Connecticut Health Policy Project

The Grove, 760 Chapel St., New Haven CT 06510
Phone (203) 562-1636 • Fax (203) 562-1637 • www.cthealthpolicy.org

PUBLIC COMMENT to the SIM Practice Transformation Taskforce
June 24, 2014
Re: National Standards for Patient-Centered Medical Homes in CT
Ellen Andrews, PhD
Executive Director

Thank you for the opportunity to share our opposition to SIM's decision last year to reject national standards and develop Connecticut-specific standards for patient-centered medical homes (PCMHs). We at the CT Health Policy Project are dedicated to improving access to health care for every Connecticut resident. No one is more committed to constructive health reform than consumer advocates. Independent consumer advocates have offered constructive, feasible options to improve the SIM plan almost from its inception.

We hear every day from callers on our helpline and others about the difficulty accessing needed care in our state's increasingly fragmented, stressed and expensive health system. The best available tool to address these problems has been PCMHs, accredited by national standard setting bodies. National standards ensure that we are paying for value and that consumers are getting the best care possible. Substantial and growing evidence demonstrates that care delivered inside PCMHs is higher quality, affords better access, earns better patient experience of care scores, and is controlling costs. The evidence of PCMH effectiveness is extremely strong in our state Medicaid program. Medicaid has benefited from the shift to a PCMH- focused program in many ways including fewer non-urgent ED visits, fewer hospital admissions, 32% more participating providers, and a **2% reduction** in per person costs. Naturally advocates are very concerned about eroding that hard-won progress and moving backward by rejecting national PCMH standards that are working.

Using successful national standards for PCMHs will avoid unnecessary state spending and would be extremely costly to replicate. NCQA, the most commonly adopted national PCMH standard, spent eight years and almost $10 million developing their standards. PCMH certification is a complex process, as it should be to ensure consumers are getting what we pay for. Attached to this document is a copy of the standards for just one NCQA PMCH element, with its twelve detailed factors. PCMH certification includes six standards, 27 elements and countless factors. NCQA now devotes 35 FTEs to supporting practices during the transformation and application process. For example, many resources are devoted to answering practice questions about the standards such as "Does the way that we do that count?" It would require substantial state resources to duplicate national PCMH standards, the infrastructure to implement them, and to revise them as best practices and research evolves. The savings to Connecticut, in both time and money, of continuing to utilize national PCMH standards could serve much better purposes such as increasing provider payment levels, auditing PMCHs annually, glide path loans to more practices, quality improvement research, intensive care management for high risk patients, and learning collaboratives.

NCQA's program has considerable flexibility to work with states to tailor standards – required and optional – to each state's needs. Cultural competence and linguistic access standards that are optional under NCQA could be required. NCQA is now working with New York to develop a certification for school-based health centers. Oral and behavioral health care can be included within NCQA's flexibility and/or in annual audits/reviews as happens now in Connecticut's Medicaid program.

Concerns have been raised that small practices cannot accomplish practice transformation despite considerable evidence to the contrary. In fact, 89% of NCQA recognized PCMHs nationally have less than ten clinicians. Over 2,500 practices with one or two clinicians have earned NCQA recognition – the vast majority as Level 3 PCMHs (the highest level).

It has also been suggested that it costs practices $200,000 for NCQA recognition. In fact, NCQA's price for PCMH recognition of a Connecticut practice with five clinicians is $2,280 for three years minimal compared to reimbursements. In 2012, Connecticut's Medicaid program averaged $150,000 in higher reimbursements to PCMHs – and that is only from one payer. There are staff costs to implement practice transformation ($200,000 is probably an excessive estimate), but that is exactly the point of becoming a PCMH. Being available beyond usual business hours, referral tracking, arranging appointments, reminding patients, tracking down lab tests and X rays, daily team huddles and other PCMH functions will have a cost to implement at least initially, especially in a practice that is not currently providing any of these services. But those beneficial services are exactly what PMCH certification is meant to reward.

Concerns have been raised that NCQA does not audit practices between three-year certifications, but that is not entirely accurate. NCQA does audit a sample (5%) of practices, according to meeting materials. In addition during re-certification, NCQA looks backward at the practice's performance during their earlier PCMH certification period as part of the new evaluation. Our state Medicaid program goes further and reviews PCMHs annually between NCQA certifications to ensure that practice transformation is sustained. The bottom line however is that whatever NCQA is doing, whatever their "secret sauce", it is working – quality and access to care are improved and costs are moderated. The longer practices have had PCMH status, the better their performance.

As emphasized in the materials circulated for this meeting, PCMHs serve as the foundation for future health reforms. You can't build anything on shifting sand. Nationally recognized PCMHs serve as a strong, well-tested foundation for future delivery and payment reforms. In fact, one of the readings for this meeting noted that most states participating in the CPCI program used NCQA to certify PCMHs. Using existing, proven standards avoids delay and moves Connecticut toward long-overdue reforms.

The slides suggest a bias in favor of requiring payment reforms for PCMH recognition. While thoughtful payment reform is an important goal, creating a new barrier to PCMH transformation is unwise for two reasons. Currently, even without requiring financial risk and expanding practices' liability, PCMHs are controlling costs – there is no need to layer on required payment reforms. PCMH transformation to can

be difficult for practices; introducing a far more challenging requirement will reduce the number of new PCMHs in Connecticut and deny Connecticut the benefits of PCMH expansion.

The materials also emphasize the importance of building PCMHs into a health neighborhood. Connecticut's Medicaid program is in the final stages of designing a health neighborhood pilot for members eligible for both Medicare and Medicaid. Unlike SIM, that process has been open and inclusive, engaging all voices at the table in a thoughtful, well-informed, consensus-building process that is responsive to all concerns and respectful of all stakeholders. The MAPOC/DSS collaborative health neighborhood design should serve as a model to SIM for better policymaking.

There is also an inherent unfairness to infringing on national organizations' intellectual property rights by adopting their standards. These nonprofits invested millions of dollars and years of work in developing very effective standards. Connecticut policymakers using their work without compensation is neither appropriate nor fair.

I urge you not to unravel one of the only things working in Connecticut's health care system. I urge you to resist moving backward, and to commit to using nationally recognized standards for PMCHs in Connecticut's SIM model so we can all move on to the much larger, much harder challenges in reforming our broken health care system.