HealthFirst Connecticut Authority

(draft) Report to the Legislature

December 17, 2008
HealthFirst Ct Authority

Achieving the twin goals of coverage and care

Report to the Legislature (draft)
Our Charge

• Achieve universal coverage and access to care consistent with IOM principles

• Coverage: continuous, equitable, affordable

• Care: Patient centered, timely, safe, effective
And...

• Address cost, cost containment and financing

• Improve safety and quality

• Improve chronic disease care and management

• Consider role of electronic health records and patient satisfaction
Voice of the People

- Here are a few stories (go to tape)
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
Recommendations

• Building block approach, ensuring that every state resident will have access to health coverage via a health insurance pool, whether public or private
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.

- 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 Charter Oak but with out of pocket expense tied to affordability indices.
Publicly Sponsored Plans

- 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

• Create the CT Health Partnership (CHP)

• Open state employees plan to individuals and groups

• Allows businesses and organizations to join a much larger pool, take advantage of purchasing power of state, and decrease costs of researching and administering own plans

• Under CHP, the state will make value-based design changes to state purchased insurance
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

• 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

• Data collection, analysis, and use to drive design and health planning

• 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 a 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
• Work with new federal administration
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