



March 8, 2012

Rep. Peter Villano
Sheila Amdur
Co-Chairs
Duals Model Design Workgroup
Medicaid Complex Cases Subcommittee
Medical Assistance Program Oversight Council
Legislative Office Building Room 3000
Hartford, CT 06106

Re: Concern with Proposed Model for Shared Savings with Providers

Dear Rep. Villano and Ms. Amdur:

We are a broad coalition of advocates and providers concerned with access to care for low-income older and disabled people who are eligible for both Medicaid and Medicare (often known as “dual eligibles”). We understand that your workgroup is charged with designing the specific outlines of the new person-centered demonstration model for this vulnerable population.

We write to express our concern with the model of “shared savings” with providers that the Department of Social Services (DSS) has proposed for this Demonstration project. We take particular issue with the Department’s proposal to share savings with providers based on the amount of money they save in providing care to this vulnerable group versus improvements in the quality of care they provide. Particularly since the Department does not impose such a financing system on the bulk of low-income Medicaid enrollees (including elderly and disabled individuals who are **not** also on Medicare), who are generally far less medically compromised than this dual eligible group, we urge you not to adopt this approach for dual eligibles. We urge you to apply the kinds of incentives under the Department’s person-centered medical home program (“PCMH”) program, which are based on quality improvements, and calculate shared savings with providers based on performance on these measures (many of which should also bring substantial savings), rather than specific dollar reductions.

First, we should make clear our broad agreement on many aspects of the Department’s proposal. We fully support the Department in its plan to share in savings with CMS when, for a given dual eligible population, the Department is able to produce savings by better coordinating care, which can avoid ER visits, temporary institutionalizations and duplicative services. We agree that substantial savings can be gained from appropriately coordinating care for this group. We also support the Department’s concept of “health neighborhoods,” whereby a multi-faceted

group of providers can work together to coordinate and improve care for older and disabled people, and can receive incentive payments based on success in improving the quality of the care they provide. And we support the concept of the amount of the incentive payments to the neighborhood of providers being based on the amount of shared savings which DSS receives from CMS, perhaps as a fixed percentage of those amounts.

Second, it is important to emphasize the particular challenges facing low-income dually eligible Medicaid/Medicare enrollees, who are the subjects of the Demonstration, over and above Medicaid enrollees in general. These dually eligible people are far more likely to suffer from multiple chronic conditions, serious mental illness, dementia, and heavy reliance on medications, and to be substantially more isolated than the average Medicaid enrollees, most of whom are younger and healthier and qualify for Medicaid based on the status of being children or in families with minor children. Further, dually eligible individuals, in general, are far less capable of advocating for themselves. Accordingly, whatever model design protections have been adopted, or are being adopted, for the broader population should also apply to this particularly vulnerable population.

In light of these realities, sharing savings with a neighborhood of providers based on money saved, rather than on quality improvements, threatens to harm the vulnerable dual eligible patients they will serve. This is inherent with any system, as proposed by the Department, where providers share in overall savings for a given population, no matter how the savings are generated. But such a shared savings model is particularly worrisome for a population which is more vulnerable and less able to advocate for itself.

While the Department has mentioned saving money from avoiding ER visits, re-hospitalizations and redundant tests, which most everyone would agree are things to be avoided, under its particular proposal, the **calculation** of the money received by providers would not be so limited. The savings could just as easily come from the neighborhood limiting access to physical or occupational therapy for individuals who recently had a stroke, providing less expensive (but less accurate) imaging services for individuals suspected of having malignancies, restricting the number of home care hours per week provided to someone who has great difficulty at home (but who will not likely go to the ER if their home care hours are cut back), or other harmful limitations. And, when this occurs, the patients in many cases will not even know that a decision to recommend a lower cost treatment has been proposed, at least in part, because of these financial incentives. Such a narrowing of options for care in pursuit of savings is contradictory to the person-centered model at the heart of the Demonstration.

Although the Department also mentions the need to reduce wasteful and inefficient medical spending, shared savings with providers, no matter how they are generated, is too vague a tool to tackle that concern. More likely, a neighborhood of providers which gets to keep a portion of any money saved will focus on saving money where the largest sums are involved, whether or not the services at issue are wasteful or necessary. While few would disagree that there is some concern with over-utilization where a fee-for-service system is involved, that concern is far less relevant to the Medicaid population, which, due to low provider rates, already has serious access problems, particularly in the area of specialty care. The last thing dually eligible people need is for their providers to have yet another incentive not to provide them with care.

The Department's arguments for shared savings with providers based on money saved by them are not persuasive. First, the Department assures us that we need not worry about providers restricting care to save money because there are quality measures which must be met for the providers to participate in shared savings. This position ignores the myriad ways in which a neighborhood of providers with a direct financial incentive to limit care can do so while still technically meeting quality measures. The further argument that the shared savings will be shared among a group of providers, so there will be little incentive for any one provider to limit care, is belied by the Department's rationale for proposing shared savings with neighborhoods of providers in the first place: to encourage them to "economize" because they get a financial reward for doing so.

Finally, the Department points to advocates' support for the Department's Integrated Care Organization (ICO) proposal submitted last year to CMS, which included shared savings with providers. Last year, following the Department's assertion that CMS would require shared savings with providers as an element in any demonstration model to coordinate the care of dual eligibles, some advocates did support that proposal as a less harmful alternative than fully capitating providers, as the Department initially proposed. But that support is not applicable to the present circumstances. It has since been made clear that, for the Department's current proposal, no shared savings with providers are required at all by CMS. More importantly, the ICO proposal did not specify **how** the proposed shared savings payments specifically would be calculated, which could be fully consistent with what we support here: shared savings calculated and paid to providers solely on the basis of quality improvements.

More fundamentally, the PCMH model which the Department subsequently developed for broad use with the relatively healthy Medicaid population, after the ICO proposal was submitted to CMS, is dispositive of the inappropriateness of imposing shared savings based directly on money saved on the more vulnerable dual eligible population. PCMH providers are to be paid under three methods: fee-for-service for health care services delivered, extra payments for care coordination services, and after-the-fact financial rewards for quality improvements. While the measures for obtaining these financial rewards are aimed at quality improvements which are expected to both improve care and save money (e.g., numbers of adults with in-patient admissions for whom there is a claim for post-admission follow-up within seven days of discharge date), incentive payments to providers are specifically **not** premised on money saved. Such incentives in fact were rejected by the PCCM/PCMH/Care Management Subcommittee of the Medical Assistance Program Oversight Council and by the provider advisory group which assisted the Department in designing those measures.

Accordingly, there is no "person-centered" justification for imposing shared savings with providers in the dually eligible Demonstration based on money saved rather than care improved. Therefore, if the Department is going to adopt a demonstration model including shared savings with providers, those incentive payments should be based solely on quality improvements, as with the Department's PCMH model, and not on the amount of money saved in the provision of care to low-income older and disabled people. The pool of money available to be shared with providers, as a portion of the shared savings DSS itself obtains from CMS, can and should be divided up among the providers based on their performance on the agreed upon quality measures.

Thank you for your attention to our concerns in this matter.

Sincerely,

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