September 23, 2015

To: SIM PMO, MAPOC Care Management Committee
From: Ellen Andrews, CT Health Policy Project
Re: CCIP Standard Review

I am writing to provide feedback on yesterday's presentation webinar for the MAPOC Care Management Committee on draft CCIP standards. It is clear that a great deal of work has gone into the draft standards and the intention is to provide a valuable service for consumers experiencing gaps in care. I want to thank the Practice Transformation Task Force, your office, and the consultants for your efforts.

However I remain concerned and confused about how this proposed program will integrate with the myriad care coordination efforts already established and functioning across Connecticut's health system, especially our successful Medicaid Person-Centered Medical Home (PCMH) program. Adding another layer of care coordination may not be helpful; too many consumers are being contacted by multiple care managers with competing demands too often offering contradictory services and advice.

I am very concerned that CCIP, and the previous SIM Advanced Medical Home Vanguard Program, are unintentionally undermining Medicaid PCMHs and ongoing successful efforts to recruit more providers to participate in the program. Of the first 35 practices approved for the Vanguard program, only two are listed as participating in Medicaid. PCMH certification is lucrative for practices, returning $150,000 on average to Medicaid PCMHs in the first year, and potentially far more from insurers. PCMH certification is also becoming a requirement for participation in new payment models, such as Accountable Care Organizations (ACOs), which have the potential to generate even more revenue for practices. However becoming certified requires costly technical assistance. Before the Vanguard program, the only state-sponsored source for that assistance was through Medicaid's PCMH glide path program, which requires participation in our state's Medicaid program. Medicaid's PCMH glide path program also provides higher reimbursement rates while practices are in the process of transformation. This has been a very effective recruiting tool for practices to join the Medicaid program, and as the higher reimbursements are tied to providing services, the incentives support a meaningful participation in the program. Since the inception of the PMCH program in Medicaid, the number of participating providers has grown substantially. Now however, practices that choose not to take Medicaid clients have another state-funded route to PCMH certification that bypasses the state's program serving our most fragile residents.

The presentation offered yesterday also raises concerns that CCIP could undermine currently practicing PMCHs. For instance, under your plan CCIP's Comprehensive Care Teams (CCTs) would be administering needs assessments for patients, developing care plans, linking patients to specialists, and then transitioning them back to their PCMH team in the network. Those functions are best performed with the patient in the context of the PCMH team. PCMH-based care planning allows for continuity of care, strengthens the connection to the network, strengthens the Primary Care Provider (PCP)-patient relationship, allows better access to patient records for the people providing patient care, and supports primary care. At best, the CCT risks duplicating work done by the PCMH -- at worst conflicts could impact care delivery and patient self-management progress.

Plans to address health equity gaps through CCIP are unclear. I am especially confused about how the substantial requirements in CCIP's plan will support PCMHs in their foundational work in person-centered care. It appears that CCIP staff will again develop care plans with patients independently of their PCMH. Leaving the primary care team out of care planning is not as likely to be successful.

CCIP plans for behavioral health integration duplicate the promising assistance program recently begun by CHNCT for Medicaid practices to support meaningful integration. This optional, new service has been very well received by Medicaid PMCHs so far, as it helps practices fill an anticipated need -- updated PCMH certification will require behavioral health integration.

I am also concerned about CCIP's plans to develop Community Health Boards. Most communities have similar existing entities. Recent Affordable Care Act non-profit hospital Community Health Needs Assessments have served as a beacon in many communities for inclusive, collaborative health planning. DPH and local health departments have been very active in local health planning for many years. In our research, advocates have found that states with the most promising Medicaid shared savings programs require that ACOs establish local Community Health Councils themselves. These Councils are effective in guiding ACOs toward successful community connections and improved population health precisely because they are connected to and sponsored by the ACO. Based on that experience, the independent Connecticut consumer advocates' Medicaid Study Group has recommended establishment of similar Councils in MQISSP with standards informed by the experience of leading states.

I continue to be troubled that CCIP's overly prescriptive approach to community and clinical integration will result in a loss of innovation and local responsiveness. For example, CCIP would designate specialty sources for e-consults (in a specialty area chosen by the network) but networks will be expected to pay for those services from CCIP's chosen source. This undermines autonomy and flexibility for Medicaid ACOs/networks to choose an array of services that best meet their population's needs. I am also unclear from the presentation whether SIM is still intending to use the pre-defined target populations identified in the earlier presentation to our committee for enhanced care rather than allow ACOs to analyze and respond to the needs of their

specific patient population. Those designated populations are still included in the new presentation, but in later slides.

As a member of MAPOC's Care Coordination Committee, I would recommend that SIM take more time to fully discuss the CCIP plans with DSS, the committee and other stakeholders. At a minimum, a survey of available overlapping services, within Medicaid and beyond, is prudent to avoid duplicating services, wasting resources, and confusing patients.

Participation in CCIP should be optional for MQISSP networks in the first wave of enrollment next year and SIM should allow ACOs to choose among the pieces of CCIP that fit their patients' needs. Some networks may need help with oral health integration but not with care transitions; others may prefer to work with CHNCT and Medicaid's PCMH glide path program to integrate behavioral health into their practice/network. This also allows time to assess the impact of CCIP on Medicaid's successful PCMH program, to determine if it is supportive or counter-productive. This more measured approach still supports SIM's goals, but also allows enough time to prevent serious problems and supports an eventually successful MQISSP program.

Please let me know if you have questions or thoughts. Thank you for your time and efforts to improve the health of every Connecticut resident.