October 23, 2018

Medical Administration
Department of Social Services
State of Connecticut
Via email

The Medicaid Study Group of independent consumer advocates respectfully request that the following questions be addressed in upcoming reports on quality and savings in the PCMH Plus program. Most come from our previous recommendations and letters regarding the program.

- How has DSS monitored for adverse selection between provider panels to generate false shared savings payments, as has happened in other states?
- Will DSS commission a statistically significant survey of all members who have opted out of PCMH+ conducted by an independent entity? Will this survey include, at a minimum, asking why they left and if they were encouraged to do so by anyone, within the ACO or outside; if they have complaints with the ACO or its providers; what their health issues/conditions are and social determinants that may affect their "compliance" levels?
    - Independent advocates would be happy to work with DSS and an independent entity with experience surveying underserved populations to develop a meaningful survey that is actionable and builds trust.
- Regarding Intensive Care Management (ICM) transitions:
    - Will the number and timing of members transitioned from CHNCT's ICM program to the ACOs for enhanced care management be publicly reported by ACO, and will this include the reason for each transition?
    - Will the number of ACO members remaining in CHNCT's ICM program be reported?
    - Are the members remaining in CHNCT's ICM program still attributed to their ACO? If so, how are savings resulting from state-funded ICM services deducted from savings attributed to the ACO?
    - How are members losing successful ICM services notified of the loss of services?
        - Are they notified that they have a right to opt-out of PCMH+ and thus keep their ICM services?
        - Are you monitoring access to care, costs and patient satisfaction of ICM members who transition to the ACOs before and after the transition?
        - Can members transitioned to an ACO later opt-out and regain their ICM services? How are they notified of this option?
    - How is DSS handling ACOs that continue to make referrals to ICM, as described in the RFP responses and the July MAPOC presentation?

    - How much has ICM enrollment dropped? How much direct savings in lower payments to CHNCT does that represent to the state?
    - How is DSS monitoring ACOs' care management capacity to ensure that members who need ICM services are getting them?
- How many members chose their PCP vs. were attributed based on visits or other methods?
- How is DSS monitoring to ensure that all members attributed to a PCMH (no plus), including those who opt out of PCMH+, continue to receive foundational care management services required in PCMH and FQHC standards and for which practices are currently compensated outside PCMH Plus?
- How is DSS monitoring ACOs for adequate patient engagement? Will DSS require repeated, personal outreach from humans to reach a 90% or higher engagement rate given the very low response rates reported in some compliance reviews?
- How is DSS addressing ACOs' weak progress engaging consumers in governance as reported in compliance reviews? How will DSS ensure meaningful member input into ACO policy setting, implementation and evaluation of the program? Is there evidence that consumers' input is being communicated to the highest-level governing body at each ACO, and to DSS? Have any policies been influenced by consumer input? Does each ACO have a robust conflict of interest policy? Is it being used to ensure consumer input is independent?
- What is DSS doing to require robust community linkages by ACOs?
    - Are community organizations and local public health departments being paid for their expanded services that are intended to drive savings to the ACO and the state, and if so by whom are they being paid?
    - How many community organizations and local health departments have signed contracts with ACOs?
    - How many have connections in each category?
        - Housing, utility bill assistance
        - Nutrition, food assistance
        - Employment assistance
        - Education, child care
        - Transportation
        - Language and literacy training
        - Peer support services and networks
        - Criminal justice system
        - Elder support services
        - Other state, local programs, medical and non-medical
        - Local health departments
- Are all ACOs at 100% PCMHs now? If not, why not? What is the ratio within ACOs – the full corporate structure, not just the PCMH+ participating practices?

- Quality measures
    - Avoidable ED, hospitalizations
    - See list provided by advocates to DSS (appendix)
    - Metrics by ACO, with names of organizations – before and after
- Regarding underservice prevention, monitoring and enforcement:
    - Describe each ACO's program to monitor, identify and address underservice – both program, evidence of monitoring, actions taken
    - Given the lack of ACO underservice policies or processes found in compliance reviews, what is DSS doing to make clear this is a priority and that instances of underservice will disqualify ACOs from savings and, potentially, from the entire program?
    - Describe findings in each program area of underservice prevention and tracking
        - Shared savings design elements – which implemented where, auditing for effectiveness in reducing/preventing underservice
        - Preventive and access to care measures
        - Member surveys
        - Utilization Trend Tracking
        - Member Education and Grievances
        - Peer review
- Regarding behavioral health integration progress at each ACO:
    - Are behavioral health specialists part of each primary care team, included in daily huddles?
    - Qualifications of behavioral health specialists
    - Can medical providers get behavioral health services immediately when a consumer needs it now? Do patients receive warm handoffs or just referrals?
    - Can medical providers make appointments for behavioral health care onsite, in real time directly into the appointment calendar?
    - Describe communications, follow up between behavioral health and medical care providers for each patient
    - Describe population tracking of behavioral health issues within ACOs and across the program, to identify challenges to accessing care, quality, and outcomes. Does each ACO produce formal reports shared with DSS including identified challenges/gaps, with an action plan to address them?
    - Does each ACO have an EHR with shared records across medical and behavioral health care?
    - Is care planning shared and coordinated? Do care plans include identified resources for every patient's problem list item?
    - Do ACO's EHR systems have the ability to identify potential undiagnosed behavioral health problems and alert medical care providers?
- Will DSS be evaluating the impact of PCMH Plus on:
    - The current, successful PCMH (no plus) program in HUSKY

    - Burden on safety net and other community services. Is PCMH Plus diverting scarce capacity away from other populations, both inside and outside the Medicaid program?
    - Market access, patient steering and choice within and beyond the ACO network

Savings, financials

- Total spending and savings, per member per month,
    - by ACO, by practice, and by provider if possible
    - per person PCMH Plus vs. PCMH vs. fee for service
    - broken out by geography
    - for people with disabilities, chronic illnesses (by large illness category), and people with behavioral health conditions
    - by ER, inpatient, outpatient, physician services, clinic services, pharmacy, home health, dental, vision, family planning, lab & X-ray, alcohol & drug services, emergency and non-emergency transportation, and durable medical equipment.
- Trend over Wave 1 contract vs. control trend
    - Identify drivers in each group
- What were net savings after accounting for consulting, upfront costs, SIM grants, and other costs, including DSS staff time?
- Impact of quality performance on savings payments -- both pools of payments
- Risk scores in each ACO and PCMH+ aggregate vs. the rest of Medicaid
    - Rates of chronic illness, diagnosis categories
    - Risk scores of people who opt-ed out vs. those that didn't
    - Risk scores of patients shifted to different PCPs, in or out of the ACO
- Costs to the state including CCIP, DSS, Mercer costs
- Pharmacy spend changes – including maintenance medications
- Primary care vs. specialist care spending before and after Wave 1
- How many ACOs reached the 2% benchmark savings?
- Quality performance compared with savings/losses by ACO
- What happened to retained savings, i.e. ACO savings that did not reach the 2% benchmark or denied due to underservice? Were those funds reinvested in quality improvement?
- How many patients reached the cost truncation limit? Are they still in the ACO, or have they been shifted to another practice/ACO?