Board of Directors Meeting

January 21, 2016

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Agenda

A. Call to Order and Introductions
B. Public Comment
C. Votes
    - November 19, 2015 Regular Meeting Minutes
    - Election of Vice-Chair
D. CEO Report
E. 2016 OE Update
F. Operations Update
G. Technical Operations & Analytics
H. Medicaid Overview
I. Legislative Requirement – Adverse Selection Study (Vote)
J. Adjournment

Public Comment

Votes

CEO Update

2016 Open Enrollment Update

Open Enrollment Update

Open Enrollment

- Successfully kicked off Open Enrollment 2016. Continuing to update CMS on daily reporting and request. System monitoring continues with mitigation plans completed for system performance with impact to consumers. Planning and meetings underway for preparation of 2017 Open Enrollment.

Communication plan

- Continue to have success with our broadened stakeholder communication plan. Daily calls with stakeholders show that increase participation and involvement has greatly mitigated consumer impacts and consumer communication. Continuing outreach campaign to non-auto renewed population that have an active 2015 coverage with no 2016.

System Performance

- Continue to monitor system health during last days of Open Enrollment. Currently no issues are being tracked that are impacting consumers or consumer experience.

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Plan Management / Dental Update

Plan Management Key Milestones

- Continue to work with internal and external departments to validate overall 2017 calendar with key milestones
- Discussions and planning currently underway around proposed quality rating methodology (QRS – Quality Rating System) for Open Enrollment 2017

Dental Update

- As of 01/13/2015 there are currently 1317 memberships within our dental offering
- Currently there are 689 new dental enrollments from 11/1 to 1/13
- We continue to work with our partners to increase visibility and participation within dental
- There are meetings currently underway that will help strengthen the overall product offering, making the dental products more attractive within our current market demographics

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Operations Update

Open Enrollment Member Update as of 01-19-2016

Brand New QHP Customers	**15,214**
Increase in QHP Enrollment Since 11-1-15	**15,245**

QHP Enrollments	
APTC	29,290
APTC + CSR	55,349
NO APTC	24,191
TOTAL	**108,830**

Medicaid Determinations	
New to Eligibility System - Medicaid	34,590
Total Medicaid Determinations During OE	238,178

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Open Enrollment Update

OPEN ENROLLMENT ENDS JANUARY 31, 2016
El período de inscripción termina el 31 de enero, 2016

Individuals must be enrolled by **January 15, 2016** for coverage to be effective on February 1, 2016.

November 1, 2015 – January 11, 2016					
Calls Answered by Call Center	Store and CEP Visitors	Store and CEP **QHP Enrollments**	Store and CEP **QHP Renewals**	Store and CEP **Medicaid Enrollments**	Store and CEP **Medicaid Renewals**
288,173	8,159	4,924	1,043	2,654	1,456

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Open Enrollment Update

JANUARY 31, 2016: Open Enrollment ends
El período de inscripción termina el 31 de enero, 2016

SPECIAL ENROLLMENT

Generally, a person can enroll *only* during the Open Enrollment period unless he or she meets at least **one** of the following criteria:

- he or she has a **Qualifying Life Event** during the year
- he or she becomes eligible for Medicaid (HUSKY A and D) or the Children's Health Insurance Plan (CHIP),
- he or she is an American Indian or Alaska Native, or

If a person qualifies to enroll during the special enrollment period, he or she can get health care coverage through Access Health CT or make changes to their current plan.

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Open Enrollment Update: *Special Enrollment*

What is considered a Qualifying Life Event?

- Getting married to someone who is already enrolled in an Access Health CT plan
- Having or adopting a child, having a foster child placed in your household, or being ordered to provide coverage through child support or court order
- Permanently moving to Connecticut from another state
- Having a change in eligibility for financial assistance - an Advanced Premium Tax Credit (APTC) or Cost Sharing Reduction (CSR) - which includes changes in income, household status or citizenship or lawful presence, as well as certain changes to an employer sponsored health plan or the cost of an employer sponsored plan
- Losing certain other health coverage due to:
  - Job loss, divorce, loss of eligibility for Medicaid or CHIP, expiration of COBRA coverage, health plan being de-certified or when a health plan violated a material part of its contract for a specific consumer, an employer canceling health care coverage for employees or their beneficiaries. Loss of coverage cannot be because the consumer did not pay their premiums.

Consumers will be required to provide the proper documentation showing that he or she qualifies for Special Enrollment

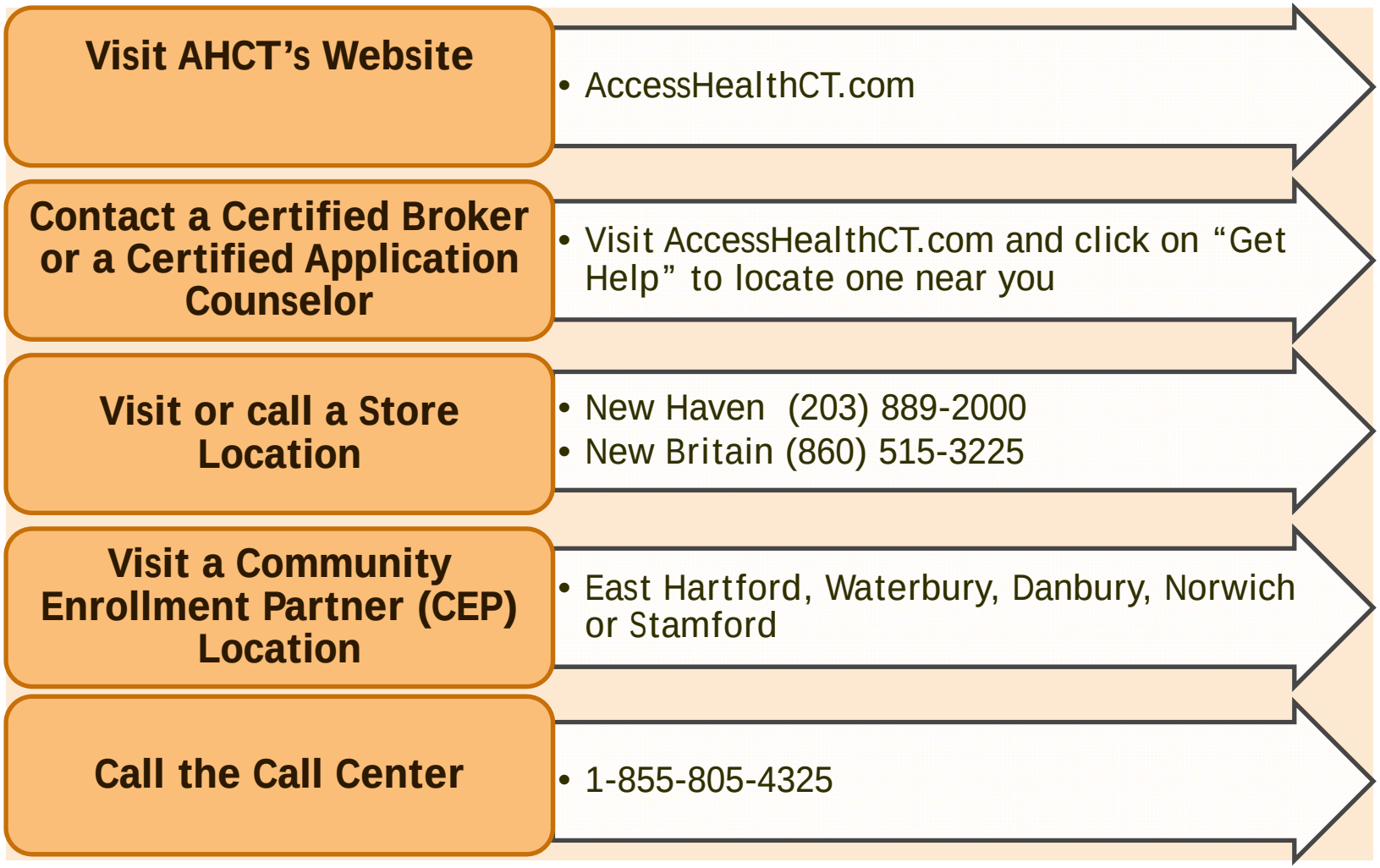
Open Enrollment Update: *Special Enrollment*

When can a person enroll during the Special Enrollment Period?

- A person can enroll at **any time** if he or she…
  - qualifies for Medicaid/CHIP,
  - is a member of federally recognized tribes, or
  - is an Alaska Native

- Generally Special Enrollment periods last for 60 days from the date of the Qualifying Life Event.

Enrollment Assistance



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Enrollment Assistance

Store Front Locations

New Britain	New Haven
200 Main St	55 Church St
860-515-3225	203-889-2000

Hours of Operation
Monday – Friday 9:00 AM – 5:00 PM
Saturday 9:00 AM – 1:00 PM

Call Center

1-855-805-4325

Hours of Operation(during OE)
Monday – Friday 8:00 AM – 6:00 PM
Saturday 10:00 AM – 3:00 PM

Hours (post OE)
Monday – Friday 8:00 AM – 4:00 PM

Norwich

United Community and Family Services
Monday – Thursday 9:30 AM-5:00 PM
Friday 9:30 AM-4:30 PM

Danbury

Danbury Women's Center
Monday – Friday 9:30 AM-4:30 PM

Stamford

The Ferguson Library
Tuesday – Friday 10:30 AM-6:00 PM
Friday 9:30 AM-4:30 PM

Waterbury

Opportunities Industrialization Center(Navigator)

Monday – Friday 10:00 AM-4:30 PM

East Hartford

Raymond Main Library (Navigator)
Monday – Thursday 9:30 AM-5:00 PM
Friday 9:30 AM-4:30 PM

Indicates Community Enrollment Specialist Location

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1095 A

Form	Recipient	Accountable Party
1095 A	**All QHP enrollees**	**The Market Place Exchange** is responsible for mailing to enrollee by 01/31/16

- All 1095 calls will flow through Call Center's Interactive Voice Response (IVR) system at which point 1095 B calls will be routed to DSS' 1095 Call Center
- The Call Center's staff has been trained to resolve basic 1095 inquires (Tier 1)
- Complex inquiries will be transferred to an experienced team of AHCT employees (Tier 2)
- Dedicated Tier 2 staff members will have specific assignments regarding carrier relations to expedite any issues that arise
- Tier 2 staff have bilingual capabilities

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Husky Transition

18,500 individuals scheduled to transition off Transitional Medical Assistance (TMA) on July 31, 2016

These individuals must enroll in coverage by July 15, 2016 to ensure they have no gap in coverage.

- AHCT, DSS, OHA, and OPM have conducted their first meeting to plan and review proposed outreach and communication to this population
- AHCT and DSS will meet separately to finalize the schedule of communications (notices, direct mailing, phone calls, etc.)
- A detailed project plan is being used to track the following:
  - Planning
  - Development of Communications
  - Outreach Execution

Technical Operations & Analytics

Medicaid Overview

Connecticut Medicaid 101

January 21, 2016

Connecticut Department of Social Services

Making a Difference

We are transforming every aspect of how we provide health services to Connecticut residents.

- We are putting systems in place to **help people qualify for services more easily and timely**.

- We have **expanded Medicaid eligibility.**

- Our partner Administrative Services Organizations are **supporting people in using their medical, behavioral health, and dental benefits well and in connecting with providers**.

- We are investing in **primary, preventative care**.
- We are working to **integrate medical and behavioral health care**.
- We are **enabling people who need long-term services and supports to receive them in the community**.

- We are **using our rich set of claims data to identify and monitor the needs of beneficiaries**, as well as to **make informed policy decisions**.

- We are moving to **shift from paying for procedures and services, to reimbursing in a way that rewards outcomes**.

- We are examining means of **addressing social determinants of health.**

Why are we doing this?

Because, consistent with the mission of the Department of Social Services:

Guided by shared belief in human potential, we aim to increase the security and well-being of Connecticut individuals, families, and communities.

Goals

- Set context (enrollment, expenditures, outcomes)
- Share core concepts of Medicaid coverage
  - Medicaid State Plan
  - Contrasting Medicaid and Medicare
  - Eligibility and coverage groups
  - Means of covering services
- Provide overview of key DSS health reform strategies

Setting Context

Medicaid Enrollment

- Connecticut Medicaid and CHIP, which are known as HUSKY Health, are major payers of health services and currently serve over **750,000** beneficiaries

- **4 out of 10 births in Connecticut** are to mothers who are Medicaid beneficiaries (note that this figure is much higher in many cities and “distressed” municipalities)

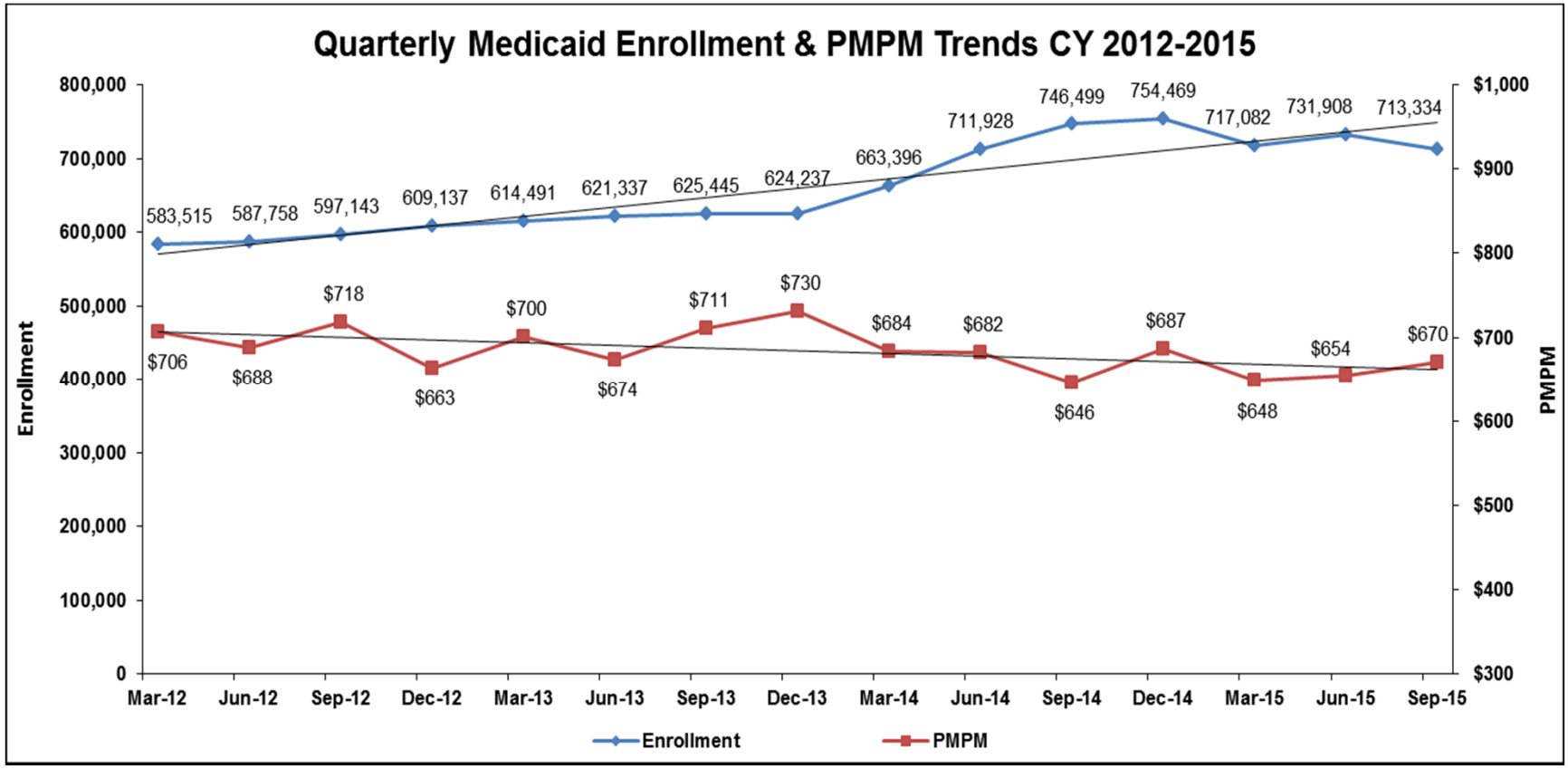
Medicaid Enrollment (cont.)

- As of November, 2015, HUSKY Health was serving over **750,000** beneficiaries (**~21%** of the state population)

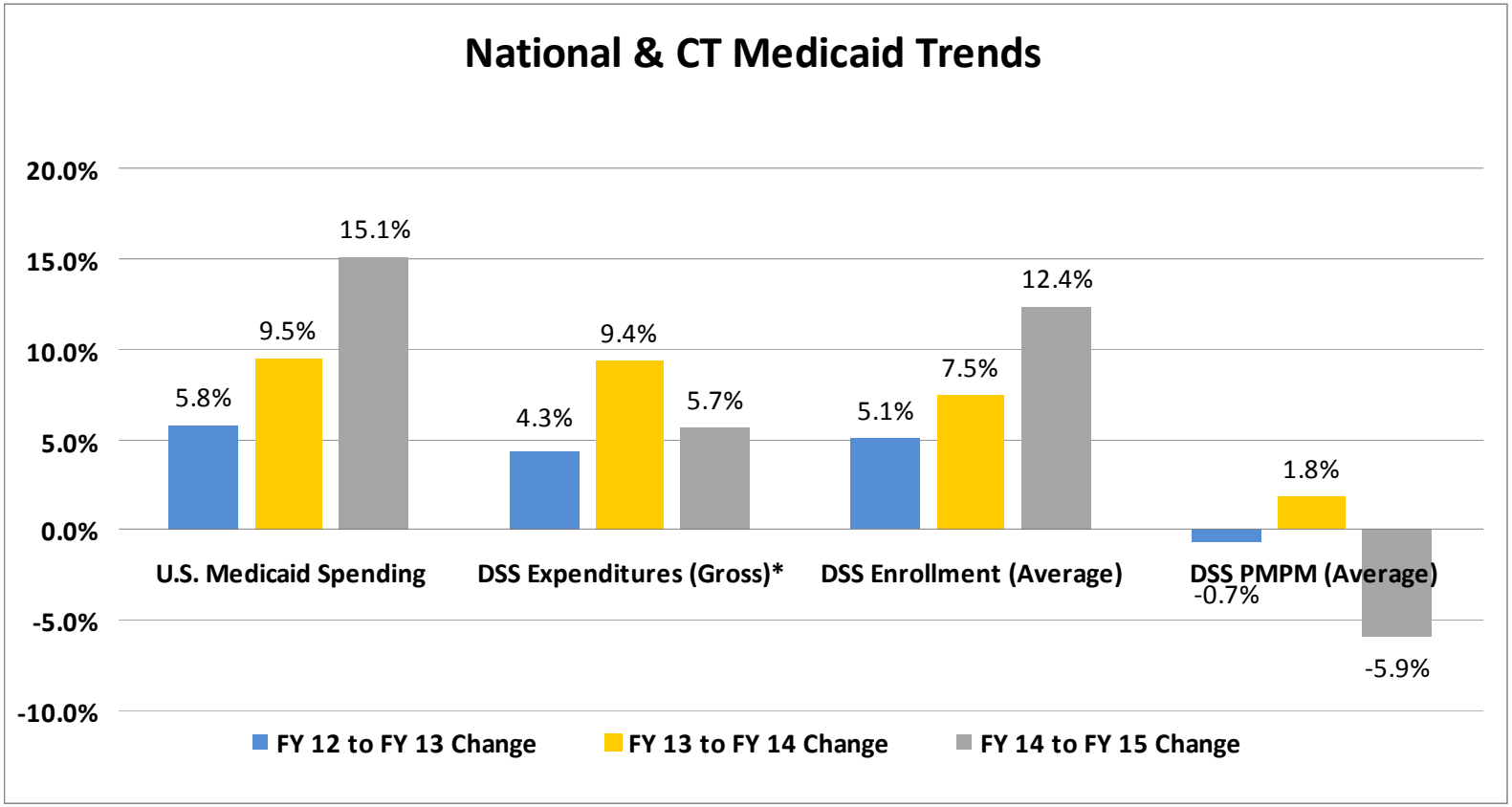
  - **442,680** HUSKY A adults and children
  - **15,362** HUSKY B children
  - **94,830** HUSKY C older adults, blind individuals, individuals with disabilities and refugees
  - **184,641** HUSKY D low-income adults age 19-64
  - **~ 2,500** limited benefit individuals (includes behavioral health for children served by DCF, tuberculosis services, and family planning services)

Medicaid Expenditures

- While enrollment growth has increased over this period, PMPM's have remained steady and have actually decreased slightly.



Medicaid Expenditures (cont.)



** Expenditures are net of drug rebates and include DMHAS' behavioral health costs claimable under Medicaid.*

Medicaid Outcomes

- Historically, key health indicators for Connecticut Medicaid beneficiaries, including hospital readmission rates and outcomes related to chronic disease, have been in need of improvement

- The Department is also deeply conscious of other indicators, such as incidence of Adverse Childhood Events (ACEs), that have bearing on coverage of and means of providing services

Medicaid Outcomes (cont.)

How are we doing with outcomes?

Over SFY'15:

- Overall admissions per 1,000 member months (MM) **decreased by 13.2%**
- Utilization per 1,000 MM for emergent medical visits **decreased by 5.4%**
- Utilization per 1,000 MM for all other hospital outpatient services **decreased by 5.3%**

Medicaid Outcomes (cont.)

- Over SFY'15, through a range of strategies (Intensive Care Management, behavioral health community care teams) and in cooperation with the Connecticut Hospital Association, **the Emergency Department visit rate was reduced** by:
  - 4.70% for HUSKY A and B
  - 2.16% for HUSKY C
  - 23.51% for HUSKY D

Medicaid Outcomes (cont.)

- Connecticut Medicaid's medical ASO, CHNCT, has:
  - for those members who received ICM, **reduced emergency department (ED) usage** by **22.72%** and **reduced inpatient admissions by 43.87%**
  - for those members who received Intensive Discharge Care Management (IDCM) services, **reduced readmission rates by 28.08%**

Medicaid Outcomes (cont.)

- We have also seen improvement in a range of other measures, including, but not limited to:
  - the rate for Controlling High Blood Pressure
  - the rate of Spirometry Testing in the Assessment and Diagnosis of COPD
  - Well Child Visit rate in the third, fourth, fifth and sixth year of life
  - Adolescent Well Care Visit rate
  - Lead Screening rate
  - Immunization rates
  - Timeliness and frequency of Prenatal and Postpartum Care Visits
  - Use of Preventative Dental services by children

Medicaid Outcomes (cont.)

We have improved provider experience with Medicaid, and have also been attentive to developing a broad and expanding network

- Providers now have the benefits of an electronic enrollment process, uniform statewide rate schedule, ASO-based utilization management support, and bi-weekly claims cycles

Medicaid Outcomes (cont.)

- Rate enhancements (primary care, dental), careful network geoaccess analysis, and provider support have enabled access

- Over SFY'15, Connecticut Medicaid:
  - increased the number of Primary Care Providers (PCPs) enrolled in Medicaid by 7.49% and specialists by 19.34%
  - recruited and enrolled 22 new practices into DSS' Person-Centered Medical Home (PCMH) program

Medicaid Outcomes (cont.)

- Under the Person-Centered Medical Home initiative:
  - 101 practices (affiliated with 366 sites and 1,332 providers) are participating
  - Over 274,000 beneficiaries are being served
  - In 2013, eligible practices received an average of **$121,000 in enhanced payments, $6,000 in incentive payments and $13,900 in improvement payments**

Medicaid Outcomes (cont.)

- PCMH practices achieved better results than non-PCMH practices on measures including, but not limited to:
  - adolescent well care
  - ambulatory ED visits
  - asthma ED visits
  - LDL screening
  - readmissions
  - well child visits

Medicaid Outcomes (cont.)

- Practices achieved an **overall member satisfaction** rating of 91.1% among adults and 96.1% on behalf of children

- **Immediate access to care increased** to 92.5% of the time, when requested by adults, and 96.7% of the time, when requested on behalf of children

- Among a number of **measures of courtesy and respect** shown to HUSKY members, communication before and during care, PCMH providers were rated overwhelmingly positively by HUSKY members

Medicaid Outcomes (cont.)

- All of that said, there remain diverse opportunities to continue to improve quality and care experience, to enable access, to ensure health equity and to support progress toward value-based payment

- Our next frontier in Medicaid will be to focus upon the range of social determinants that affect access to and utilization of Medicaid benefits

Core Concepts of Medicaid Coverage

Core Concepts of Medicaid Coverage

- Medicaid State Plan
- Contrasting Medicaid and Medicare
- Eligibility and coverage groups
- Means of covering services

Medicaid State Plan

- **Medicaid State Plan:** A written plan between a State and the Federal Government that outlines Medicaid eligibility standards, provider requirements, payment methods, and health benefit packages. A Medicaid State Plan is submitted by each State and approved by the Centers for Medicare and Medicaid Services (CMS)

Medicaid Aims

- The purpose of Medicaid is to enable states **"to furnish rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care."**

- Further, the Medicaid Act requires that each state medical assistance program be administered **in the "best interests of the recipients."**

Medicaid State Plan

- Generally, State Medicaid plans must, among other requirements:
  - ensure that services are provided in all parts of the state (the **“statewideness”** requirement)
  - provide a fair hearing process through which applicants and participants can appeal denials or failure to act on applications within the standard of promptness

Medicaid State Plan (cont.)

- establish or designate a single State agency to administer the plan - in Connecticut this is the Department of Social Services (DSS)
- require the State health agency - in Connecticut, this is the Department of Public Health (DPH) - to establish health standards for medical providers
- provide coverage to certain categorically eligible individuals

Medicaid State Plan (cont.)

- describe the extent to which the State is covering optional groups of individuals
- provide services for all recipients in the same amount, duration and scope (the **“comparability”** requirement)
- impose cost sharing in a manner that is consistent with federal law

Medicaid State Plan (cont.)

- describe financial eligibility standards;
- implement estate recovery, asset transfer restrictions and evaluation of trusts in a manner that is consistent with federal law
- provide individualized plans of care for recipients

Medicaid Authorities

- Federal law:
  - 42 U.S.C. Section 1396 *et seq.*
  - 42 C.F.R. Parts 430-455
- State law:
  - Chapter 319v (Secs. 17b-220 to 17b-319), and various others
- Department of Social Services Uniform Policy Manual (UPM)

Contrasting Medicaid and Medicare

- The **Medicaid** program is a medical welfare program based on financial and functional need
- Applicants must meet income and asset eligibility requirements, or must demonstrate a qualifying disability or functional need for services
- Generally, Medicaid has a more comprehensive array of covered services than does Medicare

Contrasting Medicaid and Medicare

- Further, with several important exceptions, recipients of Medicaid are not typically required to participate in cost sharing (e.g. copayments or deductibles)

Contrasting Medicaid and Medicare

- By contrast, eligibility for **Medicare** is not based on financial need

- Individuals who have met the required minimum number of “quarters” of work to qualify for Social Security retirement benefits, or have been receiving Social Security disability benefits for at least two years, automatically qualify for Medicare (children with End-Stage Renal Disease or Lou Gehrig’s Disease who meet identified criteria qualify more rapidly)

Contrasting Medicaid and Medicare

- Medicare provides a standard benefit that provides partial coverage of hospital and nursing facility services, physician services, some preventative services, and durable medical equipment

- Medicare beneficiaries are required to pay deductibles and copayments for most services, and there are strict durational limits for certain services: notably, coverage of care in a nursing facility

Medicaid Eligibility and Coverage Groups

- Medicaid is composed of different "**coverage groups**", each with their own eligibility requirements
- Eligibility requirements include categorical, income, asset, and other requirements
- Categorical requirements describe categories of individuals eligible for coverage, such as aged, blind and disabled individuals, children under age 19 and their parents, pregnant women and low-income childless adults

Eligibility and Coverage Groups (cont.)

- **HUSKY A** – Provides coverage to:
  - Children under age 19 and their parents/caretaker relatives
  - Pregnant women
- **HUSKY C** – Provides coverage to:
  - Individuals age 65 and older
  - Disabled individuals
  - Blind individuals
- **HUSKY D** – Provides coverage to:
  - Low Income childless adults age 19 through 64 who do not receive Medicare

Medicare Savings Programs (MSP)

- Qualified Medicare Beneficiary (QMB)
  - Pays Medicare Part A and Part B Premiums
  - Medicare deductibles
  - Medicare co-insurance
- Specified Low Income Medicare Beneficiary (SLMB)
  - Pays Medicare Part B Premiums
- Additional Low Income Medicare Beneficiary (ALMB)
  - Pays Medicare Part B Premiums

All MSP categories confer eligibility for the Medicare Part D Prescription Drug Program's Low Income Subsidy (also known as "Extra Help")

Eligibility and Coverage Groups (cont.)

- Since the passage of the federal Affordable Care Act (ACA), HUSKY A and HUSKY D are one part of a health care coverage continuum that also includes:
  - The Children's Health Insurance Program (HUSKY B) Provides coverage to children in families with incomes too high to qualify for Medicaid
  - Subsidized Qualified Health Plans
  - Unsubsidized Qualified Health Plans
- Household income determined using "MAGI" tax-based rules

Eligibility and Coverage Groups (cont.)

Category	Connecticut Coverage Groups and income limits (% of Federal Poverty Level*)							
	<=138%	<=155%	<=201%	<=254%	<=263%	<=323%	<=400%	>400%
Pregnant Women	Medicaid (Husky A)	Medicaid (Husky A)	Medicaid (Husky A)	Medicaid (Husky A)	Medicaid (Husky A)	Subsidized Insurance	Subsidized Insurance	Unsubsidized Insurance
Children < 19	Medicaid (Husky A)	Medicaid (Husky A	Medicaid (Husky A)	CHIP Band 1 (Husky B)	CHIP Band 2 (Husky B)	CHIP Band 2 (Husky B)	Subsidized Insurance / Subsidized Insurance	Unsubsidized Insurance / Unsubsidized Insurance
Primary Caretaker or Parent of Children < 19	Medicaid (Husky A)	Medicaid (Husky A)	Subsidized Insurance	Subsidized Insurance	Subsidized Insurance	Subsidized Insurance	Subsidized Insurance	Unsubsidized Insurance
Childless Adult 19 to 65	Medicaid (Husky D)	Subsidized Insurance	Subsidized Insurance	Subsidized Insurance	Subsidized Insurance	Subsidized Insurance	Subsidized Insurance	Unsubsidized Insurance

***Income limits include a 5% FPL general income deduction**

Eligibility and Coverage Groups (cont.)

Monthly Income Limits – HUSKY A, B and D

Family Size	HUSKY D 138% FPL	HUSKY A Parents 155% FPL	HUSKY A Children 201% FPL	HUSKY B Band 1 Children 254% FPL	HUSKY A Pregnant Women 263% FPL	HUSKY B Band 2 Children 323% FPL
1	$1,353.78	$1,520.55	$1,971.81	$2,491.74	$2,580.03	$3,168.63
2	$1,832.64	$2,058.40	$2,669.28	$3,373.12	$3,492.64	$4,289.44
3	$2,311.50	$2,596.25	$3,366.75	$4,254.50	$4,405.25	$5,410.25
4	$2,788.98	$3,132.55	$4,062.21	$5,133.34	$5,315.23	$6,527.83

Eligibility and Coverage Groups (cont.)

HUSKY C

- Age 65 or older
- Disability - age 18-64 and disabled per Social Security criteria
- Blind
- Asset limit - $1,600 for one; $2,400 for married couples
  - Home is excluded (no lien on home)
  - Usually 1 car excluded (or if not $4,500 equity excluded)

Eligibility and Coverage Groups (cont.)

HUSKY C

Spenddowns:

- Person is over the income limit, but meets all other requirements
- Person must ‘spend down’ the amount which is over the income limit, before Medicaid can start
- DSS uses 6 month ‘spenddown’ periods - excess for 1 mo. x 6 = spenddown amount
- must owe the 6 mo. amount on medical expenses and submit bills (paid or unpaid)
- similar to an insurance deductible

Eligibility and Coverage Groups (cont.)

HUSKY C

**** Spenddown Example ****

- Monthly applied income is $960 per month
- The income limit, including disregards, is $860
- The “excess” income is $100 per month or $600 for the 6-month spenddown period
- Once client has incurred $600 in medical bills, HUSKY C will pay future medical bills for the rest of the 6-month spenddown period

Eligibility and Coverage Groups (cont.)

Medicare Savings Program Monthly Income Limits			
	QMB	**SLMB**	**ALMB**
Single	**$2,069.91**	**$2,266.11**	**$2,413.26**
Couple	**$2,802.08**	**$3,067.68**	**$3,266.88**

Means of Covering Services

- States must under their State Plans cover identified mandatory services (e.g. inpatient hospital care, FQHC services, physicians' services) and may elect to cover optional services (e.g. dental, behavioral health, medical transportation)

- Connecticut covers a broad range of optional services

Means of Covering Services (cont.)

- The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid

Means of Covering Services (cont.)

- Under EPSDT, states are required to provide comprehensive services and furnish all Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, based on certain federal guidelines

Means of Covering Services (cont.)

- EPSDT is made up of the following screening, diagnostic, and treatment services:
  - Screening Services
  - Vision Services
  - Dental Services
  - Hearing Services
  - Other Necessary Health Care Services
  - Diagnostic Services
  - Treatment

Means of Covering Services (cont.)

- Another means of covering services is through “waivers”
- Waivers permit states to be excused from one or more of the Medicaid State Plan requirements – an example of this is the “statewideness” requirement
- The Affordable Care Act also provides some new options for coverage through State Plan Amendments

Means of Covering Services (cont.)

Authority	Features
1915(c) home and community-based waiver (In Connecticut: CT Home Care Program for Elders, Personal Care Assistant, Acquired Brain Injury, DDS, mental health, autism)	An option through which states can cover home and community-based long-term services and supports for target populations. Services can include care management, homemaker, home health aide, personal care, adult day health, habilitation, and respite care. Must identify a cap on participation.
1115 research and demonstration waiver	An option through which states can implement demonstration projects to expand eligibility, provide services not typically covered by Medicaid, and/or use innovative service delivery systems. Must demonstrate budget neutrality and accept a cap on total expenditures over a five year period.

Means of Covering Services (cont.)

Authority	Features
1915(b) managed care waiver	An option under which states can implement a managed care delivery system that restricts the types of providers from which beneficiaries can receive services and use associated savings to provide other services
1915i State Plan Amendment (SPA)	An option under which states can provide home and community-based services to individuals who meet identified functional criteria. In that it is a SPA, must serve all eligible individuals and cannot cap enrollment.

A Federal/State Partnership

- Under the federal law, states are required to pay no less than 40% of total program costs and the Federal government pays the remainder
- This remainder is called the Federal Medical Assistance Percentage (FMAP)
- Connecticut's FMAP for most Medicaid services is 50%

A Federal/State Partnership (cont.)

- Connecticut's FMAP for CHIP services is 88%
- Connecticut’s FMAP for newly eligible (ACA expansion) individuals on HUSKY D is 100%
- Several other initiatives (e.g. administrative activities of the medical Administrative Services Organization, Electronic Health Record project, health home) are eligible for FMAP that is greater than 50%

Means of Covering Services (cont.)

- The Affordable Care Act has provided new opportunities for Medicaid state plan coverage with enhanced FMAP

- Notable exampled of this include coverage of tobacco cessation and the health home option

Means of Covering Services (cont.)

- ACA requires that states implement the following:
  - coverage of comprehensive tobacco cessation services (counseling, treatment, and medications including over-the-counter nicotine replacement products) for all pregnant women covered by the Medicaid Program
  - coverage of tobacco cessation products, barbituates and benzodiazapines

Health Home: Overview

- ACA built upon existing efforts to **integrate medical, behavioral and social services and supports for individuals with behavioral health and chronic conditions** by permitting states to seek approval of state plan amendments to implement such coverage

- ACA "health home" amendments qualify states to receive eight quarters of **enhanced Federal Medical Assistance Payment (FMAP)** in support of this work

- By contrast to the typical Connecticut FMAP of 50% FMAP for health homes is at **90%**

Health Home: Eligibility

- To be eligible for the health home option, beneficiaries must have at least one of the following:
  - two or more chronic conditions
  - one chronic condition and risk of developing a second or
  - a serious and persistent mental health condition
- Chronic conditions are defined as including behavioral health conditions, substance use disorders, asthma, diabetes and heart disease

Health Home: Design Considerations

- States have the option to elect health home funding for all beneficiaries with these conditions, or to limit the set of conditions that are included
- States may define the level of severity that is required to qualify
- CMS has stated that electing health home funding in support of one population tolls the eight quarters only for that group, and does not foreclose electing successive 90% FMAP periods for other populations

Connecticut Medicaid coverage

Connecticut Medicaid Coverage Groups

- **Husky A**: children
- **Husky B**: Children's Health Insurance Plan (CHIP)
- **Husky C**: Aged, Blind and Disabled (ABD)
- **Husky D**: Medicaid for Lowest Income Populations (MCLIP)

Connecticut Medicaid Structure

- Historically:
  - Individuals covered under HUSKY A & B were served by multiple, at-risk, capitated Managed Care Organizations (MCOs)
  - Individuals covered under HUSKY C (coverage for older adults and individuals with disabilities) were served in an unmanaged fee-for-service arrangement

Connecticut Medicaid Structure (cont.)

- Individuals up to 53% of the Federal Poverty Level (FPL) who were historically served by SAGA medical became eligible effective April, 2010 for new HUSKY D (Low Income Adult, LIA) group
- Connecticut was the first state in the country to gain CMS approval for an early expansion group
- This is the group for which income eligibility expanded under ACA, effective January 1, 2014

Connecticut Medicaid Structure (cont.)

- Effective January 1, 2012, Connecticut transitioned Medicaid **medical services** for all coverage groups to a single Administrative Services Organization (ASO): CHN-CT

- This represents a “managed fee-for-service” approach, which contrasts with most other states that are moving almost exclusively to a managed care approach

Connecticut Medicaid Structure (cont.)

- Medicaid **behavioral health services** have since January 1, 2006 been overseen by the Connecticut Behavioral Health Partnership, and managed by a behavioral health ASO (Value Options)

- Medicaid **dental services** have since September 1, 2008 been managed by a dental ASO (BeneCare)

- Medicaid **Non-Emergency Medical Transportation services** have since Spring, 2013 been managed by a transportation ASO (Logisticare)

Context (cont.)

- By contrast, Medicaid **pharmacy** benefits are administered by the Department through contractor HP

- HP also serves many other key functions, including provider credentialing and enrollment, claims processing, provider communications and management of a data warehouse

Rationales for Use of ASOs

Use of ASOs for all Medicaid services will:

- build upon a model that had worked successfully for Medicaid behavioral health and dental services
- improve access to and use of data in support of best use of public resources and transparency
- centralize and streamline administration, utilization management and member and provider supports

The Central Hypothesis . . .

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.

Comparison of Past and Present Models

	MCO	ASO
Structure	Multiple managed care entities	One managed fee-for-service entity
Contract	Administrative	Department withholds 7.5% of each quarterly administrative payment contingent upon ASO's success in meeting performance targets related to beneficiary health outcomes and experience of care, as well as provider satisfaction
Payment model	Capitated payment	Managed fee-for-service

Contrast with MCO Arrangement (cont.)

	MCO	ASO
Care delivery model	Each MCO handled utilization management (e.g. prior authorization) on its own terms	Utilization management has been standardized for all Medicaid beneficiaries, Intensive Care Management (ICM) is available to all Medicaid beneficiaries
Data	Multiple data sets, inconsistent/non-standard reporting of data to Department	One integrated data set is immediately available to Department, provides much greater level of detail and transparency

Contrast with MCO Arrangement (cont.)

	MCO	ASO
Provider enrollment	Providers enrolled in one or many MCOs	Enrollment is handled through an online process by the Department's contractor, HP
Provider rates	Established by each MCO (non-standard)	Department uses a standard rate schedule and common service definitions for all services
Provider payment	Each MCO was responsible for payment	Payment is made by HP on a twice per month

The Results of the ASO Approach

- Transition of all Medicaid services to a streamlined ASO platform has improved member and provider support; has through predictive modeling, ICM and data sharing enabled tailored responses to members' needs; and created a partnership between DSS and its ASOs that is mission-driven toward improving the health outcomes and satisfaction of those served by Medicaid

Current Medicaid State Plan-Covered Services

- For a summary of covered services under HUSKY A (children and parents/relative caregivers), C (older adults and people with disabilities) and D (single childless adults age 19-64), please use this link:

http://www.huskyhealthct.org/members/member_postings/member_benefits/HUSKY_A-C-D-Handbook_9-15.pdf

Current Medicaid State Plan-Covered Services (cont.)

- For a summary of covered services for HUSKY B (Children's Health Insurance Plan/CHIP, uninsured children under age 19), please use this link:

http://www.huskyhealthct.org/members/member_postings/member_benefits/HUSKY%20B%20Handbook_9-15.pdf

Coverage Exclusions

- Medicaid does not cover:
  - pilot projects
  - out of state care with providers who refuse to enroll in Connecticut Medicaid
  - experimental care
  - research

Process for Seeking New Medicaid Coverage

- Discuss in concept with DSS
- Develop service definition, coverage parameters, provider credentials and synopsis of fiscal impact
- Pursue OPM review and approval
- Partner with DSS on development of State Plan Amendment (SPA) or waiver
- Support DSS in responding to CMS Requests for Additional Information (RAI)

For reference:
Connecticut Medicaid reform strategies

What is our conceptual framework?

DSS is 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 the population
- 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.

Improving the Patient Experience Of Care

Issues Presented	DSS Strategies	Anticipated Result
Individuals face access barriers to gaining coverage for Medicaid services	• ConneCT, ImpaCT • MAGI income eligibility • Integrated eligibility process with Access Health CT	Streamlined eligibility process that optimizes use of public and private sources of payment
Individuals have difficulty in connecting with providers	• ASO primary care attribution process and member support with provider referrals • Support for primary care providers (Person-Centered Medical Home, Electronic Health Record funding, ACA rate increase)	DSS will help to increase capacity of primary care network and to connect Medicaid beneficiaries with medical homes and consistent sources of specialty care
Individuals struggle to integrate and coordinate their health care	• ASO predictive modeling and Intensive Care Management (ICM) • Health home initiative • MQISSP initiative	Individuals with complex health profiles and/or co-occurring medical and behavioral health conditions will have needed support

Improving the Health of Populations

Issues Presented	DSS Strategies	Anticipated Result
A significant percentage of Connecticut residents does not have health insurance	• Medicaid expansion • Integrated eligibility determination with Access Health CT	Increased incidence of individuals covered by either Medicaid or an Exchange policy
Many Connecticut residents do not regularly use preventative primary care	• PCMH initiative in partnership with State Employee Health Plan PCMH	Increased regular use of primary care; early identification of conditions and improved support for chronic conditions
Many health indicators for Medicaid beneficiaries are in need of improvement, and Medicaid has the opportunity to influence other payers	• Behavioral health screening for children • Rewards to Quit incentive-based tobacco cessation initiative • Obstetrics and behavioral health P4P initiatives	Improvement in key indicators for Medicaid beneficiaries; greater consistency in program design, performance metrics and payment methods among public and private payers

Reducing the Per Capita Cost of Care

Issues Presented	DSS Strategies	Anticipated Result
Connecticut's historical experience with managed care did not yield the cost savings that were anticipated	• Conversion to managed fee-for-service approach using ASOs • Administrative fee withhold and performance metrics	DSS and OPM will have immediate access to data with which to assess cost trends and align strategies and performance metrics in support of these
Connecticut Medicaid's fee-for-service reimbursement structure promotes volume over value	• PCMH performance incentives • Obstetrics pay-for-performance initiative • MQISSP shared savings arrangement	Evolution toward value-based reimbursement that relies on performance against established metrics
Connecticut Medicaid's means of paying for hospital care is outmoded and imprecise	• Conversion of means of making inpatient payments to DRGs and making outpatient payments to APCs	DSS will be more equipped to assess the adequacy of hospital payments and will be able to move toward consideration of episode-based approaches

Reducing the Per Capita Cost of Care (cont.)

Issues Presented	DSS Strategies	Anticipated Result
Connecticut expends a high percentage of its Medicaid budget on a small percentage of individuals who require long-term services and supports; historically, this has primarily been in institutional settings Consumers strongly prefer to receive these services at home	• Strategic Rebalancing Initiative (State Balancing Incentive Program, Money Follows the Person, nursing home diversification funding, workforce analysis, My Place campaign)	Connecticut will achieve the stated policy goal of making more than half of its expenditures for long-term services and supports at lower cost in home and community-based settings

In conclusion . . .

Connecticut Medicaid is utilizing diverse strategies to enable access to services, expand eligibility, connect Medicaid beneficiaries to primary care, enhance utilization of health care services, integrate medical and behavioral health care, and shift towards paying for value.

Legislative Requirement
Adverse Selection Study
(Vote)

WAKELY CONSULTING GROUP

CONSULTING ACTUARIES & HEALTHCARE SPECIALISTS

Access Health CT
2015 Adverse Selection Study
January 21, 2016 Board of Directors Meeting

Julia Lambert, FSA, MAAA
President

Chris Bach, ASA, MAAA, FCA
Senior Consulting Actuary

Purpose of Study

Access Health Connecticut (AHCT) is required by legislation to:

- Report annually on the impact of adverse selection on the exchange
- Provide recommendations to address any negative impact reported
- Provide recommendations to ensure sustainability of the exchange

Scope of Presentation

AHCT retained Wakely Consulting Group (Wakely) to perform the adverse selection analysis. This presentation provides a high level summary of the analysis, results and recommendations. The full report can be found in Appendix A.

Disclosures

- Wakely relied on data provided by others to complete this study
- Data was reviewed for reasonability and appropriateness
- Study and results are intended to fulfill the legislative reporting requirements; any other use of this information may not be appropriate

Defining, Identifying & Measuring Adverse Selection

For purposes of this study, adverse selection is:

- Defined as one segment of the market attracting enrollees with higher health risk than another segment of the market
- Identified by higher risk scores in one segment of the market than another
- Measured by the difference in risk scores between market segments

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Nature of Adverse Selection

- Impossible to completely remove adverse selection in any insurance market where there is a choice of coverage
- Impact of adverse selection can be managed or mitigated through regulation and policies

Areas of Potential Adverse Selection

Wakely analyzed three areas of potential adverse selection, including:

- Adverse selection between on and off exchange plans
- Adverse selection between grandfathered and non-grandfathered plans
- Adverse selection related to self-funding in the small group market

Methodology

For each potential area of adverse selection considered, the analysis included:

- Quantitative analysis based on plan enrollment, federal risk scores and risk adjustment transfer payments.
- Subjective comments based on survey responses from carriers and other market data available to Wakely

Conclusions: Individual Market On Exchange vs. Off Exchange

- On exchange enrollees have higher risk scores than off exchange plan enrollees in individual market
- May indicate potential adverse selection
- Minimal impact in market due to protection of risk adjustment mechanisms

Conclusions: Small Group Market On Exchange vs. Off Exchange

- Small group on exchange enrollment is low and not fully credible by metal tier
- Can not make any conclusions regarding adverse selection
- Low enrollment should be monitored outside context of adverse selection to ensure sustainability of market

Conclusions: Individual Market Grandfathered vs. Non-Grandfathered

- Individual grandfathered policies appear to experience favorable selection
- Portion of enrollees in grandfathered plans is minimal and declining
- Minimal impact to individual market

Conclusions: Small Group Market Grandfathered vs. Non-Grandfathered

Since there was no small group grandfathered plan enrollment as of June 2015, no analysis of adverse selection was performed.

Conclusions: Self-Funding in the Small Group Market

- Connecticut data indicates increase in prevalence of self-funded small groups in recent years but data may not be credible
- National data indicates no significant change in prevalence of self-funded small groups in recent years but may not be appropriate to compare to CT due to differences in small group regulations.

Conclusions: Self-Funding in the Small Group Market, cont.

- Lack of credible or comparable data results in no clear conclusion whether there is adverse selection in the small group market
- Issue needs to be closely monitored as more data becomes available to ensure healthier small groups do not move to a self-funded basis leading to significant adverse selection

Other Adverse Selection Considerations

Many carriers indicated in the survey responses that one of the most significant issues impacting adverse selection in their plans is the special enrollment period (SEP).

Conclusions: Other Adverse Selection Considerations

Based on survey responses, there appears to be a significant concern on the impact of the Special Enrollment Period (SEP):

- Experience is significantly worse members enrolling during SEP than those enrolled during open enrollment
- A higher proportion of enrollees who enroll during SEP drop coverage in the first three months than those enrolled during open enrollment

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Conclusions: Other Adverse Selection Considerations, cont.

This issue is not surprising to AHCT:

- AHCT & CID are aware of the SEP issues and determining next steps to minimize adverse selection by SEP enrollees
- Many other states and carriers have indicated concern that SEP's are causing a significant adverse selection impact to their plans

Recommendations

On vs. Off Exchange Adverse Selection

- Continue to monitor small group enrollment on the exchange to ensure sustainability
- Participate with other states and carriers to lobby for improvements in the federal risk adjustment formula to improve its accuracy

Recommendations, cont.

Grandfathered vs. Non-Grandfathered Plans

- No changes for grandfathered plans due to minimal impact of adverse selection
- Consider terminating the grandfathered plans at some future point due to low membership and economical inefficiency

Recommendations, cont.

Self-Funding in Small Group Market

- Closely monitor small group market to ensure healthier small groups do not move to a self-funded basis leading to adverse selection (i.e., healthier groups opting out of the fully insured risk pool to get lower, experience-based cost options)

Recommendations, cont.

Self-Funding in Small Group Market, cont.

- Consider implementing a stop loss insurance regulation to limit adverse selection due to migration of small groups to self-funded plans

Recommendations, cont.

Other Considerations

- Continue to consider ways to mitigate adverse selection among SEP enrollees possibly including:
  - Stricter documentation requirements for SEP enrollees
  - Termination of enrollment in the case of misrepresentation or fraud

Recommendations, cont.

Other Considerations, cont.

- Continue to administer the same criteria to review both on and off exchange filings, thereby ensuring similar review and regulation for both on and off exchange plans

Future Considerations

- Limited experience makes it difficult form a definitive opinion on the impact of adverse selection at this time
- Analysis indicates there may be some adverse selection going on in the Connecticut health insurance market
- Future studies with more mature experience may provide more definitive results

Questions?

Adjournment