CONNECTICUT HOSPITAL ASSOCIATION

October 25, 2024

Andrea Barton Reeves
Commissioner
The Department of Social Services
55 Farmington Avenue
Hartford, CT 06105

RE: CHA COMMENT – HUSKY Health Report

Dear Commissioner Barton Reeves,

Thank you for the opportunity to comment on Section 17 of Public Act 23-171, which requires the Department of Social Services (DSS) to develop a strategy to redesign Medicaid to improve Medicaid provider reimbursement, healthcare outcomes, community health, and health equity to support HUSKY Health members.

Section 17 calls out six goals for Medicaid redesign which are of fundamental importance to achieving a sustainable care delivery system, advancing the long-term health and well-being of Medicaid patients, and resolving the enduring disparities of both race and place that exist throughout our state.

These goals include the following:

1. Improve healthcare access and outcomes
2. Increase adoption of interventions to support improved access to preventive care services
3. Identify and address social, economic and environmental drivers of health to advance long-term preventive health and healthcare outcomes
4. Explore innovative financing reforms that support high quality care, promote integration of primary, preventive and behavioral healthcare and address health-related social needs and long-term preventive outcomes
5. Improve collaboration and coordination among healthcare providers and cross-sector community partners
6. Improve Medicaid reimbursement and performance to achieve a sustainable healthcare delivery system and improve healthcare affordability for all

Overview

We believe that the goals outlined in Section 17 can best be achieved through a comprehensive redesign of the Medicaid program, one that enables the coordination of multiple financing and systems change solutions to achieve long-term statewide impact. Among the foremost goals of this redesign should be resolving the chronic underinvestment in the cost of delivering care to Medicaid beneficiaries, cost that is otherwise borne by commercial insurance. This is the most significant immediate contribution that Medicaid can make to drive affordability for all (Goal 6), while improving healthcare access and outcomes (Goal 1).

Another important opportunity in Medicaid is addressing the upstream social, economic, and environmental drivers of health and the root causes of health inequities. Multi-sector health partnerships, which exist in many communities across the state, should be enlisted as agents of regional change to achieve long-term prevention outcomes such as child development, self-reported health and well-being, reductions in the incidence and prevalence of avoidable chronic illness, behavioral health conditions, maternal/child health outcomes, and life expectancy at birth. Doing so will improve health, healthcare, and equity outcomes, attenuate cost growth, and drive affordability for all. Numerous studies have now documented that the financial and economic benefits of addressing health inequities are vast and far-reaching.[1] Doing so, however, requires that we extend our focus to the problems of place that limit what can be achieved in clinical settings alone.

Finally, the state should advance a regional investment and accountability framework that provides sustainable financing to support the work of hospitals and the multi-sector partnerships in which they participate, and primary care. We offer the following recommendations, which are further detailed in this letter, to serve as the cornerstones of Medicaid redesign to achieve the goals of Section 17.

- ***Recommendation 1: Address Medicaid Hospital Underpayment.*** *Increase reimbursement* to e*liminate the hospital shortfall and provide for annual trend updates that keep pace with the rising cost of care.*
- ***Recommendation 2: Engage Multi-Sector Partnerships.*** *Support and strengthen the role of multi-sector health partnerships, which are essential community assets with the means to address root cause issues and promote health and health equity in their communities and the Medicaid population*.
- ***Recommendation 3: Regional Investment and Accountability Model.*** *Establish a financing and accountability framework that provides substantial and sustained new investment funding for the work of hospitals and the multi-sector partnerships in which they participate. Return for reinvestment 100% of the savings that result from achieving long-term prevention, healthcare, and equity outcomes.*

[1] The $2.8 Trillion Opportunity: How Better Health for All Can Drive US Economic Growth, The Deloitte Center for Health Solutions, September 2024

Medicaid Reimbursement and Healthcare Affordability

Medicaid redesign presents an opportunity to enhance Medicaid's support for the cost of sustaining access to a high quality healthcare delivery system and promoting affordability for all. Today, Connecticut's healthcare system comprises a complex network of hospital, professional, behavioral health, home care, pharmacy, transportation, and nursing home services that meet the healthcare needs of Medicaid, Medicare, and commercially insured individuals alike. All payers must contribute their fair share of the cost of our care delivery system, and today, Medicaid is not fulfilling that requirement.

There is strong evidence that Medicaid is not investing its fair share. In a presentation to the Medical Assistance Program Oversight Council (MAPOC) DSS highlighted the extent of its under-investment (see presentation, slide 20). In 2022, as a percent of total state expenditures, Connecticut spent 22.6% on Medicaid versus an average of 28.8% among its northeastern peers. In other words, **Connecticut spent 27% less than other peer states on Medicaid**—this a long-standing disparity extending back at least six years.

There are important consequences of Connecticut's chronic underinvestment in Medicaid rates:

- Medicaid beneficiaries have poorer access relative to their commercially insured counterparts, have poorer health and healthcare outcomes, and experience preventable health disparities related to income, race and ethnicity, disability, sexual orientation, and gender identity.
- Commercial health insurers pay higher rates to make up for Medicaid underpayment at the expense of affordability; this amounts to a *hidden tax* on employers and their employees who ultimately bear the cost of these higher rates.

If Connecticut committed to a comparable level of investment, it would need to increase its Medicaid spend by more than $2.5 billion annually. By consistently underspending on Medicaid relative to its northeastern peer states, on average by 6% from 2017 to 2022, **Connecticut left more than $7.5 billion in federal revenue on the table**. Combined with the state share, that's revenue that could have strengthened the care delivery system, driven better health outcomes for Medicaid beneficiaries, promoted affordability by reducing pressure on commercial prices, and contributed to the broader economy. *Maximizing federal support for the cost of care should be a Medicaid redesign priority*.

Fair and Sustainable Hospital Reimbursement

Hospital reimbursement has long been an area of underpayment, directly contributing to growth in commercial prices and declining affordability. The hospital operating shortfall resulting from Connecticut's Medicaid payment and tax policy has grown steadily over the past 10 years, reaching $1.23 billion in FY 2022. According to the state's own calculations, hospitals were reimbursed 62 cents on the dollar for the services provided to Medicaid beneficiaries.

This problem will soon become much worse. In the second year of the 2026/2027 biennium, annual hospital rate increases will diminish to zero if no action is taken to prevent this. *As the cost of providing medical care rises, every dollar not covered by Medicaid will add to the cost of commercial coverage and forego federal matching dollars.*

Recommendation 1: Address Medicaid Hospital Underpayment ***Goal 1 and 6***

In order to achieve a sustainable healthcare delivery system and improve healthcare affordability for all, Medicaid redesign must provide for the following:

A. ***Eliminate the Medicaid Shortfall***: Substantially reduce or eliminate Medicaid hospital underpayment, which we view as the combined effect of the state's Medicaid reimbursement and hospital tax policy.

B. ***Annual Trend Updates***: Provide for Medicaid annual trend updates that keep pace with the rising cost of hospital care.

Social, Economic, and Environmental Drivers of Health

One of the most important, but often neglected opportunities to reduce healthcare spending and improve affordability is to address the social, economic, and environmental conditions that drive increasing rates of avoidable illness and make it difficult to manage effectively the conditions that are most prevalent in the Medicaid population. *Place-based interventions that improve these long-term prevention outcomes, healthcare outcomes, and associated health inequities for Medicaid beneficiaries will provide a broad benefit that extends to those covered by commercial insurance and Medicare and, as such, are an essential element of our long-term efforts to achieve affordability for all.*

Social Drivers of Health and Health-Related Social Needs

The social drivers of health (SDOH)—which are the macro-level social context that affect health—and health-related social needs (HRSN)—which are individual-level situations like food insecurity, housing instability, and transportation barriers that result from larger systems in which an individual interacts—are key explanations for the level and distribution of health.[2,3] Existing evidence establishes that SDOH account for about half of the variation in health outcomes and in some studies, your ZIP code, where you live, accounts for a larger percentage of your health outcomes than your genetic code.[4] The factors that make up the root causes of health inequity are diverse, complex, evolving, and interdependent in nature.[5] One connection that's increasingly being understood is how what happens outside the walls of hospitals and exam rooms affects patients' long-term preventive health outcomes.

[2] Berkowitz, S. A. (2023). Health Care's New Emphasis on Social Determinants of Health. *NEJM Catalyst Innovations in Care Delivery*, *4*(4).
[3] US Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Healthy People 2030. 2021. Accessed October 7, 2024. https://health.gov/healthypeople/priority-areas/social-determinants-health
[4] Hood CM. County Health Rankings: Relationships between Determinant Factors and Health Outcomes. Am J Prev Med. 2016 Feb;50(2):129-35 and Lakhani CM, Tierney BT, Manrai AK, Yang J, Repurposing large health insurance claims data to estimate genetic and environmental contributions in 560 phenotypes. Nat Genet. 2019 Feb;51(2):327-334.
[5] National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on Community-Based Solutions to Promote Health Equity in the United States; Baciu A, Negussie Y, Geller A, et al., editors. Communities in Action: Pathways to Health Equity. Washington (DC): National Academies Press (US); 2017 Jan 11. 3, The Root Causes of Health Inequity. Available from: https://www.ncbi.nlm.nih.gov/books/NBK425845

Upstream Interventions to Promote Well-being and Health Equity in Connecticut

There has been recent growth of clinical screening for social risks and referral to resources outside the healthcare system for example through the development of social needs screening tools to assess food and housing insecurity and other social needs. Such "*awareness and assistance*" approaches, as defined by the 2019 proceedings on social care from the National Academy of Science, Engineering, and Medicine,[6] help healthcare providers to identify social needs and refer patients to community social services. However, without structural changes to address the root causes of health inequities, which require partnership across relevant sectors, this approach may be hamstrung by traditional healthcare's limitations and the capacity of community-based organizations to address social needs. Importantly, these awareness and assistance approaches fall short of improving health along the life course and across the population.

Connecticut's hospitals and health systems hold a shared value of advancing health and well-being across the lifespan and see opportunities to address health conditions and more specifically health disparities for Medicaid beneficiaries in areas such as maternal health, diabetes, hypertension, mental health, and other chronic conditions where inequities persist or are increasing.[7] Embracing these opportunitchies requires both improving the delivery of care for high-need populations with acute or chronic healthcare conditions, ***and*** addressing "upstream" drivers of health that tackle the root causes of poor health. These upstream factors that drive the well-being of Connecticut residents include investments in the social and economic factors that impact the conditions in which Connecticut residents live, learn, work, worship, and play. Upstream factors, which on the surface might seem unrelated to medicine or healthcare, have proven to have "downstream" effects on life expectancy, chronic conditions, and mental health.[8]

Multi-Sector Community Partnerships to Advance Health and Health Equity

Importantly, the further upstream interventions are focused—and therefore the more fundamental they are to tackling the social drivers of health—*the less likely these interventions are to lie within the domain or capability of any single organization*.[9] Cross-sector partnerships are becoming an essential component of health system efforts to combat health inequities and improve population health and well-being. The National Academy of Science, Engineering, and Medicine, the Robert Wood Johnson Foundation, and the Center for Medicare & Medicaid Innovation have each recognized that healthcare alone cannot fully address health inequities across the life course.[10]

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[6] National Academies of Sciences, Medicine Division, & Committee on Integrating Social Needs Care into the Delivery of Health Care to Improve the Nation's Health. (2019). Integrating social care into the delivery of health care: Moving upstream to improve the nation's health.

[7] Connecticut Health Foundation, Health Disparities in Connecticut. Resources and Fact Sheets https://www.cthealth.org/publication/health-disparities-in-ct/ accessed October 15, 2024; Becker, AL. Connecticut Health Foundation, Health Disparities in Connecticut: Causes, Effects, and What We Can Do 2020; and DataHaven Health Equity in Connecticut, 2023

[8] American Medical Association, Health Equity Plan, 2021-2023

[9] Williams, D. R., Costa, M. V., Odunlami, A. O., & Mohammed, S. A. (2008). Moving upstream: how interventions that address the social determinants of health can improve health and reduce disparities. *Journal of public health management and practice*, *14*(6), S8-S17.

[10] Accountable Health Communities Model-First Evaluation Report, 2023. Accessed October 7, 2024 https://www.cms.gov/priorities/innovation/innovation-models/ahcm and Plough AL. Building a culture of health: a critical role for public health services and systems research. *Am J Public Health* 2015;105 Suppl 2:S150–2 and Robert Wood Johnson Foundation *From vision to action: measures to mobilize a culture of health*. Princeton, NJ: Robert Wood Johnson Foundation, 2015. And Chandra A, Acosta JD, Carman K, et al. and *Building a national culture of health: Background, action framework, measures, and next steps*. Santa Monica, CA: RAND Corporation, 2016.

Hospitals currently participate in cross-sector collaboratives, including Health Enhancement Communities, that promote collective action to address community conditions that impact health and drive health equity. By both definition and geographic scope, hospitals are anchor institutions rooted in place and contribute significantly to the upstream conditions of a community through the neighborhoods, communities, and economies in which they are located. Collaborative approaches, including multi-sectoral partnerships, have the potential to create shared incentives and drive coordinated investment in the upstream social drivers of health.[11] In these partnerships, the diverse sectors that impact or are impacted by the social drivers of health collaborate and coordinate to influence the broad and interconnected array of factors and upstream "safety fences" that influence health.

Some examples of hospital leadership in upstream investments as part of community collaboratives include addressing food and nutrition desserts through investments in grocery stores, vacant lot greening, rehabilitation of dilapidated, abandoned properties, local hiring and purchasing initiatives, and revitalization of contaminated sites for end uses that promote health. These investments all serve to promote mental health, healthy lifestyles, a living wage, the local economy, safe neighborhoods, and reduced exposure to environmental contaminants through water, air, and soil.

Supporting Data Infrastructure to Advance Community Health

Improving health outcomes using upstream initiatives has been shown to have a direct impact on health, but it may take years and at times even a decade, to see results.[12] These macro level upstream initiatives can be challenging to assess due to the complexity in pathways and links to direct health outcomes as the yield on health is often long-term. Accurate measurement of investments in the upstream drivers of health will require investments in the creation of shared terminology and measures, data infrastructure, and robust longitudinal tracking of outcomes. Through the use of data, community-hospital collaboratives can increase their understanding of the underlying causes and conditions of health inequities as a method to inform effective interventions in clinical care and upstream drivers to promote health equity.[13]

[11] Wakefield, M., Williams, D. R., & Le Menestrel, S. (2021). *The future of nursing 2020-2030: Charting a path to achieve health equity*. National Academy of Sciences and Crowder SJ, Tanner AL, Dawson MA, Felsman IC, Hassmiller SB, Miller LC, Reinhard SC, Toney DA. Better together: Coalitions committed to advancing health equity. Nurs Outlook. 2022 Nov-Dec; 70 (6 Suppl 1):S48-S58. And Alderwick, H., Hutchings, A., Briggs, A., & Mays, N. (2021). The impacts of collaboration between local health care and non-health care organizations and factors shaping how they work: a systematic review of reviews. *BMC Public Health*, *21*, 1-16.

[12] Taylor, L. A., Tan, A. X., Coyle, C. E., Ndumele, C., Rogan, E., Canavan, M., ... & Bradley, E. H. (2016). Leveraging the social determinants of health: what works?. *PloS one*, *11*(8), e0160217.

[13] Hilts, K. E., Yeager, V. A., Gibson, P. J., Halverson, P. K., Blackburn, J., & Menachemi, N. (2021). Hospital Partnerships for Population Health: A Systematic Review of the Literature. *Journal of Healthcare Management*, *66*(3), 170-198.

Previous research, including an examination that used timely small-area (below county) Medicaid data and public health data from local and state agencies, has found that Community Health Needs Assessment-related collaboration can improve the quality of the assessment process and thus provide a better basis for community health improvement planning and related community-wide health improvement efforts.[14] Some states, such as Indiana, have developed structures that encourage partnership around data sharing between hospitals, state agencies and local health departments to improve the coordination of and investment in community health improvement efforts across sectors.[15]

Recommendation 2: Engage Multi-Sector Health Partnerships Goals 3, 5, and 6

In order to promote collaboration and coordination among healthcare providers and cross-sector community partners; to identify and address social, economic, and environmental drivers of health; and to support the application of improvement science Medicaid redesign must provide for the following:

A. ***Multi-Sector Health Partnerships***: Support and strengthen the role of multi-sector health partnerships or community collaboratives, which are essential community assets with the means to promote health and health equity in their communities and the Medicaid population

B. ***Shared Accountability***: Employ an accountability framework that fosters a common sense of purpose among multi-sector health partnerships, their hospital partners, and primary care, with shared accountability for improving health, healthcare outcomes, and health equity, and reducing the rate of healthcare cost growth

C. ***Trust Framework***: There must be mechanisms in place to ensure transparency, trust, and accountability among all of the partners—the state, primary care providers, hospitals, and community organizations—including as it relates to equitable distribution of funds

D. ***Community-Directed Change***: Multi-sector health partnerships and the work of community health transformation must honor the principles of community-directed change. Community members who contribute by lending their experience and expertise should have the opportunity to receive stipends or other financial incentives and consideration for childcare and transportation costs.

E. ***Data to Support Continuous Improvement***: The state should maximize access to Medicaid and other data, to the maximum extent permitted under federal law, to enable hospitals and their community partners to identify opportunities for improvement and enable rapid cycle evaluation of community health and care delivery innovations.

Klaiman T, Chainani A, Bekemeier B. The importance of partnerships in local health department practice among communities with exceptional maternal and child health outcomes. *J Public Health Manag Pract.* 2016;22(6):542–549.
Laymon B, Shah G, Leep CJ, Elligers JJ, Kumar V. The proof's in the partnerships: are Affordable Care Act and local health department accreditation practices influencing collaborative partnerships in community health assessment and improvement planning? *J Public Health Manag Pract.* 2015;21(1)
Mays GP, Smith SA. Geographic variation in public health spending: correlates and consequences. *Health Serv Res.* 2009;44(5 pt 2):1796–1817
Pennel CL, McLeroy KR, Burdine JN, Matarrita-Cascante D. Nonprofit hospitals' approach to community health needs assessment. *Am J Public Health.* 2015;105(3):e103–e113

[14] Singh SR, Carlton EL. Local health departments' involvement in hospitals' implementation plans. *Front Public Health Serv Syst Res.* 2016;5(4):34–39

[15] https://astho.org/Indiana-CHNA-Case-Study/

Innovative Financing Reforms

Hospitals and health systems cannot diagnose and treat the myriad of life-course health risks in isolation. Approaches that do not meaningfully, equitably, and sustainably align across sectors and focus upstream will be similarly unsuccessful. The funding structures that shape the well-being of Connecticut's residents must move toward a more seamless partnership across sectors to address the upstream drivers of health and well-being preventively and holistically. Although the promise of innovative cross-sector models has generated enthusiasm, the absence of substantial, sustainable funding has limited the scale and spread of successful models and requires addressing both financing and governance issues.[16]

Limitations of Today's Population-Based Payment Models

Most population-based payment models, such as Medicare's Accountable Care Organization model or Connecticut's PCMH+ program, focus on improving coordination of care and quality of care for patients with complex or chronic conditions, primarily by investing in primary care. The main focus of these models is to improve healthcare outcomes and drive short-term reductions in cost, a portion of which are shared with the primary care clinics and practices that generate these outcomes. On the whole, these models can move the needle a bit on clinical care outcomes and cost, but the benefits are substantially limited by the social, economic, and environmental factors noted above. Moreover, none of these initiatives focus on long-term prevention outcomes, such as the incidence and prevalence rates of acute and chronic diseases, mental health and substance-related conditions, and maternal child birth outcomes, which are largely beyond the control of primary care. These outcomes are among those recommended by the DSS Advisory Board for Transparency on Medicaid Cost and Quality established pursuant to Governor Lamont's Executive Order No. 6.[17] Finally, these models leave behind individuals who do not have a usual source of primary care (approximately 40% of the adult Medicaid population) and smaller practices who do not care for enough Medicaid beneficiaries to participate.

Although we endorse a focus on advanced primary care as a means to improve healthcare access and outcomes (Goal 1) and to support improved access to preventive care services (Goal 2), we believe that the innovative Medicaid financing reforms called for in Goal 4, could also be an effective means to promote multi-sector collaboration (Goal 5) and address the social, economic, and environmental drivers of health to advance long-term preventive health and healthcare outcomes (Goal 3) and health equity, producing a far greater benefit to Medicaid beneficiaries and the state over the long term. **Moreover, this approach will substantially improve our ability to drive long-term prevention savings and affordability**. An actuarial study conducted by OHS of its Health Enhancement Community model

[16] Hudon C. Bridging the gap to meet complex needs: an intersectoral action well supported by appropriate policies and governance. Health Res Policy Syst. 2024 Jul 3;22(1):75.
[17] Recommendations presented by Brad Richards, MD, CMO for DSS, in its "Report from Advisory Board for Transparency on Medicaid Cost and Quality" as required by Executive Order No. 6 in the July 2021 meeting of the Medical Assistance Program Oversight Council (MAPOC).

estimated billions in Medicare savings over a ten-year period **solely as a result of achieving prevention-related outcomes**.[18] Additional unpublished studies undertaken by OHS identified $1.1 to $1.9 billion in prevention related savings for Medicaid and $1.8 to $2.3 billion for commercial over this same period.[19]

Regional Financing and Accountability Framework

We recommend that future Medicaid financing reforms enable the above recommended shift in accountability to regional hospital and community partnerships with the aim of promoting collaboration and coordination among healthcare providers and cross-sector community partners. This approach would entail a hybrid attribution model. The primary means of attribution would be geographic—hospitals and their multi-sector partners, along with primary care, would share accountability for health, equity, and cost outcomes for all Medicaid beneficiaries who reside in a given region regardless of whether they are using primary care or other healthcare services and without regard to where they go for care.

Recommendation 3: Regional Investment and Accountability Model ***Goals 3, 4, 5, and 6***

There are four financing innovations that would be required to drive impact over time. These financial recommendations do not stand on their own. They are elements of a comprehensive model, all of which are required to achieve the goals envisioned in the legislation.

A. ***New Investments in Hospitals and Multi-Sector Partnerships***: Hospitals and the multi-sector partnerships in which they participate will require substantial and sustained funding to support the design, implementation, and coordination of a regional community health and care delivery transformation strategy. This strategy would include a wide range of initiatives including a focus on place-based root cause initiatives to address social, economic, and environmental drivers of health along with downstream initiatives that support the care of individuals with complex and chronic healthcare needs. *We would be open to discussing how hospitals could support the financing of these new investments with little or no new cost to the state.*

B. ***100% Reinvestment of Savings***: In order to reward collective impact and provide an ongoing source of funds to broaden the scope and scale of regional change initiatives, we recommend the state establish regional cost growth benchmarks and return 100% of the savings to hospitals and their community partners, and primary care. A majority share of the savings should be apportioned to hospitals and their communities, based in part on measured performance. A share of the regional savings should also be allocated to primary care practices, based on the number of attributed beneficiaries and quality performance. This approach would solve for the actuarial barriers that prevent some practices from participating in PCMH+ and other traditional accountable care models.

[18] Connecticut State Innovation Model (SIM) Health Enhancement Community Initiative Proposed Framework: Technical Report, Revised April 2019, pp 130 to 135

[19] HEC CT Medicaid Study 2020 (See Executive Summary tab); HEC CT Commercial Study 2020 (See Executive Summary tab); although HECs were established in some regions of the state, they received nominal funding, which has now ended and the Medicaid based sustainable funding strategy was not implemented.

C. ***Ensuring Rewards for Long-Term Prevention***: In contrast to existing population-based models, we recommend that the state establish regional cost growth benchmarks for an extended period of time (e.g., 10 years), to allow hospitals, communities, and primary care to benefit from upstream interventions that often take many years to materialize. In addition, there should be no downward adjustments to the cost benchmark when the health and well-being of the community improves (i.e., health risk or social vulnerability) and total cost of care, declines. This is the only way to ensure that the financial value of improvements in health can be captured and shared for reinvestment.

D. ***Coverage for HRSN Services***: Extend Medicaid coverage for HRSN services to enable community organizations to build capacity and address the needs of individuals for whom food insecurity, housing instability, and lack of transportation are barriers to effective care.

Thank you for your consideration of our comments.

For additional information, please contact me at 203.530.9874 or schaefer@chime.org.

Sincerely,

Mark C. Schaefer
Vice President, System Innovation and Financing

MCS:ljs
By E-mail