Connecticut Health Policy Project

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Connecticut's Medicaid redesign – Pros and Cons

Connecticut's Medicaid program has earned national recognition for combining improved access to high quality care with an impressive record of cost control. Shifting the program from a financial risk payment model to care coordination through person-centered medical homes (PCMHs) four years ago is widely credited with that success. Last year the administration began developing a new, ambitious reform plan, Medicaid Quality Improvement and Shared Savings Program (MQISSP) committed to build on and support the success of the PCMH program. The goals of MQISSP are to "improve health and satisfaction outcomes for Medicaid beneficiaries"[1].

Under MQISSP, the state intends to contract with competitively selected networks of providers, both Federally Qualified Health Centers and advanced networks (i.e. Accountable Care Organizations). Networks[2] will coordinate person-centered care among a continuum of providers and community resources. Networks will share in the resulting savings in the total cost of care for their attributed members if they meet quality standards. Over the last year, the Department of Social Services (DSS) has worked with the Care Management Committee of Connecticut's legislative Medical Assistance Program Oversight Council to develop the program. The Care Management Committee includes legislators, providers, consultants, and consumer advocates. As of April 2016, that process is largely complete and drafting has begun on the MQISSP application for networks.

To inform the process, last year over a dozen independent consumer advocates met to form the Medicaid Study Group. Based on available literature, research on other state Medicaid programs, the experience of early shared savings programs, and other sources the group developed design recommendations for MQISSP to balance protecting Connecticut Medicaid's fragile progress with efforts to further improve access to high-quality care, improve health and satisfaction outcomes and maximize resources.

Of fourteen main MQISSP design decisions reached by DSS with the Care Management Committee, eleven are consistent with the Medicaid Study Group's recommendations – pros. We are grateful that the state recognized these important protections and agreed with consumer advocates on these issues. However, three decision points are not consistent with independent advocates' recommendations – cons. Advocates remain concerned about the potential to undermine PCMHs, deny care coordination to the members who need it most, insufficient quality standards, and incentives to inappropriately deny needed care. There

[1] A Brief Primer on the Medicaid Quality Improvement and Shared Savings Program (MQISSP), DSS, 5-10-15

[2] Note – throughout this document "network" refers to both Advanced Networks and Federally Qualified Health Centers as described by MQISSP

also remain some important issues yet to be resolved. Advocates look forward to continuing our collaborative work with DSS and the Care Management Committee to develop those issues.

MQISSP foundational principles[3]

- "Improved health and satisfaction outcomes" are the main goals of MQISSP, followed by cost savings
- Only networks that meet meaningful quality standards will receive shared savings payments
- PCMHs are foundational to any reforms and must be preserved and strengthened in all MQISSP planning
- Providers found to be inappropriately underserving or manipulating their panel of patients, either inside or outside of the network, will be completely disqualified from shared savings for the time period during which shared savings were generated

MQISSP pros

Pro – Networks will not share in any financial losses in the cost of care for their members. MQISSP is an upside-only shared savings program.

Pro – Members will be attributed to networks based on choice and history, but assigned to their network at the beginning of the contract period. Networks should have no incentives to stop serving less lucrative or more difficult members.

Pro – MQISSP will reward improvements in quality even if they are not accompanied by cost savings. The Challenge Pool, composed of savings not disbursed initially to networks that earned savings, will be available to all networks, based on quality performance, regardless of whether they achieved savings or not.

Pro -- Quality standards are gradual and designed to drive improvement at all levels. Rewards must reflect both high performance and networks' quality improvement to benefit all Medicaid members, not just those attributed to the highest-performing practices. Incentives must also be tied to the level of quality or improvement to avoid an all-or-nothing "cliff" effect encouraging aggressive action to meet a single standard. MQISSP has adopted gradual quality incentives that encourage improvement at all levels.

Pro –MQISSP will not include a Minimum Savings Rate. A savings threshold that networks must meet to share in savings could create a strong incentive to deny needed care or cherry pick patients to achieve it.

Pro -- Direct compensation of network providers cannot be based, even in part, on savings generated from their individual panel of patients. This is important to avoid a strong incentive to reduce care inappropriately and to recognize that appropriate savings are due to the efforts of an entire team of caregivers. MQISSP consultants stated in a public meeting

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[3] MQISSP Primer, MQISSP Shared Savings Calculation Webinar, DSS, March 2, 2016

that this recommendation has been adopted and will be reflected in the MQISSP Request for Proposals.

Pro – MQISSP adopted protections to mitigate the impact of unanticipated, non-preventable high costs. Examples include care for high-cost members, a bad flu season or expensive new drugs. MQISSP will exclude from shared savings calculations members' treatment costs above $100,000 per individual in a year. MQISSP will also risk-adjust shared savings calculations and will use the PCMH attributed, but not MQISSP-enrolled, population over the same time period to calculate the trend adjustment. Total shared savings for networks will be capped at 10% of expected costs. The state further agreed to consider adding social and demographic modifiers for risk adjustment calculations as they become available.

Pro – The Community and Clinical Integration Plan (CCIP) will be optional for networks, at least for the first year. Advocates and others are very concerned that the CCIP plan is overly prescriptive, costly, inadequately funded, and not evidence-based.

Pro – Networks must be free of any insurer ownership or financial investment. This is critical to maintain our program's independence, transparency, accountability and substantial success since moving away from for-profit managed care plans in 2012.

Pro – Savings denied to networks due to systematic underservice will be invested in quality incentives. Savings denied due to underservice will not be paid to the underserving network or revert to the General Fund. Instead they will move to a Challenge Pool to be disbursed based on quality performance to networks that did not underserve.

Pro -- Only members attributed to PCMHs will be included in MQISSP, both for quality/ member satisfaction monitoring and shared savings calculations. Advocates have been supportive of this decision. However, it creates a new problem that could be harmful to Medicaid members who need PCMH care the most. (see below)

MQISSP cons

Con – Minimal PCMH requirements for primary care practices in MQISSP networks.
As networks will be allowed to have both PCMH and non-PCMH primary care practices but shared savings calculations will only include PCMH-attributed members, will be there will be incentives to shift "compliant" members likely to result in savings and better quality and member satisfaction scores into PCMHs. Networks could also maximize revenues by moving more difficult, less satisfied, less lucrative members out of PCMHs. In addition to denying care coordination to those who need it most, these incentives could result in a false finding of successful savings in MQISSP, driven by risk selection rather than any meaningful reforms. The state could be in the position of making "shared savings" payments to MQISSP networks while also making higher payments to those same networks for non-MQISSP members, with the net effect that the network ends up costing more money than without MQISSP. This will lower value in the program driving higher state spending with no change or reductions in quality, satisfaction and access. DSS has acknowledged that the current monitoring system cannot identify this type of panel manipulation, but they have committed to developing such a system in the future and any network found to have engaged in such manipulation will be denied any shared savings.

Advocates strongly urged adoption of this 100% PCMH participation requirement to avoid this currently unmonitorable adverse incentive. When told that it was a worthwhile goal but it was not feasible, advocates urged DSS to at least adopt specific expectations for when networks would be 100% PCMHs, with meaningful enforcement such as removal from the shared savings program or denial of shared savings. DSS did agree to expect 100% PCMH participation within 18 months of the contract start but refused meaningful enforcement, citing the success of CHNCT's purely voluntary PCMH glide path program to date. Instead, DSS plans for networks that do not reach 100% PCMHs within 18 months will receive a Corrective Action Plan from CHNCT. This places CHNCT in a conflicted role with networks – working collaboratively on the glide path, providing technical assistance for practice transformation, but also enforcing non-compliance with Corrective Action Plans.

Con – Current MQISSP quality standards are not sufficient to protect members or drive improvement. Unlike other state Medicaid shared savings programs, quality standards MQISSP networks must meet to access savings payments are limited to just eight narrow, process metrics that apply only to sub-groups of Connecticut's Medicaid population[4]. CAHPS consumer satisfaction scores, routinely collected in Connecticut's Medicaid program for years and one of MQISSP's three main goals,[5] was demoted to a Challenge Pool quality standard at the last minute. No measures of avoidable hospitalization or emergency department use are among any category of MQISSP measures. These measures are a critical and broad indicator of inadequate care and apply to the entire population. The Office of Health Care Access measures and reports on these standards for the entire state of Connecticut. OHCA receives all Connecticut hospital data including care for Medicaid members.

Con – Networks will not receive up-front financial assistance with start up costs. Building a network is costly, potentially creating "de facto" downside risk, if a network does not achieve savings to recoup their investment. This effect is amplified underlying lower Medicaid provider payment rates. This could create an incentive to deny needed care to achieve savings and just break even. The state's budget is not in a position to provide upfront payments to networks.

MQISSP – still to be developed

- **Detailed underservice and adverse selection measures and monitoring** These must be in place before the launch of MQISSP including enforcement mechanisms, peer review with whistleblower protections, and secret shopper surveys to detect adverse selection.

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[4] Among state Medicaid shared savings programs only VT does not use member satisfaction as a benchmark quality standard. Other states use between nine (VT) and nineteen (NJ) benchmark quality standards for eligibility for shared savings payments. Quality Measurement Approaches of State Medicaid Accountable Care Organizations, CHCS, September 2014; Medicaid Shared Savings Program ACO Performance Standards, VT Green Mountain Board, 2016

[5] MQISSP Primer

- **Monitoring for de facto downside risk** In any substantial payment reform, it is critical to monitor the impact, intended and unintended, of changes. Of particular concern are the influence of network investments and Medicaid payment levels.
- **Clear consumer and provider communications to explain rights and responsibilities.** Objective, readable consumer notices, including information about possible negative consequences from financial incentives under shared savings, grievance procedures, and monitoring for patient choice are critical.
- **Transparency and public reporting** by both DSS and networks.
- **Independent monitoring and evaluation of the impact of MQISSP on the successful PCMH program**
- **Governance requirements for networks** The state must ensure meaningful consumer representation on policy-making boards, network accountability to communities, strong conflict of interest standards, and transparency.
- **Future network requirements to achieve national ACO certification** National certification is at the core of Connecticut's PCMH success.