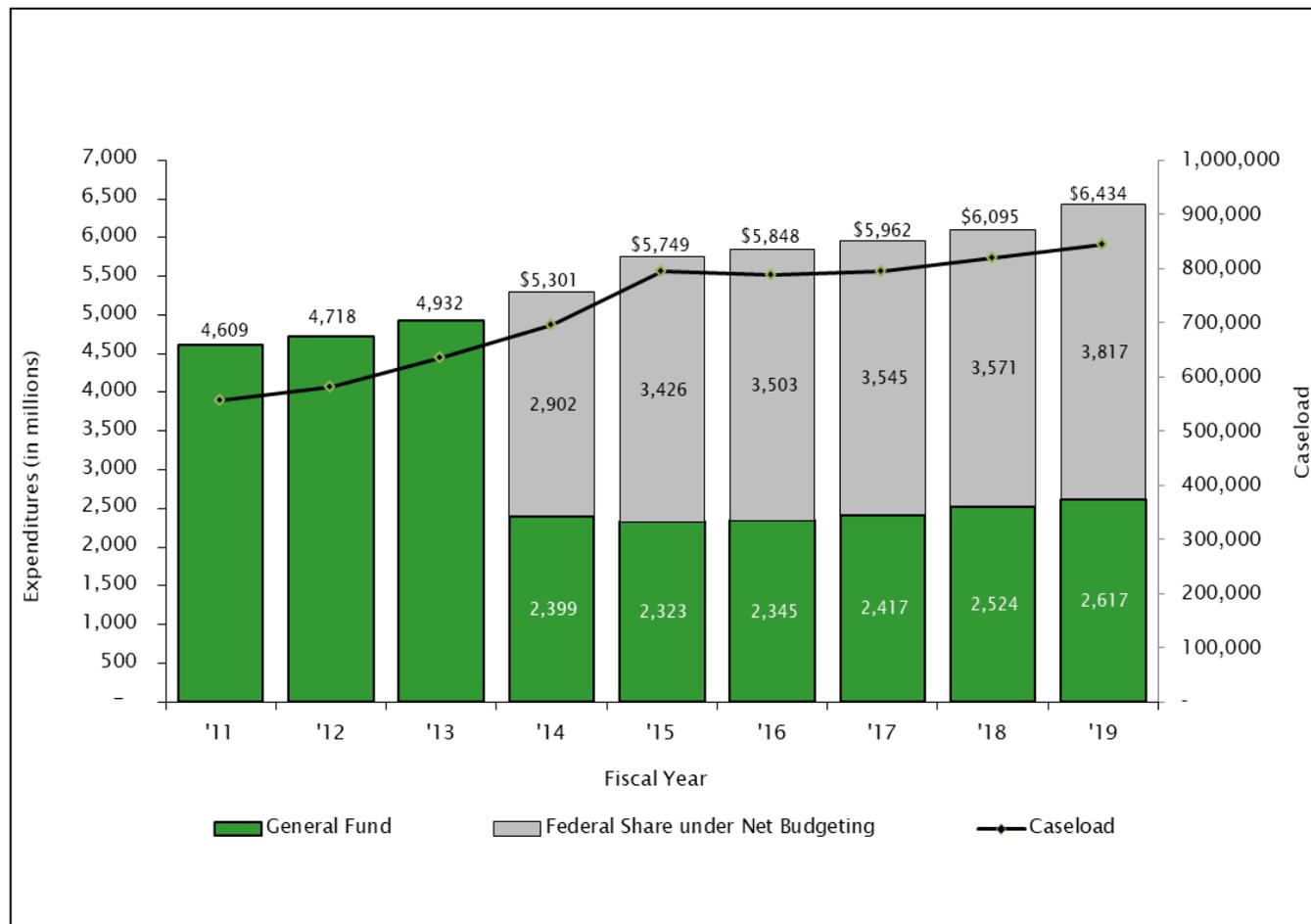
\*Per National Association of State Budget Officers (NASBO) State Expenditure Reports; includes both federal and state Medicaid shares

CT's state share of Medicaid costs have remained stable.

State share of costs was virtually unchanged from SFY 2013 to 2017.

SFY 2019 state share was only \$151 million, or 6.1%, higher than the estimated SFY 2013 state share. This equates to an average annual increase of 1.0%.

SFY 2018 and 2019 began to rise due to lower federal reimbursement for single adults and hospital rate increases.



\*Excludes hospital supplemental payments

**Questions?**