Questions on the new SIM proposal for Medicaid

Proposal 1 -- Shared savings plan for 200,000 plus Medicaid consumers
January 1, 2016
Connecticut's community health centers are the foundation of care for many Medicaid members offering services in areas of the state that are not attractive to other providers, connecting to other community services vital to health outcomes, and offering affordable options to uninsured and underinsured state residents. They must be a part of any plan to reform the system. To ensure clinics are stable and sustainable, their financial interests must be protected in any reforms.

Community health centers are far better organized and integrated than the fragmented care available to Medicaid consumers outside clinics. There is very little evidence of overtreatment for patients within clinics. It is likely that most overtreatment for clinic patients occurs outside the clinic, where FQHCs have little control. Prevention takes time to generate savings. Even sophisticated, fully coordinated ACOs in other states are having trouble generating savings.

It is very difficult to secure appropriate specialty care for Medicaid consumers. Concerns have been raised that if clinics have a financial disincentive to refer, and more importantly, advocate to get specialty care for consumers, access to necessary care may decline further.

Questions:

- What monitoring and protection is envisioned to ensure appropriate access to specialty care?
- How will clinics' investments in prevention be reimbursed given that shared savings may not be realized for years?
    - Will SIM create a separate quality-only incentive pool (as in health neighborhoods pilot) to ensure that providers can rely on a return on investments in prevention?
    - How will the state adjust for churn in the single-eligible Medicaid population? How will clinics be compensated for preventive care provided to members who leave the program or their geographic area before the savings are recovered?
- How will the state monitor for cherry picking or steering consumers to community providers based on likely savings potential and risk adjustment?
- Will SIM commit to maintain current clinic reimbursement levels for care, and adjust for inflation, to ensure that shared savings do not displace other funding and create no incentives to deny needed care?

- Will SIM make a commitment not to transition to downside risk in the future?
- What form will underservice monitoring take? Will penalties be meaningful?
- How will SIM monitor for network adequacy – including specialists?
- How will SIM monitor for unintended consequences such as reductions in safety net capacity, and maintaining consumer choice?
- How will SIM adjust for externalities in the calculation of shared savings, i.e., a bad flu season, expensive new Hepatitis drugs?
- What will be a fair distribution of savings between providers who generated the savings and the state? McKinsey estimated for Medicaid in the SIM plan that 30% of savings would go back to providers.
- Will there be enhanced liability protection for providers? Reducing care, even inappropriate care, may place providers at risk.
- How will SIM monitor market consolidation and price increases? What is the state prepared to do if problems are found?
- How will SIM handle conflicts of interest, corporate ties driving care and referral patterns rather than quality?
- The HUSKY HMO program was rolled out by county over only a few months with a great deal of disruption and delays in care. Is there any plan to pilot this program and fix problems before expanding to 200,000 people?

Proposal 2- Medicaid 1115 waiver proposal
1115 waivers put the state at substantial financial risk by capping federal reimbursements. Because 1115 waivers require federal budget neutrality, as a condition of approval, federal matching funds are capped over the life of the waiver.[i] If health costs and/or Medicaid enrollment rise, the state would have to pay the full costs above the federal cap. Unfortunately, those things usually happen at the same time the economy is bad and the state budget moves into deficit.

Medicaid 1115 waivers have been historically used by states to cover childless adults. With passage of the Affordable Care Act most states have transitioned those groups to a Medicaid expansion category.
New 1115 waiver applications are coming from states that did not expand Medicaid -- to use premium assistance and work requirements for low income, childless adults to buy coverage in the insurance exchange rather than expanding Medicaid. Unfortunately, due to a legislative staff error, Connecticut state statute includes a provision authorizing premium assistance, so legislative approval wouldn't be needed to implement that.

SIM leaders have stated that the intention of the 1115 waiver is narrow and to cover new treatments that are not covered now. However once in place, the waiver could be used by future administrators in ways that are not as intended.

The SIM Medicaid brief gives three goals for the 1115 waiver – funding Community Health Worker care, providing air conditioners for people with asthma, and coverage of adaptive equipment. However, it appears there are other, less risky, quicker ways to achieve those goals without an 1115 waiver.

- CMS recently changed regulations to allow coverage of care provided by community health workers[ii]
- Under the EPSDT provisions, air conditioners are already covered for children on Medicaid where medically necessary
- A quick calculation finds that providing air conditioners to 75% of adult Medicaid consumers with asthma (an unlikely event), would cost only $2.1 million more with all state funds than with Medicaid coverage[iii]
- Past litigation and CMS response has confirmed that Medicaid coverage of adaptive equipment even for adults is limited only by whether a device is medically necessary and is the least costly of equally effective devices

Questions:

- What provisions can or will SIM put in place to ensure the current vision for the 1115 waiver does not change? What is the plan if spending in the program approaches the federal cap on reimbursements? Will state leaders make an enforceable commitment to find funding elsewhere in the budget and prohibit:
  - Premium assistance
  - Work requirement or other barriers to coverage
  - Reductions in current fee-for-service reimbursements
  - Future cuts in enrollment, i.e. cutting HUSKY parents from the program, expecting them to secure coverage in the insurance exchange instead
  - Future cuts to benefits or covered services
- What are the program goals of the 1115 waiver?
  - Have state planners fully explored other, less risky, ways to achieve them?
  - Please give details on current prevalence of the intended program target problems, costs, utilization patterns, ideally by geography, eligibility category and population
  - Please give specifics on intended interventions, costs, capacity to deliver interventions (i.e. specialty or treatment availability)
  - Please share evidence of effectiveness of proposed treatments compared with other options, especially those currently covered under Medicaid

General questions:

- When will we have more information on program goals, for both the shared savings program and the 1115 waiver, to explore other, less risky ways to achieve them?
- Why can't we pursue Medicaid reform as originally described in the SIM final plan – pilot health neighborhoods, learn lessons, and consider if it makes sense to expand to the rest of the population? And, in the meantime, expand to more Medicaid consumers the successful patient-centered medical home/glide path program that is now improving care and reducing costs for one third of current members.

July 8, 2014

[i] R. Rudowitz et.al. A Look at Section 1115 Medicaid Demonstration Waivers Under the ACA: A Focus on Childless Adults, Kaiser Family Foundation, Oct. 9, 2013.
[ii] Medicaid and children's health insurance programs: essential health benefits in alternative benefit plans, eligibility notices, fair hearing and appeal processes, premiums and cost sharing, exchanges: eligibility and enrollment; final rule. Centers for Medicare & Medicaid Services. 78 Fed Reg 42160 (July 15, 2013). The relevant section is, "a. Diagnostic, Screening, Preventive, and Rehabilitative Services (Preventive Services) (§ 440.130)" (paragraph citation: 78 FR 42226)
[iii] Assumptions and calculations available upon request