Care Delivery and Payment Reforms in HUSKY Health: A Snapshot of Progress

Health Care Cabinet
February 19, 2019

In Brief

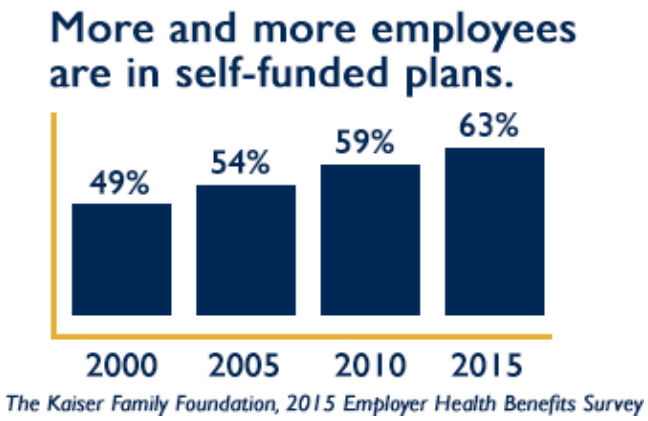
It's been seven years since the State of Connecticut implemented a new model in its Medicaid program. Today we provide a brief snapshot of:

- the strategies we are using to improve outcomes for people and to control costs
- implementation and results of care coordination initiatives and Alternative Payment Models (APMs)
- our financial trends

Structure

- Since 2012, Connecticut HUSKY Health has been structured as a self-insured, managed fee-for-service model through which DSS manages the risk for medical, behavioral health, dental and pharmacy benefits and uses care coordination and payment reforms to improve outcomes and care experience, and control costs

- A self-insured approach is typical of employee health plans; less so for Medicaid programs



How has this worked?

- Health outcomes, such as emergency department use, inpatient admissions, and readmissions, have improved
- Members' report of care experience has also improved
- Our per member, per month costs, and the state share of Medicaid, continue to be very stable
- Centralizing and standardizing processes has made it easier for providers to do business with Medicaid and has enabled us to significantly reduce administrative costs (currently, only 3.2%)

Strategic Approach

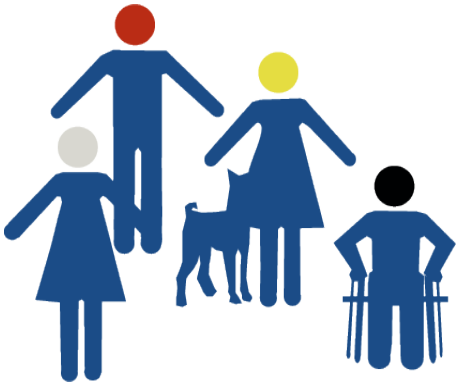
Strategies and Levers

The strategies and levers that the program has used to improve outcomes and control costs include:

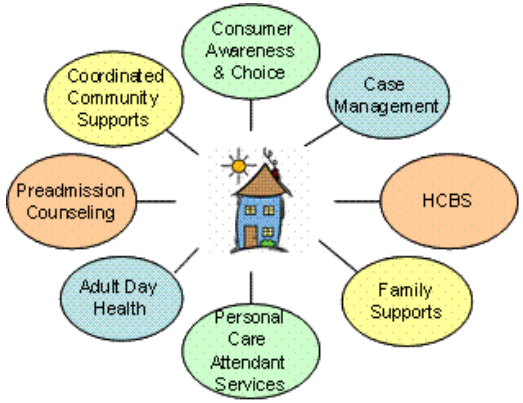
- covering an extensive array of preventative services
- making investments in primary care
- adopting statewide rate schedules and utilization management guidelines (including a statewide Preferred Drug List)
- using a fully integrated, statewide claims data set to examine and respond to needs on a population-based and individual basis
- implementing federated and local care coordination initiatives
- adopting APMs (pay-for-performance; upside-only shared savings)

The focus is on effectively supporting people with complex needs.

Prevention Agenda



Integration Agenda



Long-Term Services and Supports Rebalancing Agenda

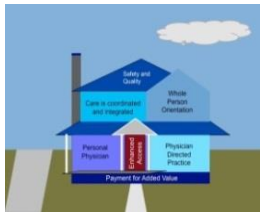
Primary Care Foundation

Our view is that primary care is the best foundation on which to meet the needs of people with complex health profiles and life circumstances, so we have made a lot of investments there, taking a layering approach:

- expansion of covered services (e.g. smoking cessation)
- Electronic Health Record payments
- maintenance of ACA primary care “rate bump”
- PCMH practice coaching, enhanced rates, performance and year-over-year improvement payments
- PCMH+ supplemental care coordination payments and upside-only shared savings arrangements

Our Roadmap

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 team (health homes, PCMH+)

Supports for social determinants (ICM, transition/tenancy sustaining services, interventions for childhood trauma)

PCMH+

with the desired result of creating

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

Implementation and Results of Care Coordination Initiatives and APMs

Care Coordination and APMs

Connecticut HUSKY Health has been progressing . . .

- in **care coordination** . . . from an entirely federated statewide approach through Administrative Services Organizations, to a more local basis, through PCMH and PCMH+

- in **adopting Alternative Payment Models (APMs)** . . . to include pay-for-performance initiatives (PCMH, obstetrics) and upside-only shared savings arrangements (PCMH+) – over 285,000 members are now served in an APM (Category 2C pay-for-performance and Category 3A upside-only shared savings)

PCMH Overview

The Person-Centered Medical Home (PCMH) initiative, which includes limited embedded care coordination, extended hours and use of EHR:

- has grown and matured, now including 122 practices and over 2,000 providers
- is supporting half of HUSKY Health members, who have chosen to receive their care at those practices
- has been associated with strong positive scores through mystery shopper (measuring access) and CAHPS (measuring consumer experience of care)

- has demonstrated strong outcomes:
  - PCMH practices' quality measure results show a linear trend and improvement in all measures except post admission follow-up and the readmission measure
  - Emergency department utilization trend over time shows a significantly better outcome in PCMH practices that have received performance payments, although there have been fluctuations. The Pediatric and Adult combined 2016 ED rate for these practices (61.2) is lower than Statewide ED rate (68.7) and National Medicaid ED rate (65)
- has incentivized practices to improve and maintain high quality care with approximately $28 million dollars to date
- is a prerequisite to participation in our shared savings initiative, PCMH+

PCMH Participation

As of January 31, 2019

PCMH Program Participants		Sites		Providers	
12/31/18	1/31/19	12/31/18	1/31/19	12/31/18	1/31/19
122	122	534	534	2,087	2,101

92
PCMH Approved Practices
Recognized at NCQA Level 2 or Level 3

19
Glide Path Practices
Working towards NCQA recognition

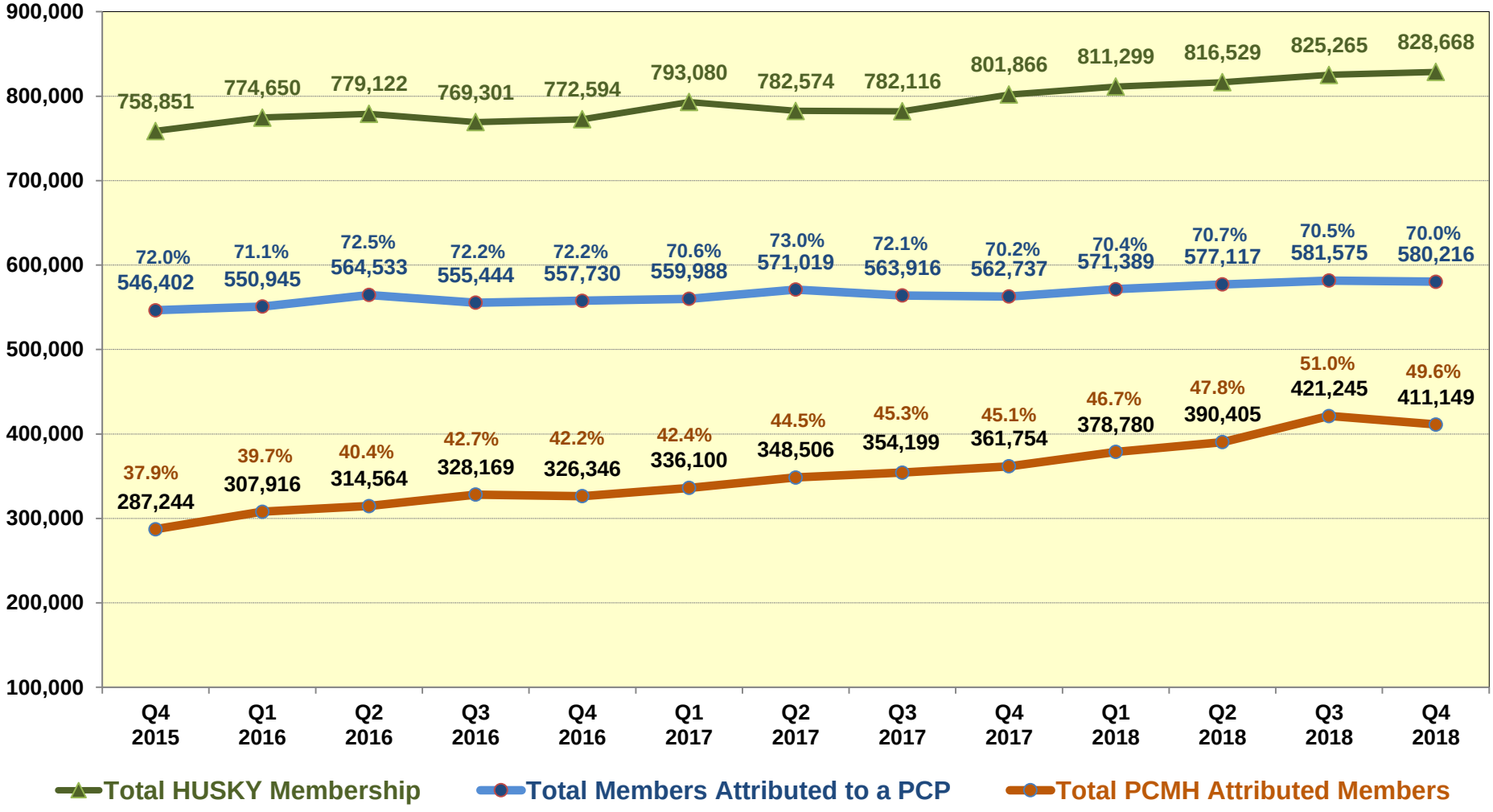
0
Glide Path Renewal Practice
Working towards NCQA renewal recognition

16
PCMH Accredited Practices
Includes FQHCs

Note: 5 Practices have sites in both PCMH & Glide Path Programs

PCMH Member Attribution

Summary of Total PCMH Attributed Members, Total Members Attributed to a PCP, and Total HUSKY Membership By Quarter Ending December 2015 through December 2018



Source: CHNCT Run Date: December 2, 2018

PCMH+ Overview

The Person-Centered Medical Home + (PCMH+) initiative, which includes enhanced features of care coordination, supplemental care coordination payments to FQHCs, and an upside-only shared savings approach:

- completed its first wave (a one-year period), and is in progress with a second wave (two-year period)
- is supporting over 180,000 Medicaid members, who have chosen to receive their care at those practices
- has showed very low opt-outs and complaints, and has been associated with strong positive scores through mystery shopper (measuring access) and CAHPS (measuring consumer experience of care)

PCMH+ Overview (cont.)

- was competitively procured and now includes nine Federally Qualified Health Centers (FQHCs) and five "advanced networks"
- has shown progress in local adoption of enhanced care coordination features, as well as connections between primary care practices and community-based organizations:
  - behavioral health integration
  - cultural competency (through Culturally and Linguistically Appropriate Services in Health and Health Care standards)
  - children and youth with special health care needs
  - disability competency
- has shown positive results on some quality measures, although others did not show improvement in Wave 1

PCMH+ Overview (cont.)

- has incentivized FQHC Participating Entities with $5.5 million dollars in supplemental care coordination payments in support of behavioral health integration and expansion of care teams to include community health workers (CHWs)
  - these are Medicaid payments that are made up of state funds and federal match
  - these payments are recouped in the shared savings calculation
- showed some savings, and associated shared savings payments, which are presently being finalized

Detailed PCMH+ Results

For more detail on PCMH+ results, please see the following:

- **Quality results**:

https://www.cga.ct.gov/med/council/2018/1109/20181109ATTACH_PCMH_Year%201%20Nov%20MAPOC_Final.11.6.18.pdf

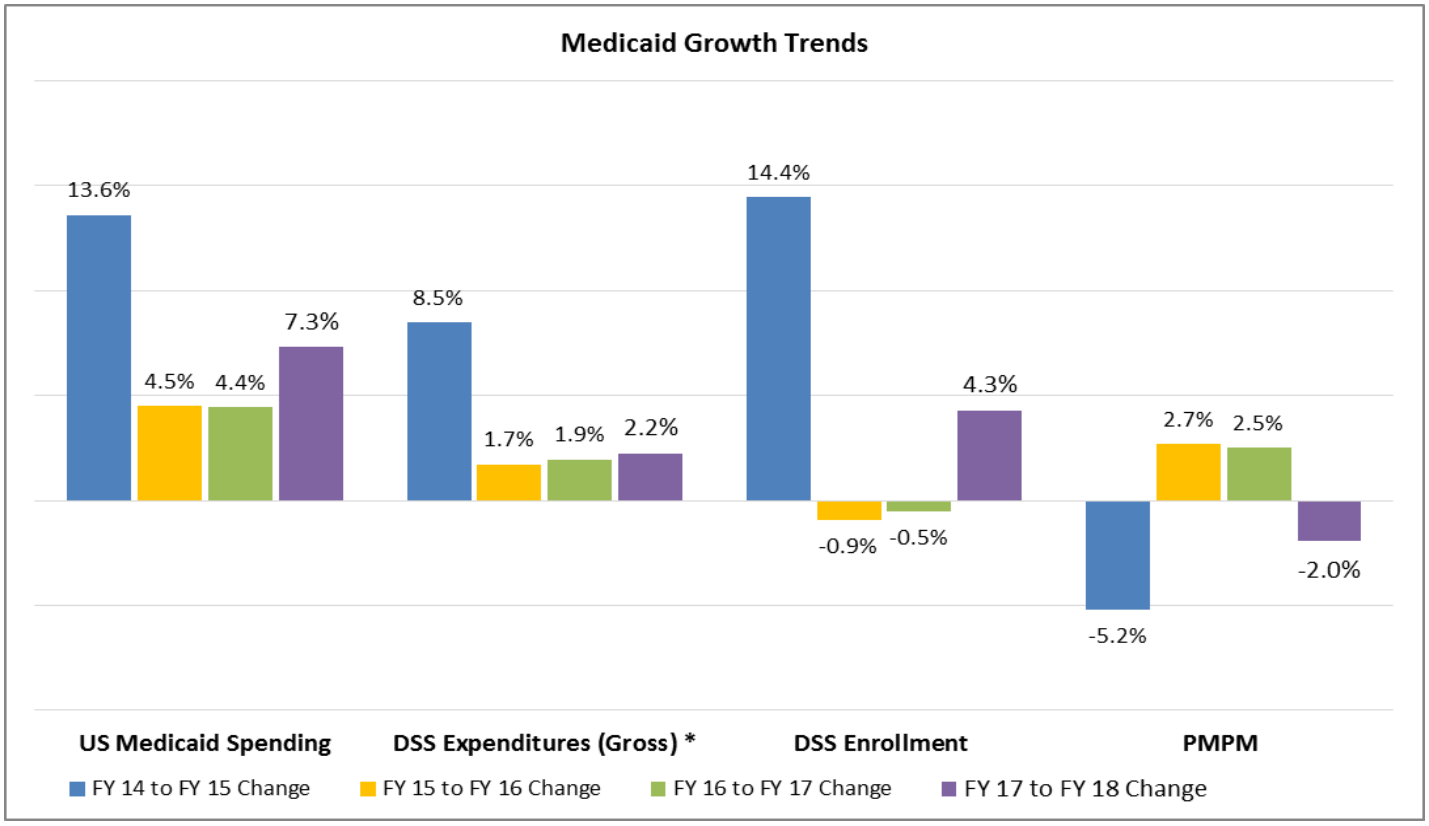
- **Draft shared savings results**, which are currently being finalized:

https://www.cga.ct.gov/med/council/2018/1214/20181214ATTACH_PMCH_Shared%20Savings%20Calculation%20Results%20MAPOC%2012-14-18.pdf

HUSKY Health Financial Trends

Financial Trends

Over FY 2018, Medicaid expenditures in the Department of Social Services (DSS) grew by only 2.2%, demonstrating again that Connecticut's service model continues to bend the cost curve while improving health outcomes.



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

Financial Trends (cont.)

- In December, 2018, MACPAC issued its annual "MACStats: Medicaid and CHIP Data Book", which includes a wealth of data points, information on trends, and cross-state comparisons

- Excitingly, pp. 67-69 of the report [available at: https://www.macpac.gov/wp-content/uploads/2018/12/December-2018-MACStats-Data-Book.pdf] shows Connecticut ranked number 22 in the country on Medicaid spending per enrollee - a significant improvement over our past profile

- As of FY'17, we are less costly per person than all other New England states (New Hampshire, Maine, Massachusetts, Vermont, Rhode Island), and also New York and New Jersey

Financial Trends (cont.)

- HUSKY Health PMPM has decreased 2.2% over the four-year period from SFY 2014 to SFY 2018
- Financial trends reflect increases in spending on primary care and community-based long-term services and supports, as compared to higher historical spend on acute and institutional care
- Another important financial indicator is that HUSKY Health's administrative expenses are approximately 3.5% - well under Medicaid managed care norms of close to 12%

Financial Trends (cont.)

- The State share of Medicaid expenses has been quite stable since SFY 2013, growing by only $58 million (2.4%; less than half a percent per year)

- The percentage of the state budget used for Connecticut Medicaid is tied with New Jersey as the lowest of all of the New England states, New Jersey and New York, and is lower than the national average

- For more detail on HUSKY Health financial trends, please see the following:

https://www.cga.ct.gov/med/council/2019/0208/20190208ATTACH_MAPOC%202-8-19%20HUSKY%20Financial%20Trends.pdf

Questions or comments?