Connecticut Health Policy Project

703 Whitney Avenue, New Haven, CT 06511
Phone (203) 562-1636 • Fax (203) 562-1637 • www.cthealthpolicy.org

September 14, 2011

Mark Schaefer, PhD
Director of Medical Administration
Department of Social Services
25 Sigourney Street
Hartford CT 06106

Dear Dr. Schaefer:

I am writing on behalf of the CT Health Policy Project to provide comments on your recent person-centered medical home (PCMH) proposal for Medicaid members. We applaud the Department in moving from the current HMO-based capitated managed care environment to a more accountable, transparent and person-centered model. The CT Health Policy Project has been a strong supporter of PCMHs in Medicaid for many years including policy development, fiscal tracking, provider and consumer recruitment and evaluation of Primary Care Case Management, the current PCMH program in HUSKY. Health care delivery reform, centered on PCMHs, is critical to overcoming the considerable challenges facing our state's Medicaid program including a growing caseload, limited access to care, too few participating providers, 140,000 new members in 2014 from national health reform, and fragmented care, all in the context of scarce resources.

We share the goals stated in your proposals, especially to "deliver . . . the right service, in the right place, at the right time in a person-centered manner."[i] There are several parts of your proposal that we support including a focus on people as a whole rather than patients, linking payment to performance, and a recognition of the difficulty of PCMH transformation for practices. However, we are concerned that other aspects of your proposal do not support the stated goals of the program.

The success of your proposal requires a great deal of trust on the part of providers and consumers, but unfortunately the history of the program does not inspire that trust. We understand and applaud the motivation to boost provider payment rates in this program, but the best answer to the problems in the current program are clear, rational, thoughtful standards, resources for practices to reach those standards, accountability and the fair application of rules.[ii]

Enhanced Fee for Service

Primary among our concerns is reliance on an enhanced fee-for-service (FFS) payment system. The American health care system's traditional reliance on FFS payment has been blamed for driving escalating costs and inhibiting quality improvement. Most payers are moving away from fee-for-service to payment systems that align incentives to improve quality and efficiency.[iii] Your

enhanced FFS proposal codifies that broken system. As FFS has been the predominant payment arrangement in Connecticut for most of our history, if it had solved our health system issues, we wouldn't need reform.

We are very concerned about unintended consequences that may result from an enhanced FFS system. Consider the example of a child successfully treated for an ear infection. To get paid for PCMH services provided to the family, the child's provider cannot follow up on his status by phone or email if appropriate, they must bring the child back into the office for a face-to-face visit. That visit requires taking the child out of school, taking a parent out of work, state payment for transportation to the visit, and exposes the child to a waiting room full of children with illnesses. It also diverts a slot in the schedule of a busy primary care provider that should be made available to another sick child. Treatment decisions should be based on best practices, the needs of the whole person/family, and the most appropriate site and provider of services, not by the bottom line. While we firmly believe that most providers are dedicated professionals and provide the best care possible to every patient, there is evidence that changes in compensation systems do influence treatment patterns.[iv]

Enhanced FFS encourages overtreatment and over-utilization of services. It does nothing to encourage innovative services such as email, group visits, referral tracking, medication management, and care management that serve as the foundation of successful PCMHs in other states. Your enhanced FFS proposal provides no incentive to coordinate care with specialists, mental health or oral health providers. In fact, to maximize revenue, PCMHs will have an incentive to provide as many services in their offices as possible, both to receive higher rates and to ensure that patients are attributed to their practice (see below).

Enhanced fees are also unlikely to serve as a salient incentive to current or potential Medicaid providers. Medicaid pays providers far less than other payers. It is entirely possible that providers will respond to an increase as only a down payment on reasonable rates and not recognize it as payment for new PCMH services. In our recent study following the impact of Medicaid rate increases in 2008, found little effect on provider participation or satisfaction with the program. 17% of Medicaid practices reported that they did not notice the increase.[v] Evidence from the field of behavioral economics teaches that retrospective payment buried in usual payments is one of the least effective ways to deliver an incentive. This is the reason that companies send rebate checks to customers rather than just reducing prices or premiums.

PCMH transformation is a lengthy, disruptive process and a costly investment for most practices. Many describe it as "painful". To expect practices to make the upfront investment of staff time and resources for PCMH recognition for the potential of increased reimbursement at a later time is unrealistic. Most primary care practices operate on a very thin margin and do not have resources for such an investment. Primary care practices are also extremely busy; there is growing evidence of a primary care shortage in Connecticut. They do not need Medicaid business to meet their bottom line. Expecting providers to cost shift from possible future reimbursement to fund upfront costs is unrealistic.

Rate increases are also unlikely to motivate providers to participate in the program. Connecticut's Medicaid rates are already higher than most states' rates[vi]; unfortunately our provider participation rates are still very low.[vii] Payment rates for preventive care are scheduled to increase to Medicare levels in 2013 under national health reform. Primary care providers can

simply wait for increased Medicaid rates and avoid the expense of PCMH transformation and recognition. Community health centers, the main providers of care to Medicaid patients, already receive higher payment rates than other providers.

Most states use a prospective per member per month (pmpm) system to compensate providers for PCMH functions in Medicaid. Very few states use an enhanced FFS system and those that do are planning to abandon it.[viii] Prospective pmpm payment systems, combined with quality bonuses and vigilant surveillance, have been endorsed by Connecticut and national stakeholder groups as the preferred PCMH payment system.[ix]

Fairly compensating providers for PCMH functions indirectly through enhanced FFS payments is problematic. Your proposal presentation states that allocation of costs are "meant to cover the portion of PCMH required expenses and activities associated with the Medicaid members in an average practice."[x] Estimating those extra payments will be extremely difficult given the lack of historical trends. Those costs will impact practices differently. If the state errs on the side of overpaying providers, it will be extremely difficult to reduce payment rates in the future. Prospective pmpm rates that accurately reflect reasonable PCMH costs are easier to develop both because predictable labor costs can be apportioned across a provider's panel and because Connecticut can draw on the experience of successful states now using the pmpm system.

Risk adjustment

We have related concerns regarding your assertion that enhanced FFS payments are a proxy for risk adjusting rates. Risk adjustment is a growing practice by payers to ensure that resources are directed to those who need them most and to discourage providers from avoiding riskier patients. If FFS was effective in guarding against "discourag[ing] providers from avoiding risk associated with patient needs" as described in your proposal[xi], given that FFS has been the predominant payment system for most of Connecticut's history, adverse selection would not be a concern. FFS provides financial incentives to treat healthier patients; your attribution proposal adds to those incentives (see below). As providers would be paid retrospectively under your proposal, there are fewer incentives to provide preventive care to keep patients well and out of the office. There is no way for providers to recoup costs incurred in keeping people healthy. Your proposal provides dual incentives to bring healthy, compliant patients into the office more often at the expense of more complex, more difficult patients both for higher reimbursement rates and to ensure that healthy patients, with better outcomes, are attributed to the practice, earning the provider a higher quality bonus. Your proposal focuses on reducing current costs, not on avoiding future problems.

Fairly risk adjusting rates is critical to the success of PCMHs and the entire Medicaid program. Not only does effective risk adjustment align incentives to prevent future illness and to improve outcomes, it also gives providers important information about their assigned patients, using information unavailable to the provider to identify which are at risk for health problems and helping them work with patients to develop more effective treatment plans. We strongly urge the department to consult with actuaries experienced in risk adjustment. It is critical to get this right – unintended consequences can be expensive and very difficult to remedy.

Attribution

Your payment proposal recognizes the importance and difficulty of getting attribution right. The PCMH model rests on a clear understanding between people and providers that they are linked and a mutual understanding of each other's rights and responsibilities in the relationship. A home is only a home if you know where you live. However your proposal for retrospective attribution does not support that mutual understanding.

Attribution is hard and current methods, while evolving, remain controversial. The medical and insurance establishments are far behind other industries in identifying and serving customers. Virtually every doctor has a story of being "dinged" by a health plan for a patient they've never heard of that didn't receive care. Not only is this aggravating and insulting to physicians and practice managers, it is also wasteful. It often takes hours on the phone with someone at the plan, also wasting their time, to correct errors.

Getting attribution right is essential to effective care, to respecting providers and, very importantly, to the ability to track quality. It is critical that policymakers be able to track both troubling instances of quality, but equally important to be able to identify positive outliers. Being able to identify practices that are providing exceptional care and better outcomes, we can create a learning system that shares those best practices so every Medicaid consumer can benefit.

Unfortunately your proposal codifies the current, unproductive retrospective association between providers and people. Retrospective systems do not support the PCMH model for many reasons. Associations should be thoughtful and considered, based on the needs of both providers and people including geography, age, care management resources and culture, provider specialty, language preference, and the comfort level of both parties. Too often Medicaid consumers don't have an opportunity to choose a preventive or maintenance care setting thoughtfully and are forced to find any willing provider when they become ill. We are hopeful that the PCMH model will change this counterproductive model of care.

Specifically, we sent your proposal to national experts on attribution and PCMH. The feedback was that it was vague and confusing, it does not appear to be a clear process, and raises too many detailed operational questions. In Step 1, you are basing attribution on past claims. As described above, there is general consensus that too many Medicaid consumers are not accessing care appropriately or in the best way for their needs. PCMHs are designed to fix that problem, not perpetuate it. You do not describe your "sophisticated algorithm" in Step 2. There are many "systems" for attribution seeking placement and funding (and consultants who sell their services to them) – too many are oversold in the experience of experts we consulted. What is the system? What has been other customers' experience – both payers and the practices that have to deal with errors? Has it been evaluated? By whom? What are the qualifications of those who developed it? How much does it cost and who pays? Will DSS have access to designers to adjust the methodology as inevitably there will be problems or is this just off-the-shelf? What will upgrades and adjustments cost? In Step 3, it is unclear whether people with a usual source of care (USC) that is not a great match but more a product of desperation will be informed that they have other, more appropriate options beyond the USC you have assigned them to?

Currently about 25% of new HUSKY enrollees are defaulted into health plans; they do not make a considered choice. That percentage has been relatively stable over the years. What plans does the department have to ensure that people are making better choices in the new PCMH system? Your proposal predicts that many people will remain unattributed to any PCMH or primary care provider.[xii] What are your plans to address that problem?

Your proposal acknowledges that this model does not attribute people directly to individual providers but to larger practices with diffused responsibility for outcomes and performance. This does not support continuity of care or the critical doctor-patient relationship that is the core of primary care. There is strong evidence in the literature that the best outcomes are found when people associate their usual source of care with an individual provider.[xiii] After much research, the diverse advocate/provider/DSS agency working group that developed the PCCM program endorsed an individual-to-individual attribution model of mutual responsibility.

And perhaps most importantly, will people and practices have input early into the attribution process? The quality of data in this program has been a significant challenge from the beginning, with no evidence of progress. Often practices have better information about who their patients are than the department or HMOs, whose care they are already managing. People are the best judges of who is providing effective care and care management. It makes sense to begin by engaging consumers and practices at the beginning of the process. It also makes sense to have a feedback loop confirming attribution with both providers and people to ensure accuracy. Your data-driven attribution model relies too heavily on questionable data, inviting expensive and aggravating problems that could sabotage the program before it begins.

Quality performance payments (P4P)

Your proposed "performance payments" are very similar to pay-for-performance (P4P) payments used by many other payers, including most Medicaid programs. P4P programs were designed to reward providers who deliver excellent care. Unfortunately they have not reached the initial promise, especially with physician practices. The literature suggests some improvement on the measures chosen for payment, but there is evidence of decline in other areas, and further evidence that over time, even the areas of improvement are not sustained.[xiv] Your proposal to set a ceiling on performance payments is especially likely to hit this limit on improvement. Connecticut's Medicaid program has little to no history of performance incentives; our history of even measuring quality of care is troubled. We are very concerned that the floor for payment, in this provider-driven policy development process, will become so easy to reach that virtually everyone will receive payment regardless of quality. Furthermore P4P plans are not popular with providers and are unlikely to encourage many to participate in Medicaid. And we raise again our objection to retrospective payments linked to expectations that providers will make prospective investments of scarce time and money. Innovative payers are moving beyond rudimentary P4P plans, as you have proposed, into better designed incentive arrangements that are more effective at promoting quality.[xv]

Glide Path

While we recognize the department's good intentions responding to providers' requests for fee increases and help with upfront costs of PCMH transformation, we are concerned about the specifics of your proposal.

Most other state Medicaid PCMH programs emphasize technical assistance over cash payments. One administrator commented that she would rather provide practices with the services they need ensuring that scarce resources are efficiently devoted to PCMH goals rather than cash payments which may be used in any way, with little accountability. The state, buying those services in bulk, can ensure quality and effectiveness in purchasing contracting services in ways that practices cannot. The state can also hold contractors accountable to ensure practices reach PCMH recognition more effectively than individual practices. We urge the department to follow the lead of successful Medicaid PCMH programs in other states and provide technical assistance to practices.[xvi] This model is also more fair to PCMH first-adopters that have already made the investment in transformation. This approach also removes any requirement that the department penalize practices that cannot reach PCMH recognition.

We understand that Connecticut's provider community is not as cohesive as other states and a contractor that works for one practice will not be accepted by another. We also recognize that practices are in different places in the journey to PCMH recognition and have different needs. In the SustiNet PCMH Advisory Committee, we proposed a list of state-approved consultants with varying PCMH support services, certified and funded by the state. This model of assistance is being used very effectively by eHealthConnecticut in their federally-funded role assisting providers implementing meaningful use of electronic medical records.

Outright cash payments carry the extra concern of accountability. Is the department prepared to recover funds paid to practices that do not meet goals? Does the department have the staff, or consulting funding, to create a realistic set of goals for each practice, evaluate progress and assist lagging practices? Does the department have the staff to ensure the effectiveness, appropriateness, absence of conflicting interests, or other problems in consultants chosen by practices across the state paid for with tax dollars? We are again concerned that glide path rate increases will not be salient to providers and associated with PCMH expectations, but seen as a well-deserved increase in rates.

Health homes integration and federal funds maximization

We are concerned about how the department's proposal will integrate with the extraordinary health home opportunity in the Affordable Care Act. The department's proposal for PCMHs is far from the model described in the Act and in Centers for Medicare and Medicaid Services (CMS) communication. It is critical that Connecticut be able to provide this exciting model of care coordination for Medicaid consumers and, equally importantly, access the 90% matching funds available in the Act. It is inconsistent to claim to CMS that your proposal is a simple payment rate increase for purposes of avoiding a waiver, but later to claim that the payments are actually for care management for purposes of securing the higher federal match rate. Whether Connecticut can get the 90% match under the department's proposal is an open question. The only states now using enhanced FFS for Medicaid PCMH are phasing out those payment systems and changing to a different payment arrangement for health homes.

Economic incentives

We have touched on concerns about doubtful economic incentives built into your proposal in other parts of this letter, but they bear more scrutiny. For the record, we do not believe that

providers are strongly influenced by economic incentives. Connecticut providers are, as a group, strongly ethical and strongly committed to providing the best available care to all patients regardless of insurance status. It is our experience that Medicaid providers are especially driven by a strong sense of ethics and are probably even less sensitive to economic incentives given that they participate in a less lucrative program. However, the design of your proposal should support those compassionate values.

Your proposal gives providers two economic incentives to err on the side of bringing patients into the office. First, to receive higher reimbursement rates and second, to ensure that healthier patients are attributed to their practice, earning the higher P4P payment. Your proposal seems to assume that primary care practices have extra capacity in their schedules, which is not the case. Busy primary care practices are turning away even private pay patients. Practices can easily fill their schedules with more compliant, healthier patients. Bringing patients into the office when unnecessary in order to get paid is counterproductive to people's health and costly to the program.

The department expects providers to use a fee increase to provide unfunded care management services. Without appropriate accountability, incentives may not be used as intended. Other states have only released funds when practices have demonstrated that they have hired care managers.[xvii] Connecticut is also pursuing a different path than other states and than other payers in our state. Providers are less likely to agree to special requirements to participate in Medicaid, which already has numerous barriers.

As stated above, burying incentives in rate increases paid retroactively is far less likely to be salient to providers than prospective payments, especially at the low levels you propose. And we renew concerns that the FFS payment system is contrary to aligning incentives to improve quality. Most payers are moving away from FSS systems.

Medical ASO model/role

We renew objections stated in our earlier letter to you concerning centralized care management. The most effective care management happens in local PCMHs in conversations between provider and patients as close to each person's community as possible. Realistic risk assessment, developing a realistic care plan with clearly defined roles for both patient and provider and patient self-management education does not happen between strangers. We are also very concerned that locating care management funding with the centralized ASO removes any economic incentives for that organization to assist in fostering a robust network of PCMHs across CT, as those resources would migrate to local practices as the network grows.

Standards for PCMHs

We are concerned that your proposal limits PCMH recognition to only the National Center for Quality Assurance's (NCQA) program. NCQA is currently the most widely adopted standard, however others are gaining in use and it is unclear which standards will become generally accepted. Different standard setting groups have natural and historic constituencies among providers. While your proposal leaves open the possibility of allowing additional standards in the future, it would be most inclusive to consider any nationally recognized standards now and evaluate differences. It is possible that unique features of other recognition programs may have

important benefits for providers and people; it would be a shame to lose that opportunity to learn and identify best practices.

Policy Development Process

We also feel compelled to comment on the process used by the department to develop this proposal since the initiative was first announced by the Lieutenant Governor and OPM Secretary Barnes on February 8th. The department has refused to accept consumer advocate input or to meet with advocates. Thankfully, the department has solicited a great deal of input from providers with at least two groups specifically dedicated to them. You have also held focus groups with consumers, however it is unlikely that consumers in the program raised issues about enhanced FFS payment systems, the lack of accountability in glide path payments, the proposal's differences from the rest of Connecticut's health care market or any of the other concerns raised here and elsewhere by advocates.

We were repeatedly directed to the PCCM Subcommittee of the Medicaid Care Management Oversight Council as our only opportunity for input. As an open meeting that committee has an important role in airing concerns. However, as an open meeting, it is dominated by people with financial interests in the program including providers, consultants hoping to get grants either from providers and/or the department, and others seeking employment. For example, my concerns raised about the lack of accountability in your glide path proposal received a hostile response from the majority at the meeting, most of whom would benefit from those payments and lack of oversight. We received your proposal, marked FINAL DRAFT, by email just two hours before the meeting described as our only opportunity for input.

A better model of respectful input from diverse groups of stakeholders given in a safe environment was offered by OPM in soliciting input on developing Connecticut's health insurance exchange. Your proposal would have benefitted from a more respectful process to collect input.

We strongly support creation of PCMHs in Connecticut, particularly for Medicaid consumers, and offer these comments as constructive input. We stand ready to work with the department to ensure that this project is a success.

Sincerely,

Ellen Andrews, PhD
Executive Director

cc: Commissioner Roderick Bremby
Medicaid Care Management Oversight Council

[i] DSS PCMH payment proposal, 8/17/11, p.1

[ii] Andrews E, Roccapriore B, and S Tartajana, Fixing Medicaid: Healing Connecticut's Largest Health Care Program, CT Health Policy Project, May 2011.

[iii] Pay for Value Policy Forum, June 18-19, Mayo Clinic, Value over Volume: Quality based health care purchasing for state policymakers, Council of State Governments/Eastern Regional Conference, February 2010, Executive Office of the President, Council of Economic Advisors, The Economic Case for Health Care Reform, June 2009, Ginsburg P and J Grossman, When the Price Isn't Right: How Inadvertent Payment Incentives Drive Medical Care, Health Affairs w5: 376-384 (2005)

[iv] Helmchen L and A LoSasso, How Sensitive is Physician Performance to Alternative Compensation Schedules? Evidence from a Large Network of Primary Care Clinics, Health Economics 19:1300-1317 (2010)

[v] Andrews E, Roccapriore B, and S Tartajana, Fixing Medicaid: Healing Connecticut's Largest Health Care Program, CT Health Policy Project, May 2011.

[vi] Zuckerman, et. Al., Trends in Medicaid Physician Fees, 2003-2008, Health Affairs 28:w510-519 (2009)

[vii] Most Physicians Serve Covered Children but Have Difficulty Referring them for Specialty Care, GAO 11-624 (2011)

[viii] Takach M, Reinventing Medicaid: State Innovations to Qualify and Pay For Patient-Centered Medical Homes Show Promising Results, Health Affairs 30: 1325-1334 (2011)

[ix] SustiNet PCMH Advisory Committee, Final Recommendations, July 2010, Spann S., et al, Task Force Report 6: Report on Financing the New Model of Family Medicine, Ann Fam Med 2: S1-21 (2004)

[x] DSS presentation to the PCCM Medicaid Care Management Oversight Council Subcommittee, slide 6

[xi] DSS PCMH payment proposal, 8/17/11, p.1

[xii] DSS PCMH payment proposal, 8/17/11, p. 4

[xiii] Starfield B and L Shui, The Medical Home, Access to Care, and Insurance: A Review of Evidence, Pediatrics 113:1493-1498 (2004)

[xiv] Campbell S et al, Effects of Pay for Performance on the Quality of Primary Care in England, NEJM 361:368-378 (2009)

[xv] Value over Volume: Quality based health care purchasing for state policymakers, Council of State Governments/Eastern Regional Conference, February 2010

[xvi] VT, CO, NC and PA, Bielaszka-DuVernay C, Vermont's Blueprint for Medical Homes, Community Health Teams, and Better Health at Lower Cost, Health Affairs 30:383-386 (2011), Takach M, Reinventing Medicaid: State Innovations to Qualify and Pay For Patient-Centered Medical Homes Show Promising Results, Health Affairs 30: 1325-1334 (2011)

[xvii] Takach M, Reinventing Medicaid: State Innovations to Qualify and Pay For Patient-Centered Medical Homes Show Promising Results, Health Affairs 30: 1325-1334 (2011)