

Financial Trends in the Connecticut HUSKY Health Program - A Foundation for Sustainability

Presentation to the
Medical Assistance Program Oversight Committee

February 8, 2019
Revised February 15, 2019

- Foundation for sustainability
 - Administrative expenses
 - Category of service “rebalancing”
 - Per member per month cost trends
 - State share of Medicaid expenses
 - Medicaid share of the total CT state budget
- Enrollment and expenditure overview
- Summary and financial strengths of managed fee-for-service (FFS) system



Connecticut's Medicaid Financial Trends: Sustainability Benchmarks

- **Strategic financial benchmarks – five pillars of success**
 1. **Administrative load**
 2. **Category of service “rebalancing”**
 3. **Per member per month cost trends**
 4. **State share of Medicaid expenses**
 5. **Medicaid share of total state budget**

What trends are we seeing?

- **Cost trends** in select service categories **align with strategic objectives.**
- 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 stable while the **federal share has increased.**
- HUSKY Health's **financial trends compare very favorably with national Medicaid trends.**

Review of Medicaid Administrative Spending – Administrative Load

Financial Benchmark #1

- Recent MACPAC* report for FFY 2017 cites CT Medicaid administrative costs at 5.4%.
- The MACPAC data includes costs associated with all eligibility staff and systems operations and development. CT incurred over \$157 million in eligibility staff and system support costs in FFY 2017.
- Once these eligibility costs are removed, the MACPAC adjusted admin load for CT would be 3.5% which is actually under the national average of 3.6%, if a similar adjustment is made to all other states.
- Additionally, the exclusion of managed care administrative costs from the comparative data has a major impact on these statistics.

*MACPAC-Medicaid and CHIP Payment and Access Commission

- 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
- 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% 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



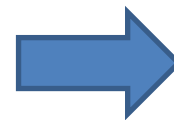
MCO program component at 50%, or \$5 billion

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%

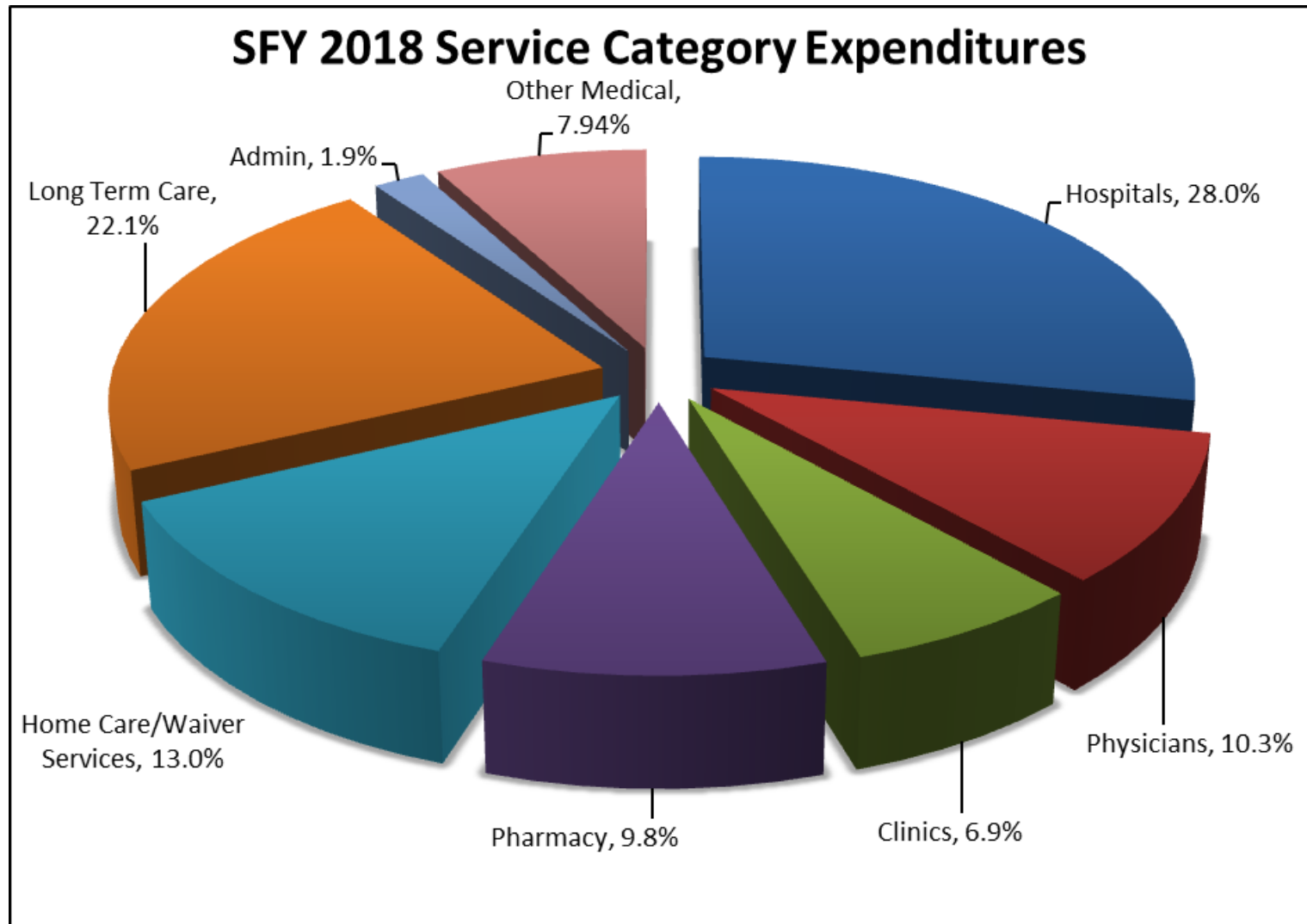


CT's managed fee-for-service system demonstrates clear admin cost efficiencies – if MCO admin costs were considered, CT would rank in the top 5 for lowest percent of administrative spending

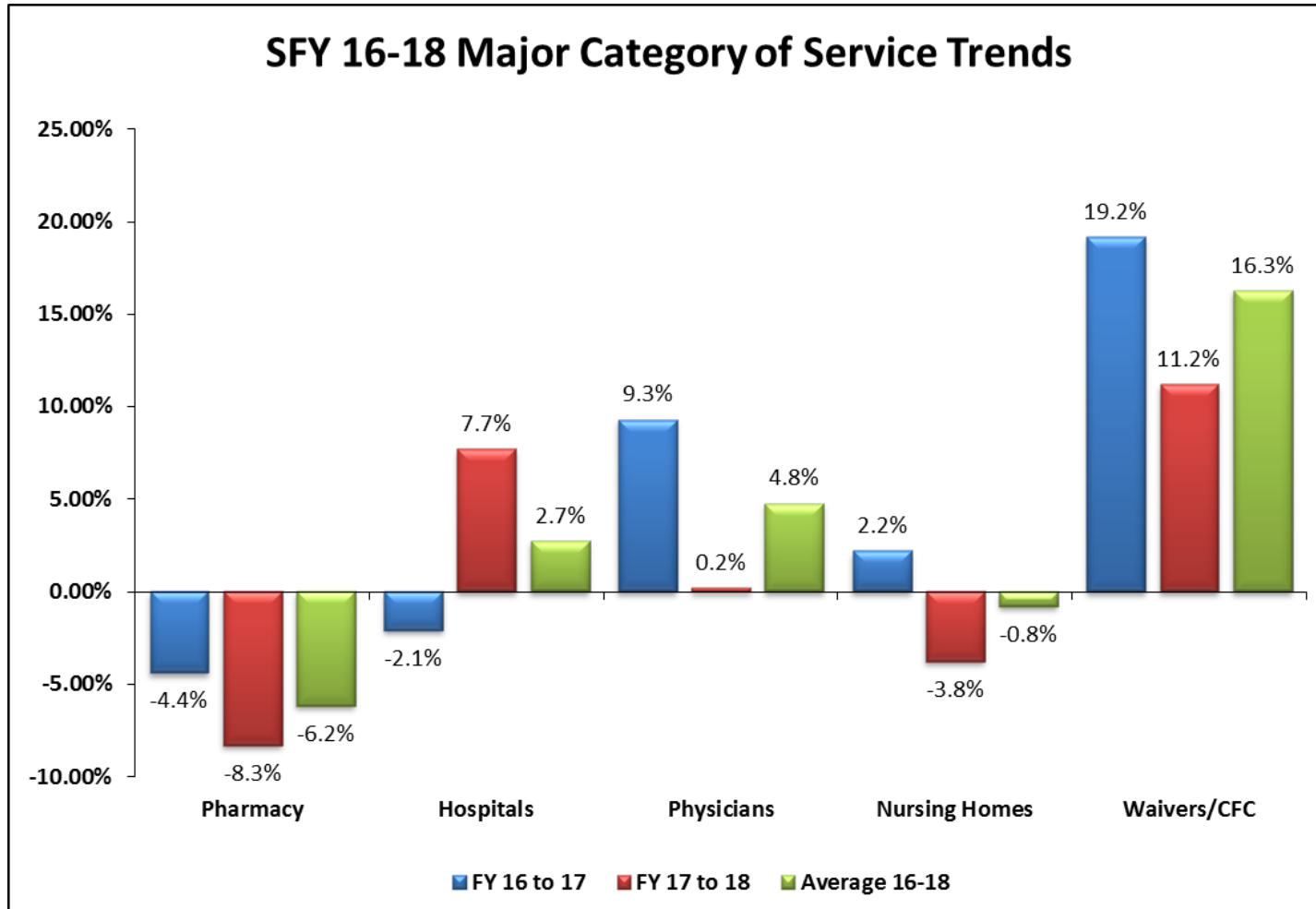
- DSS continues all possible efforts to maximize federal reimbursement for Medicaid administrative and eligibility costs.
- Based upon efforts with Access Health CT (AHCT) on the health insurance exchange, and DSS work on the ImpaCT system, we now receive 75% on all Medicaid allocable eligibility staff and systems operation costs.
- Exclusive of one-time system development costs, which are generally reimbursable at 90%, the federal share of administrative costs has increased to 61.5% in FFY 2018 from 56.7% in FFY 2013.
- As a result of this change and other efficiencies, DSS administrative costs after federal reimbursement are approximately \$6 million less than they were in FFY 2013.

Review of Medicaid Spending by Service Category and Rebalancing

Financial Benchmark #2



- Category of services trends in major areas
- Rebalancing long-term services and supports (LTSS)
 - Investment in LTSS waivers
 - Stability in nursing home costs
- Payment reform/cost controls
 - Stability in net pharmacy costs
 - Stability in hospital costs
- Service investments
 - Increase in physician expenditures



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

- Pharmacy expenses and enhanced rebates
 - Pharmacy rebate growth has exceeded the growth in gross pharmacy costs, resulting in a reduction in net pharmacy costs
 - CT's rebate percentage has grown from 49.4% in SFY 2015 to 67.2% in SFY 2018
 - CT ranked 16th in the nation in terms of its rebate recovery percentage in FFY 2017

Actual	SFY 15	SFY 16	SFY 17	SFY 18	SFY 18 vs. 15
Pharmacy Gross Expenses*	1,071,729,224	1,238,980,681	1,281,608,644	1,301,447,228	229,718,004
Medicaid Drug Rebates	(529,399,553)	(752,456,475)	(816,519,421)	(875,006,383)	(345,606,830)
Net Pharmacy Expenses	542,329,671	486,524,207	465,089,223	426,440,845	(115,888,826)
% Change by Year		-10.3%	-4.4%	-8.3%	-21.4%
% Rebates	49.4%	60.7%	63.7%	67.2%	17.8%

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

■ Hospital payments

- Hospital inpatient payments converted to a DRG system in 2015 and outpatient converted to an APC system in 2016
- Rate increases for both inpatient and outpatient services were provided in SFY 2018 (estimated at \$73 million; \$175 million once annualized)
- Without the hospital rate increase, the overall 1.0% growth in the Medicaid account would have been a 0.2% decrease and the 1.6% decrease in the Medicaid account PMPM would have been a 2.8% decrease

Category of Service	SFY15	SFY 16	SFY 17	SFY 18	Difference
Hospital Inpatient	\$ 829,467,388	\$ 849,065,795	\$ 843,173,368	\$ 881,827,156	\$ 52,359,769
Hospital Outpatient	\$ 706,823,261	\$ 764,201,753	\$ 736,146,297	\$ 819,260,999	\$ 112,437,737
Total	\$ 1,536,290,649	\$ 1,613,267,548	\$ 1,579,319,665	\$ 1,701,088,155	\$ 164,797,506

*DRG-Diagnosis Related Groups; APC-Ambulatory Payment Classification

- **Primary care investments**
 - Physician expenditures increased from \$302 million in SFY 2013 (pre-ACA rate increase) to \$479 million in SFY 2018
 - The primary care rate increase is estimated to account for \$53.8 million of that difference
 - Some of that increase is attributable to a change in the categorization of hospital physician expenditures resulting from our DRG conversion

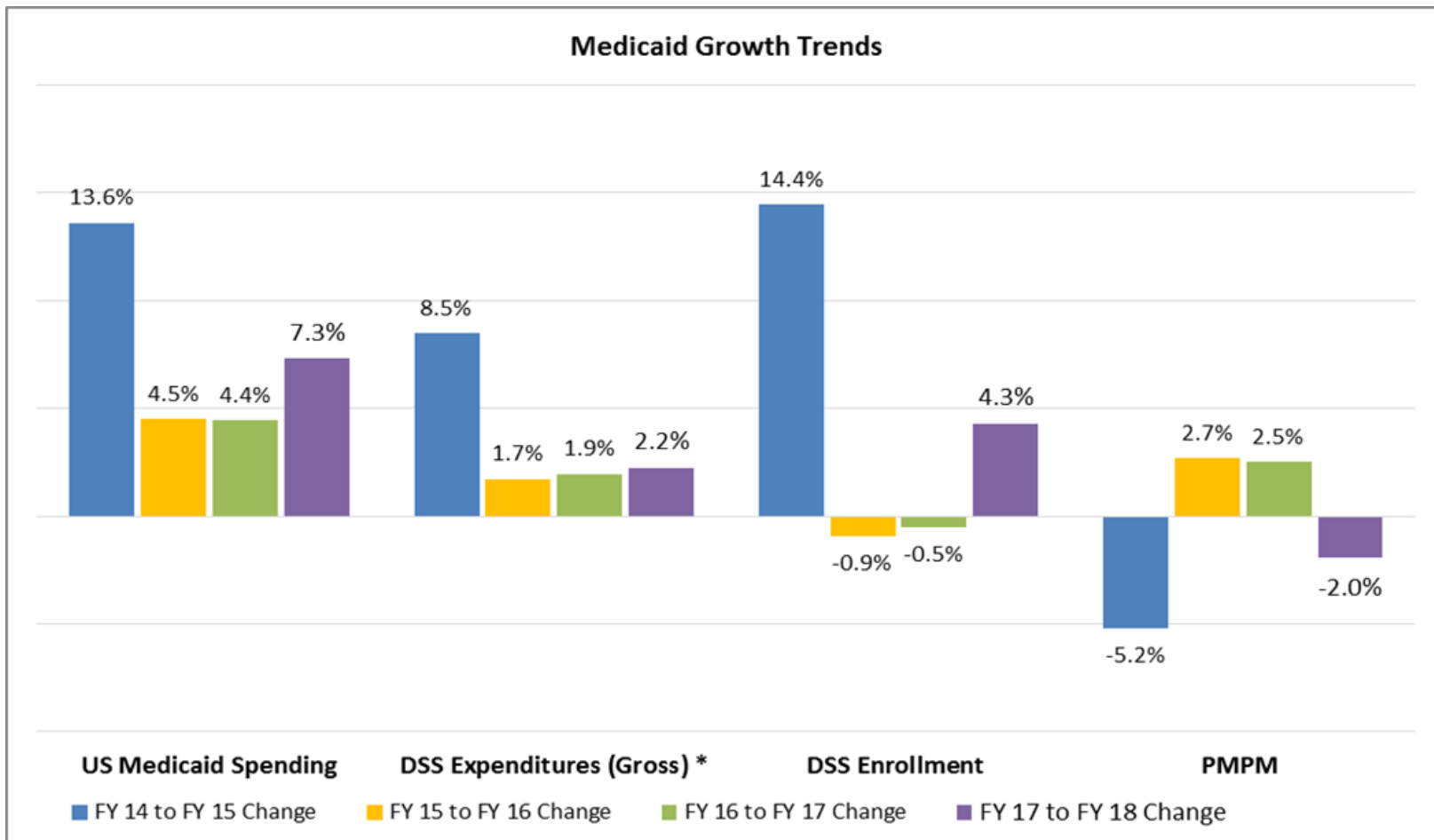
- **Long-term services and supports rebalancing**
 - Nursing home cost stability evidenced by a 0.8% decrease from SFY 2016 to 2018; relatively steady since SFY 2013
 - Waiver services and Community First Choice investments increasing over 16% between SFY 2016 and 2018

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.
- Connecticut was reported as having reduced its per-person spending by a greater percentage (5.7%) than any other state in the country.
- Overall and in Connecticut, Medicaid tracked lower nationally than both private health insurance and Medicare in the cost trend comparisons.

- Last year's MAPOC financial trend update included preliminary enrollments pending a full release of the Open Data portal updates
- At that time the data was preliminary, pending additional review and validation of the ImpaCT system reports, and completion of full EMS case conversions
- The PMPM data presented utilizes corrected enrollment figures as currently reported in the Open Data portal as of February 2019

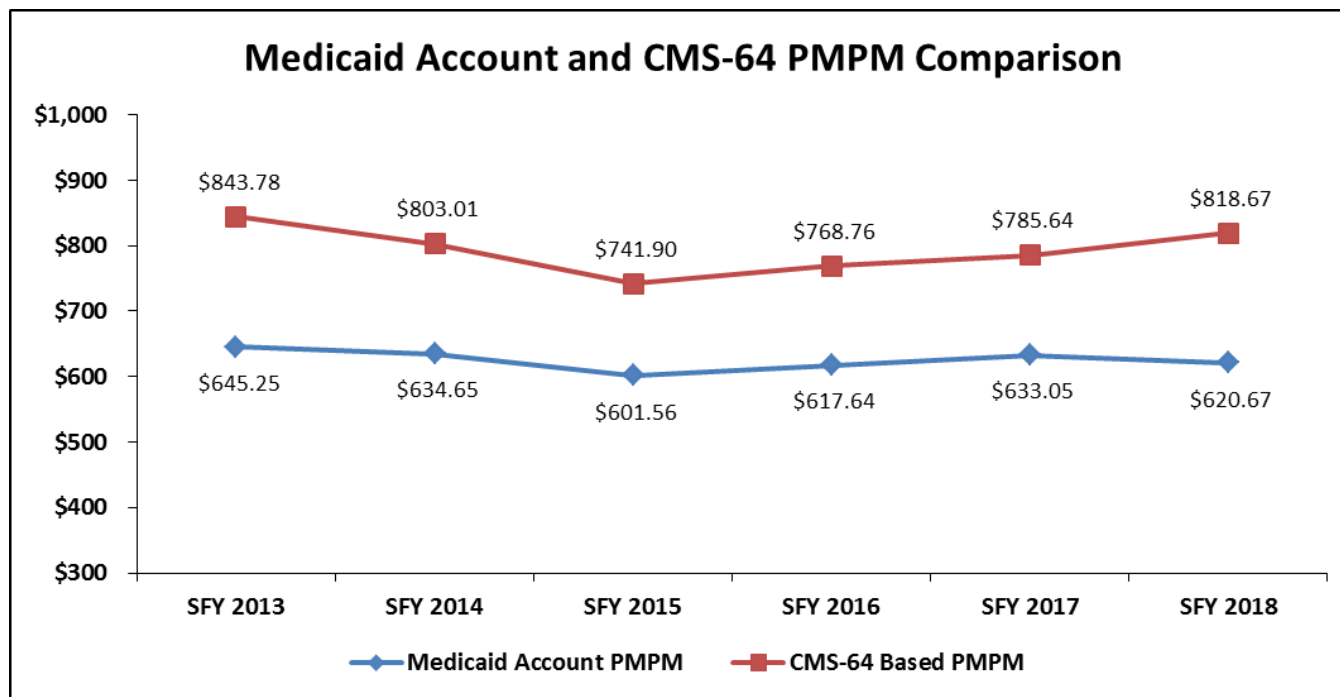


** Expenditures are net of drug rebates and exclude hospital supplemental payments given the significant variance in that area over the years*

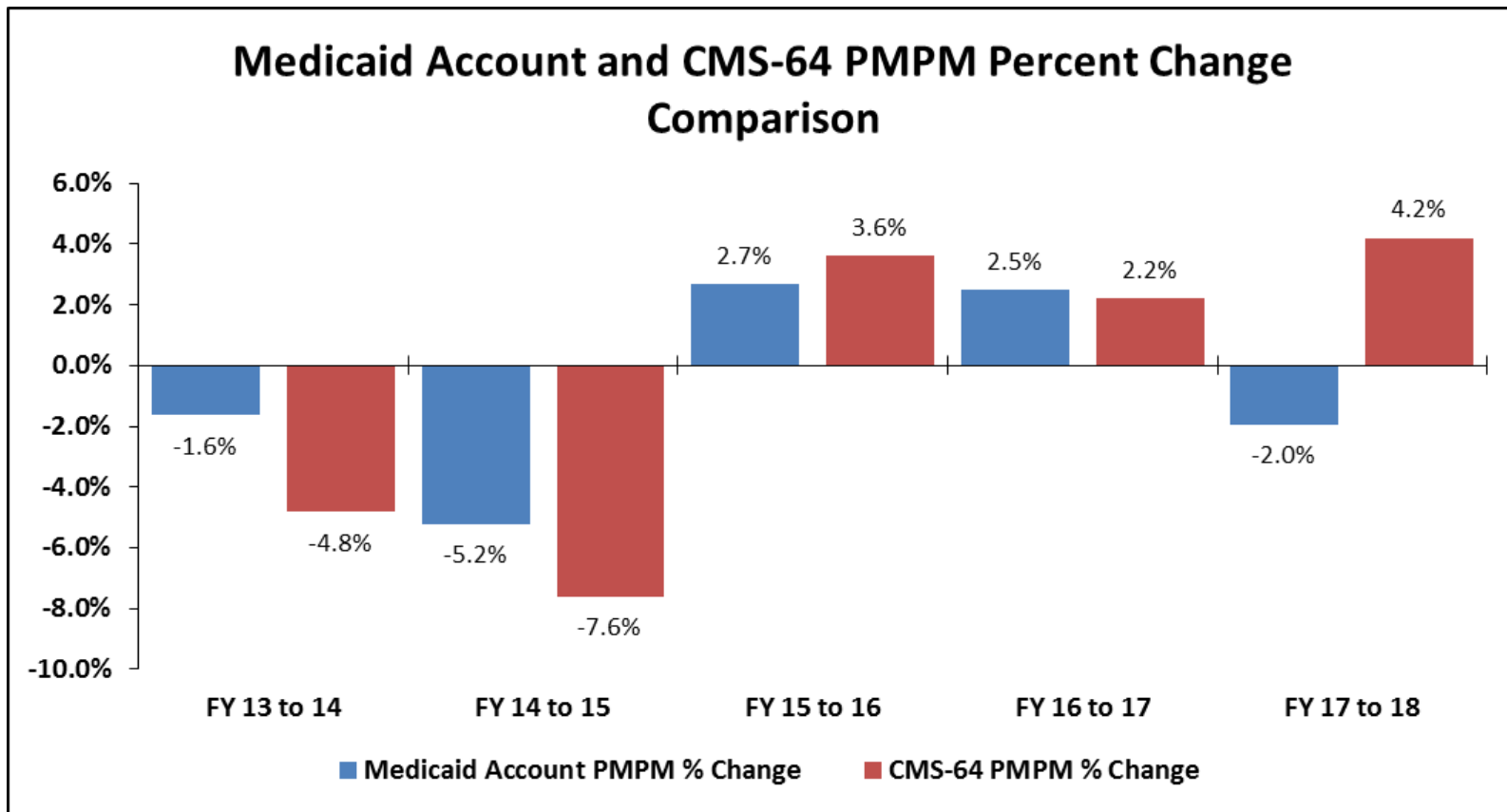
- PMPM Trends in the Medicaid Account
 - DSS PMPM growth was as low as a 5.2% decrease in SFY 2015, and at its highest reached a 2.7% increase in SFY 2016
 - The most recent PMPM for SFY 2018 decreased by 2.0%
 - Comparing SFY 2018 to SFY 2014, the PMPM decreased by 2.2% over that four year period
 - If CT Medicaid expenditures had grown at the national average for SFY 2018, costs could have been \$300 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
 - 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*
 - Global CMS-64 PMPM is also favorable over the period since SFY 2013 as shown below
 - Comparing SFY 2018 to SFY 2013, the PMPM decreased by 3.0%



*Using updated enrollment data from the Open Data portal; CMS data may differ



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

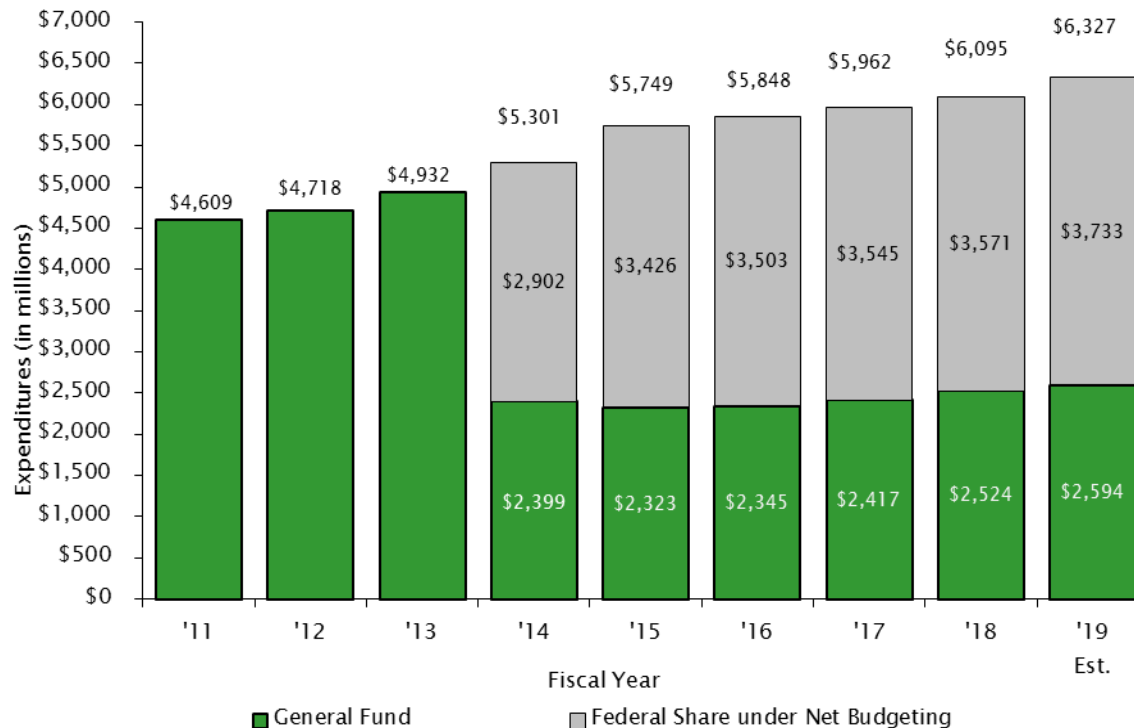
Financial Benchmark #4

CT's state share of Medicaid costs have stabilized.

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

SFY 2018 state share was only \$58 million, or 2.4%, higher than the estimated SFY 2013 state share.

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



*Excludes hospital supplemental payments

- The federal share of Medicaid program expenses has increased to 59%, up from 50% pre-ACA, due to enhanced federal funding for HUSKY D, currently at 93% for calendar year 2019.
- The federal share of HUSKY B (CHIP) is currently 88%, but falling to 76.5% in FFY 2020 and 65% in FFY 2021.
- Federal reimbursement for new systems development costs that support Medicaid is 90%.
- Systems operation costs, including eligibility systems built to support ACA, are now 75% reimbursed, as are the associated Medicaid eligibility staff costs.

*ACA-Affordable Care Act

Connecticut Medicaid as a Share of the Overall State Budget

Financial Benchmark #5

- In SFY 2018, the “all states” average Medicaid expenditures as a percentage of total State expenditures:
 - 29.7%*
- Connecticut’s SFY 2018 Medicaid expenditures as a percentage of total State expenditures:
 - 24.7*
- Going back as far as SFY 2010, CT compares extremely favorably to its “peer” states (New England, NY and NJ). For the entire period, we consistently were among the three states with the lowest percentage. In SFY 2015 through 2018, Connecticut had the lowest percentage share of the total state budget of all our peer states.

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

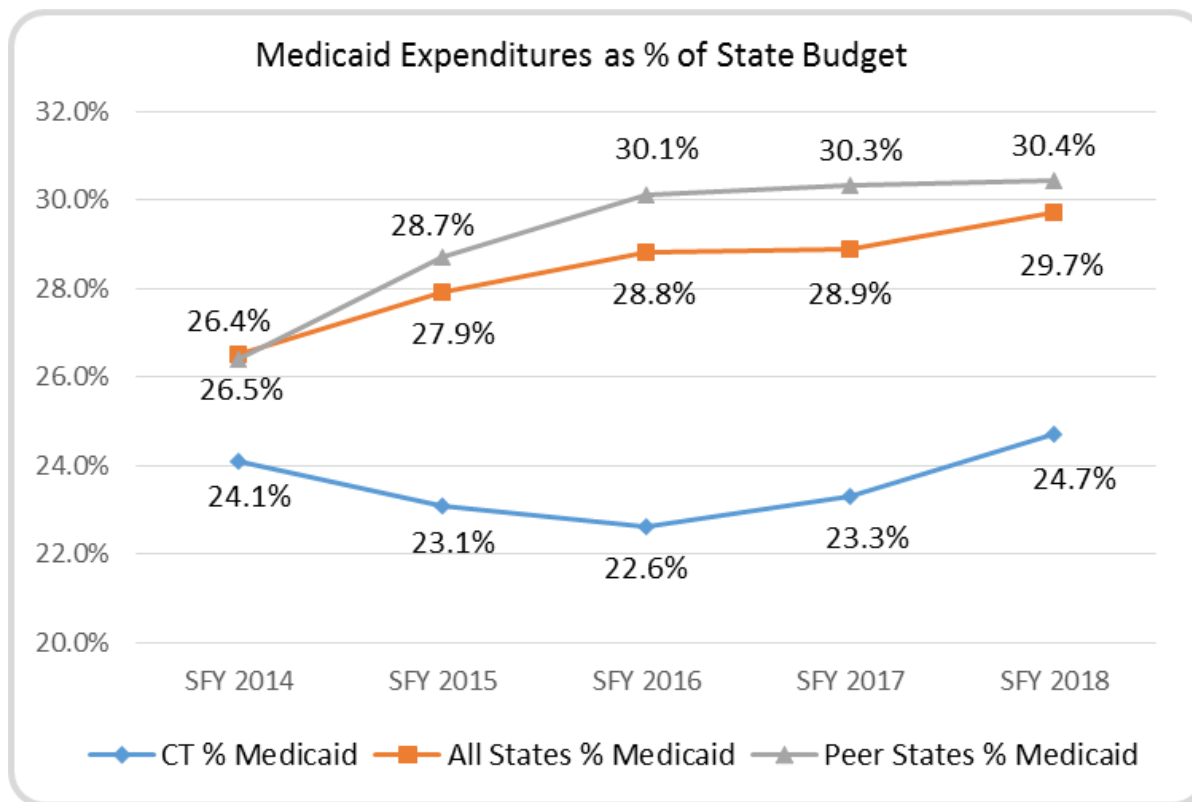
- Total Medicaid expenditures as a percentage of the total state budget - detail on peer states and national data*

	<u>SFY 2015</u>	<u>SFY 2016</u>	<u>SFY 2017</u>	<u>SFY 2018</u>
All States	27.9%	28.8%	28.9%	29.7%
Connecticut	23.1%	22.6%	23.3%	24.7%
Maine	32.8%	33.0%	32.3%	33.1%
Massachusetts	23.7%	27.8%	27.8%	28.8%
New Hampshire	29.7%	34.7%	36.6%	35.6%
Rhode Island	30.4%	29.0%	29.8%	28.6%
Vermont	28.5%	29.5%	28.8%	28.2%
New Jersey	24.2%	25.0%	24.5%	24.7%
New York	31.7%	31.9%	32.6%	34.0%
Peer State Avg (w/o CT)	28.7%	30.1%	30.3%	30.4%

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 2018

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

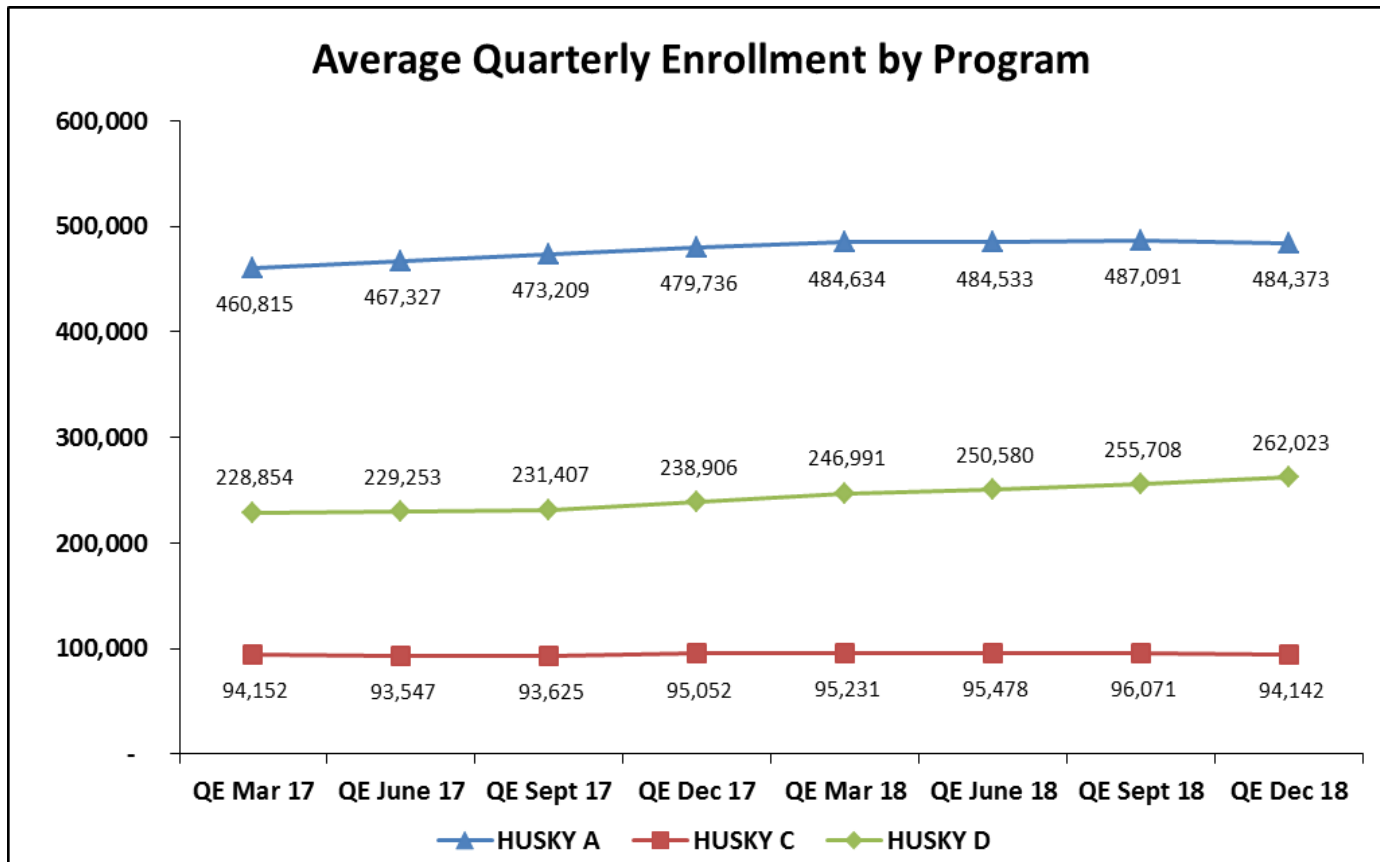
- CT Medicaid expenditures as a percentage of the total state budget - detail on peer states and national data*



CT has increased its favorable position compared to other states, moving from a favorable spread of approximately 2% to over 5% in terms of having the lowest Medicaid expense as a percentage of the total state budget

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

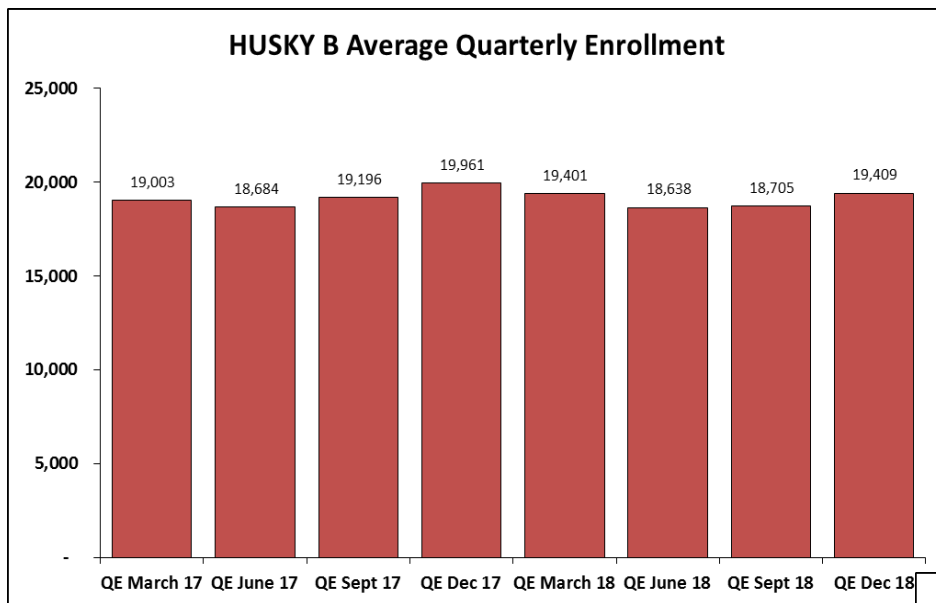
Trends in Enrollment and Expenditures By HUSKY Health Program



Total HUSKY Medicaid enrollment of over 840,000, with an additional 19,400 under HUSKY B

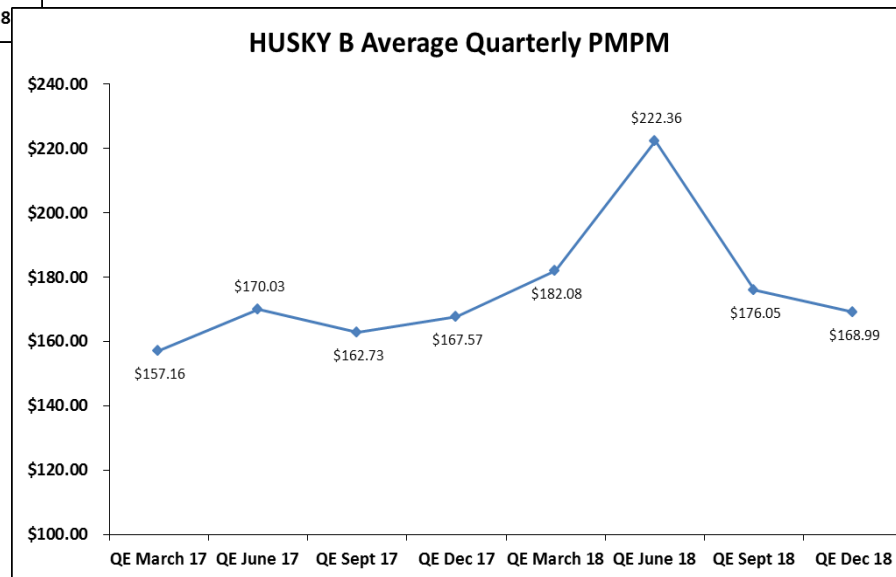
Significant HUSKY D enrollee growth has contributed to its increasing share of overall Medicaid enrollees.

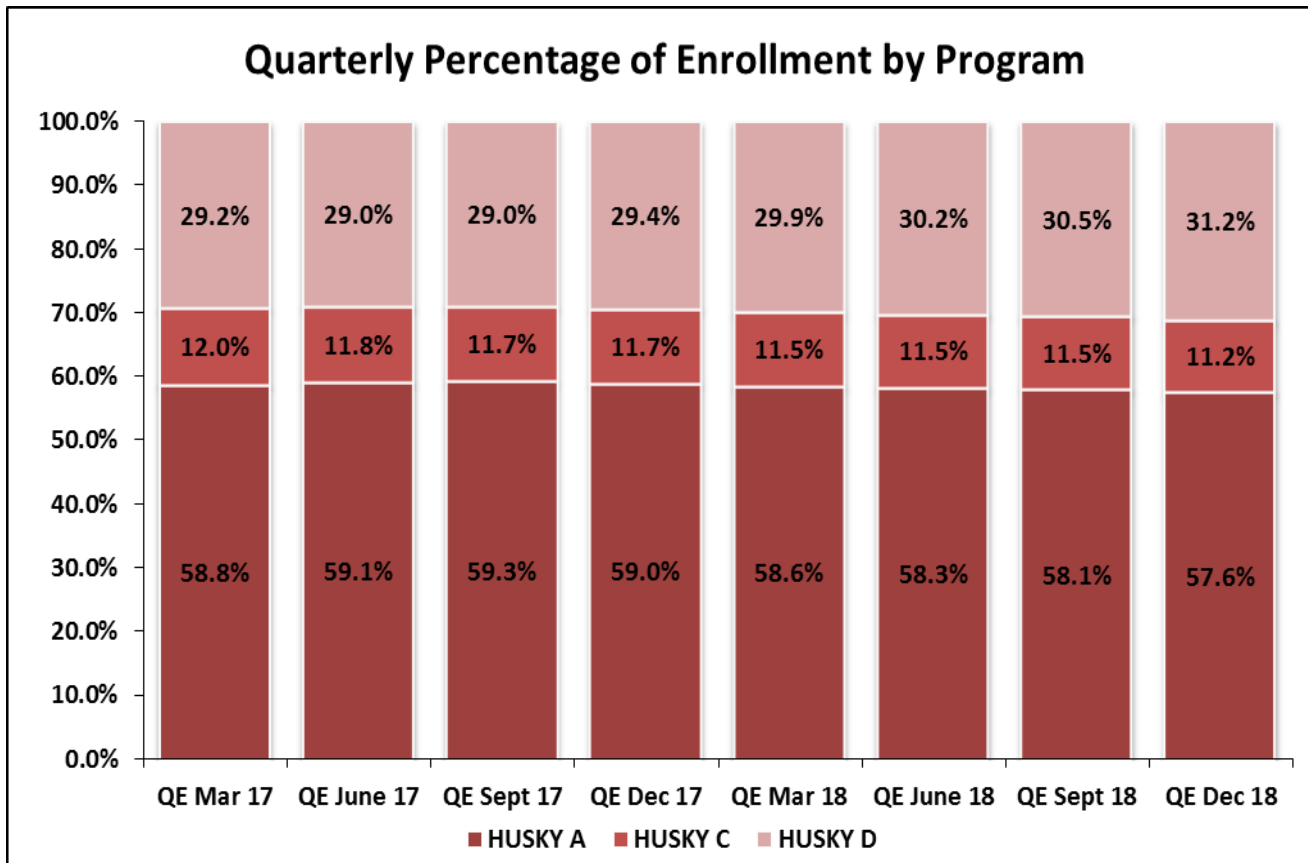
HUSKY A – Families and children
 HUSKY C – Aged and disabled
 HUSKY D – ACA single adults



HUSKY B average enrollment at 19,409 in the December 2018 quarter

HUSKY B PMPM has been relatively steady with the exception of expenses in the quarter ending June 2018

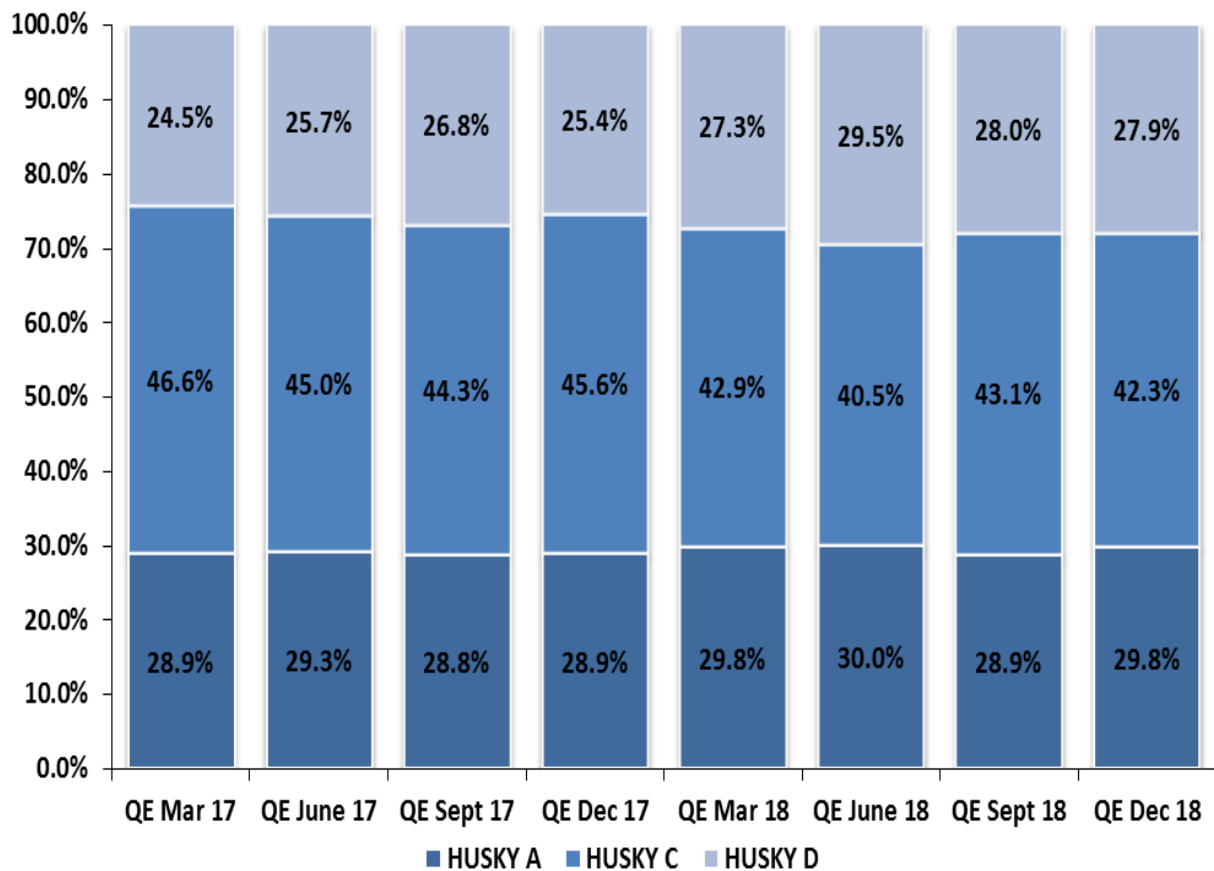




Significant HUSKY D enrollee growth has contributed to its increasing share of overall Medicaid enrollees, resulting in slightly smaller shares of both HUSKY C and HUSKY A enrollees

HUSKY A – Families and children
 HUSKY C – Aged and disabled
 HUSKY D – ACA single adults

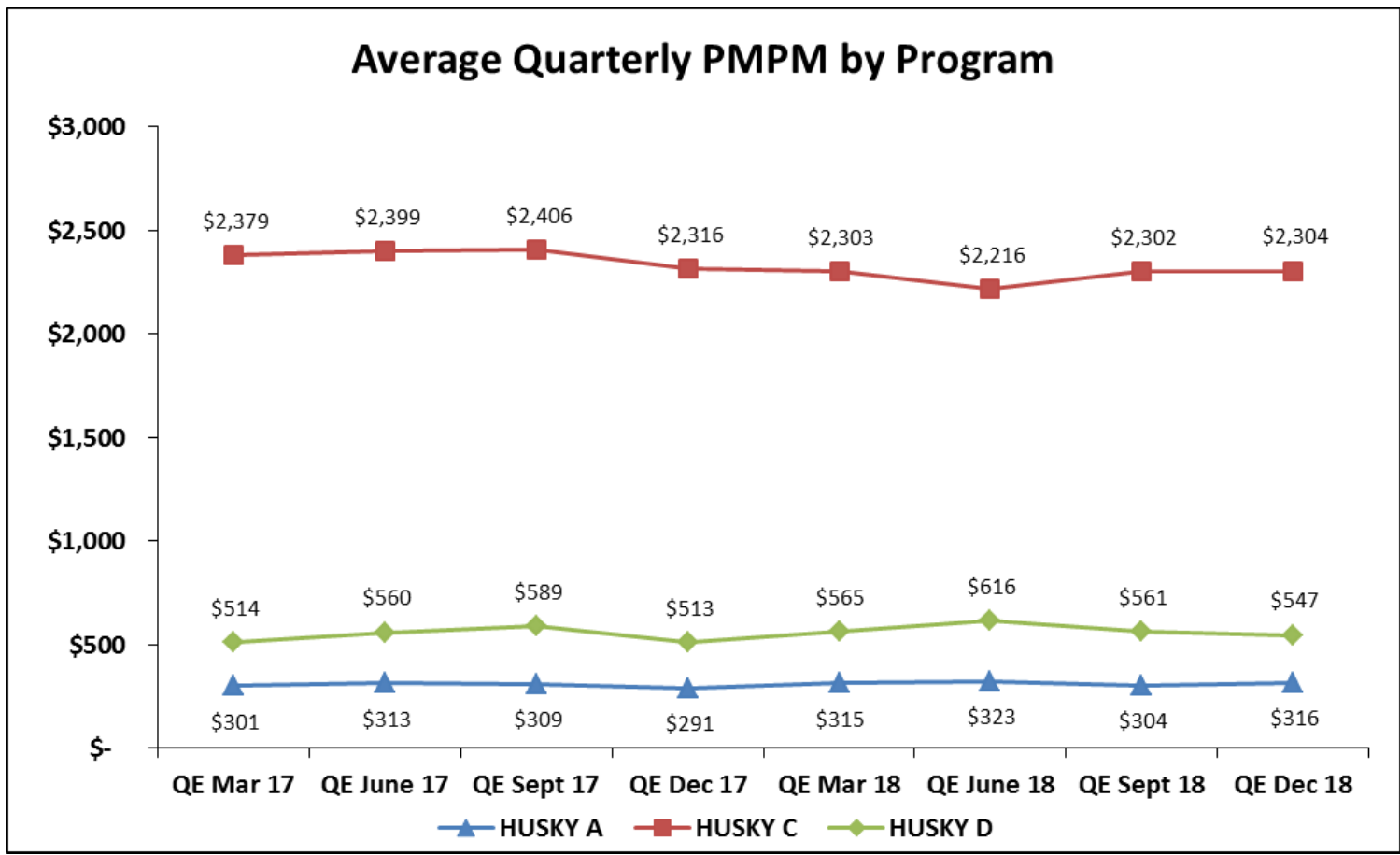
Quarterly Percentage of Expenditures by Program



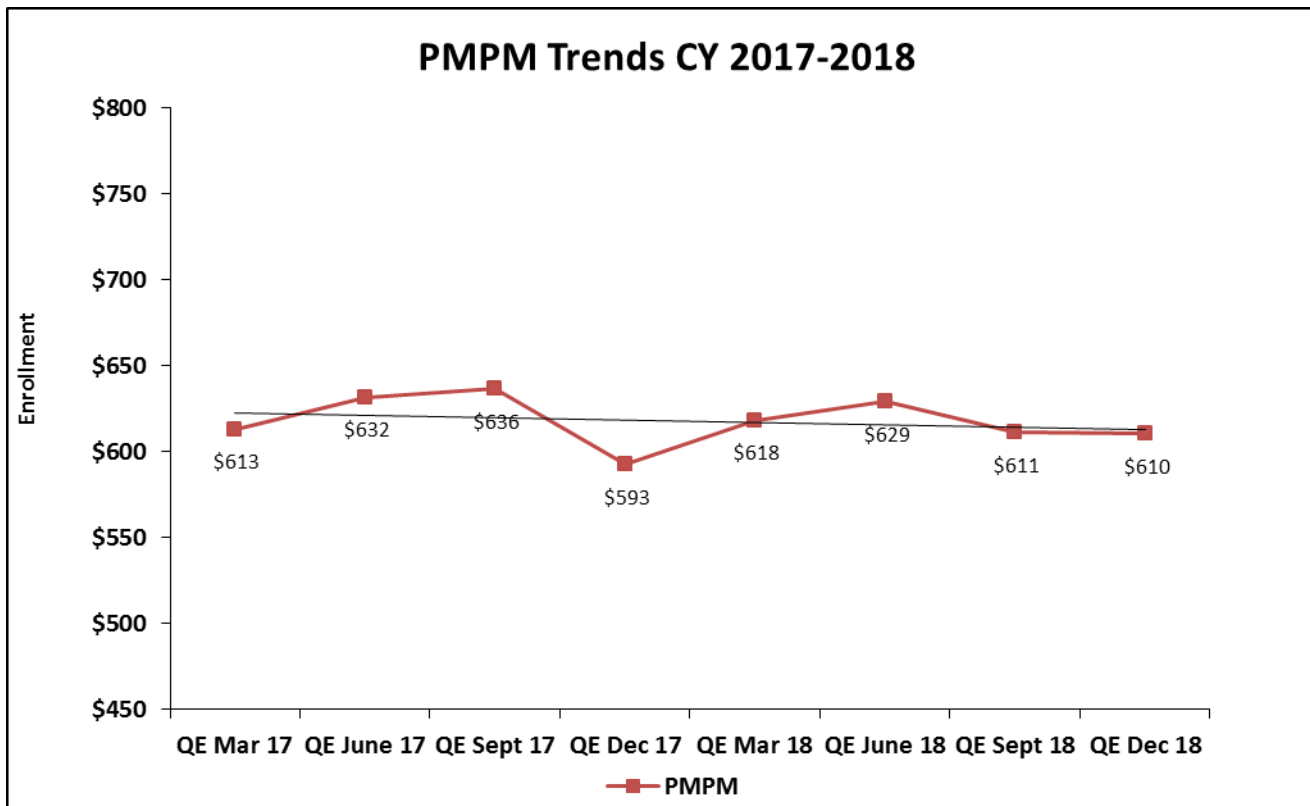
HUSKY D clients represent 31% of enrollees and 28% of overall expenditures

HUSKY C clients make up 11% of the enrollees but comprise 42% of expenses

HUSKY A clients comprise 58% of enrollees but account for only 30% of program costs



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



Overall, quarterly PMPM trends have similarly remained steady over the last eight quarters

Recap – Significant Financial Benchmarks

- Administrative expenses at approximately 3.5% are well under Medicaid managed care norms of close to 12%
- Service investments and rebalancing indicating enhanced primary care expenditures and shifts to community-based waiver and related services
- PMPM cost stability with an 2.2% PMPM decrease over the four year period from SFY 2014 to SFY 2018

- Stability in the State share of Medicaid expenses as our SFY 2018 state share was only \$58 million, or 2.4%, higher than the estimated SFY 2013 state share (less than half a percent per year).
- Favorable percentage of Medicaid ratio of costs to overall State budget costs when compared to both national averages and “peer” regional states by a significant 5-6% differential

Self-Insured/Managed FFS	vs.	Capitated Managed Care
<p>Connecticut Medicaid does not make payments to managed care plans and reimburses providers directly. It pays administrative costs and has centralized and expedited processing of health care claims.</p> <p>Results: More timely provider payments; lower administrative costs (currently 3.2%); greater proportion of spending goes to direct services for members (8% more to direct services, or as much as \$270 m for HUSKY A & D only).</p>	<p>Payments</p>	<p>Medicaid agency pays prospective monthly premiums to a Medicaid managed care organization (MCO). Each MCO pays its own health care claims.</p> <p>Implications: Less timely payments to providers; lack of standardization across plans; administrative costs typically in excess of 11%, resulting in an immediate 8% cost increase in Connecticut; prospective payments could cause one-time payment acceleration of \$560 m (based on HUSKY A & D only).</p>
<p>Connecticut Medicaid assumes financial risk.</p> <p>Results: 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>Assumption of Risk</p>	<p>The Medicaid MCO assumes financial risk.</p> <p>Implications: 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>Results: Lower administrative costs across 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.</p>	<p>Plan Design</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>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.</p>
<p>Connecticut Medicaid has a fully integrated, statewide set of claims data.</p> <p>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</p>	<p>Data</p>	<p>Each Medicaid MCO produces limited “encounter data” for the Medicaid program.</p> <p>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</p>

- 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

- HUSKY Health is improving outcomes while controlling costs (continued)
- **Connecticut's expenditure trends, when measured by PMPM costs across the entire program or by the level of State share, have remained exceptionally steady the past five years**