

DSS Responses to SIM Questions Posed by Advocates

- **What monitoring and protection is envisioned to ensure appropriate access to specialty care?**

Connecticut Medicaid's medical ASO is currently charged with, and will continue, monitoring and ensuring appropriate access to specialty care for Medicaid beneficiaries, including those attributed under SIM Strategy 1. Means of doing so include, but are not limited to, ongoing assessment of network adequacy through such tools as geomapping, analysis of claims to examine trends in referrals to specialists and through the assessment of the beneficiary care experience through consumer satisfaction and provider satisfaction surveys. We intend to oversample Medicaid beneficiaries so that we can compare levels of specialty access reported by Medicaid and commercial populations. I would welcome your participation in the design and content of these surveys as part of the work of MAPOC.

Additionally, however, Medicaid is currently assessing means through which to enable reimbursement for e-consults between primary care providers and specialists. Our motivation for doing so is to facilitate more timely, relevant connections that may inform course of treatment, including evaluation of the necessity of face to face follow up with specialists. E-consult may be among the capabilities that advanced networks and FQHCs are required to develop in order to participate in our SSP.

- **How will clinics' investments in prevention be reimbursed given that shared savings may not be realized for years?**
- **Will SIM create a separate quality-only incentive pool (as will be the case in the Department's duals demonstration "health neighborhoods" initiative) to ensure that providers can rely on a return on investments in prevention?**
- **How will the state adjust for churn in the single-eligible Medicaid population? How will clinics be compensated for preventive care provided to members who leave the program or their geographic area before the savings are recovered?**
- **How will the state monitor for cherry picking or steering consumers to community providers based on likely savings potential and risk adjustment?**
- **Will SIM commit to maintain current clinic reimbursement levels for care, and adjust for inflation, to ensure that shared savings do not displace other funding and create no incentives to deny needed care?**

We have proposed under Strategy 1 to restore FQHC eligibility for the Medicaid Person-Centered Medical Home (PCMH) enhanced fee-for-service (FFS) and performance payments. Both of these will provide direct, near-term support for FQHCs' prevention activities. We intend for the enhanced fees to help cover some of the costs of practice transformation (e.g. expanded care teams, person-centered practice, attention to health literacy, access to specialty care through non face-to-face means, and applied efforts to reduce health disparities). We are also proposing Mercer will support the Department in development of the Strategy 1 shared savings methodology.

- **What will be the process to develop the shared savings strategy, will it include advocate/stakeholders and what degree of flexibility do we have with the methodology post application submission?**

- **More specifically, can we develop a shared savings methodology that looks like the duals demo shared savings strategy?**

All aspects of the proposed shared savings method will be developed with interested stakeholders through a transparent, deliberative and inclusive planning process that is currently being developed by DSS, the MAPOC and the SIM PMO. The model developed for use under the duals demonstration will inform the Department's thinking, and no entity participating in Strategy 1 will share in savings unless it meets identified benchmarks on the performance measures that are identified by the relevant SIM councils. We also intend to disqualify practitioners from receipt of shared savings if they demonstrate repeated or systematic under-service. Under Strategy 1, we are proposing to attribute beneficiaries who have already received care from a participating FQHC or advanced network. In support of this, we will adapt the attribution method that is currently in place for the PCMH initiative. We acknowledge the potential for migration of beneficiaries across payer sources, including Exchange policies and Medicaid. FQHCs will be compensated for preventative care provided through their encounter rates, as well as the above referenced payments. The attribution method is an effective safeguard against cherry picking and steering in that it involves retrospective evaluation of where beneficiaries have themselves sought care. Note that there is considerable interest, both nationally and in Connecticut, in examining how best to migrate the current FQHC PPS method, which is based on historically premised encounter rates, to a means of reimbursement that better rewards value. All aspects of any proposed changes in the encounter rate method will also be offered for review and comment by the MAPOC and appropriate committees.

- **Will SIM make a commitment not to transition to downside risk in the future?**

The Department has affirmed in its materials on Strategy 1 that it will involve upside risk only and the SIM Grant Application states this explicitly.

- **What form will underservice monitoring take? Will penalties be meaningful?**

The Department will adopt for use under Strategy 1 the methods of under-service monitoring, as well as means of enforcement, that are recommended by the relevant SIM councils. As noted above, no entity participating in Strategy 1 will share in savings unless it meets identified benchmarks on the performance measures that are identified by the relevant SIM councils. In addition, we intend to disqualify practitioners from receipt of shared savings if they demonstrate repeated or systematic under-service.

- **How will SIM monitor for network adequacy – including specialists?**

Please see above.

- **How will SIM monitor for unintended consequences such as reductions in safety net capacity, and maintaining consumer choice?**

The process of member attribution in no way inhibits member choices of providers. As in the Duals Demonstration, there is no closed panel for attributed participants who retain the flexibility inherent in a fee-for-service system to seek care from providers who are not part of their "Neighborhood." As indicated above, CHN will monitor network capacity ongoing.

- **How will SIM adjust for externalities in the calculation of shared savings, i.e., a bad flu season, expensive new Hepatitis drugs?**

The Department will consult with Mercer as to the best means of applying actuarial adjustments to account for these types of externalities.

- **What will be a fair distribution of savings between providers who generated the savings and the state? McKinsey estimated for Medicaid in the SIM plan that 30% of savings would go back to providers.**

The Department does not have a predisposition with respect to the percentage of savings that will be shared with providers. This is still to be determined.

- **Will there be enhanced liability protection for providers? Reducing care, even inappropriate care, may place providers at risk.**

It is important to point out that the goal of the SIM demonstration is to support current medical best practice, not to arbitrarily diminish care. There is no evidence that best practice guidelines have had any impact on provider liability and we would not anticipate that to occur in this instance. In a worst case scenario, if this did become an issue and providers withdrew as a result, the Department could take action to redress their grievances. However, the Department has not planned for any such liability insurance protection.

- **How will SIM monitor market consolidation and price increases? What is the state prepared to do if problems are found?**

SIM will not alter the Department's commitment to fee-for-service nor do we believe that Medicaid participation will hasten consolidation and increase prices because fees are not negotiated. The pressures on provider rates will be much the same as they are today. We are not contemplating entering into negotiations with networks of care. Note that market consolidation is being tracked by the Attorney General's office in accordance with the passage of PA 14-168 in the 2014 legislative session.

- **How will SIM handle conflicts of interest, corporate ties driving care and referral patterns rather than quality?**

The Department has a longstanding commitment to the enforcement of federal and state regulations on self-referrals and conflicts of interests as enforced by the Division of Quality Assurance. Those efforts will remain in place to ensure provider compliance.

- **The HUSKY HMO program was rolled out by county over only a few months with a great deal of disruption and delays in care. Is there any plan to pilot this program and fix problems before expanding to 200,000 people?**

The Department affirms its responsibility to engage with, and educate, both beneficiaries and providers in advance of implementation of Strategy 1, effective January 1, 2016. Under Strategy 1, the Department plans to utilize an attribution method adapted from the method currently utilized for the Department's PCMH initiative. This attribution method recognizes where beneficiaries themselves have

sought care, and in this way explicitly honors their choices. Additionally, the Department is not planning in any way to limit beneficiaries' choice of provider within the Medicaid provider network. By contrast to the implementation of managed care, the Department is not proposing to limit choice of provider or to assign beneficiaries within defined, closed networks. As a result of its planned method, the Department anticipates that beneficiaries will continue to receive care from their preferred provider and that there will not be interruptions of service or any new barriers to care. The timeframe to implement Strategy 1 is significantly longer than the time available to implement the transition away from the MCO to the ASO program structure.

- **What provisions can or will SIM put in place to ensure the current vision for the 1115 waiver does not change? What is the plan if spending in the program approaches the federal cap on reimbursements? Will state leaders make an enforceable commitment to find funding elsewhere in the budget and prohibit:**
 - **Premium assistance**
 - **Work requirement or other barriers to coverage**
 - **Reductions in current fee-for-service reimbursements**
 - **Future cuts in enrollment, i.e. cutting HUSKY parents from the program, expecting them to secure coverage in the insurance exchange instead**
 - **Future cuts to benefits or covered services**

Historically, it has been customary for the Legislature to enact enabling legislation to frame the proposed federal authority and parameters for new waiver initiatives in Medicaid. The Department anticipates that such legislation will be raised and enacted in advance of implementation of Strategy 2. With respect to potential budget exposure, we are proposing to use a narrowly tailored, geographically limited approach under the 1115 for a defined population of participants. A critical element of planning for the 1115 will be to seek technical assistance on budget forecasting from other states that have implemented 1115 approaches (e.g. Oregon, Minnesota) and from the Centers for Medicare and Medicaid Services (CMS). To reinforce, the Department is not proposing to utilize an 1115 approach for the entirety of the Medicaid program. The Connecticut Medicaid State Plan specifies which eligibility groups are covered and under what terms, the scope of covered services (both those services that are identified in federal law as mandatory and those optional services that the State has elected to cover) and conditions of coverage (e.g. prior authorization, cost sharing). Further, the Department is accountable to state statutes, regulations (e.g. the Uniform Policy Manual, UPM) and various policy memoranda issued by the Department, with respect to terms and conditions of service under Medicaid. In order to make any changes in these terms, the Department would have to seek authorization through processes (e.g. notice, opportunity for comment) identified by CMS for State Plan Amendments (SPAs) and/or waivers (e.g. 1115 waiver), as well as requirements enumerated in state statute for waiver approvals, amendments of waivers, and promulgation or revision of regulations.

With regard to your specific questions on potential negative outcomes, it is of course difficult to foresee every eventuality in the future. But the Department's interest in pursuing the 1115 waiver is in no way predicated on a reduction in the coverage afforded to Medicaid members, in terms of their eligibility or their access to care. If budget issues arise at some point in the future Medicaid eligibility will not be compromised as a price of retaining waiver authority. Additionally, the 1115 waiver is but one of several tools that will be evaluated as a means of supporting the needs of individuals and families beyond the reach of eligible Medicaid services.

- **What are the program goals of the 1115 waiver?**

The materials issued by the Department illustrate our goals with Strategy 2. Specifically, "we propose to expand on that same theme of clinical and community integration by developing with sister department DPH and diverse stakeholders a demonstration project specifically related to population health, better supporting the needs of whole family systems, and particularly addressing childhood trauma. Medicaid has keen interest in this not only to support the current day needs of children and families, but also to prevent the likely effects of failing to intervene in Adverse Childhood Events - failure which is associated in those children growing up to become adults challenged by chronic conditions, obesity and tobacco dependence." Further, "Overall, our goals with both of these strategies are to:

- better address whole person needs of beneficiaries;
- continue to enable practice transformation, and to extend the reach of transformation to encompass community integration; and
- overcome some of the rigidity of services approvable under our Medicaid State Plan by enabling coverage of additional supports."

The over-arching goal of an 1115 waiver or other tool is to link the delivery of both social services and medical care in such a way as to actually improve the lives of Medicaid members (i.e., by meaningfully impacting their life situation, not just addressing an immediate short-term need.

It is not correct to describe some of the enabling means that have been proposed by the Department (e.g. coverage of community health workers, coverage of items or services that are not currently covered under the State Plan) as goals. Instead, these represent a non-exclusive list of means through which to achieve the above listed goals.

- **Have state planners fully explored other, less risky, ways to achieve them?**

The Department is proposing, along with its partner DPH and diverse stakeholders, including the advocate community, to engage in a thoughtful, deliberative, and transparent process to design an 1115 waiver in support of the above referenced goals. Although it is correct that there are a number of federal authorities under which the Department could implement various of the above strategies (e.g. covering community health workers as a preventative service, which has been authorized in concept in a CMS State Medicaid Director (SMD) letter but has not yet been clarified as to means of reimbursement), it is the position of the Department that the 1115 authority is the best means of providing flexibility for the full range of potential strategies that may be selected. Among these are use of bundled payments (e.g. bundled payments for trauma-informed wrap-around services for children and families, coverage of community health workers, and coverage of services and supports that are not currently covered by the Medicaid State Plan). Beyond Medicaid funding mechanisms, additional tools will be sought and evaluated concurrent with the 1115 waiver option.

- **Please give details on current prevalence of the intended program target problems, costs, utilization patterns, ideally by geography, eligibility category and population**

These aspects will all be determined in consultation with DPH and a broad, diverse stakeholder group. The Department does not have a predisposition as to these criteria.

- **Please give specifics on intended interventions, costs, capacity to deliver interventions (i.e. specialty or treatment availability). Please share evidence of effectiveness of proposed treatments compared with other options, especially those currently covered under Medicaid.**

Through the planning process described above, the Department plans to bring forward capsules of diverse examples of strategies from other states for review and consideration as to evidence basis and relevance for Connecticut. Non-exclusive examples of these include 1115 efforts in Oregon and Minnesota, use of bundled payments such as under the Wrap-Around Milwaukee approach, use of Health Savings Accounts (such as in Indiana, which provides a financial incentive for enrollees to receive state-recommended preventive services) and others. The Department does not have a predisposition as to any aspect of model design.

- **When will we have more information on program goals, for both the shared savings program and the 1115 waiver, to explore other, less risky ways to achieve them?**

Please see above as well as the goals set forth in the SIM Test Grant application.

- **Why can't we pursue Medicaid reform as originally described in the SIM final plan – pilot health neighborhoods, learn lessons, and consider if it makes sense to expand to the rest of the population? And, in the meantime, expand to more Medicaid consumers the successful patient-centered medical home/glide path program that is now improving care and reducing costs for one third of current members.**

The Department has endeavored to address this question in the materials that it has released concerning Medicaid participation in SIM. Specifically:

"A key element of the SIM initiative is multi-payer alignment around the care delivery and payment reform strategies that are chosen. Throughout the project, there has been strong alignment with respect to care delivery reform with the Department's existing, successful Person Centered Medical Home (PCMH) and Glide Path program, which is now serving a third of the over 700,000 Medicaid beneficiaries.

With respect to payment reform, the Department's original position was that we would inaugurate our use of shared savings with the CMS Demonstration to Improve Care for Medicare-Medicaid Enrollees. The Department further committed in the SIM State Health Innovation Plan to align with other payers to the extent of implementing an upside only shared savings program for the general Medicaid population. In support of this, the Department proposed to review the early experience of other payers with this approach, to assess the need for protections for Medicaid beneficiaries and on that basis to determine when during the test grant period to implement an upside only shared savings program.

Following submission of the Innovation Plan, the SIM PMO conducted a comprehensive review of the Innovation Plans submitted by other Model Test and Model Design states. This review revealed that Medicaid was the leading strategy that states used to achieve care delivery and payment reform and the primary means of driving innovations in community integration and social determinants. It also became apparent that Medicaid participation is essential if Connecticut is to make real progress in closing the health equity gaps that predominate in the Medicaid population. As a result, the SIM PMO and its state agency partners prepared Issue Brief #4, which proposed a strategy for engaging advanced networks

and FQHCs in care delivery reforms focused on clinical integration, community integration, and expanded care teams as a means to address social determinants.

When the funding opportunity announcement was released for Round 2 of the model test grant funds, for which Connecticut is applying it became clear that:

1. Medicaid participation in both care delivery and payment reform is a requirement of the grant application; and
2. early participation within the grant period is warranted in support of achieving CMS identified goals related to a federal return on investment.

The Department has affirmed its support for the SIM care delivery strategies relating to primary care practice transformation. We have also spent the last three weeks carefully reevaluating our position with respect to payment reform. In many respects, the Connecticut Medicaid program has unique features. In contrast to most other states:

1. we are using no managed care;
2. instead, we are using performance based contracts with ASOs for medical, dental, behavioral health and NEMT;
3. we have also incorporated predictive modeling tools to risk stratify our beneficiaries, and an Intensive Care Management program and PCMH effort that have shown great initial promise;
4. the ASO approach has also enabled creation of a consolidated set of Medicaid utilization data, as well as unprecedented analytic capability; and
5. it has also been the vehicle for practice transformation supports for primary care practices, both for those on the glide path to recognition and those already recognized as PMCH practices.

Moreover, enhancement of access to primary care and integration of behavioral health and medical care are two of the three key strands of our current Connecticut Medicaid reform agenda.

We recognize that payment reform is essential to support flexibility in practice and non-visit based methods for engaging and supporting individual health needs. Moreover, Medicaid's participation in payment reform, along with other payers, is the only means by which we can change the focus of our care delivery system from service volume to beneficiary value.

In reviewing our position on payment reform, we were guided by a number of important values:

1. focus on protecting the interests of our beneficiaries, who face unique challenges associated with poverty, housing instability, food insecurity, and personal safety; and
2. interest in building on the platform of our PCMH effort, as well as the strengths of our ASO analytic capability; and
3. attention to where our beneficiaries are seeking care, and what factors may be inhibiting the health outcomes and care experience that they desire;

After considered review, we are proposing two strategies . . . The intention with [these] is to provide a broad schema of what we intend to do. Many details remain to be considered, and we intend to use the same strong stakeholder process that we have used for the duals demonstration to seek comment and advice. These include, but are not limited to, qualifications of providers and means of protecting beneficiary interests."

