Connecticut Health Policy Project

January 2017

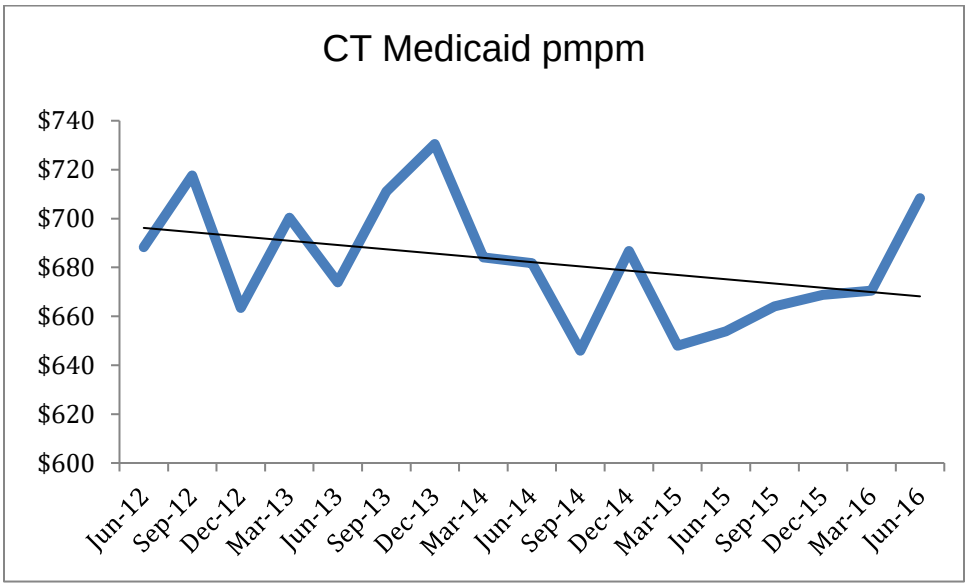
What you won't hear – Busting Medicaid Financing Myths

As with most health care in Connecticut, Medicaid spending was rising quickly before 2012 growing by almost half over the prior four years. But in 2012, Connecticut made a remarkable and unique move -- Medicaid switched from a capitated payment model using private insurers to a care coordination, self-insured payment model. Since then, state spending on Medicaid has decreased, saving over $100 million annually. The shift also resulted in significant improvements in quality, access to care and consumer satisfaction at the same time enrollment grew by over 300,000 members.[1]

Connecticut Medicaid accomplished this remarkable success without a waiver, without an increase in federal funding, and without new federal Medicaid "flexibility". Unfortunately, persistent myths remain that costs in Connecticut's Medicaid program remain out of control.

Myth: Medicaid is not saving money

In fact: Connecticut **Medicaid per person costs (pmpm) are stable**, in contrast to Medicaid nationally.

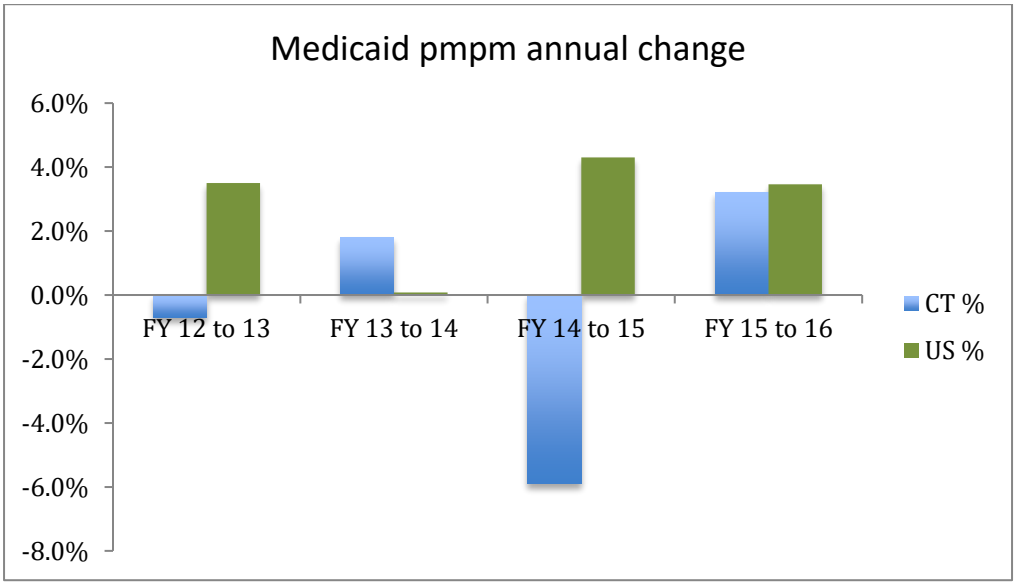


Source: DSS[2]

[1] DSS presentation to MAPOC, 10/2016; DSS enrollment presentations to MAPOC, 10/2012, 1/2016

[2] DSS presentations to MAPOC, 10/2014, 10/2015, 1/2016

From 2012 to 2016, per member costs in Connecticut Medicaid grew four times more slowly than the national Medicaid average. This lower growth rate saved our state's program $471.7 million over those years.



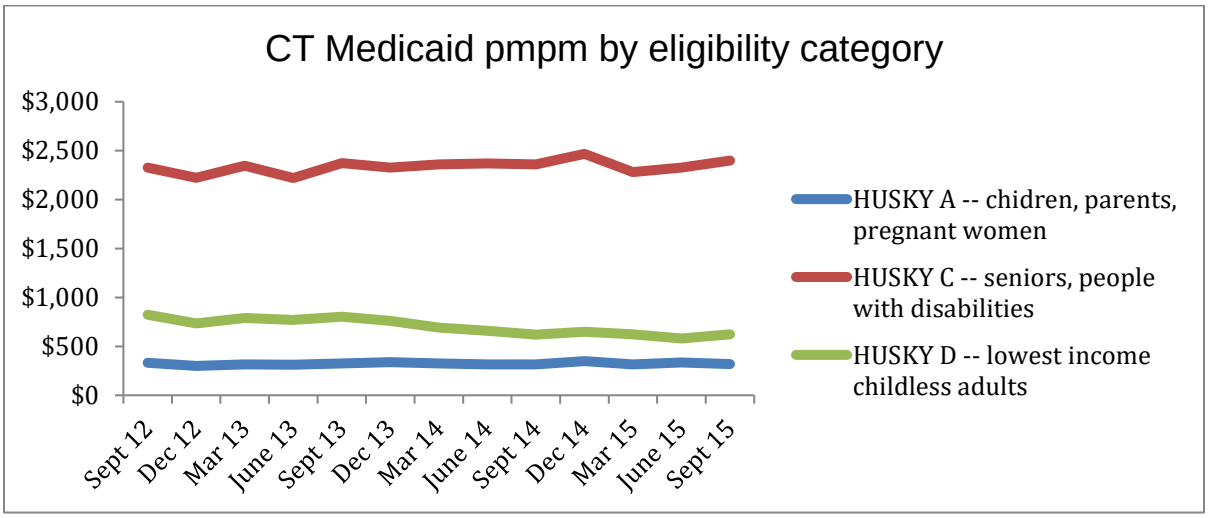
$471.7 million

CT savings compared to US Medicaid per person growth rate

Sources: HHS, DSS[3]

Myth: If we are reducing average per person costs, it is only because we brought in healthier young adults through the Affordable Care Act who have lowered the average; costs for the other eligibility categories are still out of control.

In fact: **Per member costs are stable across all three eligibility categories**. It is true that Connecticut did a great job of enrolling lots of new eligibles (HUSKY Part D) through the Affordable Care Act – mainly childless adults. On average, HUSKY D members' costs are between the other two categories.

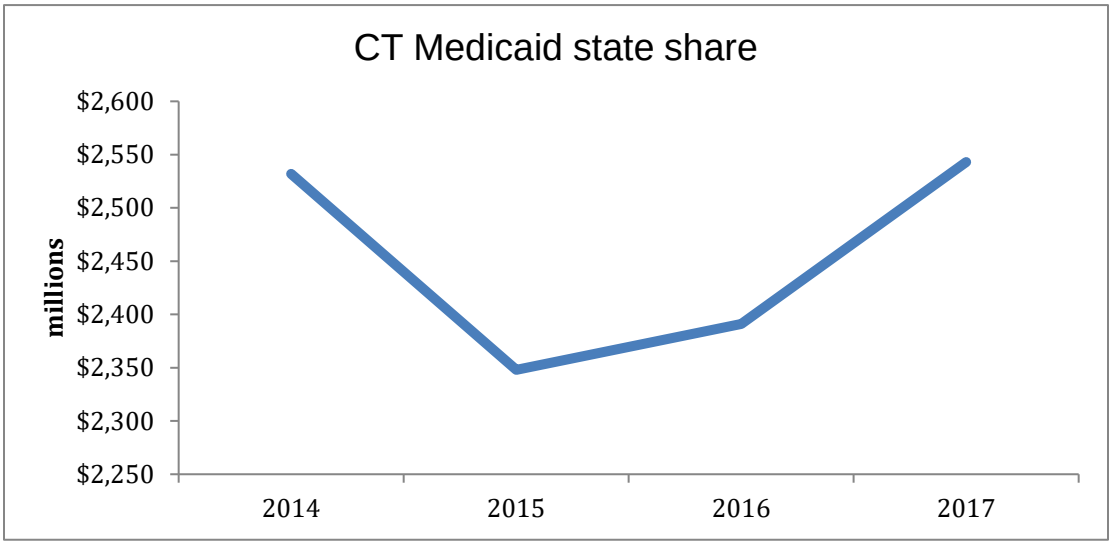


Source: DSS[4]

[3] 2015 Actuarial Report on the Financial Outlook for Medicaid, CMS, July 2016; DSS presentations to MAPOC 10/2015, 10/2014, 1/2016

Myth: In any event, Medicaid is eating up more and more of the state's budget. Even if it's saving money per person, taxpayers can't afford it.

In fact: **State spending on Medicaid dropped significantly** between 2014 and 2015. Only this year will state spending on Medicaid rise again to pre-2014 levels. The reductions are due both to lower per person costs and higher federal reimbursements through the Affordable Care Act.

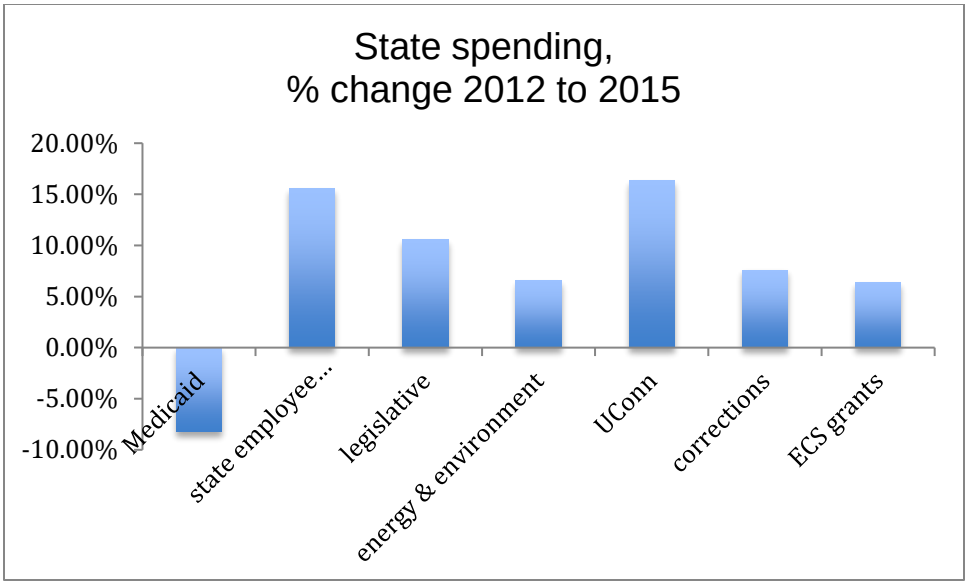


Sources: DSS, OSC[5]

Myth: Costs must be out of control or the state wouldn't have cut 10,000 HUSKY parents from the program last year.

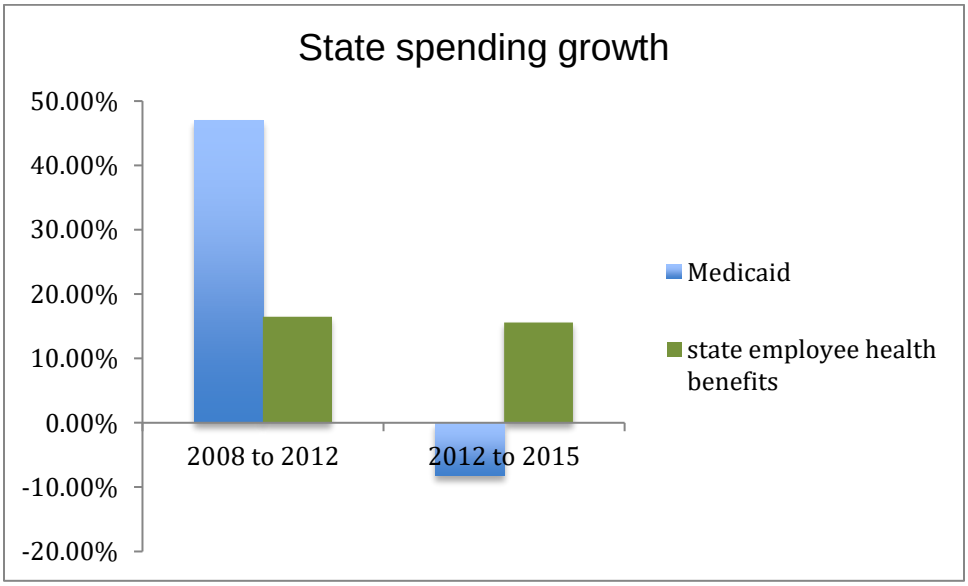
In fact: **Medicaid's state spending trend from 2012 to 2015 is in sharp contrast to many other areas of the budget.** However, despite significantly savings, Medicaid eligibility for working parents was cut to further to address state deficits.

[4] DSS presentations to MAPOC 10/2014, 1/2016
[5] DSS report to MAPOC 1/2016, Annual Reports of the State Comptroller – Budgetary Basis



Sources: OSC, HHS[6]

As for most health care, Medicaid spending was rising quickly before 2012. From 2008 to 2012, Connecticut Medicaid spending grew three times faster than state employee health benefits. However, when Connecticut Medicaid switched from a capitated payment model using private insurers to a care coordination, self-insured payment model state spending on Medicaid dropped sharply while state employee cost growth was unchanged.



Sources: OSC, HHS[7]

[6] Annual Reports of the State Comptroller – Budgetary Basis; Medicaid State Expenditures Reports, MBES, CMS-64 reports, HHS

[7] Annual Reports of the State Comptroller -- Budgetary Basis, Office of State Comptroller; Expenditure reports from MBES, CMS-64 data, HHS

Myth: Medicaid is doing nothing innovative to control costs.

In fact: Connecticut **Medicaid has implemented dozens of innovations** to control costs and improve the value of health care[8]. A few of those innovations include:

- High-cost, high-need member interventions
- Intensive Care Management – physical and behavioral health programs
- Person-Centered Medical Homes (PCMH)
- Behavioral Health Homes to integrate physical and behavioral health care
- PCMH + shared savings
- Long Term Services and Supports rebalancing
    - Home and Community-based waivers
    - Nursing home right-sizing
    - Workforce initiatives
    - My Place consumer portal
    - Community First Choice state plan option for self-directed personal care support
- CMCS Innovation Accelerator Program on Medicaid-Housing Partnerships
- Electronic health record payments
- Primary care rate increases to equal Medicare
- Money Follows the Person housing and supports
- Obstetrics, PCMH payments for quality improvement
- Hospital payment modernization and updates
- Fully integrated claims data, moving to data match across state programs including social services and corrections
- Streamlined, consistent, reliable administration, enrollment, provider and consumer information
- Basing quality payments on, among other things, consumer satisfaction performance

Bottom Line: Medicaid is not driving either rising health costs in Connecticut or the state's budget deficit. In fact, Medicaid has provided significant relief to both state and federal budgets as well as leading innovative reform of our state's health system.

[8] State Agency Response to Request for Input/Feedback on Possible Strategies and Current Context, DSS report to the Health Care Cabinet, June 2016