Medicaid Study Group
PCMH Plus Update

June 27, 2017

Summary

Connecticut Medicaid's latest experiment in payment reform, "PCMH Plus" or "PCMH +", began operation January 1, 2017, with 137,037 members. From its inception, independent advocates have been concerned that the new payment model creates incentives to deny appropriate care (underservice) and shift less lucrative, difficult members out of the program (cherry picking), as happened with HUSKY managed care organizations in the past. Advocates are also very concerned that the program will undermine the current, successful Patient-Centered Medical Home (PCMH)(no "+") program that has improved care access and quality while controlling costs, without imposing any financial risk on providers. As PCMH+ nears the end of its second quarter, the Medicaid Study Group offers this update on the program, highlighting growing areas of concern and offering recommendations for a path to success.

While even a preliminary evaluation of the current, first wave of the program will not be available until October, the Request for Proposals (RFP) to provider networks for Wave 2 to enroll another 200,000 Medicaid members has already been drafted and is scheduled to be released in August 2017. Despite having no meaningful information on whether people are being harmed or the state is paying **more** under this program, DSS is now considering entering into three-year contracts, locking the state into years of potential losses. Enrollment in Wave 2 is scheduled to begin January 1, 2018.

In addition to being late, the evaluation plan is very weak. DSS surveyed only seven of the 1,808 members who have opted-out of the program to date. "Actionable data" about underservice on the first 137,000 members will not be available until July of 2018, six months **after** Wave 2 is scheduled to begin. UConn reports that they have internal capacity to provide timely information on performance but have not been able to secure the data. There is no meaningful underservice plan to keep the state's promise not to grant shared savings payments to any grantee that systematically underserves members. There is no mechanism to monitor for cherry picking lucrative members, despite recent evidence that it is happening in other states.

Notices to consumers informing them about the program change, the risks and their rights were eroded in response to political pressure from PCMH+ Accountable Care Organizations (ACOs), the large provider networks awarded contracts. Readers now need a college education to understand the letter.

ACO plans for behavioral health integration, collecting feedback from members, community linkages, and targeted care coordination are very weak in most cases.

DSS regulations for the program open the possibility of ACOs that underserve or cherry pick members receiving the false "shared savings" payments generated by those actions, and make provision of PCMH+ expanded care management and add-on services **voluntary** for ACOs, negating any benefits of being in the program for members.

Contrary to expectations, it is likely that the experiment will result in **higher** costs to the state, at a time Connecticut cannot afford costly mistakes. PCMH+ ACOs are already receiving millions in state and federal grants for upfront costs. There are potential opportunities to shift high-cost members onto a state-funded care management program, from which the ACOs would reap half the savings while contributing nothing. In fact, that is the intended strategy of one ACO. Three ACOs intend to rely heavily on volunteers, students and interns to fulfill critical care management functions.

Introduction

PCMH + (PCMH Plus) is Connecticut Medicaid's initial program of shared savings using networks of providers, Accountable Care Organizations[1] (ACOs). The Medicaid Study Group is a collaboration of independent consumer advocates dedicated to protecting and expanding on Connecticut Medicaid's recent success in expanding access to care, improving quality and controlling costs. While the Medicaid Study Group has shared deep concerns about shifting Connecticut's Medicaid program back to a financial risk model that has "failed spectacularly" in the past, we participated constructively in design meetings to develop the program. Some of our concerns were addressed, others were not. This is an update, from independent advocates' perspectives, on where PCMH+ stands at the mid-year mark, new and old concerns, and recommendations for improvement.

PCMH+ status

PCMH+ began operation January 1, 2017 with 137,037 members attributed to nine ACOs. By May, enrollment had dropped to 112,494 due to members opting-out of the program, losing HUSKY eligibility, or being excluded from the PCMH+ program. As of May 10th, 1,808 members exercised their right to affirmatively opt-out of the shared savings program. Regulations to operate the program have been drafted, despite advocates' objections that negotiated design decisions were compromised, endangering important consumer protections.

[1] We use the term Accountable Care Organizations (ACOs) used in health policy literature to describe provider networks that take on financial risk for the costs of care for their attributed members. PCMH Plus and DSS call their ACOs "Participating Entities" -- either Community Health Centers or Advanced Networks.

	Enrollment as of Jan. 1st	% of total enrollment as of Jan. 1st	Members who opted-out by May 10th
NEMG/Yale New Haven	7,509	5.5%	147
Value Care Alliance – St. Vincent's (lead), Griffin, Middlesex and Western CT Health Network (Danbury, New Milford and Norwalk hospitals)	18,086	13.2%	405
Fairhaven HC	7,811	5.7%	84
Cornell Scott-Hill HC	13,781	10.1%	165
Generations Family HC	8,000	5.8%	135
Southwest CHC	8,299	6.1%	91
Community Health Center, Inc.	44,917	32.8%	480
Optimus HC	21,304	15.5%	228
Charter Oak HC	7,330	5.3%	73
Total	**137,037**	100.0%	**1,808**

Significant state and federal upfront funds have been granted to ACOs to cover transformation costs even before shared savings calculations. Funds include $5.57 million in state Medicaid funds this year to Community Health Center ACOs in per-member-per month care coordination payments, $500,000 to each of three ACOs in state-directed federal SIM (State Innovation Model) funds, and federal Practice Transformation Network grants to Community Health Center ACOs.

Not much is changing. Most ACOs are not taking PCMH+ requirements seriously. Based on ACOs' responses to the RFP, advocates are very concerned that the good features of PCMH+ will not materialize. All but one ACO believes they are already doing everything in the RFP. Only two have a concrete plan to meet PCMH+ requirements. Many didn't answer specific questions, especially about required enhanced services specific to PCMH+, e.g., universal behavioral health screenings, compliance with National CLAS standards for Culturally and Linguistically Appropriate Standards.

Most ACOs don't intend to do anything differently. Some report that they will add capacity to expand what they are already doing but several make no commitment. In fact, one ACO is honest enough to state that they won't do anything at all without extra up-front funding, and will only do what that extra funding covers. **Three ACOs plan to rely heavily on unpaid students, volunteers and interns to provide critical care coordination services.** One is using student volunteers for everything beyond nurse (RN) care managers who coordinate clinical care only for high-risk patients.

Plans for behavioral health integration, a key goal of PCMH +, are very weak. Two of the nine ACOs report that they currently have a truly integrated model. Three report

that they eventually plan to integrate, one admits it is not integrated and offers no plans, and two are just "coordinating" behavioral and medical care between separate entities/units, in one case with an outside agency as it has no behavioral health services in-house. Completely misunderstanding the concept of behavioral health integration, one ACO's overall PCMH+ plan involves relying on massive shifts to Medicaid's state-funded Intensive Care Management (ICM) program to address members with behavioral health needs (see below). Only one ACO addresses oral health integration.

Most ACOs are not very committed to receiving feedback on their services from the people they serve. In their RFP responses, ACOs report lots of variation in how they receive feedback from consumers. Some use only one feedback option. Three ACOs report doing nothing to collect feedback; concerns must be brought to their attention from Board members or, in one case, from staff.

Advocates were very disappointed at the weak reports of community linkages. This is a critical feature of successful ACOs in other states. Meaningful connections to non-medical support services that address social determinants of health hold great promise to improve health outcomes. All but three of the nine ACOs provided a meager response to this question in the RFP. Several were vague, listing connections with less than five specific organizations. Several rely on membership in community coalitions – i.e. CCT, hospital community based needs assessment planning groups -- or plan to just refer members to local Community Action Agencies.

As targeted care coordination is another cornerstone of ACO success in other states, we were similarly disappointed in the responses to RFP questions about this vital function. Only one ACO is planning to make improvements to their current system. Some state they plan to hire new coordinators but one is clear that they will add capacity only if funds become available. Several use bachelor's level care coordinators; one uses only RN nurse coordinators for high-risk patients. Three rely heavily on unpaid students, volunteers and interns. Only one mentioned use of Community Health Workers.

Very weak evaluation plan

In addition to being too late to inform Wave 2, the proposed PCMH+ evaluation plan is very weak. Current activities rely on unverified ACO-reported information or consumers having full information on the program, despite eroded and confusing notices making this extremely unlikely. Once programs are implemented in Connecticut, it is very difficult to make significant changes or, if necessary, discontinue them, and that is certainly true if, as intended here, the program is dramatically expanded to half the Medicaid population before knowing the results with the first group of enrollees. Advocates are concerned that this policy invites serious harm to consumers, taxpayers or both.

DSS's evaluation plan is very weak. The plan is reminiscent of "evaluations" of the HUSKY MCO program in the past that regularly gave the program high marks

despite overwhelming evidence of excessive premiums, underservice, poor quality, provider flight from the program, and low access to care. For example, they will interview Medicaid recipients enrolled in PCMH+ but they are only meeting with two members from each ACO who will be **chosen by the ACO**. The remarkable reason given was the desire to reduce the burden on the ACOs.

Advocates are very concerned because this pretense is being portrayed as a legitimate evaluation. As it is unlikely to reveal any problems, advocates are concerned that PCMH+ proponents will assert this as evidence that there are no problems in the program. You can't find problems you aren't looking for.

DSS's proposed PCMH+ evaluation tool[2]	Problem
PCMH+ Monthly Participating Entity (PE) Compliance Reports	Unverified ACO self reports
PCMH+ Participation Detail Report	Enrollment number report – not an evaluation tool
Opt-out survey findings	Poorly designed and executed survey with only 7 respondents
Grievances report	Requires informed consumers, which was undermined by eroded notice
Consumer survey (CAHPS)	2015 data given, no info on PCMH+ Expect 2016 data in the middle of 2018, far too late to inform RFP
Mystery shopper	2016 data given, no info on PCMH+ Mercer admits that this will not "line up" with a PCMH+ evaluation Expect 2016 data in the middle of 2018, far too late to inform RFP
Claims	This the best source of data But will not be available until July 2018, 6 months **AFTER** Wave 2 members enter program. Some data available sooner but will only be shared with ACOs through CHNCT portal
Offsite desk review	Too late to inform RFP, very small sample
Onsite visits	Too late to inform RFP, very small sample

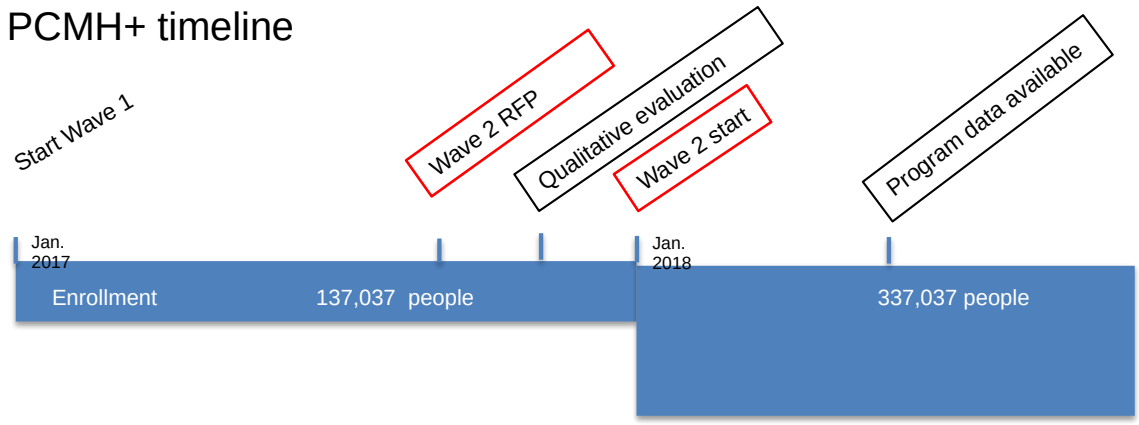
Advocates urged DSS to survey members who chose to opt-out of PCMH+, and were assured this would occur. Advocates are concerned that ACOs may encourage less

[2] From PCMH+ Evaluation Tools, Working Draft 4/19/17, DSS

lucrative or more difficult members to leave the program to artificially improve their shared savings payments by patient selection rather than improving care. In response, DSS conducted a survey of the 1,808 members who have opted-out of the program to date. However, they only surveyed **seven** members and asked open questions. Not surprisingly, they found that members "were confused by the letter and did not want to make any changes." There was no analysis of risk scores, of concentration of opt-outs by practice or provider, whether certain conditions are more common such as mental health or substance abuse conditions, nor were they asked if anyone urged them to opt-out. In any event, 7 out of 1,808 is a meaningless sample size.

Rushing to lock in the program without data

Advocates are deeply concerned that a massive expansion of PCMH+ is being locked into place before any meaningful assessment of whether people are being harmed or taxpayers are overpaying—under a program primarily intended to **save** taxpayer money. The RFP for Wave 2, to cover another 200,000 people, is to be released in August and implementation is planned for January 1, 2018. According to DSS, claims data to determine if harm is being done will not be available for at least six months after that, in July of 2018. And DSS is now considering making the next contract period longer; three years was suggested. State contracts generally adhere tightly to RFP requirements and applicants' responses. It is extremely rare for an RFP to be withdrawn completely. Thus, if we learn that people are being harmed, and/or shared savings are being inappropriately paid to ACOs, it will be too late, as we will be locked into long-term contracts.



It is important to point out that UConn's Collaborative Innovation for Analytics and Information Management Solutions group reports that they have in-house the analytic capacity necessary to perform Medicaid performance analyses, and experience from other states in providing robust and extensive such analyses. However, they have been unable to secure Medicaid claims data from DSS for the analysis.

Extremely weak underservice, cherry-picking monitoring plan

From its inception, independent advocates have been concerned about the danger of the shared savings payment model in PCMH+ rewarding inappropriate underservice and the cherry picking of members, and expressed those concerns. Underservice was rampant in the risk-based HUSKY managed care program that "failed spectacularly" in the 1990's and 2000's. Managed care organizations routinely denied care, engaged few participating providers, and consequently reaped significant profits.

Advocates are also very concerned about rewards in the model for panel selection or cherry-picking members. As only members receiving care from a certified PCMH are attributed to PCMH+, ACOs have an incentive to move less lucrative or difficult patients out and more lucrative, compliant patients into PCMHs, to maximize apparent "savings" in the program. While this will waste taxpayer dollars rewarding false savings without any improvements in quality or care, it will also harm patients by moving those that could benefit the most **out** of PCMHs and vice versa. It is relatively easy to shift patient attribution and select panels, and this in fact is happening in other states.[3] For this reason, advocates urged DSS to limit PCMH+ to only ACOs with 100% PCMHs to eliminate any opportunities to shift patients between practices in the ACO (see below).

It is critical to develop a robust system to prevent, monitor, identify and correct underservice and cherry picking. SIM's Equity and Access Council developed policies and standards for such a system and we were assured that they would be in place for PCMH+. Despite those assurances, DSS has no meaningful plan to monitor for underservice and has stated publicly that they have no mechanism to monitor for cherry picking or panel selection. In fact, regulations subsequently drafted to operate the program leave open the possibility that ACOs, demonstrated to have inappropriately underserved members, could still receive the shared savings payments generated by that underservice, despite repeated assurances that the Council's unanimous recommendation of a ban on receipt of shared savings in this event would be followed. In the unlikely event that they encounter evidence of either underservice and/or cherry-picking, the remedy is only to develop a correction plan together with the ACO.

ACOs' responses to RFP questions about guarding against underservice and cherry-picking were similarly meager and seemed to disregard the potential. Two ignored the question entirely. One stated clearly that underservice would **never** happen in their health system and consequently there was **no need to monitor for it**. Six of the nine had vague, brief answers to the question, claiming that their current quality improvement plans would be sufficient.

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[3] J Hsu, et. al., Substantial Physician Turnover and Beneficiary "Churn" in a Large Medicare Pioneer ACO, Health Affairs 36:640-648, April 2017; A O'Malley, et. al., Patient Dismissal by Primary Care Practices, JAMA Internal Medicine, published online May 15, 2017.

During development of PCMH+, advocates were concerned that compensating individual providers directly based on savings generated on their own panel of patients creates a strong incentive to deny care directly. This is common practice in most existing ACOs. In response, DSS, again following the Equity and Access Council's recommendations, included a prohibition against this practice and included four RFP questions about provider compensation and safeguards against underservice. But the two non-community health center ACOs' responses were noncommittal and left open the possibility that it may nevertheless happen.

State spending will likely increase

Advocates are further concerned that there are opportunities for PCMH+ to **increase** costs to the state without generating any value. Those opportunities include false savings payments to ACOs generated through cherry-picking attributed members, shifting care coordination activities to the state-funded ICM program that has demonstrated success in improving care and lowering costs, and receipt of direct, upfront grants. Given the state's current budget crisis, advocates are very concerned that these avoidable higher costs will lead to further Medicaid cuts in care to members.

The probability that this program will generate savings is very low. In fact, if PCMH+ ACOs mirror the performance of Connecticut's Medicare ACOs in the first years, it could cost the state $90 million more.[4] Even sophisticated shared savings programs nationally have struggled. Most ACOs in their responses to the RFP don't plan to make any changes, making savings even less likely. And the state is devoting considerable upfront spending to the program – all new money.

Estimates of ACO up-front payments[5]	Estimated add-on payment	CCIP funding	Other funds
NEMG/Yale New Haven		$500,000	
Value Care Alliance – St. Vincent's (lead), Griffin, Middlesex and Western CT Health Network (Danbury, New Milford and Norwalk hospitals)		$500,000	
Fairhaven HC	$421,794		PTN
Cornell Scott-Hill HC	744,174		PTN
Generations Family HC	432,000		PTN
Southwest CHC	745,000		PTN
Community Health Center, Inc.	2,425,518	$500,000	PTN

[4] Shared Savings Could Increa Connecticut Medicaid Spending by Over $90 Million, CT Health Policy Project, September 2015

[5] Add-on payment estimates based on contracts – Medicaid funds; CCIP funds from SIM grant – federal funds; Practice Transformation (PTN) Grant recipients – federal grant, unknown amount

Optimus HC	1,150,416		PTN
Charter Oak HC	395,820		PTN
Total	**$5.57 million**	**$1.5 million**	

ICM overlap – serious opportunity for overpayments, false savings, cost shifting to the state[6]

Connecticut Medicaid's ICM program has been very successful in moving high-cost, high-need members out of ERs and into primary care[7]. This success has not only improved the health of Medicaid's most fragile members, it is likely responsible for a great deal of the program's savings to date. Programs to target the needs of high-risk members have demonstrated significant savings in other states and are one of the foundational ACO innovations.[8] Advocates are strongly supportive of the current ICM program and urge the state to support it as an important value-based innovation providing relief to both Medicaid members and taxpayers.

However, the ICM program provides a powerful opportunity for PCMH+ ACOs to shift high-cost, high-need members into this program, let the state pay the costs of intensive care management and then reap half of the savings generated by these state-funded interventions. In fact, this is the main tactic for one of the ACOs. According to their response to the RFP, they plan to increase the number of their members receiving ICM services from 20 to 453 by increasing referrals. They plan to hire a care coordinator to enhance referrals and coordinate with the ICM program, assuring that the state itself pays for the extra services for which the ACO will be financially rewarded if savings are generated

PCMH (No "+") at risk

Connecticut Medicaid's success improving quality, access and cost control is largely due to adoption of the proven PCMH model of care delivery.[9] Unfortunately, enrollment in PCMHs remains stuck at about 60% of members with an attributed primary care provider, and the number of PCMH practices participating in the program has leveled off.[10]

It was universally agreed in development of PCMH+ that the PCMH (no plus) program must be protected and expanded. In fact, this guiding principle led DSS to limit attribution of members to only primary care practices that have achieved PCMH certification. Given that PCMH+ was designed to support and grow PCMHs, it is disappointing to learn that it hasn't.

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[6] This issue may have been discussed with ACOs in a private meeting earlier this month. No policy details have been made public to ensure that cost shifting does not occur.
[7] Connecticut HUSKY Health, DSS presentation to MAPOC, October 14, 2016
[8] High-Cost, High-Need Patients, Commonwealth Fund, http://www.commonwealthfund.org/topics/current-issues/high-need-high-cost-patients
[9] Connecticut Moves Away from Private Insurers to Administer Medicaid Program, *Wall Street Journal*, March 18, 2016
[10] PCMH update, DSS presentation to MAPOC Care Management Committee, June 14, 2017

However, concerns arose that the structure of the PCMH+ program provided incentives for ACOs to shift members likely to generate savings into PCMH practices within the health system and move members with less lucrative problems or who are more difficult **out** of PCMHs. Since that time, it has been documented that this is happening in shared savings programs in other states.[11] Evidence has shown that it is relatively easy to shift patients and entire practices in and out of ACO networks to maximize savings payments.[12] Not only does this serve to waste state funding, granting false shared savings payments to ACOs that only shifted risk, but it also denies PCMH services to exactly the members who most need them.

To avoid this problem and restore support for PCMH growth, advocates urged DSS to require 100% of primary care practices in ACOs to be certified PCMHs.[13] Unfortunately, DSS refused this but did require that the ACOs reach that standard within 18 months. It is important to note that all of the community health center ACOs are 100% PCMH certified.

Unfortunately, the two non-community health center ACOs' responses to the RFP did not make clear how many of their health systems' primary care practices are certified PCMHs, and how many are not, to ascertain if this dangerous shift might be likely to occur. In response to questions about the RFP, DSS affirmed that ACOs could include only a subset of their practices in the PCMH+ network.

Erosion of promises, transparency

Trust has been a serious and repeated problem in development of the PCMH+ program, as it is in the rest of Connecticut's health policy environment.[14] But this has repeatedly been violated in the development of PCMH+. For example, advocates agreed to participate in developing the program based on assurances that only upside risk would be included in the program. Downside risk, with providers sharing losses with the state if their members' health costs rise, creates significant incentives to underserve and cherry pick members.[15] However, we subsequently learned that DSS was not honoring that commitment and was open to considering a shift to downside risk in the Medicaid program.[16] DSS has refused to allow all but one committee of the Medical Assistance Program Oversight Council to review any PCMH+ policies or implementation. An independent advocate responded to an RSVP on a public website to attend the first PCMH+ learning collaborative meeting

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[11] J Hsu et. al. *op. cit.*
[12] A O'Malley, et. al., *op. cit.*
[13] Independent advocates' letter, March 8, 2016, http://www.cthealthpolicy.org/pdfs/20160308_pcmh_in_mqissp_letter.pdf
[14] Mistrust in Connecticut Health Policymaking, CT Health Policy Project, April 2017
[15] SIM Equity and Access Council recommendations, *op. cit.*
[16] Setting the Record Straight on Broken Promises, Now Let's Move On, CT Health Policy Project, October 2016

but was told by DSS she could not attend. Subsequent meetings have been held out of public view.

Perhaps most concerning, after negotiations with the ACOs, DSS drafted regulations for PCMH+ that reversed important protections agreed to in months of program development. Regulations now allow ACOs to receive shared savings payments even if it is demonstrated that they inappropriately underserved members, denying appropriate care, and to make delivery of PCMH+ essential and add-on services **voluntary**. Advocates are concerned that the latter change undermines the only benefit to members of participating in the program. Indeed, new consumer notices must be sent making this clear, since the notices advising of the right to opt out stated, apparently falsely, that anyone not opting out would be guaranteed these extra services.

This problem is very clearly illustrated by the eroded consumer notices as PCMH+ launched. Federal regulations require that consumers receive notice when Medicaid's payment model changes to give providers an incentive to reduce care. Last summer, in an open, publicly-noticed, transparent consensus process over several meetings, providers, advocates, DSS, consultants and other stakeholders developed a balanced notice. It was a contentious process. The notice was carefully crafted, with input from all stakeholders, to be respectful of the provider-patient relationship. The notice informed members of the change in the program, explained the new financial incentives, urged them to talk with their provider, offered a number to call with concerns, and provided an opportunity to opt-out of the program, as is their right. The notice was readable at a seventh grade level.

Just before the notice was scheduled to be mailed, however, ACO-affiliated physicians exerted political influence to erode the notice over the strong objections of independent advocates. The new notice requires a college education to understand. In addition, the eroded notice further weakens DSS's evaluation as the plan relies heavily on informed consumers. Subsequently, DSS also approved at least one notice from an ACO to their 7,500 members that was extremely misleading, ignored the new financial incentives and risks, and did not inform members of their rights.

What really works; two ACOs got it right

The literature on best practices to both improve health status and control costs is large and growing. The successful ICM program mirrors lessons learned in other programs serving Medicaid members. And two of the ACOs' responses indicate that they are following that literature.

Charter Oak Health Center's response to the RFP was refreshing. They surveyed the population health needs of their members -- medical, social and community -- and developed a realistic, patient-centered plan to address the problems. They were very clear about the gaps in care, with a specific plan to use PCMH+ resources to bridge those gaps. Following the experience of other states, they plan to build their

own intensive care management program for high-risk members. Their plans for evaluation and consumer engagement are substantial and indicate a willingness to learn from experience and change accordingly.

Community Health Center, Inc.'s response was also impressive. They already have a substantial array of care coordination and community supports in place. Their quality improvement program is very sophisticated. Behavioral health is thoroughly integrated with medical care. They have a robust care management system for high-risk members. In the response, they were specific about planned additions to staff and capacity building with PCMH+ funds to enhance and expand the current system, as opposed to reliance upon volunteers, college students and interns.

Both of these ACOs are 100% PCMH certified and do not compensate providers based on savings at all.

Independent Advocates' concerns for the future:

- Hundreds of thousands of people will be rushed into the experimental program before there is any chance to see if people are harmed or costs are increasing, and with no time to fix the problems.
- Standards for PCMHs, the only thing that has proven to improve quality and control costs in Connecticut Medicaid and beyond[17], will be undermined.
- State "shared savings" payments will go to ACOs that inappropriately deny care, as now allowed by DSS regulations, and/or manipulate their panels of attributed members by cherry picking.
- There will be no meaningful oversight or enforcement of
    - the promised PCMH + extra/add-on services
    - care coordination
    - connections to community services
    - meaningful integration of behavioral health with medical care
    - independent consumers' role in governance
- The state will lose money, risking further cuts to Medicaid
    - when ACOs take half the savings for high-cost, high-need members shifted onto the current, successful, and state-funded ICM program
    - when less lucrative members are shifted out of the program and more lucrative members are shifted in by cherry-picking/attribution shifting, as is happening in other states
    - when paying millions in upfront costs, with most ACOs stating that they intend to do nothing differently
- Transparency in policymaking will continue to decline, further undermining trust in policymaking

[17] A Sinaiko, et. al., Synthesis of Research on Patient-Centered Medical Homes Brings Systematic Differences into Relief, Health Affairs 36:500-508, March 2017

Independent Advocates' recommendations:

- Delay release of the Wave 2 RFP until a meaningful evaluation of Wave 1 is complete and oversight committees have had input
- Include at least the evaluation metrics and populations included in the list provided to DSS and MAPOC's Care Management Committee by independent advocates, including complete claims data from Wave 1
- Regularly solicit and incorporate broad independent, real-world input on the program from stakeholders
- Submit all future consumer notices (either from DSS or from ACOs) to review and revision by multi-stakeholder oversight committees, and abide by their feedback regardless of political pressure from ACOs or otherwise
- Build trust by honoring all commitments; do not erode policies on behalf of conflicted ACOs

Bottom line

PCMH+ may still have potential to improve Connecticut's Medicaid program, building on current success, engaging stakeholders working together, building trust and continuing cost control. But it is an experiment -- and no experiment should be dramatically expanded without a careful review of the effects of its first incarnation, especially as this experiment involves the health and lives of vulnerable low-income Connecticut residents. Nevertheless, the current timeline signals an intent to move forward with a major expansion of the experiment without regard to harm to either enrollees or taxpayers.

It will take resolve by DSS to hear both ideas and concerns from stakeholders, cooperate with others, and hold ACOs and providers responsible, despite the inevitable pushback it has received and will continue to receive from them. Advocates look forward to rebuilding trust and accountability to make Connecticut Medicaid even better, and avoid a slide back into a model like the unaccountable risk-based MCOs from which it took over a decade for Connecticut Medicaid to extricate itself.

The first step is the need to take a step back and carefully evaluate before expanding PCMH+ or committing the taxpayers to long-term contracts with ACOs.