



HealthFirst Connecticut Authority

Report to the Legislature
February 26, 2009

HealthFirst Ct Authority



Achieving the twin goals of coverage and care

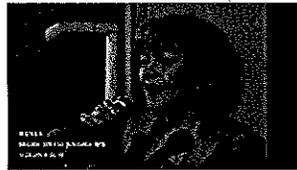
Report to the Legislature



Our Charge



- Achieve universal coverage and access to care consistent with IOM principles
- Coverage: continuous, equitable, affordable
- Care: Patient centered, timely, safe, effective
- Considering cost, quality, access, safety, HIT, chronic disease



Principles of Care



- Access—close to home, patient-centered
- Quality and Efficiency
- Coordinated and culturally appropriate
- Emphasizing wellness
- Integrity and responsibility
- Emphasized engaged, activated patients and consumer



Principles of Coverage



- Affordable
- Care is available
- Benefit structure is evidence based
- Value-driven and supportive of the principles of care



Process



- First met October 2008
- Immediately moved to create diversity on Authority
- Created two large workgroups, Quality/Access/Safety and Cost/Cost Containment Finance
- 27 meetings in total
- And held 9 public hearings across Connecticut

HealthFirst CT Vision: Protect, Promote, Maintain The Health Of All People Of CT



- Access to group-based public or private insurance for all
- Access to a medical/dental healthcare home for all
- Prevention a priority
- Care that meets the IOM principles: (timely, safe, effective, patient centered)
- Coverage that meets the IOM principles (continuous, equitable, affordable)

Building Blocks



- Every residents with incomes below 300%FPL will have access to a public (Medicaid or schip) product
- Premiums, deductibles, co pays, will be consistent with generally accepted affordability indices
- All insurance paid for in full or part by CT will incorporate value based design elements that encourage prevention, early detection of disease, and effective disease management



Recommendations



- Build upon the current employer sponsored healthcare system
- Maximize federal reimbursement for all public programs
- Avoid “crowd out” of ESI. Allow state flexibility to subsidize low income workers with access to employer sponsored insurance but unable to afford premiums



Recommendations



- Engage all health care providers in the care of the publicly insured through addressing inadequacies in (Medicaid) fee schedule for all public programs: increase to Medicare upper payment limit
- Residents with incomes > 300% FPL who do not have access to ESI, or who have pre-existing conditions that render coverage unobtainable or unaffordable, access a redesigned Charter Oak with out of pocket expense tied to affordability indices



Publicly Sponsored Plans: steps to take



- CT will submit waivers to CMS requesting:
- Conversion of SAGA to Medicaid
- Conversion of Charter Oak(a) to Medicaid, with upper limit of 300% FPL
- Charter Oak (b) non-Medicaid > 300% FPL
- Expansion of HUSKY A Parent eligibility to 300% FPL (consider premium/co-pay)
- Support HUSKY B parents with stepped premium scale



Private Coverage



- All insurance that Ct. pays for will incorporate value based design elements.
- Did not reach consensus on opening the state employee health plan to small employers, non profits, and individuals.
- Supporters point to evidence that suggest allowing small employers to join pool would decrease uninsured in these ranks, provide lower cost alternative for some individuals and businesses, create value-based design option
- Opponents point to possible cost implications, adverse selection, too large a public plan



Transforming Care



- “Medical home”/High performance health systems
- Health Information Technology
- Access to full range of primary care providers
- Support patients and providers in managing chronic disease care and coordination
- Adopt common performance measures
- Adopt common patient safety reporting measures



Transforming Care



- Create health data infrastructure that drives planning, value design, evaluation, accountability. Without data we can neither plan, nor monitor, nor evaluate, nor improve. It is critical
- Develop automatic enrollment of providers into public programs at time of licensure, with opt out provision
- Increase provider reimbursement rates under public programs to equal Medicare rates
- Develop statewide plan for expansion of safety net system of FQHCs in areas of geographic or population need—but must meet NCQA medical home standards



Priorities



- Universal coverage
- Improvement in chronic disease care and coordination (potential model submitted)
- Data collection, analysis, and use to drive design and health planning (potential model submitted)
- Healthcare workforce planning



Oversight Entity



- Health reform that includes both coverage expansion and care transformation has four critical functions
 - data collection and analysis
 - policy development based on analyses
 - implementation of programs that support these policies
 - monitoring and evaluation of effects



Recommendations



- Assign an entity to oversee reforms and coordinate state spending on health care
- For now, staffing to come from existing resources
- Guided by board that is free of conflicts of interest



Conclusion



- Pressing need for both coverage and care
- Data driven-value based to control costs
- New approach to chronic disease care and coordination is called for.
- Speed up HIE adoption and expansion
- Address healthcare workforce shortages
- Recommendations align with direction of federal plans
- Dr. Jon Gruber of MIT is preparing financial models



With Thanks To...



- Members of the HealthFirst Authority, Statewide Primary Care Access Authority, QAS and CCF workgroups
- Joseph Goldman and Beverley Henry, State of CT
- Barbara Ormond and Randy Bovbjerg, Urban Institute
- Enrique Martinez, Academy Health

