April 10, 2015

The Honorable Nancy Wyman
State Capitol
Hartford, Connecticut
Lt.Governor.Wyman@ct.gov

Re: Concern with Precipitous Inclusion of Medicaid Enrollees in Untested SIM Incentives Program

Dear Lieutenant Governor Wyman,

We are writing with grave concerns about the current plans for widespread precipitous changes in the methods for Medicaid payment predicated on pressures from the proponents of the SIM plan.

We represent a diverse group of consumers, advocates and providers who care for, and care deeply about, Medicaid members' welfare. We advocated for over a decade to reform the Medicaid program to focus on care management and remove financial incentives to deny care, which ultimately culminated in the administration's decision, shortly after taking office, to replace the inefficient risk-based Medicaid managed care organizations with a unitary administrative services organization and broad use of patient-centered medical homes (PCMHs), effective on January 1, 2012. You made it clear at the February 2011 press conference announcing this important reform that the small, carefully developed primary care case management pilot already operating in Medicaid would be an important starting place for developing the new PCMHs.

Alongside DSS and the Oversight Council on the Medical Assistance Program (MAPOC), we have worked over the last three years to make the non-risk Medicaid program the remarkable success and national model it now is, with greatly improved access and quality of care in addition to flat or even slightly reduced per member costs. But that progress is fragile and more work remains. Significant issues of lack of access persist in parts of the Medicaid program.

We are very troubled by SIM's plans to move 200,000 or more Medicaid members precipitously back into a financial model with similar incentives to the failed model we rejected three years ago, with all Medicaid enrollees to follow in a few short years. While the SIM plan states that the model will include upside-only risk, because of Medicaid's unique qualities, with fee for service rates that do not cover the costs of care, there is still a significant risk of strong financial pressures on providers to deny needed care even under this upside-only model. When providers are underpaid, especially those not providing care to Medicaid members now, they risk significant **losses** if they do not earn shared savings payments. We remain deeply concerned that data systems and policies are not adequate to identify the likely resulting underservice. The SIM and MAPOC committees charged with

developing the under-service detection methods are just beginning their laborious work.

The rush to force 200,000 or more vulnerable Medicaid enrollees into shared savings under SIM contrasts sharply with the inclusive, methodical approach that the Department of Social Services has undertaken in previous policy changes. Collaborative development of the health neighborhoods shared savings proposal for dual eligible (Medicare/Medicaid) individuals, under the thoughtful guidance of the Complex Care Committee of the MAPOC, has taken over three years and engaged diverse stakeholders, selected by the various interests themselves, in the designing of a successful program.

We also note that DSS has wisely negotiated an important protocol with the SIM Project Management Office which ensures that all decisions about the application of SIM to Medicaid must be made in the "best interests" of Medicaid enrollees, which would necessarily include decisions about timing, scope, provider RFP development, payment methodology and consumer protections. In fact, this is a requirement under the federal Medicaid Act (42 USC § 1396a(a)(19)), which ensures that state decisions are not made to benefit other groups or interests at the expense of vulnerable low-income Medicaid enrollees. Putting Medicaid enrollees into an untested shared savings program, with wholly inadequate planning, is not in the "best interests" of Medicaid enrollees.

We urge you to reconsider your decision to move 200,000 or more members precipitously into the SIM-defined plan for Medicaid. It is critical to ensure that we do not disrupt what is currently working in the program. We strongly urge you to return to the original promise in the December 2013 SIM "final" plan, to first implement the health neighborhood pilot and use the lessons learned there to inform carefully moving the rest of the Medicaid population into a shared savings financial risk model with carefully developed consumer protections. We further urge you to consider other innovative options, including targeting resources to improving care and lowering costs for high utilizing Medicaid members who need more than a PCMH can provide. Many other states have had success in improving access, health outcomes and controlling costs with this model.[1]

We are firmly committed to building value in our system and linking incentives to quality care while protecting consumers. We believe that through strong collaborative efforts over the last three years, Connecticut has built a solid foundation for progress toward that shared goal. We remain committed to continuing that important work.

Respectfully,

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[1] C Hong, et. al., Caring for High-Need, High-Cost Patients: What Makes for a Successful Care Management Program?, The Commonwealth Fund, August 2014; Coordinating Care for High-Need, High-Cost Patients: A Better Idea for SIM's Medicaid Plans, CT Health Policy Project, April 2015

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cc:

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