September 12, 2014

Center for Medicare & Medicaid Innovation
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Independent Consumer Advocates' Concerns about and Request for Revisions to Medicaid-Related Provisions in Connecticut's State Innovation Model Grant Proposal, dated July 19, 2014

Dear Madam/Sir,

Executive Summary

We are a broad coalition of advocates for people receiving health care through Connecticut's Medicaid program, which numbers over 700,000 individuals. We share a longstanding and informed concern for the Medicaid population in Connecticut which includes the most vulnerable of individuals due to low incomes, disabilities, chronic medical conditions and other socio-economic challenges. The signatories to this letter include individuals who are on various Connecticut SIM committees.

We appreciate and share the overarching goals of the SIM grant proposal to reduce the overall cost of medical care in Connecticut while improving the quality of care and health outcomes. We also appreciate the importance of receiving federal funds to accomplish crucial health care reform, several components with which we agree, particularly the expansion of patient-centered medical homes (PCMHs). It is a delicate and serious matter to express concern with this proposal. However, our extensive experience with the varying Medicaid improvement proposals over the years and their effects on Medicaid enrollees, combined with our professional responsibilities as attorneys and advocates, require that we make our significant concerns known.

If CMS is going to approve this proposal, we urge it to require Connecticut to substantially revise the Medicaid-related provisions to require an initial roll-out of shared savings in other populations, including those who are dually enrolled in both Medicare and Medicaid ("dual eligibles"), before applying shared savings to other Medicaid populations, and use the experience with those populations and payors to fashion essential consumer protections. Additionally, DSS must be required to demonstrate, to independent stakeholders, its capacity for producing, in a timely manner, accurate and verifiable data essential to monitoring the standards required to protect Medicaid recipients from underservice and disparate treatment. We have well-founded concerns about DSS' technological capacity.

The Medicaid population would be placed at unacceptably high risk from shared savings plans on the timeline proposed in Connecticut's SIM application

Medicaid recipients in Connecticut are among Connecticut's lowest income residents and are disproportionately Black and/or Hispanic. They also have low educational attainment levels and are challenged by disabilities, physical and mental, disproportionate to the general population. They suffer the harshest effects of poverty, struggling every day to make ends meet and provide shelter, food and clothing to themselves and their children and families.

The cost containment goal of shared savings plans, a central feature of Connecticut's SIM proposal, is based on the premise that Connecticut residents receive more treatment than is medically appropriate and that this over-treatment must be controlled so that costs can decrease. The SIM proposal also seeks to improve healthcare outcomes by incentivizing coordinated, appropriate, treatment based on the premise that Connecticut residents receive too much "piecemeal" or inappropriate treatment. These worthy goals, directly applicable to the general health care population, are based on premises less clearly apposite to the experience of people on Medicaid in Connecticut where important reforms are already underway.

The first goal, decreasing over-treatment, is not relevant to the Medicaid population in Connecticut. Overwhelmingly, the problem for Medicaid clients is not excessive treatment but *lack of access to Medicaid providers*, particularly specialists, and other services. Historically, doctors have been reluctant to accept Medicaid patients for various reasons such as low reimbursement rates, patients missing appointments and not following through on care, and other social and financial factors. These challenges are often explained by lack of medical transportation, lack of education, limited literacy, and a myriad of other barriers to receiving and benefiting from quality health services. Many of these access issues disproportionately affect persons of color. They have begun to be addressed through Connecticut's PCMH program, discussed below.

The second goal of shared savings, decreasing uncoordinated ("piecemeal") and inappropriate treatment, is being addressed by the PCMH program. Connecticut's PCMH program emphasizes comprehensive care by primary care physicians supported by intensive care management from the contracted Administrative Services Organization (ASO). Furthermore, as discussed below, Connecticut's costs for its Medicaid program are already going down.

Connecticut's Healthcare Innovation Plan, submitted in December 2013, acknowledged the risk of under service that could result from financially incentivizing providers to reduce the cost of patient care. Under service can take many forms ranging from patient abandonment to denials of medically appropriate care, to failure to prescribe expensive medicines or make referrals to specialists. Without first testing shared savings with other populations and payors, it is difficult, if not impossible, to know all the forms that under service might take. Connecticut's health policy leaders, including DSS, acknowledge that Medicaid beneficiaries are least able to safely bear these risks. They are among the least educated and literate of consumers, and they have the most mentally and physically disabled members. They are distinctly disadvantaged by under service and they are also least able to self-advocate even if they knew they were being under served which is why public advocacy of the kind we do is crucial, and critically important within the context of this application process.

At earlier stages of the development of Connecticut's SIM application, Connecticut's Medicaid agency shared some of the concerns and hesitation we bring before you now. Before CMS allows Connecticut to put its least educated, most health challenged, health care consumers at risk, several steps should be taken:

1. Connecticut should first assess the results of the shared savings plan model in other populations, including the "dual eligible." "Dual eligibles" will be subject to a shared savings pilot/model expected to begin in January 2015. No data or outcomes are yet available. Nor is there much experience with this plan in the private market in Connecticut or in other states which are ahead of us in this process. Because there is no data yet, it is not known if the dual eligible program and other shared savings programs will save money or improve care, and not result in under service. Connecticut acknowledged this lack of data and experience, and the risks associated with an early inclusion of the Medicaid population, in earlier stages of the planning process. In its December 2013 Healthcare Innovation Plan, Connecticut excluded the Medicaid population initially, opting to wait until, "based on the earlier experience of other payers with this approach, [the state can] assess the need for protections for Medicaid beneficiaries and on this basis determine when during the test grant period to implement an upside only SSP [for Medicaid]."

No degree or type of oversight can substitute for first testing and assessing the results of shared savings in other populations, including in the dual eligible pilot, recognizing that Medicare is a very different program from Medicaid. Connecticut should carefully plan for the gradual folding in of Medicaid recipients after seeing the results of initial testing of shared savings.

2. Experience with the shared savings model is necessary, to learn what protections the Medicaid population specifically needs beyond this general monitoring system. As Connecticut acknowledged in the December 2013 Plan, "a focus on quality metrics may not prevent systemic efforts to underserve, particularly for uncommon conditions or conditions outside the scope of such metrics." Because of the particular vulnerability of Medicaid recipients, it is imperative to gauge how shared savings plans work with other populations before "experimenting" on Medicaid clients. The provision in the grant proposal, at page 11, stating that "DSS will not implement the Medicaid QISSP until reasonable and necessary methods for monitoring under-service are in place, and will make ongoing adjustments to these methods as appropriate," is inadequate to protect Medicaid enrollees. Without knowledge of the experience of other populations and payors, the under-service measures being developed by the SIM Equity and Access Council will not detect all the ways in which Primary Care Providers (PCPs) may unconsciously stint on care provided to unknowing Medicaid enrollees because of the financial incentives under shared savings. The consequences of under service imperil the health of Medicaid recipients in the short term, and in the long term it undermines the benefit of any shared savings.

3. Even if it were somehow possible to have adequate standards and metrics in place, based on meaningful experience with shared shavings in other populations, before the anticipated roll-out to 200,000 Medicaid recipients on January 1, 2016, there are still independently verifiable concerns about the state's capacity to produce, in a timely manner, adequate and accurate data essential to monitoring those standards. The RFP (p. 43) requires states to be able to produce the data necessary to monitor implementation of its proposed

changes. These data will be critical in monitoring the impact of shared savings on the Medicaid population. However, DSS has faced numerous challenges in recent years as it has moved forward in efforts to improve its technological capabilities.[1]

It is imperative that CMMI require Connecticut to broadly demonstrate to independent stakeholders its capacity to monitor the standards and metrics it develops, accurately and effectively, as a condition of approving the grant. If this grant is approved, CMMI should impose specific conditions on the state that will hold it accountable for demonstrating, *before* shared savings is implemented on Medicaid beneficiaries, its technological capacity for generating timely and accurate data measuring the impact of the shared savings system on those beneficiaries. CMMI should not simply accept assurances that Connecticut can or will do so. Given Connecticut's track record with well-intentioned data systems, it is both reasonable and essential that the federal government assure that this anticipated health care reform model can be accurately and effectively monitored.

Already-existing Connecticut Medicaid Reform Models are Saving Money and Improving Health Outcomes

[1] *See, e.g., CTNewsJunkie*, August 21, 2014 (Federal Medicaid reimbursements withheld due to poor DSS accounting regarding classification of Medicaid applications under Medicaid expansion and interface with new exchange), http://www.ctnewsjunkie.com/archives/entry/feds_stopped_medicaid_payments_in_january_small_surplus_still_possible/

CTMirror.org, August 30, 2013 (complaints that "modernization" through scanning and an automated task-based system has made access to DSS benefits worse), http://ctmirror.org/dss-modernization-has-made-things-worse-some-say/

CTNewsJunkie, November 20, 2013 (DSS cannot determine how many people were illegally terminated from Medicaid due to failure of agency to process timely submitted redetermination forms after implementing electronic case records because of inability of agency to ascertain reasons for its terminations), http://www.ctnewsjunkie.com/archives/entry/legal_aid_attorneys_say_dss_is_discontinuing_benefits_when_their_clients_ar/

CTMirror.org, April 15, 2014 (new, under-resourced DSS call centers result in 39 minute average waits and 2/3rds of callers needing help with benefits hanging up (as of March 2014), but DSS can't tell if they hang up because of waiting so long or because they got their issues addressed otherwise), http://ctmirror.org/dss-call-center-wait-times-drop-but-two-thirds-of-callers-still-hanging-up/

Council on Medical Assistance Program Oversight, June 13, 2014 DSS presentation (average wait time at DSS call centers increased to 53 minutes as of May, 2014), http://www.cga.ct.gov/med/council/2014/0613/20140613ATTACH_DSS%20ConneCT%20Dashboard.pdf

Delaying the imposition of shared savings on Medicaid recipients other than dual eligibles, until first applied to other payors and populations and the state has examined those experiences and determined all the necessary consumer protections for Medicaid recipients, makes good financial sense for the state and federal governments. The general assumption is that health care costs are spiraling out of control. But this is less true with Medicaid programs than with Medicare or private coverage, and particularly inaccurate in the case of Connecticut's Medicaid program.

Connecticut has been engaged in broad-based Medicaid reform for the past 2.5 years. Its growing Patient Centered Medical Home (PCMH) Medicaid program is improving care and saving money.[2] Participating PCPs receive extra payment for coordinating care and potentially receive additional payments for doing well on agreed-upon quality measures (like emergency department use reduction), but they have no financial incentives to restrict access to care or to provide unnecessary care. The model is structured such that PCPs receive additional payment if they act as neutral "brokers" for the kinds of supportive services shown to be effective in enabling Medicaid patients to improve their consumption of health care services and their outcomes.

Imposing broad-scale shared savings on Medicaid PCPs, without assessing the effects of shared savings on other populations, will fundamentally undermine, not "build on," this very successful reform model in Connecticut's existing Medicaid program. The state should not to try to fix what is already working, particularly at the expense of people already challenged by poverty, chronic illness, disabilities, and lack of opportunity.

It is inappropriate to impose risks on the Medicaid population for the reasons outlined earlier, and unnecessary to take these risks because Connecticut is already saving money through its Medicaid program's reform models. While it is unclear exactly why Medicaid costs have dropped, the per member per month (PMPM) outlays dropped by 2% after Connecticut ceased contracting with Medicaid managed care organizations. Since Connecticut already has a downward PMPM Medicaid trend (a distinction shared by no other state, to our knowledge), it is unnecessary, as well as inappropriate, to impose on Connecticut's Medicaid population the risks of an untested shared savings program.

Conclusion

Medicaid beneficiaries already face greater barriers to accessing health care services due

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[2]Medicaid enrollees in the PCMH program are, compared to those not in that program:

23% more likely to receive adolescent care
20% more likely to receive well child visits in the 3rd through 6th years of life
26% more likely to receive adult preventive health services
27% more likely to receive an eye exam as part of diabetes care

"Connecticut's Medicaid program success: Significant improvements in access to quality care and cost control", http://www.cthealthpolicy.org/briefs/201402_medicaid_success.pdf

to poverty, chronic illness, disabilities, and other social factors. They should not be put at the increased risk that would ensue from including them into shared savings plans, without the benefit of experience with other groups. A key hypothesis of shared savings plans—that over-treatment, inappropriate treatment or piecemeal treatment will be avoided by coordinating care and incentivizing providers for positive outcomes-- is already being tested in the Connecticut Medicaid program's PCMH program.

We therefore ask CMMI to require Connecticut, as a condition of any approval of its SIM proposal, to substantially revise the Medicaid-related provisions to base its initial roll-out of shared savings in that population on the experience of shared savings in other populations, including the "dual eligible," and use the experience with other populations to first fashion essential consumer protections for Medicaid enrollees. Additionally, DSS must be required to demonstrate, to independent stakeholders, its capacity for producing, in a timely manner, accurate and verifiable data essential to monitoring the standards required to protect Medicaid recipients.

The SIM goals for the Medicaid population can be achieved through a carefully staged rollout of shared savings with Medicaid enrollees, informed by the experience of other populations within the program and property monitored with accurate and verifiable data.

Thank you for your attention to this request. We look forward to continuing to work with you and the state of Connecticut toward improving health care and health outcomes for our communities.

Respectfully,

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