May 10, 2019
To: DSS, Mercer
From: Medicaid Study Group
Re: Recommendations for possible Wave 3 of PCMH+

The first year of Connecticut Medicaid's PCMH Plus experiment in shared savings was disappointing. The program cost the state at least $1.3 million extra tax dollars and quality did not improve compared to Medicaid members outside the program. Every Accountable Care Organization (ACO), regardless of savings or quality improvement, was rewarded with a payment. The highest and lowest quality performing ACOs received the same payment per member-months. The program rewarded lower performing provider groups. PCMH Plus ACOs had **higher** per member costs and higher emergency room visit rates than other Medicaid providers; PCMH Plus did not make progress in closing that gap.

As the state considers whether to continue PCMH Plus, Connecticut Medicaid's shared savings program, we offer these recommendations to protect both consumers and taxpayers. This input builds on our original recommendations (September 2015), our update on the program (June 2017), questions about the program (October 2018), and most recently our list of proposed quality measures for any potential Wave 3 (April 2019, attached), among other input and advice, much of it solicited by DSS.

- **Carefully consider whether this experiment is worth continuing.** The first year was not encouraging, Connecticut cannot afford many years of experimenting, and more mature shared savings programs have not saved money or improved quality. This doesn't seem to be the best use of scarce tax dollars. The Medicaid Study Group stands ready to work with DSS on alternatives that do not place members at risk of underservice and adverse selection, are easier to implement, and are more likely to succeed in controlling costs and improving quality, especially among the current low-performing ACOs.
- **Do not automatically renew current ACOs, regardless of performance, as was the case in Wave 2.** Some very low performers were never even asked to explain what they've done to address gaps and concerns in their plans outlined in the Wave 1 Requests for Proposals.
- **Start over on the quality improvement benchmarks and incentives.** Give higher weights to metrics that reflect health outcomes. Remove self-reported process measures, which have the lowest likelihood of reliable connection to quality. Increase rewards for ACOs that out-perform the comparison group. Quality improvement payments should only reward improvement that is higher than the background of the comparison group.
- **We are concerned about a post-hoc change to the comparison group methodology**. It is dangerous to change the rules when performance has been below expectations. There must be very strong reasons to change the terms of the program; otherwise, the testing is likely to be changed in a way that produces higher grades without any actual improvement in quality. PCMH Plus enrollment is not high enough to justify the argument that a valid comparison group can't be created (and the Department assured

everyone before rolling out PCMH Plus that there would be a comparison group for conducting a meaningful comparison study). If there is a change, it is important to report future performance compared to both the original and new comparison groups to evaluate the impact on the program's goals.

- **The risk score methodology may be distorting payments without reflecting true differences between patient populations**. The ACO with the largest payments by far experienced a large increase in the risk scores of their patient population. Other ACOs did not see a large change in population risk scores. Using only patient risk scores from the inception of the program for benchmark setting throughout all years would lower the potential for intended or unintended gaming and ensure that ACOs serving higher risk members continue to receive more resources as their patients' health improves to maintain those gains.
- **Consider using CHNCT's health risk questionnaire of new members to adjust for social determinants of health and to track improvement**. Avoid indirect proxies for these metrics such as geography, race or income which do not distinguish well between the level of needs between patients. These attenuated metrics invite cherry picking and gaming the system.
- **Cross reference upfront payment requirements with existing standards, such as for Patient-Centered Medical Homes (PCMH, no Plus) for which ACOs are already being compensated, to ensure the state isn't paying twice for the same level of service.**
- **Disenroll members receiving Intensive Care Management (ICM) from PCMH Plus. Our** ICM programs have a strong record of providing exceptional care management to high-need, high-cost members. Connecticut Medicaid's ICM programs, CHNCT and Beacon, have demonstrated that quality, outcomes, and costs are significantly improved for people served by these innovative programs. MAPOC's Complex Care Committee learned that 67% of CHNCT and 100% of Beacon's PCMH Plus members continue to receive state-funded ICM care even after attribution to an ACO. It is very likely that ACOs are being credited with cost savings that were actually generated by ICMs and the state is paying twice; this can be avoided by removing these individuals from PCMH Plus (the solution of removing them ICM should not be done, as it will likely cause harm to people given the effectiveness of ICM).
- **Expand the minimum number of members for each ACO from 2,500 to at least 5,000.** Lower numbers invite random variations that could cost the state dearly. Reliable quality and cost improvement measures are critical to ensuring we are not rewarding ACOs for luck.
- **As originally promised, require participating ACOs to have 100% of primary care practices in their health system certified as PCMHs, whether or not they participate in PCMH Plus.** This is an important protection to avoid adverse selection by shifting less lucrative patients to non-participating practices within the larger entity, as has happened in other states. It also fulfills the stated intention of the program to expand the number of PCMHs in our state.
- **Conduct valid consumer surveys** of the care experience of PCMH Plus vs. PCMH No Plus members. Interviews of three consumers for each ACO chosen by the ACOs is

meaningless. Stop using those surveys to "demonstrate" that people are happy with the program; it is inherently misleading.

- **People have a right to know what is happening to them and why. Send PCMH Plus members effective, understandable notices that clearly state that their providers are at financial risk for the total costs of their care which could result in stinting.** The notices should encourage patients to ask questions of their providers about all possible treatment options, including effectiveness and costs, and how they arrived at their recommendation as outlined by the SIM Equity and Access Council. Start with the original, consensus PCMH Plus notices that were eviscerated at the last minute to accommodate PCMH Plus administrators. Certainly stop using notices that misleadingly declare that the shared savings payments are based only on making patients "healthier", since that is factually not true.
- **Improve program evaluation to emphasize underservice and adverse selection.** Prohibitions against payment if either is demonstrated are hollow if you aren't looking for them. Our suggested quality measures include many underservice and outcome measures.
- **Expand and equalize upfront payments to include non-FQHC ACOs.** To lower state losses in the program, divide the current level of funds among all ACOs evenly.
- **Stop using the low level of opt-outs and grievances as evidence that consumers are happy with the program.** In outreach to members to ensure they have the facts, we've found that virtually none are aware that providers are at financial risk for their total cost of care. Many are concerned but, following up, we have found that they didn't complete the opt-out process. Most common reasons include higher priority problems in their lives, no time or lost the materials, not wanting to "make the doctor mad", and/or a resignation that all providers are "just about making money" and that opt-ing out is pointless.
- **Require all PCMH Plus practices to have robust, functional Electronic Health Records (EHRs) integrated with behavioral health, emergency care, and other systems that are actually used by clinicians.** EHRs are important for provider communication but also to track quality and population health trends that should be addressed in a systemic way, and to improve patient safety over handwritten/FAXed/scanned and emailed communications between providers providing care to the same patient, either in the same timeframe or for later episodes of care.
- **Do not even consider adding dually eligible Medicaid and Medicare members to PCMH Plus without extensive evaluation over many years of the current program, collecting and evaluating the experience of other states, and engaging stakeholders in a through and meaningful process to build trust.**

Thank you for considering our recommendations. As always, we remain ready to offer our assistance and advice in improving care for every Connecticut Medicaid member.

April 3, 2019
To: DSS, Mercer
From: Medicaid Study Group
Re: Quality measures for Wave 3 PCMH+
Emphasis on outcomes

Measure	From?
Comprehensive diabetes care HbA1c poor control	CMS
Medication reconciliation	CMS, member survey
Depression remission at 12 months	CMS
ED visits for asthma	
Asthma control questionnaire	E Juniper
Avoidable ED visits	CMS, OHCA
Avoidable hospitalizations	CMS, OHCA
Patient safety, medical errors	CMS
Unplanned Hospital Readmission within 30 Days of Principal Procedure	CMS
Survey ACO community partners listed for quality of partnership and sharing payments	
Risk score improvement over time (incentive) vs. decline (penalty)	
Patient assessment of health status – change over time	PLOS Medicine
Care planning for high-cost, high-need patients – comply with standards? Is it used? Shared decision-making?	Complex Care Committee standards, patient survey
HIV viral load suppression	CMS
Follow up for patients diagnosed with HIV and with low viral load	CMS
Reduced food insecurity	PLOS Medicine
Vision assessment and correction in place (satisfactory glasses)	PLOS Medicine
Reduction in tobacco use, patient panel smoking prevalence	HHS, PLOS Medicine
Reliable access to home heating and cooling	PLOS Medicine
Provision of effective contraception	PLOS Medicine
Effective addiction care	PLOS Medicine
Effective chronic pain care	PLOS Medicine
Flu vaccination	HHS
Follow up after hospitalization for mental illness	HHS, CID
Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and Alcohol & Other Drug Use Disorder Treatment at Discharge	HHS
Nutrition Care Plan for Patients Identified as Malnourished after a Completed Nutrition Assessment – plan, follow up with resources, effectiveness	HHS
Controlling high blood pressure	CID
Follow up after ED visit for mental illness	CID

Follow up after ED visit or hospitalization for alcohol or other drug dependence	CID
Anti-depressant medication management	CID

PLOS Medicine -- B Saver et. al., Care That Matters: Quality Measurement and Healthcare, 11/17/2015, https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001902

E Juniper et. al., Development and validation of a questionnaire to measure asthma control, 1999, https://erj.ersjournals.com/content/14/4/902.long