

September 28, 2015

Honorable Nancy Wyman  
Lieutenant Governor  
State Capital  
Hartford, CT 06106  
[Lt.Governor.Wyman@ct.gov](mailto:Lt.Governor.Wyman@ct.gov)

**Re: PMO's Push For Accelerated Development of MQISSP Without Promised Input**

Dear Lt. Governor Wyman:

As independent advocates who represent or assist Medicaid clients throughout Connecticut, we write to express our grave concern with the hyper-accelerated schedule for the development of the Medicaid Quality and Shared Savings Program, or MQISSP, at the insistence of the State Innovation Model (SIM) Project Management Office (PMO). This schedule precludes any opportunity for meaningful input by the members of the MAPOC's Care Management Committee, charged with counselling DSS in the development of the MQISSP shared savings model, on many central issues concerning the design of that model, despite repeated assurances to the contrary. The PMO's ill-advised and arbitrary rush is forcing all decisions related to the MQISSP networks' RFP to be finalized by October 5<sup>th</sup>. This timeline places DSS and members of the committee in the untenable position of working to meet an arbitrary deadline instead of in the best interests of Medicaid enrollees. And if the timeline is not eased, not only do we risk harm, due to inadequate planning, to our Medicaid enrollees, but Connecticut Medicaid will be forced to gamble with the taxpayers' money under an untested model -- which has **increased** costs in other contexts.

As you know, advocates throughout the state have been concerned for some time with the PMO's insistence that a large numbers of vulnerable Medicaid enrollees be included in shared savings under SIM despite inadequate planning. In the fall of 2013, in response to statewide consumer advocacy, the PMO agreed with DSS that enrollees would not be placed into shared savings arrangements until these largely untested payment models were first applied to the less vulnerable commercial population, and careful stock was taken of what needed to be adjusted to protect this vulnerable group. However, a few short weeks before the grant proposal was due in July 2014, the PMO announced that its proposal would require that 1/3 of the Medicaid population be included in the untested model in just a few short months from now, dishonoring its commitment and dramatically altering the proposal.

Given the abruptness of the PMO's decision to violate prior assurances of a "go-careful" approach to Medicaid involvement, advocates wrote to CMS in September of last year objecting to this change in direction, urging a return to careful planning. Advocates noted both that Medicaid enrollees are particularly vulnerable and that there was no need to move forward quickly with shared savings for this population, given that Connecticut's Medicaid program is already a major success story, in both quality **and** cost savings.

Since the Malloy Administration shifted our state's Medicaid program from the inefficient managed care organization (MCO) system to a non-risk system that focuses on care coordination, with extensive use of patient-centered medical homes, in January of 2012, the program has accomplished a remarkable turnaround. Since the shift, 32% more providers are participating in the program, hospital admissions are down, fewer people are visiting an ER for non-urgent problems, and more people are getting primary care such as immunizations and cancer screenings. We are effectively targeting intensive care management to the people with complex, and costly, conditions who need it most, with impressive results. Perhaps the best news is that per person costs in Connecticut Medicaid are actually down, saving the state hundred of millions in tax dollars each year. Connecticut's Medicaid program is busting the myth that improving care has to drive up costs; in fact, it can be the key to controlling costs. All of this was addressed in our September, 2014 letter to CMS.

You quickly responded to our letter to CMS, in a letter dated September 30, 2014, to assure us as follows:

“We appreciate the concerns raised in your letter of September 12, 2014 to the Center for Medicare and Medicaid Innovation, and your longstanding commitment to our Medicaid program and its clients. We acknowledge that we have accelerated our commitment to the use of a shared savings program as one means to achieve our shared vision for better healthcare for Medicaid beneficiaries.

“While developing Connecticut's SIM grant application and in the application itself, we provided assurances that **the Department of Social Services (“Department”) will engage the care management committee of the Medical Assistance Program Oversight Council to review and comment on all aspects of the shared savings program design** and the selection of provider participants. This process will enable advocates to further articulate issues of interest and concern, and work with the Department to refine the program's design to ensure protection of beneficiary interests.” (emphasis added).

Although still concerned, advocates were somewhat reassured by your commitment that the MAPOC committee would have the opportunity to “review and comment on **all aspects** of the shared savings program design,” a commitment repeated by other state officials in various SIM-related public meetings thereafter. Evidence of this commitment is the final protocol negotiated between DSS and the PMO which provided, consistent with the requirements of federal Medicaid law:

“DSS is the single state Medicaid agency for Connecticut. Consistent with federal law, ***DSS' primary obligation is to promote and safeguard the interests of Medicaid beneficiaries.*** DSS acknowledges and supports the role that the Medicaid program will play in achieving the goals of the SIM initiative. These goals include continuous improvement of health, quality and equity in healthcare, and affordability for all citizens of Connecticut. ***DSS retains authority to participate in the SIM initiative in the manner that it determines to be in the best interest of Medicaid beneficiaries.***” (emphasis added).

In April, after input from the Care Management Committee, a final primer on MQISSP was produced by DSS stating:

“To implement MQISSP, the Department must take actions including, but not limited to the following, **on each matter seeking review and comment by the Care Management Committee...**” (emphasis added).

Just three examples of matters to be discussed with the Care Management Committee were:

- “***establish a timeline*** for development and implementation of the project;”
- “frame provider qualifications and program parameters;” and
- “develop and implement the shared savings methodology (including, but not limited to, eligibility for and means of distribution) for FQHCs and advanced networks.” (emphasis added).

Finally, DSS indicated, in response to advocates’ concerns, that a six month extension in Medicaid shared savings rollout, until July 1, 2016, would be sought from CMS. All of this gave some additional assurance to advocates that the best interests of Medicaid enrollees would be the primary driver of decision-making, not an arbitrary deadline.

However, subsequently, an October 5<sup>th</sup> deadline was adopted for finalizing the RFP for MQISSP. The appropriateness of the arbitrary October 5<sup>th</sup> deadline was not offered for discussion at the August 26, 2015 meeting of the Care Management Committee; we were told that all substantive decisions relative to the RFP **had** to be made by October 5<sup>th</sup>. From this meeting and the following one on September 9th, we understand that the arbitrary October 5<sup>th</sup> date was “dictated by” the intention to meet the PMO’s arbitrary July 1, 2016 rollout date. Shortly before the August 26th meeting of the Care Management Committee, a “concept paper” was shared with many important policy decisions (or assumptions) on substantive matters, each of which requires hours of discussion by the Committee for thoughtful consideration and a full response. The paper was to be submitted to CMS in less than a week. There was no attempt to defend the rushed process as being in the “best interests” of Medicaid enrollees, as required by federal law, leaving essentially no time at all for discussion of such basic questions as what groups should be in the shared savings program for the first roll-out, the methodology for paying any shared savings, who will be eligible to receive such payments, how resources will be dedicated to quality improvement, and how we will monitor for under-service.

In fact, there are many additional critical decisions which necessarily must be made before the RFP is finalized, each of which requires extensive discussion and research for prudent and responsible policymaking. As one example, in response to the request of DSS and the co-chairs of the Care Management Committee to all stakeholders, advocates on and off of this committee formed a working group to explore the critical decisions which must be made in the design of MQISSP and to make suggestions to the Committee for how they should be decided. This group, known as the Medicaid Study Group, has been meeting all summer, taking a deep dive into complex policy issues, contacting other states, and surveying the literature. Attached is the result of their work: a nine-page document identifying critical issues and providing recommendations to ensure we build on the Medicaid program’s success. The recommendations,

along with feedback from other stakeholder groups, should serve as a starting point for the important conversations needed to ensure reforms are constructive and Connecticut avoids past mistakes.

Indeed, even the timeline developed by DSS's consultant, Mercer, from April 2015, for a limited number of issues, [https://www.cga.ct.gov/med/committees/med1/2015/0415/20150415ATTACH\\_MAPOC%20Care%20Management%20Committee%20DRAFT%20MQISSP%20Stakeholdering%20Timeline.pdf](https://www.cga.ct.gov/med/committees/med1/2015/0415/20150415ATTACH_MAPOC%20Care%20Management%20Committee%20DRAFT%20MQISSP%20Stakeholdering%20Timeline.pdf), indicates that October 5<sup>th</sup> is an impossible date to meet just for these issues, since specified dates have passed but many of the issues that are specified have not yet been addressed or even discussed. (It is our understanding that this was in part because the PMO delayed getting funding for the contract with Mercer.) It is clear that we will need several more weeks of work before we can set a timeline for finalizing the RFP for providers.

At the last SIM Steering Committee meeting on September 17th, advocates and others raised substantial concerns about this hurried process, driven by the PMO. Mark Schaefer made several arguments based on false assumptions, in his attempt to explain the PMO's inadequate timeframe:

- CMS/CMMI may hold up the SIM grant funds if the MQISSP is not actually implemented by July 1, 2016.
  - However, CMS has already indicated it is willing to grant one Medicaid extension and routinely grants multiple extensions, as it did in the development of the shared savings proposal for dual eligible individuals. And we understand that CMS is very willing to revise the SIM grant timelines to ensure successful reform.
- It is important to get the quality improvements promised under SIM to Medicaid members as quickly as possible.
  - However, given the major advances in quality made by the Medicaid program in the last three years since we moved past the MCO system and implemented a variety of successful innovations, quality improvement has already been significant. Connecticut's Medicaid program is in fact a model for the nation, and DSS officials regularly, and appropriately, present both here and around the country on its substantial successes. *See, e.g., A Precip of the Connecticut Medicaid Program* (available at <http://www.ct.gov/dss/lib/dss/powerpoint/MAPOC101014.pdf>).
  - In fact, the accelerated timeline threatens to **reverse** CT's quality improvements.

Finally, we note that not only does the PMO's accelerated timeline jeopardize hard-won accomplishments in our Medicaid program, but it also is a threat to state taxpayers. Remarkably, Connecticut Medicaid has stabilized and reduced per person medical costs since moving to the non-risk, care coordination-based model. By contrast, the recent news that the Medicare shared savings program, the basic model for SIM's shared savings model, has produced a net **loss** for the Medicare program, *see* September 14, 2015 Kaiser Health News report (available at

<http://khn.org/news/medicare-yet-to-save-money-through-heralded-medical-payment-model/>), is reason for pause about this model. If Connecticut's shared savings networks perform in Medicaid as they have in Medicare's program, costs in the program would actually rise by tens of millions of dollars. Medicare's results serve as strong caution against rushing into shared savings, particularly for Connecticut's Medicaid program which is already performing well in cost control.

Accordingly, we urge you to intervene with the PMO to assure that the commitment that DSS "will engage the care management committee ... to review and comment on *all aspects* of the shared savings program design" is fully honored, i.e., that all substantive and procedural decisions needed to finalize the RFP are first fully vetted before the Care Management Commitment, and that the issues in the attached document are opened for full and meaningful discussion **before** any decisions are finalized. This will almost certainly require an additional extension from CMS, consistent with DSS's paramount duty to act in the best interests of Medicaid enrollees. In any event, we owe it to Connecticut's taxpayers to assure that the recent quality improvements and financial success of the \$6 **billion** per year Medicaid program are not undone by an imprudent and unnecessary rush to satisfy deadlines, falsely perceived as rigid, outlined in a much smaller federal grant. We are confident that CMS will be receptive and agree that the needs of Medicaid members are paramount.

Thank you for your attention to this critical matter.

Respectfully yours,

Steve Karp  
National Association of Social Workers-CT  
Member, Consumer Advisory Board

Karyl Lee Hall  
Conn. Legal Rights Project  
Member, Care Management Committee

Kristen Noelle Hatcher  
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Enc.

cc: Social Services Commissioner Roderick Bremby  
Mark Schaefer, Ph.D  
Members, SIM Steering Committee and Councils  
Members, MAPOC and MAPOC Care Management Committee