Connecticut Health Policy Project

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May 25, 2012

Kate McEvoy, J.D.
Department of Social Services
Division of Medical Administration
25 Sigourney Street
Hartford, Connecticut, 06106

Dear Ms. McEvoy:

I am writing to convey the CT Health Policy Project's strong conceptual support for the Department of Social Services' proposed demonstration to integrate care for dual eligible Medicare/Medicaid enrollees. As a policy research organization advocating for consumers, we are very excited about the potential for this proposal to radically change the way Connecticut delivers care to our most fragile residents, moving from an antiquated fee-for-service non-system to one that measures and rewards quality, improves health outcomes, aligns incentives between payers, encourages teamwork and care coordination across provider groups, reduces incentives for dangerous and wasteful over-treatment, and maximizes resources to ensure sustainability. I am proud that our state is moving into the forefront of health care innovation and offer the Project's full commitment to ensure its success.

I am very pleased to have participated in development of this proposal as a member of the statutory Medicaid Assistance Program Oversight Council, its Complex Care Committee (and that committee's Executive Committee), and the Model Design Workgroup. DSS staff and consultants have devoted many hours over the better part of the last year engaging stakeholders in developing this proposal. We are grateful to DSS for hearing concerns raised by advocates and others, honoring the lessons of the HUSKY program, and deciding not to engage capitated managed care plans to administer this new program. Advocates are grateful to have worked with DSS to build a successful proposal. In that spirit of constructive comment, we support and echo many of the concerns raised in the advocates' comment letter. Specifically we agree with advocates that the proposal would be improved with the following modifications.

- Include performance incentives in shared savings rewards – we urge DSS to follow the unanimous compromise recommendation of all the relevant advisory committees to ensure that health neighborhoods that improve performance but, despite best efforts, are not successful in generating short term savings for their members are rewarded for their efforts[1]. It is critical to note that the recommendation was a compromise between stakeholders who supported

[1] Generating savings in health care systems is not an exact science. Even very sophisticated provider groups have struggled with generating savings, i.e. G Wilensky, Lessons from the Physician Group Practice Demonstration — A Sobering Reflection, NEJM 365;18, 11/3/2011 . Providers can be more confident of their ability to improve performance and quality. To attract applicants, it is wise to ensure some reward for improved performance.

rewards-based only on performance, as is the case in some other growing CT shared savings models, and the department's proposal.

- Enrolling participants based on affirmative consent, in an opt-in process
- Ensure that funds and services be shared across the neighborhood – there is concern that large institutions likely to apply as health neighborhood leads must share the rewards earned by the entire neighborhood with the rest of the neighborhood[2].
- Extend care plans to all program participants – this is a very fragile population of patients. Every one can benefit from a patient-centered care plan. To ensure that patients are an active participant in development of the plan, are aware of it, and have agreed to their part of it, it is critical to document their approval with a signature.
- Provide fairness between participants in the ASO and health neighborhoods with equivalent access to services
- Improve consumer protections
- Fund drug co-pays for all participants

In addition to issues raised by the advocates' letter, the Project wishes to raise and expand on other concerns.

- Conflict of interest protections -- we urge DSS to exclude neighborhood health lead organizations that also provide direct services to patients. It is not wise to create incentives to steer patients to the health lead's own providers over the rest of the neighborhood. Such a conflict could complicate sharing resources across the neighborhood. If it is impossible to attract truly independent health lead applicants with strong conflict of interest provisions, it is incumbent on the department to closely monitor utilization and referral patterns.
- Robust evaluation and monitoring – This proposal charts new territory both for CT and the nation. As an innovative pilot, it is likely that modifications will be necessary as the pilot develops. It is critical that the department have a strong, multi-method evaluation plan, make the results public, acknowledge areas that need improvement, and have the will to make changes in response.

In addition, we offer recommendations on the very recent addition of a behavioral health co-lead to the proposal. The Project appreciates and endorses recognition of the unique needs of the 38% of potential program participants who suffer from serious mental illness. We regularly hear from callers to our helpline struggling to access mental health care and strongly support integration of behavioral and physical health care in the neighborhoods and the teams of care. This integration is critical to mitigating stigma, treating patients as whole people, ensuring adequate resources for all care, and improving efficiency across the system through reduced fragmentation and duplication.

[2] There is precedent for this concern. HUSKY HMOs were criticized for not sharing resources with critical safety net providers who provided the care. The law of unintended consequences is strong. The integrity of the safety net, critical to this population as well as others, cannot be compromised by this proposal. We are very concerned that some providers, if they are disadvantaged by this pilot, will not complain but just join the many other providers who have dropped out of the Medicaid program.

We share concerns raised in the advocates' letter about the process and timing of the addition of behavioral health co-leads in the proposal. Unfortunately this provision has not benefitted from the lengthy process that successfully resolved other outstanding issues through the committee process. The addition of behavioral health co-leads has raised many concerns that, with time, could be addressed collaboratively.

- Preserving competition – It is very possible that the late addition of such a substantial requirement will reduce the number of willing applicants to lead health neighborhoods.
- Level playing field – In many areas of the state there is only one potential co-lead organization, for either physical or behavioral health. In that case, the single organization will essentially be able to choose the other co-lead, possibly among a number of potential applicants.
- Making the best choices for consumers – Interested physical and behavioral health organizations may create partnerships based on corporate or financial considerations rather than what is best for consumers. Requiring applicants to partner themselves could result in compromising the best physical health co-lead to get the best behavioral health co-lead or vice versa. Independent procurements would solve this problem.
- Questions about the role of state-run behavioral health co-leads – Allowing state-run behavioral health organizations to participate in these competitive applications raises concerns about shared savings and biases in choosing among applicants. However, excluding them raises concerns in some parts of the state where no potential private applicants may exist or be willing to apply.
- Operational and financial concerns – How will savings and resources be apportioned between the co-leads; this proposal amplifies concerns about resource sharing across the entire neighborhood. There is a concern that co-leads could give conflicting guidance, providers in the neighborhood may be confused about which co-lead is responsible for each administrative function, patients will not know who to contact for each issue, and a host of other potential confusions. It is important to guard against wasteful duplication of functions.
- Opens the door to other co-leads – There have already been suggestions of co-leads from other service areas.
- Creating co-leads undermines the unifying concept of neighborhoods and team-based care – This proposal, while intended to do the opposite, could lead to more fragmentation and silos in Connecticut's health care landscape.

While we support the intention, we urge DSS to consider two modifications.

- Create, monitor and enforce standards of care for access to behavioral health services – Access to behavioral health services should be guaranteed without delay when needed. Standards should include how care will be made available and accessible to enrollees. Appropriate financing must follow. There are precedents for these standards in the HUSKY managed care contracts; those provisions were very effective in protecting patients needing critical services.
- Delay implementation of behavioral health co-leads – This would allow the concept to be fully vetted, questions answered, outcomes modeled, and consensus achieved. A later, separate, and independent procurement for behavioral health co-leads could also address some anti-

competitive concerns. There is no reason the rest of the proposal, as originally conceived, could not move ahead while this study is taking place. Delay will ensure that the recent addition does not jeopardize the proposal's momentum, and improves the chances that physical and behavioral health integration will ultimately be successful.

The CT Health Policy Project is very excited about this promising proposal and hopeful that the department will make these modifications to strengthen the application to CMS. Please contact me if you have any questions. Thank you for your energy, commitment and expertise on behalf of this proposal and all consumers in the department's care.

Sincerely,

Ellen Andrews, PhD
Executive Director