Connecticut Health Policy Project

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Coordinating Care for High-Need, High-Cost Patients: A Better Idea for SIM's Medicaid Plans

Independent consumer advocates and others have raised grave concerns about Connecticut's State Innovation Model (SIM) plans to radically change financial incentives in our state's Medicaid program. The experience of other states offers a proven alternative, targeting resources toward patients who use a disproportionate amount of care. This alternative meets the same goals of improving health outcomes and further controlling costs without the dangers of broader incentives to reduce care.

Connecticut's Medicaid program is finally improving Connecticut's Medicaid program has benefitted substantially from a move three years ago away from capitated financial incentives to deny needed care.[1] Since we moved to a unitary Administrative Services Organization for all of Medicaid coupled with a care management, person-centered medical home (PCMH) focused program that rewards quality, 32% more providers are participating, non-urgent trips to the emergency department are down, and hospital admissions are down. Per member Medicaid costs are now flat or even dropping. That remarkable success, in a national model touted by the Department of Social Services, has saved the state $410 million over the last two years, while building a program that rivals private coverage in the quality of care.[2]

What is SIM's plan? In a sudden, imprudent change of plans just before the federal grant application was due, SIM staff developed a skeletal, but radical, proposal for Medicaid.[3] The new plan is to move all Medicaid members into a shared savings financial model, starting with 200,000 or more members on January 1, 2016. The model moves consumers into large networks of providers, for-profit and non-profit, for their care and returns to the networks part of the savings they are able to generate on their patients' total cost of care. Unlike other states, Connecticut does not regulate these large provider networks despite their assumption of substantial financial risk. There will be quality standards to receive shared savings payments and, theoretically, systematic under-service will disqualify networks from payments.

What are the concerns with the SIM plan? Medicaid is unique for a number of reasons. Medicaid provider rates that are lower than the cost of delivering the care already create incentives to under-serve patients, which could be exacerbated by shared savings. The

[1] Connecticut's Medicaid Program Success: Significant Improvements in Access, Quality Care and Cost Control, CT Health Policy Project, February 2014
[2] Governor Proposes Deep Cuts to Medicaid, Jeopardizing Progress on Quality, Cost Control, CT Health Policy Project, February 2015
[3] CT State Innovation Model Proposed Medicaid Approach, June 23, 2014

Governor's provider rate cuts will make these problems worse. We are especially concerned about the entry into the program of for-profit providers who have not taken Medicaid patients in the past because they lose money. Those practices will have an over-riding imperative to generate savings, just to break even. Combined with the nature of Medicaid's at-risk populations and fewer available providers, this would jeopardize the gains of the last two years. The proposal also accelerates consolidation in Connecticut's health care market, ultimately raising costs for everyone.

The science of monitoring for underservice, the only meaningful safeguard against inappropriate restrictions on access to care resulting from the financial incentives of shared savings, is very new. Connecticut doesn't yet have the data or analytic capacity to even identify systematic denials of necessary care, and the work of the SIM and legislative committees charged with developing the methods to detect this is just in its infancy.

What's the better idea? Managing the care of high-need, high-cost patients who use a great deal of health services has been used successfully in many communities and states.[4] These programs target care management resources to patients with multiple, complex, chronic conditions, often including behavioral health and socioeconomic challenges, patients who need more intensive care management than a PCMH can provide. Programs in other states have achieved impressive quality improvements with up to 74% reductions in hospital admissions and 47% reductions in emergency department visits. One program was able to reduce the total cost of care for their high-need, high-cost patients by 56%. Adopting this plan for Connecticut's Medicaid program has the twin advantages of concentrating scarce resources to benefit those most in need and most likely to achieve savings for the state, while avoiding disruption of ongoing reforms in the general HUSKY population that have been so successful.

We believe community health centers are best placed to implement this program, having closer ties to community supports needed by high-need, high-cost patients and more experience caring for this population. As community health centers in Connecticut are paid higher rates than private providers that cover their costs of providing the care, they should have no incentive to deny care to generate savings. Any savings will truly be an upside bonus. In contrast to for-profit, provider-investor large practices, the salaried providers who order treatments in community health centers cannot benefit financially from those decisions.

Bottom line: To sustain hard-won progress and reach the goals of improved care and controlling costs further, Connecticut's Medicaid program should follow the lead of many other successful states and target care management resources toward high-need, high-cost patients.

[4] C Hong, et. al., Caring for High-Need, High-Cost Patients: What Makes for a Successful Care Management Program?, The Commonwealth Fund, August 2014