

Connecticut HUSKY Health:

**Cost Drivers, Reform Agenda, Outcomes, Future
State and Response to Bailit Recommendations
to Health Care Cabinet**

**Presentation to the
Medical Assistance Program Oversight Council**

October 14, 2016

- Overview
- Cost drivers
- Reform agenda
- Documented outcomes
- Long-term strategies: future state
- Response to Bailit recommendations

HUSKY Health Overview

Critical source of economic security and well-being to over 750,000 individuals (21% 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.

- Administrative costs are 5.2%. Total staffing (131 individuals) 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 (70.7% of department budget) are increasing based on caseload growth, but trends in per person costs are stable and quality outcomes have improved.

Programs supported:

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

SFY 2016 estimated staffing costs: \$8.3 million

Administrative cost ratio: 5.2%

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

SFY'17 proposed program budget:

- \$3.20 billion (appropriated)
- \$6.87 billion (total)

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



HUSKY Health is improving outcomes while controlling costs.

Health outcomes and care experience are improving. We are enabling independence and choice for people who need long-term services and supports.

Provider participation has increased.

Enrollment is up, but per member per month costs are stable.

The state share of HUSKY Health costs has decreased.

HUSKY Health has maximized benefits under the Affordable Care Act.

- 100% federal coverage for expansion of Medicaid eligibility (HUSKY D)
- coverage of new preventative services including smoking cessation and family planning
- new resources for behavioral health integration through DMHAS-led health homes
- \$77 million in funding under the State Balancing Incentive Program for home and community-based long-term services and supports (LTSS)

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.

We have two critical reform hypotheses:

Centralizing management of services for all Medicaid beneficiaries in self-insured, managed fee-for-service arrangements with Administrative Services Organizations, as well as use of predictive modeling tools and data to inform and to target beneficiaries in greatest need of assistance, will yield improved health outcomes and beneficiary experience, and will help to control the rate of increase in Medicaid spending.

Building on current preventative and coordinative interventions (e.g. PCMH, ASO-based Intensive Care Management, DMHAS health home) by migrating current interventions to a more community-based approach and incorporating appropriate value-based payment methodologies (e.g. pay-for-performance, bundled payments, payment episodes, shared savings arrangements) will yield further improvements in health outcomes and beneficiary experience, and will continue to control the rate of increase in Medicaid spending.

Cost Drivers

Key cost drivers for Medicaid include the following:

- “high need, high cost” individuals with complex health requirements
- individuals who receive long-term services and supports (LTSS)

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:

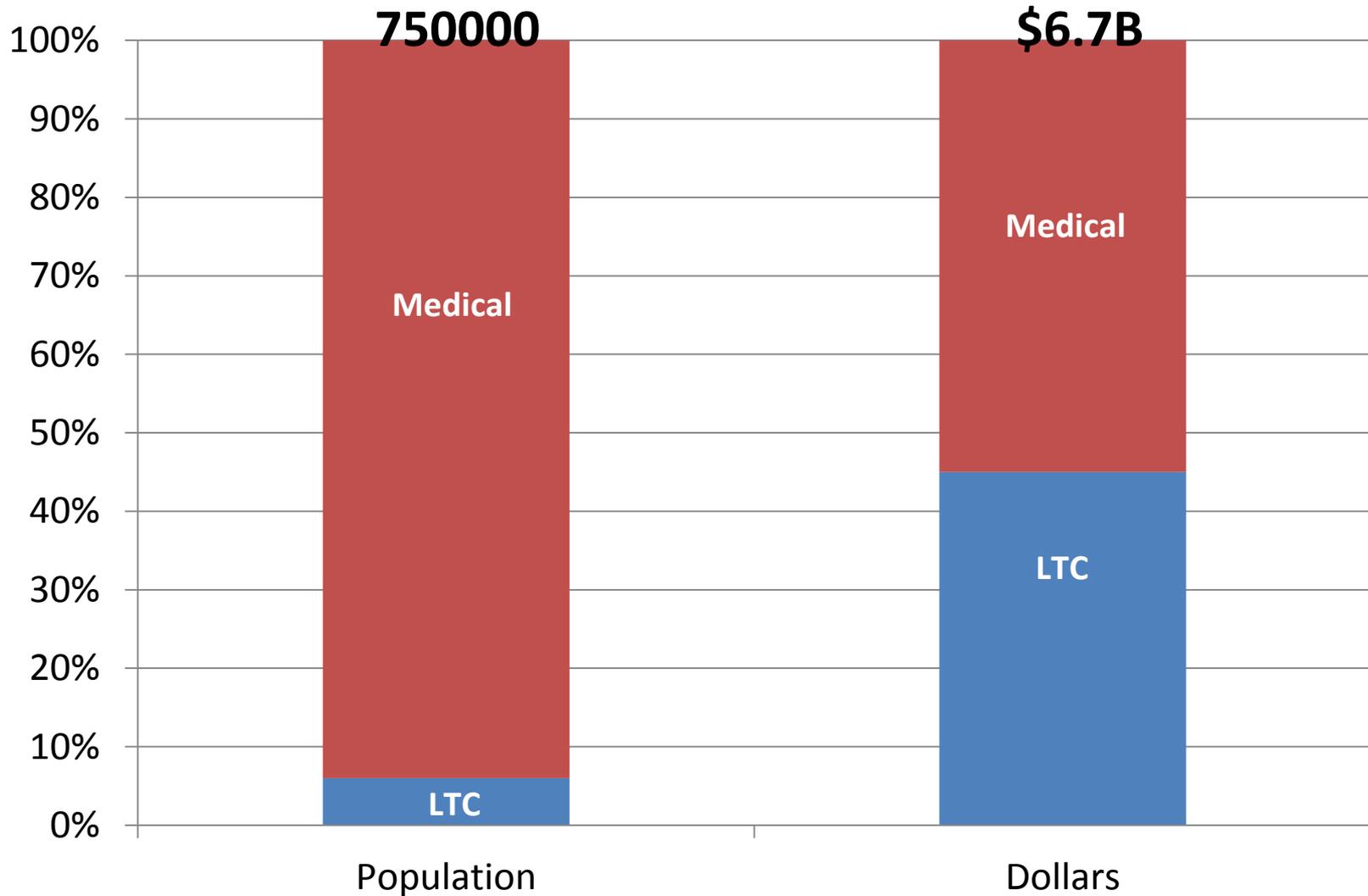
1. Highest 10% members by cost, **excluding nursing home (NH) residents**
2. Highest 10% of members with hospital admission
3. Highest 10 % of members with ED utilization
4. Total unduplicated members from 1, 2, & 3

Hospital Inpatient Conditions Adults & Children

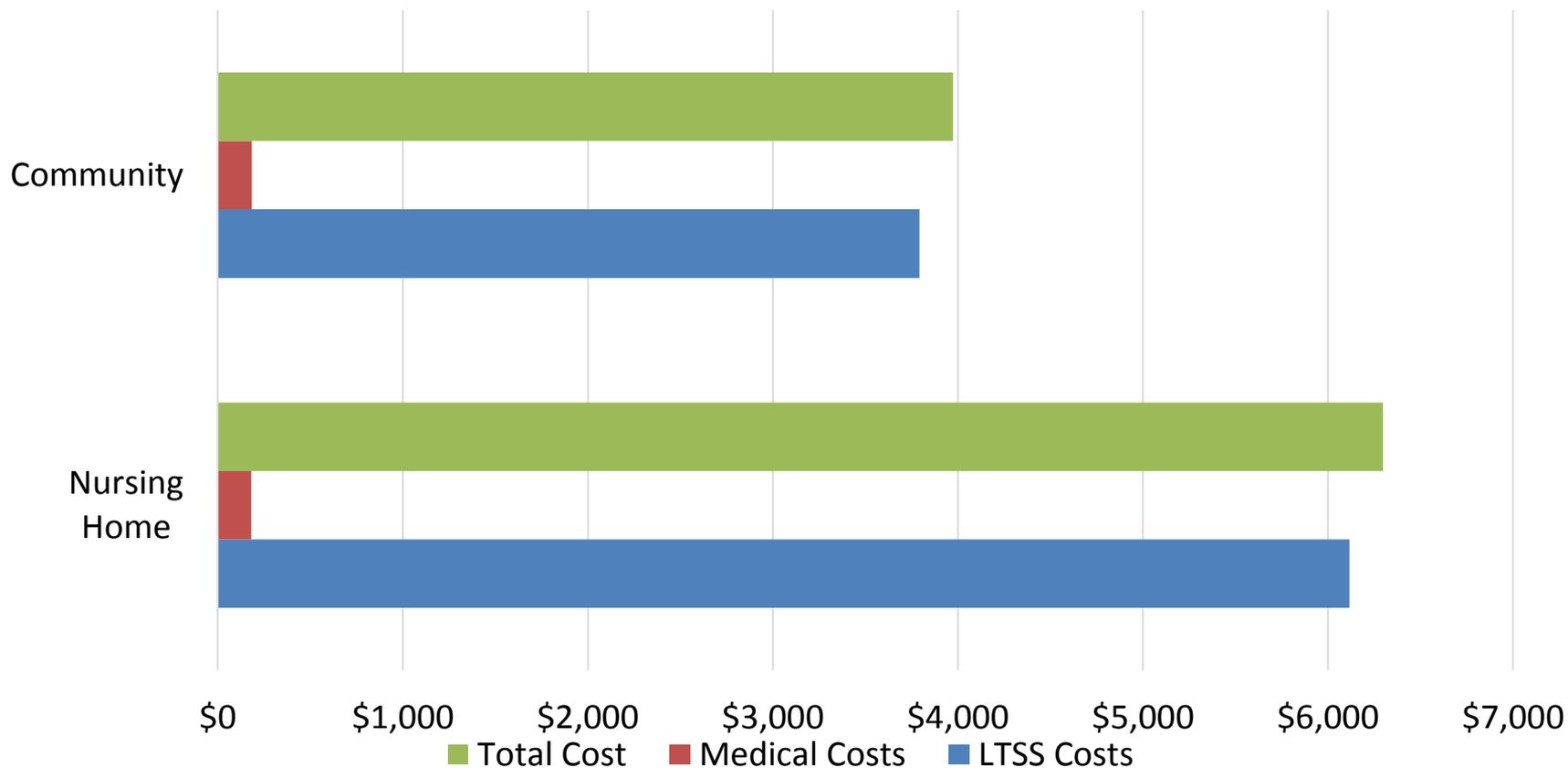
Inpatient Conditions	Total Adults admits: 7,457	Total Children admits: 3,315
Infectious/Neoplasms/Nutritional/ Diseases of Blood	1,459 (20%)	419 (13%)
Mental Disorder	1,413 (19%)	669 (20%)
Diseases of Nervous/Circulatory/Genitourinary System	1,251 (17%)	264 (8%)
Diseases of Respiratory/Digestive	1,627 (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%)

Individuals who receive LTSS:

- 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**



A comparison of average community and institutional costs for individuals at nursing home level of care (2012)



Connecticut Medicaid Reform Agenda: Addressing Cost Drivers through Care Coordination, Practice Transformation and New Payment Modalities

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 that contracts with Administrative Services Organizations**
- **unique, cross-departmental collaborations including administration of the Connecticut Behavioral Health Partnership (DSS, DCF, DMHAS), 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, Electronic Health Record payments)
- comprehensive coverage of preventative behavioral health and dental benefits

Coordinating and integrating care through . . .

- ASO-based Intensive Care Management (ICM)
- Cross ASO collaboration
- PCMH practice transformation
- DMHAS-led behavioral 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 . . .**

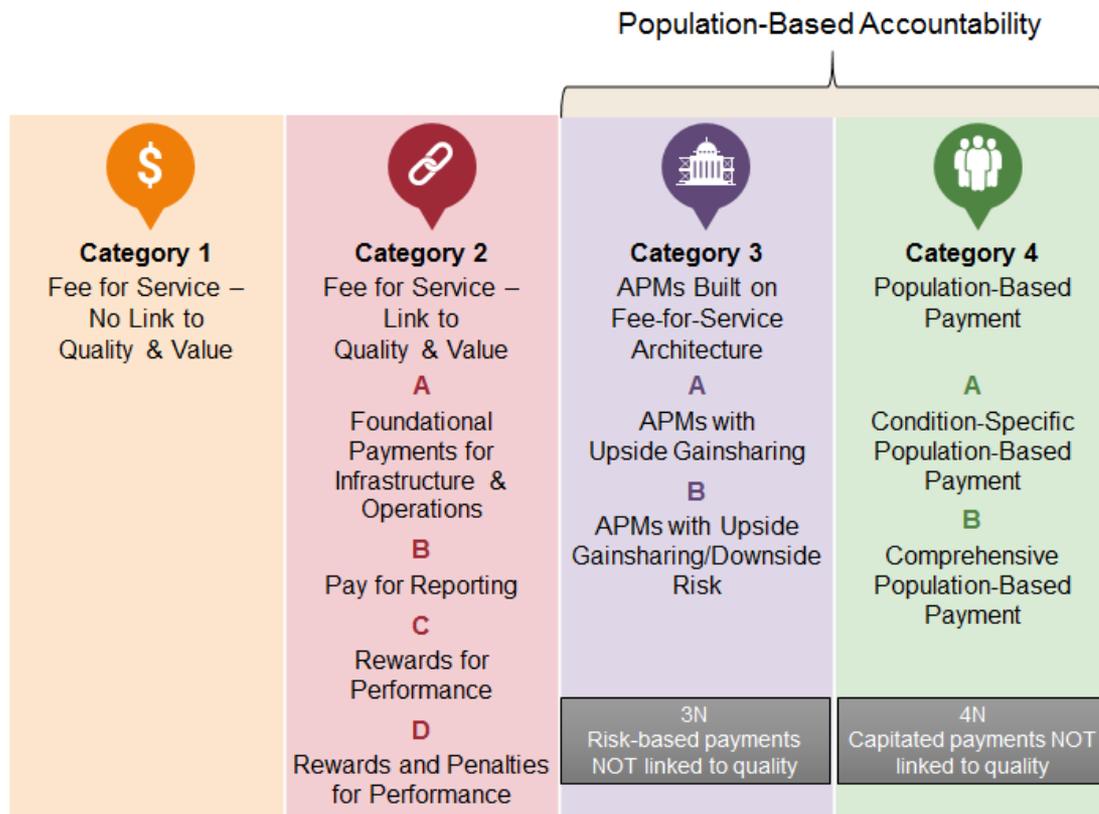
**A multi-faceted Governor-led re-
balancing plan that includes:**

- **Extensive collaboration by DSS, DMHAS, DDS, DOH**
- **State Balancing Incentive Program (BIP) activities**
- **LTSS waivers (DSS, DMHAS, DDS)**
- **Nursing home “right sizing”**
- **Workforce initiatives**
- **My Place consumer portal**

**Moving toward Value-Based
Payment approaches through . . .**

- **Hospital payment modernization**
- **Pay-for-performance (PCMH, OB)**
- **PCMH+ shared savings initiative**

HCP-LAN Framework for Alternative Payment Models (APMs)



The framework situates existing and potential APMs into a series of categories.

N = payment models in Categories 3 and 4 that do not have a link to quality and will not count toward the APM goal.

 = example payment models will not count toward APM goal.

Source: <https://hcp-lan.org/groups/apm-fpt/apm-framework/>

It is important to note that:

- 43% of Connecticut Medicaid members are already served in a Category 2C Alternative Payment Model (APM) through the Person-Centered Medical Home initiative
- PCMH+, which will launch on January 1, 2017 and is an example of a Category 3A APM, will further build out Connecticut Medicaid's commitment to APMs

	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 and those not served by MCOs had no organized source of care coordination	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



Documented Outcomes

HUSKY Health analyzes its outcomes through the following means:

- Use of a broad array of HEDIS and hybrid measures
- Use of Consumer Assessment of Healthcare Providers & Systems (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 access to services?

■ Medical Providers

- Overall participation:
 - Primary care providers: **3,454**
 - Specialists: **13,379**
- Network growth over calendar year 2015: **7.22%**
- Recruited and enrolled **17 new practices** into DSS' Person-Centered Medical Home (PCMH) program

■ Behavioral Health Providers

- Overall participation:
 - Behavioral health providers: **4,537**
- Network growth over calendar year 2015: **15.94%**

■ Dental Providers

- Overall participation:
 - Primary care providers: **1,787**
 - Specialists: **415**
- Network growth over calendar year 2015: **10.00%**

What relevant results do we see in Connecticut, related to our PCMH initiative?

- As of October, 2016, **108 practices** (representing **435 sites** and **1,518 providers**) were participating
- These practices are serving **328,169 Medicaid members** – **over 43%** of all members

- **PCMH practices achieved better results than non-PCMH practices** on measures including, but not limited to, ambulatory ED visits and readmissions within 30 days – physical and behavioral health
- **92.2% of adults, and 95.8% of adults responding for children,** surveyed reported immediate access to care
- **92.8% of adults, and 98.6% of adults responding for children,** surveyed reported overall positive experience with the program

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

- Over SFY'16, Connecticut Medicaid's medical ASO, CHNCT, has:
 - for those members who received ICM, **reduced emergency department (ED) usage by 22.28%** and **reduced inpatient admissions by 39.08%**
 - for those members who received Intensive Discharge Care Management (IDCM) services, **reduced readmission rates by 27.18%**

- Connecticut Medicaid's dental ASO, BeneCare, has:
 - from SFY'14 to SFY'15, **reduced emergency visits for dental conditions by 9.6%**
 - from SFY'15 to SFY'16, **increased use of preventative services:**
 - **by 5.46%** for adults
 - **by 3.88%** for children

What relevant results do we see in Connecticut, related to overall utilization trends?

- Over SFY'16, through a range of strategies (e.g. Intensive Care Management, behavioral health community care teams) and in cooperation with the Connecticut Hospital Association, **the Emergency Department visit rate was reduced by:**
 - **5.80%** for HUSKY A and B
 - **3.10%** for HUSKY C
 - **8.57%** for HUSKY D

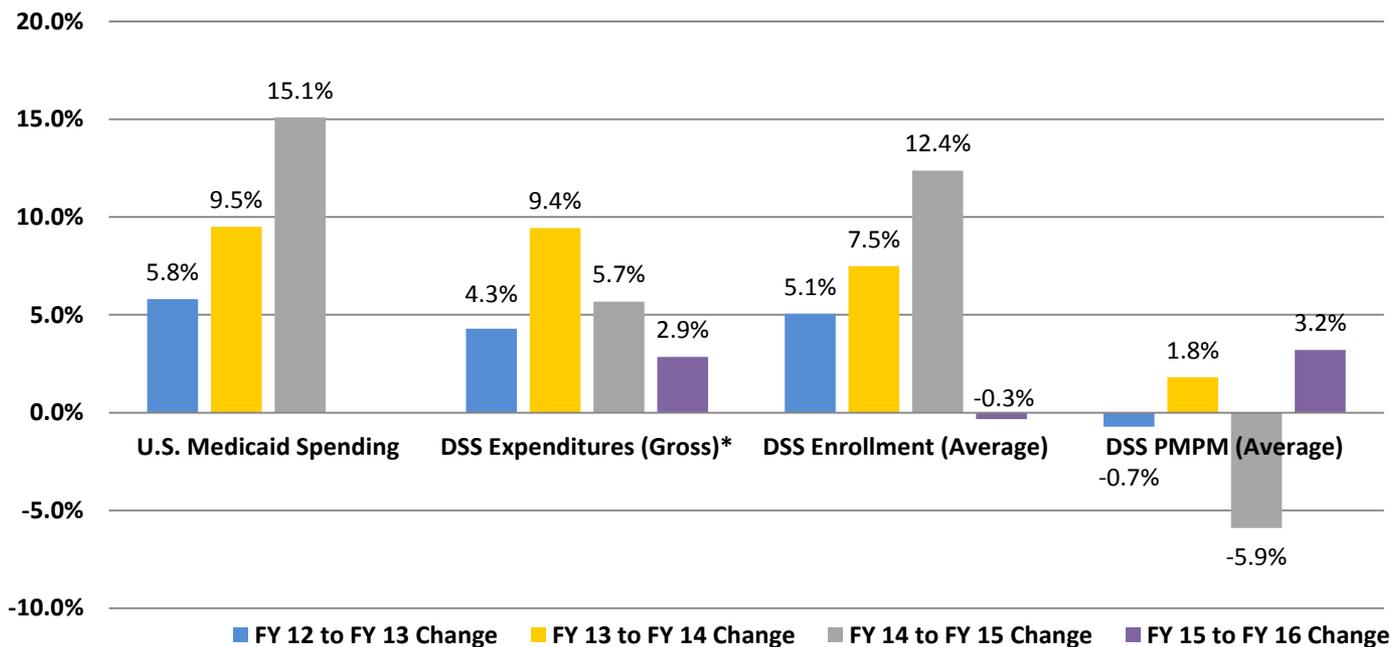
Over SFY'16:

- Overall admissions per 1,000 member months (MM) **decreased by 5.4%**
- Utilization per 1,000 MM for emergent medical visits **decreased by 4.3%**
- Utilization per 1,000 MM for non-emergent medical visits **decreased by 2.7%**

What relevant results do we see in Connecticut, related to LTSS rebalancing?

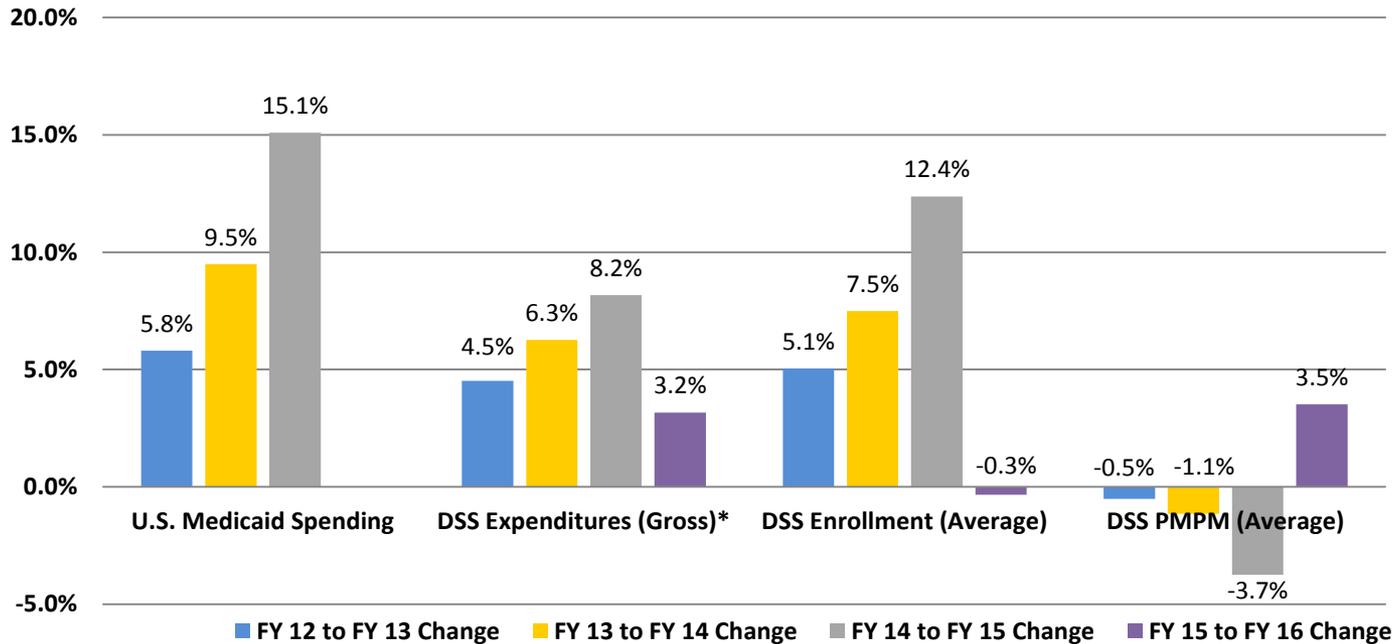
- Over SFY'16, the Money Follows the Person (MFP) Program supported 804 individuals in transitioning from institutional environments to the community
- Since the inception of the program, there have been over 3,800 individuals transitioned
- DSS also launched self-directed personal care supports under the Community First Choice State Plan option

Medicaid Trends

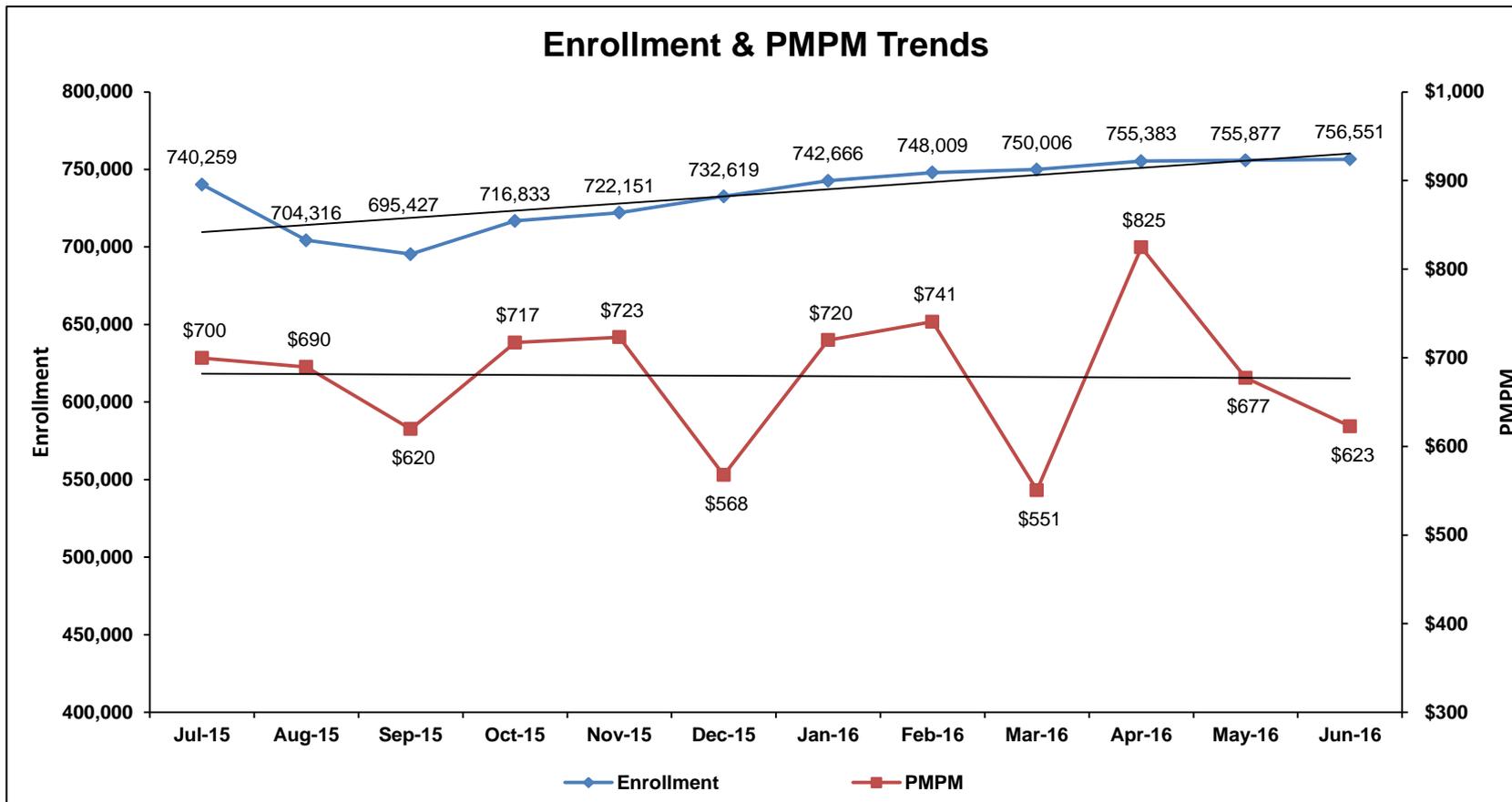


* Expenditures are net of drug rebates and include DMHAS' behavioral health costs claimable under Medicaid. This depiction **includes** all hospital supplemental and retro payments.

Medicaid Trends

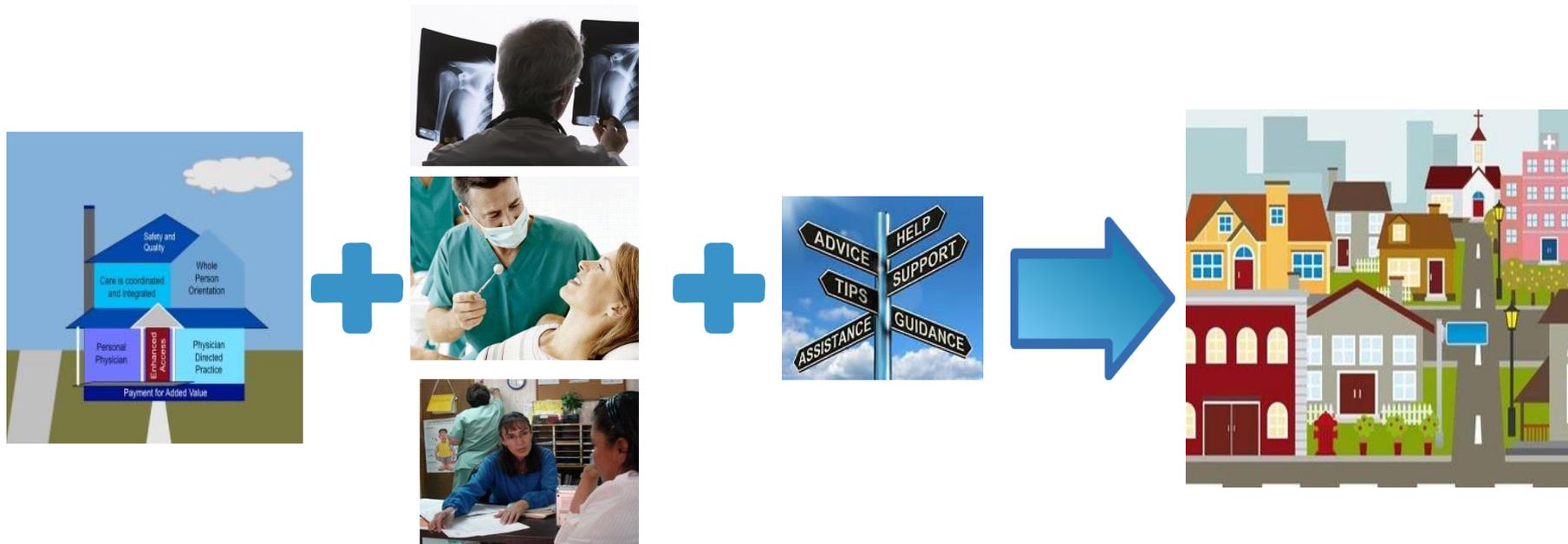


** Expenditures are net of drug rebates and include DMHAS' behavioral health costs claimable under Medicaid. This depiction **excludes** all hospital supplemental and retro payments.*



Expenditures have increased proportionate to the increase in enrollment, but per member per month costs have remained remarkably steady.

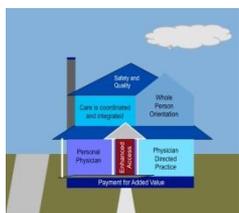
Long-Term Strategies for Cost Containment: The Future State



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



Development of additional value-based payment strategies



PCMH+



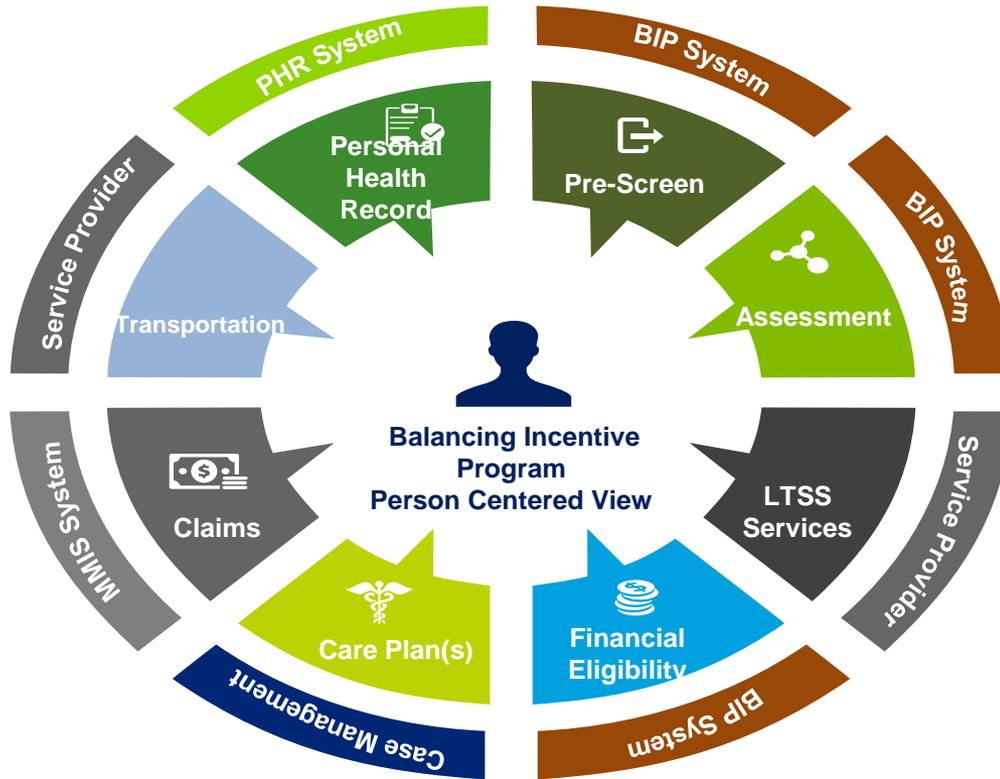
PCMH enhanced fees and performance payments

Obstetrical P4P

Shared savings arrangements

Episodes of care





Achievement of a person-centered, integrative, rebalanced system of long-term services and supports



Responses to Bailit Recommendations

The following core values inform DSS' responses:

- **Do no harm to Connecticut Medicaid members** – model design, structure and Medicaid authority must promote the rights and interests of members, meaningfully contribute to improvement of their health outcomes and care experience, and anticipate and safeguard members from denial of appropriate service or under-service.

- **Build upon existing, proven care delivery interventions in Connecticut Medicaid that have already contained costs** – use of data analytics to risk stratify and predictively model the needs of Medicaid members with complex health profiles, as well as ASO-based Intensive Care Management and embedded Person-Centered Medical Home care management, have established a foundational structure upon which we are building enhanced PCMH+ care coordination activities, and should continue to be the basis of any regional, provider network model that emerges.

- **Take the time to develop and mature oversight of protections for members and the elements of vertical and horizontal integration that are necessary prerequisites for a regional, multi-disciplinary provider model and will be furthered under PCMH+ – under-service protections, Health Information Exchange (HIE) and associated tools, data analytics, financial support for care coordination payments, cross-disciplinary relationships among health and social services providers.**

Bailit recommendation: *The Legislature should require the Medicaid program and the Office of the State Comptroller (OSC) to pursue a Consumer Care Organization (CCO) strategy that includes the use of independent but aligned purchasing strategies, including contract language, with entities that are each accountable for the cost of a comprehensive set of services (e.g., “total cost of care”) for an attributed population using a fee-for-service approach, with a retrospective reconciliation that holds providers accountable for their quality performance, patient access and efficiency.*

Bailit's time frame for implementation of CCOs:

- *Begin contracting with CCOs on January 1, 2019*
- *All CCOs are in a shared savings model, which could be nearly identical to the PCMH+ model, with the exception that CCOs would be provided the opportunity to share in additional savings, from January 1, 2019 to December 31, 2019, if the CCO voluntarily chooses, and demonstrates the capacity, to assume shared risk.*

- *CCOs that are comprised of a substantial number of providers that are participating in PCMH+, or that have participated in any Medicare or commercial shared savings model, move into a shared risk arrangement on January 1, 2020. This is in keeping with the state's commitment to not require Medicaid providers to move risk-based contracts during the SIM initiative.*
- *CCOs that did not exist in any form or did not have prior experience with shared risk, move into shared risk on January 1, 2021.*

DSS response to recommendation on CCOs:

- DSS appreciates assurances that Connecticut Medicaid will not implement downside risk arrangements during the SIM Model Test Grant period.
- Connecticut Medicaid should commit to examining experience on health outcomes, care experience and costs under an upside-only risk arrangement (PCMH+), and ongoing, evaluate the readiness of providers to undertake downside risk, but should not commit at this time to any specific timetable for downside risk.

- Prerequisite features needed to responsibly consider implementation of downside risk include, but are not limited to:
 - development of a package of strategies designed to prevent and mitigate under-service to members;
 - provider experience with upside risk;
 - a functioning HIE or other means of data sharing;
 - up-front funding for care coordination; and
 - development of provider relationships across disciplines.

- It will also be important for DSS to examine the range of existing Medicaid authorities under which a regional approach could be implemented, and to assess the merits, risks, and feasibility of each, before committing to a specific authority pathway.

Bailit recommendation: *The legislature should A) adopt a state-wide health care cost growth cap, B) set targets for value-based payment for all payers in the state.*

DSS response to recommendation on cost cap and targets for value-based payment:

- Bailit has already indicated that the cost cap is not intended for Medicaid.
- DSS has already demonstrated cost containment in Medicaid and will continue to rigorously examine and transparently report on cost trends in Medicaid, but does not support use of a cost cap.

- Further, DSS commits to continuing to build participation in Alternative Payment Models, including the PCMH initiative (a Category 2C APM, currently serving 43% of members) and PCMH+ (a Category 3A APM, launching January 1, 2017), but does not support use of a specific target for value-based payments.

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 represents 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.
PCMH+	PCMH+	PCMH+ is a Connecticut Medicaid initiative under which DSS will enter into shared savings arrangements with FQHCs and advanced networks.
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 helps to ensure effective delivery of the core functions of primary health care.
Value-Based Payment	VBP	VBP links provider payments to improved performance on quality measures.