Connecticut Health Policy Project

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PUBLIC COMMENT to the SIM Steering Committee
June 26, 2014
Re: Medicaid plans and national standards for patient-centered medical homes
Ellen Andrews, PhD
Executive Director

Thank you for the opportunity to share both our strong support for the Practice Transformation Workgroup's recommendations on patient-centered medical home (PCMHs) and our strong opposition to SIM's new proposal for Medicaid payment reform.

We at the CT Health Policy Project are dedicated to improving access to health care for every Connecticut resident. No one is more committed to constructive health reform than consumer advocates. Independent consumer advocates have offered constructive, feasible options to improve the SIM plan almost from its inception.

We hear every day from callers on our helpline and others about the difficulty accessing needed care in our state's increasingly fragmented, stressed and expensive health system. The best available tool to address these problems has been PCMHs, accredited by national standard setting bodies. After thoughtful discussion and building on the successful Medicaid PCMH program and others, the SIM Practice Transformation Workgroup affirmed the use of those national standards, specifically NCQA, as the best choice for promoting effective care delivery reform in Connecticut. We are very grateful for their wise decision and are eager to help the Committee move forward in any way we can.

However, yesterday morning I learned of SIM's very new proposal to make radical changes to incentives in our Medicaid program. The Executive Committee of the MAPOC Complex Care Committee was briefed on a plan to shift approximately one third of Medicaid members into a shared savings model and a possible 1115 waiver with a global cap. Advocates' concerns are many – only a few are mentioned here. Concerns about responsibly implementing a shared savings model and a future cap on Medicaid spending are too detailed to outline here; those will be described elsewhere.

This proposal was described to the committee yesterday as necessary to secure the SIM grant. I need to emphasize that consumers have no interest, pro or con, in the state securing a new federal grant for its own sake, only in the intended purpose of the activities. To put the potential $50 million SIM grant in perspective, Connecticut policymakers are now lobbying CMS to restore over $77 million in Medicaid reimbursements for DMHAS spending on hospitals. While prospects for regaining that reimbursement we counted on in the budget (and future similar reimbursements) are growing dim, no one is talking about radical changes to DMHAS services or payments.

It was also reported that we must include radical payment reforms for Medicaid for a successful grant application. My reading of the FOA does not indicate such a preference. In fact, the FOA relies heavily on Medicare innovations and building on current successful models in the state. In yesterday's meeting it was argued by proponents that other states successful in Round I SIM funding in prior years emphasized Medicaid reforms. I note that this is not news – those successful plans have been available for over a year. Those are more mature states and their plans build on prior successful Medicaid reforms, some going back over a decade, that represent a natural progression for their states' reform journey. Connecticut is not in that league, but advocates sincerely hope we will be and stand ready, as always, to participate constructively in that process.

This SIM process does not promote good policymaking. This plan is far too rushed and insufficiently supported for meaningful evaluation or feedback. There is less detail in this plan, that we were expected to respond to yesterday, than legislators had when approving the original HUSKY capitated HMO plan. We eventually found many problems with that plan, developed with far more analysis and thought than this, and we are still repairing the consequences of that poor design. The HUSKY HMOs were rolled out over months, county by county, and there was great confusion and disruption. SIM planners expect to flip a switch on 200,000 or more Medicaid members and their providers on a single day. The lack of input from legislative branch elected officials, their staff or any representatives appointed by legislators is deeply troubling to good process.

As a better alternative, I urge you to look to Connecticut's plans for health neighborhoods for people eligible for both Medicare and Medicaid, an expensive population with complex medical needs. The plan is to create five pilots integrating care across the continuum with community supports to support people's health. The health neighborhood shared savings incentives were carefully crafted to promote and require quality improvement. The plan also includes strong underservice monitoring and protections. The plan was developed over more than a year with an inclusive, transparent process that included all stakeholders. My reading of the FOA, with its emphasis on building on existing Medicare initiatives in the state, is that the health neighborhoods would be a far better fit for our state's SIM application. As a feasible, consensus-driven plan, it should be more attractive to CMS reviewers.

Thank you for your time and attention to public comment.