Office of the Healthcare Advocate

State Innovation Model – Project Management Office

Response to advocates' questions of January 24, 2014, on the Connecticut Healthcare Innovation Plan (12/30/13 submission).

- The SIM plan is silent on downside risk in Medicaid and statements about how and when upside-only risk will be implemented are confusing. Please clarify your plans for Medicaid – specifically:
    - Is there a commitment not to implement **any** risk-based payment models in Medicaid until meaningful underservice metrics and monitoring are agreed to in a transparent, inclusive consensus process?
    - Is there a commitment not to implement downside risk in Medicaid, at least during the five year period of the proposed grant?

Response: Page 15 of the Connecticut Healthcare Innovation Plan notes that "Medicaid will establish an upside only shared savings program, although the timing has not been determined." On page 102, the Innovation Plan further indicates "Medicaid will align with other payers to the extent of implementing an upside only shared savings program for the general population. The Department will, based on the early experience of other payers with this approach, assess the need for protections for Medicaid beneficiaries and on this basis will determine when during the test grant period to implement an upside only shared savings program. Specific questions regarding Medicaid participation should be directed to DSS. DSS has indicated that the design of the SSP for general Medicaid will be considered in consultation with the Complex Care Committee.

- We are grateful that on p. 96 the plan is clear that you do not propose eliminating fee-for-service provider payments, which will remain the foundation for payment reform. To clarify -- is this a commitment not to propose provider capitation models (which is inherently inconsistent with fee for service)?

Response: We are proposing to retain a fee-for-service foundation for the duration of the five year plan.

- We are grateful that the final plan includes a commitment to deny value-based payments to providers who have demonstrated systemic under-service. However the advocates strongly urged that the system of monitoring for under-service be in place BEFORE value-based service models are implemented for **all** payers, to ensure people are protected from incentives to withhold needed care. Can you describe your timeline and process to develop the monitoring and enforcement system?

Response: The Equity and Access Council will be responsible for making recommendations in this area. We are proposing to establish the Equity and Access Council by April of this year. We will encourage all workgroups including the Equity and Access Council to make their recommendations by October of this year. Value-based payment models are already underway for many payers and providers. The SIM initiative seeks to guide the continued development of these models in Connecticut.

- Given recently described concerns about the impact of CT ACOs on critical community providers, will you include the impact on safety net and essential community providers in your evaluation of the program? Will you consider contracting requirements and/or benchmarking for AMHs to protect consumer access and choice of providers similar to HUSKY HMO and insurance exchange QHP requirements?

Response: We have not yet determined the scope of the evaluation. The proposed evaluation scope and methods will be presented to the Steering Committee for review. We will also offer the Consumer Advisory Board the opportunity to provide input into the plan for evaluation.

- Are your plans to create Prevention Service Centers meant to supplant current funding sources or to represent new funding and preserve the current level and diversity of options for consumers to choose among for those services?
    - This raises significant concerns of shifting decision-making about support for community-based public health services from public health authorities to medical practices that are guided by different models of care. The success of many public health programs is precisely because they approach issues from an alternative perspective to the medical model. CT's health landscape is richer for having both perspectives. If the shift you have outlined in the SIM plan is meant to solve the problem of linkage between CT's public health and medical care sectors, there are less disruptive ways to do that.
    - If this is meant to replace or shift the landscape of existing programs and consumer choice -- leaving the choice of which programs survive up to medical practices and ACOs could be problematic. We are concerned about financial and/or corporate ties defining choices available to consumers.
    - If this is meant as new funding, will there be mechanisms to share information (2-way communication) between those non-contracted programs and AMHs for consumers who choose a preventive care program that is not contracted with their ACO or AMH?

Response: These issues will be among those considered by the Practice Transformation Taskforce and the Steering Committee during the detailed design phase.

- Your community health section states an intention to engage and empower communities in priority setting but sets specific priorities for the entire state – tobacco use, obesity, and diabetes. While many CT communities have identified these in local, community-driven initiatives, some have focused on other issues. Will there be an opportunity for communities to modify and/or change the SIM-determined priorities?

Response: The priorities that are specifically called out in this section have been identified by the CMMI and CDC as areas that should be addressed by all states. We will consider options for flexibility when we begin planning for the Health Enhancement Community pilots.

- Please give us more detail on AMH standard setting? Is there a commitment to ensure that it will be at least as rigorous as the well-established and widely-accepted NCQA standard for PCMHs, which (with the glide path option) has been successfully deployed in the Medicaid program? The plan notes some potential extra requirements but nothing references **easing** some requirements that providers have complained about. What are those standards you intend to drop? Who will decide on AMH standards and will providers possibly subject to those standards recuse themselves from voting?

Response: The Practice Transformation Taskforce will be responsible for making specific recommendations with respect to AMH standards. We expect that these issues will be addressed during the detailed design phase.